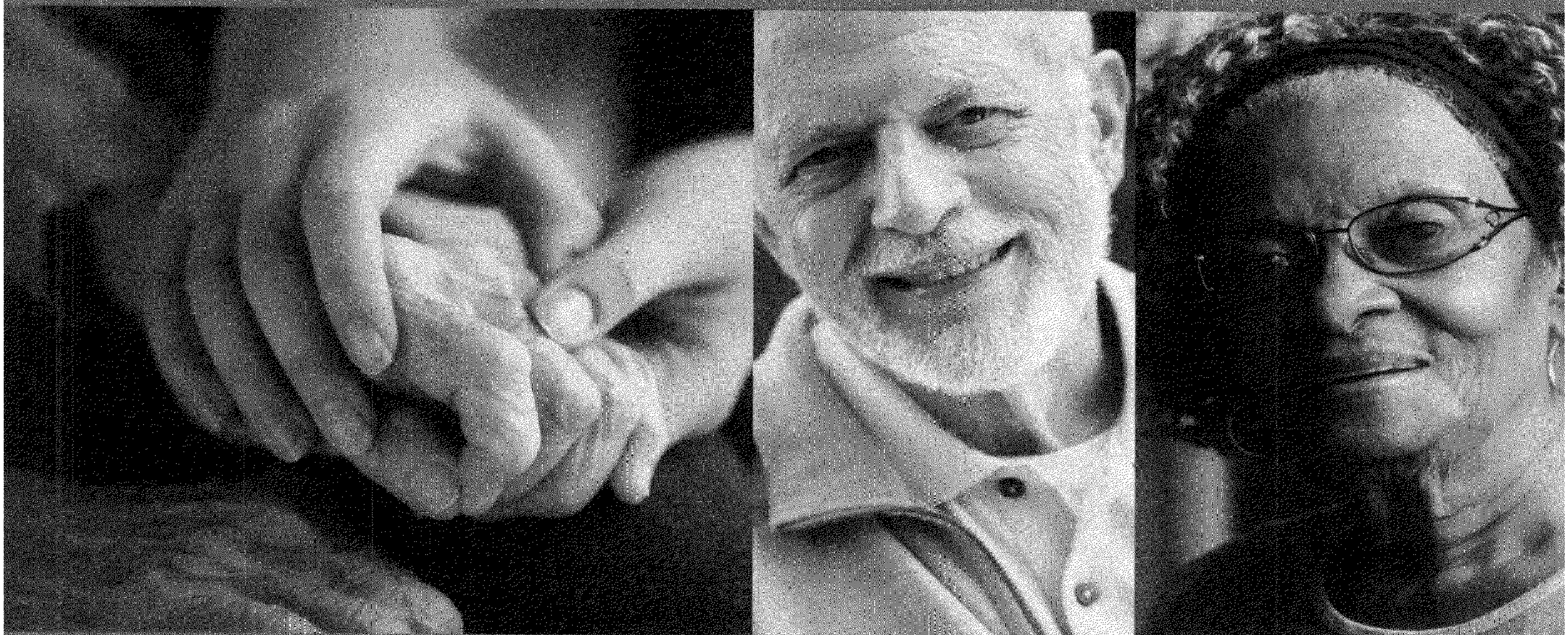
Response to **ALTCS E/PD**

RFP YH12-0001

Binder 1



Yuma La Paz **Apache** Coconino **Mohave**
Navajo **Pima** Santa Cruz **Maricopa**

IASIS HEALTHCARE®

Health CHOICE

Response to **ALTCS E/PD**

RFP YH12-0001

Binder 1

Health CHOICE

OFFEROR'S CHECKLIST

A. GENERAL MATTERS

Subject:	*Reference*	*Offeror's Page #*
Offeror's Signature Page	Front Page	2
Solicitation Amendment 1 Signature Page	Front Page	4
Solicitation Amendment 2 Signature Page	Front Page	5
Offeror's Checklist	N/A	6
Completion of all items in Section G of the RFP	Section G	8

Indicate the GSA for which the Offeror is submitting a bid.

GSA	*Bidding*
42 - Yuma, La Paz	✓
44 - Apache, Coconino, Mohave, Navajo	✓
50 - Pima, Santa Cruz	✓
52 - Maricopa	✓

B. CAPITATION

Subject:	*Requirement #*	*Offeror's Page #*
Capitation Rate Bid (via EFT/SFTP and hard copy)	1	15

C. ORGANIZATION

Subject:	*Requirement #*	*Offeror's Page #*
Moral and Religious Objection	2	24
Organization and Staffing	3	25
	4	64
	5	65
Sanctions	6	76
Claims	7	77
	8	86
	9	87
Encounters	10	90
Information Systems	11	95
	12	115
	13	117
	14	118
Grievance Systems	15	120
Corporate Compliance	16	127
Finance and Liability Management	17	131
	18	361

	19	364

D. PROGRAM

Subject:	***Requirement #***	***Offeror's Page #***
Case Management	20	368
	21	370
	22	372
	23	375
	24-A	377
	24-B	380
	24-C	382
	24-D	384
Medical Management	25	386
	26	392
	27	394
	28	395
Quality Management	29	397
	30	400
	31-A	402
	31-B	404
	32	406
	33	408
	34	410
Oral Presentation	35	The Offeror shall submit the names and resumes of the participating individuals via the EFT/SFTP server by 3 p.m. on April 8.

E. PROVIDER NETWORK

Subject:	***Requirement #***	***Offeror's Page #***
Provider Network	36	414
	37	460
	38	461
	39	463
	40	466
	41	469
	42	471
	43	472
	44	474
Network Summary via EFT/SFTP	45	N/A

F. OTHER

Subject:	***Requirement #***	***Offeror's Page #***

A. General Matters

A. GENERAL MATTERS

Offeror's Signature Page

	Notice of Request for Proposal		AHCCCS Arizona Health Care Cost Containment System
AHCCCS	SOLICITATION NO.: **YH12-0001**	PAGE 1	701 East Jefferson, MD 5700
		OF 160	Phoenix, Arizona 85034

Solicitation Contact Person:

Jamey Schultz
Contracts and Purchasing Section
701 E. Jefferson, MD5700
Phoenix, Arizona 85034

Telephone: (602) 417-4629
Telefax: (602) 417-5957
E-Mail: Jamey.Schultz@azahcccs.gov
Issue Date: January 31, 2011

LOCATION: **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)**
Contracts and Purchasing Section (First Floor)
701 E. Jefferson, MD5700
Phoenix, Arizona 85034

DESCRIPTION: **ARIZONA LONG TERM CARE SYSTEM (ALTCS) ELDERLY & PHYSICALLY DISABLED (E/PD) CONTRACT FOR CONTRACTORS**

PROPOSAL DUE DATE: **April 1, 2011** **AT 3:00 P.M. MST**

Pre-Proposal Conference:

A Pre-Proposal Offeror's Conference has been scheduled for **Wednesday, February 9, 2011 from 8:30 AM to 4:30 PM, MST**. The Conference will be held in the following location:

Gold Room, Third Floor
701 E. Jefferson Street
Phoenix, Arizona

QUESTIONS CONCERNING THIS SOLICITATION SHALL BE SUBMITTED TO THE SOLICITATION CONTACT PERSON NAMED ABOVE, IN WRITING VIA E-MAIL BY MARCH 4, 2011, AT THE LATEST. SEE SECTION I, PARAGRAPH 11, FOR TIMELINES REGARDING SUBMISSION AND RESPONSE TO QUESTIONS.

In accordance with A.R.S. § 41-2501 (G.), which is incorporated herein by reference, competitive sealed proposals will be received at the above specified location, until the time and date cited. Proposals received by the correct time and date will be opened and the name of each Offeror will be publicly read.

Proposals must be in the actual possession of AHCCCS on or prior to the time and date and at the location indicated above. **Late proposals shall not be considered.**

Proposals must be submitted in a sealed envelope or package with the Solicitation Number and the Offeror's name and address clearly indicated on the envelope or package. All proposals must be typewritten. Additional instructions for preparing a proposal are included in this solicitation document.

Persons with a disability may request a reasonable accommodation, such as a sign language interpreter, by contacting the appropriate Procurement Agency. Requests should be made as early as possible to allow time to arrange the accommodation. A person requiring special accommodations may contact the solicitation contact person responsible for this procurement as identified above.

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION.

OFFER

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, amendments, and best-and-final offers (if any). Signature also acknowledges receipt of all pages indicated in the Table of Contents.

Arizona Transaction (Sales) Privilege Tax License No.: N/A

For clarification of this offer, contact:

Name: Carolyn Rose

Federal Employer Identification No.: 139763092

Phone: 480-968-6866

E-Mail Address: CRose@iasishealthcare.com

Fax: 480-784-2933

Health Choice Arizona
Company Name

Carolyn Rose
Signature of Person Authorized to Sign Offer

410 N. 44th Street Suite 900
Address

Carolyn Rose
Printed Name

Phoenix	AZ	85008
City	State	Zip

CEO
Title

CERTIFICATION

By signature in the Offer section above, the bidder certifies:

The submission of the offer did not involve collusion or other anti-competitive practices.
The bidder shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 99-4 or A.R.S. §§ 41-1461 through 1465.
The bidder has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with the submitted offer. Failure to provide a valid signature affirming the stipulations required by this clause shall result in rejection of the offer. Signing the offer with a false statement shall void the offer, any resulting contract and may be subject to legal remedies provided by law.

The bidder certifies that the above referenced organization ___is/___is not a small business with less than 100 employees or has gross revenues of $4 million or less.

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

Your offer, including all exhibits, amendments and best-and-final offer (if any), contained herein, is accepted.

The Contractor is now bound to provide all services listed by the attached contract and based upon the solicitation, including all terms, conditions, specifications, amendments, etc., and the Contractor's Offer as accepted by AHCCCS.

This contract shall henceforth be referred to as Contract No. YH12-0001-________.

Awarded this ________ **day of** ________________ **2011**

____
Michael Veit, as AHCCCS Contracting Officer and not personally

Solicitation Amendment
1
Signature Page

AHCCCS	**SOLICITATION AMENDMENT** Solicitation Number: RFP YH12-0001 Amendment Number 1 (One) Solicitation Due Date: April 1, 2011 3:00 PM (MST)	Arizona Health Care Cost Containment System (AHCCCS) 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Contract Management Specialist: Jamey Schultz, CMS E-mail: Jamey.Schultz@azahcccs.gov

A signed copy of this amendment shall be included with the proposal, which must be received by AHCCCSA no later than the Solicitation due date and time. This solicitation is amended as follows:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 24th day of February, 2011, in Phoenix, Arizona.
Carolyn Rose	4/01/11	
Signature	Date	Michael Veit
Carolyn Rose, CEO		
Typed Name and Title		Michael Veit
Health Choice Arizona		Contracts and Purchasing Administrator
Name of Company		

Solicitation Amendment 2 Signature Page

AHCCCS	**SOLICITATION AMENDMENT** Solicitation Number: RFP YH12-0001 Amendment Number 2 (Two) Solicitation Due Date: April 1, 2011 3:00 PM (MST)	Arizona Health Care Cost Containment System (AHCCCS) 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Contract Management Specialist: Jamey Schultz, CMS E-mail: Jamey.Schultz@azahcccs.gov

A signed copy of this amendment shall be included with the proposal, which must be received by AHCCCSA no later than the Solicitation due date and time. This solicitation is amended as follows:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 11th day of March, 2011, in Phoenix, Arizona.
Carolyn Rose	4/01/11	
Signature	Date	Michael Veit
Carolyn Rose, CEO		
Typed Name and Title		Michael Veit
Health Choice Arizona		Contracts and Purchasing Administrator
Name of Company		

Offeror's Checklist

Completion of all items in Section G of RFP

REPRESENTATION AND CERTIFICATIONS OF OFFEROR

The Offeror must complete all information requested below.

1. CERTIFICATION OF ACCURACY OF INFORMATION PROVIDED

By signing this offer the Offeror certifies, under penalty of law, that the information provided herein is true, correct and complete to the best of Offeror's knowledge and belief. Offeror also acknowledges that should investigation at any time disclose any misrepresentation or falsification, any subsequent contract may be terminated by AHCCCS without penalty to or further obligation by AHCCCS.

2. CERTIFICATION OF NON-COERCION

By signing this offer the Offeror certifies, under penalty of law, that it has not made to any provider any requests or inducements not to contract with another potential Contractor in relation to this solicitation.

3. CERTIFICATION OF COMPLIANCE - ANTI-KICKBACK / LABORATORY TESTING

By signing this offer, the Offeror certifies that it has not engaged and will not engage in any violation of the Medicare Anti-Kickback or the "Stark I" and "Stark II" laws governing related-entity and compensation there- from. If the Offeror provides laboratory testing, it certifies that it has complied with and has sent to AHCCCS simultaneous copies of the information required to be sent to the Centers for Medicare and Medicaid Services. (See 42 USC §1320a-7b, PL 101-239, PL 101-432, and 42 CFR §411.361.)

4. AUTHORIZED SIGNATORY

Authorized Signatory for Health Choice Arizona
[OFFEROR'S Name]

Carolyn Rose	Chief Executive Officer
[INDIVIDUAL'S Name]	[Title]

is the person authorized to sign this contract on behalf of Offeror.

5. OFFEROR'S MAILING ADDRESS

AHCCCS should address all notices relative to this offer to the attention of:

Carolyn Rose		Chief Executive Officer
Name		Title
410 N. 44th Street, Suite 900		480-968-6866
Address		Telephone Number
Phoenix	AZ	85008
City	State	ZIP

6. OFFEROR GENERAL INFORMATION

a. If other than a government agency, when was your organization formed? 1990

b. License/Certification: Attach a list of all licenses and certification (e.g. federal HMO status or State certifications) your organization maintains. Use a separate sheet of paper listing the license requirements and the renewal dates.

Have any licenses been denied, revoked or suspended within the past 10 years? Yes ☐ No ☒
If yes, please explain.

c. Civil Rights Compliance Data: Has any federal or state agency ever made a finding of noncompliance with any civil rights requirements with respect to your program? Yes _☐_ No _☒_ If yes, please explain.

d. Accessibility Assurance: Does your organization provide assurance that no qualified person with a disability will be denied benefits of or excluded from participation in a program or activity because the Offeror's facilities (including subcontractors) are inaccessible to or unusable by persons with disabilities? (Note: Check local zoning ordinances for accessibility requirements). Yes_☒_ No _☐_ If yes, describe how such assurance is provided or how your organization is taking affirmative steps to provide assurance.

Health Choice Arizona works with facility management to assure we comply with the requirements of the Americans with Disabilities Act. Additionally, we provide all reasonable accommodations.

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

N/A

f. Federal Government Suspension/Exclusion: Has Offeror been suspended or excluded from any federal government programs for any reason? Yes_☐_ No _☒_ If yes, please explain.

g. Provide the name(s) of the in-house or independent actuary, or actuarial firm used to assist in developing capitation rates and / or reviewing published capitation rate information.

Kevin Lurito, Principal Services provided by Mercer Health & Benefits LLC

Name

Address	City	State
2325 East Camelback Road, Suite 600	Phoenix	AZ

h. Did any other firm or organization provide the Offeror with any assistance in making this offer (to include developing capitation rates or providing any other technical assistance and/or reviewing published capitation rates)? Yes_☒_ No ☐ If yes, what is the name of this firm or organization?

Mark Heit, Principal Services provided by Sellers Dorsey

Name

Address	City	State
230 South Broad Street Suite 1802	Philadelphia	PA

i. Has the Offeror contracted or arranged for Management Information Systems, software or hardware, for the term of the contract? Yes_☒_ No _☐_ If yes, is the Management Information System being obtained from a vendor? Yes _☒_ No _☐_ If yes, please provide the vendor's name, the vendor's background with AHCCCS, the vendor's background with other HMOs or managed care entities, and the vendor's background with other Medicaid programs.

Jay Dunlap Services provided by Landacorp a division of SHPS; 2080 East 20th Street, Suite 170 Chico CA Landacorp has over 30 years of experience building and maintaining health care software with health care systems and health plans. These plans utilize the tools provided in Landacorp's software platforms to enable collaboration for their members, the providers who serve them and their health plan medical management staff. Landacorp is proud of their heritage in care management and remain committed to the growth and evolution of care management technology and services to meet the needs of the Medicaid and Long Term Care Populations.

In addition to Health Choice Arizona, Landacorp products (Care Radius, Care Affiliate, CareWise, Care Find) are leveraged by many clients across the country including the State of Kentucky who utilizes their platform to support Medicaid and Long Term Care medical management initiatives. Landacorp's Care Radius and legacy medical management software platforms provide the infrastructure for health plans and systems that cover over 44 million lives, many of which are Medicaid and Long Term Care populations.

CareRadius is delivered with a unique, extensible configuration feature, the 'Client Subsystem', which allows clients to segment their member population by their lines of business, plan types and contracts. Reporting by government programs such as Medicare, Medicaid and FEHBP is accomplished by using this Feature.

Below are some additional statistics on the clients Landacorp serves:

Thirteen of our clients are health plans serving a combined total of 44 million + lives today.

Total of 212 years of customer usage.

Average of 6.8 years of usage per customer.

92% year over year customer usage

7. FINANCIAL DISCLOSURE STATEMENT

The Offeror must provide the following information as required by 42 CFR 455.103. This Financial Disclosure Statement shall be prepared as of December 31, 2010. However, continuing Offerors who have filed the required Financial Disclosure Statement to AHCCCS within the last 12 months need not complete this section if no significant changes have occurred since the last filing.

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

Name	Address	Percent of Ownership or Control
IASIS Healthcare Corp.	117 Seaboard Lane, Building E Franklin, TN 37067	100.00%

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

Name	Address	Percent of Ownership or Control
N/A		

Names of above persons who are related to one another as spouse, parent, child or sibling:

N/A

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

IASIS Healthcare Corporation

Health Choice Generations

Mountain Vista Medical Center

St. Luke's Behavioral Hospital
St. Luke's Medical Center
Tempe St. Luke's Hospital
Physician Group of Arizona

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

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction
N/A		

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

Name	Address	Title
N/A		

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

Name	Address	Description of Debt	Amount of Security
N/A			

g. Outstanding Legal Actions:

1. Are there any lawsuits, judgments, tax deficiencies or claims pending against your organization?

Yes _☐_ No _☒_ If yes, provide details including the dollar amount.

2. Has your organization ever gone through bankruptcy? Yes _☐_ No _☒_ If yes, provide the year.

8. RELATED PARTY TRANSACTIONS

a. Board of Directors: List the names and addresses of the Board of Directors of the Offeror.

Name/Title	Address
N/A	

b. Related Party Transactions: Describe transactions between the Offeror and any related party in which a transaction or series of transactions during any one fiscal year exceeds 2% of the total operating expenses of the disclosing entity. List property, goods, services and facilities in detail noting the dollar amounts or other consideration for each transaction and the date thereof. Include a justification as to (1) the reasonableness of the transaction, (2) its potential adverse impact on the fiscal soundness of the disclosing entity, and (3) that the transaction is without conflict of interest:

i) Describe all transactions between Offeror and any related party which includes the lending of money, extensions of credit or any investment in a related party. This type of transaction requires review and approval in advance by the Office of the Director:

Description of Transaction	Name of Related Party and Relationship	Dollar Amount for Reporting Period
Payment for medical services	Mountain Vista Medical Center	$4,494,831
Payment for medical services	Tempe St. Luke's Hospital	$1,975,767
Payment for medical services	St. Luke's Medical Center	$2,926,255
Corporate Fees/Information Services	IASIS Healthcare Corporation	$5,691,654
Administrative Expense Charged to HCG	Health Choice Generations	$5,861,462

Justification:

Health Choice Arizona (HCA) is owned by IASIS HealthCare Corporation, which also owns the hospitals listed above. HCA contracts with these facilities to provide medical services to its members. The transactions are reasonable because the hospitals are reimbursed at or below 100% of AHCCCS fee-for-service rates, as are other contracted hospitals in the HCA network. There is no adverse impact on the fiscal soundness of HCA, as the services would be performed at other facilities were it not for the IASIS facilities. The transactions are without conflict of interest because the hospitals are being paid for performing necessary services at reimbursement rates that are consistent with rates that non-IASIS hospitals are being paid.

Payment to IASIS Healthcare Corporation is for information systems services and infrastructure, corporate management fees, insurance, tax and legal departments, and other administrative support. The transactions are reasonable because HCA is reimbursing IASIS for mission-critical support services and resources that are absolutely necessary for HCA to be operational. There is very little potential impact on the fiscal soundness of HCA, because the intercompany charges make up a very small percentage of HCA's operating expense. The transactions are without conflict of interest because IASIS is being reimbursed at a very reasonable rate for performing mission critical services for HCA. This is one of the reasons that HCA consistently maintains a very low administrative cost ratio.

Transactions between HCA and Health Choice Generations (HCG) are for the purpose of appropriately sharing administrative costs between the two health plans. Expenses are charged to HCG in two ways, 1) allocation of shared expenses, and 2) direct charges for expenses paid by HCA on behalf of HCG. The transactions are reasonable because they are either direct charges for specific

HCG costs that were simply paid from the HCA accounts payable bank account, or they are allocations for mission-critical services that HCG requires to be in business. The impact on the fiscal soundness of the offeror is a positive one, as the sharing of administrative expense makes HCA more cost effective, and any costs unrelated to HCA are charged to HCG directly, and entirely. The transactions are without conflict of interest because HCG is being charged directly for its own expenses, and shared expenses are being allocated based on a reasonable method. The allocation is based on the revenue earned by each entity as a percentage of the combined total. Using revenue (as opposed to member months, for example) as a basis for allocation ensures that more expense is allocated to HCG per member, as HCG members are more labor and cost intensive. The dollar amount listed for HCG above represents charges from HCA to HCG.

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

Name	Address	Owner Or Controller	Has Controlling Interest? Yes / No
N/A			

9. OFFEROR'S OFFSHORE PERFORMANCE OF WORK PROHIBITED

Due to security and identity protection concerns, direct services under this contract shall be performed within the borders of the United States. Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modification of software for the State shall be performed within the borders of the United States. Unless specifically stated otherwise in the specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers. **Offerors shall declare all anticipated offshore services in the proposal.**

N/A

END OF SECTION

B. Capitation

B. CAPITATION

Capitation Rate Bid (via EFT/SFTP and hard copy)

Requirement #1

AHCCCS Capitation Calculation For Rates for CYE12
EPD RFP Bid Submission [1]

Service Category	Health Choice Arizona / GSA 42		
	Gross	MIX	Net
Nursing Facility	$ 4,947.07	41.20%	$ 2,038.19
Share of Cost			$ (290.22)
Net Nursing Facility			**$ 1,747.97**
HCBS Home and Community	$ 1,128.51	58.80%	$ 663.57
Net HCBS			**$ 663.57**
Acute Care Prior to Reinsurance			$ 495.17
Reinsurance Offset			$ (186.69)
Net Acute Care			**$ 308.48**
Medical Component [2]			**$ 2,720.02**
Case Management [3]			$ 123.05
Administration [4]		4.00%	$ 121.19
Sub-Total of Scored Components			**$ 2,964.26**
Risk/Contingency at 1%			$ 31.51
Net Capitation			**$ 2,995.77**
Premium Tax (98% of Final Cap)			$ 61.14
Net Cap w/ Premium Tax			**$ 3,056.91**

Key

user input

user input using AHCCCS provided numbers

formula

Notes

1) Numbers reflect the bid submitted by Health Choice Arizona and are on a Per Member Per Month (PMPM) basis.
2) Scored component, must be within the range provided by AHCCCS or will not be accepted.
3) Scored component (no max, no range supplied).
4) Scored component. Bidder must enter admin as a %. Admin dollars will be a calculation. Max admin accepted for bid is 8%. If bidders bid admin % above the max will not be accepted. Admin % is calculated as: Admin / (Net NF + Net HCBS + Acute Care Prior to RI + Case Management)
5) The above template must be provided for each GSA bid.
6) With bid submission bidder must submit an actuarial certification signed by a qualified actuary.
7) Bidder must use AHCCCS provided numbers for SOC, HCBS Mix % and Reinsurance Offsets when submitting their bid.

AHCCCS Capitation Calculation For Rates for CYE12 EPD RFP Bid Submission [1]

Service Category	Health Choice Arizona / GSA 44		
	Gross	MIX	Net
Nursing Facility	$ 4,983.01	32.13%	$ 1,601.04
Share of Cost			$ (304.75)
Net Nursing Facility			**$ 1,296.29**
HCBS Home and Community	$ 1,053.58	67.87%	$ 715.06
Net HCBS			**$ 715.06**
Acute Care Prior to Reinsurance			$ 493.25
Reinsurance Offset			$ (106.81)
Net Acute Care			**$ 386.44**
Medical Component [2]			**$ 2,397.79**
Case Management [3]			$ 137.04
Administration [4]		4.00%	$ 105.67
Sub-Total of Scored Components			**$ 2,640.50**
Risk/Contingency at 1%			$ 27.47
Net Capitation			**$ 2,667.97**
Premium Tax (98% of Final Cap)			$ 54.45
Net Cap w/ Premium Tax			**$ 2,722.42**

Key

user input
user input using AHCCCS provided numbers
formula

Notes

1) Numbers reflect the bid submitted by Health Choice Arizona and are on a Per Member Per Month (PMPM) basis.
2) Scored component, must be within the range provided by AHCCCS or will not be accepted.
3) Scored component (no max, no range supplied).
4) Scored component. Bidder must enter admin as a %. Admin dollars will be a calculation. Max admin accepted for bid is 8%. If bidders bid admin % above the max will not be accepted. Admin % is calculated as: Admin / (Net NF + Net HCBS + Acute Care Prior to RI + Case Management)
5) The above template must be provided for each GSA bid.
6) With bid submission bidder must submit an actuarial certification signed by a qualified actuary.
7) Bidder must use AHCCCS provided numbers for SOC, HCBS Mix % and Reinsurance Offsets when submitting their bid.

AHCCCS Capitation Calculation For Rates for CYE12 EPD RFP Bid Submission [1]			
Service Category	**Health Choice Arizona / GSA 50**		
	Gross	MIX	Net
Nursing Facility	$ 5,417.67	33.24%	$ 1,800.83
Share of Cost			$ (265.64)
Net Nursing Facility			**$ 1,535.19**
HCBS Home and Community	$ 1,664.21	66.76%	$ 1,111.03
Net HCBS			**$ 1,111.03**
Acute Care Prior to Reinsurance			$ 534.53
Reinsurance Offset			$ (195.45)
Net Acute Care			**$ 339.08**
Medical Component [2]			**$ 2,985.30**
Case Management [3]			$ 123.37
Administration [4]		3.00%	$ 99.12
Sub-Total of Scored Components			**$ 3,207.79**
Risk/Contingency at 1%			$ 34.03
Net Capitation			**$ 3,241.82**
Premium Tax (98% of Final Cap)			$ 66.16
Net Cap w/ Premium Tax			**$ 3,307.98**

Key

user input

user input using AHCCCS provided numbers

formula

Notes

1) Numbers reflect the bid submitted by Health Choice Arizona and are on a Per Member Per Month (PMPM) basis.
2) Scored component, must be within the range provided by AHCCCS or will not be accepted.
3) Scored component (no max, no range supplied).
4) Scored component. Bidder must enter admin as a %. Admin dollars will be a calculation. Max admin accepted for bid is 8%. If bidders bid admin % above the max will not be accepted. Admin % is calculated as: Admin / (Net NF + Net HCBS + Acute Care Prior to RI + Case Management)
5) The above template must be provided for each GSA bid.
6) With bid submission bidder must submit an actuarial certification signed by a qualified actuary.
7) Bidder must use AHCCCS provided numbers for SOC, HCBS Mix % and Reinsurance Offsets when submitting their bid.

AHCCCS Capitation Calculation For Rates for CYE12 EPD RFP Bid Submission [1]			
Service Category	**Health Choice Arizona / GSA 52**		
	Gross	MIX	Net
Nursing Facility	$ 5,529.50	25.82%	$ 1,427.72
Share of Cost			$ (223.08)
Net Nursing Facility			**$ 1,204.64**
HCBS Home and Community	$ 1,536.81	74.18%	$ 1,140.00
Net HCBS			**$ 1,140.00**
Acute Care Prior to Reinsurance			$ 645.41
Reinsurance Offset			$ (229.85)
Net Acute Care			**$ 415.56**
Medical Component [2]			**$ 2,760.20**
Case Management [3]			$ 131.07
Administration [4]		4.00%	$ 124.84
Sub-Total of Scored Components			**$ 3,016.11**
Risk/Contingency at 1%			$ 32.46
Net Capitation			**$ 3,048.57**
Premium Tax (98% of Final Cap)			$ 62.22
Net Cap w/ Premium Tax			**$ 3,110.79**

Key

user input

user input using AHCCCS provided numbers

formula

Notes

1) Numbers reflect the bid submitted by Health Choice Arizona and are on a Per Member Per Month (PMPM) basis.
2) Scored component, must be within the range provided by AHCCCS or will not be accepted.
3) Scored component (no max, no range supplied).
4) Scored component. Bidder must enter admin as a %. Admin dollars will be a calculation. Max admin accepted for bid is 8%. If bidders bid admin % above the max will not be accepted. Admin % is calculated as: Admin / (Net NF + Net HCBS + Acute Care Prior to RI + Case Management)
5) The above template must be provided for each GSA bid.
6) With bid submission bidder must submit an actuarial certification signed by a qualified actuary.
7) Bidder must use AHCCCS provided numbers for SOC, HCBS Mix % and Reinsurance Offsets when submitting their bid.

Actuarial Certification

Kevin Lurito, FSA, MAAA

Government Human Services Consulting
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
+1 602 522 6564
kevin.lurito@mercer.com
www.mercer.com

MERCER

Mr. Chris Coleman
Chief Financial Officer
Health Choice Arizona
410 N. 44th Street, Suite 900
Phoenix, AZ 85008

March 23, 2011

Subject: Actuarial memorandum for the contract year ending 2012 (CYE12) Arizona Long Term Care System (ALTCS) bids

Dear Mr. Coleman:

In partnership with Health Choice Arizona (Health Choice), Mercer Government Human Services Consulting (Mercer) has developed capitation rate ranges for use in developing competitive bids for the CYE12 ALTCS Elderly and Physically Disabled managed care program. This work focused on developing rate ranges for the following four Geographic Service Areas (GSAs):

- GSA 42 – La Paz and Yuma counties
- GSA 44 – Apache, Coconino, Mohave and Navajo counties
- GSA 50 – Pima and Santa Cruz counties
- GSA 52 – Maricopa County

Data reliance

In developing the CYE12 rate ranges for each GSA, Mercer relied on the following data sources and supplemental information:

Information provided by AHCCCS

- Encounter data
- Completion factors
- Impact of encounter underreporting
- Audited and unaudited financial statements
- Base period share of cost adjustments
- Acute Care Only services exclusions
- Benefit changes
- Fee schedule changes
- Historical actuarial certification memos

- CYE12 Home- and community-based nursing facility member mix assumptions
- CYE12 share of cost per member per month (PMPM) offsets
- CYE12 reinsurance offsets
- Risk and contingencies margin
- Premium tax

Information provided by Health Choice Arizona

- AHCCCS acute care trends
- Development of case management PMPMs
- Development of administrative requirement
- Targeted managed care efficiencies for acute care services

Summary

Mercer developed CYE12 rate ranges for each of the four GSAs requested by Health Choice. When feasible, Mercer performed checks for reasonability and consistency with the various data sources and assumptions provided by AHCCCS and Health Choice. A 21-month base period encompassing all 12 months of CYE09 and the first nine months of CYE10 was utilized as the base data for the development of the GSA-specific rate ranges.

Adjustments were applied to the base data to reflect only the populations and benefits covered under the ALTCS program. For example, acute care services were excluded from the base data for members who are not eligible for the ALTCS program. Additional adjustments were applied to account for the following:

- Base period share of cost
- Benefit changes
- Fee schedule changes
- Prospective trends
- Efficiency adjustments

This process yields the gross medical PMPMs which are grouped into three major components: (1) nursing facility services, (2) home- and community-based services and (3) acute care services.

Assumptions provided by AHCCCS are then applied by GSA to reflect the assumed CYE12 member placement percentages, the CYE12 share of cost offsets and the CYE12 assumed reinsurance offsets.

Case management PMPMs and administrative requirements are provided by Health Choice and reviewed for reasonability and consistency against current ALTCS Contractors. Finally, loads for risk and contingencies and premium tax are provided by AHCCCS and loaded onto the final net capitation rates by GSA.

As part of the CYE12 rate development process, ranges are provided to Health Choice for each GSA in order to reflect the variability inherent in developing prospective capitation rates. It is important to note that the midpoint of the rate range for each GSA reflects the best estimate for expected costs based on the information provided. Any material changes to the information utilized or the assumptions provided in developing the rate ranges may require a restatement of the results presented in this certification.

For bids that are submitted between the lower bound and the midpoint of the CYE12 GSA-specific rate range, it should be recognized that the bid reflects more aggressive assumptions related to lower trend assumptions, more aggressive savings resulting from Contractor efficiencies, more aggressive case management assumptions and administrative requirements, and potentially better than average risk selection. It is important that Health Choice understands the impact of these variables and the results produced in the rate development process. These results should be both reasonable and attainable to Health Choice when determining the final bid submission for each GSA.

The final CYE12, GSA-specific rate ranges are detailed below.

GSA	Counties	CYE12 Rate Range		
		Lower	Mid	Upper
42	La Paz, Yuma	$2,963.43	$3,110.35	$3,263.17
44	Apache, Coconino, Mohave, Navajo	$2,722.42	$2,854.44	$2,991.90
50	Pima, Santa Cruz	$3,249.58	$3,416.42	$3,590.15
52	Maricopa	$3,096.41	$3,215.08	$3,337.60

Note: Additional detailed documentation of the specific assumptions, rate impact, rate development processes and disclosures for the CYE12 ALTCS rate ranges has been provided to Health Choice in a separate correspondence.

MERCER

Certification of final rate ranges

Mercer certifies that the CYE12 ALTCS rate ranges are developed in accordance with generally accepted actuarial practices and principles by actuaries meeting the qualification standards of the American Academy of Actuaries for the populations and services covered under the managed care contract. Rates developed by Mercer are actuarial projections of future contingent events. Actual costs will differ from these projections. Mercer has developed these rate ranges in partnership with Health Choice Arizona for purposes of submitting competitive bids for four GSAs in responding to the ALTCS CYE12 Elderly and Physically Disabled Request for Proposal. The use of these rate ranges is not appropriate for any other purpose other than that described in this certification and Mercer disclaims any responsibility for the use of these rate ranges by any other parties for any purpose.

If you have any questions related to this certification, please call us at 602 522 6564 or 602 522 6567.

Sincerely,

Kevin Lurito

Kevin Lurito, FSA, MAAA

Zach Aters

Zach Aters, ASA, MAAA

KL/ZA/RO/lm

C. Organization

C. ORGANIZATION

Moral and Religious Objection

Requirement #2

MORAL AND RELIGIOUS OBLIGATION

REQUIREMENT #2

Submit a statement of any moral and religious objections to providing any services covered under Section D, Program Requirements of the ALTCS RFP. If moral and religious objections are identified describe, in as much detail as possible, all direct and related services that are objectionable. Provide a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc.

Health Choice Arizona has no moral or religious objections to providing any services covered under Section D, Program Requirements of the ALTCS RFP.

Organization and Staffing

Requirement #3

ORGANIZATION AND STAFFING

REQUIREMENT #3

Submit current resumes of key personnel as required in Section D, Paragraph 25, Staff Requirements and Support Services documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included long term care experience. If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description is limited to 2 pages.

Required Position	Title used by Health Choice	Full Time/ Part Time	Name of Incumbent
Administrator/CEO/COO	Chief Executive Officer	Full Time	Carolyn Rose, MA
Administrator/CEO/COO	Chief Operating Officer	Full Time	Michael Uchrin. MBA, M.Eng.
Medical Director/CMO	Chief Medical Officer/Medical Management Coordinator	Full Time	Chukwuemeka Oranyeli, M.D.
Medical Director	Medical Director	Full Time	Rene Bartos, M.D., MPH
Chief Financial Officer/CFO	Chief Financial Officer	Full Time	Christopher Coleman, BS, BA
Pharmacy Director/Coordinator	Pharmacy Director	Full Time	Randy Hromika
Dental Director/Coordinator	Co-Dental Director	Part Time	Carole Ann Slencsak, DDS
Dental Director/Coordinator	Co-Dental Director	Part Time	Seymour Rosen, DDS
Compliance Officer	Compliance Director	Full Time	Kathy Harris, BS
Dispute and Appeals Manager	Medical Services Director	Full Time	Carol Allis, MBA/HCM, BS
Business Continuity Planning Coordinator	Director of Information Systems / BCP Coordinator	Full Time	Jesse Perlmutter, MBA, MHSM
Contract Compliance Officer	Compliance Director	Full Time	Linda Ross, MBA
Quality Management Coordinator	Quality Management Director	Full time	Linda Beurle, RN, BSN
Performance/Quality Improvement Coordinator	Director of Performance Improvement	Full time	Joseph J. Schaller, BS
Maternal Health/EPSDT Coordinator	EPSDT Coordinator	Full Time	Linda Ross, MBA
Maternal Health/EPSDT Coordinator	Vice President, Medical Management	Full Time	Martha Olds, RN, MBA
Medical Management Coordinator	UM/Medical Management Coordinator	Full Time	Delores Johnson, RN
Behavioral Health Coordinator	Behavioral Health Manager	Full Time	Heidi Eccleston, LMSW
Member Services Manager	Member Services Director	Full Time	Suzan Irmer
Provider Services Manager	Provider Service Director	Full Time	Carol Allis, MBA/HCM, BS
Claims Administrator	Claims Director	Full Time	Adrian Brown
Provider Claims Educator	Provider Claims Educator	Full Time	Abby Catalan, ME
Case Management Administrator	Case Management Administrator	Full Time	Heidi Eccleston, LMSW
Network Services Director	Network Services Director	Full Time	Tommy Ashley

Carolyn Rose, MA

Professional Experience

Health Choice Arizona
President and Chief Executive Officer, 11/1999 – Present

- Responsible for executive oversight of all administrative and fiscal operations of Health Choice Arizona, a managed care health plan and Health Choice Generations a Medicare Advantage Special Needs Plan.
- Interfaces with the State of Arizona, CMS, government agencies, legislators, media, physicians, hospitals, vendors, and plan membership.
- Oversees the development of operating standards for each department, the development of annual budgets, and the HCA response to AHCCCS RFP's and Operation and Financial Reviews.
- Assesses ongoing operations to ensure planning and implementation of necessary internal controls/internal audits.
- Reviews and approves all monthly, quarterly and annual management and financial reports, both internal and AHCCCS, in conjunction with CFO.
- Reviews monthly operation reports to identify potential trends and works with HCA management team to develop and implement timely operational improvements.

IASIS Healthcare
Vice President, IPA/TPA/HMO Development & Operations, 9/1998 – 11/1999

- Designed and implemented programs to coordinate IPA growth and development with IASIS hospital strategy.
- Assisted IPAs with delegated risk contracts by providing infrastructure to support contracts. This infrastructure included medical technology, claims management systems, medical management systems, and support for credentialing and physician database management.
- Developed the IASIS Employee Health Plan TPA for the purpose of servicing health benefits needs of employees.
- Provided oversight for managed care "risk" contracting operations and HMOs owned or managed by IASIS Healthcare.

Stamos & Associates
Partner, 1/1995 – 6/1998

- Partnered in a consulting firm based in San Francisco and New York City, the focus of which was health system strategy and implementation of strategy.
- Spent two years in New York area organizing medical groups and IPAs to approach the payor market in partnership with hospitals.
- Developed and implemented two "MSOs" for the purpose of practice management and managed care contracting.
- Served as acting CEO for both organizations during the development and initial operational states.
- Served on development team for nine IPAs across one large health system consisting of nine hospitals on Long Island.

California Pacific Medical Group/California Pacific Medical Services Organization
Chief Executive Officer, 8/1989 – 1/1995

- Founding CEO for IPA and MSO, which became one of the largest and most successful groups in Northern California.
- Merged four competing IPAs during merger of two hospitals.
- The IPA was responsible for nearly 200,000 lives at global risk with all administrative services delegated.
- Revenues for the professional fee and hospital components of contracts were in excess of $250 million annually.
- The IPA held commercial contracts by Medicare and MediCal.

Education and Certifications

- Bachelor's of Science Degree, University of Kansas
- Master's of Arts Degree, University of Kansas

Awards

- Scholarship Recipient, University of Kansas
- University of Kansas Endowment Award
- Administrator Grant from NEY

Professional Experience

Health Choice Arizona
Chief Operating Officer, 9/2006 – Present

Responsible and accountable for the day to day health plan operations comprised of a Medicaid Plan (~200,000 Covered Lives) with an associated Medicare Special Needs Plan with elderly, long term care and physically disabled populations(~4,200 Covered Lives). More specifically holds direct oversight and responsibility of the Claims, Medicare SNP, Call Center / Member Service, and Information Technology Divisions. Ensures technology initiatives are aligned with organizational strategies and objectives. Possess lead role in communicating and coordinating initiatives and program implementations between the Arizona Health Care Cost Containment System (AHCCCS) and Health Choice Arizona (HCA) Leadership. Specific results attained include:

- Led a large member transition of over 80,000 members during service area expansion with no interruptions in service.
- Led Successful PBM Migration from Caremark to ESI
- Led Successful RBM Implementation (MedSolutions)
- Development of 2 year Technology Plan aligning organization's strategies and goals with enabling technology initiatives by leveraging ITIL and COBIT Frameworks
    - Integrated Care Management Software Solution to meet current Medicare/Medicaid Requirements
- Developed strategy and tactical plans to re-engineer care management process
- Developed enhanced Program Integrity strategy and tactical plans
- Developed Medicare Star Rating Remediation Plan
- Successful AHCCCS Operational and Financial Reviews
    - Led Policy/Procedure development and maintenance for both Medicaid and Medicare product business
- Security and Controls Remediation leading to a successful Sarbanes Oxley (SOx) (NON 404) audit from E&Y Auditors.
- Developed and Maintained comprehensive Business Continuity and Disaster Recovery Plan
- Re-Structure of Claims Organization resulting in improved financial and payment accuracy metrics by over 200 basis points.
- Call Center re-organization and alignment of duties to achieve AHCCCS and CMS required key performance indicators
- Implementation of IS and Network outreach strategies that led to an increase in electronic claims receipts from 27% of total volume to 70% of total volume and EFT Payments from 32% of total volume to 71% of total volume.
- Developed Claims Process and Software Strategy the resulted in the increase of claims Auto-Adjudication rates from near 0% to over 46% in 9 months.
- Developed Integrated Provider Scheduling Program aimed at
    - Reducing Re-Admits
    - Increasing Performance Measures

Health Choice Arizona
Chief Information Officer, 4/2005 – 8/2006

Responsible and accountable for Member Services Call Center Operations as well as the Information Technology Department. Technology responsibilities included the planning, development and execution of strategic and tactical technology initiatives to enable each business unit to carry out their objectives more efficiently and effectively while reducing cost. Call center responsibilities included organizational structure, staffing, as well as meeting key performance indicators for call abandonment and speed of answer that are requirements of the AHCCCS contract. Successful initiatives included:

- Claims scanning strategy development and execution
- EDI strategy development and execution
- Claims process re-engineering for the medical review and adjudication of claims received electronically
- Medicare and Medicaid member retention strategy development and execution

- Deployment of physician portal that enables providers to gain access to medical review criteria, forms, reports as well as application modules to verify member eligibility, review claim status as well as upload claims electronically
- Created in-house software development program to augment functionality of the claims and medical management software platforms
    - Agile Development Methodologies

Health Choice Arizona
Director, Information Systems, 5/2003 – 4/2005

Responsible for the planning, implementation, operation, security and maintenance of the Health Plan's Management Information Systems. Further capacities include development and management of capital and operational budgets, vendor selection and governance, and new technology research. Developed an agile but aligned IT organization that is not only responsive to the health plan's changing needs, but aligned to the business units to ensure all initiatives are driven by business needs and meet the guidelines of strategic initiatives. Large initiatives implemented to date include:

- Infrastructure Improvement:
    - Hub to Switch Technology,
    - Server Hardware Upgrade
    - Software Migration from Novel 3.1 to MS 2003 Server.
    - MS Office '97 Upgrade to 2003
    - Remote Connectivity/Devices for mobile users
    - Segregated Server Environments that enable Configuration Management
- Federal/State Guideline Compliance Projects
    - HIPAA Compliant Transactions and Code Sets
    - HIPAA Security
- Application Development / Improvements
    - Thin Client Architecture
    - Claims Adjudication Application edits and automation
    - User Driven Reporting / Data Mining Applications

Health Choice Arizona
Senior Project Analyst, 11/2002 – 5/2003

Responsible for large project analysis, design, build, implementation, and management. Focused on building documentation and communication channels between the business units and IS.

Venturi Technology Partners (Now Comsys)
Held Branch Manager and Analyst Positions, 8/1999 – 11/2002

Education

- Master of Engineering, Software, Ira A. Fulton School of Engineering, Arizona State University
- Master of Business Administration, W.P. Carey School of Business, Arizona State University
- Change Management and Decision Support Systems classes, Keller Graduate School
- Disaster Recovery Planning, Venturi Technology Partners
- Bachelor of Science, Geosciences with Geophysics Concentration, University of Arizona
- MIS Minor, University of Arizona

Associations

- Greater Phoenix Area CIO Council
- GITA RFP Evaluation Team - Rural Arizona RHIO Facilitation Project
- Advisor to the Rural RHIO Formation Project that is currently being implemented by GITA

Awards

- Manager of the Year, 2004, Health Choice Arizona, INC.
- Starfish Award, 2003: Excellence in Community Service, Health Choice Arizona, INC

Chukwuemeka Oranyeli, M.D.

Professional Experience

Health Choice Arizona/Health Choice Generations
Chief Medical Officer/Medical Management Coordinator, 05/2008 - Present

- Oversee and direct all medical management functions to include prior authorization services, medical necessity/pharmacy reviews, medical assessments for appeals/grievances, claims and outlier review, inpatient concurrent review, and day to day network and non-network physician and facility interventions.
- Ensure that appropriate inpatient and outpatient medical necessity criteria are adopted and consistently applied.
- Develop, implement and monitor care coordination, disease management and case management functions.
- Monitor, analyze and implement appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services.
- Oversee the department Directors and Managers responsible for Medicare Advantage Special Needs Plan.
- Provide oversight and direction to the following staff: Medical Director, Vice President of Medical Services, QMUM Director, and the Director of Pharmacy Services.
- Provide leadership and/or oversight of health plan committees to include QM/UM, Pharmacy and Therapeutics, Credentialing, Medical Management.
- Provide oversight and direction for all medical management and medical coordination function.
- Provide oversight and medical necessity reviews for concurrent and retrospective inpatient and subacute level member health care delivery.
- Oversee and assist the department Directors and Managers responsible for maternal child/EPSDT health services, behavioral health services, dental services and transplant services.
- Provide guidance and direction to Quality and Utilization Management, including the areas of health performance measures, credentialing, delegation, HEDIS, performance improvement projects, provider/member incentive initiatives and/or outreach.
- Assist Network and Medical Services departments with day to day network and non-network provider/facility growth, development, communications and interventions.
- Ensure that Health Choice Arizona remains contractually compliant with AHCCCS in all areas, and adheres to state rules and regulations pertaining to AHCCCS Acute Care contractor responsibilities.

La Paz Regional Hospital (LPRH)
Attending Physician / Medical Director, 12/2004 – 05/2008

- Manage patients in three outpatient offices affiliated with the LPRH, namely La Paz Family Practice, Bouse Clinic, and Tri Valley Clinic.
- Admit patients for inpatient care.
- Serve as medical director in two clinics (Bouse Clinic and Tri Valley Clinic).

Howard University Hospital Family Medicine Residency Program
Resident, 10/2002 – 09/2007
Intern, 09/2001 – 09/2002

Central Wits Health Region, Johannesburg, South Africa
Principal Medical Officer / District Surgeon, 01/1998 – 08/2001

- Worked with a group of senior physicians in the outpatient family practice office. This was a multidisciplinary polyclinic affiliated to a tertiary specialist care facility.

Chris Hani Baragwanath Hospital, South Africa
Senior House Officer / Medical Resident, 07/1996 – 12-1997

- Trained in a 3500 bed tertiary hospital, Internal medicine department. Six months in internal medicine and six months in the GIT as a senior house officer.
- Another 3 months in general medicine and 3 months in ICU as medical resident.

Central Wits Health Region, Johannesburg, South Africa
Senior Medical Officer, 10/1995 – 06/1996

- Worked in a multidisciplinary outpatient office which served as a family practice and primary care center.

Staff & Family Clinics, Federal Aviation Authority, Lagos, Nigeria
Senior Medical Officer, 11/1993 – 09/1995

- Managed patients in a family practice outpatient clinic, under a team of family physicians.

Nigeria Airways Staff / Family Clinics, Lagos, Nigeria
Junior Medial Officer, 11/1992 – 10/1993

- Worked with a group of senior family physicians in a multidisciplinary clinic with admission and observational facilities.
- This was part of a compulsory National Youth Service Corps program for University graduates.

<u>**Education and Certifications**</u>

- Diplomate in Family Medicine, American Board of Family Medicine
- Diplomate in Family Medicine, Colleges of Medicine of South Africa
- Family Medicine Resident, Howard Univ Hospital Family Medicine Residency Program, 10/2002 – 09/2004
- Family Medicine Resident, College of Medicine, University of Pretoria, 11/2000 – 08/2001
- Principal Medical Officer / District Surgeon,Central Wits Health Region affiliated to University of Witwatersrand, 01/1998 – 10/2000
- Internal Medicine Resident, Chris Hani Baragwanath Hospital affiliated to College of medicine, University of Witwatersrand, 07/1996 – 12/1997
- Senior Medical Officer, Central Wits Health Region affiliated to Univ of Witwatersrand, 10/1995 – 06/1996
- Bachelor of Medicine and Bachelor of Surgery (MBBS), University of Nigeria College of Medicine
- Board Certified, American Board of Family Medicine, Dec. 2004
- ECFMG (Educational Commission for Foreign Medical Graduates) certified
- ACLS (Advanced Cardiac Life Support) certified
- BLS (Basic Life Support) certified
- Currently hold an unrestricted Medical License for the State of Arizona since October 2004. Passed the USMLE, (United States Medical Licensure Examination) Steps 1, 2, Clinical Skills Assessment and Step 3 exams.

<u>**Research Experience / Publications**</u>

- H. Pylori Infection – Acquisition in Children. South African Medical Journal (SAMJ, 87 (6), 1997).
- In -Vitro Antibiotic Efficacy To Helicobacter Pylori. South African Medical Journal (SAMJ, 87 (6), 1997).
- Cross Sectional Study on Prevalence and Effects of Alcohol Consumption in Undergraduate Students of the University Of Nigeria, Enugu Campus (1988). This was a compulsory requirement for completion of Community Medicine Course.

<u>**Professional Memberships**</u>

- Member, Arizona Academy of Family Physicians (AzAFP)
- Delegate 2006, La Paz County, Arizona Academy Of Family Physicians
- Member, American Academy Of Family Physicians (AAFP)
- Member, South African Academy of Family Medicine & Primary Care (SAAFMPC)
- Member, South African HIV Clinicians Society (SAHCS)
- Member, Healthcare Professions Council of South Africa (HPSA)
- Member, Nigerian Medical Association (NMA)

<u>**Volunteer Experience**</u>

- Chief of Staff, Medical Staff, La Paz Regional Hospital, 01/2008 – 08/2008
- Vice Chief Of Staff, Medical Staff, La Paz Regional Hospital, 10/2006- 12/2007
- Secretary, Medical Staff, La Paz Regional Hospital. 01/2006 – 12/2006
- Member Clinical Improvement Committee, La Paz Regional Hospital, 01/2005 – 08/2008
- Medical Officer, Central Wits Health Region (SOWETO CLINICS), 11/1995 – 01/1996

René E. Bartos, MD, MPH

Professional Experience

Health Choice Arizona
Medical Director, 2/2007 - Present

- Oversee prior authorization decisions, review and sign Notice of Action (denial) letters.
- Assist with Concurrent and Retrospective Review.
- Develop and oversee Quality Management program and Performance Improvement.
- Develop coverage policies and criteria for both Medicaid and Medicare lines of business.
- Chair Quality/Utilization Management Committee and Credentialing Committee.
- Develop and oversee the Child Health (EPSDT) Unit.
- Oversee and implement activities to improve HEDIS performance measures.
- Oversee and implement activities to improve Performance Improvement Projects (PIPs).
- Represent health plan at Administrative Law Judge hearings for appeals.
- Research and present Practice Guidelines present to the QM/UM Committee for adoption.
- Assist in developing Disease Management programs.
- Develop and implement provider incentive Pay-for-Performance program.
- Develop and implement member incentive programs.

Phoenix Health Plan/Community Connections and Abrazo Health Plan
Medical Director and Director of Quality, 8/2005 – 2/2007

- Developed coverage policies and criteria for both Medicaid and Medicare lines of business.
- Oversaw prior authorization decisions, reviewed and signed Notice of Action (denial) letters.
- Directed Concurrent Review nursing staff, providing daily oversight and review of hospitalized patients.
- Developed and oversaw Quality Management program.
- Chaired Quality Management Committee, Credentialing and Peer Review Committee as well as Utilization Review Committee.

Arizona Department of Health Services, Office for Children with Special Health Care Needs and Children's Rehabilitative Services
Medical Director, 3/2004 – 8/2005

- Provided medical direction for the Office for Children with Special Health Care Needs (OCSHCN) and Children's Rehabilitative Services (CRS), including formulating medical policy and rules.
- Represent OCSHCN and CRS at the national, state and local levels.
- Consulted with other programs within the Department of Health Services, other state agencies and medical organizations.
- Provided advice and assistance regarding children with special health care needs and the programs that serve them.
- Coordinated programmatic activities and decisions with regional medical directors of CRS clinics and the Arizona Health Care Cost Containment System (AHCCCS).
- Conducted literature reviews and provided education to health care providers on best medical practices for children with special health care needs and their families.
- Prepared position statements and facilitated resolution of problems and appeals.
- Developed and drafted program plans, budget requests, legislation and grant applications.

Arizona Department of Health Services, Division of the Office of Women's and Children's Health
Chief, Research and Statistical Analysis, 6/2003 – 3/2004

- Directed evaluation and assessment activities with the Office of Women's and Children's Health, including data analysis, technical assistance and guidance with program evaluation and planning.
- Directed preparation of the Five-year Maternal and Child Health Needs Assessment and Arizona's Annual Title V Block Grant application.
- Managed the Arizona Perinatal Trust contract.
- Served on the Governor's Commission Data subcommittee on Prevention of Violence Against Women.

Pima County Health Department
Senior Public Health Officer, 9/2001-6/2003

- Provided primary care, including physical exams and referrals to children and adolescents.
- Provided family planning services to women, teens and the homeless throughout Pima County.
- Served as the Medical Committee Chairperson for the Children's Assistance Resource Event (CARE Fair), a two-day event serving over 10,000 individuals.
- Developed medical policies and guidelines for County Clinics.
- Provided education to and serve as a resource for public health nurses and community providers.

Education and Certifications

- Pediatric Residency, University of Arizona
- M.P.H. in Maternal and Child Health, Johns Hopkins University School of Hygiene and Public Health
- M.D., University of Michigan Medical School
- B.S., Biology, Summa Cum Laude, Michigan State University
- Arizona Board of Medicine—unrestricted medical license
- American Board of Pediatrics, board certified 10/24/2000, currently in progress for re-certification
- Fellow, American Academy of Pediatrics, Section on Adolescent Health, Section on Community Pediatrics, Section on Injury and Poison Prevention, Section/Committee on Children with Disabilities—Arizona State Liaison

Publications

- Goldblum J.R., Bartos R.E., Carr K.A., Frank T.S.: Hepatitis B and alterations of the p53 tumor suppressor gene in hepatocellular carcinoma. American Journal of Surgical Pathology. 17.1244-1251.1993.
- Frank T.S., Bartos R.E., Haefner H.K., Roberts J.A., Wilson M.D., Hubbell G.P.: Loss of heterozygosity and overexpression of the p53 gene in ovarian carcinoma. Modern Pathology. 7:3-8.1994.
- Cook S.M., Bartos R.E., Pierson C.L., Frank T.S.: Detection and characterization of atypical mycobacteria by the polymerase chain reaction. Diagnostic Molecular Pathology. 3:53-58. 1994.
- Caduff R.F., Svoboda-Newman S.M., Bartos R.E., Frank T.S.: Comparative Analysis of Histologic Homologues of Endometrial and Ovarian Carcinoma. American Journal of Surgical Pathology. 22 (3): 319-326. 1998
- Frank T.S., Johnston C.M., Bartos R.E., Caduff R.F.: Patterns of gene expression and loss in carcinomas of the endometrium vary with histologic subtype (platform presentation, United States-Canadian Academy of Pathology, 1994) Modern Pathology.7(1):88A.1994.

Research

- Research Assistant, University of Michigan Department of Pathology 1992-1993Investigated tumor suppressor gene alterations in endometrial, ovarian, and hepatocellular carcinoma and developed a protocol for characterizing atypical mycobacteria utilizing DNA extraction, polymerase chain reaction, restriction enzyme digestion, electrophoresis, southern blots, and immunohistochemistry studies.
- Research Assistant, Harvard University Department of Biology 1988-1989Performed exercise physiology studies, including determining the effects of exercise on mitochondria, oxygen consumption, lung capacity, and other adaptations in the body. Performed gait studies and determined joint forces for various exercise modalities (i.e., jumping, running, walking)
- Molecular Biology, Independent study, Michigan State University 1988
- Created a protocol for students to learn transformation, isolation, and mapping using the bacterial plasmid PBR322.
- Physiology Independent study, Michigan State University 1988
- Performed endocrinology research presented at an international symposium in Madison, Wisconsin.

Christopher M. Coleman, BS, BA

Professional Experience

Health Choice Arizona
Chief Financial Officer, 3/2005 – Present

- Oversee preparation and presentation of monthly, quarterly and annual financial statements as well as many other ad hoc reports.
- Coordinate annual financial audit, direct staff to complete audit requests, and work directly with auditors to address any outstanding issues.
- Participate in strategic planning and decision making for an acute care Medicaid health plan and a Medicare Advantage Special Needs Plan.

Health Choice Arizona
Director of Finance, 9/2003 – 3/2005

- Oversaw preparation of monthly, quarterly and annual financial statements and presented results to senior management.
- Coordinated annual budget process, directing the Accounting and Financial Analysis staff and working with Directors from other departments.
- Managed workload, set priorities and performed quality control function for the Financial Analysis Department.

Arizona Health Care Cost Containment System (AHCCCS)
Financial Consultant III, 1/2002 – 9/2003

- Managed financial aspects of Arizona's long-term managed care system, with an annual budget of over $750,000,000.
- Monitored financial performance and solvency of contracted health plans, set payment rates for government contracts, supervised two compliance auditors, and provided technical assistance on financial statement preparation.
- Provided financial analysis and other reporting to executive management and the Arizona State Legislature.

Lifemark Corporation
Assistant Controller, 10/2000 – 12/2001

- Oversaw preparation of financial statements and reported results to senior management.
- Supervised accounting staff for two health plans.
- Streamlined accounting processes and created new reporting tools using spreadsheet and database skills.

Lifemark Corporation
Financial Analyst, 11/1997 – 10/2000

- Gathered financial and statistical data for financial statement preparation, rate setting, and physician contracting.
- Provided trend analysis, revenue forecasts, and other support for annual budgets.
- Developed new reports for tracking profitability of physician contracts, estimating medical expenses, and compiling cost data retrieved from database queries.

National Century Financial Enterprises
Financial Analyst, 4/1996 – 10/1997

- Evaluated the true value of healthcare receivables and set contractual rates for receivables purchasing agreements.
- Performed risk analysis and due diligence site visits of potential clients and reported findings to senior management.
- Monitored receivable balances of existing clients and provided ongoing reporting, identified problem clients and wrote action plans for improving collections of Medicare, Medicaid, and other receivables.

Saint Agnes Medical Center
Administrative Assistant, 7/1995 – 4/1996

- Produced radiology reports, prepared x-rays for shipment to physician practices, connected physicians to telephone radiology reporting system, and located lost x-rays and medical records.

Arizona Lost Boys Center
Volunteer Treasurer, Board of Directors, 6/2003 – 3/2006

- Served on the board of directors and as Treasurer for the Arizona Lost Boys Center, a non-profit community center for Sudanese refugees.
- Performed all accounting functions including payroll, accounts payable, bank reconciliations and tax returns.

<u>**Education and Certifications**</u>

- Bachelor's of Science Degree in Business Administration, California State University
- Bachelor's of Arts Degree in German, California State University

Randy Hromika

Professional Experience

Health Choice Arizona
Director of Pharmacy Services, 10/2008–Present
- Responsible for Medicaid, Medicare formulary development
- Prior authorization process ,specialty pharmacy, pharmacy call center
- Pharmacy PBM operation

Medicis Pharmaceutical
Clinical Product Safety, 2/2006–2008
- Manage adverse event reports from clinical studies and marketed products
- Maintain current awareness of US FDA drug and device regulations
- Communicate with healthcare professionals on reported cases of adverse events

Fry's Food & Drug, Phoenix
Pharmacist/Manager (part time/full time), 6/1989–Present
- Perform professional duties and responsibilities with dispensing prescriptions
- Responsible for adherence to Federal and State Pharmacy laws
- Ensure prompt and courteous service by all pharmacy associates.

PCS Health Systems, 1984-1990 and 1998-1999
Director Clinical Services Western Region
- Provide leadership to team of Clinical Pharmacist Specialists responsible for detailing physicians on formulary prescribing patterns and therapeutic interchanges
- Responsible for revenue of 2.1 million dollars
- Accountable for budget, staffing, performance planning and report distribution

Sales Director
- Ranked in top five on national sales force
- Direct marketing responsibility for third party prescription drug programs as part of employee benefit for insurance companies, HMOs and Fortune 500 companies
- Developed cost management analyses and recommendations to corporate clients identifying methods and opportunities to reduce prescription costs

Manager Pharmacy Audit
- Responsible for monitoring and ensuring the integrity of the claims payment system
- Developed and implemented automated audit system and regional field auditor program
- Increased number of audits from 300 to 3000 and recoveries 700% while reducing costs

Health Resource Publishing Company
Senior Director of Retail, 1996-1998
- Sales and marketing of direct targeted customer drug information at point of sale to pharmacy chains and food and drug stores. Increased sales by 40%
- Responsible for development and growth of western region retail network
- Oversee installations, operations, staffing and monitoring of network compliance

Smitty's Food and Drug Store Chain
Director of Pharmacy (Company sold), 1994-1996
- Responsible for corporate chain pharmacy revenue, purchasing, staffing and daily operations
- Accountable for all third party prescription programs and managed care network participation
- Ensure regulatory compliance of State and Federal pharmacy regulations

National Data Corporation (NDC)
Regional Sales Manager, 1992-1994

- Direct sales responsibility for on-line healthcare claims transaction services to pharmacy chains in Western United States
- Increased sales 34 percent and maintained retention of client base
- Assured customer success through coordinated efforts of marketing and customer service representatives

Education and Certification

- Bachelor of Science degree, Pharmacy, Duquesne University
- State Licensed Pharmacist: Arizona, Maryland, Pennsylvania

Carole Ann Slencsak, DDS

Professional Experience

Health Choice Arizona
Dental Co-Director, 1/2006 - Present

- Coordinate dental activities of Health Choice and provide required communication between Health Choice and AHCCCS.
- Perform dental preauthorization and claims review.
- Assist with writing and reviewing dental clinical guidelines.
- Report suspected provider fraud and abuse for further follow-up by Oral Health Program Manager.

Private Practice in Tempe and Scottsdale Arizona
Dentist, 01/1988 – Present

Bridgeway Health Solutions
Pharmacy Clinical Consultant,10/05 – Present

Independent Contractor for Various Hospital, Retail and Home Health Pharmacies
Staff Pharmacist, 02/1988 - Present

American Heart Association
Instructor, Advanced Cardiac Life Support, 09/1998 – 07/1991

The Ohio State University College of Pharmacy
Clinical Instructor, 7/1984 – 6/1986

Riverside Methodist Hospitals
Pharmacist, 9/1981 – 1/1988

The Central Ohio Poison Control Center
Poison Information Specialist/Pharmacist, 10/1981 – 7/1982

Education and Certifications

- Resident, Dental Anesthesiology, College of Dentistry/Department of Anesthesiology, The Ohio State University Hospitals
- Doctor of Dental Surgery and Bachelors of Science in Pharmacy, The Ohio State University
- State of Arizona: Dental Board, No. 3687; Pharmacy Board, No. 8979

Awards

- The American Dental Society of Anesthesiology Award
- Dean's List, Undergraduate Studies

Publications and Presentations

- Slencsak, CA, Nahata, MC, Camp, J: Effect of chlorophyllin on urinary odor in geriatric patients. Drug Intell and Clin Pharm 1983; 17:732-34
- Slencsak, CA, Nahata, MC: Monitoring digoxin levels in a group of nursing home patients. J or the Am Geriatrics Soc 1982; 30:360
- Oxygen Delivery Systems, The Ohio Dental Association Annual Session September 11-14, 1986.
- Handling Office Emergencies, The Ohio State University Dental Assistants Lecture Series, August 6, 1986.

Organizations

- The Ohio State University Alumni Association
- The Ohio State University College of Dentistry Alumni Association
- The Ohio State University College of Pharmacy Alumni Association

Additional Experience

- Research involving the effect of fentanyl on the amnestic properties of midazolam in dental outpatient surgery (07/86 - 08/87)
- Clerkship in oral surgery, didactic and clinical experience (01/86 - 06/86)
- Clerkship in intravenous sedation, participated in pilot program and helped to develop course for undergraduate dental students (08/85 - 12/85)
- Pedodontic Club member, volunteer, providing dental services to mentally and physically challenged children (03/85 - 06/86)
- Extern, The Medical College of Ohio, Department of Dentistry (07/85 - 08/85)
- Conducted a drug study comparing the effectiveness of chlorophyllin versus placebo as a urinary deodorant (06/81 - 07/81)
- Monitored digoxin pharmacokinetics in nursing home patients (06/81 - 07/81)
- Clerkship in geriatrics, The Ohio State University, Colleges of Medicine, Pharmacy and Nursing, member of pilot program and coordinated course utilizing the team approach to medical care (05/81 - 06/81)

Seymour L Rosen, DDS

Professional Experience

Health Choice of Arizona
Dental Co-Director, 2001-Present

- Coordinate dental activities of Health Choice and provide required communication between Health Choice and AHCCCS.
- Perform dental preauthorization and claims review.
- Assist with writing and reviewing dental clinical guidelines.
- Report suspected provider fraud and abuse for further follow-up by Oral Health Program Manager.

North Mountain Dentistry
General Dentistry, 1982-Present

- Provide diagnostic and comprehensive treatment planning, pedodontics, oral surgery, endodontics, periodontics, fixed, removable, and implant prosthetics.
- Business management of a 12 employee multi office dental practice.

Denta-Health of Arizona
General Dentistry, 1980 - 1982

- Provided general dentistry services.

Erie County
Pedodontist, 1978 – 1979

- Provided Pedodontic treatment in various school settings.

Education and Certifications

- B.S. Biology, Chemistry, Brooklyn College
- Doctor of Dental Surgery , State University of NY at Buffalo School of Dentistry

Kathleen Harris, BS

Professional Experience

Health Choice Arizona
Compliance Director, 8/2005 – Present

- Oversee the Health Choice Arizona (HCA) Compliance Program and ensure compliance with the contractual requirements of the Arizona Health Care Cost Containment System (AHCCCS) and federal law.
- Coordinate the preparation and execution of specific contract requirements such as OFR's, random audits, and ad hoc visits.
- Manage and oversee the day to day duties for provider claim disputes, member appeals, fraud & abuse, and requests for hearings.
- Oversee appropriateness and adherence to operation policies and procedures.
- Coordinate and oversee cultural competency program.
- Coordinate the tracking and submission of all contract deliverables and responses to AHCCCS inquiries.
- Represent the company in appeals at the Administrative Law level.

MAXIMUS, Inc
Project Manager, 12/2003 – 8/2005

- Managed the project and day to day duties of the Direct Service Claiming program for Arizona including supervision of thirteen people.
- Program serves over 250 Local Education Agencies in Arizona and generates an average of $1 million in disbursement per week.
- Program processes all claims and prepares claims for payment from AHCCCS and CMS, issues checks to LEA's, program training, program updates and information, program promotion, compliance audits, compliance to both State and Federal laws and rules, customer service, technical assistance to Submitters, consulting services to AHCCCS, and comprehensive eligibility match process.
- Program exceeded its financial projects in the first year of operations by 60%.

Mullen & Associates
Program Manager, 1/2000 – 12/2003

- Managed the oversight responsibilities for the Administrative Claiming program for Arizona.
- Managed the program and the day to day duties of the company's fee-for-service billing and consulting program.
- Supervised staff of six people.
- FFS program served up to 85 LEA's in Arizona; approximately 45% of the participating LEA's.
- Administrative program served over 220 LEA's in Arizona.

Health Choice Arizona
Grievance Coordinator / Fraud & Abuse Coordinator, 10/1996 – 12/1999

- Managed all incoming grievances and appeals.
- Researched and issued decisions on all grievances.
- Represented the company in all appeals at the Administrative Law level.
- Developed policy and procedure for Fraud & Abuse program within the company, as mandated by AHCCCS contract.
- Reviewed and prepared all incoming fraud referrals.

Managed Care Solutions
Grievance Coordinator, 1994 - 1996

- Managed all incoming grievances and appeals for this company's acute AHCCCS-contracted health plan and its long-term AHCCCS-contracted health plan.
- Researched and issued decisions on all grievances.
- Represented the company in all appeals at the Administrative Law level.

Samaritan Health Services
Account Representative IV, 1990 – 1994

- Followed up and collected recoveries for AHCCCS-responsible patient accounts.
- Submitted grievances for accounts as necessary.
- Attended administrative hearings for accounts for appeals.

Education and Certifications

- Bachelors of Science in Business Management, University of Phoenix
- Member of National Health Care Anti-Fraud Association

Carol Allis, BS Ed., MBA/HCM

Professional Experience

Health Choice Arizona
Provider Services Director, 2/2006-Present

- Responsible for daily operations of Health Choice Arizona Network Department and assuring that a sufficient provider network is in place.
- Implement and manage the network operations plan for the Arizona Health Care Cost Containment System (AHCCCS) statewide contract.
- Respond to provider inquiries and assist providers in resolving problems.
- Assure that providers are educated about the AHCCCS program.
- Oversee contract development and negotiations with current and prospective providers.
- Maintain policies and procedures and oversee the quarterly provider and member newsletters.
- Work in collaboration with all departments and providers to ensure Health Choice Arizona maintains adequate services to contracted providers and members statewide.

Health Choice Arizona
Director of Inpatient Utilization Management, 12/2004-2/2006

- Responsible for daily operations and training of all Utilization Specialists performing concurrent and retro review for all acute admissions.
- Provided ongoing education and training on acute care criteria to document medical necessity and continuity of care.
- Worked in collaboration with all departments and providers.
- Responsible for daily operations of Case and Disease Management, tracking, trending and assigning referrals.
- Worked in collaboration with providers on special projects for members.

St. Luke's Medical Center
Director of Case Management, 6/2001-12/2004

- Responsible for the daily operations and training of case managers performing utilization resource management, case management, concurrent review, and discharge planning in collaboration with all departments and physicians.
- Managed and facilitated the pre-admission screening program in cooperation with admitting physicians and physician advisor. Provided ongoing education and training for case managers and physicians on interqual criteria.
- Interfaced and developed relationships with physicians, department directors and providers to ensure quality and continuity of care.
- Maintained hospital/department policies and procedures, departmental budget, staffing, interqual training, and hospital Medicare Liaison.

Geriatrix
Case Manager, 1/2001-6/2001

- Lead in the facilitation of the sub-acute case management program in collaboration with acute care case managers, physicians, and nurse practitioners.
- Pre-screened patients for sub-acute criteria and provided concurrent reviews for medical necessity and discharge planning.

St. Luke's Medical Center
Case Manager, 2/2000-12/2000

- Responsible for case managing a 25 patient case load. Duties included initial criteria assessment, concurrent reviews, case management and discharge planning.
- Provided weekend case management for all levels of acute care, as well as facilitated the pre-admission screening for new patients.
- Made rounds with the hospitalist to initiate plan of care and facilitate timely discharge plans.

Arizona State Veterans Home/Sonoran Rehabilitation and Care Center/Chris RidgeVillage
Director of Social Service, 8/1994-2/2000

- Responsible for providing medical screening for sub-acute patients and discharge planning, as well as completing annual reviews on long term residents to ensure quality of care and quality of life standards of care were followed.
- Interfaced with Department of Health Services, Area Agency on Aging, Managed Care, Medicare/Medicaid, and Arizona Long Term Care during the implementation of Prospective Payment System.

Education and Certifications

- MBA/HCM, University of Phoenix
- BS Health Science and Physical Education, East Stroudsburg University

Jesse Perlmutter, MBA, MHSM

Professional Experience

Health Choice Arizona
Director of Information Systems / Business Continuity Plan Coordinator, 8/2010 - Present

- Lead all facets of the Information Systems Department, including staffing, budgeting and project planning for the business analysis, infrastructure, and development teams
- Ensure customer service focus for all staff in assessing and analyzing business needs, and aligning with strategic objectives
- Coordinate with new vendors to integrate outsourced processes
- Maintain Business Continuity Plan, updating as processes, hardware and software configurations change; coordinate testing of backup/restore and emergency processes; provide training for new employees regarding emergency procedures.

Health Choice Arizona
Manager of Information Technology / Business Continuity Plan Coordinator, 12/2007 – 8/2010

- Manage the activities of the development team to automate manual processes and make data more readily available to management.
- Manage infrastructure team to maintain a stable network, and resolve user hardware and software issues.
- Maintain Business Continuity Plan, updating as processes, hardware and software configurations change; coordinate testing of backup/restore and emergency processes; provide training for new employees regarding emergency procedures.

Health Choice Arizona
Project Manager, 5/2007 – 12/2007

- Developed and implemented a corrective action plan to increase the percentage of electronic claims received from providers, resulting in an increase from 27% to 51% of all claims receipts.
- Led implementation of project to consolidate printing and mailing of checks and remits via Emdeon Business Services.
- Implemented RightFax Fax Server to allow the high fax volume Prior Authorization department to send and archive authorization responses more efficiently.

Health Choice Arizona
Business Analyst, 10/2006 – 5/2007

- Managed implementation of National Provider Identifier project including system enhancements and reporting progress to AHCCCS.
- Assessed users' needs and coordinated claims adjudication system enhancements with IT staff, management, and outsourced developers.
- Maintained project documentation per company policy; assisted in technical analysis and testing of system changes.

Caremark
IT Project Management Intern, 5/2006 – 8/2006

- Designed and developed software enhancements for HP Nonstop claims processing engine, resulting in improved routing of 15 million claims per month.
- Facilitated construction and testing of a new development environment for National Provider Identifier project.
- Coordinated development efforts with business analysts, testing, infrastructure, and other technical teams.

Howell Sterling
Co-founder / Owner, 2/2002 – 10-2006

- Created an online antiques business and grew the company to over $100,000 in revenue.
- Managed company finances to maximize business tax deductions and minimize overhead.
- Evaluated sales trends; purchased undervalued merchandise according to market demand.

The IQ Group
Web Designer, 10/2002 – 10-2004

- Designed and produced over 700 dynamic advertisements for 150 life and health insurance carriers and wholesalers targeting insurance agents and financial planners.
- Acted as liaison with sales department to promote client relationships and increase contract renewals.

SalemGlobal Internet
Lead Web Developer, 10/2001 – 10/2002

- Managed website architecture, design and development on over 75 client and in-house websites.
- Supervised and delegated tasks to freelance developers and group of interns.

Education and Certifications

- Bachelor's of Science Degree in Industrial Technology, Arizona State University
- Master's of Business Administration Degree – Information Management Specialization, W. P. Carey School of Business, Arizona State University
- Master's of Health Sector Management Degree, W. P. Carey School of Business, Arizona State University

Linda M. Ross, MBA

Professional Experience

DIRECTOR OF PROGRAM DEVELOPMENT
HEALTH CHOICE ARIZONA, Phoenix, AZ, Aug. 2010 - Present

- ~ A managed care organization that provides healthcare to people in Arizona's Medicaid Program, Arizona Health Care Cost Containment System (AHCCCS).
- ~ Reports directly to the Chief Executive Officer to assist the company with defining and positioning new and existing program and service opportunities for its' provider/hospital network, members and company staff.

- ~ Collaborate with senior management team and other key personnel to develop customized solutions for identified members.
- ~ Collect product and service feedback from stakeholders, and relay information to management to enhance program strategy.
- ~ Assist the marketing function with the planning and executions of outreach activities, advertising, promotion, and special events.
- ~ Participate with senior management staff in strategic planning processes. Develop tactical plans within area of responsibility and oversee plan execution, including monitoring progress, adhering to budgets, and periodic reporting to the CEO and senior management team.

CHIEF FINANCIAL OFFICER - AACHC / EXECUTIVE DIRECTOR, HEALTHCARE CONNECT, Sept. 2009 – Aug. 2010
CHIEF OPERATING OFFICER, June 2004 - Sept. 2009
ARIZONA ASSOCIATION OF COMMUNITY HEALTH CENTERS (AACHC*)*, Phoenix, AZ

- ~ Arizona's Primary Care Association *(PCA*), advancing the expansion of Federally Qualified Health Centers (FQHCs) and advocating for the health care interests of the medically underserved and uninsured.
- ~ Served as COO for 5 years and subsequently transitioned under new management to CFO role in 2009 while retaining shared services operation and assuming leadership of Healthcare Connect.

Provide executive leadership, directing 35 direct and indirect reports, building extensive external relationships, and playing integral role in strategic planning and program implementation / management to meet organizational and membership goals. Contribute to tactical planning, deliver presentations, and report to several boards.

Ensure cost-effective financial management, manage budgets totaling $1+ million, administer grant programs, and ensure adherence to funding charter. Collaborate with COOs and CFOs of 36 members of the association statewide with 150 sites, identifying and facilitating program needs; also assist HR and clinical groups.

- ~ **Served as interim CEO during CEO's 8-week medical leave and frequently serve as organizational representative** on behalf of CEO at national meetings. Served as only COO on CEO-only national steering committee based on reputation for getting the job done.
- ~ **Serve membership comprised of 36 health organizations** with delivery sites statewide; includes 17 FQHCs.
  - Introduced physician recruitment program that became one of the top programs countrywide to respond to state's chronic shortages and better meet demand for medical services at the community health centers.
  - Increased attendees and related revenues 100% for regional 4-state annual conference.
  - Implemented online registration and changes that improved effectiveness of training and conferences.
  - Redesigned and developed publications and collateral to increase awareness and improve image.
- ~ **Advocate for members,** lobbying at the state and national level. Teamed with state Medicaid office to address issues; includes securing $2 million for particular center through resolution of reimbursement issue.
- ~ **Secure and administer grants** for Healthcare Connect and the Association; such as $650,000 telemedicine equipment grant and planning grants.

- ~ **Brought greater structure, enhanced compliance, and ensured clean audits** by drafting and documenting an array of new policies and creating policy manuals for various internal functions.
- ~ **Implemented competitive bidding process and cultivated relationships** to secure vendor discounts and receive most favorable contract prices for the benefit of members.

ADMISSIONS COUNSELOR

UNIVERSITY OF PHOENIX ONLINE, College of Health Care & Nursing, Phoenix, AZ, 2003

Contributed to growth objectives, prospecting, relationship building, and follow up of inquiries. Clearly promoted academic programs / quality within healthcare discipline.

- ~ **Surpassed / met goals** by differentiating programs from competitors and execution of marketing programs.

BUSINESS MANAGER, 1992-2002

MOTOROLA, GEG / SPS, Finance / R&D Departments, Scottsdale, Mesa and Tempe, AZ, 1982 -2002

Earned multiple promotions, ultimately progressing to business management role for different departments.

Directed staff of 10, oversaw financial activities, and maintained fiscal responsibility for multiple R&D and engineering departments in worldwide locations with budgets totaling over $50M to maximize profits. Recruited, hired, and assisted with training of 200+ employees. Centralized departmental purchasing, developed list of preferred vendors and managed high-volume of vendor contracts. Held Secret Security Clearance for various engineering projects.

- ~ **Drove costs down and recovered substantial dollars**:
  - Reduced expenses 20% through cost-effective vendor negotiations.
  - Saved as much as $1 million by uncovering and correcting erroneous purchase orders.
  - Purchased software licenses at discount and sold internally to domestic and global company locations. Served as key contact to vendors / internal customers for Preferred Vendor Software Program.
- ~ **Conscientious in meeting budget parameters**. Created and maintained expense and capital budgets, actual versus budget analysis, variance reporting and general ledger journal entries.
- ~ **Led a major relocation** as well as contributed as team member on shutdown of fabrications operations within required timeframe; included deploying employees / equipment and managing financial activities.
- ~ **Served in team-driven environment**, identifying bottle necks, gaps, and solutions to boost efficiency.
- ~ Earlier positions included Manager, Production Control / Project Manager; created costing method for product line development. Oversaw production control functions for R&D semiconductor department.

Education

MASTER OF BUSINESS ADMINISTRATION (MBA) in **HEALTH CARE MANAGEMENT - 2008**
Regis University, Boulder, CO

MASTER OF SCIENCE IN PROJECT MANAGEMENT - 1999
George Washington University, Phoenix, AZ

BACHELOR OF SCIENCE (B.S.) in BUSINESS ADMINISTRATION / ACCOUNTING MINOR - 1996
BACHELOR OF ARTS (B.A.) IN BUSINESS MANAGEMENT
University of Phoenix, Phoenix, AZ

Linda Hale Beuerle, RN

Professional Experience

Health Choice Arizona
Quality Management Director, 04/2004 - Present

- Oversee functions of the Health Plan's Medicaid and Medicare Quality Management program, Credentialing, and HEDIS.
- Ensure individual and systematic quality of care and integrate quality throughout the organization.
- Ensure provider network is credentialed.
- Assure survey (AHCCCS and CMS) readiness.
- Coordinate QM/PI plan development, monitoring and evaluation
- Oversee recommendations for corrective actions and program development.
- Coordinate disease management activities for diabetic members.
- Investigate quality of care grievances and report conclusions to AHCCCS/CMS.
- Educate staff on how to handle quality of care issues.
- Participate in Corporate Advisory Board, QM/PI, QOC and Credentialing Committees.

Evercare Select Health Plan
Quality Management Manager, 07/2002 - 04/2004

- Provided oversight of the quality management department, which included all aspects of the quality management program for both Medicaid (ALTCS) and Medicare members.
- Audited all contracted providers (nursing homes, home health agencies, alternate care facilities) to assure compliance with State and Federal guidelines pertaining to managed care; investigated member quality issues; interacted with external and internal customers; facilitated performance improvement teams; orientated new employees to QM.
- Assured survey readiness for the health plan in quality.
- Developed and participated in quality improvements projects (QIP/QAPI) for both State and Federal agencies.
- Policy/procedure development; developed the Quality Management plan and work plan to meet State (AHCCCS) requirements; developed Case Management plan.

Maricopa Integrated Health Systems Health Plans
Quality Management Manager, 10/2000 - 06/2002

- Provided leadership and oversight of the managed care QM programs (including EPSDT, Maternal Child Health and Credentialing) for four health care insurance products including Medicaid and Medicare, serving over 60,000 members.
- Regulatory oversight responsibilities; survey readiness.
- Oversaw completion of CMS and AHCCCS clinical studies.
- Acted as a managed care QM liaison (State and Federal) to healthcare agency departments, AHCCCS administration, QM vendors and community agencies (CMS, QIO, ADHS, APS).
- Managed a department of thirteen members; mentored and provided orientation and training to QM coordinators and other staff regarding managed care QM and risk management issues.

Chandler Regional Hospital
Performance Improvement RN, 3/2000 - 10/2000

- Resource liaison for all aspects of performance improvement for the medical staff, department personnel and administration.
- Facilitated team meetings, prepared statistical data for presentation at Committees, chart review for performance improvement (PI) indicators, in-serviced staff on PI tools and functions, chart review for HCFA, interfaced with utilization management and risk management.

Phoenix Baptist Hospital
Risk Manager, 11/1999 - 2/2000

- Handled all risk management activities for the hospital including claims, complaint resolution, and medical record review; in-serviced/orientated staff on risk issues.

- Interacted with corporate and community attorneys.
- Developed reports to inform various committees of risk management information.
- EMTALA review, monitoring and data collection.

Mutual Insurance Company of AZ
Senior Risk Management Representative, 5/1999 - 11/1999

- Conducted risk management audits in office practices and acute care facilities. Reviewed medical records for specific audits.
- Responded to insured risk management situations via the "Hot Line" phone calls.
- Conducted in-services on risk management topics for small groups.

Medical Mutual Insurance Company of Maine
Senior Risk Manager, 1/1997 - 5/1999

- Initiated risk management needs assessment of acute care facilities, office practices and nursing homes; reviewed medical records.
- Designed and developed risk management surveys/tools.
- Investigated, evaluated and solved risk management issues from members using the Internet, consulting with attorneys, and networking intra-departmental (claims and underwriting).
- Wrote risk management risk alerts and practice tips on topics of interest which was sent to members on a quarterly basis.
- Education of insured risk managers and other staff on topics such as EMTALA, infant abduction policies, fall reduction programs, and other topics, in an effort to take a proactive approach to risk reduction.

Lockport Memorial Hospital
Quality Management and Risk Management Director/RN, 11/1987 - 12/1996

- Coordinated all hospital quality improvement activities including risk management activities, safety, and all aspects of physician credentialing.
- Conducted risk management education for corporate orientation of new employees in risk management and quality management.
- Initiated methods for identification of patient care problems; received, evaluated and referred problem forms; met with administration, department heads, and medical staff to discuss problems; analyzed computer data and logs to identify problems.
- Reviewed patient charts for mortality and morbidity review, blood usage review, surgical case review, reportable incidents, and generic screening.
- Evaluated and coordinated activities to ensure that the hospital was in compliance with the Joint Commission standards and the department of health.
- Prepared reports to administration on department activities including budgetary, staffing and planning.

Education and Certifications

- Healthcare Administration curriculum in Master's degree program, St. Joseph's College, Windham, Maine
- Bachelors of Science degree in Nursing, State University of NY at Buffalo
- Associates degree in Science/Human Services, Erie Community College
- Certified Professional in Healthcare Quality (CPHQ) since 1996
- Member of AzAHQ, NAHQ
- Arizona – Registered Professional Nurse
- New York, Maine – Registered Professional Nurse (inactive)

Joseph J. Schaller

Professional Experience

Health Choice Arizona
Director, Performance Improvement, 7/2005–Present

- Created reporting system to track performance quality to identify areas for improvement
- Implemented processes to help healthcare providers improve quality performance measures
- Reported clinical quality performance measure data to management, and regulating bodies
- Communicated clinical quality performance measure data to health care providers to facilitate improvement
- Coordinated tracking and reporting of all clinical quality performance measure data for the health plan
- Developed analysis tool to gather data for evaluation of clinical quality performance measures for healthcare providers
- Performed statistical analysis of claims data to determine areas for improvement
- Managed all requests for analysis of health care data for Medicaid health plan
- Designed Provider Profile for analysis of performance quality of healthcare providers
- Performed all financial forecasting and budgeting
- Assisted in estimating new rates for the bid process to obtain new business
- Analyzed contracts to assist network department on the most effective reimbursement strategies
- Tracked claims data to determine areas for improvement of performance measures
- Improved process for generating reconciliation data to determine profitability of different business segments
- Developed new reporting processes for trending of enrollment and financial data

Encompass Holdings LLC
Owner/Manager, 3/2004–7/2005

- Assisted in transition of a company from the primary shareholder to his heirs upon the owner's death
- Coordinated all information provided to an appraiser for valuation of the company for estate tax purposes
- Designed, built and implemented custom organization management system which allowed the company to quickly identify the most productive lines in the organization and duplicate successful processes
- Set up new accounting system and controls and performed all accounting duties for company
- Managed day to day operations of organization including accounting, marketing and general business management functions
- Provided business consulting services to a company which split operations into three separate entities
- Defined structure of new entities for company to stream line operational performance
- Prepared and filed all corporate paperwork to set up Limit Liability Companies for new entities
- Coordinated all tax and license application information for creation of new entities
- Set up new accounting system, procedures and controls for accounting within and between each new company
- Designed and built custom purchase order tracking system to improve process quality for large local school district
- Implemented custom built commission tracking system for local insurance agency

Allied Waste Industries, Inc.
Senior Financial Analyst, 8/2002–2004

- Forecasted future financial results using trending models and historical operational and financial data
- Created custom automated retrieval reports to facilitate data analysis using Cognos Powerplay and Excel
- Performed operational and financial analysis to help identify problem areas within the company and find solutions

Internal Reporting Manager, 10/2000– 8/2002

- Performed Price Volume Analysis to analyze quarterly changes in total company revenue and volume
- Member of corporate budget team that developed new budget system to process and gather data from over eight hundred business units to accumulate into total company budget package
- Developed analysis tools to help managers more efficiently analyze the operating results of the company
- Analyzed forecast information for reporting to senior management

Arizona Heart Institute, Ltd.
Comptroller, 9/1998 – 10/2000

- Managed the day to day functions of Accounting and Business Office staff including all billing, collections, data entry, cash management, general ledger and financial reporting functions
- Designed and implemented clinic automation system to efficiently capture billing information at source to help maximize the accuracy of medical charges and diagnosis submitted for payment from insurance companies

Lifemark Corp.
Assistant Controller, 8/1997 – 9/1998

- Responsible for preparing monthly financial statements for Health Plan
- Ensured that all account reconciliation's were complete and account balances were accurately stated
- Participated in creating Health Plan budget and insured that the budgets were used in the financial reporting process
- Implemented quality improvement in processes by establishing and organizing Assistant Controller's meetings

Financial Analyst Manager, 6/1996 – 8/1997

- Developed and implemented budgeting process for company
- Created and processed monthly financial package for distribution to Board of Directors and Senior Management team
- Worked with management team to develop costing model for business analysis and pricing of new and existing contracts

Genetrix, Inc.
Controller, 11/ 1993 – 6/1996

- Managed the day to day financial operations including financial reporting, general ledger, accounts payable, cash receipts, payroll and purchasing functions for the company
- Set up and serviced a custom information retrieval and financial reporting system for quality improvement

Financial Analyst, 9/1992 – 11/1993

- Analyzed and consolidated yearly budget data to implement into the full company budget package for Board approval
- Developed and maintained procedures to reconcile the accounts receivable sub ledger with the accounting software

<u>Education and Certifications</u>

- Bachelor of Science Degree in Accounting, DeVry Institute of Technology
- Bachelor of Science Degree in Business Operations, DeVry Institute of Technology

Martha Olds, RN, MBA

Health Choice of Arizona 11/2010 – Present

Vice President of Medical Services & Medical Management Coordinator

Oversees all functions of the Medical Services department which include; Prior Authorization, Grievance, Utilization Management, Case Management and Disease Management services. Manages end-to-end and has full accountability for directing the development, evaluation and implementation of new medical management programs that support's Health Choice of Arizona's organizational strategies.

CIGNA Health Plan 08/2009 – 11/2010

National Project Lead – Quality & Improvement

Oversees and directs the development evaluation and implementation of new or changing health care programs and medical services for organization at the national level. Responsible for program execution and drives medical program management for specific clinical programs. Negotiates with vendor to provide programs and product development. Managers end-to-end and has full accountability for product, systems, installation.

Responsibilities included:
Drive project initiatives – Collaborative Accountable Care/Patient Center Medical Home/ACO
Provide consulting to field project leads for Southeast, Central and Western region of the US
Program development including:
Health Advocacy/Care Coordination/Case Management integrated model
Standard Key focus action plan definition from each initiative
Payment method
Future- Learning collaborative, enhancement of tools and processes
End to end program oversight and responsibility – includes and support of outcomes measurement
End to end project oversight as a consultative support of PCMH/CAC/ACO initiatives
Integrates initiatives with CIGNA internal partners and how Health Advocacy encompasses all systems and integration with future and pending IT program rollout and enhancements
Sales support – growth and retention
Communications development and maintenance

CIGNA Medical Group Phoenix AZ – 4/2002 – 8/2009
Director of Operations – Population Health Management Department (PHM)

Oversaw and directed the design development, evaluation and implementation of clinical management service programs. PHM health care services and programs support CIGNA's national CMS "Medicare Select" contract and NCQA quality improvement compliance requirements.

Responsibilities included:
Partners and negotiates with internal and external customers to provide programs and product development

1. Oversees programs deliverables while assuring programs meet CMS compliance requirements.
2. Design and develop clinical program strategy component for CIGNA Medical Groups (CMG).
3. Achieve cost management PMPM and Low Net Cost goals as determined by CMG Bed Day Management strategy.
4. Manage team of clinical managers through strategies and tactics identified in strategic plan.
5. Lead program design to highlight the value of CIGNA Medical Groups medical and specialty service integration.
6. Serves as champion for clinical conditions provided through CMG disease management programs.
7. Develop and implement alternative programs such as CMS Special needs Programs (SNP), Chronic Health Improvement Program (CHIP), Care Coordination, Transition of Care Nurse Program, and

HomeBase Provider visit Program

8. Develop and implement alternative programs for improving health and wellness
9. Develop and apply telemedicine techniques for medical management for identified high-risk customers
10. Develop and apply clinical support tools for an integrated disease management programs (CHIP/SNP) that supports all interdisciplinary team members in managing a member's care plan.
11. Develop and maintain appropriate clinical, evidence-based documentation that supports all programs.
12. In association with marketing, develop supporting material that highlights competencies in cost and clinical management.

2006 / 2007 Health Service Manager
Oversaw and directed the development of a new department Population Health Management (PHM). The department included all Health Center RN Care Coordinators, Home Base providers and their supporting staff, CIGNA hospitalist, Diabetic Education nutritionists and the support and development of all health/wellness programs.
2004 / 2006 Case Nurse Consultant
Developed additional High Risk Patient Management programs; such as Home Base provider visit programs for the homebound and high risk hospital DC patients. Developed and managed the implementation of prioritized efforts through the project lifecycle. Established a tracking and reporting system that demonstrated program measures of success.
2002 / 2004 Case Manager Specialist
Developed RN Care Coordination Program and Implemented program across the 18 CMG Health Care Centers. Utilized this new nursing role to leverage their collective strengths, expertise and best practice. Outcome improvements included improved
CIGNA Healthcare of AZ
1997 ~ 2002 Rehabilitation Vendor Manager
Independently Managed Capitates Medical Rehab vendors and participates with the development of vendor strategy and standards. Assisted with the development and implementation of operational procedures.
1993 ~ 1997 Patient Care Coordinator
CIGNA In Patient Case Manager – Responsible for utilization review of acute admissions. Specialized in Acute medical Rehab Catastrophic Case Management

Licensed in:

- **Arizona Registered Nurse RN046371**

Honor or award Grantor Issue Date

- **Six Sigma Yellow Belt** **6/2009**
- **Delta Mu Delta Honor Society** **3/2006**
- **Graduated with Honors Western International University** **5/200**

EDUCATION
2006 – Masters of Business Administration – Western International University, Phoenix, AZ
2001 – Bachelors of Science Healthcare Systems Management – Western International University Phx AZ
1996 – Certified Rehabilitation Registered Nurse (CRRN)
1993 – Certified Quality Management, UR Management, and Risk Management
1975 – Associate Degree in Applied Science – Register Nurse – Clark State College – Springfield Ohio

Delores Johnson, RN

Professional Experience

Health Choice Arizona
Concurrent Review Coordinator/Medical Management Coordinator, 2/2006 – Present

- Responsible for day to day operations of the concurrent review process and inpatient utilization management.
- Provide direct oversight of concurrent review staff.
- Ensure adoption and consistent application of appropriate inpatient medical necessity criteria.
- Ensure appropriate concurrent review and discharge planning of inpatient stays is conducted.
- Ensure policies and procedures are followed for inpatient concurrent, retrospective and pre-payment review. Provide training and education to Utilization Review Nurses.
- Assure department efficiency, implement, enforce and make decisions on established policies and procedures.

St. Luke's Medical Center
RN, 8/1978 – 2/2006

- Held positions as UR Case Manager for Medical/Surgical and Telemetry, and Behavioral Health.
- Supervised the UR Case Managers.
- Held positions as Staff Nurse in Pain and Stress reduction and Behavioral Health.
- Staff Nurse Behavioral Health
- Staff Nurse Adolescent Behavioral Health

Education and Certifications

- School of Nursing, Pennsylvania Hospital
- Certificate for Geriatric Nursing, Georgetown University
- Undergrad classes – Humanities & Social Studies, Mesa Community College
- Counseling courses – Arizona State University
- Certificate – Coding Classes

Heidi Eccleston, LMSW

Professional Experience

Health Choice Arizona
Behavioral Health Manager, 6/2006 - Present

- Ensure provision of Mental Health benefits to categorically eligible members and coordinate such care with medically necessary services for Medicaid Managed Care Plan and Medicare Advantage Special Needs Plan
- Develop, implement, and monitor Health Choice Arizona Behavioral Health policies and procedures.
- Participate in the identification of best practices for behavioral health in a primary care setting.
- Coordinate care efforts of the member, Health Plan, Health Plan providers, and the Regional Behavioral Health Authority (RBHA) according to AHCCCS Behavioral Health guidelines.
- Implement and monitor Health Choice Arizona's behavioral health services through documentation and data reporting.

Phoenix Health Plan
Behavioral Health Coordinator, 9/2004 – 6/2006

- Assisted health plan members in obtaining behavioral health services through the Regional Behavioral Health Authority.
- Identified community resources for members within the community to assist members in achieving independence in their daily living.
- Maintained a case load of individuals identified through the assessment process to be in need of assistance with their daily medical and/or behavioral health care needs.
- Worked in a team environment with other Case Managers developing treatment goals, discharge plans and plans of care.

Value Options
Area Clinical Care Coordinator/Centro Esperanza Clinic, 3/2003 – 9/2004

- Provided daily clinical oversight to all Clinical Liaisons and Case Managers.
- Monitored discharge planning and service planning for enrolled consumers.
- Actively involved with the management team to identify and develop best practice procedures.
- Provided individual and group supervision to clinical staff.

Value Options
Team Lead/West Camelback Clinic, 3/2002 – 32003

- Provided clinical supervision and oversight to a team of case managers.
- Ensured all consumers on the team were receiving appropriate behavioral health care.
- Monitored those consumers on Court Ordered Treatment to ensure the clinical team was following up with the consumer on a monthly basis.
- Participant of the management team to develop more efficient clinical operations for both consumers and employees.

St Luke's Behavioral Health Center
Therapist III/Intake and Assessment, 5/2000 – 3/2002

- Provided psychiatric and chemical dependency assessments and level of care determination for adults, adolescents and children.
- Utilization of programs such as Substance Abuse Detoxification, Outpatient Chemical Dependency Programs, Inpatient Psychiatric Hospitalization and Outpatient Partial Hospital Program.
- Conducted case reviews and consultation with managed care companies, public/private community based agencies and contracted physicians.

ComCare
Adult Case Manager I, 2/1998 – 8/1998

- Responsible for the coordination and monitoring of services of adults in the Behavioral Health System, diagnosed with a Serious Mental Illness.
- Participant in a clinical team setting.
- Identified and implemented treatment and service plans.

Education and Certifications

- Master of Social Work, Arizona State University
- Bachelor of Arts in Sociology/Law, Criminology and Deviance, University of Minnesota
- Licensed Master Social Work with the Arizona Board of Behavioral Health, License Number LMSW-11650

Suzan Irmer

Professional Experience

Health Choice Arizona
Member Service Director, 7/2007 – Present
Member Services Manager, 9/2006 – 7/2007

- Oversee member service operations and resolve complex member and provider issues and inquiries.
- Analyze call volume and assure that telephone abandonment rates and hold times meet or exceed AHCCCS contract requirements.
- Coordinate communications with members, educate members, and act as a member advocate.
- Manage, motivate, train, and coach member service staff to assure that members are given the best care possible.
- Maintain member data base and oversee verification of member enrollment.

Express Scripts
Manager Prescription Processing, 7/2005 - 9/2006

- Managed Supervisors, Pharmacists and Pharmacy Technicians in the day to day Operation of entering an average of 15,000+ prescriptions for 300+ accounts daily. Main account handling for the Department of Defense.
- Responsible for meeting daily, monthly and yearly metrics of each individual account.
- Provided oversight for all facets of prescriptions from imaging, entering, exceptions, escalations, adjudication and verification, utilizing 8 different computer applications.
- Interacted with all levels and numerous departments throughout the company, locally and nationally. Communicated and reported to high ranking Military Personnel on a regular basis.

Olympian Labs Inc.
National Sales Manager, 2004-2005

- Responsible and accountable for the daily operation of inbound/outbound sales, customer service, and key accounts maintenance for over 13 thousand direct sale accounts calls.
- Direct oversight of 10 inside and outside sales reps responsible for selling nutraceutical vitamins and supplements for a multi-million dollar research and development company.
- Provided oversight for all aspects of sales center including; trade shows, radio shows, co-op advertising, Business Improvement plans, strategic market planning and all support services necessary to maintain support to wholesale, retail and direct to consumer sales.

Marcolin USA
Manager Customer Service, 2003-2004

- Accountable for the daily operation of the inbound/outbound sales, customer service, and key accounts maintenance for over 50 thousand direct sale accounts.
- Direct oversight of customer service supervisor, training lead, and data entry order processors inclusive of 25 customer service representatives.
- Provided oversight for all aspects of call center to the service resource group offering support to 30,000 callers monthly.

Ulta, Inc., Mesa, Arizona
Assistant Manager, 2002-2003

- Accountable for all facets of retail sales and customer service.
- Responsible for selection, hiring, training and on going development of team. Accountable for reporting and exceeding set sales goals, merchandising, inventory, shrinkages, building maintenance, vendor relationships and overall store success.

IntelliRisk Management Corp
Manager, 2000-2002

- Directly responsible for all facets of call center environment. Provided inbound customer service, sales and collections for PrimeCo.

- Developed team synergy and loyalty in a group of 8-15 supervisors and 250 consultants. Utilized monitoring and management reporting tools to consistently evaluate programs and efficiencies.
- Translated vendor vision and expectations into directions, plans and measurable objectives. Managed through large-scale change successfully while exceeding vendor expectations.

America West Airlines, INC - Tempe Reservations Team
Manager, Specialty Sales and Services, 1987-2000

- Directly responsible for all facets of the daily operation of a 600 position inbound/outbound contact center. Provided inbound customer service, sales and technical support to over 40,000 callers daily.
- Span of control and direct accountability for the management of the FlightFund Service Center (Airline loyalty program), More Care (Travel Agency Services), Quality Management, International Sales, Emergency Response Center, Group/Convention and Meeting Services, Internet Support.
- Assessed operation standards, efficiencies and redundancies and established effective vehicles for implementing necessary change. Assessed and changed PNP on a regular basis. Developed and implemented process changes continually.
- Responsible for all personnel aspects including: change management, union avoidance, training, development, coaching, annual reviews, progressive disciplinary action, interviewing, terminations, EEOC issue, HR issues, security compliance, total file maintenance.
- Interfaced will all levels of management and internal/external clientele.

Education and Certifications

- Degree Business Administration, Detroit College of Business
- Course Certification: Strategic Management, Finance, Accounting, Labor Relations, Quantitative Analysis and Critical Thinking
- Lean Organizational Training
- Licensed Pharmacy Technician
- CERT National Certification, Citizens Emergency Response Team

Adrian Brown

Health Choice Arizona - *Claims Manager 2010-present*
Oversee operations of the claims department and resolution services: monitor claims statistics, production levels and payment and procedural accuracy, compare AHCCCS, and other payer policies, with HCA's policies for needed revisions or additions, evaluate departmental needs and implement necessary controls and interfaces/ counsel staff in regards to HCA, AHCCCS, Medicare and CMS claims payment guidelines. Identify and implement cost containment practice. *Interface with HCA's IS department and identify and participate in development of system. Organize efforts to reduce overpayments and recoupments. Continue professional growth and development to maintain high quality work.*

United Healthcare - *Claims Supervisor 2007-2010*
Manage teams of 20-25 claims examiners who are responsible for timely adjudication of Medicaid claims for the states of Maryland, Texas, Nebraska and Arizona. Facilitated a cross-functional workgroup, with the goal of reducing the number of pended claims for the state of Texas. Developed strong matrix partner relationships through the process and was able reduce pended inventory and maintain a 30 day TAT at 99% monthly. Implemented similar process for the State of Maryland and reduced pended inventory by 40% of total inventory and reduced pended claims over 30 days by 94%. Responsible for monitoring provider contracts (NPI), fee schedules, adjustment trends and system configuration to minimize late payment interest. Accountable to update all operating instructions for each state plan and work with system configuration team to ensure integrity of data within the system is compliant with all state and federal guidelines. Excellent knowledge of claim operation strategy and business.

CIGNA HealthCare - *Claims Manager 2005-2007*
Manages the accurate and timely adjudication of claims and administers disposition according to contractual benefits and company procedures. Provides direction regarding policies, procedures, workflows, claim service quality, and training needs for a team of 27. Monitoring claim service standards. Trend issues and develop action plans for improvement. Monitors Performance Guarantees to minimize financial impacts.
Additional roles: *Call Manager 2005-2006, Site Hiring Manager 2006 - present*
Interviewing, coordinating career fairs, new hire orientation and presentations. Liaison to internal and external staffing resources. Compensation decisions.

TIGER FINANCIAL - *Branch Manager 2001-2005*
Responsible for all store operations, uphold customer service standards, build revenue and personnel management. Created a management tool that is utilized in several markets to increase efficiency in daily store operations. Prepare multiple reports for weekly, monthly and quarterly meetings. Designed a project checklist and proposal guidelines for special promotional events. Developed an employee assessment in the Arizona market to assist with employee development and production. Created and implemented a metrics to provided data for analyzing production and creating individual goals and store objectives. Staff consistently earned 95% development and training scores.

INSIGHT ENTERPRISE INC. - *Account Executive 1998-2000*
Member of the #1 sales team. First team in company history to achieve 100% of its year-end quota goal. Target businesses for direct marketing of brand name computers, hardware and software through a combination of strong outbound telemarketing, electronic commerce, and electronic marketing. Generate leads, customer driven quotes and manage accounts. Analyze client's business strategies and budget constraints

YOUNGSTOWN STATE UNIVERSITY - *Assistant Basketball Coach 1995-1998*
Generate lists of high school and junior college prospects. Evaluate, recruited and signed a strong class of prospects during a pivotal year. Create and maintained relationship with scouts, high school coaches, AAU coaches, and college coaches for the purpose of obtaining new prospects. Scouted opponents for the purpose of analyzing, preparing and presenting scouting reports. Coordinate team travel. Monitor academic progress of student-athletes. Director of summer camps and league. Liaison for the City of Youngstown/Assistant Director of city Summer Youth programs.

EASTERN KENTUCKY UNIVERSITY Richmond, KY 1993
Bachelor of Arts, Broadcasting, Public Relations
Obtained 33 hours of Master's of Business Administration with a goal of completing degree in 2008

Abby A. Catalan, ME

Professional Experience

Health Choice Arizona
Provider Claims Educator, 10/2007 –Present

- Facilitate the exchange of information between providers and Health Choice's grievance, claims processing, and provider relations systems.
- Educate providers on the appropriate submission of claims, coding updates, electronic claims transactions and electronic funds transfer.
- Assure providers understand provider manuals, websites, and fee schedules.
- Develop and maintain processes to track and trend providers claims coding issues and validate provider education/training.
- Analyze and evaluate claims encounter data and appeals/grievance data to establish provider claims and coding issues.
- Maintain frequent communication with providers to assure that information is exchanged effectively and recommend strategies to improve provider satisfaction.

Value Options of Arizona
Contracts Administrator, Maricopa County RHBA, 5/2006 – 9/2007

- Contracted and re-contracted network practitioners and facilities.
- Participated in annual analysis fee schedules.
- Assisted in reviewing utilization review and claims data.
- Managed all provider data input including creation of new providers, vendors, fee schedules, maintenance of liability insurance and OBHL licensure.
- Coordinated internal review and determined/evaluated administrative feasibility throughout contracting process.
- Monitored accuracy of CMS assigned National Provider ID number and AHCCCS and ADHS/DBHS provider registration process.
- Prepared single case agreement letters with contracted providers for services not included in existing contracts and out-of-network providers.

Pacific Life & Annuity/Pacificare
Claims Examiner III, 4/2002 – 3/2006

- Adjudicated hospital and medical claims within contract and policy provisions.
- Maintained corresponding state compliance on pending claims.
- Reviewed claims for coordination of benefits, TPL, and Medicare/Medicaid eligibility.
- Completed comprehensive review of medical records for pre-existing investigation.

Independent Consultant
Health Claims/Systems and Development, 9/1999 – 4/2002

- Completed assignments with Jacobsen and Associates, Perot Systems, and Claims Net.
- Analyzed and implemented cost effective contractual agreements with healthcare providers and institutions to assure compliance with state and federal regulatory requirements.
- Performed claims examination, auditing, benefit coding, systems interface, and planning.

SRT Corporation
Benefits Coordinator, 1992 – 1998

- Supervised workflow of claims processing.
- Performed quality reviews and audits of targeted completed adjustments for client reports.
- Acted as a liaison between client's benefits department, members, and provider network.
- Provided system testing for system enhancement and client requested modifications.
- Handled appeals and grievances.

Self Employed
Counselor, 1988 - 1991

- Performed crisis intervention and counseling.
- Developed and provided individual treatment plans.
- Evaluated and documented clients' progress.

James Benefits
Manager, Greyhound Claims Operations, 1985 – 1987

- Managed office personnel, performed administrative duties, and assured staff were trained.
- Maintained effective working relationships with clients, providers, and vendors.
- Assisted with implementation of new business lines and technological configuration and software conversions.

Education and Certifications

- Master of Education in Counseling, Northern Arizona University
- Bachelor of Arts in Languages, Kent State University

Tommy Ashley

Professional Experience

Health Choice Arizona
Director, Network Services, 5/2010 –Present
Manager, Network Services, 9/2007–4/2010

- Oversee contract operations and processes.
- Maintain and update Network Development plan to comply with annual strategic plan.
- Perform network analysis to ensure adequate provider to membership ratios.
- Manage 12 members of the Network staff.
- Ensure contractual compliance with State and Federal requirements.
- Educate staff to ensure proper education is being given to the provider community.
- Develop and maintain policies and procedures.
- Responsible for presenting possible new contractual relationships to Senior Management

Network Account Manager, 7/2007–8/2007

- Management of all level 1 (large) provider groups.
- Responsible for provider rate negotiations.
- Finalize contract agreements and verification of accuracy.
- Prepare credentialing packets prior to submitting to the Credentialing Coordinator.
- Directly responsible for production and efficiency of subordinates.

Network Services Representative, 2/2006–6/2007

- Success in the areas of provider education, network evaluations and management of contractual agreements.
- Primary contact for contracted providers in South Phoenix, Tempe, portions of the West Valley and all of Pinal County in the areas of claims, quality, and general education.
- Perform network evaluations based upon population, geographic, and financial factors to determine network need.

Harrah's Prairie Band Casino
Accounting Clerk, 4/2004–9/2005

- Work with assigned vendors to ensure accurate and prompt payments.
- Rectify non-sufficient funds accounts.
- Generate payment letters to guests for in-house collections.
- Deal with guest bankruptcy issues. Assigned to liquor inventory.
- Coordinate with Purchasing Department to resolve quantity and/or cost discrepancies.

Total Rewards Representative, 8/2003–3/2004

- Welcome guests by providing information regarding casino programs and promotions.
- Interacted with guests to increase awareness and utilization of the "Total Rewards Program".

Blue Cross/Blue Shield of Kansas, 12/1995–6/2002
Medicaid Provider Relations Representative

- Member of provider education team assigned to improve knowledge and understanding of the Medicaid program.
- Worked with Medicaid providers, including physicians, administrators, pharmacies, and nursing homes.
- Prepared and facilitated presentations of educational materials.

Education and Certifications

- Bachelor of Business Administration, Washburn University
- General Studies, Allen County Community College

Requirement #4

REQUIREMENT #4

For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each. If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s).

Health Choice Arizona (HCA) contracts with two dentists on a part time basis who fill the position of Dental Director. The dentists are able to put in the required time to meet the current needs of the health plan for dental review on an as needed basis. As the health plan grows, or adds additional lines of business, HCA is planning on hiring a full time Dental Director.

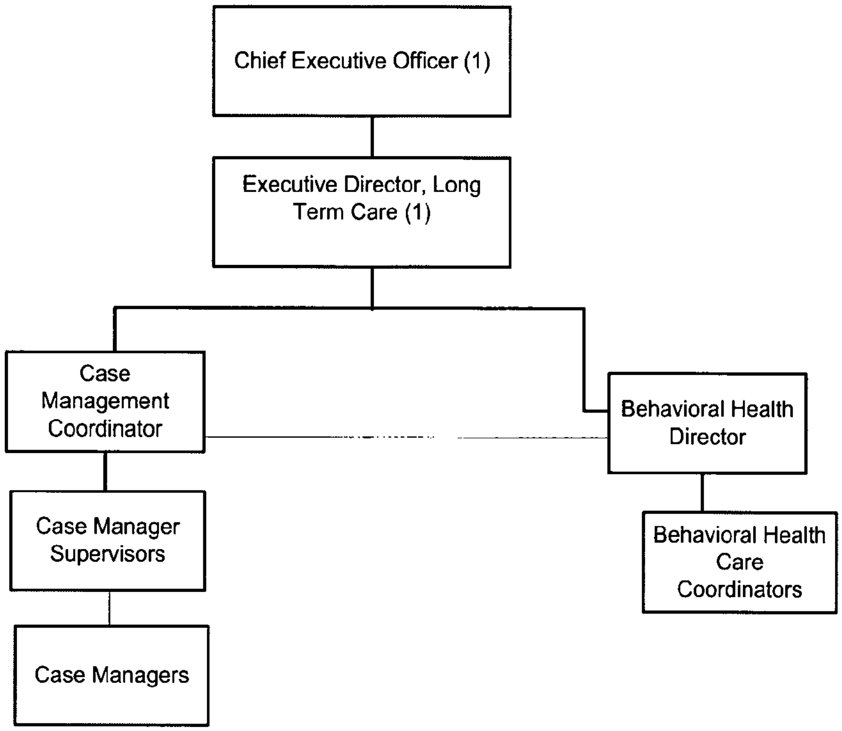
All other positions are full time and will remain full time in the foreseeable future.

Requirement #5

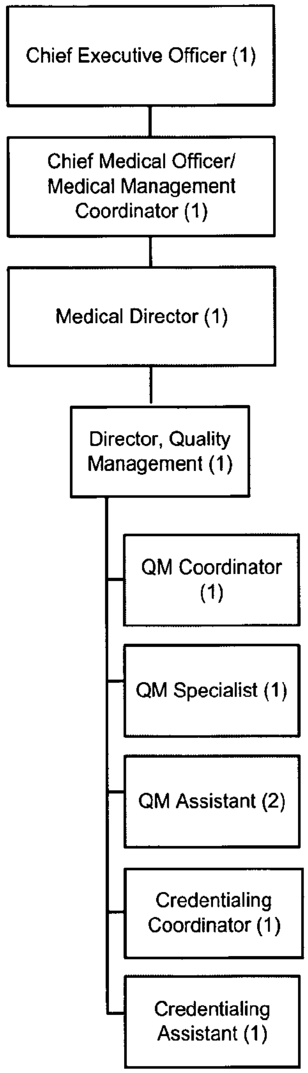
REQUIREMENT #5

Submit a functional organizational chart of the key program areas, responsibilities and areas that report to that position for the following functional areas: Case Management, Quality Management, Medical Management, Prior Authorization, Grievance System (Member Grievances and Appeals and Provider Claim Disputes) Provider Services, Finance, Claims, Encounters and Information Systems. The chart must identify the functions that will be subcontracted in a Delegated Agreement, Management Service Agreement and or Service Level Agreement.

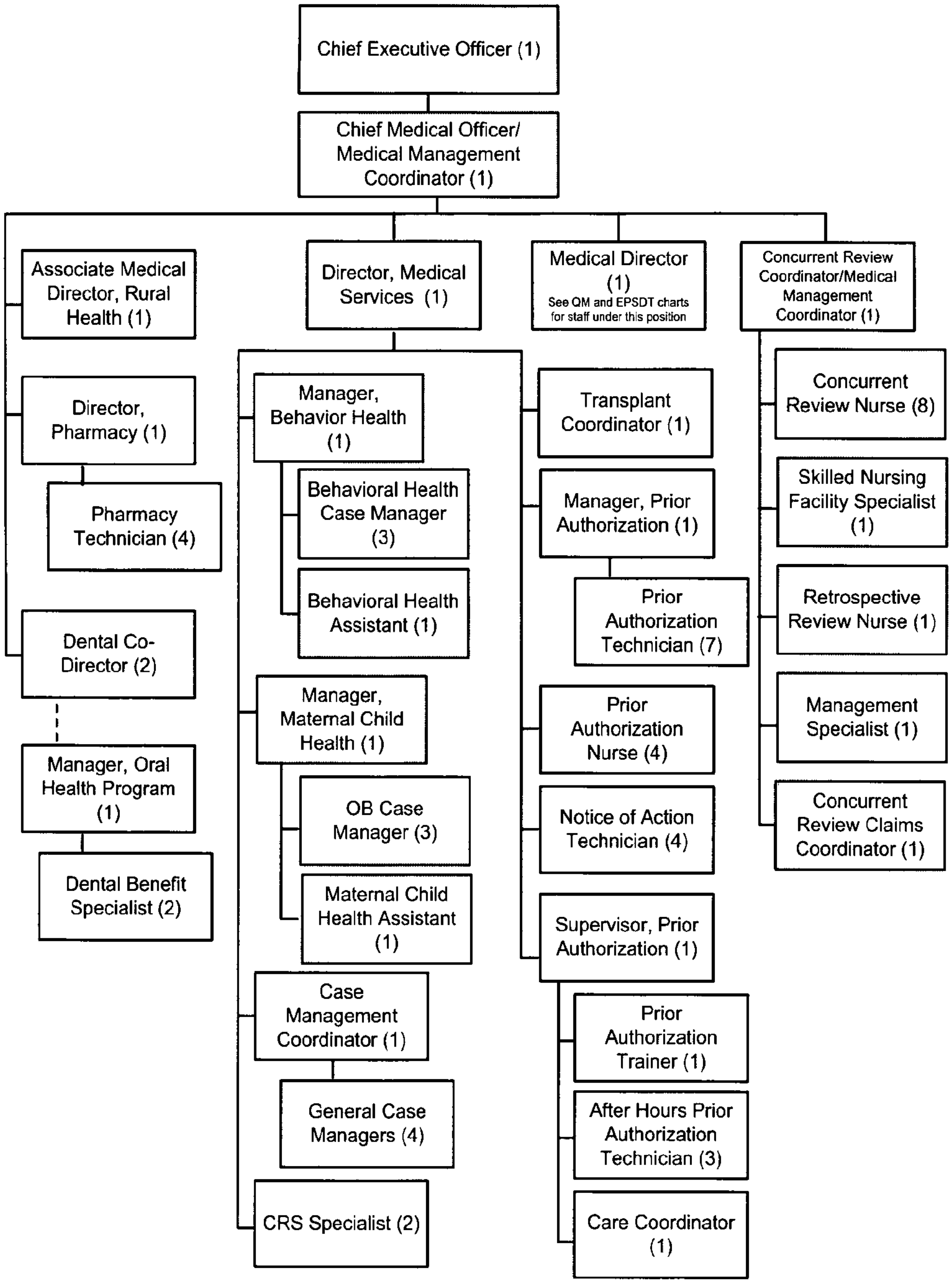
Health Choice Arizona
Case Management Staff



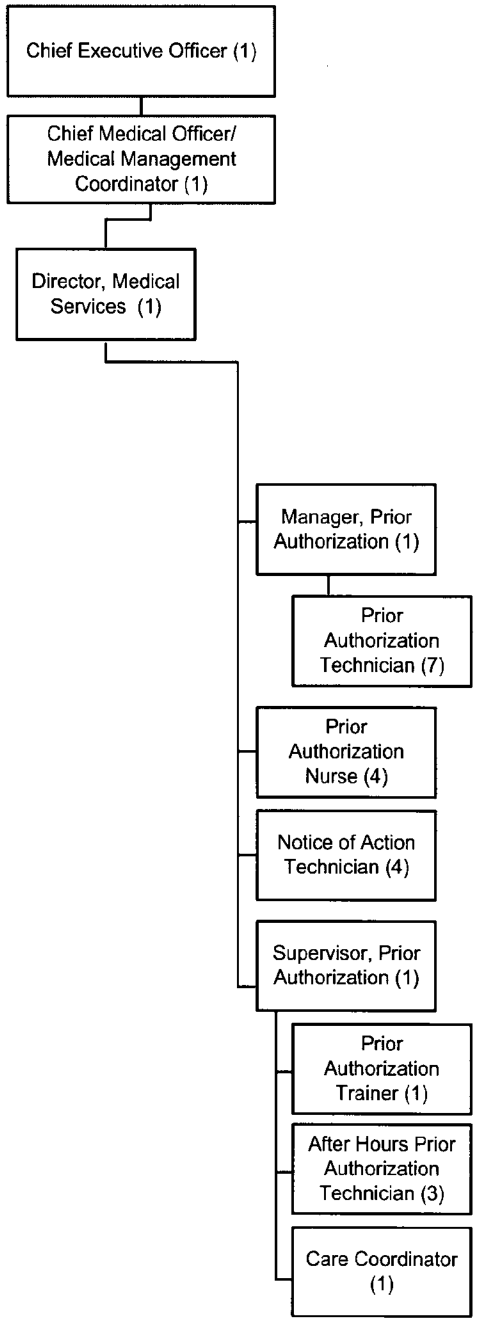
Health Choice Arizona
Quality Management Staff



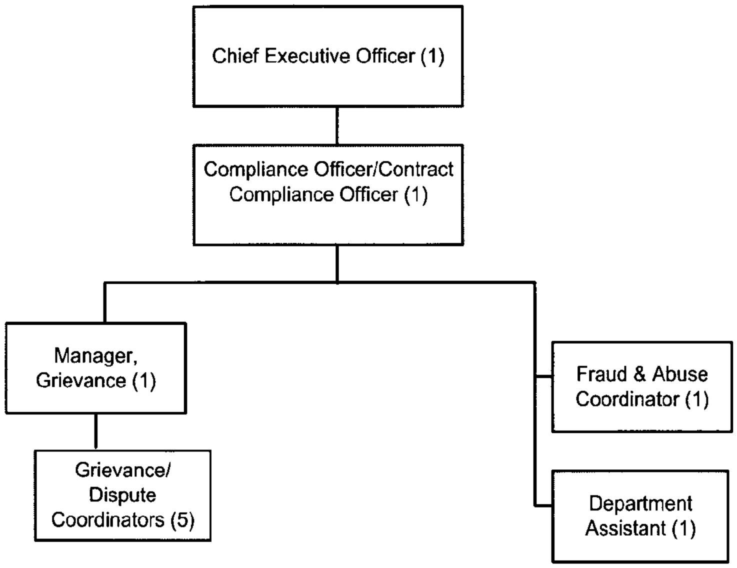
Health Choice Arizona
Medical Management Staff



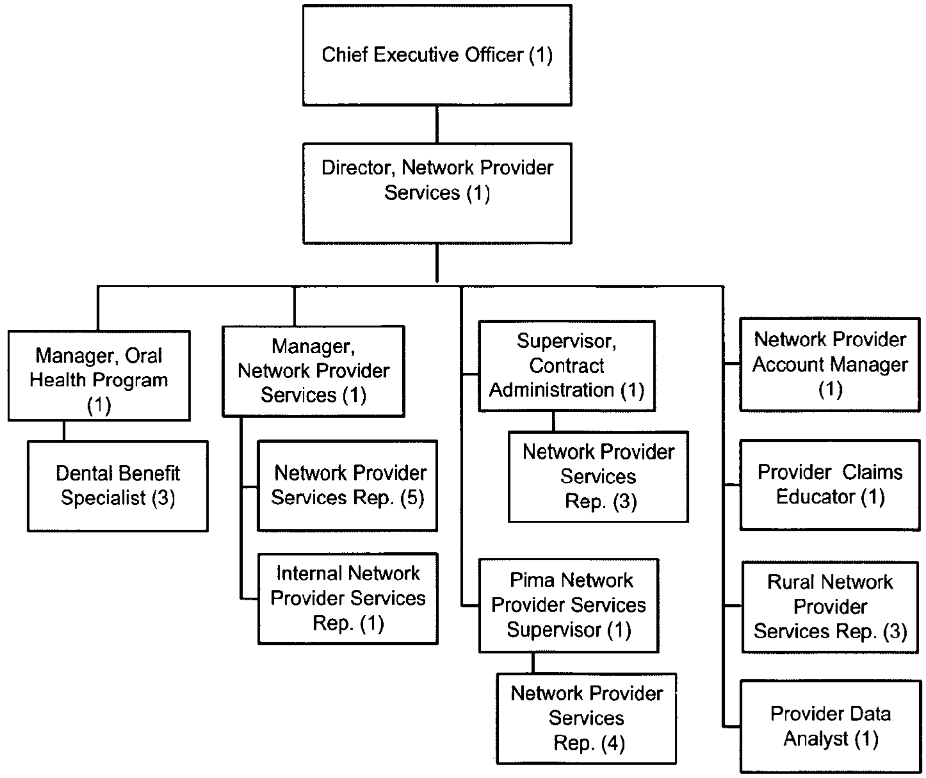
Health Choice Arizona
Prior Authorization Staff



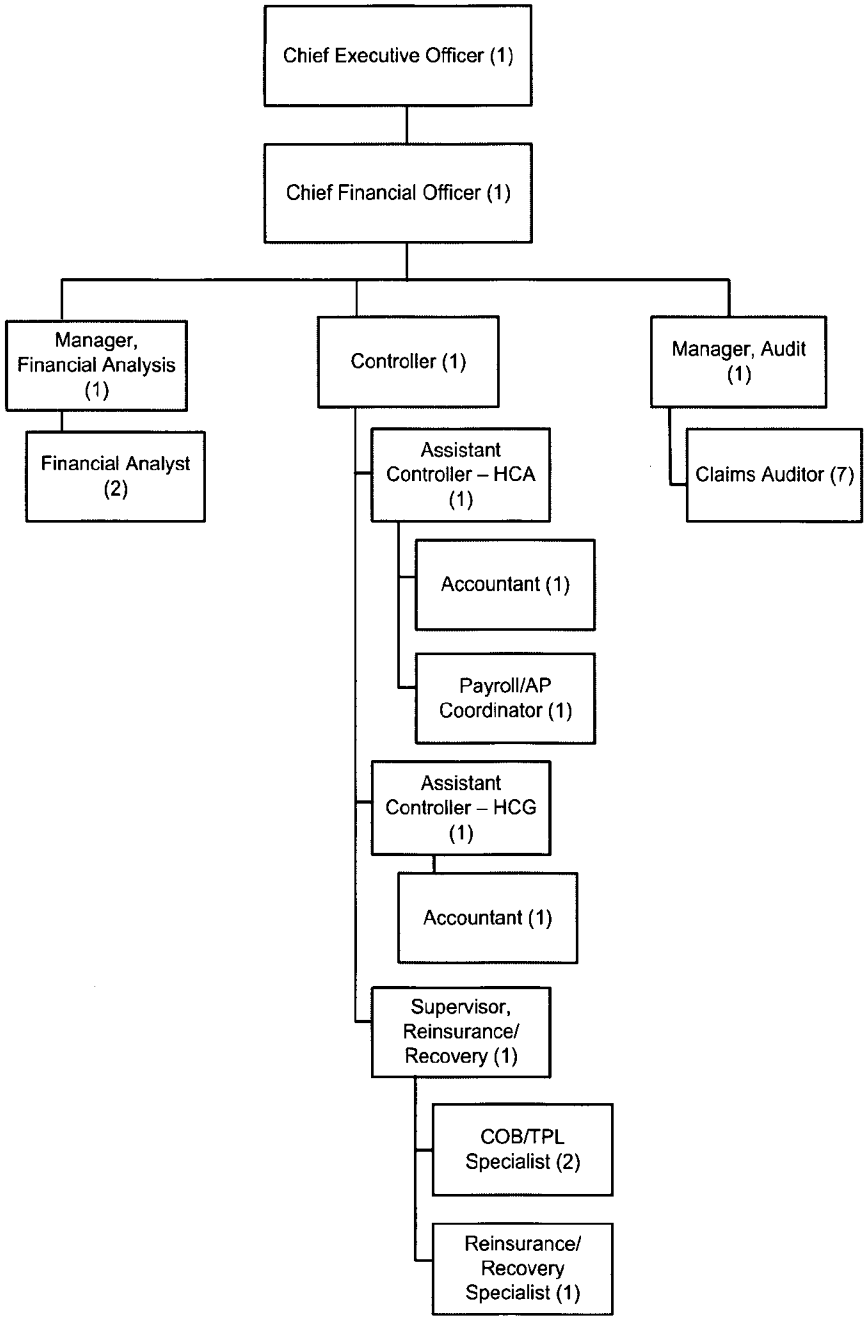
Health Choice Arizona
Grievance System Staff



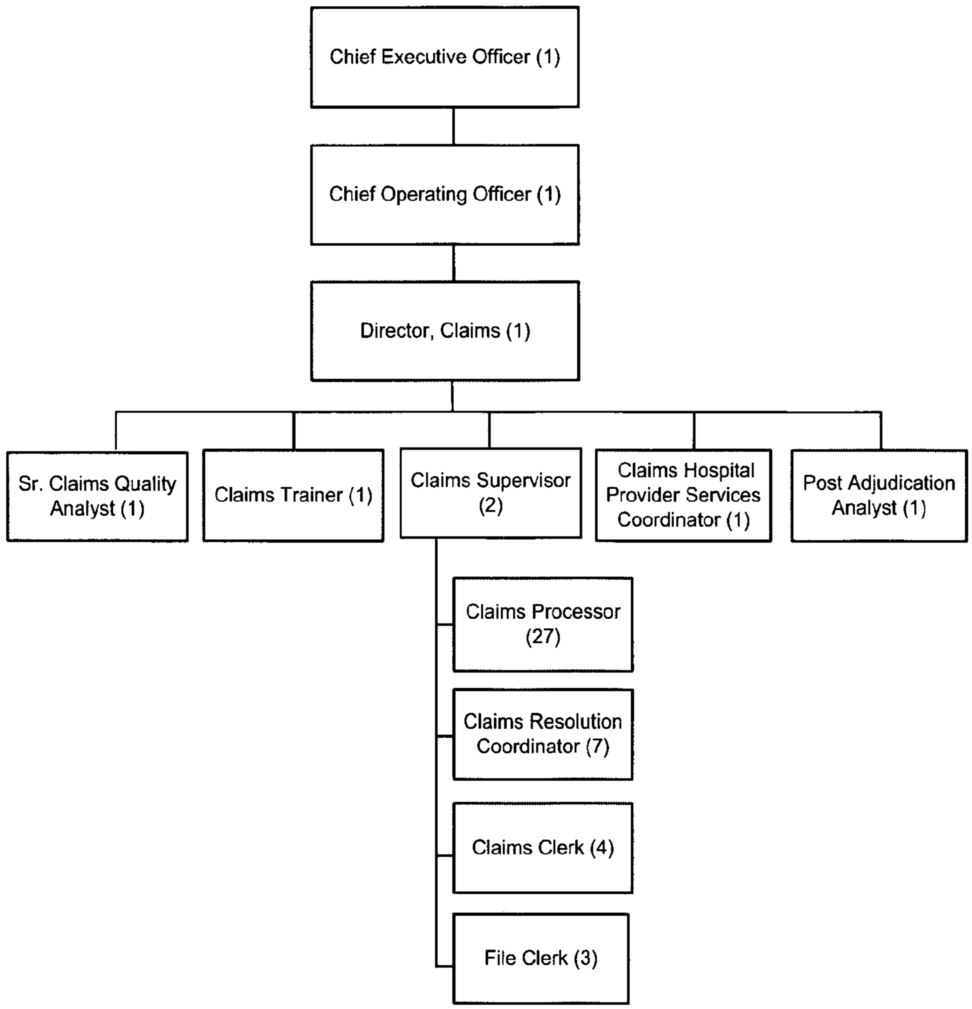
Health Choice Arizona
Network Provider Services Staff



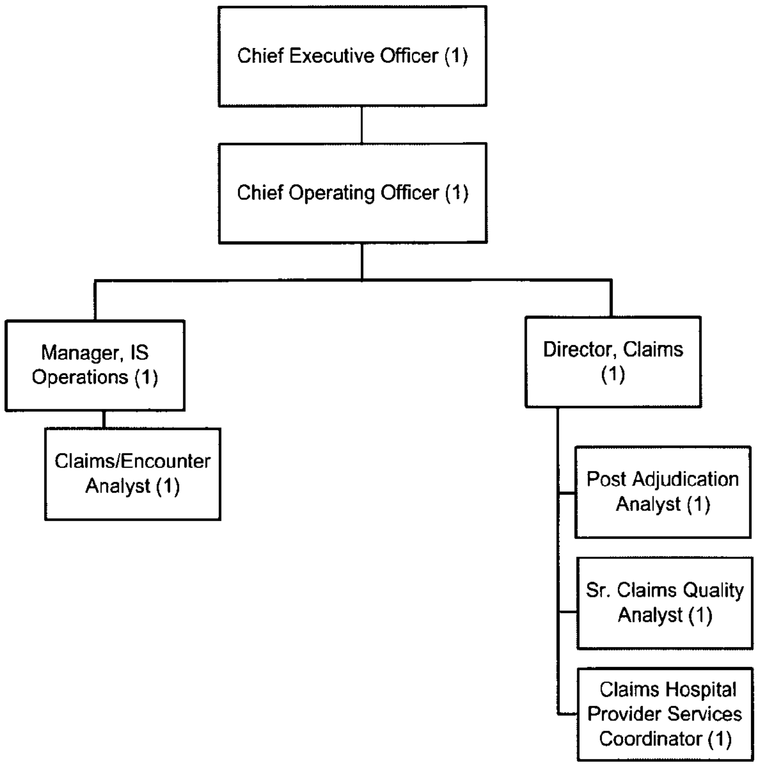
Health Choice Arizona
Finance Staff



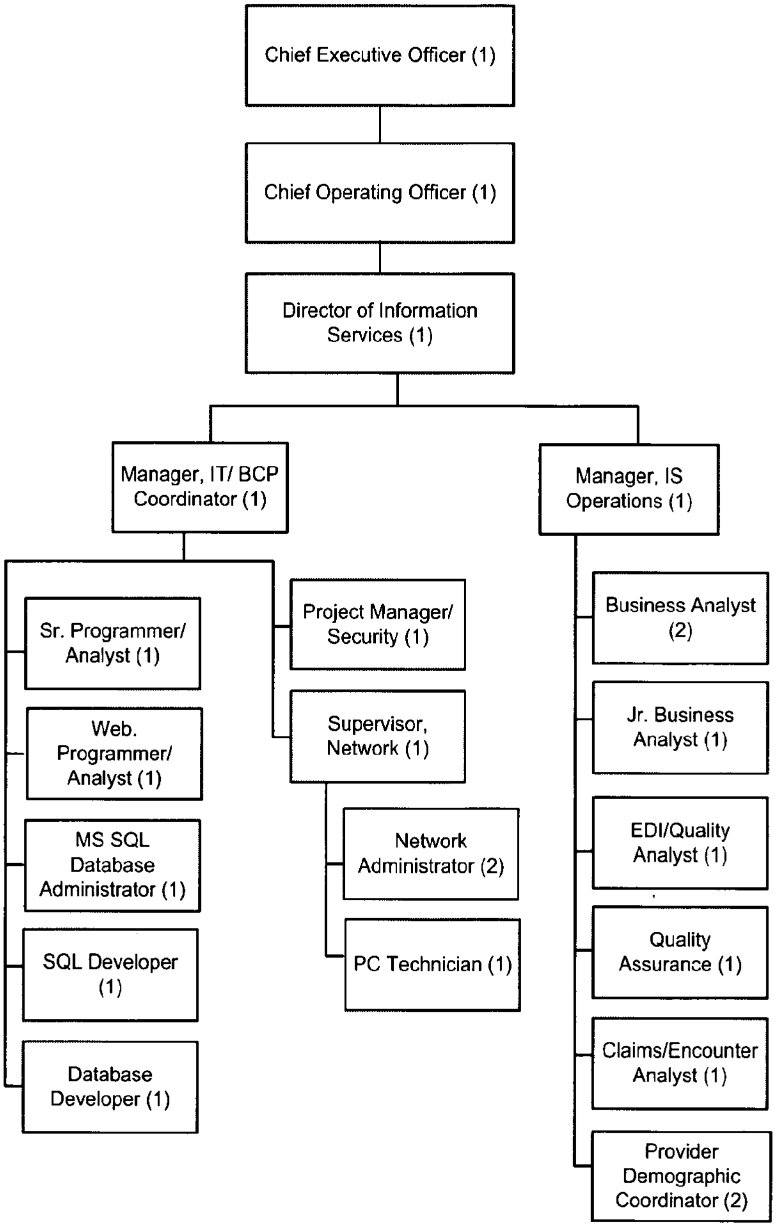
Health Choice Arizona
Claims Staff



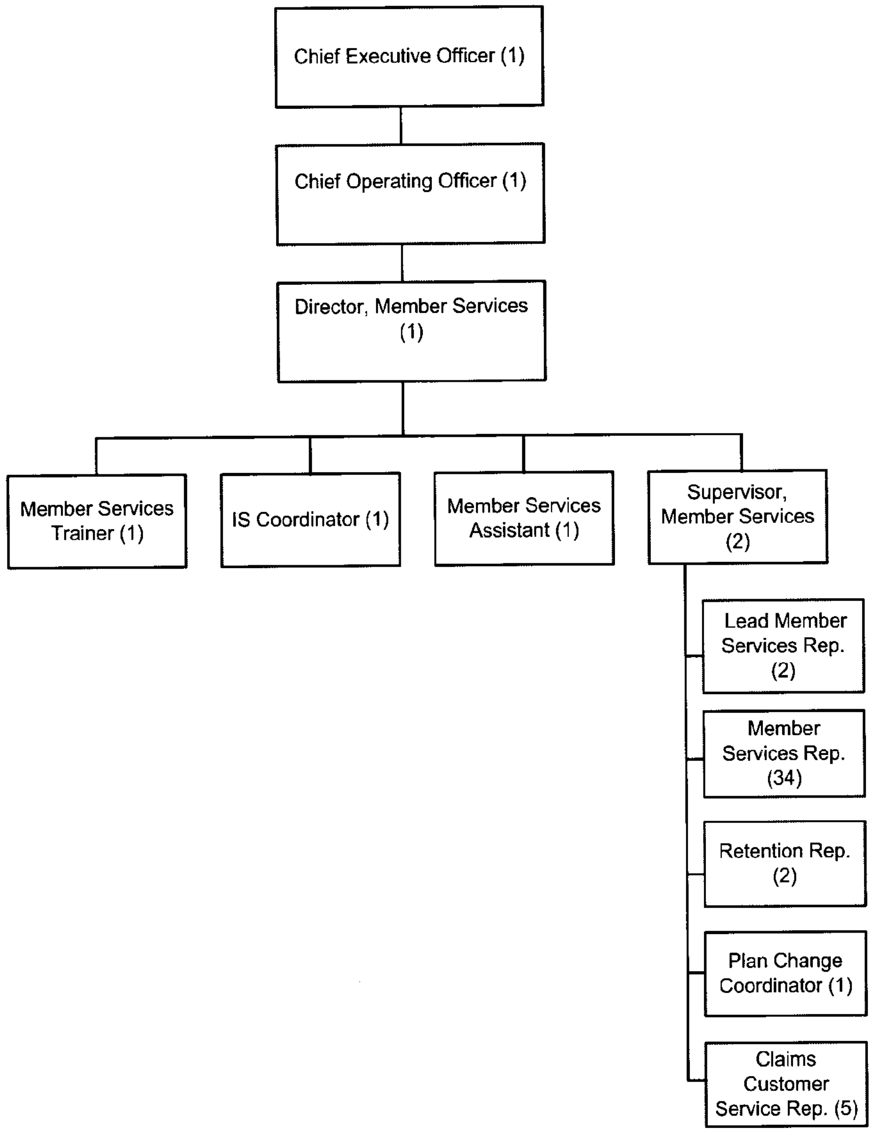
Health Choice Arizona
Encounters Staff



Health Choice Arizona
Information Systems Staff



Health Choice Arizona
Member Services Staff



Sanctions

Requirements #6

SANCTIONS

REQUIREMENT #6

Describe any sanctions levied against the Offeror, its parent corporation or any legally related corporate entity since January 1, 2008 that have been imposed by AHCCCS, Medicaid programs in other states, Medicare or any state insurance regulatory body. Include the description of the sanction, the specific reason for the sanction and the timeline to resolve or correct the deficiency. Indicate any sanctions that are currently in dispute. Sanctions are defined as any monetary and non-monetary punitive actions taken by regulatory bodies.

Health Choice Arizona (HCA) works diligently to maintain the highest possible level of compliance with its AHCCCS and CMS contracts, while providing quality and value to its members and providers. With compliance an integral part of all core strategic processes and objectives, HCA has been able to achieve optimal operating benchmarks, preventing sanctions levied from being significant enough to adversely affect the plan operationally or financially.

Encounter Data Validation Studies
Encounter Data Validation sanctions are based on the results of the AHCCCS system-wide audit to match encounter data with that of provider medical records. After challenges are reviewed, AHCCCS issues final results categorized by errors and omissions that determine sanction liability. The sanction liability includes an amount that is to be taken out of the health plan's capitation payment and an amount that the health plan must exhaust to remediate the process from which the errors occurred. Below is the detailed sanction activity since January 1, 2008. Regarding the amounts to be spent by the health plan, HCA has utilized those funds to perform continuous education to providers through the use of provider newsletters, area training meetings/seminars, and the Provider Claims Educator for more detailed one on one provider training.

CYE05 (10/01/05 to 9/30/06) Sanction amount:
$19,323 (levied November 2009)
$4,292 was taken from cap
$15,031 spent on Provider Education and Training

Encounter Sanctions
Encounter sanctions are assessed quarterly by AHCCCS for every health plan, calculated from the number of pended encounters aged more than 120 days. After challenges are reviewed, AHCCCS issues final results. To date, HCA has received notices of the following sanctions:

- January – March 2008 – Sanction amount: Waived
- April – June 2008 – Sanction amount: Waived
- July – September 2008 – Sanction amount: $41,925
- October – December 2008 – Sanction amount: $41,805
- January – March 2009 – Sanction amount: $2,795
- April – June 2009 – Sanction amount: $1,430
- July – September 2009 – Sanction amount: $20
- October – December 2009- Sanction amount: $0
- January – March 2010 – Sanction amount:
- April – June 2010 - Waived
- July – September 2010 – Sanction amount: $765
- October – December 2010 – Sanction amount: $240

Against Health Choice Generations (Medicare MA/PDP/SNP plan)
None

Against IASIS Healthcare (parent company)
None

Claims

Requirement #7

REQUIREMENT #7

Provide a detailed flowchart and narrative description of the claims adjudication process, addressing both paper and electronic claims submissions. Include in the description the following: monitoring process for accurate and timely claim adjudication; how deficiencies are identified and resolved; timeliness standards and cost avoidance/TPL activities; and how claim inquiries are handled. Include an actual sample of the remittance advice (front and back) or a written narrative of the remittance advice. The submission requirement will be a maximum of four pages of narrative and an additional five pages of flowcharts.

Claims Operation

Monitoring Process For Accurate and Timely Adjudication and Deficiency Resolution

Claims processing is one of the most important operational requirements of a health plan. It impacts all areas of the health plan including network management, financial management, medical management and contract compliance. Health Choice Arizona's (HCA) approach to claims adjudication is based on the following key objectives:

- Provide and promote the use of electronic billing through many methods including direct, clearinghouse, and/or direct data entry.
- Continuously increase claims auto adjudication rate to increase accuracy and consistency
- Pay claims often, accurately, and leverage EFT to increase the speed at which payments are deposited into the provider's accounts
- Continuously monitor and audit the claims process to ensure timely, accurate payments
- Process encounters and submit to AHCCCS timely and reconcile encounters to paid claims

To ensure these objectives can be met, HCA has established a set of performance measures and monitoring techniques to enable optimal claims adjudication and payment. The table below illustrates our recent performance against plan and AHCCCS measures:

Measure	AHCCCS Standard	HCA Standard	Current Performance
Timeliness (% w/i 30days)	95.0%	98.0%	99.61%
Daily Inventory 'Days Out'	N/A	11 Days	9 Days
Payment Percentage	N/A	97.5%	99.84%
Payment Accuracy	N/A	97.5%	97.75%
Encounter Acceptance	N/A	97.5%	99.48%
ECR Rate	60.0%	70.0%	72.18%
EFT Rate	60.0%	70.0%	71.98%
EDI Auto Processing Rate	N/A	20%	22.15%
Total Claims Inventory	N/A	<130,000(65% of Membership)	110,799

To effectively manage inventory and the claims adjudication operation, HCA utilizes data from all claim sources (clearinghouse, electronic direct, imaging, and manual entry) to develop a real time Work in Progress (WIP) report. This report includes claims volumes for each claim type and pend category, with associated age calculated in days. This tool allows the claims management team, including the COO, to view possible inventory issues in real time and solve those issues before they become acute and affect provider payment timelines. If an issue is identified, the root cause is determined and a corrective action plan is developed for remediation. Progress is evaluated daily with Executive Management and the Claims Leadership team.

In order to analyze monthly trends, HCA closely monitors the monthly Claims Dashboard. Fluctuations in volume of claims receipts, pends, and denials are included in the Claims Dashboard. Problematic trends or deficiencies identified via the Claims Dashboard are communicated immediately to all pertinent stakeholders including the Provider Claims Educator, Network services, Medical Services and Claims Customer Service Call Center. Meetings are then scheduled to develop and execute strategies and tactical remediation plans.

The Internal Audit Unit in the Finance Department is the independent unit responsible for reviewing, tracking, trending, and subsequently reporting on the accuracy of claims payment to management. Each week, the Audit Unit develops detailed reports of claims audits that include, but are not limited to High Dollar ($\geq$\$2,500), Electronic, and

Performance (1% of Processor's Production Volume). These audits include financial, procedural and payment measures.

When internal benchmarks are not being met, the Claims Department assigns the necessary additional staff to cover the claims that may be exceeding the timeliness threshold. Occasionally HCA has maintained timeliness by utilizing solutions such as reassigning claims staff, offering overtime, and/or utilizing temporary help to assist with any backlog, in order to ensure claims are processed in a timely manner.

The dashboard and audit reports are reviewed in the Provider Relations Improvement Committee. Claims trends, denial rates, and adjudication error trends are reviewed in detail at the claim and provider level to ensure integrity and accuracy of the claims process. These discussions and plans also drive agendas for provider coding seminars and monthly JOC's. The WIP report, Claims Dashboard, audit accuracy reports as well as interdisciplinary teams such as the Provider Relations Improvement Committee are an effective tool set for continuously monitoring the claims adjudication workflow.

Claims Adjudication Process

HCA has optimized the workflow for claim adjudication, and has implemented auto adjudication enhancements for Med/MC that have significantly increased both claims processing timeliness and accuracy. Exhibit A presents the claims adjudication workflow for electronic claims, and Exhibit B presents the claims adjudication workflow for paper claims.

Claims Receipt

HCA accepts the standard CMS 1500, UB04, and ADA 2006 claim forms, and HIPAA compliant ANSI 837P, 837I, 837D 275 (Claims Attachment) and NCPDP electronic formats. HCA provides several, easy to use, claim submission options, including the Emdeon Business Services (EBS) Clearinghouse, Direct Electronic submission via Secure FTP, or as an upload through the HCA Provider Portal.

Batching and Data Conversion/Entry

Preparation/Batching: Paper claims are received at the HCA headquarters in Phoenix, Arizona and routed to the claims file room. In the file room, the claims are sorted and grouped into specific claim types (i.e. CMS 1500's, UB inpatient. UB outpatient, SNF, etc.), batched in groups of 25, and sent to Emdeon Business Services (EBS) for imaging and Optical Character Recognition (OCR). To ensure detailed tracking of those claims sent, each claim form type is counted, logged, and reconciled with those that are received back and imaged by EBS.

EBS scans each claim and assigns a document control number. Each field must have a confidence interval of 100% to be accepted. Any field below 100% will be sent to a field verify operator to verify the claim information and enter it into the application. After the OCR and verification processes are complete, the claim is formatted into the ANSI X12 837 format. These electronic claim files are placed on an FTP server where they are downloaded by HCA. EBS contracted OCR response/turn around metrics are 50% within 24 hours, 99% within 48 hours, and 100% within 72 hours, while contracted accuracy is 99% at the field level.

Med/MC Claims Adjudication

Med/MC is the claims adjudication platform leveraged by Health Choice. The Med/MC adjudication workflow includes the following high level processes:

Front End Edits The Med/MC electronic upload process leverages initial edits such as member eligibility that if failed will result in a Front End Reject with a subsequent detailed letter of the reject reason being sent to the provider. Once the initial edits are passed, the claims are associated with the matching provider record in the Med/MC Provider Module. Claims that cannot be assigned a matching provider record are placed on an exception report to be worked by the Provider Demographic Coordinator. Once the reason for the non-match is found and fixed, if applicable, the file is reloaded in order to interface any claims for the impacted providers. Claims that do not interface at this stage trigger a reject letter to be sent to the provider due to lack of AHCCCS registration or incorrect demographic information.

Claims Scrubbing
In order to proactively ensure encounter data accuracy, HCA has designed Med/MC to require appropriate provider billing through system edits that include, but may not be limited to the following:

- Comparison of date of service to receipt date to ensure initial claim was received within 6 months from date of service or eligibility posting
- Edit for comparison of date of service to receipt date when this exceeds 12 months
- Possible duplicate claim identification
- Exact duplicate claims identification
- System alerts for members with other insurance coverage/TPL
- Alerts for members under case management
- Verification that prior authorization information matches date/type of service on claim
- Alerts for members with Prior Period Coverage (PPC)
- Alerts for invalid or terminated procedure/diagnosis codes
- Edit for age limitations for CPT/Diagnosis codes
- Edit for frequency limitations on CPT/Diagnosis codes
- Confirmation that the provider is approved to render a particular service per AHCCCS guidelines
- Automatic calculation of anesthesia base and time unit maximums for anesthesia to ensure that HCA payment is limited to the maximum allowable units per AHCCCS guidelines
- Edit check for bundling and unbundling of codes (CCI)
- Global Day Bundling
- Multi Channel Lab Test Bundling
- Multiple Surgical Reductions
- Edit check for validity of diagnosis to CPT/HCPC code combinations.(CCI)
- Edits for NPI number validation
- Edits for Occurrence codes and dates, Condition codes, and Value Codes and amounts on institutional claims
- Edits for valid field values on Admit/Discharge hour, Type, Source and Status
- Edits for Prior Authorization requirements that align with plan guidelines
- Edit for CPT to Modifier combinations
- OPFS logic using AHCCCS Reference tables

Additionally, HCA utilizes the medical coding and provider information supplied by AHCCCS from each 'Refe' file cycle as well as multiple industry-standard coding tools such as Ingenix Data Files and Encoder Pro to confirm the appropriateness and correctness of the services billed.

Adjudication
HCA has implemented enhancements in Med/MC to enable many claims to be auto adjudicated without the need for claims processor review. Based on the complexity and expected adjudication result, HCA determines whether each category of claim meets criteria for auto adjudication. All claims are adjudicated in accordance with AHCCCS rules and regulations as well as HCA policies and procedures. If claims or claim lines are not approved, they are denied or reduced, and appropriate reason codes are included with denied claims detail on the provider's remittance advice.

Coordination of Benefits/Third Party Liability
HCA utilizes cost-avoidance processes to ensure it is payer of last resort, in accordance with AHCCCS rules, when it is known that a third party will cover the service. Post-payment recovery or 'pay and chase' is utilized when it is not known if a member has third party coverage at the time the claim was initially adjudicated. HCA will identify all potentially liable third parties and pursue reimbursement, except in the circumstances defined by AHCCCS that require referral to the Contractor by AHCCCS or AHCCCS' authorized representative. HCA subcontracts with Recovery Management Services (RMS) to pursue third party recoveries and coordinate joint settlements with AHCCCS' authorized representative. Med/MC has strict COB edits and alerts the Claim Processors when it is known that a member has other insurance. If the primary insurance covers the service(s) on the claim with no prior payment, the claim will be denied. If an EOB is present with the claim, HCA limits any cost-sharing responsibilities for applicable copayments, coinsurance, and deductibles as defined in the *ALTCS contract* and the *AHCCCS Medicare Cost Sharing Policy*.

Coordination of Benefits (COB) information may be identified through multiple sources including claims, EOBs, hospital admission/face sheets as well as member or provider calls. HCA has established a workflow for third party coverage verification and it is illustrated in Exhibit C. Any previously unconfirmed COB information is forwarded to the COB/TPL Coordinator using a *COB Referral Form.* The COB/TPL Coordinator verifies that the proposed insurance is in effect, and the Member Module of Med/MC is then updated accordingly. In a nightly batch process, all new COB segments are sent to AHCCCS to provide the Agency with the responsible insurance entities. Any previously paid claims without appropriate coordination with the appropriate insurer are then adjusted accordingly within AHCCCS guidelines and A.R.S. 36-2923.

HCA follows industry standard practices for Third Party Liability. System edits have been put in place to prompt during claims adjudication when there is possible primary insurance coverage. The Claims Department will notify the recovery team about any claim submissions that include injuries that frequently indicate a potential Third Party Liability (TPL) which include, but are not limited to: other primary insurance, accidents involving one or more motor vehicles, assaults, violent crimes victims, multiple traumas, work related injuries, and other unnatural events. The Recovery/Reinsurance Supervisor forwards the notifications of probable TPL cases for the TPL Contractor to review, research and lien filing (see Exhibit D).

Provider Payment/Remittance Advice

Provider payments and remittances are produced twice weekly and reflect applicable provider transactions. The remittance advice (also called the Explanation of Benefits, or EOB) for each claim includes: the member, procedure code(s), diagnosis code(s), billed amount, paid amount and detailed reasons for denials, if any. A copy of the remittance advice is included in Exhibit E.

Four files are created in the Payment cycle. The first, the ANSI X12 835 (EFT Segment Only) is sent to Bank of America to perform the Electronic Funds Transfer (EFT) the day following file receipt. The remaining 3 files: ANSI X12 835 ERA, Paper Check and Paper EOB files are sent to HCA's post adjudication clearinghouse, Emdeon Business Services (EBS). EBS distributes the electronic remit, paper check, and/or paper EOB based on the provider's preference. HCA also provides a link from within the secure HCA Provider Portal to allow providers to download a printable copy of the EOB. For providers that do not have systems capable of automatically posting payments via the ANSI 835 ERA but want the quick payment afforded by the EFT, a downloadable remit serves as an ideal solution.

Provider Claims Inquiries

The Claims Customer Service (CCS) Unit handles provider claims inquiries. Specific functions and roles have been segregated from the main queue to better serve large individual providers. These roles include Post Adjudication Analysts and Provider IT Coordinator. The Post Adjudication Analysts work directly with facility providers to status and work their aged claims on a daily basis. The Provider IT Coordinator is responsible for troubleshooting any electronic claims or provider portal issue that the provider may be experiencing.

The CCS team uses the HCA Provider Inquiry Application to record, document and track provider inquiries. When provider offices call to request information regarding electronic claims submission, claims adjudication, payment, or any other issues, customer service representatives enter a description of the provider's call into the application. If the CCS Representative was able to resolve the issue or answer the inquiry, the call is closed out. If follow-up is required by a claims subject matter expert or Provider Relations Representative, the call is assigned to the specific area for follow-up. All inquiries are responded to within 3 days and resolved within 30 days. Reports are generated from the Provider Inquiry Application and reviewed frequently by Administration and Operations personnel to identify trends in provider issues as well as to ensure all inquiries were followed up on and resolved in a timely and satisfactory manner. This allows HCA to remediate provider issues quickly and effectively, facilitating the growth of a strong provider network to serve HCA members' medical needs.

The Provider Claims Educator conducts weekly in service training with claims the HCA CCS personnel to ensure they have the necessary tools to not only understand the provider's issue, but also develop strong analytical and problem solving skills to resolve the issue while the provider is still on the phone. The CCS Team works with claims and IS on a day to day issues to quickly identify claims processor or system specific issues before they escalate. If the provider wishes to file a dispute, the CCS Representative helps the provider understand the dispute procedures and if requested, walk them through the process.

Exhibit A:

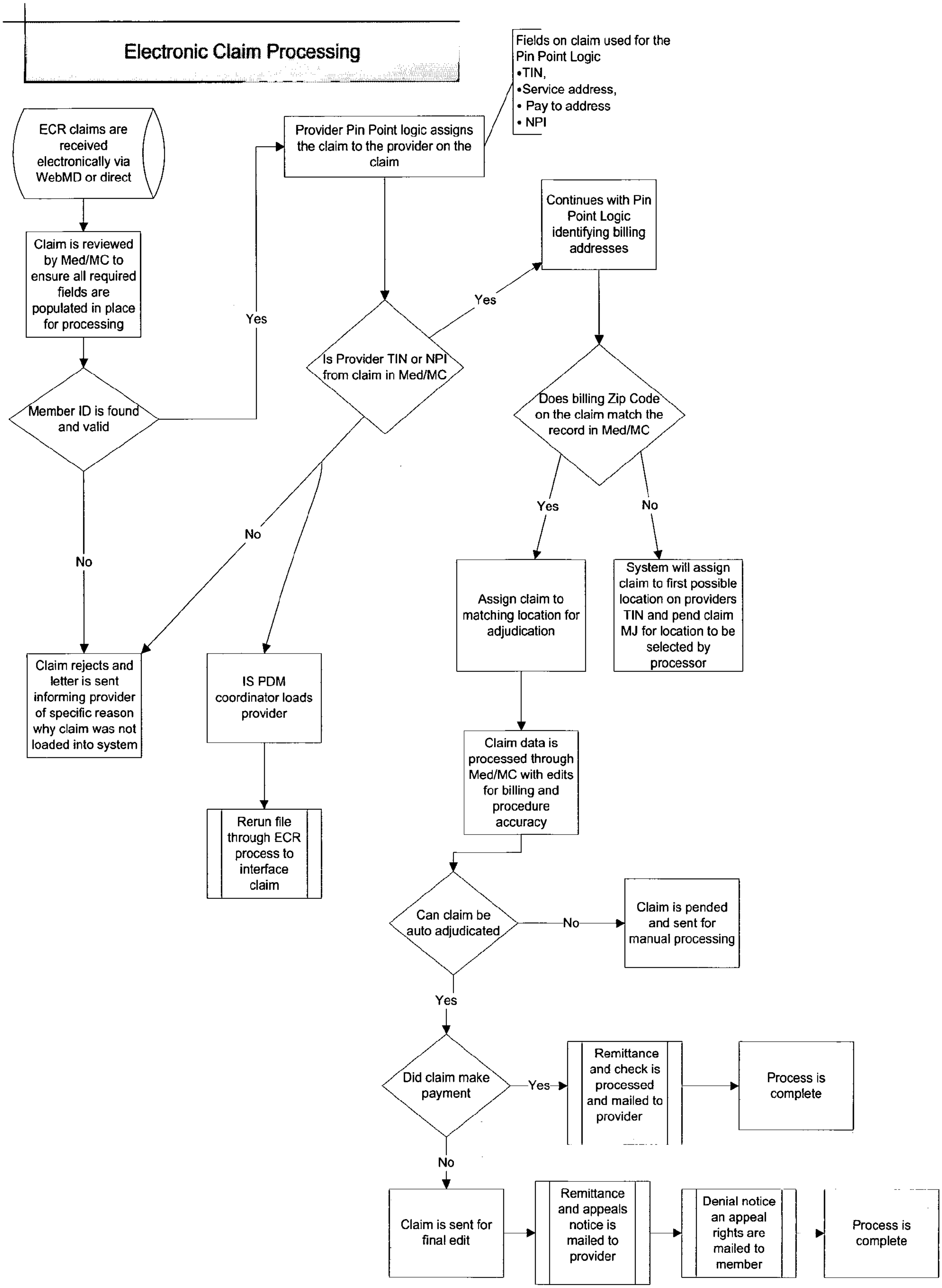

Electronic Claim Processing
Fields on claim used for the Pin Point Logic
•TIN,
•Service address,
• Pay to address
• NPI
ECR claims are received electronically via WebMD or direct
Provider Pin Point logic assigns the claim to the provider on the claim
Continues with Pin Point Logic identifying billing addresses
Claim is reviewed by Med/MC to ensure all required fields are populated in place for processing
Yes
Yes
Is Provider TIN or NPI from claim in Med/MC
Member ID is found and valid
Does billing Zip Code on the claim match the record in Med/MC
No
No
Yes
No
Assign claim to matching location for adjudication
System will assign claim to first possible location on providers TIN and pend claim MJ for location to be selected by processor
Claim rejects and letter is sent informing provider of specific reason why claim was not loaded into system
IS PDM coordinator loads provider
Claim data is processed through Med/MC with edits for billing and procedure accuracy
Rerun file through ECR process to interface claim
Can claim be auto adjudicated
No
Claim is pended and sent for manual processing
Yes
Did claim make payment
Yes
Remittance and check is processed and mailed to provider
Process is complete
No
Claim is sent for final edit
Remittance and appeals notice is mailed to provider
Denial notice an appeal rights are mailed to member
Process is complete

Exhibit B:

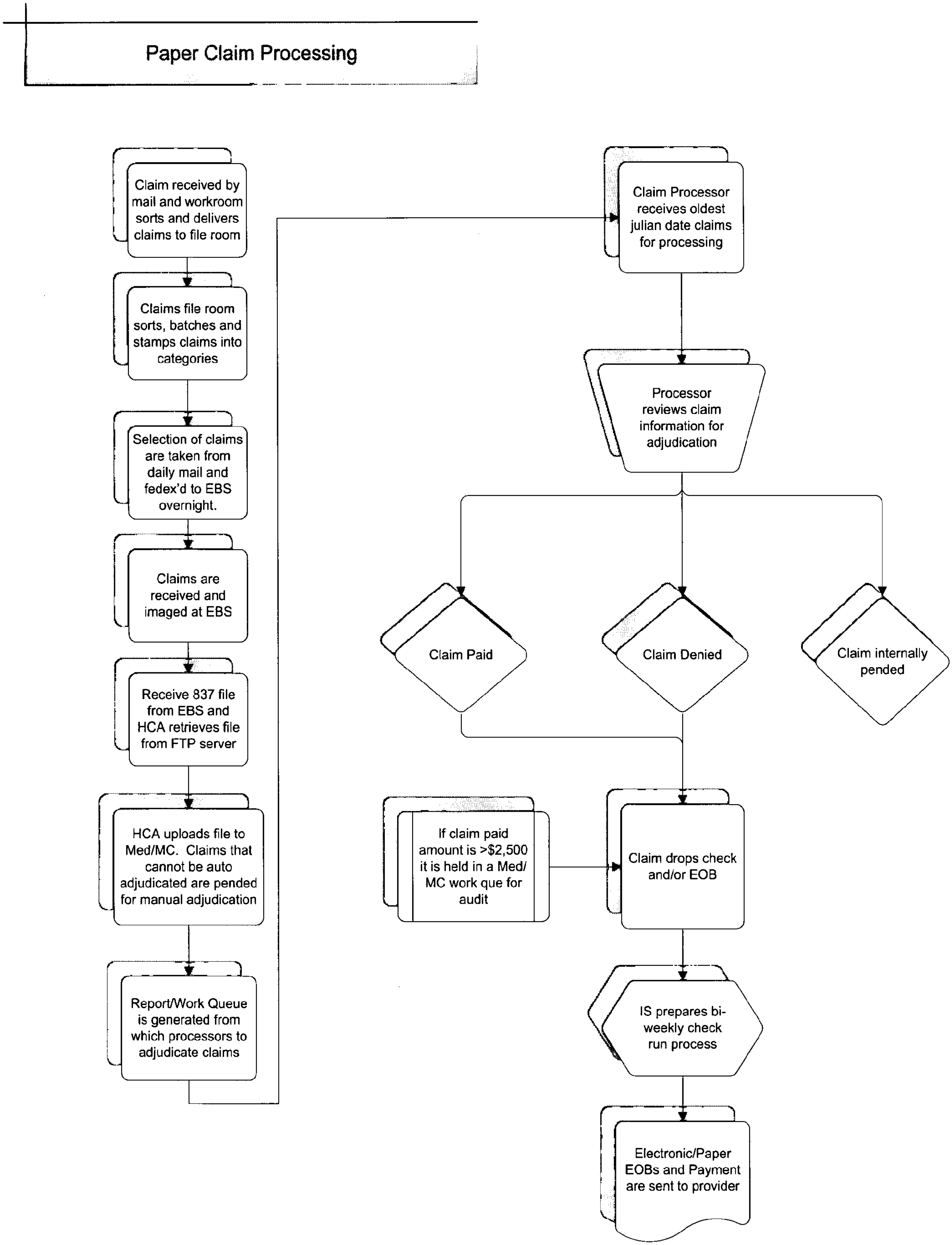


Exhibit C:

Coordination Of Benefits / Cost Avoidance

Health Choice Arizona

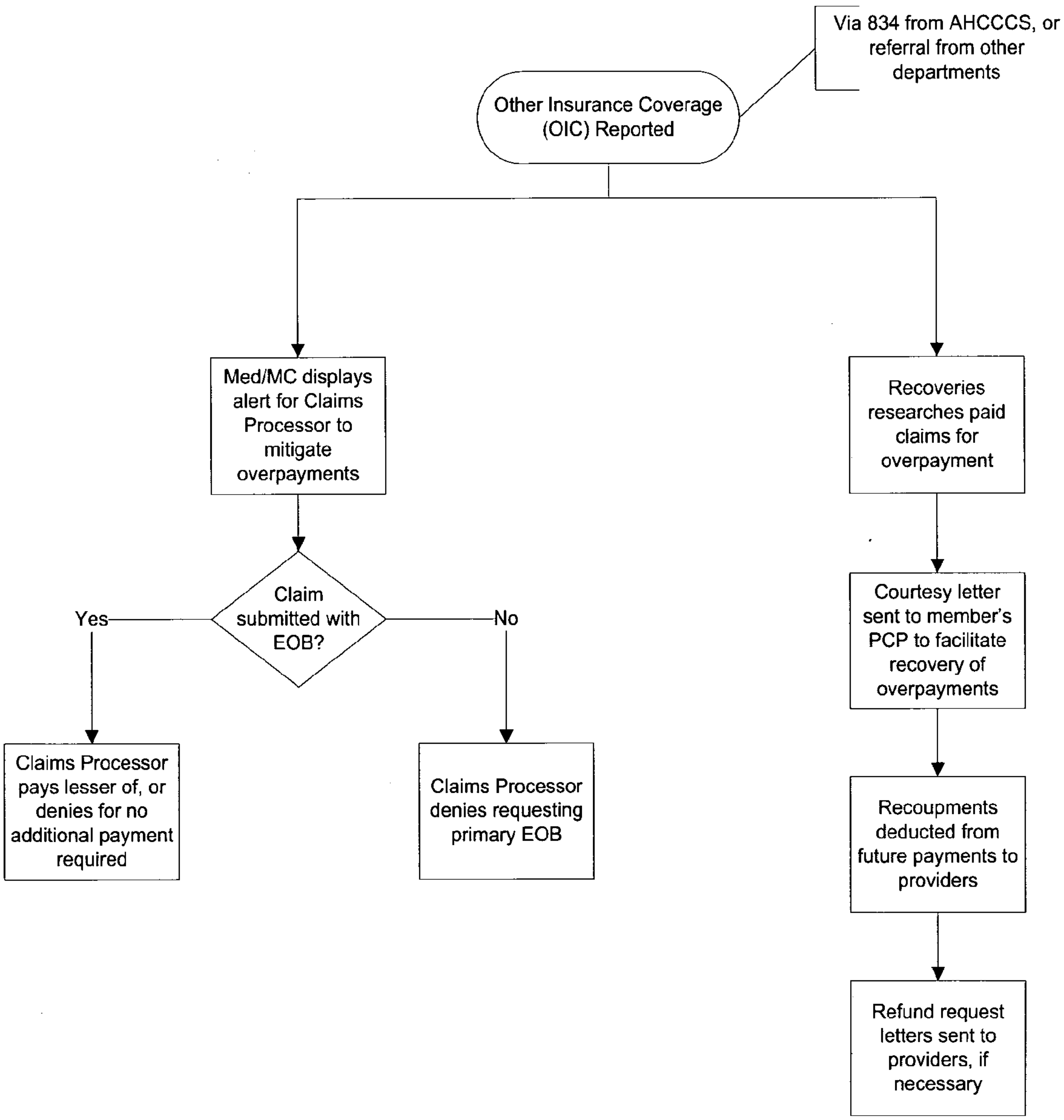


Exhibit D:

Third Party Liability

Health Choice Arizona

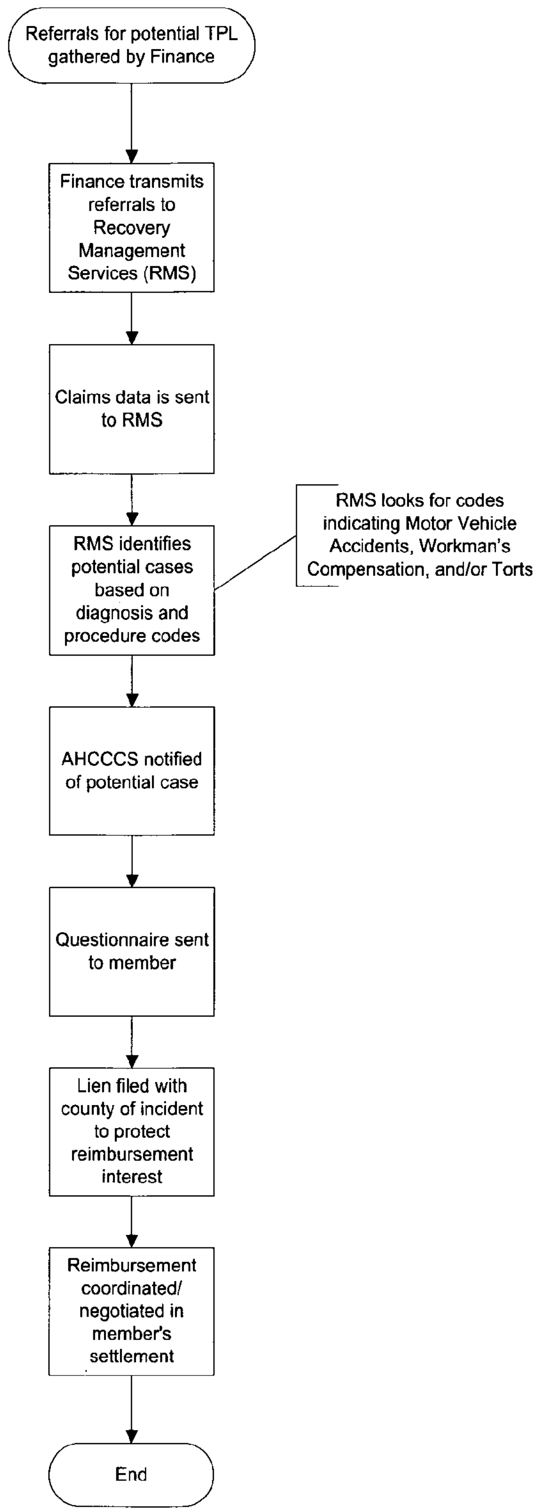


Exhibit E:

ENV 2718

P9907028002

Exhibit 13-1 Sample Medical EOB

Health Choice Arizona, Inc.
410 N. 44th St., Ste 900
Phoenix, AZ 85008

Forwarding Service Requested

Health CHOICE

IF you have any questions
Please call (480) 968-6866

NEW SMS 1500 FORM IS AVAILABLE – PLEASE SUBMIT MEDCIAL CLAIMS ON THIS FORM

Invoice #	123456
Check no:	654321
Provider TIN:	112223333
Date:	1/03/08

Sample Provider, MD
1351 Sample Dr.
Tempe, AZ 85282

Service Dates From To	Service Code	# Units	Amount Billed	Excluded/ Deductible	Not Allowed	Allowed Amount	C.O.B. Insurance	Co-Pay Amount	Withhold Amount	Paid Amount	Adjustment-Reason/code
Member:	SAMPLE PATIENT	**Member #:**	A00002222					**Claim #:**	666555888		
Provider:	SAMPLE PROVIDER	**Account No:**	SAM21212					**Plan:**	2420		
10/24/07-10/24/07	72110TC	1	175.00	0.00	137.57	37.43	29.94	0.00	0.00	7.49	R1
10/24/07-10/24/07	7211026	1	40.00	0.00	25.22	14.78	11.82	0.00	0.00	2.96	R1
10/24/07-10/24/07	72170TC	1	85.00	0.00	65.37	19.63	15.70	0.00	0.00	3.93	R1
10/24/07-10/24/07	7217026	1	19.00	0.00	8.99	10.01	6.67	0.00	0.00	3.34	R1
10/24/07-10/24/07	99203	1	130.00	0.00	37.99	92.01	73.61	0.00	0.00	18.40	R1
Claim Totals:			449.00	0.00	275.14	173.86	137.74	0.00	0.00	36.12	
Member:	SAMPLE PATIENT	**Member #:**	A00002222					**Claim #:**	666555889		
Provider:	SAMPLE PROVIDER	**Account No:**	SAM21212					**Plan:**	2420		
10/17/07-10/17/07	99212	1	54.00	0.00	17.30	36.70	29.36	0.00	0.00	7.34	R1
Claim Totals:			54.00	0.00	17.30	36.70	29.36	0.00	0.00	7.34	
Member:	SAMPLE PATIENT	**Member #:**	A00002222					**Claim #:**	666555890		
Provider:	SAMPLE PROVIDER	**Account No:**	SAM21212					**Plan:**	2420		
10/24/07-10/24/07	73590	1	99.00	0.00	70.65	28.35	22.68	0.00	0.00	5.67	R1
10/24/07-10/24/07	99212	1	54.00	0.00	17.30	36.70	29.36	0.00	0.00	7.34	R1
Claim Totals:			153.00	0.00	87.95	65.05	52.04	0.00	0.00	13.01	
Member:	SAMPLE PATIENT	**Member #:**	A00002222					**Claim #:**	666555890		
Provider:	SAMPLE PROVIDER	**Account No:**	SAM21212					**Plan:**	2420		
11/08/07-11/08/07	L1906NU	1	120	0.00	120	28.35	22.68	0.00	0.00	0	14
11/08/07-11/08/07	73610	1	103	0.00	70.18	32.82	29.36	0.00	0.00	32.82	
Claim Totals:			223.00	0.00	190.18	32.82	52.04	0.00	0.00	32.82	

	Amount Billed	Excluded/ Deductible	Not Allowed	Allowed Amount	C.O.B. Insurance	Co-pay Amount	Withhold Amount
Statement Totals:	879.00	0.00	570.57	308.43	219.14	0.00	0.00

Adjustment-Reason/code Descriptions

R1 REDUCED BY MEDICARE/OTHER INSURANCE
14 REQUIRES AUTHORIZATION
*** "SEE OUR WEBSITE @HealthchoiceAz.com FOR INFORMATION ON CLAIMS DISPUTE RESOLUTION"
*** * HCA IS LIVE WITH EMDEON FOR ELECTRONIC CLAIMS. PAYOR ID 62179. PLEASE SUBMIT ALL CLAIMS ELECTRONICALLY. PLEASE SUBMIT ONLY THE 6 DIGIT

AHCCCS ID OR NPI.

Requirement #8

REQUIREMENT #8

Describe what the Offeror will be doing to promote and advance electronic claims submissions and assist providers to accept electronic funds transfers.

Health Choice Arizona (HCA) has been diligent and determined in the promotion of Electronic Claims Receipt (ECR) and Electronic Funds Transfer (EFT) with its provider network. HCA has realized significant benefits in improved claims processing and greater provider satisfaction as a result of these efforts. To promote and advance electronic claims submissions and assist providers to accept electronic funds transfers, Health Choice has made the subject mandatory for all claims inquiries calls. During a claim inquire call, the CCR is trained to look up the provider profile to determine if the provider is currently sending electronic claims and or on EFT. If they are not, the CCR has scripts to describe the benefits of both that include but are not limited to billing accuracy and faster payment. Additionally, Health Choice Network Representative review the benefits with their providers during regularly scheduled site visits. The benefits of ECR and EFT are presented at coding seminars and jointly sponsored provider events with Emdeon Business Services, Health Choice's Clearinghouse. Additionally, ECR and EFT is the subject of a recurring article in the Health Choice Provider Newsletter.

For all new provider contract relationships and current provider contract renewals, Health Choice requires providers to submit electronic claims and be paid electronically. This type of 'Opt Out' program has been key to Health Choice raising its electronic rates to over 70% for both ECR and EFT.

Electronic Claims Submission Options

HCA provides several methods of claims submission to satisfy the varied capabilities and resources of its providers, especially those in rural areas. For electronic claims submission, providers can submit through any clearinghouse they currently work with, at no additional cost to the provider. The clearinghouse will transmit their claims to Emdeon, HCA's clearinghouse, which transfers them to HCA. In addition, HCA makes two direct submission options available to providers. In the first option, IS infrastructure staff works directly with the provider's staff to enable a Virtual Private Network (VPN) connection. The VPN connection allows providers to securely send HIPAA 837 files via File Transfer Protocol (FTP), and saves the providers the transaction costs associated with a clearinghouse. The second option, requiring less IT knowledge for the provider, allows them to upload HIPAA 837 files via a secure web session on the provider portal. To assist providers further in setting up and troubleshooting electronic claims submissions, HCA maintains a full-time employee within the Claims Customer Service Department as the Provider IT Coordinator.

HCA has heavily promoted its electronic claims submission options over paper claims submission, resulting in a substantial increase in electronic claims, from 27% in 2007 to over 70% in 2011.

Electronic Remittance Advice and Electronic Payment by EFT

HCA makes an EFT payment option available to its providers. In each payment cycle, HCA forwards payment data to its bank, Bank of America, to perform the Electronic Funds Transfer (EFT) the day following file receipt. Providers who participate in this program receive their payments directly into their designated bank that same day.

HCA has developed a number of payment options to make it easy for providers to advance toward greater automation. Through Emdeon Business Services (EBS), providers have the ability to download electronic remittance advice for each check run's paid claims. In addition, HCA makes available a downloadable print file on the HCA provider portal, enabling providers to securely access it directly. These options can make it easier and more efficient for provider office staff to manage paid and denied claims. In addition, providers who accept EFT, receive payment 2 3 days sooner and more reliability than through mailed payment checks.

As stated above, HCA uses all available communications channels to educate and inform providers of the array of electronic services and self service capabilities which can strengthen the relationship between the provider and HCA.

Requirement #9

REQUIREMENT #9

Provide a description of the clinical edits and data related edits included in the claims adjudication process.

Health Choice Arizona (HCA) utilizes the Med/MC Claims Adjudication System (Med/MC) for claims adjudication and payment. HCA has customized Med/MC to meet AHCCCS/Medicaid managed care functionality requirements. Med/MC is a versatile system with flexible programming options enabling HCA to leverage claim edits to optimize data integrity, correct coding, cost avoidance, timeliness, as well as enrollment, network and benefit adherence.

HCA has worked diligently to ensure AHCCCS clinical and data related edits are fully integrated with the Med/MC claims adjudication logic. HCA utilizes the data from the Reference ('Refe'), Eligibility (ANSI X12 834), and Provider Profile Records to drive adjudication edit logic. This integrated approach enables the provider community to maintain one set of billing practices for both HCA and AHCCCS, reducing their administrative burden, while increasing their focus on quality of care for our members. Standard CCI Edits and mandatory copays have been integrated into the Med/MC claims payment process, in both auto-adjudicated and manually adjudicated workflows.

Claims edits logic maintenance is not a static project, but an evolutionary process that matures with industry standards and best practices such as HIPAA taxonomy, the Correct Coding Initiative (CCI), and National Provider Identification (NPI). HCA has developed a stable, flexible foundation with Med/MC that enables updated and new edits to be easily created to apply AHCCCS and HCA policy as well as national initiatives and best practices.

Types of Edits
There are several categories of edits that are implemented in Med/MC:

- **Validation Edits** are applied to logically ensure that required data is present and syntactically correct. These are simple data attribute edits that largely exist to catch data entry / interface edits and to validate complex EDI data requirements.
- **Relationship Edits** compare data present on the claim with information which is on file in Med/MC. Comprising the bulk of Med/MC edits, relationship edits are table driven and have been continuously refined to meet both AHCCCS and HCA policy. Duplicate check edits are another type of relationship edit which compares member/service date/and service code relationships across claims or internally on the same claim. Another example of a relationship edit is Max Units and Benefit Counters. If a claim has a max benefit of 15 over a one year period, Med/MC will deny the 16th occurrence or quantity of the specific code.
- **Clinical Edits** implement medical policy or medical practice standards as defined by an independent health care reference authority, such as the American Medical Association for Current Procedure Terminology (CPT) procedure codes, or CMS for HCPCS and Correct Coding Initiative edits. Many of these edits are implemented based on information HCA has received from AHCCCS on reference files or in loading updates files from AMA and CMS.

The following edits are part of the current claims adjudication module logic of Med/MC, against which claims are scrubbed to ensure data integrity along with clinical adherence.

Member Eligibility and Benefit Verification Edits
As the claim is interfaced with Med/MC, the member is validated against the member module for an accurate member ID number with an eligibility segment that intersects with the date of service. If a matching eligibility segment is not found, the claim is denied for 'Member Not Eligible on Date of Service'. If a matching eligibility segment is found, the date of service from the claim is compared to Coordination of Benefit (COB) data in the member module. If an active primary payer segment is found, the processor is alerted to coordinate the benefits appropriately.

At a more granular level, the rate code linked to the eligibility segment in which the date of service resides is validated against the services billed. Each rate code is associated with a specific benefit package or compilation of codes for which the member is eligible. If the code billed is not within the member's benefit package upon the date of service, or the service billed does not meet any of the other criteria, the corresponding line of the claim is denied with a detailed reason code that is clearly marked on the EOB.

A specific AHCCCS Prior Period Coverage (PPC) edit exists so associated rate codes are not just tied to a specific benefit package, but also allow reduced prior authorization requirements. The claim processing logic is driven by place of service to automatically split the claim for purposes of reinsurance. The member module of Med/MC contains date sensitive alert codes from which claims adjudication logic is driven. Alert codes provide a pop up dialogue box on the processor screen when a claim for a member with an associated alert code is being adjudicated. These dialogue boxes provide the processor with detailed information on how to adjudicate the claim if it cannot be adjudicated by the system. Current examples of alert code indicators include case management, maternal or obstetrical care, prescription restrictions, catastrophic reinsurance, asthma, , dual eligible member, Head Start, hospice, transplant, and RBHA.

Provider Eligibility Edits
Rendering and billing service providers are validated against the provider module of Med/MC to ensure current AHCCCS registration for the dates of service billed. This comparison is performed by a complex series of 'pinpoint' logic that includes National Provider Identification Number (NPI), Tax Identification Number (TIN), as well as billing and service address data. If their registration has lapsed or is invalid, the claim is denied.

The provider eligibility or AHCCCS registration date segment is then queried to determine in/out of network classification. Each classification has specific prior authorization and medical record criteria for services rendered. If the criteria are not met, the claim is denied with a detailed reason code and communicated to the provider via an EOB.

If the AHCCCS registration is valid for the date(s) of service associated with the claim, the logic of Med/MC then ensures that the services billed fall within the provider's AHCCCS assigned Category of Service (COS). This is possible because of the hierarchical adjudication logic within Med/MC. Each provider is assigned one to many COS, which are linked to corresponding CPT and HCPCS codes. If the provider is not registered to provide the COS under which the CPT or HCPCS reside, the associated claim lines are denied with detailed reason codes and communicated to the provider via an EOB.

To administer custom provider contract terms that are especially prevalent in the rural counties, notes or indicators are placed on the corresponding provider's records in the Med/MC provider module. 'Pop up' boxes are activated for a corresponding provider to alert claims processing, prior authorizations, or member PCP assignment staff of special pricing methodologies, claim adjudication, and/or prior authorization instructions. These edits assist in reducing the risk of incorrect adjudication and subsequent recoupment of erroneously paid claims.

Date Related Edits
To ensure the integrity of claims data, Med/MC has numerous edits that validate the interfaced or inputted provider, member and claim information. Provider DEA and NPI numbers are validated against their national verification algorithms to ensure accuracy.

To validate that claims and subsequently their encounters are received within the AHCCCS timeliness standards, two date of service sensitive edits are run. The first edit verifies the claim has been received by HCA within 12 months from the date of service. If this edit passes, a second edit validates the initial claim was received within 6 months from the date of service or date the corresponding eligibility segment was posted by AHCCCS. Two tiers of timeliness edits enables claims processors to verify any initial claim submissions within the six month timeframe.

Med/MC validates the accuracy and status of all codes billed. This verification is performed by comparing the codes and date(s) of service on the claim with to those ICD-9, CDT, CPT, HCPCS, and/or Revenue codes obtained from Ingenix, HCA's reference information supplier. If the code does not match or is not active on the date of service, the corresponding claim line(s) is denied with a detailed reason code communicated to the provider via an EOB. Med/MC utilizes duplicate claim logic to ensure against paying the same claim more than once. For CMS 1500 forms, this duplicate logic yields positive if a comparison performed with another claim against member identification number, provider identification number (AHCCCS ID or NPI), billed code, billed charges and date of service match. This claim is subsequently denied for exact duplicate. For institutional claims, bill type and revenue code are included. When adjudicating dental claims, tooth number and surface identifiers are a part of the logic. If only four of the criteria match, a possible-duplicate edit will alert the processor to analyze the claim more closely to determine if in fact the claim is a duplicate to a previous submission.

In addition to the edits referenced above, institutional claims are validated at the header level for valid Admit/Discharge hour, Admit Type, Admit Source, Patient Status and Condition codes. The national values are downloaded from Ingenix and stored in Med/MC. Occurrence codes and their dates along with principal procedure codes and their date combinations are edited to ensure they are billed when appropriate and valid when billed.

All institutional claims with outpatient places of service are edited against AHCCCS specific Outpatient Fee Schedule (OPFS) methodology that is downloaded from the 'Refe' Files twice monthly. All AHCCCS OPFS decision tree logic has been emulated in Med/MC to review revenue codes, procedure codes, modifier applicability and pricing, along with ER and Surgery bundling and unbundling logic. Furthermore, Med/MC is configured to pay the provider the OPFS fee schedule at the appropriate provider peer group multiplier per the provider reference table. This capability, while difficult to implement, has enabled HCA to auto adjudicate most outpatient claims.

Clinical Edits

Clinical edits are in place to ensure all billed services are in compliance with age restrictions, frequency limitations, multiple surgery reductions, global day bundling, multi channel lab test bundling, National Correct Coding Initiatives (NCCI), Local Coverage Determinations (LCD or LMRP) and gender restrictions that are integrated into Med/MC. NCCI and LCD or LMRP are utilized to determine mutually exclusive and/or comprehensive coding accuracy. Med/MC's Mutually Exclusive Edits check for codes billed together that cannot be billed on the same date of service. Two procedures representing two different methods to accomplish the same therapeutic result may have been employed and only the successful procedure need be reported. The alternative procedure will be denied by Med/MC. Column1/Column 2 Edits – Formerly known as Comprehensive and component codes, are unbundled pairs that should be part of the same service. An example of this would be billing a surgeon billing for amputation of an arm and wound therapy with instructions for home care. Med/MC edits will deny for these inappropriate billings.

Multiple Surgery Reductions are automated, the first is paid at 100%, and the rest of the surgeries (not inclusive of the first) will be paid at 50%, unless there is a bi lateral modifier which pays at 150% of the AHCCCS fee schedule.

Global day bundling edits are in place to catch those additional or follow-up claims that should have been included in services that were previously billed. For major procedures the edit is 90 days and for minor procedures the edit is 10 days from the date of the original procedure.

Multiple channel lab test bundling is the billing for multiple, individual lab tests that are included in or a part of a comprehensive lab. Med/MC currently edits for and denies these multiple lab tests as included in the comprehensive lab test fee. Additionally, the validity of diagnosis to CPT/HCPCS combinations is automatically reviewed against the Arizona specific LCD/LMRPs to distinguish medical reasonableness of the coding.

For dental procedures, tooth number and surface count are verified. If a modifier is billed with a HCPCS or CPT code, the modifier is reviewed for status, applicability, and percent of fee schedule change to be applied. The values utilized to validate this information are downloaded directly from the AHCCCS 'Refe' files twice monthly.

In conjunction with the edits above, logic exists within Med/MC to trigger medical review for claims that meet specific criteria. Claims triggered for Medical Review are routed to the HCA Medical Services Department for review by clinical staff. Claims reviewed by clinical staff include those with a condition code 61 which meet the statewide outlier threshold, inpatient claims on which concurrent review authorization does not match the claim billed, claims on which associated prior authorization is in a "hold" or "review" status, claims for which services incurred are during the member's PPC eligibility segment, claims billed with a generic or non-descript code, such as CPT or HCPCS codes ending in "-99", and claims comprised of code(s) whose corresponding payment are denoted "by report" (BR). These medical review criteria are analyzed quarterly to ensure they are a value added requirement of the HCA claims adjudication process. Over the past year, several requirements have been relaxed.

Claims Edits and Effective Provider Network Management

HCA believes that edits are only part of the job of ensuring that services rendered to AHCCCS members are medically effective, covered Medicaid services and are performed subject to program limitations and sound practice. These strong edits coupled with vigorous and detailed provider communication channels including the HCA Provider Portal, Remittance Advice (RA), coding seminars, newsletters, claims call center inbound/outbound correspondence, as well as onsite one-on-one claim issue education. These efforts ensure that providers understand what benefits are covered before the patient is treated, so that services rendered can be reimbursed accurately and promptly, resulting in a high level of provider satisfaction with HCA.

Encounters

Requirement #10

ENCOUNTERS

REQUIREMENT #10

Submit a description of the Offeror's encounter submissions process including, but not limited to, how accuracy, timeliness and completeness are ensured, how data is extracted from the system and the remediation process when AHCCCS standards are not met. The description should include the tracking, trending, reporting, process improvement, and monitoring submissions of encounters and encounter revisions. Include any feedback mechanisms to the encounter process that improves encounter accuracy, timeliness and completeness. The submission requirement will be a maximum of four pages and four pages of flowcharts.

Health Choice Arizona (HCA) understands the significance of providing accurate and timely encounter data, as this data is the cornerstone from which some of the most important AHCCCS processes and measures are based. HCA understands that excellent encounter data is a key measure of excellent health plan performance, and has committed the organization to a process of continuous quality improvement to encounter data processing.

Encounter Quality Begins with Accurate Provider Billing
HCA has honed a special cooperative relationship with the providers in its provider network. HCA has established claim submission time limits and requirements that are communicated to providers via the HCA Provider Manual, HCA Provider Portal, site-visits, coding seminars and the Claims Customer Service Call Center. In addition Health Choice has learned that providers who use electronic claim submission methods have higher claims adjudication rates, and benefit from faster payment, and fewer rebills. HCA has heavily promoted its electronic claims submission options over paper claims submission, resulting in a substantial increase in electronic claims, from 27% in 2007 to over 70% in 2011.

HCA Reference Files are aligned with AHCCCS Reference Files
HCA utilizes the medical service codes, ASC Fee Schedules, Outpatient Fee Schedules, and provider information supplied by AHCCCS from each 'refe' file cycle as well as multiple industry-standard coding tools to confirm the appropriateness and correctness of the services billed. This routine process keeps HCA plan data in synch with AHCCCS data in PMMIS that is used for Encounter Data Processing. When a discrepancy is found between national standards and AHCCCS determinations on code coverage and limitations, HCA's Chief Medical Officer and the Claims Manager coordinate with AHCCCS medical and operations staff to resolve the issue(s) and subsequently update the provider community through outreach and education if necessary.

ANSI 834 Files for Daily and Monthly Enrollment Notification, Potential Transition Listing, Active Care Listing, Prior Plan Listing, Members with Choice, Review, and Third Party Liability are all continuously processed and loaded into the Member Master in Med/MC, and forwarded to ESI as applicable for pharmacy claims processing.

Med/MC Processing Accuracy
In order to proactively ensure encounter data accuracy, HCA has designed Med/MC to require appropriate provider billing through system edits that includes at a minimum that same edits that AHCCCS applies to encounter processing. HCA has refined its claims adjudication system over 15 years of continuous operations our edits include:

- Comparison of date of service to receipt date to ensure initial claim was received within 6 months from date of service or eligibility postingEdit for comparison of date of service to receipt date when this exceeds 12 months
- Possible duplicate claim identification
- Exact duplicate claims identification
- System alerts for members with other insurance coverage/TPL
- Alerts for members under case management
- Verification that prior authorization information matches date/type of service on claim
- Alerts for members with Prior Period Coverage (PPC)
- Alerts for invalid or terminated procedure/diagnosis codes
- Edit for age limitations for CPT/Diagnosis codes
- Edit for frequency limitations on CPT/Diagnosis codes
- Confirmation that the provider is approved to provide a particular service per AHCCCS guidelines
- Automatic calculation of anesthesia base and time unit maximums for epidural anesthesia to ensure that HCA payment is limited to the maximum allowable units per AHCCCS guidelines
- Edit check for bundling and unbundling of codes (CCI)
- Global Day Bundling

- Multi Channel Lab Test Bundling
- Multiple Surgical Reductions
- Edit check for validity of diagnosis to CPT/HCPC code combinations.(CCI)Edits for NPI number validation
- Edits for Occurrence codes and dates, Condition codes, and Value Codes and amounts on institutional claims
- Edits for valid field values on Admit/Discharge hour, Type, Source and Status
- Edits for Prior Authorization requirements that align with plan guidelines
- Edit for CPT to Modifier combinations
- OPFS logic using AHCCCS Reference tables

Encounter Data Submission Processing
Med/MC, the claims adjudication engine that is leveraged by Health Choice has a native encounters module to generate encounter data files for all paid and denied/non covered claims, claims adjustments, and claim voids which are processed. These data files are in HIPAA compliant ANSI 837, P,I, and D and NCPDP formats ready for submission to AHCCCS and include billed and paid units and charges. Encounters are submitted for all covered services rendered by AHCCCS registered providers, including those services provided during Prior Period Coverage (PPC). HCA ensures adherence to AHCCCS encounter timeliness guidelines by submitting encounters to AHCCCS within 240 days from the end of the 6 months of service, or the date of enrollment, whichever is later.

Exhibit F is a flowchart which depicts the steps in the HCA Encounter Data Submission Process. HCA adheres to the *AHCCCS Technical Interface Guidelines* and the *AHCCCS Encounter Reporting User Manual* for the submission of all encounter data to AHCCCS.

Five days prior to the close of the twice monthly AHCCCS encounters cycle, the HCA Claims/Encounter Analyst generates distinct encounter files for CMS-1500 claims (837P), Universal Billing (UB 04) claims (837I), dental claims (837D), pharmacy claims (NCPDP) and Pended Encounter Corrections. Each file contains all claims that were paid or denied, as well as all encounter pends that were corrected since the previous submission (Replacement and Voids). All encounter transactions are transferred to the AHCCCS FTP server via a secure FTP connection. To ensure all adjudicated claims were exported to an AHCCCS encounter file, the Claims/Encounter Analyst runs a reconciliation job within Med/MC that compares successfully adjudicated claims (Paid and Denied) to those on the encounter file. If there are exceptions, those claims are then exported to be included within the encounter files to be submitted to AHCCCS.

After submission, Transaction Insight (TI) is leveraged to track and trend throughput rates as well as rejected encounter reasons. This trending of detailed encounter issues is reviewed by Med/MC business analysts as well as claims management staff to refine claims policies and procedures as well as claims processor education materials. Additionally, the claims and IS teams develop enhancements to the Med/MC claims engine logic to further reduce encounter rejects and pends. Furthermore, TI is a streamlined resource leveraged by HCA to identify file syntax errors not otherwise caught in Med/MC or Claredi, the mainstream ANSI X12 transaction editing software used by HCA for validation.

The Healthcare Payer Unsolicited Claims Status Transaction (U277) is generated by AHCCCS and sent to the plans as notification of status for current, distinct encounters that have been adjudicated by AHCCCS during the most recent cycle. Once the U277 is received by Health Choice from AHCCCS, it is processed by Med/MC, updating the appropriate claim records. One of the reasons HCA has achieved success in encounter processing is Med/MC's ability to natively manage both the claims processing and encounter submission process, without the need for a separate system or service. The encounter information as well as the claim adjudication results are housed within the same module and set of screens.

If a claim encounter is pended by AHCCCS due to the result of a subcontracted relationship requiring specific payment rules outside normal operating guidelines, HCA provides the subcontract and/or medical record information to the encounters unit to resolve the pended claims quickly.

Once the encounters team receives the pended and denied encounters for the cycle in a Med/MC work queue, the oldest encounters are reviewed and fixed first. For each corrected claim/encounter, replacement or voided encounters will be sent to AHCCCS during the next available cycle to reflect the appropriate change.

When HCA must delete a pended encounter, HCA documents the deletion in the delete log with the associated Claims Reference Number (CRN) and reason for the deletion. These are also viewed by management and the IS business analysts to develop process and system configuration changes to avoid their future occurrence.

Although the AHCCCS benchmark for aged encounters is set at 120 days, the Health Choice internal standard is to fix all claims within 30 days to ensure plenty of time to resubmit and process. Within the past 12 months, Health Choice has been able to reduce those encounters aged over 120 days to below 40.

Tracking and Trending to Continuously Improve Encounter Data Quality

Because the successful submission and adjudication of encounters is a strategic core process, HCA maintains several tracking and trending reports to ensure its success. First and foremost, HCA utilizes the Encounter Submission Tracking Report (ESTR) to record by submission month and form type: the number of claims encountered, adjudicated, pended, and resolved. In addition, the TA1, 997 and 824 transaction reports generated by AHCCCS are utilized to track and reconcile the transfer process. Deleted encounters are documented in the encounter deletion log. Encounter per member months trends are also reviewed to ensure there are no macro fluctuations to the number of encounters being submitted per claim type. Exhibit G depicts the encounter data monitoring and reconciliation processes used by HCA to ensure that each encounter record is processed. In the event a file transfer fails, the information is recorded with the error being corrected and the file being resubmitted to AHCCCS within the required submission timeframe.

To monitor the encounter submission process, HCA has developed 3 additional auditing tools to validate that all adjudicated claims are accurately submitted as encounters to AHCCCS and that a response is received from AHCCCS for each encounter.

- **Encounter Omission Tool** The first tool is utilized to trap encounter omissions. Found omissions are consequently resent to AHCCCS during the following cycle and a root cause analysis is performed to understand and ultimately fix the issue that resulted in the encounter or response not to be transmitted.
- **Encounter Reconciliation Tool** The second tool queries Med/MC for any claims that have been finalized (adjudication plus final edits), but do not indicate as being sent to AHCCCS as an encounter. This tool uses logic that performs a comparison of the claim events in Med/MC with all AHCCCS encounter responses. Encounters, to which a response has not been received, are resubmitted to AHCCCS and a root cause analysis is performed to determine the source of and ultimately develop a solution for the issue.
- **Financial Reconciliation Tool** The third tool encompasses a monthly comparison between the adjudicated encounter's financial fields and the financial fields within Med/MC to ensure that the amount being paid to the provider mirrors the amount being encountered. This reconciliation process enables HCA to accurately forecast and balance expenses and encounter submission accuracy while ensuring AHCCCS actuaries receive an accurate reflection of the expense incurred to cover the benefit package for which HCA is responsible.

Feedback Mechanisms

An additional source of process improvement is quarterly AHCCCS Encounters and Reinsurance one-on-one meetings. In these meetings, AHCCCS personnel from the encounters and reinsurance units discuss trends in encounter issues. What is valuable about these meetings is that the AHCCCS personnel not only relay the issues, but help problem solve with the plan as to why the issue may be occurring. This process has resulted in many encounter areas of opportunity being fixed before acute issues arose.

As stated earlier, Health Choice encounter analysts work with Claims and IS Management after each encounters cycle to track and trend denial, pend and reject rates and reasons. These are then translated into either system configuration changes, enhanced system logic/edits, and/or manual process changes that can be made on the claims adjudication floor to reduce these trends and ultimately increase throughput and adjudication accuracy.

Exhibit F:

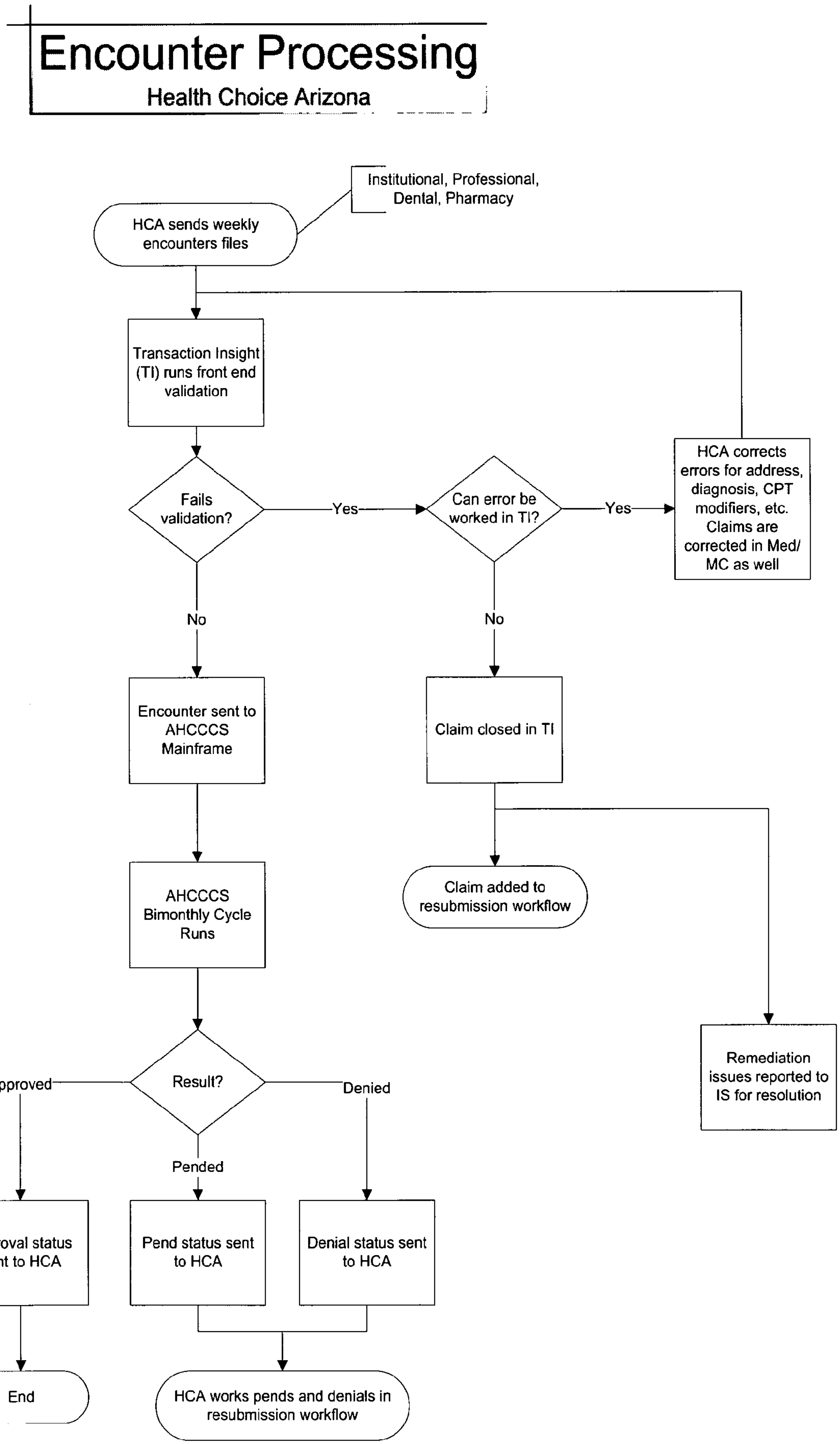
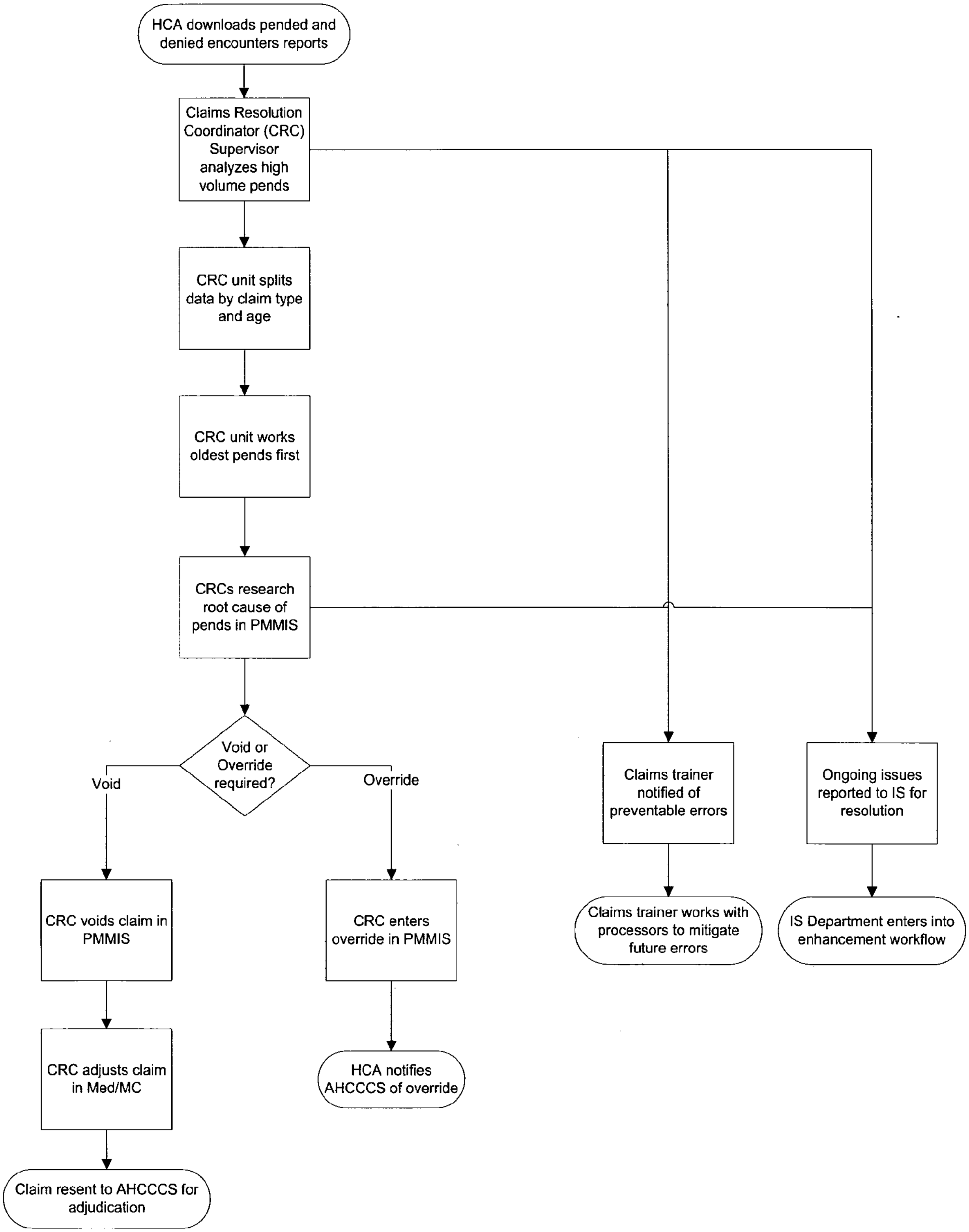


Exhibit G:

Encounter Resubmission

Health Choice Arizona



Information Systems

Requirement #11

INFORMATION SYSTEMS

REQUIREMENT #11

Describe the structure (internal and external) of the Offeror's information system and the hardware and software that supports or will support the ALTCS line of business, including a diagram of the information system and data processing flow with all existing or planned interfaces. If not a current ALTCS Contractor, the Offeror must include a detailed plan for ensuring that all IS requirements will be met prior to the contract start date. The submission requirement will be a maximum of ten pages, plus flowcharts.

Health Choice Arizona (HCA) is a health plan that places a high priority on serving the needs of its members, who are Medicaid and Medicare beneficiaries with unique health needs and health care access challenges. To ensure that members' needs are met, clinical, administrative and financial information is maintained in an accurate and accessible format to support decision making and health plan operations. An information-driven organization, HCA places a high priority on Information Systems, which are located in the HCA headquarters in Phoenix, Arizona.

Information Systems Organization

The HCA IS Department is organized functionally into three teams: operational support/business analysis, software development, and infrastructure. The Director of Information Systems oversees the operational and technical components of the IS organization. The Director is responsible for deploying IS resources, as required by state and federal agencies, senior leadership, and the needs of the business units. The Director works closely with Administration, Medical Management and Operations leadership in order to define short and long term needs of the organization.

The Director provides training and leadership to the IS Department, plans long term initiatives, and ensures a strong customer focus among all IS staff. In addition, the Director serves as the primary liaison with outside vendors on both new implementations and continuing projects.

Operations and Business Analysis Team

The IS Operations Manager oversees the operational support team. The operations team consists of Business Analysts, Quality Analysts, Provider Demographics Coordinators and a Claims/Encounters Analyst. The Business and Quality Analysts are primarily responsible for all design, maintenance, documentation and quality assurance for HCA's software environment, which includes the Med/MC Claims Adjudication System (Med/MC), CareRadius Medical Management System, and proprietary web applications and business intelligence components.

- **Business Analysts** are well versed in HCA's core strategic business processes and continuously educated regarding Medicaid regulations and requirements as set forth in the current contract and agency updates.
- **Quality Analysts** are tasked with verification and validation of software updates, enhancements, bug fixes, and .NET Framework application modules. This process along with the disparate system environments of development, test, staging and production, allows HCA to thoroughly assess system updates and changes before deployment to the business users.
- **Provider Demographic Coordinators** are responsible for the accurate and timely input of provider demographic and contract payment data into Med/MC. These positions are located within the IT department to ensure segregation of duties between individuals negotiating and executing the provider agreements and those inputting those agreements into Med/MC.
- **Claims/Encounter Analysts** are responsible for daily file exchanges, provider check runs, and processing of EDI files into Med/MC. In addition to these daily processes, the Claims/Encounter Analyst receives and transmits file requests with HCA's business partners such as Emdeon Business Services (EBS) and Express Scripts Incorporated (ESI). The Claims/Encounter Analyst not only performs the computer operator functions, but audits for validation and troubleshoots file errors.

System Development Team

The development team consists of Web Developers, Database Developers, Report Analysts and a Database Administrator. The Director of IS works closely with the system development team to make architectural decisions, implement suitable technologies for HCA's business needs, and guide the development of web applications.

- **Web Developers** are responsible for the development and maintenance of .NET Framework applications written in C#, as well as the maintenance of the HCA internet, intranet and extranet.

- **Database Administrator** is responsible for data architecture and data management including performance tuning, optimization, and support of the development and production database environments for all application projects.
- **Report Analysts** are responsible for fulfilling report requests based upon business needs. The Report Analyst uses a robust set of tools provided by Microsoft Visual Studio and SQL Server in conjunction with web based reporting tools. These reports are designed with multiple user-defined parameters for input, allowing management to sort and filter critical business data as their needs change.

Infrastructure Team

Infrastructure support is performed by a Network Supervisor, 2 System Administrators and a PC Technician. These roles maintain the integrity/security and overall appropriate working order of all networked devices by establishing and maintaining LAN security, workstation and network performance, troubleshooting network issues, maintaining technical knowledge, evaluating software, and maintaining documentation. The Network Supervisor is also responsible for business continuity plan testing, and training new employees on HIPAA security.

The combination of these three units enables the IS organization to achieve optimal alignment with core strategic functions of the health plan as well as the Medicaid Program as a whole. It is this combination on inward focus and outside orientation that enables IS to be so effective in support of HCA.

HCA Software Environment

HCA's business process understanding serves as the model on which its technical foundation rests. Using technology to propel, rather than steer the business, HCA has built internal and external facing capabilities that complement tailored third party software applications that are integrated and operated as a multifaceted systems environment supporting both transaction processing and analytical business needs. The HCA software environment is composed of best of breed components which are tailored to the business needs of HCA.

Overview of HCA Software Environment

The HCA software environment is designed around a heterogeneous operational environment that enables HCA to fully integrate and interoperate across different systems and to communicate effectively with internal and external data sources in real time (see Exhibit H). HCA has taken an evolutionary approach to its systems capabilities, and has built upon the core elements of its claims processing system, Med/MC, and Care Management System, CareRadius, which serves as the central application for all HCA Medical Management activities. What makes the environment distinctive and innovative is the creative use of the newest information technology to support unique HCA information needs for provider data management, data warehouse and analytical reporting, quality management, and web portal access. In addition, HCA contracts with Emdeon to provide data acquisition and fulfillment services, enabling HCA to operate in a nearly paperless environment.

Med/MC

Med/MC is the claims adjudication software that is leveraged by Health Choice. Med/MC was developed and is currently supported by CPU Medical Management Systems (CPU). It was developed utilizing CL, RPG, and ILE languages, and IBM's DB/2 database. Med/MC provides HCA with a comprehensive and cost effective solution for managing its member's claims. The robust Med/MC solution integrates member and provider data with claims adjudication and provider payment functionality. Med/MC enables both auto-adjudication and manual adjudication of paper and electronic claims, and readily supports both fee-for-service and capitation payment functionality.

The Med/MC electronic upload process leverages initial edits such as member eligibility that if failed will result in a Front End Reject with a subsequent detailed letter of the reject reason being sent to the provider. Once the initial edits are passed, the claims are associated with the matching provider record in the Med/MC Provider Module. Claims that cannot be assigned a matching provider record are placed on an exception report to be worked by the Provider Demographic Coordinator. Once the reason for the non-match is found and fixed, if applicable, the file is reloaded in order to interface any claims for the impacted providers. Claims that do not interface at this stage trigger a reject letter to be sent to the provider due to lack of AHCCCS registration or incorrect demographic information.

Claims Scrubbing

In order to proactively ensure claims and encounter data accuracy, HCA has designed Med/MC to require appropriate provider billing through system edits that include, but may not be limited to the following:

The Med/MC claims adjudication system allows HCA access to multiple years of claims history. In addition to claims adjudication, other principal components of the Med/MC software enable HCA to maintain core information related to benefit plans, members, claims, providers, medical procedure coding and prior authorization. The Med/MC claims processing system receives claims in ANSI 837 or NCPDP formats and completes the claims adjudication and payment processes to generate both ANSI 835 and EFT payments and checks. Med/MC contains numerous clinical and relationship edits for claims adjudication These edits include member eligibility, provider verification, and clinical edits, as well as strong data validation processes.

- **Validation Edits** are applied to logically ensure that required data is present and syntactically correct. These are simple data attribute edits that largely exist to catch data entry edits and to validate complex EDI data requirements.
- **Relationship Edits** compare data present on the claim with information which is on file in Med/MC. Comprising the bulk of Med/MC edits, relationship edits are table driven and have been continuously refined to meet both AHCCCS and HCA policy. Duplicate check edits are another type of relationship edit which compares member/service date/and service code relationships across claims or internally on the same claim.
- **Clinical Edits** implement medical policy or medical practice standards as defined by an independent health care reference authority, such as the American Medical Association for Current Procedure Terminology (CPT) procedure codes, or CMS for HCPCS and Correct Coding Initiative edits. Many of these edits are implemented based on information HCA has received from AHCCCS on reference files or in loading updates from AMA and CMS.

More specifically, these edits include:

- Comparison of date of service to receipt date to ensure initial claim was received within 6 months from date of service or eligibility posting
- Edit for comparison of date of service to receipt date when this exceeds 12 months
- Possible duplicate claim identification
- Exact duplicate claims identification
- System alerts for members with other insurance coverage/TPL
- Alerts for members under case management
- Verification that prior authorization information matches date/type of service on claim
- Alerts for members with Prior Period Coverage (PPC)
- Alerts for invalid or terminated procedure/diagnosis codes
- Edit for age limitations for CPT/Diagnosis codes
- Edit for frequency limitations on CPT/Diagnosis codes
- Confirmation that the provider is approved to render a particular service per AHCCCS guidelines
- Automatic calculation of anesthesia base and time unit maximums for anesthesia to ensure that HCA payment is limited to the maximum allowable units per AHCCCS guidelines
- Edit check for bundling and unbundling of codes (CCI)
- Edit check for validity of diagnosis to CPT/HCPC code combinations.(CCI)
- Edits for NPI number validation
- Edits for Occurrence codes and dates, Condition codes, and Value Codes and amounts on institutional claims
- Edits for valid field values on Admit/Discharge hour, Type, Source and Status
- Edits for Prior Authorization requirements that align with plan guidelines
- Edit for CPT to Modifier combinations
- OPFS logic using AHCCCS Reference tables

Additionally, HCA utilizes the medical coding and provider information supplied by AHCCCS from each 'Refe' file cycle as well as multiple industry-standard coding tools such as Ingenix Data Files and Encoder Pro to confirm the appropriateness and correctness of the services billed.

Information Hub and Data Exchange Med/MC is HCA's primary data store on which our members' and providers' PHI is securely maintained. Daily transfers as well as reports are generated from the data residing in Med/MC. Med/MC has been designed to fully integrate all AHCCCS Technical Interfaces. ANSI 834 Files related to Daily and Monthly Enrollment Notification, Potential Transition Listing, Active Care Listing, Prior Plan Listing, Members with Choice, Review, and Third Party Liability are loaded into the Member Master in Med/MC. Processing of the ANSI 834 files results in the generation of automated reports, which are reviewed by HCA's Member Services Department.

Member Services reviews the eligibility data loaded to Med/MC and ensures that valid dates and rate codes are displayed for new members. ANSI 820 Capitation files, Daily and Monthly Rate Code Summaries, and Reinsurance reports are also loaded to Med/MC for analysis by the HCA Finance Department. IS operations staff load Reference files from AHCCCS to ensure that current service codes, ASC Group Bundling, and Outpatient Fee Schedules are applied accurately for claims adjudication. Med/MC also creates encounter files in HIPAA 837 and NCPDP formats, for weekly transmission to Medicaid. Pended encounter files and response files are processed and displayed by Med/MC. HCA integrates its provider data through bi-directional data feeds with AHCCCS, in order to maintain up-to-date provider registration information. When HCA loads the Provider File from AHCCCS, the IS Department generates the resultant reports with Network Services. These reports are reviewed to ensure data quality, such as to validate date fields.

Member Management Med/MC contains a proven member services module for supporting HCA membership. This module contains member demographics, plan history, eligibility data, and links directly to the primary care physician record. Each member's record allows for easy access to all claims for services rendered for the member, including labs, PCP, and specialist visits. Member call tracking is conducted through the member services module as well, giving HCA staff the ability to effectively view a snapshot of any member's call history, and related support documentation. Member letters can also be produced from this module, simplifying integrated outreach to members regarding enrollment, plan changes, disease management, case management, and health and wellness programs.

Provider Payment Med/MC provides efficient, accurate payments to providers for fee-for-service and capitation payment methodologies. The capitation features enabled by Med/MC are varied and flexible, supporting a wide array of provider contracting options. This is critical in working with HCA's large rural provider network. The capitation module can apply varied fee schedules based on county, zip codes, and member rate codes, and allows for flat-rate payments based on assigned members, which is often used for ancillary or intuitional care providers. For more complex contracts, Med/MC can house capitation fee schedules with specific procedure code carve-outs to be paid using a fee-for-service methodology.

CareRadius Medical and Care Management System

CareRadius is the medical management software that supports HCA's Medicaid and Medicare Special Needs Plans. Landacorp, a division of SHPS, is the firm that developed CareRadius. CareRadius is an enterprise-level care management workflow solution, developed using state-of-the-art technology. CareRadius provides HCA with a single platform for managing all medical management activities. The architecture of the CareRadius software suite is extremely flexible, allowing for detailed workflow customizations, multiple data source integration, complex reporting, and comprehensive clinical decision support tools.

Long Term Care Functionality CareRadius provides a fully featured suite of workflow tools that is uniquely targeted to meeting the varied needs of a Long Term Care population. Due to its configurable assessment capabilities, CareRadius can easily be used as the platform for the standard ALTCS Universal Assessment Tool (UAT). Once a case manager enters answers for a member's UAT, CareRadius will analyze the member's diagnoses, and through the use of industry standard clinical criteria (McKesson's InterQual Coordinated Care Content), a targeted Individualized Service Plan (ISP) will be created for the Case Manager to then edit and tailor to the specific needs of the member. Once an ISP is saved for the member, CareRadius will trigger follow-up tasks for other members of the interdisciplinary care team. For example, if the member is diabetic, a task would be sent to a diabetic case manager/educator to review the member's history, and depending on the severity of the case, recurring tasks could be generated on a set schedule.

Care Management CareRadius has enabled HCA's Medical Management leadership team to operationalize its broad medical management strategy, focusing on high-risk case management and improving health outcomes for members. This is especially important in managing special needs and ALTCS members. The member risk profiling functionality in CareRadius examines claims history for each member, and calculates risk metrics, such as likelihood of a hospital admission and overall risk score. These risk metrics, when combined with the specific diagnoses of each member, triggers enrollment in case management (CM) and disease management (DM) programs. HCA has created targeted, flexible care plans for its CM and DM programs in order to treat conditions such as congestive heart failure, diabetes, and cancer. Each of these CM and DM programs has an associated workflow in CareRadius, which enables streamlined care coordination between members of the interdisciplinary care team. Following these care plans, HCA clinical staff engages in written and telephonic communication with members enrolled in these programs, offering assistance tailored to each member's needs. Outreach activity is prompted through workflow triggers and actions are logged within CareRadius, as part of the holistic member profile, which is available to all pertinent HCA staff.

Utilization Management CareRadius also contains robust utilization management (UM) and prior authorization (PA) modules. The primary feature of the UM module is a daily inpatient census report/work queue. HCA enlists a team of nurses that coordinate care for members in the inpatient setting, and work closely with each hospital's case managers to ensure that lengths of stay are in line with industry standards, as defined by McKesson's InterQual product. CareRadius tightly integrates the InterQual guidelines within the inpatient authorization user interface in order to determine a proper authorization end date. Reporting of re-admits and discharges are readily available within the UM reporting features as well. Upon admit or re-admit, Care Radius send notifications to both the concurrent review nurse as well as the case manager to collaborate and coordinate care. CareRadius also supports HCA's transition-of-care planning, enabling case managers to provide care plans for members being discharged from an acute hospital inpatient stay to a nursing facility or group home. In addition, all notes and InterQual responses are saved in the member's inpatient UM case within CareRadius, allowing for efficient retro review processes.

Prior Authorization The PA module of CareRadius allows integration of faxed authorization requests and streamlined provider portal entry by provider staff.. The medical record contained in the fax request or web-based request allows efficient processing based on HCA clinical guidelines. Workflows for various scenarios have been defined within the application, including outpatient surgery, specialist visits, radiology and durable medical equipment. Each workflow contains the ability to approve, deny, downgrade from expedited to standard, reduce approved units, or cancel the PA request, depending on the situation. In scenarios where the request clearly meets HCA's clinical criteria, the authorization can be automatically approved. Once a PA request is finalized, the assigned staff member generates the required notifications in CareRadius. These include member and provider letters, and faxed responses to the requesting provider offices.

In order to support claims payment, authorization data is exchanged between CareRadius and Med/MC. Each authorized service or group of services is made available to the claims system, along with the procedure codes, diagnosis codes, referring physician, referred to physician, and PA notes. In designing the exchange with Med/MC, great care was employed to ensure the proper grouping of procedures within authorization types. By creating groups of codes, HCA prevents overburdening providers with the need to request each specific procedure or revenue code to be billed, while continuing to manage care and ensure fiscal responsibility.

HCA Software Applications

The HCA software environment contains an array of internally developed modules that integrate with Med/MC and CareRadius. Applying the Microsoft SQL database tools and .NET development framework, these modules form a cohesive unit that supports all critical operations within HCA, including reporting, outreach, and external communications with providers and members.

Technical Overview HCA has built internal and external Web Services, Web applications, and reporting services on current Microsoft .NET platforms, utilizing industry-specific patterns and practices. Standardizing on Windows servers, SQL Server data stores, and Visual Studio development environments, HCA focuses its efforts within the wide array of .NET frameworks and tools.

HCA applies Data Transfer Systems and SQL Server Integration Services automation to create reports and share key business data. Applying these toolsets to its data allows HCA to reorganize and restructure information to support efficient and independent internal data consumption, while assuring the highest data integrity. Internal services and Intranet applications are closely integrated to the core Med/MC data structures to present claims and adjudication data clearly and precisely targeted for the intended audience and business use. Using this approach, HCA can display the most critical aspects of claims, authorization, member, and provider data to serve the unique needs of groups such as medical management, case management, disease management and utilization review.

Microsoft Internet Information Services (IIS) web applications are deployed within secure firewalls, using time-tested data exchange protocols, and built upon the trusted software architecture and component-driven development available via the growing and highly-respected Windows .NET framework. Using SOA, HCA can integrate with business partners quickly and securely at a business process level as the need arises. SOA allows business processes to be packaged as services, and securely exchanged with other applications or platforms without the need for a tight coupling at the data level. The ultimate result of an SOA approach is increased interoperability with varied stakeholders.

HCA Recoupment Application The HCA Recoupment Application streamlines the business processes for the Recoveries Department. The application contains functionality for tracking of all recoupment activities, reconciliation with claims data from Med/MC, and reporting of outstanding and processed provider refunds. In addition, provider notifications are generated, tracked, and reported via the application. Any potential recoupments aged more than one year or in excess of $50,000 are reported by the Recoupment Application for HCA to request approval from AHCCCS.

HCA Pharmacy Benefit Administration Pharmacy data is integrated with Med/MC using a comprehensive set of tools from ESI, the HCA Pharmacy Benefit Administrator. HCA's pharmacy prior authorization and medical management incorporate ESI portal tools to house eligibility information, track pharmacy benefits, and manage the HCA formulary. Prior authorizations for HCA member prescriptions are tracked within the ESI web-based tools. A valuable reporting application *Trend Central* allows the Pharmacy Director to identify utilization trends. When the prescription is dispensed, ESI's *Anchor Adjudication System* applies the relevant payment methodology at the point of sale to ensure a seamless transaction for the member.

HCA Quality Management The Quality Management (QM) Application maintains AHCCCS-mandated QM metrics and member grievance reporting related to availability of services, denial of covered benefits, effectiveness of care, fraud, and member rights. All quality of care issues, statuses, and interventions are tracked via the QM Application. The application also produces reports of open QM cases as well as monthly and quarterly internal and external reports.

HCA EPSDT Tracking HCA has developed an Early Prevention, Screening, Diagnosis, and Treatment (EPSDT) tracking system designed to facilitate the review process of the 5,000 EPSDT forms received each month and to better organize data collection. EPSDT forms are reviewed on a daily basis by Unit Specialists and the information is entered into the HCA EPSDT Tracking where it is analyzed by provider or lab services ordered, requested referrals, and for complementary care need indicated by age-appropriate screenings. This information is utilized to identify trends, and to provide outreach and education.

HCA Childhood Immunization The Childhood Immunization Application is yet another QM tool, which provides progressive tracking of childhood immunizations. The application tracks and reports immunization data for HCA members', including Med/MC claims data and data from the Arizona State Immunization Information System (ASIIS). The Childhood Immunization Application efficiently manages all aspects of member and provider outreach and monitoring, and assists HCA to identify specific issues and barriers associated with childhood immunization rates. EPSDT Specialists review immunization status and proactively initiate member outreach before key age milestones of 9 months, 15 months, 18 months and 24 months.

HCA Credentialing The Credentialing Application is a vital part of HCA's integrated software environment. This application stores and tracks a wide range of data on the HCA provider network, including board certifications, specialty codes, languages spoken, and provider demographics. The application creates advanced reporting by provider specialty and location, PCP panel reporting, and audits for appointment availability. It also produces mailing lists and outreach notifications for providers that are nearing their re-credentialing period. The Credentialing Application assists the Network Services department to re-credential providers within required timeframes, reducing potential hassle factor for providers, and ensuring that HCA maintain a high-quality network of physicians across the state of Arizona.

HCA Provider Demographic Maintenance (PDM) PDM is a key component for the Network Services department at HCA. This application allows for the timely input, storage, display, and reporting of provider contracts and demographic data. Closely integrated with Med/MC, PDM extends functionality to allow the Audit department to verify that contracts are loaded correctly to assure timely and accurate claims payment. The application maintains a full audit trail of all provider changes, and once verified for accuracy, the data is posted back to the Med/MC provider database.

HCA Site Visit To manage the Network Services Department's required outreach to providers, the IS Department has built and deployed a Site Visit Application. The Site Visit Application serves as a common gateway for the Network staff to input and search provider data, and generate reports. Network representatives are all equipped with laptops to securely VPN into the HCA network and log visits into the Site Visit Application. A call log form is integrated into the application as well, to allow tracking of call history to each provider.

HCA Provider Inquiry In order to quickly identify any provider issues, HCA has developed a Provider Inquiry Application. When provider offices call to request information regarding electronic claims submission, claims adjudication, payment, or any other issues, customer service representatives enter a description of the provider's call into the application. Reports are generated from this application, and reviewed frequently by Administration and Operations personnel to identify trends in provider issues. This allows HCA to remediate provider issues quickly and effectively, facilitating the growth of a strong provider network to serve HCA members' medical needs.

HCA Provider Portal HCA's software environment makes a wealth of tools available in support of the diverse needs of its provider network and community. The primary electronic tool used by HCA providers is the Provider Portal, available via secure login to the HCA website. The Provider Portal provides functionality to view and search claims status, member eligibility, and prior authorizations. Providers can also upload HIPAA 837 files via a secure web session on the provider portal. The HCA website also includes information regarding billing requirement changes, formulary updates, clinical criteria, links to commonly used referral/prior authorization forms, and the most recent provider manual.

HCA Member Portal In support of members' needs for timely information and access to services, the HCA data integrates closely with the external HCA website http://www.healthchoiceaz.com. The member portion of the site contains a number of member-centric tools including a dynamic, searchable provider directory. The directory allows searches by provider name, specialty, sub-specialty, zip code, county, and language spoken. All AHCCCS-required information is available on the website, including drug formulary, member handbook, performance measure results, and provider listing. Members are guided to make healthier life choices in areas including prenatal care, oral health, diabetes care, and other preventive measures. The member portal also includes information on how to obtain transportation and detailed descriptions of the member rights and responsibilities, and HCA's partnerships with community-based organizations.

HCA Transportation Tracking (AAA) HCA has built an application to automatically import key data from AAA Cab Service on an hourly basis. The application integrates with AAA's trip tracking system, and makes reservation and availability information accessible by the HCA Member Services department in its Phoenix. Through the AAA Application, HCA can ensure both the highest quality customer service by staffing the function internally, and the timeliest access to transportation information needed by its members. The end result of this application is fewer missed trips and greater access to care for the member, while improving call center service metrics for the Member Services department.

HCA Data Warehouse The data sources within the software environment are aggregated into a data warehouse using multidimensional Online Analytical Processing (OLAP) cubes, designed in SQL Server 2008 Analysis Services. The data warehouse consists of three main tiers. Data is extracted from Med/MC and the other sources and placed in a staging area, where error trapping and data cleansing take place. From there, the data presentation layer is built, consisting of dimensional data marts that correspond to specific business processes. The final layer consists of data access tools. The data access tools include web-based tools for report generation, and Microsoft Excel for display of complex data via pivot tables and standard grid views.

HCA Data Warehouse provides management with both aggregate and drill-down views of utilization data. Subsets of data are defined based on the types of reports end users need. The HCA Data Warehouse produces critical reports that analyze member and provider utilization, claims and financial data. Examples of these reports include HEDIS measures, EPSDT measures, HCA Provider Profile and the Quarterly Quality Management reports. In addition to these standard reports, HCA creates reports on an ad hoc basis as questions arise during the normal course of business.

Information Systems Environment and Interfaces

HCA employs rigorous hardware and data processing standards to maintain the highest possible level of performance and security for all internal and external stakeholders. A schematic illustrating the HCA systems environment is included as Exhibit I.

Data Center All hardware is housed in HCA's state-of-the-art data center, which is a fully secured and controlled environment facilitating the highest levels of reliability and performance. The data center is secured through a combination of RF proximity access card, biometric scanning, and 24/7 video surveillance. The data center contains redundant air conditioning units which maintain proper air temperature and control humidity and static buildup to ensure optimal operation of equipment. Fire suppression is handled by an automated deployment system to deliver the waterless FM-200 fire suppressant. All servers in the datacenter boast dual power supplies, connected to independent electrical circuits, with each circuit protected by its own enterprise level uninterruptible power supply (UPS). The UPS is supplemented by a refillable diesel generator that can indefinitely provide power to the data center. This quadruple redundancy of system power allows for 24/7 uptime even during major equipment failure or prolonged utility power outages.

Hardware The hardware environment is comprised of a proven, IBM iSeries server hosting Med/MC, state-of-the-art virtual servers hosting the CareRadius Care and Medical Management system, and high performance Microsoft Windows servers deployed across multiple redundancy technologies. IBM iSeries provides unified management of a set of integrated hardware and software technologies. This system supports development, testing, production, and file transfer functionality within an integrated platform. The iSeries server is fully capable of supporting HCA's growing business, both at the Phoenix headquarters and satellite locations.

HCA utilizes server virtualization using VMWare vSphere. HCA is able to save power and consolidate its data center footprint, with an unparalleled level of system reliability and uptime. VMWare allows HCA to fully test environment changes before implementing them into production, and to maintain entirely separate development, testing, and production environments for the CareRadius and HCA applications. Network management and support servers are virtualized whenever feasible in order to take advantage of the many management, performance, and reliability advantages of server virtualization.

HCA utilizes clustering technology for its database, file/print, and virtual server environments. This ensures uninterrupted performance in the event of server hardware outage and all but eliminates the need for maintenance outages. HCA's Internet sites and web applications are hosted on load-balancing clusters to ensure optimal access for its employees, provider network, and members.

All virtual servers and clustered environments are hosted on high performance blade servers. The optimized platform of the blade architecture allows the server environment to be cohesively managed and easily expandable. The blade architecture provides a high standard of connectivity and optimal performance for HCA's data systems.

Data Storage is satisfied through the implementation of IBM System Storage DS3400 disk systems, which are designed to provide storage area network (SAN) infrastructure, enabling optimum levels of performance and reliability. Utilizing high-speed serial attached disks with dual controller and fiber channels the IBM SAN allows HCA to achieve the right balance of capacity and performance for its storage environment. In its current configuration, the SAN has a twelve terabyte (12TB) capacity. The SAN hardware is highly scalable, and the hot-swappable disk architecture enables HCA to respond quickly to changing storage needs and future growth without compromising performance.

Data Recovery

The IBM iSeries runs automated off-site backups to a remote storage facility twice a day. These ensure that the most recent data possible is available at any time, and recoverable to alternate facilities or back to the main Health Choice facility in case of catastrophic system or building issues. In the event of an outage necessitating recovery of data from off-site, an emergency contact at the remote storage unit will facilitate recovery to failover to an iSeries failover partition housed at their backup data center. For Windows, file backups run every day except Sunday. File backups include the System State of each server and any data drives in their entirety. Full backups commence Friday evening and run through Saturday. Monday through Thursday evening a differential backup is run, backing up any files changed since the last full backup. SQL backups run every morning except Saturday, as the full file backup is still running. SQL backups are flat file backups of the prior night's backup generated by Microsoft SQL Server. All SQL backups are full backups.

Data Communications In case of hardware failures in the infrastructure, connectivity to multiple entities (stack switches) eliminates the risk of a single point of failure. The Cisco Adaptive Security Appliance 5520 (ASA) firewall comprehensively protects the network from being compromised by ensuring all the security features are integrated into every possible element of the network. The ASA device includes firewall, voice over IP security, and intrusion prevention services. To improve network resiliency, HCA uses two Cisco firewalls in an active/active configuration with integrated VPN to provide email and FTP real time protection. HCA employs versatile Site-to-Site VPN and remote user access through Secure Socket Layer and IP security technologies to provide effective protection for business partners and provider network staff in rural areas. Access to the network for the Tucson satellite office is via a secure Point-to-Point T1 data connection, secured by Cisco routers. Together, the network hardware and firewalls are vital to ensuring that remote users, providers, and third party vendors have uninterrupted secure access to efficiently transfer data to and from HCA.

Voice Communications HCA has the most current hardware in place to support HCA phone operations, including call center, fax, and intra-office lines, the NEC NEAX2400 IPX PBX. This is the latest version of the system, and enables both digital and internet protocol (IP) expansion. The NEC PBX is highly stable, maintaining uptimes of 99.999%. Dual CPU units, inherent software stability, makes the NEC switch highly available and crash resistant. Due to the mission criticality of the HCA call center, network technicians maintain a stock of redundant PBX hardware, and are fully trained to be able to support a phone outage caused by a failure at the PBX level, with recovery time measured in minutes.

The IP system offered by the PBX allows expansion via media gateways so that remote offices can be attached to the main system, and still run independently in the occurrence of line contact loss or even catastrophic failures at the central location. This feature is especially important in supporting phone operations for HCA's Tucson office. Direct hand-off of IP conversations has been implemented as well, so that once initiated, the voice traffic is passed directly from phone to phone, thus saving PBX processing power. The current phone switch is configured to simultaneously support up to 70 local calls and 94 long-distance or 800-number calls. Even at peak call volumes for all inbound and outbound calls including prior authorization and member services, utilization of the available 164 lines in the PBX is less than 50 percent. The PRI lines for calls from/to the PBX are backed up by a secondary voice setup in which voice traffic can be routed over one of several internet connections in cases of emergency, or even fail over to a temporary off-site backup system via our emergency support vendor. Even in the case of catastrophic building or system loss, calls can be routed and answered by staff remotely.

Key Interfaces Supporting HCA

HCA has implemented a broad spectrum of interfaces with external business partners and with AHCCCS to support health plan operations. HCA has achieved the highest level of performance as a result of the effective and frequent exchange of data. A schematic illustrating the HCA systems interfaces is included as Exhibit J.

Major Data Processing Functional Workflows

HCA uses contemporary data processing techniques to integrate the elements of the software environment to meet critical health plan processing activities. This section presents a series of functional workflows for major health plan functions. The workflows are presented in Exhibits K through P below.

Implementation of the ALTCS Line of Business

HCA maintains the full array of system capabilities necessary to support ALTCS. HCA's approach is to define a new set of benefit plans that correspond to each of the set of benefits appropriate to ALTCS members, which varies based on their care setting, Medicare arrangement (FFS or MA), and AHCCCS eligibility. HCA has developed a preliminary implementation plan that is included as Exhibit Q.

Exhibit H: HCA Software Environment

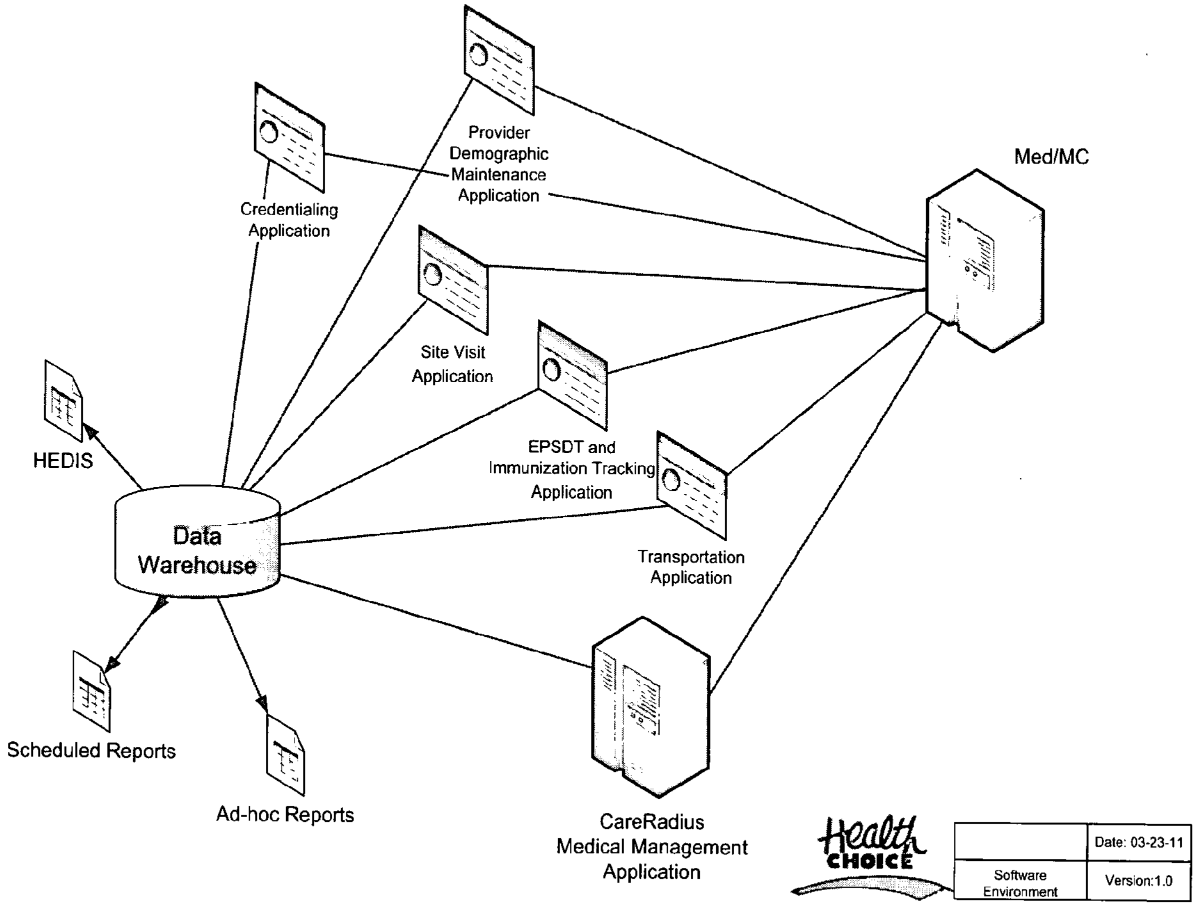


Exhibit I:

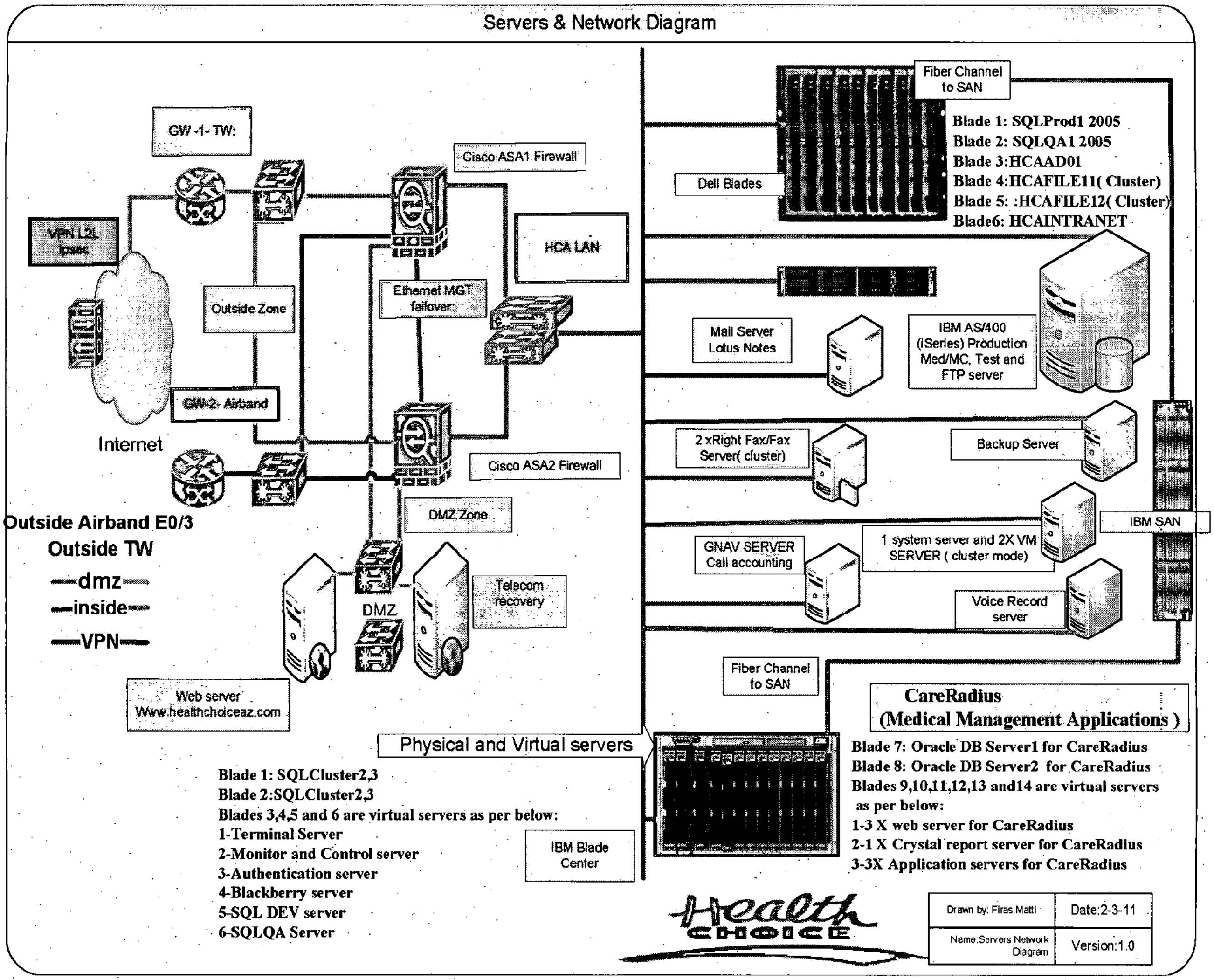

Servers & Network Diagram
Fiber Channel to SAN
Blade 1: SQLProd1 2005
Blade 2: SQLQA1 2005
Blade 3:HCAAD01
Blade 4:HCAFILE11(Cluster)
Blade 5: :HCAFILE12(Cluster)
Blade6: HCAINTRANET
GW -1- TW:
Cisco ASA1 Firewall
Dell Blades
VPN L2L Ipsec
HCA LAN
Outside Zone
Ethernet MGT failover
Mail Server Lotus Notes
IBM AS/400 (iSeries) Production Med/MC, Test and FTP server
GW-2- Airband
Internet
2 xRight Fax/Fax Server(cluster)
Backup Server
Cisco ASA2 Firewall
DMZ Zone
IBM SAN
Outside Airband E0/3
Outside TW
dmz
inside
VPN
GNAV SERVER Call accounting
1 system server and 2X VM SERVER (cluster mode)
Telecom recovery
DMZ
Voice Record server
Fiber Channel to SAN
Web server Www.healthchoiceaz.com
CareRadius (Medical Management Applications)
Physical and Virtual servers
Blade 7: Oracle DB Server1 for CareRadius
Blade 8: Oracle DB Server2 for CareRadius
Blades 9,10,11,12,13 and14 are virtual servers as per below:
1-3 X web server for CareRadius
2-1 X Crystal report server for CareRadius
3-3X Application servers for CareRadius
Blade 1: SQLCluster2,3
Blade 2:SQLCluster2,3
Blades 3,4,5 and 6 are virtual servers as per below:
1-Terminal Server
2-Monitor and Control server
3-Authentication server
4-Blackberry server
5-SQL DEV server
6-SQLQA Server
IBM Blade Center
Health Choice
Drawn by: Firas Matti
Date:2-3-11
Name:Servers Network Diagram
Version:1.0

Exhibit J: Technical Interfaces

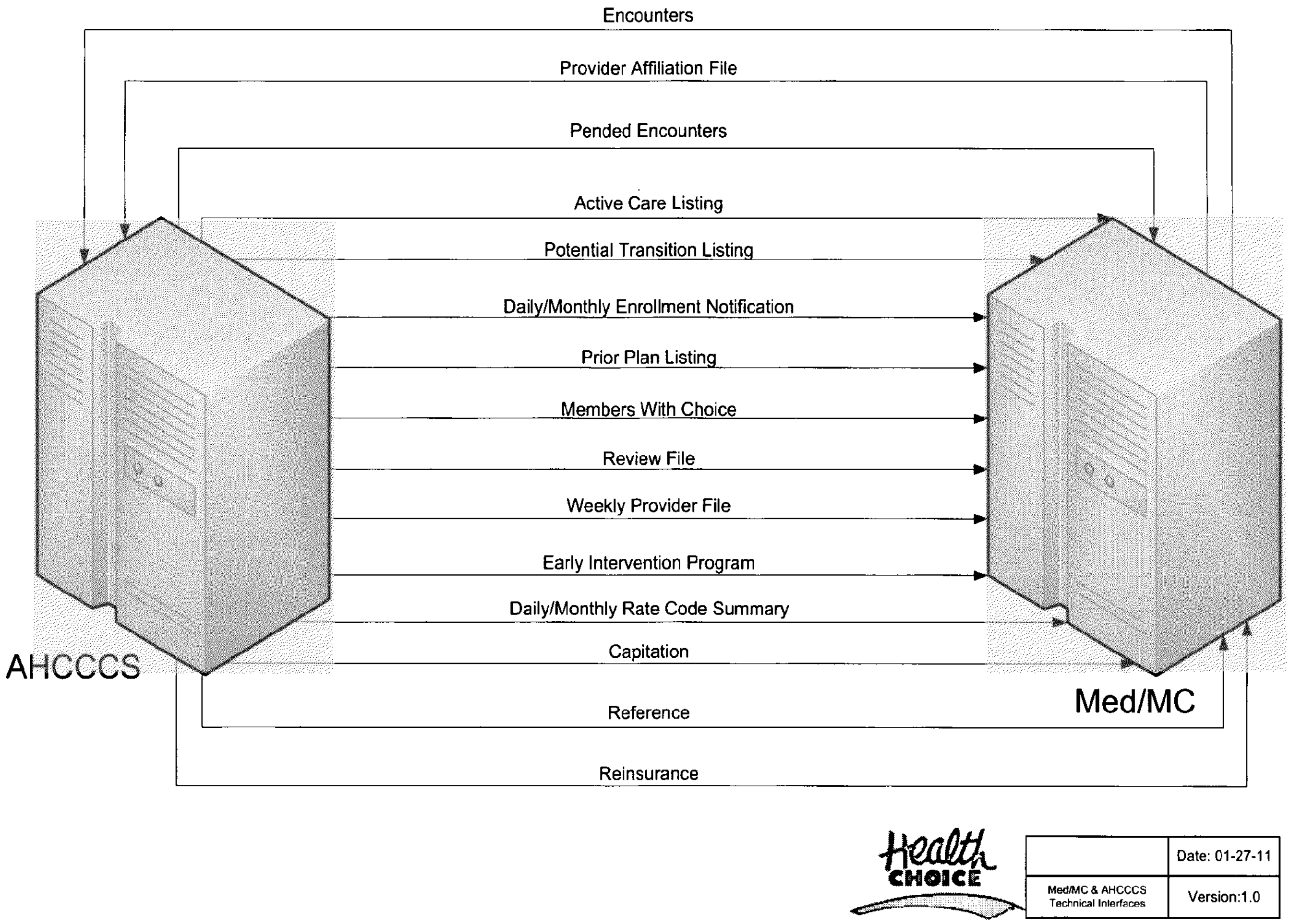


Exhibit K: Member Eligibility and Roster Processing

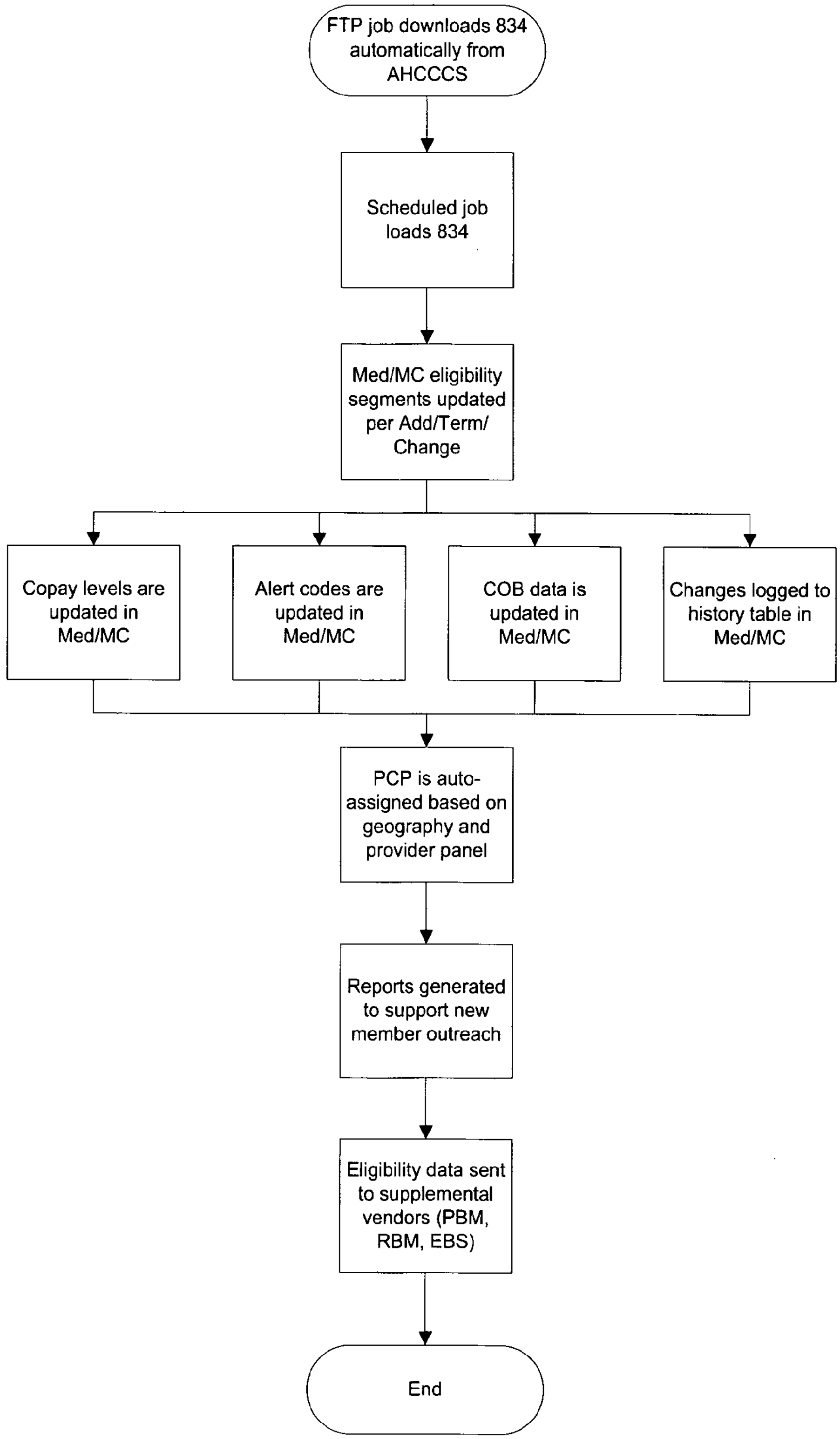
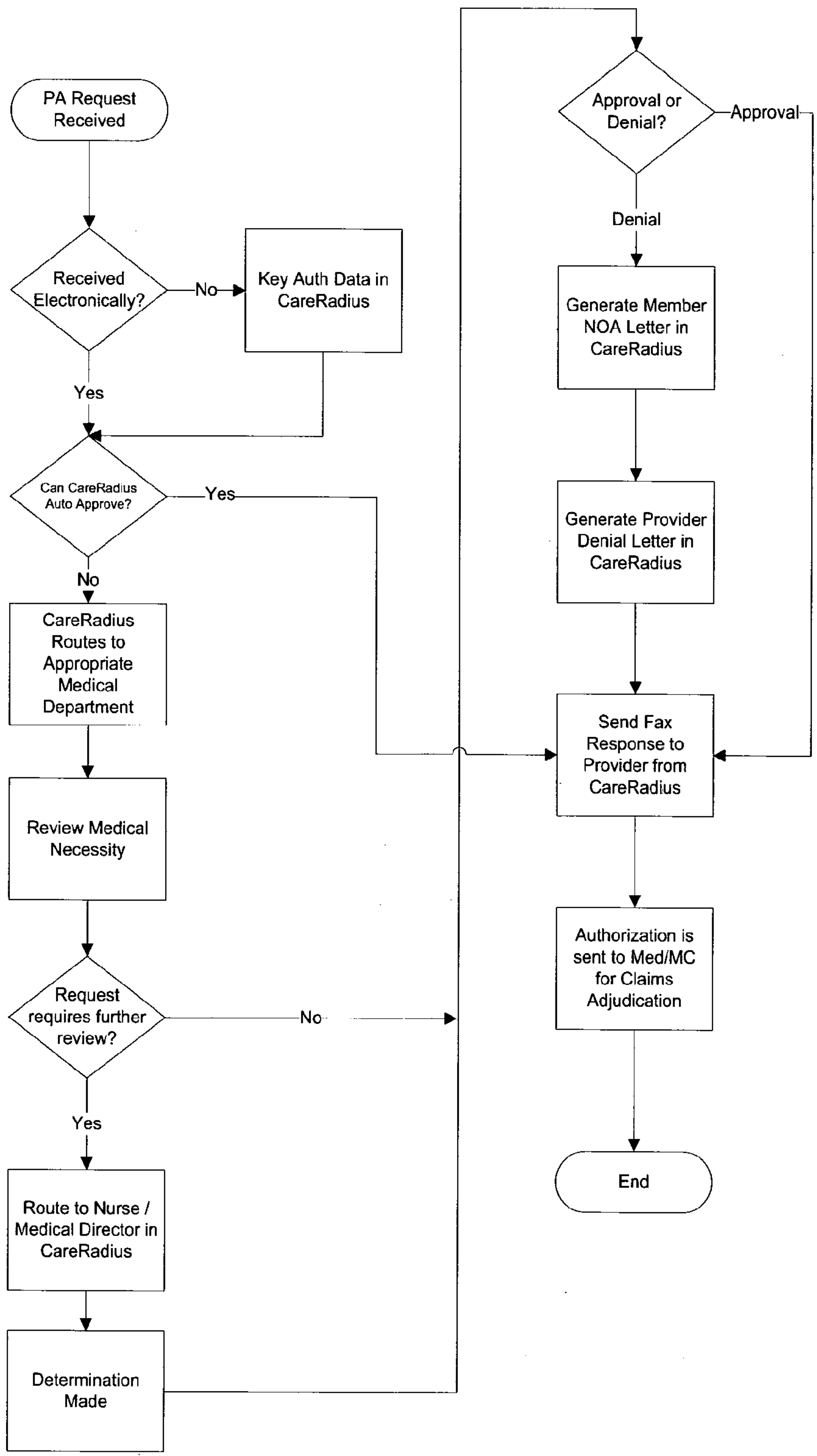
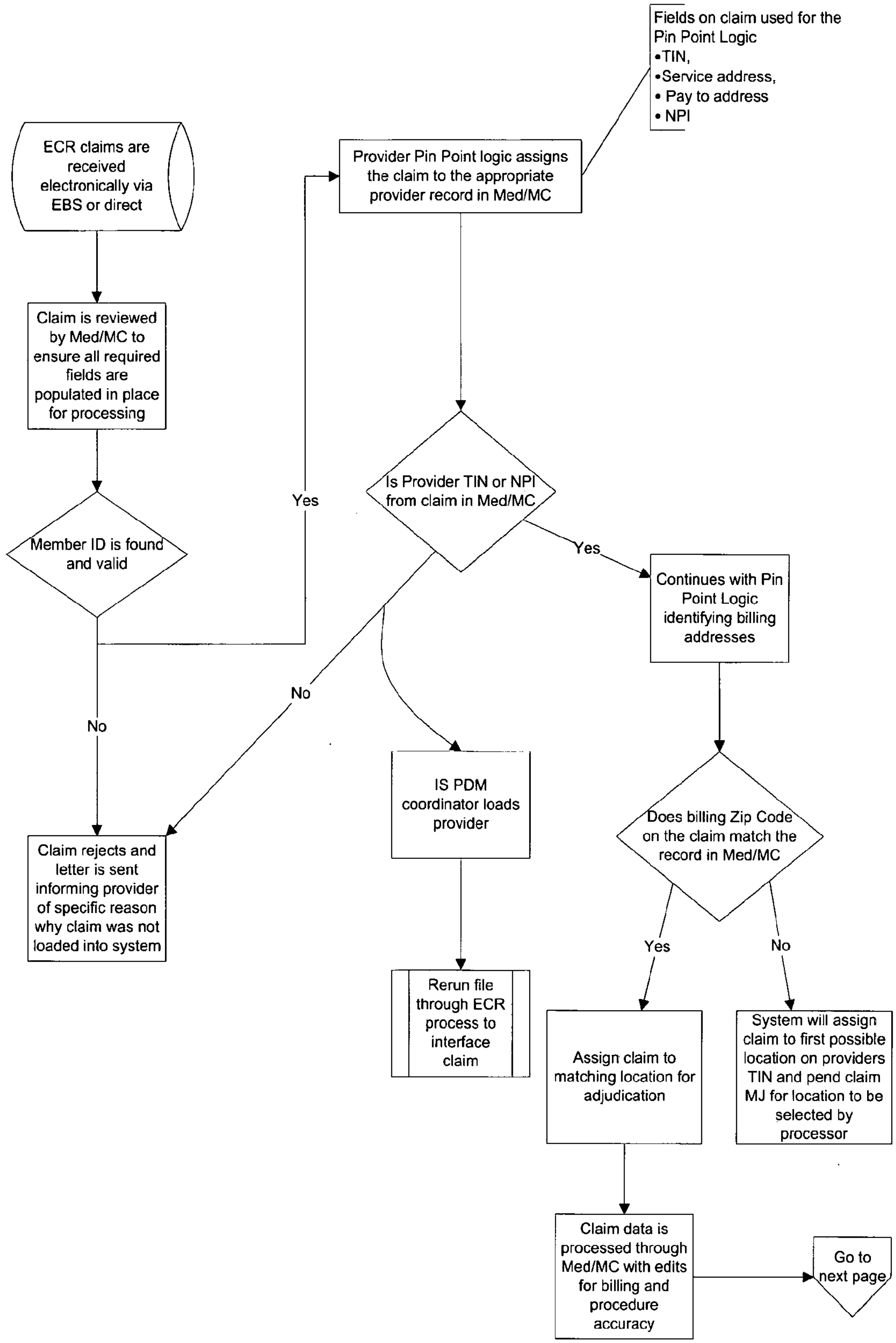


Exhibit L: Medical Management Processing



Electronic Claim Processing



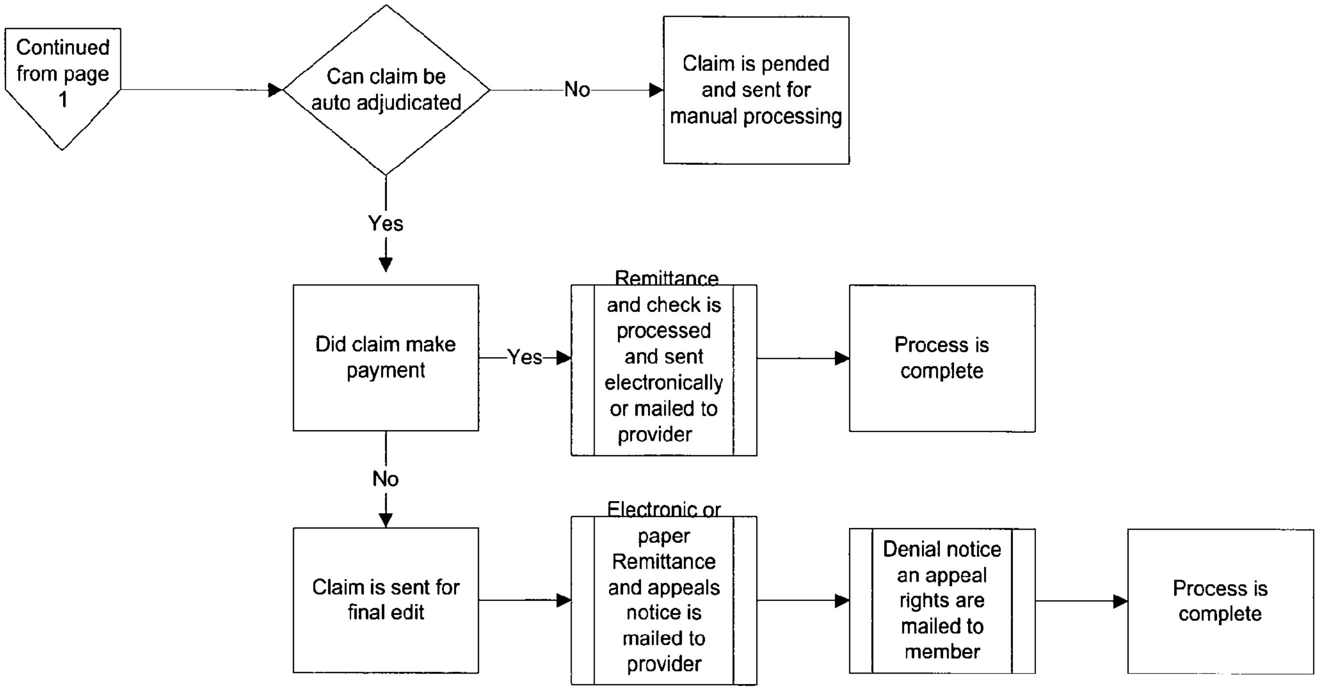

Continued from page 1
Can claim be auto adjudicated
No
Claim is pended and sent for manual processing
Yes
Did claim make payment
Yes
Remittance and check is processed and sent electronically or mailed to provider
Process is complete
No
Claim is sent for final edit
Electronic or paper Remittance and appeals notice is mailed to provider
Denial notice an appeal rights are mailed to member
Process is complete

Exhibit N: Encounter Processing

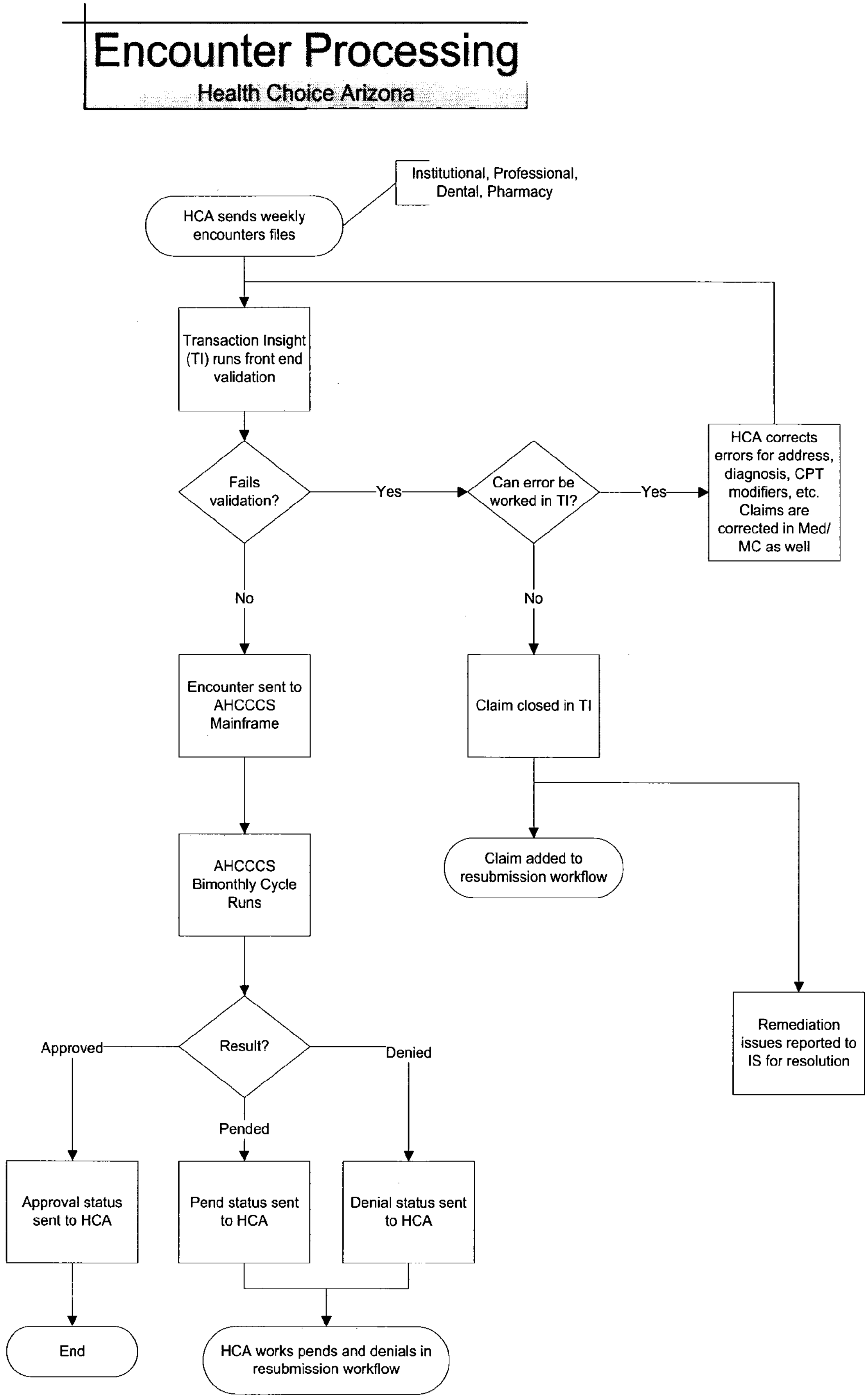


Exhibit O: Provider Data Exchange

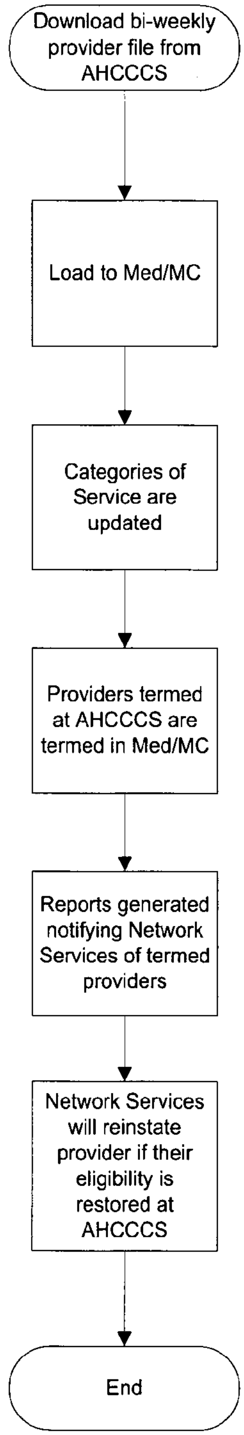


Exhibit P: Capitation Processing

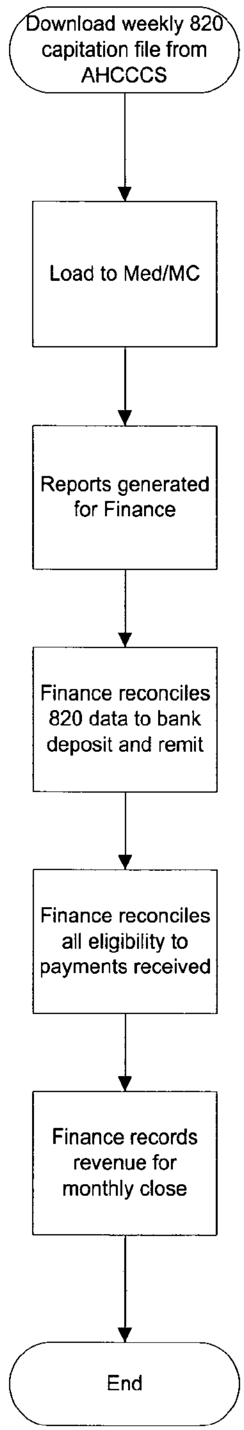


Exhibit Q: Implementation Plan

Task Name	Duration	Start	Finish
Define ALTCS Requirements	40 days	Tue 2/1/11	Mon 3/28/11
− **Design System Enhancements**	**16 days**	**Tue 3/29/11**	**Tue 4/19/11**
Member Eligibility	2 days	Tue 3/29/11	Wed 3/30/11
Provider File and Interfaces	2 days	Thu 3/31/11	Fri 4/1/11
Benefit Design Setup	2 days	Mon 4/4/11	Tue 4/5/11
Prior Auth Requirements Setup	2 days	Wed 4/6/11	Thu 4/7/11
Claims Processes	5 days	Fri 4/8/11	Thu 4/14/11
Misc Interfaces	3 days	Fri 4/15/11	Tue 4/19/11
ALTCS Plan Awarded	0 days	Mon 5/2/11	Mon 5/2/11
Submit Enhancements to Vendors	2 days	Mon 5/2/11	Tue 5/3/11
− **Vendor Programming**	**28 days**	**Wed 5/4/11**	**Fri 6/10/11**
Member Eligibility	5 days	Wed 5/4/11	Tue 5/10/11
Provider File and Interfaces	3 days	Wed 5/11/11	Fri 5/13/11
Claims Processes	15 days	Mon 5/16/11	Fri 6/3/11
Misc Interfaces	5 days	Mon 6/6/11	Fri 6/10/11
− **Testing**	**33 days**	**Wed 5/11/11**	**Fri 6/24/11**
Member Eligibility	10 days	Wed 5/11/11	Tue 5/24/11
Provider File and Interfaces	5 days	Mon 5/16/11	Fri 5/20/11
Claims Processes	15 days	Mon 6/6/11	Fri 6/24/11
Misc Interfaces	5 days	Mon 6/13/11	Fri 6/17/11
− **Data Loads**	**65 days**	**Mon 5/2/11**	**Fri 7/29/11**
Provider Data	60 days	Mon 5/2/11	Fri 7/22/11
Benefit Structure	5 days	Mon 7/25/11	Fri 7/29/11
Auth Requirements	2 days	Mon 6/27/11	Tue 6/28/11
Fee Schedules	4 days	Mon 7/25/11	Thu 7/28/11
− **Supplemental Vendor Setup**	**90 days**	**Mon 5/2/11**	**Fri 9/2/11**
PBM	90 days	Mon 5/2/11	Fri 9/2/11
RBM	90 days	Mon 5/2/11	Fri 9/2/11
Clearinghouse	90 days	Mon 5/2/11	Fri 9/2/11
Claims Scanning Vendor	90 days	Mon 5/2/11	Fri 9/2/11

Requirement #12

REQUIREMENT #12

Describe the Offeror's information system change order and software modification processes, the date of the last major version update, and indicate if there is a planned system conversion within the contract period (five years). If yes, indicate which subsystems were/will be affected and describe the planning and system implementation process.

Health Choice Arizona (HCA) has developed and implemented a detailed and stringent set of change controls within its software configuration management program. Information system changes are driven by changes in business requirements, and organizationally impact all aspects of health plan operations. Effective policies and procedures are used to guide the change and configuration management processes, consistent with all other health plan areas. The HCA Policy Application Controls – Med/MC Change Management, C 4.174.00 details the change management process for the software environment, including the Med/MC Claims Adjudication System and the CareRadius Medical Management System, and other HCA softwareapplications. The policy governs all areas responsible for a secure and standardized method of developing and promoting new application enhancements into the HCA Production Environments.

These processes have been thoroughly reviewed and audited by Ernst and Young (E&Y). E&Y determined that these change control processes meet Sarbanes-Oxley (SOx) guidelines, and satisfy best practices for controls of internally developed and vendor-managed software applications. This audit occurs on an annual basis and results have been consistent, with no negative findings.

HCA Change Request Process

HCA utilizes an electronic change request system for end users to request system modifications. Through the HCA intranet, end users can submit an IS Service Request (SR) to request an enhancement. The request is reviewed by the IS Director and/or the IS Operations Manager and approved if a system modification is necessary to implement the business requirement. Senior management is then briefed on proposed enhancement and estimated cost, and the Chief Operating Officer makes a final determination to approve the request and set its priority based on workload or regulatory deadlines. If a request cannot be approved, it may be deferred, or returned for further analysis and justification.

Once the enhancement has been approved, the IS Operations Manager assigns an IS Business Analyst to work with the business unit to develop the specification. The IS Business Analyst documents the request, the business needs, return on investment (if applicable), and works with the users to define the function and requirements of the software change. During this process, all information is electronically stored in the OnTime software application that is utilized as the IS project management and task tracking application. Supplemental development artifacts and documentation for each task is attached to the OnTime task folder throughout the process, allowing for centralized and secure storage of pertinent data related to the enhancements.

Testing of Modifications

The Application Controls policy states that each enhancement will be adequately tested in both test and staging environments by relevant HCA stakeholders. IS staff save all testing documentation in the corresponding task folder, along with stakeholder approvals of business requirements, specifications and promotions from test to staging and production. All enhancements are created and tested in the test environment. Primary application data is refreshed into the HCA staging environments on a regular basis to ensure that testing is performed on valid, recent data. The System Administrator ensures the data defined in the Application Controls – Med/MC Data Refresh Policies & Procedures has been refreshed appropriately.

At this time, additional data/files are identified via the Med/MC Application Enhancement Form and refreshed by the System Administrator, if required, for full and complete testing of the enhancement.

Change Management Coordination with System Vendors

HCA has an established set of protocols that have been developed with each system vendor. For example, CPU creates two sets of instructions for each enhancement to Med/MC. The first set of instructions details the commands necessary to move the enhancement from the test environment to the staging environment. The second set of instructions details the commands necessary to move the enhancement from the staging environments to the production environments. Each set of instructions only references the objects specifically defined in each enhancement task description.

Med/MC enhancements are coded and tested by CPU, however, the responsibility for migrating enhanced programs lies with the HCA System Administrator to provide proper separation of duties. The System Administrator moves the enhancement from the test environment to the staging environment and from the staging environment to the production environment. The IS Operations Manager/IS Business Analyst manages each enhancement task to ensure each responsible internal party has signed and dated the Med/MC application enhancement form when they have completed the activity for which they are accountable.

System down time involved with implementing new application enhancements is kept to a minimum and conducted outside normal hours of operation. Security access is restricted to only those users that require the necessary permissions, in order to limit unwarranted access to programs and data. Within this policy, the process of regression testing and promotion from our test, staging to production software environments is documented in the OnTime task, along with the end user acceptance signature before software changes are promoted into production.

Implementing System Modifications in Production
IS Operations Manager/IS Business Analysts email all HCA users describing the logic of the implemented enhancement and the effects/changes on the Med/MC application. Prior to the promotion to production, the IS Business Analyst invites all affected users to the IS Training Room to review the upcoming changes in functionality, and test results, in the Staging Environment. If issues are identified at this session, the enhancement is pulled from the move schedule, and sent to be reworked. At the end of each week the IS Security Specialist validates the Med/MC Application enhancement forms to ensure each step has been documented and completed appropriately. All documentation relating to each task are stored in a secure location within the electronic change request system, with PDF copies of paper forms serving as backup to show signatures of the stakeholders involved.

After working closely with AHCCCS, HCA successfully implemented a major revision of Med/MC in September 2010 in order to satisfy mandatory copays for TMA and TWG acute care populations. The set of enhancements comprising the version change included logic to properly adjudicate claims using copays submitted on claims or deducting copays from the final payment if providers did not collect.

Requirement #13

REQUIREMENT #13

Indicate how many years the Offeror's IT organization or software vendor has supported the current or proposed information system software version currently operated by the Offeror. If Offeror's software is vendor supported, include vendor name(s), address, contact person and version(s) being used.

The Health Choice Arizona (HCA) Health Plan Information System includes two core components that support managed care and care management capabilities.

Med/MC

HCA utilizes CPU Medical Management System's (CPU) Med/MC Managed Care Information System (Med/MC) to support provider, benefit plan, reference, claims adjudication, payment and member management functionality. Med/MC has been utilized as HCA's claims adjudication system since October 1994 and has been continuously supported by the software vendor for maintenance as well as system enhancements from 1994 to present. Currently HCA has implemented Med/MC Version 7.0, which is the current production release of Med/MC.

The following is the contact information for the Vice President of the Managed Care Division at CPU:

Duane Findling
CPU Medical Management Systems
9235 Activity Road, Suite 104
San Diego, CA 92126-4440
(800) 597-0875 Ext. 248

CareRadius Medical Management System

CareRadius is the medical management software that supports HCA's Medicaid and Medicare Special Needs Plans. Landacorp/SHPS developed CareRadius. CareRadius is an enterprise-level expert driven care management workflow solution. CareRadius provides HCA with a single platform for managing all medical management activities, including, care management, utilization management and prior authorization processing. Landacorp is the developer of CareRadius and has continuously supported the application since it was introduced in 2009.

HCA implemented CareRadius Version 1.5 in 2011, and is supported by the software vendor for maintenance as well as system enhancements. It is the current production release of CareRadius.

HCA considers its software vendors to be business associates and trusted partners. It is our expressed policy to contract for system support and customized enhancements with each vendor.

The following is the contact information for the General Manager at Landacorp/SHPS:

Jay Dunlap
Landacorp, a division of SHPS
2080 East 20th Street, Suite 170
Chico, CA 95928
Tel 530.891.0853

Requirement #14

REQUIREMENT #14

Describe the Offeror's plans and ability to support current and future IT Federal Mandates.

As new transaction formats and technology initiatives have been introduced and required by regulatory entities, Health Choice Arizona (HCA) has assumed a leadership role among the AHCCCS Managed Care Organizations (MCOs) to ensure functional and technical criteria of the AHCCCS program is met. Specific examples of this leadership in technology adoption over this past are:

- First MCO to accept and process an 834 Eligibility Transaction
- First, if not one of the first MCO's to pass all testing requirements and go live with the AHCCCS OPFS Methodology
- Key Member of the ANSI X12 835 Workgroup, as well as the National Provider Identifier (NPI) and HIPAA Consortiums
- Implemented new claim form types: CMS 1500, UB04, in addition to NPI within Federally mandated timelines that allowed lagging providers the flexibility to submit legacy form types and ID's without interrupting claim adjudication and payments.
- Advisor to the Rural Health Grant Program of Arizona Government Information Technology Agency (GITA)

Today, a rising tide of change is sweeping over the health care industry, federal mandates are driving health care to new, coordinated and information driven processes, that are based on evidence based standards of practice and greater accountability. Both the 2009 American Recovery and Reinvestment Act and the 2010 Affordable Care Act have numerous provisions that impact the Medicaid program, change state Medicaid agency requirements, and specify changes in health insurance coverage, provider reporting, and payment reform.
At the state level, AHCCCS faces difficult budget constraints while the demand for services grows in the economic downturn. The Arizona legislature is likely to mandate additional changes in AHCCCS policy to keep Arizona solvent. HCA is prepared to adapt and change its coverage and policy in sync with AHCCCS.

HIPAA Administrative Simplification Provisions
HCA will utilize this same proven approach of collaboration along with functional and technical expertise to support and provide leadership to the AHCCCS Program for all future HIPAA as well as other HIT initiatives. Subsequently, HCA has already commenced development of the ANSI X12 5010 versions of HIPAA transaction and code sets for implementation in 2012.

HCA is also preparing for the nationwide adoption of new diagnosis and institutional procedure codes with the implementation of ICD10-CM that substantially increases the level of specificity for diagnosis codes, and enables a much finer definition of hospital procedures.
At the state level, HCA is preparing for the adoption of the UB billing for long term care services as AHCCCS has specified for later in 2011. In addition HCA is planning for replacement of Roster billing for HCBS services in 2013. While not a federal mandate, it represents an adoption of national standards to make billing more uniform across all of health care.

HCA currently supports all HIPAA transactions including, but not limited to the ANSI X12: 270/271 (Eligibility Verification and Response), 276/277 (Claims Status Request and Response), 278 (Prior Authorization), 834 (Enrollment), 835 (Remittance Advice), 820 (Capitation), 837(claims/encounters: Professional, Institutional, and Dental), U277 (Unsolicited Encounter Status), as well as the NCPDP 3.2 and 5.1 (Pharmacy Claims) transactions. Additionally, HCA is audited annually by an external party, Ernst & Young, to ensure the regulatory requirements of HIPAA and Sarbanes Oxley are met. Several HCA technical and operational employees, including the Director of Information Systems and IS Operations Manager, actively participate in HIPAA related consortiums and workgroups in conjunction with AHCCCS and other AHCCCS contractors to guarantee the plan understands all transaction requirements and their potential impacts.

ARRA HITECH ACT Provisions
HCA has a particular focus on assisting small rural providers in adapting to change and continuing to serve the AHCCCS population and HCA members. At the state level, HCA senior management participate in the Health-e Connection Legal Working Group as well as play a critical role in GITA's Rural Healthcare Information Technology

Adoption (RHITA) Program, which includes our recent RHITA Grant partnership with LaPaz Regional Hospital. HCA supports the efforts of the Arizona Regional Extension Center for Health Information Technology (REC) the Arizona Health e Connection AzHeC, as they assist providers in adopting electronic health record systems, often with federal incentives available from the Medicare and Medicaid programs. HCA believes this involvement provides the leadership, support, and expertise that is necessary for HIT initiatives to garner the support and momentum required to achieve successful sustainability.

These efforts and involvements ensure HCA's internal technology infrastructure is designed and deployed well within the timeframes necessary to meet the requirements of the aggressive Arizona e-Health roadmap. Furthermore, to ensure seamless operational success when transaction and code sets are implemented and/or updated, HCA's internal stakeholders that include, but are not limited to the COO, CFO, Provider Services Director, Provider Claims Educator, Director of IS, IS Operations Manager, Claims Manager, Audit Director, and Claims Customer Service Call Center Director develop a detailed project plan with associated communication matrix to ensure all AHCCCS and HCA requirements are met, if not exceeded. This planning methodology encompasses an iterative or agile approach to the project development life cycle in order to incorporate the stakeholder learning curve with regard to new Health Information Technology (HIT) initiatives. It is this detailed approach to project planning and communication that enables HCA personnel to mitigate project risks while exceeding the proposed benefits and returns such as reduced cost and provider hassle factor reduction.

Patient Protection and Affordable Care Act Provisions

The PPACA of 2010 (commonly known as ACA) contains numerous provisions that impact increased regulatory requirements for privacy and security, new health insurance transparency and medical expense ratio threshold requirements that impact all health plans including HCA.

HCA is actively studying the ACA in order to develop a strategic approach that enables HCA to adapt and prosper from new requirements that can broaden Medicaid coverage and provide additional coverage opportunities through the health insurance exchanges.

HCA is also analyzing other significant Medicaid requirements that apply new program integrity requirements on health plans, additional provider and health plan enumeration provisions and new administrative standardization provisions that will establish truly uniform claims data element definitions.

As detailed above, HCA is an organization dedicated to the technological advancement of healthcare. To this end, HCA recognizes that our staff, with the required software and hardware resources, needs to anticipate as well as adapt to the ever-changing healthcare industry. As leaders in the industry, HCA must educate not only ourselves and our personnel, but ensure that we educate our strategic business partners such as our contracted providers and community-based organization partners on HIT and health reform that, when implemented, will positively impact the quality of care for our member population while reducing system cost. This leadership begins with a managed approach to learning and understanding the forms and character of the data utilized that is provided by health care providers and other public information sources.

Grievance Systems

Requirement #15

GRIEVANCE SYSTEM

REQUIREMENT #15

Provide a flowchart and comprehensive written description of the Offeror's grievance system. At a minimum, the description should include the member grievance and appeal process, and the provider and subcontractor claim dispute process. Include in the description how data resulting from the grievance system is used to improve the operational performance of the Offeror. The submission requirement will be a maximum of four pages of narrative with a maximum of three pages of flowcharts.

Since effectively accepting and managing member inquires and complaints increases member access to care and member satisfaction, and is the information from which its operation can effectuate improvement initiatives and performance measures, these competencies are considered strategic core processes of Health Choice Arizona (HCA). Regardless of the HCA staff member's position, they are trained to recognize the difference between an inquiry, a grievance and an appeal. HCA provides all new employees with New Hire Orientation (NEO) within 30 days of hire. NEO includes an overview of HCA internal processes for member inquiries, grievances and appeals. An annual refresher class is required of every HCA employee.

Member Grievances

The majority of member grievances are taken in by the Member Services Department at HCA, although all employees are trained to recognize a member grievance and to document it accordingly. Members may file their grievance verbally or in writing. A Member can report a grievance at any time, compliant with ALTCS and AHCCCS requirements. When a member contacts Member Services with a grievance, the MSR fills out the *Grievance Form*, which is subsequently submitted to and reviewed for completion by the Member Services management team. Once the form is deemed complete, the Member Services management team immediately routes the form to the QM Unit.
Once received in QM, the grievance is reviewed by the clinical staff to determine the medical consequences of the grievance. The grievance is logged into the QM application module of Care Radius and a file is opened for investigation by a QM Specialist to determine all issues. A written acknowledgement letter is issued to the grievance within 5 business days of original receipt. Both medical and operational issues are researched by the QM Specialist.

For medical issues, the QM Specialist, under the direction of the QM Director and Medical Director, will initiate investigation of the quality of care concerns, including requesting information from providers, HCA staff and facilities. The provider has 10 working days in which to respond to requests for information. If no response is received, the request will be repeated. The provider will be given 5 additional days to respond. If there is still no response, the quality of care concern will be reviewed with the Chief Medical Officer/Medical Director who will either contact the provider directly or determine an alternative course of action. For operational issues, the QM Specialist will communicate with the applicable department manager to gather information. Internal staff has 10 working days in which to respond to the request for information. Depending on the severity of the issue(s), department managers may meet to discuss the issue in a more formal forum. The minutes to these meetings along with the before mentioned questions and their responses are documented in the corresponding QM file for reference.

All complaints regarding quality of care are trended and those that indicate serious quality, utilization or risk management issues are addressed through HCA's formalized peer review process. To identify clinical quality of care concerns, the QM process includes: assessing the level of severity of the issue; taking action (documenting, interventions as appropriate, monitoring the success of the interventions, incorporating the interventions into the QM Plan, as appropriate, assigning new interventions (when necessary); review by the QM department, Quality of Care (QOC), and QM Committee when appropriate; referring/reporting the issue to the appropriate regulatory agency for further review/action; notifying the appropriate licensing board or regulatory agency when a QOC involves suspension or termination of a provider from the network; documentation of the criteria and process for closure of the review.
All cases referred to the QM Unit are reviewed at weekly QM department meetings to assess the level of severity. Cases in which criteria is met are presented during the bi-monthly QOC meeting where action plans are further developed and the decision is made to present the case to the QM Committee. Cases that do not reveal a potential quality of care concern will be closed and maintained in the QM Application as well as being placed in the provider's file for tracking.
The QM staff is trained to monitor for outlier trends. When an issue reaches this threshold based upon on risk and/or volume, the information is immediately conveyed to the appropriate HCA staff for assessment and resolution.
Following a review by the QM Department, if it is found that the grievance, both quality and/or non-quality, is substantiated, a request for corrective action will be made of the provider involved in the complaint. The provider is given 10 business days to provide HCA with a plan of action. Depending on the severity level and nature of the issue, the QM staff may request provider and provider staff education by an appropriate representative of HCA,

development and implementation by the provider of a corrective action plan addressing the specific issues necessary to improve the quality of care provided, and policy and procedure development or revision by the provider.

At the end of the investigation and within the required timeframes, a closure letter is sent to the member outlining the resolution of the grievance, identifying actions to be taken by HCA, and clarifying follow-up that must be completed by the member. In addition, HCA identifies a contact person/phone number within the QM Department as well as the Member Services Department phone number in the event the member needs further assistance with their Medical home. The internal benchmark for resolving these grievances is 30 days. The majority of the more complex medical cases that exceed 30 days are resolved in less than 60 days, but no later than 90 days from receipt of the grievance. The average number of days to process a complaint during the previous contract year (CYE 2010) was **25.90 days**. QM staff is trained to monitor for outlier trends. When an issue becomes an outlier based on risk, volume or being problem prone, the information is immediately conveyed to the appropriate HCA staff for assessment and resolution. At the end of the investigation, a closure letter is sent to the member.

Standard Member Appeals

Member appeals are handled in the Medical Services Department, under the direction of the Dispute & Appeal Manager. Appeals are handled by a qualified, trained Member Appeals Coordinator (MAC). Medical issues are reviewed by appropriately qualified medical staff, and as required by 42 CFR 438.2. Members have the right to file an appeal in response to an action taken by the health plan. An action may include, but is not limited to, Notice of Action (NOA), denial for a plan change, and denial for coverage of provided services. A member may file a formal appeal either verbally or in writing. If a member wishes to appeal verbally, he or she may call HCA's toll-free phone number and speak with either a Member Services Representative (MSR) or an Appeal Coordinator. If an MSR receives a verbal appeal, the MSR documents the appeal on an HCA *Member Appeal Form* and sends it to the Appeal Coordinator via email, which is accessible by the Appeal Coordinators and the Dispute & Appeal Manager.

Both the HCA *Member Handbook* and the member section of the HCA website provide members with information regarding their rights to file an appeal. Additionally, every written NOA or denial letter that is sent to a member includes information regarding appeal rights. Members may also be given verbal notification of the right to file a grievance or an appeal. If the member speaks a language other than English, appeal correspondence will be translated into the member's preferred language. Other accommodations are considered, as requested. A member can also appoint a representative to handle the appeal process on his/her behalf. In order to ensure proper legal rights and HIPAA protection, HCA requires that the member appoint his/her representative in writing or another verifiable way. If a representative is appointed, the representative becomes the primary contact; however, the member is copied on all HCA correspondence simultaneously.

If a member has received an NOA to reduce, suspend or terminate an existing service, the NOA provides written instructions on how to request that services be continued during the appeal process. The requesting doctor may request continuation of services and the member may also request continuation of services within 10 days from the date of the denial. If the member does request continuation of services timely, the MAC informs the member that arrangements for the continuation of services will be made and that if the appeal and/or hearing is not favorable to the member, he/she may be liable for the costs associated with the services that have been continued. The MAC then communicates with the HCA Medical Services department and/or the provider of service to arrange for the continuation of services during the appeal process. The member has 60 days from the date of the NOA or from the date of the adverse action (if the action is not related to a medical service request) to file the appeal.

Member appeals are tracked in the appeals application module of Care Radius. A physical file is created to hold all documentation received from the member, all documentation issued by HCA, and documents collected from research. Upon receipt of the appeal, a written acknowledgement is mailed to the member within 5 calendar days. If the appeal was taken by someone other than the MAC working the file, the MAC will contact the member to ensure that all information is in the appeal file for review and that their request is clearly understood. If the appeal is in regards to a requested medical service, the MAC will issue a written questionnaire to the requesting provider and to any other appropriate provider. The questionnaire allows the requesting provider to provide HCA any other information, facts, opinions or explanation as to why the service was requested to ensure that medical review is thorough. If the provider does not respond within the requested deadline, a second request is sent; however, if no response is received, the medical review will be done without the additional information.

HCA resolves all appeals no later than 30 days from the date HCA receives the appeal, unless an extension is in effect. The resolution timeframe for the appeal decision may be extended up to 14 calendar days if the member requests an extension, or if HCA establishes a need for additional information and such a delay is in the member's best interest. HCA notifies the member of the extension both verbally and in writing. The appeal decision is issued in writing. The decision is sent through the United States Postal Service. If the decision is not fully in the member's favor, the decision is sent using the Certified Mail process. The decision letter includes the following: Member's name and ID, assigned appeal number, date the appeal was received, summary of the issue presented in the appeal, summary of the research that was done, the results of the resolution, reference to legal citations or authorities supporting the determination process, date the decision was issued, statement of right to file for a State Fair Hearing, instructions on how to request a State Fair Hearing, information on how to contact HCA for any questions. After the decision is issued, if the decision was to overturn any or all of the plan's original decision, the MAC is responsible for communicating with applicable parties to effectuate the appeal decision.

Expedited Member Appeals
A member has a right to expedite the appeal process in specific circumstances. If HCA issues an NOA to deny or to limit, reduce or terminate a requested medical service, and it is determined that waiting the standard 30 days to process an appeal would seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, HCA will process the appeal within 3 working days of receiving the appeal. All processes for an expedited process are the same as the standard process, with the exceptions noted below. When a member requests the expedited process, the MAC immediately takes the file to the Medical Director for confirmation. If the Medical Director disagrees that the member's condition warrants the expedited process, the member is notified both verbally and in writing, and the file is handled through the standard process. If the requesting doctor requests the expedited process, the file is handled through the expedited process. The acknowledgment letter is issued within 1 day, and an attempt to acknowledge verbally is made. The final decision is issued within 3 business days, and an attempt to provide the decision verbally is made. If an extension is needed, as described above, a maximum of 14 calendar days is added to the 3 business days for the final decision.

Provider Complaint Process
The point of intake for provider complaints is typically from the Claims Customer Service Call Center or Network Department, although complaints may also be identified through the Claim Dispute process or even through a call to Prior Authorization staff in Medical Services. A complaint may be in writing or verbal. Regardless of the point of intake, all complaints are entered into the Provider Inquiry and Complaint module of Care Radius. Data in this module is monitored and reviewed by the Provider Claims Educator and the Network Director so that issues can be prioritized by severity and provider impact. In addition to the review of inquires and complaints, the Network Director receives various reports from other HCA departments that show trending of provider issues within those departments. Information derived from both the Inquiry and Complaint module and the reports is reviewed and analyzed by the Provider Relations Improvement Committee to assign priorities to the issues. Escalated issues are taken to Executive Management for review and resolution.

Provider Claim Dispute Process
The Provider Claim Dispute process is a formal process where providers can address specific issues involving claims. The dispute must be submitted to the health plan in writing. Provider Disputes are tracked in the disputes application module of Care Radius. This disputes application module is protected by role-based settings so only the Disputes Department staff has authority to enter and make changes to it. The disputes application module holds data such as member's name and ID, provider name and ID, and a brief description of the dispute. It also tracks all timelines such as date appeal received, date acknowledged, date decision issued, and if an extension was in place. Hearing information is tracked on the same file; the hearing process is described in the section below. The disputes application module tracks information such as type of dispute, decision made, reason if original plan decision was overturned; this information is used to identify trends and create reports.
A physical file is created to hold all documentation received from the provider, all documentation issued by HCA, and documents collected from research. All documentation received from the provider is date stamped. All documentation created and/or issued by HCA is dated. Upon receipt of the dispute, a written acknowledgement is issued within 5 calendar days. The acknowledgement letter is sent to the provider.

HCA resolves all disputes no later than 30 days from the date HCA received the dispute, unless an agreed-upon extension is in effect. The resolution timeframe for the dispute decision may be extended up to 30 calendar days if HCA establishes a need for additional information. HCA notifies the provider in writing of the extension. The dispute decision is issued in writing. The decision is sent through the United States Postal Service; decisions which are not entirely in the provider's favor are sent using the Certified Mail process,. The decision letter includes the following: claim information, including member name and ID, assigned dispute number, date the dispute was received, summary of the issue presented in the dispute, summary of the research that was done, the results of the resolution, reference to legal citations or authorities supporting the determination process, date the decision was issued, statement of right to file for a State Fair Hearing, instructions on how to request a State Fair Hearing, information on how to contact HCA for any questions. A copy of the decision letter is kept in the physical appeal file. The dispute file also contains the provider's dispute, a copy of the acknowledgement letter, documentation of research and medical reviews, and documentation of any contact between HCA and the provider. If a request for hearing is made, all hearing documentation is kept in this same dispute file. After the decision is issued, if the decision was to overturn any or all of the plan's original decision, the dispute coordinator is responsible for communicating with applicable parties to effectuate the appeal decision.

Hearing Process

Members have the right to request a State Fair Hearing in response to HCA's appeal decision, and providers have the right to request a State Fair Hearing in response to HCA's dispute decision. The members have a right to appoint a representative, including legal representation, to handle their hearing process, as well as the right to view the HCA appeal file. The member has the right to request that previously terminated, reduced or suspended medical services continue during the hearing process as long as the member has timely requested the same during the appeal process. For the purposes of this response, this explanation of the hearing process applies to both the member appeals and the provider dispute process from this point forward. For ease of reading, the term "complainant" will be used to indicate either member or provider, in regards to the member appeals or the provider dispute process.

The complainant must request the State Fair Hearing, in writing, within 30 days from the date of HCA's decision. The HCA decision letter, regardless of the decision, always contains information on how to request a hearing. Upon receipt of the request for hearing, the file is pulled, the application is updated to reflect the request, and the hearing coordinator prepares the file. A complete copy of the file is sent along with a transmission cover letter. The packet is then sent to AHCCCS Office of Legal Assistance (OLA) within 5 days from receipt of the request for hearing. The AHCCCS OLA is responsible for forwarding the file to the State of Arizona Office of Administrative Hearings (OAH) and setting the hearing date. HCA receives the Notice of Hearing information simultaneous to the complainant receiving the information. The hearing coordinator arranges for health plan witnesses to appear, prepares for the case presentation and presents the case in person at hearing. If the Director's Decision requires HCA to take action, the hearing coordinator effectuates that decision as required immediately; if the health plan is ordered to pay a claim, the claim will be paid within 15 calendar days. The Dispute & Appeal Manager receives a copy of all Final Decisions and notifies the appropriate management staff of the decision so that policies or procedures can be changed to better conform to the expectations of the agency.

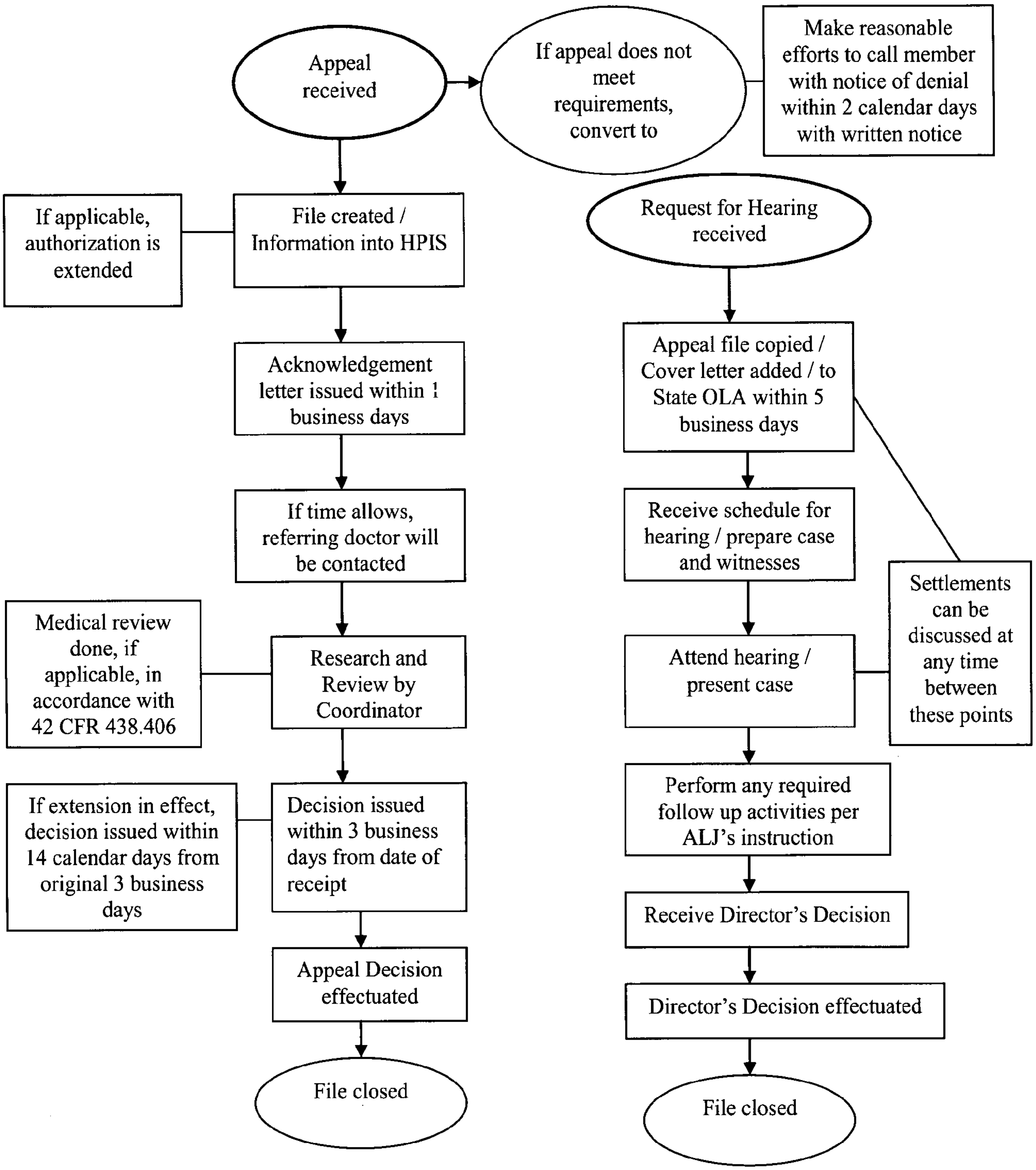
Reports and Trending

As required by AHCCCS, HCA submits a monthly Grievance report to AHCCCS. Information is collected in the Appeal and Dispute application so that accurate information is reported. The report is generated by the Dispute & Appeal Manager and submitted to the Contracts Compliance Officer to be submitted along with the Member Grievance Report and the Prior Authorization Report.

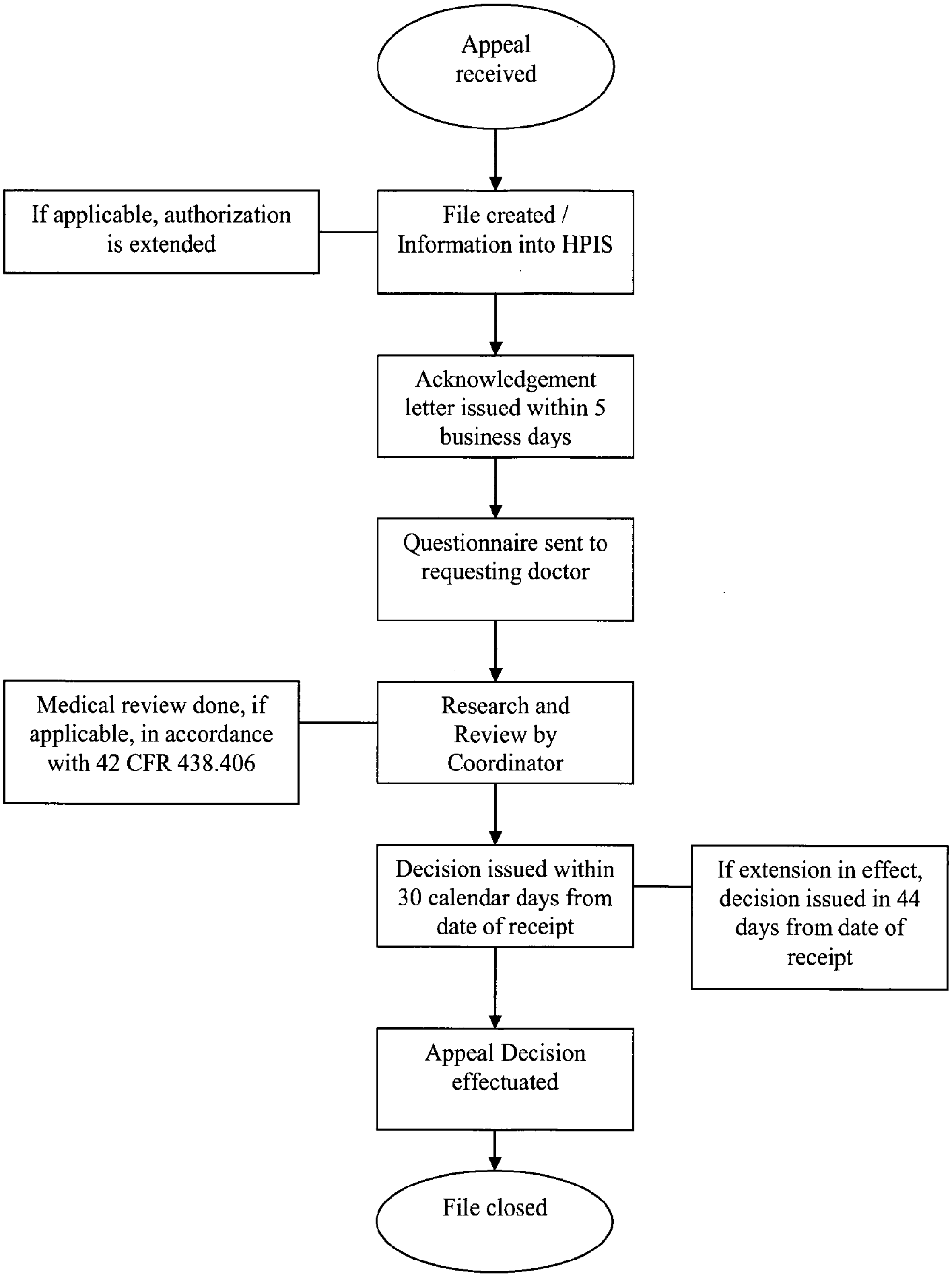
HCA has added other fields to the Appeal application, which are not required by AHCCCS. At least quarterly, the Dispute & Appeal Manager prepares a trending report for presentation to the HCA UM/QM Committee. This committee consists of the HCA Medical Directors, the Quality Management Director, and a committee of doctors who work in the community. The committee's purpose is to provide direction to HCA for optimum medical care to its members. The information gathered from trending member appeals provides valuable insight into the issues that are important to health plan members.

Dispute and Appeal coordinators are encouraged to identify trends they uncover in their file research. The Dispute & Appeal Manager reviews various reports on a routine basis to identify other trends and root cause issues in order to provide valuable information back to key department managers, in an effort to continue improving the process for providers and for improving health plan performance.

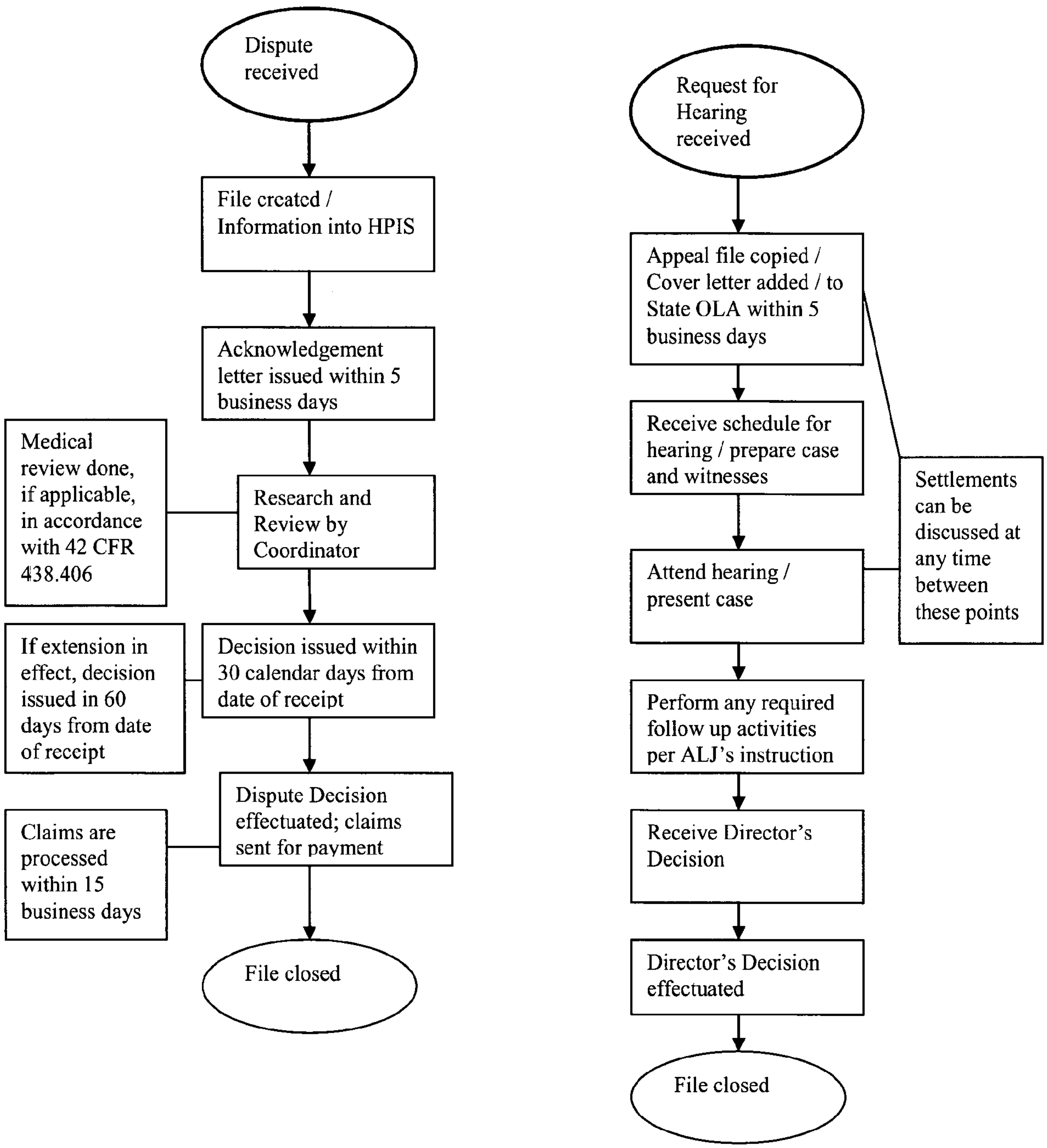
Member Appeals (Expedited) Flow Chart



Member Appeals (Standard) Flow Chart



Claims Dispute Flow Chart



Corporate Compliance

Requirement #16

CORPORATE COMPLIANCE

REQUIREMENT #16

Describe the Offeror's Corporate Compliance Program including the Compliance Officer's levels of authority and reporting relationships. Include an organizational chart of staff involved in compliance along with staff levels of authority. (The submission requirement will be a maximum of three pages of narrative plus one organizational chart)

Offeror's Corporate Compliance Program

Health Choice Arizona (HCA) has implemented a Corporate Compliance Program, which is overseen by the Compliance Officer and within the Compliance Department. The Compliance Program is further enforced by HCA's parent company, IASIS, which provides the structure for Code of Conduct and guidance in applicable regulations of the Health Insurance Portability and Accountability Act (HIPAA).

Compliance Officer's level of authority and reporting relationships

The Compliance Officer is a member of the Health Choice Arizona (HCA) senior management. In addition to the duties of implementing and overseeing the Compliance Plan, the Compliance Officer is authorized to

- Independently report suspected cases of fraud and abuse to AHCCCS OPI,
- Assess records of the health plan,
- Call committee meetings immediately or as necessary,
- Have access to other senior management and legal counsel,
- Attend AHCCCS Compliance Officer Network Group (CONG) meetings, and
- Carry out the requirements of the Compliance Plan

The Compliance Officer reports directly to the Chief Executive Officer (CEO) of HCA, and regularly interacts with all members of the HCA management team. HCA intertwines the HCA Compliance Program with the IASIS Compliance Program. The HCA Compliance Officer interacts and meets with the IASIS Compliance Officer as needed in order to administer the compliance plans uniformly. The HCA Compliance Officer, attends the AHCCCS Compliance Officer Network Group (CONG) meetings, and reports meeting information back to senior staff, and other staff, as necessary. To support the compliance mission, the Compliance Officer has the authority to call together ad hoc committee to discuss cases. Having the flexibility to call meetings as needed and to invite other staff as needed gives the compliance program the quick response, which is required by the contract and the applicable laws. Regardless of the use of committees, the Compliance Officer has the authority to independently make referrals to OPI.

Intake and Processing of Referrals

In accordance with ARS 36-2918.01 and the *AHCCCS Contractor Operation Manual*, Chapter 100, HCA has a process in place to ensure that suspected cases of fraud and abuse are efficiently identified and referred to AHCCCS Office of Program Integrity (OPI) in the required timeframe of 10 business days. Referrals are taken from sources that include but are not limited to internal staff, members, and providers (both contracted and non-contracted). Referrers can use the HCA *Referral* form or they can report verbally or in via email directly to the Compliance Officer. This variety in reporting options reduces the barriers to reporting and makes the reporting process more accessible. All referrals are logged into the Compliance Review tracking system. Referrals are reviewed to collect necessary information and/or documentation to understand the nature of the situation. The Compliance Officer does final review of all referrals and makes the determination for action, which shall include referral to OPI when appropriate. Referrals to OPI are submitted on the AHCCCS *Referral For Preliminary Investigation* form or via the AHCCCS website. Supporting documentation is supplied as applicable.

Training, Education and Outreach - Staff

As required by applicable laws, training is provided to all employees. The Compliance Officer or a designee provides training to new employees within 30 days of hire. Employees are required to sign in for this training. The training incorporates the corporate compliance training, which covers HIPAA, Code of Conduct and disciplinary policies. Each year, all employees are required to take refresher courses and to pass the tests provided at the end of the courses. Both the new employee training and the annual training consist of information gathered by both the AHCCCS Compliance requirements and the Deficit Reduction Act. To further make the lines of communication more efficient, HCA is using the HCA Intranet as a way to provide information to employees on the identification of fraud and abuse and the DRA requirements. To further reduce the barriers to referrals, employees are provided with a list of numbers for reporting. In the event that an employee wishes to remain anonymous and/or not report to the Compliance Officer, they have the option of using external/confidential hotlines such as the IASIS Compliance Help-line, the AHCCCS Fraud/Abuse Member Hotline, AHCCCS Fraud/Abuse Provider Hotline, and the DHHS/Office of Inspector General number.

Training, Education and Outreach - Providers

As required by AHCCCS, the DRA and other applicable laws, education is provided to HCA subcontractors to ensure that providers are educated on all health plan and AHCCCS policies, and in a manner to reduce probability of fraud and abuse. In the *HCA Provider Manual*, which is available to both contracted and non-contracted providers, there is a section devoted to Compliance, Fraud and Abuse and the DRA. All new and existing HCA providers are briefed on the contents of the provider manual and informed about its availability on the HCA website. The HCA website also includes two links to the AHCCCS website where the provider can view the State's FWA training, which contains all the required elements of the DRA. The HCA contract also requires that subcontractors meet the requirements of the DRA by providing training to their employees, if applicable. Furthermore, HCA educates the subcontracts on their obligation to ensure they do not employ Excluded Providers by using the U.S. Department of Health & Human Services Office of Inspector General's List of Excluded Individuals/Entities List as part of their hiring process.

Training, Education and Outreach - Members

The HCA *Member Handbook* has a section devoted to Fraud and Abuse. Examples of fraud and abuse are given as well as recommendations to prevent fraud and abuse. Member Service staff is trained to listen for fraud indicators when a member calls in. For example, if the member calls in to change doctors, and the Member Service Representative (MSR) hears the member explain a situation where fraud of the provider is suspected, the MSR can relay the member's information to the Compliance Officer without the member having to taken any further action. This is another way to reduce the barrier to referrals.

Other elements of the Compliance Plan

The HCA Compliance Program is documented in health plan policy. The supporting requirements for Code of Conduct and other elements of the IASIS Corporate Compliance Plan are documented in IASIS policy. Policies are available to all employees through the shared computer network. HCA policies are updated as needed or at least annually. If there is suspicion of fraud that requires HCA to reduce, suspend or terminate an existing authorization of services to a member, HCA will issue a written Notice of Action not sooner than 5 days from the date the authorization is to end. In addition to sending referrals to AHCCCS OPI, there are occasions when AHCCCS OPI or other authorized agencies require information provided to them from HCA. Those requests are processed through the Compliance Department and logged into the Compliance Review tracking system. Authorized requests are responded to in a timely and thorough manner. HCA will act upon direction of AHCCCS OPI. In the event AHCCCS OPI requires payments to a provider be put on hold, the Compliance Officer has the authority to authorize the monies be held by HCA. In the event an AHCCCS OPI investigation requires monies to be recouped by the health plan, the Compliance Officer has the authority to authorize those recoupments. HCA will cooperate with the AHCCCS OPI for any onsite audit activities, whether the audit is planned or without prior notice.

Activities to prevent Fraud

The HCA claims system has a robust claims editing function that prevents various inappropriate payments. One of the most common edits is the duplicate claim edit. This prevents claims from being paid more than once. The system is loaded with the Correct Coding Initiative (CCI) edits which prevents payments for things such as unbundled services and inappropriate modifiers which may unnecessarily increase payment or issue payment when payment is not warranted. Other edits watch for quantity and unit overages. Many CPT codes have limitations, whether lifetime, annual, monthly, weekly or daily. For example, if a claim comes in for an appendectomy but our system indicates that an appendectomy has already been paid for before, the second will not be paid because it's medically impossible. To support the edits in the claims system is the encounter system. All claims encounters are sent to AHCCCS on a regular basis. The AHCCCS encounter system runs all encounters through another variety of edits. For those edits, HCA has a department of highly trained claims processors who review these edits on a daily basis for reconciliation. If the conflict cannot be supported or explained, the claim is promptly sent for recoupment. In the event that an edit becomes prevalent, the Claims Manager has the authority to place front end edits in the claims system to prevent claims from paying.

In addition to the encounter department, HCA also has a Claims Audit department. The Audit department routinely conducts a variety of claims audits which are designed to prevent incorrect payments from going out and to catch trends by both claims processors and providers. The Audit Department uses tools such as CCI edits, AHCCCS Rules, the HCA Claims Processing Manual, certified coder reviews and medical reviews to ensure the integrity of the claims adjudication process.

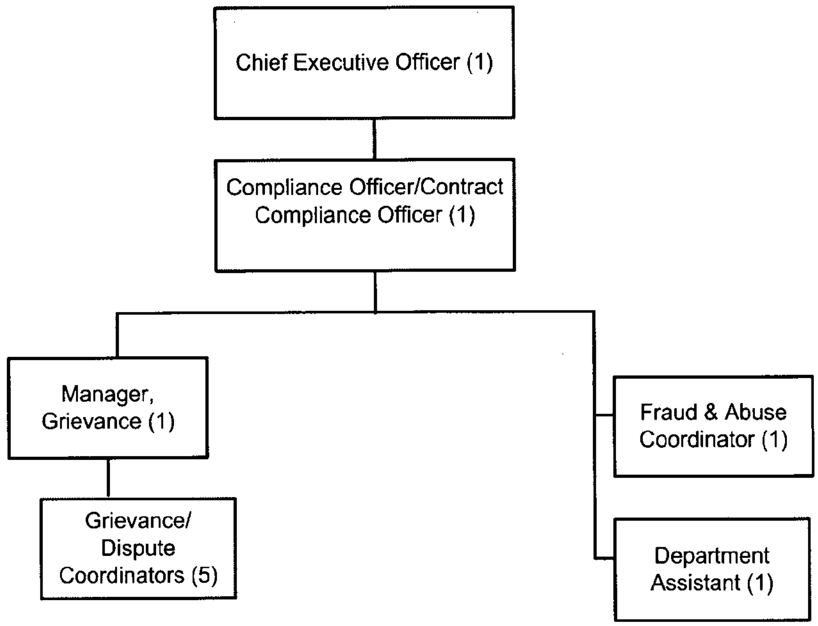
A common fraud scheme is for a provider to collect full payment from more than one payer in the case where the member may have coverage from more than one payer. HCA uses the AHCCCS member eligibility file to watch for indications of other insurance coverage. This edit will stop a claim from paying until the processor can verify that an Explanation of Benefits (EOB) has been provided with the claim so that benefits can be properly coordinated. If an EOB is not present and the service is not known to be non-covered by that payer, then the claim is denied. The reverse is also true; if an EOB is present but the system shows no indication of that coverage, the claims processor will create a referral to the Recoveries department to verify coverage. Once Recoveries has verified coverage, they will enter the information into our member system so that no new claims will be paid without an EOB. They will also notify AHCCCS within 5 days of discovery so that the AHCCCS system can also be updated.

To prevent providers from getting paid for services not rendered due to the member not being eligible, such as services after a member's date of death, HCA loads the member eligibility file from AHCCCS on a daily basis. The member's date of death also appears on this file; the claims system edits are set up to be date sensitive to the periods of eligibility. This also prevents HCA from paying for a claim when the member was actually enrolled with another AHCCCS health plan so that the provider gets paid only once for a single service.

In some national fraud schemes, people have found ways to bill for services and receive reimbursement when they are not actually a valid provider. To mitigate this happening at HCA, we require that members use our known network of contracted providers whenever possible. To establish a provider into our network, their request to contract is put through the Contracting Committee. For most provider types, credentialing by HCA is required and done before a contract is extended. Once contracted, the network rep does on onsite visit and provides education on the AHCCCS and HCA rules and provides a Provider Manual. By having contact with providers and doing the onsite visit, this mitigates the chances of an inappropriate provider being added to our network. In the cases where a member must see a non-contracted provider, either because it is a category for which we do not typically contract (i.e., anesthesiologist, lab readings, emergency services) or the member has gone outside of the service area for emergency services, it is not possible to know these providers prior to services being rendered. In that case, we use a process of verification to ensure the provider has at least minimum credentials before any payment is issued. The HCA claims system will not allow a payment to be issued unless the provider is set up in the provider section of the system. Once an unidentified provider submits a claim to HCA, the claims processor will pend the claim and send it for validation. The provider's information is queried in the AHCCCS PMMIS provider registration system. If found, the information is entered into the HCA system and the claim is returned for further processing. If the provider is not found, the claim is returned for appropriate denial until such time that the provider can obtain a valid provider registration with the State of Arizona.

As required by federal law, HCA is not allowed to pay funds to any provider who has been excluded by the Department of Health and Human Services Office of Inspector General. Providers and entities who appear on the exclusion list are termed by AHCCCS in the Provider Registration system; a notice is sent to the health plans. When HCA receives such notices, the provider is terminated in the HCA system. This is done either through the normal process of updating the provider files from AHCCCS or, if not already done, a manual request to end date a provider upon receipt of the written notice from AHCCCS. Additionally, our contracted Pharmacy Benefits Manager (PBM) is required to watch the exclusion list and keep their provider database updated. If an excluded provider writes a script, the PBM system will prohibit the script from going through. HCA educates the network of their obligation to check the exclusion lists (List of Excluded Individuals / Entities and the Excluded Party List System) before hiring clinicians. In addition to excluded providers, the State of Arizona may place restrictions on providers. These notices also come from AHCCCS. Once received, HCA Network reviews the notice and takes appropriate action such as placing those restrictions in the providers file so that the provider cannot be authorized for those service or cannot receive payment for those services, or the provider may be terminated from the HCA network.

Health Choice Arizona
Grievance System Staff



Finance and Liability Management

Requirement #17

FINANCE AND LIABILITY MANAGEMENT

REQUIREMENT #17

Submit the organization's three most recent audited financial statements and the related parent company financial statements if applicable. (The Offeror may exceed the three-page limit.)

Note: The organization refers to the separate corporation established for the purposes of this contract. If no separate corporation currently exists, the Offeror should submit audited financial statements for the line of business most like the services provided under this contract.

AUDITED FINANCIAL STATEMENTS

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)
Year Ended September 30, 2008
With Report of Independent Auditors

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Audited Financial Statements

Year Ended September 30, 2008

Contents

0812-1014357

Ernst & Young LLP
One Nashville Place
Suite 1400
150 Fourth Avenue North
Nashville, Tennessee 37219

Tel: +1 615 252 2000
Fax: +1 615 242 9128
www.ey.com

Report of Independent Auditors

The Board of Directors
Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

We have audited the accompanying balance sheet of Health Choice Arizona (the Plan), a division of Health Choice Arizona, Inc., which is a wholly owned subsidiary of IASIS Healthcare LLC, as of September 30, 2008 and the related statements of earnings, changes in equity of Parent and cash flows for the year then ended. These financial statements are the responsibility of the Plan's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Plan's internal control over financial reporting. Our audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Health Choice Arizona at September 30, 2008, and the results of its operations and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States.

Our audit was conducted for the purpose of forming an opinion on the basic financial statements taken as a whole. The details of the attached schedules of other financial information are presented for purposes of additional analysis and are not a required part of the basic financial statements. Such information, except for that portion marked "unaudited," on which we express no opinion, has been subjected to the auditing procedures applied in our audit of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

Ernst + Young LLP

January 15, 2009

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Balance Sheet

September 30, 2008

Assets	
Current assets:	
Cash and cash equivalents	$ 5,000,000
AHCCCS receivables, net	30,261,417
Due from affiliates	142,651,458
Other current assets	1,160,680
Total current assets	179,073,555
Furniture and equipment, net of accumulated depreciation of $1,848,716	1,690,076
Other intangible assets, net of accumulated amortization of $12,000,000	33,000,000
Goodwill	5,756,914
Total assets	$ 219,520,545
Liabilities and equity of Parent	
Current liabilities:	
Accounts payable and accrued expenses	$ 1,858,164
Medical claims payable	89,402,010
Total current liabilities	91,260,174
Equity:	
Equity of Parent	128,260,371
Total liabilities and equity of Parent	$ 219,520,545

See accompanying notes.

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Statement of Earnings

Year Ended September 30, 2008

Revenues:	
Capitation premiums	$452,796,011
Hospital supplemental premiums	9,800,045
Delivery supplemental premiums	35,473,285
HIV-AIDS supplemental premiums	1,340,070
Total revenues	499,409,411
Medical expenses:	
Hospitalization, net	143,585,990
Medical compensation	113,597,810
Other medical, net	174,459,837
Total medical expenses	431,643,637
Administrative expenses	36,767,731
Total expenses	468,411,368
Earnings before income taxes	30,998,043
Income taxes	12,274,862
Net earnings	$ 18,723,181

See accompanying notes.

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Statement of Changes in Equity of Parent

	Contributed Capital	Retained Earnings	Totals
Balance at September 30, 2007	$ 85,875,813	$ 23,661,377	$ 109,537,190
Net earnings	–	18,723,181	18,723,181
Balance at September 30, 2008	$ 85,875,813	$ 42,384,558	$ 128,260,371

See accompanying notes.

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Statement of Cash Flows

Year Ended September 30, 2008

Cash flows from operating activities	
Net earnings	$ 18,723,181
Adjustments to reconcile net earnings to net cash provided by operating activities:	
Depreciation	737,884
Amortization	3,000,000
Changes in operating assets and liabilities:	
AHCCCS receivables	(16,263,318)
Other current assets	(262,140)
Accounts payable and accrued expenses	115,548
Medical claims payable	16,536,000
Net cash provided by operating activities	22,587,155
Cash flows from investing activities	
Purchases of furniture and equipment	(990,249)
Net cash used in investing activities	(990,249)
Cash flows from financing activities	
Change in due from affiliates	(21,596,906)
Net cash used in financing activities	(21,596,906)
Change in cash and cash equivalents	–
Cash and cash equivalents, beginning of year	5,000,000
Cash and cash equivalents, end of year	$ 5,000,000

See accompanying notes.

1. Organization and Basis of Presentation

Health Choice Arizona (the Plan) is a division of Health Choice Arizona, Inc. (the Parent), which is a wholly owned subsidiary of IASIS Healthcare LLC (IASIS). IASIS is a hospital management company that also owns and operates 15 acute care hospital facilities and one behavioral health hospital facility in six states. The Plan is a prepaid Medicaid managed health plan that derives substantially all of its revenue through a contract with the Arizona Health Care Cost Containment System (AHCCCS) to provide specified healthcare services to qualified Medicaid enrollees through contracts with providers. AHCCCS is the state agency that administers Arizona's Medicaid program. The contract requires the Plan to arrange for healthcare services for enrolled Medicaid patients in exchange for fixed monthly premiums, based on negotiated per capita member rates, and supplemental payments from AHCCCS. These services are provided regardless of the actual costs incurred to provide these services. The Plan receives reinsurance and other supplemental payments from AHCCCS to cover certain costs of healthcare services that exceed certain thresholds.

On May 14, 2008, Health Choice was awarded a new contract with AHCCCS that provides for a three-year term commencing October 1, 2008, with AHCCCS having the option to renew for two additional one-year periods. The contract is terminable without cause on 90 days' written notice or for cause upon written notice if the Company fails to comply with any term or condition of the contract or fails to take corrective action as required to comply with the terms of the contract. Additionally, AHCCCS can terminate the contract in the event of the unavailability of state or federal funding.

Under the new contract, the Plan subcontracts with hospitals, physicians and other medical providers within Arizona and surrounding states to provide services to its enrollees in Apache, Coconino, Maricopa, Mohave, Navajo, Pima, Yuma, LaPaz and Santa Cruz counties.

2. Summary of Significant Accounting Policies

Cash and Cash Equivalents

The Plan considers all highly liquid investments with original maturities of three months or less when purchased to be cash equivalents.

2. Summary of Significant Accounting Policies (continued)

Due from Affiliates

Due from affiliates represents the net excess of funds transferred to the centralized cash management account of IASIS over funds transferred to or paid on behalf of the Plan. Due from affiliates balances are readily available to the Plan for settlement of the Plan's current liabilities as they become due. Generally, this balance is decreased by automatic cash transfers from the account to reimburse the Plan's bank accounts for operating expenses and to pay for fees and services provided by IASIS, including information systems services, and other operating expenses, such as payroll and insurance. Generally, the balance is increased through daily cash deposits by the Plan to the centralized cash management account of IASIS. Management fees totaling $552,000, which represent an allocation of corporate office expenses of IASIS, were recognized during the year ended September 30, 2008, and are included within administrative expenses in the accompanying statement of earnings. Interest income is not earned on outstanding balances due from affiliates.

Furniture and Equipment

Furniture and equipment is stated at cost. The Plan uses the straight-line method of depreciation over the estimated useful lives of the respective assets, which generally range from 3 to 15 years. Depreciation expense totaling $737,884 was recognized during the year ended September 30, 2008, and is included within administrative expenses in the accompanying statement of earnings.

Goodwill and Intangible Assets

Pursuant to the provisions of SFAS No. 142, *Goodwill and Other Intangible Assets,* goodwill is not amortized but is subject to annual impairment reviews or more often if events or circumstances indicate it may be impaired. An impairment loss is recorded to the extent that the carrying amount of goodwill exceeds its implied fair value. The Plan has completed its annual impairment test for the 2008 fiscal year, which resulted in no impairment.

Intangible assets consists solely of the Plan's contract with AHCCCS and is amortized over a period of 15 years, which approximates the contract's estimated useful life, including assumed renewal periods. Amortization of intangible assets totaled $3,000,000 for the year ended September 30, 2008, and is included in administrative expenses in the accompanying statement of earnings.

2. Summary of Significant Accounting Policies (continued)

When events, circumstances or operating results indicate that the carrying values of certain long-lived assets and related identifiable intangible assets (excluding goodwill) that are expected to be held and used might be impaired, the Plan considers the recoverability of assets to be held and used by comparing the carrying amount of the assets to the undiscounted value of future net cash flows expected to be generated by the assets. If the assets are identified as impaired, the impairment is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets as determined by independent appraisals or estimates of discounted future cash flows.

Revenue Recognition

Capitation premiums are recognized as revenue in the month that members are entitled to healthcare services. Certain other supplemental payments, such as reimbursement of healthcare services provided to AHCCCS eligible beneficiaries prior to enrollment into the Plan (prior period coverage or PPC), are recognized as revenue as services are provided, including estimates at the end of each accounting period. Included in capitation premiums in the accompanying Statement of Earnings for the year ended September 30, 2008, is PPC reconciliation settlement revenue totaling $7,893,254, Title XIX Waiver Group reconciliation settlement revenue totaling $7,266,479, Social Security Disabled Income – Temporary Medical Coverage settlement revenue totaling $1,547,440 and Rural Hospital pass-through revenue totalling $37,059.

Delivery supplemental premiums are payments received per newborn delivery and are intended by AHCCCS to cover the cost of maternity care for qualified pregnant women. Such premiums are billed and recognized in the month that delivery occurs.

Hospital supplemental premiums are one-time payments for members who enroll with the Plan while in an inpatient setting. These supplemental payments are intended to help defray the cost of inpatient services provided to the member, prior to the Plan's ability to manage the member's health care. Such premiums are recognized in the month that the member's enrollment and related inpatient stay is identified by the Plan.

HIV-AIDS supplemental premiums are payments received for eligible members receiving approved HIV-AIDS medications to help defray the cost of their treatment for HIV-AIDS. Such premiums are recognized in the month that services occur.

2. Summary of Significant Accounting Policies (continued)

Medical Expenses

Monthly capitation payments to primary care physicians and other healthcare providers are expensed in the month services are contracted to be performed. Claims expense for non-capitated arrangements is accrued as services are rendered by hospitals, physicians and other healthcare providers during the year.

Medical claims payable includes claims received but not paid and an estimate of claims incurred but not reported. Incurred but not reported claims are estimated using a combination of historical claims experience (including severity and payment lag time) and other actuarial analysis including number of enrollees, age of enrollees and certain enrollee health indicators to predict the cost of healthcare services provided to enrollees during any given period. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from estimates given changes in the healthcare cost structure or adverse experience. During the year ended September 30, 2008, the Plan received independent actuary analysis resulting in an increase to medical expenses of approximately $286,000 related to estimates for prior years.

Contracts between the Plan and primary care physicians contain incentives to encourage physicians to practice preventive healthcare. These incentives, which are based on annual performance, are estimated monthly and recorded in medical claims payable in the accompanying balance sheet. Actual incentives are paid periodically throughout the year.

Reinsurance

Contractually, the Plan is reimbursed by AHCCCS for healthcare costs that exceed stated amounts at a rate ranging from 75% to 100% of qualified healthcare costs in excess of stated levels of up to $50,000, depending on the eligibility classification of the member. Qualified costs must be incurred during the contract year and are the lesser of the amount paid by the Plan or the AHCCCS fee schedule. Amounts are recognized under the contract, with AHCCCS when healthcare costs exceed stated amounts as provided under the contract, including estimates of such costs at the end of each accounting period. In the event that AHCCCS is unable to honor its reinsurance commitment, the Plan may be responsible for excess costs incurred. Reinsurance recoveries totaling $28,917,616 were recognized during the year ended September 30, 2008, and are included as a reduction of hospital medical expenses in the accompanying statement of earnings.

2. Summary of Significant Accounting Policies (continued)

Administrative Expenses

The Plan shares its property leases and employees with Health Choice Generations (HCG), another division of the Parent. Administrative costs are shared between the Plan and HCG based on the revenue earned by each plan. Except for certain costs that are specific to one plan or the other, all administrative expenses are paid by the Plan and allocated to HCG according to HCG's percentage of the total combined revenue of the Parent. Costs pertaining only to the Plan, such as premium tax, are not allocated. Costs that can be specifically identified as pertaining to HCG only, such as the HCC Life Insurance Company (HCC) reinsurance premiums and certain data processing and marketing costs, are directly charged to HCG.

Income Taxes

IASIS files consolidated Federal and state income tax returns, which include the operating results of the Plan. IASIS allocates taxes to the Plan pursuant to the asset and liability method, as if the Plan were a separate taxpayer. For balance sheet purposes, such allocations are included in due from affiliates in the accompanying balance sheet.

Fair Value of Financial Instruments

Cash and cash equivalents, AHCCCS receivables, due from affiliates, accounts payable and accrued expenses, and medical claims payable represent financial instruments as defined by Statement of Financial Accounting Standards No. 107, *Disclosures About Fair Value of Financial Instruments*. The carrying value of these financial instruments approximates their fair market value due to the short-term nature of these instruments.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

3. Transactions with Affiliates

The Plan remitted fee-for-service payments totaling $11,711,321 during the year ended September 30, 2008, to facilities which are owned and operated by IASIS.

4. AHCCCS Receivables

The AHCCCS receivables consist of the following at September 30, 2008:

Reinsurance, net	$ 8,041,164
Hospital supplement	267,809
Delivery supplement	720,388
HIV-AIDS supplement	676,346
Capitation receivable	1,215,436
TWG, PPC and SSDI-TMC reconciliation settlements	19,340,274
	$ 30,261,417

5. Leases

The Plan leases its office facilities under various operating lease agreements. The following is a schedule of the future minimum lease payments required under noncancelable leases with initial or remaining terms in excess of one year at September 30, 2008:

Fiscal year 2009	$ 1,187,652
2010	1,206,770
2011	1,226,835
2012	1,258,367
2013	1,275,565
Thereafter	1,472,740
	$ 7,627,929

Rental expense totaled $1,086,014 for the year ended September 30, 2008, and is included within administrative expenses in the accompanying statement of earnings.

6. Commitments and Contingencies

Professional, General and Other Liability Insurance

The Plan is subject to claims and lawsuits arising in the ordinary course of business, including, but not limited to, injuries arising from patient treatment and denials thereof. The Plan believes that its liability for damages resulting from such claims and lawsuits is adequately covered by insurance or is adequately provided for in its financial statements.

The Plan's contract with AHCCCS requires the Plan to maintain professional liability insurance, comprehensive general insurance, and automobile liability insurance coverage of at least $1,000,000 for each occurrence. During the year ended September 30, 2008, the Plan was covered under IASIS' umbrella policy. IASIS, on behalf of the Plan, carries professional and general liability insurance, as well as workers' compensation insurance, in excess of self-insured retentions through an unrelated commercial insurance carrier in amounts that IASIS believes to be sufficient for the Plan, although some claims may exceed the scope of coverage in effect. IASIS maintains reserves for professional and general liability and workers' compensation claims. Accordingly, no reserve for liability risks are recorded on the accompanying balance sheet. The cost for the year ended September 30, 2008, totaled $88,927 and $169,828 for professional and general liability and workers' compensation, respectively, and is included within administrative expenses in the accompanying statement of earnings. The Plan is currently not a party to any such proceedings that, in the Plan's opinion, would have a material adverse effect on the Plan's business, financial condition or results of operations.

Employee Benefit Insurance Risks

The Plan participates in a self-insured program for health insurance and other medical benefit programs administered by IASIS. The cost of employee health and other medical benefits is allocated by IASIS based on total covered employees and dependents. The cost allocated to the Plan, net of employee premiums, totaled $1,721,252 for the year ended September 30, 2008, and is included within administrative expenses in the accompanying statement of earnings.

6. Commitments and Contingencies (continued)

Performance Guarantee

If the Plan fails to effectively manage healthcare costs, these costs may exceed the premiums received by the Plan. The Plan believes the capitated premiums, together with reinsurance and other supplemental premiums, are sufficient to pay for the services the Plan is obligated to deliver. Pursuant to its contract with AHCCCS, the Plan is required annually to provide performance bonds or letters of credit, in an acceptable form, to guarantee performance of the Plan's obligations under its contract to provide and pay for the healthcare services. The amount of the performance guaranty that AHCCCS requires is generally based upon the membership in the Plan and the related capitation paid to the Plan. As of September 30, 2008, the Plan provided performance guarantees in the form of a $20,577,306 irrevocable standby letter of credit for the benefit of AHCCCS and maintained a cash balance of $5,000,000. As of October 1, 2008, in connection with the new contract with AHCCCS and related performance guarantee requirements, the Plan increased its letter of credit to $36,651,654.

State and Federal Laws and Regulations

The Plan is subject to state and federal laws and regulations. The Centers for Medicare and Medicaid Services and AHCCCS have the right to audit the Plan to determine the Plan's compliance with such standards. The Plan is required to file periodic reports with AHCCCS and to meet certain financial viability standards. The Plan must also provide its enrollees with certain mandated benefits and must meet certain quality assurance and improvement requirements. The Plan believes it is in compliance with these AHCCCS requirements. The Plan must also comply with the electronic transactions regulations and privacy standards of the Health Insurance Portability and Accountability Act (HIPAA). The Plan believes it is in compliance with the HIPAA security standards as set forth in 45 CFR Part 164. The Plan has also complied with the requirements for health plans defined in 45 CFR Part 162.

6. Commitments and Contingencies (continued)

Other

On March 31, 2008, the United States District Court for the District of Arizona (the "District Court") dismissed with prejudice the *qui tam* complaint against IASIS Healthcare Corporation (IAS), parent company of IASIS. The *qui tam* action sought monetary damages and civil penalties under the federal False Claims Act (" FCA") and included allegations that certain business practices related to physician relationships and the medical necessity of certain procedures resulted in the submission of claims for reimbursement in violation of the FCA. The case dates back to March 2005 and became the subject of a subpoena by the Office of Inspector General ("OIG") in September 2005. In August 2007, the case was unsealed and became a private lawsuit after the Department of Justice declined to intervene. The United States District Judge dismissed the case from the bench at the conclusion of oral arguments on IAS' motion to dismiss. On April 21, 2008, the court issued a written order dismissing the case with prejudice and entering formal judgment for IAS. On May 7, 2008, the *qui tam* relator's counsel filed a Notice of Appeal to the United States Court of Appeals for the Ninth Circuit to appeal the District Court's dismissal of the case. On May 21, 2008, IAS filed a Notice of Cross-Appeal to the United States Court of Appeals for the Ninth Circuit from a portion of the April 21, 2008 Order and, on July 22, 2008, IAS filed a Motion to Disqualify relator's counsel related to their misappropriation of information subject to a claim of attorney-client privilege by IAS. On August 21, 2008, the court issued a written order denying IAS' Motion to Disqualify and resetting the briefing schedule associated with the Ninth Circuit appellate proceedings. On October 21, 2008, the relator filed his appeal brief with the United States Court of Appeals for the Ninth Circuit. IAS' cross-appeal brief is due on January 20, 2009. Currently, the appeals process is expected to take one to two years to complete. If the appeal of the order dismissing the *qui tam* action with prejudice was to be resolved in a manner unfavorable to IAS, it could have a material adverse effect on the business, financial condition and results of operations of IAS and the Plan, including exclusion from the Medicare and Medicaid programs.

7. Retirement Plan

Substantially all employees of the Plan, upon qualification, are eligible to participate in IASIS' defined contribution 401(k) plan. Employees who elect to participate generally make contributions from 1% to 20% of their eligible compensation and IASIS matches, at its discretion, such contributions on behalf of the Plan up to a maximum percentage. Generally, employees immediately vest 100% in their own contributions and vest in the employer portion of contributions over a period not to exceed five years. Defined contribution expense totaled $110,820 for the year ended September 30, 2008, and is included within administrative expenses in the accompanying statement of earnings.

Other Financial Information

Health Choice Arizona, Inc. Fiscal Year Ending 2008 Total Counties	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC with Med	SSDI-TMC with out Med	SSDI Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	–	–	–	–	–	**–**	–	–	–	–	9,047	–	**9,047**	–	–	**–**	**9,047**
PPC Member Months	3,360	38,333	19,602	8,993	2,324	**72,612**	1,468	2,934	2,476	24,897	–	3,941	**108,328**	–	–	**–**	**108,328**
Pros. Member Months	106,040	634.062	259,170	119,670	35,469	**1,154,411**	94,301	86,660	8,797	198,982	–	26,230	**1,569,381**	1	603	**604**	**1,569,985**
Total Member Months	109,400	672.395	278,772	128,663	37,793	**1,227,023**	95,769	89,594	11,273	223,879	9,047	30,171	**1,686,756**	1	603	**604**	**1,687,360**
Pros. & FPS Mbr. Mths	106,040	634.062	259,170	119,670	35,469	**1,154,411**	94,301	86,660	8,797	198,982	9,047	26,230	**1,578,428**	1	603	**604**	**1,579,032**
Pros. & PPC Mbr. Mths	109,400	672.395	278,772	128,663	37,793	**1,227,023**	95,769	89,594	11,273	223,879	–	30,171	**1,677,709**	1	603	**604**	**1,678,313**
REVENUES																	
305 Capitation	55,604,318	69,588.654	56,164,811	17,374,242	13,899,449	**212,631,474**	15,255,341	60,375,026	8,320,028	89,839,707	169,680	5,728,571	**392,319,827**	1,159	698,657	**699,816**	**393,019,643**
310 PPC Capitation	3,762,438	2,273,398	4,409,248	1,761,706	882,018	**13,088,808**	201,857	1,003,701	5,541,046	22,309,110	–	887,613	**43,032,135**	–	–	**–**	**43,032,135**
312 Hospital Supplement	–	–	–	–	–	**–**	–	–	9,800,045	–	–	–	**9,800,045**	–	–	**–**	**9,800,045**
315 SOBRA Supplement	–	–	13,801,639	–	–	**13,801,639**	12,983	611,439	12,883	669,401	–	20,364,941	**35,473,286**	–	–	**–**	**35,473,286**
320 HIV-AIDS Supplement	13,674	45,230	105,186	57,852	2,104	**224,046**	(64,163)	471,233	28,400	676,346	–	4,207	**1,340,069**	–	–	**–**	**1,340,069**
321 TWG Settlement	–	–	–	–	–	**–**	–	–	952,155	6,314,325	–	–	**7,266,480**	–	–	**–**	**7,266,480**
322 PPC Settlement	560,114	(21,287)	(132,569)	209,043	(22,159)	**593,142**	(31,500)	(16,814)	2,436,561	4,366,737	–	545,128	**7,893,254**	–	–	**–**	**7,893,254**
325 Investment Income	–	–	–	–	–	**–**	–	–	–	–	–	–	**–**	–	–	**–**	**–**
330 Other Income	30,766	–	10,044	–	–	**40,810**	(10,181)	(4,162)	3,430	3,885	–	3,277	**37,059**	–	1,547.440	**1,547,440**	**1,584,499**
TOTAL REVENUES	59,971,310	71,885,995	74,358,359	19,402,843	14,761,412	**240,379,919**	15,364,337	62,440,423	27,094,548	124,179,511	169,680	27,533,737	**497,162,155**	1,159	2,246,097	**2,247,256**	**499,409,411**
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	32,598,952	5,064,593	16,224,929	2,646,658	3,173,437	**59,708,569**	3,148,321	21,624,199	5,060,392	29,671,725	–	13,269,441	**132,482,647**	–	597.276	**597,276**	**133,079,923**
404 Hospital Risk Pool Expenses	–	–	–	–	–	**–**	–	–	–	–	–	–	**–**	–	–	**–**	**–**
406 PPC-Hospital Inpatient	5,855,652	1,657,912	2,871,310	1,435,399	582,915	**12,403,188**	544,170	1,957,278	9,608,065	13,896,682	–	1,014,300	**39,423,683**	–	–	**–**	**39,423,683**
Total Hospitalization	38,454,604	6,722.505	19,096,239	4,082,057	3,756,352	**72,111,757**	3,692,491	23,581,477	14,668,457	43,568,407	–	14,283,741	**171,906,330**	–	597,276	**597,276**	**172,503,606**
Medical Compensation																	
408 Primary Care Physician	7,493,080	9,969,984	5,338,838	1,213,538	778,596	**24,794,036**	702,093	3,095,502	285,743	5,317,330	31,583	706,042	**34,932,329**	–	4,482	**4,482**	**34,936,811**
410 Referral Physician	7,333,680	8,277,774	13,315,934	2,476,473	2,371,853	**33,775,714**	2,184,524	10,175,251	1,449,012	16,434,157	8,873	7,140,070	**71,167,601**	–	–	**–**	**71,167,601**
412 Physician Risk Pool Expenses	–	–	–	–	–	**–**	–	–	–	–	–	–	**–**	–	–	**–**	**–**
414 PPC - Physician Services	569,362	447,376	635,251	242,650	127,884	**2,022,523**	20,401	140,989	2,122,376	2,890,855	–	296,254	**7,493,398**	–	–	**–**	**7,493,398**
Total Medical Comp	15,396,122	18,695,134	19,290,023	3,932,661	3,278,333	**60,592,273**	2,907,018	13,411,742	3,857,131	24,642,342	40,456	8,142,366	**113,593,328**	–	4,482	**4,482**	**113,597,810**
Other Medical Expenses																	
416 Emergency Services	1,900,102	4,823,110	4,112,798	1,079,345	364,586	**12,279,941**	88,318	1,935,229	202,211	4,139,156	7,540	450,599	**19,102,994**	–	–	**–**	**19,102,994**
418 Pharmacy	791,925	4,096,946	5,860,782	2,163,735	1,988,721	**14,902,109**	325,136	10,465,989	460,884	11,193,952	35,500	412,474	**37,796,044**	187	246,231	**246,418**	**38,042,462**
420 Lab, X-ray, & Medical Imaging	634,749	1,426,430	4,882,117	745,023	946,695	**8,635,014**	770,597	2,736,070	318,853	5,799,051	1,027	1,779,060	**20,039,672**	–	171	**171**	**20,039,843**
422 Outpatient Facility	1,630,248	5,624,662	8,822,251	1,835,765	1,584,548	**19,497,474**	1,158,371	6,474,592	917,358	10,629,919	14,239	1,563,490	**40,255,443**	–	–	**–**	**40,255,443**
424 Durable Medical Equipment	214,735	962,481	684,114	304,015	131,809	**2,297,154**	155,273	932,085	74,980	1,103,058	52	105,117	**4,667,719**	–	704	**704**	**4,668,423**
426 Dental	6,537	12,468,416	1,906,260	1,116,339	73,846	**15,571,398**	155,402	499,403	55,966	769,281	–	126,513	**17,177,963**	–	–	**–**	**17,177,963**
428 Transportation	1,426,040	2,482,537	2,305,913	767,914	340,795	**7,323,199**	531,649	2,474,412	241,318	3,737,085	1,745	527,265	**14,836,673**	3	1,317	**1,320**	**14,837,993**
430 Nursing Facility, Home Health Care	172,778	50,245	283,873	52,159	281,126	**840,181**	585,947	1,948,593	526,268	3,048,470	–	43,927	**6,993,386**	–	–	**–**	**6,993,386**
432 Physical Therapy	233,084	206,540	397,109	148,079	127,964	**1,112,776**	59,590	228,805	42,140	726,591	–	14,674	**2,184,576**	–	–	**–**	**2,184,576**
434 Other Risk Pool Expenses	–	–	–	–	–	**–**	–	–	–	–	–	–	**–**	–	–	**–**	**–**
436 Miscellaneous Medical Expenses	25,335	650,756	232,056	117,710	60,347	**1,086,204**	620,317	671,713	71,719	615,909	–	12,460	**3,078,322**	–	–	**–**	**3,078,322**
438 PPC-Other	190,208	746,570	1,258,775	442,289	232,334	**2,870,176**	90,981	204,584	1,875,716	4,054,683	–	478,764	**9,574,904**	–	–	**–**	**9,574,904**
Total Other Medical	7,225,741	33,538,693	30,746,048	8,772,373	6,132,771	**86,415,626**	4,541,581	28,571,475	4,787,413	45,817,155	60,103	5,514,343	**175,707,696**	190	248,423	**248,613**	**175,956,309**
TOTAL MEDICAL EXP	61,076,467	58,956,332	69,132,310	16,787,091	13,167,456	**219,119,656**	11,141,090	65,564,694	23,313,001	114,027,904	100,559	27,940,450	**461,207,354**	190	850.181	**850,371**	**462,057,725**
Less:																	
440 Reinsurance	(3,102,644)	(402,829)	(1,850,257)	(127,584)	(60,514)	**(5,543,828)**	(237,006)	(4,383,750)	(4,087,047)	(14,338,333)	–	(201,491)	**(28,791,455)**	–	–	**–**	**(28,791,455)**
441 PPC-Reinsurance	–	–	–	–	–	**–**	–	–	(19,641)	(106,520)	–	–	**(126,161)**	–	–	**–**	**(126,161)**
442 Third Party Liability	(1,408)	(211,390)	(268,094)	(114,602)	(55,565)	**(651,059)**	(36,618)	(171,254)	(57,126)	(574,568)	(349)	(5,498)	**(1,496,472)**	–	–	**–**	**(1,496,472)**
TOTAL NET MEDICAL EXP	57,972,416	58,342,113	67,013,959	16,544,905	13,051,377	**212,924,769**	10,867,466	61,009,690	19,149,187	99,008,483	100,210	27,733,461	**430,793,266**	190	850,181	**850,371**	**431,643,637**
TOTAL ADMIN EXP	3,264,500	3,955,051	4,096,917	1,056,079	813,024	**13,185,571**	847,032	3,434,731	1,304,179	6,246,290	9,313	1,484,742	**26,511,858**	–	–	**–**	**26,511,858**
TOTAL EXPENSES	61,236,915	62,297,164	71,110,876	17,600,984	13,864,401	**226,110,340**	11,714,498	64,444,421	20,453,366	105,254,773	109,523	29,218,203	**457,305,124**	190	850.181	**850,371**	**458,155,495**
Inc (loss) from operations	(1,265,605)	9,588,831	3,247,483	1,801,859	897,011	**14,269,579**	3,649,839	(2,003,998)	6,641,182	18,924,738	60,157	(1,684,466)	**39,857,031**	969	1,395,916	**1,396,885**	**41,253,916**
Non-operating inc (loss)	–	–	–	–	–	**–**	–	–	–	–	–	–	**–**	–	–	**–**	**–**
Inc (loss) before taxes	(1,265,604)	9,588,831	3,247,484	1,801,860	897,008	**14,269,579**	3,649,839	(2,003,998)	6,641,182	18,924,738	60,157	(1,684,466)	**39,857,031**	969	1,395,916	**1,396,885**	**41,253,916**
Income taxes	322,071	2,495,471	1,283,759	489,917	370,477	**4,961,695**	825,572	282,024	1,380,239	4,605,171	12,619	(28,717)	**12,038,603**	169	236,090	**236,259**	**12,274,862**
Premium taxes	1,263,319	1,529,958	1,584,970	408,432	314,635	**5,101,314**	327,705	1,328,661	505,216	2,415,120	3,611	574,246	**10,255,873**	–	–	**–**	**10,255,873**
NET INCOME (LOSS)	(2,850,994)	5,563,402	378,755	903,511	211,696	**4,206,570**	2,496,562	(3,614,683)	4,755,727	11,904,447	43,927	(2,229,995)	**17,562,556**	800	1,159.826	**1,160,626**	**18,723,181**

Health Choice Arizona, Inc. Fiscal Year Ending 2008 Apache County	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC with Med	SSDI-TMC with out Med	SSDI Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	–	–	–	–	–	–	–	–	–	–	132	–	132	–	–	–	132
PPC Member Months	27	360	173	128	47	735	27	24	23	295	–	52	1,156	–	–	–	1,156
Pros. Member Months	957	5,388	2,918	2,068	564	11,895	1,324	881	103	2,496	–	522	17,221	–	14	14	17,235
Total Member Months	984	5,748	3,091	2,196	611	12,630	1,351	905	126	2,791	132	574	18,509	–	14	14	18,523
Pros. & FPS Mbr. Mths	957	5,388	2,918	2,068	564	11,895	1,324	881	103	2,496	132	522	17,353	–	14	14	17,367
Pros. & PPC Mbr. Mths	984	5,748	3,091	2,196	611	12,630	1,351	905	126	2,791	–	574	18,377	–	14	14	18,391
REVENUES																	
305 Capitation	498,471	638,430	704,302	342,487	209,900	2,393,590	200,619	566,559	93,550	1,210,441	2,347	125,514	4,592,629	–	16,220	16,220	4,608,849
310 PPC Capitation	21,199	21,303	37,904	24,884	16,926	122,216	4,448	8,899	48,506	272,897	–	11,803	468,769	–	–	–	468,769
312 Hospital Supplement	–	–	–	–	–	–	–	–	72,212	–	–	–	72,212	–	–	–	72,212
315 SOBRA Supplement	–	–	264,092	–	–	264,092	–	6,441	–	12,883	–	424,619	708,035	–	–	–	708,035
320 HIV-AIDS Supplement	–	3,156	–	–	–	3,156	–	–	–	3,156	–	–	6,312	–	–	–	6,312
321 TWG Settlement	–	–	–	–	–	–	–	–	(47,948)	(67,075)	–	–	(115,023)	–	–	–	(115,023)
322 PPC Settlement	(12,535)	32,038	10,773	95,335	132,730	258,341	(1,938)	(31)	(88,658)	447,116	–	(4,077)	610,753	–	–	–	610,753
325 Investment Income	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
330 Other Income	3,294	–	3,556	–	–	6,850	1,651	305	2,093	738	–	401	12,038	–	52,039	52,039	64,077
TOTAL REVENUES	510,429	694,927	1,020,627	462,706	359,556	3,048,245	204,780	582,173	79,764	1,880,156	2,347	558,260	6,355,725	–	68,259	68,259	6,423,984
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	445,592	111,077	214,471	81,860	70,365	923,365	(12,422)	52,389	7,867	408,325	–	186,362	1,565,886	–	–	–	1,565,886
404 Hospital Risk Pool Expenses	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
406 PPC-Hospital Inpatient	7,301	14,992	15,308	149,182	34,822	221,605	–	7,433	36,858	164,537	–	–	430,433	–	–	–	430,433
Total Hospitalization	452,893	126,069	229,779	231,042	105,187	1,144,970	(12,422)	59,822	44,725	572,862	–	186,362	1,996,319	–	–	–	1,996,319
Medical Compensation																	
408 Primary Care Physician	81,215	57,891	41,570	13,833	7,636	202,145	4,194	11,790	971	52,518	74	12,136	283,828	–	–	–	283,828
410 Referral Physician	18,830	49,882	148,073	35,746	33,208	285,739	10,063	30,378	899	220,603	–	131,864	679,546	–	–	–	679,546
412 Physician Risk Pool Expenses	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
414 PPC - Physician Services	1,073	14,993	5,091	27,353	17,269	65,779	52	441	4,050	45,320	–	1,063	116,705	–	–	–	116,705
Total Medical Comp	101,118	122,766	194,734	76,932	58,113	553,663	14,309	42,609	5,920	318,441	74	145,063	1,080,079	–	–	–	1,080,079
Other Medical Expenses																	
416 Emergency Services	13,471	35,279	32,087	12,755	5,508	99,100	280	7,038	344	33,140	–	13,080	152,982	–	–	–	152,982
418 Pharmacy	2,498	8,675	25,652	8,027	23,620	68,472	1,005	5,481	(256)	76,673	531	4,717	156,623	–	3,816	3,816	160,439
420 Lab, X-ray, & Medical Imaging	4,992	10,294	41,306	6,577	10,758	73,927	2,898	9,955	514	63,377	–	20,656	171,327	–	–	–	171,327
422 Outpatient Facility	13,804	42,993	100,706	29,460	42,344	229,307	7,904	99,729	2,579	132,870	1	24,757	497,147	–	–	–	497,147
424 Durable Medical Equipment	1,754	9,132	7,747	4,811	1,832	25,276	1,637	1,149	205	9,105	–	1,275	38,647	–	16	16	38,663
426 Dental	–	74,229	9,800	7,072	607	91,708	1,064	3,034	336	7,196	–	1,711	105,049	–	–	–	105,049
428 Transportation	21,267	56,792	47,704	23,410	3,995	153,168	7,992	8,338	294	72,219	–	11,308	253,319	–	43	43	253,362
430 Nursing Facility, Home Health	372	345	357	233	–	1,307	21,295	360	16,399	6,867	–	–	46,228	–	–	–	46,228
432 Physical Therapy	438	767	373	597	1,146	3,321	292	356	–	3,066	–	30	7,065	–	–	–	7,065
434 Other Risk Pool Expenses	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
436 Miscellaneous Medical Expen	–	6,084	2,620	1,247	34	9,985	312	376	–	1,091	–	181	11,945	–	–	–	11,945
438 PPC-Other	409	23,013	13,642	14,224	13,710	64,998	351	134	15,096	113,093	–	5,667	199,339	–	–	–	199,339
Total Other Medical	59,005	267,603	281,994	108,413	103,554	820,569	45,030	135,950	35,511	518,697	532	83,382	1,639,671	–	3,875	3,875	1,643,546
TOTAL MEDICAL EXP	613,016	516,438	706,507	416,387	266,854	2,519,202	46,917	238,381	86,156	1,410,000	606	414,807	4,716,069	–	3,875	3,875	4,719,944
Less:																	
440 Reinsurance	–	–	(8,173)	–	(3,075)	(11,248)	–	(50,123)	(63,866)	(154,298)	–	–	(279,535)	–	–	–	(279,535)
441 PPC-Reinsurance	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
442 Third Party Liability	–	(1,660)	(3,856)	–	–	(5,516)	(69)	–	–	–	–	–	(5,585)	–	–	–	(5,585)
TOTAL NET MEDICAL EXP	613,016	514,778	694,478	416,387	263,779	2,502,438	46,848	188,258	22,290	1,255,702	606	414,807	4,430,949	–	3,875	3,875	4,434,824
TOTAL ADMIN EXP	28,681	36,486	55,490	20,227	12,496	153,380	11,273	31,988	11,851	82,593	129	31,115	322,329	–	–	–	322,329
TOTAL EXPENSES	641,697	551,264	749,968	436,614	276,275	2,655,818	58,121	220,246	34,141	1,338,295	735	445,922	4,753,278	–	3,875	3,875	4,757,153
Inc (loss) from operations	(131,268)	143,663	270,659	26,092	83,281	392,427	146,659	361,927	45,623	541,861	1,612	112,338	1,602,447	–	64,384	64,384	1,666,831
Non-operating inc (loss)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Inc (loss) before taxes	(131,268)	143,663	270,659	26,092	83,281	392,427	146,659	361,927	45,623	541,861	1,612	112,338	1,602,447	–	64,384	64,384	1,666,831
Income taxes	(19,077)	32,227	56,657	1,504	21,147	92,458	27,257	72,911	11,702	99,663	309	24,514	328,814	–	11,115	11,115	339,929
Premium taxes	11,078	14,117	21,381	7,823	4,834	59,233	4,360	12,399	4,615	31,923	50	11,884	124,464	–	–	–	124,464
NET INCOME (LOSS)	(123,269)	97,319	192,621	16,766	57,300	240,736	115,042	276,617	29,306	410,275	1,253	75,940	1,149,169	–	53,269	53,269	1,202,438

Health Choice Arizona, Inc. Fiscal Year Ending 2008 Coconino County	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC with Med	SSDI-TMC with out Med	SSDI Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	-	-	-	-	-	-	-	-	-	-	388	-	388	-	-	-	388
PPC Member Months	99	879	571	276	84	1,909	48	91	134	1,170	-	138	3,490	-	-	-	3,490
Pros. Member Months	2,767	13,038	6,500	3,310	1,039	26,654	2,029	1,791	277	7,972	-	910	39,633	-	12	12	39,645
Total Member Months	2,866	13,917	7,071	3,586	1,123	28,563	2,077	1,882	411	9,142	388	1,048	43,511	-	12	12	43,523
Pros. & FPS Mbr. Mths	2,767	13,038	6,500	3,310	1,039	26,654	2,029	1,791	277	7,972	388	910	40,021	-	12	12	40,033
Pros. & PPC Mbr. Mths	2,866	13,917	7,071	3,586	1,123	28,563	2,077	1,882	411	9,142	-	1,048	43,123	-	12	12	43,135
REVENUES																	
305 Capitation	1,442,341	1,544,797	1,569,737	547,954	385,951	5,490,780	307,825	1,151,044	252,632	3,867,491	6,913	219,056	11,295,741	-	13,903	13,903	11,309,644
310 PPC Capitation	75,128	52,092	125,184	52,792	30,841	336,037	7,547	32,720	301,792	1,085,884	-	30,648	1,794,628	-	-	-	1,794,628
312 Hospital Supplement	-	-	-	-	-	-	-	-	277,973	-	-	-	277,973	-	-	-	277,973
315 SOBRA Supplement	-	-	276,975	-	-	276,975	-	6,441	-	38,648	-	644,127	966,191	-	-	-	966,191
320 HIV-AIDS Supplement	-	-	6,311	-	-	6,311	-	-	-	2,104	-	-	8,415	-	-	-	8,415
321 TWG Settlement	-	-	-	-	-	-	-	-	138,826	(464,714)	-	-	(325,888)	-	-	-	(325,888)
322 PPC Settlement	109,169	94,695	47,916	46,694	(1,966)	296,508	(2,463)	(9,985)	204,891	430,019	-	(11,844)	907,126	-	-	-	907,126
325 Investment Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
330 Other Income	13,336	-	8,710	-	-	22,046	2,482	613	4,346	2,458	-	1,286	33,231	-	37,886	37,886	71,117
TOTAL REVENUES	1,639,974	1,691,584	2,034,833	647,440	414,826	6,428,657	315,391	1,180,833	1,180,460	4,961,890	6,913	883,273	14,957,417	-	51,789	51,789	15,009,206
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	877,290	265,614	399,062	66,665	139,228	1,747,859	14,239	312,138	144,742	976,317	-	400,888	3,596,183	-	13,452	13,452	3,609,635
404 Hospital Risk Pool Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
406 PPC-Hospital Inpatient	190,045	60,353	135,074	25,869	9,809	421,150	17,133	51,910	292,669	624,446	-	3,499	1,410,807	-	-	-	1,410,807
Total Hospitalization	1,067,335	325,967	534,136	92,534	149,037	2,169,009	31,372	364,048	437,411	1,600,763	-	404,387	5,006,990	-	13,452	13,452	5,020,442
Medical Compensation																	
408 Primary Care Physician	253,927	248,375	136,287	27,725	27,346	693,660	11,739	45,789	9,276	163,214	737	18,915	943,330	-	-	-	943,330
410 Referral Physician	159,895	179,325	317,303	85,902	52,381	794,806	62,863	122,027	27,622	510,261	206	238,358	1,756,143	-	-	-	1,756,143
412 Physician Risk Pool Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
414 PPC - Physician Services	48,066	22,597	36,267	9,365	7,707	124,002	485	1,747	124,974	154,922	-	5,963	412,093	-	-	-	412,093
Total Medical Comp	461,888	450,297	489,857	122,992	87,434	1,612,468	75,087	169,563	161,872	828,397	943	263,236	3,111,566	-	-	-	3,111,566
Other Medical Expenses																	
416 Emergency Services	50,797	98,624	129,382	31,068	15,230	325,101	4,433	65,587	10,415	198,946	-	15,348	619,830	-	-	-	619,830
418 Pharmacy	10,437	60,634	107,626	35,199	52,359	266,255	4,987	238,133	11,188	248,722	441	10,921	780,647	-	8,493	8,493	789,140
420 Lab, X-ray, & Medical Imaging	17,822	26,862	105,912	15,452	28,596	194,644	9,890	45,277	9,163	169,299	11	44,891	473,175	-	-	-	473,175
422 Outpatient Facility	28,271	72,294	234,034	27,890	51,669	414,158	27,087	132,597	14,782	312,664	-	31,421	932,709	-	-	-	932,709
424 Durable Medical Equipment	3,658	17,698	18,615	10,085	3,271	53,327	3,032	9,133	2,378	33,806	-	1,818	103,494	-	14	14	103,508
426 Dental	500	270,012	37,303	22,667	3,787	334,269	4,226	14,378	1,603	17,524	-	1,255	373,255	-	-	-	373,255
428 Transportation	51,399	74,299	62,060	28,355	12,574	228,687	21,960	86,449	11,208	219,844	-	3,275	571,423	-	37	37	571,460
430 Nursing Facility, Home Health	2,249	-	4,976	335	2,374	9,934	12,631	63,915	22,556	91,299	-	327	200,662	-	-	-	200,662
432 Physical Therapy	7,851	4,535	27,972	3,751	7,513	51,622	5,194	6,201	7,131	27,272	-	118	97,538	-	-	-	97,538
434 Other Risk Pool Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
436 Miscellaneous Medical Expen	156	11,601	9,917	1,825	937	24,436	9,729	16,307	30	3,297	-	288	54,087	-	-	-	54,087
438 PPC-Other	14,683	26,285	54,605	16,999	12,490	125,062	2,289	2,333	92,859	194,251	-	15,170	431,964	-	-	-	431,964
Total Other Medical	187,823	662,844	792,402	193,626	190,800	2,027,495	105,458	680,310	183,313	1,516,924	452	124,832	4,638,784	-	8,544	8,544	4,647,328
TOTAL MEDICAL EXP	1,717,046	1,439,108	1,816,395	409,152	427,271	5,808,972	211,917	1,213,921	782,596	3,946,084	1,395	792,455	12,757,340	-	21,996	21,996	12,779,336
Less:																	
440 Reinsurance	(105,865)	(42,399)	(129,656)	-	-	(277,920)	-	(22,645)	(105,573)	(578,280)	-	-	(984,418)	-	-	-	(984,418)
441 PPC-Reinsurance	-	-	-	-	-	-	-	-	2,045	1,417	-	-	3,462	-	-	-	3,462
442 Third Party Liability	-	-	(1,112)	-	-	(1,112)	-	(6,177)	(1,624)	(5,000)	-	-	(13,913)	-	-	-	(13,913)
TOTAL NET MEDICAL EXP	1,611,181	1,396,709	1,685,627	409,152	427,271	5,529,940	211,917	1,185,099	677,444	3,364,221	1,395	792,455	11,762,471	-	21,996	21,996	11,784,467
TOTAL ADMIN EXP	83,406	87,874	108,886	33,075	22,926	336,167	17,348	65,430	46,077	275,072	379	49,143	789,616	-	-	-	789,616
TOTAL EXPENSES	1,694,587	1,484,583	1,794,513	442,227	450,197	5,866,107	229,265	1,250,529	723,521	3,639,293	1,774	841,598	12,552,087	-	21,996	21,996	12,574,083
Inc (loss) from operations	(54,613)	207,001	240,320	205,213	(35,371)	562,550	86,126	(69,696)	456,939	1,322,597	5,139	41,675	2,405,330	-	29,793	29,793	2,435,123
Non-operating inc (loss)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inc (loss) before taxes	(54,613)	207,001	240,320	205,213	(35,371)	562,550	86,126	(69,696)	456,939	1,322,597	5,139	41,675	2,405,330	-	29,793	29,793	2,435,123
Income taxes	7,686	59,609	56,582	41,320	(122)	165,075	18,952	(2,733)	84,543	312,846	992	16,216	595,891	-	4,114	4,114	600,005
Premium taxes	32,257	34,001	42,073	12,788	8,874	129,993	6,716	25,358	17,820	106,447	147	19,017	305,498	-	-	-	305,498
NET INCOME (LOSS)	(94,556)	113,391	141,665	151,105	(44,123)	267,482	60,458	(92,321)	354,576	903,304	4,000	6,442	1,503,941	-	25,679	25,679	1,529,620

0812-1014357

Health Choice Arizona, Inc. Fiscal Year Ending 2008 Gila County	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC with Med	SSDI-TMC with out Med	SSDI Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	–	–	–	–	–	–	–	–	–	–	236	–	236	–	–	–	236
PPC Member Months	55	688	437	229	57	1,466	60	65	60	672	–	64	2,387	–	–	–	2,387
Pros. Member Months	1,979	13,796	7,562	3,822	1,225	28,384	4,055	3,049	346	7,570	–	690	44,094	–	19	19	44,113
Total Member Months	2,034	14,484	7,999	4,051	1,282	29,850	4,115	3,114	406	8,242	236	754	46,717	–	19	19	46,736
Pros. & FPS Mbr. Mths	1,979	13,796	7,562	3,822	1,225	28,384	4,055	3,049	346	7,570	236	690	44,330	–	19	19	44,349
Pros. & PPC Mbr. Mths	2,034	14,484	7,999	4,051	1,282	29,850	4,115	3,114	406	8,242	–	754	46,481	–	19	19	46,500
REVENUES																	
305 Capitation	1,047,455	1,655,526	1,507,470	518,640	467,257	5,196,348	744,718	1,831,091	362,311	3,111,611	4,691	137,266	11,388,036	–	22,537	22,537	11,410,573
310 PPC Capitation	41,784	40,785	95,827	43,869	21,273	243,538	9,507	23,315	134,409	587,939	–	14,081	1,012,789	–	–	–	1,012,789
312 Hospital Supplement	–	–	–	–	–	–	–	–	343,161	–	–	–	343,161	–	–	–	343,161
315 SOBRA Supplement	–	–	320,569	–	–	320,569	–	6,542	–	13,084	–	556,089	896,284	–	–	–	896,284
320 HIV-AIDS Supplement	–	–	–	6,311	3,156	9,467	–	14,726	–	15,778	–	–	39,971	–	–	–	39,971
321 TWG Settlement	–	–	–	–	–	–	–	–	71,444	673,472	–	–	744,916	–	–	–	744,916
322 PPC Settlement	8,715	(10,620)	140,298	(8,012)	16,752	147,133	(6,149)	(14,509)	388,199	184,532	–	153	699,359	–	–	–	699,359
325 Investment Income	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
330 Other Income	(6,599)	–	(10,294)	–	–	(16,893)	(8,210)	(2,235)	(10,505)	(2,636)	–	(962)	(41,441)	–	133,601	133,601	92,160
TOTAL REVENUES	1,091,355	1,685,691	2,053,870	560,808	508,438	5,900,162	739,866	1,858,930	1,289,019	4,583,780	4,691	706,627	15,083,075	–	156,138	156,138	15,239,213
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	442,246	178,442	513,576	73,160	80,806	1,288,230	165,397	812,505	309,246	1,136,244	–	375,213	4,086,835	–	–	–	4,086,835
404 Hospital Risk Pool Expenses	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
406 PPC-Hospital Inpatient	61,587	111,179	126,419	18,016	12,115	329,316	41,849	50,134	464,959	376,175	–	2,513	1,284,946	–	–	–	1,284,946
Total Hospitalization	503,833	289,621	639,995	91,176	92,921	1,617,546	207,246	862,639	794,205	1,512,419	–	377,726	5,371,781	–	–	–	5,371,781
Medical Compensation																	
408 Primary Care Physician	171,860	262,201	166,450	41,276	21,065	663,761	28,157	98,400	10,809	180,729	145	15,332	997,333	–	–	–	997,333
410 Referral Physician	106,772	186,495	397,849	99,788	86,995	876,899	85,871	306,413	76,375	577,645	128	168,582	2,091,913	–	–	–	2,091,913
412 Physician Risk Pool Expenses	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
414 PPC - Physician Services	15,669	7,731	25,482	6,588	2,021	57,491	395	2,830	74,082	85,793	–	3,816	224,407	–	–	–	224,407
Total Medical Comp	294,301	455,427	589,790	147,652	110,981	1,598,151	114,423	407,643	161,266	844,167	273	187,730	3,313,653	–	–	–	3,313,653
Other Medical Expenses																	
416 Emergency Services	71,624	241,721	271,614	74,783	16,081	675,823	7,199	117,638	15,324	309,125	–	25,906	1,151,015	–	–	–	1,151,015
418 Pharmacy	15,953	87,202	270,689	88,041	107,681	569,566	19,347	477,114	16,533	557,342	1,094	13,501	1,654,497	–	5,804	5,804	1,660,301
420 Lab, X-ray, & Medical Imaging	9,884	29,194	181,495	27,872	24,772	273,217	21,872	105,496	13,140	218,435	8	57,881	690,049	–	–	–	690,049
422 Outpatient Facility	46,697	408,816	523,374	122,832	107,504	1,209,223	123,214	442,308	61,393	689,103	646	104,417	2,630,304	–	–	–	2,630,304
424 Durable Medical Equipment	2,782	24,072	26,811	8,441	2,700	64,806	4,239	44,607	2,652	33,165	–	2,002	151,471	–	23	23	151,494
426 Dental	8	199,378	47,079	26,007	2,088	274,560	4,774	15,819	830	27,939	–	1,629	325,551	–	–	–	325,551
428 Transportation	60,416	105,957	183,111	49,565	15,443	414,492	31,518	184,225	35,266	237,239	–	39,345	942,085	–	58	58	942,143
430 Nursing Facility, Home Health	4,148	–	21,925	232	1,546	27,851	47,235	105,767	8,326	95,225	–	2,189	286,593	–	–	–	286,593
432 Physical Therapy	1,572	4,274	8,721	2,542	2,405	19,514	1,777	3,899	2,212	17,226	–	6	44,636	–	–	–	44,636
434 Other Risk Pool Expenses	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
436 Miscellaneous Medical Expen	291	25,543	11,691	4,339	84	41,948	25,270	21,737	12,616	4,757	–	1,090	107,418	–	–	–	107,418
438 PPC-Other	3,926	27,565	82,527	33,136	12,238	159,392	1,493	7,395	149,705	207,728	–	13,507	539,220	–	–	–	539,220
Total Other Medical	217,301	1,153,722	1,629,037	437,790	292,542	3,730,392	287,938	1,526,005	317,997	2,397,286	1,748	261,473	8,522,839	–	5,885	5,885	8,528,724
TOTAL MEDICAL EXP	1,015,435	1,898,770	2,858,822	676,618	496,444	6,946,089	609,607	2,796,287	1,273,468	4,753,872	2,021	826,929	17,208,273	–	5,885	5,885	17,214,158
Less:																	
440 Reinsurance	(10,124)	(9,907)	(170,129)	–	–	(190,160)	–	(166,452)	(212,045)	(588,094)	–	(32,360)	(1,189,111)	–	–	–	(1,189,111)
441 PPC-Reinsurance	–	–	–	–	–	–	–	–	230	(7,058)	–	–	(6,828)	–	–	–	(6,828)
442 Third Party Liability	–	(430)	(19,354)	(10,818)	–	(30,602)	(1,707)	(3,482)	(5,000)	(49,942)	–	–	(90,733)	–	–	–	(90,733)
TOTAL NET MEDICAL EXP	1,005,311	1,888,433	2,669,339	665,800	496,444	6,725,327	607,900	2,626,353	1,056,653	4,108,778	2,021	794,569	15,921,601	–	5,885	5,885	15,927,486
TOTAL ADMIN EXP	59,891	93,269	105,780	31,284	27,032	317,256	41,456	103,099	45,823	205,020	257	38,839	751,750	–	–	–	751,750
TOTAL EXPENSES	1,065,202	1,981,702	2,775,119	697,084	523,476	7,042,583	649,356	2,729,452	1,102,476	4,313,798	2,278	833,408	16,673,351	–	5,885	5,885	16,679,236
Inc (loss) from operations	26,153	(296,011)	(721,249)	(136,276)	(15,038)	(1,142,421)	90,510	(870,522)	186,543	269,982	2,413	(126,781)	(1,590,276)	–	150,253	150,253	(1,440,023)
Non-operating inc (loss)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Inc (loss) before taxes	26,153	(296,011)	(721,249)	(136,276)	(15,038)	(1,142,421)	90,510	(870,522)	186,543	269,982	2,413	(126,781)	(1,590,276)	–	150,253	150,253	(1,440,023)
Income taxes	17,575	(36,387)	(116,236)	(19,966)	2,338	(152,676)	25,728	(140,440)	39,205	70,414	459	(15,325)	(172,635)	–	29,944	29,944	(142,691)
Premium taxes	23,148	36,080	40,885	12,085	10,458	122,656	16,035	39,892	17,818	79,164	100	15,055	290,720	–	–	–	290,720
NET INCOME (LOSS)	(14,570)	(295,704)	(645,898)	(128,395)	(27,834)	(1,112,401)	48,747	(769,974)	129,520	120,404	1,854	(126,511)	(1,708,361)	–	120,309	120,309	(1,588,052)

0812-1014357

Health Choice Arizona, Inc. Fiscal Year Ending 2008 Maricopa County	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC with Med	SSDI-TMC with out Med	SSDI Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	-	-	-	-	-	-	-	-	-	-	3,305	-	3,305	-	-	-	3,305
PPC Member Months	1,824	19,656	8,902	3,630	1,037	35,049	543	1,321	841	9,284	-	1,672	48,710	-	-	-	48,710
Pros. Member Months	53,555	314,129	104,446	46,420	14,254	532,804	41,749	41,050	3,536	70,403	-	9,451	698,993	-	201	201	699,194
Total Member Months	55,379	333,785	113,348	50,050	15,291	567,853	42,292	42,371	4,377	79,687	3,305	11,123	751,008	-	201	201	751,209
Pros. & FPS Mbr. Mths	53,555	314,129	104,446	46,420	14,254	532,804	41,749	41,050	3,536	70,403	3,305	9,451	702,298	-	201	201	702,499
Pros. & PPC Mbr. Mths	55,379	333,785	113,348	50,050	15,291	567,853	42,292	42,371	4,377	79,687	-	11,123	747,703	-	201	201	747,904
REVENUES																	
305 Capitation	28,750,243	33,724,703	21,997,879	6,727,739	5,761,120	96,961,684	6,779,616	30,529,852	3,799,559	33,631,330	68,903	1,987,182	173,758,126	-	234,037	234,037	173,992,163
310 PPC Capitation	2,266,334	1,165,654	2,027,406	721,102	399,631	6,580,127	67,504	442,406	1,858,783	7,857,491	-	380,950	17,187,261	-	-	-	17,187,261
312 Hospital Supplement	-	-	-	-	-	-	-	-	4,299,633	-	-	-	4,299,633	-	-	-	4,299,633
315 SOBRA Supplement	-	-	5,462,808	-	-	5,462,808	-	316,063	-	283,865	-	7,635,080	13,697,816	-	-	-	13,697,816
320 HIV-AIDS Supplement	5,259	41,023	77,838	39,971	-	164,091	7,363	261,913	4,207	389,188	-	-	826,762	-	-	-	826,762
321 TWG Settlement	-	-	-	-	-	-	-	-	419,132	3,237,832	-	-	3,656,964	-	-	-	3,656,964
322 PPC Settlement	326,568	45,017	(136,641)	(25,945)	(126,539)	82,460	9,304	(51,029)	1,490,316	2,681,498	-	223,558	4,436,107	-	-	-	4,436,107
325 Investment Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
330 Other Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	509,390	509,390	509,390
TOTAL REVENUES	31,348,404	34,976,397	29,429,290	7,462,867	6,034,212	109,251,170	6,863,787	31,499,205	11,871,630	48,081,204	68,903	10,226,770	217,862,669	-	743,427	743,427	218,606,096
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	16,620,782	2,669,452	7,165,901	911,520	1,196,389	28,564,044	1,379,206	10,787,673	2,338,776	11,752,164	-	5,296,065	60,117,928	-	232,408	232,408	60,350,336
404 Hospital Risk Pool Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
406 PPC-Hospital Inpatient	3,810,954	1,016,295	1,491,656	428,867	224,505	6,972,277	181,751	1,076,289	4,349,218	6,231,479	-	606,350	19,417,364	-	-	-	19,417,364
Total Hospitalization	20,431,736	3,685,747	8,657,557	1,340,387	1,420,894	35,536,321	1,560,957	11,863,962	6,687,994	17,983,643	-	5,902,415	79,535,292	-	232,408	232,408	79,767,700
Medical Compensation																	
408 Primary Care Physician	3,448,499	4,918,778	2,239,344	513,198	329,069	11,448,888	341,635	1,541,436	123,739	2,092,970	10,513	258,621	15,817,802	-	1,824	1,824	15,819,626
410 Referral Physician	3,794,965	3,875,353	5,351,995	937,613	891,637	14,851,563	1,036,387	5,070,786	650,119	6,434,383	3,120	2,661,480	30,707,838	-	-	-	30,707,838
412 Physician Risk Pool Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
414 PPC - Physician Services	317,371	226,832	278,162	80,066	33,890	936,321	9,257	68,071	917,803	1,240,103	-	122,352	3,293,907	-	-	-	3,293,907
Total Medical Comp	7,560,835	9,020,963	7,869,501	1,530,877	1,254,596	27,236,772	1,387,279	6,680,293	1,691,661	9,767,456	13,633	3,042,453	49,819,547	-	1,824	1,824	49,821,371
Other Medical Expenses																	
416 Emergency Services	1,086,018	2,510,527	1,602,221	394,915	141,580	5,735,261	34,359	812,743	81,965	1,365,055	2,096	170,214	8,201,693	-	-	-	8,201,693
418 Pharmacy	436,027	2,091,223	2,334,850	1,046,513	718,658	6,627,271	124,178	5,602,195	198,236	4,503,310	11,585	140,384	17,207,159	-	115,090	115,090	17,322,249
420 Lab, X-ray, & Medical Imaging	328,655	693,284	1,701,675	302,667	381,273	3,407,554	429,527	1,218,228	125,262	2,095,524	709	571,441	7,848,245	-	171	171	7,848,416
422 Outpatient Facility	928,215	2,995,132	3,061,727	595,570	457,893	8,038,537	435,879	2,331,747	182,424	3,275,116	3,790	486,742	14,754,235	-	-	-	14,754,235
424 Durable Medical Equipment	124,499	464,881	285,385	122,195	44,659	1,041,619	74,642	487,968	31,522	486,469	-	56,985	2,179,205	-	237	237	2,179,442
426 Dental	2,463	6,546,075	831,326	476,095	29,401	7,885,360	65,412	215,640	27,494	265,128	-	56,120	8,515,154	-	-	-	8,515,154
428 Transportation	451,373	894,137	644,187	222,457	100,437	2,312,591	179,224	830,182	84,643	976,999	37	155,724	4,539,400	-	305	305	4,539,705
430 Nursing Facility, Home Health	89,187	24,501	159,429	30,883	65,619	369,619	262,203	1,063,990	325,063	1,500,191	-	17,099	3,538,165	-	-	-	3,538,165
432 Physical Therapy	162,659	101,449	238,173	84,322	75,763	662,366	31,651	129,799	14,795	423,380	-	6,822	1,268,813	-	-	-	1,268,813
434 Other Risk Pool Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
436 Miscellaneous Medical Expens	14,820	287,188	84,467	52,271	18,709	457,455	307,222	256,663	29,652	294,650	-	3,966	1,349,608	-	-	-	1,349,608
438 PPC-Other	98,456	345,308	482,622	133,440	74,633	1,134,459	37,113	69,316	494,511	1,299,383	-	188,187	3,222,969	-	-	-	3,222,969
Total Other Medical	3,722,372	16,953,705	11,426,062	3,461,328	2,108,625	37,672,092	1,981,410	13,018,471	1,595,567	16,485,205	18,217	1,853,684	72,624,646	-	115,803	115,803	72,740,449
TOTAL MEDICAL EXP	31,714,943	29,660,415	27,953,120	6,332,592	4,784,115	100,445,185	4,929,646	31,562,726	9,975,222	44,236,304	31,850	10,798,552	201,979,485	-	350,035	350,035	202,329,520
Less:																	
440 Reinsurance	(1,839,109)	(273,741)	(577,835)	(48,857)	804	(2,738,738)	(101)	(1,719,697)	(2,068,534)	(6,021,772)	-	7,260	(12,541,582)	-	-	-	(12,541,582)
441 PPC-Reinsurance	-	-	-	-	-	-	-	-	(29,264)	(59,689)	-	-	(88,953)	-	-	-	(88,953)
442 Third Party Liability	(376)	(139,454)	(139,574)	(78,497)	(37,768)	(395,669)	(21,256)	(76,730)	(10,466)	(271,872)	(286)	(3,877)	(780,156)	-	-	-	(780,156)
TOTAL NET MEDICAL EXP	29,875,458	29,247,220	27,235,711	6,205,238	4,747,151	97,310,778	4,908,289	29,766,299	7,866,958	37,882,971	31,564	10,801,935	188,568,794	-	350,035	350,035	188,918,829
TOTAL ADMIN EXP	1,704,960	1,921,163	1,626,244	411,971	338,706	6,003,044	376,833	1,734,917	547,947	2,319,964	3,780	550,284	11,536,769	-	-	-	11,536,769
TOTAL EXPENSES	31,580,418	31,168,383	28,861,955	6,617,209	5,085,857	103,313,822	5,285,122	31,501,216	8,414,905	40,202,935	35,344	11,352,219	200,105,563	-	350,035	350,035	200,455,598
Inc (loss) from operations	(232,014)	3,808,014	567,335	845,658	948,355	5,937,348	1,578,665	(2,011)	3,456,725	7,878,269	33,559	(1,125,449)	17,757,106	-	393,392	393,392	18,150,498
Non-operating inc (loss)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inc (loss) before taxes	(232,014)	3,808,014	567,335	845,658	948,355	5,937,348	1,578,665	(2,011)	3,456,725	7,878,269	33,559	(1,125,449)	17,757,106	-	393,392	393,392	18,150,498
Income taxes	227,243	1,057,983	370,610	228,083	275,603	2,159,522	361,632	327,910	666,895	1,846,712	6,779	(101,117)	5,268,333	-	65,804	65,804	5,334,137
Premium taxes	660,015	743,189	629,145	159,361	131,071	2,322,781	145,812	671,023	212,090	897,010	1,467	212,950	4,463,133	-	-	-	4,463,133
NET INCOME (LOSS)	(1,119,272)	2,006,842	(432,420)	458,214	541,681	1,455,045	1,071,221	(1,000,944)	2,577,740	5,134,547	25,313	(1,237,282)	8,025,640	-	327,588	327,588	8,353,228

Health Choice Arizona, Inc. Fiscal Year Ending 2008 Mohave County	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC with Med	SSDI-TMC with out Med	SSDI Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	-	-	-	-	-	-	-	-	-	-	1,212	-	1,212	-	-	-	1,212
PPC Member Months	272	3,704	2,237	1,149	292	7,654	212	438	474	3,753	-	459	12,990	-	-	-	12,990
Pros. Member Months	8,384	53,102	26,221	13,449	4,538	105,694	9,005	8,244	1,340	26,202	-	3,321	155,806	1	82	83	155,889
Total Member Months	8,656	56,806	28,458	14,598	4,830	113,348	9,217	8,682	1,814	31,955	1,212	3,780	170,008	1	82	83	170,091
Pros. & FPS Mbr. Mths	8,384	53,102	26,221	13,449	4,538	105,694	9,005	8,244	1,340	28,202	1,212	3,321	157,018	1	82	83	157,101
Pros. & PPC Mbr. Mths	8,656	56,806	28,458	14,598	4,830	113,348	9,217	8,682	1,814	31,955	-	3,780	168,796	1	82	83	168,879
REVENUES																	
305 Capitation	4,366,751	6,292,153	6,327,938	2,227,211	1,679,533	20,893,586	1,365,777	5,296,901	1,212,840	13,681,184	21,768	800,628	43,272,684	1,159	94,205	95,364	43,368,048
310 PPC Capitation	208,175	219,770	489,560	219,251	107,925	1,244,681	33,780	155,680	1,061,547	3,485,279	-	100,722	6,081,689	-	-	-	6,081,689
312 Hospital Supplement	-	-	-	-	-	-	-	-	1,337,359	-	-	-	1,337,359	-	-	-	1,337,359
315 SOBRA Supplement	-	-	1,293,179	-	-	1,293,179	-	90,178	6,441	64,413	-	2,503,128	3,957,339	-	-	-	3,957,339
320 HIV-AIDS Supplement	-	-	-	-	-	-	1,052	12,622	3,156	37,867	-	-	54,697	-	-	-	54,697
321 TWG Settlement						-	-	-	(56,818)	502,575	-	-	535,757	-		-	535,757
322 PPC Settlement	51,667	46,325	53,697	69,854	109,334	330,877	8,166	1,153	177,749	153,809	-	118,678	790,432	-	-	-	790,432
325 Investment Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
330 Other Income	38,538	-	35,054	-	-	73,592	10,928	2,675	23,287	8,610	-	4,298	123,390	-	129,810	129,810	253,200
TOTAL REVENUES	4,665,131	6,558,248	8,199,428	2,516,316	1,896,792	23,835,915	1,419,703	5,559,209	3,765,561	18,023,737	21,768	3,527,454	56,153,347	1,159	224,015	225,174	56,378,521
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	2,543,056	338,913	1,439,174	344,313	441,818	5,107,274	72,690	2,389,594	718,575	4,920,687	-	1,384,395	14,593,215	-	51,860	51,860	14,645,075
404 Hospital Risk Pool Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
406 PPC-Hospital Inpatient	356,100	64,959	257,988	290,322	121,926	1,091,295	55,658	134,727	1,174,281	1,744,377	-	101,835	4,302,173	-	-	-	4,302,173
Total Hospitalization	2,899,156	403,872	1,697,162	634,635	563,744	6,198,569	128,348	2,524,321	1,892,856	6,665,064	-	1,486,230	18,895,388	-	51,860	51,860	18,947,248
Medical Compensation																	
408 Primary Care Physician	641,037	853,499	584,863	129,747	100,445	2,309,591	64,392	306,346	46,861	757,238	3,215	70,817	3,558,460	-	-	-	3,558,460
410 Referral Physician	502,024	829,822	1,461,467	270,283	333,993	3,397,589	202,093	978,745	201,493	2,474,732	1,407	793,385	8,049,444	-	-	-	8,049,444
412 Physician Risk Pool Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
414 PPC - Physician Services	31,982	47,336	56,959	17,185	43,123	196,585	2,746	16,221	198,194	290,966	-	44,714	749,426	-	-	-	749,426
Total Medical Comp	1,175,043	1,730,657	2,103,289	417,215	477,561	5,903,765	269,231	1,301,312	446,540	3,522,936	4,622	908,916	12,357,330	-	-	-	12,357,330
Other Medical Expenses																	
416 Emergency Services	141,702	429,301	490,791	165,409	61,133	1,288,336	11,903	202,409	31,655	682,560	555	44,739	2,262,157	-	-	-	2,262,157
418 Pharmacy	72,382	291,906	622,159	293,521	262,905	1,542,873	37,857	747,467	71,969	1,462,867	5,069	54,842	3,922,944	187	33,745	33,932	3,956,876
420 Lab, X-ray, & Medical Imaging	41,507	118,300	522,982	80,753	113,526	877,068	38,130	244,965	53,708	800,918	230	214,188	2,229,207	-	-	-	2,229,207
422 Outpatient Facility	120,135	519,515	1,099,036	292,076	295,394	2,326,156	166,242	859,028	324,977	1,985,015	735	154,596	5,816,749	-	-	-	5,816,749
424 Durable Medical Equipment	18,751	88,037	68,882	22,299	18,065	216,034	4,459	77,251	9,736	139,731	-	8,525	455,736	-	95	95	455,831
426 Dental	851	1,391,087	356,873	202,932	9,140	1,960,883	16,853	80,906	7,504	158,032	-	25,130	2,249,308	-	-	-	2,249,308
428 Transportation	285,644	392,016	329,913	118,333	67,169	1,193,075	71,836	324,671	40,906	688,865	1,708	65,750	2,386,811	3	263	266	2,387,077
430 Nursing Facility, Home Health	15,617	7,548	43,096	397	19,483	86,141	29,180	151,240	61,110	196,973	-	4,956	529,600	-	-	-	529,600
432 Physical Therapy	18,336	19,573	30,489	14,279	17,815	100,492	6,165	33,703	5,666	78,368	-	2,017	226,411	-	-	-	226,411
434 Other Risk Pool Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
436 Miscellaneous Medical Expen	898	58,658	25,250	8,344	419	93,569	53,918	24,720	548	37,450	-	1,466	211,671	-	-	-	211,671
438 PPC-Other	30,335	125,653	179,194	66,601	54,970	456,753	33,234	55,587	370,196	655,467	-	78,633	1,649,870	-	-	-	1,649,870
Total Other Medical	746,158	3,441,594	3,768,665	1,264,944	920,019	10,141,380	469,777	2,801,947	977,975	6,886,246	8,297	654,842	21,940,464	190	34,103	34,293	21,974,757
TOTAL MEDICAL EXP	4,820,357	5,576,123	7,569,116	2,316,794	1,961,324	22,243,714	867,356	6,627,580	3,317,379	17,074,246	12,919	3,049,988	53,193,182	190	85,963	86,153	53,279,335
Less:																	
440 Reinsurance	(478,175)	(6,406)	(529,594)	(26,745)	(606)	(1,041,586)	-	(558,079)	(371,750)	(2,587,389)	-	(177,026)	(4,735,830)	-	-	-	(4,735,830)
441 PPC-Reinsurance	-	-	-	-	-	-	-	-	1,798	(18,752)	-	-	(16,954)	-		-	(16,954)
442 Third Party Liability	-	(14,401)	(7,937)	(727)	(6,445)	(29,510)	(4,320)	(25,254)	(25,252)	(79,109)	-	-	(163,525)	-	-	-	(163,525)
TOTAL NET MEDICAL EXP	4,342,182	5,555,256	7,031,585	2,289,322	1,954,273	21,172,618	863,036	6,044,247	2,922,175	14,388,916	12,919	2,872,962	48,276,873	190	85,963	86,153	48,363,026
TOTAL ADMIN EXP	251,680	358,288	446,331	134,650	98,358	1,289,307	77,032	305,534	199,540	950,721	1,196	187,330	3,010,660	-	-	-	3,010,660
TOTAL EXPENSES	4,593,862	5,913,544	7,477,916	2,423,972	2,052,631	22,461,925	940,068	6,349,781	3,121,715	15,339,637	14,115	3,060,292	51,287,533	190	85,963	86,153	51,373,686
Inc (loss) from operations	71,269	644,704	721,512	92,344	(155,839)	1,373,990	479,635	(790,572)	643,846	2,684,100	7,653	467,162	4,865,814	969	138,052	139,021	5,004,835
Non-operating inc (loss)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inc (loss) before taxes	71,269	644,704	721,512	92,344	(155,839)	1,373,990	479,635	(790,572)	643,846	2,684,100	7,653	467,162	4,865,814	969	138,052	139,021	5,004,835
Income taxes	52,351	188,215	209,403	34,204	(2,937)	481,236	105,520	(86,307)	162,215	683,466	1,460	118,298	1,465,888	169	23,107	23,276	1,489,164
Premium taxes	97,408	138,615	172,629	52,096	38,066	498,814	29,790	118,233	77,625	368,134	464	72,400	1,165,460	-	-	-	1,165,460
NET INCOME (LOSS)	(78,490)	317,874	339,480	6,044	(190,968)	393,940	344,325	(822,498)	404,006	1,632,500	5,729	276,464	2,234,466	800	114,945	115,745	2,350,211

0812-1014357

Health Choice Arizona, Inc. Fiscal Year Ending 2008 Navajo County	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC with Med	SSDI-TMC with out Med	SSDI Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	–	–	–	–	–	–	–	–	–	–	552	–	552	–	–	–	552
PPC Member Months	120	1,292	753	511	105	2,781	70	134	228	1,076	–	208	4,497	–	–	–	4,497
Pros. Member Months	3,732	19,671	9,893	5,980	1,455	40,731	3,254	3,128	508	8,820	–	1,614	58,055	–	27	27	58,082
Total Member Months	3,852	20,963	10,646	6,491	1,560	43,512	3,324	3,262	736	9,896	552	1,822	63,104	–	27	27	63,131
Pros. & FPS Mbr. Mths	3,732	19,671	9,893	5,980	1,455	40,731	3,254	3,128	508	8,820	552	1,614	58,607	–	27	27	58,634
Pros. & PPC Mbr. Mths	3,852	20,963	10,646	6,491	1,560	43,512	3,324	3,262	736	9,896	–	1,822	62,552	–	27	27	62,579
REVENUES																	
305 Capitation	1,944,890	2,330,789	2,397,352	988,933	544,328	8,206,292	493,499	2,011,104	459,230	4,278,780	9,942	388,887	15,847,734	–	31,170	31,170	15,878,904
310 PPC Capitation	92,853	76,646	165,025	97,550	39,264	471,338	10,885	47,492	511,092	998,913	–	45,911	2,085,631	–	–	–	2,085,631
312 Hospital Supplement	–	–	–	–	–	–	–	–	301,362	–	–	–	301,362	–	–	–	301,362
315 SOBRA Supplement	–	–	579,209	–	–	579,209	6,441	19,324	6,441	38,648	–	1,345,720	1,995,783	–	–	–	1,995,783
320 HIV-AIDS Supplement	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
321 TWG Settlement	–	–	–	–	–	–	–	–	(150,614)	114,919	–	–	(35,695)	–	–	–	(35,695)
322 PPC Settlement	5,944	24,537	(55,818)	46,588	9,376	30,627	(920)	(20,247)	538,429	694,077	–	23,944	1,265,910	–	–	–	1,265,910
325 Investment Income	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
330 Other Income	14,322	–	11,369	–	–	25,691	3,866	993	8,196	2,547	–	1,851	43,144	–	31,500	31,500	74,644
TOTAL REVENUES	2,058,009	2,431,972	3,097,137	1,133,071	592,968	9,313,157	513,771	2,058,666	1,674,136	6,127,884	9,942	1,806,313	21,503,869	–	62,670	62,670	21,566,539
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	1,590,069	138,206	545,356	181,027	206,943	2,661,601	123,734	367,668	149,372	1,106,765	–	767,384	5,176,524	–	4,941	4,941	5,181,465
404 Hospital Risk Pool Expenses	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
406 PPC-Hospital Inpatient	109,601	46,460	24,330	27,231	16,567	224,189	71,816	48,753	389,492	730,740	–	29,797	1,494,787	–	–	–	1,494,787
Total Hospitalization	1,699,670	184,666	569,686	208,258	223,510	2,885,790	195,550	416,421	538,864	1,837,505	–	797,181	6,671,311	–	4,941	4,941	6,676,252
Medical Compensation																	
408 Primary Care Physician	327,661	294,112	247,208	63,558	55,999	988,538	19,114	114,878	17,469	209,921	2,656	49,873	1,402,449	–	–	–	1,402,449
410 Referral Physician	366,015	263,948	616,393	204,365	234,157	1,684,878	71,377	361,864	64,439	673,797	598	502,658	3,359,611	–	–	–	3,359,611
412 Physician Risk Pool Expenses	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
414 PPC - Physician Services	15,599	20,521	15,249	19,623	7,689	78,681	1,377	4,585	187,454	216,023	–	10,706	498,826	–	–	–	498,826
Total Medical Comp	709,275	578,581	878,850	287,546	297,845	2,752,097	91,868	481,327	269,362	1,099,741	3,254	563,237	5,260,886	–	–	–	5,260,886
Other Medical Expenses																	
416 Emergency Services	60,678	131,978	171,344	78,362	19,592	461,954	2,861	86,896	17,085	195,599	1,250	38,399	804,046	–	–	–	804,046
418 Pharmacy	17,077	77,960	233,142	68,893	106,977	504,049	14,319	290,677	17,238	359,973	2,279	24,173	1,212,708	–	14,592	14,592	1,227,300
420 Lab, X-ray, & Medical Imaging	24,733	37,143	171,368	37,128	59,359	329,731	16,422	106,301	20,011	165,639	154	85,948	744,206	–	–	–	744,206
422 Outpatient Facility	33,784	144,237	497,383	146,482	141,661	963,547	41,254	269,933	98,185	638,544	570	101,776	2,113,809	–	–	–	2,113,809
424 Durable Medical Equipment	4,973	27,572	33,190	12,606	6,763	85,104	8,619	47,028	3,559	55,239	27	6,989	206,565	–	31	31	206,596
426 Dental	27	428,253	63,665	52,565	3,936	548,446	8,793	20,162	2,177	33,412	–	9,257	622,247	–	–	–	622,247
428 Transportation	213,801	121,765	155,141	71,994	34,958	597,659	32,692	143,456	13,458	227,905	–	115,628	1,130,798	–	82	82	1,130,880
430 Nursing Facility, Home Health	3,210	117	331	5,916	19,334	28,908	2,681	24,209	21,384	83,583	–	–	160,765	–	–	–	160,765
432 Physical Therapy	5,569	4,451	12,072	8,743	3,750	34,585	2,232	10,061	2,440	23,481	–	607	73,406	–	–	–	73,406
434 Other Risk Pool Expenses	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
436 Miscellaneous Medical Expenses	224	38,293	11,019	6,231	1,161	56,928	2,359	2,592	1,485	5,723	–	937	70,024	–	–	–	70,024
438 PPC-Other	14,713	44,954	63,371	53,282	7,785	184,105	1,683	6,979	278,828	341,333	–	21,642	834,570	–	–	–	834,570
Total Other Medical	378,789	1,056,723	1,412,026	542,202	405,276	3,795,016	133,915	1,008,296	475,850	2,150,431	4,280	405,356	7,973,144	–	14,705	14,705	7,987,849
TOTAL MEDICAL EXP	2,787,734	1,819,970	2,860,562	1,038,006	926,631	9,432,903	421,333	1,906,044	1,284,076	5,087,677	7,534	1,765,774	19,905,341	–	19,646	19,646	19,924,987
Less:																	
440 Reinsurance	(38,212)	–	(41,617)	(50,485)	(44,253)	(174,567)	–	(60,251)	(83,739)	(619,978)	–	–	(938,535)	–	–	–	(938,535)
441 PPC-Reinsurance	–	–	–	–	–	–	–	–	3,142	(20,137)	–	–	(16,995)	–	–	–	(16,995)
442 Third Party Liability	–	(2,294)	–	(91)	–	(2,385)	(296)	(2,533)	–	(1,209)	–	–	(6,423)	–	–	–	(6,423)
TOTAL NET MEDICAL EXP	2,749,522	1,817,676	2,818,945	987,430	882,378	9,255,951	421,037	1,843,260	1,203,479	4,446,353	7,534	1,765,774	18,943,388	–	19,646	19,646	18,963,034
TOTAL ADMIN EXP	112,331	132,514	173,075	59,843	32,129	509,892	28,107	114,330	70,413	292,947	547	98,085	1,114,321	–	–	–	1,114,321
TOTAL EXPENSES	2,861,853	1,950,190	2,992,020	1,047,273	914,507	9,765,843	449,144	1,957,590	1,273,892	4,739,300	8,081	1,863,859	20,057,709	–	19,646	19,646	20,077,355
Inc (loss) from operations	(803,844)	481,782	105,117	85,798	(321,539)	(452,686)	64,627	101,076	400,244	1,388,584	1,861	(57,546)	1,446,160	–	43,024	43,024	1,489,184
Non-operating inc (loss)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Inc (loss) before taxes	(803,844)	481,782	105,117	85,798	(321,539)	(452,686)	64,627	101,076	400,244	1,388,584	1,861	(57,546)	1,446,160	–	43,024	43,024	1,489,184
Income taxes	(119,744)	112,635	48,363	25,345	(48,407)	18,192	15,567	39,751	92,628	314,750	442	8,296	489,826	–	7,215	7,215	497,041
Premium taxes	43,363	51,211	56,817	23,108	12,416	196,915	10,860	44,213	27,337	113,186	212	37,676	430,399	–	–	–	430,399
NET INCOME (LOSS)	(727,463)	317,936	(10,063)	37,345	(285,548)	(667,793)	38,200	17,112	280,079	960,648	1,207	(103,518)	525,935	–	35,809	35,809	561,744

0812-1014357

Health Choice Arizona, Inc. Fiscal Year Ending 2008 Pima County	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC with Med	SSDI-TMC with out Med	SSDI Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	–	–	–	–	–	–	–	–	–	–	2,226	–	2,226	–	–	–	2,226
PPC Member Months	667	7,874	4,444	2,046	462	15,493	361	609	518	6,629	–	999	24,609	–	–	–	24,609
Pros. Member Months	25,471	153,688	73,607	30,785	8,581	292,132	22,563	19,322	1,778	51,768	–	7,164	394,727	–	140	140	394,867
Total Member Months	26,138	161,562	78,051	32,831	9,043	307,625	22,924	19,931	2,296	58,397	2,226	8,163	421,562	–	140	140	421,702
Pros. & FPS Mbr. Mths	25,471	153,688	73,607	30,785	8,581	292,132	22,563	19,322	1,778	51,768	2,226	7,164	396,953	–	140	140	397,093
Pros. & PPC Mbr. Mths	26,138	161,562	78,051	32,831	9,043	307,625	22,924	19,931	2,296	58,397	–	8,163	419,336	–	140	140	419,476
REVENUES																	
305 Capitation	12,690,461	16,052,001	16,076,692	4,144,641	3,393,579	52,357,374	3,467,374	13,467,836	1,188,942	21,117,983	35,378	1,561,698	93,196,585	–	161,457	161,457	93,358,042
310 PPC Capitation	830,003	466,997	1,011,747	406,724	177,489	2,892,960	44,911	203,853	1,180,567	6,261,601	–	227,086	10,810,778	–	–	–	10,810,778
312 Hospital Supplement	–	–	–	–	–	–	–	–	2,214,735	–	–	–	2,214,735	–	–	–	2,214,735
315 SOBRA Supplement	–	–	4,067,385	–	–	4,067,385	–	133,738	–	158,981	–	5,118,186	9,478,290	–	–	–	9,478,290
320 HIV-AIDS Supplement	8,415	(10,519)	10,519	1,052	(1,052)	8,415	(75,734)	145,157	12,622	134,638	–	4,207	229,305	–	–	–	229,305
321 TWG Settlement	–	–	–	–	–	–	–	–	465,071	841,713	–	–	1,306,784	–	–	–	1,306,784
322 PPC Settlement	27,139	(158,261)	(161,136)	(71,488)	(146,114)	(509,860)	(30,431)	19,599	(492,138)	(223,406)	–	135,148	(1,101,088)	–	–	–	(1,101,088)
325 Investment Income	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
330 Other Income	–	–	–	–	–	–	–	–	–	–	–	–	–	–	183,757	183,757	183,757
TOTAL REVENUES	13,556,018	16,350,218	21,005,207	4,480,929	3,423,902	58,816,274	3,406,120	13,969,983	4,569,799	28,291,510	35,378	7,046,325	116,135,389	–	345,214	345,214	116,480,603
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	7,457,139	918,941	3,977,295	458,485	785,914	13,597,774	1,048,698	4,629,618	952,152	6,636,962	–	3,541,930	30,407,134	–	6,806	6,806	30,413,940
404 Hospital Risk Pool Expenses	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
406 PPC-Hospital Inpatient	997,234	223,176	513,410	194,626	124,503	2,052,949	161,197	367,373	1,724,596	3,010,412	–	183,325	7,499,852	–	–	–	7,499,852
Total Hospitalization	8,454,373	1,142,117	4,490,705	653,111	910,417	15,650,723	1,209,895	4,996,991	2,676,748	9,647,374	–	3,725,255	37,906,986	–	6,806	6,806	37,913,792
Medical Compensation																	
408 Primary Care Physician	1,856,448	2,344,139	1,323,835	288,741	145,193	5,958,356	165,765	664,090	47,855	1,261,064	9,377	203,730	8,310,237	–	2,501	2,501	8,312,738
410 Referral Physician	1,717,661	2,012,110	3,601,541	543,016	506,143	8,380,471	468,409	2,155,340	273,220	3,733,998	2,096	1,991,332	17,004,866	–	–	–	17,004,866
412 Physician Risk Pool Expenses	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
414 PPC - Physician Services	106,709	77,911	156,898	57,367	11,115	410,000	3,201	31,392	402,870	649,026	–	80,592	1,577,081	–	–	–	1,577,081
Total Medical Comp	3,680,818	4,434,160	5,082,274	889,124	662,451	14,748,827	637,375	2,850,822	723,945	5,644,088	11,473	2,275,654	26,892,184	–	2,501	2,501	26,894,685
Other Medical Expenses																	
416 Emergency Services	303,373	862,607	954,745	205,926	69,686	2,396,337	16,645	410,158	21,793	959,495	2,618	101,248	3,908,294	–	–	–	3,908,294
418 Pharmacy	159,420	998,597	1,545,008	410,000	477,236	3,590,261	67,679	2,104,296	93,567	2,661,216	12,085	116,419	8,645,523	–	32,988	32,988	8,678,511
420 Lab, X-ray, & Medical Imaging	151,721	361,321	1,432,036	184,872	218,395	2,348,345	172,529	639,951	66,309	1,394,544	(282)	553,780	5,175,176	–	–	–	5,175,176
422 Outpatient Facility	290,054	949,558	2,273,006	383,127	344,109	4,239,854	200,841	1,552,543	128,917	2,304,698	3,084	491,360	8,921,297	–	–	–	8,921,297
424 Durable Medical Equipment	45,984	232,401	165,211	77,719	39,459	560,774	39,914	202,136	13,065	225,530	–	22,797	1,064,216	–	163	163	1,064,379
426 Dental	2,528	2,553,917	372,386	204,492	16,874	3,150,197	33,745	93,925	11,613	161,069	–	20,288	3,470,837	–	–	–	3,470,837
428 Transportation	170,522	473,539	521,862	140,782	64,500	1,371,205	113,894	557,624	24,823	837,973	–	88,953	2,994,472	–	208	208	2,994,680
430 Nursing Facility, Home Health	16,746	10,249	50,598	12,489	66,973	157,055	159,013	303,000	50,853	681,756	–	17,040	1,368,717	–	–	–	1,368,717
432 Physical Therapy	21,107	50,751	49,584	20,299	6,003	147,744	7,952	18,824	6,278	88,257	–	4,466	273,521	–	–	–	273,521
434 Other Risk Pool Expenses	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
436 Miscellaneous Medical Expen	6,232	161,349	52,955	31,784	36,487	288,807	139,635	291,329	10,501	197,490	–	3,219	930,981	–	–	–	930,981
438 PPC-Other	18,115	110,531	237,595	83,685	30,856	480,782	5,738	47,427	299,313	893,615	–	107,059	1,833,934	–	–	–	1,833,934
Total Other Medical	1,185,802	6,764,820	7,654,986	1,755,175	1,370,578	18,731,361	957,585	6,221,213	727,032	10,405,643	17,505	1,526,629	38,586,968	–	33,359	33,359	38,620,327
TOTAL MEDICAL EXP	13,320,993	12,341,097	17,227,965	3,297,410	2,943,446	49,130,911	2,804,855	14,069,026	4,127,725	25,697,105	28,978	7,527,538	103,386,138	–	42,666	42,666	103,428,804
Less:																	
440 Reinsurance	(451,804)	(19,282)	(166,073)	1,510	8,274	(627,375)	(236,905)	(1,123,123)	(822,102)	(2,527,009)	–	635	(5,335,879)	–	–	–	(5,335,879)
441 PPC-Reinsurance	–	–	–	–	–	–	–	–	2,481	(9,657)	–	–	(7,176)	–	–	–	(7,176)
442 Third Party Liability	(746)	(43,459)	(66,003)	(16,371)	(9,892)	(136,471)	(3,464)	(56,113)	(9,775)	(122,743)	(64)	(1,621)	(330,251)	–	–	–	(330,251)
TOTAL NET MEDICAL EXP	12,868,443	12,278,356	16,995,889	3,282,549	2,941,828	48,367,065	2,564,486	12,889,790	3,298,329	23,037,696	28,914	7,526,552	97,712,832	–	42,666	42,666	97,755,498
TOTAL ADMIN EXP	743,779	907,896	1,163,818	250,465	196,352	3,262,310	188,933	767,061	252,916	1,523,288	1,940	380,215	6,376,663	–	–	–	6,376,663
TOTAL EXPENSES	13,612,222	13,186,252	18,159,707	3,533,014	3,138,180	51,629,375	2,753,419	13,656,851	3,551,245	24,560,984	30,854	7,906,767	104,089,495	–	42,666	42,666	104,132,161
Inc (loss) from operations	(56,204)	3,163,966	2,845,500	947,915	285,722	7,186,899	652,701	313,132	1,018,554	3,730,526	4,524	(860,442)	12,045,894	–	302,548	302,548	12,348,442
Non-operating inc (loss)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Inc (loss) before taxes	(56,204)	3,163,966	2,845,500	947,915	285,722	7,186,899	652,701	313,132	1,018,554	3,730,526	4,524	(860,442)	12,045,894	–	302,548	302,548	12,348,442
Income taxes	119,128	739,161	726,165	215,296	82,921	1,882,671	153,338	204,206	225,070	953,657	1,206	(82,536)	3,337,612	–	51,857	51,857	3,389,469
Premium taxes	287,813	351,254	450,573	96,877	76,019	1,262,536	73,104	296,736	97,962	588,656	752	147,132	2,466,878	–	–	–	2,466,878
NET INCOME (LOSS)	(463,145)	2,073,551	1,668,762	635,742	126,782	4,041,692	426,259	(187,810)	695,522	2,188,213	2,566	(925,038)	6,241,404	–	250,691	250,691	6,492,095

Health Choice Arizona, Inc. Fiscal Year Ending 2008 Pinal County	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC with Med	SSDI-TMC with out Med	SSDI Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	-	-	-	-	-	-	-	-	-	-	996	-	996	-	-	-	996
PPC Member Months	296	3,880	2,085	1,024	240	7,525	147	252	198	2,018	-	349	10,489	-	-	-	10,489
Pros. Member Months	9,195	61,250	28,023	13,836	3,813	116,117	10,322	9,195	909	21,751	-	2,558	160,852	-	108	108	160,960
Total Member Months	9,491	65,130	30,108	14,860	4,053	123,642	10,469	9,447	1,107	23,769	996	2,907	172,337	-	108	108	172,445
Pros. & FPS Mbr. Mths	9,195	61,250	28,023	13,836	3,813	116,117	10,322	9,195	909	21,751	996	2,558	161,848	-	108	108	161,956
Pros. & PPC Mbr. Mths	9,491	65,130	30,108	14,860	4,053	123,642	10,469	9,447	1,107	23,769	-	2,907	171,341	-	108	108	171,449
REVENUES																	
305 Capitation	4,863,707	7,350,255	5,583,441	1,876,638	1,457,782	21,131,823	1,895,914	5,520,639	950,955	8,940,876	19,737	508,341	38,968,285	-	125,128	125,128	39,093,413
310 PPC Capitation	226,962	230,150	456,595	195,534	88,670	1,197,911	23,273	89,535	444,350	1,759,107	-	76,411	3,590,587	-	-	-	3,590,587
312 Hospital Supplement	-	-	-	-	-	-	-	-	953,611	-	-	-	953,611	-	-	-	953,611
315 SOBRA Supplement	-	-	1,537,422	-	-	1,537,422	6,542	32,711	-	58,880	-	2,137,993	3,773,548	-	-	-	3,773,548
320 HIV-AIDS Supplement	-	11,570	10,519	10,519	-	32,608	3,156	36,815	8,415	93,616	-	-	174,610	-	-	-	174,610
321 TWG Settlement	-	-	-	-	-	-	-	-	113,062	1,385,604	-	-	1,498,666	-	-	-	1,498,666
322 PPC Settlement	43,448	(95,018)	(31,659)	56,017	(15,731)	(42,943)	(7,069)	58,235	217,774	(907)	-	59,567	284,657	-	-	-	284,657
325 Investment Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
330 Other Income	(32,125)	-	(38,351)	-	-	(70,476)	(20,898)	(6,512)	(23,986)	(7,831)	-	(3,597)	(133,300)	-	469,457	469,457	336,157
TOTAL REVENUES	5,101,992	7,496,957	7,517,967	2,136,708	1,530,721	23,786,345	1,900,918	5,731,423	2,664,181	12,229,345	19,737	2,778,715	49,110,664	-	594,585	594,585	49,705,249
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	2,622,779	443,948	1,970,095	529,628	251,975	5,818,425	356,778	2,272,613	439,663	2,734,256	-	1,317,204	12,938,939	-	287,809	287,809	13,226,748
404 Hospital Risk Pool Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
406 PPC-Hospital Inpatient	322,832	120,497	307,126	301,286	38,668	1,090,409	14,767	220,660	1,155,992	1,014,515	-	86,981	3,583,324	-	-	-	3,583,324
Total Hospitalization	2,945,611	564,445	2,277,221	830,914	290,643	6,908,834	371,545	2,493,273	1,595,655	3,748,771	-	1,404,185	16,522,263	-	287,809	287,809	16,810,072
Medical Compensation																	
408 Primary Care Physician	712,433	990,989	599,272	135,459	90,943	2,529,096	67,097	312,773	28,763	599,677	4,865	76,617	3,618,888	-	158	158	3,619,046
410 Referral Physician	667,517	881,838	1,421,313	299,760	233,339	3,503,767	247,461	1,149,697	154,844	1,808,740	1,318	652,412	7,518,239	-	-	-	7,518,239
412 Physician Risk Pool Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
414 PPC - Physician Services	32,893	29,456	61,143	25,103	5,071	153,666	2,888	15,702	212,949	208,702	-	27,048	620,955	-	-	-	620,955
Total Medical Comp	1,412,843	1,902,283	2,081,728	460,322	329,353	6,186,529	317,446	1,478,172	396,556	2,617,119	6,183	756,077	11,758,082	-	158	158	11,758,240
Other Medical Expenses																	
416 Emergency Services	172,438	513,074	460,613	116,129	35,776	1,298,030	10,638	232,759	23,629	395,222	1,021	41,665	2,002,964	-	-	-	2,002,964
418 Pharmacy	78,130	480,748	721,656	213,541	239,265	1,733,360	55,764	1,000,625	52,409	1,323,849	2,416	47,518	4,215,941	-	31,702	31,702	4,247,643
420 Lab, X-ray, & Medical Imaging	55,434	150,032	725,342	89,702	110,016	1,130,526	79,330	365,897	30,746	871,316	197	230,275	2,708,287	-	-	-	2,708,287
422 Outpatient Facility	169,287	492,117	1,032,985	238,328	143,974	2,076,691	155,951	786,706	104,102	1,291,910	5,414	168,422	4,589,196	-	-	-	4,589,196
424 Durable Medical Equipment	12,334	98,688	78,273	45,859	15,061	250,215	18,731	62,815	11,864	120,014	26	4,725	468,390	-	125	125	468,515
426 Dental	161	1,005,465	187,828	124,511	8,014	1,325,979	20,535	55,539	4,409	98,981	-	11,124	1,516,567	-	-	-	1,516,567
428 Transportation	171,616	364,033	361,935	113,019	41,719	1,052,322	72,533	339,467	30,720	476,042	-	47,282	2,018,366	-	321	321	2,018,687
430 Nursing Facility, Home Health	41,249	7,486	3,162	1,674	105,797	159,368	51,708	236,112	20,577	392,576	-	2,316	862,657	-	-	-	862,657
432 Physical Therapy	15,552	20,739	29,725	13,546	13,570	93,132	4,328	25,960	3,617	65,539	-	608	193,184	-	-	-	193,184
434 Other Risk Pool Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
436 Miscellaneous Medical Expen	2,712	62,040	34,137	11,669	2,516	113,074	81,872	57,989	16,888	71,450	-	1,313	342,586	-	-	-	342,586
438 PPC-Other	9,572	43,261	145,219	40,922	25,653	264,627	9,081	15,413	175,209	349,813	-	48,900	863,043	-	-	-	863,043
Total Other Medical	728,485	3,237,683	3,780,875	1,008,900	741,361	9,497,324	560,471	3,179,282	474,170	5,456,712	9,074	604,148	19,781,181	-	32,148	32,148	19,813,329
TOTAL MEDICAL EXP	5,086,939	5,704,411	8,139,824	2,300,136	1,361,377	22,592,687	1,249,462	7,150,727	2,466,381	11,822,602	15,257	2,764,410	48,061,526	-	320,115	320,115	48,381,641
Less:																	
440 Reinsurance	(179,356)	(51,034)	(227,181)	(3,008)	(21,658)	(482,237)	-	(683,380)	(359,438)	(1,261,510)	-	-	(2,786,565)	-	-	-	(2,786,565)
441 PPC-Reinsurance	-	-	-	-	-	-	-	-	(73)	7,357	-	-	7,284	-	-	-	7,284
442 Third Party Liability	(286)	(9,691)	(30,257)	(8,098)	(1,461)	(49,793)	(5,506)	(966)	(5,009)	(44,613)	-	-	(105,887)	-	-	-	(105,887)
TOTAL NET MEDICAL EXP	4,907,297	5,643,686	7,882,386	2,289,030	1,338,258	22,060,657	1,243,956	6,466,381	2,101,861	10,523,836	15,257	2,764,410	45,176,358	-	320,115	320,115	45,496,473
TOTAL ADMIN EXP	279,772	417,560	417,292	114,564	85,025	1,314,213	106,051	312,372	129,611	596,688	1,084	149,731	2,609,750	-	-	-	2,609,750
TOTAL EXPENSES	5,187,069	6,061,246	8,299,678	2,403,594	1,423,283	23,374,870	1,350,007	6,778,753	2,231,472	11,120,524	16,341	2,914,141	47,786,108	-	320,115	320,115	48,106,223
Inc (loss) from operations	(85,077)	1,435,711	(781,711)	(264,886)	107,438	411,475	550,911	(1,047,330)	432,709	1,108,821	3,396	(135,426)	1,324,556	-	274,470	274,470	1,599,026
Non-operating inc (loss)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inc (loss) before taxes	(85,077)	1,435,711	(781,711)	(264,886)	107,438	411,475	550,911	(1,047,330)	432,709	1,108,821	3,396	(135,426)	1,324,556	-	274,470	274,470	1,599,026
Income taxes	36,908	342,028	(67,786)	(35,869)	39,935	315,216	117,579	(133,274)	97,780	323,664	971	2,937	724,873	-	42,935	42,935	767,808
Premium taxes	108,236	161,490	161,466	44,294	32,897	508,383	41,028	120,808	49,949	230,601	419	58,133	1,009,321	-	-	-	1,009,321
NET INCOME (LOSS)	(230,221)	932,193	(875,391)	(273,311)	34,606	(412,124)	392,304	(1,034,864)	284,980	554,556	2,006	(196,496)	(409,638)	-	231,535	231,535	(178,103)

0812-1014357

Health Choice Arizona, Inc.
Year Ended: 09/30/2008
Medical Claims Payable Report

Payable Type	RBUCS 1-30	RBUCS 31-60	RBUCS 61-90	RBUCS Over 90	Total RBUCS	IBNR	Total Payable
Account: 220 - Medical Claims Payable							
Hospitalization	9,999,999	93,125	–	10,842	10,103,966	9,217,523	19,321,489
Medical	6,020,539	11,029	6,912	11,510	6,049,990	25,126,789	31,176,779
Other	11,030,792	22,209	992	6,765	11,060,758	6,742,006	17,802,764
Total Prospective	$ 27,051,330	$ 126,363	$ 7,904	$ 29,117	$ 27,214,714	$ 41,086,317	$ 68,301,031
Total PPC	3,205,120	61,850	1,355	1,810	3,270,135	17,372,032	20,642,167
Total Payable	$ 30,256,450	$ 188,213	$ 9,259	$ 30,927	$ 30,484,849	$ 58,458,349	$ 88,943,198 *

* Differs form the medical claims payable on the balance sheet by the following non-fee-for-service balances:

Subcapitation Payable	66,082
Physician Incentive Pool	392,730
Total Non-fee-for-service medical claims payable	458,812
Total medical claims payable	89,402,010

U ited

Health Choice Arizona, Inc.
Year Ended: 09/30/2008
Claims Lag Report - PPC
Expense Type: Hospital

Payment Qtr	Current	1st Prior	2nd Prior	3rd Prior	4th Prior	5th Prior	6th Prior*	Total
Current	1,286,941	4,571,731	1,435,998	181,011	50,391	11,349	3,291	7,540,713
1st Prior		1,221,851	5,263,489	1,520,748	447,690	126,409	32,633	8,612,820
2nd Prior			1,431,897	5,095,529	1,651,504	358,498	286,832	8,824,259
3rd Prior				1,584,438	5,400,254	1,592,278	524,970	9,101,940
4th Prior					1,727,773	4,620,334	2,048,880	8,396,987
5th Prior						1,651,256	6,293,583	7,944,839
6th Prior*							89,905,595	89,905,595
Totals	1,286,941	5,793,583	8,131,384	8,381,726	9,277,611	8,360,124	99,095,784	140,327,153
Expense	9,638,399	11,047,241	9,048,294	9,689,749	9,754,314	10,024,619	92,117,665	151,320,282
Adjustment							(1,202,410)	(1,202,410)
Remaining	8,351,457	5,253,659	916,910	1,308,023	476,703	1,664,496	(8,180,528)	9,790,720

* Amounts in this column or row include the amounts for the 6th prior period, and any earlier periods where the expenses reported exceed the payments made to date.

0812-1014357

U ited

Health Choice Arizona, Inc.
Year Ended: 09/30/2008
Claims Lag Report - PPC
Expense Type: Medical

Payment Qtr	Current	1st Prior	2nd Prior	3rd Prior	4th Prior	5th Prior	6th Prior*	Total
Current	313,440	958,080	309,348	64,865	23,408	7,199	198	1,676,538
1st Prior		252,615	1,052,758	354,140	80,900	20,443	6,452	1,767,307
2nd Prior			298,151	958,075	339,741	61,194	17,483	1,674,643
3rd Prior				326,082	1,123,807	317,912	77,357	1,845,157
4th Prior					293,231	937,442	305,141	1,535,814
5th Prior						343,722	1,213,387	1,557,109
6th Prior*							31,770,116	31,770,116
Totals	313,440	1,210,694	1,660,257	1,703,162	1,861,087	1,687,911	33,390,134	41,826,685
Expense	2,118,355	1,917,386	1,779,040	1,678,619	2,017,770	1,495,797	36,680,019	47,686,985
Adjustment							(283,534)	(283,534)
Remaining	1,804,915	706,692	118,783	(24,543)	156,683	(192,114)	3,006,351	5,576,767

* Amounts in this column or row include the amounts for the 6th prior period, and any earlier periods where the expenses reported exceed the payments made to date.

0812-1014357

U ited

Health Choice Arizona, Inc.
Year Ended: 09/30/2008
Claims Lag Report - PPC
Expense Type: Other

Payment Qtr	Current	1st Prior	2nd Prior	3rd Prior	4th Prior	5th Prior	6th Prior*	Total
Current	502,855	1,451,893	304,789	58,863	36,809	4,946	1,534	2,361,690
1st Prior		369,079	1,424,738	379,215	77,254	25,873	(1,781)	2,274,379
2nd Prior			330,226	1,263,024	453,873	69,577	98,371	2,215,071
3rd Prior				322,856	1,386,222	377,250	96,351	2,182,680
4th Prior					367,318	1,245,710	333,203	1,946,231
5th Prior						274,134	1,336,474	1,610,608
6th Prior*							34,564,908	34,564,908
Totals	502,855	1,820,973	2,059,753	2,023,958	2,321,477	1,997,491	36,429,061	47,155,567
Expense	2,817,433	2,370,679	2,336,478	2,050,314	2,395,542	1,576,203	39,048,239	52,594,888
Adjustment							(164,640)	(164,640)
Remaining	2,314,579	549,706	276,724	26,356	74,065	(421,288)	2,454,538	5,274,680

* Amounts in this column or row include the amounts for the 6th prior period, and any earlier periods where the expenses reported exceed the payments made to date.

0812-1014357

Health Choice Arizona, Inc.
Year Ended: 09/30/2008
Claims Lag Report
Expense Type: Hospital

Payment Qtr	Current	1st Prior	2nd Prior	3rd Prior	4th Prior	5th Prior	6th Prior*	Total
Current	11,899,867	18,477,407	1,801,255	649,444	251,312	48,816	(107)	33,127,994
1st Prior		11,599,397	18,707,369	3,471,399	566,847	366,650	243,419	34,955,081
2nd Prior			13,371,256	17,507,689	2,477,144	861,426	396,845	34,614,359
3rd Prior				11,351,887	17,778,111	2,065,298	1,146,152	32,341,447
4th Prior					11,901,840	16,318,736	2,325,229	30,545,805
5th Prior						11,052,336	18,161,431	29,213,768
6th Prior*							537,213,632	537,213,632
Totals	11,899,867	30,076,804	33,879,880	32,980,419	32,975,254	30,713,261	559,486,601	732,012,087
Expense	32,578,673	32,330,078	34,707,733	33,463,439	32,005,738	30,235,159	543,744,109	739,064,929
Adjustment**	–	–	–	–	8,011,160	–	4,257,486	12,268,646
Remaining	20,678,806	2,253,274	827,853	483,020	7,041,644	(478,102)	(11,485,006)	19,321,489

* Amounts in this column or row include the amounts for the 6th prior period, and any earlier periods where the expenses reported exceed the payments made to date.

**The adjustment made in 9/30/07 quarter (4th Prior) is a reclassification of payments after a correction to HCA's Category of Service table.

0812-1014357

Unaudited

Health Choice Arizona, Inc.
Year Ended: 09/30/2008
Claims Lag Report
Expense Type: Medical

Payment Qtr	Current	1st Prior	2nd Prior	3rd Prior	4th Prior	5th Prior	6th Prior*	Total
Current	11,312,563	10,755,104	1,116,469	346,330	129,091	19,813	4,971	23,684,341
1st Prior		10,927,322	12,142,861	1,182,144	285,276	166,225	(13,399)	24,690,429
2nd Prior			10,346,229	9,356,349	1,017,470	132,921	103,778	20,956,746
3rd Prior				10,318,634	10,750,305	1,375,629	364,900	22,809,468
4th Prior					8,325,105	8,799,577	1,023,966	18,148,647
5th Prior						8,728,699	10,654,550	19,383,248
6th Prior*							340,543,869	340,543,869
Totals	11,312,563	21,682,426	23,605,559	21,203,456	20,507,246	19,222,862	352,682,635	470,216,749
Expense	24,967,377	26,601,329	23,039,202	22,925,930	19,951,684	19,321,577	361,883,005	498,690,104
Adjustment	–	–	–	–	–	–	2,703,424	2,703,424
Remaining	13,654,814	4,918,902	(566,357)	1,722,474	(555,563)	98,715	11,903,794	31,176,779

* Amounts in this column or row include the amounts for the 6th prior period, and any earlier periods where the expenses reported exceed the payments made to date.

0812-1014357

Health Choice Arizona, Inc.
Year Ended: 09/30/2008
Claims Lag Report
Expense Type: Other

Payment Qtr	Current	1st Prior	2nd Prior	3rd Prior	4th Prior	5th Prior	6th Prior*	Total
Current	26,620,074	13,858,106	976,266	248,258	187,705	323,958	(1,336)	42,213,031
1st Prior		24,664,987	13,906,341	1,135,432	336,223	71,318	2,686	40,116,986
2nd Prior			23,878,864	12,117,105	1,464,695	393,496	196,872	38,051,032
3rd Prior				22,135,758	11,592,031	1,272,630	638,339	35,638,759
4th Prior					19,755,811	10,566,864	1,084,785	31,407,460
5th Prior						19,641,900	11,441,641	31,083,541
6th Prior*							575,540,979	575,540,979
Totals	26,620,074	38,523,093	38,761,470	35,636,553	33,336,466	32,270,166	588,903,966	794,051,787
Expense	43,764,836	42,897,373	39,701,080	36,214,677	32,336,859	30,246,652	591,496,852	816,658,329
Adjustment**	–	–	–	–	(8,011,160)	–	3,207,382	(4,803,778)
Remaining	17,144,762	4,374,281	939,609	578,124	(9,010,767)	(2,023,514)	5,800,268	17,802,764

* Amounts in this column or row include the amounts for the 6th prior period, and any earlier periods where the expenses reported exceed the payments made to date.

**The adjustment made in 9/30/07 quarter (4th Prior) is a reclassification of payments after a correction to HCA's Category of Service table.

0812-1014357

AUDITED FINANCIAL STATEMENTS

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)
Year Ended September 30, 2009
With Report of Independent Auditors

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Audited Financial Statements

Year Ended September 30, 2009

Contents

ERNST & YOUNG

Ernst & Young LLP
One Nashville Place
Suite 1400
150 Fourth Avenue North
Nashville, TN 37219
Tel +1 615 252 2000
Fax +1 615 242 9128
www.ey.com

Report of Independent Auditors

The Board of Directors
Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

We have audited the accompanying balance sheet of Health Choice Arizona (the Plan), a division of Health Choice Arizona, Inc., which is a wholly owned subsidiary of IASIS Healthcare LLC, as of September 30, 2009 and the related statements of earnings, changes in equity of Parent and cash flows for the year then ended. These financial statements are the responsibility of the Plan's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Plan's internal control over financial reporting. Our audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Health Choice Arizona at September 30, 2009, and the results of its operations and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States.

Our audit was conducted for the purpose of forming an opinion on the basic financial statements taken as a whole. The details of the attached schedules of other financial information are presented for purposes of additional analysis and are not a required part of the basic financial statements. Such information, except for that portion marked "unaudited," on which we express no opinion, has been subjected to the auditing procedures applied in our audit of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

Ernst + Young LLP

January 25, 2010

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Balance Sheet

September 30, 2009

Assets	
Current assets:	
AHCCCS receivables, net	$ 1,157,405
Due from affiliates	223,169,950
Other current assets	1,650,853
Total current assets	225,978,208
Furniture and equipment, net of accumulated depreciation of $962,843	1,935,769
Other intangible assets, net of accumulated amortization of $15,000,000	30,000,000
Goodwill	5,756,914
Total assets	$ 263,670,891
Liabilities and equity of Parent	
Current liabilities:	
Accounts payable and accrued expenses	$ 2,161,156
Medical claims payable	107,220,302
Total current liabilities	109,381,458
Equity:	
Equity of Parent	154,289,433
Total liabilities and equity of Parent	$ 263,670,891

See accompanying notes.

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Statement of Earnings

Year Ended September 30, 2009

Revenues:	
Capitation premiums	$ 614,316,248
Delivery supplemental premiums	43,488,073
Total revenues	657,804,321
Medical expenses:	
Hospitalization, net	162,597,652
Medical compensation	148,883,984
Other medical, net	259,983,051
Total medical expenses	571,464,687
Administrative expenses	43,276,005
Total expenses	614,740,692
Earnings before income taxes	43,063,629
Income taxes	17,034,567
Net earnings	$ 26,029,062

See accompanying notes.

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Statement of Changes in Equity of Parent

Year Ended September 30, 2009

	Contributed Capital	Retained Earnings	Totals
Balance at September 30, 2008	$ 85,875,813	$ 42,384,558	$ 128,260,371
Net earnings	–	26,029,062	26,029,062
Balance at September 30, 2009	$ 85,875,813	$ 68,413,620	$ 154,289,433

See accompanying notes.

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Statement of Cash Flows

Year Ended September 30, 2009

Cash flows from operating activities	
Net earnings	$ 26,029,062
Adjustments to reconcile net earnings to net cash provided by operating activities:	
Depreciation	448,325
Amortization	3,000,000
Loss on sale of asset	151,111
Changes in operating assets and liabilities:	
AHCCCS receivables, net	29,104,012
Other current assets	(490,173)
Accounts payable and accrued expenses	302,992
Medical claims payable	17,818,292
Net cash provided by operating activities	76,363,621
Cash flows from investing activities	
Purchases of furniture and equipment, net	(845,129)
Net cash used in investing activities	(845,129)
Cash flows from financing activities	
Change in due from affiliates	(80,518,492)
Net cash used in financing activities	(80,518,492)
Change in cash and cash equivalents	(5,000,000)
Cash and cash equivalents, beginning of year	5,000,000
Cash and cash equivalents, end of year	$ –

See accompanying notes.

1. Organization and Basis of Presentation

Health Choice Arizona (the Plan) is a division of Health Choice Arizona, Inc. (the Parent), which is a wholly owned subsidiary of IASIS Healthcare LLC (IASIS). IASIS is a hospital management company that also owns and operates 15 acute care hospital facilities and one behavioral health hospital facility in six states. The Plan is a prepaid Medicaid managed health plan that derives substantially all of its revenue through a contract with the Arizona Health Care Cost Containment System (AHCCCS) to provide specified healthcare services to qualified Medicaid enrollees through contracts with providers. AHCCCS is the state agency that administers Arizona's Medicaid program. The contract requires the Plan to arrange for healthcare services for enrolled Medicaid patients in exchange for fixed monthly premiums, based on negotiated per capita member rates, and supplemental payments from AHCCCS. These services are provided regardless of the actual costs incurred to provide these services. The Plan receives reinsurance and other supplemental payments from AHCCCS to cover certain costs of healthcare services that exceed certain thresholds.

Effective October 1, 2008, Health Choice began its current contract with AHCCCS, which provides for a three-year term, with AHCCCS having the option to renew for two additional one-year periods. The contract is terminable without cause on 90 days' written notice or for cause upon written notice if the Plan fails to comply with any term or condition of the contract or fails to take corrective action as required to comply with the terms of the contract. Additionally, AHCCCS can terminate the contract in the event of the unavailability of state or federal funding.

Under the contract, the Plan subcontracts with hospitals, physicians and other medical providers within Arizona and surrounding states to provide services to its enrollees in Apache, Coconino, Maricopa, Mohave, Navajo, Pima, Yuma, LaPaz and Santa Cruz counties.

2. Summary of Significant Accounting Policies

Due from Affiliates

Due from affiliates represents the net excess of funds transferred to the centralized cash management account of IASIS over funds transferred to or paid on behalf of the Plan. Due from affiliates balances are readily available to the Plan for settlement of the Plan's current liabilities as they become due. Generally, this balance is decreased by automatic cash transfers from the account to reimburse the Plan's bank accounts for operating expenses and to pay for fees and services provided by IASIS, including information systems services, and other operating expenses, such as payroll and insurance. Generally, the balance is increased through daily cash deposits by the Plan to the centralized cash management account of IASIS. Management fees totaling $564,000, which represent an allocation of corporate office expenses of IASIS, were recognized during the year ended September 30, 2009, and are included within administrative expenses in the accompanying statement of earnings. Interest income is not earned on outstanding balances due from affiliates.

Furniture and Equipment

Furniture and equipment is stated at cost. The Plan uses the straight-line method of depreciation over the estimated useful lives of the respective assets, which generally range from 3 to 15 years. Depreciation expense totaling $448,325 was recognized during the year ended September 30, 2009, and is included within administrative expenses in the accompanying statement of earnings.

Goodwill and Intangible Assets

Pursuant to accounting guidance related to goodwill and other intangible assets, goodwill is not amortized but is subject to annual impairment reviews or more often if events or circumstances indicate it may be impaired. An impairment loss is recorded to the extent that the carrying amount of goodwill exceeds its implied fair value. The Plan has completed its annual impairment test for the 2009 fiscal year, which resulted in no impairment.

Intangible assets consists solely of the Plan's contract with AHCCCS and is amortized over a period of 15 years, which approximates the contract's estimated useful life, including assumed renewal periods. Amortization of intangible assets totaled $3,000,000 for the year ended September 30, 2009, and is included in administrative expenses in the accompanying statement of earnings.

2. Summary of Significant Accounting Policies (continued)

When events, circumstances or operating results indicate that the carrying values of certain long-lived assets and related identifiable intangible assets (excluding goodwill) that are expected to be held and used might be impaired, the Plan considers the recoverability of assets to be held and used by comparing the carrying amount of the assets to the undiscounted value of future net cash flows expected to be generated by the assets. If the assets are identified as impaired, the impairment is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets as determined by independent appraisals or estimates of discounted future cash flows.

Revenue Recognition

Capitation premiums are recognized as revenue in the month that members are entitled to healthcare services. Certain other supplemental payments, such as reimbursement of healthcare services provided to AHCCCS eligible beneficiaries prior to enrollment into the Plan (prior period coverage or PPC), are recognized as revenue as services are provided, including estimates at the end of each accounting period. Included in capitation premiums in the accompanying statement of earnings for the year ended September 30, 2009, are accruals for PPC reconciliation settlement payables totaling $16,018,929, Title XIX Waiver Group reconciliation settlement payables totaling $5,003,420, Social Security Disabled Income – Temporary Medical Coverage settlement payables totaling $152,145 and Risk Factor adjustments totaling $6,284,302. Included in the aforementioned accruals is approximately $10,600,000 in reductions in premium revenue associated with settlements of various prior year program receivables.

Delivery supplemental premiums are payments received per newborn delivery and are intended by AHCCCS to cover the cost of maternity care for qualified pregnant women. Such premiums are billed and recognized in the month that delivery occurs.

2. Summary of Significant Accounting Policies (continued)

Medical Expenses

Monthly capitation payments to primary care physicians and other healthcare providers are expensed in the month services are contracted to be performed. Claims expense for non-capitated arrangements is accrued as services are rendered by hospitals, physicians and other healthcare providers during the year.

Medical claims payable includes claims received but not paid and an estimate of claims incurred but not reported. Incurred but not reported claims are estimated using a combination of historical claims experience (including severity and payment lag time) and other actuarial analysis including number of enrollees, age of enrollees and certain enrollee health indicators to predict the cost of healthcare services provided to enrollees during any given period. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from estimates given changes in the healthcare cost structure or adverse experience. During the year ended September 30, 2009, the Plan received independent actuary analysis resulting in a decrease to medical expenses of approximately $15,500,000 related to estimates for prior years.

Reinsurance

Contractually, the Plan is reimbursed by AHCCCS for healthcare costs that exceed stated amounts at a rate ranging from 75% to 100% of qualified healthcare costs in excess of stated levels of up to $50,000, depending on the case type of the member. Qualified costs must be incurred during the contract year and are the lesser of the amount paid by the Plan or the AHCCCS fee schedule. Amounts are recognized under the contract, with AHCCCS when healthcare costs exceed stated amounts as provided under the contract, including estimates of such costs at the end of each accounting period. In the event that AHCCCS is unable to honor its reinsurance commitment, the Plan may be responsible for excess costs incurred. Reinsurance recoveries totaling $22,716,310 were recognized during the year ended September 30, 2009, and are included as a reduction of hospital medical expenses in the accompanying statement of earnings.

2. Summary of Significant Accounting Policies (continued)

Administrative Expenses

The Plan shares its property leases and employees with Health Choice Generations (HCG), another division of the Parent. Administrative costs are shared between the Plan and HCG based on the revenue earned by each plan. Except for certain costs that are specific to one plan or the other, all administrative expenses are paid by the Plan and allocated to HCG according to HCG's percentage of the total combined revenue of the Parent. Costs pertaining only to the Plan, such as premium tax, are not allocated. Costs that can be specifically identified as pertaining to HCG only, such as the HCC Life Insurance Company (HCC) reinsurance premiums and certain data processing and marketing costs, are directly charged to HCG.

Income Taxes

IASIS files consolidated Federal and state income tax returns, which include the operating results of the Plan. IASIS allocates taxes to the Plan pursuant to the asset and liability method, as if the Plan were a separate taxpayer. For balance sheet purposes, such allocations are included in due from affiliates in the accompanying balance sheet.

Fair Value of Financial Instruments

AHCCCS receivables, due from affiliates, accounts payable and accrued expenses, and medical claims payable represent financial instruments. The carrying value of these financial instruments approximates their fair market value due to the short-term nature of these instruments.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Subsequent Events Consideration

The Plan evaluated events and transactions occurring subsequent to September 30, 2009 through January 25, 2010, the date the financial statements were issued. During this period, there were no subsequent events that required recognition in the financial statements.

3. Transactions with Affiliates

The Plan remitted fee-for-service payments totaling $8,570,700 during the year ended September 30, 2009, to facilities which are owned and operated by IASIS.

4. AHCCCS Receivables

The AHCCCS receivables consist of the following at September 30, 2009:

Reinsurance, net	$	11,116,627
Delivery supplement		896,908
Capitation receivable		2,863,521
TWG, PPC and Risk Factor reconciliation settlements		(13,719,651)
	$	1,157,405

5. Leases

The Plan leases its office facilities under various operating lease agreements. The following is a schedule of the future minimum lease payments required under noncancelable leases with initial or remaining terms in excess of one year at September 30, 2009:

Fiscal year:		
2010	$	1,228,577
2011		1,241,168
2012		1,275,565
2013		1,309,962
2014		775,849
Total	$	5,831,121

Rental expense totaled $1,500,578 for the year ended September 30, 2009, and is included within administrative expenses in the accompanying statement of earnings.

6. Commitments and Contingencies

Professional, General and Other Liability Insurance

The Plan is subject to claims and lawsuits arising in the ordinary course of business, including, but not limited to, injuries arising from patient treatment and denials thereof and personal injuries. The Plan believes that its liability for damages resulting from such claims and lawsuits is adequately covered by insurance or is adequately provided for in its financial statements.

The Plan's contract with AHCCCS requires the Plan to maintain professional liability insurance, comprehensive general insurance, and automobile liability insurance coverage of at least $1,000,000 for each occurrence. During the year ended September 30, 2009, the Plan was covered under IASIS' umbrella policy. IASIS, on behalf of the Plan, carries professional and general liability insurance, as well as workers' compensation insurance, in excess of self-insured retentions through an unrelated commercial insurance carrier in amounts that IASIS believes to be sufficient for the Plan, although some claims may exceed the scope of coverage in effect. IASIS maintains reserves for professional and general liability and workers' compensation claims. Accordingly, no reserve for liability risks are recorded on the accompanying balance sheet. The cost for the year ended September 30, 2009, totaled $145,240 and $110,558 for professional and general liability and workers' compensation, respectively, and is included within administrative expenses in the accompanying statement of earnings. The Plan is currently not a party to any such proceedings that, in the Plan's opinion, would have a material adverse effect on the Plan's business, financial condition or results of operations.

Employee Benefit Insurance Risks

The Plan participates in a self-insured program for health insurance and other medical benefit programs administered by IASIS. The cost of employee health and other medical benefits is allocated by IASIS based on total covered employees and dependents. The cost allocated to the Plan, net of employee premiums, totaled $1,566,698 for the year ended September 30, 2009, and is included within administrative expenses in the accompanying statement of earnings.

6. Commitments and Contingencies (continued)

Performance Guarantee

If the Plan fails to effectively manage healthcare costs, these costs may exceed the premiums received by the Plan. The Plan believes the capitated premiums, together with reinsurance and other supplemental premiums, are sufficient to pay for the services the Plan is obligated to deliver. Pursuant to its contract with AHCCCS, the Plan is required annually to provide performance bonds or letters of credit, in an acceptable form, to guarantee performance of the Plan's obligations under its contract to provide and pay for the healthcare services. The amount of the performance guaranty that AHCCCS requires is generally based upon the membership in the Plan and the related capitation paid to the Plan. As of September 30, 2009, the Plan provided performance guarantees in the form of irrevocable standby letters of credit for the benefit of AHCCCS totaling $43,204,401.

State and Federal Laws and Regulations

The Plan is subject to state and federal laws and regulations. The Centers for Medicare and Medicaid Services and AHCCCS have the right to audit the Plan to determine the Plan's compliance with such standards. The Plan is required to file periodic reports with AHCCCS and to meet certain financial viability standards. The Plan must also provide its enrollees with certain mandated benefits and must meet certain quality assurance and improvement requirements. The Plan believes it is in compliance with these AHCCCS requirements. The Plan must also comply with the electronic transactions regulations and privacy standards of the Health Insurance Portability and Accountability Act (HIPAA). The Plan believes it is in compliance with the HIPAA security standards as set forth in 45 CFR Part 164. The Plan has also complied with the requirements for health plans defined in 45 CFR Part 162.

6. Commitments and Contingencies (continued)

Other

On March 31, 2008, the United States District Court for the District of Arizona (the District Court) dismissed with prejudice the *qui tam* complaint against IASIS Healthcare Corporation (IAS), parent company of IASIS. The *qui tam* action sought monetary damages and civil penalties under the federal False Claims Act (FCA) and included allegations that certain business practices related to physician relationships and the medical necessity of certain procedures resulted in the submission of claims for reimbursement in violation of the FCA. The case dates back to March 2005 and became the subject of a subpoena by the Office of Inspector General (OIG) in September 2005. In August 2007, the case was unsealed and became a private lawsuit after the Department of Justice declined to intervene. The United States District Judge dismissed the case from the bench at the conclusion of oral arguments on IAS' motion to dismiss. On April 21, 2008, the court issued a written order dismissing the case with prejudice and entering formal judgment for IAS. On May 7, 2008, the *qui tam* relator's counsel filed a Notice of Appeal to the United States Court of Appeals for the Ninth Circuit to appeal the District Court's dismissal of the case. On May 21, 2008, IAS filed a Notice of Cross-Appeal to the United States Court of Appeals for the Ninth Circuit from a portion of the April 21, 2008 Order and, on July 22, 2008, IAS filed a Motion to Disqualify relator's counsel related to their misappropriation of information subject to a claim of attorney-client privilege by IAS. On August 21, 2008, the court issued a written order denying IAS' Motion to Disqualify and resetting the briefing schedule associated with the Ninth Circuit appellate proceedings. On October 21, 2008, the relator filed his appeal brief with the United States Court of Appeals for the Ninth Circuit. IAS filed its cross-appeal brief on January 20, 2009. Currently, the Ninth Circuit appeal is expected to take another six to nine months to complete. If the appeal of the order dismissing the *qui tam* action with prejudice was to be resolved in a manner unfavorable to IAS, it could have a material adverse effect on the business, financial condition and results of operations of IAS and the Plan, including exclusion from the Medicare and Medicaid programs.

7. Retirement Plan

Substantially all employees of the Plan, upon qualification, are eligible to participate in IASIS' defined contribution 401(k) plan. Employees who elect to participate generally make contributions from 1% to 20% of their eligible compensation and IASIS matches, at its discretion, such contributions on behalf of the Plan up to a maximum percentage. Generally, employees immediately vest 100% in their own contributions and vest in the employer portion of contributions over a period not to exceed five years. Defined contribution expense totaled $118,156 for the year ended September 30, 2009, and is included within administrative expenses in the accompanying statement of earnings.

Other Financial Information

Profitability by Risk Group

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/09 Total Counties	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC	State Only Transplants	State Only Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	0	0	0	0	0	0	0	0	0	0	8,328	0	8,328	0	0	0	8,328
PPC Member Months	3,248	42,822	22,624	12,361	3,656	84,711	1,827	2,647	2,723	32,412	0	4,066	128,386	0	1	1	128,387
Pros. Member Months	109,470	819,841	360,330	182,879	60,843	1,533,363	126,037	103,033	10,007	283,883	0	31,748	2,088,071	0	19	19	2,088,090
Total Member Months	112,718	862,663	382,954	195,240	64,499	1,618,074	127,864	105,680	12,730	316,295	8,328	35,814	2,224,786	0	20	20	2,224,806
Pros. & FPS Mbr. Mths	109,470	819,841	360,330	182,879	60,843	1,533,363	126,037	103,033	10,007	283,883	8,328	31,748	2,096,399	0	19	19	2,096,418
Pros. & PPC Mbr. Mths	112,718	862,663	382,954	195,240	64,499	1,618,074	127,864	105,680	12,730	316,295	0	35,814	2,216,467	0	20	20	2,216,477
REVENUES																	
305 Capitation	54,304,362	89,350,026	88,036,306	26,092,496	24,403,195	282,186,385	19,272,504	76,232,299	14,981,503	159,055,566	163,808	7,812,230	559,704,295	0	800	800	559,705,095
310 PPC Capitation	3,923,304	2,679,483	5,786,097	2,649,746	1,618,828	16,657,458	246,044	1,097,739	19,767,463	36,495,598	0	1,033,901	75,298,203	0	0	0	75,298,203
312 Hospital Supplement (Adj for CYE 08 and prior)	0	0	0	0	0	0	0	0	475,870	0	0	0	475,870	0	0	0	475,870
315 Delivery Supplement	0	0	16,853,497	0	0	16,853,497	12,846	681,768	6,726	651,346	0	25,281,893	43,488,076	0	0	0	43,488,076
320 Reserved	1,052	1,052	(1,052)	(1,052)	0	0	(8,415)	8,415	(12,622)	23,141	0	1,052	11,571	0	0	0	11,571
321 TWG Settlement	0	0	0	0	0	0	0	0	(524,695)	(4,478,722)	0	0	(5,003,417)	0	0	0	(5,003,417)
322 PPC Settlement	(794,861)	(234,780)	(880,359)	(415,016)	95,433	(2,229,583)	(85,111)	105,315	(2,856,471)	(11,225,212)	0	272,130	(16,018,932)	0	0	0	(16,018,932)
325 Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
330 Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0	(152,145)	0	(152,145)	(152,145)
TOTAL REVENUES	57,433,857	91,795,781	109,794,489	28,326,174	26,117,456	313,467,767	19,437,868	78,125,536	31,837,774	180,521,717	163,808	34,401,206	657,955,666	(152,145)	800	(151,345)	657,804,321
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	33,664,422	7,310,106	21,030,343	4,178,937	4,853,189	71,036,997	3,787,580	23,008,259	5,647,772	36,288,179	0	15,684,928	165,453,715	0	40,144	40,144	165,493,859
404 Hospital Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
406 PPC-Hospital Inpatient	2,781,312	617,321	1,622,883	543,605	645,593	6,210,714	402,646	1,593,243	8,447,911	12,682,109	0	483,480	29,820,103	0	0	0	29,820,103
Total Hospitalization	36,445,734	7,927,427	22,653,226	4,722,542	5,498,782	77,247,711	4,190,226	24,601,502	14,095,683	48,970,288	0	16,168,408	195,273,818	0	40,144	40,144	195,313,962
Medical Compensation																	
408 Primary Care Physician	7,452,888	12,536,437	7,679,321	1,911,084	1,384,334	30,964,064	882,781	3,362,943	378,516	7,623,326	44,871	812,680	44,069,181	0	42	42	44,069,223
410 Referral Physician	5,463,709	9,544,632	17,613,752	3,730,565	4,213,307	40,566,965	2,590,687	11,579,929	1,568,524	22,809,327	8,380	8,167,902	87,290,714	0	0	0	87,290,714
412 Other Professional	1,377,543	2,034,108	2,153,524	596,806	241,755	6,403,736	237,812	1,109,454	134,132	2,146,144	985	681,612	10,713,875	0	0	0	10,713,875
414 PPC - Physician Services	313,214	441,370	621,905	227,616	178,894	1,782,999	28,943	114,512	1,753,350	2,831,855	0	298,513	6,810,172	0	0	0	6,810,172
Total Medical Comp	14,607,354	24,556,547	28,068,502	6,466,071	6,018,290	79,716,764	3,740,223	16,166,838	3,834,522	35,410,652	54,236	9,960,707	148,883,942	0	42	42	148,883,984
Other Medical Expenses																	
416 Emergency Facility Services	1,872,985	6,184,508	5,952,890	1,792,586	660,124	16,463,093	113,397	2,434,255	215,221	6,115,589	1,454	469,226	26,812,235	0	0	0	26,812,235
418 Pharmacy	797,696	6,118,386	8,975,293	3,097,238	3,629,044	22,617,657	358,165	14,326,393	824,557	18,592,039	33,556	564,088	57,316,455	(200)	941	741	57,317,196
420 Lab, X-ray, & Medical Imaging	718,577	2,147,101	8,293,914	1,437,532	1,874,259	14,471,383	925,745	3,951,296	593,077	9,816,903	2,255	2,579,838	32,340,497	0	13	13	32,340,510
422 Outpatient Facility	2,217,409	8,262,378	13,658,643	3,479,411	3,915,105	31,532,946	1,669,339	7,989,149	1,502,990	18,589,271	14,398	1,981,069	63,279,162	0	0	0	63,279,162
424 Durable Medical Equipment	275,352	1,250,367	1,080,404	425,896	283,061	3,316,080	214,554	1,232,323	108,303	1,587,964	28	140,168	6,598,420	0	21	21	6,598,441
426 Dental	16,702	19,587,540	3,450,304	2,273,561	131,826	25,459,933	250,041	775,373	104,831	1,571,104	0	170,822	28,332,104	0	0	0	28,332,104
428 Transportation	1,682,147	3,617,191	3,373,969	1,275,178	590,293	10,538,778	852,500	3,253,447	326,892	5,912,420	1,136	655,816	21,540,989	0	45	46	21,541,034
430 Nursing Facility, Home Health Care	256,118	166,148	393,164	50,926	174,999	1,041,356	562,228	2,331,717	483,151	3,317,470	0	86,656	7,822,577	0	0	0	7,822,577
432 Physical Therapy	250,620	337,631	588,146	245,342	241,673	1,663,412	73,005	360,884	62,018	1,170,546	0	12,581	3,342,446	0	0	0	3,342,446
434 Other Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
436 Miscellaneous Medical Expenses	28,982	1,173,600	459,442	226,208	129,069	2,017,301	778,250	864,426	49,401	546,010	0	35,590	4,290,978	0	0	0	4,290,978
438 PPC-Other	210,301	862,360	1,394,148	544,126	287,450	3,298,386	90,857	213,625	2,132,390	4,860,732	0	587,647	11,183,636	0	5	5	11,183,641
Total Other Medical	8,326,889	49,707,210	47,620,317	14,848,004	11,916,903	132,419,323	5,888,081	37,732,888	6,402,831	72,080,048	52,827	7,283,501	261,859,498	(200)	1,025	825	261,860,324
TOTAL MEDICAL EXP	59,379,977	82,191,184	98,342,045	26,036,617	23,433,975	289,383,798	13,818,530	78,501,228	24,333,036	156,460,988	107,063	33,412,616	596,017,258	(200)	41,211	41,011	596,058,270
Less:																	
440 Reinsurance	(2,754,401)	(778,737)	(3,341,130)	(879,253)	(497,135)	(8,250,656)	(20,512)	(6,766,234)	(582,230)	(6,967,053)	0	(129,625)	(22,716,310)	0	0	0	(22,716,310)
441 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
442 Third Party Liability	(6,748)	(93,114)	(463,746)	(160,116)	(90,779)	(814,503)	(17,931)	(219,032)	(185,098)	(616,421)	(1,704)	(22,584)	(1,877,273)	0	0	0	(1,877,273)
TOTAL NET MEDICAL EXP	56,618,828	81,319,333	94,537,169	24,997,248	22,846,061	280,318,639	13,780,087	71,515,962	23,565,708	148,877,514	105,359	33,260,407	571,423,878	(200)	41,211	41,011	571,464,887
TOTAL ADMIN EXP	2,530,500	3,969,239	4,768,910	1,229,758	1,116,175	13,614,582	852,564	3,380,022	1,457,573	8,301,307	7,147	1,490,287	29,103,482	0	32	32	29,103,514
TOTAL EXPENSES	59,149,328	85,288,572	99,306,079	26,227,006	23,962,236	293,933,221	14,632,651	74,895,984	25,023,281	157,178,821	112,506	34,750,694	600,527,158	(200)	41,243	41,043	600,568,201
Inc (loss) from operations	(1,715,471)	6,507,209	10,488,410	2,099,168	2,155,220	19,534,536	4,805,217	3,229,552	6,814,493	23,342,896	51,302	(349,488)	57,428,508	(151,945)	(40,443)	(192,388)	57,236,120
Non-operating inc (loss)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Inc (loss) before taxes	(1,715,471)	6,507,209	10,488,410	2,099,168	2,155,220	19,534,536	4,805,217	3,229,552	6,814,493	23,342,896	51,302	(349,488)	57,428,508	(151,945)	(40,443)	(192,388)	57,236,120
Income taxes	142,989	2,037,469	3,034,865	646,381	642,136	6,503,840	1,092,774	1,313,922	1,682,904	6,251,072	11,692	219,235	17,075,439	(33,174)	(7,698)	(40,872)	17,034,567
Premium taxes	1,214,185	1,920,498	2,309,616	599,867	543,157	6,587,323	407,368	1,627,487	735,802	4,098,896	3,415	712,200	14,172,491	0	0	0	14,172,491
NET INCOME (LOSS)	(3,072,645)	2,549,242	5,143,929	852,920	969,927	6,443,373	3,305,075	288,143	4,395,787	12,992,928	36,195	(1,260,923)	26,180,678	(118,771)	(32,745)	(151,516)	26,029,062

0910-1101319

Profitability by Risk Group

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/09 Apache County	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC	State Only Transplants	State Only Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	0	0	0	0	0	0	0	0	0	0	202	0	202	0	0	0	202
PPC Member Months	40	589	328	249	52	1,258	38	29	56	530	0	45	1,956	0	0	0	1,956
Pros. Member Months	2,018	14,168	7,165	4,670	1,717	29,738	2,944	2,631	172	7,256	0	565	43,306	0	0	0	43,306
Total Member Months	2,058	14,757	7,493	4,919	1,769	30,996	2,982	2,660	228	7,786	202	610	45,464	0	0	0	45,464
Pros. & FPS Mbr. Mths	2,018	14,168	7,165	4,670	1,717	29,738	2,944	2,631	172	7,256	202	565	43,508	0	0	0	43,508
Pros. & PPC Mbr. Mths	2,058	14,757	7,493	4,919	1,769	30,996	2,982	2,660	228	7,786	0	610	45,262	0	0	0	45,262
REVENUES																	
305 Capitation	954,708	1,597,089	1,987,865	748,685	726,904	6,016,261	490,523	2,102,621	247,214	4,321,786	3,884	154,002	13,336,281	0	0	0	13,336,281
310 PPC Capitation	47,436	36,673	87,206	53,604	23,214	248,133	5,327	11,759	407,030	598,928	0	11,887	1,283,064	0	0	0	1,283,064
312 Hospital Supplement(Adj for CYE 08 and prior)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
315 Delivery Supplement	0	0	358,987	0	0	358,987	0	12,648	0	0	0	465,673	837,308	0	0	0	837,308
320 Reserved	0	0	0	0	0	0	0	0	0	1,052	0	0	1,052	0	0	0	1,052
321 TWG Settlement	0	0	0	0	0	0	0	0	47,738	131,209	0	0	178,947	0	0	0	178,947
322 PPC Settlement	(197,252)	2,557	(63,303)	(53,654)	23,540	(288,112)	(6,001)	(15,474)	379,661	(2,156,850)	0	23,089	(2,063,687)	0	0	0	(2,063,687)
325 Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
330 Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0	10,661	0	10,661	10,661
TOTAL REVENUES	804,892	1,636,319	2,370,755	748,635	773,658	6,334,259	489,849	2,111,554	1,081,643	2,896,125	3,884	654,651	13,571,965	10,661	0	10,661	13,582,626
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	551,469	153,504	402,047	66,572	152,207	1,325,799	39,115	313,701	89,017	609,206	0	253,784	2,630,622	0	0	0	2,630,622
404 Hospital Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
406 PPC-Hospital Inpatient	13,675	7,369	22,695	3,560	0	47,299	1,163	1,363	156,161	97,642	0	12,561	316,189	0	0	0	316,189
Total Hospitalization	565,144	160,873	424,742	70,132	152,207	1,373,098	40,278	315,064	245,178	706,848	0	266,345	2,946,811	0	0	0	2,946,811
Medical Compensation																	
408 Primary Care Physician	154,829	195,917	172,520	46,539	50,562	620,367	18,480	81,475	6,437	201,543	1,667	18,274	948,243	0	0	0	948,243
410 Referral Physician	77,860	103,965	266,821	52,950	93,807	595,403	45,845	177,235	15,452	360,196	186	99,990	1,294,307	0	0	0	1,294,307
412 Other Professional	15,728	43,565	81,715	11,510	5,838	158,356	7,275	22,092	0	52,379	0	62,834	302,936	0	0	0	302,936
414 PPC - Physician Services	1,771	5,414	8,967	2,802	3,952	22,906	892	150	46,662	38,292	0	2,527	111,429	0	0	0	111,429
Total Medical Comp	250,188	348,861	530,023	113,801	154,159	1,397,032	72,492	280,952	68,551	652,410	1,853	183,625	2,656,915	0	0	0	2,656,916
Other Medical Expenses																	
416 Emergency Facility Services	41,398	91,271	90,592	35,063	21,558	279,882	3,420	42,197	539	103,678	0	14,645	444,361	0	0	0	444,361
418 Pharmacy	11,451	53,303	135,680	48,391	71,574	320,399	2,799	271,709	13,122	392,413	1,772	5,952	1,008,166	(1)	0	(1)	1,008,166
420 Lab, X-ray, & Medical Imaging	11,905	24,755	131,397	20,910	36,133	225,100	17,963	60,609	6,941	198,021	0	27,956	536,590	0	0	0	536,590
422 Outpatient Facility	41,267	113,167	284,457	84,726	128,086	651,703	122,982	363,497	18,072	601,202	0	24,719	1,782,176	0	0	0	1,782,176
424 Durable Medical Equipment	7,550	23,001	38,663	10,805	6,641	86,660	4,185	18,566	556	25,969	0	3,261	139,197	0	0	0	139,197
426 Dental	0	282,639	69,808	48,282	5,529	406,258	7,646	19,248	2,105	42,422	0	4,301	481,980	0	0	0	481,980
428 Transportation	94,399	111,856	130,933	98,679	37,184	473,051	44,770	69,914	2,340	193,985	0	50,717	834,777	0	0	0	834,777
430 Nursing Facility, Home Health Care	613	34,996	7,627	0	0	43,236	1,852	37,443	25,667	17,822	0	0	126,020	0	0	0	126,020
432 Physical Therapy	11,762	5,211	7,046	4,992	5,440	34,451	1,399	4,828	1,938	25,182	0	314	68,112	0	0	0	68,112
434 Other Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
436 Miscellaneous Medical Expenses	33	32,073	29,950	5,833	161	68,050	526	612	0	4,479	0	300	73,967	0	0	0	73,967
438 PPC-Other	1,529	22,093	21,714	17,485	10,010	72,831	3,853	85	71,678	78,789	0	27,094	254,310	0	0	0	254,310
Total Other Medical	221,907	794,365	947,867	375,166	322,316	2,661,621	211,395	888,708	142,958	1,683,942	1,772	159,259	5,749,656	(1)	0	(1)	5,749,654
TOTAL MEDICAL EXP	1,037,239	1,304,099	1,902,632	559,099	628,682	5,431,751	324,165	1,484,724	456,687	3,043,200	3,625	609,229	11,353,381	(1)	0	(1)	11,353,380
Less:																	
440 Reinsurance	(10,623)	0	(5,047)	(16,978)	0	(32,648)	0	(1,737)	(1,545)	(165,346)	0	0	(201,276)	0	0	0	(201,276)
441 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
442 Third Party Liability	0	0	(4,928)	0	0	(4,928)	0	0	(16,374)	(30,080)	0	0	(51,382)	0	0	0	(51,382)
TOTAL NET MEDICAL EXP	1,026,616	1,304,099	1,892,657	542,121	628,682	5,394,175	324,165	1,482,987	438,768	2,847,774	3,625	609,229	11,100,723	(1)	0	(1)	11,100,722
TOTAL ADMIN EXP	43,699	70,559	105,127	34,444	32,330	286,159	21,506	91,603	26,744	212,334	169	27,599	666,114	0	0	0	666,114
TOTAL EXPENSES	1,070,315	1,374,658	1,997,784	576,565	661,012	5,680,334	345,671	1,574,590	465,512	3,060,108	3,794	636,828	11,766,837	(1)	0	(1)	11,766,836
Inc (loss) from operations	(265,423)	261,661	372,971	172,070	112,646	653,926	144,178	536,964	616,131	(163,983)	90	17,823	1,805,128	10,662	0	10,662	1,815,790
Non-operating inc (loss)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Inc (loss) before taxes	(265,423)	261,661	372,971	172,070	112,646	653,926	144,178	536,964	616,131	(163,983)	90	17,823	1,805,128	10,662	0	10,662	1,815,790
Income taxes	(42,965)	65,305	93,337	34,810	23,106	173,593	32,775	123,112	123,901	26,916	63	10,111	490,471	2,416	0	2,416	492,887
Premium taxes	20,875	34,077	50,724	16,733	15,640	138,049	10,339	44,375	13,711	102,645	81	13,180	322,380	0	0	0	322,380
NET INCOME (LOSS)	(243,333)	162,279	228,910	120,527	73,900	342,283	101,064	369,477	478,519	(293,544)	(54)	(5,468)	992,277	8,246	0	8,246	1,000,523

Profitability by Risk Group

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/09 Coconino County	TANF <1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC	State Only Transplants	State Only Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	0	0	0	0	0	0	0	0	0	0	559	0	559	0	0	0	559
PPC Member Months	145	1,888	1,088	616	165	3,902	72	106	168	1,944	0	226	6,418	0	0	0	6,418
Pros. Member Months	5,993	46,204	22,094	11,505	3,303	89,099	5,626	4,796	585	18,676	0	2,171	120,953	0	0	0	120,953
Total Member Months	6,138	48,092	23,182	12,121	3,468	93,001	5,698	4,902	753	20,620	559	2,397	127,930	0	0	0	127,930
Pros. & FPS Mbr. Mths	5,993	46,204	22,094	11,505	3,303	89,099	5,626	4,796	585	18,676	559	2,171	121,512	0	0	0	121,512
Pros. & PPC Mbr. Mths	6,138	48,092	23,182	12,121	3,468	93,001	5,698	4,902	753	20,620	0	2,397	127,371	0	0	0	127,371
REVENUES																	
305 Capitation	2,836,959	5,207,015	6,132,280	1,844,506	1,396,691	17,417,461	937,890	3,831,719	841,741	11,120,484	10,711	591,869	34,751,866	0	0	0	34,751,866
310 PPC Capitation	173,305	117,607	289,196	132,143	72,190	784,441	9,734	43,634	1,258,435	2,195,942	0	59,699	4,351,886	0	0	0	4,351,886
312 Hospital Supplement(Adj for CYE 08 and prior)	0	0	0	0	0	0	0	0	12,104	0	0	0	12,104	0	0	0	12,104
315 Delivery Supplement	0	0	1,018,652	0	0	1,018,652	6,242	56,751	0	25,214	0	1,774,405	2,881,264	0	0	0	2,881,264
320 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
321 TWG Settlement	0	0	0	0	0	0	0	0	10,709	228,334	0	0	239,043	0	0	0	239,043
322 PPC Settlement	117,400	(27,468)	(33,234)	(113,235)	(36)	(56,573)	(3,246)	47,019	(438,605)	(1,012,523)	0	16,327	(1,447,601)	0	0	0	(1,447,601)
325 Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
330 Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0	(2,208)	0	(2,208)	(2,208)
TOTAL REVENUES	3,127,664	5,297,154	7,406,894	1,863,414	1,468,845	19,163,971	950,620	3,979,123	1,684,384	12,557,451	10,711	2,442,300	40,788,560	(2,208)	0	(2,208)	40,786,352
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	1,986,929	461,798	1,316,197	151,663	283,389	4,199,976	95,861	1,236,909	104,464	2,439,971	0	1,109,392	9,186,573	0	0	0	9,186,573
404 Hospital Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
406 PPC-Hospital Inpatient	104,127	13,994	46,993	0	166,002	331,116	27,804	3,474	214,543	570,394	0	45,127	1,192,458	0	0	0	1,192,458
Total Hospitalization	2,091,056	475,792	1,363,190	151,663	449,391	4,531,092	123,665	1,240,383	319,007	3,010,365	0	1,154,519	10,379,031	0	0	0	10,379,031
Medical Compensation																	
408 Primary Care Physician	484,586	762,915	468,077	101,143	78,611	1,895,332	30,021	142,923	19,293	421,535	4,199	59,320	2,572,623	0	0	0	2,572,623
410 Referral Physician	212,870	749,080	1,083,609	234,816	173,056	2,453,431	115,818	615,417	117,567	1,388,368	502	540,275	5,231,378	0	0	0	5,231,378
412 Other Professional	173,220	37,830	66,741	24,965	7,317	310,073	1,046	41,878	0	37,147	0	31,227	421,371	0	0	0	421,371
414 PPC - Physician Services	27,419	28,674	37,221	10,845	12,870	117,029	3,242	18,870	94,317	205,783	0	16,236	455,477	0	0	0	455,477
Total Medical Comp	898,095	1,578,499	1,655,648	371,769	271,854	4,775,865	150,127	819,088	231,177	2,052,833	4,701	647,058	8,680,849	0	0	0	8,680,849
Other Medical Expenses																	
416 Emergency Facility Services	99,742	343,360	415,250	106,443	44,668	1,009,463	5,602	142,381	11,226	553,253	0	25,952	1,747,877	0	0	0	1,747,877
418 Pharmacy	31,460	301,762	469,702	150,556	132,763	1,086,243	11,480	649,680	108,131	1,060,222	1,530	31,310	2,948,596	(16)	0	(16)	2,948,580
420 Lab, X-ray, & Medical Imaging	40,153	112,506	447,643	68,471	76,901	745,674	31,226	154,364	31,534	501,103	162	128,188	1,592,251	0	0	0	1,592,251
422 Outpatient Facility	59,126	294,005	612,630	240,367	114,230	1,320,358	97,693	301,840	43,497	945,852	0	126,440	2,835,680	0	0	0	2,835,680
424 Durable Medical Equipment	9,651	61,640	48,562	20,230	7,524	147,607	11,710	49,129	6,591	78,762	0	4,990	298,789	0	0	0	298,789
426 Dental	2,605	1,255,146	160,709	105,313	5,128	1,528,901	9,739	37,048	8,208	65,667	0	9,696	1,659,259	0	0	0	1,659,259
428 Transportation	78,066	306,189	265,920	109,822	52,348	812,345	66,473	235,169	11,414	650,112	0	31,306	1,806,819	0	0	0	1,808,819
430 Nursing Facility, Home Health Care	4,053	6,077	3,105	0	22,265	35,500	14,623	63,600	7,263	215,374	0	103	336,463	0	0	0	336,463
432 Physical Therapy	3,733	16,330	45,841	15,566	6,853	88,323	3,517	18,107	4,351	78,140	0	1,694	194,132	0	0	0	194,132
434 Other Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
436 Miscellaneous Medical Expenses	1,696	67,797	50,682	10,842	5,413	136,430	46,088	104,311	3,134	13,397	0	1,714	305,074	0	0	0	305,074
438 PPC-Other	20,241	31,809	55,306	23,856	8,417	139,629	2,245	20,510	164,660	347,129	0	26,838	701,011	0	0	0	701,011
Total Other Medical	350,526	2,796,621	2,575,350	851,466	476,510	7,050,473	300,396	1,776,139	400,009	4,509,011	1,692	388,231	14,425,951	(16)	0	(16)	14,425,935
TOTAL MEDICAL EXP	3,339,677	4,850,912	5,594,188	1,374,898	1,197,755	16,357,430	574,188	3,835,610	950,193	9,572,209	6,393	2,189,808	33,485,831	(16)	0	(16)	33,485,816
Less:																	
440 Reinsurance	(111,564)	(23,435)	(164,786)	(77,154)	(1,112)	(378,051)	0	(359,809)	(58,095)	(782,255)	0	(10,894)	(1,589,104)	0	0	0	(1,589,104)
441 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
442 Third Party Liability	0	0	(14,300)	0	(1,297)	(15,597)	0	(644)	(47,627)	(47,167)	0	(2,631)	(113,666)	0	0	0	(113,666)
TOTAL NET MEDICAL EXP	3,228,113	4,827,477	5,415,102	1,297,744	1,195,346	15,963,782	574,188	3,475,157	844,471	8,742,787	6,393	2,176,283	31,783,061	(16)	0	(16)	31,783,046
TOTAL ADMIN EXP	131,103	229,022	319,995	84,545	63,453	828,118	41,321	170,940	82,873	567,312	466	106,654	1,797,684	0	0	0	1,797,684
TOTAL EXPENSES	3,359,216	5,056,499	5,735,097	1,382,289	1,258,799	16,791,900	615,509	3,646,097	927,344	9,310,099	6,859	2,282,937	33,580,746	(16)	0	(16)	33,580,729
Inc (loss) from operations	(231,552)	240,655	1,671,797	481,125	210,046	2,372,071	335,111	333,026	757,040	3,247,352	3,852	159,363	7,207,816	(2,192)	0	(2,192)	7,205,623
Non-operating inc (loss)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Inc (loss) before taxes	(231,552)	240,655	1,671,797	481,125	210,046	2,372,071	335,111	333,026	757,040	3,247,352	3,852	159,363	7,207,816	(2,192)	0	(2,192)	7,205,623
Income taxes	(20,410)	88,534	391,214	110,444	53,789	623,571	72,625	106,106	176,556	769,839	892	52,095	1,801,684	(561)	0	(561)	1,801,123
Premium taxes	62,785	111,072	155,248	41,258	30,647	401,010	19,830	82,045	43,987	278,508	223	50,734	876,397	0	0	0	876,397
NET INCOME (LOSS)	(273,927)	41,049	1,125,335	329,423	125,610	1,347,490	242,596	144,875	536,497	2,199,005	2,737	56,534	4,529,734	(1,631)	0	(1,631)	4,528,103

0910-1101319

Profitability by Risk Group

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/09 Gila County	TANF <1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC	State Only Transplants	State Only Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	0	0	0	0	0	0	0	0	0	0	(1)	0	(1)	0	0	0	(1)
PPC Member Months	1	2	2	0	0	5	0	0	0	1	0	0	6	0	0	0	6
Pros. Member Months	(9)	0	0	0	0	(9)	1	0	0	0	0	0	(8)	0	0	0	(8)
Total Member Months	(8)	2	2	0	0	(4)	1	0	0	1	(1)	0	(3)	0	0	0	(3)
Pros. & FPS Mbr. Mths	(9)	0	0	0	0	(9)	1	0	0	0	(1)	0	(9)	0	0	0	(9)
Pros. & PPC Mbr. Mths	(8)	2	2	0	0	(4)	1	0	0	1	0	0	(2)	0	0	0	(2)
REVENUES																	
305 Capitation	(4,726)	(93)	7	0	0	(4,812)	119	(120)	0	14	(20)	0	(4,819)	0	0	0	(4,819)
310 PPC Capitation	741	117	431	0	0	1,289	0	0	0	842	0	0	2,131	0	0	0	2,131
312 Hospital Supplement(Adj for CYE 08 and prior)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
315 Delivery Supplement	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
320 Reserved	0	0	0	0	0	0	0	(1,052)	0	1,052	0	0	0	0	0	0	0
321 TWG Settlement	0	0	0	0	0	0	0	0	(69,381)	(523,991)	0	0	(593,372)	0	0	0	(593,372)
322 PPC Settlement	38,878	14,326	(22,787)	(9,960)	368	20,826	1,868	6,609	(37,081)	(93,685)	0	7,487	(93,977)	0	0	0	(93,977)
325 Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
330 Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0	398	0	398	398
TOTAL REVENUES	34,893	14,350	(22,349)	(9,960)	368	17,302	1,987	5,437	(106,462)	(615,768)	(20)	7,487	(690,037)	398	0	398	(689,639)
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
404 Hospital Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
406 PPC-Hospital Inpatient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Hospitalization	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical Compensation																	
408 Primary Care Physician	710	(12)	29	0	6	733	(61)	(116)	0	(10)	0	4	550	0	0	0	550
410 Referral Physician	183	0	0	0	0	183	4	(121)	0	0	0	0	66	0	0	0	66
412 Other Professional	85	0	0	0	0	85	(1)	(6)	0	0	0	0	78	0	0	0	78
414 PPC - Physician Services	64	5	13	0	0	82	0	0	0	13	0	0	95	0	0	0	95
Total Medical Comp	1,042	(7)	42	0	6	1,083	(58)	(243)	0	3	0	4	789	0	0	0	789
Other Medical Expenses																	
416 Emergency Facility Services	261	0	0	0	0	261	0	0	0	0	0	0	261	0	0	0	261
418 Pharmacy	(101)	299	250	679	3,824	4,951	(483)	6,079	(130)	3,901	4	24	14,346	(4)	0	(4)	14,342
420 Lab, X-ray, & Medical Imaging	50	1	3	0	0	54	(1)	9	0	0	0	0	62	0	0	0	62
422 Outpatient Facility	219	(45)	0	0	0	174	3	(18)	0	0	0	0	159	0	0	0	159
424 Durable Medical Equipment	24	(14)	(4)	(2)	(2)	2	2	0	2	(7)	0	(1)	(2)	0	0	0	(2)
426 Dental	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
428 Transportation	226	(33)	(11)	(9)	(3)	170	(20)	(4)	7	(11)	0	(3)	139	0	0	0	139
430 Nursing Facility, Home Health Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
432 Physical Therapy	6	0	0	0	0	6	0	0	0	0	0	0	6	0	0	0	6
434 Other Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
436 Miscellaneous Medical Expenses	1	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	1
438 PPC-Other	3	3	15	0	0	21	0	0	0	10	0	0	31	0	0	0	31
Total Other Medical	689	211	253	668	3,819	5,640	(499)	6,066	(121)	3,893	4	20	15,003	(4)	0	(4)	14,999
TOTAL MEDICAL EXP	1,731	204	295	668	3,825	6,723	(557)	5,823	(121)	3,896	4	24	15,792	(4)	0	(4)	15,788
Less:																	
440 Reinsurance	0	0	(19,326)	0	0	(19,326)	0	(12,293)	(32,079)	(60,793)	0	0	(124,491)	0	0	0	(124,491)
441 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
442 Third Party Liability	0	0	(6,241)	(6,276)	0	(12,517)	(861)	(20,509)	(6,041)	(7,356)	0	0	(47,284)	0	0	0	(47,284)
TOTAL NET MEDICAL EXP	1,731	204	(25,272)	(5,608)	3,825	(25,120)	(1,418)	(26,979)	(38,241)	(64,253)	4	24	(155,983)	(4)	0	(4)	(155,987)
TOTAL ADMIN EXP	(137)	1	21	0	0	(115)	6	(56)	0	91	(1)	0	(75)	0	0	0	(75)
TOTAL EXPENSES	1,594	205	(25,251)	(5,608)	3,825	(25,235)	(1,412)	(27,035)	(38,241)	(64,162)	3	24	(156,058)	(4)	0	(4)	(156,062)
Inc (loss) from operations	33,299	14,145	2,902	(4,352)	(3,457)	42,537	3,399	32,472	(68,221)	(551,606)	(23)	7,463	(533,979)	402	0	402	(533,577)
Non-operating inc (loss)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Inc (loss) before taxes	33,299	14,145	2,902	(4,352)	(3,457)	42,537	3,399	32,472	(68,221)	(551,606)	(23)	7,463	(533,979)	402	0	402	(533,577)
Income taxes	6,349	2,708	866	(621)	(699)	8,603	661	6,617	(14,343)	(111,777)	(5)	1,425	(108,819)	233	0	233	(108,586)
Premium taxes	(86)	1	9	0	0	(76)	3	(25)	0	40	0	0	(58)	0	0	0	(58)
NET INCOME (LOSS)	27,036	11,436	2,027	(3,731)	(2,758)	34,010	2,735	25,880	(53,878)	(439,869)	(18)	6,038	(425,102)	169	0	169	(424,933)

0910-1101319

Profitability by Risk Group

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/09 LaPaz County	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC	State Only Transplants	State Only Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	0	0	0	0	0	0	0	0	0	0	25	0	25	0	0	0	25
PPC Member Months	18	236	110	93	28	485	27	61	31	282	0	24	910	0	0	0	910
Pros. Member Months	374	2,794	1,187	818	229	5,402	899	740	79	2,215	0	138	9,473	0	0	0	9,473
Total Member Months	392	3,030	1,297	911	257	5,887	926	801	110	2,497	25	162	10,408	0	0	0	10,408
Pros. & FPS Mbr. Mths	374	2,794	1,187	818	229	5,402	899	740	79	2,215	25	138	9,498	0	0	0	9,498
Pros. & PPC Mbr. Mths	392	3,030	1,297	911	257	5,887	926	801	110	2,497	0	162	10,383	0	0	0	10,383
REVENUES																	
305 Capitation	168,229	286,808	234,507	97,473	78,003	865,020	147,947	486,354	232,443	947,970	519	28,266	2,708,519	0	0	0	2,708,519
310 PPC Capitation	21,926	14,538	26,287	19,685	11,398	93,834	3,701	25,225	220,526	304,675	0	5,483	653,444	0	0	0	653,444
312 Hospital Supplement(Adj for CYE 08 and prior)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
315 Delivery Supplement	0	0	81,047	0	0	81,047	0	0	0	0	0	80,884	161,931	0	0	0	161,931
320 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
321 TWG Settlement	0	0	0	0	0	0	0	0	(2,900)	6,069	0	0	3,169	0	0	0	3,169
322 PPC Settlement	2,107	2,595	(557)	2,333	3,806	10,284	(265)	(1,493)	(38,089)	2,198	0	1,223	(26,142)	0	0	0	(26,142)
325 Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
330 Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL REVENUES	192,262	303,941	341,284	119,491	93,207	1,060,186	151,383	510,086	411,980	1,260,912	519	115,856	3,500,921	0	0	0	3,500,921
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	178,627	2,246	61,916	0	3,160	245,949	69,597	54,968	38,748	343,299	0	62,847	815,408	0	0	0	815,408
404 Hospital Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
406 PPC-Hospital Inpatient	4,808	0	18,215	0	0	23,023	1,679	0	120,731	276,490	0	0	421,923	0	0	0	421,923
Total Hospitalization	183,435	2,246	80,131	0	3,160	268,972	71,276	54,968	159,479	619,789	0	62,847	1,237,331	0	0	0	1,237,331
Medical Compensation																	
408 Primary Care Physician	30,833	29,125	15,440	5,094	2,877	83,369	2,555	9,023	717	42,648	13	3,036	141,361	0	0	0	141,361
410 Referral Physician	3,286	21,576	55,147	12,560	12,581	105,150	6,322	22,920	570	179,121	0	31,561	345,644	0	0	0	345,644
412 Other Professional	3,780	3,232	3,030	1,005	303	11,350	251	1,324	53	10,126	0	2,090	25,194	0	0	0	25,194
414 PPC - Physician Services	575	9,351	2,987	18,093	9,917	40,923	51	997	4,404	41,523	0	416	88,314	0	0	0	88,314
Total Medical Comp	38,474	63,284	76,604	36,752	25,678	240,792	9,179	34,264	5,744	273,418	13	37,103	600,513	0	0	0	600,513
Other Medical Expenses																	
416 Emergency Facility Services	5,265	18,308	13,044	5,033	2,217	43,867	190	5,925	250	29,527	0	3,451	83,210	0	0	0	83,210
418 Pharmacy	2,591	10,649	15,411	9,685	7,734	46,070	1,957	98,170	14,526	130,947	0	7,325	298,995	0	0	0	298,995
420 Lab, X-ray, & Medical Imaging	2,193	5,997	18,853	2,888	4,845	34,776	2,183	9,203	401	63,210	0	6,126	115,899	0	0	0	115,899
422 Outpatient Facility	5,466	22,813	42,295	11,678	17,783	100,035	5,416	87,006	1,512	119,746	0	6,698	320,413	0	0	0	320,413
424 Durable Medical Equipment	2,390	2,618	5,889	2,022	748	13,667	1,296	986	232	6,469	0	342	22,992	0	0	0	22,992
426 Dental	0	38,521	3,984	2,790	244	45,539	721	2,554	244	6,411	0	452	55,921	0	0	0	55,921
428 Transportation	7,291	21,114	16,020	6,832	901	52,158	2,673	4,803	0	58,719	0	2,604	120,957	0	0	0	120,957
430 Nursing Facility, Home Health Care	145	165	145	65	0	520	15,943	303	10,600	5,741	0	0	33,107	0	0	0	33,107
432 Physical Therapy	171	398	152	236	461	1,418	198	300	0	2,732	0	8	4,656	0	0	0	4,656
434 Other Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
436 Miscellaneous Medical Expenses	0	3,157	1,065	492	14	4,728	212	317	0	972	0	48	6,277	0	0	0	6,277
438 PPC-Other	236	15,716	8,575	9,980	8,525	43,032	371	368	17,178	111,995	0	2,582	175,526	0	0	0	175,526
Total Other Medical	25,748	139,456	125,433	51,701	43,472	385,810	31,160	209,935	44,943	536,469	0	29,636	1,237,953	0	0	0	1,237,953
TOTAL MEDICAL EXP	247,657	204,986	282,168	88,453	72,310	895,574	111,615	299,167	210,166	1,429,676	13	129,586	3,075,797	0	0	0	3,075,797
Less:																	
440 Reinsurance	0	0	(4,839)	0	0	(4,839)	0	0	0	(34,320)	0	0	(39,159)	0	0	0	(39,159)
441 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
442 Third Party Liability	0	0	0	0	0	0	0	0	0	(1,414)	0	0	(1,414)	0	0	0	(1,414)
TOTAL NET MEDICAL EXP	247,657	204,986	277,329	88,453	72,310	890,736	111,615	299,167	210,166	1,393,942	13	129,586	3,035,224	0	0	0	3,035,224
TOTAL ADMIN EXP	8,192	12,846	14,113	5,026	3,811	43,988	6,584	22,349	20,921	53,952	20	4,477	152,291	0	0	0	152,291
TOTAL EXPENSES	255,849	217,832	291,442	93,479	76,121	934,723	118,199	321,516	231,087	1,447,894	33	134,063	3,187,515	0	0	0	3,187,515
Inc (loss) from operations	(63,587)	86,109	49,842	26,012	17,086	115,462	33,184	188,570	180,893	(186,982)	486	(18,207)	313,406	0	0	0	313,406
Non-operating inc (loss)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Inc (loss) before taxes	(63,587)	86,109	49,842	26,012	17,086	115,462	33,184	188,570	180,893	(186,982)	486	(18,207)	313,406	0	0	0	313,406
Income taxes	(11,573)	19,541	12,674	6,179	4,100	30,921	7,729	41,993	38,718	(30,727)	99	(2,154)	86,679	0	0	0	86,679
Premium taxes	3,961	6,289	7,129	2,444	1,866	21,689	3,162	10,652	9,400	26,111	11	2,371	73,396	0	0	0	73,396
NET INCOME (LOSS)	(55,975)	60,279	30,039	17,389	11,120	62,852	22,293	135,925	132,775	(182,366)	376	(18,424)	153,431	0	0	0	153,431

0910-1101319

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/09 Maricopa County	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC	State Only Transplants	State Only Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	0	0	0	0	0	0	0	0	0	0	2,637	0	2,637	0	0	0	2,637
PPC Member Months	1,409	18,743	8,755	4,423	1,356	34,686	597	915	672	10,819	0	1,286	48,976	0	0	0	48,976
Pros. Member Months	43,581	335,999	115,553	55,866	16,185	667,184	40,402	39,637	2,688	78,328	0	8,232	736,471	0	12	12	736,483
Total Member Months	44,990	354,742	124,308	60,289	17,541	601,870	40,999	40,552	3,360	89,147	2,637	9,518	788,083	0	12	12	788,095
Pros. & FPS Mbr. Mths	43,581	335,999	115,553	55,866	16,185	667,184	40,402	39,637	2,688	78,328	2,637	8,232	739,108	0	12	12	739,120
Pros. & PPC Mbr. Mths	44,990	354,742	124,308	60,289	17,541	601,870	40,999	40,552	3,360	89,147	0	9,518	785,446	0	12	12	785,458
REVENUES																	
305 Capitation	24,341,955	37,611,174	26,878,684	7,839,271	6,421,436	103,092,520	5,757,820	28,645,362	3,821,345	47,451,380	49,597	1,991,305	190,809,329	0	480	480	190,809,809
310 PPC Capitation	1,722,298	1,241,347	2,246,925	995,715	606,931	6,813,216	79,462	389,770	5,152,235	14,303,055	0	329,367	27,067,106	0	0	0	27,067,106
312 Hospital Supplement(Adj for CYE 08 and prior)	0	0	0	0	0	0	0	0	53,040	0	0	0	53,040	0	0	0	53,040
315 Delivery Supplement	0	0	5,583,025	0	0	5,583,025	0	227,801	6,726	287,226	0	6,901,725	13,006,503	0	0	0	13,006,503
320 Reserved	1,052	2,104	(2,104)	(1,052)	0	0	0	3,156	0	5,259	0	1,052	9,467	0	0	0	9,467
321 TWG Settlement	0	0	0	0	0	0	0	0	(151,879)	(2,524,958)	0	0	(2,676,837)	0	0	0	(2,676,837)
322 PPC Settlement	(438,174)	(253,385)	(158,367)	(105,719)	(69,283)	(1,024,928)	(23,065)	15,091	(611,741)	(3,349,566)	0	113,400	(4,880,809)	0	0	0	(4,880,809)
325 Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
330 Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0	(52,896)	0	(52,896)	(52,896)
TOTAL REVENUES	25,627,131	38,601,240	34,548,163	8,728,215	6,959,084	114,463,833	5,814,217	29,281,180	8,269,726	56,172,396	49,597	9,336,849	223,387,798	(52,896)	480	(52,416)	223,335,382
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	12,203,127	3,424,480	7,264,787	1,181,074	1,393,351	25,466,819	1,172,625	9,500,176	1,302,933	12,735,306	0	4,710,885	54,888,744	0	40,144	40,144	54,928,888
404 Hospital Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
406 PPC-Hospital Inpatient	922,954	213,412	791,323	212,781	151,253	2,291,723	105,284	404,570	2,879,759	5,060,873	0	206,465	10,948,674	0	0	0	10,948,674
Total Hospitalization	13,126,081	3,637,892	8,056,110	1,393,855	1,544,604	27,758,542	1,277,909	9,904,746	4,182,692	17,796,179	0	4,917,350	65,837,418	0	40,144	40,144	65,877,562
Medical Compensation																	
408 Primary Care Physician	2,725,327	5,196,540	2,402,970	592,568	379,392	11,296,797	292,812	1,212,229	94,874	2,151,424	10,232	215,857	15,274,225	0	42	42	15,274,267
410 Referral Physician	2,612,762	3,902,835	5,394,547	1,139,852	1,092,306	14,142,302	845,440	4,352,334	367,399	6,722,170	2,757	2,123,091	28,555,493	0	0	0	28,555,493
412 Other Professional	183,170	727,153	747,536	198,648	79,080	1,935,587	148,827	443,454	45,854	997,550	0	217,611	3,788,883	0	0	0	3,788,883
414 PPC - Physician Services	120,075	160,120	203,564	80,360	45,786	609,905	10,597	35,706	694,925	1,226,840	0	101,485	2,679,458	0	0	0	2,679,458
Total Medical Comp	5,641,334	9,986,648	8,748,617	2,011,428	1,596,564	27,984,591	1,297,676	6,043,723	1,203,052	11,097,984	12,989	2,658,044	50,298,059	0	42	42	50,298,101
Other Medical Expenses																	
416 Emergency Facility Services	863,896	2,866,556	1,850,897	507,525	159,617	6,248,491	29,707	844,468	54,915	1,661,734	274	128,530	8,968,119	0	0	0	8,968,119
418 Pharmacy	330,811	2,771,790	2,772,660	1,042,911	965,882	7,884,054	87,265	5,307,842	178,951	5,228,993	10,745	162,170	18,860,020	(88)	477	389	18,860,409
420 Lab, X-ray, & Medical Imaging	288,525	920,083	2,420,180	430,279	519,824	4,578,891	370,649	1,425,744	209,742	2,810,374	879	596,472	9,992,751	0	13	13	9,992,764
422 Outpatient Facility	925,810	3,892,145	3,477,501	848,416	666,655	9,810,527	401,115	2,108,471	210,145	4,097,395	11,956	457,078	17,096,687	0	0	0	17,096,687
424 Durable Medical Equipment	119,927	516,638	342,651	134,784	93,057	1,207,057	83,415	510,483	31,202	513,763	3	37,967	2,383,890	0	14	14	2,383,904
426 Dental	3,977	7,975,215	1,110,122	753,014	28,314	9,870,642	74,728	270,107	23,504	384,906	0	40,800	10,664,687	0	0	0	10,664,687
428 Transportation	322,013	1,021,843	768,911	255,289	97,362	2,465,418	181,893	889,209	47,798	1,212,305	4	97,559	4,894,186	0	24	24	4,894,210
430 Nursing Facility, Home Health Care	138,433	80,291	157,067	8,992	44,981	429,764	229,052	1,059,280	162,095	1,523,668	0	21,588	3,425,467	0	0	0	3,425,467
432 Physical Therapy	161,926	147,815	242,841	88,755	84,378	725,716	30,736	136,649	15,045	432,944	0	2,131	1,343,220	0	0	0	1,343,220
434 Other Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
436 Miscellaneous Medical Expenses	12,249	418,842	124,832	61,296	55,863	673,082	342,345	277,847	20,134	205,769	0	5,042	1,524,219	0	0	0	1,524,219
438 PPC-Other	68,127	327,812	473,026	160,781	65,345	1,095,091	21,001	77,075	512,646	1,583,963	0	150,296	3,440,072	0	0	0	3,440,072
Total Other Medical	3,235,694	20,939,030	13,740,688	4,292,042	2,781,278	44,988,732	1,851,906	12,907,175	1,466,177	19,655,834	23,861	1,699,633	82,593,318	(88)	528	440	82,593,758
TOTAL MEDICAL EXP	22,003,109	34,563,570	30,545,415	7,697,325	5,922,446	100,731,865	4,427,491	28,855,644	6,851,921	48,549,997	36,850	9,275,027	198,728,795	(88)	40,714	40,626	198,769,421
Less:																	
440 Reinsurance	(1,249,011)	(487,767)	(1,025,507)	(461,068)	(53,763)	(3,277,116)	0	(3,272,174)	(335,902)	(2,194,587)	0	(29,510)	(9,109,289)	0	0	0	(9,109,289)
441 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
442 Third Party Liability	(95)	(52,341)	(198,204)	(99,339)	(39,487)	(389,466)	(10,329)	(58,589)	(29,634)	(266,368)	(1,704)	(6,024)	(762,114)	0	0	0	(762,114)
TOTAL NET MEDICAL EXP	20,754,003	34,023,462	29,321,704	7,136,918	5,829,196	97,065,283	4,417,162	25,524,881	6,486,385	46,089,042	35,146	9,239,493	188,857,392	(88)	40,714	40,626	188,898,018
TOTAL ADMIN EXP	1,134,792	1,679,108	1,494,866	376,388	298,861	4,984,015	256,323	1,267,146	356,090	2,591,943	2,192	405,349	9,863,058	0	21	21	9,863,079
TOTAL EXPENSES	21,888,795	35,702,570	30,816,570	7,513,306	6,128,057	102,049,298	4,673,485	26,792,027	6,842,475	48,680,985	37,338	9,644,842	198,720,450	(88)	40,735	40,647	198,761,097
Inc (loss) from operations	3,738,336	2,898,670	3,731,593	1,214,909	831,027	12,414,535	1,140,732	2,489,153	1,427,251	7,491,411	12,259	(307,993)	24,667,348	(52,808)	(40,255)	(93,063)	24,574,285
Non-operating inc (loss)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Inc (loss) before taxes	3,738,336	2,898,670	3,731,593	1,214,909	831,027	12,414,535	1,140,732	2,489,153	1,427,251	7,491,411	12,259	(307,993)	24,667,348	(52,808)	(40,255)	(93,063)	24,574,285
Income taxes	960,666	890,787	1,046,045	315,853	220,212	3,433,563	264,426	732,904	375,143	1,997,695	2,832	14,630	6,821,193	(11,587)	(7,669)	(19,256)	6,801,937
Premium taxes	543,242	810,993	724,501	184,417	146,757	2,409,910	121,850	610,441	189,058	1,297,242	1,033	192,766	4,822,300	0	0	0	4,822,300
NET INCOME (LOSS)	2,234,428	1,196,890	1,961,047	714,639	464,058	6,571,062	754,456	1,145,808	863,050	4,196,474	8,394	(515,389)	13,023,856	(41,221)	(32,586)	(73,807)	12,950,048

0910-1101319

Profitability by Risk Group

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/09 Mohave County	TANF <1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC	State Only Transplants	State Only Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	0	0	0	0	0	0	0	0	0	0	1,405	0	1,405	0	0	0	1,405
PPC Member Months	464	6,211	3,772	2,340	645	13,432	291	492	865	6,469	0	562	22,111	0	1	1	22,112
Pros. Member Months	15,495	119,180	63,198	35,702	13,015	246,590	24,003	19,322	3,307	68,904	0	5,558	367,684	0	4	4	367,688
Total Member Months	15,959	125,391	66,970	38,042	13,660	260,022	24,294	19,814	4,172	75,373	1,405	6,120	391,200	0	5	5	391,205
Pros. & FPS Mbr. Mths	15,495	119,180	63,198	35,702	13,015	246,590	24,003	19,322	3,307	68,904	1,405	5,558	369,089	0	4	4	369,093
Pros. & PPC Mbr. Mths	15,959	125,391	66,970	38,042	13,660	260,022	24,294	19,814	4,172	75,373	0	6,120	389,795	0	5	5	389,800
REVENUES																	
305 Capitation	7,333,801	13,431,976	17,538,316	5,723,806	5,503,354	49,631,253	3,999,988	15,438,583	4,763,367	41,027,142	26,951	1,515,920	116,303,204	0	200	200	116,303,404
310 PPC Capitation	555,065	386,906	1,001,332	504,903	284,437	2,732,643	40,086	199,901	6,420,737	7,311,963	0	149,257	16,854,587	0	0	0	16,854,587
312 Hospital Supplement (Adj for CYE 08 and prior)	0	0	0	0	0	0	0	0	157,347	0	0	0	157,347	0	0	0	157,347
315 Delivery Supplement	0	0	2,773,512	0	0	2,773,512	0	169,680	0	131,900	0	4,202,585	7,277,677	0	0	0	7,277,677
320 Reserved	0	0	0	0	0	0	(1,052)	0	0	0	0	0	(1,052)	0	0	0	(1,052)
321 TWG Settlement	0	0	0	0	0	0	0	0	(723)	(88,484)	0	0	(89,207)	0	0	0	(89,207)
322 PPC Settlement	(116,177)	14,901	(8,962)	83,750	162,689	136,201	(21,203)	113,093	(494,767)	(1,157,910)	0	(20,092)	(1,444,678)	0	0	0	(1,444,678)
325 Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
330 Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0	(29,140)	0	(29,140)	(29,140)
TOTAL REVENUES	7,772,689	13,833,783	21,304,198	6,312,459	5,950,480	65,173,609	4,017,819	15,921,257	10,845,961	47,224,611	26,951	5,847,670	139,057,878	(29,140)	200	(28,940)	139,028,938
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	5,352,310	838,761	4,319,192	1,470,102	987,895	12,968,260	941,017	5,609,070	1,946,141	9,464,451	0	2,520,049	33,448,988	0	0	0	33,448,988
404 Hospital Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
406 PPC-Hospital Inpatient	205,550	128,459	303,523	74,473	106,597	818,602	8,526	603,383	2,982,153	2,985,443	0	24,659	7,422,766	0	0	0	7,422,766
Total Hospitalization	5,557,860	967,220	4,622,715	1,544,575	1,094,492	13,786,862	949,543	6,212,453	4,928,294	12,449,894	0	2,544,708	40,871,764	0	0	0	40,871,764
Medical Compensation																	
408 Primary Care Physician	1,101,110	2,335,977	1,709,356	515,872	375,013	6,037,328	205,584	765,526	160,351	2,262,544	7,781	114,631	9,663,746	0	0	0	9,663,746
410 Referral Physician	402,269	1,509,553	3,863,397	1,027,682	1,061,946	7,864,847	564,913	2,747,599	564,660	6,638,874	1,909	1,275,265	19,658,087	0	0	0	19,658,087
412 Other Professional	462,732	226,143	212,287	82,211	25,608	1,008,981	22,421	158,736	52,671	375,305	0	84,461	1,702,676	0	0	0	1,702,676
414 PPC - Physician Services	41,596	56,219	121,341	37,287	19,507	275,950	3,268	21,380	440,795	415,542	0	25,559	1,182,494	0	0	0	1,182,494
Total Medical Comp	2,007,707	4,127,892	5,906,381	1,663,052	1,482,074	15,187,106	796,186	3,693,241	1,218,497	9,692,265	9,690	1,499,916	32,096,901	0	0	0	32,096,901
Other Medical Expenses																	
416 Emergency Facility Services	305,361	999,479	1,417,109	500,785	178,332	3,401,066	33,159	592,792	93,022	1,572,717	81	107,011	5,799,848	0	0	0	5,799,848
418 Pharmacy	152,497	937,898	2,127,287	759,011	911,031	4,887,724	90,191	3,155,677	308,252	5,291,449	3,035	119,577	13,855,905	(20)	514	494	13,856,399
420 Lab, X-ray, & Medical Imaging	94,102	346,156	1,812,902	378,949	434,114	3,066,225	148,563	975,832	183,712	2,887,330	759	505,893	7,768,314	0	(2)	(2)	7,768,312
422 Outpatient Facility	276,580	1,594,518	3,525,554	946,249	1,029,200	7,372,101	380,898	2,195,861	639,298	6,482,423	763	357,940	17,429,284	0	0	0	17,429,284
424 Durable Medical Equipment	30,172	186,716	196,466	90,203	56,891	560,448	26,926	208,022	37,783	395,019	0	16,760	1,244,958	0	3	3	1,244,961
426 Dental	3,235	3,688,644	950,921	648,214	41,994	5,333,008	63,770	210,067	48,463	604,159	0	46,969	6,306,436	0	0	0	6,306,436
428 Transportation	485,101	934,739	920,482	352,824	168,063	2,861,209	247,422	841,103	181,754	1,516,415	262	203,637	5,851,802	0	13	13	5,851,815
430 Nursing Facility, Home Health Care	39,813	8,003	85,125	17,328	10,287	160,556	92,190	435,418	156,207	517,091	0	10,379	1,371,841	0	0	0	1,371,841
432 Physical Therapy	22,677	64,111	103,684	60,119	68,473	319,064	11,664	106,924	23,154	294,110	0	1,261	756,177	0	0	0	756,177
434 Other Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
436 Miscellaneous Medical Expenses	1,916	198,205	78,676	43,204	15,057	337,058	121,795	107,260	18,109	95,689	0	4,391	684,302	0	0	0	684,302
438 PPC-Other	43,853	175,349	285,585	147,999	53,253	706,039	10,237	35,292	711,194	1,045,499	0	95,876	2,604,137	0	0	0	2,604,137
Total Other Medical	1,455,307	9,133,820	11,503,791	3,944,885	2,966,695	29,004,498	1,226,815	8,864,248	2,400,948	20,701,901	4,900	1,469,694	63,673,004	(20)	528	508	63,673,512
TOTAL MEDICAL EXP	9,020,874	14,228,932	22,032,887	7,152,512	5,543,261	57,978,466	2,972,544	18,769,942	8,547,739	42,844,060	14,590	5,514,318	136,641,669	(20)	528	508	136,642,167
Less:																	
440 Reinsurance	(549,270)	(66,651)	(598,015)	(98,140)	(2,250)	(1,314,326)	(3,935)	(1,381,123)	(196,857)	(1,673,638)	0	(33,033)	(4,602,912)	0	0	0	(4,602,912)
441 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
442 Third Party Liability	(1,173)	(12,230)	(11,060)	(12,211)	(8,111)	(44,785)	(2,763)	(12,286)	(5,415)	(66,249)	0	(622)	(132,120)	0	0	0	(132,120)
TOTAL NET MEDICAL EXP	8,470,431	14,150,051	21,423,812	7,042,161	5,532,900	56,619,355	2,965,846	17,376,533	8,345,467	41,104,173	14,590	5,480,663	131,906,627	(20)	528	508	131,907,135
TOTAL ADMIN EXP	341,358	592,722	915,917	265,779	247,847	2,363,623	174,495	682,713	481,066	2,059,078	1,186	256,239	6,018,400	0	7	7	6,018,407
TOTAL EXPENSES	8,811,789	14,742,773	22,339,729	7,307,940	5,780,747	58,982,978	3,140,341	18,059,246	8,826,533	43,163,251	15,776	5,736,902	137,925,027	(20)	535	515	137,925,542
Inc (loss) from operations	(1,039,100)	(908,990)	(1,035,531)	(995,481)	169,733	(3,809,369)	877,478	(2,137,989)	2,019,428	4,061,360	11,175	110,768	1,132,851	(29,120)	(335)	(29,455)	1,103,396
Non-operating inc (loss)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Inc (loss) before taxes	(1,039,100)	(908,990)	(1,035,531)	(995,481)	169,733	(3,809,369)	877,478	(2,137,989)	2,019,428	4,061,360	11,175	110,768	1,132,851	(29,120)	(335)	(29,455)	1,103,396
Income taxes	(141,205)	(68,906)	(25,256)	(149,397)	89,045	(295,719)	203,566	(290,270)	488,309	1,162,817	2,493	73,520	1,344,716	(6,429)	(56)	(6,485)	1,338,231
Premium taxes	164,520	288,275	444,597	129,931	120,767	1,148,090	84,241	329,782	236,708	1,011,264	562	122,490	2,933,137	0	0	0	2,933,137
NET INCOME (LOSS)	(1,062,415)	(1,128,359)	(1,454,872)	(976,015)	(40,079)	(4,661,740)	589,671	(2,177,501)	1,294,411	1,887,279	8,120	(85,242)	(3,146,002)	(22,591)	(279)	(22,870)	(3,167,872)

0910-1101319

Profitability by Risk Group

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/09 Navajo County	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC	State Only Transplants	State Only Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	0	0	0	0	0	0	0	0	0	0	673	0	673	0	0	0	673
PPC Member Months	124	2,076	1,155	771	197	4,323	68	114	200	1,518	0	225	6,448	0	0	0	6,448
Pros. Member Months	5,857	42,949	21,853	12,861	4,127	87,647	6,667	5,988	911	16,914	0	2,275	120,402	0	0	0	120,402
Total Member Months	5,981	45,025	23,008	13,632	4,324	91,970	6,735	6,102	1,111	18,432	673	2,500	127,523	0	0	0	127,523
Pros. & FPS Mbr. Mths	5,857	42,949	21,853	12,861	4,127	87,647	6,667	5,988	911	16,914	673	2,275	121,075	0	0	0	121,075
Pros. & PPC Mbr. Mths	5,981	45,025	23,008	13,632	4,324	91,970	6,735	6,102	1,111	18,432	0	2,500	126,850	0	0	0	126,850
REVENUES																	
305 Capitation	2,772,890	4,840,120	6,066,332	2,062,444	1,744,849	17,486,635	1,111,054	4,785,711	1,310,972	10,071,993	12,899	620,960	35,400,224	0	0	0	35,400,224
310 PPC Capitation	149,184	129,396	306,705	166,156	87,029	838,470	9,011	46,203	1,482,050	1,714,876	0	59,958	4,150,570	0	0	0	4,150,570
312 Hospital Supplement(Adj for CYE 08 and prior)	0	0	0	0	0	0	0	0	48,414	0	0	0	48,414	0	0	0	48,414
315 Delivery Supplement	0	0	966,225	0	0	966,225	0	25,296	0	31,538	0	1,774,979	2,800,038	0	0	0	2,800,038
320 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
321 TWG Settlement	0	0	0	0	0	0	0	0	64,269	83,923	0	0	148,192	0	0	0	148,192
322 PPC Settlement	5,627	(6,531)	(74,253)	(60,388)	(1,001)	(136,546)	(2,938)	(5,883)	(623,640)	(801,961)	0	13,251	(1,567,717)	0	0	0	(1,567,717)
325 Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
330 Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0	(7,555)	0	(7,565)	(7,565)
TOTAL REVENUES	2,927,701	4,962,985	7,267,009	2,168,212	1,830,877	19,156,784	1,117,127	4,851,327	2,282,065	11,100,371	12,899	2,469,148	40,989,721	(7,555)	0	(7,565)	40,982,166
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	1,628,127	567,007	1,077,011	341,829	149,909	3,763,883	(64,202)	864,823	691,014	1,695,935	0	1,025,633	7,977,086	0	0	0	7,977,086
404 Hospital Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
406 PPC-Hospital Inpatient	64,705	2,326	53,226	33,640	12,727	166,624	91,805	1,761	350,313	485,188	0	43,245	1,138,956	0	0	0	1,138,956
Total Hospitalization	1,692,832	569,333	1,130,237	375,469	162,636	3,930,507	27,603	866,604	1,041,327	2,181,123	0	1,068,878	9,116,042	0	0	0	9,116,042
Medical Compensation																	
408 Primary Care Physician	465,444	679,832	587,286	164,942	131,640	2,029,144	50,242	242,892	38,356	557,170	3,337	68,748	2,989,889	0	0	0	2,989,889
410 Referral Physician	334,094	625,654	1,098,740	299,332	385,603	2,743,423	133,812	562,756	104,183	1,381,520	95	628,923	5,554,714	0	0	0	5,554,714
412 Other Professional	104,709	147,310	183,999	83,308	10,108	529,434	7,816	246,761	10,258	168,678	0	48,987	1,011,934	0	0	0	1,011,934
414 PPC - Physician Services	9,983	26,853	36,580	12,891	12,239	98,546	1,765	5,699	97,061	135,607	0	16,049	354,727	0	0	0	354,727
Total Medical Comp	914,230	1,479,649	1,906,605	560,473	539,590	5,400,547	193,635	1,058,110	249,858	2,242,975	3,432	762,707	9,911,264	0	0	0	9,911,264
Other Medical Expenses																	
416 Emergency Facility Services	89,343	315,218	326,545	126,867	47,601	905,574	3,561	133,158	20,931	322,461	81	29,882	1,415,648	0	0	0	1,415,648
418 Pharmacy	32,135	298,377	603,018	217,766	280,444	1,431,740	18,475	749,191	65,002	1,186,740	3,018	33,442	3,487,608	(21)	0	(21)	3,487,587
420 Lab, X-ray, & Medical Imaging	42,845	114,283	480,001	98,904	143,754	879,787	39,640	217,383	44,097	592,891	1	134,150	1,907,949	0	0	0	1,907,949
422 Outpatient Facility	104,551	462,257	1,326,214	310,136	555,512	2,758,670	114,607	697,576	221,343	1,583,999	(77)	133,020	5,509,138	0	0	0	5,509,138
424 Durable Medical Equipment	20,697	69,674	94,605	33,149	20,013	238,138	15,039	114,094	6,702	115,099	6	20,692	509,770	0	1	1	509,771
426 Dental	741	1,134,341	222,971	154,790	13,030	1,525,873	19,805	51,555	6,887	100,794	0	21,117	1,726,031	0	0	0	1,726,031
428 Transportation	268,316	328,666	277,923	149,669	43,069	1,067,843	73,766	283,358	40,747	551,234	0	102,897	2,119,645	0	4	4	2,119,649
430 Nursing Facility, Home Health Care	5,274	7,048	17,735	3,413	1,216	34,686	14,816	83,384	10,507	198,093	0	1,551	343,037	0	0	0	343,037
432 Physical Therapy	20,304	20,076	67,814	24,964	20,885	154,043	5,227	27,976	12,024	121,281	0	2,653	323,204	0	0	0	323,204
434 Other Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
436 Miscellaneous Medical Expenses	1,712	121,244	42,560	31,588	2,239	199,343	10,152	26,987	3,409	17,449	0	3,599	260,939	0	0	0	260,939
438 PPC-Other	24,288	50,798	129,285	44,434	24,000	272,805	955	11,442	177,711	276,412	0	41,975	781,300	0	5	6	781,305
Total Other Medical	610,206	2,921,982	3,588,671	1,195,680	1,151,763	9,468,302	316,043	2,396,104	609,360	5,066,453	3,029	524,978	18,384,269	(21)	10	(11)	18,384,258
TOTAL MEDICAL EXP	3,217,268	4,970,964	6,625,513	2,131,622	1,853,989	18,799,356	537,281	4,320,818	1,900,545	9,490,551	6,461	2,356,563	37,411,575	(21)	10	(11)	37,411,564
Less:																	
440 Reinsurance	(58,767)	(96,427)	(148,933)	(126,552)	(1,061)	(431,740)	0	(163,074)	(18,425)	(444,306)	0	(40,268)	(1,097,813)	0	0	0	(1,097,813)
441 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
442 Third Party Liability	0	0	(5,403)	(7,061)	(3,847)	(16,311)	(1,173)	(35,996)	(31,501)	(9,391)	0	(3,811)	(98,183)	0	0	0	(98,183)
TOTAL NET MEDICAL EXP	3,158,501	4,874,537	6,471,177	1,998,009	1,849,081	18,351,305	536,108	4,121,748	1,850,619	9,036,854	6,461	2,312,484	36,215,579	(21)	10	(11)	36,215,568
TOTAL ADMIN EXP	126,619	213,377	314,976	95,503	78,653	829,128	48,595	210,674	120,541	503,461	563	108,608	1,821,570	0	0	0	1,821,570
TOTAL EXPENSES	3,285,120	5,087,914	6,786,153	2,093,512	1,927,734	19,180,433	584,703	4,332,422	1,971,160	9,540,315	7,024	2,421,092	38,037,149	(21)	10	(11)	38,037,138
Inc (loss) from operations	(357,419)	(124,929)	480,856	74,700	(96,857)	(23,649)	532,424	518,905	310,905	1,560,056	5,875	48,056	2,952,572	(7,534)	(10)	(7,544)	2,945,028
Non-operating inc (loss)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Inc (loss) before taxes	(357,419)	(124,929)	480,856	74,700	(96,857)	(23,649)	532,424	518,905	310,905	1,560,056	5,875	48,056	2,952,572	(7,534)	(10)	(7,544)	2,945,028
Income taxes	(50,423)	16,254	159,655	33,320	(1,838)	156,968	114,181	140,758	93,462	417,139	1,291	29,373	953,172	(1,657)	(2)	(1,659)	951,513
Premium taxes	60,924	103,658	153,104	46,490	38,207	402,383	23,360	101,302	59,456	246,693	269	51,010	884,473	0	0	0	884,473
NET INCOME (LOSS)	(367,920)	(244,841)	168,097	(5,110)	(133,226)	(583,000)	394,883	276,845	157,987	896,224	4,315	(32,327)	1,114,927	(5,877)	(8)	(5,886)	1,109,042

0910-1101319

Profitability by Risk Group

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/09 Pima County	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC	State Only Transplants	State Only Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	0	0	0	0	0	0	0	0	0	0	2,020	0	2,020	0	0	0	2,020
PPC Member Months	742	9,129	5,111	2,473	698	18,163	374	475	387	7,721	0	1,203	28,313	0	0	0	28,313
Pros. Member Months	26,012	178,849	86,634	38,323	10,970	340,788	22,710	20,361	1,492	63,042	0	9,217	457,610	0	3	3	457,613
Total Member Months	26,754	187,978	91,745	40,796	11,668	358,941	23,084	20,836	1,879	70,763	2,020	10,420	487,943	0	3	3	487,946
Pros. & FPS Mbr. Mths	26,012	178,849	86,634	38,323	10,970	340,788	22,710	20,361	1,492	63,042	2,020	9,217	459,630	0	3	3	459,633
Pros. & PPC Mbr. Mths	26,754	187,978	91,745	40,796	11,668	358,941	23,084	20,836	1,879	70,763	0	10,420	485,923	0	3	3	485,926
REVENUES																	
305 Capitation	11,367,871	18,216,286	20,185,261	4,932,678	4,403,720	59,105,816	3,251,508	14,497,970	1,994,262	30,702,034	42,525	2,143,378	111,737,493	0	120	120	111,737,613
310 PPC Capitation	888,658	515,419	1,270,401	488,143	307,741	3,470,362	49,750	194,036	2,873,188	6,871,410	0	298,863	13,757,609	0	0	0	13,757,609
312 Hospital Supplement (Adj for CYE 08 and prior)	0	0	0	0	0	0	0	0	55,789	0	0	0	55,789	0	0	0	55,789
315 Delivery Supplement	0	0	4,586,271	0	0	4,586,271	6,604	157,897	0	124,544	0	7,404,399	12,279,715	0	0	0	12,279,715
320 Reserved	0	(1,052)	1,052	0	0	0	(7,363)	7,363	(12,622)	15,778	0	0	3,156	0	0	0	3,156
321 TWG Settlement	0	0	0	0	0	0	0	0	(233,044)	(822,147)	0	0	(1,055,191)	0	0	0	(1,055,191)
322 PPC Settlement	(180,989)	(19,433)	(482,609)	(204,572)	(55,323)	(942,926)	(22,020)	(5,578)	(662,295)	(2,413,486)	0	76,720	(3,969,585)	0	0	0	(3,969,585)
325 Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
330 Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0	(22,489)	0	(22,489)	(22,489)
TOTAL REVENUES	12,075,540	18,711,220	25,560,376	5,216,249	4,656,138	66,219,523	3,278,479	14,851,688	4,015,278	34,478,133	42,525	9,923,360	132,808,986	(22,489)	120	(22,369)	132,786,617
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	7,885,637	1,178,976	4,835,187	630,931	1,113,926	15,644,657	783,708	3,615,237	1,094,464	6,088,728	0	4,392,653	31,619,447	0	0	0	31,619,447
404 Hospital Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
406 PPC-Hospital Inpatient	783,534	163,786	284,565	105,898	100,735	1,438,518	65,378	394,520	1,071,467	2,193,742	0	90,139	5,253,764	0	0	0	5,253,764
Total Hospitalization	8,669,171	1,342,762	5,119,752	736,829	1,214,661	17,083,175	849,086	4,009,757	2,165,931	8,282,470	0	4,482,792	36,873,211	0	0	0	36,873,211
Medical Compensation																	
408 Primary Care Physician	1,820,378	2,387,127	1,597,358	329,900	179,523	6,314,286	150,200	632,174	38,106	1,366,020	15,331	260,733	8,776,850	0	0	0	8,776,850
410 Referral Physician	1,454,800	1,714,571	3,878,401	591,648	702,672	8,342,092	423,819	2,099,759	296,642	3,969,460	2,119	2,661,674	17,795,565	0	0	0	17,795,565
412 Other Professional	196,116	648,778	671,717	144,530	76,475	1,737,616	28,082	135,261	17,283	359,622	935	180,538	2,459,337	0	0	0	2,459,337
414 PPC - Physician Services	72,826	109,653	148,281	39,295	23,659	393,714	4,998	15,180	272,619	521,361	0	92,488	1,300,360	0	0	0	1,300,360
Total Medical Comp	3,544,120	4,860,129	6,295,757	1,105,373	982,329	16,787,708	607,099	2,882,374	624,650	6,216,463	18,385	3,195,433	30,332,112	0	0	0	30,332,112
Other Medical Expenses																	
416 Emergency Facility Services	311,763	980,731	1,136,926	279,148	79,249	2,787,817	12,427	449,177	19,927	1,228,053	489	110,533	4,608,423	0	0	0	4,608,423
418 Pharmacy	189,201	1,240,186	2,204,689	564,545	614,017	4,812,638	60,410	2,567,350	75,480	3,785,467	9,493	157,618	11,468,456	(33)	(50)	(83)	11,468,373
420 Lab, X-ray, & Medical Imaging	182,503	450,263	2,059,125	291,517	345,357	3,328,765	184,849	782,535	84,691	1,871,870	357	907,616	7,160,683	0	2	2	7,160,685
422 Outpatient Facility	665,720	1,202,668	2,769,653	618,881	772,685	6,029,607	199,881	1,303,288	237,785	2,962,541	1,159	686,390	11,420,651	0	0	0	11,420,651
424 Durable Medical Equipment	63,319	264,648	244,064	87,585	45,884	705,500	45,166	228,333	18,964	306,306	18	45,917	1,350,204	0	3	3	1,350,207
426 Dental	5,120	3,414,639	493,554	291,569	15,049	4,219,931	34,065	106,480	10,853	230,746	0	25,073	4,627,148	0	0	0	4,627,148
428 Transportation	181,887	566,039	618,796	176,428	75,208	1,618,358	122,443	598,636	25,950	1,145,720	0	109,753	3,620,860	0	4	4	3,620,864
430 Nursing Facility, Home Health Care	52,673	20,521	69,086	17,245	29,106	188,631	89,204	482,045	81,153	579,233	0	46,749	1,467,015	0	0	0	1,467,015
432 Physical Therapy	12,116	55,477	79,319	29,937	26,115	202,964	7,389	36,748	2,502	147,147	0	2,315	399,065	0	0	0	399,065
434 Other Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
436 Miscellaneous Medical Expenses	9,851	245,912	94,668	54,732	29,549	434,712	119,019	280,836	2,558	146,203	0	5,339	988,667	0	0	0	988,667
438 PPC-Other	24,638	127,423	253,040	67,141	41,633	513,875	4,877	15,440	272,081	908,195	0	163,209	1,877,677	0	0	0	1,877,677
Total Other Medical	1,698,791	8,568,507	10,022,920	2,478,728	2,073,852	24,842,798	879,730	6,850,868	831,944	13,311,481	11,516	2,260,512	48,988,849	(33)	(41)	(74)	48,988,775
TOTAL MEDICAL EXP	13,912,082	14,771,398	21,438,428	4,320,930	4,270,842	58,713,681	2,335,915	13,742,999	3,622,525	27,810,414	29,901	9,938,737	116,194,172	(33)	(41)	(74)	116,194,098
Less:																	
440 Reinsurance	(294,246)	(73,997)	(1,081,270)	(61,923)	(302,458)	(1,813,894)	(16,577)	(1,188,154)	3,824	(1,244,075)	0	0	(4,258,876)	0	0	0	(4,258,876)
441 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
442 Third Party Liability	(2,777)	(23,826)	(71,489)	(25,994)	(34,003)	(158,089)	(2,031)	(79,626)	(9,562)	(127,114)	0	(9,496)	(385,918)	0	0	0	(385,918)
TOTAL NET MEDICAL EXP	13,615,059	14,673,575	20,285,670	4,233,013	3,934,381	56,741,698	2,317,307	12,475,219	3,616,787	26,439,225	29,901	9,929,241	111,549,378	(33)	(41)	(74)	111,549,304
TOTAL ADMIN EXP	530,351	807,209	1,126,227	232,877	202,266	2,898,930	144,616	644,817	200,988	1,596,862	1,814	428,505	6,916,532	0	4	4	6,916,536
TOTAL EXPENSES	14,145,410	15,480,784	21,411,897	4,465,890	4,136,647	59,640,628	2,461,923	13,120,036	3,817,775	28,036,087	31,715	10,357,746	117,465,910	(33)	(37)	(70)	117,465,840
Inc (loss) from operations	(2,069,870)	3,230,436	4,148,479	750,359	519,491	6,578,896	816,556	1,731,652	197,503	6,442,046	10,810	(434,386)	15,343,076	(22,456)	157	(22,299)	15,320,777
Non-operating inc (loss)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Inc (loss) before taxes	(2,069,870)	3,230,436	4,148,479	750,359	519,491	6,578,896	816,556	1,731,652	197,503	6,442,046	10,810	(434,386)	15,343,076	(22,456)	157	(22,299)	15,320,777
Income taxes	(309,030)	793,027	1,048,283	195,163	144,992	1,872,435	185,712	485,822	92,528	1,609,824	2,540	(4,002)	4,244,869	(4,808)	29	(4,779)	4,240,080
Premium taxes	255,693	390,875	543,571	113,175	98,354	1,401,668	68,895	309,931	102,563	788,383	888	205,298	2,877,626	0	0	0	2,877,626
NET INCOME (LOSS)	(2,016,533)	2,046,534	2,556,625	442,021	276,145	3,304,792	561,949	935,899	2,412	4,043,839	7,382	(635,682)	8,220,591	(17,648)	128	(17,520)	8,203,071

0910-1101319

Profitability by Risk Group

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/09 Pinal County	TANF <1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC	State Only Transplants	State Only Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	0	0	0	0	0	0	0	0	0	0	(6)	0	(6)	0	0	0	(6)
PPC Member Months	1	10	9	5	0	26	0	0	0	6	0	0	31	0	0	0	31
Pros. Member Months	(2)	(1)	0	0	0	(3)	(1)	0	0	(1)	0	0	(5)	0	0	0	(5)
Total Member Months	(1)	9	9	5	0	22	(1)	0	0	5	(6)	0	20	0	0	0	20
Pros. & FPS Mbr. Mths	(2)	(1)	0	0	0	(3)	(1)	0	0	(1)	(6)	0	(11)	0	0	0	(11)
Pros. & PPC Mbr. Mths	(1)	9	9	5	0	22	(1)	0	0	5	0	0	26	0	0	0	26
REVENUES																	
305 Capitation	(1,065)	(731)	(325)	(52)	(179)	(2,352)	(219)	0	0	(546)	(119)	0	(3,236)	0	0	0	(3,236)
310 PPC Capitation	741	555	1,942	930	0	4,168	0	0	0	5,113	0	0	9,281	0	0	0	9,281
312 Hospital Supplement(Adj for CYE 08 and prior)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
315 Delivery Supplement	0	0	0	0	0	0	0	0	0	0	0	6,542	6,542	0	0	0	6,542
320 Reserved	0	0	0	0	0	0	0	(1,052)	0	0	0	0	(1,052)	0	0	0	(1,052)
321 TWG Settlement	0	0	0	0	0	0	0	0	(172,996)	(996,434)	0	0	(1,169,430)	0	0	0	(1,169,430)
322 PPC Settlement	(28,266)	23,937	(2,934)	36,032	(2,609)	26,160	(1,403)	(42,630)	(131,591)	(129,442)	0	23,551	(256,356)	0	0	0	(256,355)
325 Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
330 Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0	(48,916)	0	(48,916)	(48,916)
TOTAL REVENUES	(28,590)	23,761	(1,317)	36,910	(2,788)	27,976	(1,622)	(43,682)	(304,587)	(1,121,309)	(119)	30,093	(1,413,250)	(48,916)	0	(48,916)	(1,462,166)
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
404 Hospital Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
406 PPC-Hospital Inpatient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Hospitalization	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical Compensation																	
408 Primary Care Physician	242	47	(54)	(46)	(16)	173	(6)	(147)	(21)	1	4	(2)	2	0	0	0	2
410 Referral Physician	32	0	(138)	0	(7)	(113)	0	(95)	0	6	0	0	(202)	0	0	0	(202)
412 Other Professional	(26)	0	(25)	0	(1)	(52)	(3)	(12)	0	(8)	0	0	(75)	0	0	0	(75)
414 PPC - Physician Services	20	12	23	21	0	76	0	0	0	71	0	0	147	0	0	0	147
Total Medical Comp	268	59	(194)	(25)	(24)	84	(9)	(254)	(21)	70	4	(2)	(128)	0	0	0	(128)
Other Medical Expenses																	
416 Emergency Facility Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
418 Pharmacy	(1,112)	(1,168)	3,669	(5,723)	(658)	(4,992)	(504)	(1,777)	(510)	(2,256)	57	(2,564)	(12,546)	(17)	0	(17)	(12,563)
420 Lab, X-ray, & Medical Imaging	6	35	160	5	1	207	4	(2)	0	15	0	8	232	0	0	0	232
422 Outpatient Facility	2	0	0	0	0	2	2	0	0	(2)	2	0	4	0	0	0	4
424 Durable Medical Equipment	(11)	(50)	(40)	(38)	(9)	(148)	3	(1)	(8)	(49)	0	(7)	(210)	0	0	0	(210)
426 Dental	0	142	0	0	0	142	0	0	0	0	0	0	142	0	0	0	142
428 Transportation	(34)	(211)	(158)	(97)	(27)	(527)	(21)	(20)	(27)	(152)	0	(34)	(781)	0	0	0	(781)
430 Nursing Facility, Home Health Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
432 Physical Therapy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
434 Other Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
436 Miscellaneous Medical Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
438 PPC-Other	1	3	22	5	0	31	0	0	0	(11)	0	1	21	0	0	0	21
Total Other Medical	(1,148)	(1,249)	3,653	(5,848)	(693)	(6,285)	(516)	(1,800)	(545)	(2,455)	59	(2,596)	(13,138)	(17)	0	(17)	(13,155)
TOTAL MEDICAL EXP	(880)	(1,190)	3,459	(5,873)	(717)	(6,201)	(525)	(2,054)	(566)	(2,385)	63	(2,598)	(13,266)	(17)	0	(17)	(13,283)
Less:																	
440 Reinsurance	57,443	1,748	(182,796)	(37,438)	(501)	(161,544)	0	(58,711)	77,904	(186,541)	0	0	(328,892)	0	0	0	(328,892)
441 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
442 Third Party Liability	(2,703)	(4,717)	(151,610)	(9,235)	(4,034)	(172,299)	(527)	(11,382)	(33,944)	(61,056)	0	0	(279,208)	0	0	0	(279,208)
TOTAL NET MEDICAL EXP	53,860	(4,159)	(330,947)	(52,546)	(5,252)	(339,044)	(1,052)	(72,147)	43,394	(249,982)	63	(2,598)	(621,366)	(17)	0	(17)	(621,383)
TOTAL ADMIN EXP	(15)	(9)	77	42	(8)	87	(10)	(50)	0	216	(6)	311	648	0	0	0	648
TOTAL EXPENSES	53,845	(4,168)	(330,870)	(52,504)	(5,260)	(338,957)	(1,062)	(72,197)	43,394	(249,766)	57	(2,287)	(620,818)	(17)	0	(17)	(620,836)
Inc (loss) from operations	(82,435)	27,929	329,553	89,414	2,472	366,933	(560)	28,515	(347,981)	(871,543)	(176)	32,380	(792,432)	(48,899)	0	(48,899)	(841,331)
Non-operating inc (loss)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Inc (loss) before taxes	(82,435)	27,929	329,553	89,414	2,472	366,933	(560)	28,515	(347,981)	(871,543)	(176)	32,380	(792,432)	(48,899)	0	(48,899)	(841,331)
Income taxes	(15,385)	5,420	68,147	17,111	440	75,733	(69)	5,833	(65,313)	(176,453)	(36)	6,190	(164,116)	(10,781)	0	(10,781)	(164,896)
Premium taxes	(7)	(4)	34	19	(4)	38	(5)	(22)	0	97	(3)	139	244	0	0	0	244
NET INCOME (LOSS)	(67,043)	22,513	261,372	72,284	2,036	291,162	(486)	22,704	(282,668)	(695,187)	(137)	26,051	(638,561)	(38,118)	0	(38,118)	(676,679)

Profitability by Risk Group

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/09 Santa Cruz County	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC	State Only Transplants	State Only Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	0	0	0	0	0	0	0	0	0	0	215	0	215	0	0	0	215
PPC Member Months	102	1,242	749	497	196	2,786	70	83	83	954	0	126	4,102	0	0	0	4,102
Pros. Member Months	3,162	30,189	16,607	9,397	4,742	64,097	8,210	3,112	324	9,658	0	1,026	86,427	0	0	0	86,427
Total Member Months	3,264	31,431	17,356	9,894	4,938	66,883	8,280	3,195	407	10,612	215	1,152	90,744	0	0	0	90,744
Pros. & FPS Mbr. Mths	3,162	30,189	16,607	9,397	4,742	64,097	8,210	3,112	324	9,658	215	1,026	86,642	0	0	0	86,642
Pros. & PPC Mbr. Mths	3,264	31,431	17,356	9,894	4,938	66,883	8,280	3,195	407	10,612	0	1,152	90,629	0	0	0	90,629
REVENUES																	
305 Capitation	1,382,132	3,075,229	3,869,892	1,209,677	1,903,556	11,440,486	1,175,790	2,215,887	434,155	5,317,377	4,530	238,526	20,826,751	0	0	0	20,826,751
310 PPC Capitation	121,710	70,192	186,090	98,173	86,533	562,698	9,440	34,273	0	850,104	0	31,300	1,487,815	0	0	0	1,487,815
312 Hospital Supplement(Adj for CYE 08 and prior)	0	0	0	0	0	0	0	0	22,316	0	0	0	22,316	0	0	0	22,316
315 Delivery Supplement	0	0	485,473	0	0	485,473	0	13,123	0	19,727	0	787,557	1,305,880	0	0	0	1,305,880
320 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
321 TWG Settlement	0	0	0	0	0	0	0	0	(2,772)	(18,800)	0	0	(21,572)	0	0	0	(21,572)
322 PPC Settlement	(6,800)	(11,363)	(24,737)	(8,940)	(10,853)	(62,693)	(2,606)	(947)	0	(109,935)	0	2,494	(173,687)	0	0	0	(173,687)
325 Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
330 Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL REVENUES	1,497,042	3,134,058	4,516,718	1,298,910	1,979,236	12,425,964	1,182,624	2,262,336	453,699	6,058,473	4,530	1,059,877	23,447,503	0	0	0	23,447,503
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	1,595,164	248,933	842,662	188,214	215,265	3,090,238	298,303	630,663	118,394	947,140	0	502,386	5,587,144	0	0	0	5,587,144
404 Hospital Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
406 PPC-Hospital Inpatient	113,922	6,133	28,531	18,545	50,088	217,219	38,787	1,245	0	209,840	0	9,679	476,770	0	0	0	476,770
Total Hospitalization	1,709,086	255,066	871,193	206,759	265,353	3,307,467	337,090	631,928	118,394	1,156,980	0	512,065	6,063,914	0	0	0	6,063,914
Medical Compensation																	
408 Primary Care Physician	201,113	385,862	217,677	53,914	57,655	916,221	40,580	63,316	5,768	153,246	835	23,047	1,203,013	0	0	0	1,203,013
410 Referral Physician	179,684	274,137	660,476	127,168	240,268	1,481,733	152,445	311,630	42,934	666,177	141	255,053	2,910,113	0	0	0	2,910,113
412 Other Professional	24,223	103,731	114,391	31,065	26,150	299,560	10,101	20,074	2,501	60,354	50	17,300	409,940	0	0	0	409,940
414 PPC - Physician Services	15,428	11,894	25,308	13,512	4,463	70,605	617	4,184	0	88,404	0	9,882	173,692	0	0	0	173,692
Total Medical Comp	420,448	775,624	1,017,852	225,659	328,536	2,768,119	203,743	399,204	51,203	968,181	1,026	305,282	4,696,768	0	0	0	4,696,768
Other Medical Expenses																	
416 Emergency Facility Services	37,691	169,504	215,366	62,872	38,519	523,952	6,057	66,104	3,890	186,778	254	14,486	801,521	0	0	0	801,521
418 Pharmacy	17,840	245,887	258,350	128,524	246,286	896,887	21,150	338,130	11,905	449,089	744	16,207	1,734,112	0	0	0	1,734,112
420 Lab, X-ray, & Medical Imaging	17,973	50,503	344,853	53,827	129,687	596,843	61,927	111,941	12,681	294,041	(32)	87,554	1,164,955	0	0	0	1,164,955
422 Outpatient Facility	36,453	187,794	516,711	117,311	193,777	1,052,046	73,550	255,272	22,081	450,848	283	70,215	1,924,295	0	0	0	1,924,295
424 Durable Medical Equipment	6,022	47,048	39,612	25,389	24,366	142,437	17,301	36,192	2,628	46,316	0	3,552	248,426	0	0	0	248,426
426 Dental	314	501,850	84,001	62,435	9,327	657,927	12,279	15,138	2,073	30,101	0	2,903	720,421	0	0	0	720,421
428 Transportation	21,865	96,235	121,228	44,333	36,687	320,348	42,724	92,343	4,572	173,859	0	13,106	646,952	0	0	0	646,952
430 Nursing Facility, Home Health Care	2,080	2,013	11,167	3,509	38,371	57,140	58,754	49,227	8,809	125,884	0	2,438	302,252	0	0	0	302,252
432 Physical Therapy	2,622	9,973	11,185	6,197	3,318	33,295	2,893	3,034	1,121	16,495	0	639	57,477	0	0	0	57,477
434 Other Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
436 Miscellaneous Medical Expenses	774	31,705	11,945	9,704	20,168	74,296	50,809	46,953	1,875	36,956	0	460	211,349	0	0	0	211,349
438 PPC-Other	2,882	18,047	41,518	20,973	13,423	96,843	1,206	6,845	0	131,201	0	14,292	250,387	0	0	0	250,387
Total Other Medical	146,516	1,360,559	1,655,936	535,074	753,929	4,452,014	348,650	1,021,179	71,635	1,941,568	1,249	225,852	8,062,147	0	0	0	8,062,147
TOTAL MEDICAL EXP	2,276,050	2,391,249	3,544,981	967,492	1,347,818	10,527,590	889,483	2,052,311	241,232	4,066,729	2,275	1,043,199	18,822,818	0	0	0	18,822,818
Less:																	
440 Reinsurance	(319,497)	0	(57,106)	0	(1,369)	(377,972)	0	0	0	(42,275)	0	0	(420,247)	0	0	0	(420,247)
441 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
442 Third Party Liability	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL NET MEDICAL EXP	1,956,553	2,391,249	3,487,875	967,492	1,346,449	10,149,618	889,483	2,052,311	241,232	4,024,454	2,275	1,043,199	18,402,572	0	0	0	18,402,572
TOTAL ADMIN EXP	65,470	136,050	196,205	56,399	86,057	540,181	52,077	98,045	20,381	265,758	199	44,977	1,021,618	0	0	0	1,021,618
TOTAL EXPENSES	2,022,023	2,527,299	3,684,080	1,023,891	1,432,506	10,689,799	941,560	2,150,356	261,613	4,290,212	2,474	1,088,176	19,424,190	0	0	0	19,424,190
Inc (loss) from operations	(524,981)	606,759	832,638	275,019	546,730	1,736,165	241,064	111,980	192,086	1,768,261	2,056	(28,299)	4,023,313	0	0	0	4,023,313
Non-operating inc (loss)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Inc (loss) before taxes	(524,981)	606,759	832,638	275,019	546,730	1,736,165	241,064	111,980	192,086	1,768,261	2,056	(28,299)	4,023,313	0	0	0	4,023,313
Income taxes	(93,314)	148,105	206,729	65,428	125,311	452,259	57,303	39,597	42,327	403,172	447	3,754	998,859	0	0	0	998,859
Premium taxes	31,396	65,612	94,769	27,314	41,537	260,628	24,736	47,226	9,535	129,237	94	22,073	493,529	0	0	0	493,529
NET INCOME (LOSS)	(463,063)	393,042	531,140	182,277	379,882	1,023,278	159,025	25,157	140,224	1,235,852	1,515	(54,126)	2,530,925	0	0	0	2,530,925

0910-1101319

Profitability by Risk Group

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/09 Yuma County	TANF <1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	SSDI-TMC	State Only Transplants	State Only Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA FPS Mmbr Mths	0	0	0	0	0	0	0	0	0	0	599	0	599	0	0	0	599
PPC Member Months	202	2,696	1,545	894	319	5,656	290	372	261	2,168	0	369	9,116	0	0	0	9,116
Pros. Member Months	6,989	49,510	26,039	13,737	6,555	102,830	14,576	6,446	449	18,891	0	2,566	146,758	0	0	0	146,758
Total Member Months	7,191	52,206	27,584	14,631	6,874	108,486	14,866	6,818	710	21,059	599	2,935	155,473	0	0	0	155,473
Pros. & FPS Mbr. Mths	6,989	49,510	26,039	13,737	6,555	102,830	14,576	6,446	449	18,891	599	2,566	146,357	0	0	0	146,357
Pros. & PPC Mbr. Mths	7,191	52,206	27,584	14,631	6,874	108,486	14,866	6,818	710	21,059	0	2,935	154,874	0	0	0	154,874
REVENUES																	
305 Capitation	3,151,608	5,085,153	5,143,487	1,634,008	2,224,861	17,239,117	2,400,084	4,228,212	1,336,004	8,095,932	12,331	528,004	33,839,684	0	0	0	33,839,684
310 PPC Capitation	242,240	166,733	369,582	190,294	139,355	1,108,204	39,533	152,938	1,953,262	2,338,688	0	88,087	5,680,712	0	0	0	5,680,712
312 Hospital Supplement (Adj for CYE 08 and prior)	0	0	0	0	0	0	0	0	126,860	0	0	0	126,860	0	0	0	126,860
315 Delivery Supplement	0	0	998,305	0	0	998,305	0	18,572	0	31,197	0	1,883,144	2,931,218	0	0	0	2,931,218
320 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
321 TWG Settlement	0	0	0	0	0	0	0	0	(13,716)	46,557	0	0	32,841	0	0	0	32,841
322 PPC Settlement	8,785	25,084	(8,616)	19,337	44,135	88,725	(4,232)	(4,492)	(198,323)	(2,052)	0	14,680	(105,694)	0	0	0	(105,694)
325 Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
330 Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL REVENUES	3,402,633	5,276,970	6,502,758	1,843,639	2,408,351	19,434,351	2,435,385	4,395,230	3,204,087	10,510,322	12,331	2,513,915	42,505,621	0	0	0	42,505,621
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	2,283,032	434,401	911,344	148,552	554,087	4,331,416	451,556	1,182,692	262,597	1,964,143	0	1,107,299	9,299,703	0	0	0	9,299,703
404 Hospital Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
406 PPC-Hospital Inpatient	568,037	81,842	73,812	94,708	58,191	876,590	62,220	182,907	672,784	802,497	0	51,605	2,648,603	0	0	0	2,648,603
Total Hospitalization	2,851,069	516,243	985,156	243,260	612,278	5,208,006	513,776	1,365,599	935,381	2,766,640	0	1,158,904	11,948,306	0	0	0	11,948,306
Medical Compensation																	
408 Primary Care Physician	468,316	563,107	508,662	101,158	129,071	1,770,314	92,374	213,648	14,635	467,205	1,472	49,032	2,608,680	0	0	0	2,608,680
410 Referral Physician	185,869	643,261	1,312,752	244,557	451,075	2,837,514	302,269	690,493	59,097	1,503,435	671	552,070	5,945,549	0	0	0	5,945,549
412 Other Professional	213,806	96,366	72,133	19,564	10,877	412,746	11,997	39,892	5,512	84,991	0	36,564	591,702	0	0	0	591,702
414 PPC - Physician Services	23,457	33,175	37,620	12,510	46,501	153,263	3,513	12,346	102,567	158,419	0	33,871	463,979	0	0	0	463,979
Total Medical Comp	891,448	1,335,909	1,931,167	377,789	637,524	5,173,837	410,153	956,379	181,811	2,214,050	2,143	671,537	9,609,910	0	0	0	9,609,910
Other Medical Expenses																	
416 Emergency Facility Services	118,265	400,081	487,161	168,850	88,363	1,262,720	19,274	158,053	10,521	457,388	275	34,736	1,942,967	0	0	0	1,942,967
418 Pharmacy	30,923	259,403	384,577	180,893	396,147	1,251,943	65,425	1,184,342	49,828	1,065,074	3,158	33,027	3,652,797	0	0	0	3,652,797
420 Lab, X-ray, & Medical Imaging	38,322	122,517	578,797	91,782	183,643	1,015,061	68,742	213,678	19,278	598,046	129	185,875	2,100,811	0	0	0	2,100,811
422 Outpatient Facility	102,215	493,056	1,103,628	301,647	437,177	2,437,723	273,192	676,356	109,257	1,345,267	312	118,569	4,960,676	0	0	0	4,960,676
424 Durable Medical Equipment	15,611	78,448	69,936	21,769	27,948	213,712	9,511	66,519	3,651	100,317	1	6,695	400,406	0	0	0	400,406
426 Dental	710	1,296,403	354,234	207,154	13,211	1,871,712	27,288	63,176	2,494	105,898	0	19,511	2,090,079	0	0	0	2,090,079
428 Transportation	223,017	230,754	253,925	81,408	79,501	868,605	70,377	238,930	12,337	410,234	870	44,274	1,645,633	0	0	0	1,645,633
430 Nursing Facility, Home Health Care	13,034	7,034	42,107	374	28,773	91,322	45,794	121,017	20,850	134,544	0	3,848	417,375	0	0	0	417,375
432 Physical Therapy	15,303	18,240	30,264	14,576	25,750	104,133	9,982	26,318	1,883	52,515	0	1,566	196,397	0	0	0	196,397
434 Other Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
436 Miscellaneous Medical Expenses	750	54,665	25,064	8,517	605	89,601	87,304	19,303	182	25,096	0	14,697	236,183	0	0	0	236,183
438 PPC-Other	24,503	93,307	126,062	51,472	62,844	358,188	46,112	46,568	205,242	377,570	0	65,484	1,099,164	0	0	0	1,099,164
Total Other Medical	582,653	3,053,908	3,455,755	1,128,442	1,343,962	9,564,720	723,001	2,814,266	435,523	4,671,951	4,745	528,282	18,742,498	0	0	0	18,742,498
TOTAL MEDICAL EXP	4,325,170	4,906,060	6,372,078	1,749,491	2,593,764	19,946,563	1,646,930	5,136,244	1,552,715	9,652,641	6,888	2,358,723	40,300,704	0	0	0	40,300,704
Less:																	
440 Reinsurance	(218,866)	(32,208)	(53,505)	0	(134,621)	(439,200)	0	(329,159)	(21,055)	(138,917)	0	(15,920)	(944,251)	0	0	0	(944,251)
441 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
442 Third Party Liability	0	0	(511)	0	0	(511)	(247)	0	(5,000)	(226)	0	0	(5,984)	0	0	0	(5,984)
TOTAL NET MEDICAL EXP	4,106,304	4,873,852	6,318,062	1,749,491	2,459,143	19,506,852	1,646,683	4,807,085	1,526,660	9,513,498	6,888	2,342,803	39,350,469	0	0	0	39,350,469
TOTAL ADMIN EXP	149,068	228,354	281,386	78,755	102,905	840,468	107,051	191,841	147,969	450,300	545	107,568	1,845,742	0	0	0	1,845,742
TOTAL EXPENSES	4,255,372	5,102,206	6,599,448	1,828,246	2,562,048	20,347,320	1,753,734	4,998,926	1,674,629	9,963,798	7,433	2,450,371	41,196,211	0	0	0	41,196,211
Inc (loss) from operations	(852,739)	174,764	(96,690)	15,393	(153,697)	(912,969)	681,651	(603,696)	1,529,458	546,524	4,898	63,544	1,309,410	0	0	0	1,309,410
Non-operating inc (loss)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Inc (loss) before taxes	(852,739)	174,764	(96,690)	15,393	(153,697)	(912,969)	681,651	(603,696)	1,529,458	546,524	4,898	63,544	1,309,410	0	0	0	1,309,410
Income taxes	(139,721)	76,694	33,171	18,091	(16,322)	(28,087)	153,865	(78,550)	331,616	182,627	1,076	34,293	596,840	0	0	0	596,840
Premium taxes	70,882	109,650	135,930	38,086	49,386	403,934	50,897	91,780	71,384	216,676	257	52,139	889,067	0	0	0	889,067
NET INCOME (LOSS)	(783,900)	(11,580)	(265,791)	(40,784)	(186,761)	(1,288,816)	476,889	(616,926)	1,126,458	145,221	3,565	(22,888)	(176,497)	0	0	0	(176,497)

0910-1101319

Profitability by Risk Group

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/09 Yuma County	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	BBCD-TMC	State Only Transplants	State Only Total	Grand Total
REVENUE & EXPENSES																	
Member Months																	
SOBRA PPS Mmbr Mths	0	0	0	0	0	0	0	0	0	0	389	0	389	0	0	0	389
PPC Member Months	232	2,696	1,545	894	312	5,688	290	372	261	2,163	0	359	9,118	0	0	0	9,118
Pros. Member Months	6,959	49,510	26,039	13,737	6,556	103,838	14,576	8,446	442	18,831	0	2,565	146,760	0	0	0	146,760
Total Member Months	7,191	52,206	27,584	14,631	6,874	108,486	14,866	8,818	710	21,054	588	2,935	166,473	0	0	0	166,473
Pros. & PPS Mbr. Mths	6,959	49,510	26,039	13,737	6,556	102,820	14,576	8,446	442	18,831	599	2,565	146,367	0	0	0	146,367
Pros. & PPC Mbr. Mths	7,191	52,206	27,584	14,631	6,874	108,486	14,866	8,818	710	21,054	0	2,935	164,874	0	0	0	164,874
REVENUES																	
305 Capitation	3,151,608	5,065,153	5,143,492	1,834,008	2,234,861	17,339,117	2,400,064	4,228,212	1,336,004	8,085,932	12,331	520,004	33,839,884	0	0	0	33,839,884
310 PPC Capitation	242,240	105,733	369,562	180,294	132,365	1,108,294	39,533	152,938	1,853,262	2,306,653	0	83,087	6,660,712	0	0	0	6,660,712
312 Hospital Supplement (pd to CHC based pymt)	0	0	0	0	0	0	0	0	126,860	0	0	0	126,860	0	0	0	126,860
315 Delivery Supplement	0	0	908,306	0	0	838,306	0	18,572	0	31,197	0	1,863,144	2,831,218	0	0	0	2,931,218
320 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
321 TWG Settlement	0	0	0	0	0	0	0	0	(13,716)	46,557	0	0	32,841	0	0	0	32,841
322 PPC Settlement	8,765	25,004	(8,610)	19,337	44,135	88,726	(4,232)	(4,422)	(198,320)	(2,002)	0	14,660	(109,694)	0	0	0	(109,694)
325 Investment Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
330 Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL REVENUES	3,402,133	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	12,331	[illegible]	[illegible]	0	0	0	[illegible]
EXPENSES																	
Hospitalization																	
402 Hospital Inpatient	2,250,802	434,401	991,344	148,222	224,087	4,331,418	451,208	1,162,582	262,397	1,904,143	0	1,107,239	9,219,703	0	0	0	9,219,703
404 Hospital Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
409 PPC-Hospital Inpatient	508,037	81,842	73,812	94,708	58,191	878,890	82,220	182,907	672,784	802,497	0	51,805	2,648,493	0	0	0	2,648,493
Total Hospitalization	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	[illegible]	[illegible]	0	0	0	[illegible]
Medical Compensation																	
408 Primary Care Physician	405,316	563,107	508,002	101,158	129,071	1,770,314	92,374	213,843	14,835	467,205	1,477	49,032	2,608,880	0	0	0	2,608,880
410 Referral Physician	155,882	643,261	1,312,752	244,227	451,075	2,837,414	302,299	640,463	59,097	1,503,435	671	453,070	5,846,649	0	0	0	5,846,649
412 Other Professional	213,809	98,398	77,133	19,564	10,877	412,744	11,807	30,882	3,512	64,891	0	35,564	891,782	0	0	0	891,782
414 PPC - Physician Services	23,457	33,175	37,620	13,510	46,501	183,283	3,313	12,346	102,567	158,419	0	30,671	463,979	0	0	0	463,979
Total Medical Comp.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	2,563	[illegible]	[illegible]	0	0	0	[illegible]
Other Medical Expenses																	
416 Emergency Facility Services	116,295	400,061	437,161	188,650	85,363	1,282,720	19,274	158,053	10,521	457,259	275	34,735	1,943,967	0	0	0	1,943,967
418 Pharmacy	30,923	259,403	394,577	180,403	306,147	1,281,843	65,425	1,184,342	49,825	1,002,074	3,156	33,027	3,643,797	0	0	0	3,643,797
420 Lab, X-ray, & Medical Imaging	39,322	122,517	578,797	91,782	183,643	1,016,061	68,742	213,878	19,278	598,049	129	105,875	2,100,911	0	0	0	2,100,911
422 Outpatient Facility	102,215	460,056	1,100,628	301,847	437,177	2,437,723	273,192	676,358	109,257	1,345,267	312	118,369	4,960,678	0	0	0	4,960,678
424 Durable Medical Equipment	15,811	78,449	69,906	21,769	27,949	213,712	9,511	68,512	3,651	100,317	1	6,025	409,404	0	0	0	409,404
426 Dental	710	1,226,403	304,234	207,134	13,211	1,871,712	27,268	63,178	2,494	105,858	0	19,311	2,090,878	0	0	0	2,030,878
428 Transportation	223,017	230,754	233,925	81,408	79,501	848,606	70,377	739,856	12,337	410,234	670	44,274	1,846,633	0	0	0	1,846,633
430 Nursing Facility, Home Health Care	13,034	7,034	40,107	374	28,773	91,323	45,794	121,017	20,850	134,344	0	3,846	417,378	0	0	0	417,378
432 Physical Therapy	15,303	18,240	30,264	14,578	25,730	104,133	9,962	20,318	1,093	52,515	0	1,509	199,397	0	0	0	199,397
434 Other Risk Pool Expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
436 Miscellaneous Medical Expenses	750	54,505	25,064	8,517	605	89,801	67,204	19,303	182	25,096	0	14,697	236,183	0	0	0	236,183
438 PPC-Other	24,503	93,397	126,002	51,472	92,644	348,188	48,112	46,568	205,247	377,570	0	60,464	1,099,184	0	0	0	1,099,184
Total Other Medical	[illegible]	[illegible]	[illegible]	1,127,442	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	4,543	[illegible]	18,742,459	0	0	0	18,742,459
TOTAL MEDICAL EXP	[illegible]	[illegible]	[illegible]	1,743,474	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0	0	[illegible]
Less:																	
440 Reinsurance	(218,860)	(32,200)	(53,505)	0	(134,621)	(439,200)	0	(329,159)	(21,050)	(108,917)	0	(15,920)	(944,261)	0	0	0	(944,261)
441 Reserved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
442 Third Party Liability	0	0	(511)	0	0	(511)	(347)	0	(5,000)	(226)	0	0	(6,084)	0	0	0	(6,084)
TOTAL NET MEDICAL EXP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0	0	[illegible]
TOTAL ADM'N EXP	[illegible]	239,354	[illegible]	[illegible]	[illegible]	845,489	[illegible]	[illegible]	[illegible]	490,309	[illegible]	[illegible]	1,848,742	0	0	0	1,848,742
TOTAL EXPENSES	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	41,199,211	0	0	0	41,199,211
Inc (loss) from operations	(752,732)	174,784	(96,030)	15,300	(153,037)	(812,388)	681,651	(603,696)	1,529,458	546,524	4,708	83,544	1,329,410	0	0	0	1,329,410
Non-operating inc (loss)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Inc (loss) before taxes	(752,732)	174,784	(96,030)	15,300	(153,037)	(812,388)	681,651	(603,696)	1,529,458	546,524	4,708	83,544	1,329,410	0	0	0	1,329,410
Income taxes	(139,731)	75,884	33,171	16,061	(16,327)	(28,087)	153,285	(78,560)	331,816	182,627	1,676	34,293	638,840	0	0	0	638,840
Premium taxes	70,862	139,630	135,930	38,086	49,356	433,934	50,597	91,780	71,384	216,876	257	52,132	889,087	0	0	0	889,087
NET INCOME (LOSS)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	(178,497)	0	0	0	(178,497)

Unaudited
Health Choice Arizona, Inc.
Fiscal Year Ended: 9/30/09
Claims Lag Report

Expense Type: Prospective Hospital

Payment Qtr	Current	1st Prior	2nd Prior	3rd Prior	4th Prior	5th Prior	6th Prior*	Total
Current	14,097,988	22,093,481	3,477,474	1,089,907	158,380	(693)	(98,282)	40,818,255
1st Prior		12,841,647	22,028,472	3,083,229	116,987	72,742	120,756	38,263,833
2nd Prior			12,514,813	19,640,472	3,074,111	(6,925)	246,260	35,468,731
3rd Prior				10,844,702	18,960,181	2,604,512	857,465	33,266,860
4th Prior					11,899,867	18,477,407	2,750,720	33,127,994
5th Prior						11,599,397	23,355,684	34,955,081
6th Prior*							663,929,011	663,929,011
Totals	14,097,988	34,935,128	38,020,759	34,658,310	34,209,526	32,746,440	691,161,614	879,829,765
Expense	41,040,041	40,518,949	36,008,431	37,926,438	32,578,673	32,330,078	674,156,178	894,558,788
Adjustment	-	-	-	-	-	-	12,268,646	12,268,646
Remaining	26,942,053	5,583,821	(2,012,328)	3,268,128	(1,630,853)	(416,362)	(4,736,790)	26,997,669

Expense Type: Prior Period Coverage Hospital

Payment Qtr	Current	1st Prior	2nd Prior	3rd Prior	4th Prior	5th Prior	6th Prior*	Total
Current	1,780,285	6,394,143	1,270,804	144,398	172,906	41,943	1,522	9,806,001
1st Prior		1,806,383	3,248,453	898,627	449,064	66,594	38,490	6,507,611
2nd Prior			819,953	2,933,254	1,417,456	118,358	147,629	5,436,650
3rd Prior				564,355	4,818,098	1,161,676	341,534	6,885,663
4th Prior					1,286,941	4,571,731	1,682,040	7,540,712
5th Prior						1,221,851	7,390,969	8,612,820
6th Prior*							124,173,615	124,173,615
Totals	1,780,285	8,200,526	5,339,210	4,540,634	8,144,465	7,182,153	133,775,799	168,963,072
Expense	8,784,143	10,451,945	3,941,780	6,642,235	9,638,399	11,047,241	130,634,642	181,140,385
Adjustment	-	-	-	-	-	-	(1,202,410)	(1,202,410)
Remaining	7,003,858	2,251,419	(1,397,430)	2,101,601	1,493,934	3,865,088	(4,343,567)	10,974,903

* Amounts in this column or row include the amounts for the 6th prior period, and any earlier periods where the expenses reported exceed the payments made to date.

Hospital Expense from Total Profitability Report:	185,313,962
Sum of Current through 3rd Prior Expense above:	185,313,962
	0

Total Hospital: 37,972,572

Hospital Report	$	37,972,572
Medical Compensation Report		56,471,482
Other Medical Report		12,704,993
Subcapitation Payable		71,255
Total Medical Claims Payable	$	107,220,302

0910-1101319

Unaudited
Health Choice Arizona, Inc.
Year Ended: 9/30/09
Claims Lag Report

Expense Type: Prospective Medical Compensation

Payment Qtr	Current	1st Prior	2nd Prior	3rd Prior	4th Prior	5th Prior	6th Prior*	Total
Current	15,098,803	12,951,992	1,166,245	249,265	114,154	(4,386)	(9,886)	29,566,187
1st Prior		15,288,870	14,406,406	1,198,947	350,430	96,653	5,710	31,347,016
2nd Prior			14,785,069	12,928,172	937,515	221,111	70,015	28,941,882
3rd Prior				13,087,025	11,657,988	834,800	274,581	25,854,394
4th Prior					11,312,563	10,755,104	1,616,674	23,684,341
5th Prior						10,927,322	13,763,107	24,690,429
6th Prior*							421,841,979	421,841,979
Totals	15,098,803	28,240,862	30,357,720	27,463,409	24,372,650	22,830,604	437,562,180	585,926,228
Expense	37,993,542	36,950,997	27,920,075	31,434,418	24,967,377	26,601,329	447,121,398	632,989,136
Adjustment**	-	-	-	-	-	-	2,703,424	2,703,424
Remaining	22,894,739	8,710,135	(2,437,645)	3,971,009	594,727	3,770,725	12,262,642	49,766,332

Expense Type: Prior Period Coverage Medical Compensation

Payment Qtr	Current	1st Prior	2nd Prior	3rd Prior	4th Prior	5th Prior	6th Prior*	Total
Current	284,495	1,135,073	302,455	33,794	24,979	6,203	1,499	1,788,498
1st Prior		351,591	626,711	181,471	74,458	15,593	6,687	1,256,511
2nd Prior			169,878	576,917	290,344	64,903	28,431	1,130,473
3rd Prior				174,575	1,004,839	247,138	79,752	1,506,304
4th Prior					313,440	958,080	405,019	1,676,539
5th Prior						252,615	1,514,693	1,767,308
6th Prior*							38,382,839	38,382,839
Totals	284,495	1,486,664	1,099,044	966,757	1,708,060	1,544,532	40,418,920	47,508,472
Expense	2,207,051	2,147,392	1,064,830	1,390,897	2,118,355	1,917,386	43,651,245	54,497,156
Adjustment	-	-	-	-	-	-	(283,534)	(283,534)
Remaining	1,922,556	660,728	(34,214)	424,140	410,295	372,854	2,948,791	6,705,150

* Amounts in this column or row include the amounts for the 6th prior period, and any earlier periods where the expenses reported exceed the payments made to date.

**Estimated adjustment due to updated Other Medical payment codes falling out of specific criteria and defaulting to Specialist Expense.

Total Medical Compensation: 56,471,482

Medical Compensation Expense from Total Profitability Report:	148,883,984
Less: Physician Subcapitation Expense	(8,167,512)
Less: Physician Incentive Pool Expense	(131,218)
Plus: Physician Pool Reclassification to Med Comp Payable	523,948
Fee For Service Medical Compensation Expense	141,109,202
Sum of Current through 3rd Prior Expense above:	141,109,202
	0

0910-1101319

Unaudited
Health Choice Arizona, Inc.
Fiscal Year Ended: 9/30/09
Claims Lag Report

Expense Type: Other Medical

Payment Qtr	Current	1st Prior	2nd Prior	3rd Prior	4th Prior	5th Prior	6th Prior*	Total
Current	44,475,126	24,529,096	2,419,293	666,671	94,609	11,149	(46,492)	72,149,452
1st Prior		42,472,442	22,542,632	1,490,441	252,163	117,553	(21,895)	66,853,336
2nd Prior			40,115,028	20,882,992	833,080	446,974	25,723	62,303,797
3rd Prior				35,715,819	15,465,477	795,290	258,634	52,235,220
4th Prior					26,620,074	13,858,106	1,734,851	42,213,031
5th Prior						24,664,987	15,451,999	40,116,986
6th Prior*							711,721,771	711,721,771
Totals	44,475,126	67,001,538	65,076,953	58,755,923	43,265,403	39,894,059	729,124,591	1,047,593,593
Expense	73,975,108	63,128,575	54,961,533	53,807,301	43,764,836	42,897,373	729,996,120	1,062,530,846
Adjustment	-	-	-	-	-	-	(4,803,778)	(4,803,778)
Remaining	29,499,982	(3,872,963)	(10,115,420)	(4,948,622)	499,433	3,003,314	(3,932,249)	10,133,475

Expense Type: Prior Period Coverage Other Medical

Payment Qtr	Current	1st Prior	2nd Prior	3rd Prior	4th Prior	5th Prior	6th Prior*	Total
Current	749,074	2,902,013	545,863	269,731	35,603	771	532	4,503,587
1st Prior		672,002	2,144,942	589,223	89,644	7,662	2,553	3,506,026
2nd Prior			561,242	1,971,191	434,330	26,909	16,466	3,010,138
3rd Prior				470,006	1,963,079	341,361	92,600	2,867,046
4th Prior					502,855	1,451,893	406,942	2,361,690
5th Prior						369,079	1,905,300	2,274,379
6th Prior*							42,519,498	42,519,498
Totals	749,074	3,574,015	3,252,047	3,300,151	3,025,511	2,197,675	44,943,891	61,042,364
Expense	3,731,373	3,504,112	1,871,996	2,076,154	2,817,433	2,370,679	47,406,775	63,778,522
Adjustment	-	-	-	-	-	-	(164,640)	(164,640)
Remaining	2,982,299	(69,903)	(1,380,051)	(1,223,997)	(208,078)	173,004	2,298,244	2,571,518

* Amounts in this column or row include the amounts for the 6th prior period, and any earlier periods where the expenses reported exceed the payments made to date.

**Estimated adjustment due to updated Other Medical payment codes falling out of specific criteria and defaulting to Specialist Expense

Total Other Medical: 12,704,993

Other Medical Expense from Total Profitability Report:	261,860,324
Less: Other Medical Subcapitation Expense	(7,618,136)
Plus: Pharmacy Rebates Accrued	2,813,964
Fee For Service Other Medical Expense	257,056,152
Sum of Current through 3rd Prior Expense above:	257,056,152
	0

AUDITED FINANCIAL STATEMENTS AND
OTHER FINANCIAL INFORMATION

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)
Year Ended September 30, 2010
With Report of Independent Auditors

Ernst & Young LLP

ERNST & YOUNG

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Audited Financial Statements and Other Financial Information

Year Ended September 30, 2010

Contents

Ernst & Young LLP
One Nashville Place
Suite 1400
150 Fourth Avenue North
Nashville, TN 37219

Tel: +1 615 252 2000
Fax: +1 615 242 9128
www.ey.com

ERNST & YOUNG

Report of Independent Auditors

The Board of Directors
Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

We have audited the accompanying balance sheet of Health Choice Arizona (the Plan), a division of Health Choice Arizona, Inc., which is a wholly-owned subsidiary of IASIS Healthcare LLC, as of September 30, 2010 and the related statements of earnings, changes in equity of Parent and cash flows for the year then ended. These financial statements are the responsibility of the Plan's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Plan's internal control over financial reporting. Our audit included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Health Choice Arizona at September 30, 2010, and the results of its operations and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States.

Our audit was conducted for the purpose of forming an opinion on the basic financial statements taken as a whole. The details of the attached schedules (pages 15-21) of other financial information are presented for purposes of additional analysis and are not a required part of the basic financial statements. The attached schedules are the responsibility of Health Choice Arizona's management. Such information has not been subjected to the auditing procedures applied in our audit of the basic financial statements and, accordingly, we express no opinion on it.

Ernst + Young LLP

January 27, 2011

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Balance Sheet

September 30, 2010

Assets	
Current assets:	
Due from affiliates	$ 285,546,705
Other current assets	2,723,691
Total current assets	288,270,396
Furniture and equipment, net of accumulated depreciation of $1,524,525	1,675,945
Other intangible assets, net of accumulated amortization of $18,000,000	27,000,000
Goodwill	5,756,914
Total assets	$ 322,703,255
Liabilities and Equity of Parent	
Current liabilities:	
Accounts payable and accrued expenses	$ 2,432,236
AHCCCS payables, net	31,227,718
Medical claims payable	104,437,331
Total current liabilities	138,097,285
Equity:	
Equity of Parent	184,605,970
Total liabilities and equity of Parent	$ 322,703,255

See accompanying notes.

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Statement of Earnings

Year Ended September 30, 2010

Revenues:	
Capitation premiums	$ 700,743,141
Delivery supplemental premiums	41,241,904
Total revenues	741,985,045
Medical expenses:	
Hospitalization, net	189,501,054
Medical compensation	157,895,129
Other medical, net	300,231,789
Total medical expenses	647,627,972
Administrative expenses	44,176,609
Total expenses	691,804,581
Earnings before income taxes	50,180,464
Income taxes	19,863,927
Net earnings	$ 30,316,537

See accompanying notes.

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Statement of Changes in Equity of Parent

Year Ended September 30, 2010

	Contributed Capital	Retained Earnings	Totals
Balance at September 30, 2009	$ 85,875,813	$ 68,413,620	$ 154,289,433
Net earnings	–	30,316,537	30,316,537
Balance at September 30, 2010	$ 85,875,813	$ 98,730,157	$ 184,605,970

See accompanying notes.

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Statement of Cash Flows

Year Ended September 30, 2010

Operating activities	
Net earnings	$ 30,316,537
Adjustments to reconcile net earnings to net cash provided by operating activities:	
Depreciation	561,683
Amortization	3,000,000
Changes in operating assets and liabilities:	
Other current assets	(1,072,838)
AHCCCS payables, net	32,385,123
Accounts payable and accrued expenses	271,080
Medical claims payable	(2,782,971)
Net cash provided by operating activities	62,678,614
Investing activities	
Purchases of furniture and equipment, net	(301,859)
Net cash used in investing activities	(301,859)
Financing activities	
Change in due from affiliates	(62,376,755)
Net cash used in financing activities	(62,376,755)
Change in cash and cash equivalents	–
Cash and cash equivalents, beginning of year	–
Cash and cash equivalents, end of year	$ –

See accompanying notes.

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Notes to Financial Statements

September 30, 2010

1. Organization and Basis of Presentation

Health Choice Arizona (the Plan or Health Choice) is a division of Health Choice Arizona, Inc. (the Parent), which is a wholly-owned subsidiary of IASIS Healthcare LLC (IASIS). IASIS is a hospital management company that also owns and operates 17 acute care hospital facilities and one behavioral health hospital facility in seven states. The Plan is a prepaid Medicaid managed health plan that derives substantially all of its revenue through a contract with the Arizona Health Care Cost Containment System (AHCCCS) to provide specified healthcare services to qualified Medicaid enrollees through contracts with providers, including affiliates of IASIS. AHCCCS is the state agency that administers Arizona's Medicaid program. The contract requires the Plan to arrange for healthcare services for enrolled Medicaid patients in exchange for fixed monthly premiums, based on negotiated per capita member rates, and supplemental payments from AHCCCS. These services are provided regardless of the actual costs incurred to provide these services. The Plan receives reinsurance and other supplemental payments from AHCCCS to cover certain costs of healthcare services that exceed certain thresholds.

Effective October 1, 2008, Health Choice began its current contract with AHCCCS, which provides for a three-year term, with AHCCCS having the option to renew for two additional one-year periods. The contract is terminable by AHCCCS without cause on 90 days' written notice or for cause upon written notice if the Plan fails to comply with any term or condition of the contract or fails to take corrective action as required to comply with the terms of the contract. Additionally, AHCCCS can terminate the contract in the event of the unavailability of state or federal funding.

Under the contract, the Plan subcontracts with hospitals, physicians and other medical providers, including affiliates of IASIS, within Arizona and surrounding states to provide services to its enrollees in Apache, Coconino, Maricopa, Mohave, Navajo, Pima, Yuma, LaPaz and Santa Cruz counties.

2. Summary of Significant Accounting Policies

Due from Affiliates

Due from affiliates represents the net excess of funds transferred to the centralized cash management account of IASIS over funds transferred to or paid on behalf of the Plan. Due from affiliates balances are readily available to the Plan for settlement of the Plan's current liabilities as they become due. Generally, this balance is decreased by automatic cash transfers from the account to reimburse the Plan's bank accounts for operating expenses and to pay for fees and services provided by IASIS, including information systems services, and other operating expenses, such as payroll and insurance. Generally, the balance is increased through daily cash deposits by the Plan to the centralized cash management account of IASIS. Management fees totaling $564,000, which represent an allocation of corporate office expenses of IASIS, were recognized during the year ended September 30, 2010, and are included within administrative expenses in the accompanying statement of earnings. Interest income is not earned on outstanding balances due from affiliates.

Furniture and Equipment

Furniture and equipment is stated at cost. The Plan uses the straight-line method of depreciation over the estimated useful lives of the respective assets, which generally range from 3 to 15 years. Depreciation expense totaling $561,683 was recognized during the year ended September 30, 2010, and is included within administrative expenses in the accompanying statement of earnings.

Goodwill and Intangible Assets

Pursuant to accounting guidance related to goodwill and other intangible assets, goodwill is not amortized but is subject to annual impairment reviews or more often if events or circumstances indicate it may be impaired. An impairment loss is recorded to the extent that the carrying amount of goodwill exceeds its implied fair value. The Plan has completed its annual impairment test for the 2010 fiscal year, which resulted in no impairment.

Intangible assets consists solely of the Plan's contract with AHCCCS and is amortized over a period of 15 years, which approximates the contract's estimated useful life, including assumed renewal periods. Amortization of intangible assets totaled $3,000,000 for the year ended September 30, 2010, and is included in administrative expenses in the accompanying statement of earnings.

2. Summary of Significant Accounting Policies (continued)

When events, circumstances or operating results indicate that the carrying values of certain long-lived assets and related identifiable intangible assets (excluding goodwill) that are expected to be held and used might be impaired, the Plan considers the recoverability of assets to be held and used by comparing the carrying amount of the assets to the undiscounted value of future net cash flows expected to be generated by the assets. If the assets are identified as impaired, the impairment is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets as determined by independent appraisals or estimates of discounted future cash flows.

Revenue Recognition

Capitation premiums are recognized as revenue in the month that members are entitled to healthcare services. Capitation premiums are subject to an episodic/diagnostic risk factor adjustment. Health Choice receives capitation payments for Prior Period Coverage (PPC) separately from its prospective capitation payments. PPC capitation payments are intended to cover those healthcare costs incurred by individuals while they are awaiting enrollment in the Plan. PPC revenues are recognized in the month in which Health Choice is notified that a member is eligible for coverage under the Plan. AHCCCS limits the profitability and loss that health plans may recognize for both the Title XIX Waiver Group (TWG) and PPC member populations.

Delivery supplemental premiums are payments received per newborn delivery and are intended by AHCCCS to cover the cost of maternity care for qualified pregnant women. Such premiums are billed and recognized in the month that delivery occurs.

2. Summary of Significant Accounting Policies (continued)

Medical Expenses

Monthly capitation payments to primary care physicians and other healthcare providers are expensed in the month services are contracted to be performed. Claims expense for non-capitated arrangements is accrued as services are rendered by hospitals, physicians and other healthcare providers during the year. Medical compensation includes primary care and specialty physician services. Other medical expenses include hospital outpatient services and other ancillary services such as radiology and lab.

Medical claims payable includes claims received but not paid and an estimate of claims incurred but not reported. Incurred but not reported claims are estimated using a combination of historical claims experience (including severity and payment lag time) and other actuarial analysis including number of enrollees, age of enrollees and certain enrollee health indicators to predict the cost of healthcare services provided to enrollees during any given period. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from estimates given changes in the healthcare cost structure or adverse experience. During the year ended September 30, 2010, the Plan received an independent actuarial analysis resulting in a decrease to medical expenses of approximately $6,400,000 related to estimates for prior years.

Reinsurance

Contractually, the Plan is reimbursed by AHCCCS for healthcare costs that exceed stated amounts at a rate ranging from 75% to 100% of qualified healthcare costs in excess of stated levels of up to $35,000, depending on the case type of the member. Qualified costs must be incurred during the contract year and are the lesser of the amount paid by the Plan or the AHCCCS fee schedule. Amounts are recognized under the contract with AHCCCS when healthcare costs exceed stated amounts as provided under the contract, including estimates of such costs at the end of each accounting period. In the event that AHCCCS is unable to honor its reinsurance commitment, the Plan may be responsible for excess costs incurred. Reinsurance recoveries totaling $30,263,164 were recognized during the year ended September 30, 2010, and are included as a reduction of hospital medical expenses in the accompanying statement of earnings.

2. Summary of Significant Accounting Policies (continued)

Administrative Expenses

The Plan shares its property leases and employees with Health Choice Generations (HCG), another division of the Parent. Administrative costs are shared between the Plan and HCG based on the revenue earned by each plan. Except for certain costs that are specific to one plan or the other, all administrative expenses are paid by the Plan and allocated to HCG according to HCG's percentage of the total combined revenue of the Parent. Costs pertaining only to the Plan, such as premium tax, are not allocated. Costs that can be specifically identified as pertaining to HCG only, such as the HCC Life Insurance Company (HCC) reinsurance premiums and certain data processing and marketing costs, are directly charged to HCG.

Income Taxes

IASIS files consolidated Federal and state income tax returns, which include the operating results of the Plan. IASIS allocates taxes to the Plan pursuant to the asset and liability method, as if the Plan were a separate taxpayer. For balance sheet purposes, such allocations are included in due from affiliates in the accompanying balance sheet.

Fair Value of Financial Instruments

AHCCCS receivables and payables, due from affiliates, accounts payable and accrued expenses, and medical claims payable represent financial instruments. The carrying value of these financial instruments approximates their fair market value due to the short-term nature of these instruments.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

2. Summary of Significant Accounting Policies (continued)

Subsequent Events Consideration

The Plan evaluated events and transactions occurring subsequent to September 30, 2010 through January 27, 2011, the date these financial statements were available for issuance. During this period, there were no subsequent events that required recognition in the financial statements.

3. Transactions with Affiliates

The Plan remitted fee-for-service payments totaling $10,193,809 during the year ended September 30, 2010, to facilities which are owned and operated by IASIS.

4. AHCCCS Payables

The AHCCCS payables consist of the following at September 30, 2010:

Reinsurance, net	$ (15,278,914)
Delivery supplement	(483,247)
Capitation receivable	(1,344,611)
TWG and PPC reconciliation settlements, net of risk adjustments	48,334,490
	$ 31,227,718

5. Leases

The Plan leases its office facilities under various operating lease agreements. The following is a schedule of the future minimum lease payments required under noncancelable leases with initial or remaining terms in excess of one year at September 30, 2010:

Fiscal year:	
2011	$ 1,260,284
2012	1,275,565
2013	1,309,962
2014	775,849
Total	$ 4,621,660

5. Leases (continued)

Rental expense totaled $1,454,982 for the year ended September 30, 2010, and is included within administrative expenses in the accompanying statement of earnings.

6. Commitments and Contingencies

Professional, General and Other Liability Insurance

The Plan is subject to claims and lawsuits arising in the ordinary course of business, including, but not limited to, injuries arising from patient treatment and denials thereof and personal injuries. The Plan believes that its liability for damages resulting from such claims and lawsuits is adequately covered by insurance or is adequately provided for in its financial statements.

The Plan's contract with AHCCCS requires the Plan to maintain professional liability insurance, comprehensive general insurance, and automobile liability insurance coverage of at least $1,000,000 for each occurrence. During the year ended September 30, 2010, the Plan was covered under IASIS' umbrella policy. IASIS, on behalf of the Plan, carries professional and general liability insurance, as well as workers' compensation insurance, in excess of self-insured retentions through an unrelated commercial insurance carrier in amounts that IASIS believes to be sufficient for the Plan, although some claims may exceed the scope of coverage in effect. IASIS maintains reserves for professional and general liability and workers' compensation claims. Accordingly, no reserve for liability risks are recorded on the accompanying balance sheet. The cost for the year ended September 30, 2010, totaled $143,245 and $202,837 for professional and general liability and workers' compensation, respectively, and is included within administrative expenses in the accompanying statement of earnings. The Plan is currently not a party to any such proceedings that, in the Plan's opinion, would have a material adverse effect on the Plan's business, financial condition or results of operations.

Employee Benefit Insurance Risks

The Plan participates in a self-insured program for health insurance and other medical benefit programs administered by IASIS. The cost of employee health and other medical benefits is allocated by IASIS based on total covered employees and dependents. The cost allocated to the Plan, net of employee premiums, totaled $1,823,379 for the year ended September 30, 2010, and is included within administrative expenses in the accompanying statement of earnings.

6. Commitments and Contingencies (continued)

Performance Guarantee

If the Plan fails to effectively manage healthcare costs, these costs may exceed the premiums received by the Plan. The Plan believes the capitated premiums, together with reinsurance and other supplemental premiums, are sufficient to pay for the services the Plan is obligated to deliver. Pursuant to its contract with AHCCCS, the Plan is required annually to provide performance bonds or letters of credit, in an acceptable form, to guarantee performance of the Plan's obligations under its contract to provide and pay for the healthcare services. The amount of the performance guaranty that AHCCCS requires is generally based upon the membership in the Plan and the related capitation paid to the Plan. As of September 30, 2010, the Plan provided performance guarantees in the form of irrevocable standby letters of credit for the benefit of AHCCCS totaling $48,318,612.

State and Federal Laws and Regulations

The Plan is subject to state and federal laws and regulations. The Centers for Medicare and Medicaid Services and AHCCCS have the right to audit the Plan to determine the Plan's compliance with such standards. The Plan is required to file periodic reports with AHCCCS and to meet certain financial viability standards. The Plan must also provide its enrollees with certain mandated benefits and must meet certain quality assurance and improvement requirements. The Plan believes it is in compliance with these AHCCCS requirements. The Plan must also comply with the electronic transactions regulations and privacy standards of the Health Insurance Portability and Accountability Act (HIPAA). The Plan believes it is in compliance with the HIPAA security standards as set forth in 45 CFR Part 164. The Plan has also complied with the requirements for health plans defined in 45 CFR Part 162.

Other

On March 31, 2008, the United States District Court for the District of Arizona ("District Court") dismissed with prejudice the *qui tam* complaint against IASIS Healthcare Corporation (IAS), the parent company of IASIS. The *qui tam* action sought monetary damages and civil penalties under the FCA and included allegations that certain business practices related to physician relationships and the medical necessity of certain procedures resulted in the submission of claims for reimbursement in violation of the FCA. The case dates back to March 2005 and became the subject of a subpoena by the OIG in September 2005. In August 2007, the case was unsealed and

6. Commitments and Contingencies (continued)

the U.S. Department of Justice declined to intervene. The District Court dismissed the case from the bench at the conclusion of oral arguments on IAS' motion to dismiss. On April 21, 2008, the District Court issued a written order dismissing the case with prejudice and entering formal judgment for IAS and denying as moot IAS' motions related to the relator's misappropriation of information subject to a claim of attorney-client privilege by IAS. Both parties appealed. On August 12, 2010, United States Court of Appeals for the Ninth Circuit reversed the District Court's dismissal of the *qui tam* complaint and the District Court's denial of IAS' motions concerning relator's misappropriation of documents and ordered that the *qui tam* relator be allowed leave to file a Third Amended Complaint and for the District Court to consider IAS' motions concerning relator's misappropriation of documents. The District Court ordered the *qui tam* relator to file his Third Amended Complaint by November 22, 2010, and set a schedule for the filing of motions related to the relator's misappropriation of documents. On October 20, 2010, the *qui tam* relator filed a motion to transfer this action to the United States District Court for the Eastern District of Texas. That motion remains pending. On November 22, 2010, the relator filed his Third Amended Complaint. On January 3, 2011, IAS filed its renewed motion for sanctions concerning the relator's misappropriation of documents and, on January 14, 2011, IAS filed its motion to dismiss relator's Third Amended Complaint. Relator's brief in opposition to IAS' motion to dismiss is due February 18, 2011 and IAS' reply brief is due March 14, 2011. If the *qui tam* action was to be resolved in a manner unfavorable to IAS, it could have a material adverse effect on the business, financial condition and results of operations of IAS and the Plan, including exclusion from the Medicare and Medicaid programs. In addition, we may incur material fees, costs and expenses in connection with defending the qui tam action.

7. Retirement Plan

Substantially all employees of the Plan, upon qualification, are eligible to participate in IASIS' defined contribution 401(k) plan. Employees who elect to participate generally make contributions from 1% to 20% of their eligible compensation and IASIS matches, at its discretion, such contributions on behalf of the Plan up to a maximum percentage. Generally, employees immediately vest 100% in their own contributions and vest in the employer portion of contributions over a period not to exceed five years. Defined contribution expense totaled $167,705 for the year ended September 30, 2010, and is included within administrative expenses in the accompanying statement of earnings.

Other Financial Information

Unaudited

Health Choice Arizona, Inc.

Fiscal Year Ended September 30, 2010

Claims Lag Report

Expense Type: Hospital, Medical and Other (PPC and Prospective)

Payment Qtr	Current	1st Prior	2nd Prior	3rd Prior	4th Prior	5th Prior	6th Prior*	Total
Current	$ 81,498,866	$ 67,062,998	$ 9,139,870	$ 3,085,850	$ (190,081)	$ 44,248	$ 6,429	$ 160,648,180
1st Prior		86,099,033	78,126,500	10,125,667	2,240,013	1,206,852	59,652	177,857,716
2nd Prior			77,007,438	60,579,481	6,390,045	1,390,059	591,813	145,958,836
3rd Prior				89,367,490	76,310,710	8,111,167	3,771,584	177,560,952
4th Prior					76,485,770	70,005,799	12,140,410	158,631,978
5th Prior						73,432,935	74,301,399	147,734,333
6th Prior*							2,484,497,185	2,484,497,185
Totals	81,498,866	153,162,031	164,273,807	163,158,488	161,236,457	154,191,059	2,575,368,471	3,452,889,180
Expense	162,095,463	165,754,908	155,098,956	176,290,748	167,731,260	156,701,971	2,565,061,604	3,548,734,909
Adjustment	-	-	-	-	-	-	8,517,708	8,517,708
Remaining	$ 80,596,597	$ 12,592,877	$ (9,174,851)	$ 13,132,259	$ 6,494,803	$ 2,510,912	$ (1,789,159)	$ 104,363,438

* Amounts in this column or row include the amounts for the 6th prior period, and any earlier periods where the expenses reported exceed the payments made to date.

Medical Expense from Total Profitability Report:	$ 679,219,090
Less: Subcapitation Expense	(22,917,355)
Plus: Pharmacy Rebates Accrued	2,938,340
Fee For Service Medical Expense	659,240,074
Sum of Current through 3rd Prior Expense above:	659,240,075
	$ (0)

Claims Lag Report	$ 104,363,438
Subcapitation Payable	73,894
Total Medical Claims Payable	$ 104,437,331

1010-1194100

Health Choice Arizona, Inc.
Fiscal Year Ended September 30, 2010
Total GSAs

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/10 Total GSAs	TANF <1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI without Med	MED	Non - MED	SOBRA Family Planing	SOBRA Moms	Title XIX Total	State Only Transplants	State Only Total	Grand Total
Revenue and expenses																
Member months:																
SOBRA FPS Mmbr Mths	-	-	-	-	-	-	-	-	-	-	7,586	-	7,586	-	-	7,586
PPC Member Months	2,823	41,596	23,059	12,705	3,804	83,987	1,932	3,460	3,993	39,455	-	4,073	136,900	2	2	136,902
Pros. Member Months	101,931	895,919	413,485	219,071	71,214	1,701,620	136,350	107,744	14,500	411,591	-	29,871	2,401,676	25	25	2,401,701
Total Member Months	104,754	937,515	436,544	231,776	75,018	1,785,607	138,282	111,204	18,493	451,046	7,586	33,944	2,546,162	27	27	2,546,189
Pros. & FPS Mbr. Mths	101,931	895,919	413,485	219,071	71,214	1,701,620	136,350	107,744	14,500	411,591	7,586	29,871	2,409,262	25	25	2,409,287
Pros. & PPC Mbr. Mths	104,754	937,515	436,544	231,776	75,018	1,785,607	138,282	111,204	18,493	451,046		33,944	2,538,576	27	27	2,538,603
Revenues																
305 Capitation	$ 49,250,439	$ 99,729,181	$ 102,326,940	$ 31,539,164	$ 28,897,311	$ 311,743,036	$ 20,770,179	$ 83,194,264	$ 19,787,002	$ 217,350,130	$ 137,079	$ 7,389,984	$ 660,371,673	$ 551	$ 551	660,372,225
310 PPC Capitation	3,108,327	2,729,921	5,662,278	2,660,801	1,611,283	15,772,609	281,870	1,352,666	28,463,967	41,506,942	-	999,869	88,377,924	56	56	88,377,980
312 Reserved	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
315 Delivery Supplement	-	-	14,840,618	-	-	14,840,618	(6,717)	583,572	13,021	1,291,693	-	24,519,717	41,241,904	-	-	41,241,904
320 Reserved	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
321 TWG Settlement	-	-	-	-	-	-	-	-	(1,579,779)	(14,610,252)	-	-	(16,190,031)	-	-	(16,190,031)
322 PPC Settlement	(881,504)	(821,450)	(1,632,368)	(1,723,632)	(868,215)	(5,927,168)	(54,592)	(277,420)	(8,884,341)	(16,551,291)	-	(183,144)	(31,877,956)	-	-	(31,877,956)
325 Investment Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
330 Other Income	2,513	20,472	10,533	6,007	2,116	41,642	3,874	2,785	480	11,287	-	856	60,923	-	-	60,923
Total revenues	51,479,775	101,658,125	121,208,001	32,482,341	29,642,495	336,470,737	20,994,615	84,855,867	37,800,349	228,998,508	137,079	32,727,282	741,984,437	608	608	741,985,045
Expenses																
Hospitalization:																
402 Hospital Inpatient	36,556,662	7,832,429	22,589,229	4,579,139	6,216,607	77,774,067	7,223,833	25,371,897	8,769,976	47,079,297	1,107	17,005,941	183,226,118	18,941	18,941	183,245,059
404 Reserved	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
406 PPC-Hospital Inpatient	2,757,546	806,779	1,779,340	589,289	656,392	6,589,346	476,507	1,276,499	12,557,315	15,024,018	-	595,474	36,519,159	-	-	36,519,159
Total hospitalization	39,314,208	8,639,208	24,368,569	5,168,428	6,873,000	84,363,412	7,700,340	26,648,396	21,327,292	62,103,315	1,107	17,601,415	219,745,277	18,941	18,941	219,764,218
Medical compensation:																
408 Primary Care Physician	6,392,658	13,040,075	7,984,430	2,169,651	1,456,965	31,043,778	857,092	3,185,634	480,225	8,946,593	31,769	653,964	45,199,056	-	-	45,199,056
410 Referral Physician	5,181,105	10,072,043	17,340,017	4,398,621	4,775,202	41,766,988	2,643,062	10,621,723	2,778,065	28,467,205	12,761	7,084,395	93,374,199	-	-	93,374,199
412 Other Professional	1,089,943	2,328,870	2,417,747	793,068	319,121	6,948,749	267,894	1,125,722	259,899	2,126,165	2,377	744,090	11,474,896	-	-	11,474,896
414 PPC – Physician Services	409,965	405,666	622,804	199,313	150,160	1,787,908	44,859	192,906	2,495,877	3,033,747	-	291,681	7,846,978	-	-	7,846,978
Total medical comp	13,073,671	25,846,653	28,364,999	7,560,653	6,701,447	81,547,424	3,812,908	15,125,986	6,014,066	42,573,710	46,907	8,774,130	157,895,129	-	-	157,895,129
Other medical expenses:																
416 Emergency Facility Services	1,696,456	6,517,367	6,519,109	2,042,531	723,243	17,498,706	106,301	2,639,098	334,079	8,097,453	380	513,634	29,189,651	-	-	29,189,651
418 Pharmacy	688,735	7,334,891	10,352,133	3,683,226	4,285,375	26,344,359	296,784	15,136,740	1,443,607	24,639,583	25,829	573,479	68,460,379	4,946	4,946	68,465,325
420 Lab, X-ray, & Medical Imaging	673,712	2,620,339	7,715,267	1,655,148	1,941,239	14,605,706	937,469	3,988,379	992,433	12,428,534	3,640	1,765,530	34,721,692	10	10	34,721,701
422 Outpatient Facility	2,281,814	8,513,116	15,774,563	4,705,407	4,056,547	35,331,447	1,780,179	9,455,601	2,527,893	24,733,639	26,423	1,736,238	75,591,420	-	-	75,591,420
424 Durable Medical Equipment	215,215	1,365,716	1,098,076	487,478	248,379	3,414,864	190,513	949,691	167,067	2,045,806	189	87,495	6,855,625	30	30	6,855,655
426 Dental	17,944	20,151,229	3,359,180	2,361,043	110,878	26,000,274	180,304	690,999	88,015	1,915,630	-	132,570	29,007,792	-	-	29,007,792
428 Transportation	1,928,877	4,101,638	4,054,141	1,552,995	786,723	12,424,373	1,224,500	4,039,455	500,425	8,411,823	59	820,951	27,421,586	38	38	27,421,624
430 Nursing Facility, Home Health Care	173,075	346,906	460,645	117,663	214,083	1,312,371	1,130,993	2,070,123	792,258	3,613,746	-	135,579	9,055,070	7	7	9,055,077
432 Physical Therapy	244,059	313,892	613,890	258,995	253,766	1,684,602	95,197	393,305	102,013	1,467,938	-	16,341	3,759,396	-	-	3,759,396
434 Reserved	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
436 Miscellaneous Medical Expenses	21,840	1,389,815	520,714	313,536	194,964	2,440,869	948,912	837,367	132,261	721,139	-	19,522	5,100,070	-	-	5,100,070
438 PPC-Other	149,371	813,449	1,354,545	466,878	306,195	3,090,438	67,706	262,203	3,180,880	5,263,318	-	527,485	12,392,031	-	-	12,392,031
Total other medical	8,091,098	53,468,357	51,822,262	17,644,900	13,121,392	144,148,009	6,958,857	40,462,961	10,260,931	93,338,609	56,521	6,328,824	301,554,712	5,030	5,030	301,559,742
Total medical expenses	60,478,978	87,954,219	104,555,830	30,373,980	26,695,838	310,058,845	18,472,105	82,237,343	37,602,288	198,015,634	104,535	32,704,369	679,195,118	23,972	23,972	679,219,090
Less:																
440 Reinsurance	(6,089,220)	(1,048,727)	(3,125,019)	(263,858)	(1,232,691)	(11,759,514)	(82,518)	(6,539,186)	(1,591,404)	(9,652,059)	-	(594,503)	(30,219,185)	(43,265)	(43,265)	(30,262,450)
441 Reserved	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
442 Third Party Liability	(18,418)	(125,398)	(428,081)	(181,381)	(31,508)	(784,787)	(25,052)	(68,287)	(81,114)	(337,143)	(419)	(31,867)	(1,328,668)	-	-	(1,328,668)
Total net medical expenses	54,371,339	86,780,094	101,002,729	29,928,742	25,431,640	297,514,544	18,364,534	75,629,871	35,929,770	188,026,432	104,116	32,077,999	647,647,265	(19,293)	(19,293)	647,627,972
Total admin expenses	1,848,858	3,617,707	4,336,589	1,207,338	1,077,554	12,088,046	743,451	3,003,402	1,704,998	9,174,516	4,846	1,161,587	27,880,846	21	21	27,880,867
Total expenses	56,220,197	90,397,801	105,339,318	31,136,079	26,509,194	309,602,589	19,107,986	78,633,273	37,634,768	197,200,948	108,961	33,239,586	675,528,111	(19,272)	(19,272)	675,508,839
Income (loss) from operations	(4,740,422)	11,260,324	15,868,683	1,346,261	3,133,301	26,868,147	1,886,629	6,222,594	165,581	31,797,560	28,117	(512,304)	66,456,325	19,879	19,879	66,476,206
Non-operating inc (loss)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Income (loss) before taxes	(4,740,422)	11,260,324	15,868,683	1,346,261	3,133,301	26,868,147	1,886,629	6,222,594	165,581	31,797,560	28,117	(512,304)	66,456,325	19,879	19,879	66,476,206
Income taxes	(552,203)	3,189,973	4,320,471	538,735	916,729	8,413,704	557,365	1,956,809	261,312	8,520,509	6,486	142,925	19,859,109	4,818	4,818	19,863,927
Premium taxes	1,079,943	2,113,264	2,533,464	705,403	629,132	7,061,205	433,965	1,756,305	995,165	5,367,320	2,826	678,954	16,295,741	-	-	16,295,741
Net income (loss)	$ (5,268,162)	$ 5,957,088	$ 9,014,748	$ 102,123	$ 1,587,441	$ 11,393,238	$ 895,299	$ 2,509,480	$ (1,090,895)	$ 17,909,731	$ 18,805	$ (1,334,183)	$ 30,301,475	$ 15,062	$ 15,062	$ 30,316,537

1010-1194100

Health Choice Arizona, Inc.
Fiscal Year Ended September 30, 2010
GSA 2 Yuma/LaPaz

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/10 GSA 2 Yuma/LaPaz	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planing	SOBRA Moms	Title XIX Total	State Only Transplants	State Only Total	Grand Total
Revenue and expenses																
Member months:																
SOBRA FPS Mmbr Mths	-	-	-	-	-	-	-	-	-	-	672	-	672	-	-	672
PPC Member Months	189	2,629	1,460	822	297	5,397	202	392	230	2,111	-	301	8,633	2	2	8,635
Pros. Member Months	7,271	53,885	29,255	15,328	6,952	112,691	15,980	6,980	1,063	26,795	-	2,507	166,016	9	9	166,025
Total Member Months	7,460	56,514	30,715	16,150	7,249	118,088	16,182	7,372	1,293	28,906	672	2,808	175,321	11	11	175,332
Pros. & FPS Mbr. Mths	7,271	53,885	29,255	15,328	6,952	112,691	15,980	6,980	1,063	26,795	672	2,507	166,688	9	9	166,697
Pros. & PPC Mbr. Mths	7,460	56,514	30,715	16,150	7,249	118,088	16,182	7,372	1,293	28,906	-	2,808	174,649	11	11	174,660
Revenues																
305 Capitation	$ 3,722,511	$ 5,540,619	$ 5,681,062	$ 1,769,236	$ 2,460,392	$ 19,173,821	$ 2,442,137	$ 4,818,908	$ 1,723,848	$ 12,018,565	$ 12,732	$ 488,008	$ 40,678,019	$ 200	$ 200	$ 40,678,219
310 PPC Capitation	215,236	175,638	348,809	169,535	125,805	1,035,024	30,372	154,365	1,695,645	2,216,888	-	72,010	5,204,303	47	47	5,204,350
315 Delivery Supplement	-		911,472	-	-	911,472	-	24,973	-	49,947	-	1,910,456	2,896,848	-	-	2,896,848
321 TWG Settlement	-	-	-	-	-	-	-	-	(372,375)	527,946	-	-	155,571	-	-	155,571
322 PPC Settlement	117,444	(7,366)	(164,211)	(123,720)	(113,742)	(291,595)	(24,639)	30,243	(818,642)	(1,404,678)	-	6,390	(2,502,920)	-	-	(2,502,920)
325 Investment Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
330 Other Income	541	3,743	2,022	1,068	484	7,859	1,065	469	78	1,813	-	178	11,462	-	-	11,462
Total revenues	4,055,732	5,712,634	6,779,154	1,816,120	2,472,939	20,836,580	2,448,935	5,028,958	2,228,555	13,410,481	12,732	2,477,041	46,443,282	248	248	46,443,530
Expenses																
Hospitalization:																
402 Hospital Inpatient	2,234,828	237,322	1,126,350	371,599	270,108	4,240,206	887,088	1,346,419	405,428	3,016,742	-	1,185,881	11,081,764	-	-	11,081,764
406 PPC-Hospital Inpatient	234,561	62,052	95,474	12,102	37,534	441,723	69,152	142,218	773,683	658,969	-	32,386	2,118,130	-	-	2,118,130
Total hospitalization	2,469,390	299,374	1,221,823	383,700	307,641	4,681,929	956,240	1,488,636	1,179,111	3,675,712	-	1,218,267	13,199,894	-	-	13,199,894
Medical compensation:																
408 Primary Care Physician	413,907	658,982	477,161	124,921	144,836	1,819,808	82,686	165,943	33,351	543,181	2,590	27,409	2,674,968	-	-	2,674,968
410 Referral Physician	342,256	493,068	1,038,303	233,896	359,997	2,467,520	296,100	686,755	206,500	1,739,836	252	626,402	6,023,365	-	-	6,023,365
412 Other Professional	159,104	92,889	97,682	38,216	26,977	414,867	21,219	54,843	15,219	29,290	9	70,423	605,871	-	-	605,871
414 PPC - Physician Services	28,357	21,033	41,064	11,113	12,120	113,687	3,783	33,633	163,991	150,211	-	28,027	493,332	-	-	493,332
Total medical comp	943,623	1,265,972	1,654,211	408,146	543,931	4,815,883	403,768	941,175	419,061	2,462,518	2,852	752,261	9,797,537	-	-	9,797,537
Other medical expenses:																
416 Emergency Facility Services	104,812	400,461	436,047	123,775	73,487	1,138,582	9,673	205,494	28,798	511,877	-	87,826	1,982,250	-	-	1,982,250
418 Pharmacy	41,970	304,771	443,041	153,663	340,761	1,284,206	21,562	1,192,839	92,809	1,410,399	2,522	34,016	4,038,352	-	-	4,038,352
420 Lab, X-ray, & Medical Imaging	46,567	167,776	574,959	115,761	250,793	1,155,856	119,611	280,387	118,741	925,136	391	167,097	2,767,220	-	-	2,767,220
422 Outpatient Facility	73,991	397,482	766,758	240,318	439,756	1,918,305	194,509	607,096	212,412	1,694,288	16	95,453	4,722,079	-	-	4,722,079
424 Durable Medical Equipment	9,410	71,408	64,914	27,537	26,123	199,392	11,607	51,607	9,523	93,272	-	5,640	371,041	13	13	371,083
426 Dental	1,703	1,316,461	236,688	168,482	8,114	1,731,448	17,937	33,655	5,504	128,127	-	10,233	1,926,904	-	-	1,926,904
428 Transportation	271,478	289,492	293,226	79,662	84,739	1,018,596	340,219	473,828	27,166	776,173	59	63,454	2,699,495	14	14	2,699,509
430 Nursing Facility, Home Health Care	2,859	16,477	8,515	5,967	27,842	61,660	234,988	111,800	46,375	196,165	-	1,528	652,516	3	3	652,519
432 Physical Therapy	2,730	19,522	25,980	12,350	31,641	92,223	9,621	27,619	13,613	103,431	-	56	246,563	-	-	246,563
436 Miscellaneous Medical Expenses	798	85,449	42,916	18,766	7,580	155,509	173,386	96,654	2,409	42,582	-	1,040	471,580	-	-	471,580
438 PPC-Other	11,543	90,115	75,955	33,060	48,063	258,737	7,922	38,872	237,535	376,764	-	30,679	950,509	-	-	950,509
Total other medical	567,862	3,159,414	2,968,998	979,341	1,338,899	9,014,513	1,141,035	3,119,851	794,885	6,258,214	2,988	497,023	20,828,509	30	30	20,828,539
Total medical expenses	3,980,875	4,724,760	5,845,032	1,771,187	2,190,471	18,512,325	2,501,063	5,549,662	2,393,057	12,396,443	5,839	2,467,550	43,825,940	30	30	43,825,970
Less:																
440 Reinsurance	(623,559)	24,305	(55,248)	(2,241)	(87,290)	(744,033)	(2,036)	(615,653)	(34,814)	(603,026)	-	-	(1,999,561)	-	-	(1,999,561)
442 Third Party Liability	-	(4,495)	(67,601)	(4,576)	-	(76,673)	(162)	(57)	-	(37,608)	-	-	(114,499)	-	-	(114,499)
Total net medical expenses	3,357,316	4,744,570	5,722,183	1,764,369	2,103,181	17,691,619	2,498,865	4,933,953	2,358,243	11,755,809	5,839	2,467,550	41,711,879	30	30	41,711,909
Total admin expenses	138,417	201,696	245,281	68,566	91,029	744,989	87,622	176,293	121,188	503,245	450	86,928	1,720,716	9	9	1,720,725
Total expenses	3,495,733	4,946,266	5,967,464	1,832,935	2,194,210	18,436,608	2,586,487	5,110,246	2,479,431	12,259,055	6,289	2,554,479	43,432,595	39	39	43,432,634
Income (loss) from operations	560,000	766,368	811,690	(16,815)	278,729	2,399,972	(137,552)	(81,288)	(250,876)	1,151,426	6,443	(77,438)	3,010,687	209	209	3,010,896
Non-operating inc (loss)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Income (loss) before taxes	560,000	766,368	811,690	(16,815)	278,729	2,399,972	(137,552)	(81,288)	(250,876)	1,151,426	6,443	(77,438)	3,010,687	209	209	3,010,896
Income taxes	154,469	210,408	227,724	7,669	86,158	686,429	(10,932)	23,240	(32,207)	364,017	1,404	1,588	1,033,539	46	46	1,033,586
Premium taxes	81,357	117,931	143,132	39,974	53,402	435,797	50,927	103,113	70,450	294,905	262	51,050	1,006,504	-	-	1,006,504
Net income (loss)	$ 324,173	$ 438,029	$ 440,833	$ (64,458)	$ 139,169	$ 1,277,747	$ (177,547)	$ (207,642)	$ (289,120)	$ 492,504	$ 4,776	$ (130,075)	$ 970,644	$ 162	$ 162	$ 970,806

Health Choice Arizona, Inc.
Fiscal Year Ended September 30, 2010
GSA 4 Apache, Coconino, Mohave, Navajo

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/10 GSA 4 Apache, Coconino, Mohave, Navajo	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planing	SOBRA Moms	Title XIX Total	State Only Transplants	State Only Total	Grand Total
Revenue and expenses																
Member months:																
SOBRA FPS Mmbr Mths	-	-	-	-	-	-	-	-	-	-	2,449	-	2,449	-	-	2,449
PPC Member Months	736	10,962	6,282	3,871	1,115	22,966	496	900	1,758	11,039	-	1,015	38,174	-	-	38,174
Pros. Member Months	28,770	254,101	130,513	76,351	25,491	515,226	43,684	35,538	6,318	148,064	-	10,026	758,856	6	6	758,862
Total Member Months	29,506	265,063	136,795	80,222	26,606	538,192	44,180	36,438	8,076	159,103	2,449	11,041	799,479	6	6	799,485
Pros. & FPS Mbr. Mths	28,770	254,101	130,513	76,351	25,491	515,226	43,684	35,538	6,318	148,064	2,449	10,026	761,305	6	6	761,311
Pros. & PPC Mbr. Mths	29,506	265,063	136,795	80,222	26,606	538,192	44,180	36,438	8,076	159,103	-	11,041	797,030	6	6	797,036
Revenues																
305 Capitation	$ 13,652,199	$ 30,035,533	$ 36,694,975	$ 12,373,030	$ 11,563,064	$ 104,318,801	$ 7,549,389	$ 30,288,368	$ 8,673,922	$ 80,878,971	$ 42,441	$ 2,827,072	$ 234,578,964	$ 120	$ 120	$ 234,579,084
310 PPC Capitation	823,149	712,534	1,602,052	828,636	483,703	4,450,074	74,959	352,215	12,798,911	11,421,918	-	258,978	29,357,056	9	9	29,357,065
315 Delivery Supplement	-	-	4,419,139	-	-	4,419,139	-	151,297	6,304	346,723	-	7,980,865	12,904,328	-	-	12,904,328
321 TWG Settlement	-	-	-	-	-	-	-	-	(462,184)	497,137	-	-	34,954	-	-	34,954
322 PPC Settlement	(226,905)	(395,556)	(431,925)	(559,033)	(455,202)	(2,068,621)	(4,089)	246,335	(4,720,195)	(618,692)	-	40,301	(7,124,961)	-	-	(7,124,961)
325 Investment Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
330 Other Income	1,972	16,729	8,511	4,939	1,632	33,783	2,809	2,316	402	9,473	-	678	49,461	-	-	49,461
Total revenues	14,250,415	30,369,241	42,292,753	12,647,571	11,593,197	111,153,176	7,623,067	31,040,531	16,297,160	92,535,531	42,441	11,107,894	269,799,801	129	129	269,799,930
Expenses																
Hospitalization:																
402 Hospital Inpatient	10,394,813	2,276,923	7,898,907	1,689,119	2,574,366	24,834,127	1,870,446	8,724,377	3,698,626	18,952,794	1,107	5,522,040	63,603,517	-	-	63,603,517
406 PPC-Hospital Inpatient	712,867	149,240	550,871	214,040	105,908	1,732,927	42,196	508,806	5,010,188	5,552,227	-	108,626	12,954,969	-	-	12,954,969
Total hospitalization	11,107,680	2,426,163	8,449,777	1,903,158	2,680,274	26,567,053	1,912,641	9,233,183	8,708,814	24,505,021	1,107	5,630,666	76,558,486	-	-	76,558,486
Medical compensation:																
408 Primary Care Physician	1,933,032	4,080,765	2,934,767	908,003	611,635	10,468,203	305,317	1,233,544	244,461	3,641,226	9,913	234,155	16,136,818	-	-	16,136,818
410 Referral Physician	953,608	3,130,880	6,132,811	1,806,288	1,834,405	13,857,993	858,691	3,650,196	1,058,664	11,592,311	8,608	2,080,441	33,106,903	-	-	33,106,903
412 Other Professional	564,991	585,227	758,267	277,618	65,747	2,251,850	50,300	517,443	87,605	191,516	1,338	302,145	3,402,199	-	-	3,402,199
414 PPC – Physician Services	92,752	94,859	211,244	61,830	43,286	503,972	10,869	72,978	889,061	926,273	-	66,031	2,469,183	-	-	2,469,183
Total Medical Comp	3,544,382	7,891,733	10,037,090	3,053,739	2,555,073	27,082,017	1,225,177	5,474,162	2,279,791	16,351,326	19,859	2,682,771	55,115,104	-	-	55,115,104
Other medical expenses:																
416 Emergency Facility Services	525,465	2,126,303	2,719,133	976,770	335,649	6,683,320	44,562	1,096,689	171,327	3,446,679	-	197,309	11,639,886	-	-	11,639,886
418 Pharmacy	195,104	1,951,402	3,833,824	1,535,544	1,737,726	9,253,599	129,900	5,877,549	723,304	10,042,198	7,692	235,085	26,269,328	2,704	2,704	26,272,032
420 Lab, X-ray, & Medical Imaging	180,205	806,662	2,862,351	651,210	664,764	5,165,192	221,319	1,499,572	388,316	4,756,584	1,552	687,337	12,719,872	1	1	12,719,873
422 Outpatient Facility	458,263	2,767,734	7,047,162	2,299,398	1,898,392	14,470,949	774,586	4,489,653	1,606,924	11,950,513	10,083	609,661	33,912,368	-	-	33,912,368
424 Durable Medical Equipment	57,036	403,147	394,370	211,718	92,297	1,158,568	60,004	357,519	65,237	792,229	96	28,146	2,461,799	3	3	2,461,802
426 Dental	6,306	6,946,148	1,474,895	1,017,107	52,841	9,497,297	73,008	298,329	41,533	912,975	-	55,541	10,878,683	-	-	10,878,683
428 Transportation	1,068,541	1,935,095	1,904,250	819,170	379,635	6,106,691	467,297	1,728,866	286,374	3,770,704	(0)	509,068	12,869,000	8	8	12,869,009
430 Nursing Facility, Home Health Care	32,146	85,848	219,409	41,172	59,577	438,151	215,582	797,487	314,918	964,513	-	26,700	2,757,352	2	2	2,757,354
432 Physical Therapy	51,073	98,649	250,012	118,183	93,664	611,581	37,321	157,798	48,967	619,547	-	10,822	1,486,036	-	-	1,486,036
436 Miscellaneous Medical Expenses	5,363	512,910	201,609	111,068	45,483	876,433	223,666	222,634	40,441	187,923	-	8,030	1,559,127	-	-	1,559,127
438 PPC-Other	69,513	230,522	524,465	212,721	152,082	1,189,304	22,054	100,479	1,567,118	2,030,775	-	164,244	5,073,975	-	-	5,073,975
Total other medical expenses	2,649,015	17,864,419	21,431,480	7,994,061	5,512,110	55,451,085	2,269,298	16,626,576	5,254,460	39,474,640	19,422	2,531,943	121,627,426	2,718	2,718	121,630,144
Total medical expenses	17,301,077	28,182,315	39,918,347	12,950,959	10,747,458	109,100,155	5,407,117	31,333,921	16,243,066	80,330,988	40,388	10,845,381	253,301,016	2,718	2,718	253,303,734
Less:																
440 Reinsurance	(1,210,522)	(553,848)	(1,277,933)	(23,072)	(693,254)	(3,758,629)	(27,265)	(3,058,840)	(841,648)	(4,795,025)	-	(234,066)	(12,715,473)	(2,910)	(2,910)	(12,718,383)
442 Third Party Liability	(130)	(27,221)	(117,267)	(37,630)	(12,274)	(194,521)	(2,913)	(13,463)	(46,328)	(88,073)	-	(1,832)	(347,131)	-	-	(347,131)
Total net medical expenses	16,090,425	27,601,246	38,523,147	12,890,257	10,041,930	105,147,005	5,376,938	28,261,618	15,355,090	75,447,890	40,388	10,609,482	240,238,411	(192)	(192)	240,238,220
Total admin expenses	511,004	1,085,408	1,508,371	465,914	425,231	3,995,928	269,040	1,085,727	257,670	3,268,699	1,500	390,737	9,769,301	5	5	9,769,306
Total expenses	16,601,429	28,686,655	40,031,517	13,356,171	10,467,162	109,142,933	5,645,978	29,347,344	16,112,760	78,716,590	41,888	11,000,220	250,007,713	(187)	(187)	250,007,526
Income (loss) from operations	(2,351,014)	1,682,586	2,261,235	(708,599)	1,126,035	2,010,243	1,977,089	1,693,187	184,400	13,818,942	553	107,675	19,792,089	316	316	19,792,405
Non-operating inc (loss)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Income (loss) before taxes	(2,351,014)	1,682,586	2,261,235	(708,599)	1,126,035	2,010,243	1,977,089	1,693,187	184,400	13,818,942	553	107,675	19,792,089	316	316	19,792,405
Income taxes	(353,595)	591,692	816,436	(49,795)	343,547	1,348,286	471,686	603,455	158,731	3,604,777	114	104,199	6,291,248	87	87	6,291,335
Premium taxes	298,598	634,231	881,006	272,324	248,483	2,334,642	157,285	635,401	443,178	1,911,274	875	228,286	5,710,941	-	-	5,710,941
Net income (loss)	$ (2,296,018)	$ 456,662	$ 563,794	$ (931,129)	$ 534,005	$ (1,672,686)	$ 1,348,118	$ 454,331	$ (417,509)	$ 8,302,891	$ (436)	$ (224,810)	$ 7,789,900	$ 229	$ 229	$ 7,790,129

Health Choice Arizona, Inc.
Fiscal Year Ended September 30, 2010
GSA 8 Gila, Pinal

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/10 GSA 8 Gila, Pinal	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planning	SOBRA Moms	Title XIX Total	State Only Transplants	State Only Total	Grand Total
Revenue and expenses																
Member months:																
SOBRA FPS Mmbr Mths	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
PPC Member Months	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Pros. Member Months	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Member Months	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Pros. & FPS Mbr. Mths	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Pros. & PPC Mbr. Mths	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Revenues																
305 Capitation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
310 PPC Capitation	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
315 Delivery Supplement	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
321 TWG Settlement	-	-	-	-	-	-	-	-	28,395	(756,844)	-	-	(728,450)	-	-	(728,450)
322 PPC Settlement	(37,067)	27,727	(66,665)	(68,589)	5,319	(139,276)	12,942	(24,452)	(469,208)	(29,990)	-	(76,450)	(726,433)	-	-	(726,433)
325 Investment Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
330 Other Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total revenues	(37,067)	27,727	(66,665)	(68,589)	5,319	(139,276)	12,942	(24,452)	(440,814)	(786,834)	-	(76,450)	(1,454,883)	-	-	(1,454,883)
Expenses																
Hospitalization																
402 Hospital Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
406 PPC-Hospital Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total hospitalization	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical Compensation																
408 Primary Care Physician	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
410 Referral Physician	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
412 Other Professional	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
414 PPC – Physician Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total medical comp	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Medical Expenses																
416 Emergency Facility Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
418 Pharmacy	-	-	26	-	-	26	(206)	348	-	38	3	-	209	-	-	209
420 Lab, X-ray, & Medical Imaging	-	-	0	-	-	0	3	-	-	0	-	-	3	-	-	3
422 Outpatient Facility	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
424 Durable Medical Equipment	-	-	9	-	-	9	(2)	-	-	2	-	-	9	-	-	9
426 Dental	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
428 Transportation	-	-	6	-	-	6	3	-	-	0	-	-	9	-	-	9
430 Nursing Facility, Home Health Care	-	-	2	-	-	2	-	-		0	-	-	3	-	-	3
432 Physical Therapy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
436 Miscellaneous Medical Expenses		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
438 PPC-Other	-	-	(1,226)	(8,546)	-	(9,772)	-	-	(3,314)	(362)	-	-	(13,448)	-	-	(13,448)
Total other medical	-	-	(1,183)	(8,546)	-	(9,729)	(202)	348	(3,314)	(323)	3	-	(13,216)	-	-	(13,216)
Total medical expenses	-		(1,183)	(8,546)	-	(9,729)	(202)	348	(3,314)	(323)	3	-	(13,216)	-	-	(13,216)
Less:																
440 Reinsurance	6,735	43,446	118,888	-	-	169,070	-	151,678	122,071	100,419	-	-	543,238	-	-	543,238
442 Third Party Liability	(3,755)	(9,581)	(22,666)	(31,558)	-	(67,559)	(1,518)	(2,606)	-	(8,919)	-	(1,141)	(81,743)	-	-	(81,743)
Total net medical expenses	2,980	33,866	95,040	(40,104)	-	91,782	(1,720)	149,420	118,757	91,177	3	(1,141)	448,279	-	-	448,279
Total admin expenses	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total expenses	2,980	33,866	95,040	(40,104)	-	91,782	(1,720)	149,420	118,757	91,177	3	(1,141)	448,279	-	-	448,279
Income (loss) from operations	(40,047)	(6,139)	(161,705)	(28,485)	5,319	(231,058)	14,662	(173,872)	(559,571)	(878,011)	(3)	(75,310)	(1,903,162)	-	-	(1,903,162)
Non-operating inc (loss)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Income (loss) before taxes	(40,047)	(6,139)	(161,705)	(28,485)	5,319	(231,058)	14,662	(173,872)	(559,571)	(878,011)	(3)	(75,310)	(1,903,162)	-	-	(1,903,162)
Income taxes	(8,383)	(440)	(31,697)	(6,790)	1,267	(46,041)	3,192	(34,752)	(118,278)	(174,268)	(1)	(15,892)	(386,039)	-	-	(386,039)
Premium taxes	-	-	-	-	-	-	-	-	-	-	-		-	-	-	-
Net income (loss)	$ (31,665)	$ (5,699)	$ (130,008)	$ (21,695)	$ 4,051	$ (185,017)	$ 11,470	$ (139,120)	$ (441,293)	$ (703,743)	$ (3)	$ (59,418)	$ (1,517,123)	$ -	$ -	$ (1,517,123)

1010-1194100

Health Choice Arizona, Inc.
Fiscal Year Ended September 30, 2010
GSA 10 Pima, Santa Cruz

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/10 GSA 10 Pima, Santa Cruz	TANF <1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planing	SOBRA Moms	Title XIX Total	State Only Transplants	State Only Total	Grand Total
Revenue and expenses																
Member months																
SOBRA FPS Mmbr Mths	-	-	-	-	-	-	-	-	-	-	2,536	-	2,536	-	-	2,536
PPC Member Months	696	8,626	5,233	2,549	722	17,826	399	714	622	8,784	-	1,163	29,508	-	-	29,508
Pros. Member Months	28,099	226,447	115,416	54,865	17,356	442,183	32,704	24,640	2,145	101,149	-	8,633	611,454	9	9	611,463
Total Member Months	28,795	235,073	120,649	57,414	18,078	460,009	33,103	25,354	2,767	109,933	2,536	9,796	643,498	9	9	643,507
Pros. & FPS Mbr. Mths	28,099	226,447	115,416	54,865	17,356	442,183	32,704	24,640	2,145	101,149	2,536	8,633	613,990	9	9	613,999
Pros. & PPC Mbr. Mths	28,795	235,073	120,649	57,414	18,078	460,009	33,103	25,354	2,767	109,933	-	9,796	640,962	9	9	640,971
Revenues																
305 Capitation	$ 12,293,912	$ 22,832,769	$ 26,583,510	$ 7,000,131	$ 6,614,046	$ 75,324,369	$ 4,561,592	$ 18,164,147	$ 2,785,082	$ 47,500,847	$ 48,822	$ 2,008,941	$ 150,393,800	$ 203	$ 203	$ 150,394,002
310 PPC Capitation	765,639	503,467	1,257,751	504,097	307,091	3,338,046	57,880	279,443	4,001,195	6,901,960	-	279,699	14,858,222	-	-	14,858,222
315 Delivery Supplement	-	-	4,083,126	-	-	4,083,126	-	145,354	-	297,315	-	7,280,565	11,806,360	-	-	11,806,360
321 TWG Settlement	-	-	-	-	-	-	-	-	(248,985)	(6,069,952)	-	-	(6,318,937)	-	-	(6,318,937)
322 PPC Settlement	(154,692)	(84,101)	260,338	(300,347)	11,086	(267,717)	17,508	(327,252)	(1,586,850)	(2,568,215)	-	(43,104)	(4,775,630)	-	-	(4,775,630)
325 Investment Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
330 Other Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total revenues	12,904,859	23,252,135	32,184,725	7,203,881	6,932,223	82,477,823	4,636,980	18,261,693	4,950,442	46,061,955	48,822	9,526,100	165,963,815	203	203	165,964,017
Expenses																
Hospitalization																
402 Hospital Inpatient	9,168,244	1,555,387	5,096,391	986,788	1,338,715	18,145,526	1,866,826	5,010,448	1,429,232	8,510,519	-	4,865,369	39,827,919	18,941	18,941	39,846,860
406 PPC-Hospital Inpatient	513,176	92,586	354,510	67,932	251,867	1,280,071	102,763	151,883	1,607,898	2,400,374	-	149,940	5,692,929	-	-	5,692,929
Total hospitalization	9,681,419	1,647,974	5,450,901	1,054,720	1,590,582	19,425,896	1,969,589	5,162,331	3,037,130	10,910,893	-	5,015,309	45,520,848	18,941	18,941	45,539,789
Medical Compensation																
408 Primary Care Physician	1,815,889	3,103,625	1,869,757	426,773	254,960	7,471,004	199,328	691,011	53,773	1,812,566	12,621	177,793	10,418,096	-	-	10,418,096
410 Referral Physician	1,444,664	2,338,830	4,409,600	945,829	1,085,506	10,224,428	597,699	2,319,433	477,096	5,893,431	1,846	2,224,770	21,738,704	-	-	21,738,704
412 Other Professional	194,750	884,935	763,718	231,051	118,141	2,192,595	39,603	149,412	27,797	533,929	1,029	150,867	3,095,232	-	-	3,095,232
414 PPC – Physician Services	107,448	87,388	150,507	35,671	46,858	427,873	10,968	18,410	301,209	548,047	-	88,106	1,394,614	-	-	1,394,614
Total medical comp.	3,562,751	6,414,779	7,193,582	1,639,323	1,505,465	20,315,900	847,599	3,178,266	859,874	8,787,973	15,497	2,641,537	36,646,646	-	-	36,646,646
Other Medical Expenses																
416 Emergency Facility Services	319,211	1,180,777	1,261,933	310,508	98,878	3,171,307	17,682	520,671	41,316	1,554,637	380	93,259	5,399,252	-	-	5,399,252
418 Pharmacy	201,224	1,865,456	2,813,575	932,973	923,685	6,736,913	74,638	3,056,879	142,525	5,409,678	8,449	146,828	15,575,910	120	120	15,576,031
420 Lab, X-ray, & Medical Imaging	179,039	605,920	1,825,625	328,383	407,311	3,346,278	218,244	809,464	106,868	2,559,528	1,303	360,964	7,402,649	8	8	7,402,656
422 Outpatient Facility	505,421	1,294,429	4,011,796	966,943	768,433	7,547,022	391,176	1,904,589	252,508	5,036,446	6,663	650,094	15,788,498	-	-	15,788,498
424 Durable Medical Equipment	58,794	338,450	252,540	88,384	52,192	790,360	50,661	194,180	32,912	422,819	44	33,727	1,524,703	11	11	1,524,713
426 Dental	5,769	4,120,010	584,743	386,771	15,177	5,112,470	34,875	104,862	10,402	328,176	-	24,008	5,614,793	-	-	5,614,793
428 Transportation	300,164	759,126	926,616	321,428	165,152	2,472,486	190,077	947,522	71,422	1,888,078	-	143,734	5,713,319	14	14	5,713,333
430 Nursing Facility, Home Health Care	21,729	112,166	71,678	18,093	31,986	255,653	187,117	335,704	138,194	558,996	-	54,343	1,530,006	2	2	1,530,008
432 Physical Therapy	27,897	68,581	101,934	39,968	33,301	271,681	11,675	43,481	7,304	182,712	-	1,628	518,481	-	-	518,481
436 Miscellaneous Medical Expenses	5,201	334,449	122,775	98,916	74,073	635,414	211,045	220,496	33,697	196,283	-	4,917	1,301,852	-	-	1,301,852
438 PPC-Other	17,357	121,454	256,818	63,042	39,317	497,987	12,727	32,972	310,267	873,277	-	128,162	1,855,393	-	-	1,855,393
Total other medical	1,641,806	10,800,818	12,230,034	3,555,409	2,609,504	30,837,572	1,399,917	8,170,819	1,147,416	19,010,631	16,838	1,641,664	62,224,855	154	154	62,225,010
Total medical expenses	14,885,977	18,863,571	24,874,517	6,249,453	5,705,551	70,579,068	4,217,104	16,511,416	5,044,420	38,709,497	32,335	9,298,509	144,392,349	19,095	19,095	144,411,445
Less:																
440 Reinsurance	(2,064,825)	(7,681)	(543,811)	502	(201,286)	(2,817,101)	-	(666,664)	(194,488)	(1,176,511)	-	(179,715)	(5,034,479)	-	-	(5,034,479)
442 Third Party Liability	(2,196)	(13,380)	(94,962)	(20,716)	(7,806)	(139,060)	(1,760)	(10,026)	(13,156)	(74,633)	(419)	(10,663)	(249,717)	-	-	(249,717)
Total net medical expenses	12,818,955	18,842,509	24,235,744	6,229,239	5,496,459	67,622,907	4,215,344	15,834,726	4,836,775	37,458,354	31,916	9,108,132	139,108,154	19,095	19,095	139,127,249
Total admin expenses	460,888	824,764	1,127,626	264,984	244,765	2,923,026	163,400	656,881	240,059	1,929,690	1,728	337,766	6,252,551	7	7	6,252,558
Total expenses	13,279,843	19,667,273	25,363,369	6,494,223	5,741,224	70,545,933	4,378,745	16,491,607	5,076,834	39,388,044	33,644	9,445,897	145,360,704	19,102	19,102	145,379,807
Income (loss) from operations	(374,983)	3,584,862	6,821,356	709,658	1,190,999	11,931,890	258,235	1,770,085	(126,392)	6,673,911	15,178	80,203	20,603,111	(18,900)	(18,900)	20,584,211
Non-operating inc (loss)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Income (loss) before taxes	(374,983)	3,584,862	6,821,356	709,658	1,190,999	11,931,890	258,235	1,770,085	(126,392)	6,673,911	15,178	80,203	20,603,111	(18,900)	(18,900)	20,584,211
Income taxes	35,451	927,817	1,687,928	204,559	307,098	3,162,852	86,389	509,257	3,268	1,750,558	3,538	99,703	5,615,564	(3,643)	(3,643)	5,611,922
Premium taxes	269,424	481,188	658,392	154,779	142,664	1,706,447	95,214	383,285	139,932	1,128,576	1,006	197,435	3,651,896	-	-	3,651,896
Net Income (loss)	$ (679,850)	$ 2,175,857	$ 4,475,036	$ 350,320	$ 741,237	$ 7,062,591	$ 76,632	$ 877,544	$ (269,591)	$ 3,794,777	$ 10,634	$ (216,936)	$ 11,335,651	$ (15,257)	$ (15,257)	$ 11,320,393

Health Choice Arizona, Inc.
Fiscal Year Ended September 30, 2010
GSA 12 Maricopa

Unaudited

Health Choice Arizona, Inc. Fiscal Year Ended: 9/30/10 GSA 12 Maricopa	TANF < 1 MF	TANF 1-13 MF	TANF 14-44 F	TANF 14-44 M	TANF 45+	TANF Total	SSI with Med	SSI with out Med	MED	Non - MED	SOBRA Family Planing	SOBRA Moms	Title XIX Total	State Only Transplants	State Only Total	Grand Total
Revenue and expenses																
Member months:																
SOBRA FPS Mmbr Mths	-	-	-	-	-	-	-	-	-	-	1,929	-	1,929	-	-	1,929
PPC Member Months	1,202	19,379	10,084	5,463	1,670	37,798	835	1,454	1,383	17,521	-	1,594	60,585	-	-	60,585
Pros. Member Months	37,791	361,486	138,301	72,527	21,415	631,520	43,982	40,586	4,974	135,583	-	8,705	865,350	1	1	865,351
Total Member Months	38,993	380,865	148,385	77,990	23,085	669,318	44,817	42,040	6,357	153,104	1,929	10,299	927,864	1	1	927,865
Pros. & FPS Mbr. Mths	37,791	361,486	138,301	72,527	21,415	631,520	43,982	40,586	4,974	135,583	1,929	8,705	867,279	1	1	867,280
Pros. & PPC Mbr. Mths	38,993	380,865	148,385	77,990	23,085	669,318	44,817	42,040	6,357	153,104	-	10,299	925,935	1	1	925,936
Revenues																
305 Capitation	$ 19,581,817	$ 41,320,260	$ 33,367,393	$ 10,396,767	$ 8,259,808	$ 112,926,045	$ 6,217,062	$ 29,922,840	$ 6,604,150	$ 76,951,747	$ 33,083	$ 2,065,963	$ 234,720,890	$ 28	$ 28	$ 234,720,918
310 PPC Capitation	1,304,302	1,338,282	2,453,665	1,158,532	694,684	6,949,466	118,660	566,642	9,968,216	20,966,175	-	389,183	38,958,343	-	-	38,958,343
315 Delivery Supplement	-	-	5,426,881	-	-	5,426,881	(6,717)	261,948	6,717	597,708	-	7,347,831	13,634,369	-	-	13,634,369
321 TWG Settlement	-	-	-	-	-	-	-	-	(524,630)	(8,808,538)	-	-	(9,333,168)	-	-	(9,333,168)
322 PPC Settlement	(580,283)	(362,154)	(1,229,905)	(671,942)	(315,675)	(3,159,959)	(56,314)	(202,294)	(1,289,446)	(11,929,718)	-	(110,281)	(16,748,012)	-	-	(16,748,012)
325 Investment Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
330 Other Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total revenues	20,305,836	42,296,388	40,018,035	10,883,358	8,638,817	122,142,433	6,272,691	30,549,137	14,765,006	77,777,375	33,083	9,692,697	261,232,421	28	28	261,232,449
Expenses																
Hospitalization																
402 Hospital Inpatient	14,758,778	3,762,797	8,467,581	1,531,633	2,033,419	30,554,208	2,599,473	10,290,654	3,236,690	16,599,241	-	5,432,651	68,712,918	-	-	68,712,918
406 PPC-Hospital Inpatient	1,296,941	502,900	778,486	295,215	261,083	3,134,625	262,396	473,592	5,165,546	6,412,448	-	304,522	15,753,131	-	-	15,753,131
Total hospitalization	16,055,719	4,265,697	9,246,067	1,826,849	2,294,502	33,688,834	2,861,870	10,764,246	8,402,237	23,011,689	-	5,737,173	84,466,048	-	-	84,466,048
Medical compensation:																
408 Primary Care Physician	2,229,830	5,196,701	2,702,744	709,954	445,534	11,284,763	269,761	1,095,137	148,641	2,949,620	6,645	214,607	15,969,173	-	-	15,969,173
410 Referral Physician	2,440,578	4,109,265	5,759,303	1,412,609	1,495,293	15,217,048	890,572	3,965,339	1,035,805	9,241,627	2,055	2,152,782	32,505,227	-	-	32,505,227
412 Other Professional	171,099	765,818	798,081	246,183	108,255	2,089,437	156,772	404,023	129,277	1,371,430	-	220,654	4,371,594	-	-	4,371,594
414 PPC - Physician Services	181,408	202,385	219,989	90,699	47,895	742,376	19,240	67,885	1,141,617	1,409,215	-	109,518	3,489,849	-	-	3,489,849
Total medical comp	5,022,915	10,274,170	9,480,116	2,459,445	2,096,978	29,333,624	1,336,344	5,532,383	2,455,340	14,971,892	8,700	2,697,561	56,335,843	-	-	56,335,843
Other medical expenses:																
416 Emergency Facility Services	746,968	2,809,826	2,101,996	631,478	215,229	6,505,497	34,384	816,244	92,638	2,584,260	-	135,240	10,168,263	-	-	10,168,263
418 Pharmacy	250,437	3,213,263	3,261,667	1,061,046	1,283,202	9,069,615	70,891	5,009,125	484,968	7,777,271	7,163	157,549	22,576,580	2,121	2,121	22,578,701
420 Lab, X-ray, & Medical Imaging	267,900	1,039,981	2,452,332	559,794	618,372	4,938,379	378,293	1,398,956	378,508	4,187,286	395	550,131	11,831,948	1	1	11,831,950
422 Outpatient Facility	1,244,139	4,053,470	3,948,848	1,198,748	949,966	11,395,171	419,909	2,454,262	456,048	6,052,393	9,662	381,029	21,168,475	-	-	21,168,475
424 Durable Medical Equipment	89,975	552,711	386,243	159,840	77,767	1,266,536	68,243	346,384	59,396	737,485	49	19,981	2,498,074	3	3	2,498,077
426 Dental	4,166	7,768,610	1,062,854	788,683	34,746	9,659,059	54,484	254,153	30,576	546,352	-	42,788	10,587,412	-	-	10,587,412
428 Transportation	288,694	1,117,925	930,043	332,735	157,198	2,826,595	226,903	889,240	115,463	1,976,867	-	104,696	6,139,763	2	2	6,139,765
430 Nursing Facility, Home Health Care	116,340	132,416	161,040	52,430	94,678	556,905	493,306	825,132	292,770	1,894,071	-	53,009	4,115,193	-	-	4,115,193
432 Physical Therapy	162,359	127,140	235,964	88,494	95,160	709,117	36,580	164,407	32,129	562,248	-	3,835	1,508,316	-	-	1,508,316
436 Miscellaneous Medical Expenses	10,478	457,007	153,414	84,786	67,828	773,513	340,815	297,583	55,714	294,351	-	5,535	1,767,511	-	-	1,767,511
438 PPC-Other	50,958	371,358	498,533	166,600	66,733	1,154,182	25,002	89,880	1,069,274	1,982,864	-	204,401	4,525,602	-	-	4,525,602
Total other medical	3,232,415	21,643,706	15,192,934	5,124,634	3,660,879	48,854,567	2,148,810	12,545,367	3,067,484	28,595,447	17,269	1,658,194	96,887,138	2,127	2,127	96,889,266
Total medical expenses	24,311,049	36,183,573	33,919,117	9,410,927	8,052,359	111,877,025	6,347,023	28,841,996	13,925,061	66,579,028	25,969	10,092,928	237,689,030	2,127	2,127	237,691,157
Less:																
440 Reinsurance	(2,197,048)	(554,949)	(1,366,915)	(239,047)	(250,861)	(4,608,821)	(53,217)	(2,349,707)	(642,526)	(3,177,916)	-	(180,722)	(11,012,910)	(40,355)	(40,355)	(11,053,265)
442 Third Party Liability	(12,338)	(70,722)	(125,586)	(86,900)	(11,428)	(306,973)	(18,699)	(42,134)	(21,629)	(127,911)	-	(18,231)	(535,577)	-	-	(535,577)
Total net medical expenses	22,101,663	35,557,902	32,426,616	9,084,980	7,790,069	106,961,231	6,275,107	26,450,154	13,260,906	63,273,201	25,969	9,893,975	226,140,543	(38,227)	(38,227)	226,102,315
Total admin expenses	738,549	1,505,839	1,455,311	407,874	316,528	4,424,102	223,389	1,084,501	586,081	3,472,881	1,168	346,156	10,138,278	1	1	10,138,279
Total expenses	22,840,212	37,063,741	33,881,927	9,492,854	8,106,598	111,385,333	6,498,496	27,534,655	13,846,987	66,746,083	27,136	10,240,131	236,278,821	(38,226)	(38,226)	236,240,594
Income (loss) from operations	(2,534,377)	5,232,647	6,136,107	1,390,503	532,219	10,757,100	(225,805)	3,014,482	918,019	11,031,292	5,946	(547,434)	24,953,600	38,255	38,255	24,991,855
Non-operating inc (loss)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Income (loss) before taxes	(2,534,377)	5,232,647	6,136,107	1,390,503	532,219	10,757,100	(225,805)	3,014,482	918,019	11,031,292	5,946	(547,434)	24,953,600	38,255	38,255	24,991,855
Income taxes	(380,146)	1,460,495	1,620,080	383,091	178,658	3,262,178	7,030	855,609	249,798	2,975,425	1,430	(46,673)	7,304,796	8,327	8,327	7,313,123
Premium taxes	430,563	879,913	850,935	238,326	184,582	2,584,319	130,539	634,506	341,604	2,032,565	683	202,183	5,926,400	-	-	5,926,400
Net Income (loss)	$ (2,584,794)	$ 2,892,239	$ 3,665,093	$ 769,086	$ 168,979	$ 4,910,603	$ (363,374)	$ 1,524,367	$ 326,617	$ 6,023,302	$ 3,834	$ (702,944)	$ 11,722,404	$ 29,928	$ 29,928	$ 11,752,332

Ernst & Young LLP

Assurance | Tax | Transactions | Advisory

About Ernst & Young

Ernst & Young is a global leader in assurance, tax, transaction and advisory services. Worldwide, our 141,000 people are united by our shared values and an unwavering commitment to quality. We make a difference by helping our people, our clients and our wider communities achieve their potential.

For more information, please visit www.ey.com.

Ernst & Young refers to the global organization of member firms of Ernst & Young Global Limited, each of which is a separate legal entity. Ernst & Young Global Limited, a UK company limited by guarantee, does not provide services to clients. This Report has been prepared by Ernst & Young LLP, a client serving member firm located in the United States.

Report of Independent Registered Public Accounting Firm

To the Board of Directors of

IASIS Healthcare Corporation, sole member of IASIS Healthcare LLC

We have audited the accompanying consolidated balance sheets of IASIS Healthcare LLC as of September 30, 2008 and 2007, and the related consolidated statements of operations, member's equity and cash flows for each of the these years in the period ended September 30, 2008. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of IASIS Healthcare LLC at September 30, 2008 and 2007, and the consolidated results of their operations and their cash flows for each of the years in the period ended September 30, 2008, in conformity with U.S. generally accepted accounting principles.

/s/ Ernst & Young LLP

Nashville, Tennessee

December 5, 2008

IASIS HEALTHCARE LLC

CONSOLIDATED BALANCE SHEETS
(In thousands)

	September 30, 2008	September 30, 2007
ASSETS		
Current assets:		
Cash and cash equivalents	$ 80,738	$ —
Accounts receivable, less allowance for doubtful accounts of $108,500 and $97,800 at September 30, 2008 and 2007, respectively	224,138	248,281
Inventories	49,454	43,697
Deferred income taxes	38,860	29,629
Prepaid expenses and other current assets	60,053	45,023
Total current assets	453,243	366,630
Property and equipment, net	1,004,248	980,437
Goodwill	780,599	756,593
Other intangible assets, net	33,000	36,000
Other assets, net	37,057	46,762
Total assets	$ 2,308,147	$ 2,186,422
LIABILITIES AND MEMBER'S EQUITY		
Current liabilities:		
Accounts payable	$ 64,851	$ 98,488
Salaries and benefits payable	31,807	40,124
Accrued interest payable	12,460	18,865
Medical claims payable	97,343	81,309
Other accrued expenses and other current liabilities	51,802	44,276
Current portion of long-term debt and capital lease obligations	7,623	8,036
Total current liabilities	265,886	291,098
Long-term debt and capital lease obligations	1,106,999	1,023,621
Deferred income taxes	111,092	93,402
Other long-term liabilities	44,526	50,831
Minority interests	51,875	35,956
Member's equity:		
Member's equity	727,769	691,514
Total liabilities and member's equity	$ 2,308,147	$ 2,186,422

See accompanying notes.

IASIS HEALTHCARE LLC

CONSOLIDATED STATEMENTS OF OPERATIONS

(In thousands)

	Year Ended September 30, 2008	Year Ended September 30, 2007	Year Ended September 30, 2006
Net revenue:			
Acute care revenue	$ 1,523,790	$ 1,315,438	$ 1,133,055
Premium revenue	541,746	450,641	406,522
Total net revenue	2,065,536	1,766,079	1,539,577
Costs and expenses:			
Salaries and benefits	632,109	533,792	439,349
Supplies	231,259	194,915	167,616
Medical claims	452,055	376,505	347,217
Other operating expenses	283,123	266,263	223,946
Provision for bad debts	161,936	136,233	134,614
Rentals and leases	36,633	31,546	30,277
Interest expense, net	75,665	71,206	67,124
Depreciation and amortization	96,741	75,388	69,137
Management fees	5,000	4,746	4,189
Loss on extinguishment of debt	—	6,229	—
Hurricane-related property damage	3,589	—	—
Business interruption insurance recoveries	—	(3,443)	(8,974)
Total costs and expenses	1,978,110	1,693,380	1,474,495
Earnings from continuing operations before gain (loss) on disposal of assets, minority interests and income taxes	87,426	72,699	65,082
Gain (loss) on disposal of assets, net	(75)	(1,359)	913
Minority interests	(4,437)	(4,496)	(3,546)
Earnings from continuing operations before income taxes	82,914	66,844	62,449
Income tax expense	35,325	25,909	22,515
Net earnings from continuing operations	47,589	40,935	39,934
Earnings (loss) from discontinued operations, net of income taxes	(11,275)	669	(385)
Net earnings	$ 36,314	$ 41,604	$ 39,549

See accompanying notes.

IASIS HEALTHCARE LLC

CONSOLIDATED STATEMENTS OF MEMBER'S EQUITY
(In thousands)

	Member's Equity
Balance at September 30, 2005	$ 616,947
Net earnings	39,549
Balance at September 30, 2006	$ 656,496
Distribution to parent for debt financing costs	(6,586)
Net earnings	41,604
Balance at September 30, 2007	$ 691,514
Cumulative effect of adoption of FIN 48	(59)
Net earnings	36,314
Balance at September 30, 2008	$ 727,769

See accompanying notes.

IASIS HEALTHCARE LLC

CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

	Year Ended September 30, 2008	Year Ended September 30, 2007	Year Ended September 30, 2006
Cash flows from operating activities:			
Net earnings	$ 36,314	$ 41,604	$ 39,549
Adjustments to reconcile net earnings to net cash provided by operating activities:			
Loss (earnings) from discontinued operations	11,275	(669)	385
Depreciation and amortization	96,741	75,388	69,137
Amortization of loan costs	2,913	2,942	2,960
Minority interests	4,437	4,496	3,546
Deferred income taxes	19,368	24,103	21,021
Loss (gain) on disposal of assets, net	75	1,359	(913)
Hurricane-related property damage	3,589	—	—
Loss on extinguishment of debt	—	5,091	—
Changes in operating assets and liabilities, net of the effect of acquisitions and dispositions:			
Accounts receivable, net	17,131	(52,749)	(13,963)
Inventories, prepaid expenses and other current assets	(21,361)	(5,894)	(15,517)
Accounts payable, other accrued expenses and other accrued liabilities	(29,419)	26,002	51,530
Net cash provided by operating activities — continuing operations	141,063	121,673	157,735
Net cash provided by (used in) operating activities — discontinued operations	2,313	4,661	(591)
Net cash provided by operating activities	143,376	126,334	157,144
Cash flows from investing activities:			
Purchases of property and equipment	(137,415)	(194,043)	(146,262)
Cash paid for acquisitions	(16,821)	(141,585)	—
Proceeds from sale of assets	360	1,026	147
Change in other assets	4,613	5,893	166
Net cash used in investing activities — continuing operations	(149,263)	(328,709)	(145,949)
Net cash used in investing activities — discontinued operations	(1,017)	(929)	(234)
Net cash used in investing activities	(150,280)	(329,638)	(146,183)
Cash flows from financing activities:			
Payment of debt and capital lease obligations	(306,611)	(650,305)	(7,319)
Proceeds from debt borrowings	384,978	778,800	—
Debt financing costs incurred	—	(8,200)	—
Distribution to parent for debt financing costs	—	(6,586)	—
Distribution of minority interests	(5,485)	(4,850)	(2,507)
Proceeds received from sale of (costs paid for) partnership interests	15,070	(495)	5,727
Other	192	—	—
Net cash provided by (used in) financing activities — continuing operations	88,144	108,364	(4,099)
Net cash used in financing activities — discontinued operations	(502)	(475)	(544)
Net cash provided by (used in) financing activities	87,642	107,889	(4,643)
Increase (decrease) in cash and cash equivalents	80,738	(95,415)	6,318
Cash and cash equivalents at beginning of period	—	95,415	89,097
Cash and cash equivalents at end of period	$ 80,738	$ —	$ 95,415

Supplemental disclosure of cash flow information:			
Cash paid for interest	$ 83,126	$ 80,647	$ 72,271
Cash paid (received) for income taxes, net	$ (925)	$ 7,710	$ 1,082
Cash paid in loss on extinguishment of debt	$ —	$ 1,138	$ —
Supplemental schedule of noncash investing and financing activities:			
Capital lease obligations resulting from acquisitions	$ 4,849	$ 5,037	$ —
Property and equipment in accounts payable	$ 4,788	$ 6,401	$ 14,546
Partnership interests issued for acquisition	$ —	$ 3,517	$ —

See accompanying notes.

IASIS HEALTHCARE LLC

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. ORGANIZATION AND BASIS OF PRESENTATION

Organization

IASIS Healthcare LLC ("IASIS") owns and operates medium-sized acute care hospitals in high-growth urban and suburban markets. At September 30, 2008, the Company owned or leased 15 acute care hospital facilities and one behavioral health hospital facility, with a total of 2,644 beds in service, located in six regions:

- Salt Lake City, Utah;
- Phoenix, Arizona;
- Tampa-St. Petersburg, Florida;
- three cities in Texas, including San Antonio;
- Las Vegas, Nevada; and
- West Monroe, Louisiana.

The Company also owns and operates Health Choice Arizona, Inc. ("Health Choice" or the "Plan"), a Medicaid and Medicare managed health plan in Phoenix.

Principles of Consolidation

The consolidated financial statements include all subsidiaries and entities under common control of the Company. Control is generally defined by the Company as ownership of a majority of the voting interest of an entity. In addition, control is demonstrated in instances when the Company is the sole general partner in a limited partnership. Significant intercompany transactions have been eliminated.

Use of Estimates

The preparation of the financial statements in conformity with U.S. generally accepted accounting principles ("GAAP") requires management to make estimates and assumptions that affect the amounts reported in the accompanying audited consolidated financial statements and notes. Actual results could differ from those estimates.

Reclassifications

Certain prior year amounts have been reclassified to conform to the current year presentation. These reclassifications have no impact on the Company's total assets, liabilities, or member's equity. The Company adjusted its accompanying consolidated statements of operations and cash flows for the years ended September 30, 2007 and 2006, to reflect the operations and cash flows of Mesa General Hospital ("Mesa General") and Biltmore Surgery Center ("Biltmore") as discontinued operations. See Note 4 for further discussion of discontinued operations.

General and Administrative

The majority of the Company's expenses are "cost of revenue" items. Costs that could be classified as "general and administrative" by the Company would include the IASIS corporate office costs, which were $50.5 million, $55.0 million and $43.4 million, for the years ended September 30, 2008, 2007 and 2006, respectively.

2. SIGNIFICANT ACCOUNTING POLICIES

Net Revenue

Acute Care Revenue

The Company's healthcare facilities have entered into agreements with third-party payors, including government programs and managed care health plans, under which the facilities are paid based upon established charges, the cost of providing services, predetermined rates per diagnosis, fixed per diem rates or discounts from established charges.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

During the third quarter of fiscal 2006, the Company implemented an uninsured discount program offering discounts to all uninsured patients receiving healthcare services who do not qualify for assistance under state Medicaid, other federal or state assistance plans or charity care. Since implementing the program, the Company has provided uninsured discounts totaling $57.9 million, $50.3 million and $19.5 million for the years ended September 30, 2008, 2007 and 2006, respectively. These discounts to the uninsured had the effect of reducing acute care revenue and the provision for bad debts by generally corresponding amounts.

Net patient revenue is reported at the estimated net realizable amounts from third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and are adjusted, if necessary, in future periods when final settlements are determined. Net adjustments to estimated third-party payor settlements ("prior year contractuals") resulted in an increase in net revenue of $1.7 million and $365,000 for the years ended September 30, 2008 and 2007, respectively, and a decrease in net revenue of $538,000, for the year ended September 30, 2006.

In the ordinary course of business, the Company provides care without charge to patients who are financially unable to pay for the healthcare services they receive. Because the Company does not pursue collection of amounts determined to qualify as charity care, they are not reported in net revenue. The Company currently records revenue deductions for patient accounts that meet its guidelines for charity care. The Company provides charity care to patients with income levels below 200% of the federal property level. Additionally, at all of the Company's hospitals, a sliding scale of reduced rates is offered to uninsured patients, who are not covered through federal, state or private insurance, with incomes between 200% and 400% of the federal poverty level. Charity care deductions for the years ended September 30, 2008, 2007 and 2006 were $37.7 million, $31.3 million and $36.7 million, respectively.

Premium Revenue

Health Choice is a prepaid Medicaid and Medicare managed health plan that derives most of its revenue through a contract with the Arizona Health Care Cost Containment System ("AHCCCS") to provide specified health services to qualified Medicaid enrollees through contracted providers. AHCCCS is the state agency that administers Arizona's Medicaid program. The contract requires the Plan to arrange for healthcare services for enrolled Medicaid patients in exchange for fixed monthly premiums, based upon negotiated per capita member rates, and supplemental payments from AHCCCS. Capitation payments received by Health Choice are recognized as revenue in the month that members are entitled to healthcare services.

On May 14, 2008, Health Choice was awarded a new contract with AHCCCS that provides for a three-year term commencing October 1, 2008, with AHCCCS having the option to renew for two additional one-year periods. The contract is terminable without cause on 90 days' written notice or for cause upon written notice if the Company fails to comply with any term or condition of the contract or fails to take corrective action as required to comply with the terms of the contract. Additionally, AHCCCS can terminate the contract in the event of the unavailability of state or federal funding.

The Plan receives reinsurance and other supplemental payments from AHCCCS for healthcare costs that exceed stated amounts at a rate ranging from 75% to 100% of qualified healthcare costs in excess of stated levels of up to $50,000 per claim, depending on the eligibility classification of the member. Qualified costs must be incurred during the contract year and are the lesser of the amount paid by the Plan or the AHCCCS fee schedule. Reinsurance recoveries are recognized under the contract with AHCCCS when healthcare costs exceed stated amounts as provided under the contract, including estimates of such costs at the end of each accounting period.

Effective January 1, 2006, Health Choice began providing coverage as a Medicare Advantage Prescription Drug ("MAPD") Special Needs Plan ("SNP") provider pursuant to its contract with the Centers for Medicare and Medicaid Services ("CMS"). The SNP allows Health Choice to offer Medicare and Part D drug benefit coverage for new and existing dual-eligible members, or those that are eligible for Medicare and Medicaid. The contract with CMS includes successive one-year renewal options at the discretion of CMS and is terminable without cause on 90 days' written notice or for cause upon written notice if the Company fails to comply with any term or condition of the contract or fails to take corrective action as required to comply with the terms of the contract. As of December 1, 2008, Health Choice received notification that CMS is exercising its option to extend its contract through December 31, 2009.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

The Plan subcontracts with hospitals, physicians and other medical providers within Arizona and surrounding states to provide services to its Medicaid enrollees in Apache, Coconino, Maricopa, Mohave, Navajo, Pima, Yuma, LaPaz and Santa Cruz counties, and to its Medicare enrollees in Maricopa, Pima, Pinal, Coconino, Apache and Navajo counties. These services are provided regardless of the actual costs incurred to provide these services.

Cash and Cash Equivalents

The Company considers highly liquid investments with original maturities of three months or less to be cash equivalents. The Company maintains its cash and cash equivalents balances primarily with high credit quality financial institutions. The Company manages its credit exposure by placing its investments in United States Treasury securities or other high quality securities, and by periodically evaluating the relative credit standing of the financial institution.

Accounts Receivable

The Company receives payments for services rendered from federal and state agencies (under the Medicare, Medicaid and TRICARE programs), managed care health plans, including Medicare and Medicaid managed health plans, commercial insurance companies, employers and patients. During the years ended September 30, 2008, 2007 and 2006, approximately 39.9%, 39.1% and 39.1%, respectively, of the Company's net patient revenue related to patients participating in the Medicare and Medicaid programs, including managed Medicare and managed Medicaid. The Company recognizes that revenue and receivables from government agencies are significant to its operations, but does not believe that there is significant credit risks associated with these government agencies. The Company believes that concentration of credit risk from other payors is limited due to the number of patients and payors.

Net Medicare settlement receivables estimated at September 30, 2008 and 2007, totaled $2.9 million and $1.4 million, respectively, are included in accounts receivable in the accompanying consolidated balance sheets.

Allowance for Doubtful Accounts

The Company's estimation of the allowance for doubtful accounts is based primarily upon the type and age of the patient accounts receivable and the effectiveness of the Company's collection efforts. The Company's policy is to reserve a portion of all self-pay receivables, including amounts due from the uninsured and amounts related to co-payments and deductibles, as these charges are recorded. On a monthly basis, the Company reviews its accounts receivable balances, the effectiveness of the Company's reserve policies and various analytics to support the basis for its estimates. These efforts primarily consist of reviewing the following:

Revenue and volume trends by payor, particularly the self-pay components;

Changes in the aging and payor mix of accounts receivable, including increased focus on accounts due from the uninsured and accounts that represent co-payments and deductibles due from patients;

Historical write-off and collection experience using a hindsight or look-back approach;

Cash collections as a percentage of net patient revenue less bad debt expense;

Trending of days revenue in accounts receivable; and

Various allowance coverage statistics.

The Company regularly performs hindsight procedures to evaluate historical write-off and collection experience throughout the year to assist in determining the reasonableness of its process for estimating the allowance for doubtful accounts.

Inventories

Inventories, principally medical supplies, implants and pharmaceuticals, are stated at the lower of average cost or market.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Long-lived Assets

The primary components of the Company's long-lived assets are discussed below. When events, circumstances or operating results indicate that the carrying values of certain long-lived assets and related identifiable intangible assets (excluding goodwill) that are expected to be held and used might be impaired under the provisions of Statement of Financial Accounting Standards ("SFAS") No. 144, *Accounting for the Impairment or Disposal of Long-Lived Asset* ("SFAS 144"), the Company considers the recoverability of assets to be held and used by comparing the carrying amount of the assets to the undiscounted value of future net cash flows expected to be generated by the assets. If assets are identified as impaired, the impairment is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets as determined by independent appraisals or estimates of discounted future cash flows. Assets to be disposed of are reported at the lower of the carrying amount or fair value less costs to sell.

Property and Equipment

Property and equipment are stated at cost. Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase capacities or extend useful lives are capitalized. Buildings and improvements are depreciated over estimated useful lives ranging generally from 14 to 40 years. Estimated useful lives of equipment vary generally from 3 to 25 years. Leasehold improvements are amortized on a straight-line basis over the lesser of the terms of the respective leases or their estimated useful lives. Depreciation expense, including amortization of assets capitalized under capital leases, is computed using the straight-line method and was $93.7 million, $72.4 million and $66.1 million for the years ended September 30, 2008, 2007 and 2006, respectively. In connection with certain construction projects, the Company capitalized interest totaling $1.4 million, $6.9 million and $2.8 million for the years ended September 30, 2008, 2007 and 2006, respectively.

Goodwill and Other Intangible Assets

See Note 7 for the values of goodwill and other intangible assets assigned to each business segment. Intangible assets are evaluated for impairment if events and circumstances indicate a possible impairment.

Goodwill is not amortized but is subject to annual tests for impairment or more often if events or circumstances indicate it may be impaired. An impairment loss is recorded to the extent that the carrying amount of goodwill exceeds its implied fair value. The Company completed its annual impairment test of goodwill during fiscal 2008 noting no impairment.

Other Assets

Other assets consist primarily of costs associated with the issuance of debt, which are amortized over the life of the related debt, and costs to recruit physicians to the Company's markets, which are deferred and amortized over the term of expected benefit received from the respective physician recruitment agreement. Amortization of deferred financing costs is included in interest expense and totaled $2.9 million, $2.9 million and $3.0 million for the years ended September 30, 2008, 2007 and 2006, respectively. Deferred financing costs, net of accumulated amortization, totaled $18.2 million and $21.0 million at September 30, 2008 and 2007, respectively. Amortization of physician recruiting costs is included in other operating expenses and totaled $2.7 million, $5.1 million and $6.3 million for the years ended September 30, 2008, 2007 and 2006, respectively. Net physician recruiting costs at September 30, 2008 and 2007, totaled $6.8 million and $8.8 million, respectively, and are included in other assets in the accompanying consolidated balance sheets. See Note 11 for more discussion related to costs incurred to recruit physicians.

Insurance Reserves

The Company estimates its reserve for self-insured professional and general liability and workers compensation risks using historical claims data, demographic factors, severity factors, current incident logs and other actuarial analysis.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Income Taxes

The Company accounts for income taxes under the asset and liability method in accordance with SFAS No. 109, *Accounting for Income Taxes* ("SFAS 109") and Financial Accounting Standards Board ("FASB") Interpretation No. 48, *Accounting for Uncertainty in Income Taxes — An Interpretation of FASB Statement No. 109* ("FIN 48"). This approach requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply when the temporary differences are expected to reverse. The Company assesses the likelihood that deferred tax assets will be recovered from future taxable income to determine whether a valuation allowance should be established.

Minority Interest in Consolidated Entities

The consolidated financial statements include all assets, liabilities, revenue and expenses of less than 100% owned entities controlled by the Company. Accordingly, management has recorded minority interests in the earnings and equity of such consolidated entities.

Minimum Revenue Guarantees

The Company applies FASB Staff Position No. FIN 45-3, *Application of FASB Interpretation No. 45 to Minimum Revenue Guarantees Granted to a Business or Its Owners* ("FIN 45-3") to account for its minimum revenue guarantees. FIN 45-3 requires that a liability for the estimated fair value of minimum revenue guarantees be recorded for these agreements and requires disclosure of the maximum amount that could be paid on all minimum revenue guarantees. The Company records an asset for the estimated fair value of the minimum revenue guarantees and amortizes the asset from the beginning of the guarantee payment period through the end of the agreement.

Medical Claims Payable

Monthly capitation payments made by Health Choice to physicians and other healthcare providers are expensed in the month services are contracted to be performed. Claims expense for non-capitated arrangements is accrued as services are rendered by hospitals, physicians and other healthcare providers during the year.

Medical claims payable related to Health Choice include claims received but not paid and an estimate of claims incurred but not reported. Incurred but not reported claims are estimated using a combination of historical claims experience (including severity and payment lag time) and other actuarial analysis, including number of enrollees, age of enrollees and certain enrollee health indicators, to predict the cost of healthcare services provided to enrollees during any given period. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from estimates given changes in the healthcare cost structure or adverse experience.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

The following table shows the components of the change in medical claims payable for the years ended September 30, 2008, 2007 and 2006, respectively (in thousands):

	Year Ended September 30, 2008	Year Ended September 30, 2007	Year Ended September 30, 2006
Medical claims payable as of October 1	$ 81,309	$ 81,822	$ 60,201
Medical claims expense incurred during the year:			
Related to current year	464,055	396,152	362,636
Related to prior years	(2,406)	(12,107)	(8,119)
Total expenses	461,649	384,045	354,517
Medical claims payments during the year:			
Related to current year	(368,392)	(317,798)	(282,326)
Related to prior years	(77,223)	(66,760)	(50,570)
Total payments	(445,615)	(384,558)	(332,896)
Medical claims payable as of September 30	$ 97,343	$ 81,309	$ 81,822

Health Choice has experienced an increase in the number of lives served by the plan. Enrollment in Health Choice at September 30, 2008 and 2007, was 145,493 and 125,919, respectively.

Stock Based Compensation

Although IASIS has no stock option plan or outstanding stock options, the Company, through its parent, IASIS Healthcare Corporation ("IAS"), grants stock options for a fixed number of common shares to employees. Prior to October 1, 2006, the Company accounted for this stock-based incentive plan under the measurement and recognition provisions of Accounting Principles Board ("APB") Opinion No. 25, *Accounting for Stock Issued to Employees* ("APB 25"), and related Interpretations, as permitted by SFAS ("SFAS") No. 123, *Accounting for Stock Based Compensation* ("SFAS 123"). Accordingly, the Company has not recognized any compensation expense for the stock options granted prior to October 1, 2006, as the exercise price of the options equaled, or was greater than, the market value of the underlying stock on the date of grant.

Effective October 1, 2006, the Company adopted the provisions of SFAS No. 123 (revised 2004), *Share-Based Payment* ("SFAS 123(R)"), which is a revision of SFAS 123. Additionally, SFAS 123(R) supersedes APB 25, and amends SFAS No. 95, *Statement of Cash Flows*. Using the prospective transition method upon adoption of SFAS 123(R), the Company has implemented the fair value recognition provisions requiring all share-based payments to employees granted on or after October 1, 2006, including grants of employee stock options, to be recognized in the income statement based on their fair values. In accordance with the provisions of SFAS 123(R), the Company has elected to use the Black-Scholes-Merton model in determining the fair value of its share-based payments. The fair value of compensation costs will be amortized on a straight-line basis over the requisite service periods of the awards, generally equal to the awards' vesting periods.

In March 2006, the Securities and Exchange Commission ("SEC") issued Staff Accounting Bulletin No. 107 ("SAB 107"). SAB 107 addresses the interaction between SFAS 123(R) and certain SEC rules and regulations and provides the SEC staff's views regarding the valuation of share-based payment arrangements for public companies. The Company has applied the provisions of the interpretive guidance set forth in SAB 107 in its adoption of SFAS 123(R).

Fair Value of Financial Instruments

Cash and cash equivalents, accounts receivable, accounts payable and accrued liabilities are reflected in the accompanying consolidated financial statements at amounts that approximate fair value because of the short-term nature of these instruments. The fair value of the Company's long-term bank facility debt and capital lease obligations also approximate carrying value as they bear interest at current market rates. The estimated fair value of the Company's 8 3/4% senior subordinated notes due 2014 (the "8 3/4% notes") was approximately $446.5 million at September 30, 2008, based upon quoted market prices at that date.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Management Services Agreement

The Company is party to a management services agreement with TPG GenPar III, L.P., TPG GenPar IV, L.P., both affiliates of TPG, JLL Partners Inc. and Trimaran Fund Management, L.L.C. The management services agreement provides that in exchange for consulting and management advisory services that will be provided to the Company by the investors, the Company will pay an aggregate monitoring fee of 0.25% of budgeted net revenue up to a maximum of $5.0 million per fiscal year to these parties (or certain of their respective affiliates) and reimburse them for their reasonable disbursements and out-of-pocket expenses. This monitoring fee is divided among the parties in proportion to their relative ownership percentages in IASIS Investment LLC, parent company and sole stockholder of IAS. The monitoring fee will be subordinated to the senior subordinated notes in the event of a bankruptcy of the company. The management services agreement does not have a stated term. Pursuant to the provisions of the management services agreement, the Company has agreed to indemnify the investors (or certain of their respective affiliates) in certain situations arising from or relating to the agreement, the investors' investment in the securities of IAS or any related transactions or the operations of the investors, except for losses that arise on account of the investors' negligence or willful misconduct. For the years ended September 30, 2008, 2007 and 2006, the Company paid $5.0 million, $4.7 million and $4.2 million, respectively, in monitoring fees under the management services agreement.

Recently Issued Accounting Pronouncements

In September 2006, the FASB issued SFAS No. 157, *Fair Value Measurements* ("SFAS 157"), which is effective for fiscal years beginning after November 15, 2007. This statement provides a single definition of fair value, establishes a framework for measuring fair value, and expands disclosures concerning fair value measurements. The Company does not anticipate a material impact on its results of operations or financial position from the adoption of SFAS 157.

In February 2007, the FASB issued SFAS No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities* ("SFAS 159"), which is effective for fiscal years beginning after November 15, 2007. This statement permits entities to choose to measure certain financial instruments and other items at fair value at specified election dates. The Company does not anticipate a material impact on its results of operations or financial position from the adoption of SFAS 159.

In December 2007, the FASB issued SFAS No. 141(R), *Business Combinations* ("SFAS 141(R)"), which applies prospectively to business combinations for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after December 15, 2008. This statement replaces SFAS No. 141, *Business Combinations* ("SFAS 141"). This statement establishes principles and requirements for recognition and measurement of items acquired during a business combination, as well as certain disclosure requirements in the financial statements. The Company has not yet determined the impact of adopting of SFAS 141(R).

In December 2007, the FASB issued SFAS No. 160, *Noncontrolling Interests in Consolidated Financial Statements* ("SFAS 160"), which is effective for fiscal years beginning after December 15, 2008. The objective of this statement is to improve the relevance, comparability, and transparency of financial information, specifically noncontrolling interests, that is provided in consolidated financial statements. The Company has not yet determined the impact of adopting SFAS 160.

3. LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS

Long-term debt and capital lease obligations consist of the following (in thousands):

	September 30, 2008	September 30, 2007
Senior secured credit facilities	$ 629,818	$ 547,805
Senior subordinated notes	475,000	475,000
Capital leases and other obligations	9,804	8,852
	1,114,622	1,031,657
Less current maturities	7,623	8,036
	$ 1,106,999	$ 1,023,621

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Senior Secured Credit Facilities

In fiscal 2007, the Company completed the refinancing of its bank credit facility to provide for $854.0 million in senior secured credit facilities. In connection with the refinancing, the Company wrote-off $5.1 million in deferred financing costs and paid an additional $1.1 million in creditor fees, which are included in the loss on extinguishment of debt in the accompanying consolidated statement of operations for the year ended September 30, 2007.

The $854.0 million senior secured credit facilities include: (i) a senior secured term loan of $439.0 million; (ii) a senior secured delayed draw term loan of $150.0 million; (iii) a senior secured revolving credit facility of $225.0 million, which includes a $100.0 million sub-limit for letters of credit; and (iv) a senior secured synthetic letter of credit facility of $40.0 million. All facilities mature on March 15, 2014, except for the revolving credit facility, which matures on April 27, 2013. The term loans bear interest at an annual rate of LIBOR plus 2.00% or, at the Company's option, the administrative agent's base rate plus 1.00%. The revolving loans bear interest at an annual rate of LIBOR plus an applicable margin ranging from 1.25% to 1.75% or, at the Company's option, the administrative agent's base rate plus an applicable margin ranging from 0.25% to 0.75%, such rate in each case depending on the Company's senior secured leverage ratio. A commitment fee ranging from 0.375% to 0.5% per annum is charged on the undrawn portion of the senior secured revolving credit facility and is payable in arrears.

Principal under the senior secured term loan is due in 24 consecutive equal quarterly installments in an aggregate annual amount equal to 1.0% of the original principal amount ($439.0 million) during the first six years thereof, with the balance payable in four equal installments in year seven. Principal under the senior secured delayed draw term loan is due in equal quarterly installments in an aggregate annual amount equal to 1.0% of the original principal amount ($150.0 million) until March 31, 2013, with the balance payable in four equal installments during the final year of the loan. Unless terminated earlier, the senior secured revolving credit facility has a single maturity of six years. The senior secured credit facilities are also subject to mandatory prepayment under specific circumstances, including a portion of excess cash flow, a portion of the net proceeds from an initial public offering, asset sales, debt issuances and specified casualty events, each subject to various exceptions.

The senior secured credit facilities are (i) secured by a first mortgage and lien on the real property and related personal and intellectual property of the Company and pledges of equity interests in the entities that own such properties and (ii) guaranteed by certain of the Company's subsidiaries.

In addition, the senior secured credit facilities contain certain covenants which, among other things, limit the incurrence of additional indebtedness, investments, dividends, transactions with affiliates, asset sales, acquisitions, mergers and consolidations, liens and encumbrances and other matters customarily restricted in such agreements.

At September 30, 2008, amounts outstanding under the Company's senior secured credit facilities consisted of a $432.4 million term loan, $149.6 million under the delayed draw term loan and $47.8 million under the revolving credit facility. In addition, the Company had $20.8 million and $21.5 million in letters of credit outstanding under the synthetic letter of credit facility and the revolving credit facility, respectively. The weighted average interest rate of outstanding borrowings under the senior secured credit facilities was approximately 5.6% and 7.5% for the years ended September 30, 2008 and 2007, respectively.

8 3/4% Senior Subordinated Notes

The Company, together with its wholly-owned subsidiary, IASIS Capital Corporation, a holding company with no assets or operations, as issuers, have outstanding $475.0 million aggregate principal amount of 8 3/4% notes. The 8 3/4% notes are general unsecured senior subordinated obligations and are subordinated in right of payment to all existing and future senior debt of the Company. The Company's existing domestic subsidiaries, other than certain non-guarantor subsidiaries, which include Health Choice and the Company's non-wholly owned subsidiaries, are guarantors of the 8 3/4% notes. The 8 3/4% notes are effectively subordinated to all of the issuers' and the guarantors' secured debt to the extent of the value of the assets securing the debt and are structurally subordinated to all liabilities and commitments (including trade payables and capital lease obligations) of the Company's subsidiaries that are not guarantors of the 8 3/4% notes.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

$300.0 Million Holdings Senior Paid-in-Kind Loans

In fiscal 2007, IAS issued $300.0 million in Holdings Senior Paid-in-Kind ("PIK") Loans, which were used to repurchase certain preferred equity from its stockholders. The $300.0 million Holdings Senior PIK Loans mature June 15, 2014, and bear interest at an annual rate equal to LIBOR plus 5.25%. The Holdings Senior PIK Loans rank behind the Company's existing debt and will convert to cash-pay after five years, at which time accrued interest becomes payable. At September 30, 2008, the outstanding balance of the Holdings Senior PIK Loans was $343.2 million, which includes $43.2 million of interest that has accrued to the principal of these loans since the date of issuance.

4. DISCONTINUED OPERATIONS

The Company's lease agreements to operate Mesa General, located in Mesa, Arizona, and Biltmore, located in Phoenix, Arizona, expired by their terms on July 31, 2008 and September 30, 2008, respectively. The Company discontinued services at Mesa General on May 31, 2008, and Biltmore on April 30, 2008. The operating results of Mesa General and Biltmore are classified in the Company's accompanying consolidated financial statements as discontinued operations in accordance with SFAS 144. The following table sets forth the components of discontinued operations for the years ended September 30, 2008, 2007 and 2006, respectively, (in thousands):

	Year ended September 30, 2008	Year ended September 30, 2007	Year ended September 30, 2006
Total net revenue	$ 49,974	$ 88,335	$ 89,976
Operating expenses	64,648	87,254	90,587
Loss on disposal of assets	3,928	—	—
Income tax expense (benefit)	(7,327)	412	(226)
Earning (loss) from discontinued operations, net of income taxes	$ (11,275)	$ 669	$ (385)

The Company allocated to discontinued operations interest expense of $2.5 million, $2.5 million and $2.6 million for the years ended September 30, 2008, 2007 and 2006, respectively. The allocation of interest expense to discontinued operations was based on the ratio of disposed net assets of Mesa General and Biltmore to the sum of total net assets of the Company plus the Company's total outstanding debt.

Income taxes allocated to the discontinued operations resulted in related effective tax rates of 39.4%, 38.2% and 37.1% for the years ended September 30, 2008, 2007 and 2006, respectively.

5. ACQUISITIONS

Acquisition of Glenwood Regional Medical Center

Effective January 31, 2007, the Company acquired substantially all of the assets of Glenwood Regional Medical Center ("Glenwood") in West Monroe, Louisiana. The purchase price for the 237-bed hospital was $78.2 million, which was funded by cash on hand and borrowings under the Company's revolving credit facility. The results of operations of Glenwood are included in the accompanying consolidated statements of operations from the effective date of the acquisition.

The purchase price for the Glenwood acquisition, including direct transaction costs, has been allocated as follows (in thousands):

Fair value of assets acquired and liabilities assumed:		
Assets acquired		
Accounts receivable, net	$	13,727
Inventory, prepaid expenses and other current assets		4,354
Property and equipment		66,640
Other long-term assets		1,529
Total assets acquired	$	86,250
Liabilities assumed	$	8,004

Acquisition of Alliance Hospital

Effective May 31, 2007, the Company acquired substantially all of the assets of Alliance Hospital ("Alliance") in Odessa, Texas. The purchase price for the 50-bed hospital was $66.7 million, which was funded in part by the Company's senior secured credit facilities, as well as units of limited partnership interest of Odessa Regional Hospital, LP, and the assumption of certain liabilities of Alliance. Upon acquisition, the operations of Alliance were immediately merged into Odessa Regional Hospital to form Odessa Regional Medical Center. The results of operations of Alliance are included in the accompanying consolidated statements of operations from the effective date of the acquisition.

The purchase price for the Alliance acquisition, including direct transaction costs, has been allocated as follows (in thousands):

Fair value of assets acquired and liabilities assumed:		
Assets acquired		
Accounts receivable, net	$	4,230
Inventory, prepaid expenses and other current assets		1,873
Property and equipment		60,965
Goodwill		10,593
Total assets acquired	$	77,661
Liabilities assumed	$	10,932

Other

Effective February 1, 2008, IASIS Glenwood Regional Medical Center, LP, a wholly-owned subsidiary of the Company, purchased a majority ownership interest in Ouachita Community Hospital, a ten-bed surgical hospital located in West Monroe, Louisiana. The purchase price for the majority ownership interest included approximately $16.8 million in cash.

6. PROPERTY AND EQUIPMENT

Property and equipment consist of the following (in thousands):

	September 30, 2008	September 30, 2007
Land	$ 103,763	$ 102,427
Buildings and improvements	693,113	597,942
Equipment	471,207	476,359
	1,268,083	1,176,728
Less accumulated depreciation and amortization	(325,560)	(241,268)
	942,523	935,460
Construction-in-progress (estimated cost to complete at September 30, 2008 — $55.8 million)	61,725	44,977
	$ 1,004,248	$ 980,437

Included in equipment are assets acquired under capital leases of $5.2 million and $6.3 million, net of accumulated amortization of $2.1 million and $12.4 million, at September 30, 2008 and 2007, respectively.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

7. GOODWILL AND OTHER INTANGIBLE ASSETS

The following table presents the changes in the carrying amount of goodwill from September 30, 2006 through September 30, 2008 (in thousands):

	Acute Care	Health Choice	Total
Balance at September 30, 2006	$ 750,722	$ 5,757	$ 756,479
Adjustment resulting from surgery center acquisition	349	—	349
Adjustments in deferred tax assets and liabilities	(235)	—	(235)
Balance at September 30, 2007	750,836	5,757	756,593
Adjustments in deferred tax assets and liabilities	(3,769)	—	(3,769)
Adjustment resulting from Ouachita Community Hospital	17,134	—	17,134
Adjustments resulting from purchase price allocation of Alliance Hospital	10,593	—	10,593
Other purchase price adjustments	48	—	48
Balance at September 30, 2008	$ 774,842	$ 5,757	$ 780,599

Other intangible assets consist solely of Health Choice's contract with AHCCCS, which is amortized over a period of 15 years, the contract's estimated useful life, including assumed renewal periods. The gross intangible value originally assigned to the contract was $45.0 million. The Company expects amortization expense for this intangible asset, to approximate $3.0 million per year over the estimated life of the contract. Amortization of intangible assets is included in depreciation and amortization expense and totaled $3.0 million for each of the years ended September 30, 2008, 2007 and 2006. Net other intangible assets included in the accompanying consolidated balance sheets at September 30, 2008 and 2007 totaled $33.0 million and $36.0 million, respectively.

8. MEMBER'S EQUITY

Common Interests of IASIS

As of September 30, 2008, all of the common interests of IASIS were owned by IAS, its sole member.

9. STOCK OPTIONS

Management Rollover Options

In 2004, an investor group led by TPG acquired IAS, the parent company of IASIS. Prior to the acquisition, IAS maintained the IASIS 2000 Stock Option Plan. In connection with the acquisition, certain holders of 299,900 of in-the-money common stock options elected to rollover and convert such options into options to purchase an aggregate 3,263 shares of preferred stock, with an exercise price of $437.48 per share, and an aggregate 163,150 shares of common stock, with an exercise price of $8.75 per share. The rollover options are fully vested and remain outstanding and exercisable for the remainder of their original term. All of the other outstanding options under the IASIS 2000 Stock Option Plan were cancelled upon consummation of the acquisition and the plan was terminated.

In connection with the issuance of the $300.0 million Holdings Senior PIK Loans in fiscal 2007, the preferred rollover options were cancelled in exchange for a cash payment equal to the excess of the accreted value of the preferred stock over the exercise price of $437.48 per share.

2004 Stock Option Plan

The IAS 2004 Stock Option Plan (the "2004 Stock Option Plan") was established to promote the Company's interests by providing additional incentives to its key employees, directors, service providers and consultants. The options granted under the plan represent the right to purchase IAS common stock upon exercise. Each option shall be identified as either an incentive stock option or a non-qualified stock option. The plan was adopted by the board of directors and sole stockholder of IAS in June 2004. The maximum number of shares of IAS common stock that may be issued pursuant to options granted under the 2004 Stock Option Plan is 2,194,650. In addition, prior to an initial public offering, an additional 146,000 shares of common stock will be available for grant in June of each year. The options become exercisable over a period not to exceed five years after the date of grant, subject to earlier vesting provisions as provided for in the 2004 Stock Option Plan. All options granted under the 2004 Stock Option Plan expire no later than 10 years from the respective dates of grant. At September 30, 2008, there were 792,765 options available for grant. On October 2, 2008, the Company granted 476,620 in stock options at an exercise price of $34.75 per share.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Information regarding the Company's stock option activity for the year ended September 30, 2008, is summarized below:

	2004 Stock Option Plan			Rollover Options		
	Options	Option Price Per Share	Weighted Average Exercise Price	Options	Option Price Per Share	Weighted Average Exercise Price
Options outstanding at September 30, 2005	1,510,763	$ 20.00	$ 20.00	166,413	$ 8.75-$437.48	$ 17.16
Granted	237,472	$ 35.68	$ 35.68	—	—	—
Exercised	—	—	—	—	—	—
Cancelled/forfeited	(152,750)	$ 20.00-$35.68	$ 20.61	—	—	—
Options outstanding at September 30, 2006	1,595,485	$ 20.00-$35.68	$ 22.28	166,413	$ 8.75-$437.48	$ 17.16
Granted	7,080	$ 34.75-$35.68	$ 35.54	—	—	—
Exercised	—	—	—	—	—	—
Cancelled/forfeited	(111,440)	$ 20.00-$35.68	$ 25.61	(3,263)	$ 437.48	$ 437.48
Options outstanding at September 30, 2007	1,491,125	$ 20.00-$35.68	$ 22.09	163,150	$ 8.75	$ 8.75
Granted	1,080	$ 34.75	$ 34.75	—	—	—
Exercised	(9,600)	$ 20.00	$ 20.00	—	—	—
Cancelled/forfeited	(80,720)	$ 20.00-$35.68	$ 26.04	—	—	—
Options outstanding at September 30, 2008	1,401,885	$ 20.00-$35.68	$ 21.82	163,150	$ 8.75	$ 8.75
Options exercisable at September 30, 2008	1,067,945	$ 20.00-$35.68	$ 21.02	163,150	$ 8.75	$ 8.75

Given that the Company accounted for shared-based payments granted prior to October 1, 2006 under APB 25, SFAS 123(R) requires disclosure as if the Company had measured compensation cost for the stock options granted under the fair value based method prescribed by SFAS 123. Accordingly, net earnings in fiscal 2006 would have been changed to the pro forma amounts set forth below (in thousands):

	Year Ended September 30, 2006
Net earnings as reported	$ 39,549
Deduct: Total stock based employee compensation determined under fair value based method for all awards, net of related tax effects	(1,360)
Pro forma net earnings	$ 38,189

The following table provides information regarding assumptions used in the fair value measurement for options granted on or after October 1, 2006 and the weighted average assumptions used in the fair value pro forma disclosures required for stock-options granted prior to October 1, 2006.

	Options Granted On or After October 1, 2006	Options Granted Prior to October 1, 2006
Risk-free interest	3.4%	4.6%
Dividend yield	0.0%	0.0%
Volatility	30.0%	N/A
Expected option life	6.2 years	8.8 years

For options granted on or after October 1, 2006, the Company used the Black-Scholes-Merton valuation model in determining the fair value measurement. Volatility for such options was estimated based on the historical stock price information of certain peer group companies for a period of time equal to the expected option life period.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

10. INCOME TAXES

Income tax expense on earnings from continuing operations consists of the following (in thousands):

	Year Ended September 30, 2008	Year Ended September 30, 2007	Year Ended September 30, 2006
Current:			
Federal	$ 12,631	$ 132	$ 1,280
State	3,326	1,674	214
Deferred:			
Federal	15,522	23,172	19,737
State	3,846	931	1,284
	$ 35,325	$ 25,909	$ 22,515

A reconciliation of the federal statutory rate to the effective income tax rate applied to earnings from continuing operations before income taxes for the years ended September 30, 2008, 2007 and 2006, is as follows (in thousands):

	Year Ended September 30, 2008	Year Ended September 30, 2007	Year Ended September 30, 2006
Federal statutory rate	$ 29,020	$ 23,396	$ 21,857
State income taxes, net of federal income tax benefit	4,663	1,693	974
Other non-deductible expenses	418	328	678
Change in valuation allowance charged to federal tax provision	970	541	—
Other items, net	254	(49)	(994)
Income tax expense	$ 35,325	$ 25,909	$ 22,515

A summary of the items comprising the deferred tax assets and liabilities is as follows (in thousands):

	September 30, 2008		September 30, 2007	
	Assets	Liabilities	Assets	Liabilities
Depreciation and fixed asset basis differences	$ —	$ 67,317	$ —	$ 57,492
Amortization and intangible asset basis differences	—	64,742	—	55,509
Allowance for doubtful accounts	29,958	—	15,303	—
Professional liability	12,801	—	14,459	—
Accrued expenses and other liabilities	13,436	—	12,803	—
Deductible carryforwards and credits	8,709	—	9,955	—
Other, net	570	—	594	—
Valuation allowance	(5,647)	—	(3,886)	—
Total	$ 59,827	$ 132,059	$ 49,228	$ 113,001

Net current deferred tax assets of $38.9 million and $29.6 million and net non-current deferred tax liabilities of $111.1 million and $93.4 million are included in the accompanying consolidated balance sheets at September 30, 2008 and 2007, respectively. The Company had a net income tax payable of $2.2 million included in other current liabilities at September 30, 2008, and net refundable income taxes of $5.2 million included in other current assets at September 30, 2007.

The Company and some of its subsidiaries are included in IAS' consolidated filing group for U.S. federal income tax purposes, as well as in certain state and local income tax returns that include IAS. With respect to tax returns for any taxable period in which the Company or any of its subsidiaries are included in a tax return filing with IAS, the amount of taxes to be paid by the Company is determined, subject to some adjustments, as if it and its subsidiaries filed their own tax returns excluding IAS. At September 30, 2008, the net income tax payable by the Company of $2.2 million was comprised of $3.2 million net taxes refundable from taxing authorities and $5.4 million payable to IAS for tax benefits generated by IAS and utilized by the Company in the combined tax return filings. At September 30, 2007, the net refundable income taxes of $5.2 million was comprised of $5.5 million net taxes refundable from taxing authorities and $300,000 payable to IAS.

The Company maintains a valuation allowance for deferred tax assets it believes may not be utilized. The valuation allowance increased by $1.8 million and $500,000 during the years ended September 30, 2008 and 2007, respectively. The increases in the valuation allowance for both years relate to the generation of net operating loss carryforwards by certain subsidiaries excluded from the IAS consolidated federal income tax return, as well as state net operating loss carryforwards that may not ultimately be utilized. At September 30, 2008, the Company had a valuation allowance of $5.6 million, of which $300,000 relates to deferred tax assets recorded in connection with business combinations and will result in an adjustment to goodwill if realized in the future.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

As of September 30, 2008, federal net operating loss carryforwards were available to offset $4.3 million of future taxable income generated by subsidiaries of the Company that are excluded from the IAS consolidated return. A valuation allowance has been established against these carryforwards, which expire between 2026 and 2028. The Company has a federal alternative minimum tax credit carryforward of $2.5 million that does not expire. State net operating losses in the amount of $106.0 million were also available, but largely offset by a valuation allowance. The state net operating loss carryforwards expire between 2018 and 2027.

The Company adopted FIN 48 on October 1, 2007. As a result, the Company recorded a liability for unrecognized tax benefits of $8.1 million, including accrued interest of $83,000. The adjustment was comprised of a cumulative effect decrease to member's equity of approximately $59,000, and a decrease to net noncurrent deferred tax liabilities of approximately $8.1 million. An additional $9.9 million of unrecognized tax benefits were reflected as a reduction to deferred tax assets for federal and state net operating losses generated by uncertain tax deductions as of October 1, 2007.

FIN 48 permits interest and penalties on underpayments of income taxes to be classified as interest expense, income tax expense, or another appropriate expense classification based on the accounting election of the company. The Company's policy is to classify interest and penalties as a component of income tax expense. Interest expense totaling $146,000 (net of related tax benefits) is included in income tax expense for the year ended September 30, 2008.

As of September 30, 2008, the liability for unrecognized tax benefits included in the accompanying consolidated balance sheet was $9.9 million, including accrued interest of $308,000. An additional $5.9 million of unrecognized tax benefits are reflected as a reduction to deferred tax assets for federal and state net operating losses generated by uncertain tax deductions as of September 30, 2008. Of the total unrecognized tax benefits at September 30, 2008, approximately $600,000 (net of the tax benefit on state taxes and interest) represents the amount of unrecognized tax and interest that, if recognized, would favorably impact the Company's effective income tax rate. The remainder of the unrecognized tax positions consist of items for which the uncertainty relates only to the timing of the deductibility, and state net operating loss carryforwards for which ultimate recognition would result in the creation of an offsetting valuation allowance due to the unlikelihood of future taxable income in that state.

A summary of activity of the Company's total amounts of unrecognized tax benefits is as follows (in thousands):

	Year Ended September 30, 2008
Unrecognized tax benefits at October 1, 2007	$ 17,942
Additions resulting from tax positions taken in a prior period	937
Reductions resulting from tax positions taken in a prior period	(6,258)
Additions resulting from tax positions taken in the current period	2,929
Unrecognized tax benefits at September 30, 2008	$ 15,550

During the year ended September 30, 2008, the Appeals Office of the IRS concluded its review of proposed adjustments to the Company's federal income tax return for the year ended September 30, 2004. The IRS agreed that no adjustment was necessary for the issues appealed by the Company. The settlement resulted in a decrease to the liability for unrecognized tax benefits of $250,000, and a decrease to the unrecognized tax benefits shown as an offset to net operating loss deferred tax assets of $3.5 million. The recognition of these tax benefits resulted in a $3.8 million reduction to goodwill.

As of September 30, 2008, the IRS is examining the Company's corporate tax returns for the years ended September 30, 2006 and 2005, and one of its partnership's income tax returns for the year ended September 30, 2005. The Company's tax years 2005 and beyond remain open to additional examinations by U.S. federal and state taxing authorities. It is reasonably possible that unrecognized tax benefits could significantly increase or decrease within the next twelve months depending on the outcome of taxing authority examinations. However, the Company is currently unable to estimate the range of any possible change.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

11. COMMITMENTS AND CONTINGENCIES

Net Revenue

The calculation of appropriate payments from the Medicare and Medicaid programs, including supplemental Medicaid reimbursement, as well as terms governing agreements with other third-party payors are complex and subject to interpretation. Final determination of amounts earned under the Medicare and Medicaid programs often occurs subsequent to the year in which services are rendered because of audits by the programs, rights of appeal and the application of numerous technical provisions. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. In the opinion of management, adequate provision has been made for adjustments that may result from such routine audits and appeals.

Professional, General and Workers' Compensation Liability Risks

The Company is subject to claims and legal actions in the ordinary course of business, including claims relating to patient treatment and personal injuries. To cover these types of claims, the Company maintains professional and general liability insurance in excess of self-insured retentions through a commercial insurance carrier in amounts that the Company believes to be sufficient for its operations, although, potentially, some claims may exceed the scope of coverage in effect. Plaintiffs in these matters may request punitive or other damages that may not be covered by insurance. The Company is currently not a party to any such proceedings that, in the Company's opinion, would have a material adverse effect on the Company's business, financial condition or results of operations. The Company expenses an estimate of the costs it expects to incur under the self-insured retention exposure for professional and general liability claims using historical claims data, demographic factors, severity factors, current incident logs and other actuarial analysis. At September 30, 2008 and 2007, the Company's professional and general liability accrual for asserted and unasserted claims totaled $34.3 million and $38.5 million, respectively. The semi-annual valuations from the Company's independent actuary for professional and general liability losses resulted in a change related to estimates for prior years which decreased professional and general liability expense by $6.8 million and $6.6 million during the years ended September 30, 2008 and 2007, respectively, and increased professional and general liability expense by $600,000 during the year ended September 30, 2006.

The Company is subject to claims and legal actions in the ordinary course of business relative to workers' compensation and other labor and employment matters. To cover these types of claims, the Company maintains workers' compensation insurance coverage with a self-insured retention. The Company accrues costs of workers' compensation claims based upon estimates derived from its claims experience. The semi-annual valuations from the Company's independent actuary for workers' compensation losses resulted in a change related to estimates for prior years which increased workers' compensation expense by $759,000 during the year ended September 30, 2008, and decreased workers' compensation expense by $1.0 million and $3.3 million during the years ended September 30, 2007 and 2006, respectively.

Health Choice

Health Choice has entered into capitated contracts whereby the Plan provides healthcare services in exchange for fixed periodic and supplemental payments from the AHCCCS and CMS. These services are provided regardless of the actual costs incurred to provide these services. The Company receives reinsurance and other supplemental payments from AHCCCS to cover certain costs of healthcare services that exceed certain thresholds. The Company believes the capitated payments, together with reinsurance and other supplemental payments are sufficient to pay for the services Health Choice is obligated to deliver. As of October 1, 2008, the Company has provided a performance guaranty in the form of a letter of credit in the amount of $36.7 million for the benefit of AHCCCS to support its obligations under the Health Choice contract to provide and pay for the healthcare services. The amount of the performance guaranty is generally based in part upon the membership in the Plan and the related capitation revenue paid to Health Choice.

Capital Expenditure Commitments

At September 30, 2008, the Company is expanding and renovating some of its existing facilities to provide additional capacity, more effectively deliver patient care and provide a greater variety of services. The Company had incurred $58.4 million in costs toward uncompleted projects as of September 30, 2008, which is included in property and equipment in the accompanying consolidated balance sheet. At September 30, 2008, the Company had various construction and other projects in progress with an estimated additional cost to complete and equip of approximately $55.8 million, including patient tower expansions at Jordan Valley Medical Center and Davis Hospital and Medical Center, two of the Company's Utah hospitals. Additionally, in connection with the acquisition of Glenwood, the Company committed to spend $30.0 million for various expansion and renovation projects during the first four years of ownership.

Minimum Revenue Guarantees

In order to recruit and retain physicians to meet community needs and to provide specialty coverage necessary for full service hospitals, the Company has committed to certain arrangements in the form of minimum revenue guarantees with various physicians. Amounts advanced under recruiting agreements are generally forgiven pro rata over a period of 24 months, after one year of completed service. Forgiveness of these advances is contingent upon the physician continuing to practice in the respective community. In the event the physician does not fulfill his or her responsibility to maintain a practice in the respective community during the contract period, the physician agrees to repay all outstanding amounts advanced during the guarantee period and to sign a promissory note, with the physician's accounts receivable serving as collateral for the amounts owed. Additionally, certain agreements to provide specialty coverage include provisions to guarantee a minimum monthly collections base over the term of the agreement and do not require repayment.

At September 30, 2008 and 2007, the Company had liabilities for these minimum revenue guarantees totaling $2.2 million and $7.7 million, respectively. At September 30, 2008, the maximum amount of all minimum revenue guarantees that could be paid prospectively was $2.6 million.

Acquisitions

The Company has acquired and in the future may choose to acquire businesses with prior operating histories. Such businesses may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations, such as billing and reimbursement, fraud and abuse and similar anti-referral laws. Although the Company has procedures designed to conform business practices to its policies following the completion of any acquisition, there can be no assurance that the Company will not become liable for previous activities of prior owners that may later be asserted to be improper by private plaintiffs or government agencies. Although the Company generally seeks to obtain indemnification from prospective sellers covering such matters, there can be no assurance that any such matter will be covered by indemnification, or if covered, that such indemnification will be adequate to cover potential losses and fines.

Other

On March 31, 2008, the United States District Court for the District of Arizona (the "District Court") dismissed with prejudice the *qui tam* complaint against IAS, the Company's parent company. The *qui tam* action sought monetary damages and civil penalties under the federal False Claims Act (" FCA") and included allegations that certain business practices related to physician relationships and the medical necessity of certain procedures resulted in the submission of claims for reimbursement in violation of the FCA. The case dates back to March 2005 and became the subject of a subpoena by the Office of Inspector General ("OIG") in September 2005. In August 2007, the case was unsealed and became a private lawsuit after the Department of Justice declined to intervene. The United States District Judge dismissed the case from the bench at the conclusion of oral arguments on IAS' motion to dismiss. On April 21, 2008, the court issued a written order dismissing the case with prejudice and entering formal judgment for IAS. On May 7, 2008, the *qui tam* relator's counsel filed a Notice of Appeal to the United States Court of Appeals for the Ninth Circuit to appeal the District Court's dismissal of the case. On May 21, 2008, IAS filed a Notice of Cross-Appeal to the United States Court of Appeals for the Ninth Circuit from a portion of the April 21, 2008 Order and, on July 22, 2008, IAS filed a Motion to Disqualify relator's counsel related to their misappropriation of information subject to a claim of attorney-client privilege by IAS. On August 21, 2008, the court issued a written order denying IAS' Motion to Disqualify and resetting the briefing schedule associated with the Ninth Circuit appellate proceedings. On October 21, 2008, the relator filed his appeal brief with the United States Court of Appeals for the Ninth Circuit. IAS' cross-appeal brief is due on January 20, 2009. Currently, the appeals process is expected to take one to two years to complete. If the appeal of the order dismissing the *qui tam* action with prejudice was to be resolved in a manner unfavorable to the Company, it could have a material adverse effect on the Company's business, financial condition and results of operations, including exclusion from the Medicare and Medicaid programs.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

The Company's facilities obtain clinical and administrative services from a variety of vendors. One vendor, a medical practice that furnished cardiac catheterization services under contractual arrangements at Mesa General and St. Luke's Medical Center ("St. Luke's") through March 31, 2008 and May 31, 2008, respectively, has claimed that, because of deferred fee adjustments that it claims are due under these arrangements, it is owed additional amounts for services rendered since April 1, 2006 at both facilities. The Company and the vendor have not reached agreement with respect to the amount of the fee adjustment, if any, that is contractually required, nor with respect to the methodology that may appropriately be used in determining such amount. On October 1, 2008, the vendor filed a complaint in arbitration for an aggregate adjustment in excess of amounts accrued to date by the Company. Although the Company cannot currently estimate the amount of any fee adjustment that Mesa or St. Luke's ultimately may be required to pay, it believes that the aggregate adjustment sought by the vendor is substantially in excess of any such amount. Likewise, the vendor has also filed a state-court complaint alleging certain tort claims that arise from the same fee dispute, as well as from the closure of Mesa General preceding expiration of the Company's lease for the Mesa property in July 2008. The majority of the vendor's cardiac catheterization services were performed at the Mesa facility, which is included in discontinued operations in the accompanying consolidated statements of operations. The Company believes that these claims are subject to binding arbitration as required by contract and has moved for dismissal of the pending complaints on that basis.

12. LEASES

The Company leases various buildings, office space and equipment under capital and operating lease agreements. These leases expire at various times and have various renewal options.

The Company is a party to an amended facility lease with a 15 year term that expires in January 31, 2019, and includes options to extend the term of the lease through January 31, 2039. The annual cost under this agreement is $6.4 million, payable in monthly installments. Future minimum lease payments at September 30, 2008, are as follows (in thousands):

	Capital Leases	Operating Leases
2009	$ 1,589	$ 25,941
2010	1,071	20,616
2011	919	16,887
2012	651	15,351
2013	561	13,841
Thereafter	5,802	44,191
Total minimum lease payments	$ 10,593	$ 136,827
Amount representing interest (at rates ranging from 4.4% to 14.2%)	4,214	
Present value of net minimum lease payments (including $1.6 million classified as current)	$ 6,379	

Aggregate future minimum rentals to be received under noncancellable subleases as of September 30, 2008, were approximately $4.1 million.

13. RETIREMENT PLANS

Substantially all employees who are employed by the Company or its subsidiaries, upon qualification, are eligible to participate in a defined contribution 401(k) plan (the "Retirement Plan"). Employees who elect to participate generally make contributions from 1% to 20% of their eligible compensation, and the Company matches, at its discretion, such contributions up to a maximum percentage. Generally, employees immediately vest 100% in their own contributions and vest in the employer portion of contributions over a period not to exceed five years. Company contributions to the Retirement Plan were approximately $5.0 million, $4.3 million and $3.7 million for the years ended September 30, 2008, 2007 and 2006, respectively.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

14. SEGMENT AND GEOGRAPHIC INFORMATION

The Company's acute care hospitals and related healthcare businesses are similar in their activities and the economic environments in which they operate (i.e., urban and suburban markets). Accordingly, the Company's reportable operating segments consist of (1) acute care hospitals and related healthcare businesses, collectively, and (2) Health Choice. The following is a financial summary by business segment for the periods indicated (in thousands):

	For the Year Ended September 30, 2008			
	Acute Care	Health Choice	Eliminations	Consolidated
Acute care revenue	$ 1,523,790	$ —	$ —	$ 1,523,790
Premium revenue	—	541,746	—	541,746
Revenue between segments	9,594	—	(9,594)	—
Total net revenue	1,533,384	541,746	(9,594)	2,065,536
Salaries and benefits	614,442	17,667	—	632,109
Supplies	231,001	258	—	231,259
Medical claims	—	461,649	(9,594)	452,055
Other operating expenses	264,814	18,309	—	283,123
Provision for bad debts	161,936	—	—	161,936
Rentals and leases	35,466	1,167	—	36,633
Hurricane-related property damage	3,589	—	—	3,589
Adjusted EBITDA[(1)]	222,136	42,696	—	264,832
Interest expense, net	75,665	—	—	75,665
Depreciation and amortization	93,003	3,738	—	96,741
Management fees	5,000	—	—	5,000
Earnings from continuing operations before loss on disposal of assets, minority interests and income taxes	48,468	38,958	—	87,426
Loss on disposal of assets, net	(75)	—	—	(75)
Minority interests	(4,437)	—	—	(4,437)
Earnings from continuing operations before income taxes	$ 43,956	$ 38,958	$ —	$ 82,914
Segment assets	$ 2,123,069	$ 185,078		$ 2,308,147
Capital expenditures — continuing operations	$ 136,425	$ 990		$ 137,415
Goodwill	$ 774,842	$ 5,757		$ 780,599

	For the Year Ended September 30, 2007			
	Acute Care	Health Choice	Eliminations	Consolidated
Acute care revenue	$ 1,315,438	$ —	$ —	$ 1,315,438
Premium revenue	—	450,641	—	450,641
Revenue between segments	7,540	—	(7,540)	—
Total net revenue	1,322,978	450,641	(7,540)	1,766,079
Salaries and benefits	518,989	14,803	—	533,792
Supplies	194,630	285	—	194,915
Medical claims	—	384,045	(7,540)	376,505
Other operating expenses	251,167	15,096	—	266,263
Provision for bad debts	136,233	—	—	136,233
Rentals and leases	30,384	1,162	—	31,546
Business interruption insurance recoveries	(3,443)	—	—	(3,443)

Adjusted EBITDA[1]	195,018	35,250	—	230,268
Interest expense, net	71,206	—	—	71,206
Depreciation and amortization	71,828	3,560	—	75,388
Loss on extinguishment of debt	6,229	—	—	6,229
Management fees	4,746	—	—	4,746
Earnings from continuing operations before loss on disposal of assets, minority interests and income taxes	41,009	31,690	—	72,699
Loss on disposal of assets, net	(1,359)	—	—	(1,359)
Minority interests	(4,496)	—	—	(4,496)
Earnings from continuing operations before income taxes	$ 35,154	$ 31,690	$ —	$ 66,844
Segment assets	$ 2,035,386	$ 151,036		$ 2,186,422
Capital expenditures — continuing operations	$ 193,570	$ 473		$ 194,043
Goodwill	$ 750,836	$ 5,757		$ 756,593

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

	For the Year Ended September 30, 2006			
	Acute Care	Health Choice	Eliminations	Consolidated
Acute care revenue	$ 1,133,055	$ —	$ —	$ 1,133,055
Premium revenue	—	406,522	—	406,522
Revenue between segments	7,300	—	(7,300)	—
Total net revenue	1,140,355	406,522	(7,300)	1,539,577
Salaries and benefits	426,718	12,631	—	439,349
Supplies	167,332	284	—	167,616
Medical claims	—	354,517	(7,300)	347,217
Other operating expenses	210,662	13,284	—	223,946
Provision for bad debts	134,614	—	—	134,614
Rentals and leases	29,195	1,082	—	30,277
Business interruption insurance recoveries	(8,974)	—	—	(8,974)
Adjusted EBITDA(1)	180,808	24,724	—	205,532
Interest expense, net	67,124	—	—	67,124
Depreciation and amortization	65,751	3,386	—	69,137
Management fees	4,189	—	—	4,189
Earnings from continuing operations before gain (loss) on disposal of assets, minority interests and income taxes	43,744	21,338	—	65,082
Gain (loss) on disposal of assets, net	967	(54)	—	913
Minority interests	(3,546)	—	—	(3,546)
Earnings before income taxes	$ 41,165	$ 21,284	$ —	$ 62,449
Segment assets	$ 1,833,737	$ 134,098		$ 1,967,835
Capital expenditures — continuing operations	$ 145,633	$ 629		$ 146,262
Goodwill	$ 750,722	$ 5,757		$ 756,479

(1) Adjusted EBITDA represents net earnings before interest expense, income tax expense, depreciation and amortization, loss on extinguishment of debt, gain (loss) on disposal of assets, minority interests and management fees. Management fees represent monitoring and advisory fees paid to TPG, the Company's majority financial sponsor, and certain other members of IASIS Investment LLC. Management routinely calculates and communicates adjusted EBITDA and believes that it is useful to investors because it is commonly used as an analytical indicator within the healthcare industry to evaluate hospital performance, allocate resources and measure leverage capacity and debt service ability. In addition, the Company uses adjusted EBITDA as a measure of performance for its business segments and for incentive compensation purposes. Adjusted EBITDA should not be considered as a measure of financial performance under GAAP, and the items excluded from adjusted EBITDA are significant components in understanding and assessing financial performance. Adjusted EBITDA should not be considered in isolation or as an alternative to net earnings, cash flows generated by operating, investing, or financing activities or other financial statement data presented in the consolidated financial statements as an indicator of financial performance or liquidity. Adjusted EBITDA, as presented, differs from what is defined under the Company's senior secured credit facilities and may not be comparable to similarly titled measures of other companies.

15. ACCRUED EXPENSES AND OTHER CURRENT LIABILITIES

A summary of accrued expenses and other current liabilities consists of the following (in thousands):

	September 30, 2008	September 30, 2007
Employee health insurance payable	$ 10,834	$ 8,622
Accrued property taxes	10,041	8,847
Construction retention payable	4,429	2,190
Other	26,498	24,617
	$ 51,802	$ 44,276

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

16. ALLOWANCE FOR DOUBTFUL ACCOUNTS

A summary of activity in the Company's allowance for doubtful accounts is as follows (in thousands):

	Beginning Balance	Provision for Bad Debts	Other (1)	Accounts Written Off, Net of Recoveries	Acquisitions	Ending Balance
Year Ended September 30, 2006	$ 103,619	134,614	7,160	(135,516)	—	$ 109,877
Year Ended September 30, 2007	$ 109,877	136,233	6,475	(167,900)	13,144	$ 97,829
Year Ended September 30, 2008	$ 97,829	161,936	6,782	(158,092)	—	$ 108,455

(1) Represents provision for bad debts recorded at facilities which are now included in discontinued operations.

The provision for bad debts increased $25.7 during the year end September 30, 2008, primarily as a result of increases in self-pay volume and revenue, as well as the effect of a full year of operations at Mountain Vista Medical Center, Alliance and Glenwood. The provision for bad debts increased $1.6 million during the year ended September 30, 2007, primarily as a result of increases in self-pay volume and revenue, as well as the effect of acquisitions, offset by the effects of a full year of the uninsured discount program, which was implemented during the third quarter of 2006.

17. IMPACT OF HURRICANE ACTIVITY

The Medical Center of Southeast Texas, the Company's hospital located in Port Arthur, Texas, which comprises approximately 8.0% of the Company's acute care revenue, was damaged during Hurricane Ike in September 2008. The hospital sustained roof and water intrusion damage. The majority of services at the hospital became operational during October of 2008. The Company's results from operations for the year ended September 30, 2008, include $3.6 million in hurricane-related property damage.

During the years ended September 30, 2007 and 2006, the Company received business interruption insurance recoveries of $3.4 million and $9.0 million, respectively, resulting from the temporary closure and disruption of operations at The Medical Center of Southeast Texas, as a result of Hurricane Rita in 2005. Amounts received during the year ended September 30, 2007, represent the final settlement of the Company's business interruption insurance claim related to Hurricane Rita.

18. SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION

The 8 ³/₄% notes described in Note 3 are fully and unconditionally guaranteed on a joint and several basis by all of the Company's existing domestic subsidiaries, other than non-guarantor subsidiaries which include Health Choice and the Company's non-wholly owned subsidiaries.

Effective July 1, 2007, the operations of Pioneer Valley Hospital ("Pioneer"), formerly a subsidiary guarantor under the 8 ³/₄% notes, merged into Jordan Valley Hospital, a non-wholly owned subsidiary, to form Jordan Valley Medical Center. The Pioneer subsidiary was dissolved in connection with this merger. As a result, the combined operations of Jordan Valley Medical Center are included in the subsidiary non-guarantor information in the following summarized condensed consolidating financial statements.

Effective February 1, 2008, Salt Lake Regional Medical Center, LP ("Salt Lake") sold limited partner units representing, in the aggregate, a 2.2% ownership interest in Salt Lake. As a result, the Company's ownership interest in Salt Lake was reduced to 97.8%. Salt Lake is included in the condensed consolidating financial statements as a subsidiary non-guarantor.

Summarized condensed consolidating balance sheets at September 30, 2008 and 2007, condensed consolidating statements of operations and cash flows for the years ended September 30, 2008, 2007 and 2006, for the Company, segregating the parent company issuer, the subsidiary guarantors, the subsidiary non-guarantors and eliminations, are found below. Prior year amounts have been reclassified to conform to the current year presentation.

IASIS Healthcare LLC

Condensed Consolidating Balance Sheet

September 30, 2008

(in thousands)

	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Assets					
Current assets:					
Cash and cash equivalents	$ —	$ 80,336	$ 402	$ —	$ 80,738
Accounts receivable, net	—	101,291	122,847	—	224,138
Inventories	—	21,236	28,218	—	49,454
Deferred income taxes	38,860	—	—	—	38,860
Prepaid expenses and other current assets	—	19,688	40,365	—	60,053
Total current assets	38,860	222,551	191,832	—	453,243
Property and equipment, net	—	363,106	641,142	—	1,004,248
Intercompany	—	(190,870)	190,870	—	—
Net investment in and advances to subsidiaries	1,717,907	—	—	(1,717,907)	—
Goodwill	18,609	128,764	633,226	—	780,599
Other intangible assets, net	—	—	33,000	—	33,000
Other assets, net	18,210	12,944	5,903	—	37,057
Total assets	$ 1,793,586	$ 536,495	$ 1,695,973	$ (1,717,907)	$ 2,308,147
Liabilities and Member's Equity					
Current liabilities:					
Accounts payable	$ —	$ 24,708	$ 40,143	$ —	$ 64,851
Salaries and benefits payable	—	16,819	14,988	—	31,807
Accrued interest payable	12,460	(3,242)	3,242	—	12,460
Medical claims payable	—	—	97,343	—	97,343
Other accrued expenses and other current liabilities	—	38,552	13,250	—	51,802
Current portion of long-term debt and capital lease obligations	6,042	1,581	15,255	(15,255)	7,623
Total current liabilities	18,502	78,418	184,221	(15,255)	265,886
Long-term debt and capital lease obligations	1,098,928	8,071	588,172	(588,172)	1,106,999
Deferred income taxes	111,092	—	—	—	111,092
Other long-term liabilities	—	43,871	655	—	44,526
Minority interests	—	51,875	—	—	51,875
Total liabilities	1,228,522	182,235	773,048	(603,427)	1,580,378
Member's equity	565,064	354,260	922,925	(1,114,480)	727,769
Total liabilities and member's equity	$ 1,793,586	$ 536,495	$ 1,695,973	$ (1,717,907)	$ 2,308,147

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

IASIS Healthcare LLC

Condensed Consolidating Balance Sheet

September 30, 2007

(in thousands)

	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Assets					
Current assets:					
Cash and cash equivalents	$ —	$ (4,052)	$ 4,052	$ —	$ —
Accounts receivable, net	—	131,180	117,101	—	248,281
Inventories	—	19,961	23,736	—	43,697
Deferred income taxes	29,629	—	—	—	29,629
Prepaid expenses and other current assets	—	23,509	21,514	—	45,023
Total current assets	29,629	170,598	166,403	—	366,630
Property and equipment, net	—	363,295	617,142	—	980,437
Intercompany	—	23,173	(23,173)	—	—
Net investment in and advances to subsidiaries	1,627,879	—	—	(1,627,879)	—
Goodwill	21,774	111,593	623,226	—	756,593
Other intangible assets, net	—	—	36,000	—	36,000
Other assets, net	21,006	19,668	6,088	—	46,762
Total assets	$ 1,700,288	$ 688,327	$ 1,425,686	$ (1,627,879)	$ 2,186,422
Liabilities and Member's Equity					
Current liabilities:					
Accounts payable	$ —	$ 55,980	$ 42,508	$ —	$ 98,488
Salaries and benefits payable	—	24,338	15,786	—	40,124
Accrued interest payable	18,865	(2,301)	2,301	—	18,865
Medical claims payable	—	—	81,309	—	81,309
Other accrued expenses and other current liabilities	—	24,567	19,709	—	44,276
Current portion of long-term debt and capital lease obligations	4,542	3,494	11,054	(11,054)	8,036
Total current liabilities	23,407	106,078	172,667	(11,054)	291,098
Long-term debt and capital lease obligations	1,018,415	5,206	470,569	(470,569)	1,023,621
Deferred income taxes	93,402	—	—	—	93,402
Other long-term liabilities	—	49,809	1,022	—	50,831
Minority interests	—	35,956	—	—	35,956
Total liabilities	1,135,224	197,049	644,258	(481,623)	1,494,908
Member's equity	565,064	491,278	781,428	(1,146,256)	691,514
Total liabilities and member's equity	$ 1,700,288	$ 688,327	$ 1,425,686	$ (1,627,879)	$ 2,186,422

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

IASIS Healthcare LLC

Condensed Consolidating Statement of Operations

(in thousands)

	For the Year Ended September 30, 2008				
	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Net revenue:					
Acute care revenue	$ —	$ 637,773	$ 895,611	$ (9,594)	$ 1,523,790
Premium revenue	—	—	541,746	—	541,746
Total net revenue	—	637,773	1,437,357	(9,594)	2,065,536
Costs and expenses:					
Salaries and benefits	—	319,243	312,866	—	632,109
Supplies	—	104,698	126,561	—	231,259
Medical claims	—	—	461,649	(9,594)	452,055
Other operating expenses	—	111,781	171,342	—	283,123
Provision for bad debts	—	80,139	81,797	—	161,936
Rentals and leases	—	14,891	21,742	—	36,633
Interest expense, net	75,665	—	54,716	(54,716)	75,665
Depreciation and amortization	—	42,721	54,020	—	96,741
Management fees	5,000	(19,337)	19,337	—	5,000
Hurricane-related property damage	—	—	3,589	—	3,589
Equity in earnings of affiliates	(91,476)	—	—	91,476	—
Total costs and expenses	(10,811)	654,136	1,307,619	27,166	1,978,110
Earnings (loss) from continuing operations before gain (loss) on disposal of assets, minority interests and income taxes	10,811	(16,363)	129,738	(36,760)	87,426
Gain (loss) on disposal of assets, net	—	(81)	6	—	(75)
Minority interests	—	(4,437)	—	—	(4,437)
Earnings (loss) from continuing operations before income taxes	10,811	(20,881)	129,744	(36,760)	82,914
Income tax expense	34,996	—	329	—	35,325
Net earnings (loss) from continuing operations	(24,185)	(20,881)	129,415	(36,760)	47,589
Earnings (loss) from discontinued operations, net of income taxes	5,783	(12,257)	(4,801)	—	(11,275)
Net earnings (loss)	$ (18,402)	$ (33,138)	$ 124,614	$ (36,760)	$ 36,314

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

IASIS Healthcare LLC

Condensed Consolidating Statement of Operations

(in thousands)

	For the Year Ended September 30, 2007				
	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Net revenue:					
Acute care revenue	$ —	$ 577,891	$ 745,087	$ (7,540)	$ 1,315,438
Premium revenue	—	—	450,641	—	450,641
Total net revenue	—	577,891	1,195,728	(7,540)	1,766,079
Costs and expenses:					
Salaries and benefits	—	284,520	249,272	—	533,792
Supplies	—	97,043	97,872	—	194,915
Medical claims	—	—	384,045	(7,540)	376,505
Other operating expenses	—	115,542	150,721	—	266,263
Provision for bad debts	—	68,824	67,409	—	136,233
Rentals and leases	—	11,985	19,561	—	31,546
Interest expense, net	71,206	—	34,684	(34,684)	71,206
Depreciation and amortization	—	37,161	38,227	—	75,388
Loss on extinguishment of debt	6,229	—	—	—	6,229
Management fees	4,746	(16,030)	16,030	—	4,746
Business interruption insurance recoveries	—	—	(3,443)	—	(3,443)
Equity in earnings of affiliates	(117,212)	—	—	117,212	—
Total costs and expenses	(35,031)	599,045	1,054,378	74,988	1,693,380
Earnings (loss) from continuing operations before loss on disposal of assets, minority interests and income taxes	35,031	(21,154)	141,350	(82,528)	72,699
Loss on disposal of assets, net	—	(774)	(585)	—	(1,359)
Minority interests	—	(4,496)	—	—	(4,496)
Earnings (loss) from continuing operations before income taxes	35,031	(26,424)	140,765	(82,528)	66,844
Income tax expense	25,909	—	—	—	25,909
Net earnings (loss) from continuing operations	9,122	(26,424)	140,765	(82,528)	40,935
Earnings (loss) from discontinued operations, net of income taxes	(2,202)	6,314	(3,443)	—	669
Net earnings (loss)	$ 6,920	$ (20,110)	$ 137,322	$ (82,528)	$ 41,604

IASIS Healthcare LLC

Condensed Consolidating Statement of Operations

(in thousands)

	For the Year Ended September 30, 2006				
	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Net revenue:					
Acute care revenue	$ —	$ 498,794	$ 641,561	$ (7,300)	$ 1,133,055
Premium revenue	—	—	406,522	—	406,522
Total net revenue	—	498,794	1,048,083	(7,300)	1,539,577
Costs and expenses:					
Salaries and benefits	—	223,129	216,220	—	439,349
Supplies	—	83,137	84,479	—	167,616
Medical claims	—	—	354,517	(7,300)	347,217
Other operating expenses	—	110,841	113,105	—	223,946
Provision for bad debts	—	67,895	66,719	—	134,614
Rentals and leases	—	10,525	19,752	—	30,277
Interest expense, net	67,124	—	26,548	(26,548)	67,124
Depreciation and amortization	—	32,859	36,278	—	69,137
Management fees	4,189	(14,106)	14,106	—	4,189
Business interruption insurance recoveries	—	—	(8,974)	—	(8,974)
Equity in earnings of affiliates	(108,720)	—	—	108,720	—
Total costs and expenses	(37,407)	514,280	922,750	74,872	1,474,495
Earnings (loss) from continuing operations before gain (loss) on disposal of assets, minority interests and income taxes	37,407	(15,486)	125,333	(82,172)	65,082
Gain (loss) on disposal of assets, net	—	2,249	(1,336)	—	913
Minority interests	—	(3,546)	—	—	(3,546)
Earnings (loss) from continuing operations before income taxes	37,407	(16,783)	123,997	(82,172)	62,449
Income tax expense	22,515	—	—	—	22,515
Net earnings (loss) from continuing operations	14,892	(16,783)	123,997	(82,172)	39,934
Earnings (loss) from discontinued operations, net of income taxes	(1,891)	4,175	(2,669)	—	(385)
Net earnings (loss)	$ 13,001	$ (12,608)	$ 121,328	$ (82,172)	$ 39,549

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

IASIS Healthcare LLC

Condensed Consolidating Statement of Cash Flows

(in thousands)

	For the Year Ended September 30, 2008				
	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Cash flows from operating activities					
Net earnings (loss)	$ (18,402)	$ (33,138)	$ 124,614	$ (36,760)	$ 36,314
Adjustments to reconcile net earnings (loss) to net cash provided by (used in) operating activities:					
Loss (earnings) from discontinued operations	(5,783)	12,257	4,801	—	11,275
Depreciation and amortization	—	42,721	54,020	—	96,741
Amortization of loan costs	2,913	—	—	—	2,913
Minority interests	—	4,437	—	—	4,437
Deferred income taxes	19,368	—	—	—	19,368
Loss (gain) on disposal of assets	—	81	(6)	—	75
Hurricane-related property damage	—	—	3,589	—	3,589
Equity in earnings of affiliates	(91,476)	—	—	91,476	—
Changes in operating assets and liabilities, net of the effect of acquisitions and dispositions:					
Accounts receivable, net	—	23,114	(5,983)	—	17,131
Inventories, prepaid expenses and other current assets	—	2,328	(23,689)	—	(21,361)
Accounts payable, other accrued expenses and other accrued liabilities	(10,947)	(13,040)	(5,432)	—	(29,419)
Net cash provided by (used in) operating activities — continuing operations	(104,327)	38,760	151,914	54,716	141,063
Net cash provided by (used in) operating activities — discontinued operations	5,783	(884)	(2,586)	—	2,313
Net cash provided by (used in) operating activities	(98,544)	37,876	149,328	54,716	143,376
Cash flows from investing activities					
Purchases of property and equipment	—	(45,109)	(92,306)	—	(137,415)
Cash paid for acquisitions	—	(16,799)	(22)	—	(16,821)
Proceeds from sale of assets	—	94	266	—	360
Change in other assets	—	5,226	(613)	—	4,613
Net cash used in investing activities — continuing operations	—	(56,588)	(92,675)	—	(149,263)
Net cash provided by (used in) investing activities — discontinued operations	—	(1,040)	23	—	(1,017)
Net cash used in investing activities	—	(57,628)	(92,652)	—	(150,280)
Cash flows from financing activities					
Payment of debt and capital lease obligations	(303,190)	(849)	(2,572)	—	(306,611)
Proceeds from debt borrowings	384,978	—	—	—	384,978
Distribution of minority interests	—	(171)	(5,314)	—	(5,485)
Proceeds received from sale of	—	15,070	—	—	15,070

partnership interests					
Other	192	—	—	—	192
Change in intercompany balances with affiliates, net	16,564	90,592	(52,440)	(54,716)	—
Net cash provided by (used in) financing activities — continuing operations	98,544	104,642	(60,326)	(54,716)	88,144
Net cash used in financing activities — discontinued operations	—	(502)	—	—	(502)
Net cash provided by (used in) financing activities	98,544	104,140	(60,326)	(54,716)	87,642
Increase (decrease) in cash and cash equivalents	—	84,388	(3,650)	—	80,738
Cash and cash equivalents at beginning of period	—	(4,052)	4,052	—	—
Cash and cash equivalents at end of period	$ —	$ 80,336	$ 402	$ —	$ 80,738

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

IASIS Healthcare LLC

Condensed Consolidating Statement of Cash Flows

(in thousands)

	For the Year Ended September 30, 2007				
	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Cash flows from operating activities					
Net earnings (loss)	$ 6,920	$ (20,110)	$ 137,322	$ (82,528)	$ 41,604
Adjustments to reconcile net earnings (loss) to net cash provided by (used in) operating activities:					
Loss (earnings) from discontinued operations	2,202	(6,314)	3,443	—	(669)
Depreciation and amortization	—	37,161	38,227	—	75,388
Amortization of loan costs	2,942	—	—	—	2,942
Minority interests	—	4,496	—	—	4,496
Deferred income taxes	24,103	—	—	—	24,103
Loss on disposal of assets	—	774	585	—	1,359
Loss on extinguishment of debt	5,091	—	—	—	5,091
Equity in earnings of affiliates	(117,212)	—	—	117,212	—
Changes in operating assets and liabilities, net of the effect of acquisitions and dispositions:					
Accounts receivable, net	—	(37,182)	(15,567)	—	(52,749)
Inventories, prepaid expenses and other current assets	—	(3,204)	(2,690)	—	(5,894)
Accounts payable, other accrued expenses and other accrued liabilities	(1,100)	25,090	2,012	—	26,002
Net cash provided by (used in) operating activities — continuing operations	(77,054)	711	163,332	34,684	121,673
Net cash provided by (used in) operating activities — discontinued operations	(2,202)	9,306	(2,443)	—	4,661
Net cash provided by (used in) operating activities	(79,256)	10,017	160,889	34,684	126,334
Cash flows from investing activities					
Purchases of property and equipment	—	(41,987)	(152,056)	—	(194,043)
Cash paid for acquisitions	—	(78,083)	(63,502)	—	(141,585)
Proceeds from sale of assets	—	1,026	—	—	1,026
Change in other assets	—	4,272	1,621	—	5,893
Net cash used in investing activities — continuing operations	—	(114,772)	(213,937)	—	(328,709)
Net cash used in investing activities — discontinued operations	—	(874)	(55)	—	(929)
Net cash used in investing activities	—	(115,646)	(213,992)	—	(329,638)
Cash flows from financing activities					
Payment of debt and capital lease obligations	(646,663)	(1,447)	(2,195)	—	(650,305)
Proceeds from debt borrowings	778,800	—	—	—	778,800
Debt financing costs incurred	(8,200)	—	—	—	(8,200)
Distribution to parent for debt	(6,586)	—	—	—	(6,586)

financing costs					
Distribution of minority interests	—	—	(4,850)	—	(4,850)
Costs paid for partnership interests	—	(495)	—	—	(495)
Change in intercompany balances with affiliates, net	(38,095)	9,736	63,043	(34,684)	—
Net cash provided by (used in) financing activities — continuing operations	79,256	7,794	55,998	(34,684)	108,364
Net cash used in financing activities — discontinued operations	—	(475)	—	—	(475)
Net cash provided by (used in) financing activities	79,256	7,319	55,998	(34,684)	107,889
Increase (decrease) in cash and cash equivalents	—	(98,310)	2,895	—	(95,415)
Cash and cash equivalents at beginning of period	—	94,258	1,157	—	95,415
Cash and cash equivalents at end of period	$ —	$ (4,052)	$ 4,052	$ —	$ —

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

IASIS Healthcare LLC

Condensed Consolidating Statement of Cash Flows

(in thousands)

	For the Year Ended September 30, 2006				
	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Cash flows from operating activities					
Net earnings (loss)	$ 13,001	$ (12,608)	$ 121,328	$ (82,172)	$ 39,549
Adjustments to reconcile net earnings (loss) to net cash provided by (used in) operating activities:					
Loss (earnings) from discontinued operations	1,891	(4,175)	2,669	—	385
Depreciation and amortization	—	32,859	36,278	—	69,137
Amortization of loan costs	2,960	—	—	—	2,960
Minority interests	—	3,546	—	—	3,546
Deferred income taxes	21,021	—	—	—	21,021
Loss (gain) on disposal of assets	—	(2,249)	1,336	—	(913)
Equity in earnings of affiliates	(108,720)	—	—	108,720	—
Changes in operating assets and liabilities, net of the effect of dispositions:					
Accounts receivable, net	—	(1,416)	(12,547)	—	(13,963)
Inventories, prepaid expenses and other current assets	—	(8,076)	(7,441)	—	(15,517)
Accounts payable, other accrued expenses and other accrued liabilities	1,476	27,552	22,502	—	51,530
Net cash provided by (used in) operating activities — continuing operations	(68,371)	35,433	164,125	26,548	157,735
Net cash provided by (used in) operating activities — discontinued operations	(1,891)	3,171	(1,871)	—	(591)
Net cash provided by (used in) operating activities	(70,262)	38,604	162,254	26,548	157,144
Cash flows from investing activities					
Purchases of property and equipment	—	(40,175)	(106,087)	—	(146,262)
Proceeds from sale of assets	—	147	—	—	147
Change in other assets	—	673	(507)	—	166
Net cash used in investing activities — continuing operations	—	(39,355)	(106,594)	—	(145,949)
Net cash used in investing activities — discontinued operations	—	(163)	(71)	—	(234)
Net cash used in investing activities	—	(39,518)	(106,665)	—	(146,183)
Cash flows from financing activities					
Payment of debt and capital lease obligations	(4,402)	(1,409)	(1,508)	—	(7,319)
Distribution of minority interests	—	—	(2,507)	—	(2,507)
Proceeds from sale of partnership interests	—	1,105	4,622	—	5,727
Change in intercompany balances with affiliates, net	74,664	7,683	(55,799)	(26,548)	—

Net cash provided by (used in) financing activities — continuing operations	70,262	7,379	(55,192)	(26,548)	(4,099)
Net cash used in financing activities — discontinued operations	—	(544)	—	—	(544)
Net cash provided by (used in) financing activities	70,262	6,835	(55,192)	(26,548)	(4,643)
Increase in cash and cash equivalents	—	5,921	397	—	6,318
Cash and cash equivalents at beginning of period	—	88,597	500	—	89,097
Cash and cash equivalents at end of period	$ —	$ 94,518	$ 897	$ —	$ 95,415

Report of Independent Registered Public Accounting Firm

To the Board of Directors of

IASIS Healthcare Corporation, sole member of IASIS Healthcare LLC

We have audited the accompanying consolidated balance sheets of IASIS Healthcare LLC as of September 30, 2009 and 2008, and the related consolidated statements of operations, member's equity and cash flows for each of the three years in the period ended September 30, 2009. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of IASIS Healthcare LLC at September 30, 2009 and 2008, and the consolidated results of their operations and their cash flows for each of the three years in the period ended September 30, 2009, in conformity with U.S. generally accepted accounting principles.

/s/ Ernst & Young LLP

Nashville, Tennessee

November 25, 2009

IASIS HEALTHCARE LLC

CONSOLIDATED BALANCE SHEETS
(In thousands)

	September 30, 2009	September 30, 2008
ASSETS		
Current assets:		
Cash and cash equivalents	$ 206,528	$ 80,738
Accounts receivable, less allowance for doubtful accounts of $126,132 and $108,500 at September 30, 2009 and 2008, respectively	230,198	224,138
Inventories	50,492	49,454
Deferred income taxes	39,038	38,860
Prepaid expenses and other current assets	49,453	60,053
Total current assets	575,709	453,243
Property and equipment, net	997,353	1,004,248
Goodwill	717,920	780,599
Other intangible assets, net	30,000	33,000
Other assets, net	36,222	37,057
Total assets	$ 2,357,204	$ 2,308,147
LIABILITIES AND MEMBER'S EQUITY		
Current liabilities:		
Accounts payable	$ 68,552	$ 64,851
Salaries and benefits payable	42,548	31,807
Accrued interest payable	12,511	12,460
Medical claims payable	113,519	97,343
Other accrued expenses and other current liabilities	65,701	51,802
Current portion of long-term debt and capital lease obligations	8,366	7,623
Total current liabilities	311,197	265,886
Long-term debt and capital lease obligations	1,051,471	1,106,999
Deferred income taxes	106,425	111,092
Other long-term liabilities	54,222	44,526
Minority interests	53,042	51,875
Member's equity:		
Member's equity	780,847	727,769
Total liabilities and member's equity	$ 2,357,204	$ 2,308,147

IASIS HEALTHCARE LLC

CONSOLIDATED STATEMENTS OF OPERATIONS
(In thousands)

	Year Ended September 30, 2009	Year Ended September 30, 2008	Year Ended September 30, 2007
Net revenue:			
Acute care revenue	$ 1,662,469	$ 1,523,790	$ 1,315,438
Premium revenue	699,503	541,746	450,641
Total net revenue	2,361,972	2,065,536	1,766,079
Costs and expenses:			
Salaries and benefits	660,921	632,109	533,792
Supplies	250,573	231,259	194,915
Medical claims	592,760	452,055	376,505
Other operating expenses	325,735	283,123	266,263
Provision for bad debts	192,563	161,936	136,233
Rentals and leases	39,127	36,633	31,546
Interest expense, net	67,890	75,665	71,206
Depreciation and amortization	97,462	96,741	75,388
Management fees	5,000	5,000	4,746
Impairment of goodwill	64,639	—	—
Hurricane-related property damage	938	3,589	—
Loss on extinguishment of debt	—	—	6,229
Business interruption insurance recoveries	—	—	(3,443)
Total costs and expenses	2,297,608	1,978,110	1,693,380
Earnings from continuing operations before gain (loss) on disposal of assets, minority interests and income taxes	64,364	87,426	72,699
Gain (loss) on disposal of assets, net	1,465	(75)	(1,359)
Minority interests	(9,987)	(4,437)	(4,496)
Earnings from continuing operations before income taxes	55,842	82,914	66,844
Income tax expense	27,576	35,325	25,909
Net earnings from continuing operations	28,266	47,589	40,935
Earnings (loss) from discontinued operations, net of income taxes	(176)	(11,275)	669
Net earnings	$ 28,090	$ 36,314	$ 41,604

IASIS HEALTHCARE LLC

CONSOLIDATED STATEMENTS OF MEMBER'S EQUITY
(In thousands)

		Member's Equity
Balance at September 30, 2006	$	656,496
Distribution to parent for debt financing costs		(6,586)
Net earnings		41,604
Balance at September 30, 2007	$	691,514
Cumulative effect of the adoption of FASB income tax guidance		(59)
Net earnings		36,314
Balance at September 30, 2008	$	727,769
Income tax benefit resulting from exercise of employee stock options		9
Stock compensation costs		561
Other comprehensive loss		(2,926)
Contribution from parent related to tax benefit from Holdings Senior PIK Loans interest		27,344
Net earnings		28,090
Balance at September 30, 2009	$	780,847

IASIS HEALTHCARE LLC

CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

	Year Ended September 30, 2009	Year Ended September 30, 2008	Year Ended September 30, 2007
Cash flows from operating activities:			
Net earnings	$ 28,090	$ 36,314	$ 41,604
Adjustments to reconcile net earnings to net cash provided by operating activities:			
Loss (earnings) from discontinued operations	176	11,275	(669)
Depreciation and amortization	97,462	96,741	75,388
Amortization of loan costs	3,029	2,913	2,942
Minority interests	9,987	4,437	4,496
Deferred income taxes	(5,572)	19,368	24,103
Income tax benefit from parent company interest	27,344	—	—
Loss (gain) on disposal of assets, net	(1,465)	75	1,359
Impairment of goodwill	64,639	—	—
Hurricane-related property damage	938	3,589	—
Stock compensation costs	561	—	—
Loss on extinguishment of debt	—	—	5,091
Changes in operating assets and liabilities, net of the effect of acquisitions and dispositions:			
Accounts receivable, net	(7,302)	17,131	(52,749)
Inventories, prepaid expenses and other current assets	6,728	(21,361)	(5,894)
Accounts payable, other accrued expenses and other accrued liabilities	45,884	(29,419)	26,002
Net cash provided by operating activities — continuing operations	270,499	141,063	121,673
Net cash provided by operating activities — discontinued operations	1,472	2,313	4,661
Net cash provided by operating activities	271,971	143,376	126,334
Cash flows from investing activities:			
Purchases of property and equipment	(87,720)	(137,415)	(194,043)
Cash paid for acquisitions	(1,941)	(16,821)	(141,585)
Proceeds from sale of assets	5,252	360	1,026
Change in other assets	1,823	4,613	5,893
Net cash used in investing activities — continuing operations	(82,586)	(149,263)	(328,709)
Net cash provided by (used in) investing activities — discontinued operations	10	(1,017)	(929)
Net cash used in investing activities	(82,576)	(150,280)	(329,638)
Cash flows from financing activities:			
Payment of debt and capital lease obligations	(55,476)	(306,611)	(650,305)
Proceeds from debt borrowings	—	384,978	778,800
Debt financing costs incurred	—	—	(8,200)
Distribution to parent for debt financing costs	—	—	(6,586)
Distribution of minority interests	(6,750)	(5,485)	(4,850)
Proceeds received from sale (costs paid for repurchase) of partnership interests, net	(1,379)	15,070	(495)
Other	—	192	—
Net cash provided by (used in) financing activities — continuing operations	(63,605)	88,144	108,364
Net cash used in financing activities — discontinued operations	—	(502)	(475)
Net cash provided by (used in) financing activities	(63,605)	87,642	107,889
Increase (decrease) in cash and cash equivalents	125,790	80,738	(95,415)
Cash and cash equivalents at beginning of period	80,738	—	95,415

Cash and cash equivalents at end of period	$ 206,528	$ 80,738	$ —
Supplemental disclosure of cash flow information:			
Cash paid for interest	$ 66,136	$ 83,126	$ 80,647
Cash paid (received) for income taxes, net	$ 4,104	$ (925)	$ 7,710
Cash paid in loss on extinguishment of debt	$ —	$ —	$ 1,138
Supplemental schedule of noncash investing and financing activities:			
Capital lease obligations resulting from acquisitions	$ —	$ 4,849	$ 5,037
Property and equipment in accounts payable	$ 1,184	$ 4,788	$ 6,401
Partnership interests issued for acquisition	$ —	$ —	$ 3,517

IASIS HEALTHCARE LLC

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. ORGANIZATION AND BASIS OF PRESENTATION

Organization

IASIS Healthcare LLC ("IASIS") owns and operates medium-sized acute care hospitals in high-growth urban and suburban markets. At September 30, 2009, the Company owned or leased 15 acute care hospital facilities and one behavioral health hospital facility, with a total of 2,853 beds in service, located in six regions:

- Salt Lake City, Utah;
- Phoenix, Arizona;
- Tampa-St. Petersburg, Florida;
- three cities in Texas, including San Antonio;
- Las Vegas, Nevada; and
- West Monroe, Louisiana.

The Company also owns and operates Health Choice Arizona, Inc. ("Health Choice" or the "Plan"), a Medicaid and Medicare managed health plan in Phoenix.

Principles of Consolidation

The consolidated financial statements include all subsidiaries and entities under common control of the Company. Control is generally defined by the Company as ownership of a majority of the voting interest of an entity. In addition, control is demonstrated in instances when the Company is the sole general partner in a limited partnership. Significant intercompany transactions have been eliminated.

Use of Estimates

The preparation of the financial statements in conformity with U.S. generally accepted accounting principles ("GAAP") requires management to make estimates and assumptions that affect the amounts reported in the accompanying audited consolidated financial statements and notes. Actual results could differ from those estimates.

Reclassifications

Certain prior year amounts have been reclassified to conform to the current year presentation. These reclassifications have no impact on the Company's total assets, liabilities, or member's equity.

General and Administrative

The majority of the Company's expenses are "cost of revenue" items. Costs that could be classified as "general and administrative" by the Company would include the IASIS corporate office costs, which were $45.6 million, $50.5 million and $55.0 million, for the years ended September 30, 2009, 2008 and 2007, respectively.

Subsequent Events Consideration

The Company has evaluated its financial statements and disclosures for the impact of subsequent events up to the date of filing its annual report on Form 10-K with the Securities and Exchange Commission.

2. SIGNIFICANT ACCOUNTING POLICIES

Net Revenue

Acute Care Revenue

The Company's healthcare facilities have entered into agreements with third-party payors, including government programs and managed care health plans, under which the facilities are paid based upon established charges, the cost of providing services, predetermined rates per diagnosis, fixed per diem rates or discounts from established charges. Additionally, the Company offers discounts through its uninsured discount program to all uninsured patients receiving healthcare services who do not qualify for assistance under state Medicaid, other federal or state assistance plans, or charity care.

Net patient revenue is reported at the estimated net realizable amounts from third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and are adjusted, if necessary, in future periods when final settlements are determined. Net adjustments to estimated third-party payor settlements ("prior year contractuals") resulted in an increase in net revenue of $3.2 million, $1.0 million and $365,000 for the years ended September 30, 2009, 2008 and 2007, respectively.

In the ordinary course of business, the Company provides care without charge to patients who are financially unable to pay for the healthcare services they receive. Because the Company does not pursue collection of amounts determined to qualify as charity care, they are not reported in net revenue. The Company currently records revenue deductions for patient accounts that meet its guidelines for charity care. The Company provides charity care to patients with income levels below 200% of the federal property level. Additionally, at all of the Company's hospitals, a sliding scale of reduced rates is offered to uninsured patients, who are not covered through federal, state or private insurance, with incomes between 200% and 400% of the federal poverty level. Charity care deductions based on gross charges for the years ended September 30, 2009, 2008 and 2007 were $38.6 million, $37.7 million and $31.3 million, respectively.

Premium Revenue

Health Choice is a prepaid Medicaid and Medicare managed health plan that derives most of its revenue through a contract with the Arizona Health Care Cost Containment System ("AHCCCS") to provide specified health services to qualified Medicaid enrollees through contracted providers. AHCCCS is the state agency that administers Arizona's Medicaid program. The contract requires the Plan to arrange for healthcare services for enrolled Medicaid patients in exchange for fixed monthly premiums, based upon negotiated per capita member rates, and supplemental payments from AHCCCS. Capitation payments received by Health Choice are recognized as revenue in the month that members are entitled to healthcare services.

Effective October 1, 2008, Health Choice began its current contract with AHCCCS, which provides for a three-year term, with AHCCCS having the option to renew for two additional one-year periods. The contract is terminable without cause on 90 days' written notice or for cause upon written notice if the Company fails to comply with any term or condition of the contract or fails to take corrective action as required to comply with the terms of the contract. Additionally, AHCCCS can terminate the contract in the event of the unavailability of state or federal funding.

The Plan receives reinsurance and other supplemental payments from AHCCCS for healthcare costs that exceed stated amounts at a rate ranging from 75% to 100% of qualified healthcare costs in excess of stated levels of up to $50,000 per claim, depending on the eligibility classification of the member. Qualified costs must be incurred during the contract year and are the lesser of the amount paid by the Plan or the AHCCCS fee schedule. Reinsurance recoveries are recognized under the contract with AHCCCS when healthcare costs exceed stated amounts as provided under the contract, including estimates of such costs at the end of each accounting period.

Health Choice also provides coverage as a Medicare Advantage Prescription Drug ("MAPD") Special Needs Plan ("SNP") provider pursuant to its contract with the Centers for Medicare and Medicaid Services ("CMS"). The SNP allows Health Choice to offer Medicare and Part D drug benefit coverage for new and existing dual-eligible members, or those that are eligible for Medicare and Medicaid. The contract with CMS includes successive one-year renewal options at the discretion of CMS and is terminable without cause on 90 days' written notice or for cause upon written notice if the Company fails to comply with any term or condition of the contract or fails to take corrective action as required to comply with the terms of the contract. Health Choice has received notification that CMS is exercising its option to extend its contract through December 31, 2010.

The Plan subcontracts with hospitals, physicians and other medical providers within Arizona and surrounding states to provide services to its Medicaid enrollees in Apache, Coconino, Maricopa, Mohave, Navajo, Pima, Yuma, LaPaz and Santa Cruz counties, and to its Medicare enrollees in Maricopa, Pima, Pinal, Coconino, Apache and Navajo counties. These services are provided regardless of the actual costs incurred to provide these services.

Cash and Cash Equivalents

The Company considers highly liquid investments with original maturities of three months or less to be cash equivalents. The Company maintains its cash and cash equivalents balances primarily with high credit quality financial institutions. The Company manages its credit exposure by placing its investments in United States Treasury securities or other high quality securities, and by periodically evaluating the relative credit standing of the financial institution.

Accounts Receivable

The Company receives payments for services rendered from federal and state agencies (under the Medicare, Medicaid and TRICARE programs), managed care health plans, including Medicare and Medicaid managed health plans, commercial insurance companies, employers and patients. During the years ended September 30, 2009, 2008 and 2007, 43.0%, 46.0% and 47.5%, respectively, of the Company's net patient revenue related to patients participating in the Medicare and Medicaid programs, including managed Medicare and managed Medicaid. The Company recognizes that revenue and receivables from government agencies are significant to its operations, but does not believe that there is significant credit risks associated with these government agencies. The Company believes that concentration of credit risk from other payors is limited due to the number of patients and payors.

Net Medicare settlement receivables estimated at September 30, 2009 and 2008, totaled $6.3 million and $2.9 million, respectively, are included in accounts receivable in the accompanying consolidated balance sheets.

Allowance for Doubtful Accounts

The Company's estimation of the allowance for doubtful accounts is based primarily upon the type and age of the patient accounts receivable and the effectiveness of the Company's collection efforts. The Company's policy is to reserve a portion of all self-pay receivables, including amounts due from the uninsured and amounts related to co-payments and deductibles, as these charges are recorded. On a monthly basis, the Company reviews its accounts receivable balances, the effectiveness of the Company's reserve policies and various analytics to support the basis for its estimates. These efforts primarily consist of reviewing the following:

Historical write-off and collection experience using a hindsight or look-back approach;

Revenue and volume trends by payor, particularly the self-pay components;

Changes in the aging and payor mix of accounts receivable, including increased focus on accounts due from the uninsured and accounts that represent co-payments and deductibles due from patients;

Cash collections as a percentage of net patient revenue less bad debt expense;

Trending of days revenue in accounts receivable; and

Various allowance coverage statistics.

The Company regularly performs hindsight procedures to evaluate historical write-off and collection experience throughout the year to assist in determining the reasonableness of its process for estimating the allowance for doubtful accounts.

Table of Contents

Inventories

Inventories, principally medical supplies, implants and pharmaceuticals, are stated at the lower of average cost or market.

Long-lived Assets

The primary components of the Company's long-lived assets are discussed below. When events, circumstances or operating results indicate that the carrying values of certain long-lived assets and related identifiable intangible assets (excluding goodwill) that are expected to be held and used might be impaired under the provisions of Financial Accounting Standards Board ("FASB") authoritative guidance regarding accounting for the impairment or disposal of long-lived assets, the Company considers the recoverability of assets to be held and used by comparing the carrying amount of the assets to the undiscounted value of future net cash flows expected to be generated by the assets. If assets are identified as impaired, the impairment is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets as determined by independent appraisals or estimates of discounted future cash flows. Assets to be disposed of are reported at the lower of the carrying amount or fair value less costs to sell.

Property and Equipment

Property and equipment are stated at cost. Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase capacities or extend useful lives are capitalized. Buildings and improvements are depreciated over estimated useful lives ranging generally from 14 to 40 years. Estimated useful lives of equipment vary generally from 3 to 25 years. Leasehold improvements are amortized on a straight-line basis over the lesser of the terms of the respective leases or their estimated useful lives. Depreciation expense, including amortization of assets capitalized under capital leases, is computed using the straight-line method and was $94.5 million, $93.7 million and $72.4 million for the years ended September 30, 2009, 2008 and 2007, respectively. In connection with certain construction projects, the Company capitalized interest totaling $1.2 million, $1.4 million and $6.9 million for the years ended September 30, 2009, 2008 and 2007, respectively.

Goodwill and Other Intangible Assets

See Note 9 for the values of goodwill and other intangible assets assigned to each business segment. Intangible assets are evaluated for impairment if events and circumstances indicate a possible impairment.

Goodwill is not amortized but is subject to annual tests for impairment or more often if events or circumstances indicate it may be impaired. An impairment loss is recorded to the extent that the carrying amount of goodwill exceeds its implied fair value. The Company completed its annual impairment test of goodwill during fiscal 2009. Results of the Company's testing indicated impairment of goodwill associated with its Florida market. No other impairment was identified. See Note 9 for more details.

Other Assets

Other assets consist primarily of costs associated with the issuance of debt, which are amortized over the life of the related debt. Amortization of deferred financing costs is included in interest expense and totaled $3.0 million, $2.9 million and $2.9 million for the years ended September 30, 2009, 2008 and 2007, respectively. Deferred financing costs, net of accumulated amortization, totaled $15.2 million and $18.2 million at September 30, 2009 and 2008, respectively.

Insurance Reserves

The Company estimates its reserve for self-insured professional and general liability and workers compensation risks using historical claims data, demographic factors, severity factors, current incident logs and other actuarial analysis.

Income Taxes

The Company accounts for income taxes under the asset and liability method in accordance with FASB authoritative guidance regarding accounting for income taxes and its related uncertainty. This approach requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply when the temporary differences are expected to reverse. The Company assesses the likelihood that deferred tax assets will be recovered from future taxable income to determine whether a valuation allowance should be established.

Minority Interest in Consolidated Entities

The consolidated financial statements include all assets, liabilities, revenue and expenses of less than 100% owned entities controlled by the Company. Accordingly, management has recorded minority interests in the earnings and equity of such consolidated entities.

Medical Claims Payable

Monthly capitation payments made by Health Choice to physicians and other healthcare providers are expensed in the month services are contracted to be performed. Claims expense for non-capitated arrangements is accrued as services are rendered by hospitals, physicians and other healthcare providers during the year.

Medical claims payable related to Health Choice include claims received but not paid and an estimate of claims incurred but not reported. Incurred but not reported claims are estimated using a combination of historical claims experience (including severity and payment lag time) and other actuarial analysis, including number of enrollees, age of enrollees and certain enrollee health indicators, to predict the cost of healthcare services provided to enrollees during any given period. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from estimates given changes in the healthcare cost structure or adverse experience.

The following table shows the components of the change in medical claims payable for the years ended September 30, 2009, 2008 and 2007, respectively (in thousands):

	Year Ended September 30, 2009	Year Ended September 30, 2008	Year Ended September 30, 2007
Medical claims payable as of October 1	$ 97,343	$ 81,309	$ 81,822
Medical claims expense incurred during the year:			
Related to current year	620,153	464,055	396,152
Related to prior years	(18,077)	(2,406)	(12,107)
Total expenses	602,076	461,649	384,045
Medical claims payments during the year:			
Related to current year	(508,299)	(368,392)	(317,798)
Related to prior years	(77,601)	(77,223)	(66,760)
Total payments	(585,900)	(445,615)	(384,558)
Medical claims payable as of September 30	$ 113,519	$ 97,343	$ 81,309

As reflected in the table above, medical claims expense for the year ended September 30, 2009, includes an $18.1 million reduction of medical costs related to prior years resulting from favorable development in the Medicaid and Medicare product lines of $15.5 million and $2.6 million, respectively. The favorable development is attributable to lower than anticipated medical costs and is offset, in part, by $10.8 million in reductions in premium revenue associated with settlements of various prior year program receivables.

Health Choice has experienced an increase in the number of lives served by the plan. Enrollment in Health Choice at September 30, 2009 and 2008, was 190,763 and 145,493, respectively.

Stock Based Compensation

Although IASIS has no stock option plan or outstanding stock options, the Company, through its parent, IASIS Healthcare Corporation ("IAS"), grants stock options for a fixed number of common shares to employees. The Company accounts for this stock-based incentive plan under the measurement and recognition provisions of FASB authoritative guidance regarding share-based payments ("Share-Based Payments Guidance"). Accordingly, the Company has not recognized any compensation expense for the stock options granted prior to October 1, 2006, as the exercise price of the options equaled, or was greater than, the market value of the underlying stock on the date of grant.

For stock options granted on or after October 1, 2006, the Company applies the fair value recognition provisions of the Share-Based Payments Guidance, requiring all share-based payments to employees, including grants of employee stock options, to be recognized in the income statement based on their fair values. In accordance with the provisions of the Share-Based Payments Guidance, the Company uses the Black-Scholes-Merton model in determining the fair value of its share-based payments. The fair value of compensation costs will be amortized on a straight-line basis over the requisite service periods of the awards, generally equal to the awards' vesting periods.

Fair Value of Financial Instruments

Cash and cash equivalents, accounts receivable, accounts payable and accrued liabilities are reflected in the accompanying consolidated financial statements at amounts that approximate fair value because of the short-term nature of these instruments. The fair value of the Company's capital lease obligations also approximate carrying value as they bear interest at current market rates. The estimated fair values of the Company's 8 3/4% senior subordinated notes due 2014 (the "8 3/4% notes") and senior secured credit facilities were $473.8 million and $540.1 million, respectively, at September 30, 2009, based upon quoted market prices at that date.

Management Services Agreement

The Company is party to a management services agreement with affiliates of TPG, JLL Partners Inc. and Trimaran Fund Management, L.L.C. The management services agreement provides that in exchange for consulting and management advisory services that will be provided to the Company by the investors, the Company will pay an aggregate monitoring fee of 0.25% of budgeted net revenue up to a maximum of $5.0 million per fiscal year to these parties (or certain of their respective affiliates) and reimburse them for their reasonable disbursements and out-of-pocket expenses. This monitoring fee is divided among the parties in proportion to their relative ownership percentages in IASIS Investment LLC, parent company and majority stockholder of IAS. The monitoring fee will be subordinated to the senior subordinated notes in the event of a bankruptcy of the Company. The management services agreement does not have a stated term. Pursuant to the provisions of the management services agreement, the Company has agreed to indemnify the investors (or certain of their respective affiliates) in certain situations arising from or relating to the agreement, the investors' investment in the securities of IAS or any related transactions or the operations of the investors, except for losses that arise on account of the investors' negligence or willful misconduct. For the years ended September 30, 2009, 2008 and 2007, the Company paid $5.0 million, $5.0 million and $4.7 million, respectively, in monitoring fees under the management services agreement.

Recently Issued Accounting Pronouncements

In December 2007, the FASB issued new authoritative guidance regarding business combinations, which applies prospectively to business combinations for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after December 15, 2008. This new guidance establishes principles and requirements for recognition and measurement of items acquired during a business combination, as well as certain disclosure requirements in the financial statements. The Company does not believe the adoption of this new guidance will have a material impact on its results of operations or financial position; however, it is anticipated to have a material effect on the Company's accounting for future acquisitions.

In December 2007, the FASB issued new authoritative guidance regarding noncontrolling interests in consolidated financial statements, which is effective for fiscal years beginning after December 15, 2008. The objective of this guidance is to improve the relevance, comparability, and transparency of financial information, specifically noncontrolling interests, that is provided in consolidated financial statements. The Company does not believe the adoption of this new guidance will have a material impact on its results of operations or financial position; however, it could potentially have a material effect on the presentation of its financial statements.

3. LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS

Long-term debt and capital lease obligations consist of the following (in thousands):

	September 30, 2009	September 30, 2008
Senior secured credit facilities	$ 576,150	$ 629,818
Senior subordinated notes	475,000	475,000
Capital leases and other obligations	8,687	9,804
	1,059,837	1,114,622
Less current maturities	8,366	7,623
	$ 1,051,471	$ 1,106,999

Senior Secured Credit Facilities

In fiscal 2007, the Company completed the refinancing of its bank credit facility to provide for $854.0 million in senior secured credit facilities. In connection with the refinancing, the Company wrote-off $5.1 million in deferred financing costs and paid an additional $1.1 million in creditor fees, which are included in the loss on extinguishment of debt in the accompanying consolidated statement of operations for the year ended September 30, 2007.

The $854.0 million senior secured credit facilities include: (i) a senior secured term loan of $439.0 million; (ii) a senior secured delayed draw term loan of $150.0 million; (iii) a senior secured revolving credit facility of $225.0 million, which includes a $100.0 million sub-limit for letters of credit; and (iv) a senior secured synthetic letter of credit facility of $40.0 million. All facilities mature on March 15, 2014, except for the revolving credit facility, which matures on April 27, 2013. The term loans bear interest at an annual rate of LIBOR plus 2.00% or, at the Company's option, the administrative agent's base rate plus 1.00%. The revolving loans bear interest at an annual rate of LIBOR plus an applicable margin ranging from 1.25% to 1.75% or, at the Company's option, the administrative agent's base rate plus an applicable margin ranging from 0.25% to 0.75%, such rate in each case depending on the Company's senior secured leverage ratio. A commitment fee ranging from 0.375% to 0.5% per annum is charged on the undrawn portion of the senior secured revolving credit facility and is payable in arrears.

Principal under the senior secured term loan is due in 24 consecutive equal quarterly installments in an aggregate annual amount equal to 1.0% of the original principal amount ($439.0 million) during the first six years thereof, with the balance payable in four equal installments in year seven. Principal under the senior secured delayed draw term loan is due in equal quarterly installments in an aggregate annual amount equal to 1.0% of the original principal amount ($150.0 million) until March 31, 2013, with the balance payable in four equal installments during the final year of the loan. Unless terminated earlier, the senior secured revolving credit facility has a single maturity of six years. The senior secured credit facilities are also subject to mandatory prepayment under specific circumstances, including a portion of excess cash flow, a portion of the net proceeds from an initial public offering, asset sales, debt issuances and specified casualty events, each subject to various exceptions.

The senior secured credit facilities are (i) secured by a first mortgage and lien on the real property and related personal and intellectual property of the Company and pledges of equity interests in the entities that own such properties and (ii) guaranteed by certain of the Company's subsidiaries.

In addition, the senior secured credit facilities contain certain covenants which, among other things, limit the incurrence of additional indebtedness, investments, dividends, transactions with affiliates, asset sales, acquisitions, mergers and consolidations, liens and encumbrances and other matters customarily restricted in such agreements.

At September 30, 2009, amounts outstanding under the Company's senior secured credit facilities consisted of a $428.0 million term loan and a $148.1 million delayed draw term loan. In addition, the Company had $39.9 million and $24.7 million in letters of credit outstanding under the synthetic letter of credit facility and the revolving credit facility, respectively. The weighted average interest rate of outstanding borrowings under the senior secured credit facilities was 3.6% and 5.6% for the years ended September 30, 2009 and 2008, respectively.

8 3/4% Senior Subordinated Notes

The Company, together with its wholly-owned subsidiary, IASIS Capital Corporation, a holding company with no assets or operations, as issuers, have outstanding $475.0 million aggregate principal amount of 8 3/4% notes. The 8 3/4% notes are general unsecured senior subordinated obligations and are subordinated in right of payment to all existing and future senior debt of the Company. The Company's existing domestic subsidiaries, other than certain non-guarantor subsidiaries, which include Health Choice and the Company's non-wholly owned subsidiaries, are guarantors of the 8 3/4% notes. The 8 3/4% notes are effectively subordinated to all of the issuers' and the guarantors' secured debt to the extent of the value of the assets securing the debt and are structurally subordinated to all liabilities and commitments (including trade payables and capital lease obligations) of the Company's subsidiaries that are not guarantors of the 8 3/4% notes.

$300.0 Million Holdings Senior Paid-in-Kind Loans

In fiscal 2007, IAS issued $300.0 million in Holdings Senior Paid-in-Kind ("PIK") Loans, which were used to repurchase certain preferred equity from its stockholders. The $300.0 million Holdings Senior PIK Loans mature June 15, 2014, and bear interest at an annual rate equal to LIBOR plus 5.25%. The Holdings Senior PIK Loans rank behind the Company's existing debt and will convert to cash-pay after five years, at which time accrued interest becomes payable. At September 30, 2009, the outstanding balance of the Holdings Senior PIK Loans was $368.5 million, which includes $68.5 million of interest that has accrued to the principal of these loans since the date of issuance.

4. INTEREST RATE SWAPS

Effective March 2, 2009, the Company executed interest rate swap transactions with Citibank, N.A. and Wachovia Bank, N.A., as counterparties, with notional amounts totaling $425.0 million. The arrangements with each counterparty include two interest rate swap agreements, one with a notional amount of $112.5 million maturing on February 28, 2011 and one with a notional amount of $100.0 million maturing on February 29, 2012. The Company entered into these interest rate swap arrangements to mitigate the floating interest rate risk on a portion of its outstanding variable rate debt. Under these agreements, the Company is required to make monthly fixed rate payments to the counterparties, as calculated on the applicable notional amounts, at annual fixed rates, which range from 1.5% to 2.0% depending upon the agreement. The counterparties are obligated to make monthly floating rate payments to the Company based on the one-month LIBOR rate for the same referenced notional amount.

Date Range	Total Notional Amounts (in thousands)
March 2, 2009 to February 28, 2011	$ 225,000
March 2, 2009 to February 29, 2012	$ 200,000

The Company accounts for its interest rate swaps in accordance with the provisions of FASB authoritative guidance regarding accounting for derivative instruments and hedging activities, which also includes enhanced disclosure requirements. In accordance with these provisions, the Company has designated its interest rate swaps as cash flow hedge instruments. The Company assesses the effectiveness of these cash flow hedges on a quarterly basis, with any ineffectiveness being measured using the hypothetical derivative method. The Company completed an assessment of its cash flow hedge instruments during the year ended September 30, 2009, and determined its hedging instruments to be highly effective. Accordingly, no gain or loss resulting from hedging ineffectiveness is reflected in the Company's accompanying consolidated statements of operations.

On October 1, 2008, the Company adopted the new provisions of FASB authoritative guidance regarding fair value measurements, which provides a single definition of fair value, establishes a framework for measuring fair value, and expands disclosures concerning fair value measurements. The Company applies these provisions to the valuation and disclosure of its interest rates swaps. This authoritative guidance establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. These tiers include: (i) Level 1, which is defined as quoted prices in active markets that can be accessed at the measurement date; (ii) Level 2, which is defined as inputs other than quoted prices in active markets that are observable, either directly or indirectly; and (iii) Level 3, which is defined as unobservable inputs resulting from the existence of little or no market data, therefore potentially requiring an entity to develop its own assumptions.

The Company determines the fair value of its interest rate swaps in a manner consistent with that used by market participants in pricing hedging instruments, which includes using a discounted cash flow analysis based upon the terms of the agreements, the impact of the one-month forward LIBOR curve and an evaluation of credit risk. Given the use of observable market assumptions and the consideration of credit risk, the Company has categorized the valuation of its interest rate swaps as Level 2.

The fair value of the Company's interest rate swaps at September 30, 2009, reflects a liability balance of $4.7 million and is included in other long-term liabilities in the accompanying consolidated balance sheet. The fair value of the Company's interest rate swaps reflects a liability because the effect of the forward LIBOR curve on future interest payments results in less interest due to the Company under the variable rate component included in the interest rate swap agreements, as compared to the amount due the Company's counterparties under the fixed interest rate component. Any change in the fair value of the Company's interest rate swaps, net of income taxes, is included in other comprehensive loss as a component of member's equity in the accompanying consolidated balance sheet.

5. OTHER COMPREHENSIVE LOSS

A summary of activity in the Company's accumulated other comprehensive loss consists of the following (in thousands)

Balance at September 30, 2008	$	—
Change in fair value of interest rate swaps, net of income tax effect of $1,734		(2,926)
Balance at September 30, 2009	$	(2,926)

6. DISCONTINUED OPERATIONS

The Company's lease agreements to operate Mesa General Hospital ("Mesa Hospital"), located in Mesa, Arizona, and Biltmore Surgery Center ("Biltmore"), located in Phoenix, Arizona, expired by their terms on July 31, 2008 and September 30, 2008, respectively. The Company discontinued services at Mesa General on May 31, 2008, and Biltmore on April 30, 2008. The operating results of Mesa General and Biltmore are classified in the Company's accompanying consolidated financial statements as discontinued operations. The following table sets forth the components of discontinued operations for the years ended September 30, 2009, 2008 and 2007, respectively, (in thousands):

	Year ended September 30, 2009		Year ended September 30, 2008		Year ended September 30, 2007	
Total net revenue	$	974	$	49,974	$	88,335
Operating expenses		1,256		64,648		87,254
Loss on disposal of assets		—		3,928		—
Income tax expense (benefit)		(106)		(7,327)		412
Earning (loss) from discontinued operations, net of income taxes	$	(176)	$	(11,275)	$	669

The Company allocated to discontinued operations interest expense of $2.5 million for each of the years ended September 30, 2008 and 2007. The allocation of interest expense to discontinued operations was based on the ratio of disposed net assets of Mesa General and Biltmore to the sum of total net assets of the Company plus the Company's total outstanding debt.

Income taxes allocated to the discontinued operations resulted in related effective tax rates of 37.6%, 39.4% and 38.2% for the years ended September 30, 2009, 2008 and 2007, respectively.

7. ACQUISITIONS

Acquisition of Glenwood Regional Medical Center

Effective January 31, 2007, the Company acquired substantially all of the assets of Glenwood Regional Medical Center ("Glenwood") in West Monroe, Louisiana. The purchase price for the 237-bed hospital was $78.2 million, which was funded by cash on hand and borrowings under the Company's revolving credit facility. The results of operations of Glenwood are included in the accompanying consolidated statements of operations from the effective date of the acquisition.

The purchase price for the Glenwood acquisition, including direct transaction costs, has been allocated as follows (in thousands):

Fair value of assets acquired and liabilities assumed:		
Assets acquired		
Accounts receivable, net	$	13,727
Inventory, prepaid expenses and other current assets		4,354
Property and equipment		66,640
Other long-term assets		1,529
Total assets acquired	$	86,250
Liabilities assumed	$	8,004

Acquisition of Alliance Hospital

Effective May 31, 2007, the Company acquired substantially all of the assets of Alliance Hospital ("Alliance") in Odessa, Texas. The purchase price for the 50-bed hospital was $66.7 million, which was funded in part by the Company's senior secured credit facilities, as well as units of limited partnership interest of Odessa Regional Hospital, LP, and the assumption of certain liabilities of Alliance. Upon acquisition, the operations of Alliance were immediately merged into Odessa Regional Hospital to form Odessa Regional Medical Center. The results of operations of Alliance are included in the accompanying consolidated statements of operations from the effective date of the acquisition.

The purchase price for the Alliance acquisition, including direct transaction costs, has been allocated as follows (in thousands):

Fair value of assets acquired and liabilities assumed:		
Assets acquired		
Accounts receivable, net	$	4,230
Inventory, prepaid expenses and other current assets		1,873
Property and equipment		60,965
Goodwill		10,593
Total assets acquired	$	77,661
Liabilities assumed	$	10,932

Other

Effective February 1, 2008, IASIS Glenwood Regional Medical Center, LP, a wholly-owned subsidiary of the Company, purchased a majority ownership interest in Ouachita Community Hospital, a ten-bed surgical hospital located in West Monroe, Louisiana. The purchase price for the majority ownership interest included approximately $16.8 million in cash.

8. PROPERTY AND EQUIPMENT

Property and equipment consist of the following (in thousands):

	September 30, 2009	September 30, 2008
Land	$ 102,499	$ 103,763
Buildings and improvements	792,467	693,113
Equipment	500,450	471,207
	1,395,416	1,268,083
Less accumulated depreciation and amortization	(414,572)	(325,560)
	980,844	942,523
Construction-in-progress (estimated cost to complete at September 30, 2009 — $13.7 million)	16,509	61,725
	$ 997,353	$ 1,004,248

Included in equipment are assets acquired under capital leases of $4.6 million and $5.6 million, net of accumulated amortization of $3.4 million and $2.1 million, at September 30, 2009 and 2008, respectively.

9. GOODWILL AND OTHER INTANGIBLE ASSETS

The following table presents the changes in the carrying amount of goodwill from September 30, 2007 through September 30, 2009 (in thousands):

	Acute Care	Health Choice	Total
Balance at September 30, 2007	$ 750,836	$ 5,757	$ 756,593
Adjustments in deferred tax assets and liabilities	(3,769)	—	(3,769)
Adjustment resulting from Ouachita Community Hospital	17,134	—	17,134
Adjustments resulting from purchase price allocation of Alliance Hospital	10,593	—	10,593
Other purchase price adjustments	48	—	48
Balance at September 30, 2008	774,842	5,757	780,599
Impairment of Florida market goodwill	(64,639)	—	(64,639)
Other acquisitions	1,960	—	1,960
Balance at September 30, 2009	$ 712,163	$ 5,757	$ 717,920

As a result of the Company's annual impairment testing, the Company has recorded a $64.6 million non-cash charge ($43.2 million after tax) for the impairment of goodwill related to its Florida market. The Company assesses the recoverability of goodwill at its market levels and has determined the write-off of all Florida market goodwill to be appropriate. In connection with the analysis resulting in the write-off of Florida market goodwill, the Company has determined all remaining goodwill and long-lived assets to be recoverable, and therefore, no further impairment was deemed necessary.

Other intangible assets consist solely of Health Choice's contract with AHCCCS, which is amortized over a period of 15 years, the contract's estimated useful life, including assumed renewal periods. The gross intangible value originally assigned to the contract was $45.0 million. The Company expects amortization expense for this intangible asset, to be $3.0 million per year over the estimated life of the contract. Amortization of intangible assets is included in depreciation and amortization expense and totaled $3.0 million for each of the years ended September 30, 2009, 2008 and 2007. Net other intangible assets included in the accompanying consolidated balance sheets at September 30, 2009 and 2008 totaled $30.0 million and $33.0 million, respectively.

10. MEMBER'S EQUITY

Common Interests of IASIS

As of September 30, 2009, all of the common interests of IASIS were owned by IAS, its sole member.

11. STOCK OPTIONS

Management Rollover Options

In 2004, an investor group led by TPG acquired IAS, the parent company of IASIS. Prior to the acquisition, IAS maintained the IASIS 2000 Stock Option Plan. In connection with the acquisition, certain holders of 299,900 of in-the-money common stock options elected to rollover and convert such options into options to purchase an aggregate 3,263 shares of preferred stock, with an exercise price of $437.48 per share, and an aggregate 163,150 shares of common stock, with an exercise price of $8.75 per share. The rollover options are fully vested and remain outstanding and exercisable for the remainder of their original term. All of the other outstanding options under the IASIS 2000 Stock Option Plan were cancelled upon consummation of the acquisition and the plan was terminated.

In connection with the issuance of the $300.0 million Holdings Senior PIK Loans in fiscal 2007, the preferred rollover options were cancelled in exchange for a cash payment equal to the excess of the accreted value of the preferred stock over the exercise price of $437.48 per share.

2004 Stock Option Plan

The IAS 2004 Stock Option Plan (the "2004 Stock Option Plan") was established to promote the Company's interests by providing additional incentives to its key employees, directors, service providers and consultants. The options granted under the plan represent the right to purchase IAS common stock upon exercise. Each option shall be identified as either an incentive stock option or a non-qualified stock option. The plan was adopted by the board of directors and majority stockholder of IAS in June 2004. The maximum number of shares of IAS common stock that may be issued pursuant to options granted under the 2004 Stock Option Plan is 2,340,650. In addition, prior to an initial public offering, an additional 146,000 shares of common stock will be available for grant in June of each year. The options become exercisable over a period not to exceed five years after the date of grant, subject to earlier vesting provisions as provided for in the 2004 Stock Option Plan. All options granted under the 2004 Stock Option Plan expire no later than 10 years from the respective dates of grant. At September 30, 2009, there were 580,475 options available for grant.

Information regarding the Company's stock option activity for the years ended September 30, 2007 through September 30, 2009, is summarized below:

	2004 Stock Option Plan			Rollover Options		
	Options	Option Price Per Share	Weighted Average Exercise Price	Options	Option Price Per Share	Weighted Average Exercise Price
Options outstanding at September 30, 2006	1,595,485	$ 20.00-$35.68	$ 22.28	166,413	$ 8.75-$437.48	$ 17.16
Granted	7,080	$ 34.75-$35.68	$ 35.54	—	—	—
Exercised	—	—	—	—	—	—
Cancelled/forfeited	(111,440)	$ 20.00-$35.68	$ 25.61	(3,263)	$ 437.48	$ 437.48
Options outstanding at September 30, 2007	1,491,125	$ 20.00-$35.68	$ 22.09	163,150	$ 8.75	$ 8.75
Granted	1,080	$ 34.75	$ 34.75	—	—	—
Exercised	(9,600)	$ 20.00	$ 20.00	—	—	—
Cancelled/forfeited	(80,720)	$ 20.00-$35.68	$ 26.04	—	—	—
Options outstanding at September 30, 2008	1,401,885	$ 20.00-$35.68	$ 21.82	163,150	$ 8.75	$ 8.75
Granted	477,700	$ 34.75	$ 34.75	—	—	—
Exercised	—	—	—	—	—	—
Cancelled/forfeited	(119,410)	$ 20.00-$35.68	$ 31.17	—	—	—

Options outstanding at September 30, 2009	1,760,175	$ 20.00-$35.68	$ 24.70	163,150	$ 8.75	$ 8.75
Options exercisable at September 30, 2009	1,252,436	$ 20.00-$35.68	$ 21.11	163,150	$ 8.75	$ 8.75

The following table provides information regarding assumptions used in the fair value measurement for options granted on or after October 1, 2006, and the weighted average assumptions used in the fair value pro forma disclosures required for stock-options granted prior to October 1, 2006.

	Options Granted On or After October 1, 2006	Options Granted Prior to October 1, 2006
Risk-free interest	3.1%	4.6%
Dividend yield	0.0%	0.0%
Volatility	35.0%	N/A
Expected option life	7.3 years	9.8 years

For options granted on or after October 1, 2006, the Company used the Black-Scholes-Merton valuation model in determining the fair value measurement. Volatility for such options was estimated based on the historical stock price information of certain peer group companies for a period of time equal to the expected option life period.

12. INCOME TAXES

Income tax expense on earnings from continuing operations consists of the following (in thousands):

	Year Ended September 30, 2009	Year Ended September 30, 2008	Year Ended September 30, 2007
Current:			
Federal	$ 28,220	$ 12,631	$ 132
State	4,933	3,326	1,674
›eferred:			
Federal	(5,092)	15,522	23,172
State	(485)	3,846	931
	$ 27,576	$ 35,325	$ 25,909

A reconciliation of the federal statutory rate to the effective income tax rate applied to earnings from continuing operations before income taxes for the years ended September 30, 2009, 2008 and 2007, is as follows (in thousands):

	Year Ended September 30, 2009	Year Ended September 30, 2008	Year Ended September 30, 2007
Federal statutory rate	$ 19,544	$ 29,020	$ 23,396
State income taxes, net of federal income tax benefit	2,892	4,663	1,693
Nondeductible goodwill impairment charges	2,470	—	—
Other non-deductible expenses	550	418	328
Change in valuation allowance charged to federal tax provision	1,576	970	541
Other items, net	544	254	(49)
Income tax expense	$ 27,576	$ 35,325	$ 25,909

A summary of the items comprising the deferred tax assets and liabilities is as follows (in thousands):

	September 30, 2009		September 30, 2008	
	Assets	Liabilities	Assets	Liabilities
Depreciation and fixed asset basis differences	$ —	$ 77,743	$ —	$ 67,317
Amortization and intangible asset basis differences	—	55,721	—	64,742
Allowance for doubtful accounts	30,769	—	29,958	—
Professional liability	15,561	—	12,801	—
Accrued expenses and other liabilities	14,625	—	13,436	—
Deductible carryforwards and credits	9,861	—	8,709	—
Other, net	3,841	—	570	—
Valuation allowance	(8,580)	—	(5,647)	—
Total	$ 66,077	$ 133,464	$ 59,827	$ 132,059

Net current deferred tax assets of $39.0 million and $38.9 million and net non-current deferred tax liabilities of $106.4 million and $111.1 million are included in the accompanying consolidated balance sheets at September 30, 2009 and 2008, respectively. The Company had a net income tax payable of $3.4 million and $2.2 million included in other current liabilities at September 30, 2009 and 2008, respectively.

The Company and some of its subsidiaries are included in IAS' consolidated filing group for U.S. federal income tax purposes, as well as in certain state and local income tax returns that include IAS. With respect to tax returns for any taxable period in which the Company or any of its subsidiaries are included in a tax return filing with IAS, the amount of taxes to be paid by the Company is determined, subject to some adjustments, as if it and its subsidiaries filed their own tax returns excluding IAS. As of September 30, 2009, member's equity in the accompanying consolidated balance sheet includes $27.3 million in capital contributions representing cumulative tax benefits generated by IAS and utilized by the Company in the combined tax return filings, for which IAS did not require cash settlement from the Company. At September 30, 2008, the net income tax payable by the Company of $2.2 million was comprised of $3.2 million net taxes refundable from taxing authorities and $5.4 million payable to IAS for tax benefits generated by IAS and utilized by the Company in the combined tax return filings.

The Company maintains a valuation allowance for deferred tax assets it believes may not be utilized. The valuation allowance increased by $2.9 million and $1.8 million during the years ended September 30, 2009 and 2008, respectively. The increases in the valuation allowance for both years relate to the generation of net operating loss carryforwards by certain subsidiaries excluded from the IAS consolidated federal income tax return, as well as state net operating loss carryforwards that may not ultimately be utilized.

As of September 30, 2009, federal net operating loss carryforwards were available to offset $11.1 million of future taxable income generated by subsidiaries of the Company that are excluded from the IAS consolidated return. A valuation allowance has been established against $8.8 million of these carryforwards, which expire between 2026 and 2029. State net operating losses in the amount of $146.2 million were also available, but largely offset by a valuation allowance. The state net operating loss carryforwards expire between 2018 and 2029.

As a result of adopting the provisions of FASB authoritative guidance regarding accounting for uncertainty in income taxes, on October 1, 2007, the Company recorded a liability for unrecognized tax benefits of $8.1 million, including accrued interest of $83,000. The adjustment was comprised of a cumulative effect decrease to member's equity of $59,000, and a decrease to net noncurrent deferred tax liabilities of $8.1 million. An additional $9.9 million of unrecognized tax benefits were reflected as a reduction to deferred tax assets for federal and state net operating losses generated by uncertain tax deductions as of October 1, 2007.

FASB authoritative guidance regarding accounting for uncertainty in income taxes permits interest and penalties on underpayments of income taxes to be classified as interest expense, income tax expense, or another appropriate expense classification based on the accounting election of the company. The Company's policy is to classify interest and penalties as a component of income tax expense. Income tax expense for the year ended September 30, 2009, has been reduced by $122,000 due to a decrease in accrued interest payable in connection with uncertain tax positions (net of related tax benefits). Interest expense totaling $146,000 (net of related tax benefits) is included in income tax expense for the year ended September 30, 2008.

The liability for unrecognized tax benefits included in the accompanying consolidated balance sheets was $7.8 million, including accrued interest of $122,000 at September 30, 2009, and $9.9 million, including accrued interest of $308,000 at September 30, 2008. An additional $5.9 million of unrecognized tax benefits are reflected as a reduction to deferred tax assets for state net operating losses generated by uncertain tax deductions as of September 30, 2009 and 2008. Of the total unrecognized tax benefits at September 30, 2009, approximately $1.4 million (net of the tax benefit on state taxes and interest) represents the amount of unrecognized tax and interest that, if recognized, would favorably impact the Company's effective income tax rate. The remainder of the unrecognized tax positions consist of items for which the uncertainty relates only to the timing of the deductibility, and state net operating loss carryforwards for which ultimate recognition would result in the creation of an offsetting valuation allowance due to the unlikelihood of future taxable income in that state.

A summary of activity of the Company's total amounts of unrecognized tax benefits is as follows (in thousands):

	Year Ended September 30, 2009	Year Ended September 30, 2008
Unrecognized tax benefits at October 1	$ 15,550	$ 17,942
Additions resulting from tax positions taken in a prior period	14	937
Reductions resulting from tax positions taken in a prior period	(3,171)	(6,258)
Additions resulting from tax positions taken in the current period	1,965	2,929
Reductions resulting from lapse of statute of limitations	(720)	—
Unrecognized tax benefits at September 30	$ 13,638	$ 15,550

During the year ended September 30, 2009, the IRS completed its examinations of the Company's consolidated corporate tax return for the year ended September 30, 2006, and one of its partnership's income tax return for the year ended September 30, 2005. The IRS proposed no adjustments in either examination. The Company's tax years 2006 and beyond remain open to additional examinations by U.S. federal and state taxing authorities. It is reasonably possible that unrecognized tax benefits could significantly increase or decrease within the next twelve months. However, the Company is currently unable to estimate the range of any possible change.

13. COMMITMENTS AND CONTINGENCIES

Net Revenue

The calculation of appropriate payments from the Medicare and Medicaid programs, including supplemental Medicaid reimbursement, as well as terms governing agreements with other third-party payors are complex and subject to interpretation. Final determination of amounts earned under the Medicare and Medicaid programs often occurs subsequent to the year in which services are rendered because of audits by the programs, rights of appeal and the application of numerous technical provisions. In the opinion of management, adequate provision has been made for adjustments that may result from such routine audits and appeals.

Professional, General and Workers' Compensation Liability Risks

The Company is subject to claims and legal actions in the ordinary course of business, including claims relating to patient treatment and personal injuries. To cover these types of claims, the Company maintains professional and general liability insurance in excess of self-insured retentions through a commercial insurance carrier in amounts that the Company believes to be sufficient for its operations, although, potentially, some claims may exceed the scope of coverage in effect. Plaintiffs in these matters may request punitive or other damages that may not be covered by insurance. The Company is currently not a party to any such proceedings that, in the Company's opinion, would have a material adverse effect on the Company's business, financial condition or results of operations. The Company expenses an estimate of the costs it expects to incur under the self-insured retention exposure for professional and general liability claims using historical claims data, demographic factors, severity factors, current incident logs and other actuarial analysis. At September 30, 2009 and 2008, the Company's professional and general liability accrual for asserted and unasserted claims totaled $41.7 million and $34.3 million, respectively. The semi-annual valuations from the Company's independent actuary for professional and general liability losses resulted in a change related to estimates for prior years which decreased professional and general liability expense by $1.2 million, $6.8 million and $6.6 million during the years ended September 30, 2009, 2008 and 2007, respectively.

The Company is subject to claims and legal actions in the ordinary course of business relative to workers' compensation and other labor and employment matters. To cover these types of claims, the Company maintains workers' compensation insurance coverage with a self-insured retention. The Company accrues costs of workers' compensation claims based upon estimates derived from its claims experience. The semi-annual valuations from the Company's independent actuary for workers' compensation losses resulted in a change related to estimates for prior years which decreased workers' compensation expense by $526,000, during the year ended September 30, 2009, increased workers' compensation expense by $759,000 during the year ended September 30, 2008, and decreased workers' compensation expense by $1.0 million during the year ended September 30, 2007.

Health Choice

Health Choice has entered into capitated contracts whereby the Plan provides healthcare services in exchange for fixed periodic and supplemental payments from the AHCCCS and CMS. These services are provided regardless of the actual costs incurred to provide these services. The Company receives reinsurance and other supplemental payments from AHCCCS to cover certain costs of healthcare services that exceed certain thresholds. The Company believes the capitated payments, together with reinsurance and other supplemental payments are sufficient to pay for the services Health Choice is obligated to deliver. As of September 30, 2009, the Company has provided a performance guaranty in the form of letters of credit totaling $43.2 million for the benefit of AHCCCS to support its obligations under the Health Choice contract to provide and pay for the healthcare services. The amount of the performance guaranty is generally based in part upon the membership in the Plan and the related capitation revenue paid to Health Choice.

Acquisitions

The Company has acquired and in the future may choose to acquire businesses with prior operating histories. Such businesses may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations, such as billing and reimbursement, fraud and abuse and similar anti-referral laws. Although the Company has procedures designed to conform business practices to its policies following the completion of any acquisition, there can be no assurance that the Company will not become liable for previous activities of prior owners that may later be asserted to be improper by private plaintiffs or government agencies. Although the Company generally seeks to obtain indemnification from prospective sellers covering such matters, there can be no assurance that any such matter will be covered by indemnification, or if covered, that such indemnification will be adequate to cover potential losses and fines.

Other

On March 31, 2008, the United States District Court for the District of Arizona (the "District Court") dismissed with prejudice the *qui tam* complaint against IAS, the Company's parent company. The *qui tam* action sought monetary damages and civil penalties under the federal False Claims Act ("FCA") and included allegations that certain business practices related to physician relationships and the medical necessity of certain procedures resulted in the submission of claims for reimbursement in violation of the FCA. The case dates back to March 2005 and became the subject of a subpoena by the Office of Inspector General ("OIG") in September 2005. In August 2007, the case was unsealed and became a private lawsuit after the Department of Justice declined to intervene. The United States District Judge dismissed the case from the bench at the conclusion of oral arguments on IAS' motion to dismiss. On April 21, 2008, the court issued a written order dismissing the case with prejudice and entering formal judgment for IAS. On May 7, 2008, the *qui tam* relator's counsel filed a Notice of Appeal to the United States Court of Appeals for the Ninth Circuit to appeal the District Court's dismissal of the case. On May 21, 2008, IAS filed a Notice of Cross-Appeal to the United States Court of Appeals for the Ninth Circuit from a portion of the April 21, 2008 Order and, on July 22, 2008, IAS filed a Motion to Disqualify relator's counsel related to their misappropriation of information subject to a claim of attorney-client privilege by IAS. On August 21, 2008, the court issued a written order denying IAS' Motion to Disqualify and resetting the briefing schedule associated with the Ninth Circuit appellate proceedings. On October 21, 2008, the relator filed his appeal brief with the United States Court of Appeals for the Ninth Circuit. IAS filed its cross-appeal brief on January 20, 2009. Currently, the Ninth Circuit appeal is expected to take another six to nine months to complete. If the appeal of the order dismissing the *qui tam* action with prejudice was to be resolved in a manner unfavorable to IAS, it could have a material adverse effect on the Company's business, financial condition and results of operations, including exclusion from the Medicare and Medicaid programs.

The Company's facilities obtain clinical and administrative services from a variety of vendors. One vendor, a medical practice that furnished cardiac catheterization services under contractual arrangements at Mesa General and St. Luke's Medical Center ("St. Luke's") through March 31, 2008 and May 31, 2008, respectively, has claimed that, because of deferred fee adjustments that it claims are due under these arrangements, it is owed additional amounts for services rendered since April 1, 2006 at both facilities. The Company and the vendor have not reached agreement with respect to the amount of the fee adjustment, if any, that is contractually required, nor with respect to the methodology that may appropriately be used in determining such amount. On October 1, 2008, the vendor filed a complaint in arbitration for an aggregate adjustment in excess of amounts accrued to date by the Company. Although the Company cannot currently estimate the amount of any fee adjustment that Mesa General or St. Luke's ultimately may be required to pay, it believes that the aggregate adjustment sought by the vendor is substantially in excess of any such amount. Likewise, the vendor has also filed a state-court complaint asserting its fee adjustment claims and also alleging certain tort claims that arise from the same fee dispute, as well as from the closure of Mesa General preceding expiration of the Company's lease for the Mesa General property in July 2008. The majority of the vendor's cardiac catheterization services were performed at the Mesa General facility, which is included in discontinued operations in the accompanying consolidated statements of operations. The Company's motion to compel arbitration was granted without oral argument by the court in Phoenix on August 13, 2009 and the court ordered the parties to either agree on an arbitrator or submit their respective party-appointed arbitrators to the court, whereupon those appointed arbitrators would each submit a nominee for neutral third-party arbitrator to the court for the court's selection. The parties are following the court-ordered procedure for appointment of the arbitration panel, after which time, the three-person panel will meet and set up a hearing among the parties to set the schedule and structure for the arbitration.

14. LEASES

The Company leases various buildings, office space and equipment under capital and operating lease agreements. These leases expire at various times and have various renewal options.

The Company is a party to an amended facility lease with a 15 year term that expires in January 31, 2019, and includes options to extend the term of the lease through January 31, 2039. The annual cost under this agreement is $6.4 million, payable in monthly installments. Future minimum lease payments at September 30, 2009, are as follows (in thousands):

	Capital Leases	Operating Leases
2010	$ 1,118	$ 21,839
2011	923	17,560
2012	647	15,401
2013	562	14,734
2014	562	13,353
Thereafter	5,194	42,277
Total minimum lease payments	$ 9,006	$ 125,164
Amount representing interest (at rates ranging from 4.4% to 14.2%)	3,781	
Present value of net minimum lease payments (including $654 classified as current)	$ 5,225	

Aggregate future minimum rentals to be received under noncancellable subleases as of September 30, 2009, were $4.3 million.

15. RETIREMENT PLANS

Substantially all employees who are employed by the Company or its subsidiaries, upon qualification, are eligible to participate in a defined contribution 401(k) plan (the "Retirement Plan"). Employees who elect to participate generally make contributions from 1% to 20% of their eligible compensation, and the Company matches, at its discretion, such contributions up to a maximum percentage. Generally, employees immediately vest 100% in their own contributions and vest in the employer portion of contributions over a period not to exceed five years. Company contributions to the Retirement Plan were $5.7 million, $5.0 million and $4.3 million for the years ended September 30, 2009, 2008 and 2007, respectively.

16. SEGMENT AND GEOGRAPHIC INFORMATION

The Company's acute care hospitals and related healthcare businesses are similar in their activities and the economic environments in which they operate (i.e., urban and suburban markets). Accordingly, the Company's reportable operating segments consist of (1) acute care hospitals and related healthcare businesses, collectively, and (2) Health Choice. The following is a financial summary by business segment for the periods indicated (in thousands):

	For the Year Ended September 30, 2009			
	Acute Care	Health Choice	Eliminations	Consolidated
Acute care revenue	$ 1,662,469	$ —	$ —	$ 1,662,469
Premium revenue	—	699,503	—	699,503
Revenue between segments	9,316	—	(9,316)	—
Total net revenue	1,671,785	699,503	(9,316)	2,361,972
Salaries and benefits	641,893	19,028	—	660,921
Supplies	250,310	263	—	250,573
Medical claims	—	602,076	(9,316)	592,760
Other operating expenses	302,804	22,931	—	325,735
Provision for bad debts	192,563	—	—	192,563
Rentals and leases	37,563	1,564	—	39,127
Hurricane-related property damage	938	—	—	938
Adjusted EBITDA(1)	245,714	53,641	—	299,355
Interest expense, net	67,890	—	—	67,890
Depreciation and amortization	94,014	3,448	—	97,462
Impairment of goodwill	64,639	—	—	64,639
Management fees	5,000	—	—	5,000
Earnings from continuing operations before gain (loss) on disposal of assets, minority interests and income taxes	14,171	50,193	—	64,364
Gain (loss) on disposal of assets, net	1,616	(151)	—	1,465
Minority interests	(9,987)	—	—	(9,987)
Earnings from continuing operations before income taxes	$ 5,800	$ 50,042	$ —	$ 55,842
Segment assets	$ 2,109,422	$ 247,782		$ 2,357,204
Capital expenditures — continuing operations	$ 86,875	$ 845		$ 87,720
Goodwill	$ 712,163	$ 5,757		$ 717,920

	For the Year Ended September 30, 2008			
	Acute Care	Health Choice	Eliminations	Consolidated
Acute care revenue	$ 1,523,790	$ —	$ —	$ 1,523,790
Premium revenue	—	541,746	—	541,746
Revenue between segments	9,594	—	(9,594)	—
Total net revenue	1,533,384	541,746	(9,594)	2,065,536
Salaries and benefits	614,442	17,667	—	632,109
Supplies	231,001	258	—	231,259
Medical claims	—	461,649	(9,594)	452,055
Other operating expenses	264,814	18,309	—	283,123
Provision for bad debts	161,936	—	—	161,936
Rentals and leases	35,466	1,167	—	36,633
Hurricane-related property damage	3,589	—	—	3,589
Adjusted EBITDA(1)	222,136	42,696	—	264,832

Interest expense, net	75,665	—	—	75,665
Depreciation and amortization	93,003	3,738	—	96,741
Management fees	5,000	—	—	5,000
Earnings from continuing operations before loss on disposal of assets, minority interests and income taxes	48,468	38,958	—	87,426
Loss on disposal of assets, net	(75)	—	—	(75)
Minority interests	(4,437)	—	—	(4,437)
Earnings from continuing operations before income taxes	$ 43,956	$ 38,958	$ —	$ 82,914
Segment assets	$ 2,123,069	$ 185,078		$ 2,308,147
Capital expenditures — continuing operations	$ 136,425	$ 990		$ 137,415
Goodwill	$ 774,842	$ 5,757		$ 780,599

	For the Year Ended September 30, 2007			
	Acute Care	Health Choice	Eliminations	Consolidated
Acute care revenue	$ 1,315,438	$ —	$ —	$ 1,315,438
Premium revenue	—	450,641	—	450,641
Revenue between segments	7,540	—	(7,540)	—
Total net revenue	1,322,978	450,641	(7,540)	1,766,079
Salaries and benefits	518,989	14,803	—	533,792
Supplies	194,630	285	—	194,915
Medical claims	—	384,045	(7,540)	376,505
Other operating expenses	251,167	15,096	—	266,263
Provision for bad debts	136,233	—	—	136,233
Rentals and leases	30,384	1,162	—	31,546
Business interruption insurance recoveries	(3,443)	—	—	(3,443)
Adjusted EBITDA(1)	195,018	35,250	—	230,268
Interest expense, net	71,206	—	—	71,206
Depreciation and amortization	71,828	3,560	—	75,388
Loss on extinguishment of debt	6,229	—	—	6,229
Management fees	4,746	—	—	4,746
Earnings from continuing operations before loss on disposal of assets, minority interests and income taxes	41,009	31,690	—	72,699
Loss on disposal of assets, net	(1,359)	—	—	(1,359)
Minority interests	(4,496)	—	—	(4,496)
Earnings from continuing operations before income taxes	$ 35,154	$ 31,690	$ —	$ 66,844
Segment assets	$ 2,035,386	$ 151,036		$ 2,186,422
Capital expenditures — continuing operations	$ 193,570	$ 473		$ 194,043
Goodwill	$ 750,836	$ 5,757		$ 756,593

(1) Adjusted EBITDA represents net earnings before interest expense, income tax expense (benefit), depreciation and amortization, impairment of goodwill, loss on extinguishment of debt, gain (loss) on disposal of assets, minority interests and management fees. Management fees represent monitoring and advisory fees paid to TPG, the Company's majority financial sponsor, and certain other members of IASIS Investment LLC. Management routinely calculates and communicates adjusted EBITDA and believes that it is useful to investors because it is commonly used as an analytical indicator within the healthcare industry to evaluate hospital performance, allocate resources and measure leverage capacity and debt service ability. In addition, the Company uses adjusted EBITDA as a measure of performance for its business segments and for incentive compensation purposes. Adjusted EBITDA should not be considered as a measure of financial performance under GAAP, and the items excluded from adjusted EBITDA are significant components in understanding and assessing financial performance. Adjusted EBITDA should not be considered in isolation or as an alternative to net earnings, cash flows generated by operating, investing, or financing activities or other financial statement data presented in the consolidated financial statements as an indicator of financial performance or liquidity. Adjusted EBITDA, as presented, differs from what is defined under the Company's senior secured credit facilities and may not be comparable to similarly titled measures of other companies.

17. ACCRUED EXPENSES AND OTHER CURRENT LIABILITIES

A summary of accrued expenses and other current liabilities consists of the following (in thousands):

	September 30, 2009	September 30, 2008
Employee health insurance payable	$ 9,183	$ 10,834
Accrued property taxes	10,496	10,041

Health Choice program settlements payable	13,720	—
Other	32,302	30,927
	$ 65,701	$ 51,802

18. ALLOWANCE FOR DOUBTFUL ACCOUNTS

A summary of activity in the Company's allowance for doubtful accounts is as follows (in thousands):

	Beginning Balance	Provision for Bad Debts	Other (1)	Accounts Written Off, Net of Recoveries	Acquisitions	Ending Balance
Year Ended September 30, 2007	$ 109,877	136,233	6,475	(167,900)	13,144	$ 97,829
Year Ended September 30, 2008	$ 97,829	161,936	6,782	(158,092)	—	$ 108,455
Year Ended September 30, 2009	$ 108,455	192,563	641	(175,527)	—	$ 126,132

(1) Represents provision for bad debts recorded at facilities which are now included in discontinued operations.

The provision for bad debts increased $30.6 million during the year ended September 30, 2009, primarily as a result of increases in self-pay volume and revenue. The provision for bad debts increased $25.7 during the year end September 30, 2008, primarily as a result of increases in self-pay volume and revenue, as well as the effect of a full year of operations at Mountain Vista Medical Center, Alliance and Glenwood.

19. IMPACT OF HURRICANE ACTIVITY

The Medical Center of Southeast Texas, the Company's hospital located in Port Arthur, Texas, was damaged during Hurricane Ike in September 2008. The hospital sustained roof and water intrusion damage. The majority of services at the hospital became operational during October of 2008. The Company's results from operations include hurricane-related property damage of $938,000 and $3.6 million for the years ended September 30, 2009 and 2008, respectively.

During the year ended September 30, 2007, the Company received business interruption insurance recoveries of $3.4 million resulting from the temporary closure and disruption of operations at The Medical Center of Southeast Texas, as a result of Hurricane Rita in 2005. Amounts received during the year ended September 30, 2007, represent the final settlement of the Company's business interruption insurance claim related to Hurricane Rita.

20. SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION

The 8 3/4% notes described in Note 3 are fully and unconditionally guaranteed on a joint and several basis by all of the Company's existing domestic subsidiaries, other than non-guarantor subsidiaries which include Health Choice and the Company's non-wholly owned subsidiaries.

Effective July 1, 2007, the operations of Pioneer Valley Hospital ("Pioneer"), formerly a subsidiary guarantor under the 8 3/4% notes, merged into Jordan Valley Hospital, a non-wholly owned subsidiary, to form Jordan Valley Medical Center. The Pioneer subsidiary was dissolved in connection with this merger. As a result, the combined operations of Jordan Valley Medical Center are included in the subsidiary non-guarantor information in the following summarized condensed consolidating financial statements.

Effective February 1, 2008, Salt Lake Regional Medical Center, LP ("Salt Lake") sold limited partner units representing, in the aggregate, a 2.2% ownership interest in Salt Lake. As a result, the Company's ownership interest in Salt Lake was reduced to 97.8%. Salt Lake is included in the condensed consolidating financial statements as a subsidiary non-guarantor.

Summarized condensed consolidating balance sheets at September 30, 2009 and 2008, condensed consolidating statements of operations and cash flows for the years ended September 30, 2009, 2008 and 2007, for the Company, segregating the parent company issuer, the subsidiary guarantors, the subsidiary non-guarantors and eliminations, are found below. Prior year amounts have been reclassified to conform to the current year presentation.

IASIS Healthcare LLC

Condensed Consolidating Balance Sheet

September 30, 2009

(in thousands)

	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Assets					
Current assets:					
Cash and cash equivalents	$ —	$ 206,331	$ 197	$ —	$ 206,528
Accounts receivable, net	—	90,883	139,315	—	230,198
Inventories	—	22,405	28,087	—	50,492
Deferred income taxes	39,038	—	—	—	39,038
Prepaid expenses and other current assets	—	15,521	33,932	—	49,453
Total current assets	39,038	335,140	201,531		575,709
Property and equipment, net	—	347,657	649,696	—	997,353
Intercompany	—	(243,956)	243,956	—	—
Net investment in and advances to subsidiaries	1,690,127	—	—	(1,690,127)	—
Goodwill	17,331	67,445	633,144	—	717,920
Other intangible assets, net	—	—	30,000	—	30,000
Other assets, net	15,182	16,780	4,260	—	36,222
Total assets	$ 1,761,678	$ 523,066	$ 1,762,587	$ (1,690,127)	$ 2,357,204
Liabilities and Member's Equity					
Current liabilities:					
Accounts payable	$ —	$ 25,269	$ 43,283	$ —	$ 68,552
Salaries and benefits payable	—	25,008	17,540	—	42,548
Accrued interest payable	12,511	(3,239)	3,239	—	12,511
Medical claims payable	—	—	113,519	—	113,519
Other accrued expenses and other current liabilities	—	39,559	26,142	—	65,701
Current portion of long-term debt and capital lease obligations	7,431	935	20,614	(20,614)	8,366
Total current liabilities	19,942	87,532	224,337	(20,614)	311,197
Long-term debt and capital lease obligations	1,045,260	6,211	566,980	(566,980)	1,051,471
Deferred income taxes	106,425	—	—	—	106,425
Other long-term liabilities	—	53,577	645	—	54,222
Minority interests	—	53,042	—	—	53,042
Total liabilities	1,171,627	200,362	791,962	(587,594)	1,576,357
Member's equity	590,051	322,704	970,625	(1,102,533)	780,847
Total liabilities and member's equity	$ 1,761,678	$ 523,066	$ 1,762,587	$ (1,690,127)	$ 2,357,204

IASIS Healthcare LLC

Condensed Consolidating Balance Sheet

September 30, 2008

(in thousands)

	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Assets					
Current assets:					
Cash and cash equivalents	$ —	$ 80,336	$ 402	$ —	$ 80,738
Accounts receivable, net	—	101,291	122,847	—	224,138
Inventories	—	21,236	28,218	—	49,454
Deferred income taxes	38,860	—	—	—	38,860
Prepaid expenses and other current assets	—	19,688	40,365	—	60,053
Total current assets	38,860	222,551	191,832		453,243
Property and equipment, net	—	363,106	641,142	—	1,004,248
Intercompany	—	(190,870)	190,870	—	—
Net investment in and advances to subsidiaries	1,717,907	—	—	(1,717,907)	—
Goodwill	18,609	128,764	633,226	—	780,599
Other intangible assets, net	—	—	33,000	—	33,000
Other assets, net	18,210	12,944	5,903	—	37,057
Total assets	$ 1,793,586	$ 536,495	$ 1,695,973	$ (1,717,907)	$ 2,308,147
Liabilities and Member's Equity					
Current liabilities:					
Accounts payable	$ —	$ 24,708	$ 40,143	$ —	$ 64,851
Salaries and benefits payable	—	16,819	14,988	—	31,807
Accrued interest payable	12,460	(3,242)	3,242	—	12,460
Medical claims payable	—	—	97,343	—	97,343
Other accrued expenses and other current liabilities	—	38,552	13,250	—	51,802
Current portion of long-term debt and capital lease obligations	6,042	1,581	15,255	(15,255)	7,623
Total current liabilities	18,502	78,418	184,221	(15,255)	265,886
Long-term debt and capital lease obligations	1,098,928	8,071	588,172	(588,172)	1,106,999
Deferred income taxes	111,092	—	—	—	111,092
Other long-term liabilities	—	43,871	655	—	44,526
Minority interests	—	51,875	—	—	51,875
Total liabilities	1,228,522	182,235	773,048	(603,427)	1,580,378
Member's equity	565,064	354,260	922,925	(1,114,480)	727,769
Total liabilities and member's equity	$ 1,793,586	$ 536,495	$ 1,695,973	$ (1,717,907)	$ 2,308,147

IASIS Healthcare LLC

Condensed Consolidating Statement of Operations

(in thousands)

	For the Year Ended September 30, 2009				
	Parent Issuer	**Subsidiary Guarantors**	**Subsidiary Non-Guarantors**	**Eliminations**	**Condensed Consolidated**
Net revenue:					
Acute care revenue	$ —	$ 656,913	$ 1,014,872	$ (9,316)	$ 1,662,469
Premium revenue	—	—	699,503	—	699,503
Total net revenue	—	656,913	1,714,375	(9,316)	2,361,972
Costs and expenses:					
Salaries and benefits	—	336,687	324,234	—	660,921
Supplies	—	103,587	146,986	—	250,573
Medical claims	—	—	602,076	(9,316)	592,760
Other operating expenses	—	121,597	204,138	—	325,735
Provision for bad debts	—	94,662	97,901	—	192,563
Rentals and leases	—	16,138	22,989	—	39,127
Interest expense, net	67,890	—	43,063	(43,063)	67,890
Depreciation and amortization	—	42,492	54,970	—	97,462
Management fees	5,000	(21,862)	21,862	—	5,000
Impairment of goodwill	—	64,639	—	—	64,639
Hurricane-related property damage	—	—	938	—	938
Equity in earnings of affiliates	(84,640)	—	—	84,640	—
Total costs and expenses	(11,750)	757,940	1,519,157	32,261	2,297,608
Earnings (loss) from continuing operations before gain (loss) on disposal of assets, minority interests and income taxes	11,750	(101,027)	195,218	(41,577)	64,364
Gain (loss) on disposal of assets, net	—	1,598	(133)	—	1,465
Minority interests	—	(9,987)	—	—	(9,987)
Earnings (loss) from continuing operations before income taxes	11,750	(109,416)	195,085	(41,577)	55,842
Income tax expense	26,829	—	747	—	27,576
Net earnings (loss) from continuing operations	(15,079)	(109,416)	194,338	(41,577)	28,266
Earnings (loss) from discontinued operations, net of income taxes	106	(310)	28	—	(176)
Net earnings (loss)	$ (14,973)	$ (109,726)	$ 194,366	$ (41,577)	$ 28,090

IASIS Healthcare LLC

Condensed Consolidating Statement of Operations

(in thousands)

	For the Year Ended September 30, 2008				
	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Net revenue:					
Acute care revenue	$ —	$ 637,773	$ 895,611	$ (9,594)	$ 1,523,790
Premium revenue	—	—	541,746	—	541,746
Total net revenue	—	637,773	1,437,357	(9,594)	2,065,536
Costs and expenses:					
Salaries and benefits	—	319,243	312,866	—	632,109
Supplies	—	104,698	126,561	—	231,259
Medical claims	—	—	461,649	(9,594)	452,055
Other operating expenses	—	111,781	171,342	—	283,123
Provision for bad debts	—	80,139	81,797	—	161,936
Rentals and leases	—	14,891	21,742	—	36,633
Interest expense, net	75,665	—	54,716	(54,716)	75,665
Depreciation and amortization	—	42,721	54,020	—	96,741
Management fees	5,000	(19,337)	19,337	—	5,000
Hurricane-related property damage	—	—	3,589	—	3,589
Equity in earnings of affiliates	(91,476)	—	—	91,476	—
Total costs and expenses	(10,811)	654,136	1,307,619	27,166	1,978,110
Earnings (loss) from continuing operations before gain (loss) on disposal of assets, minority interests and income taxes	10,811	(16,363)	129,738	(36,760)	87,426
Gain (loss) on disposal of assets, net	—	(81)	6	—	(75)
Minority interests	—	(4,437)	—	—	(4,437)
Earnings (loss) from continuing operations before income taxes	10,811	(20,881)	129,744	(36,760)	82,914
Income tax expense	34,996	—	329	—	35,325
Net earnings (loss) from continuing operations	(24,185)	(20,881)	129,415	(36,760)	47,589
Earnings (loss) from discontinued operations, net of income taxes	5,783	(12,257)	(4,801)	—	(11,275)
Net earnings (loss)	$ (18,402)	$ (33,138)	$ 124,614	$ (36,760)	$ 36,314

IASIS Healthcare LLC

Condensed Consolidating Statement of Operations

(in thousands)

	For the Year Ended September 30, 2007				
	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Net revenue:					
Acute care revenue	$ —	$ 577,891	$ 745,087	$ (7,540)	$ 1,315,438
Premium revenue	—	—	450,641	—	450,641
Total net revenue	—	577,891	1,195,728	(7,540)	1,766,079
Costs and expenses:					
Salaries and benefits	—	284,520	249,272	—	533,792
Supplies	—	97,043	97,872	—	194,915
Medical claims	—	—	384,045	(7,540)	376,505
Other operating expenses	—	115,542	150,721	—	266,263
Provision for bad debts	—	68,824	67,409	—	136,233
Rentals and leases	—	11,985	19,561	—	31,546
Interest expense, net	71,206	—	34,684	(34,684)	71,206
Depreciation and amortization	—	37,161	38,227	—	75,388
Management fees	4,746	(16,030)	16,030	—	4,746
Loss on extinguishment of debt	6,229	—	—	—	6,229
Business interruption insurance recoveries	—	—	(3,443)	—	(3,443)
Equity in earnings of affiliates	(117,212)	—	—	117,212	—
Total costs and expenses	(35,031)	599,045	1,054,378	74,988	1,693,380
Earnings (loss) from continuing operations before loss on disposal of assets, minority interests and income taxes	35,031	(21,154)	141,350	(82,528)	72,699
Loss on disposal of assets, net	—	(774)	(585)	—	(1,359)
Minority interests	—	(4,496)	—	—	(4,496)
Earnings (loss) from continuing operations before income taxes	35,031	(26,424)	140,765	(82,528)	66,844
Income tax expense	25,909	—	—	—	25,909
Net earnings (loss) from continuing operations	9,122	(26,424)	140,765	(82,528)	40,935
Earnings (loss) from discontinued operations, net of income taxes	(2,202)	6,314	(3,443)	—	669
Net earnings (loss)	$ 6,920	$ (20,110)	$ 137,322	$ (82,528)	$ 41,604

IASIS Healthcare LLC

Condensed Consolidating Statement of Cash Flows

(in thousands)

	For the Year Ended September 30, 2007				
	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Cash flows from operating activities					
Net earnings (loss)	$ 6,920	$ (20,110)	$ 137,322	$ (82,528)	$ 41,604
Adjustments to reconcile net earnings (loss) to net cash provided by (used in) operating activities:					
Loss (earnings) from discontinued operations	2,202	(6,314)	3,443	—	(669)
Depreciation and amortization	—	37,161	38,227	—	75,388
Amortization of loan costs	2,942	—	—	—	2,942
Minority interests	—	4,496	—	—	4,496
Deferred income taxes	24,103	—	—	—	24,103
Loss on disposal of assets	—	774	585	—	1,359
Loss on extinguishment of debt	5,091	—	—	—	5,091
Equity in earnings of affiliates	(117,212)	—	—	117,212	—
Changes in operating assets and liabilities, net of the effect of acquisitions and dispositions:					
Accounts receivable, net	—	(37,182)	(15,567)	—	(52,749)
Inventories, prepaid expenses and other current assets	—	(3,204)	(2,690)	—	(5,894)
Accounts payable, other accrued expenses and other accrued liabilities	(1,100)	25,090	2,012	—	26,002
Net cash provided by (used in) operating activities — continuing operations	(77,054)	711	163,332	34,684	121,673
Net cash provided by (used in) operating activities — discontinued operations	(2,202)	9,306	(2,443)	—	4,661
Net cash provided by (used in) operating activities	(79,256)	10,017	160,889	34,684	126,334
Cash flows from investing activities					
Purchases of property and equipment	—	(41,987)	(152,056)	—	(194,043)
Cash paid for acquisitions	—	(78,083)	(63,502)	—	(141,585)
Proceeds from sale of assets	—	1,026	—	—	1,026
Change in other assets	—	4,272	1,621	—	5,893
Net cash used in investing activities — continuing operations	—	(114,772)	(213,937)	—	(328,709)
Net cash used in investing activities — discontinued operations	—	(874)	(55)	—	(929)
Net cash used in investing activities	—	(115,646)	(213,992)	—	(329,638)
Cash flows from financing activities					
Payment of debt and capital lease obligations	(646,663)	(1,447)	(2,195)	—	(650,305)
Proceeds from debt borrowings	778,800	—	—	—	778,800
Debt financing costs incurred	(8,200)	—	—	—	(8,200)
Distribution to parent for debt financing costs	(6,586)	—	—	—	(6,586)
Distribution of minority interests	—	—	(4,850)	—	(4,850)
Costs paid for partnership interests	—	(495)	—	—	(495)
Change in intercompany balances with affiliates, net	(38,095)	9,736	63,043	(34,684)	—
Net cash provided by (used in) financing activities — continuing operations	79,256	7,794	55,998	(34,684)	108,364
Net cash used in financing activities — discontinued operations	—	(475)	—	—	(475)
Net cash provided by (used in) financing activities	79,256	7,319	55,998	(34,684)	107,889
Increase (decrease) in cash and cash equivalents	—	(98,310)	2,895	—	(95,415)
Cash and cash equivalents at beginning of period	—	94,258	1,157	—	95,415
Cash and cash equivalents at end of period	$ —	$ (4,052)	$ 4,052	$ —	$ —

Report of Independent Registered Public Accounting Firm

To the Board of Directors of

IASIS Healthcare Corporation, sole member of IASIS Healthcare LLC

We have audited the accompanying consolidated balance sheets of IASIS Healthcare LLC as of September 30, 2010 and 2009, and the related consolidated statements of operations, equity and cash flows for each of the three years in the period ended September 30, 2010. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of IASIS Healthcare LLC at September 30, 2010 and 2009, and the consolidated results of its operations and its cash flows for each of the three years in the period ended September 30, 2010, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 2 to the consolidated financial statements, the Company changed its accounting and disclosure for noncontrolling interests with the adoption of the guidance originally issued in FASB Statement No. 160, *Noncontrolling Interests in Consolidated Financial Statements* (codified in FASB ASC Topic 810, *Consolidation*) effective October 1, 2009.

/s/ Ernst & Young LLP

Nashville, Tennessee

December 21, 2010

IASIS HEALTHCARE LLC

CONSOLIDATED BALANCE SHEETS

(In thousands)

	September 30, 2010	September 30, 2009
ASSETS		
Current assets:		
Cash and cash equivalents	$ 144,511	$ 206,528
Accounts receivable, less allowance for doubtful accounts of $125,406 and $126,132 at September 30, 2010 and 2009, respectively	209,173	230,198
Inventories	53,842	50,492
Deferred income taxes	15,881	39,038
Prepaid expenses and other current assets	65,340	49,453
Total current assets	488,747	575,709
Property and equipment, net	985,291	997,353
Goodwill	718,243	717,920
Other intangible assets, net	27,000	30,000
Deposit for acquisition	97,891	—
Other assets, net	36,022	36,222
Total assets	$ 2,353,194	$ 2,357,204
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 78,931	$ 68,552
Salaries and benefits payable	38,110	42,548
Accrued interest payable	12,536	12,511
Medical claims payable	111,373	113,519
Other accrued expenses and other current liabilities	106,614	65,701
Current portion of long-term debt and capital lease obligations	6,691	8,366
Total current liabilities	354,255	311,197
Long-term debt and capital lease obligations	1,044,887	1,051,471
Deferred income taxes	109,272	106,425
Other long-term liabilities	60,162	54,222
Non-controlling interests with redemption rights	72,112	72,527
Equity:		
Member's equity	702,135	750,932
Non-controlling interests	10,371	10,430
Total equity	712,506	761,362
Total liabilities and equity	$ 2,353,194	$ 2,357,204

See accompanying notes.

IASIS HEALTHCARE LLC

CONSOLIDATED STATEMENTS OF OPERATIONS

(In thousands)

	Year Ended September 30, 2010	Year Ended September 30, 2009	Year Ended September 30, 2008
Net revenue:			
Acute care revenue	$ 1,729,344	$ 1,662,469	$ 1,523,790
Premium revenue	792,062	699,503	541,746
Total net revenue	2,521,406	2,361,972	2,065,536
Costs and expenses:			
Salaries and benefits	686,303	660,921	632,109
Supplies	266,545	250,573	231,259
Medical claims	678,651	592,760	452,055
Other operating expenses	363,916	325,735	283,123
Provision for bad debts	197,680	192,563	161,936
Rentals and leases	39,955	39,127	36,633
Interest expense, net	66,810	67,890	75,665
Depreciation and amortization	96,106	97,462	96,741
Management fees	5,000	5,000	5,000
Impairment of goodwill	—	64,639	—
Hurricane-related property damage	—	938	3,589
Total costs and expenses	2,400,966	2,297,608	1,978,110
Earnings from continuing operations before gain (loss) on disposal of assets and income taxes	120,440	64,364	87,426
Gain (loss) on disposal of assets, net	108	1,465	(75)
Earnings from continuing operations before income taxes	120,548	65,829	87,351
Income tax expense	44,715	27,576	35,325
Net earnings from continuing operations	75,833	38,253	52,026
Loss from discontinued operations, net of income taxes	(1,087)	(176)	(11,275)
Net earnings	74,746	38,077	40,751
Net earnings attributable to non-controlling interests	(8,279)	(9,987)	(4,437)
Net earnings attributable to IASIS Healthcare LLC	$ 66,467	$ 28,090	$ 36,314

See accompanying notes.

IASIS HEALTHCARE LLC

CONSOLIDATED STATEMENTS OF EQUITY

(In thousands)

	Non-controlling Interests with Redemption Rights	Member's Equity	Non-controlling Interests	Total Equity
Balance at September 30, 2007 (as previously reported)	$ —	$ 691,514	$ —	$ 691,514
Adjustment to non-controlling interests from adoption of FASB authoritative guidance	44,134	(16,782)	8,604	(8,178)
Balance at September 30, 2007 (as adjusted)	44,134	674,732	8,604	683,336
Net earnings	4,285	36,314	152	36,466
Distributions to non-controlling interests	(5,313)	—	(172)	(172)
Proceeds from the sale of non-controlling interests	15,872	—	—	—
Repurchases of non-controlling intersts	(802)	—	—	—
Non-controlling interests in acquisition of Ouachita	—	—	1,897	1,897
Tax effect of adoption of FASB income tax guidance	—	(59)	—	(59)
Adjustment to redemption value of non-controlling interests with redemption rights	(3,520)	3,520	—	3,520
Balance at September 30, 2008	54,656	714,507	10,481	724,988
Net earnings	9,769	28,090	218	28,308
Distributions to non-controlling interests	(6,481)	—	(269)	(269)
Repurchases of non-controlling interests	(1,379)	—	—	—
Conversion of non-controlling interests to note payable	(691)	—	—	—
Stock compensation	—	561	—	561
Other comprehensive loss	—	(2,926)	—	(2,926)
Income tax benefit resulting from exercise of employee stock options	—	9	—	9
Contribution from parent company related to tax benefit from Holdings Senior PIK Loans interest	—	27,344	—	27,344
Adjustment to redemption value of non-controlling interests with redemption rights	16,653	(16,653)	—	(16,653)
Balance at September 30, 2009	72,527	750,932	10,430	761,362
Net earnings	8,144	66,467	135	66,602
Distributions to non-controlling interests	(8,790)	—	(194)	(194)
Repurchases of non-controlling interests	(459)	—	—	—
Stock compensation	—	2,487	—	2,487
Other comprehensive loss	—	(653)	—	(653)
Distribution to parent company in connection with the repurchase of equity, net	—	(124,962)	—	(124,962)
Contribution from parent company related to tax benefit from Holdings Senior PIK Loans interest	—	8,554	—	8,554
Adjustment to redemption value of non-controlling interests with redemption rights	690	(690)	—	(690)
alance at September 30, 2010	$ 72,112	$ 702,135	$ 10,371	$ 712,506

IASIS HEALTHCARE LLC

CONSOLIDATED STATEMENTS OF CASH FLOWS

(In thousands)

	Year Ended September 30, 2010	Year Ended September 30, 2009	Year Ended September 30, 2008
Cash flows from operating activities:			
Net earnings	$ 74,746	$ 38,077	$ 40,751
Adjustments to reconcile net earnings to net cash provided by operating activities:			
Depreciation and amortization	96,106	97,462	96,741
Amortization of loan costs	3,163	3,029	2,913
Stock compensation costs	2,487	561	—
Deferred income taxes	30,473	(5,572)	19,368
Income tax benefit from stock compensation	(1,770)	—	—
Income tax benefit from parent company interest	8,554	27,344	—
Loss (gain) on disposal of assets, net	(108)	(1,465)	75
Loss from discontinued operations	1,087	176	11,275
Impairment of goodwill	—	64,639	—
Hurricane-related property damage	—	938	3,589
Changes in operating assets and liabilities, net of the effect of acquisitions and dispositions:			
Accounts receivable, net	21,279	(7,302)	17,131
Inventories, prepaid expenses and other current assets	(19,227)	6,728	(21,361)
Accounts payable, other accrued expenses and other accrued liabilities	41,957	45,884	(29,419)
Net cash provided by operating activities — continuing operations	258,747	270,499	141,063
Net cash provided by (used in) operating activities — discontinued operations	(1,508)	1,472	2,313
Net cash provided by operating activities	257,239	271,971	143,376
Cash flows from investing activities:			
Purchases of property and equipment	(81,268)	(87,720)	(137,415)
Cash paid for acquisitions	(98,305)	(1,941)	(16,821)
Proceeds from sale of assets	57	5,252	360
Change in other assets	3,043	1,823	4,613
Net cash used in investing activities — continuing operations	(176,473)	(82,586)	(149,263)
Net cash provided by (used in) investing activities — discontinued operations	—	10	(1,017)
Net cash used in investing activities	(176,473)	(82,576)	(150,280)
Cash flows from financing activities:			
Payment of debt and capital lease obligations	(8,378)	(55,476)	(306,611)
Proceeds from debt borrowings	—	—	384,978
Distribution to parent company in connection with the repurchase of equity, net	(124,962)	—	—
Distributions to non-controlling interests	(8,984)	(6,750)	(5,485)
Proceeds received from sale (costs paid for repurchase) of non-controlling interests, net	(459)	(1,379)	15,070
Other	—	—	192
Net cash provided by (used in) financing activities — continuing operations	(142,783)	(63,605)	88,144
Net cash used in financing activities — discontinued operations	—	—	(502)
Net cash provided by (used in) financing activities	(142,783)	(63,605)	87,642

Change in cash and cash equivalents	(62,017)	125,790	80,738
Cash and cash equivalents at beginning of period	206,528	80,738	—
Cash and cash equivalents at end of period	$ 144,511	$ 206,528	$ 80,738
Supplemental disclosure of cash flow information:			
Cash paid for interest	$ 63,762	$ 66,136	$ 83,126
Cash paid (received) for income taxes, net	$ 13,528	$ 4,104	$ (925)
Supplemental schedule of noncash investing and financing activities:			
Capital lease obligations resulting from acquisitions	$ —	$ —	$ 4,849

See accompanying notes.

IASIS HEALTHCARE LLC

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. ORGANIZATION AND BASIS OF PRESENTATION

Organization

IASIS Healthcare LLC ("IASIS" or the "Company") owns and operates medium-sized acute care hospitals in high-growth urban and suburban markets. At September 30, 2010, the Company owned or leased 15 acute care hospital facilities and one behavioral health hospital facility, with a total of 3,185 licensed beds, located in six regions:

Salt Lake City, Utah;

Phoenix, Arizona;

Tampa-St. Petersburg, Florida;

three cities in Texas, including San Antonio;

Las Vegas, Nevada; and

West Monroe, Louisiana.

The Company also owns and operates Health Choice Arizona, Inc. ("Health Choice" or the "Plan"), a Medicaid and Medicare managed health plan in Phoenix.

Principles of Consolidation

The consolidated financial statements include all subsidiaries and entities under common control of the Company. Control is generally defined by the Company as ownership of a majority of the voting interest of an entity. In addition, control is demonstrated in instances when the Company is the sole general partner in a limited partnership. Significant intercompany transactions have been eliminated.

Use of Estimates

The preparation of the financial statements in conformity with U.S. generally accepted accounting principles ("GAAP") requires management to make estimates and assumptions that affect the amounts reported in the accompanying audited consolidated financial statements and notes. Actual results could differ from those estimates.

Reclassifications

Certain prior year amounts have been reclassified to conform to the current year presentation. These reclassifications have no impact on the Company's total assets or total liabilities and equity.

General and Administrative

The majority of the Company's expenses are "cost of revenue" items. Costs that could be classified as "general and administrative" by the Company would include the IASIS corporate office costs, which were $39.2 million, $45.6 million and $50.5 million, for the years ended September 30, 2010, 2009 and 2008, respectively.

Subsequent Events Consideration

The Company has evaluated its financial statements and disclosures for the impact of subsequent events up to the date of filing its annual report on Form 10-K with the Securities and Exchange Commission.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

2. SIGNIFICANT ACCOUNTING POLICIES

Net Revenue

Acute Care Revenue

The Company's healthcare facilities have entered into agreements with third-party payors, including government programs and managed care health plans, under which the facilities are paid based upon established charges, the cost of providing services, predetermined rates per diagnosis, fixed per diem rates or discounts from established charges. Additionally, the Company offers discounts through its uninsured discount program to all uninsured patients receiving healthcare services who do not qualify for assistance under state Medicaid, other federal or state assistance plans, or charity care.

Net patient revenue is reported at the estimated net realizable amounts from third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and are adjusted, if necessary, in future periods when final settlements are determined. Net adjustments to estimated third-party payor settlements ("prior year contractuals") resulted in an increase in net revenue of $5.2 million, $3.2 million and $1.0 million for the years ended September 30, 2010, 2009 and 2008, respectively.

In the ordinary course of business, the Company provides care without charge to patients who are financially unable to pay for the healthcare services they receive. Because the Company does not pursue collection of amounts determined to qualify as charity care, they are not reported in net revenue. The Company currently records revenue deductions for patient accounts that meet its guidelines for charity care. The Company provides charity care to patients with income levels below 200% of the federal poverty level ("FPL"). Additionally, at all of the Company's hospitals, a sliding scale of reduced rates is offered to uninsured patients, who are not covered through federal, state or private insurance, with incomes between 200% and 400% of the FPL. Charity care deductions based on gross charges for the years ended September 30, 2010, 2009 and 2008 were $37.9 million, $38.6 million and $37.7 million, respectively.

Premium Revenue

Health Choice is a prepaid Medicaid and Medicare managed health plan that derives most of its revenue through a contract with the Arizona Health Care Cost Containment System ("AHCCCS") to provide specified health services to qualified Medicaid enrollees through contracted providers. AHCCCS is the state agency that administers Arizona's Medicaid program. The contract requires the Plan to arrange for healthcare services for enrolled Medicaid patients in exchange for fixed monthly premiums, based upon negotiated per capita member rates, and supplemental payments from AHCCCS. Capitation payments received by Health Choice are recognized as revenue in the month that members are entitled to healthcare services.

The Plan receives reinsurance and other supplemental payments from AHCCCS for healthcare costs that exceed stated amounts at a rate ranging from 75% to 100% of qualified healthcare costs in excess of stated levels of up to $35,000 per claim, depending on the eligibility classification of the member. Qualified costs must be incurred during the contract year and are the lesser of the amount paid by the Plan or the AHCCCS fee schedule. Reinsurance recoveries are recognized under the contract with AHCCCS when healthcare costs exceed stated amounts as provided under the contract, including estimates of such costs at the end of each accounting period.

Effective October 1, 2008, Health Choice began its current contract with AHCCCS, which provides for a three-year term, with AHCCCS having the option to renew for two additional one-year periods. The contract is terminable without cause on 90 days' written notice or for cause upon written notice if the Company fails to comply with any term or condition of the contract or fails to take corrective action as required to comply with the terms of the contract. Additionally, AHCCCS can terminate the contract in the event of the unavailability of state or federal funding.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

Health Choice also provides coverage as a Medicare Advantage Prescription Drug ("MAPD") Special Needs Plan ("SNP") provider pursuant to its contract with the Centers for Medicare and Medicaid Services ("CMS"). The SNP allows Health Choice to offer Medicare and Part D drug benefit coverage for new and existing dual-eligible members, or those that are eligible for Medicare and Medicaid. The contract with CMS includes successive one-year renewal options at the discretion of CMS and is terminable without cause on 90 days' written notice or for cause upon written notice if the Company fails to comply with any term or condition of the contract or fails to take corrective action as required to comply with the terms of the contract. Health Choice has received notification that CMS is exercising its option to extend its contract through December 31, 2011.

The Plan subcontracts with hospitals, physicians and other medical providers within Arizona and surrounding states to provide services to its Medicaid enrollees in Apache, Coconino, Maricopa, Mohave, Navajo, Pima, Yuma, LaPaz and Santa Cruz counties, and to its Medicare enrollees in Maricopa, Pima, Pinal, Coconino, Apache and Navajo counties. These services are provided regardless of the actual costs incurred to provide these services.

Cash and Cash Equivalents

The Company considers highly liquid investments with original maturities of three months or less to be cash equivalents. The Company maintains its cash and cash equivalents balances primarily with high credit quality financial institutions. The Company manages its credit exposure by placing its investments in United States Treasury securities or other high quality securities, and by periodically evaluating the relative credit standing of the financial institution.

Accounts Receivable

The Company receives payments for services rendered from federal and state agencies (under the Medicare, Medicaid and TRICARE programs), managed care health plans, including Medicare and Medicaid managed health plans, commercial insurance companies, employers and patients. During the years ended September 30, 2010, 2009 and 2008, 47.6%, 45.9% and 44.9%, respectively, of the Company's net patient revenue related to patients participating in the Medicare and Medicaid programs, including Medicare and Medicaid managed health plans. The Company recognizes that revenue and receivables from government agencies are significant to its operations, but does not believe that there is significant credit risks associated with these government agencies. The Company believes that concentration of credit risk from other payors is limited due to the number of patients and payors.

Net Medicare settlement receivables estimated at September 30, 2010 and 2009, totaled $1.3 million and $6.3 million, respectively, are included in accounts receivable in the accompanying consolidated balance sheets.

Allowance for Doubtful Accounts

The Company's estimation of the allowance for doubtful accounts is based primarily upon the type and age of the patient accounts receivable and the effectiveness of the Company's collection efforts. The Company's policy is to reserve a portion of all self-pay receivables, including amounts due from the uninsured and amounts related to co-payments and deductibles, as these charges are recorded. On a monthly basis, the Company reviews its accounts receivable balances, the effectiveness of the Company's reserve policies and various analytics to support the basis for its estimates. These efforts primarily consist of reviewing the following:

Historical write-off and collection experience using a hindsight or look-back approach;

Revenue and volume trends by payor, particularly the self-pay components;

Changes in the aging and payor mix of accounts receivable, including increased focus on accounts due from the uninsured and accounts that represent co-payments and deductibles due from patients;

Cash collections as a percentage of net patient revenue less bad debt expense;

Trending of days revenue in accounts receivable; and

Various allowance coverage
statistics.

The Company regularly performs hindsight procedures to evaluate historical write-off and collection experience throughout the year to assist in determing the reasonableness of its process for estimating the allowance for doubtful accounts.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

Inventories

Inventories, principally medical supplies, implants and pharmaceuticals, are stated at the lower of average cost or market.

Long-lived Assets

The primary components of the Company's long-lived assets are discussed below. When events, circumstances or operating results indicate that the carrying values of certain long-lived assets and related identifiable intangible assets (excluding goodwill) that are expected to be held and used might be impaired under the provisions of Financial Accounting Standards Board ("FASB") authoritative guidance regarding accounting for the impairment or disposal of long-lived assets, the Company considers the recoverability of assets to be held and used by comparing the carrying amount of the assets to the undiscounted value of future net cash flows expected to be generated by the assets. If assets are identified as impaired, the impairment is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets as determined by independent appraisals or estimates of discounted future cash flows. Assets to be disposed of are reported at the lower of the carrying amount or fair value less costs to sell.

Property and Equipment

Property and equipment are stated at cost. Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase capacities or extend useful lives are capitalized. Buildings and improvements are depreciated over estimated useful lives ranging generally from 14 to 40 years. Estimated useful lives of equipment vary generally from 3 to 25 years. Leasehold improvements are amortized on a straight-line basis over the lesser of the terms of the respective leases or their estimated useful lives. Depreciation expense, including amortization of assets capitalized under capital leases, is computed using the straight-line method and was $93.1 million, $94.5 million and $93.7 million for the years ended September 30, 2010, 2009 and 2008, respectively. In connection with certain construction projects, the Company capitalized interest totaling $1.2 million and $1.4 million for the years ended September 30, 2009 and 2008, respectively. No amounts were capitalized in the year ended September 30, 2010.

Goodwill and Other Intangible Assets

See Note 10 for the values of goodwill and other intangible assets assigned to each business segment. Intangible assets are evaluated for impairment if events and circumstances indicate a possible impairment.

Goodwill is not amortized but is subject to annual tests for impairment or more often if events or circumstances indicate it may be impaired. An impairment loss is recorded to the extent that the carrying amount of goodwill exceeds its implied fair value. The Company completed its annual impairment test of goodwill during fiscal 2010, noting no impairment. During fiscal 2009, the Company's testing of goodwill indicated impairment of goodwill associated with its Florida market. See Note 10 for more details.

Other Assets

Other assets consist primarily of costs associated with the issuance of debt, which are amortized over the life of the related debt. Amortization of deferred financing costs is included in interest expense and totaled $3.2 million, $3.0 million and $2.9 million for the years ended September 30, 2010, 2009 and 2008, respectively. Deferred financing costs, net of accumulated amortization, totaled $12.0 million and $15.2 million at September 30, 2010 and 2009, respectively.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

Insurance Reserves

The Company estimates its reserve for self-insured professional and general liability and workers compensation risks using historical claims data, demographic factors, severity factors, current incident logs and other actuarial analysis.

Income Taxes

The Company accounts for income taxes under the asset and liability method in accordance with FASB authoritative guidance regarding accounting for income taxes and its related uncertainty. This approach requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply when the temporary differences are expected to reverse. The Company assesses the likelihood that deferred tax assets will be recovered from future taxable income to determine whether a valuation allowance should be established.

Non-controlling Interests in Consolidated Entities

Effective October 1, 2009, the Company adopted the provisions of FASB authoritative guidance regarding non-controlling interests in consolidated financial statements. The guidance requires the Company to clearly identify and present ownership interests in subsidiaries held by parties other than the Company in the consolidated financial statements within the equity section. It also requires the amounts of consolidated net earnings attributable to the Company and to the non-controlling interests to be clearly identified and presented on the face of the consolidated statements of operations.

The Company consolidates seven subsidiaries with non-controlling interests that include third-party partners that own limited partnership units with certain redemption features. The redeemable limited partnership units require the Company to buy back the units upon the occurrence of certain events at the fair value of the units. In addition, the limited partnership agreements for all of the limited partnerships provide the limited partners with put rights which allow the units to be sold back to the Company, subject to certain limitations, at the fair value of the units. According to the limited partnership agreements, the fair value of the units is generally calculated as the product of the most current audited fiscal period's EBITDA (earnings before interest, taxes, depreciation, amortization and management fees) and a fixed multiple, less any long-term debt of the entity. The majority of these put rights require an initial holding period of six years after purchase, at which point the holder of the redeemable limited partnership units may put back to the Company 20% of such holder's units. Each succeeding year, the number of vested redeemable units will increase by 20% until the end of the tenth year after the initial investment, at which point 100% of the units may be put back to the Company. Under no circumstances shall the Company be required to repurchase more than 25% of the total vested redeemable limited partnership units in any fiscal year. The equity attributable to these interests has been classified as non-controlling interests with redemption rights in the accompanying consolidated balance sheets.

Medical Claims Payable

Monthly capitation payments made by Health Choice to physicians and other healthcare providers are expensed in the month services are contracted to be performed. Claims expense for non-capitated arrangements is accrued as services are rendered by hospitals, physicians and other healthcare providers during the year.

Medical claims payable related to Health Choice includes claims received but not paid and an estimate of claims incurred but not reported. Incurred but not reported claims are estimated using a combination of historical claims experience (including severity and payment lag time) and other actuarial analysis, including number of enrollees, age of enrollees and certain enrollee health indicators, to predict the cost of healthcare services provided to enrollees during any given period. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from estimates given changes in the healthcare cost structure or adverse experience.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

following table shows the components of the change in medical claims payable (in thousands):

	Year Ended September 30, 2010	Year Ended September 30, 2009
Medical claims payable as of October 1	$ 113,519	$ 97,343
Medical claims expense incurred during the year:		
Related to current year	697,052	620,153
Related to prior years	(6,596)	(18,077)
Total expenses	690,456	602,076
Medical claims payments during the year:		
Related to current year	(587,292)	(508,299)
Related to prior years	(105,310)	(77,601)
Total payments	(692,602)	(585,900)
Medical claims payable as of September 30	$ 111,373	$ 113,519

As reflected in the table above, medical claims expense for the year ended September 30, 2010, includes a $6.6 million reduction of medical costs related to prior years resulting from favorable development in the Medicaid and Medicare product lines of $6.4 million and $209,000, respectively. The favorable development is attributable to lower than anticipated medical costs. Medical claims expense for the year ended September 30, 2009, includes an $18.1 million reduction of medical costs related to prior years resulting from favorable development in the Medicaid and Medicare product lines of $15.5 million and $2.6 million, respectively. The favorable development is attributable to lower than anticipated medical costs and is offset, in part, by $10.8 million in reductions in premium revenue associated with settlements of various prior year program receivables. Additional adjustments to prior year estimates may be necessary in future periods as more information becomes available.

Health Choice has experienced an increase in the number of lives served by the plan. Enrollment in Health Choice at September 30, 2010 and 2009, was 198,393 and 190,763, respectively.

Stock Based Compensation

Although IASIS has no stock option plan or outstanding stock options, the Company, through its parent, IASIS Healthcare Corporation ("IAS"), grants stock options for a fixed number of common shares to employees. The Company accounts for this stock-based incentive plan under the measurement and recognition provisions of FASB authoritative guidance regarding share-based payments ("Share-Based Payments Guidance"). Accordingly, the Company has not recognized any compensation expense for the stock options granted prior to October 1, 2006, as the exercise price of the options equaled, or was greater than, the market value of the underlying stock on the date of grant.

For stock options granted on or after October 1, 2006, the Company applies the fair value recognition provisions of the Share-Based Payments Guidance, requiring all share-based payments to employees, including grants of employee stock options, to be recognized in the income statement based on their fair values. In accordance with the provisions of the Share-Based Payments Guidance, the Company uses the Black-Scholes-Merton model in determining the fair value of its share-based payments. The fair value of compensation costs will be amortized on a straight-line basis over the requisite service periods of the awards, generally equal to the awards' vesting periods.

Fair Value of Financial Instruments

Cash and cash equivalents, accounts receivable, accounts payable and accrued liabilities are reflected in the accompanying consolidated financial statements at amounts that approximate fair value because of the short-term nature of these instruments. The fair value of the Company's capital lease obligations also approximate carrying value as they bear interest at current market rates. The estimated fair values of the Company's 8 3/4% senior subordinated notes due 2014 (the "8 3/4% notes") and senior secured credit facilities were $485.7 million and $570.3 million, respectively, at September 30, 2010, based upon quoted market prices at that date.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

Management Services Agreement

The Company is party to a management services agreement with affiliates of TPG, JLL Partners and Trimaran Fund Management. The management services agreement provides that in exchange for consulting and management advisory services that will be provided to the Company by the investors, the Company will pay an aggregate monitoring fee of 0.25% of budgeted net revenue up to a maximum of $5.0 million per fiscal year to these parties (or certain of their respective affiliates) and reimburse them for their reasonable disbursements and out-of-pocket expenses. This monitoring fee is divided among the parties in proportion to their relative ownership percentages in IASIS Investment LLC, parent company and majority stockholder of IAS. The monitoring fee will be subordinated to the senior subordinated notes in the event of a bankruptcy of the Company. The management services agreement does not have a stated term. Pursuant to the provisions of the management services agreement, the Company has agreed to indemnify the investors (or certain of their respective affiliates) in certain situations arising from or relating to the agreement, the investors' investment in the securities of IAS or any related transactions or the operations of the investors, except for losses that arise on account of the investors' negligence or willful misconduct. For each of the three years ended September 30, 2010, 2009 and 2008, the Company paid $5.0 million in monitoring fees under the management services agreement.

Recently Issued Accounting Pronouncements

The Company has adopted the new FASB authoritative guidance regarding business combinations, which applies prospectively to business combinations for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after December 15, 2008. This new guidance establishes principles and requirements for recognition and measurement of items acquired during a business combination, as well as certain disclosure requirements in the financial statements. The adoption of these provisions did not impact the Company's results of operations or financial position; however, it is anticipated to have a material effect on the Company's accounting for future acquisitions.

3. LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS

Long-term debt and capital lease obligations consist of the following (in thousands):

	September 30, 2010	September 30, 2009
Senior secured credit facilities	$ 570,260	$ 576,150
Senior subordinated notes	475,000	475,000
Capital leases and other obligations	6,318	8,687
	1,051,578	1,059,837
Less current maturities	6,691	8,366
	$ 1,044,887	$ 1,051,471

Senior Secured Credit Facilities

The $854.0 million senior secured credit facilities include: (i) a senior secured term loan of $439.0 million; (ii) a senior secured delayed draw term loan of $150.0 million; (iii) a senior secured revolving credit facility of $225.0 million, which includes a $100.0 million sub-limit for letters of credit; and (iv) a senior secured synthetic letter of credit facility of $40.0 million. All facilities mature on March 15, 2014, except for the revolving credit facility, which matures on April 27, 2013. The term loans bear interest at an annual rate of LIBOR plus 2.00% or, at the Company's option, the administrative agent's base rate plus 1.00%. The revolving loans bear interest at an annual rate of LIBOR plus an applicable margin ranging from 1.25% to 1.75% or, at the Company's option, the administrative agent's base rate plus an applicable margin ranging from 0.25% to 0.75%, such rate in each case depending on the Company's senior secured leverage ratio. A commitment fee ranging from 0.375% to 0.5% per annum is charged on the undrawn portion of the senior secured revolving credit facility and is payable in arrears.

Principal under the senior secured term loan is due in 24 consecutive equal quarterly installments in an aggregate annual amount equal to 1.0% of the original principal amount ($439.0 million) during the first six years thereof, with the balance payable in four equal installments in year seven. Principal under the senior secured delayed draw term loan is due in equal quarterly installments in an aggregate annual amount equal to 1.0% of the original principal amount ($150.0 million) until March 31, 2013, with the balance payable in four equal installments during the final year of the loan. Unless terminated earlier, the senior secured revolving credit facility has a single maturity of six years. The senior secured credit facilities are also subject to mandatory prepayment under specific circumstances, including a portion of excess cash flow, a portion of the net proceeds from an initial public offering, asset sales, debt issuances and specified casualty events, each subject to various exceptions.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

The senior secured credit facilities are (i) secured by a first mortgage and lien on the real property and related personal and intellectual property of the Company and pledges of equity interests in the entities that own such properties and (ii) guaranteed by certain of the Company's subsidiaries.

In addition, the senior secured credit facilities contain certain covenants which, among other things, limit the incurrence of additional indebtedness, investments, dividends, transactions with affiliates, asset sales, acquisitions, mergers and consolidations, liens and encumbrances and other matters customarily restricted in such agreements.

At September 30, 2010, amounts outstanding under the Company's senior secured credit facilities consisted of a $423.6 million term loan and a $146.7 million delayed draw term loan. In addition, the Company had $39.9 million and $41.4 million in letters of credit outstanding under the synthetic letter of credit facility and the revolving credit facility, respectively. The weighted average interest rate of outstanding borrowings under the senior secured credit facilities was 3.4% and 3.6% for the years ended September 30, 2010 and 2009, respectively.

8 3/4% Senior Subordinated Notes

The Company, together with its wholly-owned subsidiary, IASIS Capital Corporation, a holding company with no assets or operations, as issuers, have outstanding $475.0 million aggregate principal amount of 8 3/4% notes. The 8 3/4% notes are general unsecured senior subordinated obligations and are subordinated in right of payment to all existing and future senior debt of the Company. The Company's existing domestic subsidiaries, other than certain non-guarantor subsidiaries, which include Health Choice and the Company's non-wholly owned subsidiaries, are guarantors of the 8 3/4% notes. The 8 3/4% notes are effectively subordinated to all of the issuers' and the guarantors' secured debt to the extent of the value of the assets securing the debt and are structurally subordinated to all liabilities and commitments (including trade payables and capital lease obligations) of the Company's subsidiaries that are not guarantors of the 8 3/4% notes.

Holdings Senior Paid-in-Kind Loans

IAS has outstanding unsecured Senior Paid-in-Kind ("PIK") Loans, which were used to repurchase certain preferred equity from its stockholders in fiscal 2007. The Senior PIK Loans mature June 15, 2014, and bear interest at an annual rate equal to LIBOR plus 5.25%. At September 30, 2010, the outstanding balance of the Senior PIK Loans was $389.8 million, which includes $89.8 million of interest that has accrued to the principal of these loans since the date of issuance, and is recorded in the financial statements of IAS. In June 2012, the Senior PIK Loans, which rank behind the Company's existing debt, will convert to cash-pay, at which time all accrued interest becomes payable. In the event the Senior PIK Loans are not refinanced before their maturity, it is anticipated that principle and interest will be funded by the cash flows of the Company.

4. INTEREST RATE SWAPS

Effective March 2, 2009, the Company executed interest rate swap transactions with Citibank, N.A. and Wachovia Bank, N.A., as counterparties, with notional amounts totaling $425.0 million. The arrangements with each counterparty include two interest rate swap agreements, one with a notional amount of $112.5 million maturing on February 28, 2011 and one with a notional amount of $100.0 million maturing on February 29, 2012. The Company entered into these interest rate swap arrangements to mitigate the floating interest rate risk on a portion of its outstanding variable rate debt. Under these agreements, the Company is required to make monthly fixed rate payments to the counterparties, as calculated on the applicable notional amounts, at annual fixed rates, which range from 1.5% to 2.0% depending upon the agreement. The counterparties are obligated to make monthly floating rate payments to the Company based on the one-month LIBOR rate for the same referenced notional amount.

Date Range	Total Notional Amounts
	(in thousands)
Expiring on February 28, 2011	$ 225,000
Expiring on February 29, 2012	$ 200,000

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

The Company accounts for its interest rate swaps in accordance with the provisions of FASB authoritative guidance regarding accounting for derivative instruments and hedging activities, which also includes enhanced disclosure requirements. In accordance with these provisions, the Company has designated its interest rate swaps as cash flow hedge instruments. The Company assesses the effectiveness of these cash flow hedges on a quarterly basis, with any ineffectiveness being measured using the hypothetical derivative method. The Company completed an assessment of its cash flow hedge instruments during the years ended September 30, 2010 and 2009, and determined its hedging instruments to be highly effective in all periods. Accordingly, no gain or loss resulting from hedging ineffectiveness is reflected in the Company's accompanying consolidated statements of operations.

The Company applies the provisions of FASB authoritative guidance regarding fair value measurements, which provides a single definition of fair value, establishes a framework for measuring fair value, and expands disclosures concerning fair value measurements. The Company applies these provisions to the valuation and disclosure of its interest rate swaps. This authoritative guidance establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. These tiers include: (i) Level 1, which is defined as quoted prices in active markets that can be accessed at the measurement date; (ii) Level 2, which is defined as inputs other than quoted prices in active markets that are observable, either directly or indirectly; and (iii) Level 3, which is defined as unobservable inputs resulting from the existence of little or no market data, therefore potentially requiring an entity to develop its own assumptions.

The Company determines the fair value of its interest rate swaps in a manner consistent with that used by market participants in pricing hedging instruments, which includes using a discounted cash flow analysis based upon the terms of the agreements, the impact of the one-month forward LIBOR curve and an evaluation of credit risk. Given the use of observable market assumptions and the consideration of credit risk, the Company has categorized the valuation of its interest rate swaps as Level 2.

The fair value of the Company's interest rate swaps at September 30, 2010 and 2009, reflect liability balances of $5.7 million and $4.7 million, respectively, and are included in other long-term liabilities in the accompanying consolidated balance sheets. The fair value of the Company's interest rate swaps reflects a liability because the effect of the forward LIBOR curve on future interest payments results in less interest due to the Company under the variable rate component included in the interest rate swap agreements, as compared to the amount due the Company's counterparties under the fixed interest rate component. Any change in the fair value of the Company's interest rate swaps, net of income taxes, is included in other comprehensive loss as a component of member's equity in the accompanying consolidated balance sheets.

5. COMPREHENSIVE INCOME

Comprehensive income consists of two components: net earnings and other comprehensive income. Other comprehensive income refers to revenues, expenses, gains and losses that under the FASB authoritative guidance related to accounting for comprehensive income are recorded as elements of equity, but are excluded from net earnings. The following table presents the components of comprehensive income, net of income taxes (in thousands):

	Year Ended September 30, 2010	Year Ended September 30, 2009
Net earnings	$ 74,746	$ 38,077
Change in fair value of interest rate swaps	(1,045)	(4,660)
Change in income tax benefit	392	1,734
Comprehensive income	$ 74,093	$ 35,151

The components of accumulated other comprehensive loss, net of income taxes, are as follows (in thousands):

	September 30, 2010	September 30, 2009
Fair value of interest rate swaps	$ (5,707)	$ (4,662)
Income tax benefit	2,128	1,736
Accumulated other comprehensive loss	$ (3,579)	$ (2,926)

6. DISTRIBUTION TO PARENT

During the year ended September 30, 2010, the Company distributed $125.0 million, net of a $1.8 million income tax benefit, to IAS to fund the repurchase of certain shares of its outstanding preferred stock and cancel certain vested rollover options to purchase its common stock. The holder of the IAS preferred stock is represented by an investor group led by TPG, JLL Partners and Trimaran Fund Management. The repurchase of preferred stock, which included accrued and outstanding dividends, and the cancellation of rollover options were funded by the Company's excess cash on hand.

7. ACQUISITIONS

Effective October 1, 2010, the Company purchased Brim Holdings, Inc. ("Brim") in a cash-for-stock transaction valued at $95.0 million, subject to changes in net working capital. Brim operates Wadley Regional Medical Center, a 370 licensed bed acute care hospital facility located in Texarkana, Texas, and Pikes Peak Regional Hospital, a 15 licensed bed critical access acute care hospital facility, in Woodland Park, Colorado. In connection with the Company's agreement to purchase Brim, the Company made an agent fund deposit of $97.9 million, which is included in long-term assets in the accompanying consolidated balance sheet as of September 30, 2010.

Effective February 1, 2008, IASIS Glenwood Regional Medical Center, LP, a wholly-owned subsidiary of the Company, purchased a majority ownership interest in Ouachita Community Hospital, a ten-bed surgical hospital located in West Monroe, Louisiana. The purchase price for the majority ownership interest included $16.8 million in cash.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

8. DISCONTINUED OPERATIONS

The Company's lease agreements to operate Mesa General Hospital ("Mesa General"), located in Mesa, Arizona, and Biltmore Surgery Center ("Biltmore"), located in Phoenix, Arizona, expired by their terms on July 31, 2008 and September 30, 2008, respectively. The Company discontinued services at Mesa General on May 31, 2008, and Biltmore on April 30, 2008. The operating results of Mesa General and Biltmore are classified in the Company's accompanying consolidated financial statements as discontinued operations. The following table sets forth the components of discontinued operations (in thousands):

	Year ended September 30, 2010	Year ended September 30, 2009	Year ended September 30, 2008
Total net revenue	$ 77	$ 974	$ 49,974
Operating expenses	1,814	1,256	64,648
Loss on disposal of assets	—	—	3,928
Income tax benefit	(650)	(106)	(7,327)
Loss from discontinued operations, net of income taxes	$ (1,087)	$ (176)	$ (11,275)

The Company allocated to discontinued operations interest expense of $2.5 million for the year ended September 30, 2008. The allocation of interest expense to discontinued operations was based on the ratio of disposed net assets of Mesa General and Biltmore to the sum of total net assets of the Company plus the Company's total outstanding debt.

Income taxes allocated to the discontinued operations resulted in related effective tax rates of 37.4%, 37.6% and 39.4% for the years ended September 30, 2010, 2009 and 2008, respectively.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

9. PROPERTY AND EQUIPMENT

Property and equipment consist of the following (in thousands):

	September 30, 2010	September 30, 2009
Land	$ 102,969	$ 102,499
Buildings and improvements	811,569	792,467
Equipment	556,353	500,450
	1,470,891	1,395,416
Less accumulated depreciation and amortization	(501,952)	(414,572)
	968,939	980,844
Construction-in-progress	16,352	16,509
	$ 985,291	$ 997,353

Included in property and equipment are assets acquired under capital leases of $4.7 million and $4.6 million, net of accumulated amortization of $2.6 million and $3.4 million, at September 30, 2010 and 2009, respectively.

10. GOODWILL AND OTHER INTANGIBLE ASSETS

The following table presents the changes in the carrying amount of goodwill (in thousands):

	Acute Care	Health Choice	Total
Balance at September 30, 2008	$ 774,842	$ 5,757	$ 780,599
Impairment of Florida market goodwill	(64,639)	—	(64,639)
Other acquisitions	1,960	—	1,960
Balance at September 30, 2009	712,163	5,757	717,920
Other acquisitions	323	—	323
Balance at September 30, 2010	$ 712,486	$ 5,757	$ 718,243

For the year ended September 30, 2010, as a result of the Company's annual impairment testing, the Company has determined all remaining goodwill and long-lived assets to be recoverable. For the year ended September 30, 2009, as a result of the Company's annual impairment testing, the Company recorded a $64.6 million non-cash charge ($43.2 million after tax) for the impairment of goodwill related to its Florida market.

Other intangible assets consist solely of Health Choice's contract with AHCCCS, which is amortized over a period of 15 years, the contract's estimated useful life, including assumed renewal periods. The gross intangible value originally assigned to the contract was $45.0 million. The Company expects amortization expense for this intangible asset to be $3.0 million per year over the estimated life of the contract. Amortization of this intangible asset is included in depreciation and amortization expense in the accompanying consolidated statement of operations and totaled $3.0 million for each of the years ended September 30, 2010, 2009 and 2008. Net other intangible assets included in the accompanying consolidated balance sheets at September 30, 2010 and 2009, totaled $27.0 million and $30.0 million, respectively.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

11. MEMBER'S EQUITY

Common Interests of IASIS

As of September 30, 2010, all of the common interests of IASIS were owned by IAS, its sole member.

12. STOCK OPTIONS

Management Rollover Options

In 2004, an investor group led by TPG acquired IAS, the parent company of IASIS. Prior to the acquisition, IAS maintained the IASIS 2000 Stock Option Plan. In connection with the acquisition, certain holders of 299,900 of in-the-money common stock options elected to rollover and convert such options into fully vested options to purchase an aggregate 3,263 shares of preferred stock, with an exercise price of $437.48 per share, and an aggregate 163,150 shares of common stock, with an exercise price of $8.75 per share. All of the other outstanding options under the IASIS 2000 Stock Option Plan were cancelled upon consummation of the acquisition and the plan was terminated.

In connection with the issuance of the Senior PIK Loans in fiscal 2007, the preferred rollover options were cancelled in exchange for a cash payment equal to the excess of the accreted value of the preferred stock over the exercise price of $437.48 per share.

During the year ended September 30, 2010, the Company paid $4.9 million, net of a $1.8 million income tax benefit, to cancel the 163,150 vested rollover options to purchase its common stock. The cancellation of the rollover options resulted in the Company recognizing $2.0 million in stock compensation expense during the year ended September 30, 2010.

2004 Stock Option Plan

The IAS 2004 Stock Option Plan (the "2004 Stock Option Plan") was established to promote the Company's interests by providing additional incentives to its key employees, directors, service providers and consultants. The options granted under the plan represent the right to purchase IAS common stock upon exercise. Each option shall be identified as either an incentive stock option or a non-qualified stock option. The plan was adopted by the board of directors and majority stockholder of IAS in June 2004. The maximum number of shares of IAS common stock that may be issued pursuant to options granted under the 2004 Stock Option Plan is 2,625,975. The options become exercisable over a period not to exceed five years after the date of grant, subject to earlier vesting provisions as provided for in the 2004 Stock Option Plan. All options granted under the 2004 Stock Option Plan expire no later than 10 years from the respective dates of grant. At September 30, 2010, there were 939,646 options available for grant.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

Information regarding the Company's stock option activity is summarized below:

	2004 Stock Option Plan			Rollover Options		
	Options	Option Price Per Share	Weighted Average Exercise Price	Options	Option Price Per Share	Weighted Average Exercise Price
Options outstanding at September 30, 2007	1,491,125	$ 20.00-$35.68	$ 22.09	163,150	$ 8.75	$ 8.75
Granted	1,080	$ 34.75	$ 34.75	—	—	—
Exercised	(9,600)	$ 20.00	$ 20.00	—	—	—
Cancelled/forfeited	(80,720)	$ 20.00-$35.68	$ 26.04	—	—	—
Options outstanding at September 30, 2008	1,401,885	$ 20.00-$35.68	$ 21.82	163,150	$ 8.75	$ 8.75
Granted	477,700	$ 34.75	$ 34.75	—	—	—
Exercised	—	—	—	—	—	—
Cancelled/forfeited	(119,410)	$ 20.00-$35.68	$ 31.17	—	—	—
Options outstanding at September 30, 2009	1,760,175	$ 20.00-$35.68	$ 24.70	163,150	$ 8.75	$ 8.75
Granted	45,000	$ 34.75-$45.66	$ 43.24	—	—	—
Exercised	—	—	—	—	—	—
Cancelled/forfeited	(118,846)	$ 20.00-$35.68	$ 33.38	(163,150)	8.75	8.75
Options outstanding at September 30, 2010	1,686,329	$ 20.00-$45.66	$ 24.58	—	—	—
Options exercisable at September 30, 2010	1,374,620	$ 20.00-$35.68	$ 21.98	—	$ —	$ —

The following table provides information regarding assumptions used in the fair value measurement for options granted on or after October 1, 2006.

	Options Granted On or After October 1, 2006
Risk-free interest	3.1%
Dividend yield	0.0%
Volatility	35.0%
Expected option life	7.3 years

For options granted on or after October 1, 2006, the Company used the Black-Scholes-Merton valuation model in determining the fair value measurement. Volatility for such options was estimated based on the historical stock price information of certain peer group companies for a period of time equal to the expected option life period.

13. INCOME TAXES

Income tax expense on earnings from continuing operations consists of the following (in thousands):

	Year Ended September 30, 2010	Year Ended September 30, 2009	Year Ended September 30, 2008
Current:			
Federal	$ 11,439	$ 28,220	$ 12,631
State	2,803	4,933	3,326
Deferred:			
Federal	26,750	(5,092)	15,522
State	3,723	(485)	3,846

$ 44,715	$ 27,576	$ 35,325

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

A reconciliation of the federal statutory rate to the effective income tax rate applied to earnings from continuing operations before income taxes is as follows (in thousands):

	Year Ended September 30, 2010	Year Ended September 30, 2009	Year Ended September 30, 2008
Federal statutory rate	$ 35.0%	$ 35.0%	$ 35.0%
State income taxes, net of federal income tax benefit	3.5	4.4	5.3
Non-deductible goodwill impairment charges	—	3.8	—
Other non-deductible expenses	0.2	0.8	0.5
Income attributable to non-controlling interests	(2.4)	(5.3)	(1.8)
Change in valuation allowance charged to federal income tax expense	0.4	2.4	1.1
Other items, net	0.4	0.8	0.3
Income tax expense	$ 37.1%	$ 41.9%	$ 40.4%

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

A summary of the items comprising deferred tax assets and liabilities is as follows (in thousands):

	September 30, 2010		September 30, 2009	
	Assets	Liabilities	Assets	Liabilities
Depreciation and fixed asset basis differences	$ —	$ 76,706	$ —	$ 77,743
Amortization and intangible asset basis differences	—	66,092	—	55,721
Allowance for doubtful accounts	8,424	—	30,769	—
Professional liability	15,350	—	15,561	—
Accrued expenses and other liabilities	18,617	—	14,625	—
Deductible carryforwards and credits	10,221	—	9,861	—
Other, net	6,325	—	3,841	—
Valuation allowance	(9,530)	—	(8,580)	—
Total	$ 49,407	$ 142,798	$ 66,077	$ 133,464

Net current deferred tax assets of $15.9 million and $39.0 million and net non-current deferred tax liabilities of $109.3 million and $106.4 million are included in the accompanying consolidated balance sheets at September 30, 2010 and 2009, respectively. The Company had a net income tax receivable of $6.6 million included in other current assets at September 30, 2010, and a net income tax payable of $3.4 million included in other current liabilities at September 30, 2009.

The Company and some of its subsidiaries are included in IAS' consolidated filing group for U.S. federal income tax purposes, as well as in certain state and local income tax returns that include IAS. With respect to tax returns for any taxable period in which the Company or any of its subsidiaries are included in a tax return filing with IAS, the amount of taxes to be paid by the Company is determined, subject to some adjustments, as if it and its subsidiaries filed their own tax returns excluding IAS. Member's equity in the accompanying consolidated balance sheets as of September 30, 2010 and 2009, include $35.9 million and $27.3 million, respectively, in capital contributions representing cumulative tax benefits generated by IAS and utilized by the Company in the combined tax return filings, for which IAS did not require cash settlement from the Company.

The Company maintains a valuation allowance for deferred tax assets it believes may not be utilized. The valuation allowance increased by $900,000 and $2.9 million during the years ended September 30, 2010 and 2009, respectively. The increases in the valuation allowance for both years relate to the generation of net operating loss carryforwards by certain subsidiaries excluded from the IAS consolidated federal income tax return, as well as state net operating loss carryforwards that may not ultimately be utilized.

As of September 30, 2010, federal net operating loss carryforwards were available to offset $12.1 million of future taxable income generated by subsidiaries of the Company that are excluded from the IAS consolidated return. A valuation allowance has been established against $10.3 million of these carryforwards, which expire between 2026 and 2030. State net operating losses in the amount of $149.8 million were also available, but largely offset by a valuation allowance. The state net operating loss carryforwards expire between 2018 and 2030.

The Company adopted the provisions of FASB authoritative guidance regarding accounting for uncertainty in income taxes, on October 1, 2007. As a result, the Company recorded a liability for unrecognized tax benefits of $8.1 million, and reduced deferred tax assets for federal and state net operating losses generated by uncertain tax deductions by $9.9 million as of October 1, 2007.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

The liability for unrecognized tax benefits included in the accompanying consolidated balance sheets was $11.7 million, including accrued interest of $319,000 at September 30, 2010, and $7.8 million, including accrued interest of $122,000 at September 30, 2009. An additional $6.2 million and $5.9 million of unrecognized tax benefits are reflected as a reduction to deferred tax assets for state net operating losses generated by uncertain tax deductions as of September 30, 2010 and 2009, respectively. Of the total unrecognized tax benefits at September 30, 2010, $2.3 million (net of the tax benefit on state taxes and interest) represents the amount of unrecognized tax and interest that, if recognized, would favorably impact the Company's effective income tax rate. The remainder of the unrecognized tax positions consist of items for which the uncertainty relates only to the timing of the deductibility, and state net operating loss carryforwards for which ultimate recognition would result in the creation of an offsetting valuation allowance due to the unlikelihood of future taxable income in that state.

A summary of activity of the Company's total amounts of unrecognized tax benefits is as follows (in thousands):

	Year Ended September 30, 2010	Year Ended September 30, 2009	Year Ended September 30, 2008
Unrecognized tax benefits at October 1	$ 13,638	$ 15,550	17,942
Additions resulting from tax positions taken in a prior period	—	14	937
Reductions resulting from tax positions taken in a prior period	(1,700)	(3,171)	(6,258)
Additions resulting from tax positions taken in the current period	5,596	1,965	2,929
Reductions resulting from lapse of statute of limitations	—	(720)	—
Unrecognized tax benefits at September 30	$ 17,534	$ 13,638	$ 15,550

The Company's policy is to classify interest and penalties as a component of income tax expense. Interest expense totaling $129,000 and $146,000 (net of related tax benefits) is included in income tax expense for the years ended September 30, 2010 and 2008, respectively. Income tax expense for the year ended September 30, 2009, has been reduced by $122,000 due to a decrease in accrued interest payable in connection with uncertain tax positions (net of related tax benefits).

The Company's tax years 2007 and beyond remain open to examination by U.S. federal and state taxing authorities. It is reasonably possible that unrecognized tax benefits could significantly increase or decrease within the next twelve months. However, the Company is currently unable to estimate the range of any possible change.

14. COMMITMENTS AND CONTINGENCIES

Net Revenue

The calculation of appropriate payments from the Medicare and Medicaid programs, including supplemental Medicaid reimbursement, as well as terms governing agreements with other third-party payors are complex and subject to interpretation. Final determination of amounts earned under the Medicare and Medicaid programs often occurs subsequent to the year in which services are rendered because of audits by the programs, rights of appeal and the application of numerous technical provisions. In the opinion of management, adequate provision has been made for adjustments that may result from such routine audits and appeals.

Professional, General and Workers' Compensation Liability Risks

The Company is subject to claims and legal actions in the ordinary course of business, including claims relating to patient treatment and personal injuries. To cover these types of claims, the Company maintains professional and general liability insurance in excess of self-insured retentions through a commercial insurance carrier in amounts that the Company believes to be sufficient for its operations, although, potentially, some claims may exceed the scope of coverage in effect. Plaintiffs in these matters may request punitive or other damages that may not be covered by insurance. The Company is currently not a party to any such proceedings that, in the opinion of the Company's opinion, would have a material adverse effect on the Company's business, financial condition or results of operations. The Company expenses an estimate of the costs it expects to incur under the self-insured retention exposure for professional and general liability claims using historical claims data, demographic factors, severity factors, current incident logs and other actuarial analysis. At September 30, 2010 and 2009, the Company's professional and general liability accrual for asserted and unasserted claims totaled $41.6 million and $41.7 million, respectively. The semi-annual valuations from the Company's independent actuary for professional and general liability losses resulted in a change related to estimates for prior years which decreased professional and general liability expense by $2.6 million, $1.2 million and $6.8 million during the years ended September 30, 2010, 2009 and 2008, respectively.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

The Company is subject to claims and legal actions in the ordinary course of business relative to workers' compensation. To cover these types of claims, the Company maintains workers' compensation insurance coverage with a self-insured retention. The Company accrues costs of workers' compensation claims based upon estimates derived from its claims experience. The semi-annual valuations from the Company's independent actuary for workers' compensation losses resulted in a change related to estimates for prior years which increased workers' compensation expense by $1.1 million during the year ended September 30, 2010, decreased workers' compensation expense by $526,000, during the year ended September 30, 2009, and increased workers' compensation expense by $759,000 during the year ended September 30, 2008.

Health Choice

Health Choice has entered into capitated contracts whereby the Plan provides healthcare services in exchange for fixed periodic and supplemental payments from the AHCCCS and CMS. These services are provided regardless of the actual costs incurred to provide these services. The Company receives reinsurance and other supplemental payments from AHCCCS to cover certain costs of healthcare services that exceed certain thresholds. The Company believes the capitated payments, together with reinsurance and other supplemental payments are sufficient to pay for the services Health Choice is obligated to deliver. As of September 30, 2010, the Company has provided a performance guaranty in the form of letters of credit totaling $48.3 million for the benefit of AHCCCS to support its obligations under the Health Choice contract to provide and pay for the healthcare services. The amount of the performance guaranty is generally based in part upon the membership in the Plan and the related capitation revenue paid to Health Choice.

Acquisitions

The Company has acquired and in the future may choose to acquire businesses with prior operating histories. Such businesses may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations, such as billing and reimbursement, fraud and abuse and similar anti-referral laws. Although the Company has procedures designed to conform business practices to its policies following the completion of any acquisition, there can be no assurance that the Company will not become liable for previous activities of prior owners that may later be asserted to be improper by private plaintiffs or government agencies. Although the Company generally seeks to obtain indemnification from prospective sellers covering such matters, there can be no assurance that any such matter will be covered by indemnification, or if covered, that such indemnification will be adequate to cover potential losses and fines.

Other

On March 31, 2008, the United States District Court for the District of Arizona (the "District Court") dismissed with prejudice the *qui tam* complaint against IAS. The *qui tam* action sought monetary damages and civil penalties under the federal False Claims Act ("FCA") and included allegations that certain business practices related to physician relationships and the medical necessity of certain procedures resulted in the submission of claims for reimbursement in violation of the FCA. The case dates back to March 2005 and became the subject of a subpoena by the Office of Inspector General ("OIG") in September 2005. In August 2007, the case was unsealed and the U.S. Department of Justice declined to intervene. The District Court dismissed the case from the bench at the conclusion of oral arguments on IAS' motion to dismiss. On April 21, 2008, the District Court issued a written order dismissing the case with prejudice and entering formal judgment for IAS and denying as moot IAS' motions related to the relator's misappropriation of information subject to a claim of attorney-client privilege by IAS. Both parties appealed. On August 12, 2010, United States Court of Appeals for the Ninth Circuit reversed the District Court's dismissal of the *qui tam* complaint and the District Court's denial of IAS' motions concerning relator's misappropriation of documents and ordered that the *qui tam* relator be allowed leave to file a Third Amended Complaint and for the District Court to consider IAS' motions concerning relator's misappropriation of documents. The District Court ordered the *qui tam* relator to file his Third Amended Complaint by November 22, 2010, and set a schedule for the filing of motions related to the relator's misappropriation of documents. On October 20, 2010, the *qui tam* relator filed a motion to transfer this action to the United States District Court for the Eastern District of Texas. That motion remains pending. On November 22, 2010, the relator filed his Third Amended Complaint. IAS anticipates filing a motion to dismiss the Third Amended Complaint and motions concerning the relator's misappropriation of documents. If the *qui tam* action was to be resolved in a manner unfavorable to us, it could have a material adverse effect on our business, financial condition and results of operations, including exclusion from the Medicare and Medicaid programs. In addition, we may incur material fees, costs and expenses in connection with defending the *qui tam* action.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

15. LEASES

The Company leases various buildings, office space and equipment under capital and operating lease agreements. These leases expire at various times and have various renewal options.

The Company is a party to an amended facility lease with a 15 year term that expires in January 31, 2019, and includes options to extend the term of the lease through January 31, 2039. The annual cost under this agreement is $6.4 million, payable in monthly installments. Future minimum lease payments at September 30, 2010, are as follows (in thousands):

	Capital Leases	Operating Leases
2011	$ 933	$ 28,525
2012	652	25,766
2013	562	24,254
2014	562	20,769
2015	562	17,713
Thereafter	4,679	57,380
Total minimum lease payments	$ 7,950	$ 174,407
Amount representing interest (at rates ranging from 4.4% to 11.0%)	3,374	
Present value of net minimum lease payments (including $649 classified as current)	$ 4,576	

Aggregate future minimum rentals to be received under noncancellable subleases as of September 30, 2010, were $6.8 million.

16. RETIREMENT PLANS

Substantially all employees who are employed by the Company or its subsidiaries, upon qualification, are eligible to participate in a defined contribution 401(k) plan (the "Retirement Plan"). Employees who elect to participate generally make contributions from 1% to 20% of their eligible compensation, and the Company matches, at its discretion, such contributions up to a maximum percentage. Generally, employees immediately vest 100% in their own contributions and vest in the employer portion of contributions over a period not to exceed five years. Company contributions to the Retirement Plan were $6.7 million, $5.7 million and $5.0 million for the years ended September 30, 2010, 2009 and 2008, respectively.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

SEGMENT AND GEOGRAPHIC INFORMATION

The Company's acute care hospitals and related healthcare businesses are similar in their activities and the economic environments in which they operate (i.e., urban and suburban markets). Accordingly, the Company's reportable operating segments consist of (1) acute care hospitals and related healthcare businesses, collectively, and (2) Health Choice. The following is a financial summary by business segment for the periods indicated (in thousands):

	For the Year Ended September 30, 2010			
	Acute Care	Health Choice	Eliminations	Consolidated
Acute care revenue	$ 1,729,344	$ —	$ —	$ 1,729,344
Premium revenue	—	792,062	—	792,062
Revenue between segments	11,805	—	(11,805)	—
Total net revenue	1,741,149	792,062	(11,805)	2,521,406
Salaries and benefits (excludes stock compensation)	664,667	19,149	—	683,816
Supplies	266,347	198	—	266,545
Medical claims	—	690,456	(11,805)	678,651
Other operating expenses	339,304	24,612	—	363,916
Provision for bad debts	197,680	—	—	197,680
Rentals and leases	38,409	1,546	—	39,955
Adjusted EBITDA(1)	234,742	56,101	—	290,843
Interest expense, net	66,810	—	—	66,810
Depreciation and amortization	92,544	3,562	—	96,106
Stock compensation	2,487	—	—	2,487
Management fees	5,000	—	—	5,000
Earnings from continuing operations before gain on disposal of assets and income taxes	67,901	52,539	—	120,440
Gain on disposal of assets, net	108	—	—	108
Earnings from continuing operations before income taxes	$ 68,009	$ 52,539	$ —	$ 120,548
Segment assets	$ 2,032,246	$ 320,948		$ 2,353,194
Capital expenditures	$ 80,966	$ 302		$ 81,268
Goodwill	$ 712,486	$ 5,757		$ 718,243

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

	For the Year Ended September 30, 2009			
	Acute Care	Health Choice	Eliminations	Consolidated
Acute care revenue	$ 1,662,469	$ —	$ —	$ 1,662,469
Premium revenue	—	699,503	—	699,503
Revenue between segments	9,316	—	(9,316)	—
Total net revenue	1,671,785	699,503	(9,316)	2,361,972
Salaries and benefits (excludes stock compensation)	641,332	19,028	—	660,360
Supplies	250,310	263	—	250,573
Medical claims	—	602,076	(9,316)	592,760
Other operating expenses	302,804	22,931	—	325,735
Provision for bad debts	192,563	—	—	192,563
Rentals and leases	37,563	1,564	—	39,127
Hurricane-related property damage	938	—	—	938
Adjusted EBITDA(1)	246,275	53,641	—	299,916
Interest expense, net	67,890	—	—	67,890
Depreciation and amortization	94,014	3,448	—	97,462
Stock compensation	561	—	—	561
Impairment of goodwill	64,639	—	—	64,639
Management fees	5,000	—	—	5,000
Earnings from continuing operations before gain (loss) on disposal of assets and income taxes	14,171	50,193	—	64,364
Gain (loss) on disposal of assets, net	1,616	(151)	—	1,465
Earnings from continuing operations before income taxes	$ 15,787	$ 50,042	$ —	$ 65,829
Segment assets	$ 2,109,422	$ 247,782		$ 2,357,204
Capital expenditures	$ 86,875	$ 845		$ 87,720
Goodwill	$ 712,163	$ 5,757		$ 717,920

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

	For the Year Ended September 30, 2008			
	Acute Care	Health Choice	Eliminations	Consolidated
Acute care revenue	$ 1,523,790	$ —	$ —	$ 1,523,790
Premium revenue	—	541,746	—	541,746
Revenue between segments	9,594	—	(9,594)	—
Total net revenue	1,533,384	541,746	(9,594)	2,065,536
Salaries and benefits	614,442	17,667	—	632,109
Supplies	231,001	258	—	231,259
Medical claims	—	461,649	(9,594)	452,055
Other operating expenses	264,814	18,309	—	283,123
Provision for bad debts	161,936	—	—	161,936
Rentals and leases	35,466	1,167	—	36,633
Hurricane-related property damage	3,589	—	—	3,589
Adjusted EBITDA(1)	222,136	42,696	—	264,832
Interest expense, net	75,665	—	—	75,665
Depreciation and amortization	93,003	3,738	—	96,741
Management fees	5,000	—	—	5,000
Earnings from continuing operations before loss on disposal of assets and income taxes	48,468	38,958	—	87,426
Loss on disposal of assets, net	(75)	—	—	(75)
Earnings from continuing operations before income taxes	$ 48,393	$ 38,958	$ —	$ 87,351
Segment assets	$ 2,123,069	$ 185,078		$ 2,308,147
Capital expenditures	$ 136,425	$ 990		$ 137,415
Goodwill	$ 774,842	$ 5,757		$ 780,599

(1) Adjusted EBITDA represents net earnings from continuing operations before interest expense, income tax expense, depreciation and amortization, stock compensation, impairment of goodwill, gain (loss) on disposal of assets and management fees. Management fees represent monitoring and advisory fees paid to TPG, the Company's majority financial sponsor, and certain other members of IASIS Investment LLC. Management routinely calculates and communicates adjusted EBITDA and believes that it is useful to investors because it is commonly used as an analytical indicator within the healthcare industry to evaluate hospital performance, allocate resources and measure leverage capacity and debt service ability. In addition, the Company uses adjusted EBITDA as a measure of performance for its business segments and for incentive compensation purposes. Adjusted EBITDA should not be considered as a measure of financial performance under GAAP, and the items excluded from adjusted EBITDA are significant components in understanding and assessing financial performance. Adjusted EBITDA should not be considered in isolation or as an alternative to net earnings, cash flows generated by operating, investing, or financing activities or other financial statement data presented in the consolidated financial statements as an indicator of financial performance or liquidity. Adjusted EBITDA, as presented, differs from what is defined under the Company's senior secured credit facilities and may not be comparable to similarly titled measures of other companies.

18. ACCRUED EXPENSES AND OTHER CURRENT LIABILITIES

A summary of accrued expenses and other current liabilities consists of the following (in thousands):

	September 30, 2010	September 30, 2009
Employee health insurance payable	$ 8,265	$ 9,183
Accrued property taxes	11,645	10,496

Health Choice program settlements payable	56,487	13,720
Other	30,217	32,302
	$ 106,614	$ 65,701

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

19. ALLOWANCE FOR DOUBTFUL ACCOUNTS

A summary of activity in the Company's allowance for doubtful accounts is as follows (in thousands):

	Beginning Balance	Provision for Bad Debts	Other (1)	Accounts Written Off, Net of Recoveries	Ending Balance
Year Ended September 30, 2008	$ 97,829	161,936	6,782	(158,092)	$ 108,455
Year Ended September 30, 2009	$ 108,455	192,563	641	(175,527)	$ 126,132
Year Ended September 30, 2010	$ 126,132	197,680	—	(198,406)	$ 125,406

(1) Represents provision for bad debts recorded at facilities which are now included in discontinued operations.

The provision for bad debts increased $30.6 million during the year ended September 30, 2009, primarily as a result of increases in self-pay volume and revenue.

20. IMPACT OF HURRICANE ACTIVITY

The Medical Center of Southeast Texas, the Company's hospital located in Port Arthur, Texas, was damaged during Hurricane Ike in September 2008. The hospital sustained roof and water intrusion damage. The majority of services at the hospital became operational during October of 2008. The Company's results from operations include hurricane-related property damage of $938,000 and $3.6 million for the years ended September 30, 2009 and 2008, respectively.

21. SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION

The 8 ³/₄% notes described in Note 3 are fully and unconditionally guaranteed on a joint and several basis by all of the Company's existing domestic subsidiaries, other than non-guarantor subsidiaries which include Health Choice and the Company's non-wholly owned subsidiaries.

Effective February 1, 2008, Salt Lake Regional Medical Center, LP ("Salt Lake") sold limited partner units representing, in the aggregate, a 2.2% ownership interest in Salt Lake. As a result, the Company's ownership interest in Salt Lake was reduced to 97.8%. Salt Lake is included in the condensed consolidating financial statements as a subsidiary non-guarantor.

Summarized condensed consolidating balance sheets at September 30, 2010 and 2009, condensed consolidating statements of operations and cash flows for the years ended September 30, 2010, 2009 and 2008, for the Company, segregating the parent company issuer, the subsidiary guarantors, the subsidiary non-guarantors and eliminations, are found below. Prior year amounts have been reclassified to conform to the current year presentation.

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

IASIS Healthcare LLC

Condensed Consolidating Balance Sheet

September 30, 2010

(in thousands)

	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Assets					
Current assets:					
Cash and cash equivalents	$ —	$ 143,599	$ 912	$ —	$ 144,511
Accounts receivable, net	—	81,649	127,524	—	209,173
Inventories	—	22,793	31,049	—	53,842
Deferred income taxes	15,881	—	—	—	15,881
Prepaid expenses and other current assets	—	23,577	41,763	—	65,340
Total current assets	15,881	271,618	201,248	—	488,747
Property and equipment, net	—	351,265	634,026	—	985,291
Intercompany	—	(297,257)	297,257	—	—
Net investment in and advances to subsidiaries	1,823,973	—	—	(1,823,973)	—
Goodwill	17,331	65,504	635,408	—	718,243
Other intangible assets, net	—	—	27,000	—	27,000
Deposit for acquisition	—	97,891	—	—	97,891
Other assets, net	12,018	17,967	6,037	—	36,022
Total assets	$ 1,869,203	$ 506,988	$ 1,800,976	$ (1,823,973)	$ 2,353,194
Liabilities and Equity					
Current liabilities:					
Accounts payable	$ —	$ 32,400	$ 46,531	$ —	$ 78,931
Salaries and benefits payable	—	19,916	18,194	—	38,110
Accrued interest payable	12,536	(3,237)	3,237	—	12,536
Medical claims payable	—	—	111,373	—	111,373
Other accrued expenses and other current liabilities	—	32,326	74,288	—	106,614
Current portion of long-term debt and capital lease obligations	5,890	801	20,570	(20,570)	6,691
Total current liabilities	18,426	82,206	274,193	(20,570)	354,255
Long-term debt and capital lease obligations	1,039,370	5,517	547,170	(547,170)	1,044,887
Deferred income taxes	109,272	—	—	—	109,272
Other long-term liabilities	—	59,527	635	—	60,162
Total liabilities	1,167,068	147,250	821,998	(567,740)	1,568,576
Non-controlling interests with redemption rights	—	72,112	—	—	72,112
Equity:					
Member's equity	702,135	277,255	978,978	(1,256,233)	702,135
Non-controlling interests	—	10,371	—	—	10,371

Total equity	702,135	287,626	978,978	(1,256,233)	712,506
Total liabilities and equity	$ 1,869,203	$ 506,988	$ 1,800,976	$ (1,823,973)	$ 2,353,194

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

IASIS Healthcare LLC

Condensed Consolidating Balance Sheet

September 30, 2009

(in thousands)

	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Assets					
Current assets:					
Cash and cash equivalents	$ —	$ 206,331	$ 197	$ —	$ 206,528
Accounts receivable, net	—	90,883	139,315	—	230,198
Inventories	—	22,405	28,087	—	50,492
Deferred income taxes	39,038	—	—	—	39,038
Prepaid expenses and other current assets	—	15,521	33,932	—	49,453
Total current assets	39,038	335,140	201,531	—	575,709
Property and equipment, net	—	347,657	649,696	—	997,353
Intercompany	—	(243,956)	243,956	—	—
Net investment in and advances to subsidiaries	1,851,008	—	—	(1,851,008)	—
Goodwill	17,331	67,445	633,144	—	717,920
Other intangible assets, net	—	—	30,000	—	30,000
Other assets, net	15,182	16,780	4,260	—	36,222
Total assets	$ 1,922,559	$ 523,066	$ 1,762,587	$ (1,851,008)	$ 2,357,204
Liabilities and Equity					
Current liabilities:					
Accounts payable	$ —	$ 25,269	$ 43,283	$ —	$ 68,552
Salaries and benefits payable	—	25,008	17,540	—	42,548
Accrued interest payable	12,511	(3,239)	3,239	—	12,511
Medical claims payable	—	—	113,519	—	113,519
Other accrued expenses and other current liabilities	—	39,559	26,142	—	65,701
Current portion of long-term debt and capital lease obligations	7,431	935	20,614	(20,614)	8,366
Total current liabilities	19,942	87,532	224,337	(20,614)	311,197
Long-term debt and capital lease obligations	1,045,260	6,211	566,980	(566,980)	1,051,471
Deferred income taxes	106,425	—	—	—	106,425
Other long-term liabilities	—	53,577	645	—	54,222
Total liabilities	1,171,627	147,320	791,962	(587,594)	1,523,315
Non-controlling interests with redemption rights	—	72,527	—	—	72,527
Equity:					
Member's equity	750,932	292,789	970,625	(1,263,414)	750,932
Non-controlling interests	—	10,430	—	—	10,430

Total equity	750,932	303,219	970,625	(1,263,414)	761,362
Total liabilities and equity	$ 1,922,559	$ 523,066	$ 1,762,587	$ (1,851,008)	$ 2,357,204

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

IASIS Healthcare LLC

Condensed Consolidating Statement of Operations

(in thousands)

	For the Year Ended September 30, 2010				
	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Net revenue:					
Acute care revenue	$ —	$ 685,244	$ 1,055,905	$ (11,805)	$ 1,729,344
Premium revenue	—	—	792,062	—	792,062
Total net revenue	—	685,244	1,847,967	(11,805)	2,521,406
Costs and expenses:					
Salaries and benefits	—	351,792	334,511	—	686,303
Supplies	—	111,777	154,768	—	266,545
Medical claims	—	—	690,456	(11,805)	678,651
Other operating expenses	—	121,522	242,394	—	363,916
Provision for bad debts	—	90,564	107,116	—	197,680
Rentals and leases	—	16,736	23,219	—	39,955
Interest expense, net	66,810	—	41,270	(41,270)	66,810
Depreciation and amortization	—	40,762	55,344	—	96,106
Management fees	5,000	(22,831)	22,831	—	5,000
Equity in earnings of affiliates	(139,647)	—	—	139,647	—
Total costs and expenses	(67,837)	710,322	1,671,909	86,572	2,400,966
Earnings (loss) from continuing operations before gain (loss) on disposal of assets and income taxes	67,837	(25,078)	176,058	(98,377)	120,440
Gain (loss) on disposal of assets, net	—	273	(165)	—	108
Earnings (loss) from continuing operations before income taxes	67,837	(24,805)	175,893	(98,377)	120,548
Income tax expense	43,290	—	1,425	—	44,715
Net earnings (loss) from continuing operations	24,547	(24,805)	174,468	(98,377)	75,833
Earnings (loss) from discontinued operations, net of income taxes	650	(1,731)	(6)	—	(1,087)
Net earnings (loss)	25,197	(26,536)	174,462	(98,377)	74,746
Net earnings attributable to non-controlling interests	—	(8,279)	—	—	(8,279)
Net earnings (loss) attributable to IASIS Healthcare LLC	$ 25,197	$ (34,815)	$ 174,462	$ (98,377)	$ 66,467

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

IASIS Healthcare LLC

Condensed Consolidating Statement of Operations

(in thousands)

	For the Year Ended September 30, 2009				
	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Net revenue:					
Acute care revenue	$ —	$ 656,913	$ 1,014,872	$ (9,316)	$ 1,662,469
Premium revenue	—	—	699,503	—	699,503
Total net revenue	—	656,913	1,714,375	(9,316)	2,361,972
Costs and expenses:					
Salaries and benefits	—	336,687	324,234	—	660,921
Supplies	—	103,587	146,986	—	250,573
Medical claims	—	—	602,076	(9,316)	592,760
Other operating expenses	—	121,597	204,138	—	325,735
Provision for bad debts	—	94,662	97,901	—	192,563
Rentals and leases	—	16,138	22,989	—	39,127
Interest expense, net	67,890	—	43,063	(43,063)	67,890
Depreciation and amortization	—	42,492	54,970	—	97,462
Management fees	5,000	(21,862)	21,862	—	5,000
Impairment of goodwill	—	64,639	—	—	64,639
Hurricane-related property damage	—	—	938	—	938
Equity in earnings of affiliates	(84,640)	—	—	84,640	—
Total costs and expenses	(11,750)	757,940	1,519,157	32,261	2,297,608
Earnings (loss) from continuing operations before gain (loss) on disposal of assets and income taxes	11,750	(101,027)	195,218	(41,577)	64,364
Gain (loss) on disposal of assets, net	—	1,598	(133)	—	1,465
Earnings (loss) from continuing operations before income taxes	11,750	(99,429)	195,085	(41,577)	65,829
Income tax expense	26,829	—	747	—	27,576
Net earnings (loss) from continuing operations	(15,079)	(99,429)	194,338	(41,577)	38,253
Earnings (loss) from discontinued operations, net of income taxes	106	(310)	28	—	(176)
Net earnings (loss)	(14,973)	(99,739)	194,366	(41,577)	38,077
Net earnings attributable to non-controlling interests	—	(9,987)	—	—	(9,987)
Net earnings (loss) attributable to	$ (14,973)	$ (109,726)	$ 194,366	$ (41,577)	$ 28,090

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

IASIS Healthcare LLC

Condensed Consolidating Statement of Operations

(in thousands)

	For the Year Ended September 30, 2008				
	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Net revenue:					
Acute care revenue	$ —	$ 637,773	$ 895,611	$ (9,594)	$ 1,523,790
Premium revenue	—	—	541,746	—	541,746
Total net revenue	—	637,773	1,437,357	(9,594)	2,065,536
Costs and expenses:					
Salaries and benefits	—	319,243	312,866	—	632,109
Supplies	—	104,698	126,561	—	231,259
Medical claims	—	—	461,649	(9,594)	452,055
Other operating expenses	—	111,781	171,342	—	283,123
Provision for bad debts	—	80,139	81,797	—	161,936
Rentals and leases	—	14,891	21,742	—	36,633
Interest expense, net	75,665	—	54,716	(54,716)	75,665
Depreciation and amortization	—	42,721	54,020	—	96,741
Management fees	5,000	(19,337)	19,337	—	5,000
Hurricane-related property damage	—	—	3,589	—	3,589
Equity in earnings of affiliates	(91,476)	—	—	91,476	—
Total costs and expenses	(10,811)	654,136	1,307,619	27,166	1,978,110
Earnings (loss) from continuing operations before gain (loss) on disposal of assets and income taxes	10,811	(16,363)	129,738	(36,760)	87,426
Gain (loss) on disposal of assets, net	—	(81)	6	—	(75)
Earnings (loss) from continuing operations before income taxes	10,811	(16,444)	129,744	(36,760)	87,351
Income tax expense	34,996	—	329	—	35,325
Net earnings (loss) from continuing operations	(24,185)	(16,444)	129,415	(36,760)	52,026
Earnings (loss) from discontinued operations, net of income taxes	5,783	(12,257)	(4,801)	—	(11,275)
Net earnings (loss)	(18,402)	(28,701)	124,614	(36,760)	40,751
Net earnings attributable to non-controlling interests	—	(4,437)	—	—	(4,437)
Net earnings (loss) attributable to IASIS Healthcare LLC	$ (18,402)	$ (33,138)	$ 124,614	$ (36,760)	$ 36,314

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

IASIS Healthcare LLC

Condensed Consolidating Statement of Cash Flows

(in thousands)

	For the Year Ended September 30, 2010				
	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Cash flows from operating activities					
Net earnings (loss)	$ 25,197	$ (26,536)	$ 174,462	$ (98,377)	$ 74,746
Adjustments to reconcile net earnings (loss) to net cash provided by (used in) operating activities:					
Depreciation and amortization	—	40,762	55,344	—	96,106
Amortization of loan costs	3,163	—	—	—	3,163
Stock compensation costs	2,487	—	—	—	2,487
Deferred income taxes	30,473	—	—	—	30,473
Income tax benefit from stock compensation	(1,770)	—	—	—	(1,770)
Income tax benefit from parent company interest	8,554	—	—	—	8,554
Loss (gain) on disposal of assets	—	(273)	165	—	(108)
Loss (earnings) from discontinued operations	(650)	1,731	6	—	1,087
Equity in earnings of affiliates	(139,647)	—	—	139,647	—
Changes in operating assets and liabilities, net of the effect of acquisitions and dispositions:					
Accounts receivable, net	—	9,488	11,791	—	21,279
Inventories, prepaid expenses and other current assets	—	(8,423)	(10,804)	—	(19,227)
Accounts payable, other accrued expenses and other accrued liabilities	1,795	11,108	29,054	—	41,957
Net cash provided by (used in) operating activities — continuing operations	(70,398)	27,857	260,018	41,270	258,747
Net cash used in operating activities — discontinued operations	(216)	(1,292)	—	—	(1,508)
Net cash provided by (used in) operating activities	(70,614)	26,565	260,018	41,270	257,239
Cash flows from investing activities					
Purchases of property and equipment	—	(44,246)	(37,022)	—	(81,268)
Cash paid for acquisitions	—	(97,891)	(414)	—	(98,305)
Proceeds from sale of assets	—	20	37	—	57
Change in other assets	—	4,247	(1,204)	—	3,043
Net cash used in investing activities	—	(137,870)	(38,603)	—	(176,473)
Cash flows from financing activities					
Payment of debt and capital lease obligations	(7,521)	(43)	(814)	—	(8,378)
Distribution to parent company in connection with the repurchase of equity, net	(124,962)	—	—	—	(124,962)
Distributions to non-controlling interests	—	(194)	(8,790)	—	(8,984)
Costs paid for repurchase of non-controlling interests	—	(459)	—	—	(459)

Change in intercompany balances with affiliates, net	49,269	49,269	(211,096)	(41,270)	—
Net cash provided by (used in) financing activities	70,614	48,573	(220,700)	(41,270)	(142,783)
Change in cash and cash equivalents	—	(62,732)	715	—	(62,017)
Cash and cash equivalents at beginning of period	—	206,331	197	—	206,528
Cash and cash equivalents at end of period	$ —	$ 143,599	$ 912	$ —	$ 144,511

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

IASIS Healthcare LLC

Condensed Consolidating Statement of Cash Flows

(in thousands)

	For the Year Ended September 30, 2009				
	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Cash flows from operating activities					
Net earnings (loss)	$ (14,973)	$ (99,739)	$ 194,366	$ (41,577)	$ 38,077
Adjustments to reconcile net earnings (loss) to net cash provided by (used in) operating activities:					
Loss (earnings) from discontinued operations	(106)	310	(28)	—	176
Depreciation and amortization	—	42,492	54,970	—	97,462
Amortization of loan costs	3,029	—	—	—	3,029
Income tax benefit from parent company interest	27,344	—	—	—	27,344
Deferred income taxes	(5,572)	—	—	—	(5,572)
Loss (gain) on disposal of assets	—	(1,598)	133	—	(1,465)
Impairment of goodwill	—	64,639	—	—	64,639
Hurricane-related property damage	—	—	938	—	938
Stock compensation costs	561	—	—	—	561
Equity in earnings of affiliates	(84,640)	—	—	84,640	—
Changes in operating assets and liabilities, net of the effect of acquisitions and dispositions:					
Accounts receivable, net	—	9,319	(16,621)	—	(7,302)
Inventories, prepaid expenses and other current assets	—	1,179	5,549	—	6,728
Accounts payable, other accrued expenses and other accrued liabilities	51	30,220	15,613	—	45,884
Net cash provided by (used in) operating activities — continuing operations	(74,306)	46,822	254,920	43,063	270,499
Net cash provided by (used in) operating activities — discontinued operations	(106)	1,739	(161)	—	1,472
Net cash provided by (used in) operating activities	(74,412)	48,561	254,759	43,063	271,971
Cash flows from investing activities					
Purchases of property and equipment	—	(24,965)	(62,755)	—	(87,720)
Cash paid for acquisitions	—	(1,941)	—	—	(1,941)
Proceeds from sale of assets	—	3,018	2,234	—	5,252
Change in other assets	—	(654)	2,477	—	1,823
Net cash used in investing activities — continuing operations	—	(24,542)	(58,044)	—	(82,586)
Net cash provided by investing activities — discontinued operations	—	10	—	—	10
Net cash used in investing activities	—	(24,532)	(58,044)	—	(82,576)
Cash flows from financing activities					

Payment of debt and capital lease obligations	(55,015)	—	(461)	—	(55,476)
Distributions to non-controlling interests	—	(269)	(6,481)	—	(6,750)
Costs paid for repurchase of non-controlling interests	—	(1,379)	—	—	(1,379)
Change in intercompany balances with affiliates, net	129,427	103,614	(189,978)	(43,063)	—
Net cash provided by (used in) financing activities	74,412	101,966	(196,920)	(43,063)	(63,605)
Change in cash and cash equivalents	—	125,995	(205)	—	125,790
Cash and cash equivalents at beginning of period	—	80,336	402	—	80,738
Cash and cash equivalents at end of period	$ —	$ 206,331	$ 197	$ —	$ 206,528

IASIS HEALTHCARE LLC
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)

IASIS Healthcare LLC

Condensed Consolidating Statement of Cash Flows

(in thousands)

	For the Year Ended September 30, 2008				
	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Cash flows from operating activities					
Net earnings (loss)	$ (18,402)	$ (28,701)	$ 124,614	$ (36,760)	$ 40,751
Adjustments to reconcile net earnings (loss) to net cash provided by (used in) operating activities:					
Loss (earnings) from discontinued operations	(5,783)	12,257	4,801	—	11,275
Depreciation and amortization	—	42,721	54,020	—	96,741
Amortization of loan costs	2,913	—	—	—	2,913
Deferred income taxes	19,368	—	—	—	19,368
Loss (gain) on disposal of assets	—	81	(6)	—	75
Hurricane-related property damage	—	—	3,589	—	3,589
Equity in earnings of affiliates	(91,476)	—	—	91,476	—
Changes in operating assets and liabilities, net of the effect of acquisitions and dispositions:					
Accounts receivable, net	—	23,114	(5,983)	—	17,131
Inventories, prepaid expenses and other current assets	—	2,328	(23,689)	—	(21,361)
Accounts payable, other accrued expenses and other accrued liabilities	(10,947)	(13,040)	(5,432)	—	(29,419)
Net cash provided by (used in) operating activities — continuing operations	(104,327)	38,760	151,914	54,716	141,063
Net cash provided by (used in) operating activities — discontinued operations	5,783	(884)	(2,586)	—	2,313
Net cash provided by (used in) operating activities	(98,544)	37,876	149,328	54,716	143,376
Cash flows from investing activities					
Purchases of property and equipment	—	(45,109)	(92,306)	—	(137,415)
Cash paid for acquisitions	—	(16,799)	(22)	—	(16,821)
Proceeds from sale of assets	—	94	266	—	360
Change in other assets	—	5,226	(613)	—	4,613
Net cash used in investing activities — continuing operations	—	(56,588)	(92,675)	—	(149,263)
Net cash provided by (used in) investing activities — discontinued operations	—	(1,040)	23	—	(1,017)
Net cash used in investing activities	—	(57,628)	(92,652)	—	(150,280)
Cash flows from financing activities					
Payment of debt and capital lease obligations	(303,190)	(849)	(2,572)	—	(306,611)
Proceeds from debt borrowings	384,978	—	—	—	384,978
Distributions to non-controlling interests	—	(172)	(5,313)	—	(5,485)

Proceeds received from sale of non-controlling interests, net	—	15,070	—	—	15,070
Other	192	—	—	—	192
Change in intercompany balances with affiliates, net	16,564	90,593	(52,441)	(54,716)	—
Net cash provided by (used in) financing activities — continuing operations	98,544	104,642	(60,326)	(54,716)	88,144
Net cash used in financing activities — discontinued operations	—	(502)	—	—	(502)
Net cash provided by (used in) financing activities	98,544	104,140	(60,326)	(54,716)	87,642
Change in cash and cash equivalents	—	84,388	(3,650)	—	80,738
Cash and cash equivalents at beginning of period	—	(4,052)	4,052	—	—
Cash and cash equivalents at end of period	$ —	$ 80,336	$ 402	$ —	$ 80,738

Requirement #18

REQUIREMENT #18

Submit the organization's plan for meeting the Performance Bond or Bond Substitute requirement including the type of bond to be posted, source of funding and timeline for meeting the requirement.

Health Choice Arizona (HCA) currently meets the AHCCCS performance bond requirement for its acute care health plan with an AHCCCS approved irrevocable letter of credit (LOC) through Bank of America (BOA). HCA established this LOC with BOA in conjunction with its parent company, IASIS Healthcare Corporation (IASIS), and has a long-running relationship with BOA that will ensure HCA can continue to meet its current performance bond requirements as well as any new requirements based on ALTCS Geographic Service Areas (GSA) awarded through this RFP process.

HCA will use a new LOC issued through BOA, or an acceptable substitute agreed to by AHCCCS, to meet the performance bond requirement for new GSAs awarded through this RFP. HCA will, within 30 days of receiving notification from AHCCCS of an ALTCS award, secure a new LOC or acceptable substitute to meet the requirements of *Section D, Paragraph 46, Performance Bond and Bond Substitute and Paragraph 47, Amount of Performance Bond* of the ALTCS RFP. The value of the new LOC or acceptable substitute will be equal to at least 80% of the total capitation payments HCA expects to receive in the month of October 2011 (or another amount specified by AHCCCS). Currently, this amount is contingent on several unknown factors (i.e. final awarded capitation rates and GSAs, enrollment changes, etc) but based on HCA's projections, the total value of the performance bond needed for all GSAs included in this bid is approximately $41,000,000. The estimate by GSA is based on the following assumptions:

GSA	Max Enrollment	Estimated Capitation (monthly)	80% Capitation
42	810	$2,700,000	$2,160,000
44	1,492	$4,300,000	$3,440,000
50	4,337	$16,000,000	$12,800,000
52	8,500	$28,400,000	$22,720,000
Total	15,139	$51,400,000	$41,120,000

HCA's and IASIS' ability to obtain a new LOC or acceptable substitute that meets the additional performance bond requirements for an ALTCS contract has already been addressed with BOA. To substantiate HCA's commitment to fulfilling these RFP requirements, following is a letter from the IASIS Chief Financial Officer stating the Company's ability and intent to ensure that Health Choice's performance bond is in place and properly funded according to the AHCCCS performance bond requirements in *AHCCCS RFP YH12-0001.*

IASIS HEALTHCARE | Dover Centre • 117 Seaboard Lane • Building E • Franklin, Tennessee 37067
Phone: 615-844-2747 • Facsimile: 615-846-3006 • www.iasishealthcare.com

March 28, 2011

Mr. Tom Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson
Phoenix, AZ 85034-2246

RE: Health Choice Arizona
Arizona Long Term Care System Request for Proposals
YH12-0001

Dear Mr. Betlach:

First, I would like to express our appreciation for the opportunity to submit an offer to the Arizona Health Care Cost Containment System ("AHCCCS") to expand our business relationship to include the ALTCS program. Working together, we believe that both of our organizations will continue to enjoy success and we are excited about this opportunity.

The primary reason for my letter is to provide you and your staff with an understanding of the liquidity and capital resources of Health Choice Arizona's parent company, IASIS Healthcare Corporation (the "Company") and to highlight our banking relationship and related capital access. The Company's support to Health Choice Arizona comes in many forms, including access to capital. The Company's total capitalization at December 31, 2010 was approximately $1.8 billion. In April 2007, the Company secured the refinancing of its senior bank credit facility with a syndication of various lenders led by Bank of America. The new credit facility provides for a $225 million, five year revolving line of credit, which includes a $100 million sub-limit for letters of credit (the "Revolver LC Facility") that may be issued by the Company, plus a $40 million funded synthetic letter of credit facility (the "Synthetic LC Facility"). As of the date of this letter, the Company had issued $41.7 million in letters of credit under the Revolver LC Facility and $39.9 million under the Synthetic LC Facility, of which approximately $48.3 million have been issued in favor of, and previously approved by, AHCCCS. Through its available liquidity under the revolving line of credit, which is undrawn as of the date of this letter, and the remaining capacity under the Revolver LC Facility and additional access to the surety bond markets, the Company has the ability to provide Health Choice Arizona with letters of credit and/or other financial guaranty instruments in an amount sufficient to meet the ALTCS performance bond requirements detailed in the response to the current AHCCCS Request for Proposal.

In addition to the available credit described above, the company maintains a sufficient cash balance from which $5,000,000 will be available to Health Choice to meet the initial capitalization requirement within 30 days of a contract award from AHCCCS. Presently, the Company has a cash balance in excess of $150 million.

If you have any questions feel free to contact me at (615) 467-1203.

Sincerely,

John Doyle
Chief Financial Officer

Requirement #19

REQUIREMENT #19

Submit the organization's plan for meeting the minimum capitalization requirement.

Health Choice Arizona (HCA) is submitting a bid for the following GSAs: 42, 44, 50, and 52. Since there are several possible scenarios in which HCA is awarded GSAs that will require it to meet the maximum initial capitalization amount of $5,000,000, IASIS is prepared to provide that amount within 30 days of HCA receiving an award. The following letter from IASIS' Chief Financial Officer illustrates that IASIS has the necessary cash balance and is prepared to use it for this purpose.

IASIS HEALTHCARE | Dover Centre • 117 Seaboard Lane • Building E • Franklin, Tennessee 37067
Phone: 615-844-2747 • Facsimile: 615-846-3006 • www.iasishealthcare.com

March 28, 2011

Mr. Tom Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson
Phoenix, AZ 85034-2246

RE: Health Choice Arizona
Arizona Long Term Care System Request for Proposals
YH12-0001

Dear Mr. Betlach:

First, I would like to express our appreciation for the opportunity to submit an offer to the Arizona Health Care Cost Containment System ("AHCCCS") to expand our business relationship to include the ALTCS program. Working together, we believe that both of our organizations will continue to enjoy success and we are excited about this opportunity.

The primary reason for my letter is to provide you and your staff with an understanding of the liquidity and capital resources of Health Choice Arizona's parent company, IASIS Healthcare Corporation (the "Company") and to highlight our banking relationship and related capital access. The Company's support to Health Choice Arizona comes in many forms, including access to capital. The Company's total capitalization at December 31, 2010 was approximately $1.8 billion. In April 2007, the Company secured the refinancing of its senior bank credit facility with a syndication of various lenders led by Bank of America. The new credit facility provides for a $225 million, five year revolving line of credit, which includes a $100 million sub-limit for letters of credit (the "Revolver LC Facility") that may be issued by the Company, plus a $40 million funded synthetic letter of credit facility (the "Synthetic LC Facility"). As of the date of this letter, the Company had issued $41.7 million in letters of credit under the Revolver LC Facility and $39.9 million under the Synthetic LC Facility, of which approximately $48.3 million have been issued in favor of, and previously approved by, AHCCCS. Through its available liquidity under the revolving line of credit, which is undrawn as of the date of this letter, and the remaining capacity under the Revolver LC Facility and additional access to the surety bond markets, the Company has the ability to provide Health Choice Arizona with letters of credit and/or other financial guaranty instruments in an amount sufficient to meet the ALTCS performance bond requirements detailed in the response to the current AHCCCS Request for Proposal.

In addition to the available credit described above, the company maintains a sufficient cash balance from which $5,000,000 will be available to Health Choice to meet the initial capitalization requirement within 30 days of a contract award from AHCCCS. Presently, the Company has a cash balance in excess of $150 million.

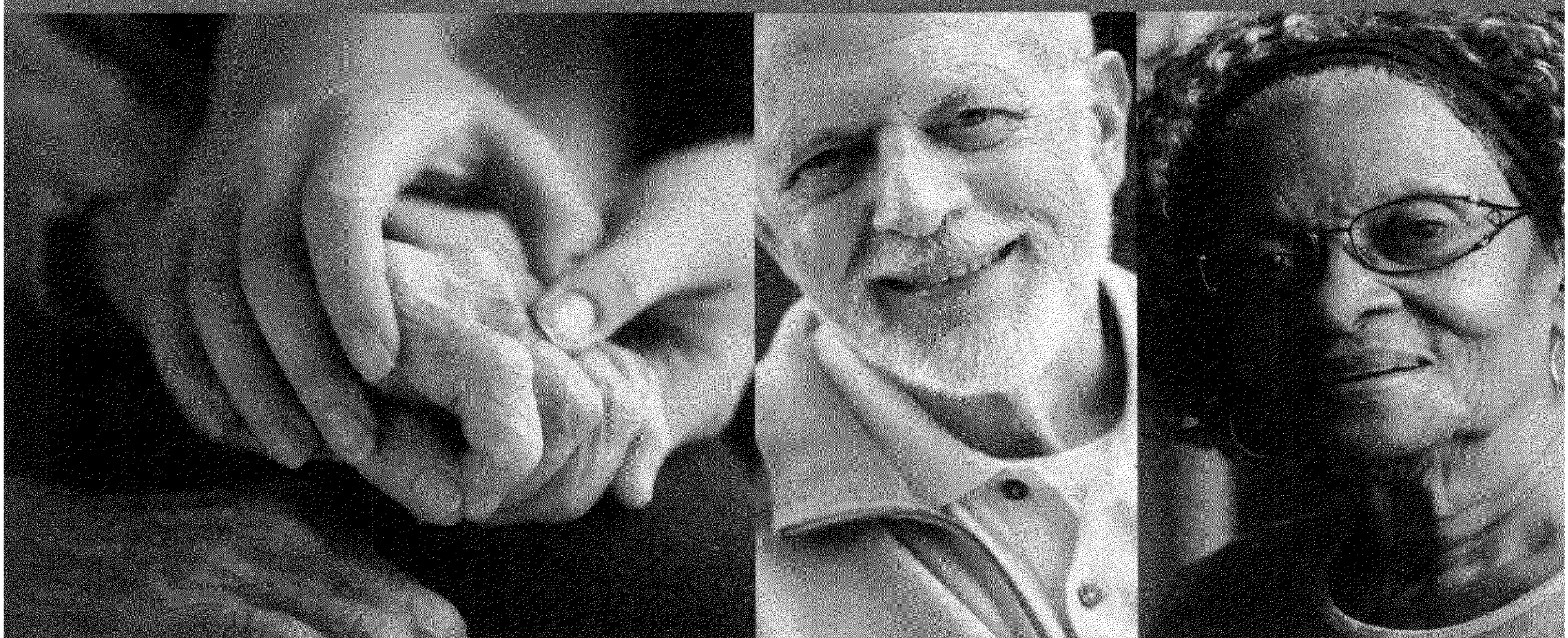
If you have any questions feel free to contact me at (615) 467-1203.

Sincerely,

John Doyle
Chief Financial Officer

Response to **ALTCS E/PD**

RFP YH12-0001 Original Binder 2



Yuma La Paz **Apache** Coconino **Mohave** Navajo **Pima** Santa Cruz **Maricopa**

IASIS HEALTHCARE®

Health CHOICE

Response to **ALTCS E/PD**

RFP YH12-0001

Original Binder 2

Health CHOICE

D. Program

D. PROGRAM

Case Management

Requirement #20

CASE MANAGEMENT SUBMISSIONS

REQUIREMENT #20

Describe how the Offeror has or will implement inter-departmental coordination between case management and other areas of the organization to improve member health and service outcomes. Provide an example of how the Offeror improved member health or service outcomes because of inter-departmental coordination.

Currently Health Choice Arizona (HCA) serves the AHCCCS Acute population and dual eligible Medicare Advantage Special Need Plan population. Similarities between these two populations and the ALTCS population will allow HCA to build upon existing organizational structures and functional expertise, encompassing interdepartmental coordination systems.

Results of the HEDIS performance measures, Medication Therapy Management Program (MTMP) and the Health Risk Assessment (HRA) for Health Choice Generation (HCG) completion rates are reported internally as part of the Care Management Program to appropriate departments and committees and externally to the applicable agencies (for example, CMS). Additionally, HCA provides ongoing communication of all selected performance measures and projects to all appropriate departments within HCA and quarterly to the HCA Quality Management Committee. Sharing data results with interdepartmental leadership allows HCA to see where the program improved and more importantly drives the health plan to analyze the data seeking to improve and initiate program changes.

Using the wide scope of resources throughout the plan, HCA is able to determine utilization trends impacting all members served. This permit the ability to customize care management programs for all members; from appropriate preventive screening and early medical intervention to the most complex diseases and case management. Through its holistic view of Care Management, HCA's comprehensive Care Management Program goals are to: measurably improve access to care, utilization of preventative care services, safety, compliance, and ultimately impact health outcomes of all HCA members. CM focuses on maximizing seamless transitions of care across healthcare settings for providers, and health services. Processes are utilized to support the Care Management Programs through internal policy and procedures.

The preventive health-screening segment of the HCA Care Management Program encourages members to take part in routine medical screenings via outbound telephone calls for such screenings as breast cancer, cervical cancer, and diabetic retinopathy to name just a few. These telephone calls are made to members who do not appear to have had such screening exams in the past year in the plans administrative review data. The program's goal is to increase the number of members taking part in preventive screening(s) as evidenced by increasing HEDIS performance measure rates in those areas. In addition, educational material regarding the importance of well adult check-ups is included in the Member Handbook (Evidence of Coverage), member newsletters, and on the HCA website.

This preventive health screening initiative could easily be incorporated into managing and improving preventive screenings for HCA ALTCS members. The same administrative review data would now list HCA ALTCS members, identifying preventive screenings gaps. The report would identify the assigned ALTCS Case Manager (CM). The CM would document the gap in the member's case file within Care Radius and provide the same outreach call to the member while forwarding communication to the member's PCP of the potential gaps in care. The same program goals; to increase the number of members taking part in preventive screening(s) as evidenced by increasing HEDIS performance measure rates in those areas, would be tracked and reported through the Quality Management Department. Care Radius would auto generate, at the case manager's discretion, the same educational material regarding the importance of well adult check-ups that would be mailed to the member. The CM would partner with the member's provider to assist with possible referrals and work with the interdisciplinary care team to assist and coordinate preventive health screenings thereby supporting gap closer. If the system identifies that the ALTCS member has medical coverage with another health plan (i.e. a MAO plan), it would be imperative for the ALTCS CM to be proactive in an outreach effort to identify the member's MAO CM. Together the Case Managers would collaborate in an effort to develop and coordinate a care plan with a goal to provide a seamless transition of services that supports gaps in care closer.

The primary point of contact for ALTCS members is the Case Manager; however, that CM will interface with multiple departments to insure that Prior Authorizations, concurrent review, home care needs etc. are meet on a continuous basis. The ALTCS CM must ensure continuity of care and safety within the home, thereby improving coordination of care leading to positive outcomes.

An example of how the case management staff coordinates with medical services staff to improved health service outcomes can be demonstrated within the Care Radius system. When an ALTCS member is hospitalized, planned or unplanned, Care Radius (HCA CM software) sends a task to the assigned concurrent review nurse as well as the assigned ALTCS Case Manager. Both staff has the ability to view prior history and the Individual Service Plan (ISP) and the member's Universal Assessment Tool (UAT). This allows the concurrent review nurse to view all the members on the patient's interdisciplinary care team allowing the UR nurse to 1.) Identify the names of medical specialist already treating the member (supporting continuity of care 2.) View the history of placement facilities 3.) Collaborate in 'real time' with the ALTCS CM to jointly begin discharge planning. The Case Manager might partner with Member Services to help identify a provider in the area if needed or assist in the coordination of transportation. This type of collaboration provides a smooth transition in care improving the chances for a safe discharge with previously proven services used; all leading to a lower chance for readmission thereby improved outcomes.

Requirement #21

REQUIREMENT #21

Describe the Offeror's plan for monitoring and improving, as needed, the level of consistency among case managers with regard to the assessment of HCBS member needs and service authorizations.

Health Choice Arizona (HCA) assures consistency among Case Management (CM) staff through CM staff orientation, ongoing education, daily supervision and measures that are consistent through annual Inter-Rater Reliability (IRR) audits. In addition to receiving a general orientation to HCA, ALTCS CM staff will undergo a thorough orientation and ongoing training on subjects relevant to the ALTCS population HCA serves. The orientation will cover ALTCS program values and objectives, including:

- The role of the case manager in utilizing a member-centered approach to ALTCS case management
- Principle of most integrated, least restrictive setting for member placement
- Member rights and responsibilities
- CM responsibilities for
  - Member Assessment:
  - Service Plan Development (ISP)
  - Uniform Assessment Tool (UAT)
  - Contingency plans
  - Reporting service gaps
  - Notice of action
  - Cost Effective Study (CES)
- CM procedures
- An overview of the AHCCCS/ALTCS program
- ALTCS services and service restrictions - procedure criteria and guidelines for member-centric assessment
- Contract provider network locations, service type and capacity
- Local resources for housing, education and employment services/programs to assist the member
- Monitor and reporting quality concerns
- General medical, behavioral health and social service information - link within Care Radius
- Pre-Admission Screening (PAS) and Pre-Admission Screening and Resident Review (PASRR) process
- EPSDT review of standard and link to EPSDT team within HCA within Care Radius
- Review of ALTCS management information system Client Assessment and Tracking System (CATS)

All HCA CMs in all Line of Business receive regular training on topics that include but not limited to:

- Policy updates
- Refresher training – medical, behavior, medication issues and CES
- Interview skills
- Cultural competency
- Assessment and observation skills
- Community resources

The HCA IS department will provide training on the Care Radius software, supporting new hire orientation as well as educational/training updates.

HCA will utilize criteria and policies and procedures for conducting assessments and re-assessments, developing and modifying individualized service plans and authorizing HCBS services. These criteria will be based upon AHCCCS and ALTCS policies as published in the AMPM, American Psychiatric Association (APA) American Geriatric Society (AGS) and American Disability Association (ADA) guidelines, National Association of States United for Aging and Disabilities (NASUAD) recommendations and other authoritative sources.

HCA ALTCS Case Managers will practice with sample cases to apply criteria. CM Supervisors will attend at least five site visits for assessments and/or re-assessments with newly hired CMs, monitoring the new CM's application of ALTCS Universal Assessment Tool (UAT) and criteria for Interdisciplinary Service Plan (ISP) development.

To confirm that all ALTCS CMs are consistent in assessment and authorizing services, HCA will conduct formal IRR audits.

at least quarterly. CM Supervisors will review no less than 5% of assigned CMs for correct application of criteria, standards and guidelines. Results will be utilized as teaching opportunities and incorporated into performance evaluations and Case Management Scorecard.

The existing HCA Policy 5.634, Medical Services Inter-Rater Reliability (IRR) Guidelines will be amended. These amendments will include but are not limited to the following;

ALTCS Case Management staff informal IRR audits:

1. Annual audits based on the quarterly IRR will be performed by the VP of Medical Services and ALTCS Director and/or his/her designee or external consultant for Medical Service staff.
2. An educational training to Case Management and their supporting staff on ALTCS LTC, HCBS and BH criteria, standards and guidelines, HCA prior authorization guidelines, AHCCCS and CMS criteria will be provided at least annually by the dedicated staff listed above and/or an external consultant.
3. Case studies will be provided during the training and will be scored for appropriate application of criteria. The overall scoring will be based on number of case studies reviewed and be included in the employee's performance standard review.
4. Employees who do not meet the scoring standards on the case studies will be required to repeat the training that will be provided the next day.
5. Corrective action will be taken with employees continuing to fall below standards after the second day of training.
6. Continuing education will be provided during Case Management staff meetings.

Requirement #22

REQUIREMENT #22

Describe the process the Offeror will employ in assessing and meeting the needs of complex care members via service planning and coordination of multiple providers and involved entities specifically for 1) members needing behavior management and 2) members with complex medical care needs.

To meet the needs of Health Choice Arizona (HCA) ALTCS members, including members that have medically complex needs and/or members needing behavioral management, HCA CM will focus on the member's strengths and needs, fostering a person-centered approach to an Individualized Service Plan (ISP) that is mutually agreed upon, appropriate and cost effective and that meets the medical, functional, social and behavioral health needs of the member in the most integrated setting.

More specifically, to help address and support the needs of our HCA ALTCS medically complex member with a diagnosis of being Seriously Mentally Ill (SMI), HCA has partnered with Northern Arizona Regional Behavioral Health Authority (NARBHA) to integrate psychiatric services with medical management services on an identified subpopulation. HCA and NARBHA have partnered with a large primary care medical practice, creating a Medical Home model, integrating clinical data from both primary and behavioral health. This program approach has been based upon a recent study by the National Institute of Mental Health (NIMH), 'CATIE study' that shows, people with serious mental illness have elevated rates of hypertension, diabetes, obesity and cardiovascular disease. These conditions are shown to be exacerbated by unhealthy practices including; inadequate physical activity, poor nutrition, smoking, substance abuse, and side effects of psychotropic medication, including weight gain.

Health Choice provides the member identification, and the tracking and trending of identified measurements through the integration of HCA's and NARBHA data, using primary care, behavioral health, medical, labs, and pharmacy claims. This information provides the ALTCS Case Management unit, NARBHA providers and the Primary Care Practice a list of the members who will receive a collaborative approach to improve the coordination of care. The program goals are to improve medical and behavioral outcomes while managing/improving medical management cost.

To improve the physical and mental health status of HCA ALTCS members with SMI, HCA and NARBHA are working to coordinate and integrate primary care services that are based within the behavioral health settings and integrated behavioral health services within primary care settings statewide.

HCA/Primary Care/Behavioral Health Medical Home Program includes:

- HCA/NARBHA to develop a registry/tracking system for all primary care needs and outcomes
- HCA ALTCS CM leads the coordination of care/services for all individuals identified in the Medical Home program, collaborating with the identified NARBHA contact and the primary care's embed nurse case managers to:
    - Develop, monitor, assess, integrate and coordinate medical and behavioral health treatment plan in the members Individual Service Plan (ISP) and the Medical Home patient care plan
    - Share the ISP and Uniform Assessment Tool (UAT) with the interdisciplinary care team
    - To support Care Conference as needed
- HCA ALTCS CM to oversee, and facilitate any required services deemed medically necessary
- HCA ALTCS CM to provide communication to the Medical Home team from the HCA concurrent review nurse on any Medical Home member hospitalized to accomplish integrated discharge management.
- Medical Home Program to provide routine primary care services in the behavioral health setting via a nurse practitioner or physician out-stationed from the full-scope healthcare home and/or routine behavioral health services in the primary care setting via a behavioral health specialist
- ALTCS CM to identify a primary care physician to provide consultation on complex health issues if there is no primary care practicing at the behavioral health site
- Medical Home program to support an embed nurse case manager within the primary care team working in the behavioral health setting, to support individuals with significantly elevated levels of glucose, lipids, blood

pressure, and/or weight.BMI This embedded CM to collaborate directly with the ALTCS CM to help manage the members healthcare needs.

- The Medical Home Program is to use evidence based practices developed to improve the health status of the general population, adapting these practices for use in the behavioral health system
- The ALTCS CM to continue to identify possible gaps in care and offer prevention and wellness support services
- ALTCS CM to facilitate screening and referral for primary care preventative and treatment needs

HCA ALTCS Case Management Program focuses on planning and coordinating services and through the integration of resources, effectively meets the member's individual needs in the most cost effective manner. Case managers are responsible for developing, monitoring, reassessing, maintaining and communicating the member's ISP with the member's interdisciplinary care team that may at time include case managers from other health plans; such as a MAO plan. The Case Manager acts as the member's advocate by resolving care delivery issues and facilitating needed services ensuring that the required services are provided and beneficial for the member. The ALTCS CM many times may need to broker services when certain services are unavailable. He or she may need to substitute combinations of other services (within cost effectiveness standards) in order to meet the member's needs. The CM looks to community resources and services to incorporate into the members ISP. The ALTCS CM acts as a gatekeeper; always proactive in anticipating the member's needs based on change in conditions and takes appropriate action in identifying service needs to prevent unnecessary Hospitalizations/Institutionalization.

The development of the ISP is coordinated with the member and/or family/representative to ensure a mutually agreed upon approach to meet the member's needs that is within the scope and limitations of the ALTCS program.

Through HCA's internal ALTCS case management program as well as through our partnerships with PharmMD, HCA's vendor for Medication Therapeutic Management Program (MTMP), ALTCS CMs are able to provide additional services in monitoring and servicing the high-risk members with complex medical and behavioral health needs. This MTMP program supports care management by integrating medication utilization and safety initiatives to improve health outcomes for the identified medically complex members and members that have medication adherence concerns.

An additional medication care management program Health Choice offers is called CareLogic. This is a Specialty Drug care program performed by the specialty drug provider of Express Scripts, CuraScript. The program offers HC ALTCS CMs who oversee and support medically complex members with unique health care needs (i.e. HIV; cancer; hepatitis; rheumatologic diseases) more clinical management interventions which consists of monitoring, proactive reporting to the prescribing Physician, compliance monitoring, patient education and an on-call pharmacist available 24 hours per day. The care goals of the program are to provide optimal clinical management of specialty drugs for chronic disease states, comprehensive education and mitigate adverse drug reactions. Monitoring consists of two dimensional reporting measurements which are intended to determine increased enrollee compliance to these often complex and expensive therapies with fewer adverse reactions/events compared to baseline estimates.

Additionally, Health Choice has partnered with Inspiris, supporting a provider home visit program "Care Plus" for identified high risk members both medically complex and in need of behavioral health management. The Inspiris providers and staff collaborate directly with HC CMs thereby facilitating seamless coordination of care/services.

To best coordinate the care of a high risk complex member with or without behavioral health management needs, when there are multiple providers servicing, treating and directing the treatment/care of a member it is essential to have a strong Individual Service Plan (ISP) based upon a well documented Uniform Assessment Tool (UAT) in place. It is the ISP that links the interdisciplinary care team to the member's goals and treatment plan that focuses on the member's medical, functional, social and behavioral health needs.

The Interdisciplinary Care Team consists of the member and all pertinent members of the client's medical team (i.e. physicians, therapists, family members, behavioral health specialists, case managers from all payer sources). The ISP and UAT will be provided and available to all participants involved in the member's interdisciplinary care team. Care Radius auto generate and mails the most up to date ISP/UAT and Summary Report to all participants.

The HCA ALTCS CM completes a Uniform Assessment Tool (UAT) based on information from the strengths/needs *assessment* and determines the member's current Level of Care.

The member's care planning which includes the completion of the ISP, UAT and CES is based on the CM's face-to-face discussion with the member and/or member representative. The evaluation includes a systematic approach to the assessment of the member's strengths and needs in at least the following areas:

a. Functional abilities
b. Medical conditions
c. Behavioral health
d. Social/environmental/cultural factors, and
e. Existing support system

Recommendations from the member's PCP, the input from ALTCS service providers, and the Pre-Admission Screening (PAS), all are documented in the member's care plan.

Care plan goals include steps that the member will take to achieve the agreed upon goals. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination processes.

The identified high-risk members both medically complex and/or members in need of behavioral health management will have the benefit of a scheduled Care Conferences that is coordinated by the HC ALTCS CM. The goal of these care conferences is to facilitate optimal outcome for all parties involved through advocacy, objectivity and collaboration with emphasis on continuity of care through effective communication/coordination of appropriate health care services.

Care Conference Example: Behavioral Health management Interdisciplinary Care Conference, Agenda/Topics/Goals Collaborate with team to update the ISP: *ALTCS 1620-VII Behavioral Health Standards*

1. Verification that a referral for a behavioral health evaluation has been made
2. The HCA ALTCS case manager ensures there has been communication with the PCP and behavioral health providers involved in the member's care and that care is coordinated with other agencies and involved parties.
3. The HCA ALTCS case manager ensure the timely involvement of a behavioral health professional to assess, develop a care plan and preserve the current placement if possible when a member in a non-behavioral health setting presents with difficult to manage behaviors (new or existing).
4. Information from the Pre Admission Screening and Resident Review (PASRR) Level II Evaluation for determination of mental illness (completed by the Arizona Department of Health Services when indicated by PASRR Level I screening) regarding a member's need for specialized services (see definition in Chapter 1200, Policy 1220 of this Manual) must be incorporated into the member's service plan.
5. The HCA ALTCS case manager documents the content and results of the initial and quarterly consultation with the behavioral health professional. The consultation must be a communication between the case manager and a behavioral health professional about the member's status and plan of treatment
6. As part of the service plan monitoring, the HCA ALTCS case manager reviews the psychotropic medications being taken by the member.
7. Documentation of the medication review is clearly evident in the member case file. The review takes place at each reassessment and includes the purpose of the medication, the effectiveness of the medication and any adverse side effects that may have occurred. Any concerns noted (for example, medication appears to be ineffective, adverse side effects are present, etc)
8. Discuss the member's perception of his/her progress toward established goals
9. Identify any barriers to the achievement of the member's goals,
10. Develop new goals as needed.

Requirement #23

REQUIREMENT #23

Describe the Offeror's process for assessment and care planning of members for home-based services by case managers.

The implementation of ALTCS within Health Choice Arizona (HCA) will include the establishment of a dedicated ALTCS Case Management unit within the HCA Medical Services Department. A Director will oversee the ALTCS service unit. At least one Case Management Supervisor will be assigned per county with a ratio of 1 Supervisor to every 9 Case Managers (CM). Each CM Supervisor has the support of a Transition of Care Coordinator (TOCC). The TOCC may support up to 10 CMs. After the CM Supervisor reviews the Pre-Admission Screening (PAS) and the Pre Admission Screening and Resident Review (PASRR) she assigns the case to the CM based on the best professional skill set needed to support the needs of the member. The TOCC holds the responsibility of identify and verifying new members' information and provides the initial outreach to the member/care giver and/or facility to verify current placement/location. The TOCC provides the name and contact information of the newly assigned Case Manager. The TOCC opens a new file in Care Radius, enters in all available information and tasks the case to the assigned CM with the new member information.

The Supervisor and TOCC will be assigned per county with supporting Case Managers (CM) of sufficient number to meet weighted caseload ratios requirements. HCA will employ a variety of Case Management professionals that include but are not limited to degreed social workers, licensed registered nursing, pharmacy and behavioral health, as well as specific expertise in housing, education and employment.

The ALTCS Case Management unit will be supported by CM software called Care Radius that house members' demographic, including placement type and Uniform Assessment Tool, Individual Service Plan (ISP), PASRR, Cost Estimate Study (CES) and all nursing documentation.

Upon enrollment upload, the system will identify members by zip, county code, for CM Supervisor assignment. The CM Supervisor has the capabilities to redirect and override any auto assignments when determined the client has potential specialized needs. The CM Supervisor assigns the case to the CM as outlined above and sends a task to the TOCC within Care Radius regarding the newly enrolled case. The system will be capable of tracking timelines, producing automated reports that identify members due for initial and monthly contact, initial assessment and re-assessment site visits, and various types of follow-up etc. In addition, based upon preloaded criteria and guidelines, Care Radius will assist CMs in ISP development with prompts based upon assessment findings. Individual Service Plans (ISP) as well as Summary Reports can be auto generated and mailed, allowing the reports to be sent to PCPs for signature, as well as shared with any and all of the members on the interdisciplinary care team. Additionally the ISP can be shared with the member and as a secondary follow up to the ISP hand written copy that will be provided and signed by the member at the initial CM face-to-face visit.

The following is a general outline of the assessment and care planning process to be undertaken by ALTCS CMs for members receiving HCBS:

1. Whenever a new ALTCS member is enrolled, the HCA enrollment department through the Care Radius IT system, will auto assign the case to the CM Supervisor based on zip code, county code.
2. CM Supervisor assigns the member an ALTCS CM with the appropriate social services, nursing or behavioral health expertise matching the members needs based upon information provided in the PAS, PASRR or Enrollment Transition Information (ETI) Form.
3. New members (Power of Attorney (POA), or residential facility, if appropriate) will be contacted within 3-5 business days of enrollment by the TOCC. The TOCC-verifies the place of residence, provides the CM's name and contact information, and advises that the CM will be contacting them within the next 5- 7 days to schedule a site visit. Care Radius supports the demographic information as well as any information that is available from a state download; such as, address, rate codes, enrollment dates and enrollment types. This information helps the CM better identify Transitional, Acute members, enrollment type etc. The TOCC opens a file for the new member in Care Radius, populating any demographic fields that are not auto populated. If the member is transferring from another ALTCS MCO, all HCBS identified in the ETI will be automatically authorized for 60 days to prevent any disruption in services.

4. After reviewing PAS, PASRR or ETI and checking for a support system, guardians or Powers of Attorney, the CM contacts the member (facility staff or member representative as appropriate) to schedule an on-site assessment visit to occur within 12 days of enrollment. Family member(s), friends and representatives, facility staff or clinicians may be invited as appropriate and desired by member.
5. For new members, during the initial on-site visit, CM will deliver the Member Handbook and Provider Directory; review Member's Rights and Responsibilities obtaining signature(s) to document member's receipt and understanding.
6. CM conducts member-centric strength and needs based assessment reviewing member's physical, psychosocial and functional status utilizing the ALTCS Uniform Assessment Tool (UAT) to determine level of care. Together they explore and document the member's goals. The CM explains ALTCS covered services and answers any questions to assist member in making informed choices.
7. Based upon member's strengths and needs identified during the assessment, CM develops an ISP that documents all the HCB services, as well as medical, behavioral informal support and other community services member is to receive regardless of the payer.
8. Part of the ISP is a contingency (back-up) plan in the event a caregiver no shows, or is unavailable, or delayed, including whether informal or paid caregivers will be utilized. The CM will include the contingency plan communication of service delivery changes/interruptions and how to report problems with service delivery.
9. Member (or representative as appropriate) agrees with ISP by signing it (or making a mark with note that "member was not able to sign"). A copy is left with the member and/or facility staff.
10. Member is provided a HCA ALTCS contact card/refrigerator magnet details the CM contact information and what to do in case of an emergency and/or after hours
11. Assessment information and the ISP is entered into Care Radius for follow-up and tracking. Care Radius triggers tasks to alert CM 7 day prior next re-assessment.
12. CM arranges for services to be implemented as early as 7 days of ISP, not later than 30 days of enrollment and enters service authorizations into Care Radius. Care Radius will alert CM or designee to contact member to verify services are in place within 10 days of ISP, and at 30-day mark.
13. Cost Effectiveness Study (CES) and placement data is entered into CATS within 10 business days of the date of assessment.
14. HCA will provide a monthly (or more frequent as necessary) outreach call to new ALTCS members to assure services are implemented and resolve any problems that may have arisen regarding service delivery. This task will be automated within Care Radius. Depending on the members' stability and clinical needs these contacts may be made by the TOCC under the direction of the CM.
15. CM will communicate any changes of status or significant events (e.g., hospitalizations, falls, etc.) to the member's service providers and physicians. The CM documents all changes or additions to the ISP, completing a needs-based re-assessment. And provides the updated Summary Report to the identified interdisciplinary care team.
16. A Re-assessment will be conducted on-site prior to 90 days. The reassessments include:
    - Review functional, medical and behavioral status (Care Radius generates additional co-morbidity questions specific to member answers on the assessment tool identifying possible Gaps in Care; such as, preventative screenings, immunization etc.) and document assessment and tasks within Care Radius
    - Update the ISP. The ISP is completed and a signature is required with each assessment, re-assessment, or at any time there is a change in members placement, or condition.
    - Review and revise contingency plan as necessary
    - Work to resolve problems that may have arisen and report any potential quality of care concerns to QM and work with QM to investigate and resolve
    - Update the ALTCS Uniform Assessment Tool (UAT)
    - Updated Summary report created – mailed to PCP and interdisciplinary team
    - Updated authorizations sent onto providers
    - Verification of any change or new services will be made within10 days
    - Update CES in CATS
    - Care conference follow up if indicated

Requirement #24-A

REQUIREMENT #24-A

Oscar is a 42 year old male. He is married with 2 children under 10 years old at home. Oscar is a newly enrolled ALTCS member. He is quadriplegic as a result of a fall from his roof. Member was working full-time in the construction field prior to his injury. He was not on AHCCCS prior to current enrollment. Oscar now has limited use of his limbs, only having very spastic control of one arm. He is mostly dependent for all ADLs and IADLs. He has begun to feed himself with a splint and adaptive utensils although this is very messy. He requires bowel care. Oscar was admitted to his current NF placement 2 weeks ago after a 3-month hospital/rehab stay. Oscar expresses dissatisfaction with the care at the nursing home. He states the caregivers are not as responsive as at "the last place". They handle him "roughly" and all the other residents are "too old" so there is nothing for him to do. Staff state that member presents as "angry" and "depressed"; he is never satisfied with whatever they do for him. He occasionally becomes very agitated when caregivers come to give his care and has ordered staff to leave. He often sleeps all morning and into the early afternoon and does not want to be disturbed for care. Oscar complains he is not getting enough Physical Therapy (PT) and that his custom wheelchair is hard to maneuver. Staff report that the member has become confused and disoriented recently. He sometimes forgets that he just had PT and also how some of the buttons on his wheelchair work. They say he gets mad if staff remind him when he forgets. Oscar has gone home once since admission so that his wife, April, could experience caring for him at home and the challenges involved. There were some accessibility barriers at home, primarily at the entrance and in the master bathroom. April would like Oscar to come home but she thinks it would be very hard to do everything for him on top of working (she has a part time job but worries that they now need a full time income) and caring for 2 kids. She also has concerns about Oscar's ability to control his anger. There is a possibility that Oscar's brother may be available to help them with care when/if Oscar is discharged. Oscar's wife asked for assistance getting a wheelchair accessible van so she could transport Oscar as needed. April would like to have more therapeutic home visits while Oscar remains in the NF to prepare them all for his homecoming. Oscar talks a lot about working again to help support his family.

Upon learning of the new enrollment and a review of the Pre-Admission Screening and Resident Review (PASRR), Pre-Admission Screening (PAS) the ALTCS Case Manager (CM) Supervisor assigns a CM with a social work background. The Transitions of Care Coordinator (TOCC) opens a file in Care Radius, contacts the nursing facility to make sure Mr. O is still a resident and to let them know the name of the assigned CM. Within 7 business days, the CM reviews PASRR to ascertain if there is a Power of Attorney (POA); there is none. While in the NF visiting another ALTCS member she stops by to introduce herself to Mr. O, scheduled an assessment visit and ask if he'd like his wife or anyone else to attend the assessment visit. The visit was scheduled within 12 days of enrollment. The wife, April is able to attend.

On the day of the assessment visit, prior to meeting the member, the CM reviewed Mr. O's medical chart and MDS to get most current information. She talked to floor staff about their impressions of Mr. O, discussing the recent confusion and angry behavior in particular.

With the wife present, the CM provides the member handbook and reviews the member's rights and responsibilities and then obtains appropriate signatures. The CM conducts an assessment of medical condition treatment(s), functional, psychosocial and physical status utilizing the ALTCS Uniform Assessment Tool (UAT) determining that Mr. O's level of care is Class 2, identifying significant anger issues, and while generally medically stable, there has been recent episodes of confusion and disorientation need to be evaluated. The CM explores Mr. O's feelings about differences between the Rehabilitation Hospital and NF daily routine, services and staff while providing education on acute rehabilitation versus nursing facility levels of care. The CM obtained more information about therapeutic home visit such as when it occurred, in-home barriers he experienced, how long it lasted, how the member felt, children react, etc. The CM discusses options available through ALTCS including residential and HCB services. Upon completion of assessment, ISP documenting agreed service(s), frequency, and date span signed by member and CM.

Both Mr. O and wife express a desire to eventually have him return home though both admit to some trepidation at how that will work. On the positive side, the CM emphasizes that Mr. O is young and has family so he is a good candidate to return home with the support of ALTCS home and community based services. With assistance from the CM, together they are able to outline the following goals/objectives:

- Short term: Remain in NF with goals:
    - Establish long-term home exercise program
    - Train family members in wheel chair car transfers
    - Therapeutic Home evaluation
    - Community/Home re-entry visits
    - Safely increasing independence in ADLs.
- Medium term: Return home with supporting services safely in place.
- Long term: Re-integrate into the community learning a new skill allowing him to support his family.

<u>Initial Individualized Service Plan (ISP):</u>

1. Identify additional payer sources:
    a. Determine what Workman's compensation coverage member has currently, that might supplement services
    b. If there is coverage, contact the WC case manager to coordinate covered services
2. Continue occupational and physical therapy to improve use of assistive devices and muscle strengthening and establish a home exercise program.
3. Behavioral Health evaluation and treatment to address possible situational depression and anxiety that are resulting to anger. This to be completed prior to Discharge.
4. Neurology consultation to evaluate and treat as appropriate recent confusion, memory loss and disorientation; will require transportation.
5. Install memory board so Mr. O knows when he is going to or has received therapy and other services/treatment.
6. Wheel chair to be evaluated and whether he is correctly and safely using it; can be performed by Physical Therapy or DME Supplier.
7. Request that Physical Therapy do staff in-service training regarding how to properly handle Mr. O especially since he recently became quadriplegic and has heightened sensitivity to being touched.
8. Plan a second therapeutic home visit during which CM will visit home to assess Mr. O's social support system and physical barriers present.
9. Provide medically necessary transportation to neurology consult; CM explains that in future other community based transportation resources exist including eventually obtaining a wheelchair accessible van.
10. If Mr. O doesn't improve enough in NF to begin transition planning to home, will consider transfer to a facility that is more age appropriate.

Upon returning to the office, CM collaborates with NF staff to obtain PCP orders for services requiring an order and arranges all of the above. After multiple calls she has been unable to identify Workman's Comp coverage at this time. In about 3-4 weeks, after the behavioral health and neurology evaluations are completed, she arranges an interdisciplinary team meeting to reassess his status and begin planning for transition to home. She also assures that behavioral health and neurology findings and treatment plans are coordinated with each other and Mr. O's PCP.

Four weeks later with above ISP fully implemented, CM convenes an inter-disciplinary team meeting to re-assess Mr. O's status and begin to make plans to transition home. Attending the meeting are Mr. O, his wife and brother, Behavioral Health Counselor, NF staff: Case Manager, PT and OT. Mr. O's mood has improved due to medication and twice weekly BH counseling. Medication has reduced but not entirely eliminated episodes of confusion/disorientation; he is due for follow-up with neurologist in one week. He has made progress on all ADLs and is anxious to go home. His children have visited him regularly and want their "daddy home again".

<u>Revised ISP: Goal is to transition Mr. O home within 4 weeks time.</u>

1. Continue OT, PT and BH sessions until discharged.
2. Arrange for a portable wheel chair ramp that can be used at the rear entrance of the home, and widen the bathroom doorway in effort to increase member's independence. Determined this is preferable to modifying front door and master bedroom because use of these will require maneuvering through narrow hallways.
3. Family room with attached bathroom will be fully equipped (hospital bed, Hoyer lift, etc.) with medically necessary DME to support Mr. O's needs.
4. Provide the brother contact information and information on working with Personal Care agency to become family care giver.
5. Initially provide 10 hours/day Monday through Friday of attendant care to provide morning care and remain with Mr. O while wife prepares children for school and goes to work. Attendant will also provide basic homemaker services including preparing his meals, doing his laundry and cleaning to maintain safe living conditions for Mr. O. Reduce to 4 hours/day, two in morning and two in early evening on weekends.
6. Brother will visit in evening to assist wife in providing evening care. Brother may re-arrange work schedule to provide more hours of care. Together brother and CM will evaluate whether he might eventually become paid caregiver.
7. Skilled nursing visits to provide bowel care and teach personal care aide and family members. (bowel care must be taught to family personal care giver who is receiving payment)

8. Home OT evaluation and visits if deemed appropriate to reinforce use of adaptive devices and make adjustments for home environment.
9. Behavior health counseling sessions to continue weekly at home with emphasis on family counseling.
10. Wife and brother to attend first Caregiver Support Group meeting two weeks before Mr. O is scheduled to return home.
11. Young Adult Program, through the local Adult Day Health center twice a week for socialization. (10 hrs of attendant care will have to be provided M, W, F, Sat, Sun).
12. After initial home visit within 10 days of returning home, re-assessment within 90 days.
13. Identify PCP who will make home visits (i.e. Inspiris 'Care Plus' Program)

Upon returning to the office, CM completes a Cost Effective Study (CES) to confirm that a HCBS setting is appropriate. CM coordinates PCP orders for those HCBS and medical services requiring orders. Upon authorization of services, CM contacts contracted providers to ensure that services have been started. Once Mr. O is transitioned home, CM schedules and conducts a HCBS assessment the day after discharge. Upon completion of the assessment, an ISP documenting agreed service(s), frequency, and date span signed by member and CM. When deemed appropriate by the family, CM will assist with community referrals for vocational rehabilitation services to address social issues as well as job training.

Requirement #24-B

REQUIREMENT #24-B

Magda is an 83 year old female. She has been enrolled in ALTCS for 2 years. She has Diabetes (is on dialysis) and was recently diagnosed with early stage Dementia. Her daughter, Raquel, moved Magda into her home from Romania a few years before she became ALTCS eligible. She is not eligible for Medicare. Also in the home are the son-in-law and 4 grandchildren (ages 10–16). Member speaks very little English. Daughter's English is better. Daughter works outside the home M-F, leaving in the late morning and returning in the evening. Member is confused and she is not always steady on her feet without guidance. She has fallen a few times while walking with her walker and fell in the shower last week. Daughter is afraid to leave Magda alone for more than a very short time when she naps in the afternoon. The member has been getting Attendant Care. The daughter leaves for work when the caregiver arrives but there have been a couple of occasions recently when the caregiver did not show up on time and daughter had to stay home from work until someone else could take over for her. The caregiver gets member out of bed and dressed and prepares her breakfast every morning, she gets member off to dialysis on M-W-F, she prepares lunch on T-Th and stays with member until oldest grandchild gets home in late afternoon. Member needs prompts to finish meals and to get enough water during the day, and to take her meds. Caregiver cleans house and does the laundry too. The member's daughter requested an increase in Attendant Care hours when the new case manager came to complete a reassessment. Daughter feels member's confusion has increased and caregiver needs to do more for her. Case manager assessed member to need less hours of service per week than prior assessment. Daughter has asked about receiving "respite" on Sundays when the family goes to church because member gets too agitated during the service to accompany them any longer. Member says she misses getting out and going to church and says her daughter is just embarrassed that she can't speak English well. Member's daughter has asked for a new PCP. She says she has difficulty making appointments with the current PCP.

Magda has been with the Health Choice Arizona (HCA) ALTCS program for 2 years; she has recently been assigned a new CM with a social work background who is to complete the 90-day re-assessment.
CM contacts member to introduce herself as the new CM and schedule an appointment to conduct a re-assessment. The daughter answers the phone and agrees to be present for the reassessment. Prior to the visit the CM reviewed prior assessments and current ISP.

CM conducts a re-assessment of medical condition/treatment(s), functional, psychosocial and physical status utilizing the ALTCS Uniform Assessment Tool (UAT) determining that Mrs. M's level of care is Class 1, lower than last assessment, indicating that less service should be necessary.

The CM explores in depth how the attendant is spending her time and discusses more creative ways the family can assist and how community resources can be utilized. She reviewed a contingency plan, that would identify–some neighbors and/or church members who can stay with member if attendant or family member is delayed. The CM advised the daughter of alternative services, such as Adult Day Health services and Assisted Living Facilities, noting there are Romanian owned ALFs but the family would need to pay room and board. The CM reviewed respite benefits and advised that "weekly services so family can go to church" would not be considered "respite" care. Alternatively CM suggests tapping into the community, finding a friend or neighbor who can sit with Mrs. M while they go to church. Perhaps the church might even have a sitting service or quiet room for mother. Finally she encourages daughter to join an Alzheimer Association Caregiver Support group providing contact information.

The daughter reiterates her commitment to keeping her mother at home as long as possible. A revised Individualized Service Plan (ISP) based upon Member Strengths and Needs Assessment is developed and agreed to with the primary goal of making sure Mrs. M is safe at all times and her needs are being met. Service Plan documenting agreed service(s), frequency, and date span was signed by daughter on behalf of member and CM.

<u>Revised Individualized Service Plan (ISP)-</u> :

1. Decrease attendant care hours in 10 days, advising daughter of appeal rights, referencing Member Handbook
2. Daughter agrees that attendant will not continue cleaning and laundry except for Mrs. M's; family will assume these chores.
3. Determine if family would consider changing agencies – one which provides translation services to better communicate member's needs, possibly decreasing her confusion.
4. CM will coordinate with dialysis to ascertain if member time could be coordinated with family's time, so mother would leave for dialysis at same time daughter leaves for work on Mondays, Wednesdays, and Fridays. Attendant would be at the home when member returns home.
5. Physical therapy for home safety evaluation and DME needs – gait training including proper use of walker, any bathing needs
6. DME, grab bar and shower seat to decrease risk of injury
7. Change to new PCP who speaks Romanian and/or has translation services available, and schedule first PCP appointment with daughter to attend.

8. Ascertain if new PCP can perform dementia assessment or would prefer to refer member to Geriatric Evaluation Center.
9. Schedule transportation if needed.
10. Consider emergency response system if dementia assessment indicates that member could use it properly.
11. Utilize language assistance services as needed.
12. Offer choice of Adult Day health for family which picks client up at home, or she goes there after dialysis.

Upon returning to the office, CM completed the necessary forms to provide the member with written notification of the reduction in attendant care hours and member appeal rights. CM coordinates PCP orders for a PT evaluation and the appropriate medically necessary DME. The CM completed Cost Effective Study (CES) that confirms the HCBS setting is appropriate. CM collaborates with Member Services to change PCP and set up initial appointment. The CM is able to rearrange dialysis schedule to coincide with daughter's work schedule. A staff complaint/grievance is filed with the Provider Network unit and copied to Quality Management to investigate why family had "difficulty making PCP appointments" and why attendant "caregiver did not show up on time".

Monitoring & Re-Assessment:

1. Follow up to ensure that new services (PT, DME, new PCP) were started and the changes (decreased Attendant care hours) were implemented.
2. Arrange for medically necessary transportation as deemed appropriate.
3. Family did not appeal decrease in attendant care hours.
4. Contact monthly via phone to see how member and family are faring.
5. Standard re-assessment to be conducted in 90 days.

Requirement #24-C

REQUIREMENT #24-C

Wanda is a 66 year old female who has been on ALTCS for the past 6 months. She is enrolled in a Medicare Advantage Plan. Her physician is in the MAP's network but not the Contractor's. She is diagnosed with Diabetes, Peripheral Neuropathy, Hypertension and Congestive Heart Failure. Wanda has required verbal prompting for bathing, dressing, grooming and eating. She also required stand by assistance when bathing. She needed assistance in putting on her shoes and socks. Wanda was living with her son and daughter-in-law while receiving Attendant Care, however, 6 weeks ago, her son moved her into an Assisted Living Facility (ALF) near them without the involvement of the case manager. She had had several falls at home and the son felt she was in need of more care and supervision than the family thought they could handle. She had been able to ambulate with the use of a walker but she was starting to forget to use it occasionally. Wanda fell for the first time at the ALF 4 weeks ago with no injury according to the son. She was hospitalized as a result of a 2nd fall 2 weeks ago that resulted in a broken nose. While in the hospital member was diagnosed with pelvic cancer and has begun treatment. Member was discharged from the hospital back to the same ALF at son's request. Member is now non-ambulatory, more confused, sometimes combative, needing near total care for ADLs, including needing to be fed. The ALF provider is willing to keep Wanda.

Mrs. W has been with ALTCS for 6 months, due to her complex medical conditions, CM with nursing background was assigned. The CM conducted the initial and 90 day reassessments and developed the ISP following both assessments. Several attempts were made to contact member/son for the second 90-day assessment; the CM sent a no contact letter to member/son asking for them to contact Health Choice Arizona (HCA) within 10 days. The following day the CM learned of recent events after Assisted Living Home (ALH) staff contacted HCA to request services. Neither the family member, hospital nor the Medicare SNP notified HCA CM of the change in member's living situation or hospitalization. The CM scheduled visit to ALH the next day due to the urgency expresses by staff. The CM was able to contact the son, with the assistance of the SNF providing a new phone number, but he was not available at the time of the scheduled visit.

Before visiting Mrs. W, HCA CM reviewed the records available at ALH. Because the information was limited, the CM calls MAO CM department and learns they have assigned her to MAO Complex Case Manager (CCM) following discharge, but MAO's initial assessment has not yet been completed. HCA CM conducts a re-assessment which includes additional questions to address, medical conditions and treatments, co-morbidities, newly diagnosed cancer identified, safety of placement, functional, psychosocial and physical status utilizing the ALTCS Uniform Assessment Tool (UAT) determining that Mrs. M's level of care had increased significantly to Class 3, or even higher in CM's opinion.

In addition to beginning treatment for pelvic cancer, she is now non-ambulatory, more confused, sometimes combative, needing near total care for ADLs, including needing to be fed. In CM's opinion Mrs. W requires a higher level of skilled care than the ALH can provide. She contacts MAO CCM to discuss next steps. Based upon the hospital discharge summary, together the CM and CCMs determine her current condition is worse than it appeared to be upon hospital discharge two days before. She was semi-ambulatory and not as confused upon discharge. Because of the increased confusion, which can often be the presenting symptom for a myriad of serious conditions in a frail elder, the MAO CCM contacts the PCP who wants her transferred back to the hospital for an emergency evaluation. HCA CM agrees to alert the son while the MAO CCM arranges for the transfer to the hospital. HCA CM advises MAO CCM that member is a dual eligible who clinically qualifies for long-term support services through ALTCS. The CM and CCM agree to coordinate the up and coming ER/hospital discharge.

The Emergency Room identified Mrs. M was suffering from an acute urinary tract infection. After successful treatment, MAO CCM arranges for transfer to SNF for a short-term rehabilitation stay to improve her mobility. Two weeks later, the SNF provider/PCP, the Family and ALF along with the MAO CCM and HCA CM have a care conference call to explore and determine placement options. It was determined that Mrs. M would transfer back to the ALH.

The HCA CM worked with the MAO CCM to provide, Home Health services within the ALH for; skilled Physical Therapy, skilled Nursing- RN evaluations to periodically evaluate her diabetes and congestive heart failure, both of which have become somewhat unstable as a result of the cancer treatments, and a Home Health Aide for personal care.

MAO CCM advised HCA CM that MAO would arrange for the follow-up appointment with PCP in two weeks. The ALTCS CM will coordinate transportation if needed.

Prior to member's SNF discharge, HCA CM meet with the member and son to discuss ALH placement. CM communicates monthly Share of Cost (SOC) and both parties are in agreement HCA CM schedules and conducts a re-assessment the day after Mrs. M is transferred back to the ALH. She is now ambulatory with assistance, using walker appropriately; able to feed herself; she is largely independent in most ADLs though still requiring some verbal prompting. Re-assessment illustrates a change in Level of Care from Class 3 to Class1. During the re-assessment, CM reviews the member's ALH Residency Agreement with all parties; all parties sign in agreement. ISP documenting agreed upon services, frequency, and date span signed by member and CM. Upon returning to the office, CM completes a Cost Effective Study (CES) to confirm that a HCBS setting is appropriate and authorizes ALH placement.

Modified ALTCS Individualized Service Plan, as follows:

1. Continue to reside at ALH with supervision of/assistance with ADLs by staff.
2. Personal Care Aide twice a week.
3. Transportation to cancer treatments; provide companion to escort if necessary.
4. Non-covered DME needs such as shower chair
5. Verify services implemented within 5 days of ISP
6. Re-assessment

To be coordinated with MAO Care Plan, as follows:

1. Cancer treatments
2. Medical follow-up by PCP
3. Skilled PT to increase mobility and promote safety in ALH.
4. Medically necessary DME
5. Skilled nursing to monitor diabetes and heart failure symptoms in ALH.

Monitoring and Re-Assessment:

1. Assure all services are implemented.
2. Monthly phone calls to ALH to check status
3. 90-day standard re-assessment
4. Ongoing communication between CM and CCM whenever either becomes aware of significant changes in Mrs. W's physical, psychosocial or functional status.
5. Ongoing assessments to continue to identify possible options to transition back to Mrs. M son's home with supporting services being available.
6. Partner with MAO CM to verify if Inspiris Home visit program - Care Plus Program, is a PCP option for the member.
7. Once no longer meeting skilled home health services via MAO, HCA could continue to provide home health nurse to monitor disease processes and any condition changes, who could then communicate closely with MAO CCM and PCP of any changes or needs.
8. Care Planning closely with MAO CCM and PCP ongoing.

Requirement #24-D

REQUIREMENT #24-D

Roger is a 39 year old male. His diagnoses include Schizoaffective Disorder and Traumatic Brain Injury. He also has seizures and occasional upper respiratory infections. His sister, Joyce, just moved him here from another state after their mother/Roger's guardian died. Joyce is now member's guardian and he is staying with her. She is struggling to manage Roger on her own despite having had some training in behavior management. Roger's behaviors include being resistive to care (refuses to bathe, change clothes and take meds), some verbal and physical aggression (uses profanity, throws objects and has taken a swing at Joyce twice since being in her care), fabrication (makes up stories about his past life and what others have done to or told him), and one recent attempt to leave home without supervision. Joyce reports that in the other state, Roger received some support services in the home (she's unclear on the nature of those services) and she thinks he went to a day program of some kind. At this time, member is only followed by a PCP. Roger needs supervision due to his impaired judgment, need for redirection and prompts and because of risks of injury related to his potential aggression. Member continues to have seizures at least twice a week; his risk of falling during seizures is high. Member's behaviors have escalated in the past month. Roger spends most of the day in his room. He says he is bored with nothing to do but watch television. Joyce reinforces Roger's positive behavior with cigarettes. Joyce wants help with Roger's behavioral health needs but she does not know what kinds of services are available for him in Arizona.

Upon learning of the new enrollment and a review of the Pre-Admission Screening and Resident Review (PASRR), the ALTCS Case Manager (CM) Supervisor assigns a CM with a behavioral health background. Within 7 business days, the CM aware that sister is the legal guardian, contacts the member's sister to set an appointment with the member and sister for a home visit. While on the phone with the sister, CM attempts to garner more information. The CM focuses' the phone assessment on the member's and sister's overall safety and/or potential risk for harm that would warrant an urgent behavioral health intervention.

The initial phone assessment was used to determine any emergent needs that must be addressed prior to the CM home visit, current medications, ER events, treatments, seizure activity, PCP needs and to request any history of previous services before relocating to AZ. The sister does not have any specifics about where and what type of treatment her brother was receiving out of state. CM suggests that sister look through her mother's paper work to see if she can find the name of a case manager or agency where member was being treated. Currently both parties deny an urgent need and member states he is not at risk of harming himself or others. CM provided the county crisis phone number and location of contracted behavioral health urgent care center. The CM was able to schedule a home visit within the required 12 day timeframe and opens a file in 'CareRadius' a case management software system.

Whenever possible, prior to the home visit, the CM attempts to contact the previous provider (in this case, the CM doesn't know who this is yet). This allows the CM to prep for opportunities for Adult Day health, possible medications unknown to the member and family, other therapies, and possible behavioral management with additional provider contact information.

With the sister present, the CM reviews member's rights and responsibilities, verifies that the member and sister have received the member handbook, provides the refrigerator magnetic health card with emergency contact phone numbers and obtains appropriate signatures. The CM conducts a thorough assessment of medical conditions/treatment (s), functional, psychosocial and physical status utilizing the ALTCS Uniform Assessment Tool (UAT) determining that Mr. R's level of care is Class 1, with significant behavioral issues. This assessment includes additional questions to address specific neurological issues and TBI/Behavioral Health questionnaire. Roger continues to exhibit behaviors including resistance to care, some verbal and physical aggression and telling fabricated stories. Mr. R has had no recent attempts of elopement per his sister.

Mr. R is not taking his Zyprexa as prescribed along with Keppra his seizure medication. Mr. R ran out of his medications a week ago. He has an established primary care physician but has not received any follow up care since his first initial office visit. He continues to have seizures at least twice a week; his risk of falling during seizures is high. His sister was able to locate prior paperwork that provided information regarding the services he received at the previous day program. The program appears to be compatible to ALTCS offered adult day health services that cater to young adults. CM explains benefits available under the ALTCS program. Upon completion of assessment, ISP documenting agreed services, frequency, and date span were signed by sister on behalf of the member and CM. Copy provided the member and sister.

<u>Together the CM and sister (brother is uncooperative and will not participate in goal setting or care planning) identify the following goals:</u>

1. Maintain both member's and sister's safety in light of increased aggression.
2. Stabilize psychiatrically and medically.
3. Promote self-care and modify anti-social behavior.
4. Once stable, promote socialization.
5. Once stable cigarette cessation
6. Leave Magnetic Health Card providing Emergency contact, PCP, CM and other emergency contacts.

Initial Individualized Service Plan (ISP):

1. Reinforce calling 911 with sister if she feels he is a danger to himself.
2. Develop safety plan whereby sister will leave home first and then call 911 from cell or neighbor's house if she feels threatened in any way.
3. Sister to supervise smoking as he may have a seizure and cause a fire.
4. Behavioral Health assessment by a psychiatrist to assess mental health needs and provide medication monitoring
5. Neurology consultation to evaluate seizures within 2-3 days.
6. Contact PCP to coordinate member's care and obtain PCP orders for those HCBS and medical services requiring orders. Provide PCP with ISP and summary plan per member initial intake.
7. Coordinate information sharing among PCP, psychiatrist and neurologist. (Summary Plan)
8. Behavioral Management Specialist to provide the sister with techniques to assist with medication adherence and to de-escalate his behaviors and suggestions for positive reinforcement. The specialist will also work with the member to increase self-management of his ADL skills.
9. Provide Personal Care Aide (PCA in morning in preparing member for Adult Day Health, transportation. The PCA is a behavioral health aide for 1 hr every am prior to Adult Day Health attendance.
10. Young Adult Program, through the local Adult Day Health center seven days a week for socialization, supervision and assistance with daytime activities, such as, medication management.
11. Longer term, investigate of possible vocational rehabilitation services.
12. Service Plan documenting agreed service(s), frequency, and date span signed by member, sister and CM

Upon returning to the office, CM:

1. Completes a Cost Effective Study (CES) to confirm that a HCBS setting is effective
2. Enters information into Care Radius – produces Summary Report for PCP/Other physicians and HCA Medical Director.
3. Create ISP, and contact providers – authorize services (system will generate alert to CM to check for authorized services are met within 5 days and again with 10)
4. Conducts care planning with BH coordinator and Medical Director post visit review of ISP.
5. Determine medication needs, refills then contact the PCP, coordinates PCP orders for those HCBS and medical services requiring orders and sends copies of care plan and Summary Report for the PCPs reviews
6. Set appointment with Neurologist, and Behavioral Health evaluation, transportation if needed (use medical home agency for mental health evaluation)
7. Set up visit of Adult Day Health programs for member and sister to visit within 1 week.
8. Set up Personal Care aid in am for 1 hr every am prior to Adult Day Health attendance.

Monitoring and Re-assessment:

1. Follow-up with psychiatrist and neurologist. Started on anti-psychotic and anti-seizure medications. Share information with PCP.
2. Follow-up weekly telephone calls with sister to assess medication adherence and affect of medications.
3. Telephone call to sister and member to assure that behavioral health services are implemented.
4. Telephone call the member to see if he feels Adult Day Health-Young Adult Program is meeting his needs.
5. Arrange for medically necessary transportation as deemed appropriate
6. Standard Re-assessment in 90 days unless change in level of care.

Medical Management

Requirement #25

MEDICAL MANAGEMENT SUBMISSIONS

REQUIREMENT #25

Describe how utilization data is gathered, analyzed, and reported by the Offeror. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. The submission requirement will be a maximum of three pages of narrative. Additionally, the Offeror must include three sample utilization reports that demonstrate how data is gathered, analyzed, monitored and evaluated when a variance has been identified. Each sample should be no more than one page.

Health Choice Arizona (HCA) gathers utilization data from a number of primary sources, the largest of which is medical claims data. Additional utilization data is obtained and analyzed by subcontractors. Examples include pharmacy claim data from Express Scripts and laboratory claim data from Laboratory Corporation of America. All data elements regardless of source are aggregated into a data warehouse from which standard as well as hoc, drill down and other focused reports are obtained.

Utilizing this data, HCA has established processes to both identify and develop action plans to address potential under utilization and over utilization of health care services. HCA collaborates interdepartmentally to compile, verify, and analyze data from multiple sources, and subsequently monitor, track, trend, and/or act on utilization data findings.

The purpose of the analysis is to provide a broad overview of over and/or under utilization of covered health care services in order to monitor organizational performance as well as individual performance of contracted providers and vendors. Additionally, HCA applies findings related to under or over utilization data in order to improve core member specific quality measures. This includes generating information on individual members, by county, PCP, zip code or other identifiers as necessary who have not had specific appointments or procedures that would improve their quality of care.

All Utilization Management (UM) activities are captured in the UM Plan that is updated at least annually by the UM Committee/Quality Management (QM) Committee and presented to Senior Management and the governing board.

HCA uses several types of utilization data that include:

1. Acute medical and behavioral health in-patient bed days
2. Acute Rehabilitation bed days
3. Dental
4. Durable Medical Equipment
5. Emergency Department visits
6. Immunizations
7. Laboratory services
8. Pharmacy (general and specialty)
9. Preventative health services
10. Primary Care Provider visits
11. High Tech Radiology services
12. Skilled Nursing Facility days
13. Transportation services

HCA uses sites/location of data analysis that includes:

1. Arizona State Immunization Information System (ASIIS)
2. Audit and recoveries data
3. Concurrent Review abstracts
4. Encounter data from claims
5. Encounter data from pharmacy benefits manager
6. Prior authorization request data
7. Reinsurance data
8. Referral data from Information Services (IS)
9. Transportation vendor reporting

On an ongoing basis, utilization reports are analyzed against available and /or appropriate benchmark data and/or plan average utilization data, historical plan data, and current utilization goals to detect any potential over or under utilization.

Those responsible for reviewing these findings include, but are not limited to:

1. Chief Executive Officer
2. Chief Financial Officer
3. Chief Medical Officer
4. Medical Director(s)
5. HCA Committees such as:
   a. Pharmacy & Therapeutic(P&T)
   b. Technical Advisory Committee (TAC) and the
   c. Utilization Management/Quality Management Committee
6. Director of Performance and Quality Improvement
7. Vice President of Medical Services
8. Senior Director of Network Services
9. Medical Management Coordinator
10. Utilization Review Director
11. Pharmacy Director(s)

The Quality Management/Utilization (Medical) Management Committee reviews' reporting provided by the HCA Medical Services Department and advises HCA on any corrective actions that should or can be taken based upon the analysis, such as:

1. Identification of inappropriate over or under utilization of services in comparison to similar providers or by internal or external benchmarks.
2. Analysis functions as a peer forum for discussion of utilization and quality within healthcare
3. Profiles are meant to be an educational tool and are distributed as such.

When inappropriate over or under utilization of services results in a plan of action or a requested corrective action by a reviewing staff member or committee, the following actions, include but are not limited to:

a. Comparative information feedback
b. Development of incentives to encourage appropriate utilization (preventive services)
c. Intensive prospective concurrent or retrospective monitoring

The most widely used standard reports to identify under and overutilization are 1) HEDIS measures, 2) Provider Profiles and 3) Service Utilization.

HEDIS measures are tracked quarterly for all of HCA membership to ensure members are receiving appropriate care. The measures are run for all Lines of Business (LOB), by GSA, and by provider, to determine if HCA has possible deficiencies in supporting adequate access to care: including both medical services as well as health prevention services. A list of members that did not receive the measured service is created. A letter is sent to the providers that are responsible for these members. Members also receive a letter encouraging them to speak to their provider about receiving the needed service(s). Case Managers outreach to the identified members-to offer assistance in coordinating needed services and removing possible barriers to care.

Provider Profiles compare individual Primary Care Providers (PCP) to their specialty averages, the GSA average and the plan average, while allowing for a member panel acuity adjustment factor. The Provider Profile measures EPSDT utilization, office visit levels, emergency room visits per 1,000 members, HbAc1 rates, eye and foot exams for diabetic members, pap smears, mammograms, generic pharmacy usage, well/preventative visits, dental visits, inpatient days and SNF days. This report is run quarterly for the PCPs with the highest number of members assigned to them. Provider Profiles are carefully reviewed by the Chief Medical Officer, Quality Director and QM Committee. Under or over utilization is investigated thoroughly as a Quality of Care issue. The formal peer review process is implemented if informal interaction between HCA staff and the offending provider are not successful.

Service Utilization reports are produced to track key utilization measures including hospital and SNF admissions/1000, days/1000, average length of stay, readmissions/1000, readmissions within 30 days of discharge, emergency room visits/1000, etc. Reports can be drilled down to the member, PCP, other provider, facility, diagnosis and county levels which allows HCA to focus initiatives and resources on identified areas of opportunity. HCA has the ability and anticipates producing service utilization reports for all ALTCS LTC institutional, HCBS and behavioral health services.

Health Choice Arizona
HEDIS Report Measures
Contract Year: 2009
Dates of Service 10/1/08 - 9/30/09
GSA: All
Provider: All

Measure	Eligible Population Measured	Measured Event	Ratio
Well-child visits in the first 15 months of life:			
Medicaid:			
Members with zero visits with a PCP	2,408	115	4.8%
Members with one visits with a PCP	2,408	153	6.4%
Members with two visits with a PCP	2,408	145	6.0%
Members with three visits with a PCP	2,408	199	8.3%
Members with four visits with a PCP	2,408	289	12.0%
Members with five visits with a PCP	2,408	406	16.9%
Members with six or more visits with a PCP	2,408	1,101	45.7%
Members with at least one visit with a PCP	2,408	2,293	95.2%
Children's Access to PCP's:			
Medicaid:			
12 - 24 Months old	143	139	97.2%
25 Months to 6 Years old	718	642	89.4%
7 - 11 Years old	1,172	856	73.0%
12 -19 years old	1,221	877	71.8%
Total	3,254	2,514	77.3%
Adolescent well-care visit:			
Kidscare 12-21 Years old	1,224	574	46.9%
Children Immunization (2 Years Old):			
Medicaid:			
DtaP/DT (initial plus three more)	1,481	835	56.4%
IPV (at least three)	1,481	732	49.4%
MMR (at least one)	1,481	971	65.6%
HiB (at least three)	1,481	849	57.3%
Hepatitis B (at least three)	1,481	364	24.6%
VZV (at least one)	1,481	936	63.2%
4:3:1:3:3:1 Series	1,481	260	17.6%
Adolescent Immunization:			
Medicaid:			
MMR (second dose)	1,306	174	13.3%
Hepatitis B (at least three)	1,306	9	0.7%
VZV (at leaste one)	1,306	206	15.8%
Combination: 2nd MMR, 3 Hep B and 1 VZV	1,306	4	0.3%
Annual dental visit:			
Medicaid:			
2 - 3 Years old	4,284	1,344	31.4%
4 - 6 Years old	4,633	3,125	67.5%
7 - 10 Years old	7,657	5,295	69.2%
11 - 14 Years old	5,662	3,327	58.8%
15 - 18 Years old	4,441	2,022	45.5%
19 - 21 Years old	2,233	656	29.4%
Total	28,910	15,769	54.5%
Adult Preventative/Ambulatory Care:			
20 - 44 Years old	15,652	9,527	60.9%
45 - 65 Years old	5,930	4,697	79.2%
65+ Years old	274	229	83.6%
Total	21,856	14,453	66.1%
Cervical Cancer Screening (3 year period):			
Women 21 - 64 Years old	14,590	7,243	49.6%
Breast Cancer Screening (2 year period):			
Women 52-69 Years old	1,960	556	28.4%
Chlamydia Screening:			
Women:			
16 - 20 Years old	1,088	495	45.5%
21 - 25 Years old	1,173	440	37.5%
Total	2,261	935	41.4%

Health CHOICE

Provider Profile
For Dates of Service 10/01/2009 through 09/30/2010
Payments Through 01/15/2011

Member Months	**5,670**
GSA	**8**
Specialty	**PEDIATRICS**
Provider	**Test Data**

Member Months by Category of Eligiblity (Risk Group)_

Risk Group	Member Months	Member Month Mix	Average Capitation Rates GSA	Specialty	Plan	Provider Risk Value % of GSA Average	Specialty Average	Total Plan Average
TWG - MED	3	0.05%	820.62	820.83	820.29			
TWG - NON MED	3	0.05%	425.54	431.08	421.59			
TANF <1, M/F - TACI	670	11.82%	433.76	430.50	430.96			
TANF 1-13, M/F - TACS	4,237	74.72%	105.05	102.65	102.93			
TANF 14-44, F - FMAL	248	4.37%	180.34	183.03	183.69			
TANF 14-44, M - MALE	269	4.75%	127.17	126.35	128.36			
TANF 45+, M/F - ADLT	0	0.00%	350.96	357.19	361.15			
SSI With Medicare - SSIW	0	0.00%	182.57	190.87	182.76			
SSI Without Medicare - SSIN	240	4.24%	564.65	578.60	579.46			
SOBRA Family Planning Services - SFPS	0	0.00%	17.67	-	16.96			
SOBRA Pregnant Female - SBR(C), (D), (F)	0	0.00%	180.34	187.64	184.90			
Total	**5,670**	**100.00%**	**231.28**	**172.70**	**226.55**	**72.7%**	**96.5%**	**73.8%**

Utilization Information:

	Provider	Value: GSA Average	Value: Specialty Average	Value: Plan Average	Provider Variance to: GSA Average	Specialty Average	Plan Average	Provider % Variance to: GSA Average	Specialty Average	Plan Average
EPSDT Participation Per Member Per Year:										
TANF <1	12.72	8.57	9.95	9.43	4.15	2.76	3.28	48.4%	27.8%	34.8%
TANF 1-13	1.76	0.94	1.32	1.03	0.81	0.44	0.73	85.9%	33.2%	70.7%
Office Visits Per Member Per Year	2.07	2.46	2.42	2.06	(0.39)	(0.35)	0.00	-15.9%	-14.6%	0.2%
% of Total New and Existing Patient Office Vistis Billed at Level 1	3.2%	2.2%	2.8%	2.9%	1.0%	0.4%	0.3%	46.0%	13.7%	11.5%
% of Total New and Existing Patient Office Vistis Billed at Level 2	1.7%	10.6%	11.8%	9.6%	-8.9%	-10.0%	-7.8%	-83.5%	-85.2%	-81.8%
% of Total New and Existing Patient Office Vistis Billed at Level 3	88.6%	61.8%	68.9%	61.3%	26.8%	19.7%	27.3%	43.4%	28.5%	44.6%
% of Total New and Existing Patient Office Vistis Billed at Level 4	6.3%	23.8%	15.8%	24.1%	-17.4%	-9.5%	-17.8%	-73.3%	-59.9%	-73.7%
% of Total New and Existing Patient Office Vistis Billed at Level 5	0.1%	1.6%	0.6%	2.1%	-1.5%	-0.5%	-2.1%	-94.4%	-85.1%	-95.7%
Emergency Room Visits Per Member Per Year	0.74	0.89	0.66	0.74	0.15	(0.08)	(0.01)	16.4%	-12.5%	-1.1%
HbA1c Rate (% of Assigned Diabetics Receiving Semi-annual Tests)	0.0%	64.6%	100.0%	72.2%	-64.6%	-100.0%	-72.2%	-100.0%	-100.0%	-100.0%
Eye Exam (% of Assigned Diabetics Receiving Semi-annual Tests)	0.0%	20.1%	23.4%	24.3%	-20.1%	-23.4%	-24.3%	-100.0%	-100.0%	-100.0%
Pap Smear Rate (% of Women ages 18-64 Receiving Annual Pap Smear)	0.0%	30.7%	34.3%	34.4%	-30.7%	-34.3%	-34.4%	-100.0%	-100.0%	-100.0%
Mammography rate (% of Women ages 50-69 receiving annual exam)	0.0%	47.8%	41.2%	38.3%	-47.8%	-41.2%	-38.3%	-100.0%	-100.0%	-100.0%
% Generic Pharmacy Utilization	73.4%	71.2%	75.9%	72.4%	2.1%	-2.6%	0.9%	3.0%	-3.4%	1.3%
Non-utilization rate (% of Members never seen by the PCP in last 12 Months)	38.5%	28.4%	33.8%	35.0%	10.1%	4.6%	3.5%	35.4%	13.7%	9.9%
Dental Appoint (% of Members under 20 with Check up in last 12 Months)	39.5%	34.9%	45.3%	41.9%	4.7%	-5.8%	-2.3%	13.4%	-12.8%	-5.6%
Inpatient Days per Member per Year	0.06	0.75	0.53	0.72	0.69	0.47	0.66	92.3%	89.2%	92.0%
SNF Days per Member per Year	-	0.11	0.00	0.11	0.11	0.00	0.11	100.0%	100.0%	100.0%

Utilizaiton
Sample Data
Sample Period

	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10
Member Months	176,578	177,036	178,226	179,096	179,004	179,495	179,456	179,246	179,885	180,639	181,378	180,985
Paid Amount	$ 16,176,075	$ 12,227,705	$ 11,279,975	$ 12,616,671	$ 12,824,213	$ 14,201,280	$ 11,910,840	$ 13,534,245	$ 11,859,099	$ 12,731,508	$ 13,630,071	$ 11,191,755
Admits	2,731	2,543	2,496	2,619	2,518	2,724	2,456	2,517	2,497	2,577	2,620	2,516
Admits/1000	157	146	142	148	143	154	139	142	141	145	146	141
Paid per Admit	$ 7,098	$ 5,762	$ 5,416	$ 5,773	$ 6,103	$ 6,248	$ 5,812	$ 6,444	$ 5,692	$ 5,921	$ 6,234	$ 5,331
Days	14,096	12,266	11,561	12,524	12,460	13,615	11,305	12,259	11,992	12,343	12,403	10,872
Days/1000	809	702	657	709	705	769	638	693	676	692	693	609
Paid per Day	$ 1,375	$ 1,195	$ 1,169	$ 1,207	$ 1,233	$ 1,250	$ 1,263	$ 1,323	$ 1,185	$ 1,236	$ 1,317	$ 1,234
ALOS	5.16	4.82	4.63	4.78	4.95	5.00	4.60	4.87	4.80	4.79	4.73	4.32
Recipiants	2,541	2,383	2,333	2,432	2,361	2,560	2,300	2,357	2,332	2,392	2,455	2,365
Recipiants/1000	146	136	133	138	134	145	130	133	131	134	137	132
Paid per Recipiant	$ 7,629	$ 6,149	$ 5,794	$ 6,217	$ 6,509	$ 6,648	$ 6,206	$ 6,881	$ 6,094	$ 6,378	$ 6,653	$ 5,671
ED Visits	13,151	11,401	10,285	11,496	11,020	11,571	10,980	11,513	11,016	11,407	11,776	11,183
ED Visits/1000	755	653	585	650	624	653	620	651	621	640	658	626
Readmits												
10 Days	73	98	106	111	97	96	93	103	106	124	98	102
Paid Amount	$ 592,160	$ 951,522	$ 868,563	$ 695,642	$ 817,624	$ 713,472	$ 701,107	$ 1,082,147	$ 723,820	$ 1,197,209	$ 650,438	$ 1,054,099
Readmit %	2.7%	3.9%	4.2%	4.2%	3.9%	3.5%	3.8%	4.1%	4.2%	4.8%	3.7%	4.1%
30 Days	103	223	237	255	214	230	216	223	228	261	228	230
Paid Amount	$ 818,177	$ 1,879,738	$ 1,750,018	$ 1,814,249	$ 1,623,696	$ 1,768,654	$ 1,434,297	$ 2,085,983	$ 1,609,713	$ 2,326,945	$ 1,891,712	$ 2,041,996
Readmit %	3.8%	8.8%	9.5%	9.7%	8.5%	8.4%	8.8%	8.9%	9.1%	10.1%	8.7%	9.1%
60 Days	103	276	330	349	311	352	296	325	314	367	330	322
Paid Amount	$ 818,177	$ 2,216,100	$ 2,194,255	$ 2,394,265	$ 2,324,448	$ 2,637,788	$ 2,055,057	$ 2,865,412	$ 2,234,641	$ 3,147,266	$ 2,718,875	$ 2,591,177
Readmit %	3.8%	10.9%	13.2%	13.3%	12.4%	12.9%	12.1%	12.9%	12.6%	14.2%	12.6%	12.8%
120 Days	103	276	360	440	459	458	422	439	401	471	437	423
Paid Amount	$ 818,177	$ 2,216,100	$ 2,404,558	$ 3,123,475	$ 3,477,720	$ 3,255,704	$ 3,034,783	$ 3,842,557	$ 2,860,819	$ 3,663,472	$ 3,562,740	$ 3,215,849
Readmit %	3.8%	10.9%	14.4%	16.8%	18.2%	16.8%	17.2%	17.4%	16.1%	18.3%	16.7%	16.8%

Requirement #26

REQUIREMENT #26

Provide an example of how the Offeror's analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system.

Health Choice Arizona (HCA) has established systems to both identify and develop action plans to address potential under utilization and over utilization of health care services. HCA collaborates interdepartmentally to compile, verify, and analyze data from multiple sources, and subsequently monitor, track, trend, and/or act on utilization data findings.

The purpose of the analysis is to provide a broad overview of over and/or under utilization of covered health care services in order to monitor organizational performance as well as individual performance of contracted providers and vendors. Additionally, HCA applies findings related to under or over utilization data in order to improve core member specific quality measures. This includes generating information on individual members by county, PCP, zip code or other identifiers as necessary, who have not had specific appointments or procedures that would improve their quality of care.

An example of how HCA has analyzed data and has implemented an initiative to successfully impacted unfavorable utilization patterns can be demonstrated by HCA ER Transition of Care Outreach program. HCA utilizes a pharmacy report (4 or More Controlled Substances Report) and the Frequency ER utilization report to identify members that may require transition of care services as well possible opportunity to improve medical/ medication management.

Currently HCA works proactively with members identified as needing pain management services or are high utilizes of the emergency room. The goals of the ER Transition of Care Outreach program are to meet the medical, functional, social and behavioral health needs of the member through a mutually agreed upon individualized care plan that focus on the member's strengths and needs, fostering a person-centered approach that is appropriate and cost effective. To meet these goals the HCA CM will:

1. Identify and support members who need coordination and possible the planning of medical and/or social services i.e. transportation to facilitate providers appointments, home health services, community resource support; such as Meals on Wheels, caregiver training; thereby addressing underutilization.
2. Educate member on HCA CM services and providing information on possible identified gaps in care (promoting wellness and preventative health care services)
3. Provide medication reconciliation and medication review to include the purpose of the medication, the effectiveness of the medication and any adverse side effects that may have occurred.
4. Validate and/or facilitate the coordination of needed services to ensure the prescribed medical services are being provided as prescribed.
5. Validate if provider follow up appointment have been scheduled post Hospital/ER discharge and that the member has transportation arranged, addressing any potential access to care issues.
6. Refer and ensure linkage of members to appropriate treatment provide including pain management doctors, behavioral health providers and other medical providers as required.

The objectives of the ER Transition of Care Outreach program are:

1. Member increase compliance with all appropriate treatment providers
2. Member improve adherence to prescribed medication régime
3. Member decrease/eliminate medication seeking behaviors
4. Member demonstrate appropriate utilization of ER services, PCP/MD and behavioral health services

Current Interventions:
The HCA CM unit monitors and assists members with issues surrounding chronic pain and frequent ER use through the assessment of the 4 or More Controlled Substances Report and the Frequent ER Utilization Report on a monthly base. The CM unit researches the medical and behavioral health background of the identified members to determine factors driving increased utilization in prescription use and ER visits while factoring in possible underutilization of provider appointments. Assessments are made based on clinical information obtained from the member and all treating providers. Members with 12 or more admits to the ER within a six (6) month period will receive a letter providing them with PCP contact information for follow up on medical needs and information on how to contact their newly assigned HCA Case Manager.

The PCP also receives a letter regarding the member's frequent ER utilization for coordination of care. Continuation of excessive ER use may result in restricting members to the key providers in their medical treatment to ensure the continuity of medical care. Members receiving multiple prescriptions from multiple prescribers and pharmacies are reviewed by the CM who then communicates with the member's PCP to determine medical necessity and to develop an individualized care plan to support appropriate medical management and improved coordination of services. Ongoing CM services are provided to all members that have been assessed as using 4 or more controlled substances or frequent ER visits.

HCA tracks and trends utilization patterned for the ER Transition of Care Program based on certain characteristics. These reports identified a correlation in members that were moving between multiple PCP's and using multiple pharmacies to total overall utilization of all services, particularly inpatient. A theory was developed that by moving between PCP's, and utilizing multiple pharmacies, the member's coordination of care was suffering and causing the use of additional services. HCA initiated a program to "lock" certain members to a specific PCP and a specific pharmacy. The Lock Down report confirms that after helping the member stay with one PCP and a limited range of pharmacies, the member experienced a better coordination of care which resulted in a decrease in the utilization of services particularly inpatient admits and total prescriptions.

Requirement #27

REQUIREMENT #27

Describe existing or planned Chronic Care/Disease Management programs that are designed to improve health care outcomes for members with one or more chronic illnesses. Describe how the Chronic Care/Disease Management programs' data are analyzed and the results utilized by the Offeror to improve member outcomes.

Health Choice Arizona's (HCA) well-established Chronic Care/Disease Management (CC/DM) Programs will be available to ALTCS members. These programs focus on special health care needs, high-risk conditions, co-morbid diseases, and chronic medical conditions. HCA CC/DM programs compliment the care offered by PCPs and specialists, are developed using evidence-based guidelines and consider the unique needs of the population served. Provider information for each CC/DM program contains current best practice guidelines from authoritative sources, and explains how each program recommendation is related to evidence-based guidelines.

HCA CC/DM programs increase member awareness; encourage disease self-management and emphasize the importance of compliance with an established plan of care and medications. HCA CC/DM programs are intended to facilitate open, culturally sensitive patient-provider communication, and drive improved practice patterns of providers while helping to control associated health care expenses. Each program has methodologies in place that evaluate both effectiveness and outcomes, including provider visit and medication compliance, emergency room utilization, preventative service utilization and hospital and SNF utilization.

The HCA Medical Management/Utilization Management Committee in addition to AHCCCS contract requirements has oversight of the selection and ongoing monitoring of CM/DM programs. With diverse backgrounds, the clinical and non-clinical committee members focus on selected disease conditions based on utilization of services, at-risk/high-risk population groups, outpatient and inpatient practice experiences, and high volume/high cost conditions. All CC/DM programs developed by HCA incorporate these guiding principles and goals:

1. Identifying members at risk of or already experiencing poor health outcomes due to their disease burden;
2. Provide interventions with specific programs that are founded on evidence based guidelines with guidelines that are communicated and disseminated to network providers;
3. Support methodologies that evaluate the effectiveness of programs;
4. Provide materials that include education which enhances the members' ability to self-manage their disease and encourages provider participation to drive positive outcomes;
5. Incorporate methods for supporting the member and the provider in establishing and maintaining relationships that foster consistent and timely interventions and an understanding and adherence to the plan of care; and
6. Support the methodology for monitoring provider compliance with the guidelines, and which are designed to bring the providers into compliance with the practice guidelines.
7. Coordinate with other payers including Medicaid, Medicare, Medicare Advantage Plans, and Medicare Advantage Special Needs Plans when appropriate.

Established HCA CC/DM Programs include:

- Healthy at Heart (includes Type I and Type II diabetes; hypertension; and dyslipidemia),
- Asthma/COPD Inspiring Quality Program
- Smoking Cessation
- Transplant
- Material Obstetrical Programs (include gestational diabetes, hypertension, preeclampsia, nausea and Vomiting)
- Chronic Pain Management Program, and
- Childhood Obesity Program.

HCA would be delighted to provide AHCCCS/ALTCS with detailed information on any of the CC/DM programs listed above.

Requirement #28

REQUIREMENT #28

Describe the process used by the Offeror for the adoption and dissemination of clinical criteria used for decision making that would ensure consistent application of the criteria for clinical decision making.

Health Choice Arizona (HCA) develops and/or adopts both clinical criteria used for decision-making and practice guidelines that are evidence based and derived from authoritative sources. HCA Medical Services staff (e.g., prior authorization, concurrent review, complex case management and chronic care/disease management) utilizes these criteria and practice guidelines in carrying out daily operations.
The following processes apply to the development, adoption and dissemination of both clinical criteria and practice guidelines.

Research and Development by Medical Directors:

1. The Medical Director(s) and/or designee will research established national criteria and guidelines to improve quality of care and to reduce variations in care.
2. The Medical Director(s) and or designee will use research and evidence based medicine to implement the criteria and practice guidelines to meet the medical needs of our members.
3. Feedback from the HCA provider network is solicited to obtain input, new ideas and/or concepts for revising or developing criteria and guidelines.

Review/Revision and Distribution of Practice Guidelines

1. The QM/UM committee and/or the Pharmacy & Therapeutic committee (P&T) review the criteria and guidelines and may offer recommendations to further enhancement.
2. As new criteria and guidelines are developed or adopted, network providers are notified through the provider correspondence as needed. In addition, HCA will provide member education through the member quarterly newsletter and postings on the HCA website.
3. HCA criteria and guidelines are listed on the HCA website at www.healthchoiceaz.com and assembled in the *Provider Manual* or directly mailed to HCA practitioners upon request.
4. HCA's guidelines are reviewed and updated every year or as needed

HCA currently uses InterQual criteria, HCA-developed prior authorization guidelines, AHCCCS and CMS criteria to make approval and denial decisions when authorizing services. To ensure that there is consistency in the application of these criteria, the following Inter-Rater Review Policy has been implemented. Quarterly IRR audits are part of the QM/UM Work Plan, with results evaluated during the UM/QM Annual Program Evaluation.

The Director of Medical Services, Utilization Review Coordinator, Pharmacy Director and/or designee will conduct and document a medical appropriateness review on approved services processed by Medical Service personnel and requests sent to the Chief Medical Officer and/or Medical Director for potential denial, in accordance with Policy 1010 of the AHCCCS Medical Policy Manual. The policy includes but is not limited to:

1. Annual audits on all Medical Services staff will be performed by the Director of Medical Services, Utilization Review Coordinator, Pharmacy Director and/or his/her designee or external consultant for Medical Service staff.
2. An educational training on InterQual criteria, Health Choice Arizona prior authorization guidelines, AHCCCS and CMS criteria will be provided by the dedicated staff listed above and/or an external consultant.
3. Case studies will be provided during the training and will be scored for appropriate application of criteria. The overall scoring will be based on number of case studies reviewed.
4. Employees who do not meet the scoring standards on the case studies will be required to repeat the training that will be provided the next day.
5. Corrective action will be taken with employees continuing to fall below standards after the second day of training.
6. Continuing education will be provided through the year in regular weekly staff meetings.

Chief Medical Officer and/or Medical Director will be audited for consistency of criteria application by an outside independent physician reviewer at least annually.

Quality Management

Requirement #29

QUALITY MANAGEMENT SUBMISSIONS

REQUIREMENT #29

Describe how the Offeror identifies quality improvement opportunities. Describe the process utilized to select a performance improvement project, and the process utilized to implement or enhance multi-departmental interventions to improve care or services. Include information on how interventions will be evaluated for effectiveness.

Quality improvement opportunities are identified as the result of input from internal and external sources; direction from the Quality Management Committee (QMC); and follow-up actions from previous projects, trends identified from clinical and service quality performance indicators and analysis of age or gender specific diagnoses that occur frequently. Additional sources include member and provider satisfaction surveys, utilization management reports, provider profiling data, peer review, on-site reviews of providers, grievances and appeals data, inter-rater reliability studies of Health Choice Arizona (HCA) medical record review staff and AHCCCS performance measures and trends.

HCA addresses quality improvement opportunities that are focused at the individual level through established processes set forth in HCA policies and procedures. For example, if the results of the ambulatory medical record review indicated deficiencies, an individual provider may be asked to submit a corrective action plan and the HCA network service representative may in-service the office staff, as appropriate. Quality improvement opportunities that are identified using a more global perspective (i.e. result of trending data over time) generally lead to the development of more formalized Performance Improvement Projects (PIP). These PIPs often impact large groups of providers or members and/or require major restructuring of current operational processes or implementation of new intervention strategies. Once identified, potential quality improvement opportunities are given to the QM Department who, in collaboration with other appropriate department(s) and with the HCA QMC: (1) analyze the issue further by assessing its extent (local community or statewide, all providers or certain provider types) and impact on members (effect on health outcomes) (2) research, if appropriate, the experience of other health plans and/or states and conduct a literature review (3) evaluate the interest of members, providers and AHCCCS in addressing the problem and (4) develop a plan for taking action on identified opportunities for improvement.

A PIP, initiated by HCA, will measure performance in one or more focused areas; undertake system interventions to improve quality; and evaluate the effectiveness of those interventions. The PIP is designed to achieve demonstrable and sustained improvement in clinical care or administrative services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Alternatively, it corrects significant systemic problems that come to the attention of HCA through internal surveillance and service delivery monitoring, credentialing/re-credentialing, tracking and trending of complaints/allegations, member and/or provider satisfaction or other mechanisms.
Topic selection is determined by the prevalence of the condition among or the need for a specific service by the HCA members, member demographic characteristics and health risks, interest of members, providers, AHCCCS and/or CMS in the aspect of care or service to be addressed. Member input is sought, whenever possible, in the selection of topics for a PIP and formulation of project goals.

Topics are systematically selected and prioritized, to achieve the greatest practical benefit for enrolled members. All potential quality improvement initiatives are ultimately submitted to and reviewed by the QMC, which plays a lead role in overseeing and carrying out the strategic direction and quality improvement initiatives. A decision method used by the QMC, in final topic selection, is the use of a scoring tool with weighted voting.
Assessment of the impact of the PIP is measured using one or more performance measures. Performance measures are objective, clearly defined, measure outcomes and are based on current clinical knowledge or health service research. HEDIS measures, Healthy People 2020 or other measures that are generally used within the medical community or the managed care industry that exist and that are applicable to the topic, will be utilized. Performance measures selected for a clinical focus topic will include a measure of change in health status, functional status or process of care for these outcomes.

For each PIP, HCA establishes a baseline measure of its performance for each measure. HCA strives to meet, maintain and/or exceed the benchmark(s) proposed for the PIP. Improvement must be evidenced in repeat measurements of the performance measures. Sustained improvement is achieved when HCA maintains or increases the improvements in performance for at least one year after the improvement in performance is first achieved, and

HCA documents continued measurement of performance measures to indicate maintenance for at least one year after the PIP achieved substantial improvement.

HCA has numerous performance improvement projects (PIPs) in various stages of implementation. The sample diabetic project, which is included as an attachment illustrates the performance improvement methodology, utilized by HCA for the Medicare population was completed in January 2010. Interventions such as periodic educational mailings to newly diagnosed diabetic members and new members with diabetes are on-going. The results of this project showed an increase from 80.97% in the baseline year to 84.75% in re-measurement year 2. We are highlighting this project as an example of our commitment to our dual members (Medicare and Medicaid), and our efforts to collaborate with available Medicare/Medicaid resources i.e., Health Services Advisory Group (QIO), the use of the National Committee for Quality Assurance (NCQA) methodology format and the use of an objective scoring tool for selecting a PIP, and the references to HEDIS technical specifications for project development. The project methodology includes: why the project was developed or the purpose of the project, why the project topic was chosen and the impact that it is expected to have of HCA members, interventions used and the barrier addressed by the intervention, what aspect of care the PIP addresses and what data will be used for analysis of the project. At the closure of the project a "lessons learned" section was completed addressing system level changes that were made and opportunities for improvement.

Prior to the implementation of this particular quality improvement project for Health Choice's Medicare population, the health plan was employing a number of strategies to educate both members and providers about the importance of increasing the rate of HbA1c testing with diabetic members to maintain control of glycemic levels. A quarterly mailing goes out to newly diagnosed diabetic members and diabetic members new to the health plan. The mailing includes a letter and four brochures to help diabetics manage their diabetes.
The goal of this project is to have diabetics HbA1c level tested at least once a year. Also, to see rates, of all eligible diabetic members, better than the national, regional and state levels for diabetics in "good control" which is defined as HbA1c <8%, for our Medicare population. On an annual basis the results of the HEDIS project were reviewed to determine the health plan's rate of compliance with this project. Upon re-measurement, interventions were assessed for effectiveness, based on whether indicators improved, decreased, or displayed no change. New interventions were created and implemented, as needed, in an effort to meet and/or exceed established goals.

Attachment: Performance Improvement Project General Information
Title of Performance Improvement Project: Improving HbA1c Testing among members with Diabetes
Date of project initiation: 10/1/2006
Date of project completion or expected project completion: 9/30/2010

Project Focus Area Type

a. Clinical Focus Area: prevention of acute/chronic conditions, treatment or care of acute/chronic conditions, high-volume services, high-risk services, continuity/coordination of care.
b. Aspect of Clinical Care Related to Focus Area is the prevalence of a clinical condition. The Centers for Disease Control and Prevention (CDC) estimates that more than million Americans age 20 years and older, or 9.6 percent of all people in this age group, have diabetes. About 1.5 million new cases of diabetes were diagnosed among people 20 years and older in 2005.An estimated 244,000 Arizona adults had a diagnosis of diabetes in 2002, the most recent year for which state-specific data are available.
c. Member demographic characteristics: The number of people in the United States with diagnosed diabetes has more than doubled in the last 15 years. The prevalence of diabetes in Arizona also has increased during that time. Contributing to this increase is the large number of "baby boomers" who are aging and living longer than previous generations. A sedentary lifestyle and a dramatic rise of obesity in the U.S. population also are increasing the incidence of diabetes.
d. Aspect of Non-Clinical Services that apply to this project: Timeliness of care
e. Performance against a guideline: The American Diabetic Association guideline recommends testing HbA1c at least annually for all diabetic patients.

Relevance of PI project topic to Medicaid population

a. Diabetes was the sixth leading cause of death in the United States in 2002, causing or contributing to at least 224,000 deaths. In the United States, Hispanics, blacks, American Indians and Alaska natives are twice as likely to have diabetes as non-Hispanic whites. National data also show higher rates of diabetes among people with low socioeconomic status or those covered by Medicaid.
b. This topic was selected based on: those areas identified, which may be problem prone, high risk or high volume and came to the attention of HCA through internal surveillance monitoring, and tracking/trending of complaints/allegations. The decision to take actions related to improvement opportunities were prioritized based on the following:
    - The impact that the project will have on the member
    - Performance below a targeted goal or performance threshold that is not acceptable to the health plan; or a
    - Regulatory requirement
    - Ability to achieve improvement/feasibility of the study

Data Sources and Collection Methodology

a. Identify the sources of data utilized in quality indicators/measures in this quality improvement project:
    - Claims/encounter data using HEDIS 2007 methodology
b. Data Analysis Cycle and Collection Cycle
    - Once a year

Performance Improvement Measures
Name: HbA1c testing improvement among members with diabetes.
Numerator description: The number of HCA members, who meet the sample frame, who had at least one HbA1c test during the measurement year.
Denominator description: All HCA members diagnosed with diabetes
Inclusion Criteria: Diagnostic codes: 250, 357.2, 362.0, 366.41, and 648.0
Exclusion Criteria: Members with steroid induced or gestational diabetes; polycystic ovaries
Performance Target: 77% (Benchmark based on current statewide performance) 89% (Healthy People 2010 goal)
Rationale/Justification for Performance Target: To increase the rate of HbA1c testing among HCA members with diabetes in order to assist members and the physicians with establishing and maintaining control of blood glucose (glycemic levels)
Data Validation: The test files (10%) will be randomly selected and the following information verified: AHCCCS identification number, member's full name and date of birth, beginning and end dates of enrollment, member meets inclusion criteria as per the methodology, if the member meets the exclusion criteria that member will be excluded from the sample, encounter/diagnosis codes are those listed in the technical specifications of the methodology. If errors are located in the files, corrections will be made and the files will be regenerated. In addition, encounter data will be validated annually through a separate process to evaluate completeness, accuracy and timeliness.
Analysis Plan: The numerator will be divided by the denominator to determine the percentage of compliance of the indicator. Other analysis such as sorting by county, gender, age, rural/urban counties will be conducted to assist in targeting interventions.

Comparative Analysis

- Differences between the baseline measurement, first re-measurement and second re-measurement will be analyzed for statistical significance and relative change.
- Results for the HEDIS measure of Diabetes will be compared to the most recent rates for HCA.
- All other stratifications as deemed appropriate (e.g. age range, race/ethnicity, gender, and urban vs. rural counties) will be compared to each other.

Requirement #30

REQUIREMENT #30

Describe how the Peer Review Committee is structured and utilized by the Offeror and how its reviews/decisions are made and incorporated into the Offeror's quality management process.

Health Choice Arizona (HCA) maintains a formal process for peer review to analyze quality of care issues arising from the activities of providers. Peer review is conducted using evidence-based guidelines, when available, or practice parameters that are nationally accepted. Providers are informed about the peer review process, including the appeals process, in the HCA contract and in the Provider Manual. Specific provider concerns as well as more global provider network issues are addressed by HCA through the peer review process. The integration of peer review with HCA's other quality management processes, such as credentialing and re-credentialing as well as projects aimed at quality improvement, underlines HCA's ongoing efforts to improve the quality of care.
The peer review process includes, but is not limited to, the following steps:

- All referrals of potential quality issues are directed to the QM Department. The QM Specialist reviews each referral for completeness of information and documentation and collects supporting documentation. A case summary (QM Worksheet) is done on every QM case, as well as a complaint worksheet. The QM Director immediately reviews all cases that appear to be level 4 with the Chief Medical Officer/Medical Director.
- A potential quality of care or quality of service issue may be referred to an HCA department manager for investigation and resolution of the issue, i.e. referring to the HCA Network Manager for a member who has been charged co-pay or photocopying fees for medical records. The department manager must respond with their findings to the QM Unit within ten business days. The QM department will review the department manager response and close or assign a severity level to the case. The QM Director/Coordinator and QM Staff close the case, and the original referrals on the case are stored in the provider's QM file for future analysis of trends/referrals.
- If a potential quality issue is identified, a preliminary severity level rating is assigned during a QM Staff review of the case and further action may be taken such as a letter of inquiry to the provider. The referral file is maintained in the QM Department until the necessary information has been obtained.
- The provider has ten (10) working days to respond to requests for information. If no response is received, the request will be repeated. The provider will be given five (5) additional days to respond. If there is still no response, the quality of care concern will be discussed with the Chief Medical Officer/ Medical Director who will either contact the provider directly, or determine another appropriate action.

By recommendation of the Chief Medical Director/ Medical Director and/or the QM Committee, a case may be referred out to an external independent medical review entity for review. HCA uses MCMC, LLC, based in Massachusetts, to provide unbiased expert opinions on medical cases that are determined to need an outside opinion, more in-depth review or a review by a specialty that is not available within our organization MCMC is a national provider for services such as medical review.

Severity Rating Levels

Based on all relevant information available, the QM staff will determine whether a quality issue exists and assigns a severity rating. Rationale for the decision is documented. Cases that do not reveal a potential quality of care concern, unable to validate due to lack of data (level 0) are immediately closed and placed in the provider's file for tracking purposes and documented in the QOC database (QM application module of the integrated Health Plan Information System (HPIS).
If the case is assigned a severity rating of level I (Known complication, with or without adverse outcome) or level 2 (Identified potential quality of care issue without adverse outcome but with the potential for adverse outcome or level 3 (Identified potential quality of care issue with temporary adverse outcome), the file is logged in the QOC database and also maintained in the provider's QM file and for future trending.

All level 4 (Identified potential quality of care issue with long-term adverse outcome), level 5 (Quality of care issue-mortality following the mortality review using the mortality review tool) and AHCCCS originated cases are reviewed by the Medical Director (QOC meeting). The Quality of Care (QOC) subcommittee workgroup is responsible for the qualitative and quantitative analysis of the research conducted by the quality management department during the preliminary review of QOC cases (level 4, level 5 and AHCCCS cases). The Quality of Care meeting is a subcommittee workgroup of the QMC and is comprised of the Chief Medical Officer/Medical Director, QM Director, QM

Coordinator, QM Specialist and others, as needed, for the purpose of reviewing more complex cases. The workgroup reviews the initial assessment of the severity of the allegations, prioritization of actions for resolution, development of an action plan and the referral of cases to the Quality Management Committee peer review section for further review, action and follow up. All level 4 and 5 cases, and AHCCCS cases may be referred to the QMC at the discretion of the Medical Director. Refer to QM Policy 9.510 for further information on the QOC/QM Committee.

Incorporation of Peer Review into Quality Management Processes

Peer review is an essential component of the HCA quality management process and is incorporated into HCA quality management as follows:

- The HCA Quality Management Plan documents all components and activities of HCA's QM program, including a detailed description of the peer review process. In addition, HCA develops an annual Quality Management Work Plan that incorporates the schedule of activities to support the requirements outlined in the plan. All planned improvements projects/interventions to address issues identified through peer review are set forth in this Work Plan, enabling HCA to monitor implementation of the proposed interventions, measure their effectiveness, and implement new interventions when needed. Activities that have been identified in the Work Plan are then addressed in the annual Quality Management Program Evaluation in the following year.

- All peer review cases are documented in the confidential and secured QM application module of the integrated HPIS. The information is reviewed and analyzed by the QM department to identify significant trends. The QM Director prepares quarterly and annual quality of care reports and peer review trend reports on cases that were closed during the reporting period. The HCA Chief Medical Officer/Medical Director and the QMC review the reports. All significant trends are identified, assessed and systems improvements, both clinical and non-clinical in nature, are then implemented, ranging from changes in the peer review process itself, to modifications to current HCA operations, to provider network education. In keeping with HCA's Plan, Do, Check, Act quality improvement model, all systems improvements and interventions are then evaluated for effectiveness, and new improvements are implemented when needed.

- HCA also utilizes peer review processes in contracting, credentialing and re-credentialing decisions by reviewing data by provider to identify trends on all quality issues referrals.
  To identify complaint patterns regarding providers in between re-credentialing periods, HCA initiated routine trending queries which are done monthly for the previous rolling twelve month period of time based on a query threshold of the sum of points on quality cases being greater than or equal to 6 points (Severity level 0 = 0 points, Severity level 1 =1 point, ...Severity level 5 = 5 points). Identified patterns will be submitted to the Chief Medical Officer/Medical Director and at his/her discretion to the QMC, for evaluation.

- The QMC Executive peer review session of the QM/UM Committee, which meets monthly, is responsible for performing peer review. The Committee investigates upper severity level cases, referred to the Committee by the Chief Medical Officer/Medical Director, involving Providers that may have an affect on the quality of care provided to members. The Committee consists of the HCA Chief Medical Officer and /or the Medical Director and at a minimum, at least six additional physicians, of which at least four must be contracted with HCA. The six physicians shall be four primary care providers and two subspecialty providers, one each from a medical and surgical subspecialty. A dentist, who works as a consultant for HCA serves on the committee when dental information is required. If additional expertise is required for a specific peer review case, other specialists are brought in on an ad hoc basis. The QMC Executive peer review session, based upon its investigation, may recommend one or more of the following actions:
  - Make a recommendation for corrective action that may include (without limitation) education.
  - Request the provider develop and implement a corrective action plan addressing the specific issues necessary to improve the quality of care provided to HCA members.
  - Reduce, restrict, suspend, terminate or not renew the provider's credentials necessary to treat members as a participating provider of HCA.
  - Recommend to assigning, or adjusting a severity rating.
  - Other action necessary to evaluate the issue and recommend appropriate adverse or corrective action.

Requirement #31-A

REQUIREMENT #31-A

The Offeror is notified of an immediate jeopardy at a facility in a rural county that has been operating without a license for several months. Efforts by the Offeror and the Arizona Department of Health Services to assist the owner in submitting the license renewal and supporting documentation have been unsuccessful. Six Medicaid members reside in this facility, two of which are enrolled with another Medicaid Contractor. The only other placement in the service area, an assisted living home, was recently shut down due to abuse and neglect of residents. There is one nursing facility in the geographic service area.

It is the policy of Health Choice Arizona (HCA) to provide a safe and healthy environment for our members in HCA network facilities. Prior to an immediate jeopardy situation, HCA would have been alerted to a facility with impending issues through various methods, i.e., memoranda from AHCCCS/ADHS would have perhaps indicated issues keeping the facility from complying with ADHS regulations thereby affecting licensure, or case manager(s) and network representatives identifying issues during routine visits, At that point, HCA would mobilize the efforts of our Network staff, ALTCS case management and quality management to work directly with the facility, either singly or in coordination with other health plans to improve the quality of the care in that facility and hopefully prevent a situation of immediate jeopardy. Meetings would be scheduled to focus on viable measure to ensure the health and safety of our members. The HCA strategy would include assisting the facility to develop a working corrective action plan in response to the ADHS regulatory deficiencies. Quality Management, for example, may do "mock medical record surveys" for the facility to determine the level of compliance with medical record regulations. This survey would be followed up with educational sessions with the appropriate staff to correct the identified deficiencies. Likewise, Network staff and Case Management staff would in-service/train the facility staff, as appropriate, to mitigate regulatory deficiencies. With those operational areas that are out of compliance that are outside of the scope of expertise of the Health Plan, the Health Plan would attempt to produce a reference for the facility to hopefully assist the facility attain compliancy. In the event that preliminary actions were ineffective and the facility is approaching as immediate jeopardy situation, as in the situation above, the following HCA would institute a more aggressive plan to keep our members safe, healthy and provide a relatively stress-free transition for our members.

On the day the HCA Compliance Officer is notified of the immediate jeopardy situation with an HCA network facility with our members, the following individuals will be notified immediately: Senior Administration member, Chief Medical Officer, Network Services Director for that location, Member Services Director, Quality Management Director, VP Medical Services, and the ALTCS Case Management leadership were notified immediately.

In response to the immediate jeopardy scenario mentioned above, HCA will take the following actions:

1) HCA Network Services will evaluate the capacity at other contracted and non-contracted facilities in the county and nearby counties to determine the best location for our members who are being displaced from their "home" facility; HCA would view the options and consider the acuity of the member and ease of transport (perhaps keeping higher acuity members closer to their "home" facility, services provided by the facilities to meet the needs of our members, wishes of the members and the member's family regarding proximity to family, etc., and meeting the member's cultural needs.
2) Potential placement options will be identified by case management such as, home of family member/friend, out-of-county Assisted Living Facility and in-county or out-of-county Nursing Facility, taking into account previously determined member facility preferences. All options may include a possible temporary placement in the local community hospital's transitional care unit (licensed SNF beds) if necessary pending transfer to the member's preferred option.
3) At this time, the case manager(s) for this facility will review and consider those preferences when determining placement. The case manager(s) will review the new options with the member and will attempt to contact the family members and legal representatives if appropriate to advise of the possibility of imminent closure and explain placement options, identify members' preferences, and initiate contingency plans. During the required routine case management visits with the members, the CM performed re-assessments and updated ISPs, so members' physical, psychosocial and functional status and needs identification are current.
4) The other Medicaid Contractor's CM departments in that same geographic area will be contacted by HCA case managers so transfers can be coordinated; transfers will be coordinated assuring that the frailest member(s) will get the nearest SNF or NF bed(s) if capacity is limited.

The CM and CM Supervisor will be dispatched to the facility to facilitate the transfers in accordance with HCA's Urgent Relocation Policy. They will document the following in accordance with the Policy Checklist:

1) Demographic and contact information (e.g., family, legal representatives, ALTCS CM, PCP), transportation method and accompaniment, PCP/level of care info,
2) Medical Records including most recent Health and Physical to include advanced directives/physician orders, ALTCS Assessment and ISP
3) Medications and Medication/Treatment Administration Records
4) Personal Belongings, DME equipment and Clothes

The Case Management Supervisor will be the liaison between the facility and the HCA staff. At the same time, member services staff will make arrangements for transportation. PCP admission orders will be faxed to the receiving facilities by the case management staff. The following placements will be executed after the CM calls each receiving facility to provide a report before the member is transported.

The following cases are examples of various scenarios and anticipated actions that will be done by HCA:

- First member – Temporarily will be placed in local community hospital's transitional care unit pending home modifications and DME delivery that will enable her to move in with her daughter. The ISP including attendant care/homemaker services, home delivered meals and emergency alert system will be fully implemented when she moves, anticipated to occur within 3-5 days.
- Second Member – Will be transferred to an Assisted Living Facility in an adjacent county. HCA is the ALTCS contractor in that county. CM will transfer the member to that county's assigned HCA CM and together they will develop the initial ISP for the new ALF.
- Third Member – Has family living in another county where she will be transferred to an assisted living facility. HCA is not the ALTCS contractor in that county, so CM worked with Member Services to complete an Electronic Transfer Information (ETI) Form for the new ALTCS contractor.

Requirement #31-B

REQUIREMENT #31-B

The Offeror is notified of an immediate jeopardy at 4:15 P.M., on a Friday, before a holiday weekend, that a nursing facility in the Phoenix area will not have air conditioning/cooling available for approximately four days. Arizona Department of Health Services licensing staff, local city staff, and the Ombudsman are on site. Reporters are on the way. It is July and currently 116 degrees outside. There are 48 Medicaid members in the facility spread out across several AHCCCS Contractors.

Upon notification, the Health Choice Arizona (HCA) Compliance Officer notified HCA's Senior Administration, Chief Medical Officer, Network Services Director for that location, Member Services Director, Quality Management Director, VP Medical Services, and the ALTCS Case Management leadership immediately. It is the intention that the process to transfer the HCA members from the above referenced facility will be done promptly and safely.

The following is a contrived scenario for the purpose of example depicting HCA's response to an immediate jeopardy situation involving a nursing facility. A census report will be obtained from the HPIS to immediately identify the fifteen HCA members who reside in the facility; ten are receiving short-term skilled services and five are long term residents of the facility. A Member Transfer summary form is initiated for all fifteen HCA members indicating basic member information, PCP/level of care, emergency/responsible party contact info. Coordinating with the CM, the Member Services Director and staff will alert the HCA transportation vendor of the situation and the need to transport approximately fifteen individuals. In the meantime, the Network Services Director has contacted the Nursing Home Administrator to offer HCA's assistance in carrying out the facility's Emergency Evacuation Plan. The Medical Director, CM Supervisor, 3CMs with social service backgrounds and 4 RNS are dispatched to the facility with the member transfer summaries for each HCA member in the facility. Support staff (case management and members services) at HCA continues to contact all family members/ responsible parties to inform them of the imminent transfer. Families may also have the option to take their family member home until the air conditioning issue is resolved. This would be an option for those members who are stable and mobile.

Upon arrival they learn that the facility's Emergency Evacuation Plan is underway. Families have been notified, the staff have assessed the residents and determined transfer priorities, as follows: 1) medically unstable, immobile and ventilator patients to hospitals 2) medically stable, but less mobile to nursing facilities, and 3) the most stable and mobile members are being temporarily moved to the air conditioned school across the street. HCA Medical Director and an RN are assigned to stay with medically unstable persons (1st category) regardless of health plan coverage. The remaining HCA staff is assigned to the fifteen HCA members who are being transferred (1st and 2nd categories) or across the street (3rd category). The CM Supervisor is the liaison between the facility and the HCA staff.

HCA CMs/RNs assess their assigned members assuring that immediate needs are met. For those with identified placement plans, they assist with transfer by arranging transportation, providing authorizations to receiving facilities, copying medical records, collecting medication/treatment administration records and belongings, calling family members, etc. Each member has a member transfer summary that all HCA staff participating in this transfer knows must be completed to indicate that the member has the appropriate information accompanying them to their temporary facility for the continuity of care. The information needed to be provided to the temporary facility includes copies of: face sheet, advanced directives, medication sheet, immunizations, treatment sheet, TB test/chest x-ray, physician orders, transfer summary record. The form is also a receipt for personal clothing, personal belongings, custom DME, and medications that will accompany the member. As members are being readied for departure, the member transfer log is filled out by a case manager. It provides an overall summary of the members including: name, AHCCCS ID#, date of transfer, receiving facility, and who accompanied the member.

For members in 3rd category, temporarily housed in the school, HCA staff works with nursing facility and HCA's Network Services staff to identify temporary arrangements such as family placement, alternative residential facilities, and other temporary short-term resources in the area. All temporary placement options identified are being coordinated and approved by Nursing Facility staff in recognition that the Nursing Facility is ultimately responsible for the safe placement of the residents.

By 10pm all Nursing Facility residents are safely evacuated and temporarily placed. CM Director makes sure that CMs are assigned to work on Saturday morning, when they:

1. Contact temporary placement facilities and members directly to assess any needs

2. Visit members if needed
3. Call families to offer assistance
4. Return to old facility to get more belongings as needed.

The following Tuesday, the state has allowed the nursing facility to reopen. CM staff performs the following:

1. Conduct re-assessments and update ISPs as needed;
2. Arrange for discharges, including transportation;
3. Assist members in transitioning back to nursing facility; and
4. For those members who don't want to return, CMs
    a. Arrange for them to stay in current facility if facility agrees, including working with Network Services to sign Letters of Intent and Quality Management to obtain organizational credentialing.
    b. Arranges for another facility if facility cannot or will not keep member.
    c. Arranges for community transitions if HCBS are an option.
    d. In the event that a member does not return to the "home" HCA facility, the entire medical record will be copied and transferred to the receiving facility within 24 hours.

Requirement #32

REQUIREMENT #32

Describe and provide an example of the Offeror's experience and commitment to improving quality of care and performance in specific measures of health care services. Describe how this commitment is spread throughout the Offeror's program.

It is the Health Choice Arizona (HCA) philosophy that quality does not simply involve the Quality Management Department or the grievance system. Every HCA employee plays a key role in directing quality improvement and ensuring members and providers receive excellent customer service. Excellent quality necessitates a focus on not just the individual task at hand, a phone call from the provider or member, or finishing a project, but on a larger focus on systems improvement. Excellence in quality improvement requires that we not only get a prior authorization approval in place when a provider calls in and it does not appear that the information the office faxed came through. Excellence requires that the employee that takes the call ascertains whether there is a problem with the fax system and makes sure the office used the appropriate fax number and correct prior authorization form.

HCA ensures that all employees are instructed in the role they play in quality, both through employee orientation and in ongoing inter-departmental coordination. The Quality Management Department provides assistance and education to other departments on how to take the concept of quality and integrate this into everyday tasks. HCA employees are provided positive feedback, for example, when they ensure letters to members have appropriate and culturally effective content, when they help coordinate care for a member with special needs, when they provide a member with assistance in getting to a specialist or remind members that it is time for them to re-enroll so that they don't lose AHCCCS coverage.

Results of HCA's continuous quality monitoring and evaluation of performance measures and performance improvement results drive the QM/QI program. The results give the HCA a method to:

- Compare our performance with that of State, Regional and National rates for benchmarking purposes. It is critical to utilize established standards and benchmarks and establish measurable objectives.
- Assure that data that is used in the internal performance measure monitoring process is valid and correct, through regular review of the HEDIS methodology technical specifications, which is undertaken at least annually and in instances in which the AHCCCS methodology changes.
- Drill down to specific data to improve performance. Data can show, for example, where interventions are needed in a particular county, zip code, or service area that is experiencing a lower rate than the rest of the state.
- Identify the need to hire staff and devote additional resources to performance measures that are below the established goal, utilizing the information gathered from detailed reports. As an example, continuous analysis of performance measures shows that rates differ in rural vs. urban counties and that members in rural counties have unique challenges in accessing care. The HCA Chief Medical Officer has significant hands-on experience and expertise in rural health.
- Identify specific areas in which cultural barriers may exist that could impact quality of care, and devote resources to improve cultural effectiveness.
- Track performance trends over time via rolling 12 month reports, consider any external factors that may have occurred i.e., a shortage of a vaccine type, difficulty scheduling a mammogram appointment, lack of providers in a particular area, etc. and implement new strategies based on analysis of trends. The performance measure that this activity would be expected to impact would be assessed, and new interventions would be implemented if the original intervention does not provide the expected outcome.
- Implement new activities and interventions to improve performance by presenting performance measure data quarterly to the Quality Management Committee (QMC) for review, comment and suggestions for additional interventions, and follow through on all suggestions or issues raised by providers, members, and other HCA departments to ensure systems changes are made when needed.
- Involve all HCA departments collaboratively in "brainstorming" to develop strategies to increase rates as well as to implement activities.
  - Impact performance measures by working collaboratively with the community and partnering with agencies that may encourage individuals to take part in routine screenings/check-ups.

A new Quality Improvement Project for Medicare was developed to increase compliance of female members over the age of 42 years with getting a screening mammogram. Although this was a project for our Medicare members, 283 out of the total participants (354) are HCA (Medicaid) members. The project was patterned after a study that was just completed in June 2010 whose objective was to determine the most effective intervention to improve mammography screening in low-income women insured by a managed care organization. Studies concluded that reminder letters, telephone calls and lay health worker outreach interventions resulted in significantly increased rates of screening mammography in some populations. This Health Choice project, called the Step- wise project, started in the latter part of September and will continue through the end of January. This stepwise study used all three (step-wise) methods: the first was a very warm and friendly letter from the health plan Medical Director reminding women to get a mammogram; the second letter sent about 2-3 months following the first letter will be sent from the member's PCP (mailing will be done by HCA) and for those members who still did not get a mammogram, they will receive a phone call from HCA asking if there is anything that HCA can do to assist the member to get their mammogram. In the study, the stepwise participants were twice as likely to receive screening as the control group.

353 letters were sent out on September 28, 2010 to members who did not have a mammogram in the past year and as of December 7, 2010, 152 of these members had mammograms (43%). 201 letters were sent out from Health Choice on behalf of the member's PCP to those members of the original group who needed to get a mammogram. Based on the information stated above, it appears that approximately 21% took action following the second letter either by having a mammogram or scheduling an appointment with their PCP to get a The following outreach QIP Breast Cancer Screening calls were made to Health Choice members from December 27, 2010 through January 20, 2011.

Members contact made	**38**	**19.00%**
Members who recently received mammogram	**4**	**2.00%**
Members had existing appointment	**18**	**9.00%**
Members just made an appointment	**8**	**4.00%**
Members "Not Available" no answer or unable to leave message, busy signal, phone out of area, voicemail is not set up, phone number is unavailable in MEDMC	**55**	**27.50%**
Members refusal	**8**	**4.00%**

Requirement #33

REQUIREMENT #33

Describe how feedback (complaints, survey results etc.) from members and providers is or will be used to drive changes and/or improvements to the Offeror's operations. Provide a member and a provider example of how feedback was used by the Offeror to drive change.

Quality Improvement opportunities may range from those targeting individual issues (i.e., provider, staff person) to more aggregate tracking and trending of those opportunities which result in the development of a Performance Improvement Project (PIP). Quality improvement opportunities are identified as the result of input from internal and external sources; direction from the Quality Management Committee (QMC) based on the analysis of trends, goals of the health plan and results of previous projects; and follow-up actions from previous projects, trends identified from clinical and service quality performance measures, data from identifiable trends in quality of care issues and analysis of age or gender specific diagnoses that occur frequently.

Additional sources include member and provider satisfaction surveys, utilization management reports, provider profiling data, peer review, on-site reviews of providers, grievances and appeals data, inter-rater reliability studies of Health Choice Arizona (HCA) medical review staff and AHCCCS performance indicators.

Data is presented in numerical trends and graphic form whenever feasible so that data can best be analyzed over time. Specific preventive care is monitored, goals set, and improvement trended on an ongoing basis or at least annually. Certain health conditions are identified (i.e., diabetes, depression) monitored, goals set, and trended improvement (i.e., percent of diabetic members receiving hbA1c results, percent of female members who receive breast cancer screening, etc).

All potential quality improvement initiatives are ultimately submitted to and reviewed by the QMC which plays a lead role in overseeing and carrying out the strategic direction and quality improvement initiatives. HCA may select a specific topic or topics to be addressed by a PIP. Topics are systematically selected using an objective scoring tool and prioritized to achieve the greatest practical benefit for enrolled members. Topic selection is determined by:

- The prevalence of the condition among or the need for a specific service by the HCA members.
- The member demographic characteristics and health risks.
- The interest of members, providers, AHCCCS and/or CMS in the aspect of care or service to be addressed.
- Member input, whenever possible, in the selection of topics for a PIP and formulation of project goals.
- Ability to achieve improvement and feasibility of the study.

In the course of QOC investigations, there appeared to be a question of whether the transportation vehicles were properly maintained and had passed routine safety inspections. There were eleven cases of mechanical problems that occurred (broken window, no air conditioning, etc). One case in particular involved a member stating that the tires on the cab that came to pick her up did not have any tread.

AAA was contacted immediately and provided the following corrective action plan

AAA uncovered an unacceptable level of importance placed on the documentation of vehicle inspections and equipment when in response to the tire allegation, interviews were conducted by AAA Quality Manager with the Rural MedEx Manager, the Shop Foreman and the AAA Phoenix MedEx Manager, the driver, the AAA Road Supervisor and the AAA Director Van Means.

There was a verbal reporting of issues with vehicles by Rural MedEx drivers but they were not submitting inspection forms daily before beginning a shift. As a result, AAA instituted a mandatory meeting that was held for all rural MedEx road supervisors, managers, Phoenix managers, shop manager and quality manager. The agenda covered the following:

- issuance of the pre-shift inspection report;
- policy regarding submittal of the inspection report;
- processes and procedures of vehicle maintenance was reviewed;
- random street inspections were instituted;
- and the supervisor's safety responsibilities and reporting requirements were identified.
- All vehicles were to be inspected immediately and the results were to be reported as per policy.

Summary:

- It appears that there is an unacceptable level of importance being placed on the documentation of vehicle inspections and equipment. This false sense that inspections are not only being done but overseen by supervisory personnel and that the necessary documentation has been submitted has led to the incident with the Health Choice member on 3/24/10.

- The Rural MedEx drivers are "verbally" reporting issues with their vehicles and do report to their supervisors when service or maintenance is necessary but have gotten away from submitting the inspection forms daily, before the beginning of their shift.

- The root cause of the grievance under Case #15388, is that a newly assigned vehicle, #R48, was issued to MedEx Driver #118250, without having been approved by AAA supervisory personnel and the releasing shop employee was not the employee who performed the inspection prior to assignment.

HCA summary:
When a trend of vehicle issues was noted by the HCA members, AAA, the transportation vendor for HCA was contacted and an investigation and corrective action plan was required. The hope is that with the new guidelines instituted regarding vehicle safety and inspection by AAA, that incidences of mechanical issues reported through the HCA QOC process will be diminished or perhaps eliminated.

A number of Primary Care Physicians in the HCA network asked for additional integrated data on their member panels to help facilitate their coverage of gaps in care. HCA has worked with vendors such as PharmMD and Lab Corp to develop reports the PCP's can utilize to identify members that have gaps in care and better coordinate their prescription and lab usage. HCA has also developed reports to show all gaps for members by PCP and sends these out on a quarterly basis to assist in helping PCP's get member in for appointments. HCA is building these reports into its Provider Portal so the providers will be able to see this information in a real time environment. Performance measure for the PCP's using this data have improved over the last three years.

Requirement #34

REQUIREMENT #34

Describe the process that will be utilized by the Offeror to monitor services and service sites of members that reside in their own home. Describe what steps will be utilized if non-compliance is identified.

Provider monitoring begins with the contracting and credentialing process. Health Choice Arizona (HCA) will require all LTC, HCBS and BH providers to meet AHCCCS/ALTCS participation requirements. Providers will be organizationally credentialed and be required to complete a facility, ancillary services or professional application and supply evidence of licensure, education or other appropriate certifications, as required by QM policy 9.006 Organizational Provider Credentialing. HCA or its designee will conduct annual on site reviews at administrative offices of providers of services in the home (e.g. attendant care, homemaker and personal care) to review policies and procedures, audit personnel records to verify training and criminal history checks, review equipment maintenance records, etc. Facility service providers (e.g. adult day health centers) will have administrative records audited as well as a cleanliness/safety review of the facility. Information on adverse actions taken by state and federal regulatory agencies will be assessed as part of the review process. Re-credentialing of organizational providers will occur every three years. Quality management data such as complaint trending, provider site visits, corrective action plans, annual review data will be part of the re-credentialing profile reviewed by the Credentialing Committee. Professional providers will have credentials verified by QM Credentialing staff and be presented to the Credentialing Committee for approval and re-credentialing every three years, as per NCQA/AHCCCS/CMS guidelines. Public data, where available will be considered when evaluating all providers.

The Case Manager will verify that the HCBS services outlined in the Individual Service Plan (ISP) were implemented and are being provided without problems. This will be done on a monthly basis following the initial assessment, and every 90 days thereafter during re-assessment visits. During all assessment and re-assessment visits the CM will reinforce the necessity of reporting attendant/homemaker staff no shows, lateness, failure to perform assigned duties, equipment malfunctions or other service problems promptly.

Routine data analysis is another method of monitoring services. Home attendant/homemaker/personal care service providers ability to staff cases in the amounts authorized in the ISP will be monitored through ongoing analysis of utilization (claims) data compared to services authorized by the CM. Both provider and member inquiry/complaint reports will be monitored for individual provider problems or global problems in particular types of service.

Finally review of quality of care (QOC) issues may uncover problems in the delivery of services to members who reside in their own home. Requests for review of potential QOC issues may be initiated by any internal HCA department or by external sources; all are referred to QM for research and review. Internal sources may include any HCA department staff members who identify potential QOC issues while conducting their daily operations, such as claims adjudication, processing member or provider complaints/appeals, on-site provider reviews and utilization review activities. QOC referrals are sent to the QM department documented on a *grievance/complaint form* with an attachment of any supporting documentation. External complainant sources include state and/or federal agencies, media reports, other providers, members, member representatives, advocates and caregivers. Information from external sources may be received via letter, phone call or email.

The QOC review process includes the following:

<u>Triage of Grievances:</u>

- A preliminary severity level 0,1,2,3,4 is determined (and level 5 following mortality review)
- Sentinel events, never events and level 4 events are reported immediately to the Chief Medical officer and/or Administration by the QM Director, as per the QM policy 9.530.
- All other severity levels 0-3 are processed within no more than 90 days for Medicaid.

<u>Assignment:</u>

- A file is opened for each complaint which includes building a QM worksheet to enter the case information in the QM QOC database. Documentation consists of identification of the issue(s), when and from whom it was received, and identification of the category/sub D category and projected time frame for resolution. All complaints that are received by the QM department are acknowledged in writing within five (5) days of receipt by the QM department by a brief letter to the complainant. Each issue, from the same complainant, has a separate file. (worksheet)
- Categories include:
  - Availability, Accessibility, Adequacy
  - Denial, Decrease or Discontinuance of Covered Benefits
  - Effectiveness/Appropriateness of Care

- Fraud, Member or Provider (Fraud)
  - Member Rights/Respect and Caring (Member Rights)
  - Non-quality of Care
  - Safety/Risk Management

Acknowledgement letter:

- A letter is sent to the complainant within 5 business days of the QM receipt of the complaint.

Investigation:

- The QM Specialist, under the direction of the QM Director, will initiate investigation of the issues. Cases that do not reveal a potential quality of care concern (level 0) are immediately closed and placed in the provider's file for tracking purposes and documented in the QOC database.
- There is a request for information from the following sources as appropriate: internal HCA department staff associated with the case; PCP/specialists medical records associated with the case; facilities, hospitals, etc. Ten business days is granted for return of information to the QM department. If no response is received, the request will be repeated. If there is still no response, the complaint may be discussed with the Network Director and or the Chief Medical Officer/Medical Director, as necessary, who will either contact the provider directly, or determine another appropriate action.
- Review of all pertinent information by the QM staff is placed in the worksheet and prepared for review by the QM staff, and the Medical Director, as appropriate.

Resolution:

- A determination is made following the investigation for a recommendation of whether the case is substantiated, unsubstantiated or unable to substantiate. Cases are then reviewed at the weekly QM department meeting to review the investigation results, and assess a level of severity of the complaints.
  - HCA Severity Levels include:
  - Severity Rating 0 Not a potential quality of care issue; unable to validate due to lack of data
  - Severity Rating I Known complication, with or without adverse outcome
  - Severity Rating 2 Identified potential quality of care issue without adverse outcome but with the potential for adverse outcome
  - Severity Rating 3 Identified potential quality of care issue with temporary adverse outcome
  - Severity Rating 4 Identified potential quality of care issue with long-term adverse outcome
  - Severity Rating 5 Quality of care issue-mortality following the mortality review using the mortality review tool
- Resolution status is also assigned at the weekly QM department meeting, as follows:
  - *Substantiated* means the allegation of abuse or complaint was verified or proven to have happened based on evidence. Substantiated allegations of abuse or complaints require a corrective action plan of steps to be taken to improve the quality of care or service delivery and/or ensure the situation will not likely happen again. The Plan of Correction, documentation of the implementation of that plan, and assessment of the effectiveness of actions taken is kept in the QM case file. All appropriate internal departments are notified of the findings and resulting plans of correction. The Provider is given ten (10) business days to provide HCA with a plan of action (plan of correction). The plan of correction is reviewed at the weekly QM department meeting for completeness and resolution of the issue and a letter may be sent back to the provider if the corrective action plan is unacceptable.
  - *Unsubstantiated* means the allegation or complaint was, based upon evidence, verified to be proven to not have occurred.
  - *Unable to Substantiate* means the evidence was not sufficient to prove or disprove the allegation of abuse or the complaint.

QOC/QM Committee:

- All level 4, 5 and AHCCCS originated cases are reviewed by the Medical Director (QOC meeting). The Quality of Care (QOC) subcommittee is responsible for the qualitative and quantitative analysis of the research conducted by the quality management department during the preliminary review of QOC cases (level 4 and AHCCCS cases). Reviewing of the initial assessment of the severity of the allegations, prioritization of actions for resolution, development of an action plan and the referral of cases to the Quality Management Committee peer review section for further review, action and follow up.

- All level 4 and 5 cases, and AHCCCS cases are referred to the QMC at the discretion of the Medical Director. Refer to QM Policy 9.510 for further information on the QOC/QM Committee.

In summary, identification of quality care issues regarding services and service sites of members who reside in their own homes will be determined by:

- Case Management auditing of HCBS services being provided as outlined in the Individual Service Plan
- Monitoring visits (scheduled and unscheduled) by the case manager to determine if the member and the premises are without issues.
- Information may be provided from monitoring by an oversight provider i.e., Inspiris, as applicable.
- The incoming quality of care (QOC) issues relating to HCBS services will tracked/trended and also be copied to the case manager for follow up and investigation. The quality department may also do an on-site inspection to further investigate a quality issue allegation. Follow-up monitoring and evaluation of improvement - To identify complaint patterns regarding providers, HCA will initiate routine trending queries which will be done monthly for the previous rolling twelve month period of time based on a query threshold of the sum of points on quality cases being greater than or equal to 6 points (Severity level 0 = 0 points, Severity level 1 =1 point, ...Severity level 4 = 4 points). Identified patterns will be submitted to the Chief Medical Officer/Medical Director and at his/her discretion the QMC for evaluation.
- Initial and re-credentialing of organizational providers to promote the delivery of quality healthcare services by assuring the organizational provider's good standing with state and federal regulatory bodies and approved by an accrediting body, if applicable.
- Annual reviews of service sites as specified in the AMPM.

Actions to Improve Care

In quality of care resolutions, member and system action may occur independently from one another. Types of member/provider action(s) to be taken for non-compliance may include but not be limited to:

- Education/training/technical assistance of the provider/provider office staff
- Changes in processes, structures forms
- Informal counseling
- Termination of affiliation with provider, and/or
- Appropriate referrals to regulatory agencies - Issues relating to quality of care cases are referred to regulatory agencies, such as Child or Adult Protective Services and AHCCCS, as appropriate. HCA will notify the appropriate regulatory agency/licensing board and AHCCCS when a provider's affiliation with the HCA network is suspended or terminated because of quality of care issues.
- Corrective action plans required for substantiated issues and follow up monitoring to ensure that compliance is sustained.

E. Provider Network

E. PROVIDER NETWORK

Provider Network

Requirement #36

Health Choice Arizona
Network Development and Management Plan
CYE 2011

Health Choice Arizona
Network Development and Management Plan
CYE 2011

Table of Contents

Network Development and Management Plan

Addendum

Network Development and Management Plan

Summary

The purpose of the Health Choice Arizona (HCA) Network Development and Management Plan is to demonstrate that HCA is compliant with all minimum standards and recommendations of the Arizona Health Care Cost Containment System (AHCCCS) and to ensure that members assigned to HCA have appropriate access to cost effective medically necessary health care.

The Network Development and Management Plan illustrates the methodology used by HCA to determine a geographically appropriate distribution of medical disciplines including but not limited to Primary Care, Long Term Care, Obstetrical Care, Specialty Care, Urgent/Emergent Care, Ancillary and Oral Health for our membership. The Network Plan also provides similar descriptions of the methodology used in establishing our Pharmacy and Non-Emergency Transportation networks. HCA demonstrates within the Network Development and Management Plan that it educates and monitors providers and other subcontractors to ensure that members experience the same access to care as do non-AHCCCS eligible citizens in each community.

The Network Development and Management Plan contains a description of the criteria used by HCA to determine the number of Primary Care Physicians (PCP), Specialists, Skilled Nursing Facilities (SNF), Home and Community Based Services (HCBS), Acute Care Facilities and Oral Health in the network. Provider hospital and outpatient affiliation privileges are considered and identified when making these determinations.

The Network Development and Management Plan outlines the current status of the HCA network and defines the future network needs of Health Choice Arizona. The plan identifies needs based on projected membership growth, provider availability, membership medical needs and choice within the HCA network. The Network Development and Management Plan estimates expected utilization based upon our mix of membership related to membership rate codes, geographic locations and specific medical needs.

Evaluation of CYE 2010

The following is a summary of the interventions and re-evaluation of outcomes for CYE 2010. Network Development and Management played a strategic role in the success of redesigning the provider network during CYE 2010.

HCA first identified Therapy Services and evaluated the network based on membership, as well as geographic area. The redesign of these services will allow for trending and monitoring of the current benefit changes. The second ancillary service identified was Radiology Services. In June 2010, HCA entered into a partnership with MedSolutions (MSI) a best in class Radiology Benefit Manager (RBM). The implementation of this program has offered best practice standards. These standards include but are not limited too: Accuracy Assessment (AA) for in office procedures, Peer to Peer review for radiology cases, and faster referral turn-around times. Through the AA program HCA has been able to better identify provider's based on referral volume and utilization of current practice standards. This has enabled HCA to strategically evaluate the Primary Care and Specialty network.

During contract year 2010 HCA also provided several coding seminars in all assigned geographic service areas. The Provider Claims Educator developed billing/coding in-services based on information received by the health plan through call tracking, encounter data, appeals/disputes and provider site visits. This intradepartmental process provided an excellent vehicle to better service the provider community on issues and concerns. Further evaluation of issues and concerns are reviewed by the Provider Complaint Committee. If necessary, issues and concerns will be elevated to the Administrative Management Team for review, and immediate action if neceessary. It is important to HCA that provider issues and concerns are addressed and resolved utilizing the 3/30 process implemented by AHCCCS.

In addition, HCA has partnered with My Health Direct, an on line integrated scheduling data base. During the past year HCA has implemented a pilot program which included 3 large medical groups with multiple locations throughout our contracted GSA's. The primary focus has been concentrated on scheduling appointments for members with their medical home and primay care providers. Due to the success of this pilot program HCA will be implementing My Health Direct plan wide over the next contract year.

When an immediate need for services is required by a non contracted provider, HCA will execute a Letter of Agreement. A Network Representative will follow through with a Request to Participate, proceed with the credentialing process, and work towards an executed agreement.

Current Network Status by Provider Type

HCA maintains a sufficient network and actively assesses the overall condition by provider type. The methodologies used to evaluate the condition of the network are to focus on how members access the system, all provider types by geographic area, and access to care for all various levels of providers. These services include but are not limited to: Acute Care Hospitals, Skilled Nursing Facilities (SNF), Home and Community Based Services (HBCS), Primary Care – OB/GYN (PCP and PCO), Specialist, Oral Health, Non Emergent Transportation, and Ancillary Services.

HCA communicates with the provider network regarding changes in contractual and/or program policies, as well as subcontractor requirements and meetings with providers via verbal, written, and electronic communication. HCA solicits providers input on addressing operational issues, network gaps and member care issues.
Feedback obtained through a variety of mechanisms, including but not limited to Complaints, Grievance and Appeals, Provider Joint Operation Committee meetings and member feedback is used to evaluate the network and make necessary changes in order to meet AHCCCS guidelines. As an example, the Behavioral Health Manager tracks and trends any provider issue(s) that are brought to HCA's attention via a case management referral form. All network providers are required to respond to the RHBA within 10 business days when asked for information/records. The Behavioral Health Manager assists in facilitating the exchange of information between the PCP, Specialist and Hospital to the RBHA as needed for members' care.
HCA utilizes Joint Operation Committee Meetings (JOC) as a mechanism to bring community physicians (PCPs and Specialists) and network hospitals together to ensure face to face contact and an exchange of ideas among the HCA network providers. JOC meetings also allow HCA to make use of these forums to foster provider relationships within network GSAs and communities and are used as an additional avenue to update network providers on contractual and program changes. JOC meetings are scheduled monthly, every other month or quarterly depending on the needs of the provider network or HCA.

Members assigned to HCA receive a new member packet which explains how to access the system and medical benefits. The member packet includes: a member hand book, provider directory and information on their assigned PCP. Members are directed to call Members Services for any questions and concerns regarding how to access care. The HCA website, www.healthchoiceaz.com, is an alternative for members to obtain information on how to access care and review plan benefits.

The current status of the provider network for HCA is sufficient and meets the minimum AHCCCS requirements in all contracted GSA's, which include: GSA-12/52, GSA-10/50, GSA-4/44, and GSA-2/52. HCA utilizes a Managed Care Accessibility Analysis (*Attestation 2)* to monitor access to care. These reports are run at a minimum yearly to evaluate the network needs and potential gaps. All provider types by service area are adequate to meet membership needs for access to care. In addition, HCA provides PCP's with a list of contracted Specialists. Some rural areas are currently more limited than others. HCA has contracts with specialists within the rural market to ease the referral base for PCP's within the rural communities. In addition, HCA utilizes a PCP referral report to referral relationships among providers within the community. HCA has found provider referral patterns to be an integral component to maintaining an adequate community based network.

HCA maintains an adequate network of contracted non-emergent transportation vendors in all contracted GSA's. The member hand book outlines the policy for non emergent transportation, as well as how to access these services, as defined in the Network Development and Management Plan. Network Services monitors various referrals and tracking reports, as well as cross departmental communication to ensure adequate access to care and referral patterns within the community.

HCA has current Letters of Intent or contracts with Skilled Nursing Facilities (SNF) and Home and Community Based Service (HCBS) Providers to provide an adequate network in all GSA's currently serviced. HCA has also expanded its current network for all Acute services to cover any additional members obtained through the ALTCS program.

Current Network Gaps

HCA works continuously to maintain a comprehensive network of providers capable of providing care in compliance with the AHCCCS guidelines. The HCA network includes access to Primary Care Physicians, Specialty Physicians, Skilled Nursing Facilities (SNF) and Home and Community Based Service (HCBS), Ancillary Services, and Urgent/Emergent Care after normal business hours. If transportation is required, HCA will arrange for the necessary transportation for members to receive services if not available within the GSA.

GSA 2/42: HCA meets the minimum network standards for primary care providers, specialists, skilled nursing facilities, home and community based services, pharmacy, oral health, ancillary and acute care hospitals within this GSA.

GSA 4/44: HCA meets the minimum network standards for primary care providers, specialist, skilled nursing facilities, home and community based services, pharmacy, oral health, ancillary and acute care hospitals within this GSA.

GSA 10/50: HCA meets the minimum network standards for primary care providers, specialist, skilled nursing facilities, home and community based services, pharmacy, oral health, ancillary and acute care hospitals within this GSA.

GSA 12/52: HCA meets the minimum network standards for primary care providers, specialist, skilled nursing facilities, home and community based services, pharmacy, oral health, ancillary and acute care hospitals in the GSA.

Note: HCA continues to market the following areas within each GSA; Fountain Hills and Youngtown in GSA 12/52, Oro Valley in GSA 10/50 and Gallup NM, in GSA 4/44. Due to the geographic area the focus is on primary care and oral health providers to decrease member travel distance for health services. These areas continue to be a challenge due to limited providers who participate in the AHCCCS program.

Methodology

HCA utilizes numerous sources of information to identify network gaps. Examples of information which is used in our research include the following:

- HCA produces periodic GeoAccess Reports in conjunction with the Arizona Department of Health Services physician to population ratio report to verify the adequacy of the PCP, Obstetrical Care, Oral Health and Pharmacy networks. These reports show the existing HCA membership to the contracted practice sites of PCPs, obstetrical care, dentists, and pharmacies in all HCA GSA's as compared to the general population. Network Services, the Oral Health Program Manager and the Medical Services Department target zip codes in any GSA identified as at-risk for failure to meet AHCCCS and HCA standards.

- At a minimum, quarterly reports are run to evaluate the individual Specialist network to ensure adequacy and availability standards meet the minimum AHCCCS requirement standards. Through these reports, Network and Medical Services Department target specialties that are required to provide medical services to underserved areas as well as, limited specialties throughout the state to meet HCA standards.

- HCA monitors all Skilled Nursing Facilities' current capacity levels, AHCCCS status and licensing status to insure availability for new members or existing members that may need to move to a new facility. HCA also works with outside consultants to explore alternatives for expanding capacity if the need arises.

- HCA monitors all Home and Community Based Service Providers current capacity levels, AHCCCS status and licensing status to insure availability for new members or existing members that may need to move to a new facility. HCA also works with outside consultants to explore alternatives for expanding capacity if the need arises.

- HCA's Pharmacy Benefit Manager (PBM) is responsible, as a part of its contract with HCA, for the development and management of the pharmacy network. The PBM also utilizes regular Geo Access reports to identify possible pharmacy network inadequacies, which are reported to HCA quarterly.

- In conjunction with MedSolutions (MSI) Radiology Benefit Manager, HCA uses monthly reports to track, trend and monitor utilization by provider by county to ensure an adequate radiology network is maintained.

- HCA monitors all Behavioral Health Providers current capacity levels, AHCCCS status and licensing status to insure availability for new members or existing members that may need to change providers. HCA also works with outside consultants to explore alternatives for expanding capacity if the need arises.

- Semi-annually, the HCA Network Services and Medical Services staff reviews HCA membership reports by age and zip code in order to assess the adequacy of its network related to specific provider types. Membership growth trends are reviewed and discussed during interdepartmental meetings to evaluate the adequacy of the network. The purpose is to note changes in the size and type of membership populations (for example, growth of pediatric membership in specific zip codes). With this information, HCA proactively assesses its future provider network needs in such areas for the capacity to accommodate the growth of specific member groups.

- HCA produces monthly provider *Member Panel Rosters*, which identify members assigned to each PCP and Primary Care Obstetrician (PCO). The HCA Management Information System reflects the maximum number of members a PCP is contracted to serve. In conjunction with the membership rosters, Network staff reviews a report listing closed PCP panels to determine if there is adequate provider coverage in a given zip code to meet accessibility requirements. If a potential gap is discovered, Network Services along with the

- Executive Management team will promptly create strategies for recruiting new providers and/or work with existing providers to increase their panel size. In addition, providers with closed panels for more than six months may be surveyed and asked to reopen their panel.

- Medical Services may identify a potential gap or provider need which is communicated to Network Services to take immediate action to fill the gap in order to provide the medical care to the member. Network Services may contract and/or execute a Letter of Agreement (LOA) with the provider(s) to provide immediate coverage to fill the gap/need. At times, for care that is projected to be brief and limited, HCA may agree to reimburse such providers as non-contracted, utilizing the AHCCCS fee-for-service schedule. If it is determined that we need to contract with the Provider, we will initiate a credentialing packet and put the provider through our temporary credentialing process. On a daily basis, Medical Services and Network Services work in concert to communicate potential network gaps.

- HCA utilizes the AHCCCS 1800 report, which consists of PCPs with more than 1800 members as a tool to evaluate the provider network. HCA recognizes that a potential gap may exist if these providers do not have accessibility for members due to high AHCCCS membership. These providers are surveyed and monitored to ensure accessibility and availability of care for HCA members.

- During the contracting process, HCA reviews the provider's hospital affiliations to ensure that the provider has hospital privileges at one or more of the HCA contracted facilities.

Short-Term Interventions

HCA proactively monitors the network to ensure gaps do not occur. If or when a gap does occur, immediate steps are taken to identify alternative sources of care until the gap is filled.

- HCA may engage the member's PCP to assist with identification of providers commonly used for referrals in his/her practice who are capable of providing and willing to provide care. HCA's Chief Medical Officer and/or Associate Medical Director(s) also provide direct input and assist in identifying providers in these circumstances. The Network Services Department then assists with the execution of an LOA and contract with the provider(s) involved. At times, for care that is projected to be brief and limited, HCA may agree to reimburse such providers as non-contracted, utilizing the AHCCCS fee-for-service schedule.

- HCA utilizes the closest specialist and/or ancillary provider when necessary and provides transportation to medically necessary appointments.

- When HCA identifies the need for a specialty or a special facility that is not currently contracted, HCA will authorize an out-of-network provider for medically necessary treatment for the member.

- When a new provider is identified and if their services are necessary to rectify a network gap, HCA executes an LOA and uses the temporary credentialing process to expedite the addition of the new provider to the network.

- At times, members become eligible with HCA through Prior Period Coverage (PPC). HCA covers medically necessary care for PPC members in accordance with AHCCCS guidelines. When discharge occurs, HCA Utilization Review Nurses are involved with the discharge planning and ensure that the member is referred to contracted providers if necessary. When it is determined that the best care for the member involves a non-contracted provider, HCA's Utilization Review Nurses will work with Network Services to ensure that the member receives the appropriate level of care. In these cases, Network Services will execute an LOA.

Long-Term Interventions

HCA strives to identify potential network gaps rather than reacting to discovered gaps. When a potential gap is identified, Network Services, in conjunction with the Medical Services Department, works to identify additional potential providers most capable of filling the specific area of need. Network Services can then direct its attention to the area and accelerate negotiations.

HCA has encountered a number of barriers which include, but are not limited to:

- **Geographic area with no providers.** At times gaps will persist despite aggesive intervention due to lack of providers in that geographic location. HCA provides transportation for members when required services are not available in the member's geographic location.

- Federally Qualified Health Clinic (FQHC) pharmacies have contractual and credentialing agreements with the HCA contracted PBM. The Pharmacy Benefit Management Company's credentialing requirements are based on industry and State of Arizona standards, FQHC pharmacies that meet these standards as well as meet the current NCPDP electronic processing requirements are included in the HCA pharmacy network. Qualified and credentialed FQHC's are of great benefit to HCA's providing additional medical and pharmacy services in underserved rural areas.

- **Members who live considerable distances from the nearest provider**. HCA provides transportation for medically necessary care.

- **Upon enrollment with HCA, a new member survey is completed by member services to assess for special health care needs**. Based on needs identified through the survey, referrals to Case Management are initiated. Case Management contacts and coordinates care with the member's providers and assists with any special arrangements that need to be made on behalf of the member. If a need for services is outside of the HCA network, Case Management will coordinate with Network Services to ensure appropriate contracts or letter of agreements are put in place to meet the needs of the member.

- **Home Care Provider**. HCA Case Management in conjunction with Medical Management and Network Services has arranged for Home Care Service Providers and has developed LOAs to see homebound members. These can be physicians or physician extenders who make visits to members who are home bound and/or have complex medical needs.

- **Medical Home**. HCA operates under a commitment to provide quality care in every community, whether urban or rural, in an atmosphere that recognizes the distinct medical and cultural environment unique to each area and the members who reside there.

HCA operates with the understanding that certain members with special health care needs may benefit from a Medical Home comprised of local and regional community health care providers/resources dedicated to serving this need, as well as the HCA departments who are responsible for ensuring that care is delivered appropriately. Each member must be made aware of the health care delivery system available to them in their community, and then how to access that system effectively. It is our intent to dialogue with our primary care providers regarding their participation as part of the members Medical Home. The Primary Care Provider will always be the common denominator of the Medical Home. The PCP has the ability to identify the member's medical needs and determine the most efficient way to meet those needs. HCA must provide the Primary Care Provider with the necessary specialty care tools to meet those needs that cannot be met in the member's community. Accordingly, the Medical Home may exist in the same community or may be comprised of parts of multiple provider communities.

- **Providers who will not participate in the AHCCCS program due to past experiences with AHCCCS members or because of a perceived substandard reimbursement**. HCA is continuously aware of the responsibility to maintain a cost effective network. However, cost consideration alone does not prevent HCA from pursuing a contract with a provider who is willing to provide a service that will result in the closure of a network gap. The provision of medically necessary care for members remains the primary goal.

- **Contracted providers with closed panels may create a network gap**. A gap is frequently defined as an area where there are no adequate providers to meet the medical needs of the members. For providers with closed panels, the Network Services contacts the providers with the goal of assessing the reasons for panel closure, establishing trust, and devising intervention strategies to assist providers with any problems they have encountered. In addition, by explaining to the provider that we are not requesting them to assume care for an additional large number of members, they will usually accept responsibility for the member in question, thus eliminating the gap. There is an administrative process that Network Services follows to facilitate the opening and closing of a provider's panel. That process is followed under all circumstances. This serves to maintain the provider's contractual relationship with HCA and often results in an open panel over time.

Network Services creates a report for analysis of the number of PCP panel closures on a semi-annual basis.

The current figures are as follows:

	# PCPs w/Close Panels		# PCPs w/Open Panels
○ **GSA 12/52**:	95	841	
○ **GSA 10/50**:	105	294	
○ **GSA 4/44:**	67	313	
○ **GSA 2/42:**	9	77	
TOTALS:		276	1,525

Outcome Measures/Evaluation of Interventions

HCA has implemented a provider inquiry/complaint process to identify issues within the health plan to improve operations. Network Services will work in concert with multiple departments to develop a thorough process that allows a provider inquiry/complaint to be monitored and tracked from inception to completion. The implementation of the process allow for status checks throughout the entire process in addition to the benefit of pulling reports as a tracking mechanism.

The Provider Claims Educator chairs the provider complaint committee to maintain and track provider inquires. The primary duties are to interface between multiple departments (claims, disputes/grievance and provider services) to track and trend claims and billing issues. This data will be exchanged between departments within HCA as well as communicated to providers. The key components of this position are to educate providers on coding and billing standards to improve accuracy of claims submission. This position requires extensive claims and coding experience with a sound knowledge base of AHCCCS and CMS coding and electronic filing. This position is responsible for providing reports to track and trend provider claims issues to educate providers. The Provider Claims Educator will organize in-services, meetings and seminars to disseminate relevant coding and claims information. As needed, the Provider Claims Educator will assist with the development and distribution of written materials (provider manuals, provider communications and website updates) along with the development of HCA policies and procedures as required.

Provider data is maintained by interfacing the PMMIS and HCA claims adjudication system. This data is managed by the Provider Data Analyst, to identify and monitor provider demographic and reimbursement issues to improve operations. As information is exchanged between AHCCCS and HCA, this individual is responsible for identifying any discrepancies in data and taking the appropriate measures to ensure that any false data is corrected.

By interfacing provider data, HCA can produce reports improving provider relations. This process greatly increases our ability to verify data and be proactive in working towards a solution.

When an immediate need for services is required by a non-contracted provider, HCA will execute an LOA. A prior authorization number is entered into the HCA system to signify that the requested services were authorized. In the event that multiple LOA's are being authorized, the Network Representative will be notified so that the provider office can be approached regarding a possible contractual agreement. The office will be asked to complete a Request to Participate Form. This form, once completed, provides all of the information that is needed by Senior Management to make a sound decision on a possible contract being offered. Pending Contract Committee approval, the provider is presented with a credentialing application. After completing the credentialing process, the provider is then offered a contract.

Ongoing Network Development Activities

The HCA network evaluation and development is a continuous process which receives ongoing critical assessment. The primary goal of HCA is to maintain the network and provider relationships for all levels of care to maximize how members access medically necessary care. In order to meet this goal, HCA may find it necessary to re-align the size of its network while remaining compliant with AHCCCS standards. The comprehensive evaluation of the network includes, but is not limited to:

- Analysis of membership demographics
- Analysis of members medical needs
- Analysis of contracted provider performance
- Analysis of specific GSA by rate code distribution
- Analysis of variations in special health care needs
- Analysis of potentially duplicated services and strategic goals
- Ongoing analysis of over and under utilization of medically necessary services
- Track and trend provider inquiries, complaints and requests for information

HCA has a policy and procedure in place for monitoring over and under utilization of medical services. This policy ensures that ongoing measures are being taken to assess utilization and that a process to develop and implement corrective action plans is in place should the health plan fail to perform this task.

Network Services and Medical Services will work together and pay particular attention to establishing and defining more focused reporting, which will identify areas of under utilization that could adversely affect health care delivery to the member.

Examples of focused reporting which will further assist HCA in making specific improvements are:

1. Monthly reporting that identifies providers who have the highest number of members utilizing the Emergency Department, suggesting that members may be under utilizing PCP/Specialist services on a non-emergent care basis. HCA will utilize this data to identify high-risk members to be placed in our disease management program and to identify providers who will use this information to better educate members and their families. Health Choice Chief Medical Officer and/or Associate Medical Director(s) and Network Services will work together to assist providers in improving access to care.

2. Medical Services and Network Services will evaluate quarterly reports from our contracted PBM that identify providers who underutilize safe, cost-effective generic drug equivalents and who have a higher rate of "dispense as written" (DAW) medications. HCA will utilize this data to inform providers how their medication utilization rates compare with their peers in an attempt to increase generic prescriptions and reduce DAW prescriptions.

3. Medical Services will develop monthly reporting that will determine which asthmatic members are regularly underutilizing established disease controlling agents and who are regularly abusing short-acting controlling agents. HCA will utilize this data to identify high risk members to be placed in our disease management program and to inform providers which members are noncompliant with the community standard of care in the treatment of asthma. This information will be shared with Network Services to provide outreach and education to providers.

4. HCA has developed a plan that encompasses the average ratio of office visits versus per member per year. PCPs will be evaluated to determine if their ratio to visits is above or below the plan's average ratio. If a significant variance exists, HCA will evaluate other factors to include member mix by age and rate code which can affect the provider's over or under utilization. Appropriate follow-up, as determined by Medical Services, will occur on a case-by-case basis.

Providers will continue to be profiled and compared to their peers in like geographic areas. Based on the results of the profiling and comparison, providers can be removed from the network to allow for adding providers who could better serve members, or we may direct members to alternative HCA existing providers. The provider profile includes such items as:

- Specialty referral patterns
- Inpatient hospital admission rates
- Lab and radiology utilization
- Outpatient services
- Rate of emergency room visitation by assigned members
- Pharmacy/formulary prescribing patterns
- Appointment availability

- Member complaints survey results
- Member complaints which are tracked and trended

Additional ongoing activities include on-site visits with the provider and ancillary network, as well as continuous contract reevaluation and management. During contract renegotiations and claims reviews, HCA produces a financial profile comparing the provider's performance versus the Plan averages. Also included is a monthly report to review emergency room visits by physicians as well as monthly specialty referral patterns.

Network Services and Medical Services consistently evaluate the hospital and ancillary network to strategically evaluate a more quality cost effective delivery of health care. Over the past year HCA has made significant contractual changes, such as invoice care outs and case rates.

Multi specialist groups and residency programs are attractive as they offer potential medical homes for our members. HCA has contractual agreements with such specialty groups along with hospitals that have residency programs. These contracts allow these providers to be chosen as the members Medical Home. These programs also provide an opportunity to bring new physicians to the Arizona market:

Maricopa County:
Cigna Medical Group, Integrated Medical Services and Maricopa Integrated Health System
Catholic Health Care West includes St. Josephs Hospital Residency Program.

Pima County:
University Medical Center, University Physicians Hospital at Kino and University Physicians Healthcare includes their residency program for Pediatrics, Family Practice, Internal Medicine and OBGYN.

Mohave County:
Kingman Regional Medical Center contract includes their affiliate Kingman Regional Medical Center Family Practice Residency Program and Specialty Services. This program provides an excellent opportunity to expand the physician market in the rural communities.

HCA has contracts with FQHC's, such as North Country Community Health Center, El Rio Health Center and Mariposa Community Health Center, which include Oral Health Residency Programs.

In addition, HCA works closely with a number of school systems and FQHC's to facilitate the treatment of HCA children in the school setting. Great care is taken to ensure coordination between the school system provider and the member's primary care providers.

Internal Department Coordination

Comprehensive assessment of HCA's network and the success of strategies for network management and development require cooperative communication between multiple departments. Weekly executive management meetings are held by Administration and attended by Network Services, Finance, Information Systems, Claims, Member Services, Compliance, Human Resources and Medical Services. During these meetings, staff exchange information and assess processes and procedures. This meeting provides a forum for all department representatives to come together and discuss matters of mutual interest and importance that impact Plan operations.

HCA has a Contract Committee that consists of an agenda developed weekly by Network Services. This committee consists of the CEO, CFO, COO, CMO, Director of Performance Improvement, Vice President of Medical Services and Director of Network Services. The committee is responsible for reviewing all contracts, network needs and strategies.

Network Services and Medical Services meet on a weekly basis. The purpose of these meetings is to discuss concerns and strategies which impact the interaction of the Chief Medical Officer and/or Associate Medical Director(s), and Director of Utilization Management and Vice President of Medical Services and the relationship of the provider network. Strategies are discussed in regards to their impact upon providing medical services plan-wide. Examples of the standard agenda items include:

- New provider contracts
- Access to care concerns
- Prior authorization challenges
- Special health care needs provision
- Provider feedback review
- Outcomes of physician committee meetings (P and T, QM, UM, Credentialing)
- Network structure & cost implications

The Network Services Department meets monthly and a representative from Medical Services, Member Services, Claims, and Grievance departments attend these meeting as needed. The standard agenda items include but are not limited to:

- New policies
- Quarterly initiatives
- Claims and coding issues
- Contract development
- Network gaps
- Provider issues (trends)
- Provider communication articles

- Reps' round table discussions

The *HCA Provider Manual* is another example of interdepartmental coordination. All departments work together to revise the manual annually or more frequent to provide a reference for provider offices regarding HCA and the AHCCCS program. The Provider Manual is now available on-line in the HCA website: http://www.healthchoiceaz.com. In addition, if a provider's office does not have access to the Internet the office may request a paper copy or CD from their Network Services Representative. Internal departments also have direct access to this information via the website.

HCA's Medical Services Department performs integral functions that ensure that HCA members receive medically necessary care in a quality-driven environment. Specific functions performed within Medical Services that require cooperation between both departments include:

- The Chief Medical Officer and/or Associate Medical Director(s) review all credentialing/recredentialing activities and documentation prior to contract execution and actively participates in any discussions surrounding the appropriateness of any provider for inclusion in the HCA network.

- Case Management, as it relates to specific medical needs for members, works with providers to facilitate the delivery of care in the best facility or provider office suited to the member's needs.

- Network Services may act as a facilitator for Case Management in circumstances where Case Management needs the assistance of or access to a provider specifically contracted to meet the needs of chronically-ill patients. Network Services may, as part of this facilitation, contract new providers, negotiate Letters of Agreement or physically intercede with a provider for the purpose of having this provider see the patient.

- Provider education and communication regarding policy changes and the availability of new services/technologies as they delvelop. The Network Services publishes provider communication articles with direct input from Medical Services along with other HCA departments.

- The Chief Medical Officer and/or Associate Medical Director(s) communicate with the provider network through multiple vehicles which include publications, direct written communication, telephonic and electronic interfaces and personal, face-to-face meetings.

- Network Services creates initiatives directed at the education of the HCA provider network. As part of these initiatives, Network Services staff along with the Provider Claims Educator will educate provider offices on a variety of topics.

Many of the initiatives are those that are already in effect and listed within the Provider Manual. Information and updates regarding practice guidelines are provided via the Provider Manual, Published Communications posted quarterly or as needed on the HCA website. Paper copies are available upon request. Ongoing education regarding practice guidelines will be provided to Network Services by Medical Services.

Monthly meetings are held with Network Services, Claims, Information Systems and/or Compliance Departments to discuss key issues that include, but are not limited to:

- Implementation of new provider contracts
- Claims and coding issues
- Contract issues
- System issues
- Claim disputes
- Provider training

The Network Services Representatives act as the liaison between HCA and the providers. As such, Network Services works closely with all other departments to work cohesively with our contracted physicians, PBM, Transportation, Ancillary and Hospital providers. Our daily interaction with Medical Services, Claims, Member Services and Finance Departments are crucial to our ability to perform the comprehensive work required. The importance of interdepartmental relationships is critical to ensure all departmental efforts are coordinated when contracting with new vendors or transitioning services. Negotiations of contracts or contract amendments require the coordinated efforts of all departments.

Coordination with Outside Organizations

HCA has developed and is continuing to develop networking opportunities and community-based relationships statewide. Our participation with Community-Based Organizations (CBO) and Corporations has helped us build a solid reputation within our customer base and the business community.

HCA has participated in numerous community projects with Chicanos Por La Causa (both in Phoenix, Tucson and Yuma) which is one of the most important Hispanic social service organizations in the state. In addition, HCA's longstanding partnership with The Friendly House, the oldest community service provider in the Phoenix area, has garnered respect and recognition within the Hispanic community. HCA also participates in fundraising activities with Valle Del Sol, another important Hispanic organization serving the uninsured/underinsured.

Health Choice participates in numerous community outreach events and activities such as health and education fairs and community sponsored events across Arizona to provide much needed information and services. Some of these outreach activities include: the Fred G. Acosta Job Corporation event, Phoenix Day Annual Health Fair, Pima County Health Fair and Tucson Care Fair, Kids Day at Kingman Regional Medical Center, Phoenix Fire Department Monthly Immunization Clinics, Annual Baby Fairs, March of Dimes Walk-a-thon, Arizona Coalition for Tomorrow (ACT) Health Fair.

HCA constantly seeks new outreach opportunities to educate and inform Arizona residents, and more specifically AHCCCS members, on the importance of good health. The new Health Choice Wellness Van was created specifically for this purpose. The Wellness Van is equipped with AHCCCS approved outreach materials that consist of health information resources such as immunizations, mammograms and cervical cancer screenings. The Wellness Van's goal is to establish a broad spectrum of alliances with FQHC's, CBO's, schools and provider offices to foster outreach and enhance awareness of health prevention campaigns and health education screenings throughout the state of Arizona in each of the GSA's contracted by HCA.

In addition, HCA works closely with the FQHC's across the state to provide outreach opportunities and health education materials to the community. These FQHC's have considerable experience with the Developmentally Disadvantaged population as well as providing primary care services in the community.

HCA participates in the annual "Head Start Health Fair" held at the Northwest Neighborhood Center in Tucson. Physicians, as well as other volunteers, donate their time to provide school physicals, immunizations, oral health screenings and vision testing to school age children.

Health Choice distributes an Oral Health Kit which includes a toothbrush, toothpaste and dental floss to promote oral hygiene. In addition, Health Choice provides information regarding our network of oral health care providers.

HCA also participates annually in the ACT Fair held in Maricopa County. Physicians, dentists, and other health volunteers donate their time and services to provide Head Start children and their families with school physicals, immunizations, vision testing, Oral Health and other screenings.

Escalante Center is a health care center focused on meeting the health care needs of women, children and seniors residing in Tempe who have encountered various barriers to accessing health care.

The Friendly House is a non-profit social service agency, which has been serving the community for many years. The agency works with disadvantaged children and families and is committed to promoting self-sufficiency through comprehensive education and job training programs. The Friendly House mission is to serve the needs of the community by fostering and achieving excellence. The Friendly House provides help with parenting classes, emergency assistance and advocacy services. HCA participates in several health fairs throughout the year organized by The Friendly House.

Tempe Health Coalition represents a unique collaborative effort to develop, facilitate, implement and evaluate a comprehensive community-based program to promote health and well-being.

Child Parent Centers, Head Start and Early Head Start Program
HCA is on the Health Advisory Committee year round. As a member of the committee, HCA assists the Child Parent Center with yearlong education on Health and Wellness for children in Southern Arizona. This includes Oral Health Presentations and utilization of the HCA Wellness Van and AHCCCS approved educational materials at events though out Pima County.

HCA coordinates care with organizations such as:

- CRS
- AzEIP
- RBHAs
- End of Life Care
- WIC
- County Health Departments

HCA is actively involved with other organizations by participating in task force and/or coalition meetings. This affords HCA the opportunity to gain knowledge and partner with these organizations in providing additional health care resources for our members.

They include:

- TAPI
- Head Start
- Arizona Department of Health Services
- Office of Oral Health
- Active Arizona for Life (Childhood obesity activities work group)
- AHCCCS
- Arizona Oral Health Association
- Wesley Community Center
- South Phoenix Healthy Partnership
- Asian Pacific Community in Action Coalition
- Kool Smiles Oral Health Group
- Maricopa County KidsCare Coalition
- Children's Action Alliance
- Phoenix Urban League
- Phoenix Birthing Project
- Keys Community Center
- Ebony House
- Healthy Mothers/Healthy Babies Coalition
- Southern Arizona Oral Health Coalition
- Care Fair Steering Committee
- Pima County Access Program (PCAP)
- Mulcahy City YMCA
- CE Rose Resource Center
- Sunnyside Family Center
- The Boys and Girls Club's
- The Santa Cruz County Exchange Club
- Grandparents Raising Grandchildren (Pilot Program with University of Arizona)

Network Design by GSA

PCP's manage the primary health needs of the members and are responsible and accountable for the coordination, supervision, deliverance, and documentation of health care services to assigned members. HCA offers its members freedom of choice in selecting a PCP within its network. Certain members with special care needs are freely able to select a specialist who can provide both primary care and the special health care needs of the member.

<u>Special Needs Populations Overview</u>

The Network Services has the ability to respond to such needs as they are identified working with Medical Services to distinguish the providers in any rural or urban community that meet the requirements that have been described. Contracting and negotiation occurs to avoid any delay in continuity of care or access to care.

Multiple examples of such special populations exist in HCA's network. These include but are not limited to:

- Case Management Programs for:
  - HIV members
  - Hepatitis C members
  - Transplant members
  - Maternity members
  - Pediatrics members
  - Dialysis members
  - Rheumatoid Arthritis members
  - Chronic Pain members
  - Behavioral Health members
  - Members who reside in a SNF
  - HCBS Members
  - Potential long-term care and developmentally delayed members
  - CRS and DDD membership
  - Members with Diabetes
  - Members with special wound care needs
  - Members with Asthma
  - Homeless members
- Coordinating care for members residing in border communities.
- Coordinating care for qualifying children to the Arizona Early Intervention Program (AzEIP).

HCA is ultimately responsible for coordinating care for the above-mentioned special needs populations with each member's Primary Care Physician or Specialists. The Medical Services and Network Services direct Case Managers who work with various community organizations to ensure the needs of the population are met.

Several examples of such coordination include:

- Direct assignment of members with HIV/AIDS to HCA AHCCCS qualified HIV/AIDS specialists who also act as the primary care provider.

- In Pima County, HCA has the ability to assign CRS enrolled children to a Primary Care Provider in the CRS clinic.

- Behavioral Health Care Coordinator directly assists PCP's enrolled members into the RBHA when the behavioral health falls outside the scope of primary care.

- Specific Case Managers who assist providers and members to gain access to care in specialty wound care centers on a case-by-case basis.

- HCA has contractual agreements with Homeless Clinics in Metropolitan Phoenix and Tucson. Members who request a homeless clinic as a PCP may be assigned to them. HCA is contracted with every FQHC and RHC in our contracted GSAs. These FQHC's have historically provided the majority of care received by the homeless population. In Pima County, El Rio Health Center provides both Primary and Specialty Care. Salvation Army (Central Administration) has been approached for contract; however, they declined due to limitation of facility resources. Crewsmobile services homeless children and Healthcare for the Homeless provides services to all populations.
  HCA has a contractual agreement with the CASS Oral Health Clinic to provider needed emergency Oral Health services for members who receive medical treatment at the CASS clinic. In addition, HCA has secured an agreement with Community Dental Services. This mobile unit provides oral health services to schools for homeless children and underserved housing areas within Maricopa County.

- Network Services provides a network of providers for members residing in Border Communities. Member Services and Medical Services may use this list to assist in PCP assignment and to coordinate care. HCA continues to recruit Hospitals, PCPs and Specialist in Border Communities. Carondelet Medical Group provides services in Nogales for Primary and Specialty Services. With the addition of Santa Cruz County, Primary Care Services are also available in Patagonia, Tubac and Rio Rico which are defined as rural border communities. In addition, behavioral health services are available in the Patagonia Clinic. HCA also has Primary Care Providers, Specialist and Hospital contracts in Utah (Hildale, Kanab and St. George) and in Gallup, New Mexico. Colorado River Medical Center, Needles California is in contract negotiations. With the addition of Yuma and La Paz Counties, HCA has contracted agreements with primary care in Blythe, and is in contract negotiations with Palo Verde Hospital. HCA has secured a sound network of providers in Lake Havasu City to ensure adequate medical coverage for La Paz County members.

HCA maintains agreements and a working relationship with several Home Health Agencies and Home and Community Based Services in all contracted GSA's. These providers include but are not limited to: alternative residential facilities, habilitation facilities, and assisted living/foster care facilities (See Attestation 2). In the event a provider such as these is needed, this allows HCA to monitor and track agencies not currently certified, and/or participating in Medicare and Medicaid Programs. This provides an alternative for members who are enrolled or pending enrollment in other AHCCCS programs to enhance continuity of care.

- HCA currently has contracts with the County Health Department's in contracted Counties for immunization services; however, it is anticipated that this contract will be amended to include home and community nursing services. HCA is in discussions with the Director of the Public Health Nursing program where there are two sites in Tucson as well as Ajo and Green Valley.

General Network Design

Specialists

HCA members have direct access to many specialty providers. The following providers require prior authorization:

Bariatric Surgery
Chiropractic
Cardiovascular Surgery
Dermatology
Developmental Pediatrics
Genetics
Maxillofacial Surgeon
Nutrition/Dietician

Neuropsychiatry
Neurosurgery
Ophthalmology

Oral Surgery
Pain Management

Physical Medicine and Rehabilitation
Plastic and Reconstructive Surgery
Podiatry
Perinatology (Maternal Fetal Medicine)
Transplantation – All consultations, evaluations and follow up
Psychiatry and other counseling services
Wound Care Specialist

Hospitalist

HCA contracts with hospitalist groups that cover facilities in Maricopa and Pima Counties. It is the hospitalist's responsibility to manage all HCA inpatient members including communicating with the member's PCP and/or specialists. Hospitalists as inpatient specialists are responsible for developing discharge plans that meet the needs of HCA members from the moment they are hospitalized, making the process more effective and more efficient.

The PCP may contact the appropriate HCA contracted hospitalist group to arrange hospitalization or call HCA for assistance. Upon discharge, the member's PCP will receive a copy of the discharge summary and the member is instructed to follow-up with their PCP. The PCP will continue to manage the patient's care after discharge.

The Hospitalist Program offer limited pediatric or obstetrical coverage. In these situations, as well as those cases where a hospital is not covered under the HCA Hospitalist Program, the PCP or Obstetrician should expect to follow the member in the hospital. The PCP or PCO should communicate directly with the HCA Prior Authorization Department when a hospital admission is necessary.

GSA 12/52

PCP	–	936
OBs	–	228
Dentists	–	355
Specialists	–	2,264

The HCA Maricopa County network is sufficient in the areas of Cardiology, Orthopedic Surgery, General Surgery, Obstetrics/Gynecology, Rheumatology, Oncology, Pain Management, Infectious Disease, Dermatology, Ophthalmology, and Nephrology. A few areas still present some challenges, such as Neurosurgery, Pediatric Neurology, and Pediatric Surgery. HCA ensures that its members are seen when medically necessary in all such areas through available contracted or non-contracted providers. HCA has noted that there may be too many providers in some specialties such as Radiology. HCA wants to make certain that our network consists of only the best providers and those providers who have historically provided timely access and quality care to our membership. Accordingly, our focus on timely access to care will be evidenced by the diligence shown by Network Services, Medical Services and Member Services to ensure our member retains choice and timely access to care.

Predicated upon the future growth of the Health Plan, HCA will focus on the specialties above to ensure that those specialties are as available to our population. HCA will be as creative as is reasonably possible in the continued recruitment of these providers. These solutions may include higher fees, less restrictive prior authorization requirements, more online functions to reduce or eliminate dependence on telephone calls and better support in the inpatient arena through the use of hospitalists.

Since the inception of the AHCCCS program, members with special medical needs have traveled to Maricopa County to gain access to the advanced technology generally found in a metropolitan city. With a higher concentration of tertiary care facilities, trauma centers and medical sub-specialists, it is incumbent upon the health plan to develop and maintain a comprehensive network of providers in keeping with the community standard. HCA has met that requirement.

HCA's Maricopa County providers are trained and capable of meeting the special needs of patients with AIDS, Hepatitis C and a variety of other diseases difficult to effectively treat in rural and/or underserved Arizona.

HCA ensures that PCP services are available on a choice basis and that the general population of members is not required to travel outside their respective communities to receive their primary medical care.

The PCP can refer members to the specialists with minimal prior authorization requirements. There are ample providers of all specialty types available to meet the needs of our Maricopa County members and those members referred in from rural areas where some specialties may not be available.

The HCA Care Coordination Department assists the PCPs in the coordination of specialty care for the medical needs of members.

HCA contracts with a variety of ancillary service providers and Maricopa County hospitals. During discharge planning, the HCA Utilization Review Nurses assist the Hospitalist and coordinate with appropriate ancillary services for continued care. The Network Services Department provides the contracted network providers an Ancillary Directory. The Medical Services Department and HCA Case Managers assist with the coordination of ancillary services for HCA's providers and members.

GSA 10/50

PCP- -	399
OBs- -	78
Dentists- -	122
Specialists-	924

Primary Care Physician panels in GSA 10 have continued to grow in the past year. With the addition of Santa Cruz County, HCA has contracts with all known AHCCCS approved providers in Nogales and surrounding areas.

In Nogales there is one FQHC, Mariposa Community Health Center. The clinic provides Primary Care Services, Specialty Services that include OB/Gyn, Oral Health, Behavioral Health, Routine Lab and Radiology Services, and Transportation for members assigned to the FQHC. The main clinic is located in the heart of Nogales. There are two other Mariposa clinics, one in Patagonia and one in Rio Rico. These clinics serve members residing outside of Nogales. Additionally, Thomas Linneman, DO, a PCP, is located in Tubac which borders Pima County and Santa Cruz County. Santa Cruz County has an array of contracted PCPs, Specialists and Ancillary providers located throughout.

HCA is currently negotiating a contract with Santa Rita Care Center, a Skilled Nursing Facility in Green Valley for Santa Cruz members. By adding this SNF to the network, Santa Cruz members will not have to be transported to Tucson.

Dermatology remains to be a present challenge within Pima County however, this specialty is represented. HCA's network has become broader in Pain Management, Oral Health, Pulmonology, Infectious Disease, Gastroenterology, and Ambulatory Surgical Centers. In addition HCA's proactive approach in identifying potential gaps secondary to the addition of Santa Cruz County the following specialties have been added to enhance the existing network.

Individual primary care providers and group practices represent the core of the delivery system. Group practices and the Federally Qualified Health Centers play a large role in GSA 10. Specialty physicians are integrated into large multi-specialist group practices facilitating continuity of care in GSA 10.

Providers within Pima County are trained and capable of meeting the special needs of patients with HIV, Hepatitis C, Asthma, Chronic Pain, Dialysis and a variety of other diseases. HCA ensures that PCP services are available on a choice basis and that the general population of members is not required to travel outside their respective communities to receive their medical care.

The PCP can refer members to the specialists with minimal prior authorization requirements. There are ample providers of all specialties available to meet the needs of our members in GSA

10 as well as those members referred in from rural areas where some specialties may not be available.

HCA contracts with a variety of ancillary service providers in GSA 10. During discharge planning, the HCA Utilization Review Nurses coordinate with appropriate ancillary services for continued care. The Network Services Department provides an Ancillary Directory to contracted network providers. The Medical Services Department and HCA Case Managers assist with the coordination of ancillary services for providers and members.

In Pima County, HCA continues to be contracted with the CRS Clinic. Members with eligible CRS conditions can be assigned to the CRS Clinic in order to improve coordination of care and establish a "Medical Home" for the member.

The FQHC in Pima County has School Based Health Centers located in Elementary and Middle Schools and/or High Schools where primary medical care, including the early intervention, diagnosis and medically necessary treatment are provided for physical and behavioral health problems.

GSA 4/44

PCP – 380
OBs – 71
Dentists – 71
Specialists – 736

HCA has been successful in developing a comprehensive network of providers sufficient to accommodate the needs of our members in GSA 4. These networks in this GSA include cities like Bullhead City, Lake Havasu, Kingman, Hildale, St. George Utah, Flagstaff, Holbrook, Winslow, Show Low and Springerville. Communities in between, like Dolan Springs, Ashfork, Seligman, Williams, St. Johns and many others receive their care through either satellite clinics operated by independent physicians or through the satellite services of a Federally Qualified Community Health Center.

HCA ensures that PCP services are available on a choice basis and that the general population of members is not required to travel outside their respective communities to receive their medical care. The PCP can refer members to the specialists with minimal prior authorization requirements.

This GSA more than any other in AHCCCS history has required Health Plans to become more creative in how we ensure quality healthcare. Communities like Flagstaff, Winslow, Holbrook, and Show Low do not pose a problem since these communities have care available at a variety of specialty levels. However vast rural expanses without healthcare providers make delivering consistently good healthcare very difficult. HCA has been very successful in contracting with a very large percentage of the providers in all of these areas. One tool that helps us do this is our relationship with the Federally Qualified Health Centers (FQHC). These health centers in Coconino, Mohave, Navajo and Apache Counties allow our members access when it would be 50-60 miles away. Specifically our relationships with North Country Community Health Center in Flagstaff and Kingman, as well as Canyonlands Community Health Center in Page allows HCA to deliver health care in isolated rural communities that otherwise would have to travel great distances to obtain even the most limited healthcare. These FQHCs provide care in Springerville, St. Johns, Fredonia, Littlefield, Ashfork and Seligman just to name a few. Our goal is to continue to support these outposts and ensure that all of our members have access to care.

The HCA Care Coordination program assists our primary care providers with the process of referring general population members and members with special needs to appropriate specialists in Maricopa County when the specialist is not available in the area.

HCA is contracted with most of the acute care hospitals in GSA 4 as well as a variety of ancillary service providers. During discharge planning, the HCA Utilization Review Nurses assist the Hospitalist and coordinate with appropriate ancillary services for continued care. Network Services provides the contracted network providers an Ancillary Directory. The

The Medical Services Department and HCA Case Managers assist with the coordination of ancillary services for HCA's providers and members.

GSA 2/42

PCP	–	86
OBs	–	17
Dentists	–	30
Specialists	–	167

HCA has been successful in establishing an extensive network of providers sufficient to accommodate the needs for our members in GSA 2. The networks within this GSA include cities such as Yuma, San Luis, Somerton, Wellton as well as Parker, Quartzsite, Bouse, Salome, Blythe and Lake Havasu. The members in these communities receive their care through satellite clinics operated by independent physicians or through the satellite services of a Federally Qualified Community Health Center and the Regional Center for Border Health Clinics.

HCA has established a sufficient network of independent contracted providers as well as an agreement with the Yuma Unified Medical Assoc. (IPA), which encompasses primary care and specialists. This has enabled HCA to solidify a sound network of providers to ensure adequate medical coverage to decrease the potential number of referrals outside of the Yuma area.

The Regional Center for Border Health consists of two clinics in Yuma and San Luis and a satellite office in Somerton. The medical services provided include: Family Practice, Internal Medicine, Pediatrics and Urology. Sunset Community Health Center is an FQHC that has four locations in the following communities: Yuma, San Luis, Somerton and Wellton. These clinics provide medical oral health and ancillary services. The addition of these health centers allows members to have access to care without traveling outside of the local areas.

Yuma Regional Medical Center, La Paz Regional Medical Center and Lake Havasu Regional Medical Center provide acute care services within this GSA. La Paz Regional Hospital is expanding medical services by adding an Urgent Care. HCA will add those services to the contract once they become available. La Paz Regional Medical Center has multiple rural health clinics associated with the Hospital that are providing health care services in Parker, Quartzsite, Salome, Bouse and surrounding areas. These rural health clinics provide easy and fast access to care for HCA members living in La Paz County.

At present, HCA is negotiating a contract with Lee Holter, Chief Financial Officer at Palo Verde Hospital located in Blythe California, to become a contracted provider. Additionally, HCA has contracted with a Primary Care Physician and has added a Pediatrician in Blythe for additional coverage for members.

In some remote rural areas, vaccines are provided by mobile clinics arranged through Clinica Adelanta to children at schools located in Dateland, Wenden, Salome and Bouse.

HCA ensures that PCP services are available on a choice basis and that the general population of members is not required to travel outside their respective communities to receive their medical care. The PCP can refer members to the specialists with minimal prior authorization requirements. In the event that additional specialty services are needed in La Paz County due to limited specialists as an example, HCA has gone to great lengths to ensure that those specialty services can be obtained in Lake Havasu so not to inconvenience the member with distance.

Having an extensive network of specialists near by in Lake Havasu only compliments the current network in Yuma and La Paz Counties. HCA's goal is to continue to support these outposts and ensure that all of our members have access to care.

Yuma has opened an Ambulatory Infusion Center located across the street from Yuma Regional Medical Center and a Sleep Study Center that HCA will add as contracted providers to the network.

Tertiary Hospital Services

For Maricopa and Pima County, access to tertiary hospitals does not present a barrier to care. In Coconino County, those members who reside near Flagstaff have immediate access to tertiary care at Flagstaff Medical Center. All other rural inhabitants will access tertiary care after first submitting for care at their local hospital. Mohave County members requiring tertiary care may be transferred to Phoenix or they may be referred to Las Vegas. Members residing in Hildale, Utah may be referred to Las Vegas or Salt Lake City. Members residing in Navajo and Apache Counties may be transferred to Phoenix, Flagstaff or Gallup, New Mexico. Yuma County does not present a barrier to tertiary care with direct access to Yuma Regional Medical Center. Members residing in La Paz County will have access to Yuma and Maricopa County as well as, Las Vegas for tertiary services.

PCP Assistance

HCA uses a number of methods to ensure that our providers are knowledgeable of our expansive network of various levels of providers.

- Referral requirements are communicated during site-visits, physician inquires HCA web site, and in the provider manual.

- All newly contracted providers are scheduled for a "New Provider Orientation" within 30 days of their contracted effective date which includes referral policies.

- All providers are given a copy of the specialty network which is also available on the HCA website. The website includes all necessary HCA forms used to facilitate requests for necessary services.

- Providers may also contact Network Services or Care Coordination/Medical Services for assistance when referring members.

- Network Services Representatives meet with our providers on a regular basis to determine what their needs are and to communicate the needs of HCA. In addition, Network Services in concert with Medical Services has developed a number of utilization report cards in an effort to assist our providers.

- Network Services Representatives provide our providers office staff continuing education on HCA referral processes, claims coding and billing procedures, preventative health care, new wellness programs for their members, updates from AHCCCS, and medical home strategies,

- HCA monitors appointment availability to ensure that our members have timely access to care. This is important to our primary care physicians in that under or over utilization of services will eventually have a negative impact on the provider either administratively or financially.

- HCA tracks provider inquiries, complaints, and requests for information by utilizing the call tracking system.

- Network Services Representatives act as liaisons with various HCA departments on a daily basis in order to resolve providers' issues and concerns in a timely fashion.

Appointment Availability Report

HCA has developed a web-based application that directly interfaces with the provider and member data base which enables Network Services to provide feedback to appropriate departments (See Attestation 1). The reporting capability of this web-based application will encompass all aspects of the site visit tool in compliance with AHCCCS standards including but not limited to appointment availability. This tool provides direct reporting on focus tools but is not limited to appointment availability. All contracted HCA PCP's and Specialists must adhere to AHCCCS standards in regards to appointment availability. HCA has outlined in the provider manual the appointment availability standards for appointments by category. There are different guidelines that must be followed based upon the provider specialty.

PCP standards are as follows:

Emergency Appointments	Same day
Urgent Appointments	Within 2 days
Routine Appointments	Within 21 days

Specialist/Oral Health standards are:

Emergency Appointments	Within 24 hours of referral
Urgent Appointments	Within 3 days of referral
Routine Appointments	Within 45 days of referral
Routine Oral Health Appointments	Within 45 days of request for appointment

OB/Prenatal Care standards are:

First Trimester	Within 14 days of request
Second Trimester	Within 7 days of request
Third Trimester	Within 3 days of request
High Risk Appointments	Within 3 days of identification of high risk or immediately if an emergency exists

The Network Services team will evaluate whether an office is compliant with the availability standards during an office visit. Any office found to be non-compliant will be asked to implement a correction plan when standards are not met. There are also standards for telephone availability. Telephone calls must be answered within 5 rings and hold times should not exceed 5 minutes. If telephone standards are not met, the provider office is educated on the possible access to care issues and a corrective action plan may be implemented.

A second medium utilized to monitor and assess appointment availability is through the "secret shopper" surveys. Calls are made at random with HCA staff members posing as HCA members looking to schedule an appointment for services. If an appointment is scheduled outside of the standards outlined for office visits, Network Services is then notified. The assigned Network Representative will visit the office informing the office staff as to the reason for the visit.

As a result of the failed availability, the office will be put on a corrective action plan with periodic monitoring to ensure that the issue is being resolved.

Provider/Staff Feedback

HCA has a variety of providers' educational processes that can and do result in provider feedback either directly to Network Services, through provider committees, or more often to the Prior Authorization Department. The Prior Authorization Department has daily interaction with the provider network. Because of the interaction between Network Services and Medical Services, the prior authorization staff is an excellent medium for the immediate dissemination of information to the provider.

The HCA Quality Management Department tracks, trends and responds to providers issues that may have a quality of care impact upon HCA members. Network Services works hand in hand with Quality Management to ensure the provider understands the importance of cooperating with Quality Management.

Health Choice has implemented a call coding system used by all employees to track and trend provider and member issues. This system is used to document any communication between internal staff with members or providers. Upon the completion of each call received, the specifics of that interaction are assigned a code that identifies the details of the communication. The coding of these communications allows any Health Choice employee to view which provider or member called along with the details from that call. This process has proven beneficial for follow up and resolution as the caller does not have to reiterate the details of the issue to another employee if they were to call in again. The rep who receives the secondary call can simply pull up all details from the original call by performing a search on the provider's name or ID number, member ID numbers can be used to search for member driven communications.

Regular reports are generated from these coded calls. These reports can be used to identify the following:

- Common providers/members that call frequently - the reports can be used to identify any particular providers/members that seem to call regularly for the same or different issues. HCA uses this as a trigger to set up an office visit for the provider or outreach to the member to address any concerns directly.
- Common issues amongst various providers/members- pulling a report on call codes can be used to identify multiple providers/members that seem to be calling about the same issue. Identifying this information is the initial step to creating a work group to address any issues and determine whether any operational changes are necessary.

Reports can be generated by using:

- Provider ID Number
- Member ID Number
- Call Code

This call coding system is not only used to track and trend phone calls, but email, fax and face-to-face interactions as well.
Upon joining the HCA Network, all members are assigned to a PCP based on geographic location, panel size and open provider panels. Member assignment will generate a letter to the member notifying them of who their assigned PCP is. If a member chooses to be seen by a PCP other than who they were assigned to, the member is welcome to contact the HCA Member Services Department for re-assignment to the PCP of their choice. As part of an HCA site visit with the providers, the Network Rep is responsible for obtaining feedback from the PCP to ensure that the PCP panel size is manageable. If the provider feels overwhelmed by the number of members assigned to his/her panel, members will be reassigned to a different provider in hopes of reducing the panel size down to a manageable level.

Occasionally, HCA will receive a member request to be seen by a provider that is not contracted with the health plan. When these requests are received, an analysis is done to identify:

- Provider specialty
- Provider office location
- Other contracted providers within the geographic area of the same specialty
- Open/Closed panels for contracted PCP's in the area
- Panel size for currently contracted providers

An analysis of these components is the first step used to identify whether a gap in the network exists. If so, the contract negotiation process will begin.

HCA issues quarterly Provider Communication articles which contain a variety of information to the provider network.

The HCA website is available to our providers via their own password to insure compliance with HIPAA requirements.

HCA provider representatives visit their providers on a regular basis, especially the primary care providers and frequently used specialty providers. The feedback from these visits assists HCA in developing its provider network strategies on a go-forward basis.

The feedback and inquiries from providers is immediately addressed by Network Services. Provider feedback and inquiries are obtained through several departments. Network Services is responsible to ensure follow up and information is disseminated to the appropriate department.

Examples:

- Network Services may collect feedback from providers about network design and/or gaps during site visits or by phone.
- Medical Services may collect feedback from providers about network requests and/or from prior authorizations requests. Medical Services will verify if the provider or specialist is contracted.
- Request for certain providers or certain specialist will be analyzed by confirming if already contracted and credentialed, verification by Medical Services for a network need based on the number of referrals received for the provider and/or specialty.
- Network Services will verify the number of providers with the same specialty in the geographic locations to determine a whether or not a need exists.
- Network Services and Medical Services will verify availability of the provider or service within the AHCCCS Accessibility & Availability Standards.
- Case Managers and Member Services will notify Network Services when a lack of availability of services has been identified and a contract is needed.

Key data that is shared with providers are high ER utilization and Pharmacy utilization. Case Management referrals are generated from the high ER utilization report and assigned to the appropriate case manager. This process has enabled the HCA Case Manager to promptly intervene with member and PCP to better coordinate plan care. Over the past year HCA has monitored and tracked pharmacy data and is implementing a Medication Therapy Management Program; this program is designed to provide pharmacy information to both the member and provider.

ADDENDUM

A. ***How does HCA assess the medical and social needs of new members to determine how the health plan may assist the member in navigating the network more efficiently?***

The HCA New Member Survey is designed to identify members with special medical and social needs and who would benefit from case management or chronic disease case management. The survey is initiated upon enrollment and is included in every new-member packet. In addition, HCA Concurrent Review Specialists, Case Managers and Member Service Representatives are continually identifying members with special needs as a part of their daily interactions with members, providers, and vendors. When HCA has identified a member with special medical or social needs, the Case Management Department educates the member on how to access appropriate services and coordinates the member's care.

B. ***What assistance is provided to members within a high severity of illness or higher utilization to better navigate the provider network?***

Case Management assignment is made when members with high severity or high utilization are identified through the new member survey, claims data, pharmacy utilization and provider referrals. Case Management and Care Coordination proactively assist the PCP and members in navigating within the provider network. The Network Services Representatives educate the providers on the roles of case management and care coordination and provide them with contact information.

There are a variety of utilization reports which include emergency room utilization, pharmaceutical information and referral frequency reports that are shared with our providers to assist them in the effective management of our chronically ill members. The HCA Chief Medical Officer and/or Associate Medical Director(s) and Network Services staff continuously monitors these reports to determine which providers require intervention.

C. ***How does HCA support the Graduate Medical Education (GME) programs within its contracted GSA(s) and pursue contracting opportunities with graduates and providers that are opening new practices in, or relocating to, Arizona especially in rural or underserved areas?***

HCA has secured GME agreements with contracted hospitals that have residency programs in GSA 12, GSA 10 and GSA 4. Network Services has representatives assigned to the hospital based residency programs to track potential contracting opportunities.

In addition, these representatives work in concert with all HCA Network Service Representatives to provide feedback to the residency programs on the status of the current medical market and share potential opportunities for new graduates and/or providers relocating to Arizona. The fact that HCA is contracted in GSA 4 presents an advantage to focus on underserved rural areas.

D. ***Describe the process HCA uses to increase provider participation in Baby Arizona?***

The Provider Tool Kit, which is given to each Provider includes information on Baby Arizona and encourages providers to work with this program. Network Representatives take the opportunity during site visits to educate providers on the program and the benefits. Provider communication postings is another way information on Baby Arizona is disseminated to providers and is also posted on the following link:

http://www.azahcccs.gov/HPlans&Providers/babyAZ.asp
This link is posted on the HCA website. Network Services along with Maternal Child Health report and track physicians to ensure all providers are informed of this program.

E. ***What interventions HCA has implemented to reduce avoidable/preventable ER utilization? What was the outcome of those interventions?***

HCA contractually requires each provider to have call availability 24 hours per day, 7 days per week and to arrange after-hours care and vacation coverage. HCA educates and provides alternative levels of care to providers to decrease ER utilization. HCA encourages providers to mention appropriate Urgent Care availability as part of after-hours answering service messaging. Additionally, as part of the HCA Credentialing application, providers are specifically required to list providers who share on-call responsibilities with them in their absence.

Health Choice implemented an ER report which identifies members who exceed 12 ER visits per year. When a member has been identified with 12 or more visits per year, medical services sends a letter to the member which is followed by a phone call. Health Choice also re-evaluates the member's ER utilization and implements other interventions as needed, such as, entry into case management services and/or the Selected Provider Program. The Selected Provider Program assists members and providers in coordinating needed medical and behavioral health services to decrease the likelihood of any duplication in services. The efficacy of this report has shown over an 80% reduction in ER visits with an average of less than 7 visits per year since the implementation. Medical Services uses this report daily to manage ER utilization, as well as identify potential high risk/chronic disease members for case management. This report is ongoing with the over-all goal being 6 visits or less per year.

Medical Services in concert with Network Services reviews this utilization and determines those providers whose membership frequents the emergency room. The implementation of the Disease and Case Management Program proactively identifies members through various outreach and survey data. Case Management is trained and educated to work with PCP's within the Medical Home environment. Once referred to Case Management, contact is made with the member and an individual plan is set up to coordinate care between the PCP, Specialist and outside providers to ensure the member's needs are met. The ongoing monitoring of ER utilization data provides trends and tracks members for over utilization. This information tool is used by Case Management to generate letters to both PCP's and members who have had 12 or more ER visits in a year. These reporting tools are used to educate members and providers, as well as identify areas within the network to evaluate PCP availability. HCA has added extended appointment availability hours with providers in the current network.

HCA's contracted PCPs and Specialists must maintain availability within the appointment standards prescribed by AHCCCS which includes same-day emergency care appointments. This is monitored during site visit and through "secret shopper" surveys.

HCA currently does not utilize an after-hours nurse call-in center or information line.

HCA has expanded the network of Urgent Care Facilities, Cigna Care Today Program, After-Hours and Extended Hours Clinics. Members are provided information about these facilities through the Member Welcome Packet, Member Newsletter and the HCA web site.

F. ***Are members with special health care needs assigned to specialist for their primary care needs? If so, what general criteria are used to determine if a member should be assigned in the manner?***

Specialists such as HIV, Hepatitis C, Pain Management, and CRS Pediatricians act as Primary Care Physicians for the continuity of care for members with special health care needs. As we identify members with special health care needs, HCA does not place barriers to members to appropriately use specialists as primary care physicians when treating chronic conditions or conditions specialized by these providers.

HCA utilizes the following tools to identify a potential special needs member. The criteria includes, but is not limited to, a Health Risk Assessment (HRA), Case Management Referral, ER utilization Report, Pharmacy Utilization and Inpatient Daily Census. HCA utilizes the following criteria to capture potential high risk members, Health Risk Assessment (HRA) will capture but is not limited to: Asthma, HTN, Diabetes, Depression, and/or Pregnant. The Case Management Referral form is based on the following criteria, but not limited to: Frequent ER, Diagnosis of Catastrophic Illness, Behavioral Health Thought Process Changes, High Risk OB, Non-Compliance, Suspected Financial/Social Problems, Deficit of Disease/Medication. Pediatric members are asked the same questions as the adult population plus additional questions to determine if they have special needs such as enrollment in CRS, nutritional supplements, outpatient therapies, previous history of being in the NICU, use of special equipment, developmental delays or being treated by a specialist are forwarded to Case Management for further assessment and follow up. In addition, immunization status is obtained and referred to HCA health promotions department for follow up if the member is behind.

Other tools used to identify high risk members include the Enrollment Transition Information form (ETI), Case management referral form, NICU records review, EPSDT exam review for pediatric members who are referred to a specialist that does not require an authorization and in patient follow up program.

Case Management collaborates with the PCP and follows up with the member and/or family to assess the issues and concerns. In addition, Case Management will work with the PCP, member and/or family to set up and initiate plan of care and manage ongoing treatment. This process includes educating the providers, members and their families.

G. ***What are the most significant barriers to efficient network deployment within the health plans service areas?***

HCA has found that the most significant barriers to developing an efficient network are the issues regarding lack of physicians or certain specialties practicing in specific geographic areas. Arizona has fewer and fewer physicians as a percentage of the states' rapidly growing population, coupled with rising liability concerns and malpractice expense which discourage providers from entering the state or that force providers to retire earlier than expected.

How can AHCCCS best support HCA's efforts to improve its network and the quality of care delivered to its membership?

AHCCCS can continue to review and update the language in the AMPM and ACOM to best reflect the needs of the population served and provide the most cost-effective policies which consider quality of care and prevention as the primary directive.

AHCCCS can update it's website to be consistent with tables regarding OPFS and provide the most current and accurate information of fee schedules, modifiers and other information in which claims adjudication requirements are governed. Also offer PMMIS viewing capabilities for hospitals and providers who are registered with AHCCCS.

AHCCCS can intervene with the state's government to bring awareness to both the medical liability crisis and emergency room over utilization affecting the state.

AHCCCS can intervene and act on provider concerns where many AHCCCS members exhibit negative behaviors which ultimately lead to abuse of privileges of the program. These behaviors are the common battles of the Health Plan in order to meet contractual requirements and maintain an adequate network. Providers often will not participate in the AHCCCS program due to past experiences with AHCCCS members and because of a perceived substandard reimbursement to manage the level of care required for AHCCCS members.

AHCCCS can entertain a reimbursement for "No Shows." This appears to be an issue for providers who treat AHCCCS members who have no opportunity for reimbursement for the loss of appointment time and money. This is not cost effective when maintaining a practice.

H. What interventions has HCA implemented to address and reduce no-show rates and how is information collected to assess the efficacy of these measures?

HCA takes a proactive approach in reducing the member no-show rate through multiple interventions, teamwork among departments, and by integrating the Medical Home Model into all health plan functions by providing training on the Medical Home model to all employees. Collaboration with providers, provider staff, and members is fundamental to promoting a Medical Home for members and reducing no-show rates across the spectrum of care. HCA is committed to building strong relationships with providers as well as their office staff, because office staff members also play an important role in member compliance with recommended health visits. HCA has developed a "missed medical Appointment Log" that is handed out to all providers at the initial/new provider in-service and at follow up site visits when updated information is given. The form is also available on the HCA web site, for easy access for providers. The form allows providers to give HCA information on members who miss appointments which gives the Health Plan the ability to follow up with the member and determine if additional services are needed, such as transportation to get to their appointments. The form is completed by the providers' office and faxed and/or mailed to Member Services for follow up. In certain circumstances, a Case Management referral may be initiated in order to assist the member in getting care and the provider in getting the member to their office for care. Network Services works closely with the providers' office in developing solutions to reduce the number of no-shows encountered. One solution providers utilize is making contact with the member a few days in advance of their appointment to decrease the number of no shows. This also allows the member the opportunity to reschedule in a timely manner if necessary. Another alternative is providers have implemented the "same day appointment" programs to decrease ER utilization and no shows.

Additionally, HCA recognizes the importance of effective member outreach in reducing no-show rates and ensuring members are utilizing preventive services, which constitute the cornerstone of the Medical Home for members. HCA's CMO has extensive experience and expertise in rural health issues, which is invaluable in devising interventions targeting members in rural areas with unique circumstances that may impact no-show rates. All interventions to reduce no-show rates are evaluated for effectiveness using the Plan-Do-Check-Act (PDCA) model of continuous quality improvement, utilizing member and provider survey information, provider feedback, no-show logs, and performance measure data collected and analyzed by HCA. Data will be taken to the HCA QM Committee for evaluation and discussion. New interventions are designed when needed.

One of the key results of the Plan-Do-Check-Act was the implementation of the 'no show' referral tool and missed medical appointment log utilized by both internal and external entities. These tools enable the plan to manage 'no show' issues within Members Services and Medical Management. Referral and missed appointment log data is used to create member letters informing them of their responsibility to attend and/or cancel appointments in a timely manner or re-assign members to another PCP. The letters also inform members of their transportation benefit. Over the past year member services has implemented a two (2) no show process that generates a case management referral. Case Management logs each referral and follows up with the member and provider to resolve issues that maybe contributing to the cause of 'no shows'.

Requirement #37

REQUIREMENT #37

Any Offeror who is new to a GSA must submit a description of how it will launch a network capable of supporting its membership by October 1, 2011. Incumbent Contractors that are not new to a GSA are exempt from this requirement.

Health Choice Arizona (HCA) is applying to participate in ALTCS in four GSAs: 42 - Yuma/La Paz; 44 - North 4 (Apache, Coconino, Mohave, Navajo); 50 - Pima/Santa Cruz; and 52 – Maricopa. While ALTCS would be a new program, HCA has been providing acute care service to AHCCCS members in all the GSAs. Therefore it has well developed acute care networks in these GSAs, as documented in its current Network Development and Management Plan CYE 2011, submitted to AHCCCS. Moreover, although LTC and HCBS are not currently covered services under HCA's AHCCCS contract, HCA often coordinates care with LTC and HCBS providers to facilitate AHCCCS members' transfer into ALTCS. Therefore, HCA has developed working relationships with many LTC and HCBS providers. Furthermore, existing skilled nursing facility and home health contracts for acute services will be amended to include the provision of long term residential, attendant/homemaker and respite services. Likewise, while HCA does not currently provide covered Behavioral Health services to AHCCCS members, it does interact with the RBHAs as well as coordinate care with behavioral health providers in its referral and case management operations.

HCA has secured contracts or Letters of Intent (LOIs) with the required providers in all areas to provide adequate network coverage for all members. Upon award of the bid, the Network team, supported by Case Management, Member Services and Senior Management has a plan in place to reach out to all providers that signed an LOI to begin contract discussions to efficiently convert the LOI to a contract. As part of the LOI process, initial discussions regarding service level and rates have been initiated to help expedite the contracting process. The conversion plan includes five to ten additional contracting staff, between two and five additional provider relations positions and two to five additional credentialing staff to assist with this contracting effort. The provider relations staff will distribute provider manuals to all providers new to HCA. New providers will also receive additional training from the provider relations staff through town hall meetings or individual meetings with their staff.

The Network Services Department is designed to manage a comprehensive network of various levels of providers. The network is constantly evaluated for member need, access to care, and referral patterns to maintain provider relationships within the communities. Provider education is a key component to servicing and maintaining an adequate network. Network Services has implemented two key positions to track and trend provider communication. The Provider Claims Educator organizes in-services, meetings and seminars to disseminate relevant coding and claims information, as well as assist with the development and distribution of written materials along with the development of HCA policies and procedures. Provider Data Analyst utilizes a Provider Data Management Program to identify incorrect data and ensure appropriate measures are implemented to correct discrepancies. The enhanced Network Services Department greatly increases HCA's ability to verify data and proactively work towards solutions. HCA has effectively implemented the necessary processes to launch and maintain an adequate network to support ALTCS membership in all GSA's.

HCA has employed and will continue to employ Network Services Representatives that reside in the service areas they are covering. The Service Representatives have a long-standing connection to the community they serve and many years of experience working with the providers. They have built relationships over the years with the provider community that enables them to ensure a very high service level to forge a strong Health Plan and Provider partnership.

Requirement #38

REQUIREMENT #38

Describe how the Offeror will communicate with its provider network in explaining the standards for the program, changes in laws and regulations, and changes in subcontract requirements.

Health Choice Arizona (HCA) realizes the strategic significance of effective provider education and communication in fostering valuable partnerships that enable all members to receive medically necessary care from qualified providers in compliance with all AHCCCS/ALTCS and Medicare standards and subsequently for those providers to be paid accurately and timely. Since changes in program standards, laws and regulations, and subcontract requirements affecting providers are developed and managed in several departments, HCA assures that communication regarding updates and changes is structured, effective and consistent with that of other plans as well as AHCCCS/CMS to ensure provider comprehension.

Weekly, leadership from Network Services, Compliance, Grievance, Information Services (IS), Claims, Claims Customer Service Call Center, Medical Services, and Marketing and Outreach gather to discuss current and future provider communications. These communications are structured within four categories: contract/regulations, claims, medical management, and quality/performance measures. Compliance leadership is responsible for the notification of all changes in laws, regulations and subcontract requirements to the team. Claims leadership is responsible for alerting the team to edit, coding, and/or process changes that will be made. IS leadership is responsible for National Provider Identification Number (NPI), Correct Coding Initiative (CCI), electronic claims, electronic payment, and Health Plan Information System (HPIS) updates that affect providers. Medical leadership is responsible for alerting the team to changes or updates with regard to prior authorization, utilization review, criteria that is utilized to make clinical decisions, health and wellness resources, maternal child health, behavioral health, credentialing, case management, chronic care/disease management, oral health and quality and/or performance measure information. Network Services is responsible for communicating policy, payment, and subcontract changes or updates to the team.

Once detailed in the network communication matrix aligned by the four content categories, Marketing and Outreach leadership determine communication mediums and, subsequently, craft copy to optimize those mediums to be reviewed by the subject matter experts of the team. Many times clarifying questions will be posed to AHCCCS/ALTCS or CMS to ensure the HCA interpretation is aligned with the intent and spirit of the change or update. Once approved, the communication piece is documented in the provider communications calendar disseminated to the Call Center and Network Services staff to ensure that all employees who interact with providers understand the subject thoroughly and can communicate it accurately to providers.

The quality and clarity of the communication's content and distribution medium correlates directly to the efficiency with which the provider is able to implement or incorporate the changes and carry out the stated objectives of the AHCCCS program. HCA has developed and continues to refine new and innovative communication delivery mechanisms. Examples of these communication delivery mechanisms are the HCA Provider Portal, general mailings, faxes, e-mail, on-site visits, quarterly Joint Operating Committee meetings for large provider groups, newsletters, dynamic provider manuals and formularies, seminars and educational events, as well as outbound one-on-one calls from the provider and claims customer service call centers.

Providers utilize the HCA Provider Portal as an extension of their in house management information system. To this end, providers are able to integrate HCA applications to perform eligibility verification, claims and prior authorization status, payment status and verification, Remittance Advice (RA) download, electronic claims upload, document management, and calendaring. All provider communication collateral is posted on the website to allow for ease of reference, download, and if necessary, printing. This collateral is driven by a dynamic document management engine to ensure the provider community is accessing the most up-to-date and current communication pieces.

Furthermore, policies and forms regarding such items as medical record requirements, medical review criteria, behavioral health coordination for RBHA enrolled members, prior authorization requirements, formulary, step therapy, dispute process, credentialing, oral health, and cultural competency to name just a few are detailed within the HCA Provider Portal. The most effective communication functionality with regard to the Provider Portal is a new update "pop up" box that executes upon login. This box details all HCA updates over the previous 30 days as well as future update with an associated links that contains more detailed information.

The HCA IS team has developed several Provider Portal initiatives will allow providers to view and receive updates for such important entities as the formulary, step therapy, medical review criteria, and prior authorization requirements. It is believed that by having this information when the provider is working directly with the patient will alleviate such inefficiencies to the system as denials and rework.

HCA uses traditional mailings, faxes and email to compliment the electronic Provider Portal. The Network Services Department tries to visit each provider site at least annually. Face-to-face interaction still proves to be the most effective means of communication as Network Services has the providers' and their staffs' full attention when discussing plan policies, requirements, and recommendations. This one-on-one interaction is a great opportunity to discuss the background and reasons for changes along with providing answers to any questions that they may have. Also, solicited during these one-on-one visits are ideas to improve future communications.

For larger providers, monthly, quarterly or as needed Joint Operating Meetings (JOC) are scheduled. These meetings are similar to onsite visits, but generally encompass larger issues and involve more health plan and provider staff. Likewise, changes to program standards, laws and regulations as well as subcontract requirements are discussed in detail during these meetings. Provider feedback is obtained and any questions related to the changes are answered. If possible, responses are given immediately. If not, feedback issues and questions are researched by the appropriate Network Services Representative personnel for a timely response.

With the many technology related changes that have occurred in the past few years, it is imperative that the health plan and its provider community partner to share information in order to successfully launch and benefit from these new initiatives. To this end, HCA has created the position of Provider IT Coordinator who is responsible for provider assistance and education regarding electronic claims submissions, rejections, payment, and any questions regarding specific health plan processes and requirements. This position serves as the central education point for all changes in transaction requirements as well as new initiatives such as NPI and CCI. It is important to note that this position works very closely with the Provider Claims Educator as their lines of responsibility blend as claim submission and coding rules become electronic.

The Provider Claims Educator is responsible for the planning and execution of in-service meetings and educational seminars with providers to provide feedback on claims, coding, electronic submission issues and any other significant, non-clinical provider concerns. The Provider Claims Educator develops the curriculums and agendas for these coding seminars by working directly with the claims leadership to incorporate those billing mistakes causing the greatest numbers of denials. In addition, she reinforces the False Claims Act requirements, Deficit Reduction Act and other national legislative concerns. One-on-one assistance to providers having specific difficulties with claims or coding issues and administers provider satisfaction surveys when appropriate is available.

The HCA Claims Customer Service Call Center receives and reacts to inbound inquiries and complaints, and provides for outbound provider communication as well. If specific claims processing methodology is forecasted to change, the Network Service Representatives make outbound phone calls explaining the changes in detail to the providers' appropriate personnel. In addition, the Provider Network Team utilizes "blast" faxes, "pop-up" windows on the provider website, email, mail and visits to providers as mechanisms to communicate alerts, changes and updates such as claims processing methodology changes. The order in which providers receive the calls is determined by detailed reports that gauge those providers who will be affected most by the change.

In addition to those communication mechanisms noted above, HCA utilizes more traditional methods such as provider newsletters, provider manuals, brochures, and memorandums to communicate changes regarding program standards, laws and regulations, as well as subcontract requirements. These continue to prove to be effective communication vehicles and will be utilized to augment the newer forms of communication until provider feedback indicates they are no longer necessary.

Provider feedback is also encouraged for the most efficient and effective way to implement changes prior to implementation. Future changes are discussed to determine how providers will be affected and what resources they may require to help them through a transition.

Requirement #39

REQUIREMENT #39

Describe how data and information obtained from throughout the organization are used to manage the network and identify how provider issues are communicated within the organization. Provide an example of how this process has been used in your organization.

The Health Choice Arizona (HCA) Network Services Department is responsible for provider network development, monitoring and if necessary, remediation of deficiencies at the direction of the Contracts Committee and senior leadership. The Analysis and Information Systems Departments provide reports and detailed drill down information for provider and network monitoring, such as provider profiles, site visits, provider/member feedback tracking, credentialing, performance measures, website inquiries, appointment availability, and a network business intelligence suite/dashboard. The network services dashboard, reviewed by the department's management team weekly, encompasses enrollment, open and closed panels, provider panel size, provider panel capacity (assigned members divided by panel size), and referral patterns for specialist and ancillary providers. The review of the aggregate dashboard in addition to the individual reports enables the HCA Network Services Department to build and maintain a provider network wherein members have continuous access to quality care from provider relationships whose shared goals are valued.

As most HCA departments interface with the provider community, it is important that the Network Services Department interacts with other departments to ensure all facets of care to the HCA membership are rendered timely, qualitatively and without barriers. To this end, the Network Services Department interacts seamlessly with Medical Services, Compliance, Grievance, Member Services, Claims, and Finance to ensure strategic alignment of an effective and efficient provider network while meeting all requirements of the AHCCCS contract.

Network Services Department utilizes the Medical Services Department results from daily functions of Prior Authorization, Case Management, Utilization Review, Quality Management (QM), and Pharmacy, to continuously monitor the contracted provider network for sufficient coverage, quality of services, and adherence to evidenced-based medicine, as well as referral and utilization patterns. The Network and Medical Services leadership teams meet weekly to share individual cases as well as the aggregate of these monitoring activities. ER utilization monitoring continues to be an area in which these departments focus in order to remediate provider and member habits that result in the rendering of higher quality, lower cost alternatives to care. This is especially important in the rural areas where Urgent Care Centers may not be accessible, thus offering lower cost alternatives to care can be more arduous and complex. In order to accomplish this joint goal of AHCCCS, CMS and HCA, ER utilization is tracked against geographic area and provider assignment; the HCA Chief Medical Officer and Network Services Director then work with these individual providers with high ER utilization rates to offer extended hours or better call coverage on nights and weekends.

The delivery of quality services in a fiscally responsible manner is the cornerstone upon which the AHCCCS program was built. The Quality Management (QM) Unit of Medical Services tracks, trends, and responds to Quality of Service (QOS) issues that are received via a myriad of intake points including Member Services, Network Services, Compliance, Claims, Audit, and Medical Services functions highlighted above to ensure the HCA membership is receiving the quality of care they deserve. Deficiencies in the network, such as transportation or specialist gaps, are shared with Network Services Management team to develop and execute remediation plans to mitigate the risks of these issues occurring in the future.

Furthermore, the QM management team reviews provider profiles which detail provider utilization trends, referral patterns, and adherence to the delivery of those services that qualify under the performance measure program. Those providers falling below performance measure thresholds are discussed between the Network Services and Medical Services leadership teams resulting in the development and execution of a remediation plan. Most initial interventions consist of the Director of Performance Improvement accompanying the appropriate Network Services Representative to a one-on-one visit with the provider to review the performance measure standards versus the actual scores of the provider. The parties then work together to develop a mutually agreeable remediation plan that results in the increase of quality care rendered to the assigned HCA membership population. Providers who are on a corrective action plan have their profiles monitored monthly to ensure progress is being made. If no progress is visible, the QM leadership team along with the Network Services team contacts the provider to communicate findings. Subsequent actions may include capping membership or terming the provider if quality improvements are not made. It is important to note that all quality issues involving providers are included in the appropriate providers' file and stringently reviewed during the re-credentialing process.

To increase the level of HCA's value to the AHCCCS program, HCA continuously strives to increase the quality of care that it provides for its membership population. This can only be achieved by a holistic approach to service quality that incorporates every competency, process, and employee within the organization. To underscore this commitment, HCA has embarked on a quality improvement initiative that will result in the health plan becoming National Committee for Quality Assurance (NCQA) accredited.

The Case Management Unit within the Medical Services Department focuses on the coordination of care and the compliance to treatment regimens for HCA's sickest and most vulnerable members. As the complexity of treatment regimen increases, any deficiencies of the health plan's network may become more apparent. Because of this, the Case Management Unit is an integral part of the provider network monitoring strategy. One example of this was when case managers experienced availability issues for home health nurses from the current home health agency network. Through internal Medical and Network Services meetings, this issue was escalated and short and long-term improvement plans were crafted. It is important to note that the Chief Medical Officer received feedback from network physicians regarding home health agency issues, which in turn validated the concerns of the case managers. As the nursing shortage worsens, those service components that rely so heavily on their skill set, like that of home health, become more arduous to deploy in an efficient and effective manner. To mitigate these issues for the long term, HCA determined the need to shift from the paradigm under which it currently organizes its home health resources. Consequently a new initiative was developed in the Medical and Network Services Department meetings whereby all home health agencies will be managed by a key group of specialist responsible for the guarantee of all home health services network wide.

Since most behavioral health services fall under the Regional Behavioral Health Authority (RBHA) rather than AHCCCS acute services, it is imperative that coordination of care be performed and the affected provider network be monitored to ensure the membership population is receiving optimal care. The Pharmacy Staff in conjuction with the Behavioral Health Case Managers continuously monitors physician management of psychotropic medication and the transfer of behavioral health services to the (RBHA). The results of these activities are presented to the QM Committee for evaluation and recommendations regarding process improvement. Those physicians who do not routinely meet the requirements of psychotropic medication management or coordination of services between the RBHA and the health plan will be educated by the Behavioral Health Case Managers and their assigned Network Services Representative. If it is determined that the provider still does not meet these requirements after multiple interventions, corrective action including panel closure or termination will ensue.

Under ALTCS, HCA will begin to provide, manage and coordinate behavioral health services through direct contracts with behavioral health providers. It will draw upon its experiences working with RBHAs and the relationships it has developed with behavior health service providers to ensure members receive medically necessary services and treatment.

To ensure provider network transparency at all levels of the organization, senior management has developed the Contracts Committee. Chaired by the CEO, senior executives representing all departments, work together in weekly meetings to monitor and review provider feedback reports to evaluate the current state of the provider community. This enables the senior team to develop and continuously refine provider network strategies and action plans that improve member access to care while reducing provider hassle factors. To ensure that the day-to-day operations align with the strategies developed, all provider contracts must be reviewed and approved by the Contracts Committee in order to be executed. This enables the health plan to not only be fiscally responsible with public funds, but ensures the agreements with its provider community are of one message.

In addition to the previously discussed internal reports and dashboards, the Network Services Department management team facilitates thorough health plan reviews of such critical AHCCCS analysis reports as the Provider Affiliation Tape and Data Validation. When HCA receives the results of the annual Data Validation project, key department managers meet to discuss innovative ways to improve the quality of data being submitted by providers. HCA has hosted statewide coding seminars that included important information related to the background of the Data Validation project, submitting all claims/encounters, and how to avoid the common coding errors.

The ability to receive and process electronic claims rests not only on the functionality of the system's translator, but on the accuracy of the provider demographic information that is loaded and maintained in the claims adjudication application. HCA created the Provider Data Analyst position that is responsible for the accuracy of all contracted demographic data to enable the seamless interfacing and processing of electronic claims.

The integrated approach deployed by HCA towards the monitoring of the provider network and the subsequent development and execution of improvement initiatives enables the seamless alignment of its strategies and goals with that of its provider network. Collaboration among all departments ensure well executed improvement initiatives, designed to reduce the "hassles" encountered by the physician, subsequently increasing the quality of care delivered to the HCA membership.

Requirement #40

REQUIREMENT #40

Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the claims dispute process.

Effectively accepting and managing provider inquiries, complaints, and information requests increases provider satisfaction, reduces administrative burdens or hassle factors, and provides information that can generate improvement initiatives. Health Choice Arizona (HCA) considers these processes strategic core competencies.

A majority of the telephonic inquiries, complaints, and requests for information received from providers are accepted and resolved within the Claims Call Center located in Phoenix, Arizona. However, telephonic inquires related to contract language, payment methodology, and demographic information are routed to and resolved by the Network Services Department to ensure that alignment with network strategies are achieved.

Most departments have daily interactions with providers ensuring expectations are effectively managed. However, because the HCA Network Services Department is ultimately accountable for the quality and well being of the provider network, this department is the central repository for all provider issues. Inquires, complaints or requests for information that have been resolved at the point of intake are still forwarded to the Network Services to be categorized, analyzed and reviewed for trends to assess and manage the network.

The business process flow from these intake points to the Network Services Department is automated through a custom, proprietary intranet application. This application enables the nature of the inquiry, complaint, or information request to be entered by intake personnel and based upon this information, the inquiry, complaint, or information request is routed to the appropriate position within the Network Services Department for tracking, trending, solution and/or follow-up. Furthermore, this application enables complete transparency into the provider inquiry, complaint and request for information processes for the entire HCA management team. This transparency results in management understanding where and when issues occur, making it relatively straightforward to effect changes swiftly.

Using the data captured by this application, and combining it with a variety of other health plan process indicators, the Network Services Department can more efficiently identify provider issues. The information is analyzed by the Provider Claims Educator and the Network Services Director who then present their findings to the Provider Complaint Committee, consisting of a core group of Network Services staff, Chief Operating Officer, Contract Compliance Officer, and as needed the Grievance Manager, the Audit Manager, the Claims Director, the Call Center Supervisors, and the IS Manager. Whereas the Network Services Director has the ability to prioritize the urgency of the identified issues, the Committee has the authority to set health plan priorities and effect change.

HCA has structured its provider call centers or queues to effectively promote and effectively receive communication from its provider community. The cornerstone of this strategy is the segregation of competencies within the queues allowing the provider or provider's office staff to reach the right HCA representative with the right knowledge as quickly as possible. Subsequently, 4 main areas have been developed that include eligibility verification, claim and authorization status, adjustments, and post adjudication analysis. Eligibility verification allows for a unique fast track communication line for PCP offices to call verifying eligibility while the member is present. This ability is especially important for those rural providers who do not have Internet access to HCA Provider Portal for eligibility verification.

For Claims Status or inquiries and/or complaints with regard to the methodology utilized for adjudication of a claim, the provider or provider's office staff will reach highly trained Claims Customer Service Representatives (CCSR). If the provider requests that a claim be reconsidered for processing, the CCSR will complete a Referral Form that is routed to the Adjustment Specialists in the Claims Department. For claims which require complex adjudication and subsequently detailed explanation, the Adjustment Specialist will receive the call to educate the provider on the adjudication methodology of the claim as well as adjust the claim while the provider is on the phone in the event there was an issue with adjudication. Facilities and large provider groups have the ability to utilize the services of a post adjudication analyst. The post adjudication analyst works one-on-one with the facility or provider group to perform an in-depth analysis of all outstanding claims. This aids the facility or provider group in reducing their Accounts Receivables (AR) as well as provides a mechanism for HCA to provide adjudication methodology education. The concept was born out of the issue caused by the Outpatient Fee Schedule (OPFS) methodology and continues to be effective today.

When the Claims Call Center receives calls of inquiry, complaint, or request for information that need to be directed to a Network Services Representative, the Customer Service Representative details the nature of the call and the callback information via the Call Tracking application. Managerial reporting is available for the call center management staff to follow-up on all unresolved inquiries or complaints to ensure that optimal customer service is attained.

Providers with Internet access can utilize the secure HCA Provider Portal for eligibility verification, claims or prior authorization status requests. The portal employs role-based security utilizing specific provider information to ensure the electronic protected health information (e-PHI) meets all HIPAA security and privacy laws for all providers, whether or not they are contracted with HCA. If providers wish to submit inquiries, complaints, and request(s) for information electronically, the portal allows the user to automatically create and submit an email to Comments@healthchoiceaz.com. The Provider Services management team receives all communications from this address ensuring that the responses are delivered timely and accurately by the appropriate individual(s).

HCA develops active partnerships with its providers, through the implementation of personal and familiar contact sources for the intake of inquiries, complaints and requests for information. To further foster this active partnership with providers, HCA has local Network Services Representatives who live and work in the GSA they service.

HCA has structured the provider to network representative assignment method as follows:

- Network Service Representatives are assigned by zip code territories and/or GSA for PCP's and specialists
- Network Service Representatives for Level One Providers (5 or more providers with 5 or more locations which encompasses statewide contracts for PCP's and Specialist)
- Ancillary Network Account Mangers (manage all statewide ancillary services)
- Facility Contract Administrators (manage hospital, Skilled Nursing Facilities (short term rehab and long term residential), Home Health Care (short term skilled and long term attendant/homemaker) Alternative Residential Facilities, and Durable Medical Equipment)
- HCBS Provider Representatives (manage HCBS providers not mentioned above, such as Emergency Alert companies, construction firms for home modifications, etc.)
- Behavioral services provider representatives
- Non-contracted Representative (handles general inquiries for provider who are not otherwise assigned to a Network Services Representative)

This provider network design offers structure and continuity for providers. Inquires received by the Network Services Representatives either by phone or during provider site visits are logged, utilizing the inquiry and complaint application, by the assigned representative to ensure follow up is completed within 48 hours. Issues which are routinely resolved by Network Services include, but are not limited to: contracting questions, requests for renewing or renegotiating a contract, assistance with navigating the health plan resources, provider file updates, and problematic claims issues.

HCA Network Services Representatives and Management are available during traditional business hours. If in the event a provider requires after-hours assistance, HCA call center staff is trained to assist providers or if the issues are not acute, direct their concerns to the appropriate Network Services Representative during the next business day.

The HCA Chief Medical Officer (CMO) and Medical Directors make it a high priority to be available to providers to discuss clinical issues. Frequently, the CMO and Medical Director call providers when prior authorization requests contain information that is difficult to interpret or in which it is felt that a different service might serve a member's needs better. This provides opportunities to discuss clinical guidelines and provides a window for providers to offer operational changes. HCA has also hired a Rural Medical Director to address the unique issues which arise in the delivery of health care in rural areas.

Provider complaints that are first reported to AHCCCS, CMS or other government agencies are relayed to the health plan's Contract Compliance Officer for coordination of health plan research and resolution. When appropriate, HCA will educate the provider on the use of the Claims Dispute process. Documentation of the information received from government agencies is tracked within the department and communicated to Network through the inquiry and complaint application.

Requirement #41

REQUIREMENT #41

Describe the process for ensuring that provider services staff receive adequate training.

Health Choice Arizona (HCA) had implemented a thorough training program for all new provider services staff that includes information on the health plan, the program, AHCCCS, interdepartmental relationships, and specific provider issues.

All newly hired staff receives the standard HCA New Employee Orientation, covering HCA's mission and values, organizational structure, covered benefits, Member Grievance and Appeals process, reporting quality of care/service issues, cultural diversity and competency, compliance and human resource policies applicable to all employees.

Upon completion, Provider Network staff undergoes classroom training covering the following topics:

1. Information Systems - MED MC Overview
    - Lines of Business
    - Main Menu/Navigation
    - Provider Demographic Files
    - Claims Information
    - Member/Subscriber files
    - Report system
    - Call Tracking System
2. Information Systems - Network Services Files and Folders
3. Network Policy and Procedures contained in Network Representative Manual/Desk Reference
4. Physician Recruitment/Contract Process
5. Contract Committee
6. Provider Credentialing Re-credentialing process
7. Provider Demographic Maintenance Application/Process
8. Claims Research and Reference Manual
9. Provider Education and In-services
10. Provider Inquiries, Complaints and Information Requests – Handling, routing and follow-up
11. Team Building
12. Provider Portal
13. GeoAccess Analysis for network adequacy reporting
14. Current Year Network Goals

After these formal sessions, new staff shadow experienced provider representatives in the field. Topics covered during this period include routine annual visits, and completing office visit checklist forms; follow-up visits for problem-solving or performance issues; provider in-service sessions; process for recruiting a new provider, etc.

Finally, the new representative's supervisor sets up a schedule whereby time is spent in every department to learn the business and understand what providers may experience in interactions with the health plan. Departments visited include: member and provider call centers; medical services to view prior authorization, concurrent review, case management, chronic care/disease management processes; claims processing, quality management, etc.

Provider network policies, procedures and forms are collected in a manual, called the Desk Reference, which is "continuously revised". This manual also contains other department policies and updates that affect providers, e.g. procedures requiring prior authorization. Whenever a revision is made, staff is alerted via email and the revised policy is maintained in the Network folder used to educate new provider representatives and staff.

Yearly training and refresher courses are required to update staff on new items and insure they continue to understand all company policies and procedures. Staff specific tailored training is provided on an ongoing basis to address specific interests or needs of each provider relations staff member.

The Network Services Director and Managers provide mentoring training and assistance through daily interactions which involve problem solving, workload assignments, and accompanying representatives in the field monitoring network staff performance. Formal performance evaluations are completed annually on all network staff. In addition, all staff including network services staff participate in on-going formal training sessions. Examples of training are: Corporate Compliance, AHCCCS Benefits, Fraud and Abuse, IHeal Testing, and Medicare Compliance.

Provider Network staff is aware of HCA's submission to participate in the ALTCS program. Letters of intent from existing and potential network providers for LTC, HCB and BH have been actively pursued and collected. Nonetheless, as part of the transition to ALTCS, the Network Services staff would undergo an ALTCS-specific training including: covered services, member characteristics and special needs, understanding of case management process (assessment, ISP development, contingency planning, monitoring and re-assessment), servicing ALTCS providers, etc. Indeed HCA anticipates Provider Network staff will play a role in helping Case Managers coordinate care for those dually eligible members who have selected another Medicare Advantage Organization or Medicare FFS for their Medicare services. We expect that some of their acute care providers will also participate in our network and have relationships with our provider network staff.

Requirement #42

REQUIREMENT #42

Describe the process for evaluating provider services staffing levels based on the needs of the provider community.

Provider Network staffing levels are based upon the numbers, types and needs of network providers. Factors considered in the evaluating the provider staffing includes:

1. Anticipated membership growth and the need to continue to meet AHCCCS/ALTCS access standards.
2. Addition of a new line of business, such as ALTCS, to recruit, contract, train and service new providers.
3. Provider Inquiry Tracking reports detailing the volume and type of provider inquiries and complaints.
4. Direct Provider comments on staffing availability and performance
5. Requests from Medical Services department or existing network providers to recruit certain individual or types of providers.
6. Geo Access report analyses highlighting network gaps.
7. Changes in regulatory requirements necessitating contract amendments, changes in provider types, provider education, etc.

Health Choice Arizona (HCA) anticipates that the awarding of the ALTCS contract will require five to ten new Network Services staff members depending upon which GSAs are awarded. These staff would be required to recruit, contract and service long term institutional, alternative residential, home and community based and behavioral health providers to serve ALTCS members. HCA is recruiting Network Services staff with specific ALTCS knowledge and experience.

HCA also recognizes that this influx of new providers will require a well-structured and sustained effort to orient and educate them prior to October 1. Newly recruited ALTCS providers will be trained on HCA policies and procedures, cultural competency, case management process, authorizations and claims processing, using the Provider Portal, how to submit an inquiry, complaint or request for information, quality management program, etc. through large and small group sessions, electronic media, and written materials, and reinforcement and follow-up as necessary.

Requirement #43

REQUIREMENT #43

The Offeror must describe how their organization will handle the potential loss (i.e., contract termination, closure) in a GSA of a) a nursing facility and b) an assisted living facility.

All providers are reviewed and monitored through annual audits, reporting requirements, review of state records and the credentialing process to identify future potential problems such as licensing issues, financial instability and potential closure. These reviews include analysis of financial information, quality concerns or complaints, state sanctions, license issues, ownership stability, as well as discussions with the members and the member's family. The provider is contacted as soon as potential issues are identified so HCA can help the provider correct the issues to avoid closure if at all possible.

To avert a potential contract termination, HCA Network Services, Medical Services and senior executive leadership will attempt to resolve the contractual issues, be they financial or quality of service/care in nature.

In the event of a closure or contract termination cannot be avoided, Health Choice Arizona's (HCA) overriding goal is to provide access to necessary care in a timely manner in accordance with the individual member's desires allowing him or her to remain in the least restrictive setting, and to return to their own home versus having to reside in an institution or alternative residential setting, if desired and feasible.

Regardless of the cause of the potential loss, upon becoming aware of the potential loss of a **nursing facility** (NF) through contract termination or closure, HCA's Medical Services, ALTCS Case Management, Quality Management and Network Services leadership would meet to formulate a contingency plan. The plan would include the following:

1. Identification of the likely date of contract termination or closure.
2. Collation of a roster of all HCA members currently residing in the NF, and pertinent information to aid in placement decisions such as whether they are receiving short-term skilled care or long-term care, expected date of discharge, ALTCS Uniform Assessment Tool Level of Care designation, etc. All such information is readily available from HCA's information system.
3. HCA Network Services will evaluate the capacity of other contracted and non-contracted NFs and other potential Alternative Residential Facilities in the area, including the county in which the NF is located, nearby counties and if necessary boarder states. Will initiate signing letters of agreement or temporary credentialing if warranted.
4. Identify all potential placement options, including names and capacity to accept new admissions: Alternative Residential Facility, Nursing Facility, Rehabilitation Facility, Acute Hospital, etc. All options included temporary acute hospital placement pending transfer to the member's preferred option, if necessary.
5. Advise members, family members, legal representatives and members' PCPs of the potential contract termination or closure.

As soon as possible, but within one to two weeks the CM will meet individually with each member, (and family members and legal representatives if appropriate) to explain placement options, perform re-assessments and updated ISPs id necessary, so members' physical, psychosocial and functional status and needs identification is as current as possible. The goal of these visits is to identify members' preferences for transfer so transfer planning can be initiated. Depending upon the time frame of closure and the number of members involved, HCA will add additional CMs to perform the visits.

The steps in facilitating transfers will depend upon the placement options selected by the member, family or legal representatives, as follows:

1. For those members who are in the NF for short-term skilled services, CM will facilitate discharge to home, another NF, acute rehab or back to the acute hospital to continue skilled services. HCA's Transition of Care unit can assist.
2. For those members who are long term residents of the nursing facility, CM will facilitate the following transfers:

a. If another ALTCS Contractor operates in the GSA and will continue to contract with the NF, member should be given the option to switch.
b. If no other ALTCS Contractor will continue to contract with NF or it will close, member may:
   - Transfer to another HCA contracted NF in the existing GSA or another GSA where HCA is the ALTCS contractor
   - Transfer to a NF in a GSA where a different MCO is the ALTCS contractor.
   - Transfer to an Alternative Residential Care Facility in the existing GSA or another GSA where HCA is the ALTCS contractor.
   - Transfer to an Alternative Residential Care Facility where a different MCO is the ALTCS contractor.
   - Move into a relative's or friend's home in the existing GSA or other GSA where HCA is the ALTCS contractor.
   - Move into a relative's or friend's home where a different MCO s the ALTCS contractor.

In all cases, HCA CM will do everything possible to accomplish the members' desired transfer, including facilitating a change in coverage to another ALTCS MCO by completing an Electronic Transfer Information Form, arranging transportation, assuring medical records and belongs are transferred with Members, obtaining necessary discharge and admission orders, performing home assessments and setting up both skilled and LT home and community based service.

Once transfer is accomplished CM will follow up with receiving facility, member and family, receiving ALTCS MCO, new CM and visit if the CM is not changed during the transfer process.

For the potential closure of an **Assisted Living Facility** (ALF), the process is essentially the same. However, members residing in an ALF would not be receiving skilled services. Every attempt would be made to transfer the member to another ALF or to a home setting. But, NF would remain an option for those members whose status may be deteriorating requiring a higher Level of Care, or if no other ALF is available, and no home setting alternatives exist.

Requirement #44

REQUIREMENT #44

Describe the process for addressing provider performance issues, up to and including contract termination.

Provider performance issues can be identified from several sources including routinely performed appointment availability verification and after hour's coverage surveys, routine provider visits or by investigation of a quality of care complaint lodged by a member, provider or any Health Choice Arizona (HCA) staff member. If a provider performance problem is detected and not corrected, the Peer Review Process is instituted.

The Plan Change Coordinator conducts appointment availability surveys at the direction of the Credentialing Unit. In addition, the Network Services Department, during routine visits' with Providers, will conduct random checks of appointment available at that time. If it is determined that a provider or group practice is not meeting the minimum appointment availability standards, the Medical Director will forward a letter to all non-compliant providers indicating the areas needing improvement. The Network Services Director receives a copy as well. A Network Services Representative meets with the provider to provide training and assistance with development of a mutually agreeable corrective action plan to be submitted to the credentialing coordinator within thirty (30) days. Providers that are on corrective action are re-surveyed in three (3) months. If the provider is found to be non-compliant after being resurveyed, the case is submitted to the Credentialing Committee to determine whether or not to impose sanctions. The Credentialing Committee makes recommendations for specific actions such as panel closure and/or capacity reduction, member moves or contract termination. In the event, Member Service Representatives or Network Representatives determine a provider has capacity issues, additional membership will not be assigned and or a providers membership panel may be closed until Network Services and/or Quality Management has verified the issues have been corrected.

In addition, HCA conducts initial site visits for the offices of all PCPs and OB/GYNs. The QM Department performs on-site provider office reviews, scoring providers on a variety of quality indicators including but not limited to; physical accessibility – Americans with Disabilities Act requirements, procedures to protect patient confidentiality, physical appearance, appointment availability, Medication and vaccine, storage and dating and adherence to medical record criteria. These on-site, provider office reviews are performed during the initial credentialing process and then approximately one year from when the provider passed the initial credentialing process and thereafter with corresponding re-credentialing cycles. If the provider achieves a site survey score below eighty five percent(85%), they are reported to the Credentialing Committee for review.

Specific provider concerns as well as more global provider network issues are addressed through peer review. Peer review is conducted using evidence-based guidelines, when available, or practice parameters that are nationally accepted. Providers are informed about the peer review process, including the appeals process, in the HCA contract and in the Provider Manual which are available to all HCA providers as a printed copy, CD ROM or on the Provider portal of the HCA website.

Referrals of potential peer review issues may be initiated by external sources or by internal HCA departments and referred to QM for research and review. Internal sources may include all HCA department staff members who identify potential specific peer review quality issues while conducting their daily operations, member or provider appeals, HCA medical committees, provider profiling reports, on-site provider reviews and utilization management reports. Internal peer review referrals are sent to the QM department documented on a *grievance/complaint form* with an attachment of any supporting documentation such as utilization reports, excerpts of medical progress notes, or other pertinent documents as available. External sources include state and/or federal agencies, media reports, other providers, members, member representatives, advocates and caregivers. Information from external sources may be received by HCA via letter, phone calls directly to the Chief Medical Officer/Medical Director, or email.

Member and Provider complaints are processed through the internal HCA Quality Management process which includes: assessing the level of severity of the issue; taking action (documenting, intervening as appropriate, monitoring the success of the interventions, incorporating the interventions into the QM Plan, as appropriate, assigning new interventions when necessary); review by the QM department, QOC committee, as appropriate, and QM Committee when appropriate; referring/reporting the issue to the regulatory agency for further review/action, as appropriate; notifying the appropriate licensing board or regulatory agency when a QOC involves suspension or termination of a Provider from the network due to quality of care issues; documentation of the criteria and process for closure of the review.

The QM department receives the complaint through the following methods: email, phone call, mail or paper grievance form. Referrals of potential complaints may be initiated by external sources (i.e., members, AHCCCS, ancillary providers, and contracted providers) or by any internal HCA department staff. The Member Services department is the main intake for issues from members although any staff member may acknowledge and submit a complaint for the member. The complaint form is available on the HCA intranet document file (QM) The member may also choose to submit a written complaint to HCA. Complaints may be routed through the quality management process and or the grievance and appeals process. Complaints (quality and non-quality) are any expression of dissatisfaction with the health plan, provider, or a facility.

Grievances are triaged using a preliminary severity level 0,1,2,3,4 are determined (and level 5 following mortality review). Sentinel events, never events and level 4 events are reported immediately to the Chief Medical officer and/or Administration by the QM Director. All other severity levels 0-3 are processed within no more than 90 days.
A file is opened for each complaint which includes building a QM worksheet to enter the case information in the QM QOC database. Documentation consists of identification of the issue(s), when and from whom it was received, and identification of the category/sub D category and projected time frame for resolution. All complaints that are received by the QM department are acknowledged in writing within five (5) days of receipt by the QM department by a brief letter to the complainant. Each issue, from the same complainant, has a separate file (Worksheet).

- Categories include:
    - Availability, Accessibility, Adequacy
    - Denial, Decrease or Discontinuance of Covered Benefits
    - Effectiveness/Appropriateness of Care
    - Fraud, Member or Provider (Fraud)
    - Member Rights/Respect and Caring (Member Rights)
    - Non-quality of Care
    - Safety/Risk Management

An Acknowledgement letter is sent to the complainant within 5 business days of the QM receipt of the complaint. The QM Specialist, under the direction of the QM Director, will initiate investigation of the issues. Cases that do not reveal a potential quality of care concern (level 0) are immediately closed and placed in the provider's file for tracking purposes and documented in the QOC database.
There is a request for information from the following sources as appropriate: internal HCA department staff associated with the case; PCP/specialists medical records associated with the case; facilities, hospitals, etc. Ten business days is granted for return of information to the QM department. If no response is received, the request will be repeated. If there is still no response, the complaint may be discussed with the Network Director and or the Chief Medical Officer/Medical Director, as necessary, who will either contact the provider directly, or determine another appropriate action.

Review of all pertinent information by the QM staff is placed in the worksheet and prepared for review by the QM staff, and the Medical Director, as appropriate.

A determination is made following the investigation for a recommendation of whether the case is substantiated, unsubstantiated or unable to substantiate as part of the resolution. Cases are then reviewed at the weekly QM department meeting to review the investigation results, and assess a level of severity of the complaints. HCA Severity Levels include:

- Severity Rating 0 - Not a potential quality of care issue; unable to validate due to lack of data
- Severity Rating I - Known complication, with or without adverse outcome
- Severity Rating 2 - Identified potential quality of care issue without adverse outcome but with the potential for adverse outcome
- Severity Rating 3 - Identified potential quality of care issue with temporary adverse outcome
- Severity Rating 4 - Identified potential quality of care issue with long-term adverse outcome
- Severity Rating 5 - Quality of care issue-mortality following the mortality review using the mortality review tool

Resolution status is also assigned at the weekly QM department meeting, as follows:

- *Substantiated* means the allegation of abuse or complaint was verified or proven to have happened based on evidence. Substantiated allegations of abuse or complaints require a corrective action plan of steps to be taken to improve the quality of care or service delivery and/or ensure the situation will not likely happen again. The Plan of Correction, documentation of the implementation of that plan, and assessment of the effectiveness of actions taken is kept in the QM case file. All appropriate internal departments are notified of the findings and resulting plans of correction. The Provider is given ten (10) business days to provide HCA with a plan of action (plan of correction). The plan of correction is reviewed at the weekly QM department meeting for completeness and resolution of the issue and a letter may be sent back to the provider if the corrective action plan is unacceptable.

- *Unsubstantiated* means the allegation or complaint was, based upon evidence, verified to be proven to not have occurred.
- *Unable to Substantiate* means the evidence was not sufficient to prove or disprove the allegation of abuse or the complaint.

If the case is assigned a severity rating I, 2, 3, 4, 5 the file is trended in the QM Department database. It is maintained in the practitioner or provider's QM file. Identified trends for closed/trended providers are discussed with the Chief Medical Officer/Medical Director(s), as appropriate.

All level 4, 5 and AHCCCS originated cases are reviewed by the Medical Director at the Quality of Care (QOC) meeting. The QOC subcommittee is responsible for the qualitative and quantitative analysis of the research conducted by the quality management department during the preliminary review of QOC cases (level 4 and AHCCCS cases). Reviewing of the initial assessment of the severity of the allegations, prioritization of actions for resolution, development of an action plan and the referral of cases to the Quality Management Committee peer review section for further review, action and follow up. All level 4 and 5 cases, and AHCCCS cases are referred to the QMC at the discretion of the Medical Director.

Upon closure of a case, a closure letter is sent to the complainant responding, as appropriate. The letter includes a simple outline of the resolution of the case, identifying what HCA will do and what the member needs to do as follow-up and all applicable external mechanisms for resolving issues. Cases that remain open after ninety (90) days, due to lack of cooperation by the provider, may be referred to the Quality Management Committee for further action (*Peer Review Process and Appeal).*

In quality of care resolutions, member and system action may occur independently from one another. Action(s) to be taken may include but not be limited to:

- Education/training/technical assistance of the provider/provider office staff
- Changes in processes, structures forms
- Informal counseling
- Termination of affiliation with provider, and/or
- Appropriate referrals to regulatory agencies - Issues relating to quality of care cases are referred to regulatory agencies, such as Child or Adult Protective Services and AHCCCS, as appropriate. HCA will notify the appropriate regulatory agency/licensing board and AHCCCS when a provider's affiliation with the HCA network is suspended or terminated because of quality of care issues.
- Complaints/grievances relating to Providers are summarized and included in the re-credentialing packets for review.
- Follow-up monitoring and evaluation of improvement - To identify complaint patterns regarding providers in between re-credentialing cycles, HCA will initiate routine trending queries which will be done monthly for the previous rolling twelve month period of time based on a query threshold of the sum of points on quality cases being greater than or equal to 6 points (Severity level 0 = 0 points, Severity level 1 =1 point, ...Severity level 4 = 4 points). Identified patterns will be submitted to the Chief Medical Officer/Medical Director and at his/her discretion the QMC for evaluation.

The actions of peer review activities and of the Quality Management Committee's recommendations and actions are documented in the providers' file. The actions of the Quality Management Committee are communicated to all appropriate HCA staff to ensure that contracting and credentialing decisions are made timely and with accurate information to ensure the highest quality medical care for members.