Section A – Table of Contents

A. General Matter [H.15.A; Section I, Exhibit A]

Subject:	***Page Number Reference***	***Offeror's Page No.***
Offeror's Checklist *(This Exhibit)*	Exhibit A	1–3
Offeror's Bid Choice Form *(Form provided below in this Exhibit and submitted with the checklist)*	See A1 below	2
Offeror's Signature Page	1 and 2	4
Signed Cover Sheets of Solicitation Amendments, if any	289	5–8
Completion of all items in Section G: Representations and Certifications of Offeror	Section G	9–24

A.1 Offeror's Bid Choice Form [H.15.A1]

ACUTE CARE PROGRAM

☒ Checking this box indicates the Offeror is bidding on the ***Acute Care Program***.

Health Net of Arizona, Inc.
Offeror's Name

is bidding on the ACUTE Care Program in the GSAs checked below:

- ☐ **GSA 2 Yuma, La Paz**
- ☐ **GSA 4 Apache, Coconino, Mohave, and Navajo**
- ☐ **GSA 6 Yavapai**
- ☐ **GSA 8 Gila, Pinal**
- ☒ **GSA 10 Pima, Santa Cruz**
- ☒ **GSA 12 Maricopa**
- ☐ **GSA 14 Graham, Greenlee, Cochise**

Authorized Signature — January 25, 2013 (Date)

Bret Morris (Print Name) — President (Title)

CHILDREN'S REHABILITATIVE PROGRAM

☐ Checking this box indicates the Offeror is bidding on the ***Children's Rehabilitative Program***.

Authorized Signature — Date

Print Name — Title

Attestation

Attestation	*Requirement No.*	*Offeror's Page No.*
	1-34	25-28

Capitation Summary

Capitation	*Requirement No.*	*Offeror's Page No.*
Acute Care Program Capitation Bid Submission Including Actuarial Certification	1	29-32
CRS Program Capitation Bid Submission Including Actuarial Attestation	2	N/A

Executive Summary and Disclosure

Executive Summary and Disclosure	*Requirement No.*	*Offeror's Page No.*
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Acute Care Narrative Submission

Access to Care/Network	*Requirement No.*	*Offeror's Page No.*
	1	37-41
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Program	*Requirement No.*	*Offeror's Page No.*
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Organization	*Requirement No.*	*Offeror's Page No.*
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	8	72-76
	9	77-81
	10	82

A.2 Offeror's Signature Page

	Notice of Request for Proposal		AHCCCS Arizona Health Care Cost Containment System
30 years 1982 - 2012	SOLICITATION NO.: **YH14-0001**	PAGE 2	701 East Jefferson, MD 5700
		OF 337	Phoenix, Arizona 85034

OFFER

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, and amendments.

Arizona Transaction (Sales) Privilege Tax License No.: 20915796

Federal Employer Identification No.: 36-3097810

E-Mail Address: Bret.A.Morris@healthnet.com

Health Net of Arizona, Inc.
Company Name

1230 W Washington Street
Address

Tempe | AZ | 85281
City | State | Zip

For Clarification of this offer, contact:

Name: Bret Morris

Phone: 602-794-1512

Fax: 602-267-1935

Signature of Person Authorized to Sign Offer

Bret Morris
Printed Name

President
Title

CERTIFICATION

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

The submission of the offer did not involve collusion or other anti-competitive practices.

The bidder shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 99-4 or A.R.S. §41-1461 through 1465.

The bidder has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with the submitted offer. Failure to provide a valid signature affirming the stipulations required by this clause shall result in rejection of the offer. Signing the offer with a false statement shall void the offer, any resulting contract and may be subject to legal remedies provided by law.

In accordance with A.R.S. §35-393, the Offeror hereby certifies that the Offeror does not have scrutinized business operations in Iran.

In accordance with A.R.S. §35-391, the Offeror hereby certifies that the Offeror does not have scrutinized business operations in Sudan.

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

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

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

This contract shall henceforth be referred to as Contract No. YH14-0001 Awarded this ___ day of _____, 2013

Michael Veit, as AHCCCS Contracting Officer and not personally

A.3 Signed Cover Sheets of Solicitation Amendments [H.6]

A.3.1 Amendment No. 1 (One)

30 years 1982 - 2012	**SOLICITATION AMENDMENT** Solicitation No.: **RFP YH14-0001** Amendment No. **1 (One)** Solicitation Due Date: **January 28, 2013 3:00 PM (Arizona Time)**	**AHCCCS** Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person. A signed copy of this signature page shall be included with the proposal, which must be received by AHCCCS no later than the Solicitation due date and time.

This solicitation is amended as follows:

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the **27th day of November, 2012**, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date** January 25, 2013	**Signature**
Typed Name Bret Morris		**Typed Name** Michael Veit
Title President		**Title** Contracts and Purchasing Administrator
Name of Company Health Net of Arizona, Inc.		**Name of Company** AHCCCS

A.3.2 Amendment No. 2 (Two)

	SOLICITATION AMENDMENT Solicitation No.: **RFP YH14-0001** Amendment No. 2 (Two) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	**AHCCCS** Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person. A signed copy of this signature page shall be included with the proposal, which must be received by AHCCCS no later than the Solicitation due date and time.

This solicitation is amended as follows, and supersedes any information previously provided that is inconsistent:

1. Section H: Instructions to Offerors, Paragraph 16, Capitation, *Acute Care Program Capitation Resources*, page 303 is amended as follows:

   On or about December 14, 2012, AHCCCS will publish an actuarially-sound capitation rate range for the medical component for each risk group that will be bid by GSA. These ranges will be equivalent to the bottom half of the actuarially sound rate ranges, from ~~the~~ an adjusted minimum to the midpoint. The minimum of each published range was increased by 1% to account for the future Payment Reform capitation withhold of at least 1%. AHCCCS' actuaries set rate ranges based on average expenditures. The rate ranges will exclude reinsurance offsets and will not reflect any withheld amounts for payment reform initiatives.

2. The Bidders' Library, Information (IT) Technology Systems Demonstration *Provisions* and *Calendar* have been revised.

3. Section H: Instructions to Offerors, Paragraph 16, Submission Requirements, E. *Oral Presentations*, page 309, is amended as follows:

   All presentations will be scheduled to occur during the weeks of February 18 ~~and~~ through March 6, 2013.

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 19th day of December, 2012, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date** January 25, 2013	**Signature**
Typed Name Bret Morris		**Typed Name** Michael Veit
Title President		**Title** Contracts and Purchasing Administrator
Name of Company Health Net of Arizona, Inc.		**Name of Company** AHCCCS

A.3.3 Amendment No. 3 (Three)

30 years	**SOLICITATION AMENDMENT** Solicitation No.: **RFP YH14-0001** Amendment No. 3 (Three) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	**AHCCCS** Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person. A signed copy of this signature page shall be included with the proposal, which must be received by AHCCCS no later than the Solicitation due date and time.

This solicitation is amended as follows:

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

   Any questions submitted that were unrelated to capitation rates/rate ranges were not addressed.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 4th day of January, 2013, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date** January 25, 2013	**Signature**
Typed Name Bret Morris		**Typed Name** Michael Veit
Title President		**Title** Contracts and Purchasing Administrator
Name of Company Health Net of Arizona, Inc.		**Name of Company** AHCCCS

A.3.4 Amendment No. 4 (Four)

30 years 1982 - 2012	**SOLICITATION AMENDMENT** Solicitation No.: **RFP YH14-0001** Amendment No. 4 (Four) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	**AHCCCS** Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

2. Section H: Instructions to Offerors, Paragraph 16, Capitation, *CRS Program Capitation Bid Submission (Submission Requirement No. 2)*, page 304 is amended as follows:

***CRS Program Capitation Bid Submission* (Submission Requirement No. 2)**

The Offeror will submit a capitation rate bid submission for the administrative component. The lowest bid will receive the maximum allowable points. However, AHCCCS may award the maximum allowable points to any bid for the administrative component equal to or below a minimum threshold considered by AHCCCS to be reasonable. ~~Conversely, the highest bid will receive the least number of points.~~

Bid component requirements:

1. Offerors will submit a single administrative component bid that will be added to the total medical component by coverage type. The administrative component will not vary by coverage type.
2. The administrative component bid will be stated as a per member per month (PMPM) figure.
   - Capitation bids submitted with an administrative component PMPM value exceeding $60 PMPM will earn an administrative component score of zero points.
3. In any instance where zero points are awarded for the administrative component and the Offeror is awarded a contract, the awarded administrative component will be $52.00 PMPM.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 10th day of January, 2013, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date** January 25, 2013	**Signature**
Typed Name Bret Morris		**Typed Name** Michael Veit
Title President		**Title** Contracts and Purchasing Administrator
Name of Company Health Net of Arizona, Inc.		**Name of Company** AHCCCS

Section B – Table of Contents

B. Attestation [H.15.B; Exhibit C]

Corporate Compliance	
AHCCCS is committed to protecting the public from fraud, waste and abuse. As part of this commitment, AHCCCS Contractors must comply with all applicable Federal and State program integrity requirements. The Offeror attests that it will:	
1. ☒	Have a corporate compliance program and plan consistent with 42 CFR 438.608, and practices which comply with program integrity requirements specified in 42 CFR 455, and the AHCCCS requirements described in ACOM Policy 103 and the contract, by the contract start date. *RFP Section D, Paragraph 62, Corporate Compliance*
Staffing	
The Offeror will demonstrate by the start date of the contract that all staff shall be fully qualified to perform the requirements of the contract. The Offeror attests that it will:	
2. ☒	Maintain a local presence within the State of Arizona as outlined in Section D, Paragraph 16, Staffing Requirements and Support Services, of the contract. *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
3. ☒	Limit Key Staff to occupying a maximum of two of the Key Staff positions. *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
4. ☒	Have local staff available 24 hours a day, seven days a week to work with AHCCCS and/or other State agencies on urgent issue resolutions. *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
5. ☒	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. *RFP, Section D, Paragraphs 16, Staff Requirements and Support Services and 62 Corporate Compliance*
6. ☒	Screen all employees and subcontractors to determine whether any of them have been excluded from participation in Federal health care programs. *RFP, Section D, Paragraphs 16, Staff Requirements and Support Services and 62 Corporate Compliance*
7. ☒	Require all staff members to have appropriate training, education, experience and orientation to fulfill the requirements of the position. *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
8. ☒	Have sufficient staffing levels to operate in compliance with the terms of the contract. *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
9. ☒	Have an Administrator/Chief Executive Officer (CEO) who shall have the authority and ability to direct Arizona priorities. *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
Information Systems	
The Offeror will demonstrate by the start date of the contract that its information system has clearly defined change control processes. The Offeror attests that it will:	
10. ☒	Maintain a change control process which includes the Offeror's ability to participate in setting and modifying the priorities for all information systems including those of the Parent Company, subcontractors and vendors. *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
11. ☒	Maintain system upgrade and conversion processes which include appropriate planning and implementation standards. *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*

***Information Systems** - continued*	
12. ☒	Have structures in place to ensure and support current and future IT Federal mandates. *RFP, Section D, Paragraph 64, Systems and Data Exchange Requirements*
Claims/Encounters Processing	
The Offeror will demonstrate by September 1, 2013 that its systems and related processes can support the following key components of the AHCCCS Medicaid claims processing lifecycle. The Offeror attests that the entity and its IT system will:	
13. ☒	Accept and process both paper and electronic submissions. *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*
14. ☒	Allow for the proper load of provider contract terms, support processing of claims within timeliness standards, incorporate coordination of benefit activities, and generate claims payments and HIPAA compliant remittance advices. *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*
15. ☒	Have the ability to generate encounter submissions and have the appropriate remediation processes in place when standards are not met. *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*
Quality Management	
The Offeror attests that, by the start date of the contract, it will have:	
16. ☒	A process to include the health risks assessment tool in the new member welcome packet. The Offeror has/will have a process for coordination of care across the continuum based on early identification of health risk factors or special care needs, including those members identified who would benefit from disease management and care coordination. [42 C.F.R. 438.208] *AMPM Chapter 900*
17. ☒	A process that requires the reporting of all incidents of abuse, neglect, exploitation, unexpected deaths, healthcare acquired and provider preventable conditions to the AHCCCS Clinical Quality Management Unit. *AMPM Chapters 900 and 1000*
18. ☒	Processes in place to receive data and forms from a provider's certified electronic medical records including Early, Periodic, Screening, Diagnostic and Treatment forms, performance measure and audit information, and information to facilitate assistance with care coordination activities. *AMPM Chapter 400*
19. ☒	A process that meets AHCCCS requirements for identifying, reviewing, evaluating and resolving quality of care or service issues raised by any source. *RFP, Section D, Paragraph 23, Quality Management and Performance Improvement (QM/PI)*
20. ☒	A process to provide recurring scheduled transportation for members with on-going medical needs, including, but not limited to dialysis, chemotherapy, and radiation. *RFP, Section D, Paragraph 11, Special Health Care Needs*
MCH/EPSDT	
The Offeror attests that it will have:	
21. ☒	A process and a plan that includes outreach and care coordination processes for children with special health care needs and other hard to reach populations, and coordination with community and government programs. *AMPM Chapter 400*
Medical Management	
The Offeror attests that it will have:	
22. ☒	A process in place for proactive discharge planning when members have been admitted to an inpatient facility. *RFP, Section D, Paragraph 24, Medical Management (MM)*

***Medical Management** - continued*	
23. ☒	A process that ensures that practice guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in that field and disseminated to providers. *RFP, Section D, Paragraph 24, Medical Management (MM)*
24. ☒	A process in place to provide emergency services without prior authorization regardless of contract status of the provider. *AMPM Chapter 310F*
25. ☒	A process to analyze utilization data and use the results to implement medical management changes to improve outcomes and experience. *RFP, Section D, Paragraph 24, Medical Management (MM)*
26. ☒	Disease and chronic care management programs that are designed to coordinate evidence based care focused on improving outcomes for members with one or more chronic illnesses which may include behavioral health conditions. *RFP, Section D, Paragraph 24, Medical Management (MM)*
Behavioral Health	
The Offeror attests that it will have:	
27. ☒	A process for identifying members with behavioral health care needs and assisting members in accessing services in the Regional Behavioral Health Authority system. *RFP, Section D, Paragraph 12, Behavioral Health Services; AMPM Chapters 400 and 1000*
Access to Care ***(Only Offerors submitting a proposal for the CRS Program must attest to #29)***	
The Offeror attests that it will have:	
28. ☒	A comprehensive network that complies with all Acute Care network sufficiency standards as outlined in RFP YH14-0001 and ACOM Draft Policy, Acute Network Standards, no later than August 1, 2013. *RFP, Section D, Paragraph 27, Network Development*
29. ☐ ***CRS Only***	A comprehensive network that complies with all CRS network sufficiency standards as outlined in RFP YH14-0001 (see Section D, Paragraphs 10, Scope of Services and 27, Network Development), no later than August 1, 2013. *RFP, Section D, Paragraph 27, Network Development*
30. ☒	A process for researching, resolving, tracking and trending provider inquiries/complaints and requests for information that includes contacting providers within three days and resolving issues within 30 days. *RFP, Section D, Paragraphs 27, Network Development and 29, Network Management*
31. ☒	A process for monitoring and addressing provider performance issues up to and including contract termination. *RFP, Section D, Paragraphs 27, Network Development and 29, Network Management*
Finance	
The Offeror attests that it will:	
32. ☒	Have a separate entity established for purposes of this contract within 120 days of the contract award if the Offeror is a non-governmental. *New Contractor*. *RFP, Section D, Paragraph 51, Separate Incorporation*
33. ☒	Meet the minimum capitalization requirements within 30 days of the contract award if the Offeror is a *New Contractor;* or, fund through a capital contribution the necessary amount to meet the equity per member requirement within 30 days of the contract award if the Offeror is a Successful Incumbent Contractor. *RFP, Section D, Paragraph 45, Minimum Capitalization; Section H, Instructions to Offerors-Paragraph 14, Minimum Capitalization*
34. ☒	Secure a performance bond as defined in amount and type in Section D, Paragraphs 46, Performance Bond or Bond Substitute and 47, Amount of Performance Bond, and ACOM policies 305 and 306 no later than 30 days after notification by AHCCCS of the amount required. *RFP, Section D, Paragraphs 46, Performance Bond or Bond Substitute; 47, Amount of Performance Bond*

ATTESTATION SIGNATURE

In order for the proposal to be considered for AHCCCS review purposes, all boxes must be checked. The attestation must be signed and dated by the Offeror. A proposal containing check boxes left blank or lacking a signature and date below will not be considered further.

Offeror's Name: Health Net of Arizona, Inc. certifies the elements attested to in this document are true and it is understood that AHCCCS will rely on this attestation in determination of the award.

	January 25, 2013
Authorized Signature	**Date**
Bret Morris	President
Individual's Printed Name	**Title**

Section C – Table of Contents

C. Capitation

C.1 Acute Care Program Capitation Bid Submission – GSA 10 and GSA 12

Acute Care RFP Bid Template - Health Net

Gross Medical Component by Risk Group and GSA

Risk Group	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14
TANF < 1	$0.00	$0.00	$0.00	$0.00	$427.17	$463.43	$0.00
TANF 1-13	$0.00	$0.00	$0.00	$0.00	$76.96	$92.76	$0.00
TANF 14-44 F	$0.00	$0.00	$0.00	$0.00	$189.06	$210.74	$0.00
TANF 14-44 M	$0.00	$0.00	$0.00	$0.00	$117.33	$137.66	$0.00
TANF 45+	$0.00	$0.00	$0.00	$0.00	$319.51	$375.78	$0.00
SSIW	$0.00	$0.00	$0.00	$0.00	$111.00	$147.57	$0.00
SSIW/O	$0.00	$0.00	$0.00	$0.00	$712.05	$746.20	$0.00
AHCCCS Care	$0.00	$0.00	$0.00	$0.00	$298.76	$387.44	$0.00
Delivery Supp	$0.00	$0.00	$0.00	$0.00	$5,161.69	$5,447.17	$0.00

Administrative Component by Risk Group and GSA

Risk Group	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14
TANF < 1	$0.00	$0.00	$0.00	$0.00	$30.07	$32.27	$0.00
TANF 1-13	$0.00	$0.00	$0.00	$0.00	$5.87	$7.02	$0.00
TANF 14-44 F	$0.00	$0.00	$0.00	$0.00	$14.59	$16.22	$0.00
TANF 14-44 M	$0.00	$0.00	$0.00	$0.00	$8.72	$10.22	$0.00
TANF 45+	$0.00	$0.00	$0.00	$0.00	$24.46	$28.64	$0.00
SSIW	$0.00	$0.00	$0.00	$0.00	$8.60	$11.41	$0.00
SSIW/O	$0.00	$0.00	$0.00	$0.00	$49.28	$52.97	$0.00
AHCCCS Care	$0.00	$0.00	$0.00	$0.00	$22.63	$29.09	$0.00
Delivery Supp	$0.00	$0.00	$0.00	$0.00	$401.46	$423.67	$0.00

C.2 Actuarial Certification

Actuarial Certification
Health Net of Arizona
AHCCCS Acute Care Capitation Rate Bids
October 1, 2013 - September 30, 2014

I, Martin F. Gibson, Consulting Actuary, am a member of the American Academy of Actuaries, and am associated with the Millennium Actuarial Group LLC. I have been retained by Health Net of Arizona (Health Net) to assist in the development and review of calculations of certain actuarial items. I meet the Academy qualification standards for rendering this certification of actuarial soundness and am experienced with the rating and financial modeling of Medicaid programs.

The purpose of this certification is to comply with Section H, Instructions to Offerors, contained in RFP No. YH14-0001 (and its amendments) issued by the Arizona Health Care Cost Containment System Administration (AHCCCSA), relating to the Acute Care Program Capitation Bid Submission and the actuarial certification required with the submitted bids. The capitation rate bids to which this certification applies are all submitted bid rates for GSAs 10 and 12 and apply to the period October 1, 2013 through September 30, 2014. This certification may not be appropriate for other purposes.

It is my opinion that the capitation rates as bid are actuarially sound and are adequate, in the aggregate, to fund claims and administrative expenses during the time period for which they are intended. I have also assumed that all adjustments made to the bid rates by AHCCCS actuaries will be actuarially sound.

My determination is based on a review of the claim experience and other information provided by AHCCCS, data provided by and discussions with Health Net, and my judgment. In performing my analysis, I relied on data and other information provided by AHCCCS and Health Net and have not audited or verified this data and other information. If the underlying data or other information is inaccurate or incomplete, the results of my analysis may likewise be inaccurate or incomplete.

I performed a limited review of the data used directly in my analysis for reasonableness and consistency and have not found any material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of my analysis.

I also relied on Health Net's description of its utilization management procedures, provider reimbursement contracts, and other administrative functions without audit. My opinion that the rates are actuarially sound is based on the assumption that Health Net is able to manage utilization consistent with the assumptions underlying the bid rates and contract with providers at reimbursement levels consistent with the AHCCCS encounter data. I did not review the financial resources or medical management abilities of any provider to confirm their ability to assume financial risk.

Actuarial Certification
Health Net of Arizona
AHCCCS Acute Care Capitation Rate Bids
October 1, 2013 - September 30, 2014

The utilization rates and average costs underlying the initial bid rates are estimates only and include assumptions regarding future experience. In my opinion, the assumptions used are applicable for the purpose of this certification and are reasonably related to the experience of plans currently providing care to AHCCCS beneficiaries and to reasonable expectations. Actual results will differ from the results indicated in the initial bid rates to the extent that future plan experience differs from the assumptions used to develop the rates.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, whose standards form the basis of this certification.

A confidential actuarial report describing the procedures followed, analyses performed, and results obtained in support of this certification will be furnished to Health Net and be available for examination by AHCCCSA officials. This certification was prepared for, and is only to be relied upon by, Health Net and the regulators where the certification is filed.

Martin F. Gibson, ASA, MAAA
Millennium Actuarial Group LLC

1/16/2013
Date

Section D – Table of Contents

D. Executive Summary and Disclosure [H.16.D]

1. Executive Summary [H.16.D.1]

Health Net of Arizona, Inc. has been providing health care services in Arizona for more than 30 years and we are excited about the opportunity to expand our coverage to the Arizona Health Care Cost Containment System (AHCCCS) eligible population in GSAs 10 and 12. Health Net of Arizona, Inc. has the full support of its parent company, Health Net, Inc. (with all of its subsidiaries), and together, in this proposal, they will be referred to as "Health Net." With origins dating back to 1979, Health Net is a nationally recognized managed care organization that delivers a full spectrum of products and services to more than 5.4 million members in 28 states and the District of Columbia. More than 78 percent or 4.2 million of these members are enrolled in the federal and state government programs we support. Our mission is to help our members be healthy, secure, and comfortable and for more than three decades, we have worked diligently earning our reputation for excellence. Our proposal underscores the many reasons we will bring added value to the AHCCCS program, including:

- **Stability.** We are a stable, well-established member of the health care community in Arizona and beyond, with a solid reputation for service excellence and patient-centered care.
- **Experience.** Our extensive government program experience and our knowledge of caring for underserved populations are well suited to the AHCCCS program.
- **Expertise.** We use unique approaches to providing high quality, affordable care and have the flexibility to respond to federal and state health care reform in a timely and innovative manner.
- **Oversight.** We take a comprehensive systematic approach to fraud, waste, and abuse detection, reporting, and recovery that meets with continuous success.
- **Efficiency.** We have a proven track record for meeting extensive government contract requirements efficiently and effectively.

We champion solutions that are as unique as the individuals, employers, and communities we serve, bringing collaborative approaches to meeting local needs. We will work closely with providers, program administrators, government agencies, and community-based organizations to ensure improved access and outcomes for all AHCCCS members. We look forward to the opportunity of using our experience and expertise in serving Arizona's Medicaid members.

Health Net's Stability

Ranked #179 in the 2011 Fortune 500 list of companies, Health Net, Inc. has the strength and stability to turn vision into reality. Everything we do reflects our belief that health care coverage should work for people, that local operations build stronger communities, that experience counts, and that financial strength fuels innovation.

Health Net provides managed care benefits in the commercial market to nearly 1.4 million individual members as well as small and large employer group members in Arizona, California, Oregon, and Washington. Our government programs includes our highly regarded California Medicaid program serving more than 1 million members in 13 counties and the TRICARE North Region program serving 3 million active duty and retired military personnel. The Department of Defense has bestowed its "Program Integrity Contractor of the Year" award on our TRICARE program.

Health Net of Arizona, Inc.'s commercial health plan is accredited by the National Committee for Quality Assurance (NCQA) and is proud to be the highest-ranked health plan in Arizona, according to their Private Health Insurance Plan Rankings for 2011-2012. This is the fifth straight year we have earned this distinction. We have been named the number one Health Management Organization (HMO) in the state of Arizona by "Ranking Arizona" for the past eight consecutive years.

The NCQA has bestowed its award for Multicultural Health Care Distinction to Health Net, Inc., including our Medicaid line of business in California. This national distinction recognizes organizations that lead the market in providing culturally and linguistically responsive services and that work to reduce health care disparities. This experience will serve the AHCCCS community well as we work to create similarly distinctive programs.

Health Net's Experience

Health Net participates in a broad range of government-sponsored programs including Medicaid, Medicare Advantage (MA) (including Chronic Disease Special Needs Plans (C-SNP) and Dual Eligible Special Needs Plans [D-SNPs]), and TRICARE. This experience will provide a solid foundation for implementing the AHCCCS program under the Acute Care contract.

Our D-SNP is already in place in Arizona, serving more than 4,100 members, and successfully meeting the unique challenges of this population. We have been actively involved in the planning of the Arizona Dual Eligible Demonstration Project and our notice of intent to apply has been accepted by the Centers for Medicare and Medicaid Services (CMS).

Health Net's California Medicaid HMO is one of the 10 largest Medicaid HMOs in the country, serving more than 1 million members in 13 counties with large percentages of Latino and seniors and persons with disabilities beneficiaries. For three consecutive years, the NCQA has ranked our California Medicaid program the highest ranked Medicaid plan in California. We have also been chosen to participate in the California Dual Eligible Demonstration Project (serving an estimated 80,000 to 100,000 new members) in Los Angeles and San Diego Counties, beginning in late 2013. As Intergroup of Arizona, Health Net previously served approximately 28,000 members as an AHCCCS health plan in Maricopa and Pima Counties during the 1990s.

Health Net is one of the nation's largest MA contractors, serving approximately 205,000 MA members. We maintain a Medicare four star rating. We also administer MA C-SNP for chronic disease such as chronic heart failure and diabetes as well as providing extra benefits, improving care, and decreasing costs through improved coordination and focused case management activities.

One of Health Net's government-contracting subsidiaries currently serves 3 million active duty and retired military personnel in 23 states and the District of Columbia for the TRICARE North Region program. We have served TRICARE and its predecessor programs since 1988. The knowledge and experience we gained through the current contract's successful implementation in addition to the successful implementations of all 13 counties for the California Medicaid contract provide an excellent example of our ability to quickly implement large-scale programs fully and efficiently. Through the TRICARE program, we have also recognized the critical need for coordination and collaboration between behavioral health services and physical medicine in improving quality outcomes.

Health Net's Expertise

Health Net has a long history of providing creative and innovative programs for its members, providers, and partners. The following is a sampling of the programs we have designed to improve our members' health and the quality of their care that may serve as models for AHCCCS member programs:

- **Health, Education, and Wellness Programs.** We encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health care services, and to follow self-care regimens and treatment therapies.
- **Fit Families for Life.** Designed for Medicaid members, this five-week family program employs stepwise goal-setting approach to childhood and family weight management issues.
- ***Be In Charge!*℠ Obesity and Breastfeeding Coaching Program.** This program provides telephonic RN coaching for breastfeeding support and weight management for Medicaid members. It includes a free workbook, DVD, and cookbook.
- ***Be In Charge!*℠ Disease Management Programs.** These programs identify members with asthma and diabetes through analysis of claims, encounter and pharmacy data and enroll members into "red" (high risk) and "green" (low risk) programs of ongoing education, telephonic coaching and monitoring. Our NCQA-certified disease management vendor, McKesson Health Solutions, uses a whole person approach to disease management.
- **Nurse Advice and Triage Line:** This provides 24/7/365 access to our members for any medical concern or acute symptom and serves to prevent unnecessary emergency room use for ambulatory care sensitive conditions and to link members to their PCP and medical home.
- **T2X.** Developed in partnership with the University of California, Los Angeles Fielding School of Public Health, T2X is our award-winning social media teen health literacy program, designed to increase low-

income teens' capacity to access and use their insurance, become more engaged in their health care, and develop pro-health attitudes.

Health Net has also created innovative programs for providers to use in caring for our members. Our provider toolkits are an excellent example. This support resource provides strategies to assess and treat conditions in overweight individuals. These kits, which includes an illustrative flip chart for use in patient exam rooms, and are available to any provider who participates in our California Medicaid programs. We also encourage better dental care for members with our dental care toolkits. Both toolkits will be offered to AHCCCS providers and members.

Health Net has implemented various aspects of health care reform. We fully support the AHCCCS-administered program, Medicaid Electronic Health Records (EHR) Incentive Program for Arizona providers, which provides financial support for eligible providers to purchase and implement EHR systems. Health Net will continue to work with providers to identify and educate those who may be eligible for the incentive program and to encourage their participation.

Additionally, Health Net was one of the original financial supporters and is a board member of the nonprofit organization Health Information Network Arizona (HINAz). The HINAz mission is to support the appropriate and secure exchange of electronic health information and the adoption of health information technology (IT) in order to enable and improve quality of care, contain costs, and support meaningful use of certified electronic health records. This entity is considered to be the health information exchange for Arizona between providers and health plans, and it provides linkage to non-hospital providers.

We have pioneered the development of innovative partnerships, such as Accountable Care Organizations (ACOs). For example, Health Net and Banner Health Network collaborated to create ExcelCare, a cost-effective commercial HMO network for Maricopa County and parts of Pinal County. Commercial and Medicare members have access to more than 2,650 Banner Health Network PCPs and specialists. ExcelCare, a gain-share partnership based on outcome performance, provides members a trusted doctor-patient relationship enhanced by wellness incentives and a highly coordinated patient experience. In Pima County, Health Net is currently negotiating to participate in the ACO sponsored by Tucson Medical Center and three federally qualified health centers (FQHCs).

Health Net also supports implementation of medical homes—a team-based health care delivery model that provides comprehensive, continuous medical care to patients in order to obtain the best health outcomes. We encourage and work with providers, particularly with FQHCs, to use this model to allow better access to health care, increase satisfaction with care, and improve health.

We also understand that AHCCCS has undertaken an initiative to move its current inpatient hospital reimbursement structure to a diagnosis-related group (DRG) payment methodology. Health Net has experience in this area and we are well positioned to employ it on behalf of AHCCCS.

Health Net Oversight

Health Net is committed to providing our members access to high-quality medical care while complying fully with all state, federal, and local laws and regulations as well as any other requirements of the AHCCCS program. In addition to a dynamic Corporate Compliance Program, Heath Net relies on the work of its Special Investigations Unit (SIU) to execute our anti-fraud plan.

Health Net uses system-based antifraud controls to assist in our detection efforts. Our claims payment system serves as front-line defense with a variety of edits that verify data accuracy and help ensure compliance. Proactive data mining identifies patterns, potential payment errors, utilization trends, and other indicators that require further study and action. We also participate in sharing critical information regarding suspected fraud at a national level through use of the Special Investigations Research Intelligence System (SIRIS).

Health Net has a strong track record for success in this area. Over the past two years, we recovered more than $5 million (cash or offset), showed savings in prepayment denials of more than $17 million, and prevented losses of more than $2.9 million for a total of nearly $25 million.

Health Net's Efficiency

Health Net has established a reputation for meeting government contract requirements effectively and in a timely manner. Our proposed approach to meeting AHCCCS contract requirements will follow a path similar to our successful implementation of the most recent TRICARE North Region contract, which provides services to more than 3 million members as well as our most recent California Medicaid implementation where we have added an

additional 75,000 members in the past year. Upon contract award, Health Net will immediately establish a Transition Management Executive Committee (TMEC) comprising of representatives from each functional area. Under the direction of an Arizona-based program administrator, the committee will develop a comprehensive implementation plan with specific activities and timelines. Action items will be based on contract terms and conditions, AHCCCS Contractors Operation Manual (ACOM) and AHCCCS Medical Policy Manual (AMPM) requirements, and AHCCCS technical guidelines and manuals. The implementation plan will be designed to attain full compliance during the readiness review in early spring and to have Health Net positioned to accept members on October 1, 2013.

Within 120 days of contract award, Health Net will establish a separate corporation, Health Net Access, Inc., whose only authorized business will be to provide AHCCCS coverage to enrolled members. By January 2014, Health Net will operate either a Medicare Demonstration plan or a D-SNP serving members eligible for both Medicaid and Medicare. Health Net will have the legal and actual authority to direct, manage, and control the operation of both programs to the extent necessary to ensure the integration of AHCCCS and Medicare services and benefits for enrolled dual eligible members. The Medicare product will be branded in a manner easily identifiable to members and providers as an integrated Medicaid and Medicare program.

Our D-SNP, established in January 2010, currently provides coverage to more than 4,100 dual eligible members in Maricopa, Pinal, Pima, and Santa Cruz Counties. For the past three years, Health Net has developed policies, procedures, and systems, including a Model of Care, designed to integrate and coordinate services between Health Net and AHCCCS acute and Arizona Long Term Care System (ALTCS) plans. We are prepared to effectuate any and all necessary changes to these processes in accordance with the requirements set forth in the CMS/AHCCCS Memorandum of Understanding or other AHCCCS initiatives for improving alignment relative to this population.

In addition, as part of the Dual Eligible Demonstration Project currently underway in California, Health Net has established implementation and governance committees which include cross-functional representation responsible for the development and implementation of the Demonstration Project. A comprehensive and detailed project plan has been executed and will be employed by the Arizona staff and modified where necessary to meet the needs and final requirements established by the Arizona Dual Eligible Demonstration Project. The project plan lays the foundation for the integration of Medicare and Medicaid services, including integration systems in benefit configuration, claim processing, care coordination, network management, provider relations, member services, quality management, medical management, compliance and an appeal and grievance system.

Health Net has the knowledge, systems, and experience to provide comprehensive, quality health care to members of the AHCCCS program. We will rely on our extensive experience and best practices in government programs to serve AHCCCS members and will build on the cooperative relationship we have with AHCCCS as demonstrated by the use of AHCCCS OnLine for our D-SNP during the past two years and our participation in the planning of the Dual Demonstration Project.

Health Net has more than three decades in the Arizona marketplace whether working in the commercial market, MA, or our prior experience as an AHCCCS health plan. We are in a unique position to build on this solid foundation to create systems and procedures to effectively and efficiently serve AHCCCS. We will leverage our robust provider network to address AHCCCS needs—a first step in providing seamless transition of care to AHCCCS members.

We have been actively participating in Arizona health reform initiatives, ranging from accountable care organizations to the use of electronic health care records, and have experience in working with state institutions and regulators. Our clearly defined and systemic approach to fraud, waste, and abuse will be expanded to ensure that all AHCCCS requirements are met successfully, issues are detected early, and losses are kept to a minimum.

Health Net and its predecessor companies have served the people of the State of Arizona for more than 30 years. AHCCCS will find us a great choice for providing high quality services and added value to the members of the AHCCCS program.

2. Moral or Religious Objection [H.16.D.2]

The bidding entity, Health Net of Arizona, Inc., does not have any moral or religious objections in providing or reimbursing for covered services on the AHCCCS Acute Care contract.

Section E – Table of Contents

E. Narrative Submission – Acute Care

Access to Care/Network

1. Question 1 [H.16.E.1; D1.3, 4, 6, 7, 8, 9, 10, 27, 29, 35, 36, 61, 66, 69, 70, 71]

Health Net has the background and experience needed to accommodate the anticipated AHCCCS membership growth in an effective and timely manner. When the California Department of Health Care Services transitioned approximately 85,000 seniors and persons with disabilities into Health Net's California Medicaid Managed Care Program between June 2011 and June 2012, we systematically absorbed these members into our system, providing high-quality care expeditiously and efficiently. We met the state access requirements and assumed responsibility for complex care coordination with little service disruption and high member satisfaction. We are currently enrolling an estimated 20,000 California Medicaid members in San Joaquin County.

We have also been selected to participate in the California Dual Eligible Demonstration Project (serving an estimated 80,000 to 100,000 new Medicare/Medicaid members) in Los Angeles and San Diego Counties, beginning in late 2013—a testament to our abilities to meet the challenges of providing care to a large influx of new members. Our proposed approach to meeting AHCCCS contract requirements will follow a path similar to our successful implementation of the most recent TRICARE North Region contract, where we quickly established processes and systems to provide services to more than three million members, building on existing relationships in the health care community to ensure seamless access to primary and specialty care providers and hospital facilities. Health Net has established a reputation for meeting government contract requirements effectively, efficiently, and in a timely manner, ensuring that transitioned members are provided access to needed care and support services.

The governance structure and the transition management approach that we will employ to ensure the successful implementation of our AHCCCS plan is based on clearly defined roles, responsibilities, timelines, and accountabilities. This structure has proven successful in all of our major government program transitions, expansions and implementations, and benefits from experiences gained and lessons learned.

1.1 Growing the Provider Network: Our Ability To Quickly Meet Increasing Capacity

We recognize that successful implementations involving large membership populations require that our operational and administrative structures be sufficiently adequate and sustainable to fulfill our contract obligations. Our first priority has always been to ensure the adequacy of the provider network with respect to availability and accessibility. From day one, members must have access to needed medical care. This will remain our main focus in launching our AHCCCS plan in GSAs 10 and 12. Health Net of Arizona, Inc. already has a

comprehensive network of providers—a network that mirrors other current AHCCCS plan's networks. This network includes 2,130 PCPs and 8,400 specialists currently serving our Arizona commercial and Medicare members, and it will be expanded to meet AHCCCS member needs. We contract with 44 hospitals, 37 rehabilitation facilities, 50 skilled nursing facilities (SNFs), and a network of 917 pharmacies, and 51 in-store clinics. We also maintain relationships with four federally qualified health centers (FQHCs) and one rural health clinic (RHC). The majority of our network in GSAs 10 and 12 have already amended their contracts to provide services to our prospective AHCCCS members. In Maricopa County, we have approximately 1,320 contracted PCPs and around 650 in Pima and Santa Cruz Counties. Many of these PCPs currently provide Medicaid coverage allowing for continuity of care for members selecting or transitioning to Health Net's AHCCCS plan. Our AHCCCS network meets the required time and distance standards governing PCPs, pharmacies, and dentists.

To supplement our PCP coverage, we also have a robust urgent care network, which is well publicized to members. Periodic mailings to members provide helpful information in the appropriate use of urgent care versus emergency care. These mailings also include a listing of contracted urgent care facilities throughout the state. Health Net has experience with the FQHC and RHC sites of care for the low-income populations. We work proactively and effectively with these clinics to ensure they provide care to all members, whether assigned or not, and to ensure they have the infrastructure to provide after-hours care and weekend care through a process of grants and incentives. We also require and audit our PCPs to provide access to care 20 hours per week, at a minimum, and to provide an after-hours message, or an answering service, with specifics about accessing care. Through these and other methods, we encourage care within the medical home model. We also host and promote a Nurse Advice and Triage Line, where members can call with questions on a 24/7/365 basis. Through this intervention, 80 percent of calls are diverted from emergency room to physician office or member self management.

Health Net uses GeoAccess reporting and analysis to assess the adequacy of our network. This process proactively identifies any possible network gaps to allow targeted network expansion. Health Net has a Fee Negotiations Unit which allows us to quickly reach out to non-contracted providers and obtain letters of agreement, and to ensure member access and transition to a lower level of care occurs in a timely manner. Our current expedited credentialing process (i.e., immediate interim sign-off on clean files by a medical director) meets the AHCCCS requirement for provisional credentialing.

With an influx in membership, Health Net will respond in the following ways:

- **An Extensive Monitoring Process.** Our Network Management team would undertake analysis of where new members reside and map that information to our network. We will then target providers (both in and out of network) in those areas and initiate the contracting process.
- **Member Grievance Data.** The Appeals and Grievance department will report member grievances concerning provider availability and accessibility to Network Management on a daily basis. Network Management will investigate the matter and implement corrective action in a timely manner through a special response team.
- **Special Response Team.** When a specific area requires an increase in the number of available providers, a task force within our Network Management department will shift into high gear. Provider Services Representatives are well versed in the details of quickly contracting with new providers. When a provider need is identified, Network Management will work closely and collaboratively with Medical Management to pursue one-time or ongoing contracts.
- **Special Communication to New Members.** New members will receive special mailings about our urgent care network and in-store clinics, for those times when urgent care is needed, but the PCP is unavailable due to patient-capacity level. We would also provide incentives to current providers—particularly the FQHCs and RHCs—to offer special weekday extended hours and Saturday hours to help members obtain appropriate access for urgent care that accommodates the member's work and school schedules.
- **PCP Panels.** The availability of coverage through the Arizona Health Exchange, coupled with a Medicaid expansion, may place a significant burden on PCP capacity resulting in closed panels. Health Net will closely monitor PCP panel closures and routinely identify available patient capacity. If a member has not selected a PCP, Health Net will assign that member to the PCP with the highest capacity within AHCCCS geographic proximity requirements. According to a 2011 AHCCCS report, FQHCs are expected to have excess capacity, and Health Net will closely collaborate with these organizations in a mutually beneficial manner.

While the availability and accessibility of the provider network is paramount to the delivery of AHCCCS-covered services, Health Net recognizes the critical importance of maintaining and sustaining a responsive operational and medical management infrastructure to service a large influx of members. To ensure optimal service performance, Health Net will have the structure and processes in place to closely monitor membership growth and systemically increase resources based upon established service/staffing matrices employed in similar circumstances.

1.2 Managing the Transition: Our Governance Structure and Approach

Upon contract award, Health Net will immediately establish a Transition Management Executive Committee (TMEC). The committee will be composed of our business executives who will provide the executive oversight for the implementation of the AHCCCS plan and will include representation from Medical Management, Quality Management, Network Management, Operations, Compliance, Information Technology, and Program Administration. The committee will meet weekly during the implementation and thereafter on an as-needed basis to address critical issues, such as risk-mitigation strategies, interdependencies, coordination of major activities and significant issue resolution.

The committee will appoint an Arizona-based program administrator with extensive tenure in the operations of large government-sponsored programs and who understands the scope, complexities and interdependent nature of the implementation. The program administrator will oversee the entire planning and implementation and report on progress to the TMEC. The position will have decision authority and all necessary resources to ensure a successful program launch.

At the functional level, we will establish core teams in each major functional area, that will be accountable to the program administrator. These core teams will serve as the project coordinators responsible for overseeing detailed implementation activities within their respective functional area. Interdepartmental core teams will also be established to develop and implement AHCCCS policies, procedures and requirements that are cross-functional.

We believe that our governance structure for the implementation of the AHCCCS plan will prove as effective and responsive as our past similar endeavors.

Transition Management

Our management approach is predicated on disciplined planning, development and execution. Our goal is to provide member care and services on the plan start date while fulfilling our contract obligations. This will remain our goal for the AHCCCS implementation. We want to obtain full compliance with the Financial and Operational Readiness Review in early spring and enroll members on October 1, 2013.

Generally, program implementation planning commences with the contract award. In the case of the AHCCCS program, Health Net recognizes the need to start the planning process prior to contract award to better position us for the readiness review. Toward this end, we have developed more than 70 AHCCCS policies and procedures that will be forwarded to a Policy Committee for approval in April. This will provide sufficient time for staff and provider training and system testing.

In November, we issued contract amendments to our current provider networks in GSAs 10 and 12 in order to adequately address any network deficiencies well before August 1, 2013. Additionally, we have conducted staff training sessions on the AHCCCS Medical Policy Manual (AMPM), AHCCCS Contractors Operation Manual (ACOM), and Technical Guidelines and Manuals to ensure familiarity with AHCCCS program and reporting requirements. These actions will facilitate our planning process and better prepare us for the readiness review.

Upon contract award, the TMEC will appoint the Arizona-based program administrator who will immediately establish a core team for each functional area. An implementation team comprising leads from each functional area will be established under the direction of the program administrator and will meet daily. The primary purpose of the committee is the development and execution of a comprehensive implementation plan.

The implementation plan will include specific actions, responsible parties, stated deliverables, prescribed timelines, and up-to-date status information. Action items will be based on contract obligations, ACOM, and AMPM policies and AHCCCS Technical Guidelines and Manuals. The plan action items will include, but not be limited to:

- Development, approval and testing of policies, procedures, processes and systems
- Drafting required plan documents including Early and Periodic Screening Diagnosis and Treatment (EPSDT), Maternal and Child Health, Medical Management, Quality Management, Network Development and Management, Business Continuity and Recovery, Cultural Competency and Compliance

- Design and submission of member correspondence to AHCCCS including member handbook, identification card, provider directory, standard correspondence templates, and web site content
- Establishment of a comprehensive training program for employees and providers
- Creation of committee structure including Quality Management, Medical Management, Peer Review, Credentialing, and Compliance
- Design and testing of information technology exchanges including member, provider and financial files and encounter reporting
- Maintenance of a contracted provider network designed to deliver AHCCCS covered services in accordance with applicable accessibility and availability standards
- Completion of required financial obligations and submittal of administrative attestations
- Identification of needed logistical and operation support such as telephone and fax lines, mailing addresses, printing, etc.
- Development of staffing plan with a delineated phase-in schedule

Staff Planning and Development

Health Net recognizes the critical need for appropriate staff planning and development to properly manage membership growth, especially when large numbers of members are transitioned at the same time.

Based on our Medicaid experience, Health Net has developed predictive staffing models based upon service levels and operational indices. These models have proven successful in determining initial and subsequent staffing levels. Our specific models are proprietary information, but we will provide general examples. Our Customer Contact Center, which will be responsible for providing member services to our AHCCCS enrollees on a 24/7 basis, has established the average number of calls per member per month for our Medicaid population, and the number of calls handled per customer service representative per month. This formula, based on membership, dictates the staffing level. The calls per member and the number of calls handled per representative are constantly monitored, and the ultimate test for staffing adequacy is based on the achievement of prescribed performance standards such as average speed of answer, first-call resolution, and abandonment rate. We plan to apply the same successful staffing model for the AHCCCS program, with the assumption that the number of AHCCCS member calls per month will be similar to Medicaid in California and, will be carefully monitored to assure appropriateness.

The initial AHCCCS staffing will be based upon projected monthly enrollment. Calls will be tracked, trends will be identified, and any staff adjustments will be made accordingly. We will have an AHCCCS-dedicated unit within the Customer Contact Center fully trained on AHCCCS benefits and services, including specialized training on the Arizona market, provider network and AHCCCS policies and procedures,especially those relating to such member rights as appeals and grievances. We will also cross-train current customer service representatives in the event that the membership enrollment exceeds projections. This will allow us to recruit and properly train needed AHCCCS representatives without service disruption. The new AHCCCS telephone response standards and reporting requirements will be followed and performance against standard will be the dominant driver for staffing determinations.

Our claims department uses a similar model in establishing appropriate staffing levels. Based upon our Medicaid experience, we know the average number of claims per member per month as well as the number of claims adjudicated per claims processor per month. Membership drives staffing and adequacy is determined on performance to established standards with the latter being the dominant factor. As with the Customer Contact Center, the Claims department will use our existing formula in determining our initial and subsequent staffing until a deviation is detected, whereby the necessary adjustments would be made. The Claims department will also have a dedicated AHCCCS unit trained on AHCCCS payment standards for timeliness and accuracy, coordination of benefits, third-party liabilities, recoupments, and encounters. As a safeguard, we will also cross train current claims processors in the event of unexpected enrollment levels. In addition, we will retain a bank of qualified applicants for both member services and claims in order to expeditiously hire and train staff as needed.

Our other operational departments, such as enrollment, case management, appeals and grievances, and medical management, have similar proven staffing models. We are confident that our staffing formulas will be adaptable to the AHCCCS program; however, we will be prepared to adjust accordingly. Health Net is committed to

providing the necessary staff resources to successfully implement and administer the AHCCCS program in an effective and sustainable manner.

Operational System Testing

Prior to the enrollment of AHCCCS members on October 1, 2013, in addition to participating in the AHCCCS readiness review, Health Net will conduct an exhaustive internal testing regimen on all operational processes to ensure effectiveness and responsiveness. As part of this testing, we will ensure that all of our operating systems are scalable regardless of membership enrollment. For example, we will verify that our membership card printer and member packet fulfillment vendor has the capacity to produce and issue member materials within two business days regardless of enrollment level, and that our phone lines have the capacity to accommodate call volume traffic. We will pay special attention to our transition of care staffing and operational processes to ensure the timely receipt and review of Enrollment Transition Information (ETI) and the responsive activation of service authorizations for members with special circumstances. Upon receipt of the three year encounter report from AHCCCS in December, we will verify that members with special health needs and chronic conditions have been identified in accordance with AMPM Policy 520.

The implementation team will remain in place to monitor service performance, detect problems, identify causative factors, and institute corrective actions. The team will continue oversight until such time as the program administrator and TMEC deem the program to be fully operational and fully compliant with contract obligations.

Business Continuity and Recovery

In addition to our initial internal testing, Health Net will continuously monitor and prepare for service disruptions and emergency conditions. We recognize the critical importance of rapid response and recovery to service disruptions, such as computer or telephonic failures. We will develop and execute a comprehensive Business Continuity and Recovery Plan specific to our Arizona AHCCCS operations. The plan will incorporate the elements and components set forth in ACOM Policy 104 and will be evaluated annually.

We believe that Health Net has the knowledge, experience, and seasoned talent in the successful management of government programs involving large and rapid membership enrollments, whether through transitions, expansions or implementations. We have established governance structure protocols, management approaches and staffing models with proven and demonstrable results that are applicable and transferable to the implementation and continuation of the AHCCCS program in accommodating high -growth anticipation. We are confident that all operating and administrative departments, not solely network management, will be properly equipped, staffed and trained to provide member medical care and support services, and fully comply with contract obligations on October 1, 2013.

2. Question 2 [H.16.E.2; D1.19, 20, 27, 28, 29, 32, 33]

For the past 30 years, Health Net has developed and maintained a comprehensive, statewide provider network to ensure medical service accessibility. We have established processes, procedures, and systems to continuously monitor and evaluate the adequacy of our network, detect gaps in service, and effectuate the necessary corrective actions in a timely manner.

We currently have networks in Maricopa, Pima, and Santa Cruz Counties. We have amended our standard provider contract to include the AHCCCS Minimum Subcontractor Provisions and have established AHCCCS contracted networks in GSAs 10 and 12. We currently have approximately 2,000 PCPs, nearly 3,700 specialists, and around 920 pharmacies in GSAs 10 and 12. Our networks presently meet the AHCCCS time and distance requirements for primary care, pharmacy, and dental. We are confident that our network will adequately address the diverse needs of the AHCCCS population, including the underserved.

2.1 Developing Networks that Provide Access to Underserved Populations

Health Net uses a variety of methodologies to develop a network that meets specific needs. They include:

- **Network Comparisons.** Through the use of a vendor, Health Net has access to competitive information regarding the networks of approximately 20 health plans that serve commercial, Medicare and AHCCCS populations. The vendor's website provides us with data to identify those providers currently participating in the Medicaid program within specified geographical areas. This process allows us to quickly reach out to providers within specific specialties, who have demonstrated the ability and willingness to best meet the needs of our members, especially the underserved.
- **Provider Nominations.** Health Net has an established process in which any member, hospital facility, or provider may request that a particular provider be added to the network. A Network Management Representative immediately responds to the request. The representative will contact the requested provider and initiate the contracting process.
- **Medical Management Referral.** Although Health Net has a robust specialty network, a sub-specialty may sometimes be required in a particular geographic area. Upon notification from our Medical Management team of a request for such a provider, the assigned provider services representative begins the contracting process as noted above.

These methods support Health Net's ability to meet the care needs of our members. We understand that the AHCCCS population includes members of all ages living with limited income, restricted transportation means and difficult residential circumstances. Our robust provider network ranges from pediatric to geriatric primary care services, after-hours care in our contracted retail in-store clinics, as well as access to all specialties including pediatric sub-specialties. Health Net holds contracts with the majority of hospitals in GSAs 10 and 12, which provide care to our members 24/7.

Health Net's contracts stipulate that all providers must render services using the same standard of care, skill and diligence as is customarily used by similar providers throughout the United States. We will also stipulate that service must be delivered to AHCCCS enrollees in the same manner and with the same availability with which the provider renders services to any other non-AHCCCS patients.

Health Net currently has the tools and processes required to ensure that we can identify and address any areas in which there may be a service gap; and they will be incorporated into our AHCCCS operations.

We will develop and maintain an AHCCCS Network Development and Management Plan that includes the elements set forth in ACOM Policy 415. Our initial plan, along with our Network Attestation, will be submitted to AHCCCS on or before November 15th, and annually thereafter. The plan will detail our processes, procedures and systems to develop, maintain, and monitor an adequate network supported by contractual agreements and capable of providing access to all AHCCCS covered services. We closely monitor provider terminations to identify provider specific issues and track systemic trends on a routine basis. We will report to AHCCCS quarterly on provider terminations due to rates and significant changes in operations that affect adequacy capacity and services including reduction in scope of services and/or closed panels.

Health Net currently submits a Network Adequacy Report annually to the Arizona Department of Insurance. This report identifies all contracted providers and all HMO enrolled members in order to ensure that Health Net meets its responsibility of providing access to care to our HMO enrollees. This process will be duplicated to report

network adequacy for our AHCCCS members. In addition to this report, Health Net will adhere to all prescribed reporting requirements set forth in ACOM Policies 415 and 417.

2.2 Ensuring Cultural and Linguistic Responsiveness for AHCCCS Members

Health Net recognizes that cultural and linguistic issues are proven barriers to medical access. We have several initiatives to address the cultural and linguistic needs of our members, and partner with providers to ensure high-quality and culturally responsive care. The following mechanisms ensure that members have providers available to them who can better understand their specific needs:

- Health Net's Cultural and Linguistic Services department, which has more than 16 years experience in supporting access to health care for Medicaid members, uses the Culturally and Linguistically Appropriate Services (CLAS) Standards to ensure culturally and linguistically appropriate access to health care services (Title VI of the Civil Rights Act). The department provides a wide range of services for employees, members, and providers including comprehensive language, cultural competency and health literacy services, and monitors all relevant quality standards.
- Health Net's Provider Directory identifies all Spanish-speaking practitioners and has text in both English and Spanish. Current and prospective members can locate physicians who speak a language other than English by accessing provider search on Health Net's website. The provider profile includes the practitioner's gender, the year licensed in Arizona, secondary language(s), specialties, board certifications, and other information helpful to members in selecting the right doctor.
- Health Net members may designate their preference to speak to a staff person in their preferred language when calling our Customer Contact Center. This service, which includes translations in more than 250 languages, assists the members in selecting the most appropriate provider.
- Health Net members may request a Spanish version of most written materials. If there is a need, documents can also be translated into additional languages. Oral translations of print materials can be provided in over 250 languages including many of the indigenous languages spoken in Arizona.
- Telephonic interpreter services at the point of service are available for members who have limited English proficiency. A call to our Customer Contact Center is all that is necessary for a member to gain access to telephonic interpreter services, which are provided at no cost to providers or members. Telephone interpreters in more than 250 languages are available. Health Net does not currently offer in-person translation services or sign language services in Arizona, but we are fully prepared to meet any AHCCCS contract requirements for these types of services.
- Health Net sends annual reminder notices to contracted providers describing the linguistic services available to them and their patients as well as information on how to access these services. Providers are also encouraged to participate in cultural competency training as part of their continuing education. Information on where to obtain details of these classes is also available.

While English and Spanish are the predominant languages in Arizona, Health Net will continue its commitment to provide a network that can meet the linguistic needs of all members. We will continue our practice of reviewing cultural and linguistic data annually to proactively maintain a provider network that reflects the unique and changing needs of our AHCCCS members.

Further, Health Net will ensure that our membership platform has the capabilities to collect and store member language preferences and any cultural or ethnic information that is provided voluntarily by members. This will allow the plan to systematically report on and meet its membership's needs with more accuracy.

Health Net does not tolerate discrimination of any kind to its members. To ensure that we are made aware of any actual or potential issues, Health Net has a detailed contract provision on nondiscrimination in all provider contracts guarding against discrimination whether on the basis of the member's coverage under a program, age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, source of payment, utilization of medical or mental health services, equipment, pharmaceuticals or supplies, etc. Further, the provider must agree to make reasonable accommodations for members with disabilities.

Sensitivity to a member's living circumstances is another important aspect of our program. Our Provider Services, Medical Management, and Customer Contact Center teams routinely assist providers with administrative issues, such as facilitating physician visits, obtaining social services, providing coaching, and other supports during a time of acute medical illness. Provider Services has a dedicated telephone staff to handle these requests.

Representatives are also available to deal with prior authorization, transportation or any medical questions or concerns. Our Customer Contact Center is staffed and trained for first-call resolution.

2.3 Detecting and Responding to Deficiencies in the Network

Health Net identifies network deficiencies in a number of ways. They include:

- **Annual Access and Availability Review.** Health Net analyzes its network annually through the use of a Geo Access report. This report summarizes any network deficiencies and includes recommendations for improvement. The Quality Improvement Committee, which comprises internal departments, Health Net medical directors and external physician members, reviews and approves these recommendations. Network Management team on the committee are then responsible for implementing the improvements.
- **GeoAccess Reporting.** Developing the process to create a quarterly GeoAccess report to proactively identify any possible network gaps is a current process improvement initiative for Provider Services. We will complete this initiative during the first quarter of 2013.
- **Medical Management Referral.** When the Medical Management team identifies a gap for a provider specialty in a specific geographic location, they give notice to Network Management.
- **Grievance Process.** Member grievances involving access to care are monitored and tracked specifically. Access issues can then be addressed on an individual member case by case basis, and upon overall review quarterly and annually to identify and add appropriate providers to better meet the needs of the population we serve.

When any of the above methods signal the need to contract with a new provider, a Network Management Representative begins the contracting process using resources such as competitive information regarding non-contracted providers in the community. The Network Management Representative documents the progress of contracting efforts until a contract has been executed or contract discussions have been terminated. Although contracting may require a prolonged completion period, Health Net has short-term intervention processes to ensure the delivery of care in a timely manner. These include but are not limited to letters of agreement and expedited (emergency or provisional) credentialing.

2.4 Meeting AHCCCS Standards for Accessibility, Availability, and Wait Times

Health Net will use two methods to ensure AHCCCS standards and member satisfaction. The first method is that we contract with an external vendor to conduct “secret shopper” calls to our contracted provider network. A statistically significant random sample of PCPs, specialists, dentists, and maternity providers will be surveyed on a quarterly basis to determine provider compliance with the AHCCCS appointment (routine, urgent, and emergent) and wait time standards.

The survey will also include the following determinations: 1) office hours are sufficient to ensure that AHCCCS members are not discriminated against and are able to access care within established standards; 2) a PCP’s practice is open at least 20-hours-per-week; 3) a specialty care provider’s practice is open at least 16-hours-per-week for AHCCCS members to schedule appointments; 4) and during evenings, weekends, and holidays, an answering service is used to ensure availability of services. In addition, specialty physicians will be contacted to assess the same criteria as well as their ability to accept AHCCCS patients.

Each provider receives three calls from different investigators. Providers with multiple locations are counted as one provider in the number of providers per county. A large group practice is represented as one provider or group. Availability is determined based upon whether the patient could receive an appointment with any provider in the group within the recommended time frame. Investigators complete one hour of updated training prior to beginning the calls to ensure consistency as well as to learn standards and changes in desired data collection.

The second method Health Net uses to gauge member satisfaction is the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey results. This survey is conducted annually to assess the experiences of beneficiaries in Commercial, Medicare Advantage plans. The analysis of the CAHPS® results facilitates the identification of areas in need of improvement, assists with the development of potential interventions, and may serve to monitor the success from past interventions.

Please note: Health Net currently performs multiple surveys throughout its operations using internal sources and external vendors. We have the tools and resources available to conduct any surveys requested by the AHCCCS administration.

2.5 Managing the Provider Network

Health Net uses a robust communication processes as the foundation for managing its provider network. These tools will be revised to reflect all AHCCCS requirements. Methods of communication include:

- **Operations Manual.** Our AHCCCS provider operations manual will be available to the provider online or in hard copy as requested. The manual will incorporate the required elements set forth in ACOM Policy 416. In addition, a condensed version or "Reference Guide" in hard copy format is provided to all offices. This Reference Guide highlights all of the most important information for day-to-day operations with Health Net.
- **Provider Toolkit.** The provider toolkit includes all information necessary for a provider office to complete all administrative functions related to Health Net members. Items such as contact information, how to file claims, how to use our web portal, pharmacy information, referral forms, prior authorization information, and so forth are included.
- **Provider Updates.** These faxed updates cover all business, regulatory and compliance requirements and will include any AHCCCS program changes. Providers are given at least 30 days notice of any material changes to their agreements.
- **Online News.** The online news feature of our provider web portal gives our network current information at a glance. Links throughout the site provide more in-depth information on a topic.
- **Provider In-service Meetings.** All newly contracted providers meet with their Network Management Representative within two weeks of their effective date. The representative reviews the toolkit and reference guide, and answers any questions the provider may have regarding Health Net policies and procedures.
- **Provider Forums.** We will hold a provider forum no less than quarterly to improve communications between Health Net and its providers, including dental providers.

Health Net continuously monitors our provider network to ensure that it adheres to all required compliance and regulatory requirements. These requirements are distributed to the provider network through provider updates and/or regular mailings.

Our formal appeals and grievance processes for both members and providers ensures that member care is the priority and is not compromised while the member issue is going through the process. All requests for provider information necessary to complete a review of an appeal or grievance are handled as a priority and within a specified period. Our Appeals and Grievances team tracks issues as identified. This allows us to identify trends and to research and resolve the issues in a timely manner. Regular reports are submitted to the Quality Management/Performance Improvement (QM/PI) Committee and specific cases can be referred to RN staff for potential quality incident assessment or forwarded to peer review committee.

Although most provider issues are resolved immediately, all provider calls are returned within 24-hours of receipt. If we are unable to resolve the issue within the 24-hours, we advise the provider of our progress while the issue is researched and resolved.

For our AHCCCS plan, Health Net will track provider inquiries to ensure that providers receive timely responses to their inquiries, requests for information and complaints. Inquiries will be acknowledged within three business days of receipt. Issues will be resolved and resolution communicated to the provider within 30 business days of receipt. All inquiries will be documented onto a tracking log. This tracking log will provide us with another tool to identify improvement opportunities and/or provider training needs.

To facilitate provider registration with AHCCCS, Health Net will provide AHCCCS registration information and a link to the AHCCCS site through our Provider Updates and through our provider portal. Health Net AHCCCS Contact Center representatives will also be educated on use of the AHCCCS site in order to provide information to providers inquiring into the process for AHCCCS registration.

2.6 Sustaining an Adequate Network

To ensure that Health Net has a network that is sufficient and adequate to provide appropriate access to health care for its members, Health Net uses access-to-care standards applicable to each state and line of business, and will similarly do so with AHCCCS standards. We measure, evaluate, and report compliance with access and availability standards using the following methodologies:

- **Practitioner Telephonic Survey.** Quarterly appointment surveys to assess member access to care and service. (This process is described above in **Section 2.4**).

- **Provider After-hours Access Surveys.** Provider telephone surveys to assess after-hours emergency information and physician after-hours access.
- **Provider Satisfaction Surveys.** This annual survey solicits—from physician's perspective—any concerns regarding compliance with the access standards. The results are made available to all applicable provider organizations through annual provider updates.
- **Member Grievance Data.** Grievance data related to access is tracked and trended on an ongoing basis to identify potential trends or problems with specific practitioners, provider groups, or geographic areas.
- **GeoAccess Analysis.** As described above, the GeoAccess Report measures compliance with Health Net's standards for enrollee distance to specified practitioners and providers.
- **Members to Practitioner/Provider Ratios.** This is an assessment of the ratio of members to PCPs, specialty care physicians, and high-volume specialty care physicians.
- **Network Percentage Open Practice Report (by State).** This report presents the percentage of PCPs open to accepting new members by line of business and percentage of specialty care physicians open to accepting new referrals.

Health Net actively pursues the use of data discovered through these surveys, reports and assessments to take action that ensures that we sustain a network that is sufficient and adequate to provide quality member care.

Health Net is a leader in the industry in provider retention. Some of our non-financial incentives and benefits to increase network participation include:

- **Onsite Trainings and Presentations.** Health Net offers onsite training to the provider's office staff.
- **Partnering with Providers and the Community.** Health Net works on collaborations, such as Teachers for Healthy Kids and school-based health programs.
- **Improving the Patient Experience Toolkit.** This toolkit contains information on best practices that assist providers in improving patient access to care, care coordination, and communication between provider and patient.
- **Customized Workshops on Cultural, Language, or Low Health Literacy.** Health Net will conduct these sessions for provider groups or in provider offices.
- **Cultural Information for Use in a Clinical Setting.** This includes information such as diabetes and culture, a cultural provider toolkit, and cross-cultural communication information.
- **Fit Providers for Life.** This is a nutrition and physical activity program for provider office staff.
- **Telephonic or Web-based Trainings.** This training occurs prior to and during complex implementations. For example, during the SNP implementation and the seniors and persons with disabilities implementation, Health Net subject matter experts taught providers, RNs, and office management staff about key programmatic requirements.
- **Child and Adolescent Overweight Provider Toolkit.** This includes a Pediatric and Adolescent Obesity Assessment and Management Guidelines, BMI training, and other resources.
- **Free Health Education Materials.** Health Net supplies free educational materials on many health topics and in many languages that providers can distribute to their patients.
- **Pregnancy Packets.** Health Net provides trimester appropriate materials to pregnant women, including information about nutrition, cigarette cessation, healthy lifestyles, appointment scheduling, and care of the newborn.
- **High Risk Pregnancy Identification Tool.** Health Net requests providers to complete this simple tool and submit to Health Net Case Management for ongoing support and referral of the high risk member during pregnancy.
- **Breastfeeding and Infant Formula Toolkit.** Health Net distributes a toolkit to PCPs and OB/GYN and pediatricians with important information about the WIC program, breastfeeding support, and formula guidelines.

Health Net is confident in our ability to develop, maintain, and sustain a robust provider network to serve the members of the AHCCCS program in a timely and effective manner.

Program

3. Question 3 [H.16.E.3; D1.19, 23, 24, 25, 30, 31, 42, 71]

For years, Health Net, in collaboration with our key stakeholders, has used evidenced-based decision support implements. These clinical tools have resulted in maximizing care coordination, improved health outcomes, increased efficiencies and improved member satisfaction.

3.1 Using Evidence-based Decision-support Tools to Guide Clinical Decisions

Health Net's existing National Committee on Quality Assurance (NCQA)-accredited performance improvement programs for both our Medicare and Medicaid plans are dedicated to rigorous monitoring and quality improvements. We are fully committed to a quality management/ performance improvement (QM/PI) process that includes appropriate medical management, continuous quality improvement, a strong focus on ensuring that preventive measures and exams are provided in a timely manner, and continuous efforts to implement a strong medical home with a well-informed provider network for our members.

Health Net has an existing quality improvement structure including committees and sub-committees designed to oversee quality management systems and quality improvement initiatives for our health plans. We will tailor these to meet AHCCCS requirements. All relevant processes will be applied to management of our AHCCCS plan providers. For example, the use of clinical practice guidelines (CPGs), InterQual® (a nationally recognized decision-support company), and medication compendia to make clinical decisions will all become an integral part of our AHCCCS plan.

CPGs are developed and adopted in order to reduce practice variation and improve the health status of our members. Health Net adopts nationally recognized evidence-based CPGs for medical and behavioral health conditions through our western region Medical Advisory Council (MAC) comprising of Health Net medical directors and network providers. This group reviews and updates CPGs every two years—more frequently when new scientific evidence or new national standards are published. Updates are based on input from recognized specialists in their respective fields of medicine. Guidelines are evaluated for consistency with Health Net benefits, utilization management criteria, and member education materials. In addition, MAC evaluates new technologies and devices for safety and effectiveness.

Approved medical policies and CPGs are published and available to network providers through the provider portal of Health Net's website and other provider communications channels. Providers and clinics are required to participate in the collection of HEDIS® data to monitor and ensure clinical care is consistent with evidence-based clinical guidelines.

In addition, Health Net holds licenses from InterQual®, which has a variety of online guidelines and tools to maximize efficiency and minimize variation in clinical decision-making. Our nurses and physicians are trained on the appropriate use of this tool and complete required annual training and testing. Through careful and appropriate application of these guidelines, we reduce variation in decision-making, ensure national criteria and guidelines are followed for approval and provision of care, and identify outlier providers. An example: We have been able to standardize the authorization and medical necessity determinations for hysterectomy to avoid over-utilization of this elective procedure in our California Medicaid population. This tool provides medical necessity guidelines for hospital and Skilled Nursing Facility (SNF) level of care as well as a broad array of clinical guidelines for the outpatient setting, including appropriate use of magnetic resonance imaging (MRI) and outpatient surgery.

In addition to InterQual® and Health Net's medical policies, our medical directors and RNs have access to, and use, decision support tools, such as medication compendia, Hayes Health Technology Assessment, and UpToDate® (an evidence-based clinical decision-support resource, written by physician experts), during their decision-making process. UpToDate® is continually updated to reflect most current research and standards of care. All medical decision denials contain a careful summary of the clinical evidence-based criteria used in making the determination to ensure that network physicians are fully aware of the guidelines. All guidelines are available for distribution to the providers upon request.

3.2 Using Evidenced-based Risk-assessment Data and Processes to Facilitate Care Coordination

To enhance care coordination for our most vulnerable Medicaid members and SNP members, Health Net follows the risk stratification and health risk assessment (HRA) process. Review of claims, pharmacy, and other authorizations as well as select member-reported data is collected by our HRA vendor, McKesson Health

Solutions. Members are risk stratified based on diagnosis, utilization, and other flags, such as requiring social services or behavioral health treatment. Members are stratified into either low-risk or high-risk categories. The HRA is a telephonic or in-person clinical assessment. A registered nurse conducts the medical portion of the assessment,. The results of the HRA are used to identify gaps in care, to develop care plans, to educate members about the medical home model, and to connect members to health and community-based services. High-risk members are offered care coordination for up to 90 days, or as needed, and/or referred into basic case management, disease management, or complex case management functions. We share a gaps-in-care report as well as the results of the health risk assessment with the member's PCP.

In addition to the process described above, children with special health care needs are assessed for risk using the Child Assessment Health Medical Information (CAHMI) tool. Developed through a special initiative with the Center for Health Care Strategies, it is now considered to be a best practice. Health Net has used this tool for more than a decade. Health Net's case managers and public programs coordinators, working alongside Health Net's member service department staff and/or the member's PCP or specialty provider, conduct needs assessments to identify service patterns, improve member access to health care, and enhance member care coordination. This process is more fully described below.

Once a Health Net member relations representative has applied the CAHMI tool and identified a member who may have special health care needs, a public programs coordinator/care coordinator conducts a follow-up outbound phone call to the child's parent or legal guardian to further evaluate the child's needs. Our public programs coordinator/care coordinator:

- Triages each case for case management services
- Provides information to the parent or legal guardian about specific programs and community resources that may benefit the child, e.g., the Arizona Early Intervention Program (AzEIP) and the Office for Children with Special Health Care Needs
- Discusses the child's special needs with the PCP and/or the participating clinic care coordinator
- Refers the case to the Health Net case manager for ongoing case management
- Facilitates referrals to appropriate specialty care

Pregnant women are assessed for high risk at their obstetrician's office, and the information is faxed to the Health Net perinatal case manager. Certain high-risk members are placed into telephonic case management. Members at risk for preterm labor are referred to a high-risk perinatologist for ongoing management. Home tocolytic therapy, home monitoring and intensive diabetic management are available through Health Net programs. Assessment of the hospital facility selected for delivery ensures that members at risk of delivering premature infants are delivered at facilities with high-level Neonatal Intensive Care Unit (NICU) capabilities. Health Net will incorporate the guidelines for developmental care developed by the Arizona Department of Health Services Office of Women's and Children's Health, High Risk Perinatal Program/Newborn Intensive Care Program (HRPP/NICP) into our perinatal outreach program in Arizona.

3.3 Using Data to Support Providers

Each year, Health Net chooses one measure for under-utilization and one measure for over-utilization to target with focused analysis, provider reporting and education, and member outreach. Health Net's analytics team, under the supervision of the QM/PI committee, performs regular data extracts to track improvement.

At present, we are monitoring provider completion and submission of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) documentation. This under-utilization measure tracks Medicaid providers' documentation of well child visits, immunizations, and other testing, counseling, and prevention treatments of children from birth to age 21. (In Arizona, this is the EPSDT Tracking Form.) Clinics and medical groups are monitored using a tracking system comparing the actual to the expected numbers of forms received. Reports on the actual versus expected utilization are shared with the clinics and medical groups on a quarterly basis. Health Net instituted a pay-for-performance program for high-volume PCPs in 2010 in California, which resulted in a 44 percent increase in receipt of these forms over a 2-year period, and subsequent improvement in HEDIS® scores based on improved performance in childhood preventive care measures. Our proposed adaptations of the program for AHCCCS is described below in **Section 3.4**.

An over-utilization measure we are currently monitoring is hospital readmissions. Health Net tracks hospital readmissions in our monthly quality indicator report, which the Utilization Management (UM) Committee reviews quarterly. Interventions to reduce readmission rates include the following activities:

- On-site complex discharge planning with face to face RN and member interaction
- Web-based appointment scheduling
- Pharmacist-led case management program to ensure appropriate medication management
- Direct referral into disease management programs
- Collaboration with concurrent review and Ambulatory Case Management during weekly rounds with the medical director to identify members at risk for re-admission and to identify an appropriate program or after-care plan
- Referrals to complex case management

We are particularly interested in ensuring discharged patients receive follow-up care from their PCP at the medical home within a few days of discharge. To accomplish this, we work with providers, members, and hospital staff to ensure an appointment is made prior to discharge. The discharge documents are made available to the PCP by the time of the follow-up visit. Hospital readmissions are carefully tracked through the QM/PI committee and the impact of the interventions mentioned above are documented and analyzed for trends. Specific reports at the clinic, group, and PCP level monitor the effectiveness of these interventions.

3.4 Using Data to Support AHCCCS and Its Members

Health Net's quality improvement programs have been structured to comply with the AHCCCS Acute RFP requirements outlined in the AMPM Chapters 400 and 900 and to meet the reporting requirements in RFP Attachment B1, Acute Care Program Contractors' Chart of Deliverables. In addition, Health Net's quality programs follow the "plan, do, check, act" framework developed by Edwards Deming.

Over the past 27 years, Health Net has been effectively managing performance improvement activities for our Medicaid, Medicare, commercial plans and other lines of business. Our QM/PI process is continuously enhanced to accommodate changes in regulatory requirements and changes within the health care industry. The outcome of this continuous improvement process has been to improve the quality of care and services provided to our more 5.4 million members across the nation, including more than one million Medicaid members in California. Health Net's leadership has extensive knowledge of Medicaid and a history of managing performance improvement programs in large populations. This experience will provide a strong foundation for success with quality programs for AHCCCS membership in the GSAs where Health Net proposes to provide services.

The Health Net quality management process incorporates, at a minimum, annual data collection from multiple sources, including claims, encounters, pharmacy, HEDIS®, grievances and appeals, and satisfaction surveys. We analyze this data for trends and identify opportunities for quality improvement. Once improvements relevant to the population and to clinical or service importance have been identified, activities are planned and implemented in collaboration with key stakeholders, including our network providers and community-based public health resources. Data collection is ongoing, enabling us to analyze results for trends and compared to benchmarks. QM/PI findings are data-driven, resulting from the review of variety of sources: research studies; industry standards and benchmarks; HEDIS®; grievances and appeals data; pharmacy, claims and membership data; disease management program information; and utilization/care management data.

Health Net has promoted a variety of health issues and designed tailored education programs and practice standards to meet the specific needs of both urban and rural populations. The goal of the QM/PI process is to provide members easy access to high-quality services that result in improved health status and member satisfaction in the most efficient and cost-effective manner. The QM/PI department oversees the quality of services provided to members using a systematic approach that monitors and analyzes data from multiple sources, develops and implements interventions, and evaluates results for improvement. Each of these functions has an impact on the outcomes of services to members and the cost of health care services to the state.

An example of how we effectively use data to support stakeholders is our recent response to addressing lack of prenatal care as a factor in birth outcomes in California. Health Net developed a maternity database, allowing us to track pregnant women through their pregnancy and delivery. The maternity database is used to identify members with high-risk pregnancies who may be in need of case management. We also send these members educational materials designed to educate them on topics such as how to have a healthy pregnancy, how to care

for a newborn, and the importance of postpartum care and of ensuring that the baby is enrolled in health insurance. Health Net has a dedicated perinatal case manager who provides care coordination and additional resources to high-risk pregnant members. In response to member needs, Health Net also created a dedicated newborn unit that reaches out to new mothers, reminding them about the importance of their postpartum checkup, newborn visits, and ensuring enrollment for the newborn. In 2012, we were able to provide support to 66 percent of our new mothers.

3.5 Using Data and Evidence-based Decision-support Tools in Arizona

Health Net maintains a robust data warehouse that contains claims, encounters and pharmacy data as well as a separate authorization data repository with a readily available tool for ad hoc queries and standard reports. This authorization data is used to create daily census reports for the onsite and telephonic concurrent review nurses, and a rounds report for the weekly meeting with medical directors, RN case managers, and concurrent review nurses. The system also allows us to carefully track turnaround time compliance as well as to create daily reports for prior authorization nurses regarding cases that are reaching due dates. In addition, we use this tool to track nursing effectiveness and case loads in order to ensure appropriate assignments.

Claims, pharmacy, and authorization data are shared with our vendor, McKesson Health Solutions, that performs HRAs, care coordination activities for new members, Nurse Advice Line functions, Disease Management, and complex case management. The Health Net ambulatory case managers have ready access to all the authorization data reporting capabilities as well as any member detail captured within any specific authorization request. This system serves as a repository of clinical information accompanying any authorization request or provider response to case management collaboration.

Health Net's data warehouse allows us to have systematic reporting to understand cost of care at both a broad and a detailed level. A team of health care analysts and actuaries prepare standard reports for regular meetings as well as ad hoc reports for unique issues and concerns.

For example, a quarterly report of revenue and health care costs, summarized per member per month, is prepared for each high-volume provider, in each county. Costs are categorized as institutional, professional and pharmacy to prepare a per-provider or per-clinic view of the medical care ratio. Through this view, we can target specific interventions for specific providers. Interventions may include modifications to existing contract rates, addition of network providers or facilities, increased focus on bed day management, increased case management for members who are frequently using emergency rooms (ERs), or increased focus on appropriate medication management. While the reports are high level, we can access greater detail to identify outliers as well as trended costs for specific diagnoses. This can initiate dialogue with our network providers and facilitate increased collaboration, clarity and understanding. Further, we can implement specific pay-for-performance programs to meet our cost-effectiveness goals as well as improve the overall quality of care for our members.

Recent enhancements to our data have allowed key medical management, network management, and other company executives to create both standing reports and ad hoc queries at their own desktop computers, without waiting for regular reporting or adding additional burden to our health care analysts. This resource allows for real-time cost management. It also allows the medical management team to have increased knowledge of any member/provider health care access issues within their specifically assigned caseload.

In addition, Health Net Pharmacy Services prepares both regular and ad hoc reports for the medical management team. Examples include an analysis of the top ten high-cost agents, top ten highest-volume medications, top medications processed through prior authorization, denial volume, injectable utilization, and narcotic utilization. Through this reporting and subsequent analysis and discussion, we are able to modify the prior authorization list, issue provider updates regarding best practice, target specific physicians for intervention, and initiate member-centered campaigns.

Example: Using Data to Provide Incentives for Cost Effectiveness Through Pay for Performance With Well-Child Visits.

The EPSDT Tracking Incentive Program is a financial incentive award program that recognizes and rewards participating California Medicaid providers who document the preventive care they provide based on the expectations to meet required EPSDT periodicity for preventive services. The program is not part of the base provider reimbursement for the wellness visit; rather, it is a supplemental compensation paid directly to providers for completing the documentation on the required form and submitting it in a timely manner. The existing

program for California Medicaid requires that eligible providers be Child Health and Disability Prevention (CHDP) certified, be in good standing with Health Net, and have a Medicaid membership of 250 members or more. Health Net proposes to replicate the EPSDT Tracking Incentive Program in Arizona with AHCCCS providers in GSAs 10 and 12.

Results from the California program bode well for its successful implementation in Arizona. EPSDT tracking form submissions increased, as did related HEDIS® measures for adolescents and younger children (**Figure 1**). EPSDT tracking submissions for the targeted 12- to 20-year-old age group increased by 44 percent from 2010 to 2011 as the number of forms submitted increased from 64,587 in 2010 to 92,725 submissions in 2011.

Standardized HEDIS® measures also improved over time with adolescent well visits increasing from 40 percent in 2010 to 54 percent in 2012 and well visits for children ages 3 to 6 years increased from 77 percent to 81 percent. Immunization rates for very young children (age 2 and under) increased from 73 percent to 84 percent in 2012.

Figure 1. HEDIS® Rates for EPSDT–Related Measures, 2010 to 2012

HEDIS® Measure	2010	2011	2012
Adolescent well visits	40.14%	45.93%	54.37%
Well visits ages 3 yrs-6 yrs	77.44%	79.81%	80.75%
Immunizations ages 0-2 yrs (Combo 3)	73.32%	75.93%	83.61%

Example: Using data to provide incentives for cost effectiveness through pay for performance in reduction of ER visits.

In California, Health Net pays FQHCs and rural clinics a per member, per month incentive for lowering ER visits compared to baseline. Incentives are determined in accordance with tiers of ER utilization with increased incentive for further reductions in ER visits for ambulatory care sensitive conditions. Providers use the provider performance incentive to fund a program(s) that improves access to care. Previous FQHC access improvements have included after-hours clinics, Saturday clinics, same-day access, care management, and other member engagement and access programs tailored to the particular clinic's needs.

To monitor improvement and calculate incentive payments, we use reporting from our data warehouse. This is coupled with monthly reports of actual member visits with their linked PCP and is shared with the clinic for purposes of intervention, outreach, engagement and education with the member. In this manner, our real time and retrospective reporting allows providers to be engaged in process improvement. Further, it supports improving health care costs associated with episodic care outside of the medical home. Health Net will work with FQHCs to replicate this program in the counties where we propose to serve AHCCCS members.

Health Net has a wealth of experience in the use of data and evidence-based decision support tools to enhance care quality and coordination for members, improve their health outcomes and work efficiently with providers while effectively controlling costs. Our quality management and performance improvement processes, developed in collaboration with our provider community, ensure that appropriate medical management is ongoing, that preventive measures are provided in a timely manner, that a strong medical home exists for our members and that our provider network is well informed and supported. We are well positioned to meet AHCCCS goals with best-practice tools, in-depth analytics, well-coordinated processes, and innovative approaches for outcome- and value-oriented payment models. We look forward to serving AHCCCS members and the State of Arizona.

4. Question 4 [H.16.E.4; D1.10, 11, 24]

4.1 Coordinating Care for Mr. Andrews

Health Net employs a variety of methods to identify high-risk members. Mr. Andrews would have been identified through routine review of the emergency room (ER) frequent utilizers report, through routine assessment of claims and pharmacy data for disease management identification, or, as is this case, through the PCP referral request for disease management participation. Regardless of the method of detection, in accordance with established medical protocols, Mr. Andrews would be categorized as a high-risk member due to his chronic obstructive pulmonary disease (COPD), his chronic cardiac condition, and his repeated ER visits. Once determined to be high risk, Mr. Andrews would be assigned to a disease management case manager to help him properly manage his conditions and access the care he needs.

Mr. Andrews' Care Needs Assessment

The case manager will contact Mr. Andrews to complete a HRA. Health Net may have an initial HRA on file from initial outreach when Mr. Andrews joined the plan. Additional needs assessment would be triggered by the PCP's referral into a disease management program. In compliance with AHCCCS requirements, the HRA will assess Mr. Andrews to determine the need for specialized treatment and care monitoring. The results will confirm his need for Health Net internal programs, (e.g., disease management and obesity coaching), and external programs, (e.g., behavioral health programs through the Regional Behavioral Health Authority [RBHA]). These results and evaluation of available encounter, pharmacy claims, lab, authorization, and self-reported data are incorporated into his care plan.

Because of his medical conditions, Mr. Andrews may be eligible for the Arizona Long Term Care System (ALTCS) program. If eligible, he could receive benefits such as home- and community-based services and assisted living or alternative residential settings. A case manager can assist Mr. Andrews in applying for ALTCS.

The PCP may have offered initial treatment for certain behavioral health issues such as depression or anxiety; however, beyond initial treatment, behavioral health services are the responsibility of the RBHA. If further treatment is needed, our AHCCCS behavioral health coordinator will work with the RBHA to determine a plan of action as well as ongoing coordination of care between Mr. Andrews' acute care providers, and the RBHA.

Mr. Andrews will also be enrolled in the appropriate disease management program, targeting his COPD and cardiovascular illnesses. During the initial outreach calls with Mr. Andrews, we will inform him about Health Net's Nurse Advice Line, a nurse-staffed advice and triage line available to all Health Net members on a 24/7/365 basis.

As Mr. Andrews is a childless adult and must maintain his eligibility in AHCCCS (he could not re-enroll due to the enrollment freeze on this population), the case manager will ascertain his redetermination date and assist him, as necessary, to ensure continued enrollment. The case manager may also assist in exploring, if he is eligible, Supplemental Security Income-Medical Assistance Only (SSI-MAO)—he may qualify given his limited mobility. If he is determined eligible, he will not be subject to an enrollment freeze for failing to timely reapply.

Mr. Andrews' Care Plan

Following a person-centered model of care, the case manager will work with Mr. Andrews and his PCP to develop goals and interventions tailored to meet Mr. Andrews' needs. This will help to avoid duplication of services, reduce hospital/ER admissions, and address his lack of family support by identifying available community services. Health Net has a stepwise approach to allow increased intensity of case management intervention should the disease management program not be adequate to needs. Disease management can refer to case management at any time the member, case manager, and PCP feel a more formal in-depth, team-based approach is needed.

The initial care plan will focus on maximizing self-care and the medication regimen. Conversations with Mr. Andrews will provide a realistic understanding of his conditions, including that COPD may be progressive and fatal. Over time, as the case manager helps him set long-term goals, self-care or independent living may be unsuitable, and discussions of long-term care placement and hospice for dignity at end of life may be appropriate.

The case manager and PCP will track Mr. Andrews' ER utilization and medication compliance, and may arrange for a consultation with a pharmacist or pulmonary specialist to analyze the medication regimen and recommend changes. Targeted interventions will be employed, such as coaching on correct use of inhalers and nebulizers or a

home-health evaluation by a Respiratory Therapist to assist in organizing medications effectively. The care manager and the PCP will work collaboratively with Mr. Andrews to help him meet his health care goals and to enable him to attain his highest level of independence, thus remaining in his home for as long as possible.

The lack of family support, his limited activity due to exhaustion and obesity, and his medical conditions put Mr. Andrews at risk of hospitalization and nursing home admission. With this in mind, his case manager will explore all resources available, including his eligibility for services and support beyond his AHCCCS benefits that might address his social isolation and encourage self-sufficiency in his current living environment.

Figure 2 provides the details of Mr. Andrews' proposed care plan. His care plan goals are realistic, achievable, and comprehensive as well as each goal is assigned a priority to ensure that the most critical issues are addressed first. Immediate focus is on education, self-management and a thorough assessment with limited home health intervention and possible specialty intervention. If his goals are not met, his team will revisit them to ensure that they are appropriate. Mr. Andrews will continue to have access to case management for as long as he needs the support, and is willing and able to participate.

Figure 2. Mr. Andrews' Care Plan

Problems	Interventions	Goals
Inability to manage his chronic obstructive pulmonary disease COPD	▪ Mr. Andrews is placed in disease management. Health problems are prioritized upon HRA completion. ▪ To address COPD, Mr. Andrews' health coach will: – Instruct Mr. Andrews to avoid irritants: cigarette smoke, aerosols, extreme temperatures, and smoke – Discuss the medical necessity for oxygen and home nebulizer and CPAP with the PCP – Arrange for any needed testing the PCP orders – Offer encouragement and reminders to vaccinate against influenza and streptococcus pneumonia – Teach Mr. Andrews about the early signs of infection and encourage him to learn more through listening to the audio library, discussing with his PCP or in weekly scheduled coaching calls, and talking to the Nurse Advice Line when acutely symptomatic – Help Mr. Andrews make proactive decisions to avoid exacerbations of his condition – Discuss Mr. Andrews' responsibilities in complying with prescribed medical treatments and regimens – Ensure that home care/service needs and level of care issues are addressed – Coach on medication management – Review barriers to accessing appointments, pharmacy refills – Assess possibility of pulmonary rehab program	▪ To control his COPD and reduce air hunger and shortness of breath ▪ To encourage self-management ▪ To address long-term as well as short-term interventions, such as end of life, long-term care as COPD worsens ▪ To maximize outpatient medication management ▪ To avoid respiratory infection ▪ To anticipate exacerbations and actively manage them with PCP and Nurse Advice Line

Problems	Interventions	Goals
Coronary artery disease (CAD), obesity, lack of physical exercise and low activity levels	Mr. Andrews' health coach will: ▪ Provide an overview of CAD self-management ▪ Educate regarding the importance that blood pressure and LDL cholesterol are in target range ▪ Consult PCP to maximize medication management ▪ Reinforce blood pressure and cholesterol tracking by ensuring member has access to data and a tracking tool ▪ Give encouragement to intersperse activity with periods of rest and set small, achievable activity goals ▪ Explore exercise and weight management activities (e.g., at YMCA or community recreation program) ▪ Explain strategies to control coronary artery disease through a program that includes a low-fat diet, aerobic exercise, and stress-reduction techniques; Create a specific meal plan in consultation with nutritionist ▪ Ensure follow up appointments are scheduled and arrange transportation if needed	▪ To reduce likelihood of repeat myocardial infarction or episodes of chest pain ▪ To improve weight management, increase activity levels and exercise ▪ To maximize medication management ▪ To maximize self-management and education and become an active participant in his care and health
Anxiety, possible depression and risk of psychological deterioration	Mr. Andrews' case manager will: ▪ Make weekly calls to alleviate anxiety and identify possible deterioration in mental state ▪ Arrange monthly PCP visits ▪ Conduct follow-up with PCP to monitor progress ▪ Connect Mr. Andrews to a "health peer" (see below) ▪ Explore accessing community-based programs ▪ Encourage Mr. Andrews to call Nurse Advice Line ▪ Coach to educate Mr. Andrews regarding appropriate use of the ER, how to access his PCP	▪ Avoid ER utilization due to anxiety and fear caused by lack of coping skills ▪ Assess for behavioral health needs beyond the scope of his PCP ▪ Reduce social isolation
Lack of support system, social environment	Mr. Andrews' Health Net case manager will: ▪ Identify transportation assistance through local ride programs to help remove barriers to socialization for non-medical activities ▪ Provide transportation assistance for medical appointments, if needed ▪ Schedule weekly calls to provide support and contact	▪ Improve compliance with medical regimen ▪ Avoid ER utilization

Ongoing Care Management

Ensuring Mr. Andrews has a strong medical home and a proactive PCP is essential to lowering his high ER utilization. Because Mr. Andrews' PCP referred him to the health plan for disease management, this informs us that the PCP is carefully monitoring Mr. Andrews and is taking the lead in managing his care.

Having a single case management point-of-contact to provide weekly check-ins, ongoing coaching, medical reminders, and anticipatory guidance is important to managing Mr. Andrews' anxiety levels. Encouraging him to be active will not only improve his physical condition, but also significantly affect his overall health, his self-esteem, and management of COPD symptoms. His care manager will also explore the possibility of finding him a "health peer" to assist with physical activities. The Health Peer Program is a Health Net value-added program where two individuals with the same condition or disorder provide encouragement and support to each other.

Finally, it is important to monitor results of the intervention on an ongoing basis and anticipate a different level of need as Mr. Andrews' disease progresses. For example, under the direction of his PCP, the case manager will explore the need for palliative services if his condition deteriorates further.

4.2 Health Net Programs and Services for Members with One or More Chronic Illnesses

Health Net has established processes to identify high-risk members and to ensure coordination across the continuum of care. We employ case finding strategies to assess members' health care, functional, and cognitive needs and assign them into appropriate programs. Case finding is performed monthly, both by analysts within our medical management department and by our disease and case management vendor, McKesson Health Solutions. Claims, HRAs, pharmacy, authorization, and encounter data for eligible members are mined to identify risk factors, such as the following:

- Chronic diseases (for inclusion in disease management programs)
- Frequent ER utilization or hospital re-admissions (for inclusion in case management)
- Multiple out-of-network specialty referrals (for inclusion in basic case management)
- High-cost and medically complex conditions (for inclusion in complex case management)
- Gaps in care, as identified during the HRA process and care coordination needs following the assessment, (e.g., transportation assistance, linkage to a medical home, to the RHBA, or to other community resources)

Member self-referrals or physician, nurse, and/or hospital facility referrals sometimes provide a more expedited alternative to case finding practices. This happens because claims information may be incomplete, physician coding may not be fully accurate, or lags may occur between services provided and final claims payment. Upon referral, we begin the process of placing the member into the appropriate program.

Case Management Services

We define "high risk" as members who are at increased risk of adverse health outcomes or deterioration of their health status if they do not receive targeted interventions. Members with one or more chronic illnesses are offered basic case management services. The Health Net AHCCCS Medical Director is responsible for Arizona's case management program, which includes low- and high-risk disease management, basic case management, care coordination/ health navigation, and complex case management. The goal is to apply clinical knowledge to coordinate care needs for members who have catastrophic illness, are medically complex, or require intensive medical/psychosocial support, providing quality services to enhance the medical home in a cost-effective manner.

The HRA provides the foundation for patient care planning. In addition to health care needs, the completed HRA screens for social and behavioral health needs, transportation needs, and nutrition/dietary needs. Services to address behavioral health require referral to and coordination with the RBHA. The HRA also identifies gaps in care and in member knowledge. When assessment or coaching indicate that a member requires a broader, less disease-focused approach, the member is transitioned to basic case management; should assessment or coaching indicate that goals will not readily be met, the member is transitioned to complex case management.

When a member is enrolled in case management, the assigned nurse case manager collects all relevant clinical information—from treating physicians, the disease care manager, the PCP, the ER and the hospital—and convenes a meeting of the interdisciplinary care team (IDCT). Participants include the member (or his or her representative), the case manager, the member's PCP, and a social worker. The team reviews all information, and the care plan is developed. The case manager acts as the primary point of contact with the member and coordinates with the IDCT to address specific care plan issues.

Health Net has significant experience in the most effective methods for engaging members in the development of and adherence to care plans. Care plans are initiated in real time as the member responds to assessment questions. The care management platform used by the IDCT will assign priorities to identified tasks and designate long- or short-term goals. Our care management platform is embedded with InterQual® Coordinated Care Content to assess a member with clinical confidence. This system uses rules logic to add goals, problems, and interventions based on responses to specific questions. Goals and problems have a one-to-one relationship with interventions related to a single problem or barrier. Interventions include instructions/educational modules to support the care manager.

Health Net has established policies and procedures that ensure service integration for continuity of care. These will be amended to incorporate AHCCCS requirements as outlined in the AHCCCS Medical Policy Manual. Our care manager will collaborate with the member's PCP to provide efficient, effective joint case management and care coordination when services must be accessed through providers and/or programs outside the Health Net scope of services or provider network.

Care managers provide ongoing and/or episodic case management and care coordination both in and out of network. The care manager is able to attend in-person meetings at the member's home or PCP office as needed. The same care manager works with the member throughout the duration of involvement in the program, bringing in additional support (e.g., a social worker, a nutritionist, a pharmacist, a mental health specialist) as needed. The care managers' responsibilities include, but are not limited to:

- Managing members' needs through the continuum of their health care needs until either they reach a maintenance level of need for services or they transition to complex case management
- Facilitating access to appropriate medical, rehabilitation, or mental health and support programs
- Providing weekly medical check-in calls to ensure that the member is informed of any conditions that require follow-up, receives appropriate training in self-care and other measures to promote health, and is aware of his or her own responsibility in complying with prescribed treatments or regimens

The care manager re-assesses the member regularly (frequency is determined by risk assignment) to measure progress toward goals, to assess health status, and to update the care plan as the member's care needs change.

Please note: When we refer to disease management and basic case management in this response, we use the term "care manager." For complex case management, we use "case manager." Our case managers are board-certified and have the CCM® credential. For disease, basic, and complex case management we employ registered nurses. Social workers and licensed practical nurses (LPNs) assist the lead care or case manager as needed.

Enrollment in Disease Management Programs

In addition to the basic case management program, members with more than one chronic condition are offered enrollment in Health Net's disease management program. This program provides severity-specific interventions to members with diabetes, asthma, congestive heart failure, coronary heart disease, and COPD. Interventions are tailored to meet the member's clinical, cultural, and linguistic needs. Members receive access to educational resources and reminder calls. Health coaches are available all day, every day. They provide guidance and identify and refer members to appropriate and available local resources such as senior centers and home- and community-based services. The program empowers members to self-direct their care, including improving their ability to manage their chronic conditions and their life habits, resulting in improved overall health.

Other Support Services

In addition to basic and disease management, Health Net has several specific programs available to members with one or more chronic illnesses that encourage member engagement. Programs are tailored according to member needs and comfort level. They include:

- **The Nurse Advice Line.** All Health Net members have access to Health Net's toll-free Nurse Advice Line, available on a 24/7/365 basis, for answers to clinical questions. The Nurse Advice Line includes an audio educational library.
- **Telephonic Support Services.** Health Net places outbound calls to members identified with a chronic illness to evaluate their illness and behavioral health risks. We provide information about available programs and invite the member to join after determining that a particular program is a good fit. Additional services available to members include access to a registered dietitian through Health Net's 24-hour Nutrition Support Line and telephonic coaching with a registered nurse care manager and/or a master social worker (MSW).
- **Cell Phone Distribution.** Cell phones are provided to select high-risk members through a program called "GenerationOne." We will provide this service to AHCCCS members. Phones are preloaded with unlimited minutes to select numbers (e.g., PCP offices, care managers, the Nurse Advice Line, etc.) to encourage members to stay in touch with providers. Members receive round-the-clock alerts and instructions to take medications and perform appropriate activities based on their prescribed medical regimen.
- **Transportation Assistance.** In accordance with AHCCCS transportation requirements, Health Net AHCCCS members will have access to both emergency and non-emergency medical transportation assistance.

Whether implementing basic case management or coordinating more complex care needs such as Mr. Andrews', Health Net has the processes and programs in place to carefully assess the needs of the member, to develop and coordinate the appropriate care plan, to educate and support the member, and to provide ongoing care management and support for the best available care—all to promote quality, cost-effective outcomes.

5. Question 5 [H.16.E.5; D1.10, 11, 12, 22, 24, 60]

5.1 Care Coordination for George Robertson

Upon notification of George Robertson's latest inpatient admission, the Health Net concurrent review nurse (CRN) would obtain and review all clinical information from the admitting hospital, using Interqual criteria to determine the medical necessity of care. The CRN would use McKesson's CareEnhance Clinical Management Software (CCMS) to access George's case file and determine how many unpaid inpatient days George has remaining in his benefit package (currently, as an adult, he is limited to 25 days per benefit year). The CRN would review his inpatient history and verify whether he has an assigned case manager. The CRN would find that George does have an assigned case manager, and that he is a dually diagnosed member with substance abuse issues and multiple acute medical conditions. His recent inpatient stay resulting in a diagnosis of traumatic brain injury (TBI) and broken ribs requires a complete reassessment of his needs as well as an updated care plan.

On the same day that notification of George's inpatient admission is received, the CRN contacts the case manager to discuss, review and coordinate care for George. Given the challenges with George's case along with the readmission within the last 30-days, the CRN and case manager agree that this case will require interdisciplinary care team (IDCT) staffing as soon as the case manager completes reassessment of George's needs.

An IDCT is a cross-functional team comprising members from various disciplines convened for the purpose of examining the status of a case and developing continued care management strategies around the clinical issues of the case. Representatives from case management, medical management and the behavioral health coordinator are core participants. The case manager will also notify Network Management that George is residing in a non-contracted facility. Network Management will immediately assess the situation and execute a contract or letter of agreement with the skilled nursing facility (SNF), and initiate the provisional credentialing process.

The IDCT meetings may involve a psychiatric consultant, medical director, the member's PCP, and the member or other representative as appropriate to the case. IDCT staffing occurs when either the case manager assessment of the member or other internal reports indicate one of the following criteria:

- Frequent emergency department visits or hospitalizations including psychiatric stays
- High utilization and/or high cost
- High volume medications or poly-pharmacy
- A current plan of care that is not being followed
- Grievance or quality of care issues
- A barrier to moving to a less restrictive setting
- Other needs identified by the case manager or other internal staff who may request that the IDCT convene

5.2 Needs Assessment/Setback Risks and Challenges

Upon notification from the skilled nursing facility, the case manager will schedule an onsite assessment with George and/or his representative within two business days of the placement change. As part of the care planning process, the case manager reviews the skilled nursing facility chart to determine George's current status, diagnosis, medications, therapies and physician treatment orders. To obtain further information regarding George's current treatment plan and progress, the case manager interviews the charge nurse, nurse aids (if applicable), rehabilitation therapist, facility social worker and the SNF's assigned physician overseeing George's care. Meeting with George to complete a reassessment of his needs will help the case manager establish his current functional, emotional, cognitive and medical status.

As part of the assessment, the case manager conducts an informal conversational-style interview with George and/or his representative to determine what strengths he has to draw upon. These strengths may include past successes in health management, problem solving, family or informal support systems, and immediate and future life goals. In a reassessment, the case manager measures George's satisfaction, the quality of services being delivered to him, goals that have been met, and any adjustment to service needs. This includes a discussion of other AHCCCS programs, for which George may qualify, as his care needs change. In this case, the case manager would discuss the ALTCS and encourage application for that program given George's recent diagnosis of TBI as well as placement in a skilled nursing facility. If needed, the case manager will provide assistance in the application process. If ALTCS does not respond to the application on the 45th day of the skilled nursing facility

placement, George and/or his representative will notify AHCCCS with a request for an expedited review to prevent George from exhausting his 90-day skilled nursing facility benefit.

Based upon the facts presented, the assumption is that George is a childless adult. At present, AHCCCS has frozen enrollment for the childless adult population. If George is not eligible for ALTCS, he must maintain his AHCCCS eligibility because he could not re-enroll due to the freeze on enrollment of the childless adult population. The case manager will ascertain George's re-determination date and assist him in his renewal application, as necessary, to ensure his continued enrollment. The case manager may also assist George in exploring with AHCCCS whether he is eligible for Supplemental Security Income-Medical Assistance Only (SSI-MAO) for which he may qualify given his TBI. If George is determined eligible for SSI-MAO, he will not be subject to an enrollment freeze for failing to reapply in a timely manner.

The case manager uses the Complex Case Assessment Tool that is entered real-time in CCMS. The Complex Case Assessment Tool is used to assess George's strengths and needs in the areas of functional ability, medical conditions, behavioral health as well as social, environmental and existing formal/informal support systems. The case manager speaks with George and/or his representative to determine his preferred setting and explains all placement options. The case manager also reviews cultural and spiritual beliefs including limitations to treatment, dietary preferences and language needs with George. This includes differentiating between covered service needs with the health plan and the services from the Regional Behavioral Health Authority (RBHA) provider.

The case manager uses motivational interviewing to address George's history of substance abuse, his recent police involvement for possession of illegal substances, and why he is active in substance abuse treatment with a RBHA provider, but not consistent in participating in treatment. This approach attempts to increase George's awareness of the potential problems caused by the substance abuse, consequences experienced, and the risks faced as a result of the behavior. The goal is to identify George's level of readiness to change his behavior as well as think differently about his behavior as he considers what might be gained through this change.

At the conclusion of the assessment, the case manager completes and prints a care plan for George, indicating the agreed-upon services and current placement in a skilled nursing facility. The case manager informs George and/or his representative that an IDCT meeting will be scheduled to discuss all of George's needs. The case manager, George and/or his representative review and sign the care plan document. A copy is placed in the skilled nursing facility chart and a copy is left for George and/or his representative.

Within three business days, an IDCT meeting is held to review George's care plan. The IDCT consists of the Health Net's AHCCCS Medical Director, the CRN, the case manager, the behavioral health coordinator, a nursing facility representative, the treating provider, or designee, from the RBHA, George and/or his representative and the assigned PCP, if available. The IDCT reviews the medical records from the motor vehicle accident and the subsequent readmission, due to unsafe living situation, along with the specialist evaluations, recommendations, and any facility long-term discharge plans.

The IDCT will discuss George's recent hospitalization activity, possible explanations that led to his readmission along with his current status as assessed by the case manager. They will review his recent TBI diagnosis and acknowledge that George is a dually diagnosed member with substance abuse issues and multiple acute medical health challenges. Therefore, the care management strategies around the clinical issues for George identified by the IDCT to be addressed and coordinated are as follows:

- Cognitive deficits and prognosis
- Ability to independently manage activities of daily living (ADLs)
- Ability to physically ambulate safely and independently, including stairs
- Lack of support system and the need to develop a social network in the community
- Current status with the police related to possession of illegal substances and potential need for legal resources
- Active substance abuse treatment with RBHA provider and inconsistent participation in treatment
- Undiagnosed behavioral health issues identification including serious mental illness (SMI)
- Appropriateness of length of stay for both admissions
- Placement in a non-contracted skilled nursing facility along with the appropriateness of the placement
- The need for a single case agreement versus a contract with the SNF
- Alternative housing needs upon discharge from skilled nursing facility

- Application to ALTCS given the complexity of his medical and behavioral health needs with better service options to manage George in a least restrictive setting
- Referral of potential quality of care issues related to the initial hospitalization and/or discharge planning process both internally and externally
- Possibility of transitioning from SNF to assisted-living facility or alternative residential setting and ordering home and community services, if medical condition warranted, in accordance with the limitations of this AHCCCS acute benefit

While the case manager has the lead on most of the coordination and clinical issues to be addressed, other department representatives have the lead for their respective areas. Our AHCCCS medical director will further review the hospitalization and clinical documentation to support the length of stay as well as determine if any gaps in care were identified. The length of the first admission and the brevity of the second (as well as the fact that the second stay ended on the same date George's 25-day annual inpatient limitation was met) all raise flags as well as the discharge to a non-contracted facility.

A Quality Management RN will investigate the case carefully to determine if coordination and timely access to appropriate utilization of health care services was completed by both the health plan and providers involved. These issues along with gaps in care and whether Health Net appropriately identified and followed George in his care would be investigated as potential quality issues (PQIs). The results from the investigations would be reported to the Peer Review Committee for any corrective action. If there were internal concurrent review gaps, these are summarized and presented to the UM manager for and process improvement.

The behavioral health coordinator will coordinate George's behavioral health care through the RBHA and also ascertain with the RBHA whether George may have other undiagnosed behavioral health issues including SMI. As George has both substance abuse problems and a traumatic brain injury, a determination that he is seriously mentally ill may not be possible; however, this should be investigated. If he is diagnosed as SMI, he would be enrolled in the Maricopa County RBHA (as of October 2013), which would provide for both his acute and behavioral care.

The Network Management Representative will follow their process to create a letter of agreement or contract with the SNF and ensure the facility has the appropriate certifications to handle TBI and AHCCCS members. In addition, the Network Management Representative will follow up with the discharging hospital to re-educate them on the use of in-network providers and the process to follow for non-contracted facilities prior to discharge.

Finally, because George's first admission was the result of a motor vehicle accident, the claim would have been flagged. The CRN would notify the Third-Party Liability (TPL) Unit of the potential for third-party responsibility for the claim depending on who was at fault for the accident. The TPL Unit would follow up on any available recoveries.

5.3 Care Plan and Outcomes

Based on the information presented, the IDCT recommendations will formulate a care plan specific to George's needs (see **Figure 3**). The purpose of the care plan is to provide George with an array of service options that support the expectations and agreements established through the mutually agreed-upon care plan process. The care plan will clearly state the identified needs, interventions, and goals to support George's ability to remain as independent as long as possible.

Figure 3. George Robertson's Care Plan

Identified Need	Intervention	Goal
Determination of the level of severity of the traumatic brain injury	The case manager will confirm with the rehabilitation therapist and/or the physician assigned to overseeing George's care in the skilled nursing facility whether documentation in the chart reflects the level of TBI severity. If necessary, there will be consultation with a neurologist on diagnosis of TBI and level of severity.	Confirm level of TBI severity of mild, moderate or severe to assist with care planning.

Identified Need	Intervention	Goal
Completion of ADLs and IADLs while residing at the skilled nursing facility	*Intervention #1:* Therapists (physical, occupational and speech) and nursing staff at the skilled nursing facility will assist and/or complete activities of daily living (ADLs) and Instrumental Activities of Daily Living (IADLs) for George. *Intervention #2:* George will receive rehabilitation services while in the skilled nursing facility.	*Goal #1:* George's ADLs and IADLs will be satisfied with continued stay at skilled nursing facility. *Goal #2:* George will perform ADLs/IADLs more independently as evidenced by improvement in the case file and/or discharge to a lower level of care.
Development of a social network to support George in his adjustment to his recent injury and reintegration into the community	George will be given information and assistance in accessing support groups such as the Brain Injury Association of Arizona, the Arizona Governor's Council on Spinal and Head Injuries, and St. Joseph's Hospital, related to his TBI diagnosis. The case manager will also provide assistance in enlisting the help of George's family, friends, and peer group for additional support.	George will have additional resources to create a social support group for himself. Upon discharge from the SNF, George will attend a minimum of three support group meetings over the next 90 days.
Determination of current status with the police related George's possession of illegal substances	If documentation does not exist in the hospital medical records regarding the current status of the possession of illegal substances charge, the case manager will contact the police department to determine whether charges were filed. If not, no further action is required. If charges were filed and legal action will be taken against George, the case manager will provide George phone numbers for community legal resources who can assist him with legal representation.	Resolve current legal issues and ensure an end to George's possession of illegal substances.
Active participation and completion of substance abuse treatment by George	The case manager will arrange a meeting to discuss service need changes with George (and/or his representative) and the RBHA provider where George currently receives (but does not participate in) substance abuse treatment. The case manager will share results of the behavioral interviewing assessment that identifies George's level of readiness to change his behavior. They will also discuss the potential need for the RBHA to complete a new functional assessment with George to assist in developing a behavioral plan that is better tailored to his current abilities and level of functioning.	George will actively participate and successfully complete the agreed-upon substance abuse treatment program.
Long-term assistance with managing George's TBI and performing ADLs and IADLs	The case manager will work with the skilled nursing facility social worker in completing an ALTCS application for George as he has a qualifying diagnosis of TBI and is no longer able to complete ADLs and IADLs independently. If accepted, George will benefit from home- and community-based services, inclusive of assisted-living services and integrated behavioral health and medical services.	Social worker at the skilled nursing facility will complete ALTCS application within 72 hours of the call with the case manager. George to be accepted in the ALTCS program.

Identified Need	Intervention	Goal
Determination of housing alternative (to living alone) once George is discharged from skilled nursing facility	The plan has the flexibility to provide limited home- and community-based services in lieu of nursing facility placement while awaiting ALTCS determination or if George is determined ineligible for ALTCS. The case manager will work with the skilled nursing facility to coordinate discharge planning to either a TBI assisted-living facility or alternative residential home, or back to his own home with home- and community-based services in place depending on George's status and functioning level.	George to be accepted in the ALTCS program where his needs can best be met with an integrated case management approach that addresses his medical, functional, social, cultural and behavioral health needs in the right setting while maximizing his ability to remain independent.

The case manager will monitor George's rehabilitation progress on a weekly basis. Prior to George's discharge, the case manager reviews the transition plan from the SNF and ensures all orders and services are in place. This includes making sure that medications have been reconciled and that George has a supply of his current medications with prescriptions for refill. The case manager schedules another contact/visit within 48 hours of George's discharge to ensure the transition occurred smoothly without any gaps in care. If George is accepted into the ALTCS program (or into the Maricopa integrated RBHA after October 1, 2013), the case manager will follow the member transition process in accordance with the AHCCCS Medical Policy Manual and AHCCCS Contractors Operation Manual requirements, which includes the sharing of the care plan and any other medical appropriate documentation with all interested parties.

6. Question 6 [H.16.E.6; D1.58, 60]

6.1 Health Net's Experience in Medicare Advantage and Medicare Special Needs Plans

Health Net has decades of experience with government-sponsored programs, including Medicare Advantage (MA) and Medicare Special Needs Plans (SNPs). We are currently one of the nation's largest Medicare Advantage contractors serving approximately 205,000 Medicare beneficiaries in three states. We also administer three Chronic Condition Special Needs Plans (C-SNP) as well as a Dual Eligible Special Needs Plan (D-SNP). Our plans maintain a four star rating with the CMS. Health Net has also been chosen to participate in the California Dual Eligible Demonstration Project and will provide coverage to an estimated 80,000 to 100,000 dual eligible (Medicaid and Medicare) members in San Diego and Los Angeles Counties, beginning in late 2013.

In Arizona, Health Net has provided managed Medicare coverage for more than 20 years. Our current MA population is 44,000 with more than 20 percent of these members in SNPs. Our D-SNP, established in January 2010, currently services 4,100 Medicaid and Medicare members in 4 counties. We also provide coverage to 6,300 Medicare beneficiaries with diabetes and congestive heart failure through our C-SNP The majority of these members reside in GSAs 10 and 12, the two service areas for which we are pursuing contract awards.

In providing coverage to the dual eligible population in Arizona during the past three years, we have developed and implemented a Model of Care that addresses members' complex and chronic needs through care coordination and service integration with the AHCCCS acute and ALTCS health plans. In 2010, AHCCCS allowed us access to AHCCCS Online, the state's Medicaid provider portal. This allowed us to retrieve information relative to the dual eligible plan enrollment, such as the member's current address and other vital information, and proved invaluable in our efforts to successfully coordinate the members' care with their AHCCCS health plans.

Since 2008, the NCQA has annually evaluated our D-SNP. We scored 100 percent on the initial three structure and process measurements, which included case management, member satisfaction, and clinical care. In 2009, NCQA added the additional measurements of care transition and coordination, and Health Net scored well on all five standards. In 2011, we received the maximum three-year CMS approval for our Model of Care.

While proud of our accomplishments in providing coverage to the dual eligible population, Health Net fully supports the Arizona Dual Eligible Demonstration Project attempt to align Medicaid and Medicare-eligible members into a single health plan. This alignment will further improve care coordination and service integration, increase operational efficiencies, lower medical costs, achieve better health outcomes and provide a stronger foundation for member-centered care. Most important: It will increase member satisfaction by providing a seamless health care delivery system.

6.2 Processes to Enhance and Maximize Care Coordination and Improve Member Experience

While serving Medicare beneficiaries in Arizona for more than 20 years, it became increasingly apparent that the medical conditions of our dual eligible members were more serious and complex than the general Medicare population. In 2010, the epidemiological characteristics of our dual eligible population were white females, 67 years of age with one or more chronic conditions along with a high incidence of mental/cognitive conditions. Care coordination proved challenging at best; non-existent at worst. To enhance and maximize care coordination and improve member experience, we designed and offered a special needs plan and developed a Model of Care tailored to meet the special needs of the dual eligible members. The SNP Model of Care provides a structured approach, through systemic processes and procedures, to improve care and service coordination across the continuum. The key elements of our Model of Care are universal case management, HRAs, individualized care plans, transitions of care management, integrated communications, specialized provider networks, interdisciplinary teams, and other additional benefits, such as disease management, community service referrals, medication therapy management, and vision and dental services. These processes are briefly described below.

Case Management

Our SNP case management program provides a collaborative and patient-centered process involving member assessment, problem identification, and care planning. Upon enrollment, every dual eligible member is assigned a case manager. The case manager is responsible for the coordination of care through the effective and efficient planning and management of medical and community resources to meet the needs of the member and achieve positive health outcomes. The planning process starts with a health risk assessment.

HRA and Risk Stratification

Health Net conducts an initial HRA within 90 days of enrollment and a reassessment annually, or earlier, based on a change in health status. The HRA tool includes information on member medical and mental health history as well as psychosocial, functional and cognitive needs. Assessment results, along with any other information available, such as Hierarchical Condition Codes or Risk Adjustment Factors, are used to stratify members into appropriate risk levels. The assigned case manger will review the data and conduct a telephonic interview with the member to determine assessment accuracy and identify other potential problems or issues. This information is documented within our electronic medical management system, and the case manager determines the composition of an IDCT based on need, and then schedules a meeting. Members and/or caregivers are strongly encouraged to actively participate on the team.

Interdisciplinary Care Teams

Every dual eligible member is assigned to an interdisciplinary care team appropriate to the member. The IDCT is responsible for overseeing, coordinating and evaluating care in a manner best designed to address member medical, cognitive, psychosocial and functional needs. At minimum, the IDCT will include a medical expert, the member's assigned PCP and case manager. Depending on the needs of the member, other professionals, such as a medical specialist, social worker, pharmacist or behavior health coordinator, may be added to the team.

Care Plans

The IDCT, in collaboration with the assigned case manager, develops a care plan specifically designed to meet the needs of the member. The plan includes prescribed interventions and desired short- and long-term goals for each problem identified. Goals are directed to improve the member's health status, quality of life perception and overall satisfaction. Goals are developed using SMART criteria:

- **Specific.** The target result to be achieved is clearly stated.
- **Measurable.** Quantifiable criteria of how the result will be measured (e.g., frequency, quantity, duration, etc.) are clearly defined.
- **Achievable.** The IDCT believes that the goal is realistic, clinically appropriate, and credible (i.e. the member is capable of attaining the goal).
- **Results-oriented.** The goal defines an outcome that must be achieved and delineates the interventions and effort required to do so.
- **Time-bound.** A specific deadline by which the goal must be achieved is identified.

Evidence-based clinical guidelines (i.e., *Milliman Chronic Care Guidelines*) are used to achieve clinically appropriate goals.

When the member and/or caregiver approve the plan, the case manager documents it in our medical management system and provides copies to the IDCT and member and/or caregiver. The case manager is responsible for ensuring the implementation of the plan interventions, coordinating care—especially with the PCP, navigating AHCCCS benefits, identifying appropriate community resources, monitoring progress and reporting results to the IDCT on a regular basis. The case manager serves as the main point of contact for the member and the primary liaison with the member's AHCCCS plan. The care plan will be modified and approved by the IDCT as new problems or medical conditions arise or interventions prove ineffective and alternative actions are required.

The care plan process is supported by a robust electronic medical management system that integrates various member and provider data sources and coordinates into a single member file that includes the care plan. For example, provider claims data and prior authorizations are loaded into the medical management system on a daily basis. This allows the case manager to closely monitor and evaluate the care plan, and to respond appropriately and expeditiously.

Our current governance structure, processes, and systems have significantly improved health outcomes, reduced medical costs and heightened membership satisfaction. We have received a three-year NCQA approval—the highest possible rating. 70 percent of our clinical measurements improved in 2012 on a year-over-year basis and 7 of the 10 measurements exceeded national averages (see **Figure 4**).

Figure 4. Measures of Clinical Care

Measures of clinical care	*Improved from previous year*	*Above national average*
Breast cancer screening	⬆	⬆
Colorectal cancer screening	⬆	⬆
Osteoporosis management	⬆	
Proper medication after a heart attack	⬆	
Cholesterol less than 100		⬆
Good control of high blood pressure	⬆	⬆
Flu vaccinations obtained		⬆
Appropriate testing for diabetics (HbA1c)	⬆	⬆
Avoid high-risk drugs for seniors		⬆
Treatment for acute depression	⬆	

While our positive results are primarily attributed to the aforementioned processes, there are other contributing factors.

Secondary Contributing Factors

The following additional programs, benefits, and services played a significant role in our clinical and service performance results:

- **Provider Network.** Our provider network has the necessary specialized expertise to meet the needs of our dual eligible members with one or more chronic conditions, and experience with complex medical cases using evidence-based clinical practice guidelines.
- **Comprehensive Training.** Health Net has a comprehensive training program for employees and providers to ensure appropriate treatment and services to our dual eligible members, including Medicaid and Medicare benefits, evidence-based clinical guidelines, program requirements and coordination of benefits and costs.
- **Add-on Benefits.** Health Net offers an array of add-on benefits to our dual eligible members designed to complement and supplement their Medicaid and Medicare benefits and promote better health outcomes. These include limited non-emergent ground transportation, dental and vision benefits, medication therapy management, disease management programs, and community referral programs.
- **Communication Network.** Open communication channels with members and providers are important in providing appropriate care at the right time in the right setting. Health Net supplies members and providers with a wide range of educational tools on our website designed to promote patient self-management and the delivery of professional medical care. Providers and members are encouraged to contact our Customer Contact Center to address questions and concerns about our D-SNP.

Our SNP Model of Care provides us with a strong foundation upon which to build. We will continuously strive to enhance our protocols and processes to best accommodate the needs of our dual eligible members.

6.3 Care Coordination for Medicaid Members Served by Other Health Plans for Medicare

Health Net providers and medical management staff are well aware that effective coordination of Medicaid benefits for members who have Medicare as their primary insurance is critical to overcoming barriers to care and avoiding member confusion. With our experience as a D-SNP plan, we have learned firsthand how dual eligible members may become easily confused when trying to navigate Medicaid and Medicare benefits and services by themselves. Service fragmentation often leads to poorer health outcomes and higher medical costs.

If the Arizona Dual Eligible Demonstration Project (as currently proposed by AHCCCS) is implemented, Health Net will develop processes to proactively interact with our Medicaid dual eligible members who elect to receive benefits from traditional Medicare, will identify Medicare providers used by those members, and will work to coordinate care and benefits with those providers. Coordination with traditional Medicare has proven more challenging than coordination with AHCCCS health plans. Therefore, Health Net will make every effort to enroll and retain dual eligible members in our Medicare demonstration plan by promoting the myriad benefits of alignment, including such features as a single point of contact, care coordination, and supplemental benefits.

If the Dual Eligible Demonstration Project is not implemented, Health Net will provide training for our staff and for our network providers on how to coordinate member benefits and services for those who receive AHCCCS services through Health Net and Medicare services from another AHCCCS health plan as well as coordinating with the member and providers for those who elect traditional Medicare. The Health Net medical management

team, which includes prior authorization, concurrent review and case management, will assist members with coordination of care by reviewing benefits and coordinating services in accordance with AHCCCS third-party-payment and coordination-of-benefits requirements. Health Net has three years of experience coordinating care for our D-SNP members with AHCCCS acute and ALTCS plans. We will use that experience and established processes to coordinate care of our AHCCCS members with the D-SNP plans. administered by another AHCCCS plan. While the primary and secondary roles become reversed and certain processes may need modification, we believe that our systemic, patient-centric approach will continue to prove effective in the delivery and coordination of care for our dual eligible members.

Health Net will participate, as needed, in any interaction that the member's Medicare case manager requests. The foundation of this coordination will occur through the framework of the member's medical home, which we will establish for all AHCCCS members upon enrollment. The medical home model supports coordination and continuity of care for members by providing continual monitoring of care, timely education about their disease states, and actively involved case management to assist members in becoming healthier and better-educated health care consumers. We will work with the member's D-SNP case manager to attempt to align the members PCP and specialist for care coordination and improved health outcomes.

6.4 Strategies to Increase and Maintain Aligned Medicaid and Medicare Enrollment

Health Net supports the Arizona Dual Eligible Demonstration Project and is prepared to serve the dual eligible population whether or not the proposed demonstration receives approval as either a Medicare demonstration plan or D-SNP. Based on experience, we recognize the challenges with the acquisition and retention of Medicaid and Medicare aligned members and the need for nontraditional sales and marketing strategies.

Our D-SNP (branded as Amber) benefit design includes dental and vision supplemental benefits that are not covered by Medicaid or Medicare. Initially, even with the supplemental benefits, Health Net experienced problems with both acquisition and retention of Amber members such as:

- Ineffective traditional marketing because the brand name had no dual eligible distinction and the targeted population was unfamiliar with the term 'dual eligible'
- Higher than expected disenrollment rates due to loss of AHCCCS eligibility for failure to re-enroll

To overcome these barriers, Health Net partnered with Altegra Health (formerly "Social Service Coordinators") to increase and maintain our Medicaid and Medicare members. Through a CMS-approved process, Altegra assists our MA members in the both the initial AHCCCS enrollment and annual recertification process. Altegra has been responsible for the acquisition and retention of more than 10,000 Amber members.

Health Net has three other distinguishing attributes to further assist in the acquisition and retention of the Medicaid and Medicare aligned members:

1. Our provider network will serve all lines of business—Commercial, Medicare, Medicaid, and Dual Eligible—which will allow members continuity of care upon change in eligibility.
2. Our MA plan will provide a safety net for the dual eligible members who lose Medicaid eligibility.
3. Our established corporate brand name awareness in the community and its inclusion within the name of the AHCCCS plan (Health Net Access) will serve as a market driver for AHCCCS acute and dual eligible membership growth

Health Net will develop and implement a strategic marketing and sales plan designed to increase aligned Medicaid and Medicare enrollment leveraging the referenced attributes. The plan will include, but not be limited to, the following components:

- Re-branding of the dual eligible product in a manner that prospective members and providers easily understand that the plan serves those eligible for both Medicaid and Medicare
- Maintaining the dual eligible outreach and advocacy program, administered by Altegra, to ensure:
  - Our MA members who newly qualify for dual eligible enrollment receive the needed education and assistance in applying for the aid category for which they qualify, enabling them to transition into Health Net's dual eligible plan
  - Those members already dually enrolled receive the education and assistance needed to ensure they retain their dual eligible status by completing the required recertification each year

- Advertising and promoting the dual eligible product by highlighting the benefits of alignment, and communicating the eligibility requirements in an understandable manner (subject to regulatory approval) through multiple media channels
- Designing and implementing an education/training outreach program to increase awareness of the Medicare demonstration plan or D-SNP among medical professionals and community-based organizations in accordance with applicable marketing regulations
- Announcing the availability of the AHCCCS acute and dual eligible plans to commercial employers and request that terminated employees and retirees be informed that they can continue Health Net coverage through these plans
- Continuing to provide supplemental benefits (as allowed) not covered by Medicaid or Medicare to improve health outcomes and quality of life, as well as to serve as a significant differentiator from traditional Medicare or other D-SNPs
- Actively marketing enrollment into our D-SNP if the demonstration is not enacted based upon the values associated with integrated and coordinated care

Health Net will also develop a comprehensive dual member retention program designed to minimize voluntary disenrollments to include the following elements:

- **Recertification Assistance.** Continue to partner with Altegra to provide annual recertification assistance to our dual eligible members to prevent unnecessary disenrollments due to loss of Medicaid eligibility. This recertification assistance program has been in place since 2007.
- **New Member Orientation.** Health Net will provide monthly orientation for new members to assist them in understanding benefits, their rights and responsibilities, network restrictions, accessing care, contact information and governing policies and procedures. The curriculum will be designed to assist members in navigating the system and preventing avoidable disenrollments due to uncertainty or confusion.
- **Ongoing Member Engagement.** The Customer Contact Center will outreach to every dual member at least quarterly to provide ongoing education about plan benefits and health topics, and an opportunity for the member to ask any questions or share concerns about the plan or related topics. This proactive measure will demonstrate our interest and concern for the member and their general well being as well as establish plan loyalty and enhance retention.
- **Broker Training.** Our Medicare Sales department will provide training to broker agents on the Arizona Dual Eligible Demonstration Project and the importance of Medicaid and Medicare alignment. We will encourage brokers not to enroll our dual eligible members into non-aligned plans.
- **Community Support Services.** Health Net will identify a business partner to provide dual members, at no cost, with community assistance, referral and enrollment services from available local private and public programs such as energy assistance and telephone discounts.
- **Disenrollment Surveys.** Health Net will forward a survey to all voluntary disenrolled dual members to ascertain the reason(s) for plan departure and, when warranted, take corrective action to avoid more disenrollments for the same reason.
- **Safety Net.** In collaboration with AHCCCS, Health Net will develop a process where our dual members losing Medicaid eligibility will be advised of their option to continue care by enrolling in our MA plan. If the member should be re-enrolled with AHCCCS, Health Net will assist the member in transferring back into our D-SNP.

Health Net has extensive experience in providing MA and Medicare SNPs, and we'll be proud to use this experience to benefit those who are eligible for both Medicare and Medicaid in Arizona. Our programs are designed to address member needs, to provide assistance in planning and coordinating appropriate care, to improve transitions of care across health care settings, providers and services, to assure appropriate utilization of services, and to support and educate the member while enhancing the quality of their care. Our case management practices and use of interdisciplinary care teams allow us to provide effective management and delivery of services that meet regulatory requirements while improving the member experience and achieving quality outcomes. Further, we have numerous strategies to increase and maintain aligned Medicaid and Medicare enrollment within the state. In summary, we look forward to serving Arizona's dual eligible population.

Organization

7. Question 7 [H.16.E.7; D1.23, 40, 41, 42, 43, 45, 46, 47, 48, 49, 50, 51, 53, 54]

7.1 Initiatives and Efforts to Combat Waste and Improve Outcomes

Many recent studies, including the Institute of Medicine Best Care at Lower Costs, have reported the excessive amount of waste within the U.S. health system. In a study published in JAMA this past April entitled Eliminating Waste In The U.S. Healthcare, it is estimated that five categories of waste consumed at minimum $476 billion, or 18 percent of the approximately $2.6 trillion annual total of all health spending in 2011. Spending in the Medicaid and Medicare programs contributed about one-third of this wasteful spending or $166 billion. In ranking the categories, wasteful costs associated with overtreatment exceeded that of fraud and abuse.

Health Net has developed and maintained systematic mechanisms and processes to prevent, detect, and reduce waste in all five categories: care delivery failure; care coordination failure; overtreatment; administrative complexity; pricing failures and fraud and abuse. We pay particular attention to overtreatment due to quality of care implications as well as high cost.

We would like to highlight our current waste program and provide specific initiatives we intend to pursue in Arizona under the AHCCCS program to combat waste.

Health Net's Current Practices

Health Net recognizes the importance of identifying and addressing sources of waste within the health care system and monitors a variety of metrics to actively support this goal. This includes the following:

- **Pharmacy Data.** We conduct monthly tracking of provider prescribing practices, including formulary versus non-formulary, brand versus generic, top-prescribed medications, high-volume prescribing practices, and periodic tracking of member drug utilization, including appropriate utilization of narcotic trends.
- **Concurrent Review Process.** We require reporting and non-payment of Provider Preventable Conditions in accord with federal requirements. Further, we provide daily oversight of all inpatient cases. Days are subject to denial if delays in care are detected, if medically unnecessary services are provided, or if the most appropriate level of care is not provided. We actively assist the hospital and member with discharge needs to home care or a lower level of care at all times to avoid unnecessary and costly inpatient stays.
- **Claim-editing Criteria.** We adopt standard claim-editing criteria from the CMS Correct Coding Initiative and American Medical Association Current Procedural Terminology (CPT) to ensure claims are not unbundled, does not exceed expected maximum units, and are billed with currently approved codes.
- **Upcoding.** We track providers for upcoding, using an expected code range to monitor physician billing. Physicians who exceed usual coding practices are subject to review of high-level claims, which includes clinician review of the clinical notes and denials as necessary. Consistent patterns are referred to our Special Investigations Unit (SIU) as well as the credentialing department and are subject to 100 percent claim review.
- **Outliers.** Through weekly and monthly queries, we identify any cost outlier claims or maximum unit outliers, referring to our fraud unit for investigation or to network directors for negotiations.
- **Reduction in Appropriate ER Visits.** ER and inpatient utilization is tracked and reported back to the group or clinic. Initiatives to reduce hospital utilization are designed in conjunction with the clinic and the facility, including grant funding for specific in-office programs. An example: Grants given to clinics to fund evening and weekend hours to prevent ER visits, after clinic-specific reporting indicated an extremely high ER visit rate among the assigned members. Health Net provides monthly eligibility reports to individual providers and clinics, and additionally indicates which members are due for an Initial Health Assessment. Subsequent monthly reporting indicates other gaps in care from preventive measures not yet performed. In this way, annual well-woman care, mammography, adolescent immunization rates, and other services can be provided appropriately.
- **Over- and Under-utilization.** Health Net has well-defined processes in place to ensure appropriate follow-up on under- and over-utilized services. The Health Net analytics team monitors trends in grievances and appeals and pharmaceutical use. Using the trends data, Health Net quality-of-care staff intervenes by referring issues for appropriate follow-up with disease management, case management, or other departments as needed to ensure improved health outcomes. Data reports are presented at the Health Net Pharmacy and Therapeutic and Utilization Management Committees for discussion and action as needed. These committees report to the

Quality Management Committee. Additionally, Health Net's clinical grievance and appeals department's team of nurses and medical directors are attuned to looking for unusual practice patterns which may indicate a larger issue of fraud, waste, and/or abuse. A full claims report and individual case review is then conducted. When patterns are identified, this results in referrals to our SIU and /or Peer Review Committee for investigation, monitoring, and action, up to and including termination from the network or referral to Medical Board, state and federal regulatory agencies.

- **Narcotic Drug Utilization Monitoring and Review.** Effective pain management continues to present a significant challenge for clinicians who are balancing the patient's subjective complaints of pain with the addictive qualities of prescription narcotic medications, in a health care system that allows multiple avenues of access to narcotics, and has limited resources to enforce an agreed-upon pain protocol. To improve provider awareness of inappropriate narcotic use, Health Net communicates regularly with providers and has an ongoing program to alert them. Health Net's Appropriate Narcotic Use program's objectives are as follows:
  - To promote appropriate narcotic (opioid) use by members
  - To reduce inappropriate use of multiple short-acting narcotic prescription medications
  - To reduce excessive acetaminophen use in acetaminophen-containing prescriptions
  - To provide prescribers with strategies and tools for proper pain assessment and treatment of their patients

  Health Net's Appropriate Narcotic Use program monitors pharmacy claims to identify members who meet the following criteria for intervention:
  - Received more than 15 narcotic prescription medication refills within a four-month period
  - Received more than 10 prescription medication refills and visited more than three physicians and pharmacies in a four-month period
  - Took medications that provide more than four grams of acetaminophen daily based on quantity dispensed and number of days supply (over a four-month period)

  The components of the narcotic initiative mailing include the following:
  - A cover letter explaining the appropriate narcotic utilization program and various resources for pain management
  - Profiles of members identified as having a high use of narcotic medications (those with high abuse potential) and high acetaminophen usage, which encourage physicians to review their patients' medication history and promote appropriate use through coordination of care among other prescribers
  - A physician reference sheet (called the Narcotic Prescribing Tool) for providers, including updated pain management guidelines and coverage restrictions
  - An optional medication contract, which can be customized and then signed by the physician and member and kept in the member's chart after the physician discusses the member's compliance to prescribed chronic narcotic medications and how to prevent pain medication misuse

Health Net has conducted initiatives to address inappropriate narcotic utilization since 2006, and has consistently demonstrated their effectiveness each year. For example, in 2011 a total of 774 members (of which 157 are Medicaid members) were identified for intervention as either a candidate for possible high-narcotic utilization and/or at risk for hepatotoxicity from excessive acetaminophen use over a 4-month period. The intervention was implemented in December 2011, and in the first 6 months, improvement was measured in all groups for both narcotics and acetaminophen use. For narcotics, 81.9 percent of Medicaid members decreased their use of narcotics. In the acetaminophen group, 79.4 percent of Medicaid members had decreased use of acetaminophen.

In 2012, the narcotic program interval expanded from annual to biannual in order to reach high-risk members more effectively and to further reduce the use of short-acting narcotics for long-term pain and decrease the use of greater than four grams of acetaminophen per day, which is known to be hepatotoxic. In 2013, there will be additional modifications to the criteria in order to be consistent with the current clinical guidelines and recommendations. Health Net anticipates these initiatives will encourage a face-to-face dialog between the prescriber and the patient around safety, fraud and avoidance of addictive behaviors.

7.2 AHCCCS-specific Waste Reduction Initiates

Electronic Health Records Initiative

Health Net actively promotes the use of electronic health care records (EHRs) in reducing waste. As such, we fully support the AHCCCS administered electronic health records incentive program, Medicaid EHRs Incentive Program for Arizona Providers, which provides financial support for eligible providers to purchase and implement EHR systems. Health Net will continue to work with its providers to identify those who may be eligible for the incentive program and to educate and encourage those providers who may not yet be eligible, based solely on their Medicaid membership, to participate in the program. Health Net is a board member and one of the original financial supporters of HINAz. HINAz is an Arizona non-profit organization that provides a secure electronic health information exchange in pursuit of its mission to support the adoption of health information technology, to enable and improve quality of care, contain costs, and support meaningful use of certified EHRs. HINAZ is the health information exchange for Arizona providers and health plans and provides linkage to nonhospital providers.

Continuation of the promotion of electronic health records initiative will result in the following outcomes:

- Improve care delivery, coordination and outcomes
- Reduce unnecessary and duplicative treatment
- Allow patients a better means to self manage care
- Lower medical and administrative costs
- Heighten member satisfaction and quality of life

Appropriate Narcotic Use and Pharmacy Home Initiative

If awarded the AHCCCS contract, Health Net would expand the Appropriate Narcotic Use program and encourage the use of a pharmacy home for AHCCCS members. While a pharmacy home for narcotic-using members is vital to prevent overdosing and to avoid inadvertent participation in addictive behavior, we consider the pharmacy home an important concept for all members. Health Net would encourage physicians to promote the concept of a pharmacy home to all members, and ask physicians and their designated staff to document the AHCCCS member's pharmacy of choice in the medical record. Such practices would benefit all types of medication dispensing needs and promote patient safety by ensuring that a single pharmacy tracks medication interactions and quantities to limit waste and abuse.

Health Net presently sends letters about patients' narcotic use to our participating commercial and Medicare physicians in Arizona. Therefore, expansion of the Appropriate Narcotic Use program to include AHCCCS physicians and members will occur within the first year of the contract effective date. Designation and promotion of the pharmacy home component of the initiative will require slightly more time to develop physician and member education materials, but should be operational within the first contract year. Health Net expects improvements similar to those realized in California.

ER Initiative

Inappropriate ER utilization is a significant source of waste in health care systems. The relative cost of treating patients in the ER is high and continuity of care often jeopardized. Several studies point to how unnecessary ER visits reduce quality of care and increase cost of care. In addition, research shows that having a regular PCP can lower ER visits, particularly when providers are available during evening hours. Findings suggest the lack of insurance is not a major factor in non-urgent ER utilization; rather, barriers in accessing primary care and socioeconomic and cultural factors help drive Medicaid members to visit the ER for non-emergent care.

To reduce inappropriate use of the ER, Health Net will provide a performance incentive to FQHCs and RHCs. To achieve the goal of improved quality of care, Health Net will collaborate with FQHCs and RHCs within its AHCCCS network to promote the identification and use of the AHCCCS member medical home. This program allows for additional payment to the FQHC and RHC sites separate from the per-visit reimbursement, and will not jeopardize the federally designated funding. When ambulatory care sensitive conditions can be seen in the clinic setting after hours, on weekends, and with same day access, the ER visits reduce and quality of care improves. Baseline utilization is compared to subsequent quarterly reports in order to calculate the award and plan access related interventions.

Components of the initiative include:

- Developing a customized Performance Incentive Initiative agreement to reduce inappropriate ER use while promoting the concept of the medical home
- Providing the practitioners with a list of their members who use the ER instead of a clinic to meet non-emergent health care needs during the hours the clinic is open
- Targeting member outreach to encourage members with high ER use to establish a medical home at the FQHC or RHC
- Providing designated per member per month incentive payments above per-visit reimbursement to the clinic when targets defined in the agreement are met

Full implementation and initiation of FQHC payouts will be dependent on the data elements of the incentive agreement and allow for claims lag to ensure accuracy of improvements.

Health Net anticipates the following improvements with implementation of the customized Performance Incentive Initiative to reduce inappropriate ER use:

- Reduction in ER utilization and associated costs for ambulatory care sensitive conditions
- Increased usage of lower cost clinic care due to extended day and/or weekend clinic hours
- Promotion of the medical home, improving physician and member interaction and coordination of care
- Increased member satisfaction with clinic and physician availability
- Access to care during evening and weekend hours, key for members who may not be able to access care during usual office hours

Operational Efficiencies Initiative

Health Net recognizes that considerable waste is attributable to the disparate operating policies and procedures employed by the various stakeholders within the Arizona market. The administrative burden could be lightened and associated costs lowered if the stakeholders could identify common ground for process standardization and uniformity—similar to the Credential Verification Organization initiative. There are untold possibilities to streamline our business practices. For example, each health plan is responsible for conducting provider site reviews. This duplicative process is disruptive to the providers and costly to the plans. The ALTCS program addressed this issue by agreeing to divide the nursing homes reviews amongst the plans and sharing the findings; thereby significantly reducing time and resources without forfeiting the need for oversight. This process, or some form thereof, could be utilized in the acute program with similar results. Health Net is interested in working with AHCCCS and its shareholders in identifying opportunities to improve operational and administrative efficiencies throughout the system.

This initiative could be enacted anytime after October 1, 2013, and the expected outcomes would be:

- Reduced administrative burden and wasteful costs
- Increased time for medical professionals to attend to patient care
- Improved relations with the provider community
- Increased provider participation in the AHCCCS Program

Identification and Education Related to Over- and Under-utilization Initiative

Health Net has a focused utilization management process directed at improving outcomes and effectiveness by identifying and rectifying over- and under-utilization of AHCCCS services. For example, as described above, we conduct daily concurrent review of inpatient stays, we assist with discharge or transfer to lower level of care in a proactive manner, and we place members into active case management who have or are at risk for repeated hospitalization. Additionally, we use systematic claims and pharmacy review to identify members for disease management programs and for case management. We work actively with our PCPs to promote a true medical home model with same-day access, timely preventive care, and cost-effective medication regimens. Reporting and care plans are shared with our PCPs regularly, and for our highest-cost/highest-risk members, PCPs are routinely included in the interdisciplinary care team meetings.

Claims review additionally identifies potential for fraud, waste, and abuse investigation. Claims are subjected to daily editing to ensure appropriate billing in accordance with Correct Coding Initiative, Health Net claims policies, AMA CPT, and all state-required coding rules. Weekly reports are reviewed to identify patterns of

billing, with outreach and education to providers who do not code according to standards. We also detect "upcoding" through this tracking mechanism, and our medical directors conduct claims reviews with clinical records and code modifications to ensure payment conforms with work actually performed. Again, providers with persistent upcoding or unbundling, or excessive treatment and testing can be educated, can be referred to our SIU for investigation, or can be referred to the Peer Review Committee.

Over-utilization is monitored, detected, and avoided through Health Net's robust utilization management process and also through systematic monitoring of our claims payment systems. Tests, treatments, and other services of known questionable value, identified as only appropriate in specific circumstances, or recognized to be generally over-utilized by the broad medical community are targeted for prior authorization and careful review. Individual tests, e.g., MRI scans, specific in-office injectables, or elective surgeries are reviewed against nationally recognized medical-necessity criteria, with approvals or denials issued following careful clinical review. The prior authorization list and requirements are reviewed annually against actual utilization and denial rates, and also considering advances in technology.

On the claims payment side, claims are edited using standard Correct Coding Initiative (CCI) edits, as well as reviewed against published Medicaid and CMS standards. Claims are audited for upcoding and assessed for potential fraud and abuse on a weekly basis. Providers with consistent upcoding or unusual coding practices are contacted, educated, or referred to our SIU unit, as needed. Health Net pays particular attention to claims for durable medical equipment (DME), correct pricing and dosing of office-injectables, increased frequency of billing of complex level office visits, and excessive in-office testing in conjunction with office visits. Programs will be established with Health Net's AHCCCS provider network to conduct regular outreach to providers who are coding outliers.

Implementation of Health Net's over- and under-utilization identification, monitoring, and outreach efforts would begin on the contract effective date. Health Net anticipates the following outcomes from the over- and under-utilization initiatives:

- Timely identification of wasteful or fraudulent billing practices, and denied or adjusted claims
- Improved coding practices through provider education
- Reduction in unnecessary ER or inpatient hospital stays due to effective case management
- Reduced health care costs due to appropriate utilization of testing and treatments in accordance with recognized standards
- Improved access for members with their PCP, including preventive visits, tests, vaccines administered in accordance with state, national and specialty society approved standards
- Appropriate referrals and action by peer review committee and state licensing agencies of providers who do not meet standards or who practice in a fraudulent manner
- Detection and referral of patients with narcotic addiction or abuse
- Improved access to care, through expanded hours, with the primary care network

8. Question 8 [H.16.E.8; D1.10, 16, 21, 62, 63, 72]

Health Net is committed to providing our members access to high-quality medical care while complying with all state, federal and local laws and regulations as well as the requirements of the AHCCCS program. We recognize that compliance is central to good business practices and expect that employees at all levels and areas of business will play an active role in our compliance activities along with our providers, business partners, and members.

Our Corporate Compliance Program is dynamic, involving multiple programs, processes and activities. It is based on the seven elements of an effective compliance program as outlined by the Office of the Inspector General, which are:

1. Written Standards, Policies and Procedures
2. Compliance Leadership and Structure
3. Training and Education
4. Internal Lines of Communication
5. Auditing, Monitoring and Screening
6. Enforcement of Compliance Standards
7. Responding to Detected Offenses with Corrective Action Plans

We evaluate it regularly to assess its effectiveness, implementing any changes necessary to meet evolving compliance needs, thus ensuring the quality of the program. The knowledge and experience we have gained through building our corporate compliance approach will dictate the activities, policies, and procedures we put into place to successfully implement the AHCCCS contract.

Health Net's expectations for employee conduct begin with our commitment to comply with all laws and regulations. Compliance training occurs as part of the new hire process and continues throughout an employee's tenure. In addition, Health Net has policies and procedures that establish expectations for employee behavior. We maintain an extensive library of policies and written guidelines so that all employees know and understand their individual responsibility for compliant and ethical business practices. All policies are reviewed annually and updated where necessary. Numerous new policies will be added in accordance with AHCCCS guidelines.

Health Net, Inc.'s Chief Compliance Officer heads the Corporate Compliance Department and is charged with overall responsibility for the effectiveness of the Corporate Compliance Program. The incumbent is Senior Vice President, Chief Regulatory and External Relations Officer, and Chief Compliance Officer for Health Net, Inc. A member of the company's five-person Executive Management Team, she reports directly to Health Net, Inc.'s Chief Executive Officer.

Health Net Medicare Compliance Officer (a vice president) reports to our Chief Compliance Officer and will also become Health Net's AHCCCS Compliance Officer and reside in Arizona. This position will therefore have a dual reporting structure. For the Medicaid program, the Compliance Officer will report directly to the AHCCCS Plan CEO. For the Medicare program, the position will report directly to our Corporate Compliance Officer. We believe that the combined responsibilities will assist us in ensuring compliance with both programs, especially with our dual eligible plan. Additional staff required for AHCCCS compliance activities will report to her. She will implement, oversee and administer our AHCCCS Compliance Program including fraud and abuse control, act as liaison between Health Net's senior management and AHCCCS officials, chair Health Net's AHCCCS Compliance Committee and ensure that we are compliant with all federal, regulatory and contractual obligations.

The AHCCCS Compliance Officer will also be responsible for immediately reporting incidents of potential or suspected fraud and abuse to AHCCCS in accordance with ACOM Policy 103 and will maintain a tracking system of fraud and abuse. The AHCCCS Compliance Officer will have the authority to assess records and independently refer suspected member and provider fraud and member abuse cases to the AHCCCS OIG, or other duly authorized law enforcement agencies. There will be established lines of open communication between our AHCCCS employees and the Compliance Officer.

At any time, the Chief Compliance Officer and/or the AHCCCS Compliance Officer may, at their discretion, escalate compliance issues directly to Health Net's Executive Management Team, the Chief Executive Officer, the Chief Operating Officer, or the Board of Directors, who are accountable for ensuring that company compliance goals are met.

At Health Net, we enlist the help of our employees, providers, business partners, and members to increase our capabilities and enhance our efforts to combat fraud, waste and abuse. Employees at all levels of the company receive mandatory compliance training that includes our Code of Business Conduct and Ethics training; general compliance training; HIPAA-specific training; false claims and statements prevention training (Deficit Reduction Act of 2005) including whistleblower protection laws training; fraud, waste and abuse training; and pharmaceutical fraud training. This training is a part of our new-hire orientation program. Additionally, all employees must repeat many of these courses on an annual or biannual basis. New training will be developed as required to meet the needs of the AHCCCS program.

We work diligently to foster a culture of compliance throughout the organization by regularly communicating the concepts of compliance and ethics, and by reinforcing the company's expectation of compliant and ethical behavior. To encourage two-way communication, we have developed a compliance communications plan that includes the following components:

- E-mail reminders
- Employee newsletters
- A robust compliance department website
- A full library of written policies and procedures pertaining to compliance
- Compliance awareness marketing efforts
- Leadership talking points to encourage compliance discussions at the department levels
- Instructional videos
- Regular features on Health Net Connect (our company intranet)

Every Health Net employee bears responsibility for ensuring the company's business is conducted in a legal and ethical manner. Health Net regularly communicates that responsibility to all employees, and encourages employees to communicate any concerns about potential violations of policies, regulations, and laws, without fear of retaliation. All employees are informed that violation of standards, policies, regulations or laws may result in appropriate disciplinary action, up to and including termination of employment.

Our standard provider contracts contain the provisions set forth in ACOM Policy 103, including anti-kickback language and reference to self-referrals. We require that our providers and business partners be trained on waste, fraud and abuse. Health Net ensures that all providers and business partners certify that they have met the requirements for education and training with respect to our Compliance as well as our Fraud, Waste and Abuse Programs. We will also require our contracted providers to train their staff on certain aspects of the Federal False Claims Act as specified in the contract. We reduce the possibility of provider fraud by making providers aware of applicable rules and regulations during the contracting process. Further, our AHCCCS provider operations manual will include comprehensive information about fraud and abuse (including member abuse), and how to report suspected occurrences to Health Net. The manual will also list the various means for member eligibility verification to prevent fraudulent member misrepresentation, and stress the importance of requesting member photo identification as a further precautionary measure. If an adult patient does not have photo identification, we will encourage the provider to utilize the AHCCCS On-Line verification tool where a MVD photo may be available.

We communicate regularly through Provider Updates via e-mail, online and/or fax. These newsletters provide information and reminders in areas such as safeguarding protected health information (PHI); completing compliance training requirements; and reporting fraud, waste and abuse or violations of standards of conduct. We also certify that providers understand how to submit accurate and complete claims, which helps us avoid later disputes.

To ensure that members understand the issues concerning fraud, waste and abuse, information is posted on our member website (www.HealthNet.com) as well as in printed member materials. We address prevention and recognition of fraud and abuse, and encourage members to report any suspected incidents without fear of retaliation. Our Customer Contact Center representatives can also advise members on how to report potential abuse and all Evidence of Coverage (EOC) documents contain detailed information. Further, we articulate definitions of and discourage member fraud and abuse with reference to penalties under law. Similar systems and materials will be developed for the AHCCCS population including placement of this information in the member handbook.

The Compliance Department works to monitor ongoing compliance, post-implementation of legislative reforms, laws, regulations and rules. A monthly report of compliance metrics, which outlines performance and progress in key areas, is delivered and discussed with the Chief Operating Officer and key Health Net senior executives for review and action. The Compliance Department is also involved with inquiries and examinations by government regulators. Generally, a compliance professional acts as the examination coordinator for the company during an examination.

Health Net's Internal Audit Department provides independent, objective and comprehensive reviews designed to evaluate and assess the adequacy and effectiveness of various areas of the company. This includes assessments of the Corporate Compliance Program's design and the Corporate Compliance Department's performance compared with the guidance published by the Office of the Inspector General (OIG).

8.1 Building on Health Net's Fraud, Waste, and Abuse (FWA) Program

Health Net has a robust Anti-fraud Plan, which will provide the foundation for fraud, waste and abuse detection activities in our work with AHCCCS. Our Special Investigations Unit (SIU) has the primary role in executing the plan's activities. The work of this team will provide tremendous added value to AHCCCS through their extraordinary efforts to gather data, conduct in-depth analysis of data, and fully and completely investigate issues – detecting, addressing and/or preventing instances of fraud, waste and abuse.

The SIU management team develops and implements an annual FWA Risk Assessment and corresponding Work Plan. The FWA Risk Assessment identifies potential risks and assigns priority. Potential risks may originate from a variety of sources including those identified by the OIG, by the CMS, by Health Net's Legal and/or Compliance departments or through other regulatory guidance and FWA alerts. The team also reviews process deficiencies identified as a result of an internal and/or external audits; past FWA referrals, cases, trends and/or schemes; activities in high-risk counties or of high-risk providers; and high-profile deliverables to regulators and/or law enforcement, which if not completed in a timely manner, can lead to noncompliance.

The annual Work Plan provides the roadmap to addressing the identified risks. It also includes planned fraud detection, prevention and correction objectives, fraud awareness initiatives, required reporting to regulators and law enforcement and estimated timeframes to completion. The Assessment and Work Plan are reviewed on a quarterly basis by SIU management to ensure that any new opportunities are identified and brought to the attention of executive management.

The SIU comprises employees who have knowledge and experience in the following areas:

- General claims practices
- The analysis of claims for patterns of fraud
- Current trends in insurance fraud
- Specific red-flag events and other criteria indicating possible fraud

The Special Investigations Unit has the ability to conduct effective investigations of suspected insurance fraud and is familiar with insurance and related law and with the use of available insurer-related database resources. Legal department staff as well as claims, finance and medical management resources are periodically called upon to assist in the investigative process.

SIU staff receive continuing training each year in areas including investigative techniques, communication with authorized government agencies, fraud indicators, emerging fraud trends and legal and related issues. Several have been credentialed as Accredited Health Care Fraud Investigators (AHFI), Certified Professional Coders (CPC), and Certified Fraud Examiners (CFE). The knowledge and experience of this exceptional team will serve AHCCCS members well as we work to create a strong fraud, waste and abuse program.

8.2 Using Our Fraud Hotline to Benefit AHCCCS

An additional element to further aid in our efforts to ensure that AHCCCS is able to combat fraud, waste and abuse is Health Net's Fraud Hotline. It is a confidential, toll-free resource available twenty-four hours a day, seven days a week, to report violations of, or to raise questions or concerns relating to fraud, waste and abuse.

The Fraud Hotline is contracted to a third-party vendor who answers and documents incoming calls, and forwards documentation of the call to the SIU for review and action. The vendor submits this information to the SIU within 24 hours of receipt of the call.

Calls to the hotline can be made anonymously. The company tracks calls to ensure proper investigation and resolution of reported matters and to identify patterns and opportunities for additional training or corrective action. The Health Net Special Investigations Unit investigates all calls and AHCCCS related matters will be forwarded to our AHCCCS Compliance Officer.

Health Net educates employees about the Health Net Fraud Hotline through our compliance training program, the compliance website, newsletter and intranet updates and via e-mail. We publish the Fraud Hotline number on the Explanation of Benefits (EOB) that members receive reflecting the services that have been billed under their benefits. If the members are not in agreement with the information included in the EOB, they are encouraged to contact a Health Net customer service representative or to call the Fraud Hotline. The Fraud Hotline number is also published in the "Contact Us" section of Health Net's website and will be made available to AHCCCS employees, providers, business partners, and members.

8.3 Using System-based Antifraud Controls to Best Advantage

Health Net has a number of system-based antifraud controls to further assist in our detection efforts. These will also be used to provide additional support for fraud, waste and abuse detection and resolution efforts in the AHCCCS program. They include the following:

- **Our Claims Payment System.** Health Net's claim processing systems serve as a front line for combating inappropriately billed claims. Each claim is subject to a variety of edits that verify data accuracy (e.g. member eligibility and provider contract status), verify that billed services are covered under the member's plan, identify recovery opportunities, process claims according to contractual arrangements with providers and uncover a variety of other issues. Edits are also set within the claim processing system to identify claims of specific providers or members that the SIU has previously determined should be reviewed prior to adjudication. Claims are audited for upcoding and assessed for potential fraud on a weekly basis. Providers with consistent upcoding or unusual coding practices are contacted, educated, or referred to our SIU, as needed. Health Net pays particular attention to claims for DME, correct pricing and dosing of office-injectables, and excessive in-office testing in conjunction with office visits.
- **Our Medical/Utilization Management System.** Our medical protocols policies and procedures are designed to prevent, detect and report inappropriate care. Our prior authorization criteria are evidence-based clinical practice guidelines to avoid approval of unnecessary medical treatment and our utilization management team routinely monitors provider over/under utilization to determine inappropriate levels of care. We also conduct retroactive medical claims reviews to determine medical necessity and cost appropriateness.
- **Proactive Data Mining.** The SIU's analytical data mining identifies patterns, potential payment errors, utilization trends and other indicators of potential fraud, waste and abuse. This analysis searches for potential fraud indicators using statistical methods and by applying targeted or stratified sampling methods. These systems also aid in investigating potential cases by quantifying the potential exposure. Our analytical data-mining program assists in detection by comparing claim information and other related data by procedure or prescription claim submitted.
- **Special Investigations Resource Intelligence System (SIRIS).** Health Net partners with the National Health Care Antifraud Association (NHCAA) in the utilization and information-sharing database known as SIRIS. SIRIS contains reports, entered by enrollee organizations, where fraud is suspected or a provider has been indicted or convicted of health care fraud. It enables us to identify potential cases of fraud more rapidly and efficiently. SIRIS provides the platform to share information about suspected providers, strengthening our fraud fighting capabilities.

8.4 Health Net's Success in Combatting Fraud, Waste, and Abuse

Health Net has a strong track record for success in this area. Over the past two years, we recovered more than $5.0 million (cash or offset), showed savings in prepayment denials of more than $17 million, and prevented losses of more than $2.9 million for a total of nearly $25 million.

A recent example of our proactive approach to combating fraud occurred beginning in December 2011. Health Net's SIU team noticed a large number of complaints that had begun streaming in from Health Net of Arizona, Inc. Medicare members. The allegations indicated that members were being disenrolled from Health Net's MA Plans into those of one of our competitor's, without the enrollee's knowledge or consent. Health Net's data analysis and internal investigation pointed to a former Health Net sales associate who had since become a broker

with another organization. Upon Health Net's reporting of the issue, the Arizona Department of Insurance launched an investigation, which eventually led to an indictment by the Grand Jury on 14 counts of criminal charges, including theft and forgery.

A second example of this proactive approach is related to a quality of care issue uncovered by Health Net's Credentialing Committee. The U.S. Attorney's Office of Public Affairs had posted a notice on its website concerning a doctor arrested on federal charges of bringing misbranded foreign cancer drugs into the United States. This case was referred to our Credentialing Committee. After following Health Net processes and procedures for a thorough investigation, review of the evidence and confirmation from Health Net's Legal Department, the Credentialing Committee voted to terminate the physician from our network. Reasons cited included potentially putting our members at risk by administering unapproved medications, misleading patients by providing unregulated medications and fraudulently billing for the cost, and exhibiting a pattern of behavior demonstrating noncompliance with Federal, State and local laws as well as disregarding regulatory standards.

8.5 Providing Added Value to AHCCCS in Combating Fraud, Waste, and Abuse

Health Net's strong commitment to compliance with all state, federal, and local laws and regulations is demonstrated throughout the policies, procedures and activities that together compose our dynamic corporate compliance program. The knowledge and experience acquired in building our successful corporate compliance program will only enhance our abilities to successfully combat fraud, waste, and abuse in our work for AHCCCS. Our Special Investigations Unit provides clear added value through their extraordinary efforts to gather data, conduct in-depth analysis, fully investigate issues, and provide all the expertise needed come detect, address and prevent fraud, waste and abuse. Further, our Fraud Hotline makes it easy for employees, providers, business partners, and members to help us in these efforts. We look forward to using our dedication to compliance as a core operational value coupled with an expert team using advanced systems to best serve the AHCCCS program in combating fraud, waste and abuse.

9. Question 9 [H.16.E.9; D1.17, 26, 38, 73]

Health Net understands that proactively monitoring our claims management process for accuracy and timeliness represents the best means to avoiding claims disputes. As part of our effort to self-monitor, self-report and continuously improve our operations, we have established quality-assurance routines within our claims function. These are based on a set of quantifiable measures and monitoring checkpoints that facilitate resolving deficiencies and avoiding disputes.

We monitor numerous measurements through a combination of automated and manual system checks-and-balances to ensure that both regulatory compliance and quality improvement opportunities are addressed as appropriate. The process often incorporates significant collaboration from cross-functional teams including claims, prepayment audit, post-payment audit, finance, and medical management.

Health Net has developed claims standards reflecting both Arizona statutory requirements as well as internal program standards. Additional standards will be identified adopted as appropriate for the AHCCCS program. Claims processors will be required to be proficient and to meet established AHCCCS timeliness and accuracy standards. A review of claim processor performance against those standards will be conducted monthly, or more frequently, if appropriate.

9.1 Ensuring the Accuracy of the Data

The first opportunity to ensure reimbursement accuracy and avoid disputes on an initial adjudication decision is through the accuracy of the data—any data that will impact or drive a claim result—that is loaded into Health Net's systems. This includes member data, provider data, and contract and benefit configuration. In order to facilitate accurate claim outcomes, all of these elements must be loaded into the system correctly. Recognizing this, Health Net employs quality control measures in each of these areas.

Health Net is prepared to update AHCCCS enrollment transactions on a daily basis as outlined in the Health Insurance Portability and Accountability Act (HIPAA) Transaction Companion Guides, Trading Partner Agreements, and the AHCCCS Technical Interface Guidelines. We will also incorporate the daily Manual Payment Transaction information. An appropriate process to perform regular reconciliations against AHCCCS eligibility records will be developed to ensure that all member data is accurate at initial enrollment—an important measure to guard against future difficulties.

Once a benefit plan has been configured, Health Net conducts interdepartmental benefit testing. Working together, our claims and benefits teams perform claims testing against the configured plan before moving that plan into the live-production environment. This ensures that claims will be adjudicated according to the parameters of the plan, and that the plan is functioning within the system in a manner that fulfills all of its commitments and obligations.

In addition to this, on a monthly basis, all benefit plan configurations are subject to a post-installation random sampling audit, based upon a stratified selection methodology. Auditors verify the accuracy of benefit data that has been entered into the system as well as test a random sample of paid claims for each tested benefit to ensure that the system is functioning in alignment with benefit data loads.

Health Net provider contract data loads undergo peer review audits of provider contract configuration to ensure the integrity and accuracy of all rates, terms, conditions and processing instructions. All provider contract configurations are also subject, on a monthly basis, to a post-installation random sampling audit based upon stratified selection methodology. Auditors verify the accuracy of contract data entered into the system as well as test a random sample of paid claims for each tested contract to ensure that system behavior is functioning in alignment with contract data loads.

9.2 Assisting Providers through Support, Training, and Communication

Health Net works to ensure that our providers have full understanding of our claims processes and procedures and know how to find answers to any questions they may have. This helps to ensure their satisfaction with any claims result, thus avoiding use of the dispute resolution process. Our AHCCCS providers will receive the following claim support, training, and communication:

- **Provider Operations Manual.** Health Net will develop, distribute and maintain an AHCCCS Provider Operations Manual in accordance with ACOM Policy 416. The manual will be provided to all contracted providers either electronically or in hard copy, based on their preference. The manual will include a claims

section that will address submission and resubmission requirements, informal claim resolution processes, formal claim dispute standards, medical claim review criteria and an explanation of remittance advice. Customer Contact Center and Network Management contact information to assist providers with claim inquiries will also be listed in the manual.

- **Provider Training.** Health Net understands the critical importance of provider training to avoid unnecessary partial- and full-claim denials. Employing the AHCCCS Provider Operations Manual as a resource tool guide, Arizona Network Management team will be responsible for training and retraining contracted providers on AHCCCS and Health Net policies and procedures relative to claim processing, including claim inquiry procedures and claim dispute standards. The primary focus of the claims training will be on billing requirements to ensure the initial submission of "clean claims."
- **The Provider Reference Guide.** The Provider Reference Guide is a condensed version of our Provider Operations Manual in hard-copy format, offering easy access to all the information providers need to work efficiently with Health Net and specifically with AHCCCS requirements. The Reference Guide includes a select listing of our policies and procedures, prior authorization information and Quick Reference info including contact information within Health Net. Providers may refer to our online AHCCCS Provider Operations Manual for any additional information they may require.
- **The Provider Toolkit.** The Provider Toolkit is a user-friendly guide offering easy access to all the information providers need to work efficiently with Health Net. The toolkit includes information on our provider portal, our provider library and our medical policy library. It also details information on how to file claims using our electronic claim-submission process and how to use our "What If" tool (an interactive claim submission and edit tool).
- **The Remittance Advice.** Health Net recognizes that it is important to clearly communicate all claims adjudication decisions to our providers. It is through this critical document that the provider understands our decisions, thus the remittance advice plays a significant role in whether the provider will feel compelled to submit a dispute. We strive to ensure that the outcomes and decisions made within the claims review process are clearly and fully explained within our paper and electronic remittance advice statements. The remittance advice includes the reasons for denials and adjustments, an adequate description of all denials and adjustments, the amount billed, the amount paid, application of Coordination of Benefits (COB) and copays, and a list of provider rights regarding claims disputes. It includes information on how to contact Health Net to informally resolve issues in lieu of filing a formal claim dispute as well as instructions for filing a provider claims dispute.
- **Customer Contact Center.** Our Customer Contact Center handles claims inquiries and serves as the initial point of contact for claims resolution. Provider service representatives will be well versed in AHCCCS processes and procedures, and will be able to answer provider questions on a variety of topics including claims and billing practices. They will be available eight hours a day, Monday through Friday.
- **Provider Claims Educator.** Knowledgeable in both AHCCCS requirements and Health Net's processes and systems, the provider claims educator will facilitate the exchange of information between Health Net departments and providers. The individual will disseminate information regarding appropriate claims submission requirements, coding updates, electronic fund transfers, and resources available to the provider as well as identify trends and guide development and implementation of strategies to increase provider satisfaction.
- **Provider Updates.** Provider Updates are faxed or e-mailed newsletters that provide a wealth of information to Health Net providers regarding any changes to our claims processing, newly added or deleted codes, information regarding billing processes, etc. Updates are published on a regular basis, but may also be sent as a "Special Alert" when more timely communication is needed, e.g., AHCCCS contract or program changes.

9.3 Safeguarding Accuracy through Ongoing Auditing

Health Net has multiple quality programs in place to monitor claims accuracy. Our Director of Claims oversees the prepayment-auditing component and our Director of Quality Assurance & Training oversees the post-payment auditing component.

- **Prepayment Claims Auditing.** An audit team within the Claims Department performs a daily prepayment audit review on claims that meet certain criteria or payment thresholds, providing a second level of review before claims are released to write checks. The claims are audited for both payment data and financial

accuracy. Any prepayment claim errors identified are returned to examiners to correct. The claims are then returned to the audit team to validate that the error has been corrected. Once approved, claims are released for payment.

- **Post-payment Claims Auditing.** Post-payment quality audit reviews are performed by an independent audit source within the Customer Services department. A multilevel audit program is used to monitor Claims operational processes, regulatory compliance and the overall customer experience. Consistent and repeatable audit methodologies are used to complete post-transactional claims audits, which identify potential defects for a given process. This architecture produces operational area accuracy metrics for various regions and lines of business as well as provides measurement of regulatory compliance.
- **Standard Claim Audits.** On a monthly basis, all paid, denied and adjusted claims are subject to a post-payment random sampling audit based on a stratified-selection methodology. Auditors verify the accuracy of system and manual claims processing and payment application reviewing all aspects of adjudication including member eligibility. The audit program audits claims against all applicable state and federal regulatory guidelines as well as internal Health Net policies and procedures. Completed audit results are reported to the Claims Department management team for review and correction.
- **Focused Claim Audits.** Various claims reviews are in place to monitor state and federal regulatory compliance. Other temporary, targeted audits are also developed as requested to provide oversight of system implementations, policy adherence, and quality improvement of specific areas of risk. Audits are post payment, with a random sample selection and are completed on a monthly basis. Completed audit results are reported to the Claims department management team for review and correction.

All completed audits are subject to re-audit by Quality Assurance Senior Auditors. A random sample of each auditor's work is reviewed monthly to ensure accuracy and consistency in the audit review procedures.

An extensive report portfolio is generated monthly that provides detailed monthly and year-to-date data. The Claims department and various other enterprise-level departments use audit findings to support in-depth trending, root-cause analysis and data-driven decision models in the pursuit of ongoing dependable performance as well as the continued strengthening of regulatory compliance.

9.4 Proactively Addressing Provider Claims Issues

The Claims leadership team (including prepayment auditing) and the Quality Audit leadership team meet monthly to review the post-payment audit scores, evaluating the most common errors and root causes as applicable, and initiating corrective action as appropriate.

The overall objective of the monthly meeting is as follows:

- To identify defects and improve claim accuracy and reduce rework
- To enhance, modify or create policies and procedures that create greater clarity
- To report system-related deficiencies for prioritization and fixes
- To identify training opportunities for the entire team or for selected examiners
- To perform cross-functional process improvements necessary to create greater accuracy among departments such as the SIU, Medical Management, Network Management, and Information Technology

Health Net's Claims team hosts weekly interdepartmental Claims Policy & Procedure Review (CPPR) meetings. Attendees include representation from Claims Management, Quality Assurance, Contract Configuration, Health Care Services and Benefits. In these meetings, current desktop and work process instructions that are being modified or updated are reviewed to ensure that all workflows will run smoothly and all affected functions are aware of any changes. Health Net recognizes the value of the AHCCCS Claims Dashboard Report as a claims tracking, reporting and trending tool. The team will review the dashboard monthly to identify deficiencies or trends requiring amelioration. All claims processes and procedures, including those specific to AHCCCS, will be reviewed annually in the CPPR meeting.

From a process perspective, when our Network Management team discovers a claims issue that may have impact on more than one provider or that may be systemic, a claims report is run. This report is used to initiate a proactive claims adjustment project to resolve issues before any provider dispute submissions can occur. Projects are logged and tracked.

In our commercial line of business, Health Net has conducted numerous projects where issues were identified without the provider having to resort to initiating a formal dispute. In addition to Network Management-driven

projects, Health Net takes the initiative in other areas as well. Claims projects may be initiated for retro contracts, contract corrections, eligibility updates—the goal is that any systemic issue be corrected proactively via preventive data mining and reporting. Any claims error addressed through this process translates into a reduction in the need for the provider to submit a formal dispute. We will develop the same process for AHCCCS.

Daily dispute inventory reporting also provides a proactive approach with an overview of dispute submissions. Our current commercial business reporting includes a "top submitter" volume report; we will develop a similar report concerning AHCCCS providers. This report allows Health Net to see whether a particular provider has a high volume of disputes. With this information, we can begin analysis to see if there is a trend among the submissions. Does the provider have a repeating issue that requires root-cause analysis and resolution? A high volume of disputes may not always be related to single issue, but the goal is to identify where there are related issues and to provide remedies that will reduce future dispute submissions.

9.5 Adhering to AHCCCS Provider Claims Dispute Standards

Health Net will adhere to the prescribed requirements, standards, and procedures set forth in the AHCCCS Provider Claim Dispute Standards. Upon contract award, we will develop and implement a written AHCCCS provider claim dispute policy and procedure for contracted and non-contracted providers. The policy will acknowledge the provider's right to file claim disputes and clearly articulate the process, including timelines, to be followed by both parties. The policy will also include the internal procedures for recording, tracking, responding, reporting, and retaining provider claim disputes along with specific documentation requirements for fair hearings. The policy will describe the informal claim resolution processes stated above and strongly encourage providers to pursue these avenues prior to filing a formal dispute.

Policy training will be provided to staff and providers. Specialized training will be given to claims, customer contact center and network management personnel to ensure procedural conformance. The policy will be incorporated into an AHCCCS Provider Operation Manual. Network Management will train existing and new providers on the manual, in general, and the claim dispute policy, in particular.

Our AHCCCS Compliance Officer will routinely monitor the provider claims dispute processes to ensure regulatory compliance.

9.6 Informally Resolving Specific Provider Claim Issues and Disputes

While a provider always has the right and recourse of a formal claim dispute process and will be informed on the remittance advice of that process, Health Net offers providers various options for resolution of any claims issues prior to the submission of a formal claims dispute. Further, we actively encourage our providers to avail themselves of these more informal methods which include:

- **Remittance Advise.** In addition to including information on filing a claim dispute, the remittance advice will also include the phone number of our Customer Contact Center for provider claim inquiries and assistance.
- **Calling the Customer Contact Center.** Provider Service Representatives are available to answer questions concerning provider claims issues. We encourage providers to contact a representative for informal review before taking any other action, such as filing a claims dispute. Provider service representatives will forward the issue for review by a claims adjuster, who will whether the claim has been correctly paid or an adjustment can be made. If satisfied with the adjustment, providers will be directed to resubmit the claim for re-adjudication. If Health Net upholds the initial decision or the provider is dissatisfied with the adjustment, providers will be reminded of their right to file a claims dispute, but will be encouraged to contact our local Network Management team or the provider claims educator to determine whether the matter can be resolved in a more informal manner.
- **Contacting the Provider Claims Educator.** Well versed in both AHCCCS requirements as well as in Health Net's processes and systems, the claims educator will be available to answer questions and coordinate information between the provider claims staff, grievances, claims processing and the provider relations system. With a thorough understanding of claims submission requirements, coding updates, electronic fund transfers and resources available to the provider (e.g., manuals, web-based information, fee schedules, etc.), this individual will be available to answer questions and satisfy concerns about provider claims. This position will also be responsible for identifying trends and will guide the development and implementation of strategies to improve provider satisfaction.

Finally, if a provider has filed a formal claim dispute and is dissatisfied with Health Net's decision regarding that dispute, we will encourage the providers to continue to work with us both before filing for a fair hearing as well as settling disputes prior to a hearing.

9.7 Minimizing the Need for Use of the AHCCCS Claims Dispute Process

Health Net has the claims procedures, processes and systems in place to ensure provider satisfaction. We proactively monitor our claims management process for quality and timeliness as a means to avoiding any unnecessary claims disputes. In addition, our training and education tools as well as our competent, committed provider network staff will ensure minimum usage of the formal dispute process.

Health Net is confident in our ability to accurately and efficiently provide claims services that render unnecessary the need for providers to use the claims dispute process to obtain proper reimbursement. Our systems and processes all support achievement of this goal. When a claim cannot be handled through our auto-adjudication process, we have numerous other avenues to a satisfactory resolution of the issue without resorting to a formal complaint. Further, our resolution rate for satisfactory closure within the 30-day regulatory calendar time frame has averaged 99.36 percent in 2012. We recognize the importance of the claims process to provider satisfaction and participation, and we will work to ensure that all AHCCCS requirements are met in the most efficient and effective manner.

10. Question 10 [H.16.E.10; D1.13, 58, 64, 65, 66, 67, 68]

For the AHCCCS Acute Care opportunity, Health Net acknowledges the following:

- Health Net acknowledges that our participation in the IT Systems Demonstration beginning on January 29, 2013, constitutes fulfillment of Submission Requirement No. 1.
- Health Net acknowledges that we will comply with the stated guidelines and calendar for the IT Systems Demonstration process.
- Health Net acknowledges that the IT Systems Demonstration will be scored as part of our proposal.