

VANGUARD HEALTH SYSTEMS INC (VHS)

10-Q

Quarterly report pursuant to sections 13 or 15(d)

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

FORM 10-Q

(Mark One)

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

For the quarterly period ended September 30, 2011

OR

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

For the transition period from _____ to _____

Commission File Number: 001-35204



VANGUARD HEALTH SYSTEMS, INC.

(Exact name of Registrant as specified in its charter)

Delaware

(State or other jurisdiction of incorporation or organization)

62-1698183

(I.R.S. Employer Identification No.)

**20 Burton Hills Boulevard, Suite 100
Nashville, TN 37215**

(Address and zip code of principal executive offices)

(615) 665-6000

(Registrant's telephone number, including area code)

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

Indicate by check mark whether the Registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of the Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the Registrant was required to submit and post such files.) Yes No

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

Large accelerated filer

Accelerated filer

Non-accelerated filer

Smaller reporting company

(Do not check if a smaller reporting company)

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

As of November 3, 2011, there were 76,853,510 shares of the Registrant's common stock outstanding.

VANGUARD HEALTH SYSTEMS, INC.
QUARTERLY REPORT ON FORM 10-Q
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**PART I
FINANCIAL INFORMATION**

Item 1. Financial Statements.

**VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
(Unaudited)**

	Recast June 30, 2011	September 30, 2011
<i>(In millions, except share and per share amounts)</i>		
ASSETS		
Current assets:		
Cash and cash equivalents	\$ 936.6	\$ 154.7
Restricted cash	2.3	2.4
Accounts receivable, net of allowance for doubtful accounts of approximately \$205.0 and \$251.2, respectively	484.4	563.6
Inventories	83.9	91.9
Deferred tax assets	91.1	86.5
Prepaid expenses and other current assets	157.9	240.4
Total current assets	1,756.2	1,139.5
Property, plant and equipment, net of accumulated depreciation	1,830.5	2,020.6
Goodwill	755.6	756.1
Intangible assets, net of accumulated amortization	94.0	83.8
Deferred tax assets, noncurrent	27.5	47.9
Investments in securities	63.3	58.4
Other assets	65.8	72.5
Total assets	<u>\$ 4,592.9</u>	<u>\$ 4,178.8</u>
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	\$ 314.3	\$ 313.7
Accrued salaries and benefits	248.9	218.7
Accrued health plan claims and settlements	114.9	119.5
Accrued interest	62.3	31.1
Other accrued expenses and current liabilities	218.3	177.0
Current maturities of long-term debt	461.8	13.9
Total current liabilities	1,420.5	873.9
Professional and general liability and workers compensation reserves	289.7	299.7
Pension benefit obligation	188.0	176.7
Other liabilities	125.8	160.4
Long-term debt, less current maturities	2,325.8	2,332.3
Commitments and contingencies		
Redeemable non-controlling interests	—	51.4
Equity:		
Vanguard Health Systems, Inc. stockholders' equity:		
Common Stock of \$0.01 par value; 500,000,000 shares authorized; 71,482,000 and 75,317,000 issued and outstanding at June 30, 2011 and September 30, 2011, respectively	0.7	0.8
Additional paid-in capital	330.5	396.3
Accumulated other comprehensive income	20.6	18.8
Retained deficit	(116.8)	(136.0)
Total Vanguard Health Systems, Inc. stockholders' equity	235.0	279.9
Non-controlling interests	8.1	4.5
Total equity	243.1	284.4
Total liabilities and equity	<u>\$ 4,592.9</u>	<u>\$ 4,178.8</u>

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
(Unaudited)

	Three months ended September 30,	
	2010	2011
	<i>(In millions, except share and per share amounts)</i>	
Patient service revenues	\$ 693.3	\$ 1,358.7
Less: Provision for doubtful accounts	(51.8)	(126.2)
Patient service revenues, net	641.5	1,232.5
Premium revenues	220.6	211.0
Total revenues	862.1	1,443.5
Costs and Expenses:		
Salaries and benefits (includes stock compensation of \$1.2 and \$0.7, respectively)	354.8	665.0
Health plan claims expense	174.1	164.7
Supplies	121.0	213.6
Rents and leases	11.0	18.0
Other operating expenses	124.7	260.1
Depreciation and amortization	37.2	62.6
Interest, net	34.8	45.8
Debt extinguishment costs	—	38.9
Acquisition related expenses	3.7	12.2
Other	1.1	(2.4)
Loss from continuing operations before income taxes	(0.3)	(35.0)
Income tax benefit	2.4	13.6
Income (loss) from continuing operations	2.1	(21.4)
Income (loss) from discontinued operations, net of taxes	0.1	(0.1)
Net income (loss)	2.2	(21.5)
Net loss (income) attributable to non-controlling interests	(1.0)	2.3
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	<u>\$ 1.2</u>	<u>\$ (19.2)</u>
Amounts attributable to Vanguard Health Systems, Inc. stockholders:		
Income (loss) from continuing operations, net of taxes	\$ 1.1	\$ (19.1)
Income (loss) from discontinued operations, net of taxes	0.1	(0.1)
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	<u>\$ 1.2</u>	<u>\$ (19.2)</u>
Earnings (loss) per share attributable to Vanguard Health Systems, Inc. stockholders		
Basic		
Continuing operations	\$ 0.03	\$ (0.26)
Discontinued operations	—	—
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	<u>0.03</u>	<u>\$ (0.26)</u>
Diluted		
Continuing operations	\$ 0.02	\$ (0.26)
Discontinued operations	—	—
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	<u>0.02</u>	<u>\$ (0.26)</u>
Weighted average shares (in thousands):		
Basic	<u>44,635</u>	<u>74,854</u>
Diluted	<u>48,603</u>	<u>74,854</u>

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF EQUITY
Three months ended September 30, 2011
(Unaudited)

	Vanguard Health Systems, Inc. Stockholders						Non- Controlling Interests	Total Equity
	Common Stock		Additional Paid-In Capital	Accumulated Other Comprehensive Income		Retained Deficit		
	Shares	Amount		Comprehensive Income	Retained Deficit			
	<i>(In millions, except share amounts)</i>							
Balance at June 30, 2011	71,482,000	\$ 0.7	\$ 330.5	\$ 20.6	\$ (116.8)	\$ 8.1	\$ 243.1	
Stock compensation (non-cash)	—	—	0.7	—	—	—	0.7	
Issuance of common stock	3,750,000	0.1	66.0	—	—	—	66.1	
Common stock issued under stock incentive plans, net	85,000	—	(0.7)	—	—	—	(0.7)	
Dividends to equity holders and related equity payments, net of taxes	—	—	(0.2)	—	—	—	(0.2)	
Distributions paid to non-controlling interests	—	—	—	—	—	(0.9)	(0.9)	
Purchase of non-controlling interest	—	—	—	—	—	(0.4)	(0.4)	
Comprehensive income (loss):								
Change in fair value of auction rate securities (net of tax)	—	—	—	0.8	—	—	0.8	
Change in fair value of available-for-sale investments (net of tax)	—	—	—	(2.6)	—	—	(2.6)	
Net income (loss)	—	—	—	—	(19.2)	(2.3)	(21.5)	
Total comprehensive income (loss)				(1.8)	(19.2)	(2.3)	(23.3)	
Balance at September 30, 2011	<u>75,317,000</u>	<u>\$ 0.8</u>	<u>\$ 396.3</u>	<u>\$ 18.8</u>	<u>\$ (136.0)</u>	<u>\$ 4.5</u>	<u>\$ 284.4</u>	

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(Unaudited)

	Three months ended September 30,	
	2010	2011
	<i>(In millions)</i>	
Operating activities:		
Net income (loss)	\$ 2.2	\$ (21.5)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:		
Loss (income) from discontinued operations	(0.1)	0.1
Depreciation and amortization	37.2	62.6
Amortization of loan costs	1.2	1.6
Accretion of principal on notes	0.7	4.1
Gain on disposal of assets	—	(1.2)
Debt extinguishment costs	—	38.9
Acquisition related expenses	3.7	12.2
Stock compensation	1.2	0.7
Deferred income taxes	(3.1)	(14.5)
Impairment and restructuring charges	—	(0.1)
Changes in operating assets and liabilities, net of the impact of acquisitions	57.1	(170.6)
Net cash provided by (used in) operating activities — continuing operations	100.1	(87.7)
Net cash provided by (used in) operating activities — discontinued operations	0.1	(0.1)
Net cash provided by (used in) operating activities	100.2	(87.8)
Investing activities:		
Acquisitions and related expenses, net of cash acquired	(49.5)	(210.1)
Capital expenditures	(44.6)	(63.4)
Proceeds from asset dispositions	—	2.2
Proceeds from sale of investments in securities	0.5	22.7
Purchases of investments in securities	—	(21.0)
Other	(0.4)	—
Net cash used in investing activities	(94.0)	(269.6)
Financing activities:		
Payments of long-term debt and capital lease obligations	(2.0)	(456.5)
Proceeds from debt borrowings	216.6	—
Payments of refinancing costs and fees	(5.5)	—
Proceeds from issuance of common stock	—	67.5
Payments of IPO related costs	—	(6.9)
Payments of tender premiums on note redemption	—	(27.6)
Dividend and related equity payments to equity holders	—	(0.2)
Distributions paid to non-controlling interests and other	(1.1)	(0.8)
Net cash provided by (used in) financing activities	208.0	(424.5)
Net increase (decrease) in cash and cash equivalents	214.2	(781.9)
Cash and cash equivalents, beginning of period	257.6	936.6
Cash and cash equivalents, end of period	\$ 471.8	\$ 154.7
Supplemental cash flow information:		
Net cash paid for interest	\$ 48.4	\$ 70.8
Net cash paid (received) for income taxes	\$ (0.5)	\$ 0.3

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
September 30, 2011
(Unaudited)

1. BUSINESS AND BASIS OF PRESENTATION

Initial Public Offering

In June 2011, Vanguard Health Systems, Inc. ("Vanguard") completed the initial public offering of 25,000,000 shares of common stock. Vanguard's common stock is now traded on the New York Stock Exchange (symbol "VHS"). Including the exercise of the underwriters' over-allotment in July 2011 of 3,750,000 shares, a total of 28,750,000 shares were sold. Immediately prior to the public offering, Vanguard completed a 59.584218-to-1 split of its issued and outstanding common shares. All common share and per common share amounts in these condensed consolidated financial statements and notes to the condensed consolidated financial statements reflect the split.

Vanguard is an investor-owned healthcare company whose subsidiaries and affiliates own and operate hospitals and related healthcare businesses in urban and suburban areas. As of September 30, 2011, Vanguard's subsidiaries and affiliates owned and managed 28 acute care and specialty hospitals with 7,064 licensed beds and related outpatient service locations complementary to the hospitals providing healthcare services in San Antonio, Harlingen and Brownsville, Texas; metropolitan Detroit, Michigan; metropolitan Phoenix, Arizona; metropolitan Chicago, Illinois; and Massachusetts. Vanguard also owns managed health plans in Chicago, Illinois and Phoenix, Arizona and two surgery centers in Orange County, California.

Basis of Presentation

The accompanying condensed consolidated financial statements include the accounts of subsidiaries and affiliates controlled by Vanguard. Vanguard generally defines control as the ownership of the majority of an entity's voting interests. Vanguard also consolidates any variable interest entities for which it is deemed to be the primary beneficiary. All material intercompany accounts and transactions have been eliminated. Certain prior year amounts from the accompanying condensed consolidated financial statements have been reclassified to conform to current year presentation, including the impact of the presentation of the provision for doubtful accounts as further discussed in Note 12. The majority of Vanguard's expenses are "cost of revenue" items. Costs that could be classified as general and administrative include certain Vanguard corporate office costs, which approximated \$17.3 million and \$13.9 million as of September 30, 2010 and 2011, respectively.

The unaudited condensed consolidated financial statements as of September 30, 2011 have been prepared in conformity with accounting principles generally accepted in the United States for interim reporting and in accordance with Rule 10-01 of Regulation S-X. Accordingly, they do not include all of the information and notes required by accounting principles generally accepted in the United States for complete financial statements. In the opinion of management, the unaudited condensed consolidated financial statements reflect all adjustments (consisting of normal recurring adjustments) necessary for a fair presentation of the financial position and the results of operations for the periods presented. The results of operations for the periods presented are not necessarily indicative of the expected results for the fiscal year ending June 30, 2012. The interim unaudited condensed consolidated financial statements should be read in connection with the audited consolidated financial statements as of and for the year ended June 30, 2011 included in Vanguard's Annual Report on Form 10-K ("10-K") filed with the Securities and Exchange Commission on August 25, 2011. The accompanying condensed consolidated balance sheet at June 30, 2011, has been derived from the audited consolidated financial statements included in the 10-K, but recast to reflect the impact of updated estimates of liabilities assumed (including the related income tax effect) in the acquisition of The Detroit Medical Center ("DMC") since June 30, 2011 as described in Note 3.

Use of Estimates

In preparing Vanguard's financial statements in conformity with accounting principles generally accepted in the United States, management makes estimates and assumptions that affect the amounts recorded or classification of items in the condensed consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

2. REVENUE DEDUCTIONS AND UNCOMPENSATED CARE

Allowance for Doubtful Accounts

Vanguard estimates the allowance for doubtful accounts using a standard policy that reserves all accounts aged greater than 365 days subsequent to discharge date plus percentages of uninsured accounts and self-pay after insurance accounts less than 365 days old. Vanguard analyzes the allowance for doubtful accounts quarterly using a hindsight calculation that utilizes write-off data for all payer classes during the previous twelve-month period to estimate the allowance for doubtful accounts at a point in time. Vanguard also supplements the analysis by comparing cash collections to net patient revenues and monitoring self-pay utilization. The standard percentages in the allowance for doubtful accounts reserve are adjusted as necessary given changes in trends from these analyses or policy changes. Significant changes in payer mix, business office operations, general economic conditions and healthcare coverage provided by federal or state governments or private insurers may have a significant impact on our estimates and significantly affect our liquidity, results of operations and cash flows. Vanguard's estimate of the allowance for doubtful accounts and recoveries of accounts previously written off determine its provision for doubtful accounts recorded during the period. Vanguard records the provision for doubtful accounts at the time the services are provided for uninsured patients, since historical experience shows that the significant majority of uninsured balances will not be collected. Vanguard records the provision for doubtful accounts related to self-pay after insurance accounts at the time the insurance payment has been received.

The allowance for doubtful accounts was approximately \$205.0 million and \$251.2 million as of June 30, 2011 and September 30, 2011, respectively. These balances as a percent of accounts receivable net of contractual adjustments were approximately 29.7% and 30.8% as of June 30, 2011 and September 30, 2011, respectively. On a same hospital basis, Vanguard's combined allowance for doubtful accounts, uninsured discounts and charity care covered approximately 92.5% and 93.5% of combined uninsured and self-pay after insurance accounts receivable as of June 30, 2011 and September 30, 2011, respectively. The increase in allowance for doubtful accounts during the three months ended September 30, 2011 was primarily the result of an increase in uninsured and self-pay after insurance accounts receivable from 20.4% Vanguard's total accounts receivable as of June 30, 2011 to 24.5% as of September 30, 2011.

Charity Care

In the ordinary course of business, Vanguard provides services to patients who are financially unable to pay for hospital care. Vanguard includes charity care as a revenue deduction measured by the value of its services, based on standard charges, to patients who qualify under Vanguard's charity care policy (typically those who meet certain minimum income guidelines and do not otherwise qualify for reimbursement under a governmental program). The estimated cost incurred by Vanguard to provide these services to patients who qualify for charity care was approximately \$5.4 million and \$13.2 million for the three months ended September 30, 2010 and 2011, respectively. These estimates were determined using a ratio of cost to gross charges calculated from Vanguard's most recently filed Medicare cost reports and applying that ratio to the gross charges associated with providing charity care for the period.

3. BUSINESS COMBINATIONS

Acquisition of Valley Baptist

Effective September 1, 2011, Vanguard acquired a 51% controlling interest in Valley Baptist Medical Center, a 586-bed acute care hospital in Harlingen, Texas, and Valley Baptist Medical Center — Brownsville, a 280-bed acute care hospital in Brownsville, Texas, as well as the assets of certain other incidental healthcare businesses, partnerships, physician practices and medical office buildings operated as part of such hospital businesses (collectively "Valley Baptist"). The Valley Baptist partnership is consolidated by Vanguard. In connection with this acquisition, Vanguard entered into a management agreement with Valley Baptist, in which Vanguard is responsible for the management of Valley Baptist's operations.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

Vanguard paid approximately \$201.4 million in cash at closing to acquire the net assets of Valley Baptist. In addition to the cash investment, Vanguard also assumed certain of the seller's debt and issued a 49% interest in the partnership to the seller. Vanguard funded the cash investment with cash on hand.

The Valley Baptist purchase price is subject to working capital and certain other customary post-closing adjustments once the closing balance sheets for the hospital businesses become available. The purchase price is required to be allocated to identifiable assets acquired, liabilities assumed and non-controlling interests based upon their estimated fair values as of September 1, 2011. The redeemable non-controlling interest resulted from an option the seller was granted as part of the acquisition to require Vanguard to redeem all or a portion of its 49% equity interest in the partnership on the third or fifth anniversary of the acquisition date at a stated redemption value, and the value of such interest has been determined based upon the expected redemption value. If Valley Baptist exercises this option, Vanguard may purchase the non-controlling interest with cash or by issuing stock. It is Vanguard's intent to settle in cash, if the option is exercised. If the put option were to be settled in shares, approximately 7,200,000 shares of Vanguard common stock would be required to be issued based upon the closing price of Vanguard's common stock on September 30, 2011. Any excess of the purchase price allocation over the fair values of the assets acquired, liabilities assumed and non-controlling interests is recorded as goodwill. Vanguard is in the process of finalizing the purchase price allocation for the assets acquired and liabilities assumed; therefore, the fair values set forth below are subject to adjustment once the valuations are complete (in millions):

Accounts receivable	\$	66.2
Inventories		7.2
Prepaid expenses and other current assets		14.4
Property and equipment		222.4
Other assets		14.0
Total assets acquired		324.2
Accounts payable		30.5
Other current liabilities		15.0
Other long term liabilities		15.3
Long term debt and capital leases		11.0
Redeemable non-controlling interest		51.4
Noncontrolling interests		(0.4)
Total liabilities and equity assumed		122.8
Net assets acquired	\$	201.4

Acquisition related expenses were \$12.2 million for the three months ended September 30, 2011, most of which relate to the Valley Baptist acquisition and are included in acquisition related expenses on the accompanying condensed consolidated statements of operations.

DMC Acquisition

Effective January 1, 2011, Vanguard purchased substantially all of the assets of DMC, a Michigan non-profit corporation, and certain of its affiliates, which assets consist of eight acute care and specialty hospitals in the Detroit, Michigan metropolitan area and related healthcare facilities. Vanguard had substantially completed its fair value estimates of the individual assets acquired and liabilities assumed related to the acquisition as of June 30, 2011. However, Vanguard continued to assess the fair value of certain liabilities assumed in the acquisition during the quarter ended September 30, 2011.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

As a result of additional information that became available after June 30, 2011 relating to the fair value of these assumed liabilities given facts and circumstances that existed at the acquisition date, Vanguard revised its estimate of these assumed liabilities and the related income tax effect as of September 30, 2011. Vanguard recast its June 30, 2011 balance sheet to reflect these revised estimates. The table below summarizes the changes in the DMC purchase price allocation resulting from these revised estimates. Vanguard expects to settle these liabilities by December 31, 2011 and will make any final adjustments to the DMC purchase price allocation at that time.

	<u>As previously reported</u>	<u>As recast</u>
	<i>(In millions)</i>	
Cash	\$ 6.4	\$ 6.4
Accounts receivable	115.1	115.1
Inventories	26.7	26.7
Prepaid expenses and other current assets	95.6	104.2
Property and equipment	524.6	524.6
Goodwill	84.3	100.2
Other intangible assets	10.7	10.7
Investments in securities	166.4	166.4
Other assets	85.2	85.2
Total assets acquired	<u>1,115.0</u>	<u>1,139.5</u>
Accounts payable	80.9	80.9
Other current liabilities	160.5	185.0
Pension benefit obligation	228.0	228.0
Other non-current liabilities	282.3	282.3
Total liabilities and equity assumed	<u>751.7</u>	<u>776.2</u>
Net assets acquired	<u>\$ 363.3</u>	<u>\$ 363.3</u>

Pro Forma Information

Revenues of approximately \$32.2 million for the Valley Baptist acquisition (effective September 1, 2011) are included in Vanguard's condensed consolidated results of operations for the three months ended September 30, 2011. The following table provides certain pro forma financial information for Vanguard as if the combined Valley Baptist and previously disclosed DMC and Resurrection acquisitions occurred at the beginning of fiscal year 2011 (in millions).

	<u>Three months ended September 30,</u>	
	<u>2010</u>	<u>2011</u>
Total revenues	<u>\$ 1,458.5</u>	<u>\$ 1,501.5</u>
Income (loss) from continuing operations, before income taxes	<u>\$ 4.5</u>	<u>\$ (40.1)</u>

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

4. FAIR VALUE MEASUREMENTS

Vanguard's financial assets recorded at fair value on a recurring basis primarily relate to investments in available-for-sale securities held by one of its captive insurance subsidiaries. The following tables present information about the assets that are measured at fair value on a recurring basis as of September 30, 2011 and June 30, 2011 (in millions). The following tables also indicate the fair value hierarchy of the valuation techniques Vanguard utilized to determine such fair values. In general, fair values determined by Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets. Vanguard considers a security that trades at least weekly to have an active market. Fair values determined by Level 2 inputs utilize data points that are observable, such as quoted prices, interest rates and yield curves. Fair values determined by Level 3 inputs are unobservable data points for the asset, and include situations where there is little, if any, market activity for the asset. Vanguard's policy is to recognize transfers between levels as of the actual date of the event or change in circumstances that caused the transfer.

	<u>September 30, 2011</u>	<u>Quoted Prices in Active Markets for Identical Assets (Level 1)</u>	<u>Significant Other Observable Inputs (Level 2)</u>	<u>Significant Unobservable Inputs (Level 3)</u>
United States short-term treasury bills	\$ 21.0	\$ 0.1	\$ 20.9	\$ —
Auction rate securities	10.0	—	—	10.0
Corporate bonds	11.4	—	11.4	—
Common stock — domestic	8.3	0.1	8.2	—
Common stock — international	7.6	7.4	0.2	—
Preferred stock — international	0.1	0.1	—	—
Investments in securities	<u>\$ 58.4</u>	<u>\$ 7.7</u>	<u>\$ 40.7</u>	<u>\$ 10.0</u>

	<u>June 30, 2011</u>	<u>Quoted Prices in Active Markets for Identical Assets (Level 1)</u>	<u>Significant Other Observable Inputs (Level 2)</u>	<u>Significant Unobservable Inputs (Level 3)</u>
United States short-term treasury bills	\$ 20.8	\$ 0.3	\$ 20.5	\$ —
Auction rate securities	8.8	—	—	8.8
Corporate bonds	14.1	—	14.1	—
Common stock — domestic	9.7	0.1	9.6	—
Common stock — international	9.7	9.4	0.3	—
Preferred stock — international	0.2	0.2	—	—
Investments in securities	<u>\$ 63.3</u>	<u>\$ 10.0</u>	<u>\$ 44.5</u>	<u>\$ 8.8</u>

The following tables provide reconciliations of the beginning and ending balances for the three months ended September 30, 2011 and the year ended June 30, 2011 for those fair value measurements using significant Level 3 unobservable inputs (in millions).

	<u>Balance at June 30, 2011</u>	<u>Redemptions</u>	<u>Realized loss on redemptions</u>	<u>Increase in fair value, pre tax</u>	<u>Balance at September 30, 2011</u>
Auction rate securities	\$ 8.8	\$ —	\$ —	\$ 1.2	\$ 10.0

	<u>Balance at June 30, 2010</u>	<u>Redemptions</u>	<u>Realized loss on redemptions</u>	<u>Increase in fair value, pre tax</u>	<u>Balance at June 30, 2011</u>
Auction rate securities	\$ 19.8	\$ (14.3)	\$ 0.5	\$ 2.8	\$ 8.8

Investments in securities

As of September 30, 2011, Vanguard held \$58.4 million in total available-for-sale investments in debt and equity securities, which are included in investments in securities on the condensed consolidated balance sheets. Investments in corporate bonds, valued at approximately \$11.4 million at September 30, 2011, consist of corporate bonds and other fixed income investments with maturities ranging from approximately 4 to 15 years.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

As of September 30, 2011, approximately \$48.4 million of the acquired DMC investments were reflected on the accompanying condensed consolidated balance sheet in investments in securities. Vanguard calculates realized gain or loss on sales of investments using the amortized cost basis, as determined by specific identification. The amortized cost basis of these investments was approximately \$51.1 million as of September 30, 2011.

The investments acquired from DMC are classified as "available-for-sale" and are recorded at fair value. The investment securities are held for the purpose of providing the funding source to pay professional liability claims covered by the captive insurance subsidiary. Vanguard adjusts the book value of these investments to fair value on a quarterly basis.

The following table provides a reconciliation of the beginning and ending balances for the three months ended September 30, 2011 (in millions).

	<u>Fair value at June 30, 2011</u>	<u>Proceeds from sales</u>	<u>Purchases of securities</u>	<u>Realized gain on sales, pre tax</u>	<u>Decrease in fair value, pre tax</u>	<u>Fair value at September 30, 2011</u>
DMC securities	\$ 54.5	\$ (22.7)	\$ 20.9	\$ 0.1	\$ (4.4)	\$ 48.4

Vanguard determines whether an other-than-temporary decline in market value has occurred by considering the duration that, and extent to which, the fair value of the investment is below its amortized cost, the financial condition and near-term prospects of the issuer or underlying collateral of a security; and Vanguard's intent and ability to retain the security in order to allow for an anticipated recovery in fair value. Other-than-temporary declines in fair value from amortized cost for available for sale equity and debt securities that Vanguard intends to sell or would be more-likely-than-not be required to sell before the expected recovery of the amortized cost basis are charged to other (income) and expense in the period in which the loss occurs. The gross unrealized loss for the DMC securities was approximately \$2.7 million (\$1.5 million, net of taxes) at September 30, 2011.

As of September 30, 2011, Vanguard held \$10.0 million in total available-for-sale investments in auction rate securities ("ARS") backed by student loans, which are included in investments in securities on the accompanying condensed consolidated balance sheets. These ARS are accounted for as long-term available for sale securities. The par value of the remaining interest in ARS was \$10.0 million at September 30, 2011. Subsequent to September 30, 2011, the remaining \$10.0 million of ARS were redeemed for cash at par. Accordingly, as of September 30, 2011, Vanguard reversed the \$1.2 million (\$0.7 million, net of taxes) temporary impairment previously included in accumulated other comprehensive income (loss) on the accompanying condensed consolidated balance sheets.

Cash and Cash Equivalents and Restricted Cash

The carrying amounts reported for cash and cash equivalents and restricted cash approximate fair value because of the short-term maturity of these instruments.

Accounts Receivable and Accounts Payable

The carrying amounts reported for accounts receivable and accounts payable approximate fair value because of the short-term maturity of these instruments.

Long-Term Debt

The fair values of the 8.0% Senior Unsecured Notes, the 2010 term loan facility, the 7.750% Senior Notes and the 10.375% Senior Discount Notes as of September 30, 2011 were approximately \$1,068.8 million, \$788.7 million, \$323.8 million and \$13.9 million, respectively, based upon stated market prices.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

5. STOCK BASED COMPENSATION

Vanguard has two stock-based compensation plans, the 2011 Stock Incentive Plan (the "2011 Plan") and the 2004 Stock Incentive Plan (the "2004 Plan"), both of which provide for the issuance of options, stock appreciation rights, restricted stock units or other stock-based awards in respect of Vanguard's common stock.

The 2004 Plan includes options and restricted stock units that were granted prior to the initial public offering and remain outstanding. As of September 30, 2011, 5,685,797 options and 543,068 restricted stock units were outstanding under the 2004 Plan. No further equity awards may be granted under the 2004 Plan.

In June 2011, Vanguard adopted the 2011 Plan, which effectively replaced the 2004 Plan. The total number of shares of common stock that may be issued under the 2011 Plan is 14,000,000 and the maximum number of shares for which incentive stock options may be granted is 14,000,000. On June 21, 2011, 1,684,733 restricted shares of common stock and 1,245,086 stock options exercisable at \$33.67 per share were issued under the 2011 Plan in connection with the merger of VHS Holdings LLC into Vanguard immediately prior to the initial public offering in exchange for equity incentive units in VHS Holdings LLC then held by certain members of management. During the first quarter of fiscal 2012, Vanguard granted the following awards under the 2011 Plan: 262,047 options with an exercise price per share of \$11.79, 680,805 time-based restricted stock units and 491,875 performance-based restricted stock units (the actual number of units earned may be increased or decreased based upon Vanguard's fiscal 2012 financial performance). The options vest ratably over 3 years, while the time-based and performance-based restricted stock units vest ratably over 4 years. As of September 30, 2011, 1,507,133 stock options, 1,172,680 restricted stock units and 1,530,139 restricted shares were outstanding under the 2011 Plan.

Vanguard used the minimum value pricing model to determine stock compensation costs related to stock option grants prior to July 1, 2006. Since July 1, 2006, Vanguard has recorded stock compensation using the Black-Scholes-Merton model. For stock options included in the Black-Scholes-Merton valuation model, Vanguard used historical stock price information of certain peer group companies for a period of time equal to the expected option life period to determine estimated volatility. Vanguard determined the expected life of the stock options by averaging the contractual life of the options and the vesting period of the options. The estimated fair value of options is amortized to expense on a straight-line basis over the options' vesting period. Vanguard records stock compensation for restricted stock units on a straight-line basis over the units' vesting periods and assumes that target awards will be earned under performance-based units until it has information that suggests an increase or decrease to the target award will be earned.

For the three months ended September 30, 2010 and 2011, Vanguard recognized stock compensation expense related to outstanding equity awards of \$1.2 million and \$0.7 million, respectively.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

6. GOODWILL AND INTANGIBLE ASSETS

The following table provides information regarding the intangible assets, including deferred loan costs, included on the accompanying condensed consolidated balance sheets as of June 30, 2011 and September 30, 2011 (in millions).

Class of Intangible Asset	Gross Carrying Amount		Accumulated Amortization	
	June 30, 2011	September 30, 2011	June 30, 2011	September 30, 2011
Amortized intangible assets:				
Deferred loan costs	\$ 65.0	\$ 52.9	\$ 8.2	\$ 9.0
Contracts	31.4	31.4	21.2	22.0
Physician income and other guarantees	35.4	38.1	29.8	31.0
Other	8.9	8.9	3.5	3.8
Subtotal	140.7	131.3	62.7	65.8
Indefinite-lived intangible assets:				
License and accreditation	16.0	18.3	—	—
Total	\$ 156.7	\$ 149.6	\$ 62.7	\$ 65.8

Amortization expense for contract-based intangibles and other intangible assets during the three month period ended September 30, 2010 and 2011 was approximately \$1.1 million and \$1.1 million, respectively.

Amortization of deferred loan costs of \$1.2 million and \$1.6 million, during the three months ended September 30, 2010 and 2011, respectively, is included in net interest. Amortization of physician income and other guarantees of \$1.1 million and \$1.2 million for the three months ended September 30, 2010 and 2011, respectively, is included in other operating expenses.

Net deferred loan costs of \$11.3 million were written off as part of the debt extinguishment costs associated with the redemption of the 10.375% Senior Discount Notes in July and August 2011 (see Note 7).

During the three months ended September 30, 2011, goodwill increased by approximately \$16.4 million related to acute care services segment acquisitions. The majority of this increase in goodwill pertains to the adjustment of certain liabilities related to the DMC acquisition (see Note 3).

7. FINANCING ARRANGEMENTS

A summary of Vanguard's long-term debt as of June 30, 2011 and September 30, 2011 follows (in millions).

	June 30, 2011	September 30, 2011
10.375% Senior Discount Notes due 2016	\$ 465.0	\$ 14.8
8.0% Senior Unsecured Notes due 2018	1,156.3	1,157.0
7.750% Senior Notes due 2019	350.0	350.0
Term loans payable under credit facility due 2016	806.9	804.9
Capital leases and other long term debt	9.4	19.5
	2,787.6	2,346.2
Less: current maturities	(461.8)	(13.9)
	\$ 2,325.8	\$ 2,332.3

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

Redemption of 10.375% Senior Discount Notes

On January 26, 2011, Vanguard issued senior discount notes due 2016 (the "Senior Discount Notes") with a stated principal amount at maturity of approximately \$747.2 million generating approximately \$444.7 million of gross proceeds, in a private placement. The Senior Discount Notes are not guaranteed by any of Vanguard's subsidiaries.

During the three months ended September 30, 2011, Vanguard used the net proceeds from its initial public offering in June 2011 and the exercise of the over-allotment option by the offering underwriters in July 2011 to redeem approximately \$450.0 million accreted value of the Senior Discount Notes and to pay \$27.6 million of redemption premiums thereof. The redemptions resulted in approximately \$14.7 million of remaining unredeemed accreted value of these notes outstanding immediately after the redemptions were completed and resulted in the recognition of debt extinguishment costs of approximately \$38.9 million, \$25.3 million net of taxes, representing tender premiums and other costs to redeem the Senior Discount Notes and the write-off of net deferred loan costs associated with the redeemed notes.

Credit Facility Debt

Vanguard's senior secured credit facilities (the "2010 credit facilities") include a six-year term loan facility ("2010 term loan facility") in the amount of \$815.0 million and a five-year \$260.0 million revolving credit facility (the "2010 revolving facility"). Vanguard's remaining borrowing capacity under the 2010 revolving facility, net of letters of credit outstanding, was \$220.6 million as of September 30, 2011.

The 2010 term loan facility bears interest at a rate equal to, at Vanguard's option, LIBOR (subject to a 1.50% floor) plus 3.50% per annum or a base rate plus 2.50% per annum. The interest rate applicable to the 2010 term loan facility was approximately 5.0% as of September 30, 2011. Vanguard also makes quarterly principal payments equal to one-fourth of one percent of the outstanding principal balance of the 2010 term loan facility and will continue to make such payments until maturity of the term debt.

Any future borrowings under the 2010 revolving facility will bear interest at a rate equal to, at Vanguard's option, LIBOR plus 3.50% per annum or a base rate plus 2.50% per annum, both of which are subject to a decrease of up to 0.25% dependent upon Vanguard's consolidated leverage ratio. Vanguard may utilize the 2010 revolving facility to issue up to \$100.0 million of letters of credit (\$39.4 million of which were outstanding at September 30, 2011). Vanguard also pays a commitment fee to the lenders under the 2010 revolving facility in respect of unutilized commitments thereunder at a rate equal to 0.50% per annum. Vanguard also pays customary letter of credit fees under this facility.

8. DMC PENSION PLAN

The components of periodic pension plan expense (credit) for Vanguard's defined benefit pension plan are as follows (in millions):

Interest cost on projected benefit obligation	\$	13.0
Expected return on assets		(14.0)
Total net pension plan credit	\$	(1.0)

The accompanying condensed consolidated balance sheets as of June 30, 2011 and September 30, 2011 include a long-term liability for the DMC pension plan (the "DMC Pension Plan") of approximately \$188.0 million and \$176.7 million, respectively. Vanguard recognizes changes in the funded status of the DMC Pension Plan as an increase or decrease in equity through accumulated other comprehensive income. The cumulative increase in equity recognized by Vanguard as of June 30, 2011 and September 30, 2011 was \$31.8 million (\$19.7 million, net of tax), in the accompanying condensed consolidated balance sheets.

Vanguard made cash contributions of \$11.6 million to the pension plan trust during the three months ended September 30, 2011.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

9. COMPREHENSIVE INCOME

Comprehensive income consists of two components: net income (loss) attributable to Vanguard Health Systems, Inc. stockholders and other comprehensive income. Other comprehensive income refers to revenues, expenses, gains and losses that under the guidance related to accounting for comprehensive income are recorded as elements of equity but are excluded from net income (loss) attributable to Vanguard Health Systems, Inc. stockholders. The following table presents the components of comprehensive income, net of taxes, for the three months ended September 30, 2010 and 2011 (in millions).

	Three months ended September 30,	
	2010	2011
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	\$ 1.2	\$ (19.2)
Change in fair value of investments in securities	—	(3.2)
Change in income tax expense	—	1.4
Net income attributable to non-controlling interests	1.0	(2.3)
Comprehensive income (loss)	<u>\$ 2.2</u>	<u>\$ (23.3)</u>

The components of accumulated other comprehensive income, net of taxes, as of June 30, 2011 and September 30, 2011 are as follows (in millions):

	June 30, 2011	September 30, 2011
Unrealized holding gain (loss) on investments in securities	\$ 0.5	\$ (2.7)
Defined benefit pension plan	31.8	31.8
Post-employment defined benefit plan	0.9	0.9
Income tax expense	(12.6)	(11.2)
Accumulated other comprehensive income	<u>\$ 20.6</u>	<u>\$ 18.8</u>

10. EARNINGS PER SHARE

Vanguard computes basic earnings (loss) per share using the weighted average number of common shares outstanding. Vanguard computes diluted earnings (loss) per share using the weighted average number of common shares outstanding, plus the dilutive effect of restricted common shares and the dilutive effect of outstanding stock options, warrants for equity incentive units and restricted stock units, computed using the treasury stock method.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

The following table sets forth the computation of basic and diluted earnings (loss) per share for the three months ended September 30, 2010 and 2011 (dollars in millions, except per share and share amounts):

	Three months ended September 30,	
	2010	2011
Numerator for basic and diluted earnings (loss) per share:		
Income (loss) from continuing operations	\$ 1.1	\$ (19.1)
Income (loss) from discontinued operations	0.1	(0.1)
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	<u>\$ 1.2</u>	<u>\$ (19.2)</u>
Denominator:		
Weighted average common shares outstanding	44,635	74,854
Effect of dilutive securities	3,968	—
Shares used for diluted earnings per share	<u>48,603</u>	<u>74,854</u>
Basic net earnings (loss) per share:		
Basic earnings (loss) from continuing operations	\$ 0.03	\$ (0.26)
Basic earnings (loss) from discontinued operations	—	—
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	<u>\$ 0.03</u>	<u>\$ (0.26)</u>
Diluted net earnings (loss) per share:		
Diluted earnings (loss) from continuing operations	\$ 0.02	\$ (0.26)
Diluted earnings (loss) from discontinued operations	—	—
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	<u>\$ 0.02</u>	<u>\$ (0.26)</u>

For the three months ended September 30, 2011, Vanguard excluded 3,626,715 potentially dilutive stock option and other stock-based awards from the calculation of diluted loss per share because their inclusion would be anti-dilutive.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

11. INCOME TAXES

Significant components of the provision for income taxes from continuing operations are as follows (in millions):

	Three months ended September 30,	
	2010	2011
Current:		
Federal	\$ 0.2	\$ 0.3
State	0.5	0.6
Total current	0.7	0.9
Deferred:		
Federal	(0.6)	(15.3)
State	(1.0)	0.7
Total deferred	(1.6)	(14.6)
Change in valuation allowance	(1.5)	0.1
Total income tax benefit	\$ (2.4)	\$ (13.6)

As of September 30, 2011, Vanguard had generated net operating loss ("NOL") carryforwards for federal income tax and state income tax purposes of approximately \$75.0 million and \$663.0 million, respectively. The remaining federal and state NOL carryforwards expire from 2020 to 2032 and 2012 to 2032, respectively.

The tax benefit for the quarter includes a \$4.5 million reduction in Vanguard's reserve for an uncertain tax position relating to success-based transaction costs incurred in its recapitalization during the fiscal year ended June 30, 2005. The Internal Revenue Service ("IRS") issued an audit directive on July 28, 2011 instructing its examining agents not to challenge success-based transaction costs that meet certain safe harbor conditions stipulated in the directive. Management has determined that the success-based transaction costs incurred during Vanguard's fiscal year ended June 30, 2005 are within the scope and parameters of the IRS audit directive safe harbor and therefore has reversed the tax reserves related to these transaction costs during the quarter ended September 30, 2011.

Vanguard's U.S. federal income tax returns for tax years 2006 and subsequent years remain subject to examination by the IRS.

12. RECENTLY ISSUED ACCOUNTING PRONOUNCEMENTS

In July 2011, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2011-07, *"Health Care Entities"* (Topic 954): *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* ("ASU 2011-07"). ASU 2011-07 is effective for fiscal years and interim periods beginning after December 31, 2011, with early adoption permitted. Changes to the presentation of the provision for bad debts related to patient service revenue in the statement of operations should be applied retrospectively to all prior periods presented. ASU 2011-07 states that a healthcare entity that recognizes significant amounts of patient service revenue at the time the services are rendered even though it does not assess the patient's ability to pay must present the allowance for doubtful accounts as a reduction of net patient revenue and not include it as a separate item in operating expenses. Vanguard early adopted this guidance effective July 1, 2011. The change in presentation and additional disclosures, as required by ASU 2011-07, are reflected in Vanguard's statement of operations, statement of cash flows and in Note 2.

In August 2011, the FASB issued ASU No. 2011-08, *"Intangibles—Goodwill and Other"* (Topic 350): *Testing Goodwill for Impairment* ("ASU 2011-08"). ASU 2011-08 is intended to simplify how entities, both public and nonpublic, test goodwill for impairment. ASU 2011-08 permits an entity to first assess qualitative factors to determine whether it is "more likely than not" that the fair value of a reporting unit is less than its carrying amount as a basis for determining whether it is necessary to perform the two-step goodwill impairment test described in Topic 350. The more-likely-than-not threshold is defined as having a likelihood of more than 50%. ASU 2011-08 is effective for annual and interim goodwill impairment tests performed for fiscal years beginning after December 15, 2011. Early adoption is permitted, including for annual and interim goodwill impairment tests performed as of a date before September 15, 2011, if an entity's financial statements for the most recent annual or interim period have not yet been issued or, for nonpublic entities, have not yet been made available for issuance. ASU 2011-08 is not expected to significantly impact Vanguard's financial position, results of operations or cash flows.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

In June 2011, the FASB issued ASU No. 2011-05, "*Comprehensive Income*" (Topic 220): *Presentation of Comprehensive Income* ("ASU 2011-05"). ASU 2011-05 eliminates Vanguard's currently elected option to present components of other comprehensive income as part of the statement of changes in stockholders' equity. Instead, ASU 2011-05 requires that all non-owner changes in stockholders' equity be presented either in a single continuous statement of comprehensive income or in two separate but consecutive statements. ASU 2011-05 is required to be applied retrospectively and is effective for public companies for fiscal years beginning after December 15, 2011, and interim periods within those fiscal years. Early adoption is permitted. Vanguard anticipates applying the provisions of ASU 2011-05 for its interim period ending March 31, 2012. As of September 30, 2011, Vanguard recognized comprehensive income related to changes in the fair value of investments in securities and pension plan (see Note 9). Accordingly, the adoption of ASU 2011-05 will impact the presentation of Vanguard's other comprehensive income.

In August 2010, the FASB issued ASU No. 2010-23, "*Health Care Entities*" (Topic 954): *Measuring Charity Care for Disclosure* ("ASU 2010-23"). Due to the lack of comparability that previously existed due to the use of either revenue or cost as the basis for disclosure of charity care, ASU 2010-23 standardizes cost as the basis for charity care disclosures and specifies the elements of cost to be used in charity care disclosures. Vanguard adopted ASU 2010-23 on July 1, 2011. In the ordinary course of business, Vanguard provides services to patients who are financially unable to pay for hospital care. Vanguard includes charity care as a revenue deduction measured by the value of its services, based on standard charges, to patients who qualify under Vanguard's charity care policy and do not otherwise qualify for reimbursement from a governmental program. The estimated cost incurred by Vanguard to provide these services was approximately \$5.4 million and \$13.2 million for the three months ended September 30, 2010 and 2011, respectively. The estimated cost of charity care services was determined using a ratio of cost to gross charges determined from Vanguard's most recently filed Medicare cost reports and applying that ratio to the gross charges associated with providing charity care for the period. See Note 2 for additional disclosures.

13. SEGMENT INFORMATION

Vanguard's acute care hospitals and related healthcare businesses are similar in their activities and the economic environments in which they operate (i.e. urban markets). Accordingly, Vanguard's reportable operating segments consist of 1) acute care hospitals and related healthcare businesses, collectively, and 2) health plans consisting of MacNeal Health Plan, a contracting entity for outpatient services provided by MacNeal Hospital and Weiss Memorial Hospital and participating physicians in the Chicago area, Phoenix Health Plan ("PHP"), a Medicaid managed health plan operating in Arizona, and Abrazo Advantage Health Plan, a Medicare and Medicaid dual eligible managed health plan operating in Arizona. The following tables provide unaudited condensed financial information by operating segment for the three months ended September 30, 2010 and 2011, including a reconciliation of Segment EBITDA to income (loss) from continuing operations before income taxes (in millions).

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

	Three months ended September 30, 2010			
	Acute Care Services	Health Plans	Eliminations	Consolidated
Patient service revenues, net (1)	\$ 641.5	\$ —	\$ —	\$ 641.5
Premium revenues	—	220.6	—	220.6
Intersegment revenues	10.8	—	(10.8)	—
Total revenues	652.3	220.6	(10.8)	862.1
Salaries and benefits (excludes stock compensation)	345.4	8.2	—	353.6
Health plan claims expense (1)	—	174.1	—	174.1
Supplies	121.0	—	—	121.0
Other operating expenses-external	125.2	10.5	—	135.7
Operating expenses-intersegment	—	10.8	(10.8)	—
Total operating expenses	591.6	203.6	(10.8)	784.4
Segment EBITDA (2)	60.7	17.0	—	77.7
Less:				
Interest, net	35.1	(0.3)	—	34.8
Depreciation and amortization	36.1	1.1	—	37.2
Equity method income	(0.3)	—	—	(0.3)
Stock compensation	1.2	—	—	1.2
Monitoring fees and expenses	1.4	—	—	1.4
Acquisition related expenses	3.7	—	—	3.7
Income (loss) from continuing operations before income taxes	<u>\$ (16.5)</u>	<u>\$ 16.2</u>	<u>\$ —</u>	<u>\$ (0.3)</u>
Segment assets	<u>\$ 2,754.7</u>	<u>\$ 195.7</u>	<u>\$ —</u>	<u>\$ 2,950.4</u>
Capital expenditures	<u>\$ 44.6</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 44.6</u>

- (1) Vanguard eliminates in consolidation those patient service revenues earned by its healthcare facilities attributable to services provided to members in its owned health plans and eliminates the corresponding medical claims expenses incurred by the health plans for those services. Amount is net of the provision for doubtful accounts consistent with the presentation in ASU 2011-07.
- (2) Segment EBITDA is defined as income (loss) from continuing operations before income taxes less interest expense (net of interest income), depreciation and amortization, equity method income, stock compensation, gain or loss on disposal of assets, realized gains or losses on investments, monitoring fees and expenses, acquisition related expenses, debt extinguishment costs, impairment and restructuring charges and pension expense (credits). Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income (loss), operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similar measures of other companies.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

	Three months ended September 30, 2011			
	Acute Care Services	Health Plans	Eliminations	Consolidated
Patient service revenues, net (1)	\$ 1,232.5	\$ —	\$ —	\$ 1,232.5
Premium revenues	—	211.0	—	211.0
Intersegment revenues	8.6	—	(8.6)	—
Total revenues	1,241.1	211.0	(8.6)	1,443.5
Salaries and benefits (excludes stock compensation)	655.2	9.1	—	664.3
Health plan claims expense (1)	—	164.7	—	164.7
Supplies	213.6	—	—	213.6
Other operating expenses-external	267.4	10.7	—	278.1
Operating expenses-intersegment	—	8.6	(8.6)	—
Total operating expenses	1,136.2	193.1	(8.6)	1,320.7
Segment EBITDA (2)	104.9	17.9	—	122.8
Less:				
Interest, net	46.1	(0.3)	—	45.8
Depreciation and amortization	61.4	1.2	—	62.6
Equity method income	(0.1)	—	—	(0.1)
Stock compensation	0.7	—	—	0.7
Gain on disposal of assets	(1.2)	—	—	(1.2)
Acquisition related expenses	12.2	—	—	12.2
Impairment and restructuring charges	(0.1)	—	—	(0.1)
Debt extinguishment costs	38.9	—	—	38.9
Pension credits	(1.0)	—	—	(1.0)
Income (loss) from continuing operations before income taxes	<u>\$ (52.0)</u>	<u>\$ 17.0</u>	<u>\$ —</u>	<u>\$ (35.0)</u>
Segment Assets	<u>\$ 4,062.3</u>	<u>\$ 116.5</u>	<u>\$ —</u>	<u>\$ 4,178.8</u>
Capital expenditures	<u>\$ 62.8</u>	<u>\$ 0.6</u>	<u>\$ —</u>	<u>\$ 63.4</u>

- (1) Vanguard eliminates in consolidation those patient service revenues earned by its healthcare facilities attributable to services provided to members in its owned health plans and eliminates the corresponding medical claims expenses incurred by the health plans for those services. Amount is net of the provision for doubtful accounts consistent with the presentation in ASU 2011-07.
- (2) Segment EBITDA is defined as income (loss) from continuing operations before income taxes less interest expense (net of interest income), depreciation and amortization, equity method income, stock compensation, gain or loss on disposal of assets, realized gains or losses on investments, monitoring fees and expenses, acquisition related expenses, debt extinguishment costs, impairment and restructuring charges and pension expense (credits). Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income (loss), operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similar measures of other companies.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

14. CONTINGENCIES AND HEALTHCARE REGULATION

Contingencies

Vanguard is presently, and from time to time, subject to various claims and lawsuits arising in the normal course of business. In the opinion of management, the ultimate resolution of these matters is not expected to have a material adverse effect on Vanguard's financial position or results of operations, except for the implantable cardioverter defibrillator matter as discussed below under "Governmental Regulation."

Capital Expenditure Commitments

As part of its acquisition of DMC, Vanguard committed to spend a total of \$850.0 million over a 5-year period, \$500.0 million of which related to a specific list of expansion projects. As of September 30, 2011, Vanguard had spent approximately \$43.2 million related to this commitment, including \$11.6 million related to the specific project list. Under the terms of the DMC acquisition agreement, Vanguard is required to spend at least \$80.0 million related to the specific list of expansion projects by December 31, 2011. To the extent this commitment is not met, Vanguard will be required to deposit cash into an escrow fund restricted for the purpose of funding capital expenditures related to the specific project list. If required, the cash escrow funds would be used for DMC capital expenditures in the subsequent measurement period. As of September 30, 2011, Vanguard estimated its remaining commitments, excluding DMC, to complete all capital projects in process to be approximately \$8.3 million.

Professional and General Liability Insurance

Given the nature of its operating environment, Vanguard is subject to professional and general liability claims and related lawsuits in the ordinary course of business. Vanguard maintains professional and general liability insurance with unrelated commercial insurance carriers to provide for losses up to \$65.0 million in excess of its self-insured retention (such self-insured retention maintained through Vanguard's captive insurance subsidiary and/or another of its subsidiaries) of \$10.0 million through June 30, 2010 but increased to \$15.0 million for its Illinois hospitals subsequent to June 30, 2010.

Vanguard self-insures its workers compensation claims up to \$1.0 million per claim and purchases excess insurance coverage for claims exceeding \$1.0 million. During the three months ended September 30, 2011, Vanguard reduced its professional and general liability reserve by \$1.2 million (\$0.7 million, or \$0.01 per share, net of taxes) for changes in claims development related to prior years.

Patient Service Revenues

Settlements under reimbursement agreements with third party payers are initially estimated during the period the related services are provided, with final estimates made at the time the applicable payer cost reports are filed. Final settlements are typically not known until future periods. There is at least a reasonable possibility that recorded estimates will change by a material amount when final settlements are known. Differences between estimates made at the cost report filing date and subsequent revisions (including final settlements) are included in the condensed consolidated statements of operations in the period in which the revisions are made. Management believes that adequate provision has been made for adjustments that may result from final determination of amounts earned under the Medicare and Medicaid programs and other managed care plans with settlement provisions. Net adjustments for final third party settlements positively impacted Vanguard's income (loss) from continuing operations before income taxes by \$0.7 million (\$0.4 million net of taxes) for the three months ended September 30, 2010 and by \$0.4 million (\$0.2 million net of taxes) for the three months ended September 30, 2011, respectively. Vanguard recorded \$20.6 million and \$50.4 million of charity care deductions during the three months ended September 30, 2010 and 2011, respectively. See Note 12 for additional disclosures related to Vanguard's adoption of ASU 2010-23, for measuring and disclosing the costs of providing charity care.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

Governmental Regulation

In September 2010, Vanguard received a letter, which was signed jointly by an Assistant United States Attorney in the Southern District of Florida and an attorney from the Department of Justice ("DOJ") Civil Division. This letter stated that the DOJ is conducting an investigation to determine whether or not certain hospitals have submitted claims for payment for the implantation of implantable cardioverter defibrillators ("ICDs") that were not medically indicated or otherwise violated Medicare payment policy. The letter also noted that the investigation covers the time period commencing with Medicare's expansion of coverage of ICDs in 2003 through the present time, and that the DOJ's preliminary but continuing review indicates that many of Vanguard's hospitals may have submitted claims for ICDs and related services that were excluded from coverage. Upon receipt of this letter, Vanguard immediately took steps to preserve all records and information pertaining or related to ICDs. DMC received a similar letter from the DOJ in respect of ICDs in December 2010. Vanguard and DMC are working cooperatively with the DOJ to identify potential Medicare claims that should not have been billed for these excluded services. Vanguard intends to continue to cooperate with the DOJ with respect to both the claims of its existing hospitals and those of DMC, which Vanguard acquired effective January 1, 2011. To date, the DOJ has not asserted any specific claim of damages against any of Vanguard's hospitals or any of the DMC hospitals. Because this investigation is in its early stages, Vanguard is unable to predict its timing or outcome at this time. However, Vanguard understands that this investigation is being conducted under the False Claims Act ("FCA"), which could expose Vanguard to the FCA's treble damages provision should the DOJ's initial analysis of Vanguard's ICD claims be substantiated. Such damages could materially adversely impact Vanguard's financial position, results of operations and cash flows. Vanguard is not aware of any material regulatory proceeding or investigation underway or threatened involving allegations of potential wrongdoing, except for this ICD matter.

Reimbursement

Laws and regulations governing Medicare, Medicaid and the other federal healthcare programs are complex and subject to interpretation. Vanguard's management believes that it is in compliance in all material respects with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing related to Medicare and Medicaid programs, except for the ICD matter discussed above. Moreover, Vanguard's compliance with such laws and regulations is subject to future government review and interpretation. Non-compliance with such laws and regulations could result in significant regulatory action including fines, penalties, and exclusion from the Medicare, Medicaid and other federal healthcare programs.

Acquisitions

Vanguard has acquired, and expects to continue to acquire, businesses with prior operating histories. Acquired companies 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 Vanguard institutes policies designed to conform practices to its standards following the completion of its acquisitions, there can be no assurance that it will not become liable for past activities of prior owners that may later be asserted to be improper by private plaintiffs or government agencies. Although Vanguard 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.

Guarantee

As part of its contract with the Arizona Health Care Cost Containment System, one of Vanguard's health plans, PHP, is required to maintain a performance guarantee, the amount of which is based upon PHP's membership and capitation premiums received. As of September 30, 2011, Vanguard maintained this performance guarantee in the form of \$55.0 million of surety bonds with independent third party insurers collateralized by letters of credit of approximately \$5.0 million.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

15. FINANCIAL INFORMATION FOR SUBSIDIARY GUARANTORS AND NON-GUARANTOR SUBSIDIARIES

Vanguard conducts substantially all of its business through its subsidiaries. Most of Vanguard's subsidiaries jointly and severally guarantee Vanguard's 8.0% Senior Unsecured Notes due 2018 and its 7.750% Senior Notes due 2019. Certain of Vanguard's other consolidated wholly-owned and non wholly-owned entities do not guarantee these Senior Notes or Vanguard's remaining 10.375% Senior Discount Notes due 2016 in conformity with the provisions of the indentures governing those notes and do not guarantee the 2010 credit facilities in conformity with the provisions thereof. The accompanying condensed consolidating financial information for the parent company, the issuers of the senior notes and term debt, the issuers of the 10.375% Senior Discount Notes, the subsidiary guarantors, the non-guarantor subsidiaries, certain eliminations and consolidated Vanguard as of June 30, 2011 and September 30, 2011 and for the three months ended September 30, 2010 and 2011 follows.

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
Condensed Consolidating Balance Sheets
June 30, 2011 (Recast)

	<u>Parent</u>	<u>Issuers of Senior Notes and Term Debt</u>	<u>Issuers of Senior Discount Notes</u>	<u>Guarantor Subsidiaries</u>	<u>Combined Non- Guarantors</u>	<u>Eliminations</u>	<u>Total Consolidated</u>
<i>(In millions)</i>							
ASSETS							
Current assets:							
Cash and cash equivalents	\$ —	\$ —	\$ —	\$ 644.1	\$ 292.5	\$ —	\$ 936.6
Restricted cash	—	—	—	0.7	1.6	—	2.3
Accounts receivable, net	—	—	—	448.1	36.3	—	484.4
Inventories	—	—	—	83.6	0.3	—	83.9
Prepaid expenses and other current assets	—	—	—	239.5	9.5	—	249.0
Total current assets	—	—	—	1,416.0	340.2	—	1,756.2
Property, plant and equipment, net	—	—	—	1,773.4	57.1	—	1,830.5
Goodwill	—	—	—	672.0	83.6	—	755.6
Intangible assets, net	—	37.4	19.4	25.3	11.9	—	94.0
Investments in consolidated subsidiaries	608.8	—	—	—	—	(608.8)	—
Investments in auction rate securities	—	—	—	63.3	—	—	63.3
Other assets	—	—	—	84.3	9.0	—	93.3
Total assets	<u>\$ 608.8</u>	<u>\$ 37.4</u>	<u>\$ 19.4</u>	<u>\$ 4,034.3</u>	<u>\$ 501.8</u>	<u>\$ (608.8)</u>	<u>\$ 4,592.9</u>
LIABILITIES AND EQUITY							
Current liabilities:							
Accounts payable	\$ —	\$ —	\$ —	\$ 280.6	\$ 33.7	\$ —	\$ 314.3
Accrued expenses and other current liabilities	—	50.5	11.8	453.7	128.4	—	644.4
Current maturities of long-term debt	—	8.2	450.6	3.0	—	—	461.8
Total current liabilities	—	58.7	462.4	737.3	162.1	—	1,420.5
Other liabilities	—	—	—	565.5	38.0	—	603.5
Long-term debt, less current maturities	—	2,305.0	14.4	6.4	—	—	2,325.8
Intercompany	365.7	(1,477.0)	(424.5)	1,927.1	(9.4)	(381.9)	—
Total equity	243.1	(849.3)	(32.9)	798.0	311.1	(226.9)	243.1
Total liabilities and equity	<u>\$ 608.8</u>	<u>\$ 37.4</u>	<u>\$ 19.4</u>	<u>\$ 4,034.3</u>	<u>\$ 501.8</u>	<u>\$ (608.8)</u>	<u>\$ 4,592.9</u>

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
Condensed Consolidating Balance Sheets
September 30, 2011

	<u>Parent</u>	<u>Issuers of Senior Notes and Term Debt</u>	<u>Issuers of Senior Discount Notes</u>	<u>Guarantor Subsidiaries</u>	<u>Combined Non- Guarantors</u>	<u>Eliminations</u>	<u>Total Consolidated</u>
<i>(In millions)</i>							
ASSETS							
Current assets:							
Cash and cash equivalents	\$ —	\$ —	\$ —	\$ 154.9	\$ (0.2)	\$ —	\$ 154.7
Restricted cash	—	—	—	0.7	1.7	—	2.4
Accounts receivable, net	—	—	—	447.0	116.6	—	563.6
Inventories	—	—	—	81.0	10.9	—	91.9
Prepaid expenses and other current assets	—	—	—	311.2	30.5	(14.8)	326.9
Total current assets	—	—	—	994.8	159.5	(14.8)	1,139.5
Property, plant and equipment, net	—	—	—	1,744.5	276.1	—	2,020.6
Goodwill	—	—	—	672.5	83.6	—	756.1
Intangible assets, net	—	36.1	7.8	26.7	13.2	—	83.8
Investments in consolidated subsidiaries	608.8	—	—	—	—	(608.8)	—
Investments in securities	—	—	—	49.6	8.8	—	58.4
Other assets	—	—	—	109.6	10.8	—	120.4
Total assets	<u>\$ 608.8</u>	<u>\$ 36.1</u>	<u>\$ 7.8</u>	<u>\$ 3,597.7</u>	<u>\$ 552.0</u>	<u>\$ (623.6)</u>	<u>\$ 4,178.8</u>
LIABILITIES AND EQUITY							
Current liabilities:							
Accounts payable	\$ —	\$ —	\$ —	\$ 250.9	\$ 62.8	\$ —	\$ 313.7
Accrued expenses and other current liabilities	—	26.6	4.5	360.6	154.6	—	546.3
Current maturities of long-term debt	—	8.2	—	3.1	2.6	—	13.9
Total current liabilities	—	34.8	4.5	614.6	220.0	—	873.9
Other liabilities	—	—	—	581.0	70.6	(14.8)	636.8
Long-term debt, less current maturities	—	2,303.7	14.8	5.4	8.4	—	2,332.3
Intercompany	324.4	(1,417.0)	31.5	1,597.0	(154.0)	(381.9)	—
Redeemable non-controlling interests	—	—	—	—	51.4	—	51.4
Total equity	284.4	(885.4)	(43.0)	799.7	355.6	(226.9)	284.4
Total liabilities and equity	<u>\$ 608.8</u>	<u>\$ 36.1</u>	<u>\$ 7.8</u>	<u>\$ 3,597.7</u>	<u>\$ 552.0</u>	<u>\$ (623.6)</u>	<u>\$ 4,178.8</u>

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
Condensed Consolidating Statements of Operations
For the three months ended September 30, 2010

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non- Guarantors	Eliminations	Total Consolidated
	<i>(In millions)</i>						
Patient service revenues, net	\$ —	\$ —	\$ —	\$ 602.8	\$ 46.0	\$ (7.3)	\$ 641.5
Premium revenues	—	—	—	14.8	206.7	(0.9)	220.6
Total revenues	—	—	—	617.6	252.7	(8.2)	862.1
Salaries and benefits	1.2	—	—	328.4	25.2	—	354.8
Health plan claims expense	—	—	—	7.9	173.5	(7.3)	174.1
Supplies	—	—	—	112.8	8.2	—	121.0
Purchased services	—	—	—	44.6	6.4	—	51.0
Other operating expenses	0.1	—	—	61.7	12.8	(0.9)	73.7
Rents and leases	—	—	—	9.2	1.8	—	11.0
Depreciation and amortization	—	—	—	34.3	2.9	—	37.2
Interest, net	—	36.2	—	(2.4)	1.0	—	34.8
Management fees	—	—	—	(4.1)	4.1	—	—
Other	—	—	—	4.8	—	—	4.8
Total costs and expenses	1.3	36.2	—	597.2	235.9	(8.2)	862.4
Income (loss) from continuing operations before income taxes	(1.3)	(36.2)	—	20.4	16.8	—	(0.3)
Income tax benefit (expense)	2.4	—	—	—	(5.5)	5.5	2.4
Equity in earnings of subsidiaries	0.1	—	—	—	—	(0.1)	—
Income (loss) from continuing operations	1.2	(36.2)	—	20.4	11.3	5.4	2.1
Income from discontinued operations, net of taxes	—	—	—	0.1	—	—	0.1
Net income (loss)	1.2	(36.2)	—	20.5	11.3	5.4	2.2
Less: Net income attributable to non-controlling interests	—	—	—	—	(1.0)	—	(1.0)
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	<u>\$ 1.2</u>	<u>\$ (36.2)</u>	<u>\$ —</u>	<u>\$ 20.5</u>	<u>\$ 10.3</u>	<u>\$ 5.4</u>	<u>\$ 1.2</u>

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
Condensed Consolidating Statements of Operations
For the three months ended September 30, 2011

	<u>Parent</u>	<u>Issuers of Senior Notes and Term Debt</u>	<u>Issuers of Senior Discount Notes</u>	<u>Guarantor Subsidiaries</u>	<u>Combined Non- Guarantors</u>	<u>Eliminations</u>	<u>Total Consolidated</u>
	<i>(In millions)</i>						
Patient service revenues, net	\$ —	\$ —	\$ —	\$ 1,163.9	\$ 76.0	\$ (7.4)	\$ 1,232.5
Premium revenues	—	—	—	14.6	200.2	(3.8)	211.0
Total revenues	—	—	—	1,178.5	276.2	(11.2)	1,443.5
Salaries and benefits	0.7	—	—	624.2	40.1	—	665.0
Health plan claims expense	—	—	—	10.5	161.6	(7.4)	164.7
Supplies	—	—	—	200.8	12.8	—	213.6
Other operating expenses	0.1	—	—	234.1	29.7	(3.8)	260.1
Rents and leases	—	—	—	16.0	2.0	—	18.0
Depreciation and amortization	—	—	—	57.2	5.4	—	62.6
Interest, net	—	36.1	10.1	(2.8)	2.4	—	45.8
Management fees	—	—	—	(6.2)	6.2	—	—
Acquisition related expenses	—	—	—	7.8	4.4	—	12.2
Debt extinguishment costs	—	—	38.9	—	—	—	38.9
Other	—	—	—	(2.5)	0.1	—	(2.4)
Total costs and expenses	0.8	36.1	49.0	1,139.1	264.7	(11.2)	1,478.5
Income (loss) from continuing operations before income taxes	(0.8)	(36.1)	(49.0)	39.4	11.5	—	(35.0)
Income tax benefit (expense)	13.6	—	—	—	(5.4)	5.4	13.6
Equity in earnings of subsidiaries	(32.0)	—	—	—	—	32.0	—
Income (loss) from continuing operations	(19.2)	(36.1)	(49.0)	39.4	6.1	37.4	(21.4)
Loss from discontinued operations, net of taxes	—	—	—	(0.1)	—	—	(0.1)
Net income (loss)	(19.2)	(36.1)	(49.0)	39.3	6.1	37.4	(21.5)
Less: Net loss attributable to non-controlling interests	—	—	—	—	2.3	—	2.3
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	<u>\$ (19.2)</u>	<u>\$ (36.1)</u>	<u>\$ (49.0)</u>	<u>\$ 39.3</u>	<u>\$ 8.4</u>	<u>\$ 37.4</u>	<u>\$ (19.2)</u>

VANGUARD HEALTH SYSTEMS, INC.
 NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
 Condensed Consolidating Statements of Cash Flows
 For the three months ended September 30, 2010

	<u>Parent</u>	<u>Issuers of Senior Notes and Term Debt</u>	<u>Issuers of Senior Discount Notes</u>	<u>Guarantor Subsidiaries</u>	<u>Combined Non- Guarantors</u>	<u>Eliminations</u>	<u>Total Consolidated</u>
<i>(In millions)</i>							
Operating activities:							
Net income (loss)	\$ 1.2	\$ (36.2)	\$ —	\$ 20.5	\$ 11.3	\$ 5.4	\$ 2.2
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:							
Income from discontinued operations, net of taxes	—	—	—	(0.1)	—	—	(0.1)
Depreciation and amortization	—	—	—	34.3	2.9	—	37.2
Deferred income taxes	(3.1)	—	—	—	—	—	(3.1)
Amortization of loan costs	—	1.2	—	—	—	—	1.2
Accretion of principal on notes	—	0.7	—	—	—	—	0.7
Stock compensation	1.2	—	—	—	—	—	1.2
Acquisition related expenses	—	—	—	3.7	—	—	3.7
Changes in operating assets and liabilities, net of effects of acquisitions	0.7	(14.5)	—	22.9	67.9	(19.9)	57.1
Net cash provided by (used in) operating activities — continuing operations	—	(48.8)	—	81.3	82.1	(14.5)	100.1
Net cash provided by operating activities — discontinued operations	—	—	—	0.1	—	—	0.1
Net cash provided by (used in) operating activities	—	(48.8)	—	81.4	82.1	(14.5)	100.2

VANGUARD HEALTH SYSTEMS, INC.
 NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
 Condensed Consolidating Statements of Cash Flows
 For the three months ended September 30, 2010
 (Continued)

	<u>Parent</u>	<u>Issuers of Senior Notes and Term Debt</u>	<u>Issuers of Senior Discount Notes</u>	<u>Guarantor Subsidiaries</u>	<u>Combined Non- Guarantors</u>	<u>Eliminations</u>	<u>Total Consolidated</u>
	<i>(In millions)</i>						
Investing activities:							
Capital expenditures	\$ —	\$ —	\$ —	\$ (43.7)	\$ (0.9)	\$ —	\$ (44.6)
Acquisitions and related expenses	—	—	—	(49.5)	—	—	(49.5)
Sales of auction rate securities	—	—	—	—	0.5	—	0.5
Other	—	—	—	(0.4)	—	—	(0.4)
Net cash used in investing activities — continuing operations	—	—	—	(93.6)	(0.4)	—	(94.0)
Net cash used in investing activities — discontinued operations	—	—	—	—	—	—	—
Net cash used in investing activities	—	—	—	(93.6)	(0.4)	—	(94.0)
Financing activities:							
Payments of long-term debt	—	(2.0)	—	—	—	—	(2.0)
Proceeds from debt borrowings	—	216.6	—	—	—	—	216.6
Payments of refinancing costs and fees	—	(5.5)	—	—	—	—	(5.5)
Distributions paid to non-controlling interests and other	—	—	—	—	(3.4)	2.3	(1.1)
Cash provided by (used in) intercompany activity	—	(160.3)	—	197.6	(49.5)	12.2	—
Net cash provided by (used in) financing activities	—	48.8	—	197.6	(52.9)	14.5	208.0
Net increase in cash and cash equivalents	—	—	—	185.4	28.8	—	214.2
Cash and cash equivalents, beginning of period	—	—	—	198.6	59.0	—	257.6
Cash and cash equivalents, end of period	\$ —	\$ —	\$ —	\$ 384.0	\$ 87.8	\$ —	\$ 471.8

VANGUARD HEALTH SYSTEMS, INC.
 NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
 Condensed Consolidating Statements of Cash Flows
 For the three months ended September 30, 2011

	<u>Parent</u>	<u>Issuers of Senior Notes and Term Debt</u>	<u>Issuers of Senior Discount Notes</u>	<u>Guarantor Subsidiaries</u>	<u>Combined Non- Guarantors</u>	<u>Eliminations</u>	<u>Total Consolidated</u>
	<i>(In millions)</i>						
Operating activities:							
Net income (loss)	\$ (19.2)	\$ (36.1)	\$ (49.0)	\$ 39.3	\$ 6.1	\$ 37.4	\$ (21.5)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:							
Loss from discontinued operations, net of taxes	—	—	—	0.1	—	—	0.1
Depreciation and amortization	—	—	—	57.2	5.4	—	62.6
Deferred income taxes	(14.5)	—	—	—	—	—	(14.5)
Amortization of loan costs	—	1.6	—	—	—	—	1.6
Accretion of principal on notes	—	0.7	3.4	—	—	—	4.1
Impairment and restructuring charges	—	—	—	(0.1)	—	—	(0.1)
Stock compensation	0.7	—	—	—	—	—	0.7
Debt extinguishment costs	—	—	38.9	—	—	—	38.9
Acquisition related expenses	—	—	—	16.6	(4.4)	—	12.2
Realized gain on investments	—	—	—	(1.2)	—	—	(1.2)
Changes in operating assets and liabilities, net of effects of acquisitions	33.0	(23.9)	4.5	(140.8)	8.6	(52.0)	(170.6)
Net cash provided by (used in) operating activities — continuing operations	—	(57.7)	(2.2)	(28.9)	15.7	(14.6)	(87.7)
Net cash used in operating activities — discontinued operations	—	—	—	(0.1)	—	—	(0.1)
Net cash provided by (used in) operating activities	—	(57.7)	(2.2)	(29.0)	15.7	(14.6)	(87.8)

VANGUARD HEALTH SYSTEMS, INC.
NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (continued)

VANGUARD HEALTH SYSTEMS, INC.
Condensed Consolidating Statements of Cash Flows
For the three months ended September 30, 2011
(Continued)

	<u>Parent</u>	<u>Issuers of Senior Notes and Term Debt</u>	<u>Issuers of Senior Discount Notes</u>	<u>Guarantor Subsidiaries</u>	<u>Combined Non- Guarantors</u>	<u>Eliminations</u>	<u>Total Consolidated</u>
	<i>(In millions)</i>						
Investing activities:							
Acquisitions and related expenses	\$ —	\$ —	\$ —	\$ (211.0)	\$ 0.9	\$ —	\$ (210.1)
Capital expenditures	—	—	—	(62.2)	(1.2)	—	(63.4)
Proceeds from asset dispositions	—	—	—	2.2	—	—	2.2
Net proceeds from sale of investments in securities	—	—	—	1.7	—	—	1.7
Net cash used in investing activities	—	—	—	(269.3)	(0.3)	—	(269.6)
Financing activities:							
Payments of long-term debt and capital lease obligations	—	(8.2)	(445.8)	(2.4)	(0.1)	—	(456.5)
Proceeds from issuance of common stock	67.5	—	—	—	—	—	67.5
Payments of IPO related costs	(6.9)	—	—	—	—	—	(6.9)
Payments of tender premiums on note redemption	—	—	(27.6)	—	—	—	(27.6)
Dividends and related equity payments to equity holders	(0.2)	—	—	—	—	—	(0.2)
Distributions paid to non-controlling interests and other	—	—	—	—	(2.0)	1.2	(0.8)
Cash provided by (used in) intercompany activity	(60.4)	65.9	475.6	(188.5)	(306.0)	13.4	—
Net cash provided by (used in) financing activities	—	57.7	2.2	(190.9)	(308.1)	14.6	(424.5)
Net decrease in cash and cash equivalents	—	—	—	(489.2)	(292.7)	—	(781.9)
Cash and cash equivalents, beginning of period	—	—	—	644.1	292.5	—	936.6
Cash and cash equivalents, end of period	<u>\$ —</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 154.9</u>	<u>\$ (0.2)</u>	<u>\$ —</u>	<u>\$ 154.7</u>

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

Forward-Looking Statements

This report on Form 10-Q contains "forward-looking statements" within the meaning of the federal securities laws that are intended to be covered by safe harbors created thereby. Forward-looking statements are those statements that are based upon management's plans, objectives, goals, strategies, future events, future revenue or performance, capital expenditures, financing needs, plans or intentions relating to acquisitions, business trends and other information that is not historical information. These statements are based upon estimates and assumptions made by management that, although believed to be reasonable, are subject to numerous factors, risks and uncertainties that could cause actual outcomes and results to be materially different from those projected. When used in this report on Form 10-Q, the words "estimates," "expects," "anticipates," "projects," "plans," "intends," "believes," "forecasts," "continues" or future or conditional verbs, such as "will," "should," "could" or "may," and variations of such words or similar expressions are intended to identify forward-looking statements.

These factors, risks and uncertainties include, among other things, statements relating to:

- Our high degree of leverage and interest rate risk;
- Our ability to incur substantially more debt;
- Operating and financial restrictions in our debt agreements;
- Our ability to generate cash necessary to service our debt;
- Weakened economic conditions and volatile capital markets;
- Potential liability related to disclosures of relationships between physicians and our hospitals;
- Post-payment claims reviews by governmental agencies could result in additional costs to us;
- Our ability to grow our business and successfully implement our business strategies;
- Our ability to successfully integrate our recent acquisition of The Detroit Medical Center, our recent acquisition of hospitals in Harlingen and Brownsville, Texas and other future acquisitions or to recognize expected synergies from such acquisitions;
- Potential acquisitions could be costly, unsuccessful or subject us to unexpected liabilities;
- Conflicts of interest that may arise as a result of our control by a small number of stockholders;
- The highly competitive nature of the healthcare industry;
- Governmental regulation of the healthcare industry, including Medicare and Medicaid reimbursement levels in general and with respect to the impact of the Budget Control Act of 2011 and other future deficit reduction plans;
- Pressures to contain costs by managed care organizations and other insurers and our ability to negotiate acceptable terms with these third party payers;
- Our ability to attract and retain qualified management and healthcare professionals, including physicians and nurses;
- The currently unknown effect on us of the major federal healthcare reforms enacted by Congress in March 2010 or other potential additional federal or state healthcare reforms;
- Potential adverse impact of known and unknown governmental investigations and audits;
- Our failure to adequately enhance our facilities with technologically advanced equipment could adversely affect our revenues and market position;
- Potential lawsuits or other claims asserted against us;
- The availability of capital to fund our corporate growth strategy and improvements to our existing facilities;
- Our ability to maintain or increase patient membership and control costs of our managed healthcare plans;
- Our exposure to the increased amounts of and collection risks associated with uninsured accounts and the co-pay and deductible portions of insured accounts;
- Dependence on our senior management team and local management personnel;
- Volatility of professional and general liability insurance for us and the physicians who practice at our hospitals and increases in the quantity and severity of professional liability claims;
- Our ability to achieve operating and financial targets and to maintain and increase patient volumes and control the costs of providing services, including salaries and benefits, supplies and bad debts;

- Increased compliance costs from further government regulation of the healthcare industry and our failure to comply, or allegations of our failure to comply, with applicable laws and regulations;
- The geographic concentration of our operations;
- Technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for, healthcare services and shift demand for inpatient services to outpatient settings;

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- A failure of our information systems would adversely impact our ability to manage our operations;
- Changes in general economic conditions nationally and regionally in our markets;
- Delays in receiving payments for services provided;
- Changes in revenue mix, including changes in Medicaid eligibility criteria and potential declines in the population covered under managed care agreements;
- Costs and compliance risks associated with Section 404 of the Sarbanes-Oxley Act of 2002;
- Material non-cash charges to earnings from impairment of goodwill associated with declines in the fair market values of our reporting units;
- Volatility of materials and labor costs for, or state efforts to regulate, potential construction projects that may be necessary for future growth;
- Changes in accounting practices; and
- Our ability to demonstrate meaningful use of certified electronic health record technology and to recognize revenues for the related Medicare or Medicaid incentive payments.

Our forward-looking statements speak only as of the date made. Except as required by law, we undertake no obligation to publicly update or revise any forward-looking statements contained herein, whether as a result of new information, future events or otherwise. We advise you, however, to consult any additional disclosures we make in our other filings with the Securities and Exchange Commission. You are cautioned not to rely on such forward-looking statements when evaluating the information contained in this report on Form 10-Q. In light of significant uncertainties inherent in the forward-looking statements included in this report on Form 10-Q, you should not regard the inclusion of such information as a representation by us that our objectives and plans anticipated by the forward-looking statements will occur or be achieved or, if any of them do, what impact they will have on our financial condition, results of operations or cash flows.

Executive Overview

As of September 30, 2011, we owned and operated 28 hospitals with a total of 7,064 licensed beds, and related outpatient service facilities complementary to the hospitals in San Antonio, Harlingen and Brownsville Texas; metropolitan Detroit, Michigan; metropolitan Phoenix, Arizona; metropolitan Chicago, Illinois; and Massachusetts. As of September 30, 2011, we also owned three health plans with approximately 245,000 members and two surgery centers in Orange County, California.

During the three months ended September 30, 2011, our revenue growth was limited by significant challenges including less demand for elective services, some of which related to a weakened general economy, and a shift from services provided to managed care enrollees to uninsured patients or to patients covered by lower paying Medicare or Medicaid plans. In addition, multiple states in which we operate cut Medicaid reimbursement during the past year, which reduced our revenues. Health plan premium revenues decreased 4.4 percent for the quarter due to capitation rate decreases at Phoenix Health Plan implemented by Arizona's Medicaid plan and changes in eligibility qualification for certain categories of patients. Most of the decrease in health plan revenue was passed along to providers through decreased claim payments and we have been successful in reducing certain costs to offset the impact of the limited revenue growth, but we are not sure these cost reduction measures will be sustainable if economic weakness persists during the remainder of fiscal 2012 and beyond. Our comprehensive debt refinancing (the "Refinancing") during January 2010 extended the maturities of our debt by up to five years. Our additional debt offerings in July 2010 and January 2011 (see further discussion in Liquidity and Capital Resources) and our initial public offering in June 2011 established a capital structure to fund our long-term growth strategies.

Our mission is to help people in the communities we serve achieve health for life by delivering a patient-centered experience in a high performance environment of integrated care. We plan to grow our business by continually improving quality of care, transforming the delivery of care to a fee per episode basis, expanding services and strengthening the financial performance of our existing operations, and selectively acquiring other hospitals, outpatient facilities or other healthcare businesses where we see an opportunity to improve operating performance and expand our mission. We believe this business strategy is a framework for long-term success in an industry that is undergoing significant change, but we may continue to experience operating challenges in the short term until the general economy improves and our initiatives are fully implemented.

Acquisition of Valley Baptist Health Systems

As previously announced, effective September 1, 2011, we acquired substantially all of the assets of the Valley Baptist Health System ("Valley Baptist") including hospitals with a combined 866 licensed beds located in Harlingen, Texas and Brownsville, Texas. We paid approximately \$201.4 million in cash at closing to acquire the net assets. In addition to the cash investment, we also assumed certain of the seller's debt and issued a 49% interest in the partnership to the seller. We funded the cash investment with cash on hand. The acquisition includes a working capital settlement provision that we expect to settle later in fiscal 2012.

Operating Environment

We believe that the operating environment for hospital operators continues to evolve, which presents both challenges and opportunities for us. To remain competitive in the markets we serve, we must transform our operating strategies to accommodate changing environmental factors into operating advantages for us relative to our peers. These factors will require continued focus on quality of care initiatives. As consumers become more involved in their healthcare decisions, we believe perceived quality of care will become an even greater factor in determining where physicians choose to practice and where patients choose to receive care. The changes to the healthcare landscape that have begun or that we expect to begin in the immediate future are outlined below.

Payer Mix Shifts

During the three months ended September 30, 2011 compared to the prior year period, we provided more healthcare services to patients who were uninsured or had coverage under Medicaid or Medicare or managed Medicaid/Medicare programs, and provided fewer healthcare services to patients who had commercial managed care coverage, a trend that began during fiscal year 2010 and continued through fiscal year 2011. Much of this shift resulted from general economic weakness in the markets we serve. As individuals lost their coverage under employer-sponsored managed care plans, many became eligible for state Medicaid or managed Medicaid programs or else became uninsured. We are uncertain how long the economic weakness will continue, but believe that conditions may not improve significantly during the remainder of fiscal 2012. A portion of this shift also resulted from our acquisition of DMC, which provides a greater percentage of services to Medicaid patients than our other facilities.

Health Reform Law

The provisions included in The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "Health Reform Law"), enacted in calendar 2010 include, among other things, increased access to health benefits for a significant number of uninsured individuals through the creation of health exchanges and expanded Medicaid programs; reductions in future Medicare reimbursement including market basket and disproportionate share payments; development of a payment bundling pilot program and similar programs to promote accountability and coordination of care; continued efforts to tie reimbursement to quality of care, including penalties for excessive readmissions and hospital-acquired conditions; and changes to premiums paid and the establishment of profit restrictions on Medicare managed care plans and exchange insurance plans. We are unable to predict how the Health Reform Law will impact our future financial position, operating results or cash flows, but we have begun the process of transforming our delivery of care to adapt to the changes from the Health Reform Law that will be implemented during the next several years.

Physician Alignment

Our ability to attract skilled physicians to our hospitals is critical to our success. Coordination of care and alignment of care strategies between hospitals and physicians will become more critical as reimbursement becomes more episode-based. During fiscal year 2011, we added more than 200 employed physicians to our physician network (net of physicians who left our network) and we expect to continue to recruit additional physicians in fiscal 2012 as market-specific needs warrant. Our acquisitions of the Arizona Heart Institute and a cardiology group in San Antonio during fiscal 2011 represented important steps in the physician alignment process. We have invested heavily in the infrastructure necessary to coordinate our physician alignment strategies and manage our physician operations. We also believe our hospitalist employment strategy is a key element in coordination of patient-centered care. Because these initiatives require significant upfront investment and may take years to fully implement, our operating results and cash flows could be negatively impacted during the short-term.

Cost pressures

In order to demonstrate a highly reliable environment of care, we must hire and retain nurses who share our ideals and beliefs and who have access to the training necessary to implement our clinical quality initiatives. While the national nursing shortage has abated somewhat during the past two years as a result of general economic weakness, the nursing workforce remains volatile. As a result, we expect continuing pressures on nursing salaries and benefits costs. These pressures include higher than normal base wage increases, demands for flexible working hours and other increased benefits, and higher nurse to patient ratios necessary to improve quality of care. We have begun multiple initiatives to stabilize our nursing workforce, including a nurse leadership professional practice model and employee engagement strategies. We experienced a decrease in nursing voluntary turnover from approximately 12% during the year ended June 30, 2009 to 10% during the year ended June 30, 2010 and this ratio remained relatively flat during fiscal 2011. During fiscal year 2010, we achieved the 72nd percentile for employee engagement within the Gallup Organization Employee Engagement Database. These results reflect progress towards both achieving stability in our nursing workforce and improving employee engagement since we began monitoring employee engagement during fiscal year 2008, our baseline year. Inflationary pressures and technological advancements continue to drive supplies costs higher. We have implemented multiple supply chain initiatives, including consolidation of low-priced vendors, establishment of value analysis teams, stricter adherence to pharmacy formularies and coordination of care efforts with physicians to reduce physician preference items, but we are uncertain if we can sustain these reductions in future periods.

Implementation of our Clinical Quality Initiatives

The integral component of each of the environmental factors previously discussed is quality of care. We have implemented many of our expanded clinical quality initiatives and are in the process of implementing several others. These initiatives include monthly review of the 55 Centers for Medicare and Medicaid Services ("CMS") quality indicators in place for federal fiscal year 2012, rapid response teams, mock Joint Commission surveys, hourly nursing rounds, our nurse leadership professional practice model, alignment of hospital management incentive compensation with quality performance indicators, and the formation of Physician Advisory Councils at our hospitals to align the quality goals of our hospitals with those of the physicians who practice in our hospitals.

Sources of Revenues

Hospital revenues depend upon inpatient occupancy levels, the medical and ancillary services ordered by physicians and provided to patients, the volume of outpatient procedures, and the charges or payment rates for such services. Reimbursement rates for inpatient services vary significantly depending on the type of payer, the type of service (e.g., acute care, intensive care or subacute) and the geographic location of the hospital. Inpatient occupancy levels fluctuate for various reasons, many of which are beyond our control.

We receive payment for patient services from:

- the federal government, primarily under the Medicare program;
- state Medicaid programs;
- health maintenance organizations, preferred provider organizations, managed Medicare providers, managed Medicaid providers and other private insurers; and
- individual patients.

The following table sets forth the percentages of net patient revenues by payer .

	Three months ended September 30,	
	2010(1)	2011(1)
Medicare	27.3%	26.6%
Medicaid	7.8%	14.7%
Managed Medicare	15.8%	10.2%
Managed Medicaid	10.5%	10.6%
Managed care	37.1%	35.1%
Self-pay	0.4%	1.4%
Other	1.1%	1.4%
Total	100.0%	100.0%

(1) The net patient revenues by payer table above reflects the impact of the reclassification of the provision of doubtful accounts from operating expenses to revenue deductions.

See "Item 1 — Business — Sources of Revenues" included in our Annual Report on Form 10-K for our fiscal year ended June 30, 2011, for a description of the types of payments we receive for services provided to patients enrolled in the traditional Medicare plan (both for inpatient and outpatient services), managed Medicare plans, Medicaid plans, managed Medicaid plans and managed care plans. In that section, we also discussed the unique reimbursement features of the traditional Medicare plan, including disproportionate share, outlier cases and direct graduate and indirect medical education. We also described the annual Medicare regulatory updates published by CMS in August 2011 that impact reimbursement rates under the plan for services provided during federal fiscal year 2012 which commenced October 1, 2011. The future impact to reimbursement for certain of these payers under the Health Reform Law was also addressed in our Form 10-K.

The American Recovery and Reinvestment Act of 2009 provides for Medicare and Medicaid incentive payments beginning calendar 2011 for eligible hospitals and professionals that adopt and meaningfully use certified electronic health record ("EHR") technology. We recognize revenues related to the Medicare or Medicaid incentive payments as we are able to complete attestations that our eligible hospitals or other healthcare facilities have adopted, implemented or demonstrated meaningful use of certified EHR technology. We recognized approximately \$7.2 million of other revenues related to Medicare and Medicaid incentive programs during the three months ended September 30, 2011.

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Volumes by Payer

During the three months ended September 30, 2011 compared to the three months ended September 30, 2010, discharges increased 51.5% and total adjusted discharges increased 55.0%. Our consolidated volumes have been significantly impacted by our acquisitions in fiscal years 2011 and 2012. Same hospital discharges decreased 1.0% and same hospital adjusted discharges increased 2.2% during the three months ended September 30, 2011 compared to the three months ended September 30, 2010.

The following table provides details of discharges by payer on a consolidated basis.

	Three months ended September 30,			
	2010		2011	
Medicare	12,439	27.7%	19,265	28.3%
Medicaid	4,605	10.2%	7,116	10.4%
Managed Medicare	6,842	15.2%	8,414	12.3%
Managed Medicaid	6,707	14.9%	12,120	17.8%
Managed care	11,654	25.9%	15,782	23.2%
Self-pay	2,564	5.7%	5,078	7.5%
Other	166	0.4%	386	0.5%
Total	<u>44,977</u>	<u>100.0%</u>	<u>68,161</u>	<u>100.0%</u>

Payer Reimbursement Trends

In addition to the volume factors described above, patient mix, acuity factors and pricing trends affect our patient service revenues. Net patient revenue per adjusted discharge on a same hospital basis was \$7,757 and \$7,709 for the three months ended September 30, 2010 and 2011, respectively. The reduction in this ratio resulted from payer mix shifts during the current year quarter. A greater percentage of our discharges during the three months ended September 30, 2011 were attributable to patients who had Medicaid or Medicare coverage or were uninsured as opposed to those with managed care coverage compared to the three months ended September 30, 2010. We typically receive lower reimbursement for the same services provided to patients covered by Medicare or Medicaid, whether under such traditional or managed programs, than those provided to patients with commercial managed care coverage. Also, multiple states in which we operate have cut Medicaid reimbursement rates during the past year, which has reduced our revenues.

Accounts Receivable Collection Risks Leading to Increased Bad Debts

Similar to other companies in the hospital industry, we face continued pressures in collecting outstanding accounts receivable primarily due to volatility in the uninsured and underinsured populations in the markets we serve. The following table provides a summary of our accounts receivable payer class mix as of each respective period presented.

June 30, 2011	0-90 days	91-180 days	Over 180 days	Total
Medicare	15.8%	1.5%	1.0%	18.3%
Medicaid	6.1%	1.2%	1.6%	8.9%
Managed Medicare	6.9%	0.7%	0.5%	8.1%
Managed Medicaid	12.2%	1.7%	1.6%	15.5%
Managed care	21.0%	2.9%	1.6%	25.5%
Self-pay(1)	10.5%	3.7%	1.5%	15.7%
Self-pay after insurance(2)	1.5%	2.2%	1.0%	4.7%
Other	1.9%	0.6%	0.8%	3.3%
Total	75.9%	14.5%	9.6%	100.0%

September 30, 2011	0-90 days	91-180 days	Over 180 days	Total
Medicare	15.4%	1.0%	1.1%	17.5%
Medicaid	6.7%	1.3%	1.6%	9.6%
Managed Medicare	6.4%	0.4%	0.7%	7.5%
Managed Medicaid	10.4%	1.2%	1.7%	13.3%
Managed care	19.4%	2.3%	3.0%	24.7%
Self-pay(1)	12.0%	4.8%	3.1%	19.9%
Self-pay after insurance(2)	1.3%	1.8%	1.5%	4.6%
Other	1.6%	0.5%	0.8%	2.9%
Total	73.2%	13.3%	13.5%	100.0%

- (1) Includes uninsured patient accounts only.
(2) Includes patient co-insurance and deductible amounts after payment has been received from the primary payer.

Our combined same hospital allowances for doubtful accounts, uninsured discounts and charity care covered 92.5% and 93.5% of combined same hospital self-pay and self-pay after insurance accounts receivable as of June 30, 2011 and September 30, 2011, respectively.

The volume of self-pay and self-pay after insurance accounts receivable remains sensitive to a combination of factors including price increases, acuity of services, higher levels of patient deductibles and co-insurance under managed care plans, economic factors, and the increased difficulties of uninsured patients who do not qualify for charity care programs to pay for escalating healthcare costs. We have implemented policies and procedures designed to expedite upfront cash collections and promote repayment plans from our patients. However, we believe bad debts will remain a significant risk for us and the rest of the hospital industry in the near term.

Governmental and Managed Care Payer Reimbursement

Healthcare spending comprises a significant portion of total spending in the United States and has been growing at annual rates that exceed the rate of inflation, wage growth and gross national product. There is considerable pressure on governmental payers, managed Medicare/Medicaid payers and commercial managed care payers to control costs by either reducing or limiting increases in reimbursement to healthcare providers or limiting benefits to enrollees. The current weakness in the U.S. economy has magnified these pressures.

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Lower than expected tax collections due to higher unemployment and depressed consumer spending have resulted in budget shortfalls for most states, including those in which we operate. Additionally, the demand for Medicaid coverage has increased due to job losses that have left many individuals without health insurance. To balance their budgets, many states, either directly or through their Medicaid or managed Medicaid programs, have changed and may continue to change program eligibility requirements, enact healthcare spending cuts or defer cash payments to healthcare providers to avoid raising taxes during periods of economic weakness. During the past twelve months, three states in which we operate have reduced Medicaid reimbursement rates and/or adjusted eligibility requirements. Further, the tightened credit markets have complicated the states' efforts to issue additional indebtedness to raise cash. The American Recovery and Reinvestment Act enacted in 2009 set aside approximately \$87 billion to provide additional Medicaid funding to states in the form of a temporary increase in the federal matching percentage (FMAP) until December 2010. In August 2010, the additional FMAP assistance was extended until June 30, 2011 with a transitional phase-out to occur from January 1, 2011 to June 30, 2011. The expiration of the FMAP program further strained state budgets and may lead to additional Medicaid reimbursement rate or eligibility cuts. During the three months ended September 30, 2011, Medicaid and managed Medicaid programs accounted for approximately 25.3% of our net patient revenues.

Managed care payers also face economic pressures during periods of economic weakness due to lower enrollment resulting from higher unemployment rates and the inability of individuals to afford private insurance coverage. These payers may respond to these challenges by reducing or limiting increases to healthcare provider reimbursement rates or reducing benefits to enrollees. During the three months ended September 30, 2011, we recognized approximately 35.1% of our net patient revenues from managed care payers.

If we do not receive increased payer reimbursement rates from governmental or managed care payers that cover the increasing cost of providing healthcare services to our patients or if governmental payers defer payments to our hospitals, our financial position, results of operations and cash flows could be materially adversely impacted.

Premium Revenues

We recognize premium revenues from our three health plans, PHP, Abrazo Advantage Health Plan ("AAHP") and MacNeal Health Providers ("MHP"). Premium revenues from these three plans decreased \$9.6 million, or 4.4%, during the three months ended September 30, 2011 compared to the three months ended September 30, 2010. PHP's average membership increased to approximately 208,000 for the three months ended September 30, 2011 compared to approximately 202,700 for the three months ended September 30, 2010. PHP's decrease in revenues despite the increase in membership during the three months ended September 30, 2011 resulted from a 5% reimbursement rate cut from the Arizona Health Care Cost Containment System ("AHCCCS") implemented in April 2011 and an enrollee mix shift into population groups with lower reimbursement rates.

AHCCCS has requested a further 5% reimbursement rate cut to be effective October 1, 2011, which has not been implemented yet as the rate reduction requires federal approval, and additional higher enrollee eligibility requirements as part of its Medicaid waiver extension application with CMS. AHCCCS could take further actions in the near term that could materially adversely impact our operating results and cash flows including reimbursement rate cuts, enrollment reductions, capitation payment deferrals, covered services reductions or limitations or other steps to reduce program expenditures including cancelling PHP's contract.

Critical Accounting Policies

Our condensed consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States. In preparing these financial statements, we make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses included in the financial statements. Management bases its estimates on historical experience and other available information, the results of which form the basis of the estimates and assumptions. We consider the following accounting policies to be critical because they involve highly subjective and complex assumptions and assessments, are subject to a great degree of fluctuation period over period and are the most critical to our operating performance:

- Revenues, Revenue Deductions and Uncompensated Care;
- Insurance Reserves;
- Health Plan Claims Reserves;
- Income Taxes; and
- Long-Lived Assets and Goodwill.

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There have been no changes in the nature or application of our critical accounting policies during the three months ended September 30, 2011 when compared to those described in our Annual Report on Form 10-K for our fiscal year ended June 30, 2011, except for the change to the critical accounting policy noted below that represents a consolidation of our previous "Revenue and Revenue Deductions" and "Allowance for Doubtful Accounts and Provision for Doubtful Accounts".

Revenues, Revenue Deductions and Uncompensated Care

In August 2010, the FASB issued ASU No. 2010-23, "Health Care Entities" (Topic 954): *Measuring Charity Care for Disclosure*. Due to the lack of comparability that previously existed due to the use of either revenue or cost as the basis for disclosure of charity care, this ASU standardizes cost as the basis for charity care disclosures and specifies the elements of cost to be used in charity care disclosures. We adopted ASU 2010-23 on July 1, 2011. In the ordinary course of business, we provide services to patients who are financially unable to pay for hospital care. We include charity care as a revenue deduction measured by the value of our services, based on standard charges, to patients who qualify under our charity care policy and do not otherwise qualify for reimbursement under a governmental program. The estimated cost incurred by us to provide these services to patients who are unable to pay was approximately \$5.4 million and \$13.2 million for the three months ended September 30, 2010 and 2011, respectively. The estimated cost of charity care services was determined using a ratio of cost to gross charges determined from our most recently filed Medicare cost reports and applying that ratio to the gross charges associated with providing charity care for the period.

Effective July 1, 2011, we adopted ASU No. 2011-07, "Health Care Entities" (Topic 954): *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*. The amendments in this ASU require healthcare entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a revenue deduction. We elected to early adopt this guidance for our September 30, 2011 financial statements. The amendments in this ASU require that presentation of the provision for bad debts as a revenue reduction in the statement of operations be applied retrospectively to all prior periods presented.

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Selected Operating Statistics

The following tables set forth certain operating statistics on a consolidated and same hospital basis for each of the periods presented.

CONSOLIDATED:	Three months ended September 30,	
	2010	2011
Number of hospitals at end of period	17	28
Licensed beds at end of period	4,490	7,064
Discharges (a)	44,977	68,161
Adjusted discharges (a)	80,858	125,320
Average length of stay (a)	4.15	4.34
Patient days (a)	186,448	296,079
Adjusted patient days (a)	335,188	544,366
Net patient revenue per adjusted discharge (a)	\$ 7,747	\$ 9,337
Inpatient surgeries (a)	9,757	16,077
Outpatient surgeries (a)	19,403	29,976
Emergency room visits (a)	173,165	292,778
Occupancy rate (a)	45.1%	45.6%
Member lives (a)	242,000	245,000
Health plan claims expense percentage (a)	78.9%	78.1%

SAME HOSPITAL (b):	Three months ended September 30,	
	2010	2011
Number of hospitals at end of period	15	15
Licensed beds at end of period	4,032	3,947
Net patient service revenues (in millions)	\$ 599.1	\$ 609.1
Discharges	42,005	41,565
Adjusted discharges	75,592	77,232
Average length of stay	4.12	4.02
Patient days	172,976	167,014
Adjusted patient days	311,288	310,328
Net patient revenue per adjusted discharge	\$ 7,757	\$ 7,709
Inpatient surgeries	9,128	9,015
Outpatient surgeries	18,343	17,762
Emergency room visits	160,880	169,992
Occupancy rate	46.6%	45.9%

- (a) The definitions for the statistics included above are set forth in Part 2, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations", "Selected Operating Statistics" in our Annual Report on Form 10-K for the year ended June 30, 2011.
- (b) Same hospital results exclude those facilities that we did not own for the respective full three-month comparative periods of both years.

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Results of Operations

The following table presents summaries of our operating results .

	Three months ended September 30,			
	2010		2011	
	<i>(dollars in millions)</i>			
Patient service revenues, net	\$ 641.5	74.4%	\$ 1,232.5	85.4%
Premium revenues	220.6	25.6%	211.0	14.6%
Total revenues	862.1	100.0%	1,443.5	100.0%
Costs and expenses:				
Salaries and benefits (includes stock compensation of \$1.2 and \$0.7, respectively)	354.8	41.2%	665.0	46.1%
Health plan claims expense	174.1	20.2%	164.7	11.4%
Supplies	121.0	14.0%	213.6	14.8%
Other operating expenses	135.7	15.7%	278.1	19.3%
Depreciation and amortization	37.2	4.3%	62.6	4.3%
Interest, net	34.8	4.0%	45.8	3.2%
Debt extinguishment costs	—	0.0%	38.9	2.7%
Acquisition related expenses	3.7	0.4%	12.2	0.8%
Other	1.1	0.1%	(2.4)	(0.2)%
Loss from continuing operations before income taxes	(0.3)	(0.0)%	(35.0)	(2.4)%
Income tax benefit	2.4	0.3%	13.6	0.9%
Income (loss) from continuing operations	2.1	0.2%	(21.4)	(1.5)%
Income (loss) from discontinued operations net of taxes	0.1	0.0%	(0.1)	(0.0)%
Net income (loss)	2.2	0.3%	(21.5)	(1.5)%
Net loss (income) attributable to non-controlling interests	(1.0)	(0.1)%	2.3	0.0%
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	<u>\$ 1.2</u>	<u>0.1%</u>	<u>\$ (19.2)</u>	<u>(1.3)%</u>

Three months ended September 30, 2011 compared to three months ended September 30, 2010

Revenues. Total revenues increased \$581.4 million or 67.4% during the three months ended September 30, 2011 compared to the prior year quarter. Net patient service revenues increased \$591.0 million or 92.1% during the current year quarter. The significant increase in net patient service revenues is primarily the result of recent acquisitions, including DMC on January 1, 2011 and Valley Baptist on September 1, 2011. On a same hospital basis, net patient service revenues increased \$10.0 million or 1.7% during the three months ended September 30, 2011. Health plan premium revenues decreased \$9.6 million or 4.4% during the current year quarter compared to the prior year quarter as a result of a 5% decrease in AHCCCS reimbursement rates in April 2011 and an enrollee mix shift to populations with lower reimbursement rates. More challenging economic conditions in Arizona during the past twelve months resulted in more individuals becoming eligible for coverage under AHCCCS, but have also strained the Arizona state budget resulting in changes to AHCCCS funding.

Our percentage of uncompensated care (defined as the sum of uninsured discounts, charity care adjustments and the provision for doubtful accounts) as a percentage of net patient revenues (prior to these uncompensated care deductions) on a same hospital basis increased to 20.5% during the current year quarter compared to 16.0% during the prior year quarter. This increase primarily resulted from an increase in same hospital self-pay discharges as a percentage of total discharges during the current year quarter and price increases implemented since the prior year quarter.

Discharges, adjusted discharges and emergency room visits increased 51.5%, 55.0% and 69.1%, respectively, during the three months ended September 30, 2011 compared to the prior year quarter. On a same hospital basis, discharges decreased 1.0%, while adjusted discharges and emergency room visits increased 2.2% and 5.7%, respectively, during the three months ended September 30, 2011 compared to the prior year quarter. On a same hospital basis, inpatient and outpatient surgeries decreased 1.2% and 3.2%, respectively, during the three months ended September 30, 2011. General economic weakness in the markets we serve continues to impact demand for elective surgical procedures. We also continue to face pricing pressures as a result of difficult managed care pricing negotiations, state efforts to reduce Medicaid program expenditures and intense competition for limited physician and nursing resources, among other factors. We expect the average population growth in the markets we serve to remain generally high in the long-term. As these populations increase and grow older, we believe that our clinical quality initiatives will improve our competitive position in those markets. However, these growth opportunities may not overcome the current industry and market challenges in the short-term.

We continue to implement multiple initiatives to transform our operations to prepare for the future changes we expect to occur in the healthcare industry. This transformation process is built upon providing positive experiences for our patients and their families through clinical excellence, aligning nursing and physician interests to provide coordination of care and improving healthcare delivery efficiencies to provide quality outcomes without overutilization of resources. The success of these initiatives will determine our ability to increase revenues from our existing operations and to increase revenues through acquisitions of other hospitals.

Costs and expenses. Total costs and expenses from continuing operations, exclusive of income taxes, were \$1,478.5 million or 102.4% of total revenues during the current year quarter, compared to \$862.4 million or 100.0% during the prior year comparative quarter. Debt extinguishment costs incurred related to the redemption of our 10.375% Senior Discount Notes due 2016 (the "2011 Discount Notes") represent the primary reason for the increase in operating expenses during the current year quarter. Salaries and benefits, health plan claims and supplies represent the most significant of our normal costs and expenses and those typically subject to the greatest level of fluctuation year over year.

- **Salaries and benefits.** Salaries and benefits as a percentage of total revenues increased to 46.1% during the current year quarter compared to 41.2% for the prior year quarter. On a same hospital basis, salaries and benefits as a percentage of total revenues was 41.1% during the current quarter compared to 40.3% for the prior year quarter. We continue to employ more physicians to support the communities our hospitals serve and have made significant investments in clinical quality initiatives that required additional human resources during the three months ended September 30, 2011 compared to the prior year quarter. As of September 30, 2011, we had approximately 41,100 full-time and part-time employees compared to approximately 22,400 as of September 30, 2010. On a same hospital basis, the number of full-time and part-time employees increased approximately 2.0% when compared to the prior year quarter. We have been successful in limiting contract labor utilization on a same hospital basis as a result of our investments in clinical quality and nurse leadership initiatives. On a same hospital basis, our contract labor expense as a percentage of net patient service revenues decreased slightly during the three months ended September 30, 2011 compared to the prior year quarter.

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- **Health plan claims.** Health plan claims expense as a percentage of premium revenues was 78.1% for the three months ended September 30, 2011 compared to 78.9% for the prior year quarter primarily due to lower utilization and acuity of services for our enrollees and the 5% provider payment reduction set forth by AHCCCS on April 1, 2011. As enrollment increases, this ratio becomes especially sensitive to the mix of members, including covered groups based upon age and gender and county of residence. We may experience an increase in this ratio if our membership mix becomes more acute or if AHCCCS implements further limits on profitability for certain member groups during the remaining term of the AHCCCS contract. Revenues and expenses between the health plans and our hospitals and related outpatient service providers of approximately \$8.6 million, or 5.0% of gross health plan claims expense, were eliminated in consolidation during the current year quarter.
- **Supplies.** Supplies as a percentage of acute care services revenue decreased to 17.2% during the current year quarter compared to 18.5% during the prior year quarter. This decrease was positively impacted by the lower surgery volumes experienced during the current year quarter compared to the prior year quarter on a same hospital basis. We also continued our focus on supply chain efficiencies including reduction in physician commodity variation and improved pharmacy formulary management during the current year quarter. Our ability to reduce this ratio in future years may be limited because our growth strategies include expansion of higher acuity services and due to inflationary pressures on medical supplies and pharmaceuticals.

Other operating expenses. Other operating expenses include, among others, purchased services, insurance, non-income taxes, rents and leases, repairs and maintenance and utilities. Other operating expenses as a percentage of net patient service revenues increased to 22.6% during the current year quarter compared to 21.2% during the prior year quarter primarily as a result of increased legal fees and related expenses and higher purchased services from the DMC acquisition.

Other. Depreciation and amortization increased \$25.4 million compared to the prior year quarter as a result of our capital improvement and expansion initiatives and acquisitions. Net interest increased \$11.0 million as compared to the prior year's amounts as a result of the issuance of the 7.75% Senior Notes due 2019 in January 2011, as discussed more thoroughly in the "Part I, Item 2, Liquidity and Capital Resources" section of this report on Form 10-Q. We also incurred \$12.2 million of acquisition-related expenses during the current year quarter primarily related to the acquisition of Valley Baptist and \$38.9 million of debt extinguishment costs related to our redemption of substantially all of the 2011 Discount Notes during the current year quarter.

Income taxes. Our effective income tax rate was approximately 38.9% during the current year quarter and was positively impacted by IRS safe harbor treatment for certain success-based transaction costs from our fiscal 2005 recapitalization that were previously reserved for uncertain tax positions.

Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders. Net loss attributable to Vanguard stockholders was \$19.2 million during the three months ended September 30, 2011 compared to net income of \$1.2 million during the prior year quarter. The net loss in the current year quarter resulted primarily from the \$38.9 million of debt extinguishment costs recognized.

Liquidity and Capital Resources

Operating Activities

As of September 30, 2011, we had working capital of \$265.6 million, including cash and cash equivalents of \$154.7 million. Working capital as of June 30, 2011 was \$335.7 million. Cash flows from operating activities decreased \$188.0 million during the first quarter of fiscal 2012 compared to the prior year quarter, primarily due to working capital increases of \$227.7 million, including a \$23.2 million increase in interest and income tax payments, the payment of fiscal 2011 incentive compensation and adverse changes to net accounts receivable days and net accounts payable days. As of September 30, 2011, our cash balance was \$154.7 million, our outstanding debt was \$2,346.2 million and we had \$220.6 million of borrowing capacity under our revolving credit facility.

Investing Activities

Cash used in investing activities increased from \$94.0 million during the three months ended September 30, 2010 to \$269.6 million during the three months ended September 30, 2011, primarily as a result of the cash paid for the Valley Baptist acquisition. Capital expenditures increased \$18.8 million during the current year quarter compared to the prior year quarter. Through September 30, 2011 we have spent approximately \$43.2 million toward our DMC five-year \$850.0 million capital commitment, including \$11.6 million of the specific project list commitment of \$500.0 million.

Financing Activities

Cash flows from financing activities decreased by \$632.5 million during the three months ended September 30, 2011 compared to the three months ended September 30, 2010 primarily due to cash paid to redeem substantially all of the 2011 Discount Notes during the current year quarter and the additional senior note borrowings during the prior year quarter, as discussed below.

On July 14, 2010, we issued \$225.0 million aggregate principal amount of 8.0% Add-on Notes (the "Add-on Notes"), which were guaranteed on a senior unsecured basis by Vanguard, Vanguard Health Holding Company I, LLC and certain restricted subsidiaries of Vanguard Health Holding Company II, LLC. The Add-on Notes were issued under the indenture governing the 8.0% Notes that we issued on January 29, 2010 as part of the comprehensive refinancing of our debt. The Add-on Notes were issued at an offering price of 96.25% plus accrued interest, if any, from January 29, 2010. The proceeds from the Add-on Notes were used to finance, in part, our acquisition of substantially all of the assets of DMC and to pay fees and expenses incurred in connection with the DMC acquisition.

On January 26, 2011, we issued an aggregate principal amount of \$350.0 million of senior notes due 2019 (the "2011 Senior Notes") and the 2011 Discount Notes with a stated principal amount at maturity of approximately \$747.2 million generating approximately \$444.7 million of gross proceeds, each in a private placement. The 2011 Senior Notes bear interest at a rate of 7.750% per annum. We pay cash interest on the 2011 Senior Notes semi-annually in arrears on February 1 and August 1 of each year, with our initial interest payment on August 1, 2011. The 2011 Senior Notes mature on February 1, 2019. We used the proceeds from the 2011 Senior Notes for general corporate purposes, including acquisitions, and to pay the related transaction fees and expenses of both notes offerings. The 2011 Discount Notes had an initial accreted value of \$602.23 per \$1,000 stated principal amount at maturity and were issued at a price of \$595.08 per \$1,000 stated principal amount at maturity. Cash interest does not accrue on the 2011 Discount Notes, but the 2011 Discount Notes accrete at a rate of 10.375% per annum, compounded semi-annually on February 1 and August 1 of each year, such that the accreted value will equal the stated principal amount at maturity on February 1, 2016. We used the proceeds from the offering of the 2011 Discount Notes to pay a dividend to our equity holders.

On June 22, 2011, we completed our initial public offering of 25,000,000 shares of common stock at a price of \$18.00 per share (prior to deducting underwriter discounts and commissions). We used the net proceeds from the offering to redeem substantially all of the 2011 Discount Notes, including the 5% redemption premium thereof, as discussed below. Immediately prior to our initial public offering, we completed a 59.584218-to-1 split of our issued and outstanding common shares. During the three months ended September 30, 2011, the 3,750,000 common stock over-allotment option was exercised by the underwriters and the net proceeds of the sale of the 3,750,000 additional shares of common stock were used to redeem an additional \$63.6 million of accreted value of the remaining 2011 Discount Notes in August 2011, including the 5% redemption premium thereof.

In July and August 2011, we redeemed approximately \$450.0 million of the 2011 Discount Notes using proceeds from our initial public offering, including the exercise of the underwriters' over-allotment option. We recorded debt extinguishment costs of \$38.9 million, \$25.3 million net of taxes, representing tender premiums and other costs to redeem the 2011 Discount Notes and the write-off of net deferred loan costs associated with the redeemed 2011 Discount Notes. The accreted value of the remaining outstanding 2011 Discount Notes was approximately \$14.8 million as of September 30, 2011.

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Debt Covenants

Our 2010 credit facilities contain a number of covenants that, among other things, restrict, subject to certain exceptions, our ability, and the ability of our subsidiaries, to: sell assets; incur additional indebtedness or issue preferred stock; repay other indebtedness (including the 8.0% Notes and the 2011 Senior Notes); pay certain dividends and distributions or repurchase our capital stock; create liens on assets; make investments, loans or advances; make certain acquisitions; engage in mergers or consolidations; create a healthcare joint venture; engage in certain transactions with affiliates; amend certain material agreements governing our indebtedness, including the 8.0% Notes and the 2011 Senior Notes; change the business conducted by our subsidiaries; enter into certain hedging agreements; and make capital expenditures above specified levels. In addition, the 2010 credit facilities include a maximum consolidated leverage ratio and a minimum consolidated interest coverage ratio. The following table sets forth the leverage and interest coverage covenant tests as of September 30, 2011.

	Debt Covenant Ratio	Actual Ratio
Interest coverage ratio requirement	2.10x	3.69x
Total leverage ratio limit	5.95x	3.77x

Factors outside our control may make it difficult for us to comply with these covenants during future periods. These factors include a prolonged economic recession, a higher number of uninsured or underinsured patients and decreased governmental or managed care payer reimbursement, among others, any or all of which could negatively impact our results of operations and cash flows and cause us to violate one or more of these covenants. Violation of one or more of the covenants could result in an immediate call of the outstanding principal amount under our 2010 term loan facility or the necessity of lender waivers with more onerous terms including adverse pricing or repayment provisions or more restrictive covenants. A default under our 2010 credit facilities would also result in a default under the indenture governing our 8.0% Notes and the indentures governing the 2011 Senior Notes and 2011 Discount Notes.

Capital Resources

We anticipate spending a total of \$400.0 million to \$450.0 million in capital expenditures during fiscal 2012, including the \$63.4 million we spent during the three months ended September 30, 2011. We expect that cash on hand, cash generated from our operations and cash available to us under our 2010 credit facilities will be sufficient to meet our working capital needs, debt service requirements and planned capital expenditure programs during the next 12 months and into the foreseeable future, including those required by the DMC purchase agreement. Under the terms of the DMC acquisition agreement, we are required to spend at least \$80.0 million on expansion projects set forth in the agreement by December 31, 2011 as part of the \$500.0 million total commitment for specified capital projects. To the extent this commitment is not met, we will be required to deposit cash into an escrow fund restricted for the purpose of funding capital expenditures related to the specific project list. If required, the cash escrow funds would be used for DMC capital expenditures in the subsequent measurement period. The redeemable non-controlling interest in the Valley Baptist acquisition was issued to the seller as part of the acquisition and enables the seller to require us to redeem all or a portion of its 49% equity interest in the partnership on the third or fifth anniversary of the acquisition date at a stated redemption value. If the seller exercises this option, we may purchase the non-controlling interest with cash or by issuing stock. It is our intent to settle in cash, if the option is exercised. These potential cash outflows could limit our ability to fund our other operating needs, including acquisitions or other growth opportunities. We cannot assure you that our operations will generate sufficient cash or that cash on hand or additional future borrowings under our 2010 credit facilities will be available to enable us to meet all of our debt service and capital requirements, especially given the current general economic weakness.

We had \$154.7 million of cash and cash equivalents as of September 30, 2011. We rely on available cash, cash flows generated by operations and available borrowing capacity under our 2010 revolving facility to fund our operations and capital expenditures. We invest our cash in accounts in high-quality financial institutions. We continually explore various options to increase the return on our invested cash while preserving our principal cash balances. However, the significant majority of our cash and cash equivalents, deposits and investments are not federally-insured and could be at risk in the event of a collapse of those financial institutions.

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As of September 30, 2011, we held \$58.4 million in total available-for-sale investments in securities. The investments include approximately \$48.4 million in securities held within one of our wholly-owned captive insurance subsidiaries acquired in the DMC acquisition. Investments in securities also include approximately \$10.0 million in auction rate securities ("ARS") backed by student loans, which are included in long-term investments in securities on our consolidated balance sheet. Subsequent to September 30, 2011, the remaining \$10.0 million of ARS were redeemed for cash at par. Accordingly, as of September 30, 2011, we reversed the \$1.2 million temporary impairment previously included in accumulated other comprehensive income (loss).

We also intend to continue to pursue acquisitions or partnering arrangements, either in existing markets or new markets, which fit our growth strategies. To finance such transactions, we may increase borrowings under our 2010 term loan facility, issue additional senior or subordinated notes, draw upon cash on hand, utilize amounts available under our 2010 revolving facility or seek additional equity funding. We continually assess our capital needs and may seek additional financing, including debt or equity, as considered necessary to fund potential acquisitions, fund capital projects or for other corporate purposes. If additional equity or debt funding is not available to us, it is likely that we will have to make borrowings from time to time under our 2010 revolving credit facility to meet our working capital and capital expenditure needs. Our future operating performance, ability to service our debt and ability to draw upon other sources of capital will be subject to future economic conditions and other business factors, many of which are beyond our control.

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Obligations and Commitments

The following table reflects a summary of obligations and commitments outstanding, including both the principal and interest portions of long-term debt, with payment dates as of September 30, 2011.

	Payments due by period				Total
	Within 1 year	During Years 2-3	During Years 4-5	After 5 Years	
<i>(In millions)</i>					
Contractual Cash Obligations:					
Long-term debt (1)	\$ 201.0	\$ 396.0	\$ 1,147.7	\$ 1,733.7	\$ 3,478.4
Operating leases (2)	50.8	74.7	50.4	49.6	225.5
Purchase obligations (2)	94.5	—	—	—	94.5
Defined benefit pension plan funding (3)	26.5	62.5	60.0	48.4	197.4
Health plan claims and settlements payable (4)	119.5	—	—	—	119.5
Estimated self-insurance liabilities (5)	101.5	128.9	84.2	86.7	401.3
Subtotal	<u>\$ 593.8</u>	<u>\$ 662.1</u>	<u>\$ 1,342.3</u>	<u>\$ 1,918.4</u>	<u>\$ 4,516.6</u>
Other Commitments:					
Construction and capital improvements (6)	\$ 112.7	\$ 300.0	\$ 400.0	\$ —	\$ 812.7
Guarantees of surety bonds (7)	55.0	—	—	—	55.0
Letters of credit (8)	—	—	34.4	—	34.4
Physician commitments (9)	6.1	—	—	—	6.1
Estimated liability for uncertain tax positions (10)	8.7	—	—	—	8.7
Subtotal	<u>\$ 182.5</u>	<u>\$ 300.0</u>	<u>\$ 434.4</u>	<u>\$ —</u>	<u>\$ 916.9</u>
Total obligations and commitments	<u>\$ 776.3</u>	<u>\$ 962.1</u>	<u>\$ 1,776.7</u>	<u>\$ 1,918.4</u>	<u>\$ 5,433.5</u>

- (1) Includes both principal and interest payments. The interest portion of our debt outstanding at September 30, 2011 assumes an average interest rate of 8.0%.
- (2) These obligations are not reflected in our condensed consolidated balance sheets.
- (3) This obligation represents our estimated minimum required funding to the DMC Pension Plan trust. For additional information about the DMC Pension Plan and the expected future benefit payments from the trust see our Annual Report on Form 10-K, which was filed on August 25, 2011.
- (4) Represents health claims incurred by members of PHP, AAHP and MHP, including incurred but not reported claims, and net amounts payable for program settlements to AHCCCS and CMS for certain programs for which profitability is limited. Accrued health plan claims and settlements are separately stated on our condensed consolidated balance sheets.
- (5) Includes the current and long-term portions of our professional and general liability, workers' compensation and employee health reserves.
- (6) Represents our estimate of amounts we are committed to fund in future periods through executed agreements to complete projects included as property, plant and equipment on our condensed consolidated balance sheets. The construction and capital improvements obligations, adjusted to reflect capital commitments under the executed DMC purchase agreement (as previously discussed in our Annual Report on Form 10-K, which was filed August 25, 2011) include the following as of September 30, 2011: \$150.0 million committed within one year; \$300.0 million committed within two to three years and \$400.0 million committed within four to five years.
- (7) Represents performance bonds we have purchased related to health claims liabilities of PHP.
- (8) Amounts relate primarily to instances in which we have letters of credit outstanding with the third party administrator of our self-insured workers' compensation program. This amount was reduced from \$39.4 million at September 30, 2011, to \$34.4 million for a subsequent reduction to the outstanding letters of credit in October 2011.
- (9) Includes physician guarantee liabilities recognized in our condensed consolidated balance sheets under the guidance of accounting for guarantees and liabilities for other fixed expenses under physician relocation agreements not yet paid.
- (10) Represents expected future tax liabilities recognized in our condensed consolidated balance sheets determined under the guidance of accounting for income taxes.

Guarantees and Off Balance Sheet Arrangements

We are currently a party to certain rent shortfall agreements with certain unconsolidated entities. In the ordinary course of business we also enter into physician income guarantees, service agreement guarantees and other guarantee arrangements, including parent-subsidary guarantees. We have not engaged in any transaction or arrangement with an unconsolidated entity that is reasonably likely to materially affect liquidity.

We had standby letters of credit outstanding of \$39.4 million as of September 30, 2011, which primarily relate to security for the payment of claims as required by various insurance programs. This amount was reduced to \$34.4 million subsequent to September 30, 2011.

Concurrent with the closing of the DMC transaction, we placed into escrow for the benefit of DMC a warrant certificate representing warrants in respect of 400,000 shares of our common stock (the "Warrant Shares"). In May 2011, Vanguard replaced the Warrant Shares with a contingent unsecured subordinated promissory note payable to the legacy DMC entity in the principal amount of \$500.0 million to collateralize our \$500.0 million specified project capital commitment, such replacement permitted by the purchase agreement for the DMC acquisition. The principal amount of the promissory note is reduced as Vanguard expends capital or escrows cash related to this capital commitment.

Effects of Inflation and Changing Prices

Various federal, state and local laws have been enacted that, in certain cases, limit our ability to increase prices. Revenues for acute hospital services rendered to Medicare patients are established under the federal government's prospective payment system. We believe that hospital industry operating margins have been, and may continue to be, under significant pressure because of changes in payer mix and growth in operating expenses in excess of the increase in prospective payments under the Medicare program. In addition, as a result of increasing regulatory and competitive pressures, our ability to maintain operating margins through price increases to non-Medicare patients is limited.

Item 3. Quantitative and Qualitative Disclosures About Market Risk.

We are subject to market risk from exposure to changes in interest rates based on our financing, investing and cash management activities. As of September 30, 2011, we had in place \$1,064.9 million of senior credit facilities bearing interest at variable rates at specified margins above either the agent bank's alternate base rate or the LIBOR rate.

Our 2010 credit facilities consist of \$804.9 million in term loans maturing in January 2016 and a \$260.0 million revolving credit facility maturing in January 2015 (of which \$39.4 million of capacity was utilized by outstanding letters of credit as of September 30, 2011). Although changes in the alternate base rate or the LIBOR rate would affect the cost of funds borrowed in the future, we believe the effect, if any, of reasonably possible near-term changes in interest rates would not be material to our results of operations or cash flows. An estimated 0.25% change in the variable interest rate under our 2010 term loan facility would result in a change in annual net interest of approximately \$2.0 million.

Our \$260.0 million revolving credit facility bears interest at the alternate base rate plus a margin ranging from 2.25%-2.50% per annum or the LIBOR rate plus a margin ranging from 3.25%-3.50% per annum, in each case dependent upon our consolidated leverage ratio. Our \$804.9 million in outstanding term loans bears interest at the alternate base rate plus a margin of 2.50% per annum or the LIBOR rate (subject to a 1.50% floor) plus a margin of 3.50% per annum. We may request an incremental term loan facility to be added to our 2010 term loan facility in an unlimited amount, subject to receipt of commitments by existing lenders or other financing institutions and the satisfaction of certain other conditions. We may also seek to increase the borrowing availability under the 2010 revolving facility to an unlimited amount subject to the receipt of commitments by existing lenders or other financial institutions and the satisfaction of other conditions.

Item 4. Controls and Procedures.

Evaluation of Disclosure Control and Procedures

As of the end of the period covered by this report, our management conducted an evaluation, with the participation of our chief executive officer and chief financial officer, of the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the "Exchange Act")). Based on this evaluation, our chief executive officer and chief financial officer concluded that, as of such date, our disclosure controls and procedures were effective to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission's rules and forms and that such information is accumulated and communicated to management, including our chief executive officer and chief financial officer, as appropriate to allow timely decisions regarding required disclosure.

Changes in Internal Control Over Financial Reporting

We completed the acquisition of DMC effective January 1, 2011. The facilities acquired as part of the DMC acquisition utilize different information technology systems from our other facilities. We are currently integrating our internal control processes at DMC. In addition, we completed the acquisition of Valley Baptist effective September 1, 2011. The facilities acquired as part of the Valley Baptist acquisition utilize different information technology systems from our other facilities. We are currently evaluating the internal controls over financial reporting at Valley Baptist. We have excluded all of the DMC and Valley Baptist operations from our assessment of and conclusion on the effectiveness of our internal control over financial reporting. The Securities and Exchange Commission's rules require us to complete this process for each acquisition by the first anniversary of such acquisition. We plan to complete this evaluation and integration within the required time frame and report any changes in internal controls in our first annual report in which our assessment of the acquired hospitals and other operations is to be included. Other than the DMC and Valley Baptist acquisitions, there have been no changes in our internal control over financial reporting during the quarter ended September 30, 2011 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

**PART II
OTHER INFORMATION**

Item 1. Legal Proceedings

Because we provide healthcare services in a highly regulated industry, we have been, and expect to continue to be, party to various lawsuits, claims and regulatory proceedings from time to time. The ultimate resolution of these matters, individually or in the aggregate, whether as a result of litigation or settlement, could have a material adverse effect on our business (both in the near and long term), financial condition, results of operations or cash flows. For information regarding currently pending legal and regulatory proceedings, other than routine matters incidental to our business, we refer you to:

- Note 14. Contingencies and Healthcare Regulation in Part I, Item 1, of this report on Form 10-Q; and
- Part I, Item 3, Legal Proceedings, of our Annual Report on Form 10-K for the year ended June 30, 2011, filed with the Securities and Exchange Commission on August 25, 2011.

There have been no material changes to the legal proceedings we previously described in our Annual Report on Form 10-K during the three months ended September 30, 2011.

Item 1A. Risk Factors

There have not been any material changes to the risk factors previously disclosed in our Annual Report on Form 10-K for the fiscal year ended June 30, 2011, which was filed with the Securities and Exchange Commission on August 25, 2011.

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

The table below summarizes our repurchases of our common stock during the three months ended September 30, 2011.

Period	Total Number of Shares Purchased	Average Price Paid Per Share
July 1, 2011 - July 31, 2011	51,326	\$ 17.80
August 1, 2011 - August 31, 2011	250	13.97
September 1, 2011 - September 30, 2011	553	11.58
Total	52,129	\$ 17.71

- (a) The 52,129 shares purchased during the three months ended September 30, 2011 were acquired from employees in connection with net share settlement arrangements to settle income tax withholding and exercise price amounts due from employees under our stock incentive plans. These shares were not part of a publicly announced program to purchase our common stock.

Item 6. Exhibits.

The exhibits filed as part of this report on Form 10-Q are listed in the Exhibit Index that is located at the end of this report on Form 10-Q.

SIGNATURE

Pursuant to the requirements of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

DATE: November 3, 2011

VANGUARD HEALTH SYSTEMS, INC.

By: /s/ Gary D. Willis
Gary D. Willis
*Senior Vice President, Controller and
Chief Accounting Officer*
(Authorized Officer and
Chief Accounting Officer)

EXHIBIT INDEX

Exhibit No. Description

- 2.1 Asset Purchase Agreement, dated August 31, 2011, by and among Valley Baptist Health System, Valley Baptist Medical Center, Valley Baptist Medical Center — Brownsville, Valley Baptist Medical Development Corporation, VB Realty Corporation, VB Realty II, LLC, Valley Baptist Insurance Holdings, Inc., Valley Baptist Hospital Holdings, Inc., Valley Baptist Management Services Corporation, Valley Baptist Medical Foundation, VHS Valley Health System, LLC, VHS Harlingen Hospital Company, LLC, VHS Brownsville Hospital Company, LLC, VHS Valley Holdings, LLC, VHS Valley Real Estate Company, LLC, Vanguard Health Financial Company, LLC, VHS Valley Management Company, Inc. and Vanguard Health Systems, Inc.
- 10.1 Employment Agreement between Vanguard Health Systems, Inc. and James H. Spalding, dated as of September 1, 2011*
- 10.2 Form of Restricted Stock Unit Agreement (Performance Vesting RSU — EBITDA) for Vanguard Health Systems, Inc. 2011 Stock Incentive Plan*
- 10.3 Form of Restricted Stock Unit Agreement (Performance Vesting RSU — EPS) for Vanguard Health Systems, Inc. 2011 Stock Incentive Plan*
- 10.4 Form of Restricted Stock Unit Agreement (Time Vesting RSU) for Vanguard Health Systems, Inc. 2011 Stock Incentive Plan*
- 10.5 Form of Nonqualified Stock Option Agreement (Time Option) for Vanguard Health Systems, Inc. 2011 Stock Incentive Plan*
- 10.6 Contract Amendment Number 16, executed on September 9, 2011, but effective as of October 1, 2011, to the Arizona Health Care Cost Containment System Administration Contract No. YH09-0001-07 between VHS Phoenix Health Plan, LLC and the Arizona Health Care Cost Containment System
- 31.1 Certification of Chief Executive Officer pursuant to Rule 13a-14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
- 31.2 Certification of Chief Financial Officer pursuant to Rule 13a-14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
- 32.1 Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
- 32.2 Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
- 101 The following financial information from the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2011, formatted in Extensible Business Reporting Language (XBRL): (i) Condensed Consolidated Balance Sheets as of June 30, 2011 and September 30, 2011, (ii) Condensed Consolidated Statement of Operations for the three months ended September 30, 2011 and 2010, (iii) Condensed Consolidated Statements of Equity for the three months ended September 30, 2011, (iv) Condensed Consolidated Statement of Cash Flows for the three months ended September 30, 2011 and 2010, and (v) Notes to Condensed Consolidated Financial Statements (tagged as blocks of text). (1)

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- (1) In accordance with Rule 406T of Regulation S-T, the XBRL related information in Exhibit 101 to this Quarterly Report on Form 10-Q shall not be deemed to be "filed" for purposes of Sections 11 or 12 of the Securities Act or Section 18 of the Exchange Act, and otherwise is not subject to liability under these sections, and shall not be part of any registration statement or other document filed under the Securities Act or the Exchange Act, except as shall be expressly set forth by specific reference in such filing.

* Management compensatory plan or arrangement

ASSET PURCHASE AGREEMENT

This Asset Purchase Agreement, dated August 31, 2011, is among Valley Baptist Health System, a Texas non-profit corporation ("**VBHS**"), Valley Baptist Medical Center, a Texas non-profit corporation ("**VBMC**"), Valley Baptist Medical Center — Brownsville, a Texas non-profit corporation ("**VBMC-B**"), Valley Baptist Medical Development Corporation, a Texas non-profit corporation ("**VBMDC**"), VB Realty Corporation, a Texas corporation ("**VBRC**"), VB Realty II, LLC, a Texas limited liability company ("**VBRC II**"), Valley Baptist Insurance Holdings, Inc., a Texas corporation ("**VBIH**"), Valley Baptist Hospital Holdings, Inc., a Texas non-profit corporation ("**VBHH**"), and Valley Baptist Management Services Corporation, a Texas corporation ("**VBMSC**"; VBHS, VBMC, VBMC-B, VBMD, VBRC, VBRC II, VBIH, VBHH and VBMSC are sometimes referred to individually as a "**Seller**" or collectively as "**Seller**"), Valley Baptist Medical Foundation (the "**Foundation**"), VHS Valley Health System, LLC, a Delaware limited liability company ("**VHS²**"), VHS Harlingen Hospital Company, LLC, a Delaware limited liability company ("**VHS-H**"), VHS Brownsville Hospital Company, LLC, a Delaware limited liability company ("**VHS-B**"), VHS Valley Holdings, LLC, a Delaware limited liability company ("**Valley Holdings**"), VHS Valley Real Estate Company, LLC, a Delaware limited liability company ("**Valley Realty**"), Vanguard Health Financial Company, LLC, a Delaware limited liability company ("**VHFC**"; VHS², VHS-H, VHS-B, Valley Holdings, Valley Realty and VHFC are sometimes referred to individually as a "**Buyer**" and collectively as "**Buyer**"), VHS Valley Management Company, Inc., a Delaware corporation ("**VMC**"), and Vanguard Health Systems, Inc., a Delaware corporation ("**Vanguard**").

RECITALS:

WHEREAS, Seller owns and operates the Hospitals and owns, leases, manages or otherwise operates the other Hospital Businesses, all located in Harlingen and Brownsville, Texas;

WHEREAS, Seller desires to sell and Buyer desires to purchase substantially all of the assets, real, personal and mixed, tangible and intangible, owned by all Persons collectively constituting Seller and associated with or employed in the conduct of the Hospital Businesses, including the Hospitals and the other Hospital Businesses but excluding the Excluded Assets;

WHEREAS, Vanguard has formed VHS² for the purpose of serving as the parent company of VHS-H, VHS-B, Valley Holdings and Valley Realty;

WHEREAS, upon the Closing of the transactions contemplated by this agreement, VHS² will be owned 51% by VMC and 49% by VBMC-B;

WHEREAS, Seller has concluded that the transactions contemplated by this agreement are in its best interests and consistent with its charitable mission of the promotion of health to the communities served by the Hospitals;

NOW, THEREFORE, for and in consideration of the premises, and the agreements, covenants, representations and warranties hereinafter set forth, and other good and valuable consideration, the receipt and adequacy of which are forever acknowledged, the parties, intending to be legally bound, agree as follows:

AGREEMENT:

1. DEFINITIONS AND REFERENCES

1.01. Definitions. For purposes of this agreement, the following definitions apply:

(1) **Accounts Receivable** means all accounts receivable of the Hospital Businesses, accrued and unaccrued, including Government Payment Program receivables and accounts that have been written off, but excluding all Cost Report settlement amounts;

(2) **Accretive Contract** means that certain (undated) Accretive Health Service Agreement between Healthcare Services, Inc., d/b/a Accretive Health and Valley Baptist Hospital Holdings;

(3) **ADR** is defined in section 10.03;

(4) **Affiliate** means any Person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another Person where "control" means the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of securities, election or appointment of directors, by contract or otherwise;

(5) **Affiliated Group** means any affiliated group within the meaning of section 1504 of the Code or any similar group defined under a similar provision of state, local or foreign law;

(6) **Affirmative Election** is defined in section 5.19(b);

(7) **Agreed Value of VBIC** means \$8,820,000, *minus* the principal amount of all indebtedness required to be reflected on the liability side of a consolidated balance sheet of VBIC prepared in accordance with GAAP on the Closing Date;

(8) **Agreed Value of VBMC-B's Membership Interest in VHS²** means 49% of (i) the Cash Portion of the Base Purchase Price, *minus* (ii) \$175 million less (a) the net book value as of the Closing Date of any long-term indebtedness of Seller that Buyer assumes at Closing, including the Imaging Notes, and capitalized lease obligations of Seller pursuant to any Assumed Contract (including the current portions thereof), and (b) the agreed value as of Closing of any other liabilities or obligations described on Schedule 2.03, *plus* (iii) the amount of all Credited Expenses;

(9) **Amended and Restated Operating Agreement** means the amended and restated operating agreement of VHS Valley Health System, LLC, in the form attached as Exhibit A, with such changes thereto as are mutually acceptable to the parties;

(10) **Assets** means all assets, real property, personal and mixed property of every kind, character or description, known or unknown, tangible or intangible owned or leased by Seller wherever located and whether or not reflected in the Financial Statements or referenced or scheduled herein, (i) including those assets held or used in connection with Seller's operation of any of the Hospital Businesses, Seller's interest in the Joint Ventures and Transferring Subsidiaries and Seller's membership in the Non-Profit Corporations, but (ii) excluding the Excluded Assets;

(11) **Assumed Contracts** is defined in section 2.01(f);

(12) **Assumed Liabilities** means (i) the current liabilities set forth on the Closing Balance Sheets, (ii) all obligations of Seller arising under the Assumed Contracts with respect to periods (or portions thereof) commencing after the Closing Date, (iii) all paid time off accruals of the Hired Employees (other than Extended Illness Bank Obligations) and estimated Taxes thereon, (iv) the Extended Illness Bank Obligations, (v) Permitted Encumbrances, (vi) the Imaging Notes and (vii) the other liabilities and obligations, if any, described on Schedule 2.03; it being understood that the Assumed Liabilities described in clauses (i) and (iii) will be included in the calculation of Net Working Capital for purposes of calculating any Purchase Price Adjustment pursuant to section 2.05(e) and that the Assumed Liabilities described in clauses (vi) and (vii) will be included in the calculation of Cash Portion of the Base Purchase Price for purposes of calculating the Cash Proceeds Payable to Seller;

(13) **Attorney General** means the Office of the Attorney General of the State of Texas;

(14) **Audited Financial Statements** means the audited consolidated balance sheets of VBHS and its consolidated Subsidiaries as of August 31, 2009 and August 31, 2010, and the related consolidated statements of operations, of changes in net assets, and of cash flows for the fiscal years then ended, and the notes thereto and the report thereon of PriceWaterhouseCoopers LLP, independent certified public accountants;

(15) **Authorized Individuals** is defined in section 10.02;

(16) **Base Purchase Price** is defined in section 2.05(a);

(17) **BGCT** means the Baptist General Convention of Texas or any committee thereof duly authorized to take action with respect to approval of the matters contemplated by this agreement;

(18) **Buyer** is defined in the preamble;

(19) **Buyer Credit Agreement** means that certain credit agreement, dated as of the date hereof, by and between VHS² (as borrower) and VHFC (as lender) pursuant to which VHFC will make available to VHS² the respective credit facilities provided for therein;

(20) **Buyer Deductible** is defined in section 9.04(a);

(21) **Buyer's Indemnified Persons** means Buyer, Vanguard, Buyer's members and Subsidiaries, Vanguard's stockholders, Affiliates, successors and assigns, and their respective stockholders, members, partners, Affiliates, directors, trustees, officers, employees, agents and representatives (in each case, other than VBMC-B);

(22) **Buyer's Plan** means a retirement plan qualified under section 401(a) of the Code that is sponsored by Buyer or one of its controlled group or affiliated service group members, as defined in section 414 of the Code;

(23) **Cash Portion of the Base Purchase Price** means the Base Purchase Price *minus* (i) the net book value as of the Closing Date of any long-term indebtedness of Seller that Buyer assumes at Closing, including the Imaging Notes, and capitalized lease obligations of Seller pursuant to any Assumed Contract (including the current portions thereof) and *minus* (ii) the agreed value as of Closing of any other liabilities or obligations described on Schedule 2.03;

(24) **Cash Proceeds Payable to Seller** means the Cash Portion of the Base Purchase Price, *minus* the Agreed Value of VBMC-B's Membership Interest in VHS², *plus* the amount of net adjustment due Seller, if any, from prorations made pursuant to section 2.06 and *minus* the amount of net adjustment due Buyer, if any, from prorations made pursuant to section 2.06;

(25) **Chapter 132** means Chapter 132, *et seq.*, Career Schools and Colleges, of the Texas Education Code, and applicable rules and regulations promulgated thereunder;

(26) **Claim Notice** means written notification of a Third Party Claim by an Indemnitee to an Indemnifying Party under article 9, including a Third Party Claim set forth in a "Revenue Agent's Report," "Statutory Notice of Deficiency," "Notice of Proposed Assessment," or any other official written notice from a Taxing authority that Taxes are due or that a Tax audit will be conducted;

(27) **Closing** is defined in section 8.01(a);

(28) **Closing Balance Sheets** means the unaudited individual and combined balance sheets of the Hospital Businesses as of the close of business on the Closing Date, as finally determined in accordance with section 2.05 following the resolution of all disputes with respect thereto;

(29) **Closing Date** means the date upon which the Closing occurs;

(30) **Closing Document** means each instrument, agreement, certificate or other document executed or delivered, or required to be executed or delivered, by a party at Closing;

(31) **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended;

(32) **Code** means the Internal Revenue Code of 1986, as amended;

(33) **Contracts** means all commitments, contracts, leases, licenses, agreements and understandings, written or oral, relating to the Assets or the operation of the Hospital Businesses to which Seller or any Subsidiary of Seller is a party or by which it or any of the Assets are bound, including agreements with payers, physicians and other providers, agreements with health maintenance organizations, independent practice associations, preferred provider organizations and other managed care plans and alternative delivery systems, joint venture and partnership agreements, management, employment, retention and severance agreements, vendor agreements, real and personal property leases and schedules, maintenance agreements and schedules, agreements with municipalities and labor organizations, and bonds, mortgages and other loan agreements;

(34) **Controlled Group** means with respect to Seller, a group consisting of each trade or business (whether or not incorporated) that, together with such Seller, would be deemed a "single employer" within the meaning of section 4001(a)(14) of ERISA;

(35) **Cost Reports** means all cost and other reports filed pursuant to the requirements of the Government Payment Programs for payment or reimbursement of amounts due from them;

(36) **Credited Expenses** is defined in section 5.21(c);

(37) **Current Donations** is defined in section 5.28;

(38) **Current Seller Plan** is defined in section 3.22(a);

(39) **Direct Buyer Losses** is defined in section 9.02(c);

(40) **EBITDA** means earnings before interest, income Taxes, depreciation and amortization, the components of which shall be determined in accordance with generally accepted accounting principles consistently applied;

(41) **Election Period** is defined in section 5.19(b);

(42) **Employee Benefit Plan** means, with respect to any Person, (i) each plan, fund, program, agreement, arrangement or scheme, in each case, that is at any time sponsored or maintained or required to be sponsored or maintained by such Person or to which such Person makes or has made, or has or has had an obligation to make, contributions providing for employee benefits or for the remuneration, direct or indirect, of the employees, former employees, directors, officers, managers, consultants, independent contractors, contingent workers or leased employees of such Person or the dependents of any of them (whether written or oral), including each deferred compensation, bonus, incentive compensation, pension, retirement, stock purchase, stock option and other equity compensation plan, or "welfare" plan (within the meaning of section 3(1) of ERISA, determined without regard to whether such plan is subject to ERISA), (ii) each "pension" plan (within the meaning of section 3(2) of ERISA, determined without regard to whether such plan is subject to ERISA), including each Multiemployer Plan, (iii) each severance, retention or change in control plan or agreement, each plan or agreement providing health, vacation or paid time off, summer hours, supplemental unemployment benefit, hospitalization insurance, medical, dental, or legal benefit and (iv) each other employee benefit plan, fund, program, agreement or arrangement, including any of the foregoing that provides cash or non-cash benefits or perquisites to current or former employees of such Person;

(43) **Employee Pension Benefit Plan** is defined in section 3(2) of ERISA;

(44) **Employee Welfare Benefit Plan** is defined in section 3(1) of ERISA;

(45) **Encumbrances** means liabilities, levies, claims, charges, assessments, mortgages, security interests, liens, pledges, conditional sales agreements, title retention contracts, rights of first refusal, options to purchase and other encumbrances (including limitations on pledging or mortgaging any of the Assets) and Contracts to create in the future any such Encumbrance or suffer any of the foregoing;

(46) **End Date** is defined in section 8.04(a);

(47) **Environmental Claim** means any written notice (or oral notice reduced to writing by Seller) by a Person alleging potential liability (including potential liability for investigatory costs, cleanup costs, Governmental Authority response costs, natural resource damages, property damages, personal injuries, or penalties) of Seller or any Subsidiary of Seller arising out of, based on or resulting from (1) the presence, or release into the environment, of any Materials of Environmental Concern at any location, whether or not owned by Seller, or (2) circumstances forming the basis of any violation, or alleged violation, of any Environmental Laws;

(48) **Environmental Laws** means any and all Legal Requirements relating to pollution or protection of human health or the environment (including ground water, land surface or subsurface strata), including Legal Requirements relating to emissions, discharges, releases or threatened releases of Materials of Environmental Concern, or otherwise relating to the manufacture, processing, distribution, use, treatment, storage, disposal, transport, recycling, reporting or handling of Materials of Environmental Concern, including the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, 42 U.S.C. §9601, *et seq.*, the Resource Conservation and Recovery Act, as amended, 42 U.S.C. §6901, *et seq.*, the Clean Air Act, 42 U.S.C. §7401, *et seq.*, the Federal Water Pollution Control Act, 33 U.S.C. §1251 *et seq.*, the Occupational Safety and Health Act, 29 U.S.C. §600, *et seq.*, and any similar state or local Legal Requirements;

(49) **ERISA** means the Employee Retirement Income Security Act of 1974, as amended;

(50) **ERISA Fiduciary** is defined in section 3(21) of ERISA;

(51) **Essential Services** means those Hospital services described on Schedule 5.14;

(52) **Exchange Act** means the Securities Exchange Act of 1934, as amended;

(53) **Excluded Assets** is defined in section 2.02;

(54) **Excluded Liabilities** means any and all liabilities of Seller other than the Assumed Liabilities, whether known or unknown, fixed or contingent, recorded or unrecorded, and whether arising before or after Closing;

(55) **Extended Illness Bank Obligations** means the Hired Employees' accrued paid time off that is in the form of an "*extended illness bank*" (i.e., paid time off that may be used by a Hired Employee during the term of employment, but the value of the unused portion of which is not paid in cash to the Hired Employee upon termination of employment);

(56) **Financial Statements** means the Audited Financial Statements and the Unaudited Financial Statements;

(57) **Foundation** is defined in the preamble;

(58) **Governmental Authority** means any executive, legislative or judicial agency, authority, board, body, commission, court, department, instrumentality or office of any federal, state, city, county, district, municipality, foreign or other government or quasi-government unit or political subdivision;

(59) **Government Payment Programs** means federal and state Medicare, Medicaid and TRICARE programs, and similar or successor programs with or for the benefit of Governmental Authorities;

(60) **Hill-Burton Act** means the Public Health Service Act, 42 U.S.C. §291, *et seq.*;

(61) **Hired Employees** means (i) those employees of Seller who accept Buyer's offer of employment as of the Closing Date and (ii) those employees of Seller employed under written Assumed Contracts;

(62) **HMC Partnerships** means Harlingen Medical Center, Limited Partnership and HMC Realty, LLC;

(63) **Hospital** means each of Valley Baptist Medical Center, Harlingen, Texas, and Valley Baptist Medical Center — Brownsville, Brownsville, Texas;

(64) **Hospital Businesses** means all businesses, assets and properties owned, leased or otherwise operated or conducted by Seller and its consolidated Subsidiaries, including the business of the Hospitals and all outpatient facilities, physician practices, medical office buildings, insurance companies, parking facilities and other related businesses;

(65) **HSR Act** means the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended;

(66) **Imaging Notes** means those certain promissory notes made by VBMC in favor of Valley Radiologists and Associates Investment Group in connection with the purchase of the assets of the Imaging Partnerships;

(67) **Imaging Partnerships** means North Brownsville Imaging Center, L.P. and Treasure Hills Imaging Limited Partnership;

(68) **Immaterial Contract** means any Contract to which Seller is a party that requires either the payment by Seller of \$50,000 or less or the provision of goods or the performance of services by Seller having a value of \$50,000 or less, in either case during the period from the date of this agreement until (i) if the Contract is terminable at any time by Seller without cause upon notice of 90 days or less, the date on which the Contract would terminate if Seller were to give notice of termination on the date of this agreement, or (ii) if the Contract is not terminable at any time by Seller without cause upon notice of 90 days or less, the expiration of the term of the Contract, *provided* that an Immaterial Contract does not include any Contract described in sections 3.18(a) through 3.18(j);

(69) **Immediate Family Member** means any individual described in the definition of "*Immediate Family Member*" found at 42 C.F.R. §411.351;

(70) **Indemnifying Party** means any Person obligated to indemnify another Person under article 9;

(71) **Indemnitee** means any Person entitled to indemnification under article 9;

(72) **Indemnity Notice** means written notification of a claim for indemnity under article 9, other than a Third Party Claim, made by an Indemnitee to an Indemnifying Party pursuant to section 9.05(b);

(73) **Indenture** is defined in section 6.05;

(74) **Information Systems** means the software (including object and source codes as applicable), hardware, application programs and similar systems owned, licensed or leased by Seller and used in the ownership or operation of the Hospital Businesses, whether or not on a system-wide basis;

(75) **Initiating Party** is defined in section 10.02;

(76) **Insurance Approvals** is defined in section 5.31;

(77) **Intellectual Properties** means (i) all inventions (whether or not patentable or reduced to practice), all improvements thereto, and all patents, patent applications, and patent disclosures, together with all reissuances, continuations, continuations-in-part, revisions, extensions, and reexaminations thereof, (ii) all trademarks, service marks, trade dress, logos, trade names, corporate names, and domain names, including all goodwill associated therewith, and all applications, registrations, and renewals in connection therewith, (iii) all copyrightable works, all copyrights, and all applications, registrations, and renewals in connection therewith, and (iv) all trade secrets and confidential business information (including ideas, research and development, know-how, formulas, compositions, manufacturing and production processes and techniques, technical data, designs, drawings, specifications, customer and supplier lists, pricing and cost information, and business and marketing plans and proposals) that are owned, licensed or leased by Seller and used in the ownership or operation of the Hospital Businesses together with all rights to sue or make any claims for any past, present, or future infringement, misappropriation or unauthorized use of any of the foregoing rights and the right to all income, royalties, damages and other payments that are now or may hereafter become due or payable with respect to any of the foregoing rights, including without limitation damages for past, present or future infringement, misappropriation or unauthorized use thereof;

(78) **Interim Closing Balance Sheets** means the unaudited individual and combined balance sheets of the Hospital Businesses as of the most recent month end available before the Closing;

(79) **Interim Period** is defined in section 5.33;

(80) **Investments** means shares of capital stock of any corporation, equity interests in partnerships or limited liability companies, or other equity or debt instruments in any other Person, and proceeds from the sale thereof;

(81) **Joint Ventures** means Odyssey HealthCare of South Texas, LLC, Amedisys Valley Texas, LLC, Churchill Dialysis, LLC, VBOA ASC Partners, L.P., Valley Cancer Center Investors, LLC, Harlingen LTACH Real Estate, Ltd., Golden Palms Realty Company, LLC, Golden Palms Operating Company, LLC, and Solara Hospital Harlingen, L.P.;

(82) **Leased Real Property** means the real property described on Schedule 2.01(b), together with all buildings, improvements and fixtures thereon owned or leased by Seller or any Subsidiary of Seller;

(83) **Legal Requirements** means, with respect to any Person, all statutes, laws, ordinances, codes, rules, regulations, restrictions, orders, judgments, rulings, writs, injunctions, decrees, determinations or awards of any Governmental Authority having jurisdiction over such Person or any of such Person's assets or businesses;

(84) **Letter Agreement** is defined in section 11.19(a);

(85) **Losses** means any and all damages, costs, losses (including any diminution in value), liabilities, expenses or obligations (including Taxes, interest, penalties, court costs, costs of preparation and investigation, and attorneys', accountants' and other professional advisors' fees and expenses);

(86) **LVN School** means the school that is currently owned and operated by VBMC to train, teach and prepare students to take the National Council Licensure Examination for Practical/Vocational Nurses (the NCLEX-PN[®] exam) for licensure as vocational nurses;

(87) **Management Services Agreement** means the management services agreement, in the form attached as Exhibit B (with such changes thereto as are mutually acceptable to the Seller and Buyer), pursuant to which an Affiliate of Buyer shall agree to provide certain financial, technical, managerial, and administrative support services for the Hospital Businesses and Buyer, including management of the day-to-day operations of the Hospital Businesses for an annual management fee described therein;

(88) **Material Adverse Change** means a material adverse change, individually or in the aggregate, on the business, assets, liabilities, financial condition, results of operations or prospects of Seller and the Hospital Businesses, taken as a whole, but excluding the effect of (i) matters described in the Schedules, (ii) changes in the economy of the United States in general, and (iii) changes in Legal Requirements generally applicable to owners and operators of general acute care hospitals in the United States or in Texas if such change does not disproportionately affect Seller or the Hospital Businesses;

(89) **Materials of Environmental Concern** means chemicals, pollutants, contaminants, wastes (including medical waste), toxic substances, petroleum and petroleum products, including hazardous wastes under the Resource Conservation and Recovery Act, as amended, 42 U.S.C. §6901, *et seq.*, hazardous substances under the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, 42 U.S.C. §9601, *et seq.*, asbestos, polychlorinated biphenyls and urea formaldehyde, and low-level nuclear materials, special nuclear materials or nuclear-byproduct materials, all within the meaning of the Atomic Energy Act of 1954, as amended, and any rules, regulations or policies promulgated thereunder;

(90) **Medical Waste** means any waste generated in the diagnosis, treatment or immunization of human beings, in research pertaining thereto, or in the production or testing of biologicals, including (i) pathological waste, (ii) blood, (iii) sharps, (iv) wastes from surgery or autopsy, (v) dialysis waste, including contaminated disposable equipment and supplies, (vi) cultures and stocks of infectious agents and associated biological agents, (vii) isolation wastes, (viii) contaminated equipment, (ix) laboratory waste, (x) various other biological waste and discarded materials contaminated with or exposed to blood, excretion, or secretions from human beings, and (xi) any substance, pollutant, material or contaminant listed or regulated under the Medical Waste Tracking Act of 1988, 42 U.S.C. §6992, *et seq.* or under the Medical Waste Law of any State;

(91) **Medical Waste Law** means the Medical Waste Tracking Act of 1988, 42 U.S.C. §6992, *et seq.*, the U.S. Public Vessel Medical Waste Anti-Dumping Act of 1988, 33 U.S.C. §2501, *et seq.*, the Marine Protection, Research, and Sanctuaries Act of 1972, 33 U.S.C. §1401, *et seq.*, The Occupational Safety and Health Act, 29 U.S.C. §651, *et seq.*, the United States Department of Health and Human Services, National Institute for Occupational Self-Safety and Health Infectious Waste Disposal Guidelines, Publication No. 88-119, and any other federal, state, regional, county, municipal, or other local laws, regulations, and ordinances insofar as they purport to regulate Medical Waste, or impose requirements relating to Medical Waste;

(92) **Merger** is defined in section 2.08;

(93) **Multiemployer Plan** is defined in section 3(37) of ERISA or section 4001(a)(3) of ERISA;

(94) **Multiple Employer Plan** means an Employee Pension Benefit Plan that is not a Multiemployer Plan and for which a Person who is not a member of a Controlled Group that includes Seller or any Subsidiary is or has been a contributing sponsor;

(95) **Net Working Capital** means the amount by which the value of (i) inventory and supplies, patient accounts receivable, other receivables, prepaid expenses and deposits (including security deposits made by Seller pursuant to Assumed Contracts) that Buyer reasonably determines will be usable after Closing, exceeds (ii) trade accounts payable, accrued expenses and employee benefit accruals (as such terms are used in the Unaudited Financial Statements), but excluding from such calculation Excluded Assets, Excluded Liabilities and any of the foregoing values attributable to VBIC (for the purpose of clarity, employee benefit accruals include paid time off accruals but exclude Extended Illness Bank Obligations);

(96) **Neutral** is defined in section 10.04;

(97) **Non-Profit Corporations** means Harlingen Physician Network, Inc., Valley Health Care Network and Rio Grande Valley Indigent Health Care Corporation;

(98) **Notice Period** is defined in section 9.05(a)(i);

(99) **Offer** means a *bona fide* written offer pursuant to which a Person that is not an Affiliate of Vanguard would purchase all, but not less than all, of the equity interest in VHS² and VBIC (or either of them) then owned, directly or indirectly, by Vanguard and its consolidated Subsidiaries for the consideration and upon the other terms and conditions set forth in such offer;

(100) **Owned Real Property** means real property owned (legally or beneficially) by Seller or any Subsidiary of Seller, including the real property described on Schedule 2.01(a), together with all buildings, improvements and fixtures thereon owned by Seller or any Subsidiary of Seller and all appurtenances and rights thereto, but excluding the real property described on Schedule 2.02(b);

(101) **PBGC** means the Pension Benefit Guaranty Corporation;

(102) **Permit** means each license, permit, right, franchise, concession, certificate, consent or other approval of a Governmental Authority owned or held by Seller relating to the ownership or operations of the Hospital Businesses and the Assets, including applications for, and pending, Permits;

(103) **Permitted Encumbrances** means the Permitted Personal Property Encumbrances and the Permitted Real Property Encumbrances;

(104) **Permitted Personal Property Encumbrances** means those Encumbrances described on Schedule 3.11 as being Permitted Personal Property Encumbrances;

(105) **Permitted Real Property Encumbrances** means those Encumbrances identified on Schedule 3.12(a) as being Permitted Real Property Encumbrances;

(106) **Person** means any individual, corporation (whether for-profit or not-for-profit), limited liability company, association, partnership, firm, joint venture, trust, trustee or other entity or organization, including a Governmental Authority;

(107) **Principal Credit Agreement** means the Credit Agreement, dated as of January 29, 2010 (as amended, modified, restated, and/or supplemented from time to time), between Vanguard Health Holding Company I, LLC, Vanguard Health Holding Company II, LLC, the lenders from time to time party thereto, Bank of America, N.A., as Administrative Agent and as Collateral Agent, and the other parties thereto, providing for the making of loans to, and the issuance of, and participation in, letters of credit for the account of the borrower thereunder, and any credit agreement or credit facility that replaces the foregoing agreement;

(108) **Prior Donations** is defined in section 5.28;

(109) **Prior Seller Plan** is defined in section 3.22(b);

(110) **Proceeding** means any action, arbitration, audit, hearing, investigation, litigation, suit or other proceeding (whether civil, criminal, administrative, judicial or investigative, whether formal or informal, whether public or private) commenced, brought, conducted, heard or held by, before, under the authority or at the direction of any Governmental Authority;

(111) **Prohibited Transaction** is defined in section 5.07;

(112) **Purchase Price** means the Base Purchase Price and 80% of the Agreed Value of VBIC, all as more particularly set forth in section 2.05(a);

(113) **Purchase Price Adjustment** is defined in section 2.05(e);

(114) **RAHC** is defined in section 5.17;

(115) **Reportable Event** is defined in section 4043 of ERISA;

(116) **Responding Party** is defined in section 10.02;

(117) **Rio Grande Valley Market** is defined in section 5.08;

(118) **Schedules** means the schedules referred to in this agreement and attached hereto at the time that this agreement is executed by each original party hereto;

(119) **Section 338 Asset Allocation Schedule** is defined in section 5.30;

(120) **Section 338(h)(10) Election** is defined in section 5.30;

(121) **Seller** is defined in the preamble;

(122) **Seller Deductible** is defined in section 9.02(a);

(123) **Seller's Indemnified Persons** means Seller and Seller's members, stockholders, Affiliates, successors and assigns, and their respective members, directors, trustees, officers, employees, agents and representatives;

(124) **Subject Interest** is defined in section 5.19(b);

(125) **Submission Date** is defined in section 10.03;

(126) **Subsidiary** means, with respect to any Person, (i) any corporation more than 50% of whose stock of any class or classes having by the terms thereof ordinary voting power to elect a majority of the directors of such corporation (irrespective of whether or not at the time stock of any class or classes of such corporation shall have or might have voting power by reason of the happening of any contingency) is at the time owned by such Person and/or one or more Subsidiaries of such Person, (ii) any partnership, limited liability company, association, joint venture or other entity in which such Person and/or one or more Subsidiaries of such Person has more than a 50% equity interest at the time and the management of which is controlled, directly or indirectly, by such Person or through one or more Subsidiaries of such Person and (iii) any entity that is organized as a not-for-profit business organization and (A) whose accounts are required in accordance with generally accepted accounting principles to be consolidated with the accounts of such Person or (B) whose sole member is such Person;

(127) **Tax** means any income, unrelated business income, gross receipts, license, payroll, employment, excise, severance, occupation, privilege, premium, net worth, windfall profits, environmental (including taxes under section 59A of the Code), customs duties, capital stock, franchise, profits, withholding, social security, unemployment, disability, real property, personal property, recording, stamp, sales, use, services, service use, transfer, registration, escheat, unclaimed property, value added, alternative or add-on minimum, estimated or other tax, assessment, charge, levy or fee of any kind whatsoever, including payments or services in lieu of Taxes, interest or penalties on and additions to all of the foregoing, that are due or alleged to be due to any Governmental Authority, whether disputed or not;

(128) **Tax Return** means any return, declaration, report, claim for refund, information return, filing obligation of any Code section 501(c)(3) organization, or statement, including schedules and attachments thereto and amendments, relating to Taxes;

(129) **Third Party Claim** is defined in section 9.05(a)(i);

(130) **Title Representations** means the representations and warranties of Seller set forth in (i) the last sentence of section 3.11 and (ii) the last sentence of section 3.12(a);

(131) **Transferring Subsidiaries** means Valley Baptist Wellness Center, LLC, VBOA ASC GP, LLC, VB Brownsville IMP ASC, LLC, VBIC, VBRC II, Valley Baptist Lab Services, LLC, and VB Brownsville LTACH, LLC;

(132) **TWC** means the Texas Workforce Commission, an agency of the State of Texas;

(133) **Unaudited Financial Statements** means the unaudited consolidated balance sheets of VBHS and its consolidated Subsidiaries as of December 31, 2010, and the unaudited consolidated statements of operations and changes in net assets and the unaudited consolidated statements of cash flows for the four-month period then ended, and the financial statements described in clauses (i) and (ii) of section 5.04(b);

(134) **UT** is defined in section 5.17;

(135) **Valley Holdings** is defined in the preamble;

(136) **Valley Realty** is defined in the preamble;

(137) **Vanguard** is defined in the preamble;

(138) **VBHH** is defined in the preamble;

(139) **VBHS** is defined in the preamble;

(140) **VBIC** means Valley Baptist Insurance Company, an insurance company organized under the laws of the State of Texas;

(141) **VBIC Purchase Price** is defined in section 2.05(a);

(142) **VBIC Shareholders Agreement** means the shareholder and voting agreement in the form attached as Exhibit C, with such changes thereto as are mutually acceptable to the parties;

(143) **VBIC Shares** means shares of VBIC common stock, par value \$1.00 per share, representing 80% of all issued and outstanding shares of capital stock of VBIC;

(144) **VBIC's Net Worth** means the total assets of VBIC minus the total liabilities of VBIC, all as shown on the Closing Balance Sheets and Interim Closing Balance Sheets;

- (145) **VBH** is defined in the preamble;
- (146) **VBMC** is defined in the preamble;
- (147) **VBMC-B** is defined in the preamble;
- (148) **VBMD** is defined in the preamble;
- (149) **VBMSC** is defined in the preamble;
- (150) **VBRC** is defined in the preamble;
- (151) **VBRC II** is defined in the preamble;
- (152) **VHFC** is defined in the preamble;
- (153) **VHS²** is defined in the preamble;
- (154) **VHS-B** is defined in the preamble;
- (155) **VHS-H** is defined in the preamble; and
- (156) **VMC** is defined in the preamble;
- (157) **WARN Act** means the Worker Adjustment and Retraining Notification Act, 29 U.S.C. §2101, *et seq.*

1.02. Certain References. As used in this agreement:

- (a) references to "*this agreement*" mean this agreement, as amended from time to time, and all exhibits and schedules attached to or referenced in this agreement;
- (b) references to "*articles*" or "*sections*" are references to articles and sections of this agreement, unless the context states or implies otherwise;
- (c) references to "*include*" or "*including*" mean including without limitation and are intended to be illustrative and not restrictive of the word or phrase to which they refer;
- (d) references to "*partners*" include general and limited partners of partnerships and members of limited liability companies;
- (e) references to "*partnerships*" include general and limited partnerships, joint ventures and limited liability companies;
- (f) references to any document are references to that document as amended, consolidated, supplemented, novated or replaced by the parties thereto;

(g) references to any law are references to that law as amended, consolidated, supplemented or replaced, and all rules and regulations promulgated thereunder;

(h) references to time are references to Harlingen, Texas time;

(i) references to "*Seller's knowledge*" mean the actual knowledge of each of the Persons whose names or titles are set forth on Schedule 1.02, after due inquiry by Seller of such Persons, but no further inquiry by such Persons;

(j) the gender of all words includes the masculine, feminine and neuter, and the number of all words includes the singular and plural; and

(k) the Table of Contents, the division of this agreement into articles and sections, and the use of captions and headings in connection therewith are solely for convenience and have no legal effect in construing this agreement.

2. SALE OF ASSETS AND RELATED MATTERS

2.01. Sale of Assets. Subject to the terms and conditions of this agreement, at Closing, Seller shall sell, and Buyer shall purchase, all right, title and interest of Seller in and to the Assets, free and clear of all Encumbrances other than the Permitted Encumbrances, including the following Assets:

(a) the Owned Real Property described on Schedule 2.01(a);

(b) the Leased Real Property described on Schedule 2.01(b);

(c) all equipment (including medical and computer equipment at the Hospital Businesses), vehicles, furniture and furnishings and other tangible personal properties owned by Seller or used in the conduct of the Hospital Businesses;

(d) all current assets included in Net Working Capital;

(e) all financial, patient, medical staff, personnel and other records of the Hospital Businesses (including equipment records, medical/administrative libraries, medical records, documents, catalogs, books, records, files and operating manuals);

(f) the Contracts listed or described on Schedule 2.01(f), the leases relating to the Leased Real Property listed or described on Schedule 2.01(b), and all Immaterial Contracts not listed or described on Schedule 2.02(i) (all such Contracts, collectively, the "**Assumed Contracts**");

(g) all Permits of Seller, to the extent legally assignable, relating to the ownership of the Assets and the conduct of the Hospital Businesses, including those described on Schedule 2.01(g);

(h) the Intellectual Properties, including those Intellectual Properties described on Schedule 2.01(h), and the Information Systems;

- (i) all property of Seller, real, personal or mixed, tangible or intangible, arising or acquired between the date of this agreement and the Closing Date;
- (j) the Investment interests in the Joint Ventures and the Transferring Subsidiaries (other than VBIC) and the membership interests in the Non-Profit Corporations, in each case including all transferable rights relating thereto;
- (k) the VBIC Shares;
- (l) subject to section 5.12(a), all insurance proceeds with respect to the Assets or the Assumed Liabilities (including insurance proceeds received by Seller or payable to Seller and all deductibles, copayments and self-insurance requirements payable by Seller) arising in connection with damage to the Assets occurring on or prior to the Closing Date, to the extent not expended for the repair or restoration of the Assets;
- (m) claims of Seller against third parties relating to the Assets or the Assumed Liabilities, choate or inchoate, known or unknown, contingent or otherwise, but excluding the Proceedings described on Schedule 3.23 and any other such claims relating to Excluded Assets or the Excluded Liabilities;
- (n) general intangibles of the Hospital Businesses, including goodwill;
- (o) Seller's provider agreements with Government Payment Programs; and
- (p) all proceeds of the foregoing and, except for the Excluded Assets, all other property of every kind, character or description, tangible and intangible, known or unknown, owned or leased by Seller, wherever located and whether or not reflected in the Financial Statements or similar to the properties described above.

2.02. Excluded Assets. Notwithstanding the generality of the definition of Assets and of the examples of Assets listed in section 2.01, the following assets (the "**Excluded Assets**") are not a part of the sale and purchase contemplated by this agreement and are excluded from the Assets, and Seller shall retain all of its right, title and interest therein and thereto from and after the Closing:

- (a) any financial, patient, medical staff, personnel and other records of the Hospital Businesses that Seller cannot transfer to Buyer due to applicable Legal Requirements by which Seller is bound;
- (b) the real property described on Schedule 2.02(b);
- (c) all cash, bank accounts, certificates of deposit, treasury bills, treasury notes, marketable securities and other cash equivalents (including the Cash Proceeds Payable to Seller and any Purchase Price Adjustment payable to Seller);
- (d) inventory and supplies disposed of or exhausted after the date of this agreement and on or before the Closing Date in the ordinary course of the Hospital Businesses, and Assets transferred or disposed of in accordance with section 5.02(e);

- (e) Cost Report settlement receivables and all appeals and appeal rights relating thereto;
- (f) all funds held by trustees pursuant to bond indentures of Seller (including the Indenture);
- (g) all deductions, benefits, claims, refunds, receivables and other rights of Seller relating to Taxes in respect of periods ending on or before the Closing Date or resulting from the consummation of the transactions contemplated by this agreement;
- (h) all other current financial assets not included in Net Working Capital;
- (i) all Immaterial Contracts that are listed or described on Schedule 2.02(i) and all other Contracts that are not Assumed Contracts (including this agreement and the Closing Documents);
- (j) all Permits to the extent not legally assignable to Buyer or not relating to the ownership of the Assets and the conduct of the Hospital Businesses;
- (k) the corporate or trade names set forth on Schedule 2.02(k) and all Intellectual Property rights relating thereto;
- (l) twenty percent (20%) of the issued and outstanding capital stock of VBIC;
- (m) all Investment interests in any Person other than the Transferring Subsidiaries and the Joint Ventures, and all interests in any entity that is organized as a not-for-profit business organization other than the Non-Profit Corporations, including all Investment interests (and all other interests with respect to a not-for-profit business organization) in each other Seller, the Foundation, Golden Palms Retirement & Health Center and, subject to section 5.20, the HMC Partnerships, and all minute books, stock transfer ledgers, financial records, Tax records and other books and records relating to the operation, ownership and corporate governance of each such Person;
- (n) all physician loans and receivables;
- (o) all right, title and interest of the Foundation in and to its assets and properties (whether owned, leased or otherwise) described on Schedule 2.02(o);
- (p) all insurance proceeds received by Seller or payable to Seller (i) with respect to other Excluded Assets or the Excluded Liabilities or (ii) that Seller is entitled to retain pursuant to section 5.12(a);
- (q) the Proceedings described on Schedule 3.23 and all rights, remedies, claims and defenses against third parties thereunder or otherwise relating solely to the Excluded Assets or to the Excluded Liabilities, whether choate or inchoate, known or unknown, contingent or otherwise;

- (r) any monies payable to Seller from Cardinal Health, Inc. or its Affiliates under terminated Contracts with such Persons;
 - (s) any other assets identified on Schedule 2.02(s) or excluded after the execution of this agreement by mutual written agreement of the parties;
- and
- (t) all proceeds of the foregoing.

2.03. Assumed Liabilities. As of the Closing Date, Buyer shall assume from Seller the Assumed Liabilities, including the Assumed Liabilities described on Schedule 2.03.

2.04. Excluded Liabilities. Notwithstanding anything to the contrary set forth in this agreement, under no circumstance will Buyer assume or be obligated to pay, and from and after the Closing, none of the Assets will be or become liable for or subject to any of the Excluded Liabilities, including the following, which Excluded Liabilities are and will remain liabilities of Seller:

- (a) all liabilities accrued on the Closing Balance Sheets, other than those included in Net Working Capital or VBIC's Net Worth, and other than capitalized lease obligations constituting Assumed Contracts;
- (b) liabilities or obligations for Taxes of the Hospital Businesses in respect of periods ending on or before the Closing Date or resulting from the consummation of the transactions contemplated by this agreement (other than real estate transfer Taxes and sales and use Taxes arising out of the transfer of the Assets, which shall be paid by Buyer as a Credited Expense);
- (c) liabilities or obligations for federal or state income Taxes of Seller or any Subsidiary or Affiliate of Seller, including amounts for which any Transferring Subsidiary, including VBIC, may be liable as a result of being a member of a consolidated, affiliated, combined, unitary or similar group that includes such other Persons;
- (d) liabilities or obligations relating to the Excluded Assets;
- (e) liabilities or obligations associated with indebtedness for borrowed money (other than capital lease obligations under any Assumed Contract);
- (f) (i) obligations required to be performed by Seller on or before the Closing Date under the Assumed Contracts, (ii) liabilities or obligations resulting from a breach or default on or before the Closing Date of any Assumed Contracts and (iii) liabilities arising under any Contracts that are not Assumed Contracts;
- (g) liabilities or obligations arising out of or in connection with the Proceedings described on Schedule 3.23, and Proceedings and claims (whether instituted before or after Closing) relating to acts or omissions that allegedly occurred on or before the Closing Date, including those relating to peer review activities;

(h) liabilities or obligations under the Hill-Burton Act or other restricted grant or loan programs;

(i) except for paid time off accruals of the Hired Employees and Extended Illness Bank Obligations, and obligations under Assumed Contracts, liabilities and obligations to Seller's employees, Employee Benefit Plans, the Internal Revenue Service, PBGC or any other Governmental Authority arising from or relating to periods before Closing (whether or not triggered by the transactions contemplated by this agreement and whether or not imposed by Legal Requirements directly on Buyer as the transferee of the Assets or successor to the Hospital Businesses), including liabilities or obligations arising under any Employee Benefit Plan, severance pay program or arrangement, EEOC claim, unfair labor practice, and wage and hour practice, and liabilities or obligations arising under the WARN Act, as a result of acts of Seller before Closing;

(j) Cost Report settlement payables relating to all Cost Report periods ending on or before the Closing Date;

(k) liabilities or obligations of Seller in respect of periods ending on or before the Closing Date, or resulting from the consummation of the transactions contemplated by this agreement, under third-party payor programs and Government Payment Programs, including recoupment rights of the Centers for Medicare & Medicaid Services or the Texas Department of State Health Services and recapture of previously reimbursed charges or expenses;

(l) liabilities or obligations owed to Cardinal Health, Inc. or any of its Affiliates under terminated Contracts with such Persons;

(m) liabilities or obligations arising under the Accretive Contract and relating to events or periods on or prior to the Closing Date; and

(n) penalties, fines, settlements, interest, costs and expenses arising out of or incurred as a result of any actual or alleged violation by Seller of any Legal Requirement.

2.05. Purchase Price; Purchase Price Adjustment.

(a) Subject to the terms and conditions of this agreement, in reliance upon the representations and covenants of Seller in this agreement, and as consideration for the sale of the Assets and the Hospital Businesses, Buyer shall assume the Assumed Liabilities from Seller, tender to Seller the Cash Proceeds Payable to Seller (in the manner provided in section 2.05(d)), and issue to VBMC-B a 49% membership interest in VHS². For purposes of calculating the Cash Portion of the Base Purchase Price and the Cash Proceeds Payable to Seller, "**Base Purchase Price**" means:

- (i) \$273,039,215, *minus*
- (ii) the Agreed Value of VBIC, *plus*

- (iii) the amount, if any, by which Net Working Capital on the Closing Balance Sheets exceeds \$45,100,000, or *minus*
- (iv) the amount, if any, by which Net Working Capital on the Closing Balance Sheets is less than \$45,100,000.

In addition to the Cash Proceeds Payable to Seller, Buyer shall pay to VBIH an amount (the "**VBIC Purchase Price**") equal to 80% of:

- (i) the Agreed Value of VBIC, *plus*
- (ii) the amount, if any, by which VBIC's Net Worth on the Closing Balance Sheets exceeds, \$4,600,000, or *minus*
- (iii) the amount, if any, by which VBIC's Net Worth on the Closing Balance Sheets is less than \$4,600,000.

(b) The portion of Net Working Capital constituting the value of inventory and supplies will be determined based on a physical count conducted by Seller on a date not more than five business days before the Closing Date. Seller shall give Buyer at least five business days' prior notice of the date of the count and permit Buyer to monitor the count. Seller shall count the usable items of inventory and supplies that are not damaged or obsolete, and that are of a type, quality and quantity that may be used in the ordinary course of the Hospital Businesses (having due regard for the services offered by the Hospital Businesses). Seller will conduct the count in the same manner that Seller conducted the count of, and will count the same classes and categories of items that Seller counted to determine the value of, inventory and supplies in the most recent Audited Financial Statements. Upon completion of the count, Seller shall determine the value of the inventory and supplies (determined by the lower of cost or market on a first in, first out basis). If the results of the count and the resulting value of inventory and supplies are available by Closing, then the portion of Net Working Capital attributable to inventory and supplies will be the value determined pursuant to the count (updated for actual usage and purchases between the date of the count and the Closing Date). If the results of the count or the resulting value of inventory and supplies are not available by Closing, then for purposes of the Closing the value of the inventory and supplies will be the amount set forth in the Interim Closing Balance Sheets and the value of the inventory and supplies determined pursuant to the count (updated for actual usage and purchases between the date of the count and the Closing Date) will be set forth in the Closing Balance Sheets.

(c) The portion of Net Working Capital constituting the value of prepaid expenses and deposits will be determined based on mutual agreement of Seller and Buyer. No more than five business days before the Closing Date, Buyer and Seller will agree on the value as of Closing of the prepaid expenses and deposits that Buyer reasonably determines will be usable after Closing.

(d) By wire transfer of immediately available funds to one or more accounts designated by Seller, Buyer shall pay to Seller at Closing the Cash Proceeds Payable to Seller. Consistent with sections 2.05(b) and 2.05(c), the Cash Proceeds Payable to Seller will be calculated by Buyer and Seller at Closing from the physical count of inventory and supplies conducted pursuant to section 2.05(b), if available, the relevant entries in the Interim Closing Balance Sheets (other than inventory and supplies if the physical inventory is available) and the parties' mutual good faith estimate as of the Closing Date of the amount of the prorations to be made pursuant to section 2.06 and the amount of the Credited Expenses.

(e) Within 60 days after the Closing Date, Seller will deliver to Buyer the Closing Balance Sheets together with any proposed revisions in the amount of the prorrations to be made pursuant to section 2.06 or the amount of the Credited Expenses (based on paid invoices delivered by Buyer to Seller within 55 days after the Closing). Except as otherwise provided herein, the Closing Balance Sheets shall be prepared using the same principles and methodologies, including the determination of accounts receivable and doubtful accounts, as used in preparing the Interim Closing Balance Sheets. The Cash Proceeds Payable to Seller and the Agreed Value of VBMC-B's Membership Interest in VHS² will each be recalculated (based on clauses (i) and (ii) below) and the VBIC Purchase Price will be recalculated (based on clause (iii) below) (collectively, the "**Purchase Price Adjustment**") to reflect (i) any such revisions in the amount of the prorrations to be made pursuant to section 2.06 or the amount of the Credited Expenses, (ii) the difference between the Net Working Capital (excluding differences in prepaid expenses and deposits calculated in accordance with section 2.05(c) and, if a physical inventory was used to calculate the Cash Proceeds Payable to Seller paid at Closing, in inventory and supplies) on the Interim Closing Balance Sheets and on the Closing Balance Sheets, and (iii) the difference between VBIC's Net Worth on the Interim Closing Balance Sheets and on the Closing Balance Sheets, *provided* that such recalculation will be dollar-for-dollar in the differences between such balance sheets and no consideration in the recalculations will be given to the fact that under generally accepted accounting principles a materiality standard applies to such Financial Statements. Following the resolution of any disputes pursuant to section 2.05(f), (A) Seller shall pay Buyer (if the Cash Proceeds Payable to Seller is adjusted downward by the Purchase Price Adjustment), or Buyer shall pay Seller (if the Cash Proceeds Payable to Seller is adjusted upward by the Purchase Price Adjustment), as the case may be, the amount by which the Cash Proceeds Payable to Seller is adjusted, by wire transfer of immediately available funds to one or more accounts designated by the recipient, within five business days after its determination, (B) the parties shall take all necessary action to amend the Amended and Restated Operating Agreement (and any exhibit thereto) to reflect the change in the Agreed Value of VBMC-B's Membership Interest in VHS² as a change to VBMC-B's initial capital contribution to VHS² and to reflect the aggregate change represented by the Purchase Price Adjustment as a corresponding change to the aggregate capital contributions to VHS² (so that VBMC-B continues to maintain a 49% membership interest in VHS²) and (C) Seller shall pay Buyer (if the VBIC Purchase Price is adjusted downward by the Purchase Price Adjustment), or Buyer shall pay Seller (if the VBIC Purchase Price is adjusted upward by the Purchase Price Adjustment), as the case may be, the amount by which the VBIC Purchase Price is adjusted, by wire transfer of immediately available funds to one or more accounts designated by the recipient, within five business days after its determination.

(f) If Buyer disputes any entry in the Closing Balance Sheets relevant to the calculation of the Purchase Price Adjustment or disputes the value of the inventory and supplies, and such dispute is not resolved to the mutual satisfaction of Seller and Buyer within 90 days after the Closing Date, either Seller or Buyer may submit the dispute to Deloitte & Touche LLP or to such other independent, certified public accounting firm as Seller and Buyer may then agree in writing, in either case acting as experts and not as arbitrators to resolve the computation or verification of the disputed Closing Balance Sheets entries in accordance with this agreement and otherwise where applicable in accordance with generally accepted accounting principles consistently applied.

(g) Seller and Vanguard (on behalf of Buyer) will each pay their own respective fees and expenses (including any fees and expenses of their accountants and other representatives) in connection with the resolution of disputes pursuant to this section 2.05. Notwithstanding the foregoing, the fees and expenses of any accounting firm incurred in connection with the resolution of such disputes will be paid by Seller and Vanguard (on behalf of Buyer) in proportion to the difference between the Purchase Price Adjustment determined by the accounting firm and the respective amounts of the Purchase Price Adjustment asserted by each such party at the time of the initial referral of the dispute to the accounting firm.

2.06. Prorations. At Closing, Buyer and Seller shall prorate real estate and personal property lease payments, real estate and personal property Taxes (except that no such proration of property Taxes will be necessary in respect of the transfer of property by any Seller that is a non-profit corporation that does not pay any property Taxes) and other assessments, and all other items of income and expense that are normally prorated upon a sale of assets of a going concern, if any. If any payment of Taxes made by Seller before Closing is credited against real estate Taxes for which Buyer will be liable, the amount of such credit will be applied as a credit against any prorations owing by Seller, to the extent available for offset, and any amounts not so applied will be paid to Seller by Buyer upon Buyer's receipt of such credit.

2.07. Funding Obligations. At Closing and pursuant to the Buyer Credit Agreement VHFC shall lend to VHS² \$175,000,000 *minus* the (a) net book value as of the Closing Date of any long-term indebtedness of Seller that Buyer assumes at Closing, including the Imaging Notes, and capitalized lease obligations of Seller pursuant to Assumed Contracts (including the current portions thereof) and (b) the agreed value as of Closing of any other liabilities or obligations described on Schedule 2.03. At Closing, VMC shall make an equity contribution to VHS² in cash in an amount equal to (a) 51% of (i) the Cash Portion of the Base Purchase Price *minus* (ii) the amount VHFC is required by the preceding sentence to lend to VHS² at Closing, *minus* (b) 49% of the Credited Expenses.

2.08. VBRC II Merger with Valley Realty. Prior to Closing, VBRC shall merge (1) with and into VB Realty Corporation, which upon consummation of the merger will own only Excluded Assets (including the ownership interest in HMC Realty, LLC), and (2) with and into VBRC II, which upon consummation of the merger will own only Assets. At Closing, VBRC II shall be merged with and into Valley Realty (the "**Merger**") pursuant to an agreement and plan of merger in form acceptable to Seller and Buyer, pursuant to which, effective as of the effective time and date of the Closing, (i) VBRC II shall be merged with and into Valley Realty, (ii) the name of the surviving company shall be Valley Baptist Realty Company, LLC and (iii) the operating agreement of Valley Realty shall be the operating agreement of the surviving company.

3. REPRESENTATIONS OF SELLER

Subject to the exceptions described in the Schedules, Seller makes the following representations to Buyer on and as of the date of this agreement and will be deemed to make them again at and as of the Closing Date:

3.01. Organization and Qualification. Each of VBHS, VBMC, VBMC-B, VBHH and VBMD is a non-profit corporation duly organized and validly existing in good standing under the laws of the State of Texas. Each of VBRC, VBIH and VBMS is a corporation duly organized and validly existing in good standing under the laws of the State of Texas. Seller is not licensed, qualified or admitted to do business in any jurisdiction other than in the State of Texas and there is no other jurisdiction in which the ownership, use or leasing of Seller's assets or properties, or the conduct or nature of its business, makes such licensing, qualification or admission necessary.

3.02. Corporate Powers; Consents; Absence of Conflicts, Etc. Seller has the requisite power and authority to conduct its business as now being conducted, to enter into this agreement and to perform its obligations hereunder. The execution, delivery and performance by Seller of this agreement and the Closing Documents to which Seller is or becomes a party and the consummation by Seller of the transactions contemplated by this agreement:

(a) are within Seller's powers, are not in contravention of its articles of incorporation, bylaws and other governing documents, and have been duly authorized by all appropriate corporate and shareholder or member action;

(b) do not conflict with, result in any breach or contravention of, or permit the acceleration of the maturity of, any liabilities of Seller (other than Excluded Liabilities satisfied as of the Closing Date), and do not create or permit the creation of any Encumbrance on or affecting any of the Assets;

(c) assuming the Attorney General does not object to the consummation of the transactions described herein and subject to compliance with all applicable requirements of the HSR Act with respect to the transactions contemplated by this agreement (including the expiration or termination of all waiting periods under the HSR Act), do not violate any Legal Requirement to which Seller or the Assets may be subject; and

(d) assuming the receipt of all consents set forth in Schedule 3.02, do not conflict with or result in a breach or violation of any material Contract to which Seller is a party or by which it is bound.

3.03. Binding Agreement. This agreement and each of the Closing Documents to which Seller is or becomes a party are (or upon execution will be) valid and legally binding obligations of Seller, enforceable against it in accordance with the respective terms hereof or thereof, except as enforceability may be restricted, limited or delayed by applicable bankruptcy or other Legal Requirements affecting creditors' rights generally and except as enforceability may be subject to general principles of equity.

3.04. Subsidiaries and Third Party Rights. Seller holds no Investment interest in any Person involved in the ownership or operation of the Hospital Businesses or the assets and properties utilized therein, other than those Persons identified on Schedule 3.04. Schedule 3.04 indicates for each Person identified thereon whether it is currently active or inactive and whether it, together with its consolidated Subsidiaries, has total assets of \$10,000 or more. Schedule 3.04 also indicates, for each Joint Venture, the percentage of the equity interests in such Joint Venture that is owned by Seller and the identity of the owning Seller. Other than each Seller and those Persons set forth on Schedule 3.04, there are no other Persons that own any interest in any of the Hospital Businesses. Golden Palms Retirement & Health Center is not actively engaged in any trade or business and does not own any Assets. There are no Contracts with or rights of any Person to acquire, directly or indirectly, any material assets, or any interest therein, including any of the Assets, other than Contracts entered into in the ordinary course of the Hospital Businesses or Contracts entered into with Vanguard or Buyer with respect to the transactions contemplated by this agreement.

3.05. Legal and Regulatory Compliance. Seller complies in all material respects with, and during the past four years has complied in all material respects with, all Legal Requirements and during the past four years has timely filed all material reports, data and other information required to be filed with Governmental Authorities. Seller has not received notice of any currently pending or threatened Proceeding against it alleging or based upon an alleged violation of any Legal Requirements. Neither Seller nor the Hospital Businesses are parties to or otherwise bound by (i) a corporate integrity agreement with the Office of Inspector General of the United States Department of Health and Human Services or written agreement with such Governmental Authority to establish or maintain a corporate integrity program applicable to any of the Hospital Businesses or (ii) a settlement or other agreement with any other Governmental Authority, other than participation agreements with Medicare and Medicaid, that imposes continuing obligations on any of the Hospital Businesses or contains obligations that have not been fully discharged.

3.06. Financial Statements. Attached as Schedule 3.06 are copies of the Audited Financial Statements and the Unaudited Financial Statements. The Financial Statements fairly present the financial condition and results of operations of the Hospital Businesses in all material respects as of the respective dates thereof and for the periods therein referred to, all in accordance with generally accepted accounting principles, subject, in the case of the Unaudited Financial Statements, to normal recurring year-end adjustments (the effect of which will not, individually or in the aggregate, have a Material Adverse Change) and the absence of notes (which, if presented, would not differ materially from those included in the Audited Financial Statements), and the Financial Statements reflect the consistent application of such accounting principles throughout the periods involved.

3.07. Undisclosed Liabilities. Except and to the extent accrued or disclosed in the Financial Statements, Seller does not have any liabilities or obligations of any nature whatsoever with respect to the Hospital Businesses or the Assets, due or to become due, accrued, absolute, contingent or otherwise, that are required by generally accepted accounting principles to be accrued or disclosed in audited financial statements, except for liabilities and obligations incurred in the ordinary course of business and consistent with past practice since the date of the Unaudited Financial Statements, and none of which could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.08. Recent Activities. Since August 31, 2010:

- (a) no material damage, destruction or loss (whether or not covered by insurance) has occurred affecting the Assets;
- (b) except in the ordinary course of the Hospital Businesses in accordance with existing Hospital personnel policies, Seller has not (i) increased or agreed to increase the compensation payable to any employees of the Hospital Businesses, (ii) agreed to make any bonus or severance payment to any of the employees of the Hospital Businesses or (iii) employed any additional management personnel in respect of the Hospital Businesses;
- (c) no labor dispute, enactment of state or local law, promulgation of state or local regulation, or other event or condition has occurred materially adversely affecting any of the Hospital Businesses;
- (d) Seller has not sold or factored, or agreed to sell or factor, any Accounts Receivable, and no Seller has sold, distributed or otherwise disposed of any other Assets except in the ordinary course of the Hospital Businesses and, for equipment having an original cost in excess of \$25,000, with a comparable replacement thereof;
- (e) no Encumbrance other than Permitted Encumbrances has been imposed on any of the Assets;
- (f) Seller has not canceled or waived any material rights in respect of the Assets, except in the ordinary course of the Hospital Businesses;
- (g) there has been no change in any accounting method, policy or practice of Seller with respect to the Hospital Businesses;
- (h) other than compensation paid in the ordinary course of employment, Seller has not paid any amount to, sold any Assets to, or entered into any Contract with any officer, director, trustee or member of Seller, or with any Affiliate of any such Person;
- (i) Seller has not paid or agreed to pay to any Person any damages, fines, penalties or other amounts in excess of \$25,000 individually or \$100,000 in the aggregate in respect of an actual or alleged violation of any Legal Requirement;
- (j) Seller has not instituted any new, or terminated or amended any existing, Employee Benefit Plan, except for amendments required to comply with applicable Legal Requirements;

(k) Seller has not entered into or agreed to enter into any transaction outside the ordinary course of the Hospital Businesses (other than the transactions contemplated by this agreement) that may cause a liability or obligation in excess of \$50,000; and

(l) No Material Adverse Change has occurred and no event or circumstance has occurred that could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.09. Accounts Receivable; Inventory.

(a) The Accounts Receivable, to the extent uncollected, are valid and existing and represent monies due for goods sold and delivered and services performed in bona fide commercial transactions, have been billed or are billable, and are not subject to any Encumbrances. Except as reflected or reserved for in the Financial Statements, no refunds, discounts or setoffs are payable or assessable with respect to the Accounts Receivable. Since August 31, 2009, Seller has not sold any Accounts Receivable, including Accounts Receivable that have been written off or fully reserved.

(b) All Assets consisting of inventory and supplies are carried at the lower of cost or market on a first-in, first-out basis and are properly stated in the Audited Financial Statements as of the dates thereof. All items of inventory and supplies are of a quality usable or saleable in the ordinary course of business, except for those items that are obsolete, below standard quality or in the process of repair and for which adequate reserves have been provided in the Financial Statements. The quantities of inventory and supplies, taken as a whole, are reasonable and justified under the normal operations of the Hospital Businesses.

3.10. Equipment. Seller has delivered to Buyer a depreciation schedule as of the date set forth therein that, to Seller's knowledge, lists all major items of equipment associated with, or constituting any part of, the Assets. All such major items of equipment are useable for their intended purpose in the ordinary course of business and are in working condition, subject to reasonable wear and tear. All medical and leased equipment has been maintained in all material respects in accordance with manufacturer and lessor requirements, and equipment maintenance logs or journals have been maintained in all material respects in compliance with required accreditation standards.

3.11. Title to Personal Property. Seller owns and holds good and valid title to all Assets constituting personal property (other than Assets leased pursuant to Assumed Contracts), free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.11. At Closing, Seller will convey to Buyer good and valid title to all Assets constituting personal property (other than Assets leased pursuant to Assumed Contracts), free and clear of any Encumbrances other than the Permitted Personal Property Encumbrances.

3.12. Owned Real Property.

(a) Seller owns fee simple title to the Owned Real Property, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.12(a). The Owned Real Property described on Schedule 2.01(a) comprises all of the real property owned by Seller that is associated with or employed in the operation of the Hospital Businesses. At Closing, Seller will convey to Buyer good and indefeasible fee simple title to all Owned Real Property, free and clear of any Encumbrances other than the Permitted Real Property Encumbrances.

(b) No Seller has received notice of condemnation or similar Proceedings relating to the Owned Real Property or any part thereof.

(c) The buildings standing on the Owned Real Property are in a state of good condition and repair, are structurally sound, and in need of no material maintenance or repairs except for ordinary, routine maintenance. To Seller's knowledge, all essential utilities (including water, sewer, gas, electricity and telephone service) are available to the Owned Real Property and, to Seller's knowledge, no conditions exist that are reasonably likely to result in the termination or reduction of the current access from the Owned Real Property to existing roadways. No part of the Owned Real Property contains, is located within or abuts any flood plain, navigable water or other body of water, tideland, wetland, marshland or other area that is subject to special State, federal or municipal regulation, control or protection (other than Legal Requirements pertaining to zoning or other land use restrictions customarily applicable to all real estate within the applicable jurisdiction).

(d) Except for tenants in possession of the Owned Real Property under Contracts described on Schedule 3.18, no Person other than Seller possesses, or claims possession of, adverse or not, any Owned Real Property, whether as lessee, tenant at sufferance, trespasser or otherwise. No tenant is entitled to any rebate, concession, or free rent, other than as reflected in the Contract with such tenant; no commitments have been made to any Tenant for repairs or improvements other than for normal repairs and maintenance in the future or improvements required by the tenant Contract; and no rents due under any of the Contracts with tenants have been assigned or hypothecated to, or encumbered by, any Person. All material obligations of Seller as landlord required to be performed under each of the tenant Contracts on or prior to the date of this agreement have been performed.

3.13. Environmental Matters and Medical Waste.

(a) Seller has all Permits required under applicable Environmental Laws, and all such Permits are listed on Schedule 2.01(g). No Environmental Claim is pending or to Seller's knowledge threatened by any Person against Seller or any other Person the liability for which Seller has retained or assumed, either contractually or by operation of law. To Seller's knowledge, no activities, circumstances, conditions, events or incidents, including the release, emission, discharge or disposal of any Materials of Environmental Concern, have occurred that could reasonably be expected to form the basis of any Environmental Claim by any Person against Seller or any other Person the liability for which Seller has retained or assumed, either contractually or by operation of law.

(b) Without in any way limiting the generality of the foregoing, (i) all on-site and, to Seller's knowledge, off-site locations where Seller stores, disposes or arranges for the disposal of Materials of Environmental Concern for the Hospital Businesses are identified on Schedule 3.13(b), (ii) all Contracts dealing with the removal, storage, disposal and handling of Materials of Environmental Concern of the Hospital Businesses are with vendors who are, to Seller's knowledge, properly licensed, (iii) all underground storage tanks, and the capacity and contents of such tanks, located on Owned Real Property are identified on Schedule 3.13(b), (iv) no asbestos is contained in or forms part of any building, building component, structure or office space owned or leased by Seller and used in the conduct of the Hospital Businesses, and (v) no polychlorinated biphenyls are used or stored at any Owned Real Property.

(c) Seller and the Hospital Businesses have complied in all material respects with all Medical Waste Laws.

3.14. Intellectual Properties and Information Systems. Seller owns or is licensed to use, free and clear of royalty and other payment obligations, claims of infringement or other Encumbrances, each of the Intellectual Properties and the Information Systems. Seller is not, in any material respect, in conflict with or in violation or infringement of, and has not received any notice alleging any conflict with or violation or infringement of, any rights of any other Person with respect to any such Intellectual Properties or Information Systems. To Seller's knowledge, no other Person is in conflict with or in violation or infringement of Seller's rights in such Intellectual Properties or Information Systems. Schedule 3.14 identifies those Intellectual Properties and Information Systems used in the conduct of the Hospital Businesses that are owned by or licensed directly to Seller (other than the Intellectual Properties and Information Systems owned by Seller, for which no copyright registration or application has been made and none of which is, individually or in the aggregate, material to the Hospital Businesses) and those Intellectual Properties and Information Systems that are owned by or licensed to third parties who provide information technology services to Seller pursuant to Contracts described in section 3.18(c).

3.15. Insurance. Schedule 3.15 describes all insurance arrangements, including self-insurance, in place for the benefit of the Assets and the conduct of the Hospital Businesses (other than Current Seller Plans described in Schedule 3.22). With respect to third party insurance, Schedule 3.15 sets forth the name of each insurer, whether such insurer is an Affiliate of Seller, and the number, coverage, limits, term and premium for each policy of insurance purchased or held by Seller covering the ownership and operation of the Assets and the Hospital Businesses. All of such policies are now, and until Closing Seller will use all commercially reasonable efforts to cause such policies to remain, valid, outstanding, in full force and effect, and enforceable with no premium arrearages. Since August 31, 2008, Seller has not been denied, or reduced or requested a reduction in the scope or amount of, any insurance or indemnity bond coverage. No insurance carrier has canceled or reduced, or given written notice of its intention to cancel or reduce, any insurance coverage and, to Seller's knowledge, there exist no reasonable grounds to cancel or avoid any such policies or the coverage provided thereby. Seller has provided to Buyer copies of all such policies and endorsements thereto. Since August 31, 2008, Seller has not made any claims against any excess insurance coverage set forth on Schedule 3.15 or any predecessor excess insurance policies applicable during such time period.

3.16. Permits. Schedule 2.01(g) describes all material Permits relating to the ownership of the Assets and the conduct of the Hospital Businesses, all of which, to Seller's knowledge, are in good standing and not subject to meritorious challenge. Seller has not received any written notice from any Governmental Authority relating to the threatened, pending or possible revocation, termination, suspension or limitation of any of such material Permits. Each of the Hospitals is duly licensed as an acute care hospital by the appropriate state agencies, and all departments or other business units that are required to be separately licensed are duly licensed by the appropriate state agencies. Valley Baptist Medical Center is licensed by the Texas Department of State Health Services for 586 beds and Valley Baptist Medical Center — Brownsville is licensed by the Texas Department of State Health Services for 280 beds. The Hospital Businesses and licensed departments or business units comply in all material respects with the applicable licensing requirements. The LVN School is exempt from the application of Chapter 132 by virtue of the fact that it is a non-profit school owned, controlled, operated, and conducted by a bona fide religious, denominational, eleemosynary, or similar public institution exempt from property taxation under the Legal Requirements of the State of Texas. Seller has provided or otherwise made available to Buyer (i) complete and accurate copies of the latest Joint Commission, Centers for Medicare & Medicaid Services, Texas Department of State Health Services licensure/survey and/or fire marshal reports of the Hospital Businesses and plans of correction or responses thereto, (ii) a list and description of any events during the three years immediately preceding the date of this agreement at the Hospitals that constitute "*sentinel events*," as defined by the Joint Commission, if any, and (iii) documentation created, prepared and/or produced by the Hospitals to satisfy Joint Commission requirements relating to addressing such sentinel events. The Hospitals have taken or are taking all reasonable steps to correct all material deficiencies noted therein.

3.17. Government Payment Programs; Accreditation. Each of the Hospitals has a current and valid provider Contract with the Government Payment Programs and/or their fiscal intermediaries, administrative contractors or paying agents and complies in all material respects with the conditions of participation therein. Each of the Hospitals is entitled to receive and is receiving payment under the Government Payment Programs for services rendered to qualified beneficiaries and, to Seller's knowledge, is not subject to any withholds or offsets in respect thereof. Seller has timely filed all Cost Reports due for Cost Report periods through August 31, 2010, and Cost Reports have been audited and notices of program reimbursement have been issued for all Cost Report periods through August 31, 2007. All amounts shown as due from Seller in the Cost Reports were remitted with such reports and all amounts shown in the notices of program reimbursement as due have been paid. Except to the extent liabilities and contractual adjustments of the Hospital under the Government Payment Programs have been properly reflected and adequately reserved in the Financial Statements in the ordinary course of business, the Hospital has not received or submitted any claim for payment in excess of the amount provided by Legal Requirements or applicable Contract and Seller has not received notice of any dispute or claim by any Governmental Authority, fiscal intermediary or other Person regarding the Government Payment Programs or the Hospital's participation therein that remains outstanding or unresolved. Each of the Hospitals is duly accredited by the Joint Commission and Seller's certification for participation in the Medicare program is based on such Joint Commission accreditation. Seller has delivered to Buyer copies of the most recent accreditation survey reports, deficiency lists, statements of deficiency, and plans of correction. Seller has taken or is taking all reasonable steps to correct all material deficiencies noted therein.

3.18. Agreements and Commitments. Schedule 3.18 identifies and sets forth certain information regarding Contracts related to the Hospital Businesses in the categories below:

- (a) Contracts that relate to the ownership or use of, title to or interest in Owned Real Property or Leased Real Property;
- (b) Contracts with (i) a physician or physician group, (ii) an Immediate Family Member of a physician on the medical staff of any Hospital, but only to the extent that Seller has knowledge of the familial relationship with such physician or (iii) any Person that provides marketing services for Seller;
- (c) Contracts relating to Intellectual Properties and Information Systems;
- (d) collective bargaining agreements or other Contracts with labor unions or other employee representatives or groups;
- (e) Contracts with directors, trustees, officers or employees of Seller;
- (f) requirements or exclusive Contracts and Contracts that prohibit or limit competition or the conduct by Seller or any Subsidiary of any lawful business;
- (g) Contracts with any health plan, health provider, independent practice association or similar Person providing for capitation or risk-sharing arrangements;
- (h) Contracts relating to the administration, operation or funding of any Employee Benefit Plan;
- (i) Contracts between Seller and any of the Joint Ventures;
- (j) equipment and other leases that are capital leases; and
- (k) all other Contracts which require payment by Seller of amounts in excess of \$100,000 after the date of this agreement, unless (i) the Contract is terminable at any time by the Seller party thereto without cause (and without payment of a penalty or other termination fee) by no later than the date which is 12 months after the date of this agreement and (ii) the amount payable under the Contract during such 12-month period would not exceed \$100,000.

3.19. The Assumed Contracts. With respect to the Assumed Contracts listed on Schedule 2.01(f):

- (a) the Assumed Contracts constitute lawful, valid and legally binding obligations of Seller and, to Seller's knowledge, each other party thereto and are enforceable against Seller and, to Seller's knowledge, against each other party thereto, in accordance with their terms;

(b) each Assumed Contract (together with all amendments and supplements thereto listed on Schedule 2.01(f)) is in full force and effect and constitutes the entire agreement by and between the parties thereto;

(c) in all material respects, all obligations required to be performed under the Assumed Contracts by Seller, and, to Seller's knowledge, each other party thereto, on or before the date of this agreement have been performed, and no event has occurred or failed to occur that constitutes, or with the giving of notice, the lapse of time or both would constitute, a default by Seller under the Assumed Contracts;

(d) no Assumed Contract contains a prohibition on competition by Seller or any Subsidiary or otherwise restricts the ability of Seller or any Subsidiary to engage in any lawful business after Closing; and

(e) the assignment of any Assumed Contract to and assumption of such Assumed Contract by Buyer will not give a third party the right to terminate such Contract, or result in the payment of any penalty or premium to, or change in the rights, remedies, benefits or obligations of, any party thereunder.

3.20. Transactions with Affiliates. Since August 31, 2010, Seller has not purchased, acquired or leased any property or services from, or sold, transferred or leased any property or services to, or lent or advanced any money to, or borrowed any money from, or acquired any capital stock, obligations or securities of, or made any management consulting or similar fee agreement with any officer, director or trustee of Seller or of any Affiliate of Seller except upon terms that would have been paid or received by Seller in similar transactions with independent parties negotiated at arm's length.

3.21. Employees and Employee Relations.

(a) Seller has delivered to Buyer (i) a list (as of the date set forth therein) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time non-physician employees of Seller working at the Hospital Businesses (indicating in the list whether each employee is classified as exempt or nonexempt by Seller), and (ii) a separate list (as of the date set forth therein) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time physician employees of Seller and its Affiliates working at the Hospital Businesses (indicating in both lists whether each employee is part-time or full-time, whether such employee is employed under written Contract, the immigration status of any such employee who is eligible for employment based solely on a temporary work permit and, if such employee is not actively at work, the reason therefor).

(b) All employees, former employees (whose employment terminated within the three months preceding the date of this agreement) and independent contractors of Seller have been properly classified as such for all purposes under the Code and ERISA and have been properly classified as exempt or nonexempt under the Fair Labor Standards Act and any applicable state law equivalent.

(c) No employee strike, work stoppage or slowdown, labor dispute, grievance or unfair labor practice at the Hospital Businesses is pending or to Seller's knowledge threatened. No employees of Seller are represented by, or have made demand for recognition of, a labor union or employee organization, and, to Seller's knowledge, no other union organizing or collective bargaining activities by or with respect to any employees of Seller are taking place. No complaint, charge or claim is pending, or to Seller's knowledge threatened to be brought or filed, with any Governmental Authority or arbitrator relating to the employment or termination of employment of any individual by Seller or the Hospital Businesses.

(d) All necessary visa or work authorization petitions have been timely and properly filed on behalf of any employees of the Hospital Businesses requiring a visa stamp, I-94 status document, employment authorization document or other immigration document to legally work in the United States, and all paperwork retention requirements with respect to such applications and petitions have been met. No employee of the Hospital Businesses who is a foreign national has ever worked without employment authorization from the Department of Homeland Security or any other Government Authority that must authorize such employment and Seller has complied with applicable immigration laws with respect to the employment of foreign nationals. Seller has timely and properly completed I-9 forms for all employees hired since the effective date of the Immigration Reform and Control Act of 1986 and has lawfully retained and re-verified all such I-9 forms. There are no Proceedings pending or, to Seller's knowledge, threatened against Seller relating to Seller's compliance with federal immigration regulations, including compliance with federal immigration laws. No Seller has received any letters from the Social Security Administration regarding the failure of an employee's social security number to match his or her name in the Social Security Administration database and no Seller has received any letters or other correspondence from the Department of Homeland Security or other Governmental Authorities regarding the employment authorization of any employees of such Seller. If Seller operates in a state or has contracts with a Governmental Authority that requires or provides a safe harbor if an employer participates in the Department of Homeland Security's e-Verify electronic employment verification system, such Seller has been participating in e-Verify for the entire period such participation has been required or available as a safe harbor or as long as such Seller has been operating in such state or contracting with such Governmental Authority.

3.22. Employee Benefit Plans.

(a) Schedule 3.22 lists each Employee Benefit Plan that Seller or any member of the Controlled Group that includes Seller maintains or to which it contributes (including employee elective deferrals), in each case as of the date of this agreement (each, a "**Current Seller Plan**").

(b) Each Current Seller Plan (and related trust, insurance contract or fund) complies in form and in operation in all material respects with applicable Legal Requirements, and has been administered and operated in all material respects in accordance with the terms of the plan and applicable Legal Requirements. All required reports and descriptions (including form 5500 annual reports, summary annual reports and summary plan descriptions) have been filed or distributed appropriately with respect to each Current Seller Plan. Seller has delivered to Buyer copies of the plan documents and summary plan descriptions, most recent determination letters received from the Internal Revenue Service, most recent form 5500 annual report, and all related trust, insurance and funding Contracts that implement each Current Seller Plan. No Governmental Authority has audited any Current Seller Plan or any other Employee Benefit Plan that Seller or any member of the Controlled Group that includes Seller has maintained, or to which it has contributed or been required to contribute, in each case during the five (5) years preceding the date of this agreement (each, a "**Prior Seller Plan**"), during the five (5) years preceding the date of this agreement and Seller has not received any notice that such an audit will or may be conducted.

(c) Each Current Seller Plan that is an Employee Pension Benefit Plan intended to be qualified under section 401(a) of the Code has a current favorable determination letter or opinion or approval letter from the Internal Revenue Service that the plan is so qualified and its trust is exempt from federal income taxation under section 501(a) of the Code, or the remedial amendment period for such Employee Pension Benefit Plan to be submitted to the Internal Revenue Service for such a determination letter or opinion or approval letter has not yet expired. All contributions (including employer contributions and employee salary reduction contributions) to each such Employee Pension Benefit Plan that are required to be paid have been paid, and all Seller contributions in respect of periods ending on the Closing Date will be accrued on the Closing Balance Sheets.

(d) The requirements of part 6 of subtitle B of Title I of ERISA and of section 4980B of the Code have been met with respect to each Current Seller Plan that is an Employee Welfare Benefit Plan, and all premiums or other payments for all periods ending on or before the Closing Date have been paid with respect to each such Employee Welfare Benefit Plan.

(e) To Seller's knowledge, there have been no "*prohibited transactions*," as defined in section 406 of ERISA and section 4975 of the Code, with respect to any Current Seller Plan that would subject Seller or any member of the Controlled Group that includes Seller to any liability. No ERISA Fiduciary has any material liability for breach of fiduciary duty or any other failure to act or comply in connection with the administration or investment of the assets of any Current Seller Plan. No Proceeding with respect to the administration or the investment of the assets of any Current Seller Plan (other than routine claims for benefits) is pending or to Seller's knowledge threatened and to Seller's knowledge there exists no basis for any such Proceeding. No "*party in interest*" (as defined in section 3(14) of ERISA) and no "*disqualified person*" (as defined in the Code) has any interest in any assets of any Current Seller Plan that is an Employee Benefit Pension Plan other than as a beneficiary by virtue of such Person's participation in the plan.

(f) No Current Seller Plan that is an Employee Pension Benefit Plan has been completely or partially terminated or the subject of a Reportable Event, and no Proceeding by the PBGC to terminate any such Employee Pension Benefit Plan has been instituted or to Seller's knowledge threatened. No Seller has incurred, and to Seller's knowledge no Seller will incur, any material liability to the PBGC (other than PBGC premium payments) or otherwise under Title IV of ERISA (including any withdrawal liability) or under the Code with respect to any Current Seller Plan or Prior Seller Plan that is or was an Employee Pension Benefit Plan.

(g) No Seller, and no member of the Controlled Group that includes Seller, contributes to, ever has contributed to, or ever has been required to contribute to any Multiple Employer Plan or any Multiemployer Plan or has any liability (including withdrawal liability) under any Multiple Employer Plan or any Multiemployer Plan. No Seller, and no member of the Controlled Group that includes Seller, maintains or contributes, ever has maintained or contributed, or ever has been required to maintain or contribute to any Employee Welfare Benefit Plan providing medical, health or life insurance or other welfare-type benefits for current or future retired or terminated employees, their spouses or their dependents (other than in accordance with section 4980B of the Code).

(h) No Current Seller Plan is a "*defined benefit plan*" within the meaning of section 3(35) of ERISA.

3.23. Proceedings and Claims. Schedule 3.23 contains a list and summary description of each Proceeding and claim (including *qui tam* Proceedings and claims) pending or, to Seller's knowledge, threatened against Seller or any Subsidiary (together with the reserve amount, if any, included in the Financial Statements for each uninsured Proceeding or claim). All such Proceedings and claims are or will be fully insured (except for applicable deductibles or self-insurance retentions) and no carrier has issued a "*reservation of rights*" letter or otherwise denied its obligation to insure and defend Seller against covered Losses arising therefrom. None of the Proceedings or claims described on Schedule 3.23, if determined adverse to Seller, could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.24. Taxes.

(a) Each Seller has filed all Tax Returns required to be filed by or on behalf of such Seller on or prior to the date of this agreement, all such Tax Returns are accurate in all material respects, and such Seller has duly paid or made provision in the Financial Statements for the payment of all Taxes shown as due and payable on such Tax Returns. Schedule 3.24 lists all federal, state, local and foreign income Tax Returns filed with respect to Valley Baptist Investment Holdings, Inc. and its Subsidiaries for the last three complete fiscal years and for the current year-to-date, and indicates those Tax Returns that have been audited and those that currently are the subject of audit or that have not been audited.

(b) Seller has withheld proper amounts from its employees' compensation in compliance with all applicable withholding and similar provisions of the Code and any and all other applicable Legal Requirements, and has withheld and paid, or caused to be withheld and paid, all Taxes on monies paid by it to independent contractors, creditors and other Persons for which withholding or payment is required by Legal Requirements.

(c) To Seller's knowledge, no Governmental Authority intends to assess any additional Taxes on any Seller for any period for which Tax Returns have been filed. No Governmental Authority has disputed in writing any Tax liability of Seller. No claim has ever been made by a Governmental Authority in a jurisdiction where Seller does not file Tax Returns that Seller is or may be subject to Tax in that jurisdiction and no Encumbrances have arisen against any Seller or its assets in connection with any failure (or alleged failure) of Seller to pay any Tax that is due and payable.

(d) No waiver of a statute of limitations in respect of Taxes or agreement to extend the time with respect to a Tax assessment or deficiency is currently in effect, in each case with respect to Seller.

(e) Seller is not a party to any Tax allocation or sharing Contract. Seller is not and has not been a member of an Affiliated Group filing a consolidated federal income Tax Return.

(f) Each Seller that is a corporation exempt from federal and state income Tax has received a favorable letter of determination from the Internal Revenue Service and the State of Texas regarding such Tax status and nothing has occurred, whether by action or failure to act, that could reasonably be expected to cause the loss of such exemption.

(g) No Seller has any liability for the Taxes of any other Person (other than another Seller under Internal Revenue Service regulation 1.1502-6), as a transferee or successor, by Contract or otherwise.

3.25. Medical Staff; Physician Relations. Seller has delivered to Buyer copies of the bylaws, policies, rules and regulations of the medical staff and medical executive committees of the Hospitals. Seller has also delivered to Buyer a list, current as of the date of this agreement, that sets forth (i) the name and age of each member of the medical staff of the Hospital (active, associate, consulting, courtesy or other), (ii) the degree (M.D., D.O., etc.), title, specialty and board certification, if any, of each Hospital medical staff member, (iii) the names of Hospital medical staff members (current and former) in respect of whom Seller has made a report to the National Practitioners Data Bank during the last three years, and (iv) the number of current medical staff members of the Hospital in respect of whom any committee of the medical staff of the Hospital has recommended adverse action with respect to any member of the medical staff of the Hospital that is not yet final. No material disputes between Seller and any Hospital medical staff members are pending or to Seller's knowledge threatened and all appeal periods in respect of any medical staff member against whom an adverse action has been taken by Seller have expired. No member of the medical staff of the Hospital has been excluded from participation in any Government Payment Program.

3.26. Restricted Assets. Except for the Prior Donations and Current Donations described on Schedule 5.28, none of the Assets is subject to any liability in respect of funds received by any Person for the purchase, improvement or use of any of the Assets or the conduct of the Hospital Businesses under restricted or conditioned grants or donations, including monies received under the Hill-Burton Act.

3.27. Brokers and Finders. Neither Seller nor the Foundation, nor any Affiliate, officer, trustee, director, employee or agent acting on behalf thereof, has engaged any finder or broker in connection with the transactions contemplated hereunder.

3.28. Payments. None of the Hospitals has made any request for payment from a Government Payment Program in respect of healthcare services furnished by or directed or prescribed by any physician or other Person who at such time was excluded from participation in such Government Payment Program. Seller has not, directly or indirectly, paid or delivered, or agreed to pay or deliver, any money or item of property, however characterized, to any Person in violation of any Legal Requirement. Neither Seller, nor any officer, director or trustee of Seller, has received or will receive as a result of the consummation of the transaction contemplated by this agreement any rebate, kickback or other improper or illegal payment from any Person with whom Seller conducts or has conducted any of the Hospital Businesses.

3.29. Solvency. As of immediately after Closing, Seller will not, as a result of the transactions contemplated by this agreement, be rendered insolvent or otherwise unable to pay its debts as they become due. Seller has no intention of filing a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or any portion of Seller's property and, to Seller's knowledge, no other Person has filed or threatened to file such a petition against Seller.

3.30. Transferring Subsidiaries, Non-Profit Corporations and Joint Ventures.

(a) Each Transferring Subsidiary (other than VBIC) is a limited liability company duly organized under the laws of the State of Texas with full limited liability company power to carry on its business as it is now being conducted. Each of the Transferring Subsidiaries is duly licensed, qualified or admitted to do business and is in good standing in the State of Texas, which is the only jurisdiction in which the ownership, use or leasing of their respective assets or properties, or the conduct or nature of their respective businesses, makes such licensing, qualification or admission necessary. All of the issued and outstanding shares of capital stock, membership interests or partnership interests of the Transferring Subsidiaries are owned by a Seller or another Transferring Subsidiary as specified on Schedule 3.30(a). All outstanding shares of capital stock, membership interests or partnership interests of the Transferring Subsidiaries have been duly and validly authorized, and are validly issued and outstanding and fully paid and non-assessable. There are no outstanding rights (including, without limitation, preemptive rights), options, warrants or agreements for the transfer by Seller of any shares of capital stock, membership interests or partnership interests of the Transferring Subsidiaries and no authorization for any such rights, options, warrants or agreements has been given. Seller has delivered to Buyer copies of the articles of incorporation or certificate of formation, bylaws, operating agreement, limited partnership agreement and other agreements, instruments and documents relating to the creation, ownership and governance of the Transferring Subsidiaries and has provided to Buyer copies of or access to the minute books of the Transferring Subsidiaries.

(b) VBIC is a domestic insurance company duly organized and validly existing in good standing under the laws of the State of Texas with full corporate power to carry on its business as it is now being conducted. VBIC is duly licensed, qualified or admitted to do business in the State of Texas, which is the only jurisdiction in which the ownership, use or leasing of its assets or properties, or the conduct or nature of its business, makes such licensing, qualification or admission necessary. All of the issued and outstanding shares of capital stock of VBIC are owned by VBIH, have been duly and validly authorized, and are validly issued and outstanding and fully paid and non-assessable. There are 750,000 shares of common stock of VBIC outstanding, par value \$1.00 per share, and no other classes of capital stock authorized, issued or outstanding, and VBIC holds no treasury shares. There are no outstanding rights (including, without limitation, preemptive rights), options, warrants or agreements for the transfer by VBIH of any shares of capital stock of VBIC and no authorization for any such rights, options, warrants or agreements has been given. Seller has delivered to Buyer copies of the articles of incorporation, bylaws and other agreements, instruments and documents relating to the creation, ownership and governance of VBIC, and has provided to Buyer copies of or access to the minute books of VBIC.

(c) Each Non-Profit Corporation is a nonprofit corporation duly organized and validly existing in good standing under the laws of the State of Texas with full corporate power to carry on its business as it is now being conducted. Each Non-Profit Corporation is organized and operated as a health organization described in section 162.001(b) of the Texas Medical Practice Act and meets the qualifications for certification contained in the rules promulgated by the Texas State Board of Medical Examiners "*Certification of Non-Profit Health Organizations*," 22 Texas Administrative Code §§ 171.1 — 177.15. Each Non-Profit Corporation is qualified or admitted to do business and is in good standing in the State of Texas, which is the only jurisdiction in which the ownership, use or leasing of their respective assets or properties, or the conduct or nature of their respective businesses, makes such qualification or admission necessary. VBMC is the sole member of Harlingen Physician Network, Inc. and Valley Health Care Network. VBHH is the sole member of Rio Grande Valley Indigent Health Care Corporation. Seller has delivered to Buyer copies of the articles of incorporation and bylaws and other agreements, instruments and documents related to the creation and governance of the Non-Profit Corporations, and has provided to Buyer copies of or access to the minute books of the Non-Profit Corporations.

(d) Each Joint Venture that is a limited liability company (other than Amedisys Valley Texas, LLC, Churchill Dialysis, LLC and Odyssey HealthCare of South Texas, LLC) is organized as a limited liability company formed under the laws of the State of Texas with full limited liability company power to carry on its business as it is now being conducted. Each of Amedisys Valley Texas, LLC, Churchill Dialysis, LLC and Odyssey HealthCare of South Texas, LLC is organized as a limited liability company formed under the laws of the State of Delaware with full limited liability company power to carry on its business as it is now being conducted. Each Joint Venture that is a limited partnership is organized as a limited partnership formed under the laws of the State of Texas. Each of the Joint Ventures is duly licensed, qualified or admitted to do business and is in good standing in the State of Texas, which is the only jurisdiction in which the ownership, use or leasing of their respective assets or properties, or the conduct or nature of their respective businesses, makes such licensing, qualification or admission necessary. The percentage interests of each Seller and/or Transferring Subsidiary in the capital and profits of the Joint Ventures are specified on Schedule 3.30(d) and, except as set forth in the operating agreements or limited partnership agreements of the Joint Ventures, the transfers to Buyer of the membership interests or partnership interests in the Joint Ventures are not subject to any preemptive rights or third party approvals. Seller has delivered to Buyer copies of the certificate of formation, limited partnership agreement, operating agreement and other agreements, instruments and documents relating to the creation, ownership and governance of the Joint Ventures, and has provided to Buyer copies of or access to the minute books of the Joint Ventures, to the extent within Seller's possession or control.

3.31. Joint Venture Partnerships.

(a) Prior to the date of this agreement, Seller has acquired the business and all or substantially all of the assets of each of the Imaging Partnerships. As of the date of such acquisition, (i) each physician partner of the Imaging Partnerships was duly licensed to practice medicine in the State of Texas and either board certified or board eligible in the medical specialty of radiology and (ii) all services and procedures provided at the imaging centers operated by the Imaging Partnerships consisted of diagnostic radiology procedures, not interventional imaging procedures constituting "*designated health services*" under the Stark law (42 U.S.C. § 1395nn) and regulations promulgated thereunder, and were at all times provided in accordance with applicable Legal Requirements relating to claims payment with respect to any federal or state health care program or private insurer, including the federal anti-kickback statute (42 U.S.C. § 1320a-7b(b)), the Stark law, and regulations promulgated thereunder.

(b) Seller has previously made available to Buyer a complete and accurate list of each Person who owns or holds, beneficially or of record, any equity or other ownership interest in VBOA ASC Partners, L.P., together with such Person's class and percentage interests in the partnership and the number of units owned or held. All limited partnership interests in VBOA ASC Partners, L.P. were issued pursuant to exemptions from the Securities Act of 1933, as amended, and regulations thereunder, are duly authorized, validly issued, fully paid and non-assessable. All services and procedures provided at the surgery center operated by VBOA ASC Partners, L.P. are and at all times have been provided in accordance with applicable Legal Requirements relating to claims payment with respect to any federal or state health care program or private insurer, including the federal anti-kickback statute (42 U.S.C. § 1320a-7b(b)), and the Stark law (42 U.S.C. § 1395nn), and regulations promulgated thereunder. The surgery center was organized and is operated by VBOA ASC Partners, L.P. in a manner that is intended to comply with the final safe harbor for investments published on November 19, 1999, by the Office of the Inspector General of the

Department of Health and Human Services. With respect to VBOA ASC Partners, L.P., physician investors were chosen from the community without regard to the volume or value of potential referrals. No Transferring Subsidiary's capital contribution to VBOA ASC Partners, L.P. was in the form of a loan from Seller or any Subsidiary of Seller. No physician partner in VBOA ASC Partners, L.P. was given the opportunity to acquire a larger percentage interest in VBOA ASC Partners, L.P. than the other physician partners because of that surgeon's anticipated volume or value of potential referrals. Seller has also previously made available to Buyer a list of former partners of VBOA ASC Partners, L.P. who have sold or have otherwise had their partnership interests in VBOA ASC Partners, L.P. repurchased, including the sale or repurchase price, the reasons for the sale or repurchase (if known), and the mechanism or methodology by which the sale or repurchase price was determined (if known). Seller has also previously made available to Buyer a list of physician partners who purchased or otherwise acquired some or all of their partnership interests in VBOA ASC Partners, L.P. after the original syndication, including the purchase price, the reasons for the new or additional purchase (if known), and the mechanism or methodology by which the purchase price was determined (if known).

3.32. Insurance Representations. VBIC is licensed as an accident and health insurance company and a Health Maintenance Organization offering a Basic Health Care Senior Plan by the Texas Department of Insurance, and has complied (except as described in the quality compliance audits and corrective action plans described in the immediately following sentence) and currently complies in all material respects with the capital, surplus, minimum reserve, liquidity and other requirements of the insurance laws of the State of Texas and the Texas Department of Insurance applicable to the conduct of VBIC's business, and with prudent actuarial practices. Seller has delivered to Buyer copies of the audited financial statements of VBIC for each of the five most recent fiscal years ended prior to the date hereof and copies of all quality compliance audits conducted since May 1, 2006 and all annual reports of financial condition and other reports (including any corrective action plans) submitted to the Texas Department of Insurance since May 1, 2006.

3.33. Operation of the Hospital Businesses. The Assets, together with the Excluded Assets, constitute all assets, properties, goodwill and businesses necessary to operate the Hospital Businesses in all material respects in the manner in which they have been operated since August 31, 2009, except for property, plant and equipment sold or disposed of since such date in the ordinary course of business. Schedule 3.33 sets forth a list of the ten largest non-governmental payors of the Hospital Businesses, determined on the basis of net patient revenues from services provided during the fiscal year ended August 31, 2010. Since August 31, 2010, no payor listed on Schedule 3.33 has terminated its contract with or materially reduced reimbursement rates to, or has notified Seller in writing of its determination to terminate its contract with or to materially reduce reimbursement rates to, the Hospitals.

3.34. Liabilities of VBRC II. As of the Closing, VBRC II will have no liabilities or obligations of any nature whatsoever, due or to become due, accrued, absolute, contingent or otherwise, except for (a) liabilities and obligations arising under this agreement and the Closing Documents to which it will be a party, (b) liabilities and obligations of VBRC that constitute Assumed Liabilities and (c) other immaterial liabilities and obligations incurred in the ordinary course of organizing VBRC II and merging it with VBRC.

3.35. Full Disclosure. The representations of Seller in this agreement and the Schedules do not contain any untrue statement of a material fact or omit to state any material fact necessary to make the statements made therein, in the light of the circumstances under which they were made, not misleading.

EXCEPT AS OTHERWISE EXPRESSLY SET FORTH IN THIS AGREEMENT, SELLER MAKES NO REPRESENTATIONS OR WARRANTIES OF ANY KIND OR NATURE, EXPRESS OR IMPLIED, AS TO THE CONDITION (INCLUDING THE ENVIRONMENTAL CONDITION), VALUE OR QUALITY OF THE ASSETS OR THE HOSPITAL BUSINESSES, AND ALL SUCH REPRESENTATIONS AND WARRANTIES ARE HEREBY EXPRESSLY DISCLAIMED. WITHOUT LIMITING THE GENERALITY OF THE FOREGOING AND EXCEPT AS OTHERWISE EXPRESSLY SET FORTH IN THIS AGREEMENT, SELLER ALSO HEREBY SPECIFICALLY DISCLAIMS ANY REPRESENTATION OR WARRANTY OF MERCHANTABILITY, USAGE, SUITABILITY OR FITNESS FOR ANY PARTICULAR PURPOSE WITH RESPECT TO THE ASSETS, OR ANY PART THEREOF, OR AS TO THE WORKMANSHIP THEREOF, OR THE ABSENCE OF ANY DEFECTS THEREIN, WHETHER LATENT OR PATENT, IT BEING UNDERSTOOD THAT SUCH ASSETS ARE BEING ACQUIRED "AS IS, WHERE IS" AT THE EFFECTIVE TIME, AND IN THEIR CONDITION AT SUCH TIME.

4. REPRESENTATIONS OF VANGUARD, VMC AND BUYER

Vanguard, VMC and Buyer make the following representations to Seller on and as of the date of this agreement and will be deemed to make them again at and as of the Closing Date:

4.01. Organization. Each of Vanguard and VMC is a corporation duly incorporated and validly existing and in good standing under the laws of the State of Delaware. Each Buyer is a limited liability company duly organized and validly existing and in good standing under the laws of the State of Delaware. Buyer is, or by Closing will be, qualified to do business in the State of Texas. VHS² is a wholly-owned Subsidiary of VMC, which is a direct wholly-owned subsidiary of VHFC and an indirect wholly-owned subsidiary of Vanguard. VHS-H, VHS-B, Valley Holdings and Valley Realty are wholly-owned Subsidiaries of VHS². Each of Vanguard, VMC and Buyer has full power and authority to own, lease and operate its properties and to conduct its business as presently conducted and as proposed to be conducted immediately following the consummation of the transactions contemplated by this agreement. No Buyer other than VHFC has conducted any business prior to the date of this agreement and no Buyer other than VHFC will conduct any business, other than in contemplation of the consummation of the transactions contemplated by this agreement prior to the Closing.

4.02. Power and Authority; Due Authorization. Each of Vanguard, VMC and Buyer has full power and authority to (a) execute and deliver this agreement and the Closing Documents to which it will be a party, (b) perform its obligations under this agreement and such Closing Documents and (c) consummate the transactions contemplated by this agreement. The execution and delivery by each of Vanguard, VMC and Buyer of this agreement and the Closing Documents to which it will be a party, the performance by each of Vanguard, VMC and Buyer of its respective obligations under this agreement and such Closing Documents, and the consummation by each of Vanguard, VMC and Buyer of the transactions contemplated by this agreement have been duly authorized on behalf of such Person by all necessary corporate or limited liability company action.

4.03. Consents; Absence of Conflicts, Etc. The execution, delivery and performance by Vanguard, VMC and Buyer of this agreement and by each of Vanguard, VMC and Buyer of the Closing Documents to which it becomes a party at the Closing, and the consummation of the transactions contemplated by this agreement:

(a) are within its corporate powers, are not in contravention of its certificates of incorporation or formation and bylaws or operating agreement, and have been approved by all required corporate and shareholder or member action;

(b) do not violate any Legal Requirement to which it is subject; and

(c) do not conflict with, result in a breach or violation of or require any consent to be obtained or notice to be given under any material agreement to which it is a party or by which it is bound.

4.04. Due Execution; Binding Agreement. This agreement has been duly and validly executed and delivered by Vanguard, VMC and Buyer. Each Closing Document to which Vanguard, VMC or Buyer will be a party will be duly and validly executed and delivered by such Person at the Closing. This agreement constitutes, and each of the Closing Documents to which Vanguard, VMC or Buyer will be a party will constitute (upon execution and delivery thereof by such Person at the Closing), the valid and legally binding obligations of each of Vanguard, VMC and Buyer that is or will be party thereto, enforceable against it in accordance with the terms hereof and thereof, except as enforceability may be restricted, limited or delayed by applicable bankruptcy or other Legal Requirements affecting creditors' rights generally and except as enforceability may be subject to general principles of equity.

4.05. Governmental Consents. Except as contemplated by section 5.31 with respect to the Insurance Approvals, Buyer is not aware of any consent, approval, license or other authorization from any Governmental Authority that it will not obtain prior to Closing, which failure to obtain would prevent the consummation of the transactions contemplated by this agreement.

4.06. Legal Compliance. Each of Vanguard, VMC and Buyer complies in all material respects with, and during the past four years has complied in all material respects with, all Legal Requirements and during the past four years has timely filed all material reports, data and other information required to be filed with Governmental Authorities.

4.07. Proceedings. No order is in effect, and no Proceeding is pending or has been threatened in writing, against Vanguard, VMC or Buyer that, individually or in the aggregate, could reasonably be expected to (a) prevent, enjoin or materially alter or delay the consummation of the transactions contemplated by this agreement, (b) impose any material liability or obligation on Buyer or any portion of the Hospital Businesses at the Closing or (c) at or following the Closing, impose any material liability or obligation on the Hospital Businesses (or the conduct thereof) or impose any Encumbrance on any of the Assets.

4.08. Availability of Funds. Vanguard, VMC and Buyer have the ability to obtain funds in cash in amounts equal to the Purchase Price and necessary to perform their obligations hereunder that are to be performed as of Closing by means of credit facilities or otherwise and will at Closing have immediately available funds in cash which will be sufficient to pay the Purchase Price and to perform their obligations hereunder that are required to be performed as of Closing.

4.09. Solvency. None of Vanguard, VMC and Buyer has any intention of filing a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or any portion of such Person's property and, to the knowledge of Vanguard, VMC and Buyer, no other Person has filed or threatened to file such a petition against Vanguard, VMC or Buyer.

4.10. Liabilities of VHS². As of the Closing, VHS² will have no liabilities or obligations of any nature whatsoever, due or to become due, accrued, absolute, contingent or otherwise (including pursuant to the Principal Credit Agreement), except for (a) liabilities and obligations arising under this agreement and the Closing Documents to which it will be a party, (b) the Credited Expenses, and (c) other immaterial liabilities and obligations incurred in the ordinary course of organizing VHS² and its Subsidiaries and qualifying them to conduct business in the State of Texas.

4.11. Brokers and Finders. Neither Buyer, nor any Affiliate of Buyer (including Vanguard), nor any officer, director, employee or agent thereof, has engaged or is liable for the payment of any fee to any finder or broker in connection with the transactions contemplated hereunder.

4.12. Occasional Sale. All of the operating assets of each Seller will be transferred to and operated by a single Buyer.

4.13. No Knowledge of Misrepresentations or Omissions. Buyer is not aware of any facts or circumstances not described in this agreement or in the Schedules that would cause the representations of Seller in article 3 to not be true and correct in any material respect.

4.14. Full Disclosure. The representations of Vanguard, VMC and Buyer in this agreement do not contain any untrue statement of a material fact or omit to state any material fact necessary to make the statements made therein, in the light of the circumstances under which they were made, not misleading.

5. COVENANTS OF THE PARTIES

5.01. Operations. Until the Closing Date and except as otherwise expressly provided in this agreement or agreed to in writing by Buyer, Seller will, and will require its Subsidiaries to, use all commercially reasonable efforts to:

(a) carry on the Hospital Businesses in substantially the same manner as it has heretofore and not make any material change in personnel, operations, finances, accounting policies, or real or personal property of the Hospital Businesses;

(b) maintain the Assets in working condition in the ordinary course of business, ordinary wear and tear excepted, and make all normal, planned and budgeted capital expenditures related to the Assets and/or the Hospital Businesses, *provided* that Seller shall consult with and solicit Buyer's input on individual capital expenditures (or a series of related capital expenditures) that exceed \$250,000;

(c) perform in all material respects, when due, all Legal Requirements and obligations under Contracts;

(d) deliver to Buyer title to the Assets free and clear of all Encumbrances (except for the Permitted Encumbrances) and to obtain appropriate releases, consents, estoppels, certificates, opinions and other instruments as Buyer may reasonably request;

(e) keep in full force and effect present insurance policies or other comparable insurance benefiting the Assets and the conduct of the Hospital Businesses and maintain sufficient liquid reserves reasonably estimated to be sufficient to meet all deductible, self-insurance and copayment requirements of such policies; and

(f) maintain and preserve its business organizations and operations intact, retain the present employees at the Hospital Businesses (subject to the right of Seller to discharge any employee in the ordinary course of the Hospital Businesses), maintain its relationships with physicians, suppliers, patients and other Persons doing business with Seller at the Hospital Businesses.

5.02. Negative Covenants. Until the Closing Date and except as otherwise expressly provided in this agreement or agreed to by Buyer in writing and except for waivers, consents and amendments to Seller's outstanding loan documents and related swap agreements, Seller will not, and will not permit any Subsidiary to:

(a) amend or terminate any Assumed Contract, or enter into any Contract except in the ordinary course of the Hospital Businesses consistent with past practices, *provided* that Seller shall consult with and solicit Buyer's input on new Contracts (or a series of related Contracts) that exceed \$500,000 in value;

(b) except as set forth on Schedule 5.02(b), make offers to any employees of the Hospital Businesses for employment with any Person after Closing;

(c) except as set forth on Schedule 5.02(c), increase compensation payable or to become payable to, make a bonus or severance payment to, or otherwise enter into one or more bonus or severance Contracts with any employee or agent of any of the Hospital Businesses except in the ordinary course of the Hospital Businesses consistent with past practices in accordance with existing personnel policies or pursuant to Contract requirements in force on the date of this agreement;

(d) create or assume any new Encumbrance upon any of the Assets other than statutory liens created in the ordinary course of business and the interests of lessors under operating leases entered into in the ordinary course of the Hospital Businesses consistent with past practices;

(e) sell or otherwise transfer or dispose of any item of property, plant or equipment having an original cost in excess of \$25,000 except in the ordinary course of the Hospital Businesses consistent with past practices with comparable replacement thereof;

(f) distribute any assets, other than cash and other Excluded Assets, to Seller or to any Subsidiary of Seller that is not a Transferring Subsidiary, *provided* that VBRC shall convey the Excluded Assets owned by it to one or more of its Affiliates, and *provided further* that VBIC shall not distribute cash if, immediately after such distribution or at Closing, VBIC does not comply with the capital, surplus, minimum reserve, liquidity and other requirements of the insurance laws of the State of Texas and the Texas Department of Insurance applicable to the conduct of VBIC's business, and with prudent actuarial practices;

(g) take any action outside the ordinary course of the Hospital Businesses;

(h) create, incur, assume, guarantee or otherwise become liable for any material liability or obligation, or agree to do any of the foregoing, except in the ordinary course of the Hospital Businesses consistent with past practices;

(i) cancel, forgive, release, discharge or waive any Person's obligation to pay or to perform obligations in respect of Accounts Receivable or other Assets, or agree to do any of the foregoing, except in the ordinary course of the Hospital Businesses consistent with past practices;

(j) sell or factor any Accounts Receivable;

(k) change any accounting method, policy or practice or reduce any reserves in the Financial Statements except (i) reductions in reserves pertaining to Government Payment Programs or third party payors made in the ordinary course of business consistent with past practices and (ii) changes required by changes in generally accepted accounting principles or applicable Legal Requirements;

(l) terminate, amend or otherwise modify in any material respect any Employee Benefit Plan, except for amendments required to comply with this agreement or applicable Legal Requirements;

(m) amend or agree to amend the articles or certificate of incorporation or bylaws of any Transferring Subsidiary or Non-Profit Corporation or otherwise take any action relating to any liquidation or dissolution of Seller, except as expressly contemplated by this agreement; or

(n) amend or agree to amend the governing documents of any Joint Venture, except immaterial amendments or amendments required to comply with applicable Legal Requirements or to assign and transfer to Buyer Seller's Investment in, or for Buyer to become a partner or member of, the Joint Venture.

5.03. Employee Matters.

(a) Subject to the exclusions set forth in this section and in reliance upon the representations of Seller in sections 3.21 and 3.22, Buyer will offer, or cause its Affiliates to offer, to employ as of the Closing Date all active employees of Seller working at the Hospital Businesses immediately before Closing (other than employees listed on Schedule 5.02(b)) on the same terms and conditions with respect to base salaries or wages, job duties, titles and responsibilities that are applicable to such employees on the date of this agreement. In addition, Buyer will offer the Hired Employees Employee Benefit Plans which are no less favorable to employees in the aggregate to those Employee Benefit Plans generally offered to employees at other hospitals operated by Vanguard's Subsidiaries in other markets.

(b) Seller acknowledges that all employment offers are for "at will" employment only and are subject to the satisfactory completion by Buyer of its customary employee background checks and pre-employment screenings. Nothing in this section or elsewhere in this agreement may be deemed to limit or otherwise affect in any manner the right of Buyer or any Affiliate of Buyer to terminate at will the employment of any Hired Employee or, subject to Buyer's covenants in section 5.03(a), to change individual features or plans in the employment compensation and benefits package of the Hired Employees, *provided* that, for at least the first 12 months after Closing, Buyer's severance policy will be comparable to Seller's severance policy attached as Schedule 5.03(b).

(c) With respect to the Hired Employees and their eligible dependents, Buyer will waive any "pre-existing condition" exclusions, waiting periods or evidence of insurability requirements in Buyer's Employee Welfare Benefit Plans to the extent that such exclusions, waiting periods and insurability requirements would not have applied under Seller's comparable Employee Welfare Benefit Plans as of the Closing Date. Buyer will give all Hired Employees credit for their paid time off accruals (whether in such form or in the form of an "extended illness bank"). Buyer shall give all Hired Employees credit, as of the Closing, for their period of service with Seller (or any assignor to, or predecessor of, Seller, service to whom Seller has previously recognized and credited) for the purpose of determining how much paid time off the Hired Employees are entitled to under Buyer's Employee Welfare Benefit Plans, for purposes of determining eligibility to participate and vesting percentages in Buyer's Employee Pension Benefit Plans, subject to the limitations in the Seller's Employee Pension Benefit Plans as of the Closing Date, and for any other purpose for which an employee's period of service is relevant under Buyer's Employee Benefit Plans. Buyer will not assume or otherwise become liable for (i) Seller's Employee Welfare Plans, (ii) long-term disability payments to any former employee of Seller who does not actively work for Buyer after Closing, or (iii) other obligations to former or currently retired employees, and will not make any contributions to Seller's pension plans. Buyer will make available group health plan continuation coverage required under COBRA to employees of Seller who are eligible for COBRA, *provided* that, with respect to COBRA beneficiaries whose qualifying events occurred on or prior to the Closing Date, Seller will reimburse Buyer for all claims of such COBRA beneficiaries paid by Buyer and its Affiliates in excess of the sum of (i) COBRA premiums collected from the COBRA beneficiaries and (ii) amounts reimbursed from stop loss insurance, determined in the aggregate with respect to all such individuals on the first anniversary of the Closing Date and again at the end of the COBRA period for all COBRA beneficiaries.

(d) As of the Closing Date, Seller shall freeze and/or terminate the participation of all Hired Employees in Seller's Employee Pension Benefit Plan and provide for distributions consistent with the applicable plans, ERISA and the Code.

(e) Between the date of this agreement and Closing, Buyer may run newspaper advertisements in the name of any of the Hospital Businesses to recruit employees for and in the name of any of the Hospital Businesses, such employment to commence on or after the Closing Date.

(f) At Closing, Seller shall deliver to Buyer a list as of Closing setting forth the names of all employees of the Hospital Businesses whose employment was terminated between the date of this agreement and the Closing Date.

(g) This section shall not apply to employees employed by Seller under Assumed Contracts. Employment of such employees will be governed by the terms and conditions of the Assumed Contracts, if any, relating to the employment of such employees.

(h) Prior to Closing, Seller will be responsible for compliance with the WARN Act and all similar state and local Legal Requirements with respect to the employees of the Hospital Businesses, and for all obligations or liabilities arising thereunder as a result of any action (or failure to act) of Seller on or prior to the Closing Date, and after Closing, Buyer will be responsible for compliance by Buyer with the WARN Act and all similar state and local Legal Requirements with respect to the employees of the Hospital Businesses, and for all obligations or liabilities arising thereunder as a result of any action (or failure to act) of Buyer after the Closing Date.

5.04. Access to and Provision of Additional Information.

(a) Except to the extent prohibited by applicable Legal Requirements (including antitrust laws), until the Closing Date, Seller shall (i) give Buyer reasonable access to and the right to inspect, during normal business hours and upon reasonable prior notice, Seller's Assets, books and records relating to the Hospital Businesses as is reasonably requested by Buyer, (ii) give Buyer reasonable access to Seller's employees and medical staff members providing services at or for the Hospital Businesses and (iii) give Buyer such additional financial, operating and other data and information (including auditors' workpapers) regarding the Hospital Businesses as Buyer may reasonably request and that is reasonably available to Seller. Buyer shall exercise its rights under this section 5.04(a) in such a manner as to cause the least possible interference with the normal operations of the Hospital Businesses. All contact between Buyer (and its representatives) and employees of Seller shall be coordinated through and supervised by a single individual designated by Seller for such purpose.

(b) Seller will deliver to Buyer:

(i) within 30 days after the end of each calendar month before the Closing Date, copies of the unaudited balance sheet and the related unaudited statements of income and cash flows of the Hospital Businesses for each such month then ended and for the fiscal year-to-date then ended, in consolidating and consolidated format;

(ii) within 45 days after the end of each fiscal quarter ending on or before the Closing Date, copies of the unaudited balance sheet and the related unaudited statements of income and cash flows of the Hospital Businesses for the fiscal quarter then ended and for the fiscal year-to-date then ended; and

(iii) promptly after prepared, copies of any other financial or operating statements, reports or analyses prepared by or for management relating to the Hospital Businesses.

(c) Until the Closing Date, Seller shall confer regularly with Buyer, as reasonably requested by Buyer, and answer Buyer's reasonable questions regarding matters relating to the conduct of the Hospital Businesses and the status of transactions contemplated by this agreement. Seller shall notify Buyer of any material changes in the operations, financial condition or prospects of the Hospital Businesses and of any material complaints, investigations, hearings or adjudicatory proceedings (or communications indicating that the same may be contemplated) of any Person and shall keep Buyer reasonably informed of the status of such matters. Buyer and Seller shall mutually develop and cooperate to implement a transition plan for the ownership and management of the Hospital Businesses and, in connection therewith, Seller will assist Buyer in establishing relationships with non-employee physicians and medical staff members, payors and other Persons having business relations with Seller in respect of the Hospital Businesses. No earlier than 30 days prior to the anticipated Closing, Buyer may, in Buyer's own name, advertise and solicit applications for post-Closing employment at the Hospital Businesses.

(d) With respect to any personal health information disclosed by Seller to Buyer pursuant to this section, Buyer and Seller shall comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. section 1320d, *et seq.*, as amended by The Health Information Technology for Economic and Clinical Health Act, and any current and future regulations promulgated thereunder, and with any state Legal Requirements that govern or pertain to the confidentiality, privacy, security of, and electronic transactions pertaining to, health care information.

(e) For the avoidance of doubt, Buyer shall not, and nothing contained in this section shall give Buyer, directly or indirectly, the right to, control or direct the Hospital Businesses (or any portion thereof) prior to the Closing.

5.05. Post-Closing Maintenance of and Access to Information.

(a) After Closing, each party may need access to books, records, documents or other information in the control or possession of the other parties for purposes of concluding the transactions contemplated by this agreement, preparing Tax Returns or conducting Tax audits, obtaining insurance, complying with Government Payment Programs and other Legal Requirements, and prosecuting or defending third party claims. Accordingly, each party shall keep and maintain in the ordinary course of business all books, records (including patient medical records), documents and other information in the possession or control of such party for a period of at least five (5) years after the Closing and otherwise in accordance with all applicable Legal Requirements and record retention policies. In addition, to facilitate the foregoing purposes, each party shall also make such books, records, documents and other information available for inspection and copying upon the reasonable request and at the expense (for out-of-pocket costs) of the other parties.

(b) Upon Buyer's receipt of appropriate consents and authorizations, Seller may remove and copy from the Hospital Businesses, at Seller's sole risk and expense, any patient or other records that relate to events or periods before Closing for purposes of pending Proceedings involving matters to which such records refer, as certified in writing before removal by counsel retained by Seller in connection with such Proceedings. Seller shall promptly return any records so removed from the Hospital to Buyer following their use.

(c) Each party shall cooperate with, and shall permit and use commercially reasonable efforts to cause its former and present directors, officers and employees to cooperate with, the other parties after Closing in furnishing information, evidence, testimony and other assistance in connection with any Proceeding or claim with respect to (i) the ownership of the Assets or the conduct of the Hospital Businesses by Buyer or (ii) the Excluded Liabilities.

(d) The exercise by any party of the rights granted in this section shall not unreasonably interfere with the conduct of business of the other parties and nothing in this section requires any party to maintain or release to any other Persons any medical or other records except in accordance with applicable Legal Requirements and record retention policies.

(e) For seven years after the Closing Date, Seller will give Buyer, within 30 days after request, an updated claims history, including losses paid and open reserves, for all professional liability, general liability and workers compensation claims relating to the conduct of the Hospital Businesses before Closing.

5.06. Governmental Authority Approvals; Consents to Assignment.

(a) Until the Closing Date, Seller and Buyer shall (i) promptly apply for and use commercially reasonable efforts to obtain before Closing all consents, approvals, authorizations and clearances of Governmental Authorities required to consummate the transactions contemplated by this agreement, (ii) provide such information and communications to Governmental Authorities as the other party or such Governmental Authorities may reasonably request, and (iii) assist and cooperate with the other parties to obtain all Permits that the other parties deem necessary or appropriate, and to prepare any document or other information reasonably required of it by any such Governmental Authorities to consummate the transactions contemplated by this agreement, *provided* that no party may be required (x) to pay any sum to Governmental Authorities other than filing fees or past due amounts, or (y) to agree to divest assets or limit the conduct of its businesses.

(b) Until the Closing Date, each of the parties shall file, if and to the extent required by applicable Legal Requirements, all reports and other documents required or requested by Governmental Authorities under the HSR Act concerning the transactions contemplated by this agreement, and shall promptly comply with any requests by the Governmental Authorities for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible. Each of the parties shall furnish to the other parties such information as the other parties reasonably require to comply with their obligations under the HSR Act and shall exchange drafts of the relevant portions of each other's report forms before filing.

(c) Each Seller shall promptly apply for and use commercially reasonable efforts to obtain before Closing all consents required to assign the Assumed Contracts to Buyer at Closing.

(d) To obtain one or more of the consents and approvals described in this section, Buyer may be required by applicable Legal Requirement or practical necessity to enter into a Contract that supersedes or replaces an existing Contract between Seller and a third party. Such new Contract may require Buyer to assume, for the benefit of such third party, certain obligations and liabilities of Seller that are Excluded Liabilities. Alternatively, Buyer may be required by Legal Requirements to assume, or may be deemed as a matter of law to have assumed, obligations and liabilities of Seller that are Excluded Liabilities. If Buyer enters into a replacement Contract or assumes such Excluded Liabilities, then — as between Seller and Buyer — such Contract or assumption of Excluded Liabilities will not affect the contractual rights and remedies provided in this agreement in respect of such Contract or Excluded Liabilities, including Buyer's rights to indemnification from Seller (subject to the limitations set forth in article 9), or otherwise diminish Seller's obligations to Buyer or enlarge Seller's liabilities to Buyer (or diminish Seller's defenses or limitations on liability) under this agreement and will under no circumstances be claimed by Seller as a defense (whether of waiver, estoppel, consent, operation of law, or otherwise) against Buyer's assertion of any claim under this agreement against Seller, and the rights and obligations of the parties to each other under this agreement will be determined as if such replacement Contract did not exist or such assumption of Excluded Liabilities was not required.

5.07. No-Shop Clause. Until termination of this agreement, Seller shall not, and shall not permit any Affiliate of Seller or any other Person acting for or on behalf of Seller or any Affiliate of Seller to, without the prior written consent of Buyer: (a) offer for sale, lease or other disposition of all or substantially all of the Assets or any material portion thereof, whether by virtue of an asset sale transaction, a lease transaction, affiliation transaction, or a change of control, change of membership, merger, consolidation or other combination transaction with respect to Seller (collectively, a "**Prohibited Transaction**"), or negotiate in respect of an unsolicited offer therefor; (b) solicit offers to acquire all or substantially all of the Assets, or any material portion thereof, in a Prohibited Transaction; (c) enter into any Contract with any Person with respect to the disposition of all or substantially all of the Assets, or any material portion thereof, in a Prohibited Transaction; or (d) furnish or permit or cause to be furnished any information to any Person that Seller knows or has reason to believe is in the process of considering a Prohibited Transaction. If Seller, any Affiliate of Seller, or any Person acting for or on behalf of any of the foregoing, receives from any Person (other than Buyer or its representatives) any offer, inquiry or informational request referred to above, Seller will promptly advise such Person, by written notice, of this section.

5.08. Noncompetition. For a period of five years after the Closing Date, Seller shall not, directly or indirectly, and Seller shall cause its Affiliates not to, in any capacity: (i) own, lease, manage, operate, control, participate in the management or control of, be employed by, or maintain or continue any interest whatsoever in any enterprise engaged in the business of providing healthcare goods or services, including hospitals and outpatient surgery or diagnostic facilities, within the geographic area described on Schedule 5.08 (the "**Rio Grande Valley Market**"), other than through VHS² and its Subsidiaries and Investments; (ii) employ or solicit the employment of any Hired Employee unless (x) such employee resigns voluntarily (without any solicitation from Seller or any of its Affiliates), (y) Buyer consents in writing to such employment or solicitation, or (z) such employee is terminated by Buyer or its Affiliates after the Closing Date; (iii) induce, cause or attempt to induce or cause any Person (including any physician employee or medical staff member) to replace or terminate any Contract for the provision or arrangement of health care services from a Hospital with products or services of any other Person after the Closing Date; or (iv) request, induce or cause any physician employee or medical staff member to terminate any Contract with or change practice patterns at the Hospital Businesses. Notwithstanding anything to the contrary in this section 5.08, the Foundation may make grants and contributions and otherwise provide financial support for healthcare-related activities and VB Realty Corporation and VBMSC may continue to hold their investment interests in the HMC Partnerships in the same amount and manner that such interests are held on the Closing Date.

5.09. Change of Corporate Names. From and after Closing, except as set forth on Schedule 5.09, Seller shall not use the names "*Valley Baptist*," "*Valley Baptist Health System*," "*Valley Baptist Medical Center*," "*Golden Palms*," "*Valley Health Care*," or any other Intellectual Properties included in the Assets in the conduct of their businesses, except as may be necessary to wind up their corporate affairs and make filings (including Tax Returns) required by Legal Requirements and except that the Foundation may continue to conduct business under its current name after Closing. The parties will enter into a License Agreement in the form attached as Exhibit D pursuant to which VHS² will grant to the Foundation, VBHH and VBHS the right to use the name "*Valley Baptist*" in connection with the conduct of their businesses after Closing. Subject to the foregoing, within five business days after Closing, Seller shall change its name, and shall cause its Subsidiaries to change their names, to the extent necessary, to names that do not include any of the foregoing names or Intellectual Properties.

5.10. Allocation of Purchase Price. Within 90 days after Closing, Buyer shall provide Seller a proposed allocation of the Purchase Price among the Hospitals and the Assets. Such allocation will be in accordance with section 1060 of the Code. Buyer's proposed allocation will become final and binding on the parties 60 days after Buyer provides the proposed allocation to Seller unless Seller objects to the proposed allocation, in which case Seller shall propose an alternative allocation. The parties shall use good faith efforts to resolve their differences within 60 days after Seller gave its objection to Buyer. If a final resolution is not reached within 60 days after Seller has submitted its objection in writing, each of Buyer and Seller shall make their own independent allocation of the total consideration among the Hospitals and the Assets. If Seller and Buyer reach agreement upon the allocation (or Seller does not object to Buyer's proposed allocation), Seller and Buyer will be bound by the agreed allocation and (for federal and state Tax purposes) account for and report the transactions contemplated by this agreement in accordance with such allocations, and will not voluntarily take any position (whether in Tax Returns, Tax audits or other Proceedings) inconsistent with such allocation. Seller and Buyer shall exchange Internal Revenue Service Forms 8594 (including supplemental forms, if required) to report the transactions contemplated by this agreement to the Internal Revenue Service in accordance with such allocation.

5.11. Further Assurances. After the Closing, upon request of Buyer, Seller shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Buyer may reasonably request to more effectively convey, assign and transfer to and vest in Buyer full legal right, title and interest in and actual possession of the Assets and the Hospital Businesses, to confirm Seller's capacities and abilities to perform its post-Closing covenants under this agreement and the Closing Documents, and to generally carry out the purposes and intent of this agreement. Seller shall also furnish Buyer with such information and documents in its possession or under its control, or which Seller can execute or cause to be executed, as will enable Buyer to prosecute any and all petitions, applications, claims and demands relating to or constituting a part of the Assets and Hospital Businesses. After the Closing, upon request of Seller, Buyer shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Seller may reasonably request to more effectively convey, assign and transfer to Buyer each of the Assumed Liabilities, to confirm Buyer's capacities and abilities to perform its post-Closing covenants under this agreement and the Closing Documents, and to generally carry out the purposes and intent of this agreement.

5.12. Casualty; Hurricane Dolly Insurance Proceeds.

(a) If, on or before the Closing Date, any of the Hospital Businesses are destroyed or damaged by fire, theft, vandalism or other cause or casualty and as a result thereof any material part of such Hospital Businesses is rendered unsuitable for its primary intended use, Buyer may elect, by giving written notice to Seller within ten business days after having actual notice of the occurrence of such destruction or damage and the extent of the loss, to: (i) terminate this agreement in accordance with section 8.04(a)(ii), (ii) consummate the transaction in spite of such destruction or damage but reduce the Purchase Price by the fair

market value of the Assets destroyed or damaged (determined as of the date immediately before the destruction or damage) or, if greater, the estimated cost to restore, repair or replace such Assets, in which event Seller will retain all right, title and interest in and to insurance proceeds payable on account of such destruction or damage, or (iii) consummate the transaction in spite of such destruction or damage without any reduction in the Purchase Price, in which event Seller shall pay, transfer and assign to Buyer at Closing the insurance proceeds (or the right to receive the insurance proceeds) payable on account of such destruction or damage, plus any deductibles or copayments required under the applicable insurance policy in respect of such claim. In the absence of an agreement among the parties regarding the amount of any Purchase Price reduction for purposes of clause (ii) above (if applicable), an MAI appraiser mutually selected by the parties and paid equally by Seller, on the one hand, and Buyer, on the other hand, will determine any reduction in Purchase Price pursuant to such clause (ii). If Buyer fails to make a timely election pursuant to this section, Buyer shall be deemed to have made the election described in clause (iii) above.

(b) Seller has recently settled a dispute with its property casualty insurer relating to the insurance proceeds payable to Seller for damage to the Hospital Businesses resulting from Hurricane Dolly in July 2008. Certain damage to the Hospitals that resulted from the hurricane has not been repaired as of the date of this agreement, which damage is described on Schedule 5.12(b). If and to the extent such repairs are not made by Seller prior to Closing, Seller will reimburse Buyer for the cost of making the repairs after Closing upon demand by Buyer and production of documentary evidence of the cost thereof.

5.13. Seller's Cost Reports. Seller will prepare and timely file all Cost Reports required to be filed after Closing for periods ending on or before the Closing Date, including terminating Cost Reports required as a result of the consummation of the transactions described in this agreement. Buyer will provide information to Seller and assist Seller in the preparation and filing of the terminating Cost Reports and the Purchase Price will be allocated in the terminating Cost Reports in a manner consistent with the allocation for Tax purposes described in section 5.10. Buyer will forward to Seller any and all correspondence, remittances and demands relating to Seller's Cost Reports within five business days after receipt by Buyer. Seller retains all rights to its Cost Reports, including any payables resulting from or reserves relating to the Cost Reports and the right to appeal any Medicare determinations relating to the Cost Reports.

5.14. Preservation of Baptist Name and Essential Services; Capital Expenditures. For at least ten years after Closing, Buyer will maintain and operate the two Hospitals under the names "*Valley Baptist Medical Center — Harlingen*" and "*Valley Baptist Medical Center — Brownsville*" and Buyer will provide at the Hospitals the Essential Services described on Schedule 5.14. If Buyer sells either one or both of the Hospitals (with the consent of Seller to the extent required pursuant to the Amended and Restated Operating Agreement), Buyer will require the purchaser to assume the obligations in this section with respect to the Hospital or Hospitals sold for the remaining period of such obligations. Buyer will make available sufficient resources to meet the capital needs of the Hospital Businesses, which resources on average shall be not less than the average annual depreciation expense of the Hospital Businesses.

5.15. Charity Care and Community Obligations.

(a) Seller has historically provided significant levels of care for indigent and low-income patients and has also provided care through a variety of community-based health programs. Subject to changes in Legal Requirements or governmental guidelines or policies, Buyer will adopt, maintain and adhere to Seller's current policy on charity care attached as Schedule 5.15 or adopt other charity care policies and procedures that are at least as favorable to the indigent and uninsured as Seller's policy attached as Schedule 5.15.

(b) Buyer is committed to continuing the outreach, education and advocacy efforts provided by the Hospitals in the communities they serve, and so long as Buyer owns and operates the Hospitals, it will support, and continue to provide care through community-based health programs, including by cooperating with local organizations that sponsor healthcare initiatives, to address community needs and improve the health status of the elderly, poor, and at-risk populations in the community. Buyer will provide the Hospital auxiliaries and volunteers with office and gift shop space and will support their efforts by participating in joint community benefit projects, and will continue Seller's existing sponsorship of community health initiatives. Buyer will generally support graduate medical education and development of the regional academic health center and nursing and staff education and will specifically provide the compensation set forth in section 5.17.

5.16. Pastoral Care Programs. In its conduct of the Hospital Businesses, Buyer will preserve and maintain the Baptist mission and Christ-centered approach that Seller has used historically in the conduct of the Hospital Businesses and oversee and fund pastoral care at the Hospitals. Buyer will maintain the pastoral care and clinical pastoral education programs of the Hospitals sufficient to meet the needs of the Hospitals, will maintain chapels in the Hospitals indefinitely, and will offer pastoral care programs and a chapel at any new or replacement hospitals. Buyer shall employ the current Vice President of Ministries. Any successor Vice President of Ministries shall be recommended by Seller to the Board of Directors of VHS² for appointment. Buyer will maintain Seller's current policies on therapeutic abortion and sterilization. Buyer will work with Seller to define the scope and mission of pastoral care programs at the Hospital Businesses after the Closing. For at least ten years after Closing, Buyer will continue to provide, at a minimum, the same level of annual financial support to the pastoral care programs at the Hospitals as was provided by Seller during Seller's fiscal year ended August 31, 2010.

5.17. Medical Education. Buyer will, at a minimum, continue the current medical education programs in place at the Hospital Businesses, including support for the expanding University of Texas ("UT") relationship and the Valley Baptist Practice Residency Program. In addition, Buyer acknowledges that Seller has committed to UT to provide commercially reasonable and fair market value compensation to UT to support (a) a total of 40 residents as reasonably required and necessary to enable the opening of the UT regional academic health center to be located in the Valley (the "RAHC") and (b) at least one-third of the total residents of the RAHC. Buyer will honor Seller's commitment if and so long as (i) the Accreditation Council for Graduate Management Education has approved the foregoing resident training slots for the academic year beginning July 1, 2011, and for each academic year thereafter, and (ii) the Centers for Medicare & Medicaid Services has approved the foregoing resident training slots as eligible for full GME/IME reimbursement for each academic year, and for each academic year thereafter.

5.18. **VHS² and VBIC to Remain Consolidated Subsidiaries of Vanguard.** Vanguard shall not effect or permit to occur, at any time during the ten-year period immediately following the Closing Date, any transaction or series of related transactions if, immediately after such transaction or transactions, either VHS² or VBIC is not a consolidated Subsidiary of Vanguard. Notwithstanding the foregoing, (a) any Subsidiary of Vanguard that owns an equity interest in VHS² or VBIC may pledge such interest pursuant to the Principal Credit Agreement, (b) the lenders under the Principal Credit Agreement (or their agent acting on their behalf) may foreclose upon such equity interest, and (c) a sale or change of control of Vanguard or any parent company of Vanguard (whether by stock sale, sale of all or substantially all assets, merger, consolidation or otherwise) shall not constitute a transaction or series of related transactions within the meaning of the first sentence of this section.

5.19. **Right of First Refusal in Favor of VBMC-B.**

(a) Vanguard shall not effect or permit to occur, at any time during the five-year period immediately following the expiration of the ten-year period described in section 5.18, any transaction or series of related transactions if, immediately after such transaction or transactions, either VHS² or VBIC is not a consolidated Subsidiary of Vanguard, unless Vanguard first complies with the provisions of section 5.19(b) and such transaction or series of related transactions is thereafter permitted by section 5.19(c). Notwithstanding the foregoing, (a) any Subsidiary of Vanguard that owns an equity interest in VHS² or VBIC may pledge such interest pursuant to the Principal Credit Agreement, (b) the lenders under the Principal Credit Agreement (or their agent acting on their behalf) may foreclose upon such equity interest, and (c) a sale or change of control of Vanguard or any parent company of Vanguard (whether by stock sale, sale of all or substantially all assets, merger, consolidation or otherwise) shall not constitute a transaction or series of related transactions within the meaning of the first sentence of this section.

(b) If Vanguard (or any of its Affiliates) receives an Offer that it desires to accept, Vanguard shall promptly provide a written notice to VBMC-B, enclosing a copy of the Offer. If VBMC-B notifies Vanguard within 60 days after the date on which notice (and a copy) of the Offer was given to VBMC-B (the "**Election Period**") that VBMC-B irrevocably elects to purchase or acquire all (but not less than all) of the equity interest in VHS² and/or VBIC that is the subject of the Offer (the "**Subject Interest**") for the consideration to be paid to Vanguard (or any of its Affiliates) pursuant to the Offer (sometimes referred to hereinafter as an "**Affirmative Election**"), then such election shall be binding upon VBMC-B and Vanguard. If VBMC-B makes an Affirmative Election, the parties shall negotiate in good faith for 30 days after the Election Period the terms and conditions of a definitive agreement to be executed by Vanguard and VBMC-B containing the principal terms set forth in the Offer, but otherwise containing substantially the same representations and warranties regarding the Hospital Businesses as are set forth in this agreement, *provided* that any representations and warranties of Vanguard about the Hospital Businesses shall relate to VHS²'s (or VBIC's, as applicable) period of ownership only. If the Offer includes any non-cash consideration, VBMC-B shall be entitled to substitute cash in an amount equal to the fair market value of such non-cash consideration. VBMC-B shall acquire the Subject Interest at a closing to be held within five business days following the date upon which the last material regulatory approval required in connection with the sale of the Subject Interest is obtained, subject to reasonable extensions mutually acceptable to Vanguard and VBMC-B, *provided* that in no event shall the closing be held later than 180 days after Vanguard gives VBMC-B notice (and a copy) of the Offer.

(c) If a copy of the Offer is given to VBMC-B as provided in section 5.19(b) and (i) VBMC-B fails to make an Affirmative Election within the Election Period, (ii) after making an Affirmative Election and entering into a definitive agreement with Vanguard, VBMC-B defaults in its obligation under such definitive agreement to timely purchase the Subject Interest, or (iii) the consent of any Governmental Authority or third party required for the consummation of the sale of the Hospital Businesses to VBMC-B cannot be obtained (following Seller's use of commercially reasonable efforts to obtain such consent or consents), then Vanguard may (but shall not be obligated to) sell or transfer the Subject Interest to the proposed purchaser named in the Offer in accordance with the terms and conditions of the Offer within 180 days after the event described in clause (i), (ii) or (iii) above, *provided* that, if the sale to such proposed purchaser does not occur on or before the expiration of such 180-day period, then the provisions of this section shall apply anew with respect to the sale of the Subject Interest thereafter.

5.20. **Rights of First Refusal in Favor of VHS².** If, at any time during the 15-year period immediately following the Closing Date, Seller (or any of its Affiliates) receives a *bona fide* written offer that Seller desires to accept, pursuant to which a Person that is not an Affiliate of Seller would purchase all or any portion of (a) Seller's legal or beneficial interest in either or both of the HMC Partnerships, or (b) any of the real property described on Schedule 5.20, Seller shall promptly provide a written notice to VHS², enclosing a copy of the offer. If VHS² notifies Seller within 60 days after the date on which notice (and a copy) of the offer was given to VHS² that VHS² irrevocably elects to purchase or acquire all (but not less than all) of the interest or property that is the subject of the offer for the consideration to be paid to Seller (or any of its Affiliates) pursuant to the offer, then such election shall be binding upon Seller and VHS². If VHS² makes an affirmative election, the parties shall negotiate in good faith for 30 days after VHS² makes such election the terms and conditions of a definitive agreement to be executed by Seller (or its Affiliate) and VHS² containing the principal terms set forth in the offer and other terms and conditions customary in transactions of like nature and acceptable to the parties. If the offer includes any non-cash consideration, VHS² shall be entitled to substitute cash in an amount equal to the fair market value of such non-cash consideration. VHS² shall acquire the interest or property at a closing to be held within five business days following the date upon which the last material regulatory approval required in connection with the sale of the interest or property is obtained, subject to reasonable extensions mutually acceptable to Seller and VHS², provided that in no event shall the closing be held later than 180 days after Seller gives VHS² notice (and a copy) of the offer. If a copy of the offer is given to VHS² and (i) VHS² fails to make an affirmative election to purchase the interest or property within the election period specified above, (ii) after making an affirmative election and entering into a definitive agreement with Seller, VHS² defaults in its obligation under such definitive agreement to timely purchase the interest or property, or (iii) the consent of any Governmental Authority or third party required for the consummation of the sale of such interest or property to VHS² cannot be obtained (following Seller's use of commercially reasonable efforts to obtain such consent or consents), then Seller may (but shall not be obligated to) sell or transfer the interest or property to the proposed purchaser named in the offer in accordance with the terms and conditions of the offer within 180 days after the event described in clause (i), (ii) or (iii) of this sentence, provided that, if the sale to such proposed purchaser does not occur on or before the expiration of such 180-day period, then the provisions of this section shall apply anew with respect to the sale of the interest or property thereafter.

5.21. Fees and Expenses.

(a) Except as otherwise expressly set forth in this agreement, whether or not the transactions contemplated by this agreement are consummated, (i) Vanguard shall bear and pay all expenses incurred by or on behalf of Buyer or Vanguard in connection with Buyer's due diligence investigation of the Assets and the Hospital Businesses, the preparation and negotiation of this agreement and Buyer's and Vanguard's performance of their respective obligations pursuant to this agreement, including counsel, accounting, brokerage and investment advisor fees and disbursements, and (ii) VBHS shall bear and pay all expenses incurred by or on behalf of Seller in connection with the preparation and negotiation of this agreement and Seller's performance of its obligations pursuant to this agreement, including counsel, accounting, brokerage and investment advisor fees and disbursements.

(b) Seller shall pay all costs reasonably necessary for Seller to remove all Encumbrances on the Assets that are not Permitted Encumbrances and all expenses incurred by Seller in obtaining any third party consents or approvals necessary to assign to Buyer any Assumed Contracts (it being understood that Seller shall have no obligation to make any material monetary payment to a third party or accept any material concession in the terms of any Contract in order to obtain any such consents or approvals).

(c) Buyer shall pay the following (collectively, the "**Credited Expenses**"): (i) all third party fees and expenses reasonably incurred by Buyer for Buyer's land title surveys and environmental, engineering and other inspections, studies, tests, reviews and analyses undertaken by or on behalf of Buyer for the benefit of Buyer, (ii) all real estate transfer Taxes and sales and use Taxes arising out of the transfer of the Assets, (iii) the premium for Buyer's title insurance policies described in section 7.05, and (iv) the HSR Act filing fee.

(d) If any party incurs legal fees or expenses in connection with any Proceeding to enforce any provision of this agreement and is the prevailing party in the Proceeding, such party will be entitled to recover from the non-prevailing party in the Proceeding the legal fees and expenses reasonably incurred by such party in connection with the Proceeding, including attorneys' fees, costs and necessary disbursements, in addition to any other relief to which such party is entitled.

5.22. Medical Staff Matters. To ensure continuity of care in the community, each Hospital's medical staff member in good standing at Closing will have medical staff privileges at the Hospital immediately after the Closing, subject thereafter to the Hospital's medical staff bylaws then in effect, as amended from time to time. Buyer intends to commit administrative and financial resources to support a long-term recruitment of physicians into the Rio Grande Valley region. Buyer also intends to involve physicians in the strategic and capital planning process for each of the Hospitals, to insure that the critical needs of the medical staff are met and that strategic initiatives and investments in the Hospital facilities are prioritized to better meet the needs of physicians who practice at the Hospitals and the patients they treat.

5.23. Post-Closing Administrative Assistance. For one year after the Closing, Buyer will provide Seller and its Affiliates (including the Foundation), at no cost to Seller or such Affiliates, (a) administrative resources reasonably requested by Seller to assist it in the disposal or discharge of the Excluded Assets and Excluded Liabilities, (b) transition services to enable Seller to carry out its post-Closing obligations under this agreement, in accordance with the terms of the Transition Services Agreement attached as Exhibit E and (c) access to the Hospital Businesses and the assistance of Hired Employees as reasonably requested by the Foundation in connection with its efforts to ensure compliance with all restrictions and conditions applicable to Prior Donations and Current Donations. Buyer, for a period of one year without charge, and thereafter upon mutually agreed terms, shall provide reasonable office space in Harlingen, Texas, in which the Foundation may carry out its activities.

5.24. Insurance Ratings. Seller will take all commercially reasonable actions requested by Buyer to enable Buyer, at Buyer's expense, to succeed to the workers' compensation and unemployment insurance ratings of Seller and the Hospital Businesses for insurance purposes. Buyer shall not be obligated to succeed to any such rating, except as it may elect to do so.

5.25. Fulfillment of Conditions. If all of the conditions to a party's obligation to consummate the transactions contemplated by this agreement at the Closing are satisfied (or waived by that party in its sole discretion), such party will execute and deliver at Closing each Closing Document that such party is required by this agreement to execute and deliver at Closing. Each party will use all commercially reasonable efforts to satisfy each condition to the obligations of the other parties to consummate the transactions contemplated by this agreement, to the extent that satisfaction of any such condition is within the control of such party.

5.26. Release of Encumbrances. Seller shall use all commercially reasonable efforts to cause all Encumbrances on the Assets other than the Permitted Encumbrances to be released and discharged at or before Closing.

5.27. Attorney General Process. Seller has previously notified the Attorney General about the pendency of the transactions contemplated herein. Seller shall cooperate with the Attorney General in connection with the Attorney General's investigation and approval or no objection process and use all commercially reasonable efforts to obtain such approval or no objection determination as soon as reasonably practicable. Buyer shall reasonably cooperate with Seller and the Attorney General in connection with Seller's efforts to obtain the Attorney General's approval of or no objection determination pertaining to the transactions described herein.

5.28. Restricted Assets. Seller has previously invested certain moneys or restricted assets in the Hospital Businesses ("**Prior Donations**") and holds certain additional monies or restricted assets for future investment in the Hospital Businesses ("**Current Donations**"), all of which Prior Donations and Current Donations are subject to certain requirements and conditions of use. Schedule 5.28 sets forth a description of the Prior Donations, the Current Donations and all requirements and conditions of use to which they are subject. Buyer will use commercially reasonable efforts to comply with all such requirements and conditions of use with respect to Prior Donations and Current Donations.

5.29. Tail Insurance. On or before the Closing Date, Seller will purchase and obtain an unlimited extended claims reporting provision for all primary and excess insurance policies in force as of the date of this agreement that cover Seller or its consolidated Subsidiaries and each physician employee of Seller (or for which Seller otherwise has an obligation to provide such insurance), and that are written on a claims-made insuring agreement. Such extended claim endorsements must name Buyer (and other Affiliates of Buyer designated by Buyer prior to the Closing) as named insureds thereunder. In the alternative, Seller will maintain self-insurance in amounts that provide substantially the same liability coverage as would be provided by the tail insurance policies described above. If Seller engages in a loss portfolio transfer for some or all of such risks with one or more insurers licensed to conduct business in the State of Texas, Seller shall require such insurers to expressly name Buyer (and such designated Affiliates) as beneficiaries thereof.

5.30. Code Section 338(h)(10) Election. Prior to Closing, Buyer and Seller will join in making an election under section 338(h)(10) of the Code, and any comparable elections, with respect to the purchase of the capital stock of VBIC, under any state or local income tax law (each, a "**Section 338(h)(10) Election**"). Buyer represents and warrants that it is qualified to make such elections. Buyer and Seller shall further (i) allocate the VBIC Purchase Price among the assets of VBIC that are deemed to have been acquired pursuant to section 338(h)(10) of the Code and comparable state income tax provisions in the manner set forth on Schedule 5.30 (the "**Section 338 Asset Allocation Schedule**") and (ii) exchange, complete and properly execute copies of Internal Revenue Service Form 8023A, the required schedules related thereto, and comparable state forms and schedules, all of which will be prepared on a basis consistent with the Section 338 Asset Allocation Schedule. If any changes are required to be made to these forms or schedules (including the Section 338 Asset Allocation Schedule) as a result of the valuation of fixed assets to be undertaken by Buyer after the Closing or of information that becomes available after the Closing Date, the parties shall promptly and in good faith reach an agreement as to the precise changes required to be made. Buyer will prepare and file all further documents and materials necessary in connection with making each Section 338(h)(10) Election, and Seller will assist Buyer and cooperate with Buyer in connection therewith. Buyer and Seller will prepare and file all Tax Returns and reports with respect to Taxes, including Internal Revenue Service Form 8594 and comparable state forms, in a manner consistent with the Section 338(h)(10) Election and the valuation of the assets as set forth in the Section 338 Asset Allocation Schedule. All Taxes imposed on the deemed sale of assets resulting from the Section 338(h)(10) Election, if any, will be included in Seller's Tax Returns as applicable and will be paid by Seller.

5.31. Insurance Approvals for Sale of VBIC Shares. If all action required to be taken and all consents and approvals of Governmental Authorities required to be obtained in connection with the transfer of the VBIC Shares ("**Insurance Approvals**") have not been taken or obtained prior to Closing, (i) the parties shall defer the transfer of the VBIC Shares, the execution and delivery of the Closing Documents specifically relating thereto and the payment of the VBIC Purchase Price until the second business day following the date on which all such Insurance Approvals have been obtained, and (ii) VBIC shall operate VBIC only in the ordinary course of business or as otherwise approved in advance by Buyer until the time of such deferred closing and shall not pay any dividend or otherwise distribute any cash or other assets of VBIC to any Seller. Promptly after the sale and transfer of the VBIC Shares, VHFC shall advance to VBIC funds for the purpose of allowing VBIC to reimburse (and shall cause VBIC to reimburse) Seller for advances made by Seller to VBIC after Closing, if any.

5.32. Amendment of VBIC Articles. Prior to Closing, Seller shall amend and cause VBIC to amend VBIC's articles of incorporation to (i) reduce the authorized number of shares of VBIC capital stock from 1,500,000 to 750,000, and (ii) limit the geographic area in which VBIC may conduct its business to the Rio Grande Valley Market, the cities of Laredo and Corpus Christi, Texas, and Webb, Nueces and San Patricio Counties, Texas, and (iii) to require that any amendment of the bylaws shall require the unanimous consent and approval of all members of the VBIC board of directors and all of the shareholders.

5.33. School of Vocational Nursing. VBMC and VHS-H shall prepare and file with the TWC all applications required to obtain a certificate of approval and other required Permits under Chapter 132 to operate the LVN School substantially in the same manner that it is currently operated by VBMC, except for changes to the LVN School required by Chapter 132 for the LVN School to operate without its current exemption. VBMC and VHS-H shall use commercially reasonable efforts to obtain the certificate of approval from the TWC and all other required Permits required of Governmental Authorities, if any. VBMC shall also notify the Texas Board of Nursing of the proposed transfer of the LVN School. Upon and effective as of the first day of the month after obtaining all required Permits, including the TWC certificate of approval, VBMC shall transfer ownership of the LVN School to VHS-H. During the period between the Closing Date and the date the LVN School is transferred to VHS-H (the "**Interim Period**"), VBMC will continue to own and operate the LVN School in the ordinary course consistent with past practices and shall not make any changes in the organizational structure or reporting channels, or to the LVN School program or its curriculum, except as required by Legal Requirements to maintain the exemption from the application of Chapter 132 or to obtain the TWC certificate of approval. If during the Interim Period the cost of obtaining the required Permits and of operating the LVN School exceeds the income of the LVN School, VHS-H shall reimburse VBMC by the amount of the excess, and if during the Interim Period the income of the LVN School exceeds such cost, VBMC shall remit the excess to VHS-H. In addition to tuition and all other revenues actually earned by the LVN School during the Interim Period, and to compensate Buyer for the foregone cost report reimbursement that would otherwise be attributable to the Interim Period had the LVN School been owned by VHS-H during the Interim Period, for purposes of the preceding sentence the LVN School shall be deemed to have additional income during the Interim Period of \$30,000 per month. Once the certificate of approval and other required Permits are received and the LVN School is transferred to VHS-H, VHS-H or one of its Affiliates shall employ all employees of the LVN School then employed by VBMC upon the terms and conditions applicable to the employment of the Hired Employees generally, and will assume the operations of, and all Assumed Contracts relating to, the LVN School.

6. CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLER

The obligations of Seller to consummate the transactions contemplated by this agreement, including by taking the actions specified in section 8.02, are subject to the satisfaction on or before Closing of the following conditions, unless waived by Seller:

6.01. Representations; Covenants.

(a) Each of the representations and warranties of Buyer in this agreement that is qualified as to materiality was true and correct on and as of the date of this agreement, each of the other representations and warranties of Buyer was true and correct in all material respects on and as of the date of this agreement, each of the representations and warranties of Buyer in this agreement that is qualified as to materiality is true and correct on and as of the Closing Date, and each of the other representations and warranties of Buyer in this agreement is true and correct in all material respects on and as of the Closing Date.

(b) Each of the covenants to be complied with or performed by Buyer on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in section 8.03) has been complied with and performed in all material respects.

6.02. Adverse Proceeding. No Proceeding by any Governmental Authority (including the Attorney General) has been instituted or threatened to restrain or prohibit the transactions contemplated by this agreement, no Governmental Authority (including the Attorney General) has taken any other action or made any request of Seller or Buyer as a result of which Seller reasonably and in good faith deems it inadvisable to proceed with the transactions contemplated by this agreement, and no order is in effect restraining, enjoining or otherwise preventing consummation of the transactions contemplated by this agreement.

6.03. Pre-Closing Confirmations. Seller has received all consents, approvals, licenses and other authorizations of Governmental Authorities required for Seller to consummate the transactions contemplated by this agreement (other than Insurance Approvals), and that all applicable waiting periods under the HSR Act have expired or been terminated.

6.04. BGCT Approval. This agreement and the transactions contemplated by this agreement were approved by the BGCT.

6.05. Redemption of the Bonds/Satisfaction of the Indenture. All actions required to be taken and all conditions required to be satisfied in connection with the defeasance or redemption of all outstanding tax-exempt debt issued by or on behalf of Seller, and the satisfaction, discharge, release, and termination of all Trust Indentures and related documents (collectively, the "**Indenture**") associated with such tax-exempt debt, and all Encumbrances created by or in connection with the Indenture, have been taken and satisfied. The Indenture and all Encumbrances created by or in connection with the Indenture shall have been satisfied, discharged and terminated, and Seller shall have received an opinion from McCall, Parkhurst and Horton L.L.P. or from a nationally recognized bond counsel to the effect that all conditions precedent to the foregoing have been satisfied and that Seller may transfer and convey the Assets to Buyer free and clear of the Indenture and all Encumbrances created by or in connection therewith.

6.06. Extraordinary Events. Neither Buyer nor Vanguard nor any Subsidiary of Vanguard that directly or indirectly holds any equity interest in Buyer (a) is in receivership or dissolution, (b) has made any assignment for the benefit of creditors, (c) has admitted in writing its inability to pay its debts as they mature, (d) has been adjudicated a bankrupt, (e) has filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state (and no such petition has been filed against Buyer or Vanguard or any Subsidiary of Vanguard that directly or indirectly holds any equity interest in Buyer), or (f) has entered into any Contract to do any of the foregoing on or after the Closing Date.

7. CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

The obligations of Buyer to consummate the transactions contemplated by this agreement, including by taking the actions specified in section 8.03, are subject to the satisfaction on or before Closing of the following conditions, unless waived by Buyer:

7.01. Representations; Covenants.

(a) Each of the representations and warranties of Seller in this agreement that is qualified as to materiality was true and correct on and as of the date of this agreement, each of the other representations and warranties of Seller in this agreement was true and correct in all material respects on and as of the date of this agreement and each of the representations and warranties of Seller in this agreement (other than the representation in section 3.08(l)) is true and correct on and as of the Closing Date, disregarding all qualifiers and exceptions relating to materiality, except where the failure of the representations and warranties of Seller to be true and correct on and as of the Closing Date has not resulted in, and would not reasonably be expected to result in, individually or in the aggregate, (i) Losses of \$10,000,000 or more, or (ii) an adverse effect on EBITDA of the Hospital Businesses of at least \$2,000,000 on an annualized basis.

(b) Each of the covenants to be complied with or performed by Seller on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in section 8.02) has been complied with and performed in all material respects.

7.02. Adverse Action or Proceeding. No Proceeding by any Governmental Authority (including the Attorney General) has been instituted or threatened to restrain or prohibit the transactions contemplated by this agreement, no Governmental Authority (including the Attorney General) has taken any other action or made any request of Seller or Buyer as a result of which Buyer reasonably and in good faith deems it inadvisable to proceed with the transactions contemplated by this agreement, and no order is in effect restraining, enjoining or otherwise preventing consummation of the transactions contemplated by this agreement.

7.03. Pre-Closing Confirmations and Contractual Consents. Buyer has obtained documentation or other evidence reasonably satisfactory to Buyer that:

(a) Buyer has received confirmation from the Texas Department of State Health Services and other applicable Governmental Authorities that all Permits required to operate the Hospital Businesses will be transferred to or issued in the name of Buyer as of the Closing Date, without the imposition of any condition that is materially burdensome to the operation of the Hospital Businesses after Closing;

(b) Buyer has received reasonable assurances that the applicable Hospital Businesses that participate in the Government Payment Programs as of the date of this agreement will be qualified effective as of Closing to participate in the Government Payment Programs in which they participate as of the date of this agreement and will be entitled to receive payment under such Government Payment Programs for services rendered to qualified beneficiaries of such Government Payment Programs immediately after the Closing Date with respect to the Hospitals, and within a reasonable period of time after the Closing Date with respect to the other applicable Hospital Businesses;

(c) Buyer has received all other consents, approvals, licenses and other authorizations of Governmental Authorities required for Buyer to consummate the transactions contemplated by this agreement and all other material consents, approvals, licenses and other authorizations of Governmental Authorities required for Buyer to operate the Hospital Businesses after Closing (in each case other than Insurance Approvals);

(d) Seller has delivered to Buyer copies of consents to assignment of the Assumed Contracts that are listed on Schedule 7.03(d); and

(e) all applicable waiting periods under the HSR Act have expired or been terminated.

7.04. Extraordinary Events. Seller (a) is not in receivership or dissolution, (b) has not made any assignment for the benefit of creditors, (c) has not admitted in writing its inability to pay its debts as they mature, (d) has not been adjudicated a bankrupt, (e) has not filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state (and no such petition has been filed against any it), and (f) has not entered into any Contract to do any of the foregoing on or after the Closing Date.

7.05. Title Insurance Policies and Surveys. Buyer has received:

(a) One or more commitments from a title insurance company chosen by Buyer to issue as of the Closing Date ALTA extended coverage owner's title insurance policies for the Owned Real Property, in amounts reasonably acceptable to Buyer, in form reasonably satisfactory to Buyer and with such endorsements as Buyer may reasonably require; and

(b) ALTA land title surveys of the Owned Real Property, in form reasonably satisfactory to Buyer and the title insurance company, from a firm designated by Buyer and certified to Buyer and the title insurance company.

7.06. Opinion of Seller's Counsel. Buyer has received an opinion from counsel to Seller (who may be in-house counsel) dated as of the Closing Date and addressed to Buyer, in substantially the form attached as Schedule 7.06.

7.07. The Indenture. The Indenture and all Encumbrances created by or in connection with the Indenture shall have been satisfied, discharged and terminated, and Buyer shall be entitled to rely on the opinion of Seller's bond counsel described in section 6.05.

7.08. Hill-Burton Facilities. No Encumbrance affects any of the Assets or Hospital Businesses relating to or arising under the Hill-Burton Act.

7.09. Acquisition of Imaging Partnerships. Buyer has acquired, directly or indirectly, substantially all of the assets owned by the Imaging Partnerships free and clear of all Encumbrances, such that the imaging center businesses formerly operated by the Imaging Partnerships will be operated as outpatient departments of the Hospitals from and after Closing.

7.10. Merger of VBRC; Rights of First Refusal. VBRC has merged into VB Realty Corporation and VBRC II, and any and all rights of first refusal or similar restrictions that purport to limit, restrict or condition the transfer of any Assets, including Seller's interests in the Joint Ventures, to Buyer are satisfied or waived by the parties holding such rights.

8. CLOSING; TERMINATION OF AGREEMENT

8.01. Closing.

(a) Consummation of the sale and purchase of the Hospital Businesses and the Assets and the other transactions contemplated by this agreement (the "**Closing**") will take place at the office of Seller at 10:00 a.m. on August 31, 2011, or if at such time any conditions to Closing set forth in articles 6 and 7 have not been satisfied (or waived by the parties entitled to the benefit thereof), on the third business day following satisfaction or waiver of such conditions, or at such time or place as the parties may mutually agree. The Closing shall be effective for all purposes as of 12:01 a.m. on the day immediately following the Closing Date.

(b) At the Closing, Seller shall deliver, or cause to be delivered, to Buyer, each of the Closing Documents and other items set forth in section 8.02, all in forms reasonably acceptable to Buyer and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, each Seller designated therein to be party thereto. At the Closing, Vanguard and Buyer shall deliver, or cause to be delivered, to Seller, each of the Closing Documents and the consideration set forth in section 8.03, all in forms reasonably acceptable to Seller and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Vanguard and Buyer.

(c) All proceedings to be taken and all documents to be executed and delivered by all parties at the Closing will be deemed to have been taken, executed and delivered simultaneously, and no proceedings will be deemed taken nor any documents executed or delivered until all have been taken, executed and delivered. At the conclusion of the Closing, all Closing Documents shall be released to the recipients thereof and the Sellers shall deliver (or cause to be delivered) to Buyer control and possession of the Hospital Businesses and the Assets.

8.02. Action of Seller at Closing. At the Closing, Seller shall deliver to Buyer:

(a) special warranty deeds, duly executed by Seller in recordable form, conveying to Buyer fee simple title to the Owned Real Property, free and clear of Encumbrances other than the Permitted Real Property Encumbrances;

(b) assignment and assumption agreements duly executed by Seller conveying to Buyer all of Seller's right, title and leasehold interest in and to the Leased Real Property;

(c) bills of sale and assignment duly executed by Seller conveying to Buyer good and valid title to all personal property Assets, free and clear of Encumbrances other than the Permitted Personal Property Encumbrances;

(d) assignments duly executed by Seller conveying to Buyer Seller's interests in the Assumed Contracts;

(e) the Amended and Restated Operating Agreement duly executed by VBMC-B;

(f) the License Agreement, in the form attached as Exhibit D, duly executed by the Foundation, VBHH and VBHS;

(g) the Transition Services Agreement, in the form attached as Exhibit E, duly executed by VBHS, VBHH and the Foundation;

(h) the VBIC Shareholders Agreement duly executed by VBIH;

(i) the agreement and plan of merger, duly executed by VBRC II, pursuant to which the Merger is consummated;

(j) a memorandum of understanding or agreement between the LVN School and VHS-H duly executed by VBMC, pursuant to which LVN School students may have opportunities for clinical and observational education at VBMC;

(k) an employee lease agreement, duly executed by VBMC, pursuant to which Buyer leases to VBMC the chief nursing officer and chief executive officer of Valley Baptist Medical Center so that such persons may continue to serve during the Interim Period in their current roles with regard to the management, authority and reporting channels of the LVN School;

(l) a balance sheet of VBIC as of the Closing Date, certified by Seller's chief financial officer as true and accurate, showing compliance with both the capital, surplus, minimum reserve, liquidity and other financial requirements of the insurance laws of the State of Texas and the Texas Department of Insurance applicable to the conduct of VBIC's business, and with prudent actuarial practices;

(m) original or certified copies of the tail insurance policies required by section 5.29 and receipts evidencing payment of the premiums therefor;

(n) copies of resolutions duly adopted by the board of directors, trustees or shareholders of each Seller, as appropriate, authorizing and approving the execution and delivery of this agreement and the Closing Documents and the consummation of the transactions contemplated therein, certified as in full force and effect as of the Closing Date by the appropriate officers of such Seller;

(o) a certificate of a duly authorized officer of VBHS certifying that (i) each of the representations and warranties of Seller in this agreement that is qualified as to materiality was true and correct on and as of the date of this agreement, (ii) each of the other representations and warranties of Seller in this agreement was true and correct in all material respects on and as of the date of this agreement, (iii) each of the representations and warranties of Seller in this agreement (other than the representation in section 3.08(l)) is true and correct on and as of the Closing Date, disregarding all qualifiers and exceptions relating to materiality, except where the failure of the representations and warranties of Seller to be true and correct on and as of the Closing Date has not resulted in, and would not reasonably be expected to result in, individually or in the aggregate, (1) Losses of \$10,000,000 or more, or (2) an adverse effect on EBITDA of the Hospital Businesses of at least \$2,000,000 on an annualized basis and (iv) each of the covenants to be complied with or performed by Seller on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in this section 8.02) has been complied with and performed in all material respects;

(p) copies of resolutions duly adopted by the board of directors and shareholders of VBRC, as appropriate, authorizing and approving the merger of VBRC into VB Realty Corporation and VBRC II, the Merger, the execution and delivery of the agreement and plan of merger, certified as in full force and effect as of the Closing Date by the appropriate officers of VBRC;

- (q) certificates of incumbency for the officers of Seller executing this agreement and the Closing Documents;
- (r) certificates of existence and good standing from the State of Texas, each dated no earlier than 15 days prior to the Closing Date;
- (s) stock certificates and certificates or other appropriate instruments of transfer of the ownership interests in the Transferring Subsidiaries (other than VBIC), the Non-Profit Corporations and the Joint Ventures, duly endorsed for transfer to Buyer, and, to the extent obtained prior to Closing, any amendment to the operating agreement, bylaws or other governing documents of each Joint Venture that Buyer determines, in its reasonable discretion, is necessary to fully effectuate the transfer of the ownership interest in the Joint Ventures to Buyer;
- (t) stock certificate(s) evidencing the VBIC Shares, duly endorsed for transfer to VHFC;
- (u) written resignations of the directors and officers of (or persons holding comparable positions in) the Transferring Subsidiaries (except, with respect to VBIC, as provided in subsection 8.02(w)), effective on and as of the Closing Date;
- (v) a certified copy of resolutions of the board of directors of VBIC reducing the size of the board of directors of VBIC to five, accompanied by written resignations of the directors and officers of VBIC effective on and as of the Closing Date, provided that one director may, at the discretion of Seller, continue to hold his or her membership on the VBIC board of directors;
- (w) an original consent of the shareholders of VBIC executed by VBIH appointing the persons named on Schedule 8.02(w) as directors of VBIC effective upon and from and after the Closing;
- (x) possession and custody of the original minute books and transfer ledgers for the Transferring Subsidiaries, the original minute books for the Non-Profit Corporations, and, to the extent in Seller's possession or control, similar organizational books for the Joint Ventures;
- (y) limited powers of attorney to permit Buyer to utilize Seller's DEA registration numbers on a temporary basis until such time as Buyer obtains its own DEA registration numbers;
- (z) a statement pursuant to section 1.1445-2(b)(2)(iv) of the Treasury Regulations under the Code, executed on behalf of each Seller conveying an interest in Owned Real Property to Buyer, certifying that such Seller is not a foreign corporation and is not otherwise a foreign person;
- (aa) a list of source or access codes to computers, combinations to safes and the location of and keys to safe deposit boxes, if any, to the extent that the foregoing are included in the Assets;

(bb) certificates of title for all motor vehicles that are Assets;

(cc) UCC termination statements or other releases for all Encumbrances on the Assets not constituting Permitted Encumbrances, which termination statements and releases will be effective as of Closing; and

(dd) an "occasional sale" sales tax exemption certificate for the benefit of each appropriate Buyer; and

(ee) such other Closing Documents as Buyer deems reasonably necessary to consummate the transactions contemplated by this agreement.

8.03. Action of Buyer at Closing. At the Closing, Buyer shall deliver to Seller:

(a) the Cash Proceeds Payable to Seller, in accordance with section 2.05(d);

(b) an assumption agreement duly executed by Buyer pursuant to which Buyer assumes the Assumed Liabilities;

(c) the Amended and Restated Operating Agreement duly executed by VMC;

(d) the License Agreement, in the form attached as Exhibit D, duly executed by VHS²;

(e) the Transition Services Agreement, in the form attached as Exhibit E, duly executed by VHS²;

(f) the VBIC Shareholders Agreement duly executed by VHFC;

(g) the Management Services Agreement, duly executed by VHS² and VMC;

(h) the Buyer Credit Agreement, duly executed by VHS² (as borrower) and VHFC (as lender);

(i) the agreement and plan of merger, duly executed by Valley Realty;

(j) the memorandum of understanding or agreement between the LVN School and VHS-H, duly executed by VHS-H;

(k) the employee lease agreement described in section 8.02(k), duly executed by Buyer or its Affiliate;

(l) copies of resolutions duly adopted by the boards of directors, members or managers of Vanguard and Buyer, as appropriate, authorizing and approving the execution and delivery of this agreement and the Closing Documents and the consummation of the transactions contemplated therein, certified as in full force and effect as of the Closing Date by the appropriate officers of Vanguard and Buyer;

(m) certificates of a duly authorized officer of each of VHS² and Vanguard certifying that each of the representations and warranties of Buyer in this agreement that is qualified as to materiality was true and correct on and as of the date of this agreement, that each of the other representations and warranties of Buyer in this agreement was true and correct in all material respects on and as of the date of this agreement, that each of the representations and warranties of Buyer in this agreement that is qualified as to materiality is true and correct on and as of the Closing Date, that each of the other representations and warranties of Buyer in this agreement is true and correct in all material respects on and as of the Closing Date, and that each of the covenants to be complied with or performed by Buyer on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in this section) has been complied with and performed in all material respects;

(n) copies of resolutions duly adopted by the board of directors and members of Valley Realty, as appropriate, authorizing and approving the Merger, the execution and delivery of the agreement and plan of merger, certified as in full force and effect as of the Closing Date by the appropriate officers of Valley Realty;

(o) certificates of incumbency for the officers of Vanguard and Buyer executing this agreement and the Closing Documents;

(p) an original consent of the shareholders of VBIC executed by VHFC appointing the persons named on Schedule 8.02(w) as directors of VBIC effective upon and from and after the Closing;

(q) certificates of existence and good standing of Vanguard and Buyer from the state in which it is incorporated or formed, each dated no earlier than 15 days prior to the Closing Date; and

(r) such other Closing Documents as Seller deems reasonably necessary to consummate the transactions contemplated by this agreement.

8.04. Termination Before Closing.

(a) Before the Closing, this agreement may be terminated, and the transactions contemplated by this agreement abandoned, upon notice by the terminating party to the other parties, solely in the following circumstances:

(i) by mutual consent of Buyer and Seller;

(ii) by Buyer in accordance with section 5.12(a) (if and when permitted thereby);

(iii) by Buyer, if (A) Buyer is not then in material breach of this agreement and (B) one of the following has occurred: (1) Seller fails to consummate the transactions contemplated by this agreement (including by failing to execute and deliver any of the Closing Documents pursuant to section 8.02) when all of the conditions to the obligations of Seller to consummate the transactions contemplated by this agreement have been satisfied, or (2) the satisfaction prior to the End Date of any condition to the obligations of Buyer to consummate the transactions contemplated by this agreement becomes impossible or impracticable with the use of commercially reasonable efforts (and the impossibility or impracticality of such conditions being satisfied has not resulted from any breach of this agreement by Buyer), or (3) the End Date has passed (and the failure of the Closing to occur by the End Date did not result from any breach of this agreement by Buyer); or

(iv) by Seller, if (A) Seller is not then in material breach of this agreement and (B) one of the following has occurred: (1) Buyer fails to consummate the transactions contemplated by this agreement (including by failing to execute and deliver any of the Closing Documents or deliver the Cash Proceeds Payable to Seller pursuant to section 8.03) when all of the conditions to the obligations of Buyer to consummate the transactions contemplated by this agreement have been satisfied, or (2) the satisfaction prior to the End Date of any condition to the obligations of Seller to consummate the transactions contemplated by this agreement becomes impossible or impracticable with the use of commercially reasonable efforts (and the impossibility or impracticality of such conditions being satisfied has not resulted from any breach of this agreement by Seller), or (3) the End Date has passed (and the failure of the Closing to occur by the End Date did not result from any breach of this agreement by Seller).

The "**End Date**" shall be September 30, 2011; *provided* that if, as of such date, all of the conditions to the obligations of each party to consummate the transactions contemplated by this agreement have been satisfied (or waived by each party entitled to the benefit thereof) other than the receipt of one or more consents, approvals, licenses and other authorizations of Governmental Authorities and/or the expiration or termination of all applicable waiting periods under the HSR Act, then either Buyer or Seller shall have the right, exercisable by giving written notice to the other, to extend the End Date to a date that is not later than December 31, 2011.

(b) If this agreement is validly terminated pursuant to this section, this agreement will be null and void, and there will be no liability on the part of any party pursuant to this agreement, except that (i) upon termination of this agreement pursuant to subparagraphs (ii), (iii) or (iv) of section 8.04(a), Seller will remain liable to Buyer and Buyer will remain liable to Seller for any breach of their respective obligations existing at the time of such termination, and each party may seek such remedies or damages against the other with respect to any such breach as are provided in this agreement or as are otherwise available at law or in equity and (ii) the expense allocation provisions of section 5.21 and the confidentiality provisions of section 11.19 shall remain in full force and effect and survive any termination of this agreement.

9. INDEMNIFICATION

9.01. Indemnification by Seller. Subject to the conditions and limitations, and solely to the extent, provided in this article, from and after the Closing, Seller shall indemnify, defend and hold harmless Buyer's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Buyer's Indemnified Persons, directly or indirectly, as a result of or arising from:

- (a) any inaccuracy in any representation or warranty of Seller set forth in this agreement or in any Closing Document to which Seller is a party, whether or not Buyer's Indemnified Persons relied thereon or had knowledge thereof, *provided* that, in determining whether there has been any such inaccuracy, any qualification as to materiality included in any representation or warranty shall not be taken into account;
- (b) the nonfulfillment of any covenant of Seller set forth in this agreement or in any Closing Document to which Seller is a party; and
- (c) the Excluded Liabilities.

9.02. Seller's Limitations.

(a) Seller will have no liability under section 9.01(a) and no claim will accrue against Seller under section 9.01(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Seller in respect of claims arising under section 9.01(a) exceeds \$500,000 (the "**Seller Deductible**") in the aggregate, at which time Buyer's Indemnified Persons shall be entitled to indemnification for all Losses under section 9.01(a) in excess of the Seller Deductible, *provided* that there shall be no minimum Loss requirement, and liability of Seller shall arise from and after \$1.00 of Losses, in respect of Losses resulting from Seller's intentional misrepresentation or fraud. In addition, Seller will have no liability under section 9.01(a) or section 9.01(b) and no claim arising under section 9.01(a) or section 9.01(b) will accrue against Seller unless Buyer's Indemnified Person's claim for indemnification is made against Seller during the period in which the representation or covenant in respect of which the claim is made survives, as provided in section 9.06.

(b) The aggregate liability of Seller to Buyer's Indemnified Persons for indemnification under section 9.01(a) shall not exceed ten percent (10%) of the Cash Proceeds Payable to Seller, except that (i) there shall be no limitation of Seller's liability for indemnification under section 9.01(a) in respect of Losses resulting from Seller's intentional misrepresentation or fraud and (ii) the aggregate liability of Seller to Buyer's Indemnified Persons for indemnification under section 9.01(a) in respect of Losses arising from any inaccuracy in the Title Representations, when added to the aggregate liability of Seller to Buyer's Indemnified Persons for indemnification under section 9.01(a) in respect of Losses arising from inaccuracies in all other representations and warranties, shall not exceed one hundred percent (100%) of the amount that is equal to the Cash Proceeds Payable to Seller *minus* the aggregate amount paid by Seller to defease the bonds under the Indenture and *minus* the out-of-pocket fees and expenses paid by Seller in connection with the transactions contemplated by this agreement and, if such Losses do exceed such amount, VBMC-B's membership interest in VHS² and stock interest in VBIC based on its fair market value at such time, shall be subject to reduction to the extent of such excess Losses.

(c) Any indemnification payment that is made by Seller under section 9.01(a) in respect of Losses that are incurred or suffered by VHS² or any Subsidiary or Investment of VHS², including the Transferring Subsidiaries and Non-Profit Corporations after Closing (such Losses, "**Direct Buyer Losses**") shall be paid by Seller only to VHS² or such Subsidiary or Investment, and Seller shall have no indemnification obligation to any other Buyer's Indemnified Persons with respect to any such Direct Buyer Losses.

(d) If Buyer's condition precedent described in section 7.01(a) is not satisfied, but is waived by Buyer, and Buyer is willing to consummate the Closing notwithstanding the failure of such condition to be satisfied, the aggregate amount of Losses for which Buyer's Indemnified Persons shall be entitled to be indemnification pursuant to section 9.01(a) with respect to the matters causing such condition to not be satisfied shall not exceed, in the aggregate, \$10,000,000 (such amount to be calculated after giving effect to the application of such Losses against the Seller Deductible).

9.03. Indemnification by Buyer. Subject to and to the extent provided in this article, from and after the Closing Date, Buyer shall indemnify, defend and hold harmless Seller's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Seller's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) the inaccuracy in any representation or warranty of Vanguard, VMC or Buyer set forth in this agreement or in any Closing Document to which such Person is a party, whether or not Seller's Indemnified Persons relied thereon or had knowledge thereof, *provided* that, in determining whether there has been any such inaccuracy, any qualification as to materiality included in any representation or warranty shall not be taken into account;

(b) the nonfulfillment of any covenant of Vanguard, VMC or Buyer in this agreement or in any Closing Document to which Vanguard, VMC or Buyer is a party;

(c) the Assumed Liabilities; and

(d) the ownership by Buyer of the Assets or the operation by Buyer of the Hospital Businesses after the Closing.

9.04. Buyer's Limitations; Payment of Certain Claims.

(a) Buyer will have no liability under section 9.03(a) and no claim will accrue against Buyer under section 9.03(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Buyer in respect of claims arising under section 9.03(a) exceeds \$500,000 (the "**Buyer Deductible**") in the aggregate, at which time Seller's Indemnified Persons shall be entitled to indemnification for all Losses under section 9.03(a) in excess of the Buyer Deductible, *provided* that there shall be no minimum Loss requirement, and liability of Buyer shall arise from and after \$1.00 of Losses, in respect of Losses resulting from any intentional misrepresentation or fraud by Vanguard or Buyer. In addition, Buyer will have no liability under section 9.03(a) or section 9.03(b) and no claim arising under section 9.03(a) or section 9.03(b) will accrue against Buyer unless Seller's Indemnified Person's claim for indemnification is made against Buyer during the period in which the representation or covenant in respect of which the claim is made survives, as provided in section 9.06.

(b) Buyer's obligation and liability to indemnify and hold harmless Seller's Indemnified Persons from and against Losses incurred or suffered by Seller's Indemnified Persons, directly or indirectly, as a result of or arising from the matters described in section 9.03(a) or section 9.03(b) (but the latter section solely with respect to any nonfulfillment by Vanguard, VMC or Buyer of a covenant in this agreement that occurred prior to the Closing) shall be paid or funded wholly by VHFC or another Subsidiary of Vanguard other than VHS² and its Subsidiaries (in recognition of the fact that such Losses were caused at a time when Seller had no direct or indirect ownership interest in Buyer but would be indemnified through cash payments made at a time when Seller has (or may have) a direct or indirect ownership interest in Buyer).

9.05. Notice and Procedure. All claims for indemnification by any Indemnitee against an Indemnifying Party under this article shall be asserted and resolved as follows:

(a) Third Party Claims.

(i) If the basis for any claim for indemnification against an Indemnifying Party pursuant to this article is a claim or demand made against an Indemnitee by a Person other than Buyer's Indemnified Person or Seller's Indemnified Person (a "**Third Party Claim**"), the Indemnitee shall deliver a Claim Notice with reasonable promptness to the Indemnifying Party (with copies of all relevant written documentation, including papers served, if any, and a reasonably accurate summary of any relevant oral discussions with such third party) specifying the nature of and alleged basis for the Third Party Claim and, to the extent then feasible and known, the alleged amount or the estimated amount of the Third Party Claim. If the Indemnitee fails to deliver the Claim Notice (and related materials) to the Indemnifying Party within 15 days after the Indemnitee receives notice of such Third Party Claim, the Indemnifying Party will not be obligated to indemnify the Indemnitee with respect to such Third Party Claim if and only to the extent that the Indemnifying Party's ability to defend the Third Party Claim or otherwise minimize the Losses for which the Indemnifying Party must indemnify the Indemnitee has been prejudiced by such failure. The Indemnifying Party will notify the Indemnitee within 15 days after receipt of the Claim Notice by the Indemnifying Party (the "**Notice Period**") whether the Indemnifying Party elects, at the sole cost and expense of the Indemnifying Party, to assume the defense of the Indemnitee against the Third Party Claim. The assumption by the Indemnifying Party of the defense of the Third Party Claim constitutes an admission by the Indemnifying Party that the claim is one for which the Indemnifying Party is ultimately liable under this article subject to the applicable limitations otherwise set forth in this article.

(ii) If the Indemnifying Party notifies the Indemnitee within the Notice Period that the Indemnifying Party elects to assume the defense of the Indemnitee against the Third Party Claim, then the Indemnifying Party will defend, at its sole cost and expense, the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnifying Party to a final conclusion or settled, at the discretion of the Indemnifying Party (with the consent of the Indemnitee, which consent shall not be unreasonably withheld with respect to any settlement that does not include any non-monetary relief). The Indemnifying Party will have full control of such defense and proceedings, including any compromise or settlement thereof; *provided* that, prior to the Indemnitee's receipt of the Indemnifying Party's notice that it elects to assume such defense, the Indemnitee may file, at the sole cost and expense of the Indemnitee, any motion, answer or other pleading that the Indemnitee reasonably deems necessary to protect its interests and that is not prejudicial to the Indemnifying Party (it being understood that, except as provided in section 9.05(a)(ii), if an Indemnitee takes any such action that is prejudicial to the Indemnifying Party, the Indemnifying Party will be relieved of its obligations hereunder with respect to that portion of the Third Party Claim (or the Losses attributable thereto) prejudiced by the Indemnitee's action); and *provided further* that, if requested by the Indemnifying Party, the Indemnitee shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party and its counsel in contesting any Third Party Claim that the Indemnifying Party elects to contest or, if related to the Third Party Claim, in making any counterclaim or cross-claim against any Person (other than the Indemnitee or its Affiliates). The Indemnitee may participate in, but not control, any defense or settlement of any Third Party Claim assumed by the Indemnifying Party pursuant to this section 9.05(a)(ii) and, except in respect of cooperation requested by the Indemnifying Party as provided in the preceding sentence, the Indemnitee will bear its own costs and expenses with respect to such participation. Notwithstanding the foregoing, the Indemnifying Party may not assume the defense of the Third Party Claim on behalf of the Indemnitee if (1) the Persons against whom the Third Party Claim is made, or any impleaded Persons, include both one or more Buyer's Indemnified Persons and one or more Seller's Indemnified Persons, and (2) representation of all of such Persons by the same counsel creates an actual or potential conflict of interest that, after giving effect to any waivers made by such Persons, would breach or violate the ethical rules applicable to such counsel, in which case the Indemnitee shall have the right to defend the Third Party Claim on its own behalf and to employ counsel at the expense of the Indemnifying Party.

(iii) If the Indemnifying Party fails to notify the Indemnitee within the Notice Period that the Indemnifying Party intends to defend the Indemnitee against the Third Party Claim, or if the Indemnifying Party gives such notice but fails to diligently prosecute or settle the Third Party Claim, or if the Indemnifying Party is precluded by the last sentence of section 9.05(a)(ii) from assuming the defense of such Third Party Claim, then (A) the Indemnitee will defend the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnitee to a final conclusion or settled at the discretion of the Indemnitee (provided, however, that no Indemnifying Party shall be liable to any Indemnitee for any Losses arising from any settlement that is made or entered into without an Indemnifying Party's prior, written consent, such consent not to be unreasonably withheld) and (B) subject to section 9.05(a)(iv), the out-of-pocket costs and expenses reasonably incurred in good faith by the Indemnitee in the defense of such Third Party Claim will be paid by the Indemnifying Party. The Indemnitee will have full control of such defense and proceedings, including any compromise or settlement thereof (subject to the proviso in the first sentence of this clause (iii)), *provided* that, if requested by the Indemnitee, the Indemnifying Party shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnitee and its counsel in contesting the Third Party Claim which the Indemnitee is contesting or, if related to the Third Party Claim in question, in making any counterclaim or cross-claim against any Person (other than the Indemnifying Party or its Affiliates).

(iv) Notwithstanding the foregoing section 9.05(a)(iii), if the Indemnifying Party notifies the Indemnitee within the Notice Period that the Indemnifying Party disputes its obligation to indemnify the Indemnitee against the Third Party Claim, and such dispute is resolved pursuant to section 9.05(c) in favor of the Indemnifying Party, the Indemnifying Party will not be required to bear the costs and expenses of the Indemnitee's defense pursuant to section 9.05(a)(iii) and the Indemnitee will reimburse the Indemnifying Party in full for all such costs and expenses.

(b) First Party Claims.

(i) If any Indemnitee has a claim against any Indemnifying Party that is not a Third Party Claim, the Indemnitee shall deliver an Indemnity Notice with reasonable promptness to the Indemnifying Party specifying the nature of and specific basis for the claim and, to the extent then feasible, the amount or the estimated amount of the claim. If the Indemnifying Party does not notify the Indemnitee within 30 days following its receipt of the Indemnity Notice that the Indemnifying Party disputes its obligation to indemnify the Indemnitee hereunder, the claim will be presumed to be a liability of the Indemnifying Party hereunder.

(ii) Upon receipt of any Indemnity Notice, the Indemnifying Party will be entitled to request in writing and receive from the Indemnitee a reasonable extension of the 30-day period in which to respond pursuant to section 9.05(b)(i) for the purpose of investigating the claims made therein or the proper amount thereof. The Indemnitee, to the extent requested by the Indemnifying Party, shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party's investigation of such claims or the proper amount thereof.

(c) Resolution of Disputes. If the Indemnifying Party timely disputes, or is deemed to have disputed, its liability with respect to a claim described in a Claim Notice or an Indemnity Notice, the Indemnifying Party and the Indemnitee shall proceed promptly and in good faith to negotiate a resolution of such dispute within 60 days following receipt by the Indemnifying Party of the Claim Notice or Indemnity Notice and, if such dispute is not resolved through negotiations during such 60-day period, it shall be resolved pursuant to article 10 and, if not resolved thereby, by other appropriate legal process.

(d) **Payment of Indemnifiable Losses.** Subject to the terms of any final order entered by a court of competent jurisdiction, the Indemnifying Party shall pay the amount of any indemnifiable Losses to the Indemnitee within 30 days following the later to occur of (i) the date on which such indemnifiable Losses are incurred or sustained by the Indemnitee or (ii) the date on which the Indemnifying Party has acknowledged its liability for such indemnifiable Losses. Indemnifiable Losses not paid when so due shall accrue interest from (and including) the date on which such indemnifiable Losses were incurred or sustained by the Indemnitee until (but excluding) the date on which such amount is paid, at the interest rate provided in section 11.17.

(e) **Certain Disclaimers.** Any estimated amount of a claim submitted in a Claim Notice or an Indemnity Notice shall not be conclusive of the final amount of such claim, and the giving of a Claim Notice when an Indemnity Notice is properly due, or the giving of an Indemnity Notice when a Claim Notice is properly due, shall not impair such Indemnitee's rights hereunder. Notice of any claim comprised in part of Third Party Claims and claims that are not Third Party Claims shall be appropriately bifurcated and given pursuant to each of section 9.05(a)(i) and section 9.05(b)(i), as applicable.

9.06. **Survival of Representations and Warranties; Indemnity Periods.** Notwithstanding any right of Buyer to investigate the Hospital Businesses or any right of any party to investigate the accuracy of the representations and warranties of the other party in this agreement, or any actual investigation by or knowledge of a party, Seller has, on the one hand, and Buyer has, on the other hand, the right to rely fully upon the representations, warranties and covenants of the other in this agreement. The representations, warranties and covenants of Seller and Buyer in this agreement respectively will survive the Closing (a) indefinitely with respect to matters covered by sections 2.04, 3.01, 4.01, 9.01(c), 9.03(c), 9.03(d) and 11.13, (b) until 60 days after the expiration of all applicable statutes of limitations (including all periods of extension) with respect to matters covered by sections 3.05, 3.07, 3.13, 3.17, 3.22, 3.23, 3.24, 3.26, 3.27, 3.28, 3.29, 4.06, 4.07, 4.09, 4.10, 4.11 and 4.13, and (c) until December 31, 2013 in the case of all other representations, warranties and covenants, except that:

(i) the right to indemnification with respect to any claim relating to a breach or default of any representation and warranty whose survival expires in accordance with clause (b) or (c) above will continue to survive if a Claim Notice or an Indemnity Notice with respect to such claim has been given on or before such expiration of such representation or covenant, until the claim for indemnification has been satisfied or otherwise resolved as provided in this article (but no further claims pursuant to any such representation and warranty may be made after the stated period of survival);

(ii) in the event of intentional misrepresentation or fraud in the making of any representation and warranty, or intentional nonfulfillment or breach of any covenant in this agreement or any Closing Document, all representations, warranties and covenants that are the subject of the intentional misrepresentation, fraud or intentional nonfulfillment or breach shall survive until 60 days after the expiration of all applicable statutes of limitations (including all periods of extension) with respect to claims made for such intentional misrepresentation, fraud or intentional nonfulfillment or breach; and

(iii) covenants to be performed or complied with after the Closing Date will survive the Closing for the term specified therein, or, if no term is specified, indefinitely.

9.07. Mitigation. Each Indemnitee shall take all commercially reasonable steps to mitigate its Losses upon and after becoming aware of any event or condition that has given rise to any Losses for which it may be indemnified pursuant to this agreement. The amount of Losses for which an Indemnitee may make an indemnification claim pursuant to this agreement shall be reduced by any amounts actually recovered by the Indemnitee under insurance policies or other collateral sources (such as contractual indemnities of any Person that are contained outside of this agreement or the Closing Documents) with respect to such Losses. Each Indemnitee must use commercially reasonable efforts to obtain recovery under such insurance policies or other collateral sources. To the extent that any payment received by an Indemnitee under any insurance policy or other collateral source was not previously taken into account to reduce the amount of indemnifiable Losses paid to such Indemnitee, such Indemnitee shall promptly pay over to the Indemnifying Party the amount so recovered or realized (after deducting therefrom the full amount of the expenses incurred by the Indemnitee in procuring such recovery or realization), but such amount paid over to the Indemnifying Party shall not exceed the sum of (a) the amount previously paid by the Indemnifying Party to the Indemnitee in respect of such matter plus (b) the amount expended by the Indemnifying Party in pursuing or defending any third party claim arising out of such matter. Notwithstanding the foregoing, no Indemnitee shall be required to seek recovery under any insurance policy issued by, or other collateral source that is, an Affiliate of the Indemnitee.

9.08. Disclaimer of Special Damages. Notwithstanding anything to the contrary set forth in this agreement, no Indemnifying Party or other party to this agreement shall be liable to or otherwise responsible to any Indemnitee or other Person for exemplary, punitive, consequential, indirect, incidental or other special damages (including loss of revenue, income or profits, loss in value of assets or securities) for any matter indemnifiable hereunder or otherwise arising out of or relating to this agreement or the transactions contemplated hereby.

9.09. Exclusive Remedy. From and after the Closing, the rights to indemnification pursuant to this article will be the sole and exclusive remedy of the parties to this agreement with respect to any and all matters arising out of or relating to this agreement or the transactions contemplated hereby (excepting only equitable relief sought pursuant to section 11.02). This section does not preclude or limit the operation of article 10 with respect to any dispute covered thereby nor does this section preclude or limit any party from initiating or otherwise participating in any Proceeding otherwise permitted by this agreement to interpret or enforce the parties' respective rights, remedies and obligations pursuant to this article.

10. ALTERNATE DISPUTE RESOLUTION

10.01. Agreement to Use the Procedure. If a dispute arises after the Closing between Vanguard and Buyer, on the one hand (which, for purposes of this article, will collectively be one party to the ADR), and Seller and the Foundation, on the other hand (which, for purposes of this article, will collectively also be one party to the ADR), that arises out of or is related to this agreement or the Closing Documents or the transactions contemplated by this agreement, the parties shall utilize the procedures specified in this article except (i) in connection with disputes relating to the Purchase Price Adjustment, in which event section 2.05 shall be utilized, (ii) that any party shall be entitled to seek equitable relief as provided by section 11.02 without first utilizing the procedures specified in this article and (iii) when otherwise expressly provided elsewhere in this agreement.

10.02. Initiation of the Procedure. A party seeking to initiate these procedures (the "**Initiating Party**") shall give written notice to the other party or parties, describing briefly the nature of the dispute and its claim and identifying an individual with authority to settle the dispute on its behalf. The party receiving such notice (the "**Responding Party**") shall have ten days within which to designate, in a written notice given to the Initiating Party, an individual with authority to settle the dispute on its behalf. The individuals so designated shall be known as the "**Authorized Individuals**."

10.03. Unassisted Settlement. The Authorized Individuals shall make such investigations as they deem appropriate and promptly thereafter (but in no event later than 15 days from the date the Initiating Party's notice is given) shall commence discussions concerning resolution of the dispute. If the dispute has not been resolved within 30 days from the commencement of discussions (such 30th day being the "**Submission Date**"), it shall be submitted to alternative dispute resolution (the "**ADR**") as provided below.

10.04. Selection of the Neutral. The parties shall have ten days from the Submission Date to select a mutually acceptable Person who is not an Affiliate or employee of any party to this agreement, and who has not had any other material relationship with any party to this agreement during the five year period preceding the Submission Date, to resolve the dispute (the "**Neutral**"). If no Neutral has been selected within such time, any party to the dispute may request that the American Arbitration Association, the Center for Public Resources, or another mutually agreed-upon provider of neutral dispute resolution services supply within ten days a list of potential Neutrals with qualifications specified by the parties. Within five days after receipt of the list, the parties shall independently rank the proposed candidates, simultaneously exchange rankings and select as the Neutral the individual receiving the highest combined ranking who is available to serve.

10.05. Time and Place for the ADR. In consultation with the Neutral, the parties shall promptly designate a mutually convenient time and place for the ADR (and unless circumstances require otherwise, such time shall be no later than 60 days after selection of the Neutral).

10.06. Exchange of Information. If any party has a substantial need for information in the possession of the other party (or its Affiliates) in order to prepare for the ADR, the parties shall attempt in good faith to agree on procedures for the expeditious exchange of such information, with the help of the Neutral if necessary.

10.07. Summary of Views. One week before the first scheduled session of the ADR, each party shall deliver to the Neutral and to the other party a concise written summary of its views on the matter in dispute, such summary not to exceed ten pages in length.

10.08. Staffing the ADR. In the ADR, each party shall be represented by the Authorized Individual and by not more than two counsel (who may be in house counsel). In addition, each party may bring such other Persons (the maximum number of which shall be agreed by the parties in advance) as may be needed to respond to questions, contribute information and participate in the negotiations, with the assistance of the Neutral, if necessary.

10.09. Conduct of the ADR. The parties, in consultation with the Neutral, will agree upon a format for the meetings designed to assure that the Neutral and the Authorized Individuals have an opportunity to hear an oral presentation of each party's views on the matter in dispute, and that the Authorized Individuals attempt to negotiate a resolution of the matter in dispute, with or without the assistance of counsel or others, but with the assistance of the Neutral. To this end, the Neutral is authorized to conduct both joint meetings and separate private caucuses with the parties. The Neutral will keep confidential all information learned in private caucus with either party unless specifically authorized by such party to make disclosure of the information to the other party.

10.10. The Neutral's Views. The Neutral shall (a) unless requested not to do so by the parties, provide his opinion to the parties on the probable outcome should the matter be litigated, and (b) if requested to do so by the parties, make one or more recommendations as to the terms of a possible settlement, upon any conditions imposed by the parties (including a minimum and maximum amount). The Neutral shall base his opinions and recommendations on information then available to the parties, excluding only such information disclosed by any party to the Neutral in confidence but not disclosed to the other party or parties. The opinions and recommendations of the Neutral shall not be binding on the parties.

10.11. Termination of the Procedure. The parties shall participate in the ADR to its conclusion (as designated by the Neutral) and not terminate negotiations concerning resolution of the matters in dispute until at least ten days thereafter. No party shall commence a lawsuit or seek other remedies before the conclusion of the 10-day post-ADR negotiation period, *provided* that either party may commence litigation (a) within five days before the date after which the commencement of litigation could be barred by an applicable statute of limitations or doctrine of laches or any applicable contractual limitation on survival set forth in section 9.06 or (b) at any time in order to request a temporary restraining order or preliminary injunction to prevent irreparable harm or any other equitable remedy provided by section 11.02, in which event the parties may mutually agree to continue (unless prohibited by court order) to participate in the ADR to its conclusion.

10.12. Fees of the Neutral; Disqualification. The parties shall share the fees of the Neutral equally. The Neutral shall be disqualified as a witness, consultant, expert or counsel for either party with respect to the matters in dispute and any litigation or other matters relating thereto.

10.13. Confidentiality. The procedures described above are intended to constitute a compromise negotiation for purposes of the Federal Rules of Evidence and state rules of evidence. The entire procedure is confidential, and no stenographic, visual or audio record shall be made. All conduct, statements, promises, offers, views and opinions, whether oral or written, made in the course of the procedure by any party, its agents, employees, representatives or other invitees, and by the Neutral (who will be the parties' joint agent for purposes of the procedure) are confidential and, where appropriate, shall be deemed to be work product and privileged. Such conduct, statements, promises, offers, views and opinions shall not be discoverable or admissible for any purposes, including impeachment, in any litigation or other proceeding involving the parties, and shall not be disclosed to anyone not an agent, employee, expert, witness or representative of any party, *provided* that evidence otherwise discoverable or admissible is not excluded from discovery or admission as a result of its use in the procedure.

11. GENERAL

11.01. Attachments; Schedules.

(a) The Schedules and exhibits attached to this agreement are integral parts of this agreement and are incorporated herein by this reference as if fully set forth in this agreement. Nothing in the Schedules shall be deemed adequate to disclose an exception to a representation or warranty made in this agreement unless the Schedule identifies the exception with reasonable particularity and, without limiting the generality of the foregoing, the mere listing of a document as an exception to any representation and warranty shall not be deemed to disclose the contents of such document as an exception to any representation or warranty (but shall be adequate to disclose the existence of the document itself).

(b) At or prior to Closing, Seller shall supplement the Schedules, deliver new Schedules or deliver written disclosures as necessary to make each of the representations and warranties of Seller contained in article 3 that is qualified as to materiality true and correct on and as of the Closing Date and each of the other representations and warranties of Seller contained in article 3 true and correct in all material respects on and as of the Closing Date; provided that, without Buyer's written consent, (i) Seller may not supplement any Schedule relating to the representations in section 3.06 pertaining to the Financial Statements, (ii) the disclosures included in the supplements shall speak as of the date the supplements are given and shall not have the effect of retroactively modifying the Schedule to which it relates, and (iii) no such supplement or written disclosure shall disclose any circumstance or event that results in or is reasonably expected to result in, individually or in the aggregate, (A) Losses of \$10,000,000 or more, or (B) an adverse effect on EBITDA of the Hospital Businesses of at least \$2,000,000 on an annualized basis.

11.02. Equitable Remedies. Each party acknowledges and agrees that its breach of this agreement, or its failure to perform its obligations pursuant to this agreement in accordance with its specific terms, would cause each other party to suffer irreparable damage or injury that would not be fully compensable by money damages, or the exact amount of which may be impossible to determine, and, therefore, such other parties would not have an adequate remedy available at law. Accordingly, each party agrees that each other party shall be entitled to seek specific performance, injunctive and/or other equitable relief from any court of competent jurisdiction (without the necessity of posting bond) as may be necessary or appropriate to enforce specifically this agreement and the terms and provisions hereof and to prevent or curtail any breach (or threatened breach) of the provisions of this agreement. Such equitable remedies shall not be the exclusive remedy of any party for any such breach or failure to perform by another party, but shall be in addition to all other remedies available to such party at law or in equity (the availability of which remedies shall be, after the Closing, subject to the applicable limitations set forth in articles 9 and 10).

11.03. Tax and Government Payment Program Effect. None of the parties (nor such parties' counsel or accountants) has made or is making in this agreement any representation to any other party (or such party's counsel or accountants) concerning any of the Tax or Government Payment Program effects or consequences on the other party of the transactions provided for in this agreement. Each party represents that it has obtained, or may obtain, independent Tax and Government Payment Program advice with respect thereto and upon which it, if so obtained, has solely relied.

11.04. Reproduction of Documents. This agreement and all documents relating hereto, including consents, waivers and modifications that may hereafter be executed, the Closing Documents, financial statements, certificates and other information previously or hereafter furnished to any party, may be reproduced by any party by any photographic, microfilm, electronic or similar process. The parties stipulate that any such reproduction, when rendered in physical form and constituting an identical representation of the original, shall be admissible in evidence as the original itself in any judicial, arbitral or administrative proceeding (whether or not the original is in existence and whether or not such reproduction was made in the ordinary course of business).

11.05. Consented Assignment. Notwithstanding anything in this agreement to the contrary, this agreement shall not constitute an agreement to assign any Assumed Contract, claim or other right if the assignment or attempted assignment thereof without the consent of another Person would (i) constitute a breach thereof, (ii) be ineffective or render the Contract, claim or right void or voidable, or (iii) in any material way affect the rights of Seller thereunder (or the rights of Buyer thereunder following any such assignment or attempted assignment). In any such event, until the requisite consent is obtained, Seller shall cooperate, at Buyer's expense, in any reasonable arrangement designed to provide for Buyer the benefits under any such Contract, claim or right, including enforcement of any and all rights of Seller against the other Person arising out of the breach or cancellation by such other Person or otherwise. After Closing, the parties shall continue to use commercially reasonable efforts to obtain the consent to the assignment of such Contract, claim or right.

11.06. Time of Essence. Time is of the essence in the performance of this agreement, *provided that*, if the day on or by which a notice must or may be given, or the performance of any party's obligation is due, is a Saturday, Sunday or other day on which banks in Harlingen, Texas are permitted or required to be closed, then the day on or by which such notice must or may be given, or that such performance is due, shall be extended to the first day thereafter that is not a Saturday, Sunday or other day on which banks in Harlingen, Texas are permitted or required to be closed.

11.07. Consents, Approvals and Discretion. Except as expressly provided to the contrary in this agreement, whenever this agreement requires any consent or approval to be given by any party or any party must or may exercise discretion, such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

11.08. Choice of Law. This agreement shall be governed by and construed in accordance with the laws of the State of Texas without regard to any conflicts of laws rules (whether of the State of Texas or any other jurisdiction).

11.09. Succession and Assignment. This agreement and all of the provisions hereof shall be binding upon, inure to the benefit of, and be enforceable by, the parties and their respective successors and permitted assigns. Neither this agreement nor any of the rights, interests or obligations of any party under this agreement may be assigned or delegated, in whole or in part, by operation of law or otherwise, by any party without the prior written consent of each other party, and any such assignment without such prior written consent shall be null and void.

11.10. Third Party Beneficiary. This agreement (including provisions regarding employee and employee benefit matters) and the Closing Documents are intended solely for the benefit of the parties to this agreement (and their respective successors and permitted assigns) and (solely in their capacities as Indemnified Persons) Buyer's Indemnified Persons and Seller's Indemnified Persons, and are not intended to confer third-party beneficiary rights upon any other Person (or, in the case of Buyer's Indemnified Persons and Seller's Indemnified Persons, to such Persons in any other capacity). Any reference in this agreement to one or more Employee Benefit Plans of Buyer includes provisions, if any, in such plans permitting their termination or amendment and any covenant in this agreement to provide any Employee Benefit Plan shall not be deemed or construed to limit Buyer's right to terminate or amend such plan of Buyer in accordance with its terms.

11.11. Waiver of Breach, Right or Remedy. The waiver by any party of (a) any breach or violation by another party of any provision of this agreement, (b) any condition to the obligations of such party to consummate the transactions contemplated by this agreement, or (c) any other right or remedy permitted the waiving party in this agreement, (i) shall not waive or be construed to waive any prior or subsequent breach or violation of the same provision or any subsequent exercise of the same right or remedy, (ii) shall not waive or be construed to waive a breach or violation of any other provision, any other closing condition or any other right or remedy, and (iii) to be effective, must be in writing and signed by each party entitled to the benefit of the provision, condition, right or remedy to be waived (provided that VBHS may execute any waiver or consent on behalf of each Person described as "Seller" and VHS² may execute any waiver or consent on behalf of each Person described as "Buyer"), and may not be presumed or inferred from any party's conduct. The election of any one or more available remedies by a party shall not constitute a waiver of the right to pursue other available remedies (the availability of which remedies shall be, after the Closing, subject to the applicable limitations set forth in articles 9 and 10).

11.12. Notices. Any notice, demand or communication required, permitted or desired to be given hereunder must be in writing and shall be deemed effectively given (i) on the date tendered by personal delivery, (ii) on the date received by fax or other electronic means, (iii) on the date tendered for delivery by nationally recognized overnight courier, or (iv) on the date tendered for delivery by United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, in any event addressed as follows:

If to Buyer: Vanguard Health Systems, Inc.
20 Burton Hills Boulevard, Suite 100
Nashville, Tennessee 37215
Attn: General Counsel
Fax: 615.665.6197
Email: generalcounsel@vanguardhealth.com

If to Seller: Valley Baptist Health System
P.O. Drawer 2588
2101 Pease Street
Harlingen, Texas 78551
Attn: Chief Executive Officer
Fax: 956.389.1675
Email: alan.johnson@valleybaptist.net

with a copy to (which shall not constitute notice):

Fulbright & Jaworski L.L.P.
600 Congress Avenue, Suite 2400
Austin, Texas 78701-2978
Attn: Jerry A. Bell, Jr.
Fax: 512.536.4598
Email: jbelle@fulbright.com

or to such other address or fax number, and to the attention of such other Person, as any party may designate in writing in conformity with this section.

11.13. Misdirected Payments; Physician Loans. Seller shall remit to Buyer with reasonable promptness any monies received by Seller (or its Affiliates, other than Buyer) constituting or in respect of the Assets and Assumed Liabilities. Buyer shall remit to Seller with reasonable promptness any monies received by Buyer (or its Affiliates, other than Seller) constituting or in respect of the Excluded Assets and Excluded Liabilities. If any funds previously paid or credited to Seller or the Hospital Businesses in respect of services rendered on or before the Closing Date have resulted in an overpayment or must be repaid, Seller shall be responsible for the repayment of said monies (and the defense of such actions), except to the extent that such credit or repayment obligation was included in the calculation of Net Working Capital or VBIC's Net Worth as shown on the Closing Balance Sheets. If Buyer suffers any

deduction to or offset or withhold against amounts due Buyer of funds previously paid or credited to Seller or the Hospital Businesses in respect of services rendered on or before the Closing Date (other than in respect of overpayments addressed by the preceding sentence), Seller shall pay to Buyer the amounts so deducted, offset or withheld within five business days after demand therefor, except to the extent that the amount of such deduction, offset or withholding was included in the calculation of Net Working Capital or VBIC's Net Worth as shown on the Closing Balance Sheets. Any amounts payable pursuant to this agreement that are due Buyer by Seller or one of their Affiliates, or due Seller by Buyer or one of their Affiliates, may be offset against monies or other funds owed by the party entitled to receive payment to the party required to make payment (other than such owed amounts that are being disputed in good faith). Seller shall use, and cause their Affiliates to use, good faith efforts to collect any and all loans and other amounts due from physicians and their Affiliates that constitute Excluded Assets.

11.14. Severability. If any provision of this agreement is held or determined to be illegal, invalid or unenforceable under any present or future law in the final judgment of a court of competent jurisdiction, then, if the rights or obligations of any party under this agreement would not be materially and adversely affected thereby: (a) such provision will be fully severable; (b) this agreement will be construed and enforced as if such illegal, invalid or unenforceable provision had never comprised a part of this agreement; (c) the remainder of this agreement will remain in full force and effect and will not be affected by the illegal, invalid or unenforceable provision or by its severance from this agreement; and (d) instead of such illegal, invalid or unenforceable provision, there will be deemed to be added to this agreement a legal, valid and enforceable provision as similar in terms to such illegal, invalid or unenforceable provision as may be possible.

11.15. Entire Agreement; Amendment. This agreement supersedes all previous contracts, agreements and understandings and constitutes the entire agreement of whatsoever kind or nature existing between or among the parties respecting the within subject matter and no party shall be entitled to benefits (including the benefit of any representation or warranty (express or implied, including any implied warranties of merchantability or fitness for a particular purpose) with respect to the Assets or the Hospital Businesses) other than those specified in this agreement. As between or among the parties, any oral or written representation, warranty, covenant, agreement or statement not expressly incorporated in this agreement, whether given before or on the date of this agreement, shall be of no force and effect unless and until made in writing and signed by the parties on or after the date of this agreement. Notwithstanding anything to the contrary, the foregoing provisions of this section shall not apply to the Letter Agreement, which Letter Agreement shall continue in full force in effect in accordance with section 11.19(a) following the execution of this agreement. The representations, warranties and covenants set forth in this agreement shall survive the Closing and remain in full force and effect as provided in section 9.06, and shall survive the execution and delivery of, and shall not be merged with or into, the Closing Documents and all other agreements, instruments or other documents described, referenced in or contemplated by this agreement. Each representation, warranty and covenant in this agreement has independent legal significance and if any party has breached any representation, warranty or covenant in any respect, whether there exists another representation, warranty or covenant relating to the same subject matter (regardless of the relative level of specificity) that such party has not breached shall not detract from or mitigate the party's breach of the first representation, warranty or covenant. This agreement may not be amended or supplemented except in a written instrument executed by each of the parties.

11.16. Counterparts; Transmission by Electronic Means. This agreement may be executed in two or more counterparts, each and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument. This agreement, and any executed counterpart of a signature page to this agreement, may be transmitted by fax or e-mail (attaching a .pdf (portable document format) copy thereof), and such delivery of an executed counterpart of a signature page to this agreement by fax or e-mail shall be effective as delivery of a manually executed counterpart of this agreement. At the Closing, the Closing Documents may be executed, and the signature pages thereto delivered, in like manner.

11.17. Interest. Any monies required to be paid by any party to another party pursuant to this agreement shall be due on the date or at the time for payment specified in this agreement, and monies not paid when due shall accrue interest from and after the due date to, but not including, the date full payment is made at an annual rate equal to the average prime rate of Bank of America, N.A., during such period plus three percent *per annum*.

11.18. Drafting. No provision of this agreement shall be interpreted for or against any Person on the basis that such Person was the draftsman of such provision, and no presumption or burden of proof shall arise favoring or disfavoring any Person by virtue of the authorship of any provision of this agreement.

11.19. Confidentiality; Public Announcements.

(a) Except as required by Legal Requirements, Vanguard, Seller and Buyer (and their respective Affiliates) shall keep this agreement and the Closing Documents and their contents confidential and not disclose the same to any Person (except the parties' attorneys, accountants or other professional advisors who need to know such contents for the purpose of advising such party in connection with the transactions contemplated hereby, and except to the applicable Governmental Authorities in connection with any required notification or application for approval or a license or exemption therefrom) without the prior written consent of the other party. With respect to information provided by Seller to Buyer in connection with and relative to this proposed transaction, the executed Letter Agreement, dated October 18, 2010 (the "**Letter Agreement**"), in respect of confidentiality between Vanguard and VBHS shall remain in effect until Closing.

(b) At all times before and after the Closing, Seller, on the one hand, and Vanguard and Buyer, on the other hand, will consult with the other before issuing or making any reports, statements or releases to the public with respect to this agreement or the transactions contemplated by this agreement and will use good faith efforts to obtain the other party's prior approval of the text of any public report, statement or release to be made by or on behalf of such party. If either party is unable to obtain the prior approval of its public report, statement or release from the other party and such report, statement or release is, in the opinion of legal counsel to such party, necessary to discharge such party's disclosure obligations under applicable Legal Requirements, then such party may make or issue the legally required report, statement or release and promptly furnish the other party a copy thereof.

12. GUARANTEES

12.01. Guarantee of Buyer's Obligations. Vanguard, as principal obligor and not merely as a surety, hereby unconditionally guarantees full, punctual and complete performance by Buyer of all of Buyer's obligations under this agreement and each of the Closing Documents subject to the terms hereof and thereof and so undertakes to Seller that, if and whenever Buyer is in default, Vanguard will on demand duly and promptly perform or procure the performance of Buyer's obligations. The foregoing guarantee is a continuing guarantee and will remain in full force and effect indefinitely (in light of the fact that, as provided in section 9.06, certain representations, warranties, covenants and indemnification obligations of Buyer survive the Closing indefinitely) and will be reinstated with respect to any sum paid to Seller or the Foundation that must be restored by Seller or the Foundation upon the bankruptcy, liquidation or reorganization of Buyer. Vanguard's obligations under this section shall not be affected or discharged in any way by any Proceeding with respect to Buyer under any federal or state bankruptcy, insolvency or debtor relief laws (or any order, judgment, ruling, writ, injunction or decree entered or made in connection therewith) or any other fact, development, occurrence or circumstance affecting the legal capacity of Buyer or the enforceability of this agreement or any of the Closing Documents against Buyer in accordance with their respective terms. Vanguard's board of directors has approved Vanguard's execution of this agreement and the performance of its obligations hereunder. If the obligation guaranteed by Vanguard hereunder is the obligation of Buyer to indemnify Seller's Indemnified Persons pursuant to section 9.03(b) (but solely with respect to any nonfulfillment by Buyer of a covenant in this agreement that occurred after the Closing), section 9.03(c) or section 9.03(d), then Vanguard's liability hereunder shall be limited to a percentage of the Loss suffered by the Indemnitee equal to (a) with respect to any such Loss (or portion thereof) that relates to VBIC, the percentage ownership held, directly or indirectly, by Vanguard in VBIC on the date of the Loss and (b) with respect to any other Loss (or portion thereof), the percentage ownership held, directly or indirectly, by Vanguard in VHS² on the date of the Loss.

12.02. Guarantee of Seller's Obligations. The Foundation, as principal obligor and not merely as a surety, hereby unconditionally guarantees full, punctual and complete performance by Seller of each Seller's obligations under this agreement and each of the Closing Documents subject to the terms hereof and thereof and so undertakes to Buyer and Vanguard that, if and whenever Seller is in default, the Foundation will on demand duly and promptly perform or procure the performance of each Seller's obligations. The foregoing guarantee is a continuing guarantee and will remain in full force and effect indefinitely (in light of the fact that, as provided in section 9.06, certain representations, warranties, covenants and indemnification obligations of Seller survive the Closing indefinitely) and will be reinstated with respect to any sum paid to Buyer or Vanguard that must be restored by Buyer or Vanguard upon the bankruptcy, liquidation or reorganization of Seller. The Foundation's obligations under this section shall not be affected or discharged in any way by any Proceeding with respect to Seller under any federal or state bankruptcy, insolvency or debtor relief laws (or any order, judgment, ruling, writ, injunction or decree entered or made in connection therewith) or any other fact, development, occurrence or circumstance affecting the legal capacity of Seller or the enforceability of this agreement or any of the Closing Documents against Seller in accordance with their respective terms. The Foundation's board of directors has approved the Foundation's execution of this agreement and the performance of its obligations hereunder.

The parties have caused this agreement to be executed in multiple originals by their duly authorized officers as of the date of this agreement.

VALLEY BAPTIST MEDICAL CENTER

VALLEY BAPTIST MEDICAL CENTER — BROWNSVILLE

By: /s/ James E. Eastham
Title: President

By: /s/ James E. Eastham
Title: President

VALLEY BAPTIST MEDICAL DEVELOPMENT CORPORATION

VB REALTY CORPORATION

By: /s/ James E. Eastham
Title: President

By: /s/ James E. Eastham
Title: President

VALLEY BAPTIST INSURANCE HOLDINGS, INC.

VALLEY BAPTIST MANAGEMENT SERVICES CORPORATION

By: /s/ James E. Eastham
Title: President

By: /s/ James E. Eastham
Title: President

VALLEY BAPTIST HEALTH SYSTEM

VALLEY BAPTIST MEDICAL FOUNDATION

By: /s/ Alan L. Johnson
Title: Chairman

By: /s/ Alan L. Johnson
Title: Board Member

VALLEY BAPTIST HOSPITAL HOLDINGS, INC.

VB REALTY II, LLC

By: /s/ James E. Eastham
Title: President

By: /s/ James E. Eastham
Title: President

VHS VALLEY HEALTH SYSTEM, LLC

By: /s/ Keith B. Pitts
Title: Executive Vice President

VHS BROWNSVILLE HOSPITAL COMPANY, LLC

By: /s/ Keith B. Pitts
Title: Executive Vice President

VHS VALLEY REAL ESTATE COMPANY, LLC

By: /s/ Keith B. Pitts
Title: Executive Vice President

VANGUARD HEALTH SYSTEMS, INC.

By: /s/ Keith B. Pitts
Title: Vice Chairman

VHS HARLINGEN HOSPITAL COMPANY, LLC

By: /s/ Keith B. Pitts
Title: Executive Vice President

VHS VALLEY HOLDINGS, INC.

By: /s/ Keith B. Pitts
Title: Executive Vice President

VANGUARD HEALTH FINANCIAL COMPANY, LLC

By: /s/ Keith B. Pitts
Title: Executive Vice President

VHS VALLEY MANAGEMENT COMPANY, INC.

By: /s/ Keith B. Pitts
Title: Executive Vice President

SCHEDULE LIST

Schedule 1.02	Persons Relevant to "Seller's Knowledge"
Schedule 2.01(a)	Owned Real Property
Schedule 2.01(b)	Leased Real Property
Schedule 2.01(f)	Assumed Contracts
Schedule 2.01(g)	Permits
Schedule 2.01(h)	Intellectual Properties
Schedule 2.02(b)	Excluded Owned Real Property
Schedule 2.02(i)	Contracts That Are Excluded Assets
Schedule 2.02(k)	Retained Corporate Trade Names
Schedule 2.02(o)	Excluded Assets of the Foundation
Schedule 2.02(s)	Other Excluded Assets
Schedule 2.03	Assumed Liabilities
Schedule 3.02	Third-Party Consents
Schedule 3.04	Subsidiaries
Schedule 3.05	Legal Regulatory Compliance
Schedule 3.06	Financial Statements
Schedule 3.08	Recent Activities
Schedule 3.11	Personal Property Encumbrances
Schedule 3.12(a)	Real Property Encumbrances
Schedule 3.12(c)	Real Property Condition
Schedule 3.13(a)	Environmental Matters and Medical Waste
Schedule 3.13(b)	Environmental Matters and Medical Waste
Schedule 3.14	Intellectual Properties and Information Systems
Schedule 3.15	Insurance
Schedule 3.18	Agreements and Commitments
Schedule 3.19	Assumed Contracts Exceptions
Schedule 3.21(c)	Employment-Related Actions
Schedule 3.22	Current Employee Benefit Plans
Schedule 3.23	Proceedings and Claims
Schedule 3.24	Tax Returns
Schedule 3.25	Disputes Between Seller and Medical Staff
Schedule 3.27	Brokers and Finders
Schedule 3.28	Payments
Schedule 3.30(a)	Transferring Subsidiaries
Schedule 3.30(d)	Joint Ventures
Schedule 3.31(a)	Imaging Partnerships
Schedule 3.33	Non-Governmental Payors
Schedule 5.02(b)	Post-Closing Employment Offers
Schedule 5.02(c)	Non-Ordinary Course Employment Benefit Changes
Schedule 5.03(b)	Severance Policy
Schedule 5.08	Rio Grande Valley Market
Schedule 5.09	Change of Corporate Names
Schedule 5.12(b)	Hurricane Damage
Schedule 5.14	Essential Services

Schedule 5.15	Charity Care Policy
Schedule 5.20	Rights of First Refusal of Real Property
Schedule 5.28	Restricted Assets
Schedule 5.30	Section 338 Asset Allocation
Schedule 7.03(d)	Consents to Assignment
Schedule 7.06	Opinion of Seller's Counsel
Schedule 8.02(w)	Directors of VBIC

Pursuant to Regulation S-K Item 601(b)(2), the above schedules have been omitted and will be furnished supplementally to the Securities and Exchange Commission upon request.

EXHIBIT LIST

Exhibit A	Amended and Restated Operating Agreement
Exhibit B	Management Services Agreement
Exhibit C	VBIC Shareholders Agreement
Exhibit D	License Agreement
Exhibit E	Transition Services Agreement

Pursuant to Regulation S-K Item 601(b)(2), the above exhibits have been omitted and will be furnished supplementally to the Securities and Exchange Commission upon request.

EMPLOYMENT AGREEMENT

THIS EMPLOYMENT AGREEMENT (this "Agreement") dated as of September 1, 2011, is made by and between Vanguard Health Systems, Inc., a Delaware corporation (the "Company"), and James H. Spalding (the "Executive").

WHEREAS, the Company desires to secure for itself or its subsidiary the services of the Executive as its Executive Vice President, General Counsel and Secretary from and after the date hereof and the Executive desires to render such services, in each case pursuant to the terms and conditions hereof;

WHEREAS; the Company's Board of Directors (the "Board" provided, that if a Compensation Committee of the Board of Directors shall have been duly appointed, the term "Board" as used herein shall mean either of such Committee or the full Board of Directors) has approved and authorized the Company's entry into this Agreement with the Executive;

WHEREAS, the parties desire to enter into this Agreement setting forth the terms and conditions of the employment relationship of the Executive with the Company; and

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein contained, the Company and the Executive hereby agree as follows:

1. Employment. The Company or its subsidiary hereby employs the Executive, and the Executive hereby accepts employment with the Company or its subsidiary, upon the terms and subject to the conditions set forth herein.

2. Term. This Agreement is for the five-year period (the "Term") commencing on the date first written above (the "Effective Date") and terminating on the fifth anniversary of the Effective Date, or upon the Executive's earlier death, disability or other termination of employment pursuant to Section 10; provided, however, that commencing on the fifth anniversary of the Effective Date and on each anniversary thereafter the Term shall automatically be extended for one additional year unless, not later than 90 days prior to any such anniversary, either party hereto shall have notified the other party hereto that such extension shall not take effect.

3. Position. During the Term, the Executive shall serve as Executive Vice President, General Counsel and Secretary of the Company or in such other senior executive position in the Company as the Executive should approve.

4. Duties and Reporting Relationship. During the Term, the Executive shall, on a full time basis, use his skills and render services to the best of his ability in supervising and conducting the operations of the Company.

5. Place of Performance. The Executive shall perform his duties and conduct his business at the principal executive offices of the Company, except for required travel on the Company's business.

6. Salary and Annual Bonus.

(a) Base Salary. The Executive's base salary hereunder shall be \$475,000 per year, payable semi-monthly. Commencing on September 1, 2012, the Board shall review such base salary at least annually and make such adjustments from time to time as it may deem advisable, but the base salary shall not at any time be reduced from the base salary in effect from time to time.

(b) Annual Bonus. The Board (or if there is a compensation committee of the Board, the compensation committee) shall provide the Executive with an annual bonus plan providing the Executive with an opportunity to earn annual bonus compensation and shall cause the Company to pay to him any earned annual bonus in addition to his base salary.

7. Vacation, Holidays and Sick Leave. During the Term, the Executive shall be entitled to paid vacation, paid holidays and sick leave in accordance with the Company's standard policies for its senior executive officers.

8. Business Expenses. The Executive will be reimbursed for all ordinary and necessary business expenses incurred by him in connection with his employment upon timely submission by the Executive of receipts and other documentation as required by the Internal Revenue Code and in conformance with the Company's normal procedures.

9. Pension and Welfare Benefits. During the Term, the Executive shall be eligible to participate fully in all health benefits, insurance programs, pension and retirement plans and other employee benefit and compensation arrangements available to senior officers of the Company generally.

10. Termination of Employment.

(a) General. The Executive's employment hereunder may be terminated without any breach of this Agreement only under the following circumstances.

(b) Death or Disability.

(i) The Executive's employment hereunder shall automatically terminate upon the death of the Executive.

(ii) If, as a result of the Executive's incapacity due to physical or mental illness, the Executive shall have been absent from his duties with the Company for any six (6) months (whether or not consecutive) during any twelve (12) month period, the Company may terminate the Executive's employment hereunder for any such incapacity (a "Disability").

(c) Cause. The Company may terminate the Executive's employment hereunder for Cause. For purposes of this Agreement, "Cause" shall mean (i) the willful failure or refusal by the Executive to perform his duties hereunder (other than any such failure resulting from the Executive's incapacity due to physical or mental illness), which has not ceased within ten (10) days after a written demand for substantial performance is delivered to the Executive by the Company, which demand identifies the manner in which the Company believes that the Executive has not performed such duties, (ii) the willful engaging by the Executive in misconduct which is materially injurious to the Company, monetarily or otherwise (including, but not limited to, conduct described in Section 14) or (iii) the conviction of the Executive of, the entering of a plea of *nolo contendere* by the Executive with respect to, a felony. Notwithstanding the foregoing, the Executive's employment hereunder shall not be deemed to have been terminated for Cause unless and until there shall have been delivered to the Executive a copy of a resolution duly adopted by the affirmative vote of not less than a majority of the entire membership of the Board at a meeting of the Board (after written notice to the Executive and a reasonable opportunity for the Executive, together with the Executive's counsel, to be heard before the Board), finding that in the good faith opinion of the Board the Executive should be terminated for cause.

(d) Termination by the Executive. The Executive shall be entitled to terminate his employment hereunder (A) for Good Reason or (B) for any other reason. To be a valid termination of employment by the Executive under this Agreement for Good Reason, the date of the actual termination of the Executive's employment due to any of the Good Reason acts or conditions set forth in Sections 10(d)(i) through 10(d)(vi) below must occur within a period of two years following the initial existence of such Good Reason act or condition which arose without the consent of the Executive. For purposes of this Agreement, "Good Reason" shall mean, (i) without the Executive's express written consent, any failure by the Company to comply with any material provision of this Agreement, which failure has not been cured within ten (10) days after notice of such noncompliance has been given by the Executive to the Company or (ii) the occurrence (without the Executive's express written consent), following a Change in Control during the term of this Agreement, of any one of the following acts by the Company, or failures by the Company to act, unless, in the case of any act or failure to act described below, such act or failure to act is corrected prior to the Date of Termination specified in the Notice of Termination given in respect thereof:

(i) a material diminution in the Executive's base compensation, except for across-the-board salary reductions similarly affecting all senior executives of the Company and all senior executives of any Person (as defined in Section 10(h)(i) below) in control of the Company provided in no event shall any such reduction reduce the Executive's base salary below \$475,000;

(ii) a material diminution in the Executive's authority, duties or responsibilities;

(iii) a material diminution in the authority, duties or responsibilities of the supervisor to whom the Executive is required to report, including a requirement that the Executive's supervisor report to a corporate officer or employee instead of reporting directly to the Board of Directors of the Company;

- (iv) a material diminution in the budget over which the Executive retains authority;
- (v) a material change in the geographic location at which the Executive must perform services under this Agreement, except for required travel on the Company's business to an extent substantially consistent with his business travel obligations prior to the Change in Control; or
- (vi) any other action or inaction that constitutes a material breach by the Company of the terms of this Agreement.

The Executive's continued employment shall not constitute consent to, or a waiver of rights with respect to, any act or failure to act constituting Good Reason hereunder.

(e) Voluntary Resignation. Should the Executive wish to resign from his position with the Company or terminate his employment for other than Good Reason during the Term, the Executive shall give sixty (60) days written notice to the Company, setting forth the reasons and specifying the date as of which his resignation is to become effective.

(f) Notice of Termination. Any purported termination of the Executive's employment by the Company or by the Executive shall be communicated by written Notice of Termination to the other party hereto in accordance with Section 18. "Notice of Termination" shall mean a notice that shall indicate the specific termination provision in this Agreement relied upon and shall set forth in reasonable detail the facts and circumstances claimed to provide a basis for termination of the Executive's employment under the provision so indicated. In respect of a Notice of Termination sent by the Executive as a result of any of the Good Reason acts or conditions set forth in Sections 10(d)(i) through 10(d)(vi) above, it must be sent by the Executive to the Company within 90 days following the initial existence of such Good Reason act or condition which arose without the consent of the Executive and if not sent within such 90 days, it shall not be a valid Notice of Termination.

(g) Date of Termination. "Date of Termination" shall mean (i) if the Executive's employment is terminated because of death, the date of the Executive's death, (ii) if the Executive's employment is terminated for Disability, the date Notice of Termination is given, or (iii) if the Executive's employment is terminated pursuant to Subsection (c), (d) or (e) hereof or for any other reason (other than death or Disability), the date specified in the Notice of Termination (which, in the case of a termination for Good Reason shall not be less than thirty (30) nor more than sixty (60) days from the date such Notice of Termination is given, and in the case of a termination for any other reason shall not be less than thirty (30) days (sixty (60) days in the case of a termination under Subsection (e) hereof) from the date such Notice of Termination is given); provided, that in the case of a termination for Cause, nothing herein shall prevent the Company from immediately terminating the Executive's employment, so long as the Company continues to meet all of its responsibilities hereunder with respect to payment of salary, benefits and other obligations during the minimum notice period described in this Subsection (g) (and for purposes of measuring such obligations, the Date of Termination shall be deemed to be the end of such minimum notice period).

events: (h) Change in Control. For purposes of this Agreement, a Change in Control of the Company shall mean the occurrence of any of the following

(i) any person or group, other than the Permitted Holders, is or becomes the "beneficial owner" (as defined in rules 13d-3 and 13d-5 under the Act) directly or indirectly of more than 50% of the total voting power of the voting stock of the Company, including by way of merger, consolidation or otherwise;

(ii) a reorganization, recapitalization, merger or consolidation (a "Corporate Transaction") involving the Company, unless securities representing 50% or more of the combined voting power of the then outstanding voting securities entitled to vote generally in the election of directors of the Company or the corporation resulting from such Corporate Transaction (or the parent of such corporation) are held subsequent to such transaction by the person or persons who were the "beneficial owners" of the outstanding voting securities entitled to vote generally in the election of directors of the Company immediately prior to such Corporate Transaction, in substantially the same proportions as their ownership immediately prior to such Corporate Transaction;

(iii) the sale or disposition, in one or a series of related transactions, of all or substantially all, of the assets of the Company to any "person" or "group" (as such terms are defined in Sections 13(d)(3) or 14(d)(2) of the Act) other than the Permitted Holders; or

(iv) during any period of 12 months, individuals who at the beginning of such period constituted the Company's Board of Directors (the "Board"), together with any new directors whose election by the Board or whose nomination for election by the stockholders of the Company was approved by a vote of a majority of the directors of the Company (then still in office) who were either directors at the beginning of such period or whose election or nomination for election was previously so approved, cease for any reason to constitute a majority of the Board, then in office;

provided, however, that such transaction also constitutes a change in control event within the meaning of Section 409A.

The term Permitted Holders as used above shall mean any of (i) Blackstone or its affiliates, and (ii) an employee benefit plan (or trust forming a part thereof) maintained by (A) the Company or (B) any corporation or other person or entity of which a majority of its voting power of its voting equity securities or equity interest is owned, directly or indirectly, by the Company. The term Blackstone as used above shall mean each of Blackstone FCH Capital Partners IV L.P., Blackstone Health Commitment Partners L.P., Blackstone Capital Partners IV-A L.P., Blackstone Family Investment Partnership IV-A L.P., Blackstone Health Commitment Partners-A L.P., Blackstone FCH Capital Partners IV-B L.P., and Blackstone FCH Capital Partners IV-A L.P., and their respective Affiliates."

(i) Resignation as Member of Board. If the Executive's employment by the Company is terminated for any reason, the Executive hereby agrees that he shall simultaneously submit his resignation as a member of the Board in writing on or before the Date of Termination if the Executive is a member of the Board at such time. If the Executive fails to submit such required resignation in writing, the provisions of this Subsection 10(i) may be deemed by the Company to constitute the Executive's written resignation as a member of the Board effective as of the Date of Termination.

11. Compensation During Disability, Death or Upon Termination.

(a) During any period that the Executive fails to perform his duties hereunder as a result of incapacity due to physical or mental illness ("Disability Period"), the Executive shall continue to receive his full salary at the rate then in effect for such period until his employment is terminated pursuant to Section 10(b)(ii) hereof, provided that payments so made to the Executive during the Disability Period shall be reduced by the sum of the amounts, if any, payable to the Executive with respect to such period under disability benefit plans of the Company or under the Social Security disability insurance program, and which amounts were not previously applied to reduce any such payment.

(b) If the Executive's employment is terminated by his death or Disability, the Company shall pay (i) any amounts due to the Executive under Section 6 through the date of such termination and (ii) all such amounts that would have become due to the Executive under Section 6 had the Executive's employment hereunder continued until the last day of the calendar year in which such termination of employment occurred, in each case in accordance with Section 13(b), if applicable.

(c) If the Executive's employment shall be terminated by the Company for Cause or by the Executive for other than Good Reason, the Company shall pay the Executive his full salary through the Date of Termination at the rate in effect at the time Notice of Termination is given, and the Company shall have no further obligations to the Executive under this Agreement.

(d) If (A) following a Change in Control the Company shall terminate the Executive's employment in breach of this Agreement, or (B) following a Change in Control the Executive shall terminate his employment for Good Reason, then

(i) the Company shall pay the Executive (x) his full salary through the Date of Termination at the rate in effect at the time Notice of Termination is given, (y) a pro rata portion of his current year annual bonus pursuant to Section 6(b) and (z) all other unpaid amounts, if any, to which the Executive is entitled as of the Date of Termination under any compensation plan or program of the Company, at the time such payments are due;

(ii) in lieu of any further salary payments to the Executive for periods subsequent to the Date of Termination, the Company shall pay as liquidated damages to the Executive an aggregate amount equal to the product of (A) the sum of (1) the Executive's annual salary rate in effect as of the Date of Termination and (2) the average of the annual bonuses actually paid to the Executive by the Company with respect to the two fiscal years which immediately precede the year of the Term in which the Date of Termination occurs; provided if there was a bonus or bonuses paid to the Executive with respect only to one fiscal year which immediately precedes the year of the Term in which the Date of Termination occurs, then such single year's bonus or bonuses shall be utilized in the calculation pursuant to this clause (2) and (B) the number three (3);

(iii) the Company shall (x) continue coverage for the Executive under the Company's life insurance, medical, health, disability and similar welfare benefit plans (or, if continued coverage is barred under such plans, the Company shall provide to the Executive substantially similar benefits) for a period equal to the greater of (A) the remainder of the Term and (B) 18 months, and (y) provide the benefits which the Executive would have been entitled to receive pursuant to any supplemental retirement plan maintained by the Company had his employment continued at the rate of compensation specified herein for a period equal to the greater of (A) the remainder of the Term and (B) 18 months. Benefits otherwise receivable by the Executive pursuant to clause (x) of this Subsection 11(d)(iii) shall be reduced to the extent comparable benefits are actually received by the Executive from a subsequent employer during the period during which the Company is required to provide such benefits, and the Executive shall report any such benefits actually received by him to the Company; and

(iv) the payments provided for in this Section 11(d) (other than Section 11(d)(iii)) shall be made not later than the fifth day following the Date of Termination, provided, however, that if the amounts of such payments, and the limitation on such payments set forth in Section 15 hereof, cannot be finally determined on or before such day, the Company shall pay to the Executive on such day an estimate, as determined in good faith by the Company, of the minimum amount of such payments to which the Executive is clearly entitled and shall pay the remainder of such payments (together with interest at the rate provided in section 1274(b)(2)(B) of the Code (as defined in Section 15)) as soon as the amount thereof can be determined but in no event later than the thirtieth (30th) day after the Date of Termination. In the event that the amount of the estimated payments exceeds the amount determined by the Company within six (6) months after payment to have been due, such excess shall be paid by the Executive to the Company, no later than the thirtieth (30th) business day after demand by the Company. At the time that payments are made under this Section 11(d), the Company shall provide the Executive with a written statement setting forth the manner in which such payments were calculated and the basis for such calculations including, without limitation, any opinions or other advice the Company has received from outside counsel, auditors or consultants (and any such opinions or advice which are in writing shall be attached to the statement).

(e) If (A) prior to any Change in Control the Company shall terminate the Executive's employment in breach of this Agreement or (B) prior to any Change in Control the Executive shall terminate his employment for Good Reason, then

(i) the Company shall pay the Executive (x) his full salary through the Date of Termination at the rate in effect at the time Notice of Termination is given, (y) a pro rata portion of his current year annual bonus pursuant to Section 6(b) and (z) any all other unpaid amounts, if any, to which the Executive is entitled as of the Date of Termination under any compensation plan or program of the Company, at the time such payments are due; for greater certainty, the pro-rata portion of the Executive's current year annual bonus will be determined following the end of the applicable measurement period and will be paid at the same as annual bonuses are otherwise paid to the Company's senior executives.

(ii) in lieu of any further salary payments to the Executive for periods subsequent to the Date of Termination, the Company shall pay as liquidated damages to the Executive an aggregate amount equal to the product of (A) the sum of (1) the Executive's annual salary rate in effect as of the Date of Termination and (2) the average of the annual bonuses actually paid to the Executive by the Company with respect to the two fiscal years which immediately precede the year of the Term in which the Date of Termination occurs; provided if there was a bonus or bonuses paid to the Executive with respect only to one fiscal year which immediately precedes the year of the Term in which the Date of Termination occurs, then such single year's bonus or bonuses shall be utilized in the calculation pursuant to this clause (2) and (B) the number two (2); such amount to be paid in substantially equal monthly installments during the period commencing with the month immediately following the month in which the Date of Termination occurs and ending with the month corresponding to the end of the Term hereunder; and

(iii) the Company shall, at its cost (provided that Executive shall continue to be responsible to pay the standard employee portion of such cost), (x) continue coverage for the Executive under the Company's life insurance, medical, health, disability and similar welfare benefit plans (or, if continued coverage is barred under such plans, the Company shall provide to the Executive substantially similar benefits) for a period equal to the greater of (A) the remainder of the Term and (B) 18 months, and (y) provide the benefits which the Executive would have been entitled to receive pursuant to any supplemental retirement plan maintained by the Company had his employment continued at the rate of compensation specified herein for a period equal to the greater of (A) the remainder of the Term and (B) 18 months. Benefits otherwise receivable by the Executive pursuant to clause (x) of this Subsection 11(e)(iii) shall be reduced to the extent comparable benefits are actually received by the Executive from a subsequent employer during the period during which the Company is required to provide such benefits, and the Executive shall report any such benefits actually received by him to the Company.

(f) The Executive shall not be required to mitigate the amount of any payment provided for in this Section 11 by seeking other employment or otherwise, and, except as provided in Sections 11(d) and 11(e) hereof, the amount of any payment or benefit provided for in this Section 11 shall (i) not be reduced by any compensation earned by the Executive as the result of employment by another employer or by retirement benefits and (ii) be the sole amount due to the Executive from the Company upon such termination of employment, the Executive hereby waiving any claim for other compensation or related damages (whether consequential, punitive or other) as a result of such termination.

(g) Notwithstanding anything to the contrary set forth in this Agreement, if the Executive is a "specified employee" within the meaning of Section 409A of the Internal Revenue Code of 1986, as amended (the "Code") and the final regulations and any guidance promulgated thereunder ("Section 409A") at the time of the Executive's termination, then for purposes solely of the amounts of liquidated damages payable to the Executive in installments pursuant to Section 11(e)(ii) above, only the portion of the Deferred Compensation Separation Benefits (as defined below) which do not exceed the Section 409A Limit (as defined below) may be made within the first six (6) months following the Executive's termination of employment in accordance with the payment schedule applicable to each such payment or benefit. The term "Deferred Compensation Separation Benefits" as used herein shall mean the liquidated damages payable to Executive pursuant to Section 11(e)(ii) above, together with any other post-termination payments or separation benefits which may be considered deferred compensation under Section 409A. The term "Section 409A Limit" as used herein shall mean the lesser of two (2) times: (i) Executive's annualized compensation based upon the annual rate of pay paid to Executive during the Company's taxable year preceding the Company's taxable year of Executive's termination of employment as determined under Treasury Regulation 1.409A-1(b)(9)(iii)(A)(1) and any Internal Revenue Service guidance issued with respect thereto; or (ii) the maximum amount that may be taken into account under a qualified plan pursuant to Section 401(a)(17) of the Code for the year in which the Executive's employment is terminated. Any portion of the Deferred Compensation Separation Benefits in excess of the Section 409A Limit shall accrue and, to the extent such portion of the Deferred Compensation Separation Benefits would otherwise have been payable within the first six (6) months following the Executive's termination of employment pursuant to Section 11(e)(ii) above, will become payable to the Executive on the first payroll date that occurs on or after the date six (6) months and one (1) day following the date of the Executive's termination of employment. All subsequent Deferred Compensation Separation Benefits, if any, will be payable in accordance with the payment schedule applicable to each payment or benefit. The parties hereto agree that this Section 11(g) is intended to comply with the requirements of Section 409A so that none of the liquidated damages payments and other separation compensation and benefits to be provided hereunder to Executive will be subject to the additional tax imposed upon Executive under Section 409A, and any ambiguities herein will be interpreted to so comply. The Company and the Executive agree to work together in good faith to consider amendments to this Agreement and to take such reasonable actions which are necessary, appropriate or desirable to avoid imposition of any additional tax or income recognition prior to actual payment to the Executive under Section 409A. Notwithstanding the foregoing, for purposes of Section 409A, the right to a series of installment payments under this Agreement shall be treated as a right to a series of separate payments and, in addition, any payment that is otherwise exempt from the application of Section 409A shall not be included in the calculation of Deferred Compensation Separation Benefits.

12. Representations.

(a) The Company represents and warrants that this Agreement has been authorized by all necessary corporate action of the Company and is a valid and binding agreement of the Company enforceable against it in accordance with its terms.

(b) The Executive represents and warrants that he is not a party to any agreement or instrument which would prevent him from entering into or performing his duties in any way under this Agreement.

13. Successors; Binding Agreement.

(a) The Company will require any successor (whether direct or indirect, by purchase, merger, consolidation or otherwise) to all or substantially all of the business and/or assets of the Company to expressly assume and agree to perform this Agreement in the same manner and to the same extent that the Company would be required to perform it if no such succession had taken place.

(b) This Agreement is a personal contract and the rights and interests of the Executive hereunder may not be sold, transferred, assigned, pledged, encumbered, or hypothecated by him, except as otherwise expressly permitted by the provisions of this Agreement. This Agreement shall inure to the benefit of and be enforceable by the Executive and his personal or legal representatives, executors, administrators, successors, heirs, distributees, devisees and legatees. If the Executive should die while any amount would still be payable to him hereunder had the Executive continued to live, all such amounts, unless otherwise provided herein, shall be paid in accordance with the terms of this Agreement to his devisee, legatee or other designee or, if there is no such designee, to his estate.

14. Confidentiality and Non-Competition Covenants.

(a) The Executive covenants and agrees that he will not at any time during and after the end of the Term, directly or indirectly, use for his own account, or disclose to any person, firm or corporation, other than authorized officers, directors and employees of the Company or its subsidiaries, Confidential Information (as hereinafter defined) of the Company. As used herein, "Confidential Information" of the Company means information of any kind, nature or description which is disclosed to or otherwise known to the Executive as a direct or indirect consequence of his association with the Company, which information is not generally known to the public or in the businesses in which the Company is engaged or which information relates to specific investment opportunities within the scope of the Company's business which were considered by the Executive or the Company during the term of this Agreement. During the Term and for a period of two years following the termination of the Executive's employment, the Executive shall not induce any employee of the Company or its subsidiaries to terminate his or her employment by the Company or its subsidiaries in order to obtain employment by any person, firm or corporation affiliated with the Executive.

(b) The Executive covenants and agrees that while the Executive remains employed by the Company or its subsidiary and for a period of two (2) years following the termination of the Executive's employment, the Executive shall not, directly or indirectly, own any interest in, operate, join, control, or participate as a partner, director, principal, officer, or agent of, enter into the employment of, act as a consultant to, or perform any services for any entity which is a hospital system or is in the hospital or hospital management business. Notwithstanding anything herein to the contrary, (1) the foregoing provisions of this Section 14(b) shall not prevent the Executive from (x) acquiring securities representing not more than 5% of the outstanding voting securities of any publicly held corporation or (y) working as an accountant or an attorney for a law or accounting firm and (2) the foregoing provisions of this Section 14(b) shall not be applicable to a termination of the Executive's employment (i) by the Company or (ii) by the Executive for Good Reason.

15. Prohibition on Parachute Payments.

(a) Notwithstanding any other provisions of this Agreement, in the event that any payment or benefit received or to be received by the Executive in connection with a Change in Control of the Company or the termination of the Executive's employment (whether pursuant to the terms of this Agreement or any other plan, arrangement or agreement with the Company, any Person whose actions result in a Change in Control or any Person affiliated with the Company or such Person) (all such payments and benefits, including, without limitation, base salary and bonus payments, being hereinafter called "Total Payments") would not be deductible (in whole or in part), by the Company, an affiliate or any Person making such payment or providing such benefit as a result of section 280G of the Code, then, to the extent necessary to make such portion of the Total Payments deductible (and after taking into account any reduction in the Total Payments provided by reason of section 280G of the Code in such other plan, arrangement or agreement), (A) the cash portion of the Total Payments shall first be reduced (if necessary, to zero), and (B) all other non- cash payments by the Company to the Executive shall next be reduced (if necessary, to zero). For purposes of this limitation (i) no portion of the Total Payments the receipt or enjoyment of which the Executive shall have effectively waived in writing prior to the Date of Termination shall be taken into account, (ii) no portion of the Total Payments shall be taken into account which in the opinion of tax counsel selected by the Company's independent auditors and reasonably acceptable to the Executive does not constitute a "parachute payment" within the meaning of section 280G(b)(2) of the Code, including by reason of section 280G(b)(4)(A) of the Code, (iii) such payments shall be reduced only to the extent necessary so that the Total Payments (other than those referred to in clauses (i) or (ii)) in their entirety constitute reasonable compensation for services actually rendered within the meaning of section 280G(b)(4)(B) of the Code or are otherwise not subject to disallowance as deductions, in the opinion of the tax counsel referred to in clause (ii); and (iv) the value of any non-cash benefit or any deferred payment or benefit included in the Total Payments shall be determined by the Company's independent auditors in accordance with the principles of sections 280G(d)(3) and (4) of the Code.

(b) If it is established pursuant to a final determination of a court or an Internal Revenue Service proceeding that, notwithstanding the good faith of the Executive and the Company in applying the terms of this Section 15, the aggregate "parachute payments" paid to or for the Executive's benefit are in an amount that would result in any portion of such "parachute payments" not being deductible by reason of section 280G of the Code, then the Executive shall have an obligation to pay the Company upon demand an amount equal to the excess of the aggregate "parachute payments" paid to or for the Executive's benefit over the aggregate "parachute payments" that could have been paid to or for the Executive's benefit without any portion of such "parachute payments" not being deductible by reason of section 280G of the Code.

16. Entire Agreement. This Agreement contains all the understandings between the parties hereto pertaining to the matters referred to herein, and on the Effective Date shall supersede all undertakings and agreements, whether oral or in writing, previously entered into by them with respect thereto. The Executive represents that, in executing this Agreement, he does not rely and has not relied upon any representation or statement not set forth herein made by the Company with regard to the subject matter, bases or effect of this Agreement or otherwise.

17. Amendment or Modification, Waiver. No provision of this Agreement may be amended or waived unless such amendment or waiver is agreed to in writing, signed by the Executive and by a duly authorized officer of the Company. No waiver by any party hereto of any breach by another party hereto of any condition or provision of this Agreement to be performed by such other party shall be deemed a waiver of a similar or dissimilar condition or provision at the same time, any prior time or any subsequent time.

18. Notices. Any notice to be given hereunder shall be in writing and shall be deemed given when delivered personally, sent by courier or telecopy or registered or certified mail, postage prepaid, return receipt requested, addressed to the party concerned at the address indicated below or to such other address as such party may subsequently give notice of hereunder in writing:

To Executive at: James H. Spalding
c/o Vanguard Health Systems, Inc.
20 Burton Hills Blvd.
Suite 100
Nashville, TN 37215

To the Company at: Vanguard Health Systems, Inc.
20 Burton Hills Blvd.
Suite 100
Nashville, TN 37215

Attention: General Counsel
Telecopy: (615) 665-6197

with a copy to:

Blackstone Management Associates IV LLC
345 Park Avenue
New York, NY 10154
Attention: Neil Simpkins

and a copy to:

Simpson Thacher & Bartlett LLP
425 Lexington Avenue
New York, NY 10017-3954
Attention: Brian Robbins

Any notice delivered personally or by courier under this Section 18 shall be deemed given on the date delivered and any notice sent by telecopy or registered or certified mail, postage prepaid, return receipt requested, shall be deemed given on the date telecopied or mailed.

19. Severability. If any provision of this Agreement or the application of any such provision to any party or circumstances shall be determined by any court of competent jurisdiction to be invalid and unenforceable to any extent, the remainder of this Agreement or the application of such provision to such person or circumstances other than those to which it is so determined to be invalid and unenforceable, shall not be affected thereby, and each provision hereof shall be validated and shall be enforced to the fullest extent permitted by law.

20. Survivorship. The respective rights and obligations of the parties hereunder shall survive any termination of this Agreement to the extent necessary to the intended preservation of such rights and obligations.

21. Governing Law; Attorney's Fees.

(a) This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee, without regard to its conflicts of laws principles.

(b) The prevailing party in any dispute arising out of this Agreement shall be entitled to be paid its reasonable attorney's fees incurred in connection with such dispute from the other party to such dispute.

22. Headings. All descriptive headings of sections and paragraphs in this Agreement are intended solely for convenience, and no provision of this Agreement is to be construed by reference to the heading of any section or paragraph.

23. Withholdings. All payments to the Executive under this Agreement shall be reduced by all applicable withholding required by federal, state or local tax laws.

24. Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

25. Termination of Severance Protection Agreement. Concurrently with the execution of this Agreement, the Company and the Executive hereby terminate the Amended and Restated Severance Protection Agreement, dated as of September 23, 2004, between the Company and the Executive.

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

VANGUARD HEALTH SYSTEMS, INC.

BY: /s/ Phillip W. Roe
Phillip W. Roe
Executive Vice President

THE EXECUTIVE

/s/ James H. Spalding
James H. Spalding

VANGUARD HEALTH SYSTEMS, INC.
 RESTRICTED STOCK UNIT AGREEMENT
 (Performance Vesting RSU — EBITDA)

THIS AGREEMENT (the "Agreement"), is made effective as of the ____ day of ____, 201__, (hereinafter called the "Date of Grant"), between Vanguard Health Systems, Inc., a Delaware corporation (hereinafter called the "Company"), and ____ (hereinafter called the "Participant").

R E C I T A L S:

WHEREAS, the Company has adopted the Vanguard Health Systems, Inc. 2011 Stock Incentive Plan, as amended (the "Plan"), which Plan is incorporated herein by reference and made a part of this Agreement. Capitalized terms not otherwise defined herein shall have the same meanings as in the Plan; and

WHEREAS, the Committee has determined that it would be in the best interests of the Company and its shareholders to grant the restricted stock units provided for herein (the "RSUs") to the Participant pursuant to the Plan and the terms set forth herein.

NOW THEREFORE, in consideration of the mutual covenants hereinafter set forth, the parties agree as follows:

1. Grant of the RSUs. The Company hereby grants to the Participant, on the terms and conditions hereinafter set forth, an opportunity to earn RSUs based on the extent to which the performance goals set forth herein are met, subject to adjustment as set forth in the Plan. The base number ("Base Number") of RSUs granted hereunder is ____ RSUs. Subject to the vesting terms set forth in Section 2 below, following completion of the Company's fiscal year ending June 30, 2012 (the "Performance Period"), the Participant shall become eligible to vest in a number of RSUs, if any, determined by multiplying the Base Number of RSUs by a performance multiplier which shall either be zero or range from 50% to 150% (the "Performance Multiplier"), depending on the extent to which the performance goals (the "Performance Goals") set forth in Annex A hereto are achieved (such product, the "Earned RSUs"). The extent to which Performance Goals have been met shall be determined by the Committee as soon as practicable following the end of the Performance Period.

2. Vesting/Form and Timing of Issuance or Transfer.

(a) Subject to the Participant's continued Employment with the Company, on each of ____, 201__, ____, 201__, ____, 201__ and ____, 201__ (each a "Scheduled Vesting Date") the Earned RSUs, if any, shall vest with respect to a number of Shares equal to 25% of the Earned RSUs.

(b) If the Participant's Employment with the Company is terminated for any reason, the RSUs (including, without limitation, any Earned RSUs) shall, to the extent not then vested, be canceled by the Company without consideration and no further Shares shall be delivered hereunder.

(c) Notwithstanding any other provisions of this Agreement to the contrary, (i) in the event of a Change in Control following the end of the Performance Period, the Earned RSUs, if any, shall, to the extent not then vested and not previously canceled, immediately become fully vested and (ii) in the event of a Change in Control prior to the end of the Performance Period, a number of RSUs equal to the number of RSUs that would have become Earned RSUs if the "target" level Performance Goal were achieved shall, to the extent the RSUs were not previously canceled, immediately become fully vested, in each case, in full satisfaction of the Participant's rights under this Agreement. The date upon which RSUs become vested upon a Change in Control shall be referred to herein as a "Change of Control Vesting Date".

(d) On each Scheduled Vesting Date or on the Change of Control Vesting Date (each a "Vesting Date"), as applicable, the Company shall issue or cause there to be transferred to the Participant, a number of Shares equal to the number of RSUs which became vested on such date; provided that, upon the issuance or transfer of Shares to the Participant, in lieu of a fractional Share, the Participant shall receive a cash payment equal to the Fair Market Value of such fractional Share.

(e) Upon each issuance or transfer of Shares in accordance with Section 2(d) of this Agreement, a number of RSUs equal to the number of Shares issued or transferred to the Participant (including fractional shares settled in cash) shall be extinguished.

(f) Notwithstanding the foregoing, the Participant's entitlement to Shares hereunder upon the occurrence of Vesting Date shall be conditioned upon the Participant's having become a party to the Company's Stockholders Agreement, dated as of November 4, 2004, as amended (the "Stockholders Agreement") prior to such Vesting Date.

3. No Right to Continued Employment. The granting of the RSUs evidenced hereby and this Agreement shall impose no obligation on the Company or any Affiliate to continue the Employment of the Participant and shall not lessen or affect the Company's or its Affiliate's right to terminate the Employment of such Participant.

4. No Rights of a Shareholder. The Participant shall not have any rights as a shareholder of the Company (including any rights to accrual or payment of dividends declared on Shares) until, and accruing only from and after, the Shares in question have been registered in the Company's register of shareholders effective on the applicable Vesting Date.

5. Certificates. Upon transfer of Shares underlying RSUs to the Participant hereunder, the Company shall issue certificates in the Participant's name for such Shares. However, the Company shall not be liable to the Participant for damages relating to any delays in issuing the certificates to him or her, any loss of the certificates, or any mistakes or errors in the issuance of the certificates themselves. The certificates representing the Shares received by the Participant in connection with the settlement of any RSUs hereunder shall be subject to the rules, regulations, and other requirements of the Securities and Exchange Commission, any stock exchange upon which such Shares are listed, and any applicable Federal or state laws, and the Committee may cause a legend or legends to be put on any such certificates to make appropriate reference to such restrictions. Notwithstanding the foregoing, the Company may elect to recognize the Participant's ownership through uncertificated book entry.

6. Transferability. The RSUs may not be assigned, alienated, pledged, attached, sold or otherwise transferred or encumbered by the Participant otherwise than by will or by the laws of descent and distribution, and any such purported assignment, alienation, pledge, attachment, sale, transfer or encumbrance shall be void and unenforceable against the Company or any Affiliate; provided that the designation of a beneficiary shall not constitute an assignment, alienation, pledge, attachment, sale, transfer or encumbrance. No such permitted transfer of the RSUs to heirs or legatees of the Participant shall be effective to bind the Company unless the Committee shall have been furnished with written notice thereof and a copy of such evidence as the Committee may deem necessary to establish the validity of the transfer and the acceptance by the transferee or transferees of the terms and conditions hereof.

7. Withholding. The Participant may be required to pay to the Company or any Affiliate and the Company shall have the right and is hereby authorized to withhold from any payment due or transfer made under the RSUs or under the Plan or from any compensation or other amount owing to a Participant the amount (in cash, Shares, other securities, other Awards or other property) of any applicable withholding taxes in respect of the RSUs, its settlement or any payment or transfer under or with respect to the RSUs or the Plan and to take such other action as may be necessary in the opinion of the Committee to satisfy all obligations for the payment of such withholding taxes.

8. Securities Laws. Upon the acquisition of any Shares pursuant to settlement of the RSUs, the Participant will make or enter into such written representations, warranties and agreements as the Committee may reasonably request in order to comply with applicable securities laws or with this Agreement.

9. Notices. Any notice necessary under this Agreement shall be addressed to the Company in care of its Secretary at the principal executive office of the Company and to the Participant at the address appearing in the personnel records of the Company for the Participant or to either party at such other address as either party hereto may hereafter designate in writing to the other. Any such notice shall be deemed effective upon receipt thereof by the addressee.

10. Choice of Law. **THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF DELAWARE WITHOUT REGARD TO CONFLICTS OF LAWS.**

11. RSUs and Shares Subject to Plan and Stockholders Agreement. By entering into this Agreement the Participant agrees and acknowledges that the Participant has received and read a copy of the Plan and the Stockholders Agreement. The RSUs (and the Shares issuable thereunder) is subject to the Plan and the Stockholders Agreement. The terms and provisions of the Plan and the Stockholders Agreement as it may be amended from time to time are hereby incorporated herein by reference. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan or the Stockholders Agreement, the applicable terms and provisions of the Plan or the Stockholders Agreement, as applicable will govern and prevail. In the event of a conflict between any term or provision of the Plan and any term or provision of the Stockholders Agreement, the applicable terms and provisions of the Stockholders Agreement will govern and prevail.

12. Signature in Counterparts. This Agreement may be signed in counterparts, each of which shall be an original, with the same effect as if the signatures thereto and hereto were upon the same instrument.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

VANGUARD HEALTH SYSTEMS, INC.

By:

Agreed and acknowledged as

of the date first above written:

Annex A

FY201_ Target Adjusted EBITDA Performance Goal = \$ _____

Determination of Performance Multiplier Based on FY201_ Adjusted EBITDA

FY201_ Adjusted EBITDA Performance Goals	Percent of Target Adjusted EBITDA	Performance Multiplier
Below \$ _____		zero
\$ _____	98%	50%
\$ _____	99%	75%
\$ _____ <i>(Target)</i>	100%	100%
\$ _____	101%	110%
\$ _____	102%	120%
\$ _____	103%	130%
\$ _____	104%	140%
\$ _____ or above	105%	150%

As used herein, "FY201_____ Adjusted EBITDA" shall mean the Company's Adjusted EBITDA for the fiscal year ended June 30, 201_____ as set forth in its Annual Report on Form 10-K filed with the Securities and Exchange Commission, subject to any additional adjustments that the Committee may approve in its sole discretion for the purpose of excluding the impact of items deemed to be unusual, unexpected or non-recurring from the determination of the applicable Performance Multiplier.

If the actual FY201_____ Adjusted EBITDA falls between two of the stated levels above for which a Performance Multiplier would apply, then the applicable Performance Multiplier shall be determined based on the Performance Goal wholly achieved and not by linear interpolation. For example, if FY201_____ Adjusted EBITDA is \$_____, then the applicable Performance Multiplier shall be 120%.

VANGUARD HEALTH SYSTEMS, INC.
 RESTRICTED STOCK UNIT AGREEMENT
 (Performance Vesting RSU — EPS)

THIS AGREEMENT (the "Agreement"), is made effective as of the _____ day of _____, 2011, (hereinafter called the "Date of Grant"), between Vanguard Health Systems, Inc., a Delaware corporation (hereinafter called the "Company"), and _____ (hereinafter called the "Participant");

R E C I T A L S:

WHEREAS, the Company has adopted the Vanguard Health Systems, Inc. 2011 Stock Incentive Plan, as amended (the "Plan"), which Plan is incorporated herein by reference and made a part of this Agreement. Capitalized terms not otherwise defined herein shall have the same meanings as in the Plan; and

WHEREAS, the Committee has determined that it would be in the best interests of the Company and its shareholders to grant the restricted stock units provided for herein (the "RSUs") to the Participant pursuant to the Plan and the terms set forth herein.

NOW THEREFORE, in consideration of the mutual covenants hereinafter set forth, the parties agree as follows:

1. Grant of the RSUs. The Company hereby grants to the Participant, on the terms and conditions hereinafter set forth, an opportunity to earn RSUs based on the extent to which the performance goals set forth herein are met, subject to adjustment as set forth in the Plan. The base number ("Base Number") of RSUs granted hereunder is _____ RSUs. Subject to the vesting terms set forth in Section 2 below, following completion of the Company's fiscal year ending June 30, 201____ (the "Performance Period"), the Participant shall become eligible to vest in a number of RSUs, if any, determined by multiplying the Base Number of RSUs by a performance multiplier which shall either be zero or range from 50% to 150% (the "Performance Multiplier"), depending on the extent to which the performance goals (the "Performance Goals") set forth in Annex A hereto are achieved (such product, the "Earned RSUs"). The extent to which Performance Goals have been met shall be determined by the Committee as soon as practicable following the end of the Performance Period.

2. Vesting/Form and Timing of Issuance or Transfer.

(a) Subject to the Participant's continued Employment with the Company, on each of _____, 201_, _____, 201_, _____, 201_____ and _____, 201_____ (each a "Scheduled Vesting Date") the Earned RSUs, if any, shall vest with respect to a number of Shares equal to 25% of the Earned RSUs.

(b) If the Participant's Employment with the Company is terminated for any reason, the RSUs (including, without limitation, any Earned RSUs) shall, to the extent not then vested, be canceled by the Company without consideration and no further Shares shall be delivered hereunder.

(c) Notwithstanding any other provisions of this Agreement to the contrary, (i) in the event of a Change in Control following the end of the Performance Period, the Earned RSUs, if any, shall, to the extent not then vested and not previously canceled, immediately become fully vested and (ii) in the event of a Change in Control prior to the end of the Performance Period, a number of RSUs equal to the number of RSUs that would have become Earned RSUs if the "target" level Performance Goal were achieved shall, to the extent the RSUs were not previously canceled, immediately become fully vested, in each case, in full satisfaction of the Participant's rights under this Agreement. The date upon which RSUs become vested upon a Change in Control shall be referred to herein as a "Change of Control Vesting Date".

(d) On each Scheduled Vesting Date or on the Change of Control Vesting Date (each a "Vesting Date"), as applicable, the Company shall issue or cause there to be transferred to the Participant, a number of Shares equal to the number of RSUs which became vested on such date; provided that, upon the issuance or transfer of Shares to the Participant, in lieu of a fractional Share, the Participant shall receive a cash payment equal to the Fair Market Value of such fractional Share.

(e) Upon each issuance or transfer of Shares in accordance with Section 2(d) of this Agreement, a number of RSUs equal to the number of Shares issued or transferred to the Participant (including fractional shares settled in cash) shall be extinguished.

(f) Notwithstanding the foregoing, the Participant's entitlement to Shares hereunder upon the occurrence of Vesting Date shall be conditioned upon the Participant's having become a party to the Company's Stockholders Agreement, dated as of November 4, 2004, as amended (the "Stockholders Agreement") prior to such Vesting Date.

3. No Right to Continued Employment. The granting of the RSUs evidenced hereby and this Agreement shall impose no obligation on the Company or any Affiliate to continue the Employment of the Participant and shall not lessen or affect the Company's or its Affiliate's right to terminate the Employment of such Participant.

4. No Rights of a Shareholder. The Participant shall not have any rights as a shareholder of the Company (including any rights to accrual or payment of dividends declared on Shares) until, and accruing only from and after, the Shares in question have been registered in the Company's register of shareholders effective on the applicable Vesting Date.

5. Certificates. Upon transfer of Shares underlying RSUs to the Participant hereunder, the Company shall issue certificates in the Participant's name for such Shares. However, the Company shall not be liable to the Participant for damages relating to any delays in issuing the certificates to him or her, any loss of the certificates, or any mistakes or errors in the issuance of the certificates themselves. The certificates representing the Shares received by the Participant in connection with the settlement of any RSUs hereunder shall be subject to the rules, regulations, and other requirements of the Securities and Exchange Commission, any stock exchange upon which such Shares are listed, and any applicable Federal or state laws, and the Committee may cause a legend or legends to be put on any such certificates to make appropriate reference to such restrictions. Notwithstanding the foregoing, the Company may elect to recognize the Participant's ownership through uncertificated book entry.

6. Transferability. The RSUs may not be assigned, alienated, pledged, attached, sold or otherwise transferred or encumbered by the Participant otherwise than by will or by the laws of descent and distribution, and any such purported assignment, alienation, pledge, attachment, sale, transfer or encumbrance shall be void and unenforceable against the Company or any Affiliate; provided that the designation of a beneficiary shall not constitute an assignment, alienation, pledge, attachment, sale, transfer or encumbrance. No such permitted transfer of the RSUs to heirs or legatees of the Participant shall be effective to bind the Company unless the Committee shall have been furnished with written notice thereof and a copy of such evidence as the Committee may deem necessary to establish the validity of the transfer and the acceptance by the transferee or transferees of the terms and conditions hereof.

7. Withholding. The Participant may be required to pay to the Company or any Affiliate and the Company shall have the right and is hereby authorized to withhold from any payment due or transfer made under the RSUs or under the Plan or from any compensation or other amount owing to a Participant the amount (in cash, Shares, other securities, other Awards or other property) of any applicable withholding taxes in respect of the RSUs, its settlement or any payment or transfer under or with respect to the RSUs or the Plan and to take such other action as may be necessary in the opinion of the Committee to satisfy all obligations for the payment of such withholding taxes.

8. Securities Laws. Upon the acquisition of any Shares pursuant to settlement of the RSUs, the Participant will make or enter into such written representations, warranties and agreements as the Committee may reasonably request in order to comply with applicable securities laws or with this Agreement.

9. Notices. Any notice necessary under this Agreement shall be addressed to the Company in care of its Secretary at the principal executive office of the Company and to the Participant at the address appearing in the personnel records of the Company for the Participant or to either party at such other address as either party hereto may hereafter designate in writing to the other. Any such notice shall be deemed effective upon receipt thereof by the addressee.

10. Choice of Law. **THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF DELAWARE WITHOUT REGARD TO CONFLICTS OF LAWS.**

11. RSUs and Shares Subject to Plan and Stockholders Agreement. By entering into this Agreement the Participant agrees and acknowledges that the Participant has received and read a copy of the Plan and the Stockholders Agreement. The RSUs (and the Shares issuable thereunder) is subject to the Plan and the Stockholders Agreement. The terms and provisions of the Plan and the Stockholders Agreement as it may be amended from time to time are hereby incorporated herein by reference. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan or the Stockholders Agreement, the applicable terms and provisions of the Plan or the Stockholders Agreement, as applicable will govern and prevail. In the event of a conflict between any term or provision of the Plan and any term or provision of the Stockholders Agreement, the applicable terms and provisions of the Stockholders Agreement will govern and prevail.

12. Signature in Counterparts. This Agreement may be signed in counterparts, each of which shall be an original, with the same effect as if the signatures thereto and hereto were upon the same instrument.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

VANGUARD HEALTH SYSTEMS, INC.

By:

Agreed and acknowledged as
of the date first above written:

Annex A

FY201_ Target EPS Performance Goal = \$ _____

Determination of Performance Multiplier Based on FY201_ EPS

FY201_ EPS Performance Goals	Percent of Target EPS	Performance Multiplier
Below \$ _____		zero
\$ _____	98%	50%
\$ _____	99%	60%
\$ _____ (<i>Target</i>)	100%	70%
\$ _____	101%	80%
\$ _____	102%	90%
\$ _____	103%	100%
\$ _____	104%	105%
\$ _____	105%	110%
\$ _____	106%	115%
\$ _____	107%	120%
\$ _____	108%	125%
\$ _____	109%	130%
\$ _____	110%	135%
\$ _____	111%	140%
\$ _____	112%	145%
\$ _____ or above	113%	150%

As used herein, "FY201_____EPS" shall mean the Company's earnings per Share for its fiscal year ending June 30, 201_, as reflected on the Company's Annual Report on Form 10-K filed with the Securities and Exchange Commission, subject to any adjustments that the Committee may approve in its sole discretion for the purpose of excluding the impact of items deemed to be unusual, unexpected or non-recurring from the determination of the applicable Performance Multiplier.

If the actual FY201_____ EPS falls between two of the stated levels above for which a Performance Multiplier would apply, then the applicable Performance Multiplier shall be determined based on the Performance Goal wholly achieved and not by linear interpolation. For example, if FY201_____ EPS is \$_____, then the applicable Performance Multiplier shall be 90%.

VANGUARD HEALTH SYSTEMS, INC.
RESTRICTED STOCK UNIT AGREEMENT
(Time Vesting RSU)

THIS AGREEMENT (the "Agreement"), is made effective as of the ____ day of ____, 2011, (hereinafter called the "Date of Grant"), between Vanguard Health Systems, Inc., a Delaware corporation (hereinafter called the "Company"), and ____ (hereinafter called the "Participant");

R E C I T A L S:

WHEREAS, the Company has adopted the Vanguard Health Systems, Inc. 2011 Stock Incentive Plan, as amended (the "Plan"), which Plan is incorporated herein by reference and made a part of this Agreement. Capitalized terms not otherwise defined herein shall have the same meanings as in the Plan; and

WHEREAS, the Committee has determined that it would be in the best interests of the Company and its shareholders to grant the restricted stock units provided for herein (the "RSUs") to the Participant pursuant to the Plan and the terms set forth herein.

NOW THEREFORE, in consideration of the mutual covenants hereinafter set forth, the parties agree as follows:

1. Grant of the RSUs. The Company hereby grants to the Participant, on the terms and conditions hereinafter set forth, an aggregate of ____ RSUs, subject to adjustment as set forth in the Plan.

2. Vesting/Form and Timing of Issuance or Transfer.

(a) Subject to the Participant's continued Employment with the Company, on each of the first, second, third and fourth anniversaries of the Date of Grant (each a "Scheduled Vesting Date") the RSUs shall vest with respect to a number of Shares equal to 25% of the RSUs initially granted to the Participant under this Agreement.

(b) If the Participant's Employment with the Company is terminated for any reason, the RSUs shall, to the extent not then vested, be canceled by the Company without consideration and no further Shares shall be delivered hereunder.

(c) Notwithstanding any other provisions of this Agreement to the contrary, in the event of a Change in Control the RSUs shall, to the extent not then vested and not previously canceled, immediately become fully vested (a "Change of Control Vesting Date").

(d) On each Scheduled Vesting Date or on the Change of Control Vesting Date (each a "Vesting Date"), as applicable, the Company shall issue or cause there to be transferred to the Participant, a number of Shares equal to the number of RSUs which became vested on such date; provided that, upon the issuance or transfer of Shares to the Participant, in lieu of a fractional Share, the Participant shall receive a cash payment equal to the Fair Market Value of such fractional Share.

(e) Upon each issuance or transfer of Shares in accordance with Section 2(d) of this Agreement, a number of RSUs equal to the number of Shares issued or transferred to the Participant (including fractional shares settled in cash) shall be extinguished.

(f) Notwithstanding the foregoing, the Participant's entitlement to Shares hereunder upon the occurrence of Vesting Date shall be conditioned upon the Participant's having become a party to the Company's Stockholders Agreement, dated as of November 4, 2004, as amended (the "Stockholders Agreement") prior to such Vesting Date.

3. No Right to Continued Employment. The granting of the RSUs evidenced hereby and this Agreement shall impose no obligation on the Company or any Affiliate to continue the Employment of the Participant and shall not lessen or affect the Company's or its Affiliate's right to terminate the Employment of such Participant.

4. No Rights of a Shareholder. The Participant shall not have any rights as a shareholder of the Company (including any rights to accrual or payment of dividends declared on Shares) until, and accruing only from and after, the Shares in question have been registered in the Company's register of shareholders effective on the applicable Vesting Date.

5. Certificates. Upon transfer of Shares underlying RSUs to the Participant hereunder, the Company shall issue certificates in the Participant's name for such Shares. However, the Company shall not be liable to the Participant for damages relating to any delays in issuing the certificates to him or her, any loss of the certificates, or any mistakes or errors in the issuance of the certificates themselves. The certificates representing the Shares received by the Participant in connection with the settlement of any RSUs hereunder shall be subject to the rules, regulations, and other requirements of the Securities and Exchange Commission, any stock exchange upon which such Shares are listed, and any applicable Federal or state laws, and the Committee may cause a legend or legends to be put on any such certificates to make appropriate reference to such restrictions. Notwithstanding the foregoing, the Company may elect to recognize the Participant's ownership through uncertificated book entry.

6. Transferability. The RSUs may not be assigned, alienated, pledged, attached, sold or otherwise transferred or encumbered by the Participant otherwise than by will or by the laws of descent and distribution, and any such purported assignment, alienation, pledge, attachment, sale, transfer or encumbrance shall be void and unenforceable against the Company or any Affiliate; provided that the designation of a beneficiary shall not constitute an assignment, alienation, pledge, attachment, sale, transfer or encumbrance. No such permitted transfer of the RSUs to heirs or legatees of the Participant shall be effective to bind the Company unless the Committee shall have been furnished with written notice thereof and a copy of such evidence as the Committee may deem necessary to establish the validity of the transfer and the acceptance by the transferee or transferees of the terms and conditions hereof.

7. Withholding. The Participant may be required to pay to the Company or any Affiliate and the Company shall have the right and is hereby authorized to withhold from any payment due or transfer made under the RSUs or under the Plan or from any compensation or other amount owing to a Participant the amount (in cash, Shares, other securities, other Awards or other property) of any applicable withholding taxes in respect of the RSUs, its settlement or any payment or transfer under or with respect to the RSUs or the Plan and to take such other action as may be necessary in the opinion of the Committee to satisfy all obligations for the payment of such withholding taxes.

8. Securities Laws. Upon the acquisition of any Shares pursuant to settlement of the RSUs, the Participant will make or enter into such written representations, warranties and agreements as the Committee may reasonably request in order to comply with applicable securities laws or with this Agreement.

9. Notices. Any notice necessary under this Agreement shall be addressed to the Company in care of its Secretary at the principal executive office of the Company and to the Participant at the address appearing in the personnel records of the Company for the Participant or to either party at such other address as either party hereto may hereafter designate in writing to the other. Any such notice shall be deemed effective upon receipt thereof by the addressee.

10. Choice of Law. **THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF DELAWARE WITHOUT REGARD TO CONFLICTS OF LAWS.**

11. RSUs and Shares Subject to Plan and Stockholders Agreement. By entering into this Agreement the Participant agrees and acknowledges that the Participant has received and read a copy of the Plan and the Stockholders Agreement. The RSUs (and the Shares issuable thereunder) is subject to the Plan and the Stockholders Agreement. The terms and provisions of the Plan and the Stockholders Agreement as it may be amended from time to time are hereby incorporated herein by reference. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan or the Stockholders Agreement, the applicable terms and provisions of the Plan or the Stockholders Agreement, as applicable will govern and prevail. In the event of a conflict between any term or provision of the Plan and any term or provision of the Stockholders Agreement, the applicable terms and provisions of the Stockholders Agreement will govern and prevail.

12. Signature in Counterparts. This Agreement may be signed in counterparts, each of which shall be an original, with the same effect as if the signatures thereto and hereto were upon the same instrument.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

VANGUARD HEALTH SYSTEMS, INC.

By:

Agreed and acknowledged as
of the date first above written:

VANGUARD HEALTH SYSTEMS, INC.
NONQUALIFIED STOCK OPTION AGREEMENT
(TIME OPTION)

THIS AGREEMENT (the "Agreement"), is made effective as of the ____ day of ____, 201__, (hereinafter called the "Date of Grant"), between Vanguard Health Systems, Inc., a Delaware corporation (hereinafter called the "Company"), and ____ (hereinafter called the "Participant").

R E C I T A L S:

WHEREAS, the Company has adopted the Vanguard Health Systems, Inc. 2011 Stock Incentive Plan (the "Plan"), which Plan is incorporated herein by reference and made a part of this Agreement. Capitalized terms not otherwise defined herein shall have the same meanings as in the Plan; and

WHEREAS, the Committee has determined that it would be in the best interests of the Company and its shareholders to grant the option provided for herein to the Participant pursuant to the Plan and the terms set forth herein.

NOW THEREFORE, in consideration of the mutual covenants hereinafter set forth, the parties agree as follows:

1. Grant of the Option. The Company hereby grants to the Participant the right and option (the "Option") to purchase, on the terms and conditions hereinafter set forth, all or any part of an aggregate of ____ Shares, subject to adjustment as set forth in the Plan. The purchase price of the Shares subject to the Option shall be \$____ per Share (the "Option Price"), reflecting the Fair Market Value of a Share as of the Date of Grant. The Option is intended to be a non-qualified stock option, and is not intended to be treated as an option that complies with Section 422 of the Code.

2. Vesting.

(a) Subject to the Participant's continued Employment with the Company, the Option shall vest and become exercisable with respect to 33¹/₃% of the Shares initially covered by the Option on each of the first, second and third anniversaries of the Date of Grant.

At any time, the portion of the Option which has become vested and exercisable as described above (or pursuant to Section 2(c) below) is hereinafter referred to as the "Vested Portion".

(b) If the Participant's Employment with the Company is terminated for any reason, the Option shall, to the extent not then vested, be canceled by the Company without consideration and the Vested Portion of the Option shall remain exercisable for the period set forth in Section 3(a).

(c) Notwithstanding any other provisions of this Agreement to the contrary, in the event of a Change in Control the Option shall, to the extent not then vested and not previously canceled, immediately become fully vested and exercisable.

3. Exercise of Option.

(a) Period of Exercise. Subject to the provisions of the Plan and this Agreement, the Participant may exercise all or any part of the Vested Portion of the Option at any time prior to the earliest to occur of:

- (i) the tenth anniversary of the Date of Grant;
- (ii) one year following the date of the Participant's termination of Employment due to death or "Disability"; and
- (iii) 90 days following the date of the Participant's termination of Employment for any reason other than due to the Participant's death or Disability.

For purposes of this Agreement:

"Disability" shall mean "disability" as defined in any employment agreement then in effect between the Participant and the Company or if not defined therein or if there shall be no such agreement, as defined in the Company's long-term disability plan as in effect from time to time, or if there shall be no plan or if not defined therein, the Participant's becoming physically or mentally incapacitated and consequent inability for a period of six (6) months in any twelve (12) consecutive month period to perform his duties to the Company.

(b) Method of Exercise.

(i) Subject to Section 3(a), the Vested Portion of the Option may be exercised by delivering to the Company at its principal office written notice of intent to so exercise; provided that, the Option may be exercised with respect to whole Shares only. Such notice shall specify the number of Shares for which the Option is being exercised and shall be accompanied by payment in full of the Option Price. The payment of the Option Price may be made at the election of the Participant (i) in cash or its equivalent (e.g., by check), (ii) to the extent permitted by the Committee, in Shares having a Fair Market Value equal to the aggregate Option Price for the Shares being purchased and satisfying such other requirements as may be imposed by the Committee; provided, that such Shares have been held by the Participant for no less than six months (or such other period as established from time to time by the Committee in order to avoid adverse accounting treatment applying generally accepted accounting principles), (iii) partly in cash and, to the extent permitted by the Committee, partly in such Shares, (iv) if there is a public market for the Shares at such time, through the delivery of irrevocable instructions to a broker to sell Shares obtained upon the exercise of the Option and to deliver promptly to the Company an amount out of the proceeds of such Sale equal to the aggregate Option Price for the Shares being purchased or (v) to the extent permitted by the Committee, by "net settlement" in Shares. No Participant shall have any rights to dividends or other rights of a stockholder with respect to Shares subject to an Option until the Participant has given written notice of exercise of the Option, paid in full for such Shares and, if applicable, has satisfied any other conditions imposed by the Committee pursuant to the Plan.

(ii) Notwithstanding any other provision of the Plan or this Agreement to the contrary, the Option may not be exercised prior to the completion of any registration or qualification of the Option or the Shares under applicable state and federal securities or other laws, or under any ruling or regulation of any governmental body or national securities exchange that the Committee shall in its sole discretion determine to be necessary or advisable.

(iii) Upon the Company's determination that the Option has been validly exercised as to any of the Shares, the Company shall issue certificates in the Participant's name for such Shares. However, the Company shall not be liable to the Participant for damages relating to any delays in issuing the certificates to him, any loss of the certificates, or any mistakes or errors in the issuance of the certificates or in the certificates themselves. Notwithstanding the foregoing, the Company may elect to recognize the Participant's ownership through uncertificated book entry.

(iv) In the event of the Participant's death, the Vested Portion of the Option shall remain exercisable by the Participant's executor or administrator, or the person or persons to whom the Participant's rights under this Agreement shall pass by will or by the laws of descent and distribution as the case may be, to the extent set forth in Section 3(a). Any heir or legatee of the Participant shall take rights herein granted subject to the terms and conditions hereof.

(v) As a condition to exercising the Option, the Participant shall (if not already a party thereto) become a party to the Company's Stockholders Agreement, dated as of November 4, 2004, as amended (the "Stockholders Agreement").

4. No Right to Continued Employment. The granting of the Option evidenced hereby and this Agreement shall impose no obligation on the Company or any Affiliate to continue the Employment of the Participant and shall not lessen or affect the Company's or its Affiliate's right to terminate the Employment of such Participant.

5. Legend on Certificates. Unless the Company issues the Shares in uncertificated form, the certificates representing the Shares purchased by exercise of the Option shall be subject to the rules, regulations, and other requirements of the Securities and Exchange Commission, any stock exchange upon which such Shares are listed, and any applicable Federal or state laws, and the Committee may cause a legend or legends to be put on any such certificates to make appropriate reference to such restrictions.

6. Transferability. The Option may not be assigned, alienated, pledged, attached, sold or otherwise transferred or encumbered by the Participant otherwise than by will or by the laws of descent and distribution, and any such purported assignment, alienation, pledge, attachment, sale, transfer or encumbrance shall be void and unenforceable against the Company or any Affiliate; provided that the designation of a beneficiary shall not constitute an assignment, alienation, pledge, attachment, sale, transfer or encumbrance. No such permitted transfer of the Option to heirs or legatees of the Participant shall be effective to bind the Company unless the Committee shall have been furnished with written notice thereof and a copy of such evidence as the Committee may deem necessary to establish the validity of the transfer and the acceptance by the transferee or transferees of the terms and conditions hereof. During the Participant's lifetime, the Option is exercisable only by the Participant.

7. Withholding. The Participant may be required to pay to the Company or any Affiliate and the Company shall have the right and is hereby authorized to withhold from any payment due or transfer made under the Option or under the Plan or from any compensation or other amount owing to a Participant the amount (in cash, Shares, other securities, other Awards or other property) of any applicable withholding taxes in respect of the Option, its exercise or any payment or transfer under or with respect to the Option or the Plan and to take such other action as may be necessary in the opinion of the Committee to satisfy all obligations for the payment of such withholding taxes.

8. Securities Laws. Upon the acquisition of any Shares pursuant to the exercise of the Option, the Participant will make or enter into such written representations, warranties and agreements as the Committee may reasonably request in order to comply with applicable securities laws or with this Agreement.

9. Notices. Any notice necessary under this Agreement shall be addressed to the Company in care of its Secretary at the principal executive office of the Company and to the Participant at the address appearing in the personnel records of the Company for the Participant or to either party at such other address as either party hereto may hereafter designate in writing to the other. Any such notice shall be deemed effective upon receipt thereof by the addressee.

10. Choice of Law. THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF DELAWARE WITHOUT REGARD TO CONFLICTS OF LAWS.

11. Option Subject to Plan and Stockholders Agreement. By entering into this Agreement the Participant agrees and acknowledges that the Participant has received and read a copy of the Plan and the Stockholders Agreement. The Option is subject to the Plan and the Stockholders Agreement. The terms and provisions of the Plan and the Stockholders Agreement as it may be amended from time to time are hereby incorporated herein by reference. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan or the Stockholders Agreement, the applicable terms and provisions of the Plan or the Stockholders Agreement, as applicable will govern and prevail. In the event of a conflict between any term or provision of the Plan and any term or provision of the Stockholders Agreement, the applicable terms and provisions of the Stockholders Agreement will govern and prevail.

12. Signature in Counterparts. This Agreement may be signed in counterparts, each of which shall be an original, with the same effect as if the signatures thereto and hereto were upon the same instrument.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

VANGUARD HEALTH SYSTEMS, INC.

By:

Agreed and acknowledged as

of the date first above written:



ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

DIVISION OF BUSINESS AND FINANCE
SECTION A: CONTRACT

1. AMENDMENT NUMBER: 16
2. CONTRACT NO.: YH09-0001-07
3. EFFECTIVE DATE OF CONTRACT: October 1, 2011
4. PROGRAM: DHCM — ACUTE

5. CONTRACTOR'S NAME AND ADDRESS:

PURPOSE OF AMENDMENT: To renew the contract for the term October 1, 2011 through September 30, 2012 and to amend Sections B, C, D, E and J.

- 7. THE CONTRACT REFERENCED ABOVE IS AMENDED AS FOLLOWS:
A. Section B contains revised Capitation Rates and extends the contract term from October 1, 2011 through September 30, 2012. (See attached rate sheet.)
B. Section C has numerous definitions revised see Section C for specific revisions.
C. Section D has been revised: 1) to match the ALTCS RFP where appropriate, 2) to address benefit changes, 3) for technical corrections and 4) to revised/clarifying language. Refer to Section D individual paragraphs for details.
D. Section E, Contract Terms and Conditions contains revisions to paragraphs (¶): ¶4-Contract Interpretation, ¶23-Non-Discrimination, ¶38-Cooperation With Other Contractors.
E. Section J, Attachments, Attachment A-Minimum Subcontractor Provisions has been removed from the Contract and placed on the AHCCCS website
F. Section J, Attachment B. Minimum Network Standards requirements for Pinal and Gila Counties were updated.
G. Section J, Attachments, Attachment F, Periodic Reporting Requirements contains revisions where reporting requirements have changed. Additionally, the Suspension and Modification listing has been updated.

NOTE: Please sign, date, and return executed file by E-Mail to: Mark Held at Mark.Held@azahcccs.gov
Sr. Procurement Specialist
AHCCCS Contracts and Purchasing
and P.J. Schoenstene at
pj.schoenstene@azahcccs.gov

8. EXCEPT AS PROVIDED FOR HEREIN, ALL TERMS AND CONDITIONS OF THE ORIGINAL CONTRACT NOT HERETOFORE CHANGED AND/OR AMENDED REMAIN UNCHANGED AND IN FULL EFFECT.

IN WITNESS WHEREOF THE PARTIES HERETO SIGN THEIR NAMES IN AGREEMENT

9. SIGNATURE OF AUTHORIZED REPRESENTATIVE: /s/ Nancy Novick
TYPED NAME: Nancy Novick
TITLE: Chief Executive Officer
DATE: September 9, 2011

10. SIGNATURE OF AHCCCSA CONTRACTING OFFICER: /s/ Michael Veit
TYPED NAME: MICHAEL VEIT
TITLE: CONTRACTS & PURCHASING ADMINISTRATOR
DATE: August 30, 2011

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SECTION B: CAPITATION RATES

The Contractor shall provide services as described in this contract. In consideration for these services, the Contractor will be paid Contractor-specific rates per member per month for the term October 1, 2011 through September 30, 2012.

Phoenix Health Plan special contract language:

HMS Credit Balance Program

I. Purpose:

The purpose of this amendment is to implement a credit balance review program by Health Management Systems, Inc. (HMS) on behalf of Phoenix Health Plan through HMS's contract with the Arizona Health Care Cost Containment System (AHCCCS). Credit Balance Review is the process used to identify and recover any Medicare or Third Party resource overpayment retained by a provider for an AHCCCS member.

II. Process:

HMS's credit balance program is comprised of two parts, which when used in conjunction, have proven to be effective recovery tools. The process begins when HMS notifies the selected provider by mail requesting they conduct a self-audit for credit balances. This will be accompanied by the AHCCCS Health Plan third party resource refund worksheet (Attachment A). Instructions allow a provider to return overpayments, which may exclude them from an on-site review. After sufficient time has been allowed for all to respond, the next step is to select providers for on-site reviews of the provider's credit balance process. Providers are selected for this review based upon their comparative returns of credit balances in the self-audit, AHCCCS and the Health Plan preference, and the likelihood of credit balances existing. AHCCCS will generate a letter to the provider notifying them of the on-site review, explaining the scope, and including a list of accounts that have been targeted for review. This list will be identified through a series of data analysis programs designed to create a profile of a member/patient with a potential credit balance. To perform this function, HMS will use a combination of data files including paid claims history, encounter data, and eligibility files. In addition, provider accounting procedures are verified to ensure the proper posting of contractual allowances, etc. HMS will schedule these reviews approximately thirty (30) days after the provider receives the notification.

Any credit balance accounts under current review or previously identified by the Health Plans shall be reported to AHCCCS prior to HMS's scheduled review. These accounts should be reported on the AHCCCS Health Plan credit balance accounts under review worksheet (Attachment B) with supporting documentation.

The providers will be directed to send the refund balances to HMS. HMS will receive and identify these refunds. AHCCCS will require HMS to process these refunds in the same manner as currently required by the AHCCCS contract with HMS. AHCCCS will require HMS to research the refunds and to provide a monthly disbursement report of the refund amounts due to the health plans and program contractors. AHCCCS will disburse a payment in the amount due to the health plans and program contractors.

An electronic report of all claims identified as credit balances where reimbursement is received from the provider, will be generated for the Health Plan and for AHCCCS. HMS will research and verify cases needing adjustments as a result of the credit balance. All recoveries are subject to reporting requirements contained in the AHCCCS Recoupment Request Policy. Depending on the program's initial success, this program may be implemented quarterly, semi-annually or annually.

Section B

CYE 12 Acute Care Contract

October 1, 2011

SECTION B: CAPITATION RATES

Contract/RFP No. YH09-0001

**ATTACHMENT A
Third Party Resource Refund Worksheet**

AHCCCS Provider Name: _____

Page: _____ of _____

AHCCCS Provider ID Number: _____

Completed By: _____
Date: _____/_____/_____

<u>MEMBER/PATIENT NAME</u>	<u>MEMBER/ PATIENT AHCCCS ID</u>	<u>DATE OF SERVICE PERIOD</u> <u>FROM</u> <u>TO</u>	<u>CLAIM REFERENCE NUMBER (CRN)</u>	<u>TOTAL BILLED CHARGES</u>	<u>TOTAL AMOUNT PAID BY AHCCCS</u>	<u>TOTAL AMOUNT PAID BY THIRD PARTY RESOURCE/ INSURANCE</u>	<u>THIRD PARTY RESOURCE/ INSURANCE NAME</u>	<u>REFUND AMOUNT DUE</u>	<u>REASON FOR REFUND</u>
--------------------------------	--	--	---	-------------------------------------	--	---	---	----------------------------------	----------------------------------

This is to certify that the information contained in this report is true, accurate and complete, to the best of my knowledge. I understand that AHCCCS will rely on this certification at the time AHCCCS certifies its expenditures to the Centers for Medicare and Medicaid Services on Form CMS-64.

Authorized Signature _____

Date: _____

Section B

CYE 12 Acute Care Contract

October 1, 2011

SECTION B: CAPITATION RATES

Contract/RFP No. YH09-0001

ATTACHMENT B
Credit Balance Accounts Under Review by AHCCCS Program Contractors

Plan Name: _____

Page: _____ of _____

Completed By: _____

Plan ID Number: _____

Date: _____ / _____ / _____

AHCCCS PROVIDER NAME	AHCCCS PROVIDER ID NUMBER	MEMBER/ PATIENT NAME	MEMBER/ PATIENT AHCCCS ID	DATE OF SERVICE PERIOD	ENCOUNTER/ CLAIM REFERENCE NUMBER (CRN)	TOTAL BILLED CHARGES	THIRD PARTY RESOURCE/INSURANCE NAME
				<u>FROM</u>	<u>TO</u>		

This is to certify that the information contained in this report is true, accurate and complete, to the best of my knowledge. I understand that AHCCCS will rely on this certification at the time AHCCCS certifies its expenditures to the Centers for Medicare and Medicaid Services on Form CMS-64.

Authorized Signature _____

Date: _____

Section B

CYE 12 Acute Care Contract

October 1, 2011



SECTION C: DEFINITIONS

Contract/RFP No. YH09-0001

SECTION C: DEFINITIONS

638 TRIBAL FACILITY	A facility that is operated by an Indian tribe and that is authorized to provide services pursuant to Public Law (P.L.) 93-638, as amended.
1931 (also referred to as TANF related)	Eligible individuals and families under Section 1931 of the Social Security Act, with household income levels at or below 100% of the federal poverty level (FPL).
ACOM	<i>AHCCCS Contractor Operations Manual</i> , available on the AHCCCS website at www.azahcccs.gov .
ADHS	Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.
ADHS BEHAVIORAL HEALTH RECIPIENT	A Title XIX or Title XXI acute care member who is receiving behavioral healthservices through ADHS and its subcontractors.
ADJUDICATED CLAIMS	Claims that have been received and processed by the Contractor which resulted in a payment or denial of payment
AGENT	Any person who has been delegated the authority to obligate or act on behalf of another person or entity.
AHCCCS	Arizona Health Care Cost Containment System, which is composed of the Administration, Contractors, and other arrangements through which health care services are provided to an eligible person, as defined by A.R.S. § 36-2902, et seq.
AHCCCS BENEFITS	See "COVERED SERVICES.
AHCCCS CARE	Eligible individuals and childless adults whose income is less than or equal to 100% of the FPL, and who are not categorically linked to another Title XIX program. (Formerly Non-MED)
AHCCCS MEMBER	See "MEMBER".
ALTCS	The Arizona Long Term Care System, a program under AHCCCS that delivers long-term, acute, behavioral health and case management services to eligible members, as authorized by A.R.S. § 36-2932.
AMBULATORY CARE	Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners physician assistants and other health care providers.

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SECTION C: DEFINITIONS

Contract/RFP No. YH09-0001

AMERICAN INDIAN HEALTH PROGRAM (AIHP)	AIHP is an acute care FFS program administered by AHCCCS for eligible American Indians which reimburses for services provided by and through the Indian Health Service (IHS), tribal health programs operated under PL 93-638 or any other AHCCCS registered provider. AIHP was formerly known as AHCCCS IHS.
AMPM	<i>AHCCCS Medical Policy Manual</i> , available on the AHCCCS website at www.azahcccs.gov .
ANNUAL ENROLLMENT CHOICE (AEC)	The opportunity for a person to change contractors every 12 months, effective on their anniversary date
ANNIVERSARY DATE	The anniversary date is 12 months from the date enrolled with the Contractor and annually thereafter. In some cases, the anniversary date will change based on the last date the member changed Contractors or the last date the member was given an opportunity to change.
APPEAL RESOLUTION	The written determination by the Contractor concerning an appeal.
ARIZONA ADMINISTRATIVE CODE (A.A.C.)	Arizona Administrative Code. State regulations established pursuant to relevant statutes. Referred to in Contract as "AHCCCS Rules".
AT RISK	Refers to the period of time that a member is enrolled with a Contractor during which time the Contractor is responsible to provide AHCCCS covered services under capitation.
A.R.S.	Arizona Revised Statutes.
BBA	The Balanced Budget Act of 1997.
BIDDER'S LIBRARY	A repository of manuals, statutes, rules and other reference material located on the AHCCCS website at www.azahcccs.gov .
BOARD CERTIFIED	An individual who has successfully completed all prerequisites of the respective specialty board and successfully passed the required examination for certification.
BORDER COMMUNITIES	Cities, towns or municipalities located in Arizona and within a designated geographic service area whose residents typically receive primary or emergency care in adjacent Geographic Service Areas (GSA) or neighboring states, excluding neighboring countries, due to service availability or distance. (R9-22-201.F, R9-22-201.G, R9-22-101.B)
BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP)	Eligible individuals under the Title XIX expansion program for women with income up to 250% of the FPL, who are diagnosed with and need treatment for breast and/or cervical cancer or cervical lesions and are not eligible for other Title XIX programs providing full Title XIX services. Qualifying individuals cannot have other creditable health insurance coverage, including Medicare.
CAPITATION	Payment to a Contractor by AHCCCS of a fixed monthly payment per person in advance, for which the Contractor provides a full range of covered services as authorized under A.R.S. § 36-2904 and § 36-2907.

CYE 12 Acute Care Contract

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SECTION C: DEFINITIONS

Contract/RFP No. YH09-0001

CATEGORICALLY LINKED TITLE XIX MEMBER	Member eligible for Medicaid under Title XIX of the Social Security Act including those eligible under 1931 provisions of the Social Security Act, Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), and SSI-related groups. To be categorically linked, the member must be aged 65 or over, blind, disabled, a child under age 19, a parent of a dependent child, or pregnant.
CLAIM DISPUTE	A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.
CLEAN CLAIM	A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. § 36-2904.
CMS	Centers for Medicare and Medicaid Services, an organization within the U.S. Department of Health and Human Services, which administers the Medicare and Medicaid programs and the State Children's Health Insurance Program.
COMPETITIVE BID PROCESS	A state procurement system used to select Contractors to provide covered services on a geographic basis.
CONTINUING OFFEROR	An AHCCCS Contractor during the CYE 08 that submits a proposal pursuant to this solicitation.
CONTRACT SERVICES	See "COVERED SERVICES.
CONTRACT YEAR (CY)	Corresponds to the federal fiscal year (October 1 through September 30).
CONTRACTOR	A person, organization or entity agreeing through a direct contracting relationship with AHCCCS to provide the goods and services specified by this contract in conformance with the stated contract requirements, AHCCCS statute and rules, and federal law and regulations as defined in A.R.S. § 36-2901.
CONVICTED	A judgment of conviction has been entered by a federal, state or local court, regardless of whether an appeal from that judgment is pending.
COPAYMENT	A monetary amount specified by the Director that the member pays directly to a contractor or provider at the time covered services are rendered, as defined in 9 A.A.C. 22, Article 7.
COST AVOIDANCE	The process of identifying and utilizing all sources of first or third-party benefits before services are rendered by the Contractor or before payment is made by the Contractor. (This assumes the Contractor can avoid costs by not paying until the first or third party has paid what it covers first, or having the first or third party render the service so that the Contractor is only liable for coinsurance and/or deductibles.)
COVERED SERVICES	The health and medical services to be delivered by the Contractor as defined in 9 A.A.C. 22, Article 2 and 9 A.A.C. 31, Article 2, the AMPM and Section D of this contract. [42 CFR 438.210(a)(4)]
CRS — Children's Rehabilitation Services	A program administered by the AHCCCS CRS Contractor. The CRS Contractor provides services to Title XIX and Title XXI members who have completed the CRS application and have met the eligibility criteria to receive CRS related services as specified in 9 A.A.C.7.

CYE 12 Acute Care Contract

10/01/11

SECTION C: DEFINITIONS

Contract/RFP No. YH09-0001

CRS-ELIGIBLE	An individual who has completed the CRS application process, as delineated in the <i>CRS Policy and Procedure Manual</i> , and has met all applicable criteria to be eligible to receive CRS-related services.
CRS RECIPIENT	An individual who has completed the CRS application process, and has met all applicable criteria to be eligible to receive CRS related Services.
DAYS	Calendar days, unless otherwise specified as defined in the text, as defined in 9 A.A.C. 22, Article 1.
DELEGATED AGREEMENT	A type of subcontract agreement with a qualified organization or person to perform one or more functions required to be performed by the Contractor pursuant to this contract.
DIRECTOR	The Director of AHCCCS.
DISENROLLMENT	The discontinuance of a member's ability to receive covered services through a Contractor.
DME	Durable medical equipment is an item or appliance that can withstand repeated use, is designated to serve a medical purpose, and are not generally useful to a person in the absence of a medical condition, illness or injury as defined in 9 A.A.C. 22, Article 1.
DUAL ELIGIBLE	A member who is eligible for both Medicare and Medicaid.
ELIGIBILITY DETERMINATION	A process of determining, through a written application and required documentation, whether an applicant meets the qualifications for Title XIX or Title XXI
EMERGENCY MEDICAL CONDITION	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].
EMERGENCY MEDICAL SERVICE	Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].
ENCOUNTER	A record of a health care-related service rendered by a provider or providers registered with AHCCCS to a member who is enrolled with a Contractor on the date of service.
ENROLLEE	A Medicaid recipient who is currently enrolled with a Contractor. [42 CFR 438.10(a)]
ENROLLMENT	The process by which an eligible person becomes a member of a Contractor's plan.
EPSDT	Early and Periodic Screening, Diagnostic and Treatment services for eligible persons or members less than 21 years of age as, defined in 9 A.A.C. 22, Article 2.
FAMILY PLANNING SERVICES EXTENSION PROGRAM	A program that provides only family planning services for a maximum of two consecutive 12-month periods to a SOBRA woman whose pregnancy has ended and who is not otherwise eligible for full Title XIX services

CYE 12 Acute Care Contract

10/01/11

SECTION C: DEFINITIONS

Contract/RFP No. YH09-0001

FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	An entity that meets the requirements and receives a grant and funding pursuant to Section 330 of the Public Health Service Act. An FQHC includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination and Education Assistance Act (P.L. 93-638) or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act (P.L. 94-437).
FEDERALLY QUALIFIED HEALTH CENTER Look-Alike	An organization that meets all of the eligibility requirements of an organization that receives a Public Health Service Section 330 Grant (FQHC), but does not receive grant funding. AHCCCS requires Contractors to credential providers employed by an FQHC Look-Alike through the temporary or provisional credentialing process.
FEE-FOR-SERVICE (FFS)	Fee-For-Service, a method of payment to registered providers on an amount-per-service basis.
FES	Federal emergency Services program covered under R9-22-217, to treat an emergency medical condition for a member who is determined eligible under A.R.S. § 36-2903.03 (D).
FFP	Federal financial participation (FFP) refers to the contribution that the federal government makes to the Title XIX and Title XXI program portions of AHCCCS, as defined in 42 CFR 400.203.
FIRST PARTY LIABILITY	The resources available from any insurance or other coverage obtained directly or indirectly by a member or eligible person that provides benefits directly to the member or eligible person and is liable to pay all or part of the expenses for medical services incurred by an AHCCCS, contractor, or member.
FISCAL YEAR (FY)	Federal Fiscal Year, October 1 through September 30.
FREEDOM OF CHOICE (FC)	The opportunity given to each member who does not specify a Contractor preference at the time of enrollment to choose between the Contractors available within the Geographic Service Area in which the member is enrolled.
FRAUD	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable state or federal law, as defined in 42 CFR 455.2.
FREEDOM TO WORK (TICKET TO WORK)	Eligible individuals under the Title XIX expansion program that extends eligibility to individuals 16 through 64 years old who meet SSI disability criteria; whose earned income, after allowable deduction, is at or below 250% of the FPL and who are not eligible for any other Medicaid program.
GEOGRAPHIC SERVICE AREA (GSA)	An area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care service to a member enrolled with that contractor of record, as defined in 9 A.A.C. 22, Article 1.
GRIEVANCE SYSTEM	A system that includes a process for enrollee grievances, enrollee appeals, provider claim disputes, and access to the state fair hearing system.
HEALTHCARE GROUP OF ARIZONA (HCG)	A prepaid medical coverage plan marketed to small, uninsured businesses and political subdivisions within the state.
HEALTH PLAN	See "CONTRACTOR".
HIPAA	The Health Insurance Portability and Accountability Act (P.L. 104-191); also known as the Kennedy-Kassebaum Act, signed August 21, 1996.

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IBNR	Incurred but not reported liability for services rendered for which claims have not been received.
IHS	Indian Health Service authorized as a federal agency pursuant to 25 U.S.C. 1661.
KIDSCARE	A program for individuals under the age of 19 years, who are eligible under the CHIP program, in households with income at or below 200% FPL. All members, except American Indian members, are required to pay a premium amount based on the number of children in the family and the gross family income. Also referred to as "Title XXI".
LIABLE PARTY	A person or entity that is or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by an AHCCCS applicant or member.
LIEN	A legal claim, filed with the County Recorder's office in which a member resides and in the county an injury was sustained for the purpose of ensuring that AHCCCS receives reimbursement for medical services paid. The lien is attached to any settlement the member may receive as a result of an injury.
MANAGED CARE	Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, medical management and the coordination of care.
MANAGEMENT SERVICES AGREEMENT	A type of subcontract with an entity in which the owner of the Contractor delegates some or all of the comprehensive management and administrative services necessary for the operation of the Contractor.
MANAGEMENT SERVICES SUBCONTRACTOR	An entity to which the Contractor delegates the comprehensive management and administrative services necessary for the operation of the Contractor.
MANAGING EMPLOYEE	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.
MATERIAL OMISSION	A fact, data or other information excluded from a report, contract, etc., the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.
MAJOR UPGRADE	Any upgrade or changes that may result in a disruption to the following: loading of contracts, providers or members, issuing prior authorizations or the adjudication of claims.
MEDICAID	A federal/state program authorized by Title XIX of the Social Security Act, as amended.
MEDICAL EXPENSE DEDUCTION (MED)	Title XIX waiver member whose family income exceeds the limits of all other Title XIX categories (except ALTCS) and has family medical expenses that reduce income to or below 40% of the FPL. MED members may or may not have a categorical link to Title XIX.

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MEDICAL MANAGEMENT	Is an integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to end of life care).
MEDICARE	A federal program authorized by Title XVIII of the Social Security Act, as amended.
MEDICARE MANAGED CARE PLAN	A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries, including Medicare Advantage Plan (MAP), Medicare Advantage Prescription Drug Plan (MAPDP), MAPDP Special Needs Plan, or Medicare Prescription Drug Plan.
MEDICARE PART D EXCLUDED DRUGS	Medicare Part D is the Prescription Drug Coverage option available to Medicare beneficiaries, including those also eligible for Medicaid. Medications that are available under this benefit will not be covered by AHCCCS for dual eligible members. There are certain drugs that are excluded from coverage by Medicare, and will continue to be covered by AHCCCS. Those medications are barbiturates, benzodiazepines, and over-the-counter medication as defined in the AMPM. Prescription medications that are covered under Medicare, but are not on a Part D Health Plan's formulary are not considered excluded drugs, and are not covered by AHCCCS.
MEMBER	An eligible person who is enrolled in AHCCCS, as defined in A.R.S. §§ 36-2931, 36-2901, 36-2901.01 and A.R.S. §36-2981.
NON-CONTRACTING PROVIDER	A person or entity that provides services as prescribed in A.R.S. § 36-2901 who does not have a subcontract with an AHCCCS Contractor.
NON-MEDICAL EXPENSE DEDUCTION (Formerly NON MED) MEMBER	See "AHCCCS CARE".
NPI	National Provider Identifier assigned by the CMS contracted national enumerator.
OFFEROR	An organization or other entity that submits a proposal to AHCCCS in response to a Request For Proposal as defined in 9 A.A.C. 22, Article 1.
PAY AND CHASE	Recovery method used by the Contractor to collect from legally liable first or third parties after the Contractor pays the member's medical bills. The service may be provided by a contracted or non-contracted provider. Regardless of who provides the service, pay and chase assumes that the Contractor will pay the provider, then seek reimbursement from the first or third party.
PERFORMANCE STANDARDS	A set of standardized measures designed to assist AHCCCS in evaluating, comparing and improving the performance of its Contractors
PIP	Performance Improvement Project (PIP), formerly referred to as Quality Improvement Projects (QIP).
PMMIS	AHCCCS' Prepaid Medical Management Information System.
POST STABILIZATION SERVICES	Medically necessary services, related to an emergency medical condition provided after the member's condition is sufficiently stabilized in order to maintain, improve or resolve the member's condition so that the member could alternatively be safely discharged or transferred to another location [42 CFR 438-114(a)].

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POTENTIAL ENROLLEE	A Medicaid-eligible recipient who is not yet enrolled with a Contractor [42 CFR 438.10(a)].
PRIMARY CARE PROVIDER (PCP)	Primary Care Provider/Practitioner, an individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of the member's or eligible person's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17 or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15.
PRIOR PERIOD COVERAGE (PPC)	The period prior to a member's enrollment, during which a member is eligible for covered services. The time frame is from the effective date of eligibility to the day a member is enrolled with a Contractor.
PROVIDER	Any person or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. § 36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. § 36-2901.
QUALIFIED MEDICARE BENEFICIARY DUAL ELIGIBLE (QMB DUAL)	A person, eligible under A.R.S. § 36-2971(6), who is entitled to Medicare Part A insurance and meets certain income and residency requirements of the Qualified Medicare Beneficiary program. A QMB, who is also eligible for Medicaid, is commonly referred to as a QMB dual eligible.
RATE CODE	Eligibility classification for capitation payment purposes.
REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA)	An organization under contract with ADHS to administer covered behavioral health services in a geographically specific area of the state. Tribal governments, through an agreement with ADHS, may operate a tribal regional behavioral health authority (TRBHA) for the provision of behavioral health services to American Indians.
REINSURANCE	A risk-sharing program provided by AHCCCS to Contractors for the reimbursement of certain contract service costs incurred for a member beyond a predetermined monetary threshold.
RELATED PARTY	A party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the Offeror and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.
RISK GROUP	Grouping of rate codes that are paid at the same capitation rate.
RFP	Request For Proposal, a document prepared by AHCCCS that describes the services required and instructs prospective Offerors about how to prepare a response (proposal), as defined in 9 A.A.C. 22, Article 1.
RURAL HEALTH CLINIC (RHC)	A clinic located in an area designated by the Bureau of Census as rural, and by the Secretary of the DHHS as medically underserved or having an insufficient number of physicians, which meets the requirements under 42 CFR 491.
SCHIP	State Children's Health Insurance Program under Title XXI of the Social Security Act (Also known as CHIP). The Arizona version of CHIP is referred to as "KidsCare". See "KIDSCARE".
SCOPE OF SERVICES	See "COVERED SERVICES.
SERVICE LEVEL AGREEMENT	A type of subcontract with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this contract.

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SOBRA	Eligible pregnant women under Section 9401 of the Sixth Omnibus Budget and Reconciliation Act of 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(ii)(IX), November 5, 1990, with individually budgeted incomes at or below 150% of the FPL, and children in families with individually budgeted incomes ranging from below 100% to 140% of the FPL, depending on the age of the child.
SOBRA FAMILY PLANNING	Female members eligible for family planning services only, for a maximum of two consecutive 12-month periods following the loss of SOBRA eligibility.
SPECIAL HEALTH CARE NEEDS	Members with special health care needs are those members who have serious and chronic physical, developmental or behavioral conditions, and who also require medically necessary health and related services of a type or amount beyond that generally required by members.
STATE	The State of Arizona.
STATE ONLY TRANSPLANT MEMBERS	Individuals who are eligible under one of the Title XIX eligibility categories and found eligible for a transplant, but subsequently lose Title XIX eligibility due to excess income become eligible for one of two extended eligibility options as specified in A.R.S. 36-2907.10 and A.R.S. 36-2907.11.
STATE PLAN	The written agreements between the State and CMS, which describes how the AHCCCS program meets CMS requirements for participation in the Medicaid program and the State Children's Health Insurance Program.
SUBCONTRACT	An agreement entered into by the Contractor with any of the following: a provider of health care services who agrees to furnish covered services to member or with any other organization or person who agrees to perform any administrative function or service for the contractor specifically related to fulfilling the contractor's obligations to AHCCCS under the terms of this contract, as defined in 9 A.A.C. 22, Article 1.
SUBCONTRACTOR	(1) A provider of health care who agrees to furnish covered services to members. (2) A person, agency or organization with which the Contractor has contracted or delegated some of its management/ administrative functions or responsibilities. (3) A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies equipment or services provided under the AHCCCS agreement.
SUPPLEMENTAL SECURITY INCOME (SSI) AND SSI RELATED GROUPS	Eligible individuals receiving income through federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or disabled and have household income levels at or below 100% of the FPL.
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)	A federal cash assistance program under Title IV of the Social Security Act established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193). It replaced Aid To Families With Dependent Children (AFDC).

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THIRD PARTY LIABILITY (TPL)	See "LIABLE PARTY".
TITLE XIX MEMBER	Member eligible for Medicaid under Title XIX of the Social Security Act including those eligible under 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI) or SSI-related groups, Medicare Cost Sharing groups, Title XIX Waiver groups, Breast and Cervical Cancer Treatment program and Freedom to Work
TITLE XXI MEMBER	A member eligible for acute care services under Title XXI of the Social Security Act, referred to in Federal legislation as the "State Children's Health Insurance Program" (SCHIP or CHIP). The Arizona version of CHIP is referred to as "KidsCare"
TRIBAL/REGIONAL BEHAVIORAL HEALTH AUTHORITY (T/RBHA)	An organization under contract with ADHS/DBHS that administers covered behavioral health services in a geographically specific area of the state. Tribal governments, through an agreement with ADHS, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian members.
WWHP	Well Woman Health-Check Program, administered by the Arizona Department of Health Services and funded by the Centers for Disease Control and Prevention. (See AMPM Chapter 300, Section 320)
YOUNG ADULT TRANSITIONAL INSURANCE (YATI)	Eligible individuals, between 18 and 21 years of age who were formerly enrolled through the foster care program.
[END OF DEFINITIONS]	

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SECTION D: PROGRAM REQUIREMENTS

INTRODUCTION

The Arizona Health Care Cost Containment System (AHCCCS) is the single state agency for the Medicaid and CHIP programs. AHCCCS has operated under an 1115 Research and Demonstration Waiver since 1982 when it became the first statewide Medicaid managed care system in the nation. The program is a model public-private collaboration that includes the state and its counties, the federal government, and managed care contractors and providers from both the public and private sectors. AHCCCS has remained a leader in Medicaid Managed Care through the diligent pursuit of excellence and cost effectiveness by Managed Care Contractors (MCOs) in collaboration with AHCCCS .

In order to continue this collaboration, Contractors must continue to add value to the program. A Contractor adds value when it:

- Recognizes that Medicaid members are entitled to care and assistance navigating the service delivery system and demonstrates special effort to assure members receive necessary services, including prevention and screening services.
- Recognizes that Medicaid members with special health care needs or chronic health conditions require care coordination, and provides that coordination. This is particularly true if a member must receive services from other AHCCCS Contractors in addition to the Contractor.
- Recognizes that Medicaid members have the right to contact their elected officials in an effort to secure necessary services and assist members in order to reduce their need to contact elected officials. The Contractor provides information to elected officials to help them respond to the member.
- Recognizes that health care providers are an essential partner in the delivery of health care services, and operates in a manner that is efficient and effective for health care providers as well as the Contractor.
- Avoids administrative practices that place unnecessary burdens on providers with little or no impact on quality of care or cost containment.
- Recognizes that performance improvement is both clinical and operational in nature and self monitors and self corrects as necessary to improve contract compliance or operational excellence.
- Recognizes that the program is publicly funded, and as such is subject to public scrutiny and behaves in a manner that is supported by the general public.
- Recognizes that the program is subject to significant regulation and operates in compliance with those regulations.

AHCCCS encourages Contractor innovation and application of best practices. AHCCCS is always looking for ways to reduce administrative costs and improve program efficiency. Over the term of the contract, AHCCCS will work collaboratively with contractors to evaluate ways to reduce program complexity, improve chronic disease management, reduce administrative burdens, leverage joint purchasing power, and reduce unnecessary Medicaid/CHIP administrative and medical costs.

1. TERM OF CONTRACT AND OPTION TO RENEW

The initial term of this contract shall be 10/1/08 through 9/30/11, with two additional one-year options to renew. All contract renewals shall be through contract amendment. AHCCCS shall issue amendments prior to the end date of the contract when there is an adjustment to capitation rates and/or changes to the scope of services contained herein. Changes to the scope of services include, but are not limited, to changes in the enrolled population, changes in covered services and changes in GSAs.

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If the Contractor has been awarded a contract in more than one GSA, each such contract will be considered separately renewable. AHCCCS may renew the Contractor's contract in one GSA, but not in another. In addition, if the Contractor has had significant problems of non-compliance in one GSA, it may result in the capping of the Contractor's enrollment in all GSAs. Further, AHCCCS may require the Contractor to renew all currently awarded GSAs, or may terminate the contract if the Contractor does not agree to renew all currently awarded GSAs.

When the Contracting Officer issues an amendment to extend the contract, the provisions of such extension will be deemed to have been accepted 60 days after the date of mailing by the Contracting Officer, even if the extension amendment has not been signed by the Contractor, unless within that time the Contractor notifies the Contracting Officer in writing that it refuses to sign the extension amendment. If the Contractor provides such notification, the Contracting Officer will initiate contract termination proceedings.

Contractor's Notice of Intent Not To Renew: If the Contractor chooses not to renew this contract, the Contractor may be liable for certain costs associated with the transition of its members to a different Contractor. The Contractor is required to provide 180 days advance written notice to the Contracts and Purchasing Administrator of its intent not to renew the contract. If the Contractor provides the Contracts and Purchasing Administrator written notice of its intent not to renew this contract at least 180 days before its expiration, this liability for transition costs may be waived by the Contracting Officer.

Contract Termination: In the event that the contract or any portion thereof, is terminated for any reason, or expires, the Contractor shall assist AHCCCS in the transition of its members to other Contractors, and shall abide by standards and protocols set forth in Paragraph 9, Transition of Members. In addition, AHCCCS reserves the right to extend the term of the contract on a month-to-month basis to assist in any transition of members. AHCCCS may discontinue enrollment of members with the Contractor three months prior to the contract termination date. The Contractor shall make provision for continuing all management and administrative services until the transition of all members is completed and all other requirements of this contract are satisfied. The Contractor shall submit, upon request, to AHCCCS for approval a detailed plan for the transition of its members in the event of contract expiration or termination. The name and title of the Contractor's transition coordinator shall be included in the transition plan. The Contractor shall be responsible for providing all reports set forth in this contract and necessary for the transition process, and shall be responsible for the following:

- a. Notification of subcontractors and members.
- b. Payment of all outstanding obligations for medical care rendered to members until AHCCCS is satisfied that the Contractor has paid all such obligations. The Contractor shall provide a monthly claims aging report including IBNR amounts to AHCCCS (due the 15th day of the month, for the prior month).
- c. Providing Quarterly and Audited Financial Statements up to the date of contract termination. The financial statement requirement will not be absolved without an official release from AHCCCS.
- d. Continuing encounter reporting until all services rendered prior to contract termination have reached adjudicated status and data validation of the information has been completed, as communicated by a letter of release from AHCCCS.
- e. Cooperation with reinsurance audit activities on prior contract years until release has been granted by AHCCCS.
- f. Cooperation with any open reconciliation activities including, but not limited to, PPC, or MED Prospective until release has been granted by AHCCCS.
- g. Supplying quarterly Quality Management and Medical Management reports will be submitted as required by Section D, Paragraphs 23, Quality Management, and 24, Medical Management, as appropriate to provide AHCCCS with information on services rendered up to the date of Contract termination. This will include quality of care (QOC) concern reporting based on the date of service.
- h. Participating in and closing out Performance Measures and Performance Improvement Projects as requested by AHCCCS.
- i. Maintaining a Performance Bond as long as the Contractor has AHCCCS-related liabilities of \$50,000 or more outstanding or 15 months following the termination date of this contract, whichever is later.

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- j. Indemnify AHCCCS for any claim by any third party against the State or AHCCCS arising from the Contractor's performance of this contract and for which the Contractor would otherwise be liable under this contract.
- k. Returning to AHCCCS, any funds advanced to the Contractor for coverage of members for periods after the date of termination. Funds must be returned to AHCCCS within 30 days of termination of the contract.
- l. Providing a monthly accounting of Member Grievances and Claim Disputes and their disposition.
- m. Preserving and making available all records for a period of five years from the date of final payment under contract.

The above list is not exhaustive and additional information may be requested to ensure that all operational and reporting requirements have been met. Any dispute by the Contractor, with respect to termination or suspension of this contract by AHCCCS, shall be exclusively governed by the provisions of Section E, *Contract Terms and Conditions*, Paragraph 26, *Disputes*.

2. ELIGIBILITY CATEGORIES

AHCCCS is Arizona's Title XIX Medicaid program operating under an 1115 Waiver and Title XXI program operating under Title XXI State Plan authority. Arizona has the authority to require mandatory enrollment in managed care. All Acute Care Program members eligible for AHCCCS benefits, with exceptions as identified below, are enrolled with Acute Care Contractors that are paid on a capitated basis. AHCCCS pays for health care expenses on a fee-for-service (FFS) basis for Title XIX- and Title XXI- eligible members who receive services through the Indian Health Service; for Title XIX eligible members who are entitled to emergency services under the Federal Emergency Services (FES) program; and for Medicare cost sharing beneficiaries under QMB program.

The following describes the eligibility groups enrolled in the managed care program and covered under this contract [42 CFR 434.6(a)(2)].

Title XIX

1931 (Also referred to as TANF-related): Eligible individuals and families under the 1931 provision of the Social Security Act, with household income levels at or below 100% of the FPL.

SSI Cash: Eligible individuals receiving Supplemental Security Income through federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or disabled and have household income levels at or below 100% of the Federal Benefit Rate (FBR).

SSI Medical Assistance Only (SSI MAO) and Related Groups: Eligible individuals are individuals who are aged, blind or disabled and have household income levels at or below 100% of the FPL.

Freedom to Work (Ticket to Work): Eligible individuals under the Title XIX expansion program that extends eligibility to individuals 16 through 64 years old who meet SSI disability criteria, and whose earned income after allowable deductions is at or below 250% of the FPL, and who are not eligible for any other Medicaid program. These members must pay a premium to AHCCCS, depending on income.

SOBRA: Under the Sixth Omnibus Budget Reconciliation Act of 1986, eligible pregnant women, with individually budgeted income at or below 150% of the FPL, and children in families with individually budgeted incomes ranging from below 100% to 140% of the FPL, depending on the age of the child.

SOBRA Family Planning: Family planning extension program that covers the costs for family planning services only, for a maximum of two consecutive 12-month periods following the loss of SOBRA eligibility.

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Breast and Cervical Cancer Treatment Program (BCCTP): Eligible individuals under the Title XIX expansion program for women with incomes up to 250% of the FPL, who are diagnosed with and need treatment for breast and/or cervical cancer or cervical lesions and are not eligible for other Title XIX programs. Eligible members cannot have other creditable health insurance coverage, including Medicare.

Title IV-E Foster Care and Adoption Subsidy: Children with special medical needs who have been placed in foster homes or have been adopted.

Young Adult Transitional Insurance (YATI): Former foster care children between 18 and 21 years of age.

Title XIX Waiver Group

AHCCCS Care: Eligible individuals and couples whose income is at or below 100% of the FPL, and who are not categorically linked to another Title XIX program. Formerly known as Non-MED members.

Title XXI

KidsCare: Individuals under the age of 19 years, eligible under the Federal State Children's Health Insurance Program (CHIP), who are in households with incomes at or below 200% FPL. All members except American Indian members are required to pay a premium amount based on the number of children in the family and the gross family income. Also referred to as Title XXI.

State-Only

State-Only Transplants: Title XIX individuals, for whom medical necessity for a transplant has been established and who subsequently lose Title XIX eligibility may become eligible for and select one of two extended eligibility options as specified in A.R.S. 36-2907.10 and A.R.S. 36-2907.11. The extended eligibility is authorized only for those individuals who have met all of the following conditions:

1. The individual has been determined ineligible for Title XIX due to excess income;
2. The individual had been placed on a donor waiting list before eligibility expired;
3. The individual has entered into a contractual arrangement with the transplant facility to pay the amount of income which is in excess of the eligibility income standards (referred to as transplant share of cost).

The following options for extended eligibility are available to these members:

Option 1: Extended eligibility is for one 12-month period immediately following the loss of AHCCCS eligibility. The member is eligible for all AHCCCS covered services as long as they continue to be medically eligible for a transplant. If determined medically ineligible for a transplant at any time during the period, eligibility will terminate at the end of the calendar month in which the determination is made.

Option 2: As long as medical eligibility for a transplant (status on a transplant waiting list) is maintained, at the time that the transplant is scheduled to be performed the transplant candidate will reapply and will be re-enrolled with his/her previous Contractor to receive all covered transplant services. Option 2-eligible individuals are not eligible for any non-transplant related health care services from AHCCCS.

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3. ENROLLMENT AND DISENROLLMENT

AHCCCS has the exclusive authority to enroll and disenroll members. The Contractor shall not disenroll any member for any reason unless directed to do so by AHCCCS. The Contractor may request AHCCCS to change the member's enrollment in accordance with the ACOM Change of Plan Policy. The Contractor may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. An AHCCCS member may request disenrollment from the Contractor for cause at any time. Please refer those requests due to situations defined in Section A (1) of the ACOM Change of Plan Policy to the AHCCCS Division of Member Services via mail or at (602) 417-4000 or (800) 962-6690. For medical continuity requests, the Contractor shall follow the procedures outlined in the ACOM Change of Plan Policy, before notifying AHCCCS.

AHCCCS will disenroll the member from the Contractor when:

- the member becomes ineligible for the AHCCCS program ;
- in certain situations when they move out of the Contractor's service areas;
- the member changes Contractors during the member's open enrollment/annual enrollment choice period;
- the Contractor does not, because of moral or religious objections, cover the service the member seeks; or
- the member is approved for a Contractor change through the ACOM Change of Plan Policy. [42 CFR 438.56].

Members may submit plan change requests to the Contractor or AHCCCS. A denial of any plan change request must include a description of the member's right to appeal the denial.

Eligibility for the various AHCCCS coverage groups is determined by one of the following agencies:

<i>Social Security Administration (SSA)</i>	SSA determines eligibility for the Supplemental Security Income (SSI) cash program. SSI cash recipients are automatically eligible for AHCCCS coverage.
<i>Department of Economic Security (DES)</i>	DES determines eligibility for families with children under section 1931 of the Social Security Act, pregnant women and children under SOBRA, the Adoption Subsidy Program, Title IV-E foster care children, Young Adult Transitional Insurance Program, the Federal Emergency Services program (FES) and Title XIX Waiver Members. (AHCCCS Care)
<i>AHCCCS</i>	AHCCCS determines eligibility for the SSI/Medical Assistance Only groups, including the FES program for this population (aged, disabled, blind), the Arizona Long Term Care System (ALTCs), the Qualified Medicare Beneficiary program and other Medicare cost sharing programs, BCCTP, the Freedom to Work program, the Title XXI KidsCare program and the State-Only Transplant program.

AHCCCS Acute Care members are enrolled with Contractors in accordance with the rules set forth in A.A.C R9-22, Article 17, A.A.C. R9-31, Articles 3 and 17.

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Member Choice of Contractor

All AHCCCS members eligible for services covered under this contract have a choice of available Contractors. Contact information for the Contractors is provided during the application process for AHCCCS benefits. If there is only one Contractor available for the applicant's Geographic Service Area, no choice is offered as long as the Contractor offers the member a choice of PCPs. Members who do not choose a Contractor prior to AHCCCS being notified of their eligibility are automatically assigned to a Contractor based on family continuity or the auto-assignment algorithm. Once assigned, AHCCCS sends a Freedom of Choice notice to the member and gives them 30 days to choose a different Contractor from the auto-assigned Contractor. See Section D, Paragraph 6, Auto-Assignment Algorithm, for further explanation.

The Contractor will share with AHCCCS the cost of providing information about the Acute Care Contractors to potential members and to those eligible for annual enrollment choice.

Exceptions to the above enrollment policies for Title XIX members include previously enrolled members who have been disenrolled for less than 90 days. These members will be automatically enrolled with the same Contractor, if still available. Women who become eligible for the Family Planning Services Extension Program, will remain assigned to their current Contractor.

The effective date of enrollment for a new Title XIX member with the Contractor is the day AHCCCS takes the enrollment action. The Contractor is responsible for payment of medically necessary covered services retroactive to the member's beginning date of eligibility, as reflected in PMMIS.

The effective date of enrollment for a Title XXI member will be the first day of the month following notification to the Contractor. In the event that eligibility is determined on or after the 25th day of the month, eligibility will begin on the 1st day of the second month following the determination.

When a member is transferred from Title XIX to Title XXI and has not made a Contractor choice for Title XXI, the member will remain with his/her current Contractor and a Freedom of Choice notice will be sent to the member. The member may then change plans no later than 30 days from the date the Freedom of Choice notice is sent.

Prior Period Coverage: AHCCCS provides prior period coverage for the period of time prior to the Title XIX member's enrollment during which the member is eligible for covered services. Prior Period Coverage means the time frame from the effective date of eligibility to the day the member is enrolled with the Contractor. The Contractor receives notification from AHCCCS of the member's enrollment. The Contractor is responsible for payment of all claims for medically necessary covered services, excluding most behavioral health services, provided to members during prior period coverage. This may include services provided prior to the contract year (See Section D, Paragraph 53, Compensation, for a description of the Contractor's reimbursement from AHCCCS for this eligibility time period).

For behavioral health services, the Contractor is responsible for the same services as outlined in Section D, Paragraph 12, Behavioral Health Services, for the prospective period.

Newborns: Newborns born to AHCCCS eligible mothers enrolled at the time of the child's birth will be enrolled with the mother's Contractor, when newborn notification is received by AHCCCS. The Contractor is responsible for notifying AHCCCS of a child's birth to an enrolled member. Capitation for the newborn will begin on the date notification is received by AHCCCS. The effective date of AHCCCS eligibility will be the newborn's date of birth, and the Contractor is responsible for all covered services to the newborn, whether or not AHCCCS has received notification of the child's birth. AHCCCS is currently available to receive notification 24 hours a day, 7 days a week via phone or the AHCCCS website. Each eligible mother of a newborn is sent a letter advising her of her right to choose a different Contractor for her child; the date of the change will be the date of processing the request from the mother. If the mother does not request a change, the child will remain with the mother's Contractor.

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Newborns of FES mothers are auto-assigned to a Contractor and mothers of these newborns sent letters advising them of their right to choose a different Contractor for their children. In the event the FES mother chooses a different Contractor, AHCCCS will recoup all capitation paid to the originally assigned Contractor and the baby will be enrolled retroactive to the date of birth with the second Contractor. The second Contractor will receive prior period capitation from the date of birth to the day before assignment and prospective capitation from the date of assignment forward. The second Contractor will be responsible for all covered services to the newborn from date of birth.

Enrollment Guarantees: Upon initial capitated enrollment as a Title XIX-eligible member, the member is guaranteed a minimum of five full months of continuous enrollment. Upon initial capitated enrollment as a Title XXI-eligible member, the member is guaranteed a minimum of 12 full months of continuous enrollment. The enrollment guarantee is a one-time benefit. If a member changes from one Contractor to another within the enrollment guarantee period, the remainder of the guarantee period applies to the new Contractor. AHCCCS Rules R9-22, Article 17, and R9-31, Article 3, describes other reasons for which the enrollment guarantee may not apply.

American Indians: American Indians, on- or off-reservation, may choose to receive services from Indian Health Service (IHS), a P.L. 93-638 tribal facility or any available Contractor. If a choice is not made within the specified time limit, American Indian Title XIX members living on-reservation will be assigned to the AHCCCS American Indian Health Program (AIHP) as FFS members. The designation of a zip code as a reservation zip code, not the physical location of the residence, is the factor that determines whether a member is considered on or off-reservation for these purposes. Further, if the member resides in a zip code that contains land on both sides of a reservation boundary and the zip code is assigned as off-reservation, the physical location of the residence does not change the off-reservation designation for the member. American Indian Title XIX members living off-reservation who do not make a Contractor choice will be assigned to an available Contractor using the AHCCCS protocol for family continuity and the auto-assignment algorithm. American Indian Title XXI members may change from AHCCCS AIHP FFS to a Contractor or from a Contractor to AHCCCS AIHP FFS at any time.

4. ANNUAL ENROLLMENT CHOICE

AHCCCS conducts an Annual Enrollment Choice (AEC) for members on their annual anniversary date [42 CFR 438.56(c)(2)(ii)]. AHCCCS may hold an open enrollment in any GSA or combination of GSAs as deemed necessary. During AEC, members may change Contractors subject to the availability of other Contractors within their Geographic Service Area. A member is mailed a printed enrollment form and other information required by the Balanced Budget Act of 1997 (BBA) 60 days prior to his/her AEC date and may choose a new Contractor by contacting AHCCCS to complete the enrollment process. If the member does not participate in the AEC, no change of Contractor will be made (except for approved changes under the ACOM *Change of Plan Policy*) during the new anniversary year. This holds true if a Contractor's contract is renewed and the member continues to live in a Contractor's service area. The Contractor shall comply with the ACOM *Member Transition for Annual Enrollment Choice Policy, Open Enrollment and Other Plan Changes Policy*, and the *AMPM*.

5. ENROLLMENT AFTER CONTRACT AWARD

In the event that AHCCCS does not award a CYE '09 contract to an incumbent contractor, AHCCCS will direct enrollment effective October 1, 2008, for those members enrolled with an exiting Contractor. Members will be auto assigned to all or select Contractors utilizing the auto assignment algorithm found in the *Conversion Group Assignment* section of Attachment G, Auto-Assignment Algorithm. The members in the Conversion Group will have the opportunity to choose an alternate Contractor, according to the details in Attachment G, Auto-Assignment Algorithm.

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AHCCCS will also use an enhanced auto-assignment algorithm in certain GSAs for new Contractors or those incumbent Contractors defined as small Contractors. This enhanced algorithm may be in effect beginning October 1, 2008, for a period of no less than three months and no more than six months. Those Contractors not defined as new or small Contractors in a GSA may not receive auto-assigned members during the enhanced algorithm period. See Attachment G, Auto-Assignment Algorithm, for details.

In addition to auto-assignment, AHCCCS will make changes to both annual enrollment choice materials and new enrollee materials prior to October 1, 2008, to reflect the change in available contractors. The auto assignment algorithm will be adjusted to exclude auto assignment of new enrollees to exiting Contractor(s) effective August 1, 2008.

6. AUTO-ASSIGNMENT ALGORITHM

Members who do not exercise their right to choose and do not have family continuity are assigned to a Contractor through an auto-assignment algorithm. Once auto-assigned, AHCCCS sends a Freedom of Choice notice to the member and gives him/her 30 days to choose a different Contractor from the auto-assigned Contractor. The algorithm is a mathematical formula used to distribute members to the various Contractors in a manner that is predictable and consistent with AHCCCS goals. For CYE 09 through CYE 12, the algorithm favors those Contractors with lower capitation rates and higher Program scores in this procurement and as described below. AHCCCS may change the algorithm at any time during the term of the contract in response to Contractor-specific issues (e.g. imposition of an enrollment cap).

AHCCCS may adjust the auto-assignment algorithm in consideration of Contractors' clinical performance measure results when calculating target percentages. Ranking in the algorithm may be weighted, based on the number of Performance Measures for which a Contractor is meeting the current AHCCCS Minimum Performance Standard (MPS) as a percentage of the total number of measures utilized in the calculation. AHCCCS will determine and communicate the adjusted auto-assignment algorithm to be used prior to the beginning of the contract year to be measured. For further details on the AHCCCS Auto-Assignment Algorithm for CYE 13, refer to Attachment G.

7. AHCCCS MEMBER IDENTIFICATION CARDS

The Contractor is responsible for paying the costs of producing AHCCCS member identification cards. The Contractor will receive an invoice the month following the issue date of the identification card.

8. MAINSTREAMING OF AHCCCS MEMBERS

To ensure mainstreaming of AHCCCS members, the Contractor shall take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual preference, genetic information, or physical or mental handicap, except where medically indicated. The Contractor must take into account a member's literacy and culture when addressing members and their concerns, and must take reasonable steps to ensure subcontractors to do the same. The Contractor must make interpreters, including assistance for the visual- or hearing- impaired, available free of charge for all members to ensure appropriate delivery of covered services. The Contractor must provide to members with information instructing them how to access these services.

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Prohibited practices include, but are not limited to, the following, in accordance with 42 CFR 438.6(f) :

- a. Denying or not providing a member any covered service or access to an available facility.
- b. Providing to a member any medically necessary covered service which is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary.
- c. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a member in any way in his or her enjoyment of any advantage or privilege enjoyed by others receiving any covered service.
- d. The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, income status, AHCCCS membership, or physical or mental handicap of the participants to be served.

If the Contractor knowingly executes a subcontract with a provider with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of the subcontract act to discourage the full utilization of services by some members); the Contractor will be in default of its contract.

If the Contractor identifies a problem involving discrimination by one of its providers, it shall promptly intervene and implement a corrective action plan. Failure to take prompt corrective measures may place the Contractor in default of its contract.

9. TRANSITION OF MEMBERS

The Contractor shall comply with the AMPM and the ACOM *Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy* standards for member transitions between Contractors or GSAs, participation in or discharge from CRS or CMDP, to or from an ALTCS Contractor and upon termination or expiration of a contract. AHCCCS may discontinue enrollment of members with the Contractor three months prior to the contract termination date. The Contractor shall develop and implement policies and procedures which comply with these policies to address transition of:

- a. Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation, chronic illness resulting in hospitalization or nursing facility placement, etc.;
- b. Members who are receiving ongoing services such as dialysis, home health, chemotherapy and/or radiation therapy, or who are hospitalized at the time of transition;
- c. Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the NICU after birth;
- d. Members who frequently contact AHCCCS, state and local officials, the Governor's Office and/or the media;
- e. Members who have received prior authorization for services such as scheduled surgeries, post surgical follow-up visits, out-of-area specialty services, or nursing home admission;
- f. Prescriptions, DME and medically necessary transportation ordered for the transitioning member by the relinquishing Contractor; and
- g. Medical records of the transitioning member (the cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing AHCCCS Contractor).
- h. Any members transitioning to CMDP.

When relinquishing members, the Contractor is responsible for timely notification to the receiving Contractor regarding pertinent information related to any special needs of transitioning members. The Contractor, when receiving a transitioning member with special needs, is responsible for coordinating care with the relinquishing Contractor in order that services are not interrupted, and for providing the new member with Contractor and service information, emergency numbers and instructions about how to obtain services.

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10. SCOPE OF SERVICES

The Contractor shall provide covered services to AHCCCS members in accordance with all applicable federal and state laws regulations and policies, including those listed by reference in attachments and this contract. The services are described in detail in AHCCCS Rules R9-22, Article 2, the *AHCCCS Medical Policy Manual (AMPM)* and the *AHCCCS Contractor Operations Manual (ACOM)*, all of which are incorporated herein by reference, except for provisions specific to the Fee-for-Service program, and may be found on the AHCCCS website (<http://www.azahcccs.gov/>) [42 CFR 438.210(a)(1)]. To be covered, services must be medically necessary and cost effective. The covered services are briefly described below. Except for annual well woman exams, behavioral health and children's dental services, covered services must be provided by or coordinated with a primary care provider.

The Contractor must ensure the coordination of services it provides with services the member receives from other entities, including behavioral health services the member receives through an ADHS/RBHA provider and Children's Rehabilitative Services (CRS). The Contractor shall ensure that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164, Subparts A and E, to the extent that they are applicable [42 CFR 438.208 (b)(2) and (b)(4) and 438.224].

Services must be rendered by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider. The Contractor shall provide the same standard of care for all members, regardless of the member's eligibility category. The Contractor shall ensure that the services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. The Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose [42 CFR 438.210(a)(3)].

The Contractor must notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. Notification must be submitted prior to entering into a contract with AHCCCS or prior to adopting the policy during the term of the contract [42 CFR 438.102(a)(2) and (b)(1)]. Members must be notified on how to access the services. The notification and policy must be consistent with the provisions of 42 CFR 438.10, must be provided to members during their initial appointment, and must be provided to members at least 30 days prior to the effective date of the policy. AHCCCS will disenroll from the Contractor members who are seeking these services and assign the members to another Contractor [42 CFR 438.56].

Authorization of Services: For the processing of requests for initial and continuing authorizations of services, the Contractor shall have in place and follow written policies and procedures. The Contractor shall have mechanisms in place to ensure consistent application of review criteria for authorization decisions. Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease [42 CFR 438.210(b)].

Notice of Action: The Contractor shall notify the requesting provider and give the member written notice of any decision by the Contractor to deny, reduce, suspend or terminate a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested, or for any action as defined in Attachment H(1). [42 CFR 438.400(b)] The notice shall meet the requirements of 42 CFR 438.404, AHCCCS Rules and ACOM *Notice of Action Policy*. The notice to the provider must also be in writing as specified in Attachment H(1) of this contract [42 CFR 438.210 (c)]. The Contractor must comply with all decision timelines outlined in ACOM *Notice of Action Policy*.

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The Contractor shall ensure that its providers are not restricted or inhibited in any way from communicating freely with members regarding their health care, medical needs and treatment options, even if needed services are not covered by the Contractor.

Ambulatory Surgery: The Contractor shall provide surgical services for either emergency or scheduled surgeries when provided in an ambulatory or outpatient setting, such as a freestanding surgical center or a hospital-based outpatient surgical setting.

American Indian Health Program (AIHP): AHCCCS Division of Fee For Service Management (DFSM) will reimburse claims for acute care services that are medically necessary, eligible for 100% Federal reimbursement, and are provided to Title XIX members enrolled with the Contractor by an IHS or a 638 tribal facility and when the member is eligible to receive services at the IHS or a tribally operated 638 program. Encounters for Title XIX services billed by an IHS or tribal facilities will not be accepted by AHCCCS or considered in capitation rate development.

The Contractor is responsible for reimbursement to IHS or tribal facilities for services provided to Title XXI American Indian members enrolled with the Contractor. The Contractor may choose to subcontract with an IHS or 638 tribal facility as part of its provider network for the delivery of Title XXI covered services. Expenses incurred by the Contractor for Title XXI services billed by an IHS or 638 tribal facility shall be encountered and considered in capitation rate development.

Anti-hemophilic Agents and Related Services: The Contractor shall provide services for the treatment of hemophilia and Von Willebrand's disease (See Section D, Paragraph 57, Reinsurance, Catastrophic Reinsurance).

Audiology: The Contractor shall provide medically necessary audiology services to evaluate hearing loss for all members, on both an inpatient and outpatient basis. Hearing aids are covered only for members under the age of 21 receiving EPSDT services.

Behavioral Health: The Contractor shall provide behavioral health services as described in Section D, Paragraph 12, Behavioral Health Services. Also refer to Prior Period Coverage in Section D, Paragraph 3, Enrollment and Disenrollment.

Children's Rehabilitative Services (CRS): Is a program for children with special health care needs. The CRS program is administered by AHCCCS utilizing a CRS Contractor for children who meet CRS eligibility criteria. The Contractor shall refer children to CRS who are potentially eligible for services related to CRS-covered conditions, as specified in R9-22, Article 2, and A.R.S. Title 36, Chapter 2, Article 3. In addition, the Contractor shall notify the member when a referral to CRS has been made. The Contractor is responsible for care of members until those members are determined eligible by the CRS Contractor. In addition, the Contractor is responsible for covered services for CRS-eligible members unless and until the Contractor has received written confirmation from the CRS Contractor that the CRS Contractor will provide the medically necessary, CRS covered service. The Contractor shall require the member's Primary Care Provider (PCP) to coordinate the member's care with the CRS Contractor. For more detailed information regarding eligibility criteria, referral practices, and Contractor-CRS coordination issues, refer to the AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractor's Operation Manual (ACOM) located on the AHCCCS website at www.azahcccs.gov.

The Contractor shall respond to requests for services potentially covered by CRSA in accordance with the related ACOM and AMPM policies. The Contractor is responsible for addressing prior authorization requests if CRSA fails to comply with the timeframes specified in the related ACOM policy. The Contractor is responsible for the payment of emergency department facility and professional claims (in or out of network), regardless of whether the service is related to the CRS condition. In addition, the Contractor remains ultimately responsible for the provision of all AHCCCS-covered services to its members including services denied by the CRS Contractor for the reason that it is not a service related to a CRS condition.

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Referral to the CRS Contractor does not relieve the Contractor of the responsibility for providing timely medically necessary AHCCCS services not covered by the CRS Contractor. In the event that the CRS Contractor denies a medically necessary AHCCCS service for the reason that it is not related to a CRS covered condition, the Contractor must promptly respond to the service authorization request and authorize the provision of medically necessary services. The CRS Contractor cannot contest the Contractor prior authorization determination if the CRS Contractor fails to timely respond to a service authorization request. Contractors, through their Medical Directors, may request review from the CRS Contractor Medical Director when it denies a service for the reason that it is not covered by the CRS Program. The Contractor may also request a review of the decision with AHCCCS if it is dissatisfied with the CRS Contractor's determination. If the AHCCCS review determines that the service should have been provided by the CRS Contractor, the CRS Contractor shall be financially responsible for the costs incurred by the Contractor in providing the service.

A member with private insurance is not required to utilize CRS. This includes members with Medicare whether they are enrolled in Medicare FFS or a Medicare Managed Care Plan. If the member uses a private insurance network for a CRS covered condition, the Contractor is responsible for all applicable deductibles and copayments. If the member is on Medicare, the ACOM *Medicare Cost Sharing for Members in Traditional Fee for Service Policy* and *Medicare Cost Sharing for Members in Medicaid Managed Care Plans Policy* shall apply. When private insurance or Medicare is exhausted, or certain annual or lifetime limits are reached with respect to the CRS covered conditions, the Contractor shall refer the member to CRS for determination of eligibility. If the member with private insurance or Medicare chooses to enroll with CRS, CRS becomes the secondary payer responsible for all applicable deductibles and copayments. The Contractor is not responsible to provide services in instances when a member with a CRS covered condition who has no primary insurance or Medicare, refuses to participate in the CRS application process, or refuses to receive CRS covered services through the CRS program. The member may be billed by the provider in accordance with AHCCCS regulations regarding billing for unauthorized services.

Chiropractic Services: The Contractor shall provide chiropractic services to members under age 21 when prescribed by the member's PCP and approved by the Contractor in order to ameliorate the member's medical condition. Medicare approved chiropractic services for any member shall be covered, subject to limitations specified in 42 CFR 410.22, for Qualified Medicare Beneficiaries, regardless of age, if prescribed by the member's PCP and approved by the Contractor.

Dialysis: The Contractor shall provide medically necessary dialysis, supplies, diagnostic testing and medication for all members when provided by Medicare-certified hospitals or Medicare-certified end stage renal disease (ESRD) providers. Services may be provided on an outpatient basis or on an inpatient basis if the hospital admission is not solely to provide chronic dialysis services.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): The Contractor shall provide comprehensive health care services through primary prevention, early intervention, diagnosis and medically necessary treatment to correct or ameliorate defects and physical or mental illness discovered by the screenings for members under age 21. The Contractor shall ensure that these members receive required health screenings, including developmental/behavioral health screenings, in compliance with the AHCCCS periodicity schedule, and the AHCCCS dental periodicity schedule (Exhibit 430-1 in the AMPM) and submit to AHCCCS Division of Health Care Management, all EPSDT reports as required by AHCCCS Medical Policy to the CQM Unit as identified in Attachment F of this contract. The Contractor is required to meet specific participation/utilization rates for EPSDT members; these are described in the AMPM and in Section D, Paragraph 23, Quality Management.

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The Contractor shall ensure the initiation and coordination of a referral to the T/RBHA system for members in need of behavioral health services. The Contractor shall follow up with the T/RBHA to monitor whether members have received these health services. The Contractor will ensure the Health Plan coordinates referrals and follow-up collaboration, as necessary, for members identified by the ADHS as needing acute care services.

The Contractor is encouraged to assign EPSDT-aged members to providers that are trained on and who use AHCCCS-approved developmental screening tools.

Early Detection Health Risk Assessment, Screening, Treatment and Primary Prevention: The Contractor shall provide primary prevention education to adult members. The Contractor shall provide health care services through screening, diagnostic and medically necessary treatment for members 21 years of age and older. These services include, but are not limited to, screening and treatment for hypertension; elevated cholesterol; colon cancer; sexually transmitted diseases; tuberculosis; HIV/AIDS; breast and cervical cancer; and prostate cancer. Nutritional assessment and treatment are covered when medically necessary to meet the over and under nutritional needs of members who may have a chronic debilitating disease. Physical examinations, diagnostic work-ups and medically necessary immunizations are also covered as found in Arizona Administrative Code Section R9-22-205. AHCCCS does not cover well exams (i.e., physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examination) for adult members.

Required assessment and screening services for members under age 21 are specified in the AHCCCS EPSDT periodicity schedule.

Emergency Services: The Contractor shall have and/or provide emergency services per the AHCCCS AMPM Policy and the following as a minimum:

- a. Emergency services facilities adequately staffed by qualified medical professionals to provide pre-hospital, emergency care on a 24-hour-a-day, 7-day-a-week basis, for an emergency medical condition as defined by AHCCCS Rule 9 A.A.C. 22, Article 1. Emergency medical services are covered without prior authorization. The Contractor is encouraged to contract with emergency service facilities for the provision of emergency services. The Contractor shall be responsible for educating members and providers regarding appropriate utilization of emergency room services including behavioral health emergencies. The Contractor shall monitor emergency service utilization (by both provider and member) and shall have guidelines for implementing corrective action for inappropriate utilization. For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this contract, a prudent layperson is a person who possesses an average knowledge of health and medicine.
- b. All medical services necessary to rule out an emergency condition; and
- c. Emergency transportation.

Per the Medicaid Managed Care regulations, 42 CFR 438.114, 422.113, 422.133 the following conditions apply with respect to coverage and payment of emergency services:

The Contractor must cover and pay for emergency services regardless of whether the provider that furnishes the service has a contract with the Contractor.

The Contractor may not deny payment for treatment obtained under either of the following circumstances:

- 1. A member had an emergency medical condition, including cases in which the absence of medical attention would not have resulted in the outcomes identified in the definition of emergency medical condition under 42 CFR 438.114.
- 2. A representative of the Contractor (an employee or subcontracting provider) instructs the member to seek emergency medical services.

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Additionally, the Contractor may not:

1. Limit what constitutes an emergency medical condition as defined in 42 CFR 438.114, on the basis of lists of diagnoses or symptoms.
2. Refuse to cover emergency services based on the failure of the emergency room provider, hospital, or fiscal agent to notify the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. Claims submission by the hospital within 10 calendar days of presentation for the emergency services constitutes notice to the Contractor. This notification stipulation is only related to the provision of emergency services.
3. Require notification of Emergency Department treat and release visits as a condition of payment unless the plan has prior approval from AHCCCS.

A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and such determination is binding on the Contractor responsible for coverage and payment. The Contractor shall comply with Medicaid Managed Care guidelines regarding the coordination of post-stabilization care.

For additional information and requirements regarding emergency services, refer to AHCCCS Rules R9-22-201 et seq. and 42 CFR 438.114.

Family Planning: The Contractor shall provide family planning services in accordance with the *AMPM*, for all members who choose to delay or prevent pregnancy. These include medical, surgical, pharmacological and laboratory services, as well as contraceptive devices. Information and counseling, which allow members to make informed decisions regarding family planning methods, shall also be included. If the Contractor does not provide family planning services, it must contract for these services through another health care delivery system or AHCCCS will disenroll from the Contractor members who are seeking these services and assign the members to another Contractor.

The Contractor shall provide services to members enrolled in the Family Planning Services Extension Program, a program that provides family planning services only, for a maximum of two consecutive 12-month periods, to women whose SOBRA eligibility has terminated. The Contractor is also responsible for notifying AHCCCS when a SOBRA woman is sterilized to prevent inappropriate enrollment in the SOBRA Family Planning Services Extension Program. Notification should be made at the time the newborn is reported or after the sterilization procedure is completed.

Foot and Ankle Services Children: The Contractor shall provide foot and ankle care services for members under the age of 21 to include bunionectomies, casting for the purpose of constructing or accommodating orthotics, medically necessary orthopedic shoes that are an integral part of a brace, and medically necessary routine foot care for patients with a severe systemic disease that prohibits care by a nonprofessional person.

Foot and Ankle Services Adults: The Contractor shall provide foot and ankle care services to include wound care, treatment of pressure ulcers, fracture care, reconstructive surgeries, and limited bunionectomy services. Medically necessary routine foot care services are only available for members with a severe systemic disease that prohibits care by a nonprofessional person as described in the *AMPM*. Services are not covered for members 21 years of age and older, when provided by a podiatrist or podiatric surgeon.

Home and Community Based Services (HCBS): Assisted living facility, alternative residential setting, or home and community based services (HCBS) as defined in R9-22, Article 2, and R9-28, Article 2 that meet the provider standards described in R9-28, Article 5, and subject to the limitations set forth in the *AMPM*. These services are covered in lieu of a nursing facility.

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Home Health: This service shall be provided under the direction of a physician to prevent hospitalization or institutionalization and may include nursing, therapies, supplies and home health aide services. It shall be provided on a part-time or intermittent basis.

Hospice: These services are covered for members who are certified by a physician as being terminally ill and having six months or less to live. See the *AMPM* for details on covered hospice services.

Hospital: Inpatient services include semi-private accommodations for routine care, intensive and coronary care, surgical care, obstetrics and newborn nurseries, and behavioral health emergency/crisis services. If the member's medical condition requires isolation, private inpatient accommodations are covered. Nursing services, dietary services and ancillary services such as laboratory, radiology, pharmaceuticals, medical supplies, blood and blood derivatives, etc. are also covered. Outpatient hospital services include any of the above services which may be appropriately provided on an outpatient or ambulatory basis (i.e., laboratory, radiology, therapies, ambulatory surgery, etc.). Observation services may be provided on an outpatient basis, if determined reasonable and necessary to decide whether the member should be admitted for inpatient care. Observation services include the use of a bed and periodic monitoring by hospital nursing staff and/or other staff to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability. Refer to the AHCCCS Medical Policy Manual for limitations on hospital stays.

Immunizations: The Contractor shall provide immunizations for adults (21 years of age and older) including but not limited to: medically necessary diphtheria, tetanus, pertussis vaccine (DTap), influenza, pneumococcus, rubella, measles and hepatitis-B and others as medically indicated. EPSDT immunization requirements include but are not limited to: diphtheria, tetanus, pertussis vaccine (DTaP), inactivated polio vaccine (IPV), measles, mumps, rubella vaccine (MMR), H. influenza, type B (HIB), hepatitis B (Hep B), hepatitis A (Hep A), Human Pappiloma virus (HPV) through age 20 for both males and females, pneumococcal conjugate (PCV) and varicella zoster virus (VZV) vaccine. (Please refer to the *AMPM* for current immunization requirements.)The Contractor is required to meet specific immunization rates for members under the age of 21, which are described in Section D, Paragraph 23, Quality Management.

Incontinence Supplies: The Contractor shall cover incontinence supplies as specified in AHCCCS Rule A.A.C. R9-22-212 and the *AMPM*.

Laboratory: Laboratory services for diagnostic, screening and monitoring purposes are covered when ordered by the member's PCP, other attending physician or dentist, and provided by a CLIA (Clinical Laboratory Improvement Act) approved free-standing laboratory or hospital laboratory, clinic, physician office or other health care facility laboratory.

Upon written request, the Contractor may obtain laboratory test data on members from a laboratory or hospital- based laboratory subject to the requirements specified in A.R.S. § 36-2903(Q) and (R). The data shall be used exclusively for quality improvement activities and health care outcome studies required and/or approved by AHCCCS.

Maternity: The Contractor shall provide pre-conception counseling, pregnancy identification, prenatal care, treatment of pregnancy related conditions, labor and delivery services, and postpartum care for members. Services may be provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, or licensed midwives. Members may select or be assigned to a PCP specializing in obstetrics. Members anticipated to have a low-risk delivery, may elect to receive labor and delivery services in their home from their maternity provider if this setting is included in the allowable settings for the Contractor, and the Contractor has providers in its network that offer home labor and delivery services. Members anticipated to have a low-risk prenatal course and delivery may elect to receive maternity services of prenatal care, labor and delivery and postpartum care provided by certified nurse midwives or licensed midwives, if they are in the Contractor's provider network. Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide those primary care services that s/he is willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all her primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice.

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The Contractor shall allow women and their newborns to receive up to 48 hours of inpatient hospital care after a routine vaginal delivery and up to 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with the mother, may discharge the mother or newborn prior to the minimum length of stay. A normal newborn may be granted an extended stay in the hospital of birth when the mother's continued stay in the hospital is beyond the 48 or 96 hour stay.

The Contractor shall inform all assigned AHCCCS pregnant women of voluntary prenatal testing and the availability of medical counseling if the test is positive. The Contractor shall provide information in the member handbook and annually in the member newsletter, to encourage pregnant women to be tested and instructions about where to be tested. Semi-annually, the Contractor shall report to AHCCCS, Division of Health Care Management (DHCM) the number of pregnant women who have been identified as HIV/AIDS-positive. This report is due no later than 30 days after the end of the second and fourth quarters of the contract year.

Medical Foods: Medical foods are covered within limitations defined in the *AMPM* for members diagnosed with a metabolic condition included under the ADHS Newborn Screening Program and specified in the *AMPM*. The medical foods, including metabolic formula and modified low protein foods, must be prescribed or ordered under the supervision of a physician.

Medical Supplies, Durable Medical Equipment (DME), and Prosthetic Devices: These services are covered when prescribed by the member's PCP, attending physician or practitioner, or by a dentist as described in the *AMPM*. Prosthetic devices must be medically necessary and meet criteria as described in the *AMPM*. For persons age 21 or older, AHCCCS will not pay for microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs. Medical equipment may be rented or purchased only if other sources are not available which provide the items at no cost. The total cost of the rental must not exceed the purchase price of the item. Reasonable repairs or adjustments of purchased equipment are covered to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit.

Nursing Facility: The Contractor shall provide services in nursing facilities, including religious non-medical health care institutions, for members who require short-term convalescent care not to exceed 90 days per contract year. In lieu of a nursing facility, the member may be placed in an assisted living facility, an alternative residential setting, or receive home and community based services (HCBS) as defined in R9-22, Article 2 and R9-28, Article 2 that meet the provider standards described in R9-28, Article 5, and subject to the limitations set forth in the *AMPM*.

Nursing facility services must be provided in a dually-certified Medicare/Medicaid nursing facility, which includes in the per-diem rate: nursing services; basic patient care equipment and sickroom supplies; dietary services; administrative physician visits; non-customized DME; necessary maintenance and rehabilitation therapies; over-the-counter medications; social, recreational and spiritual activities; and administrative, operational medical direction services. See Section D, Paragraph 41, Responsibility for Nursing Facility Reimbursement, for further details.

The Contractor shall notify the Assistant Director of the Division of Member Services, by Email, when a member has been residing in a nursing facility for 60 days. This will allow AHCCCS time to follow-up on the status of the ALTCS application and to consider potential fee-for-service coverage, if the stay goes beyond the 90-day per contract year maximum. The notice should be sent via e-mail to HealthPlan60DayNotice@azahcccs.gov.

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Notifications must include:

1. Member Name
2. AHCCCS ID
3. Date of Birth
4. Name of Facility
5. Admission Date to the Facility
6. Date they reach the 60 days
7. Name of Contractor of enrollment

Nutrition: Nutritional assessments are conducted as a part of the EPSDT screenings for members under age 21, and to assist members 21 years of age and older whose health status may improve with over and under nutritional intervention. Assessment of nutritional status on a periodic basis may be provided as determined necessary, and as a part of the health risk assessment and screening services provided by the member's PCP. Assessments may also be provided by a registered dietitian when ordered by the member's PCP. AHCCCS covers nutritional therapy on an enteral, parenteral or oral basis, when determined medically necessary to provide either complete daily dietary requirements or to supplement a member's daily nutritional and caloric intake and when AHCCCS criteria specified in the *AMPM* are met.

Oral Health: The Contractor shall provide all members under the age of 21 years with all medically necessary dental services including emergency dental services, dental screening and preventive services in accordance with the AHCCCS Dental Periodicity Schedule, as well as therapeutic dental services, dentures, and pre-transplantation dental services. The Contractor shall monitor compliance with the AHCCCS Dental Periodicity Schedule for dental screening services. The Contractor is required to meet specific utilization rates for members as described in Section D, Paragraph 23, Quality Management. The Contractor shall ensure that members are notified when dental screenings are due if the member has not been scheduled for a visit. If a dental screening is not received by the member, a second notice must be sent. Members under the age of 21 may request dental services without referral and may choose a dental provider from the Contractor's provider network.

Pursuant to A.A.C. R9-22-207, for members who are 21 years of age and older, the Contractor shall cover medical and surgical services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist. These services would be considered physician services if furnished by a physician. Limited dental services are covered for pre-transplant candidates and for members with cancer of the jaw, neck or head. Refer to the *AMPM* for specific details.

Orthotics: These services are covered for members under the age of 21 when prescribed by the member's PCP, attending physician, practitioner, or by a dentist as described in the *AMPM*. Medical equipment may be rented or purchased only if other sources, which provide the items at no cost, are not available. The total cost of the rental must not exceed the purchase price of the item.

Reasonable repairs or adjustments of purchased equipment are covered for all members over and under the age of 21 to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit. The component will be replaced if at the time authorization is sought documentation is provided to establish that the component is not operating effectively.

Physician: The Contractor shall provide physician services to include medical assessment, treatments and surgical services provided by licensed allopathic or osteopathic physicians.

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Post-stabilization Care Services Coverage and Payment: Pursuant to AHCCCS Rule A.A.C. R9-22-210 and 42 CFR 438.114, 422.113(c) and 422.133, the following conditions apply with respect to coverage and payment of emergency and of post-stabilization care services, except where otherwise noted in the contract:

The Contractor must cover and pay for post-stabilization care services without authorization, regardless of whether the provider that furnishes the service has a contract with the Contractor, for the following situations:

1. Post-stabilization care services that were pre-approved by the Contractor; or
2. Post-stabilization care services were not pre-approved by the Contractor because the Contractor did not respond to the treating provider's request for pre-approval within one hour after being requested to approve such care or could not be contacted for pre-approval.
3. The Contractor representative and the treating physician cannot reach agreement concerning the member's care and a Contractor physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the patient until a Contractor physician is reached or one of the criteria in 42 CFR 422.113(c)(3) is met.

Pursuant to 42 CFR 422.113(c)(3), the Contractor's financial responsibility for post-stabilization care services that have not been pre-approved ends when:

1. A Contractor physician with privileges at the treating hospital assumes responsibility for the member's care;
2. A Contractor physician assumes responsibility for the member's care through transfer;
3. A Contractor representative and the treating physician reach an agreement concerning the member's care; or
4. The member is discharged.

Pregnancy Terminations: AHCCCS covers pregnancy termination if the pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated, or the pregnancy is a result of rape or incest.

The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the Certificate of Necessity for Pregnancy Termination. This certificate must be submitted to the Contractor's Medical Director. The Certificate must certify that, in the physician's professional judgment, one or more of the previously mentioned criteria have been met.

Prescription Medications: Medications ordered by a PCP, attending physician, dentist or other authorized prescriber and dispensed under the direction of a licensed pharmacist are covered subject to limitations related to prescription supply amounts, Contractor formularies and prior authorization requirements. An appropriate over-the-counter medication may be prescribed as defined in the AMPM when it is determined to be a lower-cost alternative to a prescription medication.

Medicare Part D: AHCCCS covers those drugs ordered by a PCP, attending physician, dentist or other authorized prescriber and dispensed under the direction of a licensed pharmacist subject to limitations related to prescription supply amounts, and the Contractor's prior authorization requirements if they are excluded from Medicare Part D coverage. Medications that are covered by Part D, but are not on a specific Part D Health Plan's formulary are not considered excluded drugs and will not be covered by AHCCCS. This applies to members that are enrolled in Medicare Part D or are eligible for Medicare Part D.

Primary Care Provider (PCP): PCP services are covered when provided by a physician, physician assistant or nurse practitioner selected by, or assigned to, the member. The PCP provides primary health care and serves as a coordinator in referring the member for specialty medical services [42 CFR 438.208(b)]. The PCP is responsible for maintaining the member's primary medical record, which contains documentation of all health risk assessments and health care services of which they are aware whether or not they were provided by the PCP.

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Radiology and Medical Imaging: These services are covered when ordered by the member's PCP, attending physician or dentist and are provided for diagnosis, prevention, treatment or assessment of a medical condition.

Rehabilitation Therapy: The Contractor shall provide occupational, physical and speech therapies. Therapies must be prescribed by the member's PCP or attending physician for an acute condition and the member must have the potential for improvement due to the rehabilitation.

Occupational and Speech therapy is covered for all members receiving inpatient hospital (or nursing facility services). Occupational Therapy and Speech therapy services provided on an outpatient basis are only covered for members under the age of 21. Physical Therapy is covered for all members in both inpatient and outpatient settings. Outpatient physical therapy for members 21 years of age or older are subject to a 15 visit limit per contract year as described in the AMPM.

Respiratory Therapy: Respiratory therapy is covered in inpatient and outpatient settings when prescribed by the member's PCP or attending physician, and is necessary to restore, maintain or improve respiratory functioning.

Transplantation of Organs and Tissue, and Related Immunosuppressant Drugs: These services are covered within limitations defined in the AMPM for members diagnosed with specified medical conditions. Services include: pre-transplant inpatient or outpatient evaluation; donor search; organ/tissue harvesting or procurement; preparation and transplantation services; and convalescent care. In addition, if a member receives a transplant covered by a source other than AHCCCS, medically necessary non-experimental services are provided, within limitations, after the discharge from the acute care hospitalization for the transplantation. AHCCCS maintains specialty contracts with transplantation facility providers for the Contractor's use or the Contractor may select its own transplantation provider.

Transportation: These services include emergency and non-emergency medically necessary transportation. Emergency transportation, including transportation initiated by an emergency response system such as 911, may be provided by ground, air or water ambulance to manage an AHCCCS member's emergency medical condition at an emergency scene and transport the member to the nearest appropriate medical facility. Non-emergency transportation shall be provided for members who are unable to provide their own transportation for medically necessary services. The Contractor shall ensure that members have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.

Triage/Screening and Evaluation: These are covered services when provided by acute care hospitals, IHS facilities, a PL 93-638 tribal facility and after-hours settings to determine whether or not an emergency exists, assess the severity of the member's medical condition and determine services necessary to alleviate or stabilize the emergent condition. Triage/screening services must be reasonable, cost effective and meet the criteria for severity of illness and intensity of service.

Vision Services/Ophthalmology/Optomety: The Contractor shall provide all medically necessary emergency eye care, vision examinations, prescriptive lenses and frames, and treatments for conditions of the eye for all members under the age of 21. For members who are 21 years of age and older, the Contractor shall provide emergency care for eye conditions which meet the definition of an emergency medical condition, cataract removal, and/or medically necessary vision examinations and prescriptive lenses and frames, if required following cataract removal and other eye conditions as specified in the AMPM.

Members shall have full freedom to choose, within the Contractor's network, a practitioner in the field of eye care, acting within the scope of their practice, to provide the examination, care or treatment for which the member is eligible. A "practitioner in the field of eye care" is defined to be either an ophthalmologist or an optometrist.

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11. SPECIAL HEALTH CARE NEEDS

The Contractor shall have in place a mechanism to identify all members with special health care needs [42 CFR 438.240(b)(4)]. The Contractor shall implement mechanisms to assess each member identified as having special health care needs, in order to identify any ongoing special conditions of the member which require a course of treatment or regular care monitoring. The assessment mechanisms shall use appropriate health care professionals [42 CFR 438.208(c)(2)]. The Contractor shall share with other entities providing services to that member the results of its identification and assessment of that member's needs so that those activities need not be duplicated [42 CFR 438.208(b)(3)].

For members with special health care needs determined to need a specialized course of treatment or regular care monitoring, the Contractor must have procedures in place to allow members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs [42 CFR 438.208(c)(4)].

The Contractor shall have a methodology to identify providers willing to provide medical home services and make reasonable efforts to offer access to these providers.

The American Academy of Pediatrics (AAP) describes care from a medical home as:

- Accessible
- Continuous
- Coordinated
- Family-centered
- Comprehensive
- Compassionate
- Culturally effective

The Contractor shall ensure that populations with ongoing medical needs, including but not limited to dialysis, radiation and chemotherapy, have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.

12. BEHAVIORAL HEALTH SERVICES

AHCCCS members, except for SOBRA Family Planning members, are eligible for comprehensive behavioral health services. For SOBRA Family Planning members, there is no behavioral health coverage. With the exception of the Contractor's providers' medical management of certain behavioral health conditions as described under "Medication Management Services", the behavioral health benefit for these members is provided through the ADHS — Regional Behavioral Health Authority (RBHA) system. The Contractor shall be responsible for member education regarding these benefits; provision of limited emergency inpatient services; and screening and referral to the RBHA system of members identified as requiring behavioral health services.

Member Education: The Contractor shall be responsible for educating members in the member handbook and other printed documents about covered behavioral health services and where and how to access services. Covered services include:

- a. Behavior Management (personal care, family support/home care training, peer support)
- b. Behavioral Health Case Management Services
- c. Behavioral Health Nursing Services
- d. Emergency Behavioral Health Care
- e. Emergency and Non-Emergency Transportation
- f. Evaluation and Assessment

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- g. Individual, Group and Family Therapy and Counseling
- h. Inpatient Hospital Services (the Contractor may provide services in alternative inpatient settings that are licensed by the Arizona Department of Health Services, Division of Assurance and Licensure, the Office of Behavioral Health Licensure, in lieu of services in an inpatient hospital. These alternative settings must be lower cost than traditional inpatient settings.)
- i. Non-Hospital Inpatient Psychiatric Facilities Services (Level I residential treatment centers and sub-acute facilities)
- j. Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis
- k. Opioid Agonist Treatment
- l. Partial Care (Supervised day program, therapeutic day program and medical day program)
- m. Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services)
- n. Psychotropic Medication
- o. Psychotropic Medication Adjustment and Monitoring
- p. Respite Care (with limitations)
- q. Rural Substance Abuse Transitional Agency Services
- r. Screening
- s. Home Care Training to Home Care Client

Referrals: As specified in Section D, Paragraph 10, Scope of Services, EPSDT, the Contractor must provide developmental/behavioral health screenings for members up to 21 years of age in compliance with the AHCCCS periodicity schedule. The Contractor shall ensure the initiation and coordination of behavioral health referrals of these members to the RBHA when determined necessary through the screening process.

The Contractor is responsible for collaborating with RBHAs regarding referrals and follow up activities, as necessary, for other members identified by the AHCCCS contractor as needing behavioral health evaluation and treatment. Members may also access the RBHA system for evaluation by self-referral or be referred by schools, State agencies or other service providers. The Contractor is responsible for providing transportation to a member's first RBHA evaluation appointment if a member is unable to provide his/her own transportation. The Contractor will ensure coordination of referrals and follow-up collaboration, as necessary, for members identified by ADHS as needing acute care services.

Emergency Services: When members present in an emergency room setting, the Contractor is responsible for all emergency medical services including triage, physician assessment and diagnostic tests. ADHS is responsible for medically necessary professional psychiatric consultations in emergency room settings.

Reimbursement for court ordered screening and evaluation services is not the responsibility of the Contractor and instead falls to the county pursuant to A.R.S. 36-545. For additional information regarding behavioral health services refer to Title 9 Chapter 22 Articles 2 and 12. It is expected that the Contractor initiate a referral to the T/RBHA for evaluation and behavioral health recipient eligibility as soon as possible after admission.

Comorbidities: The Contractor must ensure that members with diabetes who are being discharged from the Arizona State Hospital (AzSH) are issued the same brand and model of both glucometer and supplies they were trained to use while in the facility. Care must be coordinated with the AzSH prior to discharge to ensure that all supplies are authorized and available to the member upon discharge.

In the event that a member's mental health status renders them incapable or unwilling to manage their medical condition and the member has a skilled medical need, the Contractor must arrange ongoing medically necessary nursing services. The Contractor shall also have a mechanism in place for tracking members for whom ongoing medically necessary services are required.

Coordination of Care: The Contractor is responsible for ensuring that a medical record is established by the PCP when behavioral health information is received from the RBHA or provider about an assigned member even if the PCP has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member's medical record as soon as one is established. The Contractor shall require the PCP to respond to RBHA/provider information requests pertaining to ADHS behavioral health recipient members within 10 business days of receiving the request. The response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last PCP visit, and recent hospitalizations. The Contractor shall require the PCP to document or initial signifying review of member behavioral health information received from a RBHA behavioral health provider who is also treating the member.

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Medication Management Services: The Contractor shall allow PCPs to provide medication management services (prescriptions, medication monitoring visits, laboratory and other diagnostic tests necessary for diagnosis and treatment of behavioral disorders) to members with diagnoses of depression, anxiety and attention deficit hyperactivity disorder. The Contractor shall make available, on the Contractor's formulary, medications for the treatment of these disorders. AHCCCS has facilitated the development of Clinical tool kits for the treatment of anxiety, depression, and ADHD. These tool kits are a resource only and may not apply to all patients and all clinical situations. They are not intended to replace clinical judgment. The Contractor shall ensure that PCPs and Pediatricians who have an interest or are actively treating members with these disorders are aware of these resources and/or are utilizing other recognized tools/evidence-based guidelines. The Contractor shall develop a monitoring process to ensure that PCPs utilize evidence-based guidelines/recognized clinical tools when prescribing medications to treat depression, anxiety, and ADHD.

The Contractor may implement step therapy for behavioral health medications used for treating anxiety, depression and ADHD disorders. The Contractor shall provide education and training for providers regarding the concept of step therapy. If the RBHA/behavioral health provider provides documentation to the Contractor that step therapy has already been completed, or is medically contraindicated, the Contractor shall continue to provide the medication at the dosage at which the member has been stabilized, unless there is subsequently a change in medical condition of the member. The Contractor shall monitor PCPs to ensure that they prescribe medication at the dosage at which the member has been stabilized.

The Contractor shall ensure that training and education are available to PCPs regarding behavioral health referral and consultation procedures. The Contractor shall establish policies and procedures for referral and consultation and shall describe them in its provider manual. Policies for referral must include, at a minimum, criteria, processes, responsible parties and minimum requirements no less stringent than those specified in this contract for the forwarding of member medical information.

Transfer of Care: When a PCP has initiated medication management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP or Contractor that the member should be transferred to a RBHA prescriber for evaluation and/or continued medication management services, the Contractor will require and ensure that the PCP or Contractor coordinates the transfer of care. All affected subcontracts shall include this provision. The Contractor shall establish policies and procedures for the transition of members who are referred to the RBHA for ongoing treatment. The Contractor shall ensure that PCPs maintain continuity of care for these members. The policies and procedures must address, at a minimum, the following:

1. Guidelines for when a transition of the member to the RBHA for ongoing treatment is indicated.
2. Protocols for notifying the RBHA of the member's transfer, including reason for transfer, diagnostic information, and medication history.
3. Protocols and guidelines for the transfer of medical records, including but not limited to which parts of the medical record are to be copied, timeline for making the medical record available to the RBHA, observance of confidentiality of the member's medical record, and protocols for responding to RBHA requests for additional medical record information.
4. Protocols for transition of prescription services, including but not limited to notification to the RBHA of the member's current medications and timeframes for dispensing and refilling medications during the transition period. This coordination must ensure at a minimum, that the member does not run out of prescribed medications prior to the first appointment with a RBHA prescriber and that all relevant member pertinent medical information as outlined above and including the reason for transfer is forwarded to the receiving RBHA prescriber prior to the member's first scheduled appointment with the RBHA prescriber.
5. Contractor activities to monitor to ensure that members are appropriately transitioned to the RBHA for care.

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The Contractor shall ensure that its quality management program incorporates monitoring of the PCP's management of behavioral health disorders and referral to, coordination of care with and transfer of care to RBHA providers as required under this contract.

13. AHCCCS GUIDELINES, POLICIES AND MANUALS

All AHCCCS guidelines, policies and manuals are hereby incorporated by reference into this contract. All guidelines, policies and manuals are available on the AHCCCS website, located at www.azahcccs.gov. The Contractor is responsible for complying with the requirements set forth within. In addition, linkages to AHCCCS Rules (Arizona Administrative Code), Statutes and other resources are also available to all interested parties through the AHCCCS website. Upon adoption by AHCCCS, updates will be made available to the Contractor. The Contractor shall be responsible for implementing these requirements and maintaining current copies of updates.

14. MEDICAID SCHOOL BASED CLAIMING PROGRAM (MSBC)

Pursuant to an Intergovernmental Agreement with the Department of Education, and a contract with a Third Party Administrator, AHCCCS pays participating school districts for specifically identified Medicaid services when provided to Medicaid eligible children who are included under the Individuals with Disabilities Education Act (IDEA). The Medicaid services must be identified in the member's Individual Education Plan (IEP) as medically necessary for the child to obtain a public school education.

MSBC services are provided in a school setting or other approved setting specifically to allow children to receive a public school education. They do not replace medically necessary services provided outside the school setting or other MSBC approved alternative setting. Currently, services include audiology, therapies (OT, PT and speech/language); behavioral health evaluation and counseling; nursing and attendant care (health aid services provided in the classroom); and specialized transportation to and from school on days when the child receives an AHCCCS-covered MSBC service.

The Contractor's evaluations and determinations of medical necessity shall be made independent of the fact that the child is receiving MSBC services. If a request is made for services that also are covered under the MSBC program for a child enrolled with the Contractor, the request shall be evaluated on the same basis as any request for a covered service.

The Contractor and its providers should coordinate with schools and school districts that provide MSBC services to the Contractor's enrolled members. Services should not be duplicative. Contractor case managers, working with special needs children, should coordinate with the appropriate school staff working with these members. Transfer of member medical information and progress toward treatment goals between the Contractor and the member's school or school district is required as appropriate and should be used to enhance the services provided to members.

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15. PEDIATRIC IMMUNIZATIONS AND THE VACCINES FOR CHILDREN PROGRAM

Through the Vaccines for Children Program, the Federal and State governments purchase, and make available to providers free of charge, vaccines for AHCCCS children under age 19. The Contractor shall not utilize AHCCCS funding to purchase vaccines for members under the age of 19. If vaccines are not available through the VFC Program, the Contractor shall contact the AHCCCS Division of Health Care Management, Clinical Quality Management Unit. Any provider, licensed by the State to administer immunizations, may register with ADHS as a "VFC provider" and receive free vaccines. The Contractor shall not reimburse providers for the administration of the vaccines in excess of the maximum allowable as set by CMS, found in the AHCCCS fee schedule. The Contractor shall comply with all VFC requirements and monitor its providers to ensure that, a physician if acting as primary care physician (PCP) to AHCCCS members under the age of 19 is registered with ADHS/VFC.

In some GSAs, providers may choose not to provide vaccinations due to low numbers of children in their panels, etc. The Contractor must develop processes to ensure that vaccinations are available through a VFC enrolled provider or through the county Health Department. In all instances, the antigens are to be provided through the VFC program. The Contractor must develop processes to pay the administration fee to whoever administers the vaccine regardless of their contract status with the Contractor.

Arizona State law requires the reporting of all immunizations given to children under the age of 19. Immunizations must be reported at least monthly to the ADHS. Reported immunizations are held in a central database known as ASIIS (Arizona State Immunization Information System), which can be accessed by providers to obtain complete, accurate immunization records. Software is available from ADHS to assist providers in meeting this reporting requirement. The Contractor must educate its provider network about these reporting requirements and the use of this resource and monitor to ensure compliance.

16. STAFF REQUIREMENTS AND SUPPORT SERVICES

The Contractor shall have in place the organizational, operational, managerial and administrative systems capable of fulfilling all contract requirements. For the purposes of this contract, the Contractor shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610 (a) & (b), 42 CFR §1001.1901(b), 42 CFR §1003.102(a)(2)]. The Contractor is obligated to screen all employees and contractors to determine whether any of them have been excluded from participation in Federal health care programs. You can search the HHS-OIG website by the names of any individuals. The database can be accessed at <http://www.oig.hhs.gov/fraud/exclusions.asp>.

The Contractor is responsible for maintaining a significant local (within the State of Arizona) presence. This presence includes staff designated below with an asterisk (*). All staff or functions designated with an asterisk must be located within the State of Arizona at all times throughout the term of the Contract. The Contractor must obtain approval from AHCCCS prior to moving any functions not designated with an asterisk outside the State of Arizona after Contract initiation. Such a request for approval must be submitted to the Division of Health Care Management at least 60 days prior to the proposed change in operations and must include a description of the processes in place that assure rapid responsiveness to effect changes for contract compliance. The Contractor shall be responsible for any additional costs associated with on-site audits or other oversight activities of required functions located outside of the State of Arizona. At the beginning of each contract year the Contractor must provide, to the Division of Health Care Management, a listing of all functions and their locations.

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The Contractor must employ sufficient staffing and utilize appropriate resources to achieve contractual compliance. The Contractor's resource allocation must be adequate to achieve outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with contractual and AHCCCS policy requirements, including the requirement for providing culturally competent services. If the Contractor does not achieve the desired outcomes or maintain compliance with contractual obligations, additional monitoring and regulatory action may be employed by AHCCCS, including but not limited to, requiring the Contractor to hire additional staff and actions specified in Section D, Paragraph 72, Sanctions, of the Contract.

The Contractor shall have local staff available 24 hours a day, seven days a week to work with AHCCCS and/or other State agencies (for example ADHS) on urgent issue resolutions, such as in the case of an Immediate Jeopardy (IJ), fires, or other public emergency situations. These staff person(s) shall have access to information necessary to identify members who may be at risk, their current health/service status, ability to initiate new placements/services, and to be available to perform status checks at affected facilities and potentially ongoing monitoring, if necessary. The Contractor shall supply AHCCCS CQM with the contact information for these staff persons, such as a telephone number, to call in these urgent situations.

An individual staff member shall be limited to occupying a maximum of two of the Key Staff positions listed below. The Contractor shall inform AHCCCS, Division of Health Care Management, in writing within seven days, when an employee leaves one of the Key Staff positions listed below (this requirement does not apply to Additional Required Staff, also listed below). The name of the interim contact person should be included with the notification. The name and resume of the permanent employee should be submitted as soon as the new hire has taken place. Each year on October 15th, the Contractor must provide the name, Social Security Number and date of birth of the staff members performing the duties of the Key Staff listed as a, b and c below. AHCCCS will compare this information against federal databases to confirm that those individuals have not been banned or debarred from participating in Federal programs [42 CFR 455.104]. At a minimum, the following staff is required **Key Staff:**

- a. ***Administrator/CEO/COO** or their designee must be available during working hours to fulfill the responsibilities of the position and to oversee the entire operation of the Contractor. The Administrator shall devote sufficient time to the Contractor's operations to ensure adherence to program requirements and timely responses to AHCCCS.
- b. ***Medical Director/CMO** who is an Arizona-licensed physician. The Medical Director shall be actively involved in all-major clinical programs and QM and MM components of the Contractor. The Medical Director shall devote sufficient time to the Contractor's operations to ensure timely medical decisions, including after-hours consultation as needed.
- c. **Chief Financial Officer/CFO** who is available, full time, to fulfill the responsibilities of the position and to oversee the budget, accounting systems, and financial reporting implemented by the Contractor.
- d. **Pharmacy Director/Coordinator** who is an Arizona licensed pharmacist or physician who oversees and administers the prescription drug and pharmacy benefits. The Pharmacy Coordinator/Director may be an employee or Contractor of the Plan.
- e. **Dental Director/Coordinator** that is responsible for coordinating dental activities of the Contractor and providing required communication between the Contractor and AHCCCS. The Dental Director/Coordinator may be an employee or Contractor of the plan and must be a licensed dentist in Arizona if they are required to review or deny dental services.
- f. ***Compliance Officer** who will implement and oversee the Contractor's compliance program. The compliance officer shall be a management official, available to all employees, with designated and recognized authority to access records and make independent referrals to the AHCCCS Office of the Inspector General. See Section D, Paragraph 62, Corporate Compliance.
- g. ***Dispute and Appeal Manager** who will manage and adjudicate member and provider disputes arising under the Grievance System including member grievances, appeals, and requests for hearing and provider claim disputes.

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h. **Business Continuity Planning Coordinator** as noted in the ACOM *Business Continuity and Recovery Planning Policy*.

i. ***Contract Compliance Officer** who will serve as the primary point-of-contact for all Contractor operational issues.

The primary functions of the Contract Compliance Officer may include but are not limited to:

- Coordinate the tracking and submission of all contract deliverables
- Field and coordinate responses to AHCCCS inquiries
- Coordinate the preparation and execution of contract requirements such as OFRS, random and periodic audits and ad hoc visits

j. ***Quality Management Coordinator** who is an Arizona-licensed registered nurse, physician or physician's assistant or a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers. The QM Coordinator must have experience in quality management and quality improvement.

The primary functions of the Quality Management Coordinator position are:

- Ensure individual and systemic quality of care
- Integrate quality throughout the organization
- Implement process improvement
- Resolve, track and trend quality of care grievances
- Ensure a credentialed provider network

k. **Performance/Quality Improvement Coordinator** who has a minimum qualification as a CPHQ or CHCQM or comparable education and experience in data and outcomes measurement.

The primary functions of the Performance/Quality Improvement Coordinator are:

- Focus organizational efforts on improving clinical quality performance measures
- Develop and implement performance improvement projects
- Utilize data to develop intervention strategies to improve outcomes
- Report quality improvement/performance outcomes

l. ***Maternal Health/EPSTD (child health) Coordinator** who is an Arizona licensed nurse, physician or physician's assistant; or have a Master's degree in health services, public health, health care administration or other related field, and/or a CPHQ or CHCQM. Staffing under this position should be sufficient to meet quality and performance measure goals.

The primary functions of the MCH/EPSTD Coordinator are:

- Ensuring receipt of EPSTD services
- Ensuring receipt of maternal and postpartum care
- Promoting family planning services
- Promoting preventive health strategies
- Identification and coordination assistance for identified member needs
- Interface with community partners

m. ***Medical Management Coordinator** who is an Arizona licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations; or have a Master's degree in health services, health care administration, or business administration if not required to make medical necessity determination, who manages all required Medicaid management requirements under AHCCCS policies, rules, and contract.

The primary functions of the Medical Management Coordinator are:

- Ensure adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria
- Ensure appropriate concurrent review and discharge planning of inpatient stays is conducted
- Develop, implement and monitor the provision of 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
- Monitor prior authorization functions and assure that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards.

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- n. ***Behavioral Health Coordinator** who shall be a behavioral health professional as described in Health Services Rule R9-20. The Behavioral Health Coordinator shall devote sufficient time to ensure that the Contractor's behavioral health referral and coordination activities are implemented per AHCCCS requirements.

The primary functions of the Behavioral Health Coordinator are:

- Coordinate member behavioral care needs with the RBHA system
 - Develop processes to coordinate behavioral health care between PCPs and RBHAs
 - Participate in the identification of best practices for behavioral health in a primary care setting
 - Coordinate behavioral care with medically necessary services
- o. **Member Services Manager** who shall coordinate communications with members; serve in the role of member advocate; coordinate issues with appropriate areas within the organization; resolve member inquiries/problems and meet standards for resolution, telephone abandonment rates and telephone hold times.
- p. ***Provider Services Manager** and staff to coordinate communications between the Contractor and its subcontractors. There shall be sufficient Provider Services staff to enable providers to receive prompt resolution to their problems or inquiries and appropriate education about participation in the AHCCCS program and maintain a sufficient provider network.
- q. **Claims Administrator** to develop, implement and administer a comprehensive claims processing system capable of paying claims in accordance with state and federal requirements.

The primary functions of the Claims Administrator are:

- Develop and implement claims processing systems capable of paying claims in accordance with state and federal requirements
 - Develop processes for cost avoidance
 - Ensure minimization of claims recoupments
 - Meet claims processing timelines
 - Meet AHCCCS encounter reporting requirements
- r. ***Provider Claims Educator** (full-time equivalent employee for a Contractor with over 100,000 members) The position is fully integrated with the Contractor's grievance, claims processing, and provider relations systems and facilitates the exchange of information between these systems and providers

The primary functions of the Provider Claims Educator are:

- Educate contracted and non-contracted providers (i.e.: professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available Contractor resources such as provider manuals, website, fee schedules, etc.
- Interfaces with the Contractor's call center to compile, analyze, and disseminate information from provider calls
- Identifies trends and guides the development and implementation of strategies to improve provider satisfaction
- Frequently communicates (i.e.: telephonic and on-site) with providers to assure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices

Additional Required Staff

- s. **Prior Authorization staff** to authorize health care 24 hours per day, 7 days per week. This staff shall include an Arizona-licensed nurse, physician or physician's assistant. The staff will work under the direction of an Arizona-licensed registered nurse, physician, or physician's assistant.
- t. ***Concurrent Review staff** to conduct inpatient concurrent review. This staff shall consist of an Arizona-licensed nurse, physician, or physician's assistant. The staff will work under the direction of an Arizona-licensed registered nurse, physician, or physician's assistant.
- u. ***Clerical and Support staff** to ensure proper functioning of the Contractor's operation.
- v. **Member Services staff** There shall be sufficient Member Service staff to enable members to receive prompt resolution of their inquiries/problems.

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- w. ***Provider Services staff** There shall be sufficient Provider Services staff to enable providers to receive prompt responses and assistance (See Section D, Paragraph 29, Network Management, for more information).
- x. **Claims Processing staff** There shall be sufficient, appropriately trained, Claim Processing staff to ensure the timely and accurate processing of original claims, resubmissions and overall adjudication of claims.
- y. **Encounter Processing staff** There shall be sufficient, appropriately trained, Encounter Processing staff to ensure the timely and accurate processing and submission to AHCCCS of encounter data and reports.

The Contractor must submit to the Division of Health Care Management the following items annually by October 15:

1. An organization chart complete with the "**key staff**" positions. The chart must include the person's name, title and telephone number and portion of time allocated to each Medicaid contract and other lines of business.
2. A functional organization chart of the key program areas, responsibilities and the areas which report to that position.
3. A listing of all functions and their locations; and a list of any functions that have moved outside of the State of Arizona in the past contract year.

Staff Training and Meeting Attendance

The Contractor shall ensure that all staff members have appropriate training, education, experience and orientation to fulfill the requirements of the position. AHCCCS may require additional staffing for a Contractor that has substantially failed to maintain compliance with any provision of this contract and/or AHCCCS policies.

The Contractor must provide initial and ongoing staff training that includes an overview of AHCCCS; AHCCCS Policy and Procedure Manuals; Contract requirements and State and Federal requirements specific to individual job functions. The Contractor shall ensure that all staff members having contact with members or providers receive initial and ongoing training with regard to the appropriate identification and handling of quality of care/service concerns.

New and existing transportation, prior authorization and member services representatives must be trained in the geography of any/all GSA(s) in which the Contractor holds a contract and have access to mapping search engines (e.g. MapQuest, Yahoo Maps, Google Maps, etc) for the purposes of authorizing services in; recommending providers in; and transporting members to, the most geographically appropriate location.

The Contractor shall provide the appropriate staff representation for attendance and participation in meetings and/or events scheduled by AHCCCS. All meetings shall be considered mandatory unless otherwise indicated.

17. WRITTEN POLICIES, PROCEDURES AND JOB DESCRIPTIONS

The Contractor shall develop and maintain written policies, procedures and job descriptions for each functional area of its plan, consistent in format and style. The Contractor shall maintain written guidelines for developing, reviewing and approving all policies, procedures and job descriptions. All policies and procedures shall be reviewed at least bi-annually to ensure that the Contractor's written policies reflect current practices. Reviewed policies shall be dated and signed by the Contractor's appropriate manager, coordinator, director or administrator. Minutes reflecting the review and approval of the policies by an appropriate committee are also acceptable documentation. All medical and quality management policies must be approved and signed by the Contractor's Medical Director. Job descriptions shall be reviewed at least bi-annually to ensure that current duties performed by the employee reflect written requirements.

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Based on provider or member feedback, if AHCCCS deems a Contractor policy or process to be inefficient and/or place unnecessary burden on the members or providers, the Contractor will be required to work with AHCCCS to change the policy or procedure within a time period specified by AHCCCS.

18. MEMBER INFORMATION

The Contractor shall be accessible by phone for general member information during normal business hours. All enrolled members will have access to a toll free phone number. All informational materials, prepared by the Contractor, shall be approved by AHCCCS prior to distribution to members. The reading level and name of the evaluation methodology used should be included. The Contractor should refer to the ACOM *Member Information Policy* for further information and requirements.

All materials shall be translated when the Contractor is aware that a language is spoken by 3,000 or 10%, whichever is less, of the Contractor's members, who also have limited English proficiency (LEP).

All vital materials shall be translated when the Contractor is aware that a language is spoken by 1,000 or 5%, whichever is less, of the Contractor's members, who also have LEP. Vital materials must include, at a minimum, Notices of Action, vital information from the member handbooks and consent forms.

All written notices informing members of their right to interpretation and translation services in a language shall be translated when the Contractor is aware that 1,000 or 5%, whichever is less, of the Contractor's members speak that language and have LEP [42 CFR 438.10(c)(3)].

Oral interpretation services must be available and free of charge to all members regardless of the prevalence of the language. The Contractor must notify all members of their right to access oral interpretation services and how to access them. Refer to the ACOM *Member Information Policy* [42 CFR 438.10(c)(4) and (5)].

The Contractor shall make every effort to ensure that all information prepared for distribution to members is written using an easily understood language and format and as further described in the AHCCCS *Member Information Policy*. Regardless of the format chosen by the Contractor, the member information must be printed in a type, style and size, which can easily be read by members with varying degrees of visual impairment. The Contractor must notify its members that alternative formats are available and how to access them [42 CFR 438.10(d)].

When there are program changes, notification shall be provided to the affected members at least 30 days before implementation.

The Contractor shall produce and provide the following printed information to each member/representative or household within 12 business days of receipt of notification of the enrollment date [42 CFR 438.10(f)(3)]:

- I. A member handbook which, at a minimum, shall include the items listed in the ACOM *Member Information Policy*.

The Contractor shall review and update the Member Handbook at least once a year. The handbook must be submitted to AHCCCS, Division of Health Care Management for approval within four weeks of receiving the annual renewal amendment and upon any changes prior to distribution.

- II. A description of the Contractor's provider network, which at a minimum, includes those items listed in the ACOM *Member Information Policy*.

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The Contractor must give written notice about termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each member who received their primary care from, or is seen on a regular basis by, the terminated provider. Affected members must be informed of any other changes in the network 30 days prior to the implementation date of the change [42 CFR 438.10(f)(4) and (5)]. The Contractor shall have information available for potential enrollees as described in the *ACOM Member Information Policy*.

The Contractor must develop and distribute, at a minimum, semi-annual newsletters during the contract year. The following types of information are to be contained in the newsletter:

- Educational information on chronic illnesses and ways to self-manage care
- Reminders of flu shots and other prevention measures at appropriate times
- Medicare Part D issues
- Cultural Competency, other than translation services
- Contractor specific issues (in each newsletter)
- Tobacco cessation information
- HIV/AIDS testing for pregnant women
- Other information as required by AHCCCS

The Contractor shall ensure compliance with any applicable Federal and State laws that pertain to member rights and ensure that its staff and subcontractors take those rights into account when furnishing services to members.

The Contractor shall ensure that each member is guaranteed the right to request and receive one copy of the member's medical record at no cost to the member and to request that the record be amended or corrected, as specified in 45 CFR Part 164.

The Contractor shall ensure that each member is free to exercise their rights and that the exercise of those rights does not adversely affect the way the Contractor or its subcontractors treat the member [42 CFR 438.100(c)]

The Contractor will, on an annual basis, inform all members of their right to request the following information [42 CFR 438.10(f)(6) and 42 CFR 438.100(a) (1) and (2)]:

- a. An updated member handbook at no cost to the member
- b. The network description as described in the *ACOM Member Information Policy*

This information may be sent in a separate written communication or included with other written information such as in a member newsletter.

19. SURVEYS

The Contractor may be required to perform its own annual general or focused member survey. All such Contractor surveys, along with a timeline for the project, shall be approved in advance by AHCCCS. The results and the analysis of the results shall be submitted to the AHCCCS, Division of Health Care Management, Acute Care Operations Unit within 45 days of the completion of the project. AHCCCS may require inclusion of certain questions.

For non AHCCCS required surveys, the Contractor shall provide AHCCCS notification 15 days prior to conducting any Contractor initiated member or provider survey. The notification must include a project scope statement, project timeline and a copy of the survey. The results and the analysis of the results of any Contractor initiated surveys shall be submitted to the Acute Care Operations Unit within 45 days of the completion of the project.

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AHCCCS may periodically conduct surveys of a representative sample of the Contractor's membership and providers. AHCCCS will consider suggestions from the Contractor for questions to be included in each survey. The results of these surveys, conducted by AHCCCS, will become public information and available to all interested parties on the AHCCCS website. The draft reports from the surveys will be shared with the Contractor prior to finalization. The Contractor will be responsible for reimbursing AHCCCS for the cost of these survey based on its share of AHCCCS enrollment.

At least quarterly, the Contractor is required to survey a sample of its membership that have received services to verify that services the Contractor paid for were delivered as outlined in the ACOM Policy 424 (Verification of Receipt of Services) [42 CFR 455.201].

20. CULTURAL COMPETENCY

The Contractor shall have a Cultural Competency Plan which meets the requirements of the ACOM *Cultural Competency Policy*. An annual assessment of the effectiveness of the plan, along with any modifications to the plan, must be submitted to the Division of Health Care Management, no later than 45 days after the start of each contract year. This plan should address all services and settings [42 CFR 438.206(c)(2)].

The Contractor shall ensure compliance with the Cultural Competency Plan and all requirements pertaining to Limited English Proficiency.

21. MEDICAL RECORDS

The member's medical record is the property of the provider who generates the record. Each member is entitled to one copy of his or her medical record free of charge annually. The Contractor shall have written policies and procedures to maintain the confidentiality of all medical records.

The Contractor is responsible for ensuring that a medical record is established when information is received about a member. If the PCP has not yet seen the member, such information may be kept temporarily in an appropriately labeled file, in lieu of establishing a medical record, but must be associated with the member's medical record as soon as one is established.

The Contractor shall have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information.

The Contractor shall have written standards for documentation on the medical record for legibility, accuracy and plan of care, which comply with the *AMPM*.

The Contractor shall have written plans for providing training and evaluating providers' compliance with the Contractor's medical records standards. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and which facilitates an adequate system for follow-up treatment. Medical records must be legible, signed and dated.

When a member changes PCPs, his or her medical records or copies of medical records must be forwarded to the new PCP within 10 business days from receipt of the request for transfer of the medical records.

AHCCCS is not required to obtain written approval from a member, before requesting the member's medical record from the PCP or any other agency. The Contractor may obtain a copy of a member's medical records without written approval of the member, if the reason for such request is directly related to the administration of the AHCCCS program. AHCCCS shall be afforded access to all members' medical records whether electronic or paper within 20 business days of receipt of request.

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Information related to fraud and abuse may be released so long as protected HIV-related information is not disclosed (A.R.S. §36-664(I)).

22. ADVANCE DIRECTIVES

The Contractor shall maintain policies and procedures addressing advanced directives for adult members that specify [42 CFR 422.128]:

1. Each contract or agreement with a hospital, nursing facility, home health agency, hospice or organization responsible for providing personal care, must comply with Federal and State law regarding advance directives for adult members [42 CFR 438.6(i)(1)]. Requirements include:
 - a) Maintaining written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care, and the right to execute an advance directive. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. (A health care provider is not prohibited from making such objection when made pursuant to A.R.S. § 36-3205.C.1.)
 - b) Provide written information to adult members regarding each individual's rights under State law to make decisions regarding medical care, and the health care provider's written policies concerning advance directives (including any conscientious objections) [42 CFR 438.6(i)(3)].
 - c) Documenting in the member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed.
 - d) Not discriminating against a member because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care.
 - e) Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advanced directives executed by members to whom they are assigned to provide services.
2. Contractors shall require subcontracted PCPs, which have agreements with the entities described in paragraph 1 above, to comply with the requirements of subparagraphs 1 (a) through (e) above. Contractors shall also encourage health care providers specified in subparagraph a. to provide a copy of the member's executed advanced directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record.
3. The Contractor shall provide written information to adult members that describe the following:
 - a) A member's rights under State law, including a description of the applicable State law.
 - b) The organization's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
 - c) The member's right to file complaints directly with AHCCCS.
 - d) Changes to State law as soon as possible, but no later than 90 days after the effective date of the change [42 CFR 438.6(i)(4)].

23. QUALITY MANAGEMENT (QM)

The Contractor shall provide quality medical care and services to members, regardless of payer source or eligibility category. The Contractor shall promote improvement in the quality of care provided to enrolled members through established quality management and performance improvement processes. The Contractor shall execute processes to assess, plan, implement and evaluate quality management and performance improvement activities, as specified in the AMPM [42 CFR 438.240(a)(1) and (e)(2)].

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The Contractor must ensure that the Quality Management/Quality Improvement Unit within the organizational structure is separate and distinct from any other units or departments such as Medical Management. Contractors are expected to integrate quality management processes, such as tracking and trending of issues through all areas of the organization, with ultimate responsibility for quality management/quality improvement residing within the Quality Management Unit.

The Contractor quality assessment and performance improvement programs, at a minimum, shall comply with the requirements outlined in the AMPM and this Paragraph.

A. Quality Management Program:

The Contractor shall have an ongoing quality management program for the services it furnishes to members that includes the requirements listed in AMPM Chapter 900 and the following:

1. A written Quality Assessment and Performance Improvement (QA/PI) plan, an evaluation of the previous year's QA/PI program, and Quality Management Quarterly reports that address its strategies for performance improvement and conducting the quality management activities.
2. QM/PI Program monitoring and evaluation activities that includes Peer Review and Quality Management Committees chaired by the Contractor's Chief Medical Officer.
3. Protection of medical records and any other personal health and enrollment information that identifies a particular member or subset of members in accordance with Federal and State privacy requirements.
4. Member rights and responsibilities.
5. Uniform provisional credentialing, initial credentialing, re-credentialing and organizational credential verification [42 CFR 438.206(b)(6)]. The Contractor shall demonstrate that its providers are credentialed and reviewed through the Contractor's Credentialing Committee that is chaired by the Contractor's Medical Director [42 CFR 438.214]. The Contractor should refer to the AM/PM and Attachment F, Periodic Report Requirements, for reporting requirements. The process:
 - a. Shall follow a documented process for provisional credentialing, initial credentialing, re-credentialing and organizational credential verification of providers who have signed contracts or participation agreements with the Contractor;
 - b. Shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;
 - c. Shall not employ or contract with providers excluded from participation in Federal health care programs.
6. Tracking and trending of member and provider issues, which includes investigation and analysis of quality of care issues, abuse, neglect and unexpected deaths. The resolution process must include:
 - a. Acknowledgement letter to the originator of the concern;
 - b. Documentation of all steps utilized during the investigation and resolution process;
 - c. Follow-up with the member to assist in ensuring immediate health care needs are met;
 - d. Closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of their issue, any responsibilities they have in ensuring all covered, medically necessary care needs are met, and a Contractor contact name/telephone number to call for assistance or to express any unresolved concerns;
 - e. Documentation of implemented corrective action plan(s) or action(s) taken to resolve the concern;
 - f. Analysis of the effectiveness of the interventions taken.
7. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.
8. Participation in community initiatives including applicable activities of the Medicare Quality Improvement Organization (QIO).
9. Performance improvement programs including performance measures and performance improvement projects.

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B. Performance Improvement:

The Contractor's quality management program shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in the areas of clinical care and non-clinical care that are expected to have a favorable effect on health outcomes and member satisfaction. The Contractor must [42 CFR 438.240(b)(2) and (c)]:

1. Measure and report to the State its performance, using standard measures required by the State, or as required by CMS;
2. Submit to the State data specified by the State, that enables the State to measure the Contractor's performance; or
3. Perform a combination of the activities.

I. Performance Measures:

The Contractor shall comply with AHCCCS quality management requirements to improve performance for all AHCCCS established performance measures. Complete descriptions of the AHCCCS clinical quality Performance Measure can be found in the most recently published reports of acute-care performance measures located on the AHCCCS website except the performance measure titled "EPSDT Participation". AHCCCS bases the measurement of EPSDT Participation on the methodology established in CMS "Form 416" which can be found on the AHCCCS website (<http://www.azahcccs.gov/reporting/quality/performanceasures.aspx>).

Contractors must comply with national performance measures and levels that may be identified and developed by the Centers for Medicare and Medicaid Services in consultation with AHCCCS and/or other relevant stakeholders. CMS has been working in partnership with states in developing core performance measures for Medicaid and CHIP programs. The current AHCCCS-established performance measures may be subject to change when these core measures are finalized and implemented.

AHCCCS intends to implement a hybrid methodology for collecting and reporting Performance Measure rates, as allowed by NCQA, for selected HEDIS measures. Contractors shall collect data from medical records and provide these data with supporting documentation, as instructed by AHCCCS, for each hybrid measure as requested. The number of records that each Contractor will be required to collect will be based on HEDIS sampling guidelines and may be affected by the Contractor's previous rate for the measure being collected. AHCCCS may begin implementation of the hybrid methodology with the following measures: Adolescent Immunizations and Timeliness of Prenatal Care. AHCCCS may implement hybrid methodology for collecting and reporting additional measures in future contract years.

The Contractor must have in place a process for internal monitoring of Performance Measure rates, using a standard methodology established or adopted by AHCCCS, for each required Performance Measure. The Contractor's Quality Assessment/Performance Improvement Program will report its performance on an ongoing basis to its Administration. It also will report this Performance Measure data to AHCCCS in conjunction with its Quarterly EPSDT Improvement and Adult Quarterly Monitoring Report.

The Contractor must meet AHCCCS stated Minimum Performance Standards for each population/eligibility category for which AHCCCS reports results. However, it is equally important that the Contractor continually improve performance measure outcomes from year to year. The Contractor shall strive to meet the goal established by AHCCCS.

Minimum Performance Standard – A Minimum Performance Standard (MPS) is the minimal expected level of performance by the Contractor. If a Contractor does not achieve this standard, the Contractor will be required to submit a corrective action plan and may be subject to a sanction of up to \$100,000 dollars for each deficient measure.

Goal – If the Contractor has already met or exceeded the AHCCCS Minimum Performance Standard for any measure, the Contractor must strive to meet the established Goal for the measure(s). However, it is equally important that the Contractor continually improve performance measure outcomes from year to year.

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A Contractor must show demonstrable and sustained improvement toward meeting AHCCCS Performance Standards. AHCCCS may impose sanctions on Contractors that do not show statistically significant improvement in a measure rate and require the Contractor to demonstrate that they are allocating increased administrative resources to improving rates for a particular measure or service area. AHCCCS also may require a corrective action plan and may sanction any Contractor that shows a statistically significant decrease in its rate, even if it meets or exceeds the Minimum Performance Standard.

An evidence-based corrective action plan must be received by AHCCCS within 30 days of receipt of notification of the deficiency from AHCCCS. This plan must be approved by AHCCCS prior to implementation. AHCCCS may conduct one or more follow-up on-site reviews to verify compliance with a corrective action plan.

All Performance Measures apply to all member populations [42 CFR 438.240(a)(2), (b)(2) and (c)]. AHCCCS may analyze and report results by line of business, by GSA or county, and/or applicable demographic factors.

AHCCCS has established standards for the measures listed below.

The following table identifies the Minimum Performance Standards (MPS) and Goals for each measure:

Acute-care Contractor Performance Standards

<u>Performance Measure</u>	<u>Minimum Performance Standard</u>	<u>Goal (Healthy People Goals)</u>
Immunization of Two-year-olds		
4:3:1:3:3:1 Series	74%	80%
4:3:1:3:3:1:4 Series	68%	80%
DTaP — 4 doses	85%	90%
Polio — 3 doses (*)	90%	90%
MMR — 1 dose (*)	90%	90%
Hib — 3 doses (*)	86%	90%
HBV — 3 doses (*)	90%	90%
Varicella — 1 dose (*)	86%	90%
PCV — 4 doses (*)	82%	90%
Adolescent Immunizations(1)	54%	90%
Children's Dental Visits 2 to 21 Years	57%	57%
Well-child Visits 15 Months	65%	90%
Well-child Visits 3 - 6 Years	66%	80%
Adolescent Well-care Visits	42%	50%
Children's Access to PCPs 12-24 Months	93%	97%
Children's Access to PCPs 25 months-6 Years	83%	97%
Children's Access to PCPs 7-11 Years	83%	97%

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Performance Measure	Minimum Performance Standard	Goal (Healthy People Goals)
Children's Access to PCPs 12-19 Years	81%	97%
Timeliness of Prenatal Care	80%	90%
Appropriate Medications for Asthma (2)	86%	93%
Diabetes Care: Hb A1c Testing (2)	77%	89%
Diabetes Care: Eye Exam (2)	49%	68%
Diabetes Care: LDL-C Screening (2)	70%	91%
EPSDT Participation	68%	80%
EPSDT Dental Participation — Medicaid (2)	46%	54%
EPSDT Dental Participation — KidsCare (2)	52%	60%

Notes:

Rates by Contractor for each measure will be compared with the MPS specified in the contract in effect during the measurement period. Thus, Performance Standards in the CYE 2012 contract apply to results calculated by AHCCCS based on the measurement period of CYE 2012.

Contractor Performance is evaluated annually on the AHCCCS-reported rate for each measure. Rates for measures that include only members less than 21 years of age are reported and evaluated separately for Title XIX and Title XXI eligibility groups.

The MPS is based on the most recent national HEDIS Medicaid mean reported by NCQA that is available or, if the most recent AHCCCS statewide average is greater than the national Medicaid mean, the MPS is based on the AHCCCS statewide average for Medicaid members.

Goals are based on Healthy People 2010 Objectives; if there was no comparable objective set for a particular measure, the most recent HEDIS 90th percentile rate for Medicaid plans nationally was used as the benchmark.

- (*) AHCCCS will continue to measure and report results of these individual antigens; however, a Contractor may not be held accountable for specific Performance Standards unless AHCCCS determines that completion of a specific antigen or antigens is affecting overall completion of the childhood immunization series.
- (1) NCQA introduced a new measure of adolescent immunizations in HEDIS 2010, and national HEDIS and AHCCCS results for this measure have not been reported. The MPS is based on the National Immunization Survey (NIS) overall rate of 53.8 percent for one dose of meningococcal vaccine among 13-year-olds in 2009 (the rate for at least one dose of Td or Tdap was 70.5 percent).

The Contractor shall participate in immunization audits, at intervals specified by AHCCCS, based on random sampling to verify the immunization status of members at 24 months of age and by 13 years of age. If records are missing for more than 5 percent of the Contractor's final sample, the Contractor is subject to sanctions by AHCCCS. An External Quality Review Organization (EQRO) may conduct a study to validate the Contractor's reported rates.

In addition, AHCCCS will measure and report the Contractor's EPSDT Participation Rate, utilizing the CMS 416 methodology. The Contractor must take affirmative steps to increase EPSDT Participation rates, including the EPSDT Dental Participation Rate.

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The Contractor must monitor rates for postpartum visits and low/very low birth weight deliveries and implement interventions as necessary to improve or sustain these rates. These activities will be monitored by AHCCCS during the Operational and Financial Review.

II. Performance Improvement Program:

The Contractor shall have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas as specified in the AMPM, and that involve the following [42 CFR 438.240(b)(1) and (d)(1)]:

- 1. Measurement of performance using objective quality indicators
- 2. Implementation of system interventions to achieve improvement in quality
- 3. Evaluation of the effectiveness of the interventions
- 4. Planning and initiation of activities for increasing or sustaining improvement

PIPs are mandated by AHCCCS, but Contractors may self-select additional projects based on opportunities for improvement identified by internal data and information. The Contractor shall report the status and results of each project to AHCCCS as requested using the AHCCCS PIP Reporting Template included in the AMPM. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year [42 CFR 438.240(d)(2)].

III. Data Collection Procedures:

When requested, the Contractor must submit data for standardized Performance Measures and/or Performance Improvement Projects as required by AHCCCS within specified timelines and according to AHCCCS procedures for collecting and reporting the data. The Contractor is responsible for collecting valid and reliable data and using qualified staff and personnel to collect the data. Data collected for Performance Measures and/or Performance Improvement Projects must be returned by the Contractor in the format and according to instructions from AHCCCS, by the due date specified. Any extension for additional time to collect and report data must be made in writing in advance of the initial due date and is subject to approval by AHCCCS. Failure to follow the data collection and reporting instructions that accompany the data request may result in sanctions imposed on the Contractor.

24. MEDICAL MANAGEMENT (MM)

The Contractor shall execute processes to assess, plan, implement, evaluate, and as mandated, report medical management monitoring activities. This shall include the Quarterly Inpatient Hospital Showings report, HIV Specialty Provider List, Transplant Report and Prior Authorization Requirements report as specified in the AMPM and Attachment F of this contract. The Contractor shall evaluate Medical Management (MM) activities, as specified in the AMPM Chapter 1000, including, but not limited to, the following:

- 1. Pharmacy Management; including the evaluation, reporting, analysis and interventions based on the data and reported through the MM Committee, which is chaired by the Contractor's Chief Medical Officer.
- 2. Prior authorization and Referral Management.

For the processing of requests for initial and continuing authorizations of services the Contractor shall:

- a) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;
 - b) Consult with the requesting provider when appropriate [42 CFR 438.210(b)(2)];
 - c) Monitor and ensure that all enrollees with special health care needs have direct access to care.
- 3. Development and/or Adoption of Practice Guidelines [42 CFR 438.236(b)]: that
 - a) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
 - b) Consider the needs of the Contractor's members;

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- c) Are adopted in consultation with contracting health care professionals;
 - d) Are reviewed and updated periodically as appropriate;
 - e) Are disseminated by the Contractor to all affected providers and, upon request, to enrollees and potential enrollees [42 CFR 438.236(c)];
 - f) Provide a basis for consistent decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply [42 CFR 438.236(d)].
4. Concurrent review:
- a) Consistent application of review criteria; Provide a basis for consistent decisions for utilization management, coverage of services, and other areas to which the guidelines apply;
 - b) Discharge planning.
5. Continuity and coordination of care;
6. Monitoring and evaluation of over and/or under utilization of services [42 CFR 438-240(b)(3)]
7. Evaluation of new medical technologies, and new uses of existing technologies;
8. Disease Management or Chronic Care Program that reports results and provides for analysis of the program through the MM Committee; and
9. The Contractor must review all prior authorization requirements for services, items, or medications and submit a report to AHCCCS providing the rationale for the requirements within the term of this contract.

The Contractor shall have a process to report MM data and management activities through a MM Committee. The Contractor's MM committee will analyze the data, make recommendations for action, monitor the effectiveness of actions and report these findings to the committee. The Contractor shall have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs [42 CFR 438.240(b)(4)].

The Contractor will assess, monitor and report quarterly through the MM Committee medical decisions to assure compliance with timeliness, language, Notice of Action intent, and that the decisions comply with all Contractor coverage criteria. This includes quarterly evaluation of all Notice of Action decisions that are made by a subcontracted entity.

The Contractor shall maintain a written MM plan and workplan that address the monitoring of MM activities (AMPM Chapter 1000). The plan and workplan must be submitted for review by AHCCCS Division of Health Care Management (DHCM) within timelines specified in Attachment F.

In addition to care coordination as specified in this contract, the Contractor must proactively provide care coordination for members who have multiple complaints regarding services or the AHCCCS Program. This includes, but is not limited to, members who do not meet the Contractor's criteria for case management as well as members who contact governmental entities for assistance, including AHCCCS.

25. ADMINISTRATIVE PERFORMANCE STANDARDS

This paragraph contains requirements for the Contractor's Member Services, Provider Services and Claims Services telephonic performance; as well as the measurement of credentialing timeliness. All reported data is subject to validation through periodic audit and/or Operational and Financial Review.

Telephone Standards

The maximum allowable speed of answer (SOA) is 45 seconds. The SOA is defined as the on line wait time in seconds that the member/provider waits from the moment the call is connected in the Contractor's phone switch until the call is picked up by a Contractor representative or Interactive Voice Recognition System (IVR). If the Contractor has IVR capabilities, callers must be given the choice of completing their call by IVR or by Contractor representative.

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The Contractor shall meet the following standards for its member services and centralized provider telephone line statistics. All calls to the line shall be included in the measure.

- a. The Monthly Average Abandonment Rate shall be 5% or less;
- b. First Contact Call Resolution shall be 70% or better; and
- c. The Monthly Average Service Level shall be 75% or better.

The Monthly Average Abandonment Rate (AR) is:

$$\frac{\text{Number of calls abandoned in a 24-hour period}}{\text{Total number of calls received in a 24-hour period}}$$

The ARs are then summed and divided by the number of days in the reporting period.

First Contact Call Resolution Rate (FCCR) is:

$$\frac{\text{Number of calls received in 24-hour period for which no follow up communication or internal phone transfer is needed, divided by Total number of calls received in 24-hour period}}{\text{Total number of calls received in 24-hour period}}$$

The daily FCCRs are then summed and divided by the number of days in the reporting period.

The Monthly Average Service Level (MASL) is:

$$\frac{\text{Calls answered within 45 seconds for the month reported}}{\text{Total of month's answered calls + month's abandoned calls + (if available) month's calls receiving a busysignal}}$$

Note: Do **not** use average daily service levels divided by the days in the reporting period.

On a monthly basis the measures are to be reported for both the Member Services and Provider telephone lines. For each of the Administrative Measures a through c., the Contractor shall also report the number of days in the reporting period that the standard was not met. The Contractor shall include in the report the instances of down time for the centralized telephone lines, the dates of occurrence and the length of time they were out of service. The reports should be sent to the Contractor's assigned Operations and Compliance Officer in the Acute Care Operations Unit of the Division of Health Care Management. The deadline for submission of the reports is the 15th day of the month following the reporting period (or the first business day following the 15th). Back up documentation for the report, to the level of measured segments in the 24-hour period, shall be retained for a rolling 12-month period. AHCCCS may review the performance measure calculation procedures and source data for this report.

Credentialing Timeliness

The Contractor is required to process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing a Contractor will divide the number of complete applications processed (approved/denied) during the time period by the number of complete applications that were received during the time period, as follows:

$$\frac{\text{Complete applications processed}}{\text{Complete applications received}}$$

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The standards for processing are listed by category below:

Type of Credentialing	14 days	90 days	120 days	180 days
Provisional	100%			
Initial		90%	95%	100%

The Contractor will also report the following information with regard to all credentialing applications on a quarterly basis, as specified in Attachment F, Periodic Report Requirements:

1. Number of applications received
2. Number of completed applications received (separated by type: provisional, initial)
3. Number of completed provisional credentialing applications approved
4. Number of completed provisional credentialing applications denied
5. Number of initial credentialing applications approved
6. Number of initial credentialing applications denied
7. Number of initial (include provisional in this number) applications processed within 90, 120, 180 days

26. GRIEVANCE SYSTEM

The Contractor shall have in place a written grievance system process for subcontractors, enrollees and non-contracted providers, which define their rights regarding disputed matters with the Contractor. The Contractor's grievance system for enrollees includes a grievance process (the procedures for addressing enrollee grievances), an appeals process and access to the state's fair hearing process. The Contractor shall provide the appropriate personnel to establish implement and maintain the necessary functions related to the grievance systems process. Refer to Attachments H (1) and H (2) for *Enrollee Grievance System* and *Provider Grievance System Standards and Policy*, respectively.

The Contractor may delegate the grievance system process to subcontractors, however, the Contractor must ensure that the delegated entity complies with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. The Contractor shall remain responsible for compliance with all requirements. The Contractor shall also ensure that it timely provides written information to both enrollees and providers, which clearly explains the grievance system requirements. This information must include a description of: the right to a state fair hearing, the method for obtaining a state fair hearing, the rules that govern representation at the hearing, the right to file grievances, appeals and claim disputes, the requirements and timeframes for filing grievances, appeals and claim disputes, the availability of assistance in the filing process, the toll-free numbers that the enrollee can use to file a grievance or appeal by phone, that benefits will continue when requested by the enrollee in an appeal or state fair hearing request concerning certain actions which are timely filed, that the enrollee may be required to pay the cost of services furnished during the appeal/hearing process if the final decision is adverse to the enrollee, and that a provider may file an appeal on behalf of an enrollee with the enrollee's written consent. Information to enrollees must meet cultural competency and limited English proficiency requirements as specified in Section D, Paragraph 18, Member Information, and Section D, Paragraph 20, Cultural Competency.

The Contractor shall be responsible to provide the necessary professional, paraprofessional and clerical services for the representation of the Contractor in all issues relating to the grievance system and any other matters arising under this contract which rise to the level of administrative hearing or a judicial proceeding. Unless there is an agreement with the State in advance, the Contractor shall be responsible for all attorney fees and costs awarded to the claimant in a judicial proceeding.

The Contractor will provide reports on the Grievance System as required in the Grievance System Reporting Guide available on the AHCCCS website.

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27. NETWORK DEVELOPMENT

The Contractor shall develop and maintain a provider network that is designed to support a medical home for members and sufficient to provide all covered services to AHCCCS members [42 CFR 438.206(b)(1)]. It shall ensure covered services are provided promptly and are reasonably accessible in terms of location and hours of operation [42 CFR 438.206(c)(1)(i) and (ii)]. There shall be sufficient personnel for the provision of covered services, including emergency medical care on a 24-hour-a-day, 7-days-a-week basis [42 CFR 438.206(c)(1)(iii)].

The network shall be sufficient to provide covered services within designated time and distance limits. For Maricopa and Pima Counties only, this includes a network such that 95% of its members residing within the boundary area of metropolitan Phoenix and Tucson do not have to travel more than 5 miles to visit a PCP, dentist or pharmacy. Additionally, a Contractor in Maricopa and/or Pima counties must have at least one contracted hospital in each of the service districts specified in Attachment B. In rural counties the contractor must have a sufficient network of physicians to provide adequate inpatient and outpatient services to the Contractor's members. For inpatient services Hospitalists may satisfy this requirement. See Attachment B for GSA specific requirements.

The Contractor is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network shall be designed to reflect the needs and service requirements of AHCCCS' culturally and linguistically diverse member population. The Contractor shall design their provider networks to maximize the availability of community based primary care and specialty care access and that reduces utilization of emergency services, one day hospital admissions, hospital based outpatient surgeries when lower cost surgery centers are available, and hospitalization for preventable medical problems. The Contractor must provide a comprehensive provider network that ensures its membership has access at least equal to community norms. Services shall be as accessible to AHCCCS members in terms of timeliness, amount, duration and scope as those services are available to non-AHCCCS persons within the same service area [42 CFR 438.210(a)(2)]. The Contractor is expected to consider the full spectrum of care when developing its network. The Contractor is encouraged to have available non-emergent after-hours physician or primary care services within its network. The Contractor must also consider communities whose residents typically receive care in neighboring states/border communities. If the Contractor is unable to provide any services locally, it must notify AHCCCS and shall provide reasonable alternatives for members to access care. These alternatives must be approved by AHCCCS. If the Contractor's network is unable to provide medically necessary services required under contract, the Contractor must adequately and timely cover these services through an out of network provider until a network provider is contracted. The Contractor and out of network provider must coordinate with respect to authorization and payment issues in these circumstances [42 CFR 438.206(b)(4) and (5)].

The Contractor must pay all AHCCCS registered Arizona Early Intervention Program (AzeIP) providers, regardless of their contract status with the Contractor, when Individual Family Service Plans identify and meet the requirement for medically necessary EPSDT covered services.

The Contractor is also encouraged to develop non-financial incentive programs to increase participation in its provider network.

AHCCCS is committed to workforce development and support of the medical residency and dental student training programs in the state of Arizona. AHCCCS expects the Contractor to support these efforts. AHCCCS encourages plans to contract with or otherwise support the many Graduate Medical Education (GME) Residency Training Programs currently operating in the state and to investigate opportunities for resident participation in Contractor medical management and committee activities. In the event of a contract termination between the Contractor and a Graduate Medical Education Residency Training Program or training site, the Contractor may not remove members from that program in such a manner as to harm the stability of the program. AHCCCS reserves the right to determine what constitutes risk to the program. If a Residency Training Program is in need of patients in order to maintain accreditation, AHCCCS may require a Contractor within the program's GSA to make members available to the program. Further, the Contractor must attempt to contract with graduating residents and providers that are opening new practices in, or relocating to, Arizona, especially in rural or underserved areas.

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The Contractor shall not discriminate with respect to participation in the AHCCCS program, reimbursement or indemnification against any provider based solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1)]. In addition, the Contractor must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)]. This provision, however, does not prohibit the Contractor from limiting provider participation to the extent necessary to meet the needs of the Contractor's members. This provision also does not interfere with measures established by the Contractor to control costs consistent with its responsibilities under this contract [42 CFR 438.12(b)(1)]. If a Contractor declines to include individual or groups of providers in its network, it must give the affected providers timely written notice of the reason for its decision [42 CFR 438.12(a)(1)]. The Contractor may not include providers excluded from participation in Federal health care programs, under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)].

See Attachment B, Minimum Network Requirements, for details on network requirements by Geographic Service Area.

Provider Network Development and Management Plan: The Contractor shall develop and maintain a provider network development and management plan, which ensures that the provision of covered services will occur as stated above. The requirements for the Network Development and Management Plan are found in the AHCCCS Contractor Operations Manual Policy 415, *Provider Network Development and Management Plan* [42 CFR 438.207(b)]. This plan shall be updated annually and submitted to AHCCCS, Division of Health Care Management, 45 days from the start of each contract year.

28. PROVIDER AFFILIATION TRANSMISSION

The Contractor must submit information quarterly regarding its provider network. This information must be submitted in the format described in the *Provider Affiliation Transmission User Manual* on October 15, January 15, April 15, and July 15 of each contract year. The manual may be found on the AHCCCS website. If the provider affiliation transmission is not timely, accurate and complete, the Contractor may be required to submit a corrective action plan and may be subject to sanction.

29. NETWORK MANAGEMENT

The Contractor shall have policies on how the Contractor will [42 CFR 438.214(a)]:

- a. Communicate with the network regarding contractual and/or program changes and requirements;
- b. Monitor network compliance with policies and rules of AHCCCS and the Contractor, including compliance with all policies and procedures related to the grievance/appeal process and ensuring the member's care is not compromised during the grievance/appeal process;
- c. Evaluate the quality of services delivered by the network;
- d. Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;
- e. Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English;
- f. Process expedited and temporary credentials;
- g. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;
- h. Provide training for its providers and maintain records of such training;
- i. Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;
- j. Ensure that provider calls are acknowledged within 3 business days of receipt, resolved and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from AHCCCS).

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Contractor policies shall be subject to approval by AHCCCS, Division of Health Care Management, and shall be monitored through operational audits.

Material Change to Operations and/or Provider Network

Operations: A material change to operations is defined as any change in overall business operations (i.e., policy, process, protocol, such as prior authorization or retrospective review) which affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance standards as described in this contract. It also includes any change that would impact more than 5% of total membership and/or provider network in a specific GSA.

The Contractor must submit the request for approval of a material change to operations, including draft notification to affected members and providers, 60 days prior to the expected implementation of the change. The request should contain, at a minimum, information regarding the nature of the operational change; the reason for the change; methods of communication to be used; and the anticipated effective date. If AHCCCS does not respond to the Contractor within 30 days; the request and the notices are deemed approved. A material change in Contractor operations requires 30 days advance written notice to affected providers and members. The requirements regarding material changes to operations do not extend to contract negotiations between the Contractor and a provider.

The Contractor may be required to conduct meetings with providers to address issues (or to provide general information, technical assistance, etc.) related to federal and state requirements, changes in policy, reimbursement matters, prior authorization and other matters as identified or requested by the AHCCCS.

Provider Network: All material changes in the Contractor's provider network must be approved in advance by AHCCCS, Division of Health Care Management. A material change to the provider network is defined as one which affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance and network standards as described in this contract. It also includes any change that would cause more than 5% of members in the GSA to change the location where services are received or rendered. The Contractor must submit the request for approval of a material change in their provider network, including draft notification to affected members, 60 days prior to the expected implementation of the change. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them. If AHCCCS does not respond within 30 days the request and the notice are deemed approved. A material change in the Contractor's provider network requires 30 days advance written notice to affected members. For emergency situations, AHCCCS will expedite the approval process.

The Contractor shall notify AHCCCS, Division of Health Care Management, within one business day of any unexpected changes that would impair its provider network [42 CFR 438.207 (c)]. This notification shall include (1) information about how the provider network change will affect the delivery of covered services, and (2) the Contractor's plans for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.

See Section D, Paragraph 55 regarding material changes by the Contractor that may impact capitation rates.

Contractors shall give hospitals and provider groups 90 days notice prior to a contract termination without cause. Contracts between the Contractor and single practitioners are exempt from this requirement.

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Homeless Clinics:

Contractors in Maricopa and Pima County must contract with homeless clinics at the AHCCCS Fee-for-Service rate for Primary Care services. Contracts must stipulate that:

1. Only those members that request a homeless clinic as a PCP may be assigned to them; and
2. Members assigned to a homeless clinic may be referred out-of-network for needed specialty services.

The Contractor must make resources available to assist homeless clinics with administrative issues such as obtaining Prior Authorization, and resolving claims issues.

AHCCCS will convene meetings, as necessary, with the Contractor and the homeless clinics to resolve administrative issues and perceived barriers to the homeless members receiving care. Representatives from the Contractor must attend these meetings.

E-Prescribing:

The Contractor must work in collaboration with the AHCCCS to implement E-Prescribing.

30. PRIMARY CARE PROVIDER STANDARDS

The Contractor shall include in its provider network a sufficient number of PCPs to meet the requirements of this contract. Health care providers designated by the Contractor as PCPs shall be licensed in Arizona as allopathic or osteopathic physicians who generally specialize in family practice, internal medicine, obstetrics, gynecology, or pediatrics; certified nurse practitioners or certified nurse midwives; or physician's assistants [42 CFR 438.206(b)(2)].

The Contractor shall assess the PCP's ability to meet AHCCCS appointment availability and other standards when determining the appropriate number of its members to be assigned to a PCP. The Contractor should also consider the PCP's total panel size (i.e., AHCCCS and non-AHCCCS patients) when making this determination. AHCCCS members shall not comprise the majority of a PCP's panel of patients. AHCCCS shall inform the Contractor when a PCP has a panel of more than 1,800 AHCCCS members (assigned by a single Contractor or multiple Contractors), to assist in the assessment of the size of their panel. This information will be provided on a quarterly basis. The Contractor will adjust the size of a PCP's panel, as needed, for the PCP to meet AHCCCS appointment and clinical performance standards.

The Contractor shall have a system in place to monitor and ensure that each member is assigned to an individual PCP and that the Contractor's data regarding PCP assignments is current. The Contractor is encouraged to assign members with complex medical conditions, who are age 12 and younger, to board certified pediatricians. PCP's, with assigned members diagnosed with AIDS or as HIV positive, shall meet criteria and standards set forth in the *AMPM*.

The Contractor shall ensure that providers serving EPSDT-aged members utilize AHCCCS-approved EPSDT Tracking forms and standardized developmental screening tools and are trained in the use of the tools. The Contractor is encouraged to assign EPSDT-aged members to providers that are trained in the use of, and have expressed willingness to use, AHCCCS-approved developmental screening tools.

The Contractor shall offer members freedom of choice within its network in selecting a PCP consistent with 42 CFR 438.6(m) and 438.52(d) and this contract. The Contractor may restrict this choice when a member has shown an inability to form a relationship with a PCP, as evidenced by frequent changes, or when there is a medically necessary reason. When a new member has been assigned to the Contractor, the Contractor shall inform the member in writing of his enrollment and of his PCP assignment within 10 days of the Contractor's receipt of notification of assignment by AHCCCS. The Contractor shall include with the enrollment notification a list of all the Contractor's available PCPs, the process for changing the PCP assignment, should the member desire to do so, as well as the information required in the *ACOM Member Information Policy*. The Contractor shall confirm any PCP change in writing to the member. Members may make both their initial PCP selection and any subsequent PCP changes either verbally or in writing.

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At a minimum, the Contractor shall hold the PCP responsible for the following activities [42 CFR 438.208(b)(1)]:

- a. Supervision, coordination and provision of care to each assigned member (except for children's dental services when provided without a PCP referral);
- b. Initiation of referrals for medically necessary specialty care;
- c. Maintaining continuity of care for each assigned member;
- d. Maintaining the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services including behavioral health;
- e. Utilizing the AHCCCS approved EPSDT Tracking form; and
- f. Providing clinical information regarding member's health and medications to the treating provider (including behavioral health providers) within 10 business days of a request from the provider.
- g. If serving children, for enrolling as a Vaccines for Children (VFC) provider,

The Contractor shall establish and implement policies and procedures to monitor PCP activities and to ensure that PCPs are adequately notified of, and receive documentation regarding, specialty and services provided to assigned members by specialty physicians, and other health care professionals.

31. MATERNITY CARE PROVIDER STANDARDS

The Contractor shall ensure that a maternity care provider is designated for each pregnant member for the duration of her pregnancy and postpartum care and that those maternity services are provided in accordance with the *AMPM*. The Contractor may include in its provider network the following maternity care providers:

- a. Arizona licensed allopathic and/or osteopathic physicians who are Obstetricians or general practice/family practice providers who provide maternity care services;
- b. Physician Assistants;
- c. Nurse Practitioners;
- d. Certified Nurse Midwives;
- e. Licensed Midwives.

Pregnant members may choose, or be assigned, a PCP who provides obstetrical care. Such assignment shall be consistent with the freedom of choice requirements for selecting health care professionals while ensuring that the continuity of care is not compromised. Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide those primary care services that s/he is willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all her primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice.

All physicians and certified nurse midwives who perform deliveries shall have OB hospital privileges or a documented hospital coverage agreement for those practitioners performing deliveries in alternate settings. Certified midwives perform deliveries only in the member's home. Labor and delivery services may also be provided in the member's home by physicians, certified nurse practitioners and certified nurse midwives who include such services within their practice.

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32. REFERRAL MANAGEMENT PROCEDURES AND STANDARDS

The Contractor shall have adequate written procedures regarding referrals to specialists, to include, at a minimum, the following:

- a. Use of referral forms clearly identifying the Contractor
- b. PCP referral shall be required for specialty physician services, except that women shall have direct access to in-network GYN providers, including physicians, physician assistants and nurse practitioners within the scope of their practice, without a referral for preventive and routine services [42 CFR 438.206(b)(2)]. In addition, for members with special health care needs determined to need a specialized course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow such members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. Any waiver of this requirement by the Contractor must be approved in advance by AHCCCS.
- c. Specialty physicians shall not begin a course of treatment for a medical condition other than that for which the member was referred, unless approved by the member's PCP.
- d. A process in place that ensures the member's PCP receives all specialist and consulting reports and a process to ensure PCP follow-up of all referrals including EPSDT referrals for behavioral health services.
- e. A referral plan for any member who is about to lose eligibility and who requests information on low-cost or no-cost health care services.
- f. Referral to Medicare Managed Care Plan
- g. Allow for a second opinion from a qualified health care professional within the network, or if one is not available in network, arrange for the member to obtain one outside the network, at no cost to the member [42 CFR 438.206(b)(3)].

The Contractor shall comply with all applicable physician referral requirements and conditions defined in Sections 1903(s) and 1877 of the Social Security Act and their implementing regulations which include, but are not limited to, 42 CFR Part 411, Part 424, Part 435 and Part 455. Sections 1903(s) and 1877 of the Act prohibits physicians from making referrals for designated health services to health care entities with which the physician or a member of the physician's family has a financial relationship. Designated health services include:

- a. Clinical laboratory services
- b. Physical therapy services
- c. Occupational therapy services
- d. Radiology services
- e. Radiation therapy services and supplies
- f. Durable medical equipment and supplies
- g. Parenteral and enteral nutrients, equipment and supplies
- h. Prosthetics, orthotics and prosthetic devices and supplies
- i. Home health services
- j. Outpatient prescription drugs
- k. Inpatient and outpatient hospital services

33. APPOINTMENT STANDARDS

The Contractor shall monitor appointment availability utilizing the methodology found in the ACOM *Appointment Availability Monitoring and Reporting Policy* to ensure that the following standards are met:

For purposes of this section, "urgent" is defined as an acute, but not necessarily life-threatening disorder, which, if not attended to, could endanger the patient's health. The Contractor shall have procedures in place that ensure the following standards are met.

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For **Primary Care Appointments**, the Contractor shall be able to provide:

- a. Emergency PCP appointments — same day of request or within 24 hours of the member's phone call or other notification
- b. Urgent care PCP appointments — within 2 days of request
- c. Routine care PCP appointments — within 21 days of request

For **specialty referrals**, the Contractor shall be able to provide:

- a. Emergency appointments — within 24 hours of referral
- b. Urgent care appointments — within 3 days of referral
- c. Routine care appointments — within 45 days of referral

For **dental appointments**, the Contractor shall be able to provide:

- a. Emergency appointments — within 24 hours of request
- b. Urgent care appointments — within 3 days of request
- c. Routine care appointments — within 45 days of request

For **maternity care**, the Contractor shall be able to provide initial prenatal care appointments for enrolled pregnant members as follows:

- a. First trimester — within 14 days of request
- b. Second trimester — within 7 days of request
- c. Third trimester — within 3 days of request
- d. High risk pregnancies — within 3 days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists

For **wait time in the office**, the Contractor shall actively monitor and ensure that a member's waiting time for a scheduled appointment at the PCP's or specialist's office is no more than 45 minutes, except when the provider is unavailable due to an emergency.

For **medically necessary non-emergent transportation**, the Contractor shall require its transportation provider to schedule the transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. Also see Section D, Paragraph 11, Special Health Care Needs. The Contractor must develop and implement a quarterly performance auditing protocol to evaluate compliance with the standards above for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.

The Contractor must use the results of appointment standards monitoring to assure adequate appointment availability in order to reduce unnecessary emergency department utilization. The Contractor is also encouraged to contract with or employ the services of non-emergency facilities to address member non-emergency care issues occurring after regular office hours or on weekends.

The Contractor shall establish processes to monitor and reduce the appointment "no-show" rate by provider and service type. As best practices are identified, AHCCCS may require implementation by the Contractor.

The Contractor shall have written policies and procedures about educating its provider network regarding appointment time requirements. The Contractor must develop a corrective action plan when appointment standards are not met; if appropriate, the corrective action plan should be developed in conjunction with the provider [42 CFR 438.206(c)(1)(iv), (v) and (vi)]. Appointment standards shall be included in the Provider Manual. The Contractor is encouraged to include the standards in the provider subcontracts.

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34. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) AND RURAL HEALTH CLINICS (RHCs)

The Contractor is encouraged to use FQHCs/RHCs in Arizona to provide covered services. AHCCCS requires the Contractor to negotiate rates of payment with FQHCs/RHCs for non-pharmacy services that are comparable to the rates paid to providers that provide similar services. AHCCCS reserves the right to review a Contractor's negotiated rates with an FQHC/RHC for reasonableness and to require adjustments when negotiated rates are found to be substantially less than those being paid to other, non-FQHC/RHC providers for comparable services.

The Contractor is required to submit member information for Title XIX and Title XXI members for each FQHC/RHC on a quarterly basis to the AHCCCS Division of Health Care Management. AHCCCS will perform periodic audits of the member information submitted. Contractors should refer to the AHCCCS Reporting Guide for Acute Care Contractors with the Arizona Health Care Cost Containment System for further guidance. The FQHCs/RHCs registered with AHCCCS are listed on the AHCCCS website (www.azahcccs.gov).

35. PROVIDER MANUAL

The Contractor shall develop, distribute and maintain a provider manual as described in the ACOM *Provider Network Information Policy*.

36. PROVIDER REGISTRATION

The Contractor shall ensure that all of its subcontractors register with AHCCCS as an approved service provider. For specific requirements on Provider Registration refer to the AHCCCS website at <http://www.azahcccs.gov/commercial/ProviderRegistration/registration.aspx>

The National Provider Identifier (NPI) is required on all claim submissions and subsequent encounters (from providers who are eligible for an NPI). The Contractor shall work with providers to obtain their NPI.

Except as otherwise required by law or as otherwise specified in a contract between a Contractor and a provider, the AHCCCS fee-for-service provisions referenced in the AHCCCS Provider Participation Agreement located on the AHCCCS website (e.g. billing requirements, coding standards, payment rates) are in force between the provider and Contractor.

37. SUBCONTRACTS

The Contractor shall be legally responsible for contract performance whether or not subcontracts are used [42 CFR 438.230(a) and 434.6(c)]. No subcontract shall operate to terminate the legal responsibility of the Contractor to assure that all activities carried out by the subcontractor conform to the provisions of this contract. Subject to such conditions, any function required to be provided by the Contractor pursuant to this contract may be subcontracted to a qualified person or organization. All such subcontracts must be in writing [42 CFR 438.6(l)]. See the ACOM *Contractor Claims Processing by Health Plan Subcontracted Providers Policy*.

All subcontracts entered into by the Contractor are subject to prior review and written approval by AHCCCS, Division of Health Care Management, and shall incorporate by reference the applicable terms and conditions of this contract. The following types of Administrative Services subcontracts shall be submitted to AHCCCS, Division of Health Care Management for prior approval at least 60 days prior to the beginning date of the subcontract.

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Administrative Services Subcontracts:

1. Delegated agreements that subcontract;
 - a) Any function related to the management of the contract with AHCCCS. Examples include member services, provider relations, quality management, medical management (e.g., prior authorization, concurrent review, issuance of denials or limited authorizations, member appeals, medical claims review, medical record review),
 - b) Claims processing, including pharmacy claims,
 - c) Credentialing including those for only primary source verification.
2. All Management Service Agreements;
3. All Service Level Agreements with any Division or Subsidiary of a corporate parent owner.

AHCCCS may, at its discretion, communicate directly with the governing body or Parent Corporation of the Contractor regarding the performance of a subcontractor or Contractor respectively.

The Contractor shall maintain a fully executed original or electronic copy of all subcontracts, which shall be accessible to AHCCCS within two business days of request by AHCCCS. All requested subcontracts must have full disclosure of all terms and conditions and must fully disclose all financial or other requested information. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the prior written consent of the Contractor except as required by law. All subcontracts shall comply with the applicable provisions of Federal and State laws, regulations and policies.

Before entering into a subcontract which delegates duties or responsibilities to a subcontractor the Contractor must evaluate the prospective subcontractor's ability to perform the activities to be delegated. If the Contractor delegates duties or responsibilities then the Contractor shall establish a written agreement that specifies the activities and reporting responsibilities delegated to the subcontractor. The written agreement shall also provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. In order to determine adequate performance, the Contractor shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by AHCCCS. As a result of the performance review, any deficiencies must be communicated to the subcontractor in order to establish a corrective action plan. The results of the performance review and the correction plan shall be communicated to AHCCCS upon completion [42 CFR 438.230(b)].

A merger, reorganization or change in ownership of an Administrative Services subcontractor of the Contractor shall require a contract amendment and prior approval of AHCCCS.

The Contractor must submit the Administrative Services Annual Subcontractor Assignment and Evaluation Report (within 90 days from the start of the contract year) detailing any Contractor duties or responsibilities that have been subcontracted as described under Administrative Services Subcontracts previously in this section. The Administrative Services Annual Subcontractor Assignment and Evaluation Report will include the following:

- Subcontractor's name
- Delegated duties and responsibilities
- Most recent review date of the duties, responsibilities and financial position of the subcontractor
- A comprehensive evaluation of the performance (operational and financial) of the subcontractor. The full report shall be made available upon request from AHCCCS.
- Next scheduled review date
- Identified areas of deficiency
- Corrective action plans as necessary

The Contractor shall promptly inform AHCCCS, Division of Health Care Management, within thirty (30) days if a subcontractor is in significant non-compliance that would affect their abilities to perform the duties and responsibilities of the subcontract. The Contractor will submit this in writing and provide the Corrective Action Plan and any measures taken by the Contractor to bring the subcontractor into compliance.

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Provider Agreements:

The Contractor shall not include covenant-not-to-compete requirements in its provider agreements. Specifically, the Contractor shall not contract with a provider and require that the provider not provide services for any other AHCCCS Contractor. In addition, the Contractor shall not enter into subcontracts that contain compensation terms that discourage providers from serving any specific eligibility category.

The Contractor must enter into a written agreement with any provider (including out-of-state providers) the Contractor reasonably anticipates will be providing services at the request of the Contractor more than 25 times during the contract year. Exceptions to this requirement include the following:

1. If a provider who provides services more than 25 times during the contract year refuses to enter into a written agreement with the Contractor, the Contractor shall submit documentation of such refusal to AHCCCS, Division of Health Care Management within seven days of its final attempt to gain such agreement.
2. If a provider performs emergency services such as an emergency room physician or an ambulance company, a written agreement is not required.
3. Individual providers as detailed in the *AMPM*.
4. Hospitals, as discussed in Section D, Paragraph 40, Hospital Subcontracting and Reimbursement.
5. If a provider primarily performs services in an inpatient setting.
6. If upon the Medical Director's review, it is determined that the Contractor or members would not benefit by adding the provider to the contracted network.

Any other exceptions to this requirement must be approved by AHCCCS, Division of Health Care Management. If AHCCCS does not respond within 30 days; the requested exception is deemed approved. The Contractor may request an expedited review and approval.

For all subcontracts in which the Contractor and Subcontractor have a capitated arrangement/risk sharing arrangement, the following provision must be included verbatim in every contract:

If the Subcontractor does not bill the Contractor (e.g., Subcontractor is capitated), the Subcontractor's encounter data that is required to be submitted to the Contractor pursuant to contract is defined for these purposes as a "claim for payment". The Subcontractor's provision of any service results in a "claim for payment" regardless of whether there is any intention of payment. All said claims shall be subject to review under any and all fraud and abuse statutes, rules and regulations, including but not limited to Arizona Revised Statute (A.R.S.) §36-2918.

All subcontracts must contain verbatim all the provisions of Attachment A, Minimum Subcontract Provisions located on the AHCCCS website at <http://www.azahcccs.gov/commercial/default.aspx> . In addition, each subcontract must contain the following:

1. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor.
2. Identification of the name and address of the subcontractor.
3. Identification of the population, to include patient capacity, to be covered by the subcontractor.
4. The amount, duration and scope of medical services to be provided, and for which compensation will be paid.
5. The term of the subcontract including beginning and ending dates, methods of extension, termination and re-negotiation.
6. The specific duties of the subcontractor relating to coordination of benefits and determination of third-party liability.

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7. A provision that the subcontractor agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third party liability payment before submitting claims to the Contractor.
8. A description of the subcontractor's patient, medical, dental and cost record keeping system.
9. Specification that the subcontractor shall cooperate with quality assurance programs, and comply with the utilization control and review procedures specified in 42 CFR Part 456, as specified in the *AMPM*.
10. A provision stating that a merger, reorganization or change in ownership of an Administrative Services subcontractor of the Contractor shall require a contract amendment and prior approval of AHCCCS.
11. A provision that indicates that AHCCCS is responsible for enrollment, re-enrollment and disenrollment of the covered population.
12. A provision that the subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under this subcontract, for itself and its employees, and that AHCCCS shall have no responsibility or liability for any such taxes or insurance coverage.
13. A provision that the subcontractor must obtain any necessary authorization from the Contractor or AHCCCS for services provided to eligible and/or enrolled members.
14. A provision that the subcontractor must comply with encounter reporting and claims submission requirements as described in the subcontract.
15. Provision(s) that allow the Contractor to suspend, deny, refuse to renew or terminate any subcontractor in accordance with the terms of this contract and applicable law and regulation.
16. A provision that the subcontractor may provide the member with factual information, but is prohibited from recommending or steering a member in the member's selection of a Contractor.
17. A provision that compensation to individuals or entities that conduct utilization management and concurrent review activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee [42 CFR 438.210(e)].

38. CLAIMS PAYMENT/HEALTH INFORMATION SYSTEM

The Contractor shall develop and maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, service utilization, claim disputes and appeals [42 CFR 438.242(a)].

System Requirements:

The Contractor must have a health information system that integrates member demographic data, provider information, service provision, claims submission and reimbursement. This system must be capable of collecting, storing and producing information for the purposes of financial, medical and operational management.

The Contractor shall develop and maintain a HIPAA compliant claims processing and payment system capable of processing, cost avoiding and paying claims in accordance with A.R.S. §§ 36-2903 and 2904 and AHCCCS Rules R9-22 Article 7. The system must be adaptable to updates in order to support future AHCCCS claims related policy requirements as needed.

The Contractor must include nationally recognized methodologies to correctly pay claims including but not limited to:

- Correct Coding Initiative (CCI) for Professional and Outpatient services;
- Multiple Surgical Reductions;
- Global Day E & M Bundling.

The Contractor claims payment system must be able to assess and/or apply the following data related edits:

- Benefit Package Variations;
- Timeliness Standards;
- Data Accuracy;

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- Adherence to AHCCCS Policy;
- Provider Qualifications;
- Member Eligibility and Enrollment;
- Over-Utilization Standards.

This system must produce a remittance advice related to the Contractor's payments and/or denials to providers and must include at a minimum:

- an adequate description of all denials and adjustments;
- the reasons for such denials and adjustments;
- the amount billed;
- the amount paid;
- application of COB and copays;
- provider rights for claim disputes.

The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer (EFT). The remittance advice sent related to an EFT must be sent to the provider, no later than the date of the EFT.

General Claims Processing Requirements:

AHCCCS will require the Contractor to participate in an AHCCCS workgroup to develop uniform guidelines for standardizing hospital outpatient and outpatient provider claim requirements, including billing rules and documentation requirements. The workgroup may be facilitated by an AHCCCS selected consultant. The Contractor will be held responsible for the cost of this project based on its share of AHCCCS enrollment.

Unless a shorter time period is specified in contract, the Contractor shall not pay a claim initially submitted more than 6 months after date of service or pay a clean claim submitted more than 12 months after date of service; except as directed by AHCCCS or otherwise noted in this contract. Claim payment requirements pertain to both contracted and non-contracted providers. The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the Contractor's specified claim mailing address. The paid date of the claim is the date on the check or other form of payment [42 CFR 447.45(d)]. Claims submission deadlines shall be calculated from the claim end date or the effective date of eligibility posting, whichever is later as stated in A.R.S. 36-2904.H.

Additionally, unless a subcontract specifies otherwise, a Contractor with 50,000 or more members at the end of the month that is being reported shall ensure that for each form type (Dental/Professional/Institutional), 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim. Unless a subcontract specifies otherwise, a Contractor with fewer than 50,000 members at the end of the month that is being reported shall ensure that for each form type (Dental/Professional/Institutional), 90% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

In accordance with the Deficit Reduction Act of 2005, Section 6085, Contractor is required to reimburse non-contracted emergency services providers at no more than the AHCCCS Fee-For-Service rate. This applies to in state as well as out of state providers.

In accordance with Arizona Revised Statute 36-2903 and 36-2904, in the absence of a written negotiated rate, Contractor is required to reimburse non-contracted non-emergent in state providers at the AHCCCS fee schedule and methodology, or pursuant to 36-2905.01, at ninety-five percent of the AHCCCS Fee-For-Service rates for urban hospital days. All payments are subject to other limitations that apply, such as provider registration, prior authorization, medical necessity, and covered service.

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Effective for all non-hospital clean claims, in the absence of a contract specifying other late payment terms, a Contractor is required to pay interest on late payments. Late claims payments are those that are paid after 45 days of receipt of the clean claim (as defined in this contract). In grievance situations, interest shall be paid back to the date interest would have started to accrue beyond the applicable 45 day requirement. Interest shall be at the rate of ten per cent per annum, unless a different rate is stated in a written contract. In the absence of interest payment terms in a subcontract, interest shall accrue starting on the first day after a clean claim is contracted to be paid. For hospital clean claims, a slow payment penalty shall be paid in accordance with A.R.S. 2903.01. When interest is paid, the Contractor must report the interest as directed in the AHCCCS *Encounter Reporting Manual*.

Electronic Transactions:

The Contractor is required to accept and generate required HIPAA compliant electronic transactions from/to any provider interested and capable of electronic submission or electronic remittance receipt; and must be able to make claims payments via electronic funds transfer. In addition, the Contractor shall implement and meet the following milestone in order to make claims processing and payment more efficient and timely:

- Receive and pay 60% of all claims (based on volume of actual claims excluding claims processed by Pharmacy Benefit Managers (PBMs)) electronically

Recoupments:

The Contractor's claims payment system, as well as its prior authorization and concurrent review process, must minimize the likelihood of having to recoup already-paid claims. Any individual recoupment in excess of \$50,000 per provider within a contract year must be approved in advance by AHCCCS, Division of Health Care Management Acute Care Operations Unit. If AHCCCS does not respond within 30 days the recoupment request is deemed approved. AHCCCS must be notified of any cumulative recoupment greater than \$50,000 per provider Tax Identification Number per contract year. A Contractor shall not recoup monies from a provider later than 12 months after the date of original payment on a clean claim, without prior approval from AHCCCS, as further described in the ACOM *Recoupment Request Policy*. The Contractor is required to reimburse providers for previously denied or recouped claims if the provider was subsequently denied payment by the primary insurer based on timely filing limits or lack of prior authorization and the member failed to disclose additional insurance coverage other than AHCCCS.

The provider shall have 90 days from the date they become aware that payment will not be made to submit a new claim and documentation from the primary insurer that payment will not be made. Documentation includes but is not limited to any of the following items establishing that the primary insurer has or would deny payment based on timely filing limits or lack of prior authorization; an EOB, policy or procedure, Provider Manual excerpt, etc.

The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. AHCCCS will validate the submission of applicable voids and replacement encounters upon completion of any approved recoupment that meets the qualifications of this section. All replaced or voided encounters must reach adjudicated status within 120 days of the approval of the recoupment. The Contractor should refer to the ACOM *Recoupment Request Policy* and AHCCCS *Encounter Reporting Manual* for further guidance.

Appeals:

If the Contractor or the Director's Decision reverses a decision to deny, limit, or delay authorization of services, and the member received the disputed services while an appeal was pending, the Contractor shall process a claim for payment from the provider in a manner consistent with the Contractor's or Director's Decision and applicable statutes, rules, policies, and contract terms. The provider shall have 90 days from the date of the reversed decision to submit a clean claim to the Contractor for payment. For all claims submitted as a result of a reversed decision, the Contractor is prohibited from denying claims for untimeliness if they are submitted within the 90 day timeframe. Contractors are also prohibited from denying claims submitted as a result of a reversed decision because the member failed to request continuation of services during the appeals/hearing process: a member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

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System Related Reporting:

The Contractor shall submit a monthly Claims Dashboard as specified in the AHCCCS *Claims Dashboard Reporting Guide*.

AHCCCS may in the future require Contractors to review claim requirements, including billing rules and documentation requirements, and submit a report to AHCCCS that will include the rationale for the requirements. AHCCCS shall determine and provide a format for the report.

System Changes and Upgrades:

The Contractor will ensure that changing or making major upgrades to the information systems affecting claims processing, or any other major business component, will be accompanied by a plan which includes a timeline, milestones, and adequate testing before implementation. At least six months before the anticipated implementation date, the Contractor shall provide the system change plan to AHCCCS for review and comment.

System Audits:

In support of this requirement, the Contractor may be required to have an independent audit of the Claims Payment/Health Information System. The Division of Health Care Management will monitor the scope of this audit, to include no less than a verification of contract information management (contract loading and auditing), claims processing and encounter submission processes. In addition to this requirement, the Contractor may be required in future contract years to initiate additional independent Claim System/Health Information System audit at the direction of AHCCCS. In the event of a system change or upgrade, the Contractor may be required to initiate an independent Claim System/Health Information System audit.

The Contractor shall develop and implement an internal claims audit function that will include the following:

- Verification that provider contracts are loaded correctly
- Accuracy of payments against provider contract terms

Audits of provider contract terms should be performed on a regular and periodic basis and consist of a random, statistically significant sampling of all contracts in effect at the time of the audit. The audit sampling methodology should be documented in policy and attempt to review the contract loading of both large groups and individual practitioners at least once every 5 year period in addition to any time a contract change is initiated during that timeframe. The findings of the audits described above must be documented and any deficiencies noted in the resulting reports must be met with corrective action.

39. SPECIALTY CONTRACTS

AHCCCS may at any time negotiate or contract on behalf of the Contractor and AHCCCS for specialized hospital and medical services. AHCCCS will consider existing Contractor resources in the development and execution of specialty contracts. AHCCCS may require the Contractor to modify its delivery network to accommodate the provisions of specialty contracts. AHCCCS may consider waiving this requirement in particular situations if such action is determined to be in the best interest of the State; however, in no case shall reimbursement exceeding that payable under the relevant AHCCCS specialty contract be considered in capitation rate development or risk sharing arrangements, including reinsurance.

During the term of specialty contracts, AHCCCS may act as an intermediary between the Contractor and specialty Contractors to enhance the cost effectiveness of service delivery, medical management, and adjudication of claims related to payments provided under specialty contracts shall remain the responsibility of the Contractor. AHCCCS may provide technical assistance prior to the implementation of any specialty contracts.

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AHCCCS has specialty contracts, including but not limited to, transplant services, anti-hemophilic agents and pharmaceutical related services. AHCCCS shall provide at least 60 days advance written notice to the Contractor prior to the implementation of any specialty contract.

40. HOSPITAL SUBCONTRACTING AND REIMBURSEMENT

Maricopa and Pima counties only: The Inpatient Hospital Reimbursement Program is defined in the Arizona Revised Statutes (A.R.S.) 36-2905.01, and requires hospital subcontracts to be negotiated between Contractors and hospitals in Maricopa and Pima counties to establish reimbursement levels, terms and conditions. Subcontracts shall be negotiated by the Contractor and hospitals to cover operational concerns, such as timeliness of claims submission and payment, payment of discounts or penalties and legal resolution, which may, as an option, include establishing arbitration procedures. These negotiated subcontracts shall remain under close scrutiny by AHCCCS to ensure availability of quality services within specific service districts, equity of related party interests and reasonableness of rates. The general provisions of this program encompass acute care hospital services and outpatient hospital services that result in an admission. The Contractor, upon request, shall make available to AHCCCS, all hospital subcontracts and amendments. For non-emergency patient-days, the Contractor shall ensure that at least 65% of its members use contracted hospitals. AHCCCS reserves the right to subsequently adjust the 65% standard. Further, if in AHCCCS' judgment the number of emergency days at a particular non-contracted hospital becomes significant, AHCCCS may require a subcontract at that hospital. In accordance with R9-22-718, unless otherwise negotiated by both parties, the reimbursement for inpatient services, including outliers, provided at a non-contracted hospital shall be based on the rates as defined in A.R.S. § 36-2903.01, multiplied by 95%.

All counties EXCEPT Maricopa and Pima: The Contractor shall reimburse hospitals for member care in accordance with AHCCCS Rule 9 A.A.C. 22, Article 7. The Contractor is encouraged to obtain subcontracts with hospitals in all GSA's. The Contractor, upon request, shall make available to AHCCCS, all hospital subcontracts and amendments.

For Out-of-State Hospitals: The Contractor shall reimburse out-of-state hospitals in accordance with AHCCCS Rule 9 A.A.C.22, Article 7. A Contractor serving border communities (excluding Mexico) is strongly encouraged to establish contractual agreements with those out-of-state hospitals that are identified by GSA in Attachment B.

Outpatient hospital services: In the absence of a contract, the default payment rate for outpatient hospital services billed on a UB-04 will be based on the AHCCCS outpatient hospital fee schedule, rather than a hospital-specific cost-to-charge ratio (pursuant to ARS 36-2904).

Hospital Recoupments: The Contractor may conduct prepayment and post-payment medical reviews of all hospital claims including outlier claims. Erroneously paid claims are subject to recoupment. If the Contractor fails to identify lack of medical necessity through concurrent review and/or prepayment medical review, lack of medical necessity identified during post-payment medical review shall not constitute a basis for recoupment by the Contractor. See also Section D, Paragraph 38, Claims Payment/Health Information System. For a more complete description of the guidelines for hospital reimbursement, please consult the applicable statutes and rules.

41. RESPONSIBILITY FOR NURSING FACILITY REIMBURSEMENT

The Contractor shall provide medically necessary nursing facility services as outlined in Section D, Paragraph 10, Scope of Services. The Contractor shall also provide medically necessary nursing facility services for any enrolled member who has a pending ALTCS application who is currently residing in a nursing facility and is eligible for services provided under this contract. If the member becomes ALTCS eligible and is enrolled with an ALTCS Contractor before the end of the maximum 90 days per contract year of nursing facility coverage, the Contractor is only responsible for nursing facility reimbursement during the time the member is enrolled with the Contractor as shown in the PMMIS. Nursing facility services covered by another liable party (including Medicare) while the member is enrolled with the Contractor, shall be applied to the 90 day per contract year limitation.

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The Contractor shall not deny nursing facility services when the member's eligibility, including prior period coverage, had not been posted at the time of admission. In such situations the Contractor shall impose reasonable authorization requirements. There is no ALTCS enrollment, including prior period coverage, that occurs concurrently with AHCCCS acute enrollment.

The Contractor shall notify the Assistant Director of the Division of Member Services, when a member has been residing in a nursing facility for 60 days as specified in Section D, Paragraph 10, Scope of Services, under the heading *Nursing Facility*. This will allow AHCCCS time to follow-up on the status of the ALTCS application and to consider potential fee-for-service coverage if the stay goes beyond the 90 day per contract year maximum.

42. PHYSICIAN INCENTIVES/PAY FOR PERFORMANCE

Physician Incentives

The reporting requirements under 42 CFR 417.479 have been suspended. No reporting to CMS is required until the suspension is lifted.

The Contractor must comply with all applicable physician incentive requirements and conditions defined in 42 CFR 417.479. These regulations prohibit physician incentive plans that directly or indirectly make payments to a doctor or a group as an inducement to limit or refuse medically necessary services to a member. The Contractor is required to disclose all physician incentive agreements to AHCCCS and to AHCCCS members who request them.

The Contractor shall not enter into contractual arrangements that place providers at significant financial risk as defined in 42 CFR 417.479 unless specifically approved in advance by the AHCCCS Division of Health Care Management. In order to obtain approval, the following must be submitted to the AHCCCS Division of Health Care Management 45 days prior to the implementation of the contract [42 CFR 438.6(g)]:

1. A complete copy of the contract
2. A plan for the member satisfaction survey
3. Details of the stop-loss protection provided
4. A summary of the compensation arrangement that meets the substantial financial risk definition

The Contractor shall disclose to AHCCCS the information on physician incentive plans listed in 42 CFR 417.479(h)(1) through 417.479(I) upon contract renewal, prior to initiation of a new contract, or upon request from AHCCCS or CMS.

The Contractor shall also comply with all applicable physician incentive plan requirements as set forth in 42 CFR 422.208, 422.210 and 438.6(h). These regulations apply to contract arrangements with subcontracted entities that provide utilization management services.

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Transparency

AHCCCS programs will be in compliance with Federal and State transparency initiatives. AHCCCS may publicly report or make available any data, reports, analysis or outcomes related to Contractor activities, operations and/or performance. Public reporting may include, but is not limited to, the following components:

- a) Use of evidence based guidelines (toolkits)
- b) Identification and publication of top performing Contractors
- c) Identification and publication of top performing providers
- d) Program pay for performance payouts
- e) Mandated publication of guidelines
- f) Mandated publication of outcomes
- g) Identification of Centers of Excellence for specific conditions, procedures or member populations
- h) Establishment of Return on Investment goals

Any Contractor-selected and/or -developed pay for performance initiative that meets the requirements of 42 CFR 417.479 must be approved by AHCCCS Division of Health Care Management prior to implementation.

43. MANAGEMENT SERVICES AGREEMENT AND COST ALLOCATION PLAN

If a Contractor has subcontracted for management services, the management service agreement must be approved in advance by AHCCCS, Division of Health Care Management. If there is a cost allocation plan as part of the management services agreement, it is subject to review by AHCCCS upon request. AHCCCS reserves the right to perform a thorough review of actual management fees charged and/or corporate allocations made.

If there is a change in ownership of the entity with which the Contractor has contracted for management services, AHCCCS must review and provide prior approval of the assignment of the subcontract to the new owner. AHCCCS may offer open enrollment to the members assigned to the Contractor should a change in ownership occur. AHCCCS will not permit two Contractors to utilize the same management service company in the same GSA.

The performance of management service subcontractors must be evaluated and included in the Annual Subcontractor Assignment and Evaluation Report required by Section D, Paragraph 37, Subcontracts and Attachment F: Periodic Report Requirements.

44. RESERVED

45. RESERVED

46. PERFORMANCE BOND OR BOND SUBSTITUTE

In addition to the minimum capitalization requirements, the Contractor shall be required to establish and maintain a performance bond, in accordance with the *Performance Bond Policy*, to AHCCCS for as long as the Contractor has AHCCCS-related liabilities of \$50,000 or more outstanding, or 15 months following the termination date of this contract, whichever is later, to guarantee: (1) payment of the Contractor's obligations to providers, and (2) performance by the Contractor of its obligations under this contract [42 CFR 438.116]. The Performance Bond shall be in a form acceptable to AHCCCS as described in the *ACOM Performance Bond Policy*.

In the event of a default by the Contractor, AHCCCS shall, in addition to any other remedies it may have under this contract, obtain payment under the Performance Bond or substitute security for the purposes of the following:

1. Paying any damages sustained by providers, non-contracting providers and non-providers by reason of a breach of the Contractor's obligations under this contract;
2. Reimbursing AHCCCS for any payments made by AHCCCS on behalf of the Contractor; and
3. Reimbursing AHCCCS for any extraordinary administrative expenses incurred by reason of a breach of the Contractor's obligations under this contract, including, but not limited to, expenses incurred after termination of this contract for reasons other than the convenience of the State by AHCCCS.

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In the event AHCCCS agrees to accept substitute security in lieu of the security types outlined in the *ACOM Performance Bond Policy*, the Contractor agrees to execute any and all documents and perform any and all acts necessary to secure and enforce AHCCCS' security interest in such substitute security including, but not limited to, security agreements and necessary UCC filings pursuant to the Arizona Uniform Commercial Code. The Contractor must request acceptance from AHCCCS when a substitute security in lieu of the security types outlined in the *ACOM Performance Bond Policy* is established. In the event such substitute security is agreed to and accepted by AHCCCS, the Contractor acknowledges that it has granted AHCCCS a security interest in such substitute security to secure performance of its obligations under this contract. The Contractor is solely responsible for establishing the credit-worthiness of all forms of substitute security. AHCCCS may, after written notice to the Contractor, withdraw its permission for substitute security, in which case the Contractor shall provide AHCCCS with a form of security described in the *ACOM Performance Bond Policy*.

The Contractor may not change the amount, duration or scope of the performance bond without prior written approval from AHCCCS, Division of Health Care Management. The Contractor shall not leverage the bond for another loan or create other creditors using the bond as security.

47. AMOUNT OF PERFORMANCE BOND

The initial amount of the Performance Bond shall be equal to 80% of the total capitation payment expected to be paid to the Contractor in the first month of the contract year, or as determined by AHCCCS. The total capitation amount (including delivery supplement) excludes premium tax. This requirement must be satisfied by the Contractor no later than 30 days after notification by AHCCCS of the amount required. Thereafter, AHCCCS shall review the capitation amounts of the Contractor on a monthly basis to determine if the Performance Bond must be increased. The Contractor shall have 30 days following notification by AHCCCS to increase the amount of the Performance Bond. The Performance Bond amount that must be maintained after the contract term shall be sufficient to cover all outstanding liabilities and will be determined by AHCCCS. The Contractor may not change the amount of the performance bond without prior written approval from AHCCCS, Division of Health Care Management. Refer to the *ACOM Performance Bond and Equity Per Member Requirements Policy* for more details.

48. ACCUMULATED FUND DEFICIT

The Contractor and its owners must review for accumulated fund deficits on a quarterly and annual basis. In the event the Contractor has a fund deficit, the Contractor and its owners shall fund the deficit through capital contributions in a form acceptable to AHCCCS. The capital contributions must be for the period in which the deficit is reported and shall occur within 30 days of the financial statement due to AHCCCS. AHCCCS at its sole discretion may impose a different timeframe other than the 30 days required in this paragraph. AHCCCS may, at its option, impose enrollment caps in any or all GSA's as a result of an accumulated deficit, even if unaudited.

49. ADVANCES, DISTRIBUTIONS, LOANS AND INVESTMENTS

The Contractor shall not, without the prior approval of AHCCCS, make any advances, distributions, loans or loan guarantees to related parties or affiliates including another fund or line of business within its organization. The Contractor shall not, without prior approval of AHCCCS, make advances to providers in excess of \$50,000. All requests for prior approval are to be submitted to the AHCCCS Division of Health Care Management. Refer to the *ACOM Provider and Affiliate Advance Request Policy* for further information.

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50. FINANCIAL VIABILITY STANDARDS

The Contractor must comply with the AHCCCS-established financial viability standards. On a quarterly basis, AHCCCS will review the following ratios with the purpose of monitoring the financial health of the Contractor: Current Ratio; Equity per Member; Medical Expense Ratio; and the Administrative Cost Percentage.

Sanctions may be imposed if the Contractor does not meet these financial viability standards. AHCCCS will take into account the Contractor's unique programs for managing care and improving the health status of members when analyzing medical expense and administrative ratio results. However, if a critical combination of the Financial Viability Standards are not met, or if the Contractor's experience differs significantly from other Contractors, additional monitoring, such as monthly reporting, may be required.

FINANCIAL VIABILITY STANDARDS

Current Ratio	Current assets divided by current liabilities. "Current assets" includes any long-term investments that can be converted to cash within 24 hours without significant penalty (i.e., greater than 20%). <i>Standard: At least 1.00</i> If current assets include a receivable from a parent company, the parent company must have liquid assets that support the amount of the inter-company loan.
Equity per Member	Unrestricted equity, less on-balance sheet performance bond, divided by the number of non-SOBRA Family Planning Extension Services members enrolled at the end of the period. <i>Standard: At least \$150 for Contractors with enrollment < 100,000 \$100 for Contractors with enrollment of 100,000+</i> Additional information regarding the Equity per Member requirement may be found in the <i>Performance Bond and Equity per Member Requirements</i> policy in the ACOM.
Medical Expense Ratio	Total medical expenses divided by the sum of total PPC and prospective capitation + Delivery Supplement + All Reconciliation Settlements + TPL+ Reinsurance less premium tax <i>Standard: At least 84%</i>
Administrative Cost Percentage	Total administrative expenses divided by the sum of total PPC and prospective capitation + Delivery Supplement + All Reconciliation Settlements + TPL + Reinsurance less premium tax <i>Standard: No greater than 10%</i>

The Contractor shall comply with all financial reporting requirements contained in Attachment F, Periodic Report Requirements and the *Reporting Guide for Acute Health Care Contractors with the Arizona Health Care Cost Containment System*, a copy of which may be found on the AHCCCS website. The required reports are subject to change during the contract term and are summarized in Attachment F, Periodic Report Requirements.

51. SEPARATE INCORPORATION

Within 60 days of contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract.

52. MERGER, REORGANIZATION AND CHANGE OF OWNERSHIP

A proposed merger, reorganization or change in ownership of the Contractor shall require prior approval of AHCCCS and may require a contract amendment. AHCCCS may terminate this contract pursuant to Section D, Paragraph 1, Term of Contract and Option to Renew. If the Contractor does not obtain prior approval or AHCCCS determines that the change in ownership is not in the best interest of the State, AHCCCS may offer open enrollment to the members assigned to the Contractor should a change in ownership occur. AHCCCS will not permit one organization to own or manage more than one contract within the same program in the same GSA.

The Contractor must submit a detailed merger, reorganization and/or transition plan to AHCCCS, Division of Health Care Management, for review at least 60 days prior to the effective date of the proposed change. The purpose of the plan review is to ensure uninterrupted services to members, evaluate the new entity's ability to support the provider network, ensure that services to members are not diminished and that major components of the organization and AHCCCS programs are not adversely affected by such merger, reorganization or change in ownership.

53. COMPENSATION

The method of compensation under this contract will be Prior Period Coverage (PPC) capitation, prospective capitation, delivery supplement, reinsurance and third party liability, as described and defined within this contract and appropriate laws, regulations or policies.

Actuaries establish the capitation rates using practices established by the Actuarial Standards Board. AHCCCS provides the following data to its actuaries for the purposes of rebasing the capitation rates.

- a. Utilization and unit cost data derived from adjudicated encounters
- b. Both audited and unaudited financial statements reported by the Contractor
- c. Market basket inflation trends
- d. AHCCCS fee-for-service schedule pricing adjustments
- e. Programmatic or Medicaid covered service changes that affect reimbursement
- f. Other changes to medical practices or administrative requirements that affect reimbursement

AHCCCS adjusts its rates to best match payment to risk. This further ensures the actuarial basis for the capitation rates. The following are examples of risk factors that may be included.

- a. Reinsurance (as described in Section D, Paragraph 57)
- b. Age/Gender
- c. Medicare enrollment for SSI members
- d. Delivery supplemental payment
- e. Geographic Service Area adjustments
- f. Risk sharing arrangements for specific populations
- g. Member specific statistics, e.g. member acuity, member choice, member diagnosis, etc.

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For services or pharmaceuticals, in instances in which AHCCCS has specialty contracts or legislation/policy limits the allowable reimbursement, the amount to be used in the capitation rate setting process and reconciliations will be the lesser of the contracted/mandated amount or the Contractor paid amount.

The above information is reviewed by AHCCCS' actuaries in renewal years to determine if adjustments are necessary. A Contractor may cover services that are not covered under the State Plan; however those services are not included in the data provided to actuaries for setting capitation rates [42 CFR 438.6(e)].

AHCCCS will utilize a national episodic/diagnostic risk adjustment model that will be applied to all prospective capitation rates for all risk groups (excluding supplemental payments and SFP). For CYE 12, the capitation rate risk adjustment factors will be updated. The proposed data set will be for dates of service for the twelve month period from July 1, 2010 to June 30, 2011. AHCCCS anticipates applying these risk factors by March 1, 2012 retroactively to October 1, 2011. The risk factors to be used in the interim for the capitation payments prior to the March 1, 2012 application of the revised risk factors will be the same as the CYE 11 risk factors.

Prospective Capitation: The Contractor will be paid capitation for all prospective member months, including partial member months. This capitation includes the cost of providing medically necessary covered services to members during the prospective period coverage.

Prior Period Coverage (PPC) Capitation: Except for SOBRA Family Planning, KidsCare and State Only Transplants, the Contractor will be paid capitation for all PPC member months, including partial member months. This capitation includes the cost of providing medically necessary covered services, excluding most behavioral health services, to members during prior period coverage. The PPC capitation rates will be set by AHCCCS and will be paid to the Contractor along with the prospective capitation described above. The Contractor will not receive PPC capitation for newborns of members who were enrolled at the time of delivery.

Reconciliation of Prospective Costs to Reimbursement: For CYE 12, AHCCCS will reconcile the Contractor's prospective TANF, SOBRA, SSI w/Med, SSI w/o Med, SOBRA and SOBRA Family Planning medical cost expenses to prospective net capitation paid to the Contractor for the same population for dates of service October 1, 2011 through September 30, 2012. This reconciliation will limit the Contractor's profits and losses as follows:

Profit	MCO Share	State Share	Max MCO Profit
<= 3%	100%	0%	3.0%
>3% and <= 5%	75%	25%	1.5%
>5% and <= 7%	50%	50%	1.0%
>7% and <= 9%	25%	75%	0.5%
>9%	0%	100%	0%

Loss	MCO Share	State Share	Max MCO Loss
<=3%	100%	0%	3.0%
>3% and <=6%	50%	50%	1.5%
>6%	0%	100%	0%

Adjudicated encounter data will be used to determine medical expenses. Refer to the ACOM *Prospective Risk Groups Reconciliation Policy (excluding Non-MEDs)* for further details.

Reconciliation of PPC Costs to Reimbursement: AHCCCS will reconcile the Contractor's PPC medical cost expenses to PPC capitation paid to the Contractor during the year. This reconciliation will limit the Contractor's profits and losses to 2%. Any losses in excess of 2% will be reimbursed to the Contractor, and likewise, profits in excess of 2% will be recouped. Adjudicated encounter data will be used to determine medical expenses. Refer to the ACOM *PPC Reconciliation Policy* for further details.

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Reconciliation of Prospective MED Costs to Reimbursement: Coverage for this population terminates September 30, 2011. There will be no reconciliation for CYE 12.

Reconciliation of Prospective non-MED Costs to Reimbursement: For CYE 12, AHCCCS will reconcile the Contractor's prospective non-MED medical cost expenses to prospective non-MED net capitation paid to the Contractor for dates of service during the contract year being reconciled. This reconciliation will limit the Contractor's profits and losses to 2%. Any losses in excess of 2% will be reimbursed to the Contractor, and likewise, profits in excess of 2% will be recouped. Adjudicated encounter data will be used to determine medical expenses. Refer to the *Prospective non-MED Reconciliation Policy* included in the ACOM for further details.

For CYE 12 AHCCCS will reconcile the Contractor's prospective non-MED medical cost expenses to prospective non-MED net capitation paid to the Contractor for dates of service during the contract year being reconciled. This reconciliation will limit the Contractor's profits and losses to 2%. Any losses in excess of 2% will be reimbursed to the Contractor, and likewise, profits in excess of 2% will be recouped. Adjudicated encounter data will be used to determine medical expenses. Refer to the *Prospective non-MED Reconciliation Policy* included in the ACOM for further details.

Delivery Supplement: When the Contractor has an enrolled woman who delivers during a prospective enrollment period, the Contractor will be entitled to a supplemental payment. Supplemental payments will not apply to women who deliver in a prior period coverage time period, or State Only Transplant members. AHCCCS reserves the right at any time during the term of this contract to adjust the amount of this payment for women who deliver at home.

State Only Transplants Option 1 and Option 2: The Contractor will only be paid capitation for an administrative component for those member months the member is enrolled with the Contractor. For Option 1 members the Contractor will be paid the administrative component up to a 12-month continuous period of extended eligibility. For Option 2 members the administrative component will be paid for the period of time the transplant is scheduled or performed. All medically necessary covered services will be reimbursed 100% with no deductible through Reinsurance payments based on adjudicated encounters. Delivery supplement payments will not apply to women who deliver during the 12 month continuous period of extended eligibility specified as Option 1.

54. PAYMENTS TO CONTRACTORS

Subject to the availability of funds, AHCCCS shall make payments to the Contractor in accordance with the terms of this contract provided that the Contractor's performance is in compliance with the terms and conditions of this contract. Payment must comply with requirements of A.R.S. Title 36. AHCCCS reserves the option to make payments to the Contractor by wire or National Automated Clearing House Association (NACHA) transfer and will provide the Contractor at least 30 days notice prior to the effective date of any such change.

Where payments are made by electronic funds transfer, AHCCCS shall not be liable for any error or delay in transfer or indirect or consequential damages arising from the use of the electronic funds transfer process. Any charges or expenses imposed by the bank for transfers or related actions shall be borne by the Contractor. Except for adjustments made to correct errors in payment, and as otherwise specified in this section, any savings remaining to the Contractor as a result of favorable claims experience and efficiencies in service delivery at the end of the contract term may be kept by the Contractor.

All funds received by the Contractor pursuant to this contract shall be separately accounted for in accordance with generally accepted accounting principles.

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Except for funds received from the collection of permitted copayments and third-party liabilities, the only source of payment to the Contractor for the services provided hereunder is the Arizona Health Care Cost Containment System Fund. An error discovered by the State, with or without an audit, in the amount of fees paid to the Contractor will be subject to adjustment or repayment by AHCCCS making a corresponding decrease in a current Contractor's payment or by making an additional payment to the Contractor. When the Contractor identifies an overpayment, AHCCCS must be notified and reimbursed within 30 days of identification.

No payment due the Contractor by AHCCCS may be assigned or pledged by the Contractor. This section shall not prohibit AHCCCS at its sole option from making payment to a fiscal agent hired by the Contractor.

55. CAPITATION ADJUSTMENTS

Except for changes made specifically in accordance with this contract, the rates set forth in Section B shall not be subject to re-negotiation or modification during the contract period. AHCCCS may, at its option, review the effect of a program changes, legislative requirements, Contractor experience, actuarial assumptions, and/or Contractor specific capitation factors to determine if a capitation adjustment is needed. In these instances the adjustment and assumptions will be discussed with the Contractor prior to modifying capitation rates. The Contractor may request a review of a program change if it believes the program change was not equitable; AHCCCS will not unreasonably withhold such a review.

The Contractor is responsible for notifying AHCCCS of program and/or expenditure changes initiated by the Contractor during the contract period that may result in material changes to the current or future capitation rates.

Contractor Default:

If the Contractor is in any manner in default in the performance of any obligation under this contract, AHCCCS may, at its option and in addition to other available remedies, adjust the amount of payment until there is satisfactory resolution of the default.

Change in Member Status:

The Contractor shall reimburse AHCCCS and/or AHCCCS may deduct from future monthly capitation for any portion of a month during which the Contractor was not at risk due to, for example:

- a. death of a member
- b. inmate of a public institution
- c. duplicate capitation to the same Contractor
- d. adjustment based on change in member's contract type
- e. voluntary withdrawal

Upon becoming aware that a member may be an inmate of a public institution, the Contractor must notify AHCCCS for an eligibility determination. Notifications must be sent via email to one of the following two email addresses as applicable:

For children under age 18: DMSJUVENILEIncarceration@azahcccs.gov

For adults age 18 and older: DMSADULTIncarceration@azahcccs.gov

Notifications must include:

- AHCCCS ID
- Name
- Date of Birth (DOB)
- When incarcerated
- Where incarcerated

Contractors do **not** need to report members incarcerated with the Arizona Department of Corrections.

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Pima County is submitting a daily file of all inmates entering their jail and all inmates released. AHCCCS will match the file against the database of active AHCCCS members. AHCCCS members who become incarcerated will be disenrolled from their Contractor and placed in a "no-pay" status for the duration of their incarceration. Contractors will see the "IE" code for ineligible associated with the disenrollment. Upon release from jail, the member will be re-enrolled with their previous Contractor. AHCCCS will notify Contractors if AHCCCS expands this matching process to other Counties. A member is eligible for covered services until the effective date of the member's "no-pay" status.

If a member is enrolled twice with the same Contractor, recoupment will be made as soon as the double capitation is identified. AHCCCS reserves the right to modify its policy on capitation recoupments at any time during the term of this contract.

56. MEMBER BILLING AND LIABILITY FOR PAYMENT

AHCCCS registered providers may charge AHCCCS members for services which are excluded from AHCCCS coverage or which are provided in excess of AHCCCS limits according to the guidelines set forth in A.A.C R9-22-702.

The Contractor must ensure that members are not held liable for:

- a. The Contractor's or any subcontractor's debts in the event of Contractor's or the subcontractor's insolvency;
- b. Covered services provided to the member except as permitted under R9-22-702; or,
- c. Payments to the Contractor or any subcontractors for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount the member would owe if the Contractor or any subcontractor provided the services directly.

57. REINSURANCE

Reinsurance is a stop-loss program provided by AHCCCS to the Contractor for the partial reimbursement of covered medical services, as described in this paragraph and incurred for a member beyond an annual deductible level. AHCCCS is self-insured for the reinsurance program and is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS will reimburse the Contractor for covered services incurred above the deductible. The deductible is the responsibility of the Contractor. Deductible levels are subject to change by AHCCCS during the term of this contract. Any change would have a corresponding impact on capitation rates. Refer to the *AHCCCS Reinsurance Processing Manual* for further details on the Reinsurance Program.

The following table represents deductible and coinsurance levels. The deductible level is based on the Contractor's statewide AHCCCS acute care enrollment (not including SOBRA Family Planning Extension services) as of October 1st each contract year, as shown in the table below. AHCCCS may adjust the Contractor's deductible level at the beginning of a contract year if the Contractor's enrollment changes to the next enrollment level. These deductible levels are subject to change by AHCCCS during the term of this contract. Any change in deductible levels will have a corresponding impact on capitation rates.

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<i>Statewide Plan Enrollment</i>		<i>Annual Deductible Regular Reinsurance</i>	<i>Coinsurance</i>
0-34,999	\$	20,000	75%
35,000-49,999	\$	35,000	75%
50,000 and over	\$	50,000	75%

For the contract year beginning October 1, 2011, Contractors will remain at the deductible level in place as of October 1, 2010.

Deductible at October 1, 2010		Deductible for October 1, 2011
\$20,000	\$	20,000
\$35,000	\$	35,000

Annual deductible levels apply to all members except for State Only Transplant and SOBRA Family Planning members. Beginning October 1, 2012, and annually thereafter, each of the deductible levels above may increase by \$5,000.

PPC expenses are not covered for any members under the reinsurance program unless they qualify under catastrophic or transplant reinsurance.

Reinsurance Case Types

For all reinsurance case types, For services or pharmaceuticals, in the instances in which AHCCCS has specialty contracts or legislation/policy limits the allowable reimbursement, the amount to be used in the computation of reinsurance will be the lesser of the contracted/mandated amount or the Contractor paid amount.

Regular Reinsurance Regular reinsurance covers partial reimbursement of covered inpatient facility medical services. This coverage applies to prospective enrollment periods. See the table above for applicable deductible levels and coinsurance percentages. The coinsurance percent is the rate at which AHCCCS will reimburse the Contractor for covered inpatient costs incurred above the deductible. The deductible is the responsibility of the Contractor. In certain situations as outlined in the AHCCCS Reinsurance Processing Manual, per diem rates paid for nursing facility services provided within 30 days of an acute hospital stay, including room and board, provided in lieu of hospitalization for up to 90 days in any contract year shall be eligible for reinsurance coverage. Same-day admit-and-discharge services do not qualify for reinsurance.

Catastrophic Reinsurance: The Catastrophic Reinsurance program encompasses members receiving certain biotech drugs (listed below), and those members diagnosed with hemophilia, Von Willebrand's Disease or Gaucher's Disease. For additional detail and restrictions refer to the *AHCCCS Reinsurance Processing Manual* and the *AMPM*. There are no deductibles for catastrophic reinsurance cases. For member's receiving Biotech drugs outside of the specific conditions mentioned in this paragraph, AHCCCS will reimburse at 85% of the cost of the drug only. For those members diagnosed with hemophilia, Von Willebrand's Disease and Gaucher's Disease, all medically necessary covered services provided during the contract year shall be eligible for reimbursement at 85% of the AHCCCS allowed amount or the Contractor's paid amount, whichever is lower, depending on the subcap code. Reinsurance coverage for anti-hemophilic blood factors will be limited to 85% of the AHCCCS contracted amount or the Contractor's paid amount, whichever is lower. All catastrophic claims are subject to medical review by AHCCCS.

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AHCCCS holds a specialty contract for anti-hemophilic agents and related services for hemophilia. The Contractor may access anti-hemophilic agents and related pharmaceutical services for hemophilia or Von Willebrand's under the terms and conditions of the specialty contract for members enrolled in their plans. In that instance, the Contractor is the authorizing payor. As such, the Contractor will provide prior authorization, care coordination, and reimbursement for all components covered under the contract for their members. A Contractor utilizing the contract will comply with the terms and conditions of the contract. A Contractor may use the AHCCCS contract or contract with a provider of their choice.

The Contractor must notify AHCCCS, Division of Health Care Management, Medical Management Unit, of cases identified for catastrophic reinsurance coverage within 30 days of initial diagnosis and/or enrollment with the Contractor, and annually within 30 days of the beginning of each contract year. Catastrophic reinsurance will be paid for a maximum 30-day retroactive period from the date of notification to AHCCCS. The determination of whether a case or type of case is catastrophic shall be made by the Director or designee based on the following criteria; 1) severity of medical condition, including prognosis; and 2) the average cost or average length of hospitalization and medical care, or both, in Arizona, for the type of case under consideration.

Hemophilia: Catastrophic reinsurance coverage is available for all members diagnosed with Hemophilia (ICD9 codes 286.0, 286.1, 286.2).

Von Willebrand's Disease: Catastrophic reinsurance coverage is available for all members diagnosed with von Willebrand's Disease who are non-DDAVP responders and dependent on Plasma Factor VIII.

Gaucher's Disease: Catastrophic reinsurance is available for members diagnosed with Gaucher's Disease classified as Type I and are dependent on enzyme replacement therapy.

Biotech Drugs Reinsurance: Catastrophic reinsurance is available to cover the cost of certain biotech drugs when medically necessary. These drugs, collectively referred to as Biotech Drugs, are the responsibility of the Contractor unless the members is CRS enrolled, the medications are related to the management of a CRS-covered condition, and CRS is providing coverage. Catastrophic reinsurance will cover the drug cost only. The drugs covered are Lumizyme, Aldurazyme, Fabryzyme, Myozyme, Elaprase, and Ceprotin. Effective October 1, 2011, Cerazyme will no longer be covered under the Biotech Drug cases but will be included in the catastrophic Gaucher's Disease case type. The Biotech Drugs covered under reinsurance may be reviewed by AHCCCS at the start of each contract year. AHCCCS reserves the right to require the use of a generic equivalent where applicable. AHCCCS will reimburse at the lesser of the Biotech Drug or its generic equivalent for reinsurance purposes.

Transplants Reinsurance: This program covers members who are eligible to receive covered major organ and tissue transplantation. Refer to the *AMPM* and the Reinsurance Processing Manual for covered services for organ and tissue transplants. Reinsurance coverage for transplants received at an AHCCCS contracted facility is paid at the lesser of 85% of the AHCCCS contract amount for the transplantation services rendered or 85% of the Contractor's paid amount. Reinsurance coverage for transplants received at a non-AHCCCS contracted facility is paid the lesser of 85% of the lowest AHCCCS contracted rate, for the same organ or tissue, or the Contractor paid amount. The AHCCCS contracted transplantation rates may be found on the AHCCCS website. The Contractor must notify AHCCCS Division of Health Care Management, Medical Management Unit when a member is referred to a transplant facility for evaluation for an AHCCCS-covered organ transplant. In order to qualify for reinsurance benefits, the notification must be received by AHCCCS Medical Management Unit within 30 days of referral to the transplant facility for evaluation.

If a Contractor intends to use an out of state transplant facility for a covered transplant and AHCCCS already holds an in state contract for that transplant type, the Contractor must obtain prior approval from the AHCCCS Medical Director. If no prior approval is obtained, and the Contractor incurs costs at the out of state facility, those costs will not be eligible for either transplant or regular reinsurance. In addition, those costs will be excluded from any applicable reconciliation calculations.

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Option 1 and Option 2 Transplant Services: Reinsurance coverage for State Only Option 1 and Option 2 members (as described in Section D, Paragraph 2, Eligibility Categories) for transplants received at an AHCCCS contracted facility is paid at the lesser of 100% of the AHCCCS contract amount for the transplantation services rendered, or the Contractor paid amount, less the transplant share of cost. For transplants received at a facility not contracted with AHCCCS, payment is made at the lesser of 100% of the lowest AHCCCS contracted amount for the transplantation services rendered, or the Contractor paid amount, less the transplant share of cost. The AHCCCS contracted transplantation rates may be found on the AHCCCS website. When a member is referred to a transplant facility for an AHCCCS-covered organ transplant, the Contractor shall notify AHCCCS, Division of Health Care Management, Medical Management Unit as specified in the *AMPM Chapter 300, Policy 310 Attachments A and B, Extended Eligibility Process/Procedure for Covered Solid Organ and Tissue Transplants*.

Option 1 Non-transplant Reinsurance: All medically necessary covered services provided to Option 1 members, unrelated to the transplant, shall be eligible for reimbursement, with no deductible, at 100% of the Contractor's paid amount based on adjudicated encounters.

Other Reinsurance: For all reinsurance case types other than transplants, the Contractor will be reimbursed 100% for all medically necessary covered expenses provided in a contract year, after the Contractor paid amount in the reinsurance case reaches \$650,000. It is the responsibility of the Contractor to notify AHCCCS, Division of Health Care Management, Reinsurance Supervisor, once a reinsurance case reaches \$650,000. The Contractor is required to split encounters as necessary once the reinsurance case reaches \$650,000. Failure to notify AHCCCS or failure to split and adjudicate encounters appropriately within 15 months from the end date or service will disqualify the related encounters for 100% reimbursement consideration.

Encounter Submission and Payments for Reinsurance

- a) ***Encounter Submission:*** All reinsurance associated encounters, except as provided below for "Disputed Matters" must reach a clean claim status within fifteen months from the end date of service, or date of eligibility posting, whichever is later.

Disputed Matters: For encounters which are the subject of a member appeal, provider claim dispute, or other legal action, including an informal resolution originating from a request for a formal claim dispute or member appeal, the Contractor has the longer of: 1) 90 days from the date of the final decision in that proceeding/action or 2) 15 months from the end date of service/date of eligibility posting to file the reinsurance claim AND for the reinsurance claim to reach clean claim status. Therefore, reinsurance claims for disputed matters will be considered timely if the Contractor files such claims in clean claim status no later than 90 days from the date of the final decision in that proceeding/action even though the 15 month deadline has expired.

Failure to submit encounters in clean claim status within the applicable timeframes specified above will result in the denial of reinsurance. The association of an encounter to a reinsurance case does not automatically qualify the encounter for reinsurance reimbursement.

The Contractor must void encounters for any claims that are recouped in full. For recoupments that result in a reduced claim value or any adjustments that result in an increased claim value, replacement encounters must be submitted. For replacement encounters resulting in an increased claim value, the replacement encounter must reach adjudicated status within 15 months of end date of service to receive additional reinsurance benefits. The Contractor should refer to Section D, Paragraph 65, Encounter Data Reporting, for encounter reporting requirements.

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- b) **Payment of Regular and Catastrophic Reinsurance Cases:** AHCCCS will reimburse a Contractor for costs incurred in excess of the applicable deductible level, subject to coinsurance percentages and Medicare/TPL payment, less any applicable quick pay discounts, slow payment penalties and interest. Amounts in excess of the deductible level shall be paid based upon costs paid by the Contractor, minus the coinsurance and Medicare/TPL payment, unless the costs are paid under a subcapitated arrangement. In subcapitated arrangements, AHCCCS shall base reimbursement of reinsurance encounters on the lower of the AHCCCS allowed amount or the reported health plan paid amount, minus the coinsurance and Medicare/TPL payment and applicable quick pay discounts, slow payment penalties and interest.

When a member with an annual enrollment choice changes Contractors within a contract year, for reinsurance purposes, no costs incurred for that member follow the member to the receiving Contractor. Encounters from the Contractor the member is leaving (for dates of service within the current contract year) will not be applied toward the receiving Contractor's deductible level. For further details regarding this policy and other reinsurance policies refer to the *AHCCCS Reinsurance Processing Manual*.

- c) **Payment of Transplant Reinsurance Cases:** Reinsurance benefits are based upon the lower of the AHCCCS contract amount or the Contractor's paid amount, subject to coinsurance percentages. The Contractor is required to submit all supporting encounters for transplant services. Reinsurance payments are linked to transplant encounter submissions. In order to receive reinsurance payment for transplant stages, billed amounts and health plan paid amounts for adjudicated encounters must agree with related claims and/or invoices. Timeliness for each stage payment will be calculated based on the latest adjudication date for the complete set of encounters related to the stage. Please refer to the *AHCCCS Reinsurance Processing Manual* for the appropriate billing of transplant services.

Reinsurance Audits

AHCCCS may, at a later date, perform medical audits on reinsurance cases. Terms of the audit process will be disclosed prior to implementation of the audits and Contractors will be given appropriate advance notice.

58. COORDINATION OF BENEFITS

Pursuant to federal and state law, AHCCCS is the payer of last resort except under limited situations. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The Contractor shall coordinate benefits in accordance with 42 CFR 433.135 et seq., ARS 36-2903, and A.A.C. R9-22-1001 et seq. so that costs for services otherwise payable by the Contractor are cost avoided or recovered from a liable party. The term "State" shall be interpreted to mean "Contractor" for purposes of complying with the federal regulations referenced above. The Contractor may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this contract.

The two methods used in the coordination of benefits are cost avoidance and post payment recovery. The Contractor shall use these methods as described in A.A.C. R9-22-1001 et seq. and federal and state law. See also Section D, Paragraph 60, Medicare Services and Cost Sharing.

Cost Avoidance: The Contractor shall take reasonable measures to determine all legally liable parties. This refers to any individual, entity or program that is or may be liable to pay all or part of the expenditures for covered services. The Contractor shall cost-avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. Establishing liability takes place when the Contractor receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a member. If the probable existence of a party's liability cannot be established the Contractor must adjudicate the claim. The Contractor must then utilize post payment recovery which is described in further detail below. If AHCCCS determines that the Contractor is not actively engaged in cost avoidance activities the Contractor shall be subject to sanctions in an amount not less than **three times** the amount that could have been cost avoided.

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The Contractor shall not deny a claim for timeliness if the untimely claim submission results from a provider's efforts to determine the extent of liability.

If a third party insurer other than Medicare requires the member to pay any copayment, coinsurance or deductible, the Contractor is responsible for making these payments under the method described below, even if the services are provided outside of the Contractor network.

A. If the provider is **CONTRACTED** with the Contractor:

The Contractor shall pay the **lesser** of the **difference** between:

1) The Primary Insurance Paid amount and the Primary Insurance rate, i.e., the member's copayment required under the Primary Insurance

OR

2) The Primary Insurance Paid amount and the Contractor's Contracted Rate

The lesser of methodology applies unless the Contractor's contract with the provider requires a different payment scheme.

B. If the provider is **NOT CONTRACTED** with the Contractor:

The Contractor shall pay the **lesser** of the **difference** between:

1) The Primary Insurance Paid amount and the Primary Insurance Rate, i.e., the member's copayment required under the Primary Insurance

OR

2) The Primary Insurance Paid amount and the AHCCCS Fee for Service Rate

Examples

Scenario 1

AHCCCS FFS Rate \$50
Contractor Rate \$55
Primary Insurance Rate \$45
Primary Paid \$30

Contractor Payment to Contracted Provider in this example \$15 (this is calculated from the lesser of: \$45-\$30 vs. \$55 - \$30)
Contractor Payment to NonContracted Provider in this example \$15 (this is calculated from the lesser of: \$45-30 vs. \$50-30)

Scenario 2

AHCCCS FFS Rate \$50
Contractor Rate \$55
Primary Insurance Rate \$60
Primary Paid \$40

Contractor Payment to Contracted Provider in this example \$15 (this is calculated from the lesser of: \$60-\$40 vs. \$55-\$40)
Contractor Payment to NonContracted Provider in this example \$10 (this is calculated from the lesser of: \$60-\$40 vs. \$50-\$40)

Scenario 3

AHCCCS FFS Rate \$50
Contractor Rate \$55
Primary Insurance Rate \$70
Primary Paid \$60

Contractor Payment to Contracted Provider in this example \$0 (this is calculated from the lesser of: \$70 - \$60 vs. \$55-\$60)
Contractor Payment to NonContracted Provider in this example? \$0 (this is calculated from the lesser of: \$70-\$60 vs. \$50-\$60)

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If the Contractor refers the member for services to a third-party insurer, other than Medicare, and the insurer requires payment in advance of all copayments, coinsurance and deductibles, the Contractor must make such payments in advance.

Members with CRS condition: A member with private insurance or Medicare coverage is not required to utilize CRS. This includes members with Medicare whether they are enrolled in Medicare FFS or a Medicare Managed Care Plan. If the member uses the private insurance network for a CRS-covered condition, the Contractor is responsible for all applicable deductibles and copayments. If the member has Medicare coverage, the *ACOM Medicare Cost Sharing for Members in Traditional Fee for Service Medicare* and *Medicare Cost Sharing for Members in Medicare Managed Care Plans* shall apply. When the private insurance or Medicare is exhausted, or certain annual or lifetime limits are reached with respect to CRS-covered conditions, the Contractor shall refer the member to CRS for determination of eligibility. If the member with private insurance or Medicare chooses to enroll with CRS, CRS becomes the secondary payer responsible for all applicable deductibles and copayments. The Contractor is not responsible to provide services in instances when a member with a CRS covered condition who has no primary insurance or Medicare, refuses to participate in the CRS application process, or refuses to receive CRS covered services through the CRS program. The member may be billed by the provider in accordance with AHCCCS regulations regarding billing for unauthorized services.

Post-payment Recoveries: Post-payment recovery is necessary in cases where the Contractor has not established the probable existence of a liable party at the time services were rendered or paid for, or was unable to cost-avoid. The following sections set forth requirements for Contractor recovery actions including recoupment activities, other recoveries and total plan case requirements.

Recoupments: The Contractor must follow the protocols established in the *ACOM Recoupment Request Policy*. The Contractor must void encounters for claims that are recouped in full. For recoupments that result in an adjusted claim value, the Contractor must submit replacement encounters.

Other Recoveries: The Contractor shall identify the existence of potentially liable parties through the use of trauma code edits, utilizing diagnostic codes 800 to 999.9 (excluding code 994.6) external causes of injury codes E000 through E999, and other procedures. The Contractor shall not pursue recovery in the following circumstances, unless the case has been referred to the Contractor by AHCCCS or AHCCCS' authorized representative:

Uninsured/underinsured motorist insurance	Restitution Recovery
First-and third-party liability insurance	Worker's Compensation
Tort feasons, including casualty	Estate Recovery
Special Treatment Trust Recovery	

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Upon identification of any of the above situations, the Contractor shall promptly report any cases involving the above circumstances to AHCCCS' authorized representative for determination of a "total plan" case. A total plan case is a case where payments for services rendered to the member are exclusively the responsibility of the Contractor; no reinsurance or fee-for-service payments are involved. By contrast, a "joint" case is one where fee-for-service payments and/or reinsurance payments are involved. In joint cases, the Contractor shall notify AHCCCS' authorized representative within 10 business days of the identification of a liable party case with reinsurance or fee-for-service payments made by AHCCCS. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 72, Sanctions. The Contractor shall cooperate with AHCCCS' authorized representative in all collection efforts.

Total Plan Case Requirements: In "total plan" cases, the Contractor is responsible for performing all research, investigation, the mandatory filing of initial liens on cases that exceed \$250, lien amendments, lien releases, and payment of other related costs in accordance with A.R.S. 36-2915 and A.R.S. 36-2916. The Contractor shall use the AHCCCS-approved casualty recovery correspondence when filing liens and when corresponding to others in regard to casualty recovery. The Contractor may retain up to 100% of its recovery collections if all of the following conditions exist:

- a. Total collections received do not exceed the total amount of the Contractor's financial liability for the member;
- b. There are no payments made by AHCCCS related to fee-for-service, reinsurance or administrative costs (i.e., lien filing , etc.); and,
- c. Such recovery is not prohibited by state or Federal law.

Prior to negotiating a settlement on a total plan case, the Contractor shall notify AHCCCS to ensure that there is no reinsurance or fee-for-service payment that has been made by AHCCCS. Failure to report these cases prior to negotiating a settlement amount may result in one of the remedies specified in Section D, Paragraph 72, Sanctions.

Total Plan Cases: The Contractor shall report settlement information to AHCCCS, utilizing the AHCCCS-approved casualty recovery Notification of Settlement form, within 10 business days from the settlement date. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 72, Sanctions.

Joint Cases: AHCCCS' authorized representative is responsible for performing all research, investigation and payment of lien-related costs, subsequent to the referral of any and all relevant case information to AHCCCS' authorized representative by the Contractor. In joint cases, AHCCCS' authorized representative is also responsible for negotiating and acting in the best interest of all parties to obtain a reasonable settlement and may compromise a settlement in order to maximize overall reimbursement, net of legal and other costs. The Contractor will be responsible for their prorated share of the contingency fee. The Contractor's share of the contingency fee will be deducted from the settlement proceeds prior to AHCCCS remitting the settlement to the Contractor.

Other Reporting Requirements:

If a Contractor discovers the probable existence of a liable party that is not known to AHCCCS, the Contractor must report the information to the AHCCCS contracted vendor not later than 10 days from the date of discovery. In addition, the Contractor shall notify AHCCCS of any known changes in coverage within deadlines and in a format prescribed by AHCCCS in the *Technical Interface Guidelines*. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 72, Sanctions.

Upon AHCCCS' request, the Contractor shall provide an electronic extract of the Casualty cases, including open and closed cases. Data elements include, but are not limited to: the member's first and last name; AHCCCS ID; date of incident; claimed amount; paid/recovered amount; and case status. The AHCCCS TPL Section shall provide the format and reporting schedule for this information to the Contractor. AHCCCS will provide the Contractor with a file of all other coverage information, for the purpose of updating the Contractor's files, as described in the *Technical Interface Guidelines*.

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Title XXI (KidsCare), BCCTP, and SOBRA Family Planning: Eligibility for KidsCare, BCCTP, and SOBRA Family Planning benefits require that the applicant/member not be enrolled with any other creditable health insurance plan. If the Contractor becomes aware of any such coverage, the Contractor shall notify AHCCCS immediately. AHCCCS will determine if the other insurance meets the creditable coverage definition in A.R.S. 36-2982(G).

Cost Avoidance/Recovery Report:

The Contractor shall report on a quarterly basis a summary of their cost avoidance/recovery activity. The report shall be submitted in a format as specified in the AHCCCS Program Integrity Reporting Guide.

Contract Termination: Upon termination of this contract, the Contractor will complete the existing third party liability cases or make any necessary arrangements to transfer the cases to AHCCCS' authorized TPL representative.

AHCCCS has developed a process and agreement with Blue Cross Blue Shield of Arizona (BCBSAZ) to receive both historic and current BCBSAZ coverage data.

59. COPAYMENTS

The Contractor is required to apply copayments as per ACOM and other direction by AHCCCS. Most of the AHCCCS members remain exempt from copayments while others are subject to optional or mandatory copayments. Those populations exempt or subject to optional copayments may not be denied services for the inability to pay the copayment [42 CFR 438.108]. However, for those populations subject to mandatory copayments services may be denied for the inability to pay the copayment.

60. MEDICARE SERVICES AND COST SHARING

AHCCCS has members enrolled who are eligible for both Medicaid and Medicare. These members are referred to as "dual eligibles". Generally, Contractors are responsible for payment of Medicare coinsurance and/or deductibles for covered services provided to dual eligible members within the Contractor's network. However, there are different cost-sharing responsibilities that apply to dual eligible members based on a variety of factors. Unless prior approval is obtained from AHCCCS, the Contractor must limit their cost sharing responsibility according to the *ACOM Medicare Cost Sharing Policy*. Contractors shall have no cost sharing obligation if the Medicare payment exceeds what the Contractor would have paid for the same service of a non-Medicare member. Please refer to Section D, Paragraph 10, Scope of Services, for information regarding prescription medication for Medicare Part D.

When a person with Medicare who is also eligible for Medicaid (dual eligible) is in a medical institution that is funded by Medicaid for a full calendar month, the dual eligible person is not required to pay copayments for their Medicare covered prescription medications for the remainder of the calendar year. To ensure appropriate information is communicated for these members to the Centers for Medicare and Medicaid Services (CMS), the Contractor must, using the approved form, notify the AHCCCS Member Database Management Administration (MDMA), via fax at (602) 253-4807 as soon as it determines that a dual eligible person is expected to be in a medical institution that is funded by Medicaid for a full calendar month, regardless of the status of the dual eligible person's Medicare lifetime or annual benefits. This includes:

- a. Members who have Medicare part "B" only;
- b. Members who have used their Medicare part "A" life time inpatient benefit;
- c. Members who are in a continuous placement in a single medical institution or any combination of continuous placements in a medical institution.

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For purposes of the medical institution notification, medical institutions are defined as acute hospitals, psychiatric hospital — Non IMD, psychiatric hospital — IMD, residential treatment center — Non IMD, residential treatment center — IMD, skilled nursing facilities, and Intermediate Care Facilities for the Mentally Retarded.

61. MARKETING

The Contractor shall submit all proposed marketing and outreach materials and events that will involve the general public to the AHCCCS Marketing Committee for prior approval in accordance with the AHCCCS rules and the ACOM *Marketing Outreach and Incentives Policy*, a copy of which is available on the AHCCCS Website www.azahcccs.gov [42 CFR 438.104]. The Contractor must have signed contracts with hospitals, PCPs, specialists, pharmacies, dentists, and pharmacies in order for them to be included in marketing materials. Marketing materials that have received prior approval must be resubmitted to the Division of Health Care Management every two years for re-approval.

62. CORPORATE COMPLIANCE

In accordance with A.R.S. Section 36-2918.01, and *AHCCCS Contractor Operation Manual (ACOM)*, Chapter 100, Contractors and their subcontractors and providers are required to immediately notify the AHCCCS Office of Inspector General (OIG) regarding any suspected fraud or abuse [42 CFR 455.17] The Contractor agrees to immediately (within 10 business days of discovery) inform the OIG in writing of instances of suspected fraud or abuse [42 CFR 455.1(a)(1)] by completing the confidential AHCCCS Referral for Preliminary Investigation form. This shall include acts of suspected fraud or abuse that were resolved internally but involved AHCCCS funds, contractors, or sub-contractors.

As stated in A.R.S. Section 13-2310, incorporated herein by reference, any person who knowingly obtains any benefit by means of false or fraudulent pretenses, representations, promises, or material omissions is guilty of a Class 2 felony.

The Contractor agrees to permit and cooperate with any onsite review. A review by the OIG may be conducted without notice and for the purpose of ensuring program compliance. The Contractor also agrees to respond to electronic, telephonic or written requests for information within the timeframe specified by AHCCCS. The Contractor agrees to provide documents, including original documents, to representatives of the OIG upon request. The OIG shall allow a reasonable time for the Contractor to copy the requested documents, not to exceed 20 business days from the date of the OIG request.

The Contractor shall be in compliance with 42 CFR 438.608. The Contractor must have a mandatory compliance program, supported by other administrative procedures, that is designed to guard against fraud and abuse. The Contractor shall have written criteria for selecting a Compliance Officer and job description that clearly outlines the responsibilities and authority of the position. The Compliance Officer shall have the authority to assess records and independently refer suspected member fraud, provider fraud and member abuse cases to the OIG or other duly authorized enforcement.

The compliance program shall be designed to both prevent and detect suspected fraud or abuse. The compliance program must include:

1. Written policies, procedures, and standards of conduct that articulates the organization's commitment to and processes for complying with all applicable federal and state standards.
2. The written designation of a compliance committee who are accountable to the Contractor's top management.
3. The Compliance Officer must be an onsite management official who reports directly to the Contractor's top management. Any exceptions must be approved by AHCCCS.

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- 4. Effective training and education.
- 5. Effective lines of communication between the compliance officer and the organization's employees.
- 6. Enforcement of standards through well-publicized disciplinary guidelines.
- 7. Provision for internal monitoring and auditing.
- 8. Provision for prompt response to problems detected.
- 9. A Compliance Committee which shall be made up of, at a minimum, the Compliance Officer, a budgetary official and other executive officials with the authority to commit resources. The Compliance Committee will assist the Compliance Officer in monitoring, reviewing and assessing the effectiveness of the compliance program and timeliness of reporting.
- 10. Pursuant to the Deficit Reduction Act of 2005 (DRA), Contractors, as a condition for receiving payments shall establish written policies for employees detailing:
 - a. The federal False Claims Act provisions;
 - b. The administrative remedies for false claims and statements;
 - c. Any state laws relating to civil or criminal penalties for false claims and statements;
 - d. The whistleblower protections under such laws.
- 11. The Contractor must establish a process for training existing staff and new hires on the compliance program and on the items in section 10. All training must be conducted in such a manner that can be verified by AHCCCS.
- 12. The Contractor must require, through documented policies and subsequent contract amendments, that providers train their staff on the following aspects of the Federal False Claims Act provisions:
 - a. The administrative remedies for false claims and statements;
 - b. Any state laws relating to civil or criminal penalties for false claims and statements;
 - c. The whistleblower protections under such laws.
- 13. The Contractor must notify AHCCCS of any CMS compliance issues related to HIPAA transaction and code set complaints or sanctions.

The Contractor is required to research potential overpayments identified by the OIG. After conducting a cost benefit analysis to determine if such action is warranted, the Contractor should attempt to recover any overpayments identified. The OIG shall be advised of the final disposition of the research and advised of actions, if any, taken by the Contractor.

63. RECORDS RETENTION

The Contractor shall maintain records relating to covered services and expenditures including reports to AHCCCS and documentation used in the preparation of reports to AHCCCS. The Contractor shall comply with all specifications for record keeping established by AHCCCS. All records shall be maintained to the extent and in such detail as required by AHCCCS Rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCS.

The Contractor agrees to make available, at all reasonable times during the term of this contract, any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or Federal government. The Contractor shall be responsible for any costs associated with the reproduction of requested information.

The Contractor shall preserve and make available all records for a period of five years from the date of final payment under this contract.

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HIPAA related documents must be retained for a period of six years per 45 CFR 164.530(j)(2).

If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of this contract, or costs and expenses of this contract to which exception has been taken by AHCCCS, shall be retained by the Contractor for a period of five years after the date of final disposition or resolution thereof.

64. DATA EXCHANGE REQUIREMENTS

The Contractor is authorized to exchange data with AHCCCS relating to the information requirements of this contract and as required to support the data elements to be provided to AHCCCS in the formats prescribed by AHCCCS, which include formats prescribed by the Health Insurance Portability and Accountability Act (HIPAA). Details for the formats may be found in the *HIPAA Transaction Companion Documents & Trading Partner Agreements, the AHCCCS Encounter Reporting User Manual* and in the *AHCCCS Technical Interface Guidelines*, available on the AHCCCS website.

The information so recorded and submitted to AHCCCS shall be in accordance with all procedures, policies, rules, or statutes in effect during the term of this contract. If any of these procedures, policies, rules, regulations or statutes are hereinafter changed, both parties agree to conform to these changes following appropriate notification by AHCCCS.

The Contractor is responsible for any incorrect data, delayed submission or payment (to the Contractor or its subcontractors), and/or penalty applied due to any error, omission, deletion, or erroneous insert caused by Contractor-submitted data. Any data that does not meet the standards required by AHCCCS shall not be accepted by AHCCCS.

The Contractor is responsible for identifying any inconsistencies immediately upon receipt of data from AHCCCS. If any unreported inconsistencies are subsequently discovered, the Contractor shall be responsible for the necessary adjustments to correct its records at its own expense.

The Contractor shall accept from AHCCCS original evidence of eligibility and enrollment in a form appropriate for electronic data exchange. Upon request by AHCCCS, the Contractor shall provide to AHCCCS updated date-sensitive PCP assignments in a form appropriate for electronic data exchange.

The Contractor shall be provided with a Contractor-specific security code for use in all data transmissions made in accordance with contract requirements. Each data transmission by the Contractor shall include the Contractor's security code. The Contractor agrees that by use of its security code, it certifies that any data transmitted is accurate and truthful, to the best of the Contractor's Chief Executive Officer, Chief Financial Officer or designee's knowledge [42 CFR 438.606]. The Contractor further agrees to indemnify and hold harmless the State of Arizona and AHCCCS from any and all claims or liabilities, including but not limited to consequential damages, reimbursements or erroneous billings and reimbursements of attorney fees incurred as a consequence of any error, omission, deletion or erroneous insert caused by the Contractor in the submitted input data. Neither the State of Arizona nor AHCCCS shall be responsible for any incorrect or delayed payment to the Contractor's AHCCCS services providers (subcontractors) resulting from such error, omission, deletion, or erroneous input data caused by the Contractor in the submission of AHCCCS claims.

The costs of software changes are included in administrative costs paid to the Contractor. There is no separate payment for software changes. A PMMIS systems contact will be assigned after contract award. AHCCCS will work with the contractor as they evaluate Electronic Data Interchange options.

Health Insurance Portability and Accountability Act (HIPAA):

The Contractor shall comply with the Administrative Simplification requirements of Subpart F of the HIPAA of 1996 (Public Law 107-191, 110 Statutes 1936) and all Federal regulations implementing that Subpart that are applicable to the operations of the Contractor by the dates required by the implementing Federal regulations as well as all subsequent requirements and regulations as published.

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65. ENCOUNTER DATA REPORTING

Encounter Submissions

Complete, accurate and timely reporting of encounter data is crucial to the success of the AHCCCS program. AHCCCS uses encounter data to pay reinsurance benefits, set fee-for-service and capitation rates, determine reconciliation amounts, determine disproportionate share payments to hospitals, and to determine compliance with performance standards. The Contractor shall submit encounter data to AHCCCS for all services for which the Contractor incurred a financial liability and claims for services eligible for processing by the Contractor where no financial liability was incurred including services provided during prior period coverage. This requirement is a condition of the CMS grant award [42 CFR 438.242(b)(1)][42 CFR 455.1 (a)(2)].

A Contractor shall prepare, review, verify, certify, and submit, encounters for consideration to AHCCCS. Upon submission, the Contractor certifies that the services listed were actually rendered. The encounters must be submitted in the format prescribed by AHCCCS.

Encounter data must be provided to AHCCCS as outlined in the X12 and NCPDP *Transaction Companion Documents & Trading Partner Agreements* and the *AHCCCS Encounter Manual* and should be received by AHCCCS no later than 240 days after the end of the month in which the service was rendered, or the effective date of the enrollment with the Contractor, whichever date is later. Requirements for encounter data are described in the *AHCCCS Encounter Manual* and the *AHCCCS Encounter Companion Documents*.

To support Federal Drug Rebate processing, pharmacy related encounter data must be provided to AHCCCS no later than 30 days after the end of the quarter in which the pharmaceutical item was dispensed. For the purposes of this requirement, pharmacy encounter data is defined as retail pharmacy encounters until such time AHCCCS expands Federal Drug Rebate processing to include all other pharmaceuticals reported on professional and outpatient facility encounters.

The Contractor will be assessed sanctions for noncompliance with encounter submission requirements.

Encounter Reporting

The Contractor must produce reports for the purposes of tracking, trending, reporting process improvement and monitoring submissions of encounters and encounter revisions. The Contractor will submit these reports to AHCCCS as required per the *AHCCCS Encounter Manual*.

At least twice each month, AHCCCS provides the Contractor with full replacement files containing provider and medical coding information. These files should be used by the Contractor to ensure accurate Encounter Reporting. Refer to the *AHCCCS Encounter Manual* for further information.

Encounter Corrections

Contractors are required to monitor and resolve pended encounters, encounters denied by AHCCCS, and encounters voided and voided/replaced. AHCCCS has established encounter performance standards as detailed in the *AHCCCS Encounter Manual*. In addition to adjudicated approved encounters, pended, denied and voided encounters affect completeness, accuracy and timeliness rates. Rates below the established standards (pended encounters that have pended for more than 120 days), or poor encounter performance overall, may result in Corrective Action Plans and/or sanctions.

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Contractors are required to submit replacement or voided encounters in the event that claims are subsequently corrected following the initial encounter submission. This includes corrections as a result of inaccuracies identified by fraud and abuse audits or investigations conducted by AHCCCS or the Contractor. The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. For those recoupments requiring approval from AHCCCS, replacement encounters must be submitted within 120 days of the recoupment approval from AHCCCS. Refer to the AHCCCS *Encounter Manual* for instructions regarding the submission of corrected encounters.

Encounter Validation Studies

Per the CMS requirement, AHCCCS will conduct encounter validation studies of the Contractor's encounter submissions, and may sanction the Contractor and/or require a corrective action plan for noncompliance with encounter submission requirements. The purpose of encounter validation studies is to compare recorded utilization information from a medical record or other source with the Contractor's submitted encounter data. Any and all covered services may be validated as part of these studies. The criteria used in encounter validation studies may include timeliness, correctness and omission of encounters. Refer to the AHCCCS *Data Validation Technical Document* for further information.

AHCCCS may revise study methodology, timelines, and sanction amounts based on agency review or as a result of consultations with CMS. The Contractor will be notified in writing of any significant change in study methodology.

66. ENROLLMENT AND CAPITATION TRANSACTION UPDATES

AHCCCS produces daily enrollment transaction updates identifying new members and changes to existing members' demographic, eligibility and enrollment data, which the Contractor shall use to update its member records. The daily enrollment transaction update, that is run immediately prior to the monthly enrollment and capitation transaction, is referred to as the "last daily" and will contain all rate code changes made for the prospective month, as well as any new enrollments and disenrollments as of the 1st of the prospective month.

AHCCCS also produces a daily Manual Payment Transaction, which identifies enrollment or disenrollment activity that was not included on the daily enrollment transaction update due to internal edits. The Contractor shall use the Manual Payment Transaction in addition to the daily enrollment transaction update to update its member records.

A weekly capitation transaction will be produced to provide the Contractor with member-level capitation payment information. This file will show changes to the prospective capitation payments, as sent in the monthly file, resulting from enrollment changes that occur after the monthly file is produced. This file will also identify mass adjustments to and/or manual capitation payments that occurred at AHCCCS after the monthly file is produced.

On a monthly basis AHCCCS provides the Contractor with an electronic file of all Acute members who must complete a review of their eligibility in order to maintain enrollment with the Contractor. AHCCCS strongly encourages the Contractor to utilize this file to support member retention efforts.

The monthly enrollment and monthly capitation transaction updates are generally produced two days before the end of every month. The update will identify the total active population for the Contractor as of the first day of the next month. These updates contain the information used by AHCCCS to produce the monthly capitation payment for the next month. The Contractor must reconcile their member files with the AHCCCS monthly update. After reconciling the monthly update information, the Contractor will record the results of the reconciliation, which will be made available upon request, and will resume posting daily updates beginning with the last two days of the month. The last two daily updates are different from the regular daily updates in that they pay and/or recoup capitation into the next month. If the Contractor detects an error through the monthly update process, the Contractor shall notify AHCCCS, Information Services Division.

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Refer to Section D, Paragraph 64, Data Exchange Requirements, for further information.

67. PERIODIC REPORT REQUIREMENTS

AHCCCS, under the terms and conditions of its CMS grant award, requires periodic reports, encounter data and other information from the Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions described in Section D, Paragraph 72, *Sanctions* and Attachment F, Periodic Report Requirements.

Standards applied for determining adequacy of required reports are as follows [42 CFR 438.242(b)(2)]:

- a. *Timeliness*: Reports or other required data shall be received on or before scheduled due dates.
- b. *Accuracy*: Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or AHCCCS defined standards.
- c. *Completeness*: All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.

The Contractor shall comply with all reporting requirements contained in this contract. AHCCCS requirements regarding reports, report content and frequency of submission of reports are subject to change at any time during the term of the contract. The Contractor shall comply with all changes specified by AHCCCS. The Contractor shall be responsible for continued reporting beyond the term of the contract.

68. REQUESTS FOR INFORMATION

AHCCCS may, at any time during the term of this contract, request financial or other information from the Contractor. Responses shall fully disclose all financial or other information requested. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the prior written consent of the Contractor except as required by law. Upon receipt of such requests for information, the Contractor shall provide complete information to AHCCCS as requested no later than 30 days after the receipt of the request unless otherwise specified in the request itself.

If the Contractor believes the requested information is confidential and may not be disclosed to third parties, the Contractor shall provide a detailed statement to AHCCCS, within the timeframe designated by AHCCCS, setting forth the reasons why the information is confidential and describing the specific harm or injury that would result from disclosure. In the event that AHCCCS withholds information from a third party as a result of the Contractor's statement, the Contractor shall be responsible for all costs associated with the nondisclosure, including but not limited to legal fees and costs.

69. DISSEMINATION OF INFORMATION

Upon request, the Contractor shall assist AHCCCS in the dissemination of information prepared by AHCCCS or the Federal government to its members. The cost of such dissemination shall be borne by the Contractor. All advertisements, publications and printed materials that are produced by the Contractor and refer to covered services shall state that such services are funded under contract with AHCCCS.

70. OPERATIONAL AND FINANCIAL READINESS REVIEWS

AHCCCS may conduct Operational and Financial Readiness Reviews on the Contractor and will, subject to the availability of resources, provide technical assistance as appropriate. The Readiness Review will be conducted prior to the start of business. The purpose of a Readiness Review is to assess Contractor's readiness and ability to provide covered services to members at the start of the contract year. The Contractor will be permitted to commence operations only if the Readiness Review factors are met to AHCCCS' satisfaction.

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71. OPERATIONAL AND FINANCIAL REVIEWS

In accordance with CMS requirements, AHCCCS Rule 9 A.A.C.22 Article 5, AHCCCS, or an independent agent, will conduct periodic operational and financial reviews for the purpose of (but not limited to) identifying best practices and ensuring program compliance [42 CFR 438.204]. The type and duration of the review will be solely at the discretion of AHCCCS. The reviews will identify areas where improvements can be made and make recommendations accordingly, monitor the Contractor's progress towards implementing mandated programs and provide the Contractor with technical assistance if necessary.

Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCS will give the Contractor at least three weeks advance notice of the date of the scheduled Operational and Financial Review. AHCCCS reserves the right to conduct reviews without notice. AHCCCS may conduct a review without notice in the event the Contractor undergoes a merger, reorganization, changes ownership or makes changes in three or more key staff positions within a 12-month period, or to investigate complaints received by AHCCCS. The Contractor shall comply with all other medical audit provisions as required by AHCCCS.

AHCCCS may request, at the expense of the Contractor, to conduct on-site reviews of functions performed at out of state locations. AHCCCS will coordinate travel arrangements and accommodations with the Contractor at their request.

In preparation for the reviews, the Contractor shall cooperate fully with AHCCCS and the AHCCCS Review Team by forwarding in advance such policies, procedures, job descriptions, contracts, records, logs and other material that AHCCCS may request. Any documents not requested in advance by AHCCCS shall be made available upon request of the Review Team during the course of the review. Contractor personnel as identified in advance shall be available to the Review Team at all times during AHCCCS review activities. Should the review be conducted on-site, the Contractor shall provide the Review Team with appropriate workspace, access to a telephone, electrical outlets, internet access and privacy for conferences.

The Contractor will be furnished a copy of the draft Operational and Financial Review report and given an opportunity to comment on any review findings prior to AHCCCS issuing the final report. Recommendations, made by the Review Team to bring the Contractor into compliance with federal, state, AHCCCS, and/or contract requirements, must be implemented by the Contractor. Modifications to the corrective action plan must be approved in advance by AHCCCS. Unannounced follow-up reviews may be conducted at any time after the initial Operational and Financial Review to determine the Contractor's progress in implementing recommendations and achieving compliance. Review findings may be used in the scoring of subsequent bid proposals submitted by the Contractor.

The Contractor shall not distribute or otherwise make available the Operational and Financial Review Tool, draft Operational and Financial Review Report nor final report to other AHCCCS Contractors.

In addition to the annual Operational and Financial Review AHCCCS may conduct unannounced site visits to monitor contractual requirements and performance as needed.

72. SANCTIONS

In accordance with applicable Federal and State regulations, AHCCCS Rules R9-22-606, ACOM *Sanctions Policy* and the terms of this contract, AHCCCS may impose sanctions, including but not limited to: temporary management of the contractor; monetary penalties; suspension of enrollment; withholding of payments; and suspension, refusal to renew, or terminations of the contract or any related subcontracts. [42 CFR 422.208, 42 CFR 438.700, 702, 704 and 45 CFR 92.36(i)(1) 45 CFR 74.48]. Written notice will be provided to the Contractor specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of capitation to be withheld. The Contractor may dispute the decision to impose a sanction in accordance with the process outlined in A.A.C. 9-34-401 et seq.

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Intermediate sanctions may be imposed, but are not limited to the following actions:

- a. Substantial failure to provide medically necessary services that the Contractor is required to provide under the terms of this contract to its enrolled members.
- b. Imposition of premiums or charges in excess of the amount allowed under the AHCCCS 1115 Waiver.
- c. Discrimination among members on the basis of their health status or need for health care services.
- d. Misrepresentation or falsification of information furnished to CMS or AHCCCS.
- e. Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider.
- f. Failure to comply with the requirement for physician incentive plan as delineated in Section D, Paragraph 42, Physician Incentives/Pay for Performance.
- g. Distribution directly, or indirectly through any agent or independent Contractor, of marketing materials that have not been approved by AHCCCS or that contain false or materially misleading information.
- h. Failure to meet AHCCCS Financial Viability Standards.
- i. Material deficiencies in the Contractor's provider network.
- j. Failure to meet quality of care and quality management requirements.
- k. Failure to meet AHCCCS encounter standards.
- l. Violation of other applicable State or Federal laws or regulations.
- m. Failure to fund accumulated deficit in a timely manner.
- n. Failure to increase the Performance Bond in a timely manner.
- o. Failure to comply with any provisions contained in this contract.
- p. Failure to report third party liability cases as described in Section D, Paragraph 58, Coordination of Benefits.
- q. Submitting late, incomplete or inaccurate deliverables.

AHCCCS may impose the following types of intermediate sanctions:

- a. Civil monetary penalties.
- b. Appointment of temporary management for a Contractor as provided in 42 CFR 438.706 and A.R.S. §36-2903 (M).
- c. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll [42 CFR 438.702(a)(3)].
- d. Suspension of all new enrollments, including auto assignments after the effective date of the sanction.
- e. Suspension of payment for recipients enrolled after the effective date of the sanction until CMS or AHCCCS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
- f. Additional sanctions allowed under statute or regulation that address areas of noncompliance.

Cure Notice Process:

Prior to the imposition of a sanction for non-compliance, AHCCCS may provide a written cure notice to the Contractor regarding the details of the non-compliance. If a notice to cure is provided to the Contractor, the cure notice will specify the period of time during which the Contractor must bring its performance back into compliance with contract requirements. If, at the end of the specified time period, the Contractor has complied with the cure notice requirements, AHCCCS will not impose a sanction. If, however, the Contractor has not complied with the cure notice requirements, AHCCCS may proceed with the imposition of sanctions.

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Refer to the ACOM *Sanctions Policy* for details.

Automatic Sanctions: AHCCCS will assess the sanctions listed in Attachment F, Periodic Reporting Requirements on deliverables listed under DHCM Acute Care Operations, Clinical Quality Management and Medical Management that are not received by 5:00 PM on the due date indicated. If the due date falls on a weekend or a State Holiday, sanctions will be assessed on deliverables not received by 5:00 PM on the next business day.

73. BUSINESS CONTINUITY AND RECOVERY PLAN

The Contractor shall develop a Business Continuity and Recovery Plan as detailed in the ACOM *Business Continuity and Recovery Policy*, to deal with unexpected events that may affect its ability to adequately serve members. This plan shall, at a minimum, include planning and training for:

- Electronic/telephonic failure at the Contractor's main place of business
- Complete loss of use of the main site and satellite offices out of state
- Loss of primary computer system/records
- Communication between the Contractor and AHCCCS in the event of a business disruption
- Periodic Testing

The Business Continuity and Recovery Plan shall be updated annually. The Contractor shall submit a summary of the plan to AHCCCS 15 days after the start of the contract year. All staff shall be trained and familiar with the Plan.

74. TECHNOLOGICAL ADVANCEMENT

The Contractor must have a website with links to the information as described in ACOM *Member Information and Provider Network Information Policies*.

75. PENDING LEGISLATIVE / OTHER ISSUES

The following constitute pending items that may be resolved after the issuance of this contract. Any program changes due to the resolution of the issues will be reflected in future amendments to the contract. Capitation rates may also be adjusted to reflect the financial impact of program changes. The items in this paragraph are subject to change and should not be considered all-inclusive.

Federal and State Legislation:

AHCCCS and its Contractors are subject to legislative mandates that may result in changes to the program. AHCCCS will either amend the contract or incorporate changes in policies incorporated in the contract by reference.

Payment Innovation:

AHCCCS is seeking waiver authority to allow more flexibility in payment between AHCCCS, its contractors, and/or its providers.

Health Information Technology for Economic and Clinical Health Act (HITECH):

In February 2009, as part of the federal stimulus package, Congress enacted the Health Information Technology for Economic and Clinical Health Act (HITECH). The legislation included a number of provisions designed to encourage the adoption and use of health information technology including electronic health records (EHRs) and the development of a health information exchange (HIE) infrastructure. The underlying rationale for the Act is the belief that the adoption on a nationwide basis would reduce total spending on health care by diminishing the number of inappropriate tests and procedures, reducing paperwork and administrative overhead, and decreasing the number of adverse events resulting from medical errors. AHCCCS supports providers who are choosing to adopt and use certified electronic health records. AHCCCS expects that the Contractor will support the use of certified electronic health records. AHCCCS is planning implementation for the provisions of HITECH.

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Healthcare Acquired Conditions:

The Patient Protection and Affordable Care Act, Section 2702, prohibits Medicaid payments for services related to healthcare acquired conditions (HACs) effective July 1, 2012. AHCCCS does not currently have a mechanism to prohibit payments for HACs and is currently developing a medical review policy. Contractors will utilize the policy to identify and medically review claims with HACs not present on admission. The policy will incorporate the Medicare list of conditions and preventable surgical errors as the HACs to be identified for medical review for possible payment reductions to the claim. System changes will be required for implementation. Rule and State Plan changes may be initiated as determined necessary.

76. Reserved

77. RESERVED

78. RESERVED

[END OF SECTION D]

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SECTION E: CONTRACT TERMS AND CONDITIONS

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SECTION E: CONTRACT TERMS AND CONDITIONS

1) APPLICABLE LAW

Arizona Law - The law of Arizona applies to this contract including, where applicable, the Uniform Commercial Code, as adopted in the State of Arizona.

Implied Contract Terms - Each provision of law and any terms required by law to be in this contract are a part of this contract as if fully stated in it.

2) AUTHORITY

This contract is issued under the authority of the Contracting Officer who signed this contract. Changes to the contract, including the addition of work or materials, the revision of payment terms, or the substitution of work or materials, directed by an unauthorized state employee or made unilaterally by the Contractor are violations of the contract and of applicable law. Such changes, including unauthorized written contract amendments, shall be void and without effect, and the Contractor shall not be entitled to any claim under this contract based on those changes.

3) ORDER OF PRECEDENCE

The parties to this contract shall be bound by all terms and conditions contained herein. For interpreting such terms and conditions the following sources shall have precedence in descending order: The Constitution and laws of the United States and applicable Federal regulations; the terms of the CMS 1115 waiver for the State of Arizona; the Constitution and laws of Arizona, and applicable State rules; the terms of this contract including any attachments, executed amendments and modifications; and AHCCCS policies and procedures.

4) CONTRACT INTERPRETATION AND AMENDMENT

No Parole Evidence - This contract is intended by the parties as a final and complete expression of their agreement. No course of prior dealings between the parties and no usage of the trade shall supplement or explain any term used in this contract.

No Waiver - Either party's failure to insist on strict performance of any term or condition of the contract shall not be deemed a waiver of that term or condition even if the party accepting or acquiescing in the non-conforming performance knows of the nature of the performance and fails to object to it.

Written Contract Amendments - The contract shall be modified only through a written contract amendment within the scope of the contract signed by the procurement officer on behalf of the State and signed by a duly authorized representative of the Contractor.

5) SEVERABILITY

The provisions of this contract are severable to the extent that any provision or application held to be invalid shall not affect any other provision or application of the contract, which may remain in effect without the invalid provision, or application.

6) RELATIONSHIP OF PARTIES

The Contractor under this contract is an independent contractor. Neither party to this contract shall be deemed to be the employee or agent of the other party to the contract.

7) ASSIGNMENT AND DELEGATION

The Contractor shall not assign any rights nor delegate all of the duties under this contract. Delegation of less than all of the duties under this contract must conform to the requirements of Section D, Subcontracts.

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8) INDEMNIFICATION

Contractor/Vendor Indemnification (Not Public Agency)

The parties to this contract agree that the State of Arizona, its departments, agencies, boards and commissions shall be indemnified and held harmless by the Contractor for the vicarious liability of the State as a result of entering into this contract. The Contractor agrees to indemnify, defend, and hold harmless the State from and against any and all claims, losses, liability, costs, and expenses, including attorney's fees and costs, arising out of litigation against AHCCCS including, but not limited to, class action lawsuits challenging actions by the Contractor. The requirement for indemnification applies irrespective of whether or not the Contractor is a party to the lawsuit. Each Contractor shall indemnify the State, on a pro rata basis based on population, attorney's fees and costs awarded against the State as well as the attorney's fees and costs incurred by the State in defending the lawsuit. The Contractor shall also indemnify AHCCCS, on a pro rata basis based on population, the administrative expenses incurred by AHCCCS to address Contractor deficiencies arising out of the litigation. The parties further agree that the State of Arizona, its departments, agencies, boards and commissions shall be responsible for its own negligence and/or willful misconduct. Each party to this contract is responsible for its own negligence and/or willful misconduct.

Contractor/Vendor Indemnification (Public Agency)

Each party ("as indemnitor") agrees to indemnify, defend, and hold harmless the other party ("as indemnitee") from and against any and all claims, losses, liability, costs, or expenses (including reasonable attorney's fees) (hereinafter collectively referred to as claims) arising out of bodily injury of any person (including death) or property damage but only to the extent that such claims which result in vicarious/derivative liability to the indemnitee, are caused by the act, omission, negligence, misconduct, or other fault of the indemnitor, its officers, officials, agents, employees, or volunteers.

9) INDEMNIFICATION — PATENT AND COPYRIGHT

To the extent permitted by applicable law, the Contractor shall defend, indemnify and hold harmless the State against any liability including costs and expenses for infringement of any patent, trademark or copyright arising out of contract performance or use by the State of materials furnished or work performed under this contract. The State shall reasonably notify the Contractor of any claim for which it may be liable under this paragraph.

For county governments:

To the extent permitted by applicable law, the Contractor shall defend, indemnify and hold harmless the State against any liability including costs and expenses for infringement or patent, trademark or copyright arising out of contract performance or use by the State of materials furnished or work performed under this contract. The State shall reasonably notify the Contractor of any claims for which it may be liable under this paragraph.

10) COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

The Contractor shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973 (regarding education programs and activities), and the Americans with Disabilities Act; EEO provisions; Copeland Anti-Kickback Act; Davis-Bacon Act; Contract Work Hours and Safety Standards; Rights to Inventions Made Under a Contract or Agreement; Clean Air Act and Federal Water Pollution Control Act; Byrd Anti-Lobbying Amendment. The Contractor shall maintain all applicable licenses and permits.

11) ADVERTISING AND PROMOTION OF CONTRACT

The Contractor shall not advertise or publish information for commercial benefit concerning this contract without the prior written approval of the Contracting Officer.

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12) PROPERTY OF THE STATE

Except as otherwise provided in this contract, any materials, including reports, computer programs and other deliverables, created under this contract are the sole property of AHCCCS. The Contractor is not entitled to maintain any rights on those materials and may not transfer any rights to anyone else. The Contractor shall not use or release these materials without the prior written consent of AHCCCS.

If a Contractor declares information to be confidential, AHCCCS will maintain the information as confidential and will not disclose it unless it is required by law or court order.

13) THIRD PARTY ANTITRUST VIOLATIONS

The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or services supplied by third parties to the Contractor toward fulfillment of this contract.

14) RIGHT TO ASSURANCE

If AHCCCS, in good faith, has reason to believe that the Contractor does not intend to perform or continue performing this contract, the procurement officer may demand in writing that the Contractor give a written assurance of intent to perform. The demand shall be sent to the Contractor by certified mail, return receipt required. Failure by the Contractor to provide written assurance within the number of days specified in the demand may, at the State's option, be the basis for terminating the contract.

15) TERMINATION FOR CONFLICT OF INTEREST

AHCCCS may cancel this contract without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of AHCCCS is, or becomes at any time while the contract or any extension of the contract is in effect, an employee of, or a consultant to, any other party to this contract with respect to the subject matter of the contract. The cancellation shall be effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time.

If the Contractor is a political subdivision of the State, it may also cancel this contract as provided by A.R.S. 38-511.

16) GRATUITIES

AHCCCS may, by written notice to the Contractor, immediately terminate this contract if it determines that employment or a gratuity was offered or made by the Contractor or a representative of the Contractor to any officer or employee of the State for the purpose of influencing the outcome of the procurement or securing the contract, an amendment to the contract, or favorable treatment concerning the contract, including the making of any determination or decision about contract performance. AHCCCS, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three times the value of the gratuity offered by the Contractor.

17) SUSPENSION OR DEBARMENT

The Contractor shall not employ, consult, subcontract or enter into any agreement for Title XIX services with any person or entity who is debarred, suspended or otherwise excluded from Federal procurement activity or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 [42 CFR 438.610(a) and (b) or under guidelines implementing Executive Order 12549. This prohibition extends to any entity which employs, consults, subcontracts with or otherwise reimburses for services any person substantially involved in the management of another entity which is debarred, suspended or otherwise excluded from Federal procurement activity. The Contractor is obligated to screen all employees and contractors to determine whether any of them have been excluded from participation in Federal health care programs. You can search the HHS-OIG website by the names of any individuals. The database can be accessed at <http://www.oig.hhs.gov/fraud/exclusions.asp>.

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The Contractor shall not retain as a director, officer, partner or owner of 5% or more of the Contractor entity, any person, or affiliate of such a person, who is debarred, suspended or otherwise excluded from Federal procurement activity.

AHCCCS may, by written notice to the Contractor, immediately terminate this contract if it determines that the Contractor has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity.

18) TERMINATION FOR CONVENIENCE

AHCCCS reserves the right to terminate the contract in whole or in part at any time for the convenience of the State without penalty or recourse. The Contracting Officer shall give written notice by certified mail, return receipt requested, to the Contractor of the termination at least 90 days before the effective date of the termination. In the event of termination under this paragraph, all documents, data and reports prepared by the Contractor under the contract shall become the property of and be delivered to AHCCCS. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination.

19) TEMPORARY MANAGEMENT/OPERATION OF A CONTRACTOR AND TERMINATION

Temporary Management and Operation of a Contractor: Pursuant to the Balanced Budget Act of 1997, 42 CFR 438.700 et seq. and State Law ARS §36-2903, AHCCCS is authorized to impose temporary management for a Contractor under certain conditions. Under federal law, temporary management may be imposed if AHCCCS determines that there is continued egregious behavior by the Contractor, including but not limited to the following: substantial failure to provide medically necessary services the Contractor is required to provide; imposition on enrollees premiums or charges that exceed those permitted by AHCCCS; discrimination among enrollees on the basis of health status or need for health care services; misrepresentation or falsification of information to AHCCCSA or CMS; misrepresentation or falsification of information furnished to an enrollee or provider; distribution of marketing materials that have not been approved by AHCCCS or that are false or misleading; or behavior contrary to any requirements of Sections 1903(m) or 1932 of the Social Security Act. Temporary management may also be imposed if AHCCCS determines that there is substantial risk to enrollees' health or that temporary management is necessary to ensure the health of enrollees while the Contractor is correcting the deficiencies noted above or until there is an orderly transition or reorganization of the Contractor. Under federal law, temporary management is mandatory if AHCCCS determines that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. In these situations, AHCCCS shall not delay imposition of temporary management to provide a hearing before imposing this sanction.

State law ARS §36-2903 authorizes AHCCCS to operate a Contractor as specified in this contract. In addition to the bases specified in 42 CFR 438.700 et seq., AHCCCS may directly operate the Contractor if, in the judgment of AHCCCSA, the Contractor's performance is in material breach of the contract or the Contractor is insolvent. Under these circumstances, AHCCCS may directly operate the Contractor to assure delivery of care to members enrolled with the Contractor until cure by the Contractor of its breach, by demonstrated financial solvency or until the successful transition of those members to other Contractors. Prior to operation of the Contractor by AHCCCS pursuant to state statute, the Contractor shall have the opportunity for a hearing. If AHCCCS determines that emergency action is required, operation of the Contractor may take place prior to hearing. Operation by AHCCCS shall occur only as long as it is necessary to assure delivery of uninterrupted care to members, to accomplish orderly transition of those members to other Contractors, or until the Contractor reorganizes or otherwise corrects contract performance failure.

If AHCCCS undertakes direct operation of the Contractor, AHCCCS, through designees appointed by the Director, shall be vested with full and exclusive power of management and control of the Contractor as necessary to ensure the uninterrupted care to persons and accomplish the orderly transition of persons to a new or existing Contractor, or until the Contractor corrects the Contract Performance failure to the satisfaction of AHCCCS. AHCCCS shall have the power to employ any necessary assistants, to execute any instrument in the name of the Contractor, to commence, defend and conduct in its name any action or proceeding in which the Contractor may be a party; such powers shall only apply with respect to activities occurring after AHCCCS undertakes direct operation of the Contractor in connection with this Section.

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All reasonable expenses of AHCCCS related to the direct operation of the Contractor, including attorney fees, cost of preliminary or other audits of the Contractor and expenses related to the management of any office or other assets of the Contractor, shall be paid by the Contractor or withheld from payment due from AHCCCS to the Contractor.

Termination: AHCCCS reserves the right to terminate this contract in whole or in part due to the failure of the Contractor to comply with any term or condition of the contract and as authorized by the Balanced Budget Act of 1997 and 42 CFR 438.708. If the Contractor is providing services under more than one contract with AHCCCS, AHCCCS may deem unsatisfactory performance under one contract to be cause to require the Contractor to provide assurance of performance under any and all other contracts. In such situations, AHCCCS reserves the right to seek remedies under both actual and anticipatory breaches of contract if adequate assurance of performance is not received. The Contracting Officer shall mail written notice of the termination and the reason(s) for it to the Contractor by certified mail, return receipt requested. Pursuant to the Balanced Budget Act of 1997 and 42 CFR 438.708, AHCCCS shall provide the contractor with a pre-termination hearing before termination of the contract.

Upon termination, all documents, data, and reports prepared by the Contractor under the contract shall become the property of and be delivered to AHCCCS on demand.

AHCCCS may, upon termination of this contract, procure on terms and in the manner that it deems appropriate, materials or services to replace those under this contract. The Contractor shall be liable for any excess costs incurred by AHCCCS in re-procuring the materials or services.

20) TERMINATION — AVAILABILITY OF FUNDS

Funds are not presently available for performance under this contract beyond the current fiscal year. No legal liability on the part of AHCCCS for any payment may arise under this contract until funds are made available for performance of this contract.

Notwithstanding any other provision in the Agreement, this Agreement may be terminated by AHCCCS, if, for any reason, there are not sufficient appropriated and available monies for the purpose of maintaining this Agreement. In the event of such termination, the Contractor shall have no further obligation to AHCCCS.

21) RIGHT OF OFFSET

AHCCCS shall be entitled to offset against any amounts due the Contractor any expenses or costs incurred by AHCCCS concerning the Contractor's non-conforming performance or failure to perform the contract.

22) NON-EXCLUSIVE REMEDIES

The rights and the remedies of AHCCCS under this contract are not exclusive.

23) NON-DISCRIMINATION

In accordance with ARS 41-1461 et seq. and Executive Order 2009-09, the Contractor shall provide equal employment opportunities for all persons, regardless of race, color, religion, creed, sex, age, national origin, disability or political affiliation. The Contractor shall comply with the Americans with Disabilities Act.

24) EFFECTIVE DATE

The effective date of this contract shall be the date referenced on page 1 of this contract.

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25) INSURANCE

A certificate of insurance naming the State of Arizona and AHCCCS as the "additional insured" must be submitted to AHCCCS within 10 days of notification of contract award and prior to commencement of any services under this contract. This insurance shall be provided by carriers rated as "A+" or higher by the A.M. Best Rating Service. The following types and levels of insurance coverage are required for this contract:

- a. Commercial General Liability: Provides coverage of at least \$1,000,000 for each occurrence for bodily injury and property damage to others as a result of accidents on the premises of or as the result of operations of the Contractor.
- b. Commercial Automobile Liability: Provides coverage of at least \$1,000,000 for each occurrence for bodily injury and property damage to others resulting from accidents caused by vehicles operated by the Contractor.
- c. Workers Compensation: Provides coverage to employees of the Contractor for injuries sustained in the course of their employment. Coverage must meet the obligations imposed by Federal and State statutes and must also include Employer's Liability minimum coverage of \$100,000. Evidence of qualified self-insured status will also be considered.
- d. Professional Liability (if applicable): Provides coverage for alleged professional misconduct or lack of ordinary skills in the performance of a professional act of service.

The above coverage may be evidenced by either one of the following:

- a. The State of Arizona Certificate of Insurance: This is a form with the special conditions required by the contract already pre-printed on the form. The Contractor's agent or broker must fill in the pertinent policy information and ensure the required special conditions are included in the Contractor's policy.
- b. The Accord form: This standard insurance industry certificate of insurance does not contain the pre-printed special conditions required by this contract. These conditions must be entered on the certificate by the agent or broker and read as follows:

The State of Arizona and Arizona Health Care Cost Containment System are hereby added as additional insureds. Coverage afforded under this Certificate shall be primary and any insurance carried by the State or any of its agencies, boards, departments or commissions shall be in excess of that provided by the insured Contractor. No policy shall expire, be canceled or materially changed without 30 days written notice to the State. This Certificate is not valid unless countersigned by an authorized representative of the insurance company.

- c. If the Contractor is insured pursuant to A.R.S. § 11-981, the Insurance provisions required by the Contract are satisfied.

26) DISPUTES

Contract claims and disputes shall be adjudicated in accordance with State Law, AHCCCS Rules and this contract.

Except as provided by 9 A.A.C. Chapter 22, Article 6, the exclusive manner for the Contractor to assert any dispute against AHCCCS shall be in accordance with the process outlined in 9 A.A.C. Chapter 34 and ARS §36-2903.01. All disputes except as provided under 9 A.A.C. Chapter 22, Article 6 shall be filed in writing and be received by AHCCCS no later than 60 days from the date of the disputed notice. All disputes shall state the factual and legal basis for the dispute. Pending the final resolution of any disputes involving this contract, the Contractor shall proceed with performance of this contract in accordance with AHCCCS' instructions, unless AHCCCS specifically, in writing, requests termination or a temporary suspension of performance.

27) RIGHT TO INSPECT PLANT OR PLACE OF BUSINESS

AHCCCS may, at reasonable times, inspect the part of the plant or place of business of the Contractor or subcontractor that is related to the performance of this contract, in accordance with A.R.S. §41-2547.

28) INCORPORATION BY REFERENCE

This solicitation and all attachments and amendments, the Contractor's proposal, best and final offer accepted by AHCCCS, and any approved subcontracts are hereby incorporated by reference into the contract.

29) COVENANT AGAINST CONTINGENT FEES

The Contractor warrants that no person or agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee. For violation of this warranty, AHCCCS shall have the right to annul this contract without liability.

30) CHANGES

AHCCCS may at any time, by written notice to the Contractor, make changes within the general scope of this contract. If any such change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this contract, the Contractor may assert its right to an adjustment in compensation paid under this contract. The Contractor must assert its right to such adjustment within 30 days from the date of receipt of the change notice. Any dispute or disagreement caused by such notice shall constitute a dispute within the meaning of Section E, Paragraph 26, Disputes, and be administered accordingly.

When AHCCCS issues an amendment to modify the contract, the provisions of such amendment will be deemed to have been accepted 60 days after the date of mailing by AHCCCS, even if the amendment has not been signed by the Contractor, unless within that time the Contractor notifies AHCCCS in writing that it refuses to sign the amendment. If the Contractor provides such notification, AHCCCS will initiate termination proceedings.

31) TYPE OF CONTRACT

Firm Fixed-Price stated as capitated per member per month, except as otherwise provided.

32) AMERICANS WITH DISABILITIES ACT

People with disabilities may request special accommodations such as interpreters, alternative formats or assistance with physical accessibility. Requests for special accommodations must be made with at least three days prior notice by contacting the Solicitation Contact person.

33) WARRANTY OF SERVICES

The Contractor warrants that all services provided under this contract will conform to the requirements stated herein. AHCCCS' acceptance of services provided by the Contractor shall not relieve the Contractor from its obligations under this warranty. In addition to its other remedies, AHCCCS may, at the Contractor's expense, require prompt correction of any services failing to meet the Contractor's warranty herein. Services corrected by the Contractor shall be subject to all of the provisions of this contract in the manner and to the same extent as the services originally furnished.

34) NO GUARANTEED QUANTITIES

AHCCCS does not guarantee the Contractor any minimum or maximum quantity of services or goods to be provided under this contract.

35) CONFLICT OF INTEREST

The Contractor shall not undertake any work that represents a potential conflict of interest, or which is not in the best interest of AHCCCS or the State without prior written approval by AHCCCS. The Contractor shall fully and completely disclose any situation that may present a conflict of interest. If the Contractor is now performing or elects to perform during the term of this contract any services for any AHCCCS contractor, provider or Contractor or an entity owning or controlling same, the Contractor shall disclose this relationship prior to accepting any assignment involving such party.

36) CONFIDENTIALITY AND DISCLOSURE OF CONFIDENTIAL INFORMATION

The Contractor shall safeguard confidential information in accordance with Federal and State laws and regulations, including but not limited to, 42 CFR 431 Subpart F, A.R.S. §§36-107, 36-2903 (for Acute), 36-2932 (for ALTCS), 41-1959, and 46-135, the Health Insurance Portability and Accountability Act (Public Law 107-191 Statutes 1936), 45 CFR parts 160 and 164, and AHCCCS Rules.

The Contractor shall establish and maintain procedures and controls that are acceptable to AHCCCS for the purpose of assuring that no information contained in its records or obtained from AHCCCS or others carrying out its functions under the contract shall be used or disclosed by its agents, officers or employees, except as required to efficiently perform duties under the contract. Except as required or permitted by law, the contractor also agrees that any information pertaining to individual persons shall not be divulged other than to employees or officers of the contractor as needed for the performance of duties under the contract, unless otherwise agreed to, in writing, by AHCCCS.

The Contractor shall not, without prior written approval from AHCCCS, either during or after the performance of the services required by this contract, use, other than for such performance, or disclose to any person other than AHCCCS personnel with a need to know, any information, data, material, or exhibits created, developed, produced, or otherwise obtained during the course of the work required by this contract. This nondisclosure requirement shall also pertain to any information contained in reports, documents, or other records furnished to the Contractor by AHCCCS.

37) COOPERATION WITH OTHER CONTRACTORS

AHCCCS may award other contracts for additional work related to this contract and Contractor shall fully cooperate with such other contractors and AHCCCS employees or designated agents. The Contractor shall not commit or permit any act which will interfere with the performance of work by any other contractor or by AHCCCS employees.

38) ASSIGNMENT OF CONTRACT AND BANKRUPTCY

This contract is voidable and subject to immediate cancellation by AHCCCS upon the Contractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or assigning rights or obligations under this contract without the prior written consent of AHCCCS.

39) OWNERSHIP OF INFORMATION AND DATA

Any data or information system, including all software, documentation and manuals, developed by the Contractor pursuant to this contract, shall be deemed to be owned by AHCCCS. The Federal government reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use and to authorize others to use for Federal government purposes, such data or information system, software, documentation and manuals. Proprietary software which is provided at established catalog or market prices and sold or leased to the general public shall not be subject to the ownership or licensing provisions of this section.

Data, information and reports collected or prepared by the Contractor in the course of performing its duties and obligations under this contract shall be deemed to be owned by AHCCCS. The ownership provision is in consideration of the Contractor's use of public funds in collecting or preparing such data, information and reports. These items shall not be used by the Contractor for any independent project of the Contractor or publicized by the Contractor without the prior written permission of AHCCCS. Subject to applicable state and Federal laws and regulations, AHCCCS shall have full and complete rights to reproduce, duplicate, disclose and otherwise use all such information. At the termination of the contract, the Contractor shall make available all such data to AHCCCS within 30 days following termination of the contract or such longer period as approved by AHCCCS, Office of the Director. For purposes of this subsection, the term "data" shall not include member medical records.

Except as otherwise provided in this section, if any copyrightable or patentable material is developed by the Contractor in the course of performance of this contract, the Federal government, AHCCCS and the State of Arizona shall have a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the work for state or Federal government purposes. The Contractor shall additionally be subject to the applicable provisions of 45 CFR Part 74 and 45 CFR Parts 6 and 8.

SECTION E: CONTRACT TERMS AND CONDITIONS

Contract/RFP No. YH09-0001

40) AUDITS AND INSPECTIONS

The Contractor shall comply with all provisions specified in applicable A.R.S. 35-214 and 35-215 and AHCCCS Rules and AHCCCS policies and procedures relating to the audit of the Contractor's records and the inspection of the Contractor's facilities. The Contractor shall fully cooperate with AHCCCS staff and allow them reasonable access to the Contractor's staff, subcontractors, members, and records [42 CFR 438.6(g)].

At any time during the term of this contract, and five (5) years thereafter unless a longer time is otherwise required by law, the Contractor's or any subcontractor's books and records shall be subject to audit by AHCCCS and, where applicable, the Federal government, to the extent that the books and records relate to the performance of the contract or subcontracts [42 CFR 438.242(b)(3)].

AHCCCS, or its duly authorized agents, and the Federal government may evaluate through on-site inspection or other means, the quality, appropriateness and timeliness of services performed under this contract.

41) LOBBYING

No funds paid to the Contractor by AHCCCS, or interest earned thereon, shall be used for the purpose of influencing or attempting to influence an officer or employee of any Federal or State agency, a member of the United States Congress or State Legislature, an officer or employee of a member of the United States Congress or State Legislature in connection with awarding of any Federal or State contract, the making of any Federal or State grant, the making of any Federal or State loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal or State contract, grant, loan, or cooperative agreement. The Contractor shall disclose if any funds paid to the Contractor by AHCCCS have been used or will be used to influence the persons and entities indicated above and will assist AHCCCS in making such disclosures to CMS.

42) CHOICE OF FORUM

The parties agree that jurisdiction over any action arising out of or relating to this contract shall be brought or filed in a court of competent jurisdiction located in the State of Arizona.

43) DATA CERTIFICATION

The Contractor shall certify that financial and encounter data submitted to AHCCCS is complete, accurate and truthful. Certification of financial and encounter data must be submitted concurrently with the data. Certification may be provided by the Contractor CEO, CFO or an individual who is delegated authority to sign for, and who report directly to the CEO or CFO [42 CFR 438.604 et seq.].

44) OFF SHORE 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. A Contractor shall declare all current and anticipated offshore services annually by October 15th.

45) FEDERAL IMMIGRATION AND NATIONALITY ACT

The Contractor shall comply with all federal, state and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, the Contractor shall flow down this requirement to all subcontractors utilized during the term of the contract. The State shall retain the right to perform random audits of Contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the Contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the contract for default and suspension and/or debarment of the Contractor.

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Compliance with the Federal Immigration and Nationality Act (FINA) and All Other Federal Immigration Laws and Regulations related to Immigration Status of its Employees:

By entering into the Contract, the Contractor warrants compliance with the Federal Immigration and Nationality Act (FINA) and all other Federal immigration laws and regulations related to the immigration status of its employees. The Contractor shall obtain statements from its subcontractors certifying compliance and shall furnish the statements to the Procurement Officer, upon request. These warranties shall remain in effect through the term of the Contract. The Contractor and its subcontractors shall also maintain Employment Eligibility Verification forms (I-9) as required by the U.S. Department of Labor's Immigration and Control Act, for all employees performing work under the Contract. I-9 forms are available for download at USACIS.GOV.

The State may request verification of compliance for any Contractor or subcontractor performing work under the Contract. Should the State suspect or find that the Contractor or any of its subcontractors are not in compliance, the State may pursue any and all remedies allowed by law, including, but not limited to: suspension of work, termination of the Contract for default, and suspension and/or debarment of the Contractor. All costs necessary to verify compliance are the responsibility of the Contractor.

Compliance Requirements for A.R.S. 41-4401, Government Procurement: E-Verify Requirement:

The contractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. 23-214, Subsection A. (That subsection reads: "After December 31, 2007, every employer, after hiring an employee, shall verify the employment eligibility of the employee through the E-Verify program.")

A breach of a warranty regarding compliance with immigration laws and regulations shall be deemed a material breach of the contract and the contractor may be subject to penalties up to and including termination of the contract.

Failure to comply with a State audit process to randomly verify the employment records of contractors and subcontractors shall be deemed a material breach of the contract and the contractor may be subject to penalties up to and including termination of the contract.

The State agency retains the legal right to inspect the papers of any employee who works on the contract to ensure that the contractor or subcontractor is complying with the warranty.

46) IRS W-9 FORM

In order to receive payment under any resulting contract, the Contractor shall have a current IRS W-9 Form on file with the State of Arizona.

47) CONTINUATION OF PERFORMANCE THROUGH TERMINATION

The Contractor shall continue to perform, in accordance with the requirements of the contract, up to the date of termination and as directed in the termination notice.

[END OF SECTION E]

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SECTION F: RESERVED

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SECTION G: RESERVED

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SECTION H: RESERVED

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SECTION I: RESERVED

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SECTION J: LIST OF ATTACHMENTS

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SECTION J: LIST OF ATTACHMENTS

Attachment A: RESERVED

Attachment B: Geographic Service Area; Minimum Network Requirements

Attachment C: RESERVED

Attachment D: Sample Letter of Intent: Network Submission Requirements

Attachment E: RESERVED

Attachment F: Periodic Reporting Requirements

Attachment G: Auto-Assignment Algorithm

Attachment H: Grievance System Standards and Policy

Attachment I: RESERVED

Attachment J: RESERVED

Attachment K: RESERVED

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ATTACHMENT A: RESERVED

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ATTACHMENT A: RESERVED

The Minimum Subcontract Provisions document is available on the AHCCCS Website at:

<http://www.azahcccs.gov/commercial/default.aspx>

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ATTACHMENT B: MINIMUM NETWORK STANDARDS

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ATTACHMENT B: MINIMUM NETWORK STANDARDS (By Geographic Service Area)

INSTRUCTIONS:

Contractors shall have in place an adequate network of providers capable of meeting contract requirements. The information that follows describes the minimum network requirements by Geographic Service Area (GSA).

In some GSAs there are required service sites located outside of the geographical boundary of a GSA. The reason for this relates to practical access to care. In certain instances, a member must travel a much greater distance to receive services within their assigned GSA, than if the member were not allowed to receive services in an adjoining Border Community.

Split zip codes occur in some counties. Split zip codes are those which straddle two different counties. Enrollment for members residing in these zip codes is based upon the county and GSA to which the entire zip code has been assigned by AHCCCS. The Contractor shall be responsible for providing services to members residing in the entire zip code that is assigned to the GSA for which the Contractor has agreed to provide services. The split zip codes GSA assignments are as follows:

ZIP CODE	SPLIT BETWEEN THESE COUNTIES	COUNTY ASSIGNED TO	ASSIGNED GSA
85140	Pinal and Maricopa	Maricopa	12
85120	Pinal and Maricopa	Maricopa	12
85142	Pinal and Maricopa	Maricopa	12
85192	Gila and Pinal	Gila	8
85342	Yavapai and Maricopa	Maricopa	12
85358	Yavapai and Maricopa	Maricopa	12
85390	Yavapai and Maricopa	Maricopa	12
85643	Graham and Cochise	Cochise	14
85645	Pima and Santa Cruz	Santa Cruz	10
85943	Apache and Navajo	Navajo	4
86336	Coconino and Yavapai	Yavapai	6
86351	Coconino and Yavapai	Coconino	4
86434	Mohave and Yavapai	Yavapai	6
86340	Coconino and Yavapai	Yavapai	6
85143	Pinal and Maricopa	Maricopa	12

If outpatient specialty services (OB, family planning, and pediatrics) are not included in the primary care provider contract, at least one subcontract is required for each of these specialties in the service sites specified.

In Tucson (GSA 10) and Metropolitan Phoenix (GSA 12), the Contractor must have a network that is able to provide PCP, dental and pharmacy services so that members do not need to travel more than 5 miles from their residence. The Contractor must also obtain at least one hospital contract in each service district listed on the Hospitals in Phoenix and Tucson Metropolitan area pages within this section, respectively. Metropolitan Phoenix is further defined on the Minimum Network Standard page specific to GSA # 12.

At a minimum, the Contractor shall have contracts with physicians with admitting and treatment privileges at each hospital in its network.

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ATTACHMENT B: MINIMUM NETWORK STANDARDS

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For the remaining GSAs and areas not included in the Phoenix or Tucson Metropolitan Areas, the Contractor is required to obtain contracts with Physician(s) with admission and treatment privileges in the communities identified under *Hospitals on the Minimum Network Standard* page specific to each GSA. The Contractor must have a network that is able to provide PCP, dental and pharmacy services in each of the communities identified on the Minimum Network Standard Page specific to each GSA.

Provider categories required at various service delivery sites included in the Service Area Minimum Network Standards are indicated as follows:

- H** Hospitals
- P**
- D** Primary Care Providers (physicians, certified nurse practitioners and physician assistants)
- Ph** Dentists
- Pharmacies

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HOSPITALS IN PHOENIX METROPOLITAN AREA (By service district, by zip code)

DISTRICT 1

85006 Banner Good Samaritan Medical Center
85281 St. Luke's Medical Center
85008 Maricopa Medical Center
85013 St. Joseph's Hospital Phoenix
85020 John C. Lincoln Hospital — North Mountain

DISTRICT 2

85015 Phoenix Baptist Hospital
85027 John C. Lincoln Hospital — Deer Valley
85037 Banner Estrella Medical Center
85306 Banner Thunderbird Medical Center
85308 Arrowhead Community Hospital
85338 West Valley Hospital
85351 Banner Boswell Medical Center
85375 Banner Del E. Webb Medical Center
85031 Maryvale Hospital Medical Center

DISTRICT 3

85031 Paradise Valley Hospital
85054 Mayo Clinic Hospital
85251 Scottsdale Healthcare — Osborn
85261 Scottsdale Healthcare — Shea
85255 Scottsdale Healthcare — Thompson Peak

DISTRICT 4

85201 Arizona Regional Medical Center
85202 Banner Desert Medical Center
85206 Banner Baywood Medical Center
85224 Chandler Regional Hospital
85281 Tempe St. Luke's Hospital
85296 Mercy Gilbert Medical Center
85234 Banner Gateway Medical Center
85209 Mountain Vista Medical Center
85140 Banner Ironwood Medical Center

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HOSPITALS IN TUCSON METROPOLITAN AREA (By service district, by zip code)

DISTRICT 1

85719	University Medical Center
85741	Northwest Medical Center
85745	Carondelet St. Mary's Hospital
85775	Northwest Medical Center Oro Valley

DISTRICT 2

85711	Carondelet St. Joseph's Hospital
85717	Tucson Medical Center
85713	University Physicians Hospital at Kino Campus

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ATTACHMENT B: MINIMUM NETWORK STANDARDS

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COUNTIES: LA PAZ AND YUMA

Geographic Service Area 2

Hospitals Physician(s) w/admit and
treatment privileges required in the
following communities Blythe, CA
Lake Havasu City

Parker

Yuma

Primary Care Providers

Blythe, CA

Lake Havasu City

Parker

San Luis

Somerton

Wellton

Yuma

Dentists

Blythe, CA

Lake Havasu City

Parker

San Luis

Yuma

Pharmacies

Blythe, CA

Lake Havasu City

Parker

Somerton

San Luis

Yuma



H=Hospital

P=Primary Care Physician

D=Dentist

Ph=Pharmacy

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ATTACHMENT B: MINIMUM NETWORK STANDARDS

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COUNTIES: APACHE, COCONINO, MOHAVE, AND NAVAJO

Geographic Service Area 4

Hospitals Physician(s) w/admit and treatment privileges required in the following communities
Bullhead City

Flagstaff

Gallup, NM

Kanab, UT

Kingman
Lake Havasu City

Needles, CA
Page

Payson

Show Low

Springerville

St. George, UT
Winslow

Primary Care Providers

Ash Fork/Seligman

Bullhead City

Colorado City or Hilldale or Kanab, UT

Flagstaff

Fort Mohave

Gallup, NM

Holbrook

Kingman

Lake Havasu City

Page

Payson

Sedona

Show Low or Pinetop or Lakeside

Snowflake or Taylor

Springerville or Eager

St. George, UT or Mesquite, NV

St. Johns

Williams

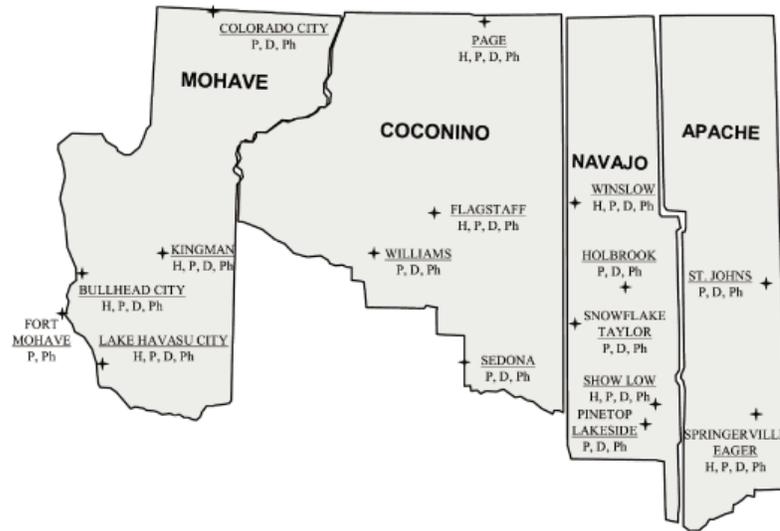
Winslow

Dentists

SAME AS PRIMARY CARE PROVIDERS (except for Fort Mohave, no dentist required)

Pharmacies

SAME AS PRIMARY CARE PROVIDERS



H=Hospital

P=Primary Care Physician

D=Dentist

Ph=Pharmacy

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ATTACHMENT B: MINIMUM NETWORK STANDARDS

Contract/RFP No. YH09-0001

COUNTY: YAVAPAI

Geographic Service Area 6

Hospitals Physician(s) w/admit
and treatment privileges required
in the following communities
Cottonwood

Flagstaff

Maricopa County

Prescott

Primary Care Providers

Ash Fork or Seligman

Camp Verde

Cottonwood

Maricopa County or Wickenburg

Prescott

Prescott Valley

Sedona

Dentists

SAME AS PRIMARY CARE

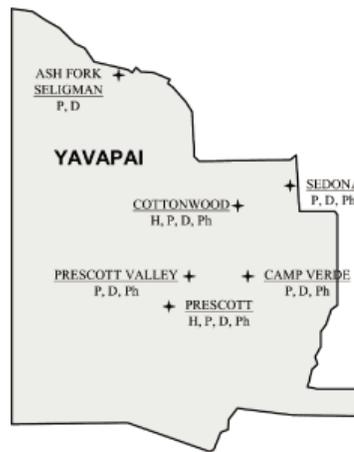
PROVIDERS

Pharmacies

SAME AS PRIMARY CARE

PROVIDERS

(except for Ash Fork/Seligman,
no pharmacy required)



H=Hospital

P=Primary Care Physician

D=Dentist

Ph=Pharmacy

CYE 12 Acute Care Contract

10/01/11

ATTACHMENT B: MINIMUM NETWORK STANDARDS

Contract/RFP No. YH09-0001

COUNTIES: PINAL AND GILA

Geographic Service Area 8

Hospitals Physician(s) w/admit

and treatment privileges required

in the following communities

Casa Grande

Globe

San Tan Valley

Payson

Primary Care Providers

Apache Junction

Casa Grande

Coolidge or Florence

Eloy

Globe or Miami or Claypool

Kearney

Mammoth or San Manuel or

Oracle

Mesa or Gilbert or Queen Creek

Payson

Dentists

Apache Junction

Casa Grande

Coolidge or Florence

Eloy

Globe or Miami or Claypool

Kearney

Mammoth or San Manuel or

Oracle

Mesa or Gilbert or Queen Creek

Payson

Pharmacies

Apache Junction

Casa Grande

Coolidge or Florence

Globe or Miami or Claypool

Kearney

Mammoth or San Manuel or

Oracle

Mesa or Gilbert or Queen Creek

Payson



H=Hospital

P=Primary Care Physician

D=Dentist

Ph=Pharmacy

CYE 12 Acute Care Contract

10/01/11

ATTACHMENT B: MINIMUM NETWORK STANDARDS

Contract/RFP No. YH09-0001

COUNTY: PIMA AND SANTA CRUZ

Geographic Service Area 10

Hospital

Tucson
District 1

Contract Required
District 2

Nogales

Contract Required
Physician(s) w/admit and
treatment privileges required

Primary Care Providers

Ajo

Green Valley

Marana

Nogales

Oro Valley

Tucson

Dentists

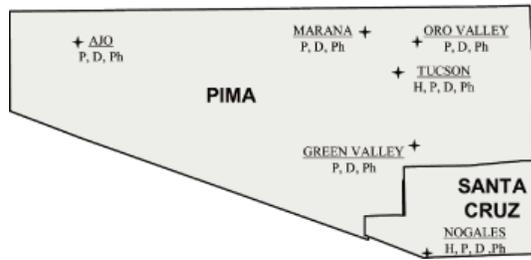
SAME AS PRIMARY CARE

PROVIDERS

Pharmacies

SAME AS PRIMARY CARE

PROVIDERS



H=Hospital

P=Primary Care Physician

D=Dentist

Ph=Pharmacy

CYE 12 Acute Care Contract

10/01/11

ATTACHMENT B: MINIMUM NETWORK STANDARDS

Contract/RFP No. YH09-0001

COUNTY: MARICOPA

Geographic Service Area 12

Hospital

- Metropolitan Phoenix*
- District 1
 Contract Required
- District 2
 Contract Required
- District 3
 Contract Required
- District 4
 Contract Required

Primary Care Providers

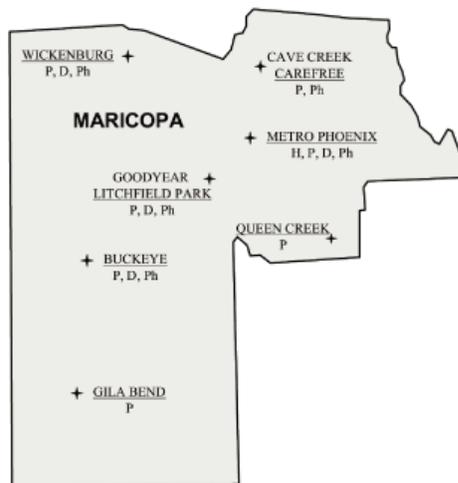
- Buckeye
- Cave Creek or Carefree
- Gila Bend
- Goodyear or Litchfield Park
- Metropolitan Phoenix*
- Queen Creek
- Wickenburg

Dentists

- Buckeye or Goodyear or Litchfield Park
- Metropolitan Phoenix*
- Wickenburg

Pharmacies

- Buckeye
- Cave Creek or Carefree
- Goodyear or Litchfield Park
- Metropolitan Phoenix*
- Wickenburg



* For Purposes of this RFP, Metropolitan Phoenix encompasses the following: Apache Junction, Avondale, Chandler, El Mirage, Fountain Hills, Gilbert, Glendale, Mesa, Paradise Valley, Peoria, Phoenix, Scottsdale, Sun City/Sun City West, Surprise, Tempe, Tolleson, and Youngtown. Within this area, distance standards must be met as specified in Attachment B.

H=Hospital

P=Primary Care Physician

D=Dentist

Ph=Pharmacy

ATTACHMENT B: MINIMUM NETWORK STANDARDS

Contract/RFP No. YH09-0001

COUNTIES: COCHISE, GRAHAM AND GREENLEE

Geographic Service Area 14

Hospitals Physician(s)

w/admit and treatment

privileges required in the

following communities

Benson

Bisbee

Douglas

Safford

Sierra Vista

Tucson

Willcox

Primary Care Providers

Benson

Bisbee

Douglas

Morenci or Clifton

Safford

Sierra Vista

Willcox

Dentists

Benson or Willcox

Bisbee

Douglas

Morenci or Clifton

Safford

Sierra Vista

Pharmacies

Benson

Bisbee

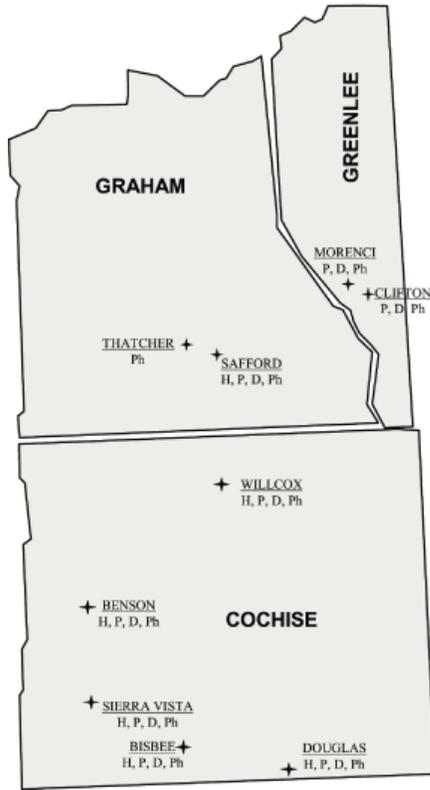
Douglas

Morenci or Clifton

Safford or Thatcher

Sierra Vista

Willcox



H=Hospital

P=Primary Care Physician

D=Dentist

Ph=Pharmacy

CYE 12 Acute Care Contract

10/01/11

ATTACHMENT C: RESERVED

Contract/RFP No. YH09-0001

ATTACHMENT C: RESERVED

CYE 12 Acute Care Contract

10/01/11

ATTACHMENT D: SAMPLE LETTER OF INTENT

The following information is provided as early notification for Offerors' benefit. However, complete instructions regarding this Letter of Intent will be provided when the RFP is released. Only instructions included in the RFP are considered official. Do not send completed Letter of Intent to AHCCCS at this time.

Letter of Intent Instructions

The following is the mandated format for the Arizona Health Care Cost Containment System, Contract Year Ending 2007 Letter of Intent (LOI). It is to be used to show a provider's intention to enter into a contract with an Offeror. No alterations or changes are permitted, except for shaded areas which identify the Offeror. The Offeror may print the form on its letterhead or insert its name or logo in the box at the top of the forms. The completed LOI or an executed contract will be acceptable evidence of an Offeror's proposed network.

If a provider has multiple sites that offer identical services, only one LOI should be signed, with additional service site information (items 1 to 6) attached to the LOI. If services differ between sites, a separate LOI must be obtained for each service site.

If a representative signs an LOI on behalf of a provider, evidence of authority for the representative must be available upon request.

CYE 12 Acute Care Contract

10/01/11

OFFEROR'S

LOGO

Please do not sign this Letter of Intent unless you seriously intend to enter into negotiations with the Offeror mentioned below and understand that the Arizona Health Care Cost Containment System (AHCCCS) requires all contracts to include Minimum Subcontract Provisions as listed at http://www.azahcccs.gov/Contracting/BidderLib_Acute.asp.

No alterations or changes are permitted, except for shaded areas which identify the Offeror. This letter is subject to verification by AHCCCS.

The provider signing below is willing to enter into contract negotiations with (Offeror's name), for provision of covered services to AHCCCS members enrolled with (Offeror's name). This provider intends to sign a contract with (Offeror's name) if (Offeror's name) is awarded an AHCCCS contract beginning October 1, 2008 in the provider's service area and an acceptable agreement can be reached between the provider and (Offeror's name). Signing this Letter of Intent does not obligate the provider to sign a contract with (Offeror's name) however, please do not sign this Letter of Intent unless you seriously intend to enter into negotiations with the above mentioned health plan.

The following information is furnished by the provider:

1. NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI) or AHCCCS PROVIDER IDENTIFICATION NUMBER _____

2. PROVIDER'S PRINTED NAME _____

3. ADDRESS (where services will be provided) _____

ZIP CODE _____

4. COUNTY _____ 5. TELEPHONE _____ 6. FAX _____

Please check here if additional service site information is attached to the Letter of Intent

7. CHECK ALL THAT APPLY

A. Primary Care Physician

- Family Practice
- General Practice
- Pediatrics
- Internal Medicine

Services:

- EPSDT
- OB

B. Primary Care Nurse Practitioner

- Family Practice
- Adult
- Pediatrics
- Midwife

ATTACHMENT D: SAMPLE LETTER OF INTENT

Contract/RFP No. YH09-0001

Services:

- EPSDT
- OB

C. Primary Care Physician's Assistant

Services:

- EPSDT
- OB

D. Physician — Specialist — (Specify) _____

E. Hospital

F. Urgent Care Facility

G. Pharmacy

H. Laboratory

I. Medical Imaging

J. Medically Necessary Transportation

K. Nursing Facility

L. Dentist

M. Therapy (Specify Physical Therapy, Occupational Therapy, Speech, Respiratory) _____

N. Behavioral Health Provider (Specify) _____

O. Durable Medical Equipment

P. Home Health Agency

Q. Other (Please Specify) _____

8. LANGUAGES SPOKEN BY THE PROVIDER (OTHER THAN ENGLISH) _____

9. NAME OF HOSPITAL(S) WHERE PHYSICIAN HAS ADMITTING PRIVILEGES _____

NOTICE TO PROVIDERS: This Letter of Intent will be used by AHCCCS in its bid evaluation and contract award process. You should only sign this Letter of Intent if you intend to enter into contract negotiations with (Offeror's name) should they receive a contract award. If you are signing on behalf of a physician, please provide evidence of your authority to do so.

Do not return completed Letter of Intent to AHCCCS. Completed Letter of Intent needs to be returned to (Offeror's name).

10. PROVIDER'S SIGNATURE _____ DATE _____

11. PRINTED NAME OF SIGNER _____ TITLE _____

CYE 12 Acute Care Contract

10/01/11



OFFEROR'S

LOGO

ADDITIONAL SERVICE SITES:

1. NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI) or AHCCCS PROVIDER IDENTIFICATION NUMBER _____

2. PROVIDER'S PRINTED NAME _____

3. ADDRESS (where services will be provided)

ZIP CODE _____

4. COUNTY _____ 5. TELEPHONE _____ 6. FAX _____

3. ADDRESS (where services will be provided)

ZIP CODE _____

4. COUNTY _____ 5. TELEPHONE _____ 6. FAX _____

3. ADDRESS (where services will be provided)

ZIP CODE _____

4. COUNTY _____ 5. TELEPHONE _____ 6. FAX _____

3. ADDRESS (where services will be provided)

ZIP CODE _____

4. COUNTY _____ 5. TELEPHONE _____ 6. FAX _____

3. ADDRESS (where services will be provided)

ZIP CODE _____

4. COUNTY _____ 5. TELEPHONE _____ 6. FAX _____



ATTACHMENT D: SAMPLE LETTER OF INTENT

Contract/RFP No. YH09-0001

3. ADDRESS (where services will be provided)

_____ ZIP CODE _____

4. COUNTY _____ 5. TELEPHONE _____ 6. FAX _____

CYE 12 Acute Care Contract

10/01/11

ATTACHMENT E: RESERVED

Contract/RFP No. YH09-0001

ATTACHMENT E: RESERVED

CYE 12 Acute Care Contract

10/01/11

ATTACHMENT F: CONTRACTORS CHART OF DELIVERABLES

The following table is a summary of the periodic reporting requirements for the Contractor and is subject to change at any time during the term of the contract. The table is presented for convenience only and should not be construed to limit the Contractor's responsibilities in any manner. Content for all deliverables is subject to review. AHCCCS may assess sanctions if it is determined that late, inaccurate or incomplete data is submitted.

The deliverables listed below are due by 5:00 PM on the due date indicated, if the due date falls on a weekend or a State Holiday the due date is 5:00 PM on the next business day.

If a Contractor is in compliance with the contractual standards on the deliverables below marked with an asterisk (*), for a period of three consecutive months, the Contractor may request to submit data on a quarterly basis. However, if the Contractor is non-compliant with any standard on the deliverable or AHCCCS has concerns during the reporting quarter, the Contractor must immediately begin to submit on a monthly basis until three consecutive months of compliance are achieved.

<i>REPORT</i>	<i>WHEN DUE</i>	<i>SOURCE/REFERENCE</i>	<i>SEND TO:</i>	<i>SUBMITTED VIA</i>
DHCM Finance				
Monthly Financial Reporting Package	30 days after the end of the month, only when required by AHCCCS	Reporting Guide For Acute Health Care Contractors	Finance Manager	FTP server with email notification
Quarterly Financial Reporting Package	60 days after the end of each quarter	Reporting Guide For Acute Health Care Contractors	Finance Manager	FTP server with email notification
FQHC Member Information	60 days after the end of each quarter	Reporting Guide For Acute Health Care Contractors; Section D, Paragraph 34	Finance Manager	FTP server with email notification
Draft Annual Financial Reporting Package	90 days after the end of each fiscal year	Reporting Guide For Acute Health Care Contractors	Finance Manager	FTP server with email notification
Final Annual Financial Reporting Package	120 days after the end of each fiscal year	Reporting Guide For Acute Health Care Contractors	Finance Manager	FTP server with email notification
Advances/Loans/Equity Distributions	Submit for approval prior to effective date	Section D, Paragraph 49;	Finance Manager	FTP server with email notification
Premium Tax Reporting	March 15 th , June 15 th , September 15 th , December 15 th	ACOM Premium Tax Reporting Policy	Finance Manager	FTP server with email notification

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ATTACHMENT F: PERIODIC REPORT REQUIREMENTS

Contract/RFP No. YH09-0001

<u>REPORT</u>	<u>WHEN DUE</u>	<u>SOURCE/REFERENCE</u>	<u>SEND TO:</u>	<u>SUBMITTED VIA</u>
Quarterly Verification of Receipt of Paid Services (Section D, ¶66 and ACOM Policy 424)	Due the 15 th day after the end of the quarter that follows the reporting quarter Oct. — Dec. due April 15 Jan. — March due July 15 April — June due Oct. 15 July — Sept. due Jan. 15	Section D, Paragraph 19 and ACOM Policy 424	Finance Manager	FTP server with email notification
Quarterly Cost Avoidance/Recovery Report	Due 45 days after the reporting quarter Oct — Dec due Feb 14 Jan — March due May 15 Apr — June due August 14 July — Sept due Nov 14	Section D, ¶58 and Program Integrity Reporting Guide	Finance Manager	FTP server with email notification

<u>REPORT</u>	<u>WHEN DUE</u>	<u>SOURCE/REFERENCE</u>	<u>SEND TO:</u>	<u>SUBMITTED VIA</u>
DHCM Data Analysis and Research				
Corrected Pended Encounter Data	Monthly, according to established schedule	Encounter Reporting User Manual	Encounter Administrator	FTP server with email notification
New Day Encounter	Monthly, according to established schedule	Encounter Reporting User Manual	Encounter Administrator	FTP server with email notification
Medical Records for Data Validation	90 days after the request received from AHCCCS	Data Validation User Manual	Encounter Administrator	FTP server with email notification

<u>REPORT</u>	<u>WHEN DUE</u>	<u>SOURCE/REFERENCE</u>	<u>SEND TO:</u>	<u>SUBMITTED VIA</u>
Office of Program Integrity				
Provider Fraud/Abuse Report	Within 10 days of discovery	Section D, Paragraph 62	Office of Program Integrity Manager	Secure email or web portal
Eligible Person Fraud/Abuse Report	Within 10 days of discovery	Section D, Paragraph 62	Office of Program Integrity Manager	Secure email or web portal

AHCCCS will assess the following sanctions on the deliverables listed below, under DHCM Acute Care Operations, Clinical Quality Management and Medical Management that are not received by 5:00 PM on the due date indicated, if the due date falls on a weekend or a State Holiday, sanctions will be assessed on deliverables not received by 5:00 PM on the next business day.

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ATTACHMENT F: PERIODIC REPORT REQUIREMENTS

Contract/RFP No. YH09-0001

Late Deliverables

1 st time "late" sanction/ 1-10 days:	\$	5,000
1 st time "late" sanction/ 11-20 days:	\$	10,000
1 st time "late" sanction/ over 21 days:	\$	15,000
2 nd time "late" sanction/ 1-10 days:	\$	10,000
2 nd time "late" sanction/ 11-20 days:	\$	20,000
2 nd time "late" sanction/over 21 days:	\$	30,000
3 rd time "late" sanction/ 1-10 days:	\$	20,000
3 rd time "late" sanction/ 11-20 days:	\$	40,000
3 rd time "late" sanction/over 21 days:	\$	60,000

The sanctions outlined above are deliverable specific. For example, if the Contractor submits its claims dashboard 5 days late in January, a \$5,000 sanction will be assessed. The next month, if the Contractor submits its administrative measures 5 days late, it will be assessed a 1st time late sanction of \$5,000. However if the Contractor submits the claims dashboard 5 days late again in March AHCCCS will assess a 2nd time late sanction of \$10,000.

REPORT	WHEN DUE	SOURCE/REFERENCE	SEND TO:	SUBMITTED VIA
DHCM Acute Care Operations				
Annual Subcontractor Assignment and Evaluation Report	90 days after the beginning of the contract year	Section D, Paragraph 37; Section D, Paragraph 43	Operations and Compliance Officer	FTP server with email notification
Provider Affiliation Transmission	15 days after the end of each quarter	Provider Affiliation Transmission Manual, submitted to PMMIS Provider-to-Contractor FTP	Operations and Compliance Officer	FTP server with email notification
* Claims Dashboard	15 th day of each month following the reporting period	Section D, Paragraph 38; Claims Dashboard Reporting Guide	Operations and Compliance Officer	FTP server with email notification
Subcontracts	As required by Contract	Section D, Paragraph 37; ACOM Templates Policy	Operations and Compliance Officer	FTP server with email notification
Third Party Administrator subcontracts	60 days prior to the effective date of the subcontract	Section D, Paragraph 37; ACOM Templates Policy	Operations and Compliance Officer	FTP server with email notification
Provider Advances	As required by Policy	ACOM Provider and Affiliate Advance Request Policy	Operations and Compliance Officer	FTP server with email notification
Claim recoupments > \$50,000	Upon identification by Contractor	Section D, Paragraph 38; ACOM Recoupment Request Policy	Operations and Compliance Officer	FTP server with email notification
* Administrative Measures	15 th day of each month following the reporting period	Section D, Paragraph 25	Operations and Compliance Officer	FTP server with email notification

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Contract/RFP No. YH09-0001

<i>REPORT</i>	<i>WHEN DUE</i>	<i>SOURCE/REFERENCE</i>	<i>SEND TO:</i>	<i>SUBMITTED VIA</i>
Grievance System Report	First Day of 2 nd Month Following Month Being Reported	Section D, Paragraph 26; Grievance System Reporting Guide	Operations and Compliance Officer	FTP server with email notification
Provider Network Development and Management Plan	45 days after the first day of a new contract year	Section D, Paragraph 27; ACOM Provider Network Development and Management Plan Policy, 415	Operations and Compliance Officer	FTP server with email notification
Quarterly Provider Terminations Due To Rates	15 days after the end of each quarter	ACOM Provider Network Development and Management Plan Policy, 415	Operations and Compliance Officer	FTP server with email notification
Cultural Competency Plan	45 days after the first day of a new contract year	ACOM Cultural Competency Policy	Operations and Compliance Officer	FTP server with email notification
Business Continuity and Recovery Plan	15 days after the beginning of each contract year	ACOM Business Continuity and Recovery Plan Policy	Operations and Compliance Officer	FTP server with email notification
Marketing Attestation Statement	45 days after the beginning of each contract year	ACOM Marketing Outreach and Incentives Policy	Operations and Compliance Officer	FTP server with email notification
Marketing and Outreach Materials	30 days prior to dissemination	ACOM Marketing Outreach and Incentives Policy	Marketing Committee Chairperson	FTP server with email notification
Member Handbook	Within 4 weeks of receiving annual amendment and upon any changes prior to distribution.	Section D, Paragraph 18; ACOM Member Information Policy	Operations and Compliance Officer	FTP server with email notification
Provider Network — Material Change	Submit change for approval prior to effective date	Section D, Paragraph 29; ACOM Provider Network Information Policy	Operations and Compliance Officer	FTP server with email notification
Provider Network — Unexpected change	Within one business day	Section D, Paragraph 29	Operations and Compliance Officer	FTP server with email notification
System Change Plan	Six months prior to implementation	Section D, Paragraph 38	Operations and Compliance Officer	FTP server with email notification
Organizational Chart with "Key Staff" positions	October 15th	Section D, Paragraph 16	Operations and Compliance Officer	FTP server with email notification
Functional Organizational Chart with key program areas, responsibilities and reporting lines.	October 15th	Section D, Paragraph 16	Operations and Compliance Officer	FTP server with email notification

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ATTACHMENT F: PERIODIC REPORT REQUIREMENTS

Contract/RFP No. YH09-0001

REPORT	WHEN DUE	SOURCE/REFERENCE	SEND TO:	SUBMITTED VIA
Key Position Change	Within 7 days after an employee leaves and as soon as new hire has taken place	Section D, Paragraph 16	Operations and Compliance Officer	FTP server with email notification
Staff functions located outside of Arizona	October 15th	Section D, Paragraph 16	Operations and Compliance Officer	FTP server with email notification

REPORT	WHEN DUE	SOURCE/REFERENCE	SEND TO:	SUBMITTED VIA
DHCM Clinical Quality Management				
EPSDT Annual Monitoring Report	Annually on December 15 th	Section D, Paragraph 10, <i>Scope of Services, AMPM</i> , Chapter 400	DHCM/CQM	FTP server with email notification
EPSDT Improvement and Adult Quarterly Monitoring Report (Template must be used)	15 days after the end of each quarter	Section D, Paragraph 10, <i>Scope of Services, AMPM</i> , Chapter 400 See Suspension list for specific items being suspended	DHCM/CQM	FTP server with email notification
Quality Assessment/Performance Improvement Plan and Evaluation (Checklist to be submitted with Document)	Annually on December 15 th	<i>AMPM</i> , Chapter 900	DHCM/CQM	FTP server with email notification
Credentialing Quarterly Report	30 days after the end of each quarter	<i>Section D, Paragraph 25</i>	DHCM/CQM	FTP server with email notification
Monthly Pregnancy Termination Report	End of the month following the pregnancy termination	<i>AMPM</i> , Chapter 400	DHCM/CQM	Secure email to CQM Administrator or fax to 602-417-4162
Maternity Care Plan	Annually on December 15 th	<i>AMPM</i> , Chapter 400	DHCM/CQM	FTP server with email notification
Stillbirth Report	Immediately following procedure	<i>AMPM</i> , Chapter 400	DHCM/CQM	Secure email to CQM Administrator or fax to 602-417-4162
Semi-annual report of number of pregnant women who are HIV/AIDS positive	30 days after the end of the 2 nd and 4 th quarter of each contract year	<i>AMPM</i> , Chapter 400	DHCM/CQM	FTP server with email notification

CYE 12 Acute Care Contract

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ATTACHMENT F: PERIODIC REPORT REQUIREMENTS

Contract/RFP No. YH09-0001

REPORT	WHEN DUE	SOURCE/REFERENCE	SEND TO:	SUBMITTED VIA
Performance Improvement Project Baseline Report (Standardized format to be utilized)	Annually on December 15 th	AMPM, Chapter 900	DHCM/CQM FTP server with email notification	
Performance Improvement Project Re-measurement Report (Standardized format to be utilized)	Annually on December 15 th	AMPM, Chapter 900	DHCM/CQM FTP server with email notification	
Performance Improvement Project Final Report (Standardized format to be utilized)	Within 180 days of the end of the project, as defined in the project proposal approved by AHCCCS DHCM	AMPM, Chapter 900	DHCM/CQM FTP server with email notification	
QM Quarterly Report	45 Days after the end of each quarter	Section D, Paragraph 23	DHCM/CQM FTP server with email notification	
Pediatric Immunization Audit	As requested	Section D, Paragraph 23	DHCM/CQM FTP server with email notification	

REPORT	WHEN DUE	SOURCE/REFERENCE	SEND TO:	SUBMITTED VIA
DHCM Medical Management				
Quarterly Inpatient Hospital Showing	15 days after the end of each quarter	State Medicaid Manual and the AMPM, Chapter 1000	DHCM/MM FTP server with email notification	
Utilization Management Plan and Evaluation	Annually on December 15 th	AMPM, Chapter 900	DHCM/MM FTP server with email notification	
UM Quarterly Report	60 Days after the end of each quarter	Section D, Paragraph 24	DHCM/MM FTP server with email notification	
HIV Specialty Provider List	Annually, on December 15 th	AMPM, Chapter 300	DHCM/MM FTP server with email notification	
Transplant Report	15 days after the end of each month	AMPM, Chapter 1000	DHCM/MM FTP server with email notification	
Non-Transplant Catastrophic Reinsurance covered Diseases	Annually, within 30 days of the beginning of the contract year, enrollment to the plan, and when newly diagnosed.	Section D, Paragraph 57	DHCM/MM FTP server with email notification	

CYE 12 Acute Care Contract

10/01/11

Suspensions and Modifications

The following describes suspensions and modifications made during the current contract or renewal period with limited application. The following suspensions and modifications will be in effect for the period from October 1, 2011 through September 30, 2012. These changes do not serve to remove the requirement for the Contractor to collect, analyze, and respond to the internal monitoring mechanisms that support compliance with contractual and statutory requirements but serve only to condense deliverable requirements in order to ease administrative burden.

Suspensions

Suspensions will be defined as a complete temporary release from the deliverable requirement as presented in Contract for the term shown in this Attachment.

Section D, Paragraph 10, Scope of Services

Certain requirements contained in the EPSDT Quarterly Report are being suspended. The reporting requirements are being reduced by suspending the PEDS tracking, Obesity Tracking, Performance Measure reporting.

Section D, Paragraph 24, Medical Management

10. Within the term of this contract, the Contractor must review all prior authorization requirements for services, items or medications and submit a report to AHCCCS providing the rationale for the requirements. AHCCCS shall determine and provide a format for the report.

Section D, Paragraph 25, Administrative Performance Standards

The Quarterly Credentialing Report is being suspended. The standards will continue to be monitored during OFRs and AHCCCS will consider re-implementing based on the results.

Section D, Paragraph 38, Claims Payment/Health Information System

The Contractor must submit a signed agreement on or before December 31st 2008, with a schedule for completion, entered into with an independent auditing firm of their selection to be approved by the AHCCCS Division of Health Care Management. The Division of Health Care Management will monitor the scope of this audit, to include no less than a verification of contract information management (contract loading and auditing), claims processing and encounter submission processes

Section D, Paragraph 38, Claims Payment/Health Information System

Within the first 6 months of the contract term, the Contractor must review claim requirements, including billing rules and documentation requirements, and submit a report to AHCCCS that will include the rationale for the requirements. AHCCCS shall determine and provide a format for the report.

Attachment F, Periodic Reporting Requirements

<u>REPORT</u>	<u>WHEN DUE</u>	<u>SOURCE/REFERENCE</u>	<u>SEND TO:</u>	<u>SUBMITTED VIA</u>
DHCM Medical Management				
UM Quarterly Report	60 Days after the end of each quarter	Section D, Paragraph 24	DHCM/MM	FTP server with email notification

CYE 12 Acute Care Contract
10/01/11

ATTACHMENT F: PERIODIC REPORT REQUIREMENTS

Contract/RFP No. YH09-0001

Modifications

Modifications will be defined as a reduction in the frequency or content of a deliverable requirement that will remain in place throughout the temporary term shown in this Attachment.

There are no modifications at this time.

CYE 12 Acute Care Contract
10/01/11

ATTACHMENT G: AUTO-ASSIGNMENT ALGORITHM

Members who have the right to choose, but do not exercise this right, will be assigned to a Contractor through an auto-assignment algorithm. The algorithm is a mathematical formula used to distribute members to the various Contractors in a manner that is consistent with AHCCCS goals.

With the exception of an enhanced auto-assignment algorithm that may be in effect at the start of a new contract cycle (October 1, 2008) for a three to six month period, the auto-assignment algorithm calculation details are as follows:

The algorithm employs a data table and a formula to assign cases (a case may be a member or a household of members) to Contractors using the target percentages developed. The algorithm data table consists of all the geographic service areas (GSA) in the state, all Contractors serving each GSA, and the target percentages by risk group within each GSA.

The Contractor farthest away from its target percentage within a GSA and risk group, the largest negative difference, is assigned the next case for that GSA. The equation used is:

$$(t/T) - P = d$$

t = The total members assigned to the GSA, per risk group category, for the Contractor

T = The total members assigned to the GSA, per risk group category, all Contractors combined

P = The target percentage of members per risk group for the Contractor

d = The difference

The algorithm is calculated after each assignment to give a new difference for each Contractor. When more than one Contractor has the same difference, and their differences are greater than all other Contractors, the Contractor with the lowest Health Plan I.D. Number will be assigned the case.

Assignment by the algorithm applies to:

1. Members who are newly eligible to the AHCCCS program that did not choose a Contractor within the prescribed time limits.
2. Members whose assigned health plan is no longer available after the member moves to a new GSA and did not choose a new Contractor within the prescribed time limits.

All Contractors, within a given geographic service area (GSA) and for each risk group, will have a placement in the algorithm and will receive members accordingly. A Contractor with a more favorable target percentage in the algorithm will receive proportionally more members. Conversely, a Contractor with a lower target percentage in the algorithm will receive proportionally fewer members. The initial algorithm formula favors Contractors with both lower awarded capitation rates and higher scores on the Program Component of the proposal.

In future contract years, AHCCCS may adjust the auto-assignment algorithm in consideration of Contractors' clinical performance measure results when calculating target percentages. Ranking in the algorithm may be weighted based on the number of Performance Measures for which a Contractor is meeting the current AHCCCS Minimum Performance Standard (MPS) as a percentage of the total number of measures utilized in the calculation. AHCCCS will determine the Performance Measures used to evaluate Contractor performance and apply the criterion universally when making the adjustment.

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Development of the Target Percentages for CYE 09 through CYE 12

Beginning in CYE '09, the algorithm target percentages will be developed using the methodology described below, subject to the enhanced algorithm described below, if applicable. However, for subsequent years, AHCCCS reserves the right to change the algorithm methodology to assure assignments are made in the best interest of the AHCCCS program and the State.

A Contractor's placement in the algorithm is based upon the following two factors, which are weighted as follows:

#	Factor	Weighting
1	The Contractor's final awarded capitation rate from AHCCCS.	50%
2	The Contractor's score on the Program component of the proposal.	50%

Points will be assigned to each Contractor by risk group by GSA. Based on the rankings of the final awarded capitation rates and the final Program component scores, each Contractor will be assigned a number of points for each of these two components **separately** using the table below:

TABLE OF POINTS FOR FACTORS #1 (LOWEST CAPITATION RATE) AND #2 (HIGHEST PROGRAM SCORE)

Number of Awards in GSA	1st Place	2nd Place	3rd Place	4th Place	5th Place	6th Place
2	60	40				
3	44	32	24			
4	35	28	22	15		
5	30	25	20	15	10	
6	26	23	19	15	11	6

Two or more Contractors that have equal final awarded capitation rates or Program component scores in a GSA for the same risk group will be given an equal percentage of the points for all of the positions held by the tied Contractors combined.

The points awarded for the two components will be combined as follows to give the target percentage for each Contractor by GSA by risk group:

Final Awarded Capitation Rate (.50) + Program Component Score (.50) = TARGET PERCENTAGE

Development of the Target Percentages for CYE 13

A Contractor's placement in the algorithm for CYE 13 will be based upon the following two factors, which are weighted as follows:

#	Factor	Weighting
1	The Contractor's final awarded capitation rate from AHCCCS.	50%
2	The Contractor's percent of all Clinical Quality Performance Measures for which the Contractor meets the Minimum Performance Standard (MPS). Only those Contractors that meet at least 75% of the Minimum Standards for the measurement period of CYE 2011 receive points.	50%

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Points will be assigned to each Contractor by risk group by GSA. Based on the rankings of the final awarded capitation rates and the Clinical Quality Performance Measure results, each Contractor will be assigned a number of points for each of these two components **separately** using the table below:

TABLE OF POINTS FOR FACTORS #1 (LOWEST CAPITATION RATE) AND #2 (CLINICAL QUALITY PERFORMANCE MEASURES)

Number of Awards in GSA for Factor #1 or Number of Contractors at or above 75% for Factor #2	1st Place	2nd Place	3rd Place	4th Place	5th Place	6th Place
2	60	40				
3	44	32	24			
4	35	28	22	15		
5	30	25	20	15	10	
6	26	23	19	15	11	6

Two or more Contractors that have equal final awarded capitation rates in a GSA for the same risk group or equal Clinical Quality Performance Measure results will be given an equal percentage of the points for all of the positions held by the tied Contractors combined.

The points awarded for the two components will be combined as follows to give the target percentage for each Contractor by GSA by risk group:

Final Awarded Capitation Rate (.50) + Clinical Quality Performance Measure results (.50) = TARGET PERCENTAGE

Enrollment Considerations

AHCCCS will favor new and small Contractors in each GSA with increased auto-assignment. A new Contractor is defined as a Contractor new to the AHCCCS program or an incumbent Contractor that is new to a GSA. Small Contractors will be determined based on enrollment as of May 1, 2008. A small Contractor is defined by GSA and has a membership level as delineated in the following table:

County/GSA	GSA-specific Enrollment Threshold
Maricopa — GSA 12	<50,000
Pima County Only	<30,000
Rural GSAs (including Santa Cruz County)	less than or equal to 45% of enrollment in the entire GSA as of May 1, 2008

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Conversion Group Auto-Assignment

Members who are enrolled as of June 30, 2008 in an Exiting Contractor (Conversion Group) will be assigned to new and small Contractors within their GSA, effective October 1, 2008 via the conversion auto-assignment algorithm. These members will be allowed to remain with the Contractor to which they were auto-assigned or to choose a different Contractor by August 31, 2008 from any of the incumbent or new Contractors in the GSA that are effective October 1, 2008. These members will again have an opportunity to change Contractors from October 1, 2008 until November 30, 2008 in order to provide them with the choice of any incumbent or new Contractors.

If the number of members in the Conversion Group in a GSA is enough to bring all new and small Contractors within the GSA above the thresholds listed in the table above, the conversion auto-assignment algorithm will be applied until all of the new and small Contractors reach the thresholds. The remaining members of the Conversion Group will be auto-assigned to all Contractors in the GSA according to the initial algorithm methodology based on awarded capitation rates and Program Component scores.

If the number of Conversion Group members in a GSA is not enough to bring all new and small Contractors within the GSA above the thresholds listed in the table above, an enhanced auto-assignment will be utilized to bring all new and small Contractors as close to equal as possible, without reducing any Contractor size.

In a rural GSA, if both Contractors are new to AHCCCS, the Conversion Group members will be auto-assigned approximately equally between the two Contractors.

For details on member choice of Contractors for the months of July, August and September 2008, see Section I. For members being auto-assigned in July 2008, the algorithm will be based on the CYE 08 Contract. For members auto-assigned during August and September 2008, the algorithm will be based on the CYE 08 Contract with exiting Contractors in each GSA excluded, except in family continuity, newborn enrollment, and 90-day re-enrollment situations. For GSAs in which all Contractors are exiting, the CYE 08 algorithm will remain in effect through September 30, 2008.

Post-Conversion Auto-Assignment

For purposes of determining the enhanced algorithm, new Contractors and Continuing Contractors still below the thresholds on September 1, 2008 will receive members under the enhanced auto-assign algorithm beginning October 1, 2008. The enhanced algorithm will continue to favor those Contractors below the threshold, for at least three months but no longer than six months, regardless of their membership level during or at the end of the time period. **In this situation, the plans not qualifying for the enhanced auto-assignment algorithm will not receive any members via auto-assignment for the time period.** After the three to six month time period, the algorithm will revert to the initial methodology based on final awarded capitation and Program Component score and all Contractors will again be included in the algorithm.

All efforts will be made to auto-assign members based on the methodology and thresholds above, however amounts may not be exact due to issues such as family continuity, newborns, 90-day re-enrollment etc.

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ATTACHMENT H(1): ENROLLEE GRIEVANCE SYSTEM STANDARDS AND POLICY

The Contractor shall have a written policy delineating its Grievance System which shall be in accordance with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. The Contractor shall provide the ACOM *Enrollee Grievance Policy* to all providers and subcontractors at the time of contract. The Contractor shall also furnish this information to enrollees within a reasonable time after the Contractor receives notice of the enrollment. Additionally, the Contractor shall provide written notification of any significant change in this policy at least 30 days before the intended effective date of the change.

The written information provided to enrollees describing the Grievance System including the grievance process, the appeals process, enrollee rights, the grievance system requirements and timeframes, shall be in each prevalent non-English language occurring within the Contractor's service area and in an easily understood language and format. The Contractor shall inform enrollees that oral interpretation services are available in any language, that additional information is available in prevalent non-English languages upon request and how enrollees may obtain this information.

Written documents, including but not limited to the Notice of Action, the Notice of Appeal Resolution, Notice of Extension for Resolution, and Notice of Extension of Notice of Action shall be translated in the enrollee's language if information is received by the Contractor, orally or in writing, indicating that the enrollee has a limited English proficiency. Otherwise, these documents shall be translated in the prevalent non-English language(s) or shall contain information in the prevalent non-English language(s) advising the enrollee that the information is available in the prevalent non-English language(s) and in alternative formats along with an explanation of how enrollees may obtain this information. This information must be in large, bold print appearing in a prominent location on the first page of the document.

At a minimum, the Contractor's Grievance System Standards and Policy shall specify:

1. That the Contractor shall maintain records of all grievances, appeals and requests for hearing.
2. Information explaining the grievance, appeal, and fair hearing procedures and timeframes. This information shall include a description of the circumstances when there is a right to a hearing, the method for obtaining a hearing, the requirements which govern representation at the hearing, the right to file grievance and appeals and the requirements and timeframes for filing a grievance, appeal, or request for hearing.
3. The availability of assistance in the filing process and the Contractor's toll-free numbers that an enrollee can use to file a grievance or appeal by phone if requested by the enrollee.
4. That the Contractor shall acknowledge receipt of each grievance and appeal. For Appeals, the Contractor shall acknowledge receipt of standard appeals in writing within five business days of receipt and within one business day of receipt of expedited appeals.
5. That the Contractor shall permit both oral and written appeals and grievances and that oral inquiries appealing an action are treated as appeals.
6. That the Contractor shall ensure that individuals who make decisions regarding grievances and appeals are individuals not involved in any previous level of review or decision making and that individuals who make decisions regarding: 1) appeals of denials based on lack of medical necessity, 2) a grievance regarding denial of expedited resolution of an appeal or 3) grievances or appeals involving clinical issues are health care professionals as defined in 42 CFR 438.2 with the appropriate clinical expertise in treating the enrollee's condition or disease.

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7. The resolution timeframes for standard appeals and expedited appeals may be extended up to 14 days if the enrollee requests the extension or if the Contractor establishes a need for additional information and that the delay is in the enrollee's interest.
8. That if the Contractor extends the timeframe for resolution of an appeal when not requested by the enrollee, the Contractor shall provide the enrollee with written notice of the reason for the delay.
9. The definition of grievance as a member's expression of dissatisfaction with any aspect of their care, other than the appeal of actions.
10. That an enrollee must file a grievance with the Contractor and that the enrollee is not permitted to file a grievance directly with AHCCCS.
11. That the Contractor must dispose of each grievance in accordance with the *ACOM Enrollee Grievance Policy*, but in no case shall the timeframe exceed 90 days.
12. The definition of action as the [42 CFR 438.400(b)]:
 - a. Denial or limited authorization of a requested service, including the type or level of service;
 - b. Reduction, suspension, or termination of a previously authorized service;
 - c. Denial, in whole or in part, of payment for a service;
 - d. Failure to provide services in a timely manner;
 - e. Failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; or
 - f. Denial of a rural enrollee's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii), when the contractor is the only Contractor in the rural area.
13. The definition of a service authorization request as an enrollee's request for the provision of a service [42 CFR 431.201].
14. The definition of appeal as the request for review of an action, as defined above.
15. Information explaining that a provider acting on behalf of an enrollee and with the enrollee's written consent, may file an appeal.
16. That an enrollee may file an appeal of: 1) the denial or limited authorization of a requested service including the type or level of service, 2) the reduction, suspension or termination of a previously authorized service, 3) the denial in whole or in part of payment for service, 4) the failure to provide services in a timely manner, 5) the failure of the Contractor to comply with the timeframes for dispositions of grievances and appeals and 6) the denial of a rural enrollee's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii) when the Contractor is the only Contractor in the rural area.
17. The definition of a standard authorization request. For standard authorization decisions, the Contractor must provide a Notice of Action to the enrollee as expeditiously as the enrollee's health condition requires, but not later than 14 days following the receipt of the authorization request with a possible extension of up to 14 days if the enrollee or provider requests an extension or if the Contractor establishes a need for additional information and delay is in the enrollee's best interest [42 CFR 438.210(d)(1)]. The Notice of Action must comply with the advance notice requirements when there is a termination or reduction of a previously authorized service OR when there is a denial of an authorization request and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service.
18. The definition of an expedited authorization request. For expedited authorization decisions, the Contractor must provide a Notice of Action to the enrollee as expeditiously as the enrollee's health condition requires, but not later than 3 business days following the receipt of the authorization request with a possible extension of up to 14 days if the enrollee or provider requests an extension or if the Contractor establishes a need for additional information and delay is in the enrollee's interest [42 CFR 438.210(d)(2)].

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19. That the Notice of Action for a service authorization decision not made within the standard or expedited timeframes, whichever is applicable, will be made on the date that the timeframes expire. If the Contractor extends the timeframe to make a standard or expedited authorization decision, the contractor must give the enrollee written notice of the reason to extend the timeframe and inform the enrollee of the right to file a grievance if the enrollee disagrees with the decision. The Contractor must issue and carry out its decision as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
20. That the Contractor shall notify the requesting provider of the decision to deny or reduce a service authorization request. The notice to the provider must be written.
21. The definition of a standard appeal and that the Contractor shall resolve standard appeals no later than 30 days from the date of receipt of the appeal unless an extension is in effect. If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's appeal shall be considered to be denied by the Contractor, and the member can file a request for hearing.
22. The definition of an expedited appeal and that the Contractor shall resolve all expedited appeals not later than three business days from the date the Contractor receives the appeal (unless an extension is in effect) where the Contractor determines (for a request from the enrollee), or the provider (in making the request on the enrollee's behalf indicates) that the standard resolution timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. The Contractor shall make reasonable efforts to provide oral notice to an enrollee regarding an expedited resolution appeal. If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's appeal shall be considered to be denied by the Contractor, and the member can file a request for hearing.
23. That if the Contractor denies a request for expedited resolution, it must transfer the appeal to the 30-day timeframe for a standard appeal. The Contractor must make reasonable efforts to give the enrollee prompt oral notice and follow-up within two days with a written notice of the denial of expedited resolution.
24. That an enrollee shall be given 60 days from the date of the Contractor's Notice of Action to file an appeal.
25. That the Contractor shall mail a Notice of Action: 1) at least 10 days before the date of a termination, suspension or reduction of previously authorized AHCCCS services, except as provided in (a)-(e) below; 2) at least 5 days before the date of action in the case of suspected fraud; 3) at the time of any action affecting the claim when there has been a denial of payment for a service, in whole or in part; 4) within 14 days from receipt of a standard service authorization request and within three business days from receipt of an expedited service authorization request, unless an extension is in effect. For service authorization decisions, the Contractor shall also ensure that the Notice of Action provides the enrollee with advance notice and the right to request continued benefits for all terminations and reductions of a previously authorized service and for denials when the physician asserts that the requested service/treatment which has been denied is a necessary continuation of a previously authorized service. As described below, the Contractor may elect to mail a Notice of Action no later than the date of action when:
 - a. The Contractor receives notification of the death of an enrollee;
 - b. The enrollee signs a written statement requesting service termination or gives information requiring termination or reduction of services (which indicates understanding that the termination or reduction will be the result of supplying that information);
 - c. The enrollee is admitted to an institution where he is ineligible for further services;
 - d. The enrollee's address is unknown and mail directed to the enrollee has no forwarding address;
 - e. The enrollee has been accepted for Medicaid in another local jurisdiction.

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26. That the Contractor include, as parties to the appeal, the enrollee, the enrollee's legal representative, or the legal representative of a deceased enrollee's estate.
27. That the Notice of Action must explain: 1) the action the Contractor has taken or intends to take, 2) the reasons for the action, 3) the enrollee's right to file an appeal with the Contractor, 4) the procedures for exercising these rights, 5) circumstances when expedited resolution is available and how to request it and 6) the enrollee's right to receive continued benefits pending resolution of the appeal, how to request continued benefits and the circumstances under which the enrollee may be required to pay for the cost of these services. The Notice of Action shall comply with ACOM Policy 414.
28. That benefits shall continue until a hearing decision is rendered if: 1) the enrollee files an appeal before the later of a) 10 days from the mailing of the Notice of Action or b) the intended date of the Contractor's action, 2) a) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment or b) the appeal involves a denial and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service, 3) the services were ordered by an authorized provider and 4) the enrollee requests a continuation of benefits.

For purposes of this paragraph, benefits shall be continued based on the authorization which was in place prior to the denial, termination, reduction, or suspension which has been appealed.

29. That for appeals, the Contractor provides the enrollee a reasonable opportunity to present evidence and allegations of fact or law in person and in writing and that the Contractor informs the enrollee of the limited time available in cases involving expedited resolution.
30. That for appeals, the Contractor provides the enrollee and his representative the opportunity before and during the appeals process to examine the enrollee's case file including medical records and other documents considered during the appeals process.
31. That the Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an enrollee's appeal.
32. That the Contractor shall provide written Notice of Appeal Resolution to the enrollee and the enrollee's representative or the representative of the deceased enrollee's estate which must contain: 1) the results of the resolution process, including the legal citations or authorities supporting the determination, and the date it was completed, and 2) for appeals not resolved wholly in favor of enrollees: a) the enrollee's right to request a State fair hearing (including the requirement that the enrollee must file the request for a hearing in writing) no later than 30 days after the date the enrollee receives the Contractor's notice of appeal resolution and how to do so, b) the right to receive continued benefits pending the hearing and how to request continuation of benefits and c) information explaining that the enrollee may be held liable for the cost of benefits if the hearing decision upholds the Contractor.
33. That the Contractor continues extended benefits originally provided to the enrollee until any of the following occurs: 1) the enrollee withdraws appeal, 2) the enrollee has not specifically requested continued benefits pending a hearing decision within 10 days of the Contractor mailing of the appeal resolution notice, or 3) AHCCCS issues a state fair hearing decision adverse to the enrollee.
34. That if the enrollee files a request for hearing the Contractor must ensure that the case file and all supporting documentation is received by the AHCCCS Office of Administrative Legal Services (OALS) as specified by OALS. The file provided by the Contractor must contain a cover letter that includes:
 - a. Enrollee's name
 - b. Enrollee's AHCCCS I.D. number
 - c. Enrollee's address
 - d. Enrollee's phone number (if applicable)
 - e. date of receipt of the appeal
 - f. summary of the Contractor's actions undertaken to resolve the appeal and summary of the appeal resolution

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35. The following material shall be included in the file sent by the Contractor:
 - a. the Enrollee's written request for hearing
 - b. copies of the entire appeal file which includes all supporting documentation including pertinent findings and medical records
 - c. the Contractor's Notice of Appeal Resolution
 - d. other information relevant to the resolution of the appeal
36. That if the Contractor or the State fair hearing decision reverses a decision to deny, limit or delay services not furnished during the appeal or the pendency of the hearing process, the Contractor shall authorize or provide the services promptly and as expeditiously as the enrollee's health condition requires irrespective of whether the Contractor contests the decision.
37. That if the Contractor or State fair hearing decision reverses a decision to deny authorization of services and the disputed services were received pending appeal, the Contractor shall pay for those services, as specified in policy and/or regulation.
38. That if the Contractor or the Director's Decision reverses a decision to deny, limit, or delay authorization of services, and the member received the disputed services while the appeal was pending, the Contractor shall process a claim for payment from the provider in a manner consistent with the Contractor's or Director's Decision and applicable statutes, rules, policies, and contract terms. The provider shall have 90 days from the date of the reversed decision to submit a clean claim to the Contractor for payment. For all claims submitted as a result of a reversed decision, the Contractor is prohibited from denying claims for untimeliness if they are submitted within the 90 day timeframe. Contractors are also prohibited from denying claims submitted as a result of a reversed decision because the member failed to request continuation of services during the appeals/hearing process: a member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.
39. That if the Contractor or State fair hearing decision upholds a decision to deny authorization of services and the disputed services were received pending appeal, the Contractor may recover the cost of those services from the enrollee.

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ATTACHMENT H(2): PROVIDER CLAIM DISPUTE STANDARDS AND POLICY

The Contractor shall have in place a written claim dispute policy for providers. The policy shall be in accordance with applicable Federal and State laws, regulations and policies. The claim dispute policy shall include the following provisions:

1. The Provider Claim Dispute Policy shall be provided to all subcontractors at the time of contract. For providers without a contract, the claim dispute policy may be mailed with a remittance advice, provided the remittance is sent within 45 days of receipt of a claim.
2. The Provider Claim Dispute Policy must specify that all claim disputes challenging claim payments, denials or recoupments must be filed in writing with the Contractor no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later.
3. Specific individuals are appointed with authority to require corrective action and with requisite experience to administer the claim dispute process.
4. A log is maintained for all claim disputes containing sufficient information to identify the Complainant, date of receipt, nature of the claim dispute and the date the claim dispute is resolved. Separate logs must be maintained for provider and behavioral health recipient claim disputes.
5. Within five business days of receipt, the Complainant is informed by letter that the claim dispute has been received.
6. Each claim dispute is thoroughly investigated using the applicable statutory, regulatory, contractual and policy provisions, ensuring that facts are obtained from all parties.
7. All documentation received by the Contractor during the claim dispute process is dated upon receipt.
8. All claim disputes are filed in a secure designated area and are retained for five years following the Contractor's decision, the AHCCCS' decision, judicial appeal or close of the claim dispute, whichever is later, unless otherwise provided by law.
9. A copy of the Contractor's Notice of Decision (hereafter referred to as Decision) shall be mailed to all parties no later than 30 days after the provider files a claim dispute with the Contractor, unless the provider and Contractor agree to a longer period. The Decision must include and describe in detail, the following:
 - a. the nature of the claim dispute
 - b. the issues involved
 - c. the reasons supporting the Contractor's Decision, including references to applicable statute, rule, applicable contractual provisions, policy and procedure
 - d. the Provider's right to request a hearing by filing a written request for hearing to the Contractor no later than 30 days after the date the Provider receives the Contractor's decision.
 - e. If the claim dispute is overturned, the requirement that the Contractor shall reprocess and pay the claim(s) in a manner consistent with the decision within 15 business days of the date of the Decision.

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10. If the Provider files a written request for hearing, the Contractor must ensure that all supporting documentation is received by the AHCCCS Office Administrative Legal Services (OALS), no later than five business days from the date the Contractor receives the provider's written hearing request. The file sent by the Contractor must contain a cover letter that includes:
 - a. Provider's name
 - b. Provider's address
 - c. Member's Name and AHCCCS Identification Number
 - d. Provider's phone number (if applicable)
 - e. the date of receipt of claim dispute
 - f. a summary of the Contractor's actions undertaken to resolve the claim dispute and basis of the determination
11. The following material shall be included in the file sent by the Contractor:
 - a. written request for hearing filed by the Provider
 - b. copies of the entire file which includes pertinent records; and the Contractor's Decision
 - c. other information relevant to the Notice of Decision of the claim dispute
12. If the Contractor's decision regarding a claim dispute is reversed through the appeal process, the Contractor shall reprocess and pay the claim (s) in a manner consistent with the decision within 15 business days of the date of the Decision.

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ATTACHMENT I: RESERVED

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ATTACHMENT I: RESERVED

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ATTACHMENT J: RESERVED

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ATTACHMENT J: RESERVED

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ATTACHMENT J(2): RESERVED

Contract/RFP No. YH09-0001

ATTACHMENT J(2): RESERVED

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ATTACHMENT K: RESERVED

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ATTACHMENT K: RESERVED

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CAPITATION RATE SUMMARY – ACUTE RATES (Risk Adjusted with 100% of 2010 factor)
Phoenix Health Plan
10/01/11 — 9/30/12**

Title XIX and KidsCare Rates ¹ :	TANF	TANF	TANF	TANF	TANF	SSI	SSI	SFP	Maternity Delivery	Non-MED	MED
	<1, M/F	1-13, M/F	14-44, F	14-44, M	45+, M/F	w/ Med	w/o Med		Supplement		
4 Apache/Coconino/Mohave/Navajo	\$ 489.54	\$ 104.13	\$ 252.22	\$ 158.36	\$ 341.47	\$ 98.53	\$ 725.83	\$ 13.38	\$ 5,623.48	\$ 394.65	\$ 1,273.31
6 Yavapai	\$ 482.75	\$ 106.45	\$ 266.45	\$ 172.85	\$ 374.96	\$ 122.17	\$ 834.32	\$ 14.79	\$ 6,359.05	\$ 447.58	\$ 1,291.38
8 Gila/Pinal	\$ 448.95	\$ 104.36	\$ 255.42	\$ 166.63	\$ 372.34	\$ 109.41	\$ 728.72	\$ 12.12	\$ 6,223.23	\$ 450.81	\$ 1,421.57
10 Pima	\$ 490.46	\$ 83.95	\$ 190.92	\$ 106.62	\$ 302.17	\$ 96.56	\$ 677.73	\$ 13.07	\$ 5,794.54	\$ 327.33	\$ 1,426.97
12 Maricopa	\$ 456.68	\$ 101.88	\$ 216.86	\$ 137.85	\$ 358.18	\$ 139.11	\$ 663.53	\$ 14.84	\$ 5,838.94	\$ 388.23	\$ 1,383.39

PPC Rates:	TANF	TANF	TANF	TANF	TANF	SSI	SSI	Non-MED	MED
	<1, M/F	1-13, M/F	14-44, F	14-44, M	45+, M/F	w/ Med	w/o Med		
4 Apache/Coconino/Mohave/Navajo	\$ 868.39	\$ 39.95	\$ 215.40	\$ 132.56	\$ 396.31	\$ 113.84	\$ 389.92	\$ 867.02	\$ 5,081.66
6 Yavapai	\$ 834.03	\$ 59.40	\$ 209.24	\$ 192.60	\$ 322.01	\$ 137.59	\$ 362.15	\$ 828.77	\$ 5,217.28
8 Gila/Pinal	\$ 829.59	\$ 61.37	\$ 196.89	\$ 145.54	\$ 278.53	\$ 101.11	\$ 382.02	\$ 773.35	\$ 6,678.09
10 Pima	\$ 969.51	\$ 50.05	\$ 161.33	\$ 117.94	\$ 339.48	\$ 109.43	\$ 294.30	\$ 573.25	\$ 4,997.42
12 Maricopa	\$ 898.41	\$ 53.71	\$ 186.23	\$ 155.81	\$ 266.39	\$ 121.78	\$ 335.81	\$ 763.47	\$ 6,528.61

Other Rates:	Option 1 Transplant		Option 2 Transplant	
4 Apache/Coconino/Mohave/Navajo	\$	16.50	\$	16.50
6 Yavapai	\$	16.50	\$	16.50
8 Gila/Pinal	\$	16.50	\$	16.50
10 Pima	\$	16.50	\$	16.50
12 Maricopa	\$	16.50	\$	16.50

1. Rates have been adjusted for \$35,000 Reinsurance Deductible

CYE 12 Acute Care Contract
10/01/11

**CERTIFICATION OF CEO PURSUANT TO
RULE 13a-14(a)/15d-14(a), AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, Charles N. Martin, Jr., Chairman and Chief Executive Officer of Vanguard Health Systems, Inc., certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Vanguard Health Systems, Inc.;
 2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
 3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
 4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
-

- (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
- (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: November 3, 2011

/s/ Charles N. Martin, Jr.

Charles N. Martin, Jr.

Chairman of the Board and Chief Executive Officer

**CERTIFICATION OF CFO PURSUANT TO
RULE 13a-14(a)/15d-14(a), AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, Phillip W. Roe, Executive Vice President, Chief Financial Officer and Treasurer of Vanguard Health Systems, Inc., certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Vanguard Health Systems, Inc.;
 2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
 3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
 4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
-

- (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
- (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: November 3, 2011

/s/ Phillip W. Roe

Phillip W. Roe

Executive Vice President, Chief Financial Officer and Treasurer

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

In connection with the Quarterly Report on Form 10-Q of Vanguard Health Systems, Inc. (the "Company") for the quarterly period ended September 30, 2011, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Charles N. Martin, Jr., Chairman of the Board and Chief Executive Officer of the Company, certify, for the purpose of complying with 18 U.S.C. Section 1350 and Rule 13a-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act"), as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that to my knowledge:

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

/s/ Charles N. Martin, Jr.

Charles N. Martin, Jr.
Chairman of the Board and Chief Executive Officer

November 3, 2011

A signed original of this written statement required by Section 906 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.

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

In connection with the Quarterly Report on Form 10-Q of Vanguard Health Systems, Inc. (the "Company") for the quarterly period ended September 30, 2011, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Phillip W. Roe, Executive Vice President, Chief Financial Officer and Treasurer of the Company, certify, for the purpose of complying with 18 U.S.C. Section 1350 and Rule 13a-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act"), as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that to my knowledge:

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

/s/ Phillip W. Roe

Phillip W. Roe

Executive Vice President, Chief Financial Officer and Treasurer

November 3, 2011

A signed original of this written statement required by Section 906 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.