



February 8, 2016

Ms. Meggan Harley
Procurement and Contracts Manager
Arizona Health Care Cost Containment System
801 E. Jefferson
Phoenix, AZ 85034

Re: Health Choice Arizona Compliance Action – Notice to Cure

Dear Ms. Harley,

Health Choice Arizona, Inc. (Health Choice) respectfully submits the following letter, and corresponding attachments in response to the Notice to Cure letter (the Letter) from AHCCCS, dated February 3, 2016.

Health Choice has served Arizona's Medicaid population for 25 years. Through its experience facilitating high quality, cost effective care to Arizona's Medicaid population as well as serving Medicare Advantage and marketplace enrollees, Health Choice firmly believes that the satisfaction and engagement of the provider community is a cornerstone for effective delivery of healthcare services to Arizona's underserved populations.

Health Choice recognizes that a combination of factors have led to the provider satisfaction concerns which AHCCCS has identified, and that no single action will remedy the concerns. Notwithstanding this, Health Choice is committed to thoroughly analyzing and addressing the concerns raised in the letter and demonstrating improvements both in relation to the AHCCCS service level requirements and the service expectations of providers and members, including their overall satisfaction with our health plan and the AHCCCS Program.

This response letter highlights the analytic process and many key actions and initiatives which have already been developed and implemented, positively impacting service levels; as well as others that are being thoughtfully developed to cure underlying causes and systemic issues. More specifically, this letter outlines detailed actions that we are taking to improve the performance of our operations, which is critical and dependent to improving overall provider satisfaction ratings.

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Even prior to receiving the results of the AHCCCS Provider Satisfaction Survey, Health Choice recognized the need to address many of the same issues and started to identify and implement an action plan to remediate health plan operations and to demonstrate to AHCCCS the sensitivity, focus, and urgency we have towards quickly correcting the issues expressed. These efforts and progress to date are detailed below:

- Performing root cause analysis of all functions that interface and/or support our provider network, claims, and member/provider call centers to identify any existing or potential issues;
- Increased staffing in key operational areas, including provider services, claim adjudication, prior authorization, and our customer service call center;
- Optimizing organizational alignment, to ensure network operations are shaped and driven based on the key priorities of the AHCCCS Program;
- Improving provider communication, including ongoing and more frequent face-to-face meetings as well as electronic communications;
- Providing our Provider Network with the most advanced and up-to-date tools for performance monitoring, such as provider tool kits and provider performance report cards;
- Materially reducing Prior Authorization (PA) and claims processing turnaround times to issue and communicate decisions in a timeframe that now exceeds contractual standards and;
- Materially reducing claim adjudication and payment turnaround times that are now much better than contractual standards, as well as working to improve accuracy to avoid the need for post-adjudication claims adjustment.

These noted improvements in our performance, and subsequently our provider satisfaction are illustrated in the graphs below.

Specifically, Health Choice has adjusted its prior authorization staffing levels to process requests received more quickly based on membership as well as provider and member service expectations. This increase in staffing, as well as the new staffing methodology is detailed in the figure below.

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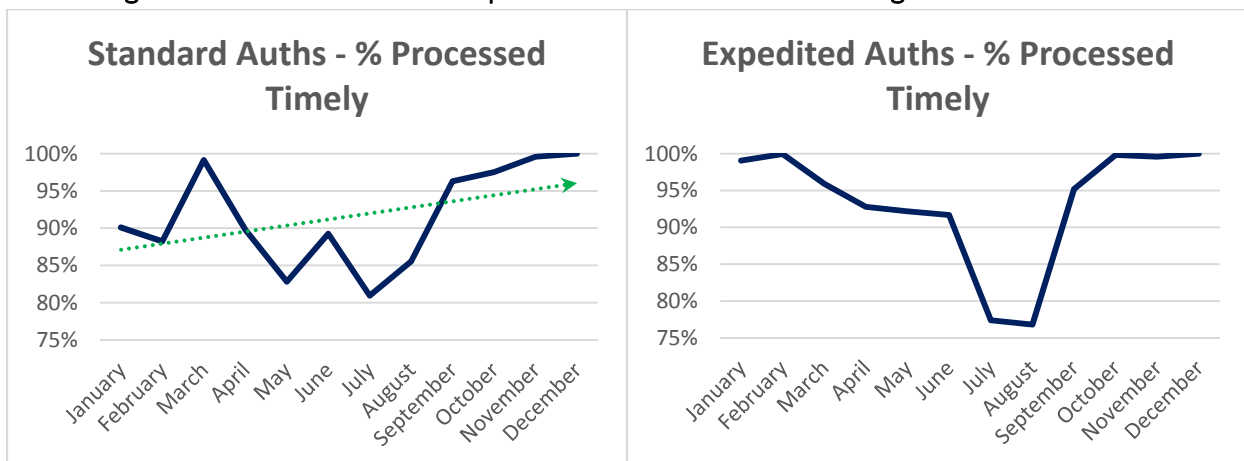
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Figure 1: Prior Authorization Staffing

Line of Business	Target Staffing Ratio	Membership	Staff Needed to Support Membership	Current Staff
HCA Total				
Prior Authorizatio Nurse	1 : 16,000	245,784	16	16
Prior Authorization Tech - Intake	1 : 8,500	245,784	29	30
Prior Authorization Tech - Calls	1 : 18,500	245,784	14	20
Non-Clinical NOA Authors	1 : 41,000	245,784	6	8

Since October when additional staff was on-boarded and trained, PA processing timeliness - noted in *Figures 2 & 3* for both standard and expedited authorization requests, have continued to sustain performance levels that exceed contractual requirements.

Figures 2 & 3: Standard and Expedited Authorization Processing Timeliness



Figures 2 & 3 represent Standard and Expedited Authorization trends month over month for calendar year 2015. Each graph demonstrates Count of Authorizations processed timely – Standard 14 calendar days, expedited 3 business days.

Additionally, with regard to the Health Choice Prior Authorization Call Center, we realized the need for greater staffing levels. This additional staff of call center based prior authorization techs were hired and on-boarded in October and November of 2015. The positive impact of this staffing on key call center metrics is detailed in figure 4 below.

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Figure 4: Prior Authorization Call Line Average Speed of Answer and Call Service Level

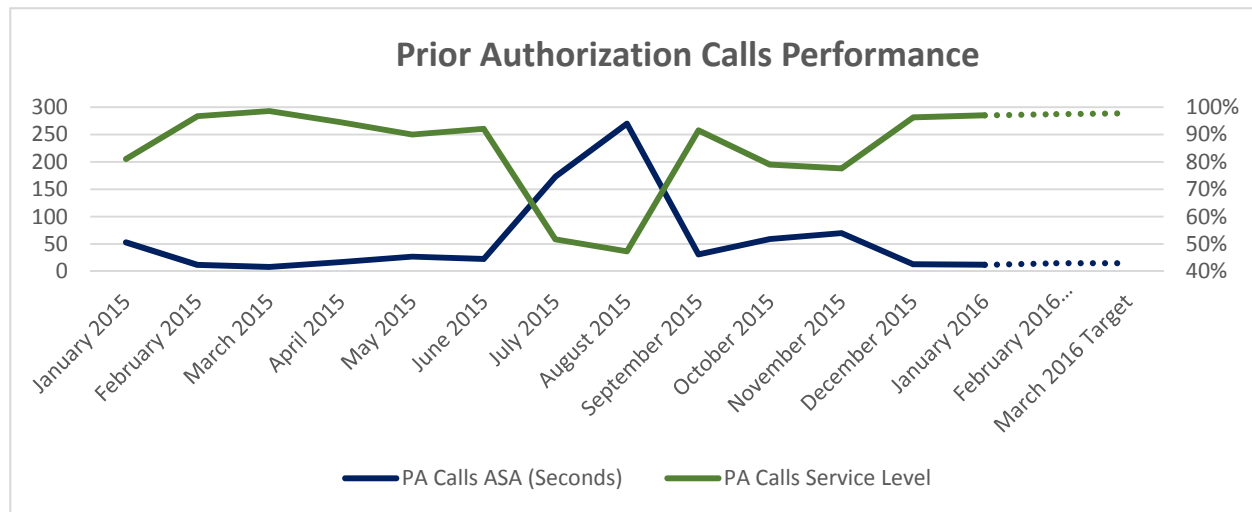


Figure 4 depicts the trend of average speed of answer and call service level over calendar year 2015. It also includes projected performance for February and March based on predictive modeling for February and March 2016.

In addition to these efforts around Prior Authorization, the timeliness of claims adjudication and payment have also been a focal point of our remediation plan. In the recent months, Health Choice has reduced the volume of pended claims by more than 50%, which continues to decline appreciably month over month (*Figure 5*). With staffing additions and process improvements as an intentional focus, we have greatly improved our adjudication and payment timeliness to under 18 days for clean claims as of the end of December 2015 (refer to *Figure 6*).

Figure 5: Total Claim Volume Pended End of Month

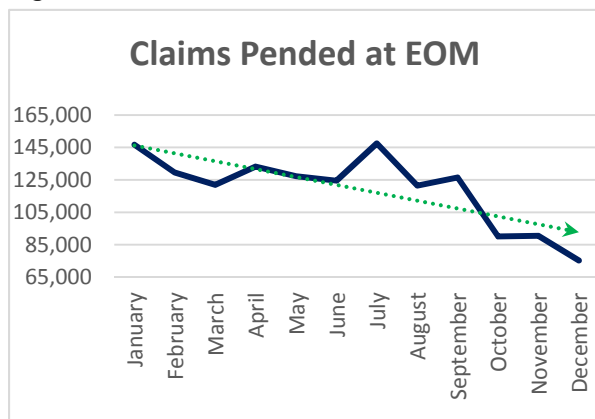


Figure 6: Average Turn Around Time

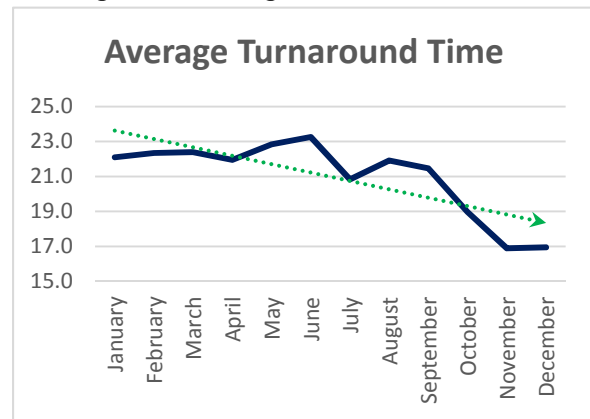


Figure 5 depicts total volume of pended claims at the end of each month for calendar year 2015. Figure 6 shows the average turnaround time for claims processing, defined as adjudicated and paid for calendar year 2015.

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This reduction in claims inventory as well as the completion of many claims projects to remediate escalated provider issues, we experienced an initial spike in interest owed and paid, which subsequently dropped in December of 2015 and is expected to return to at or below YTD average (*Figure 7*) throughout 2016. At the same time, our improved claims processing turnaround times has led to a meaningful reduction in received but unpaid claims (RBUcs) (*Figure 8*).

Figure 7: Claims Interest Paid

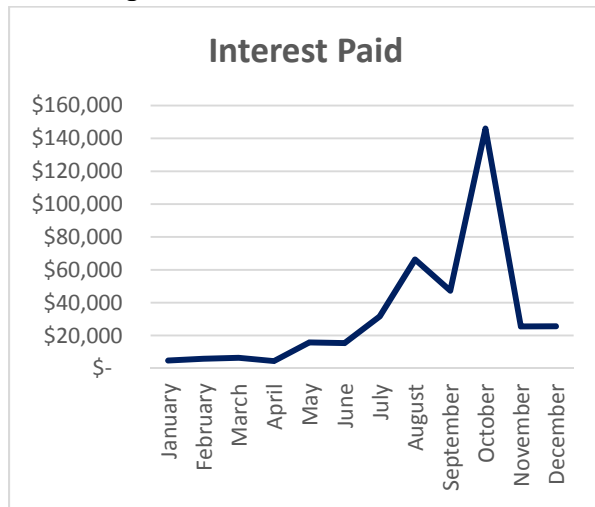


Figure 8: Received but Unpaid Claims

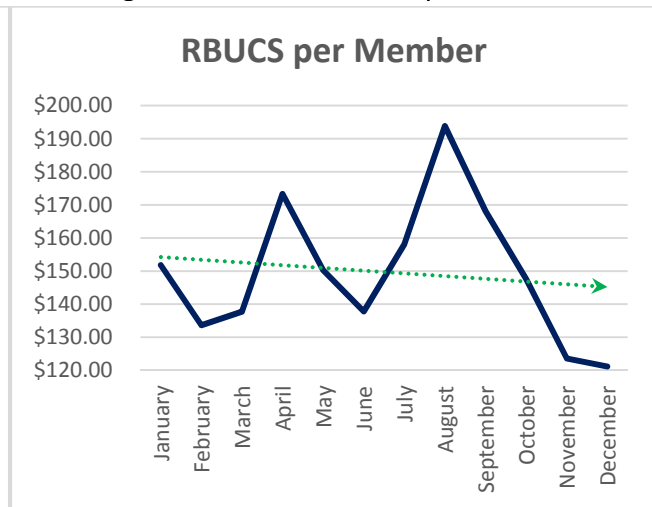


Figure 7 shows the interest paid on claims month over month for calendar year 2015. Figure 8 demonstrates received but unpaid claims liability month over month, normalized by Health Choice Arizona membership.

Critical to optimizing the provider customer service experience, is having a well-staffed claims call center with knowledgeable representatives who answer each phone call timely and handle all requests efficiently. We recognize that claims call center performance has degraded in recent months, but have identified this as a key organizational priority and are leveraging staffing, training, and process improvements that will show similar results for the claims call queue in the next 8 weeks (Refer to *Figure 9*).

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Figure 9: Claims Call Line Average Speed of Answer and Call Service Level

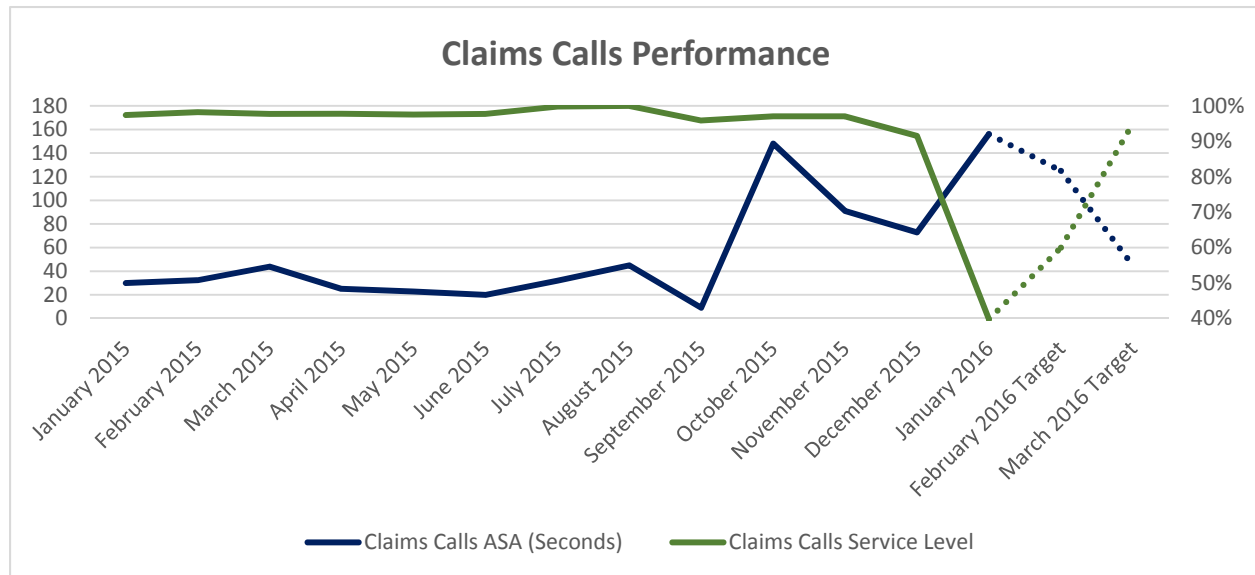


Figure 9 outlines the trend of average speed of answer and call service level for the claims customer service queue over calendar year 2015. It also includes projected performance for February and March based on predictive modeling for February and March 2016.

In addition to, and in concert with the progress we have made to date, Health Choice conducted a rigorous root cause analysis performed in response to the Provider Satisfaction Survey Results that were published. Through this effort, we identified opportunities to improve key health plan processes and systems which positively impact the performance of operations and provider satisfaction. Subsequently, remediation efforts are under way to address several key areas including paper claims scanning/OCR, provider demographic and payment maintenance, as well as clearinghouse payment transaction errors.

The following is a thorough and structured response to the specific deficiencies noted and items requested in the Letter. Additionally, more detailed task level information is included in the attached and living Action Plan (Attachment A).

1. Detailed listing of providers identified as having ongoing unresolved issues.

Health Choice has identified 31 providers having escalated issues over the past six months; these issues are in various stages of resolution (*Attachment B*). Attachment B provides details of meetings and status with each provider, including frequency of meetings, description of issues, current status and timeline for resolution if not already resolved. With providers who have claims submittal complaints, Health Choice is implementing frequent engagement points even after achieving resolution of the

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provider's expressed concerns. Health Choice is committed to providing a very high level of customer service for all provider inquiries and complaints. As such, all provider complaints will be addressed, documented and acknowledged back to the provider within 3 days of receipt, with resolution or significant progress made in relation to the complaint within 30 days.

2. Detailed description of strategies to improve provider satisfaction.

As stated above, a thorough analysis of provider complaints and the results of the AHCCCS Provider Claims Survey has been performed, and Health Choice has identified the following three overarching themes/areas which are being targeted to improve the performance of our health plan operations, in turn enhancing provider satisfaction:

- Accurate and timely processing of claims and prior authorization requests, to exceed regulatory and contractually established requirements;
- Timely review and resolution of provider issues, to collaboratively and proactively prevent issue escalation – including a well-defined process for addressing provider issues; and
- Exceptional customer service provided by all staff.

We note that the volume and nature of provider complaints received over the past six months are significantly higher than the previous six month period. Subsequently and to ensure that Health Choice's provider network operations are performed in alignment with the goals and objectives of the AHCCCS program, Health Choice has optimized organizational alignment through interdepartmental network Joint Operating Committees. This enables the work effort and priorities of the activities of the network team to be integrated and in lock step with all other critical health plan functions, ensuring that they are directly influenced by the values and priorities of the AHCCCS.

To provide better physician to physician communication and engagement, Health Choice has recently on-boarded three new associate medical directors. Two of the three physicians are still practicing, which means that they are better able to engage with their physician colleagues, and partner with providers on a peer-level basis to address any concerns and, most importantly, collaboratively manage the care for our most complex members.

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In the attached Action Plan (*Attachment A*) the specific strategies to improve each of these areas is outlined in detail.

3. Customer service training plan for Provider Representatives and all other external facing Health Choice representatives.

Health Choice is committed to promoting exceptional customer service as a core value and operational philosophy. In order to optimize the customer service experience for our AHCCCS health plan provider network, we will leverage the best practices that have helped us drive actionable results and high levels of provider satisfaction to our clinically integrated Phoenix accountable care network – Health Choice Preferred.

This excellence in customer service training program is named “Operation ALWAYS” and will include all employees, with a special concentration on Provider Network Services and Customer Service Call Center staff.

The Health Choice executive and senior leadership teams will champion the service recovery effort and reiterate focused customer service principals on a regular and ongoing basis to all Health Choice employees – especially during all company wide and departmental meetings. The overall intent is to demonstrate ways to exceed expectations for our members, providers and other stakeholders.

The key principles of Operation ALWAYS will be posted in all shared staffing spaces and distributed to all employees to post in their workspaces as a continual reminder of the importance of these service expectations and commitments:

Acknowledge all customers – members, providers, and partners – in a professional and welcoming manner

Listen to the customer and make them feel important, understood, and appreciated

Work as hard as you can to make sure the customer’s needs and questions are addressed – never say “no” or that you can’t help. Making going above and beyond the normal

Apologize sincerely for a poor experience or mistake, and reassure the customer that you will work diligently to reclaim their trust

You are a catalyst for change: document the customer experience thoroughly and share service concerns with your supervisor so that larger opportunities can be addressed

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Sincerely thank the customer for their feedback and let them know that “Health Choice is always here for you”

Additionally, Health Choice has initiated the following internal customer service focused actions to improve provider network relations and the consistency with which matters are addressed:

- Cross training of customer service call center representatives with claims processors to increase operating knowledge. New one-on-one and classroom training has been implemented;
- Monthly training meetings for customer service representatives hosted by the Claims Processing Training Manager;
- A Phone Quality Supervisor has been hired and additional phone quality analysts have been added to the customer service team which will allow for increased monitoring and evaluation of call quality and the provider experience; and
- Mandatory team meetings to further instill professionalism, education and communication will occur bi-weekly in both our Customer Service Call Center and Network Services Departments for the next 90 days. After 90 days, these will then be held monthly.

Externally facing, Health Choice has taken the following steps to further enhance the provider experience:

- Increased Communication Methods – Added new department specific email addresses, faxes and, voicemail options upon initial phone intake;
- Claims Phone Queue – Expanded the claims phone queue hours of operation by an additional hour to better align with standard physician clinic operating hours;
- Call Accounting and Code Reporting – Created new weekly call reports to identify providers high call volumes – these reports are driving targeted outreach to understand how to better improve service for these specific providers; and
- Inquiry Trend Reporting – Evaluation of coded call reasons to identify trends, implement changes, and present a report summary to executive and senior leadership weekly.

In addition, to foster a greater sense of service recovery and accountability, Health Choice institute the following training and monitoring program activities for Provider Service Representatives over the next six to twelve months.

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Training

- Knowledge – Promoting the contents of the Network "Provider Representative Training Manual" with all pertinent "how-to's", forms, and internal department information;
- Mentoring – Partnering new network provider representatives with seasoned team members to review site visit information and prepare for Joint Operating Committee (JOC) meetings with key providers and facilities.
- Coaching – All new network provider representatives will complete several mock provider site visits with the senior leadership of the Network Services Department, as well as join experienced network provider representatives on side-by-side visits.
- Group training – Global training sessions for the entire Network Team hosted by various department leaders to share information to empower our the Provider Representatives in the community.

Monitoring

- 3/30 Report – More thorough use of this report, improving transparency around tracking and monitoring of provider calls and issues from initial notification to resolution.
- Call Performance Monitoring – Live monitoring and immediate feedback for provider customer service representatives.
- Performance against Goals – Monitor progress made against established, individual specific goals on an ongoing basis.
- Surveys – Targeted monthly surveys to assess provider satisfaction with Health Choice customer service for prior authorization, claims and provider services. In addition, we will also conduct a survey that mimics the AHCCCS provider satisfaction survey in the next 6 months.

4. Description of Strategies to Improve Provider Telephone Performance Measures

Customer Service Call Center performance degraded in the fall of 2015 when Health Choice experienced both technical challenges with our call system and call center attrition due to enhanced competition from many competing local, regional, and national customer service call centers who have just recently relocated or expanded their operations in the Phoenix metropolitan area. Health Choice has worked with our call system vendor, Avaya, to successfully remedy the problems that we were experiencing throughout the late Summer and early Fall. Additionally, to remain competitive in the

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market from an employment standpoint, Health Choice conducted a comprehensive salary evaluation, which resulted in an hourly rate increase of more than 11.5% for entry level positions as well as a significant market wage adjustment for the existing call center staff. This market adjustment has had an immediate effect, drastically reducing attrition for all call center staff.

In addition to needing to backfill many vacant positions due to the attrition experienced in 2015, an analysis of all staffing ratios for the member services call center positions was performed. As an initial step to this effort, a thorough review of historical metrics was completed. In doing so, the tools and available data for call volume forecasting and measuring performance metrics were reviewed – including handle times, wait times, work time between calls, hold times while on calls, abandonment rates, and balance loads of call queues. These reviews were used to revise staffing ratios, which will result in an increase of phone representatives by 40%. Target ratios are seen below in *Table 1*.

Table 1: Staffing Ratios Identified

Line of Business	Target Staffing Ratio	Membership	Staff Needed to Support Membership
HCA Total		245,784	76
Member Services **	1 : 5,000	245,784	50
Claims	1 : 21,000	245,784	12
Prior Auth	1 : 18,500	245,784	14

Table 1 shows the staffing ratios to be used to remediate service levels.

To date, we have progressed meaningfully in terms of adding the additional staff with four call center representative cohorts having been hired. Subsequently training classes having been running congruently since January 4, 2016. These cohorts will all complete training and be on the phones by March 1, 2016 as shown in *Table 2* below.

Table 2: Customer Service Call Center Training and Onboarding Schedule

	Week Beginning	1/4	1/11	1/18	1/25	2/1	2/8	2/15	2/22	2/29	3/7	3/14	3/21	3/28
HCA Member Services	Target = 50													
<i>Existing Cohort (as of 1/28/2016)</i>	13	13	13	13	13	13	13	13	13	13	13	13	13	13
<i>Cohort A 1/4/16 Start</i>	9	Training		9	9	9	9	9	9	9	9	9	9	9
<i>Cohort B 1/25/16 Start</i>	22				Training		22	22	22	22	22	22	22	22
<i>Cohort C 2/8/16 Start</i>	6						Training		6	6	6	6	6	6
<i>Cohort D 2/15/16 Start</i>	3							Training		3	3	3	3	3
HCA Full Time Totals at Beginning of Week	50	13	13	22	22	22	44	44	50	53	53	53	53	53

Table 2 shows training cohorts' progress through the Customer Service Call Center onboarding and training schedule. Target date for onboarding completion is March 1st.

The expectation is that with the fulfillment of the revised staffing ratios, revision to the customer service training, and education and monitoring, a full return to compliant

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metrics is expected by the beginning of March, with demonstration thereof on the April 15th Telephonic Performance Report due to AHCCCS.

Health Choice is committed to having sufficient Customer Service capacity to help every provider, no matter how large or small, to have their issues resolved in a timely and satisfactory manner.

5. Process Utilized By Providers to Obtain Service and Resolution of Complaints

Health Choice has thoroughly reviewed all points of intake for provider inquiries and will thoroughly document everyone in the Care Radius system, leveraging the 3/30 report to track and trend. Additionally every touch point identified is being vetted to maximize customer service and efficiency. Individuals directly involved in any type of service delivery to providers will receive targeted training on service recovery and overall customer service. *Attachment C* details the work flow of Health Choice's process for provider service/complaint resolution.

6. Provider Service Model/Structure

Health Choice's Provider Service Model has undergone significant revision to date. Its current model is a philosophical shift away from the individual provider management model to a team-based model. The Network Department is still working to build out its infrastructure to accommodate this new model by defining the difference in internal versus external provider representatives. Each team will be led by a Pod Administrator who is responsible for overall management of the provider relationship, facilitating JOCs, and resolution of escalated issues. The Administrator will be supported by Internal and External Provider Representatives. External Provider Representatives will delegate much of their administrative duties to Internal Provider Reps to expand their time in the field, directly working with providers and their offices. Internal Provider Representatives will focus on collaboration and expedited resolution of provider inquiries and complaints in relation to administrative services. All representatives will work in concert to provide expeditious resolution to all inquiries. Additionally this team or "Pod" style model will consolidate provider management and allow for Pod Leaders to have direct supervision and leadership over the assigned representatives to a given GSA or service area. Ancillary and dental providers have also been broken out of the provider pool and assigned

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specialized representatives, allowing for targeted knowledge and attention to provide a higher level of customer service across these important benefits.

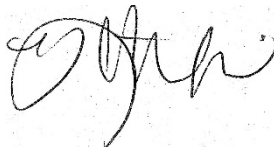
Lastly, Health Choice has continued to embrace the implementation of value-based payments and has created a separate team within its Network Department to manage those providers whose contracts fall under value based reimbursement models. Within the Value Based Payment Team comes a new era of Provider Representatives. These individuals are not only responsible for the traditional roles of the provider representatives, but also have the analytical skills to bring real-time quality and financial performance data to providers, having the capabilities to innovate around the traditional health plan to provider partnership. Ultimately this will not only provide higher levels of customer service to our provider network, but more importantly given our providers the information, perspective and tools to help them better deliver higher, more efficient care to their attributed membership. *Attachment D* details the newly developed structure of the Health Choice Network Department.

Health Choice is committed to providing the best possible customer service to our providers and members while adding significant value to the AHCCCS program. We understand that our providers are key to providing our members the highest level of care. We must partner with our providers to continue to raise the level of service and care provided to our members. Our leadership is devoted to partnering with physicians and aligning the delivery of health care services with the goals and objectives of the AHCCCS program. We understand that the submission of the enclosed action plan in and of itself will not constitute the full remediation of the identified issues. We will continue to share our progress with AHCCCS on this endeavor and appreciate the opportunity to demonstrate our agility, perseverance, and dedication throughout this process.

Sincerely,

A handwritten signature in black ink, appearing to read "Mike Uchirin".

Mike Uchirin
Chief Executive Officer

A handwritten signature in black ink, appearing to read "Katrina Cope".

Katrina Cope
V.P. Operations

A handwritten signature in black ink, appearing to read "Matthew Kingry".

Matthew Kingry
Compliance Officer

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Attachment A: Health Choice Action Plan

Description of Action Item	Owner	Due Date	Status	Comments
1. Structure and Staffing				
a. Establishing a Point Person listing and workflow for triaging escalated provider issues.	Pat Hansen/ Jimmy Blinn	11/1/15	Complete	<ul style="list-style-type: none"> Complete
b. Additional Staff – Network Department	Pat Hansen	4/1/16	In Process	<ul style="list-style-type: none"> Goal for hiring all additional Network Staff is 4/1/16
i. Sr. Director of Network Operations	Pat Hansen	4/1/16	In Process	<ul style="list-style-type: none"> Actively recruiting
ii. Sr. Director of Contracting	Pat Hansen	4/1/16	In Process	<ul style="list-style-type: none"> Actively recruiting
iii. Managers	Pat Hansen	12/1/15	Complete	<ul style="list-style-type: none"> Hired and On-boarded
iv. Dental Provider Representative	Pat Hansen	11/15/15	Complete	<ul style="list-style-type: none"> Complete; internal hire
v. Provider Representatives	Pat Hansen	3/1/16	In Process	<ul style="list-style-type: none"> 16 of 22 Provider Representative Positions filled. 6 open
vi. Provider Demographic Maintenance Coordinators	Pat Hansen	12/15/15	Complete	<ul style="list-style-type: none"> Update February 2: 4 new PDM coordinators have been hired and are currently being trained; expectation of operating at full capacity by 2/5/16.
c. Additional Staff – Claims Department	Tida Garcia	4/15/16	In Process	<ul style="list-style-type: none"> Goal for all additional Claims Staff to be hired and trained; functioning at full capacity - 4/15.
i. New Day	Tida Garcia	2/15/16	In Process	<ul style="list-style-type: none"> Update February 2: 37 Staff existing at full capacity, 4 staff in training, 2 with offers but not yet started.
ii. Adjustments	Tida Garcia	2/19/16	In Process	<ul style="list-style-type: none"> Update February 2: 17 Staff existing at full capacity, 6 staff in training, 1 position open.
iii. Encounters	Tida Garcia	4/1/16	In Process	<ul style="list-style-type: none"> Update February 2: 9 Staff existing at full capacity, 2 staff in training, 13 positions open.
iv. Misc. Clerk for Claims Resolution Documentation	Tida Garcia	2/1/16	Complete	<ul style="list-style-type: none"> Position filled
d. Additional Staff – Customer Call Center	Suzan Irmer	2/15/16	In Process	<ul style="list-style-type: none"> Staffing ratios have been re-examined and additional staffing needs have been identified.
i. Member Service Representatives	Suzan Irmer	3/1/16	In Process	<ul style="list-style-type: none"> As of 2/4: 12 Staff existing at full capacity, 15 staff in training, 19 with offers but not yet started, 4 offers made but not yet accepted, 0 position open.
ii. Claims Customer Service	Suzan Irmer	2/15/16	In Process	<ul style="list-style-type: none"> 14 total: 10 staff existing at full capacity, 2 offers made but not yet accepted, 2 positions open.
iii. Prior Authorization Representatives	Suzan Irmer	2/15/16	Complete	<ul style="list-style-type: none"> 14 Staff existing at full capacity, 0 position open.
e. Additional Staff - IS	Mark Ryczek	3/1/16	In Process	<ul style="list-style-type: none"> Expectation is to fulfill outstanding IS Staffing needs by 3/1/16

Attachment A: Health Choice Action Plan

Description of Action Item	Owner	Due Date	Status	Comments
i. EDI Staff	Mark Ryczek	3/1/16	In Process	<ul style="list-style-type: none"> 8 Capacity, 3 needs, 2 positions have been filled, 1 is being actively recruited for.
f. Additional Staff – Prior Authorization				
i. PA technicians	Susie Rodriguez	1/04/16	Completed	<ul style="list-style-type: none"> 30 Staff existing, 0 positions open
ii. PA Nurses	Susie Rodriguez	1/04/16	Completed	<ul style="list-style-type: none"> 16 Staff existing, 0 positions open
iii. NOA technicians	Susie Rodriguez	1/04/16	Completed	<ul style="list-style-type: none"> 6 Staff existing, 0 positions open
iv. PA Trainer	Susie Rodriguez	1/04/16	Completed	<ul style="list-style-type: none"> 1 Staff existing, 0 positions open
v. Quality Auditor	Susie Rodriguez	1/04/16	Completed	<ul style="list-style-type: none"> 2 Staff existing, 0 positions open
2. Education/Training				
a. Conduct Service Recovery training on the ALWAYS campaign across all departments	Laura Waugh All Departments	3/1/16 4/1/16	In Process	<ul style="list-style-type: none"> Development of initial training PPT template underway with customization for each department Each Dept to document customization of the training and evidence of training provided
b. Conduct twice monthly “lunch and learn” meeting series for Provider Services team to inform them of internal operations, programs and processes, including but not limited to claims adjudication and adjustments, claims interface, encounters, prior authorization, claims interface, web portal etc.	Pat Hansen	12/11/15	Completed	<ul style="list-style-type: none"> Initial and ongoing thereafter
c. Target training for Claims Customer Service representatives to meet the one call resolution expectation	Tida Garcia Suzan Irmer	2/1/16	Completed	<ul style="list-style-type: none"> Initial completed and ongoing thereafter
d. Provider Site Visits <ul style="list-style-type: none"> i. Initial side by side training with a season representative ii. Mock audit to monitor/confirm required items are covered 	Pat Hansen	3/1/16	Completed	<ul style="list-style-type: none"> Initial completed and ongoing thereafter
e. Provider Rep Documentation of provider inquiries and concerns	Jimmy Blinn	11/15/15	Completed	<ul style="list-style-type: none"> Monthly, Managers to monitor documentation captured by each rep in connection with the 3/30 reporting.
f. Increase % of Care Affiliate Users/Plans (Online Prior Authorization Portal)	Pat Hansen	7/1/16 3/1/16	In Process	<ul style="list-style-type: none"> Goal to register 40% of Provider Network by 7/1/16 Create instruction flyer for reps to use in training sessions Add Portal communication to PA hold message Add to bottom of fax status form PA staff training and walk through

Attachment A: Health Choice Action Plan

Description of Action Item	Owner	Due Date	Status	Comments
i. Creating "Open to the public" Webinars for CareAffiliate	Pat Hansen	5/1/16	In Process	<ul style="list-style-type: none"> Coordinate with internal stakeholders to schedule, stage and hold webinars.
g. Network Rep access and training on Credentialing Database	Katrina Cope	2/15/16 3/15/16	In Process	<ul style="list-style-type: none"> Confirm whom from Network needs training. Schedule, provide and document training.
h. Review the Provider On-boarding process	Pat Hansen	1/1/16	Complete	<ul style="list-style-type: none"> Provider Packet has been updated with Contract year relevant education.
i. Provide FileBound Training/Education for Provider Reps (scanned contracts/claims)	Pat Hansen	4/1/16	In Process	<ul style="list-style-type: none"> Supplemental training.
j. Targeted monthly surveys to assess provider satisfaction with Health Choice customer service for prior authorization, claims and provider services. <ul style="list-style-type: none"> i. Conduct a survey that mimics the AHCCCS provider satisfaction survey 	Pat Hansen Mat Brown	3/11/16 6/1/16	In Process	<ul style="list-style-type: none"> Use existing DataStat vendor in coordination with QM Targeted based on deficiencies
3. Technology				
a. Provider Portal				
i. Assignment of a technical person to review and resolve any identified issues	Mark Ryczek	3/31/16 TBD	In Process	<ul style="list-style-type: none"> Conduct assessment of any necessary changes. Remediation to follow based on priority and complexity of changes.
ii. Explore the implementation of a live chat	Mark Ryczek	3/31/16 TBD	In Process	<ul style="list-style-type: none"> Conduct assessment of this interface. Remediation to follow based on priority and complexity of mapping to add live chat.
b. IVR Option – Claims Status	Mark Ryczek /Suzan Irmer	TBD	In Process	<ul style="list-style-type: none"> Conduct assessment of this feature with remediation to follow based on priority and complexity of mapping to add live chat.
c. Electronic EOB Systematically sent by Emdeon	Mark Ryczek	3/31/16	In Process	<ul style="list-style-type: none"> Currently in Discovery Phase
d. Add Pend Reason to Portal + Additional EOB Details	Mark Ryczek	3/1/16	In Process	<ul style="list-style-type: none"> Currently in process.
e. Automate a post call survey after each customer service call	Suzan Irmer	TBD	In Process	<ul style="list-style-type: none"> Currently in Discovery Phase
4. Communications				
a. Calendar of JOCs/Provider Meeting + Agenda	Jimmy Blinn/Dania Wales	12/20/15	Complete	<ul style="list-style-type: none"> Calendar created and disseminated to all leadership for JOC's to be held each month.
i. List of Providers for Targeted JOCs	Pat Hansen	12/15/15	Complete	<ul style="list-style-type: none"> List created, reviewed and distributed.

Attachment A: Health Choice Action Plan

Description of Action Item	Owner	Due Date	Status	Comments
b. Provider Newsletter	Laura Waugh	Ongoing	Complete	<ul style="list-style-type: none"> Executed on 1/25/16. Next expected Newsletter 4/1/16. Share newsletter during provider meetings.
i. Department Specific Updates	Claims, IS, MS, Network, Medical	Ongoing	In Process	<ul style="list-style-type: none"> Compiling topics for next Newsletter
5. Meetings				
a. JOC's with Key Stakeholders	Network, Claims	Ongoing	Complete	<ul style="list-style-type: none"> Mandatory JOC's with FQHC's, hospitals, high volume providers and ancillary providers. Hold internal prep meetings prior to JOCs Begin Monthly and reduce to quarterly as need dictates Include Customer Svc Supervisors in future JOCs
b. PriCOMM (Provider Complaint Committee)	Pat Hansen/Matthew Kingry	Bi-Weekly	Complete	<ul style="list-style-type: none"> Network Provider Term report To be Co-Chaired by HCA Compliance – Matthew Kingry and Network designee
i. Investigate trends and reporting related to provider inquiries	Suzan Irmer	Bi-Weekly	Complete	<ul style="list-style-type: none"> Report to PRIComm
ii. Compliance reporting on disputes, grievances and appeals	Clarissa Angel	Bi-Weekly	Complete	<ul style="list-style-type: none"> Report to PRIComm
iii. Quality report on member complaints and grievances	Monika White	Bi-Weekly	Complete	<ul style="list-style-type: none"> Report to PRIComm
iv. Claims/Adjustment report – including inquiry reason, claims denials and interface rejections	Tida Garcia	Bi-Weekly	Complete	<ul style="list-style-type: none"> Report to PRIComm
v. Medical PA report denial and no auth trends	Diane Doran	Bi-Weekly	Complete	<ul style="list-style-type: none"> Report to PRIComm
vi. Reporting on Provider Complaints escalated to the Regulator	Matthew Kingry	Bi-Weekly	Complete	<ul style="list-style-type: none"> Report to PRIComm
6. Miscellaneous				
a. Posting the claim adjustment form to the provider portal	Katrina Cope	2/5/16	Complete	<ul style="list-style-type: none">
b. Re-structuring of the 3/30 Report	Pat Hansen	3/1/16	In Process	<ul style="list-style-type: none"> Report is currently being vetted by SME's for any additions that need to be made, expected completion date 2/9/16. Provider Rep training anticipated 2/15 – 2/22 with go live, 3/1.
c. Streamline Provider Demographic Maintenance (PDM) application workflow	Pat Hansen	5/30/16	In Process	<ul style="list-style-type: none"> Opportunity identified for efficiency

Attachment A: Health Choice Action Plan

Description of Action Item	Owner	Due Date	Status	Comments
i. Implement Provider Demographic Maintenance Dashboard and refine as needed thereafter	Pat Hansen	5/30/16	In Process	<ul style="list-style-type: none"> Dashboard metrics identified Business requirements for report programming logic under development.
d. Fee Schedule Loads				
i. 2016 Medicare Fee Schedule loaded	Mark Ryczek	12/16/15	Complete	<ul style="list-style-type: none"> Complete
ii. Medicare FQHC Loads	Katrina Cope	4/1/16	In Process	<ul style="list-style-type: none"> Manual workaround in place to receive and pay these claims. However, HCA is working with AzAHP on process which is mutually beneficial for plans and FQHCs
iii. Medicaid Custom Fee Schedules loaded for 10/1	Jimmy Blinn	12/18/15	Complete	<ul style="list-style-type: none"> Complete
e. "Operation Clean Record" – Comprehensive review of contracts against set up in claim system (Med/MC)	Pat Hansen	3/31/16	In Process	<ul style="list-style-type: none"> Working with Lexus Nexus to establish SOW. Expectation of contract execution by 3/31. Time frame in process of being 'scoped'.
f. Targeted review of and update to provider directory source data	Pat Hansen	3/31/16	In Process	<ul style="list-style-type: none"> Working with Lexus Nexus to establish SOW. Expectation of contract execution by 3/31. Time frame in process of being 'scoped'.
g. Instream (claims scanning) oversight	Tida Garcia	12/18/15	Complete	<ul style="list-style-type: none"> Established regular weekly JOCs with Instream
h. Separate claims and customer service team for "Pod" level service	Tida Garcia/ Suzan Irmer/ Pat Hansen	1/15/16	Complete	<ul style="list-style-type: none"> POD service has been implemented, coordinated with JOC calendar.
i. Establish "Pod" leadership over Kingman and Banner	Tida Garcia/ Suzan Irmer/ Pat Hansen	2/29/16	Complete	<ul style="list-style-type: none"> POD service has been implemented, coordinated with JOC calendar.
i. Running and working of the Rejected Claims Report	Katrina Cope	3/1/16	In Process	<ul style="list-style-type: none"> Currently underway, looking for opportunities to improve output to be more 'actionable'.
j. Remediating any PA Faxes Being Rejected	Troy Garland	4/1/16	In Process	<ul style="list-style-type: none"> Investigating CareRadius coding and fax list.
k. Review of the LOA Process	Pat Hansen	2/5/16	Complete	<ul style="list-style-type: none"> Process has been reviewed.
l. Establishing a Call Code Alert Report to identify high volume callers (Member + Provider).	Suzan Irmer	2/15/16	In Process	<ul style="list-style-type: none"> Version 1 created. Currently developing version 2.0. Expectation is a weekly report shared with Executive Leadership.
m. Examine and identify any inefficiencies in the COB process	Matthew Kingry/ Kelly McShall	3/1/16	In Process	<ul style="list-style-type: none"> Currently analyzing existing process for opportunities.

Attachment B
Listing of Providers with Escalated Issues

Provider	Description of Issues	Current Status	Status	Mtg Schedule
1. Arizona Center for Cancer Care	Denied claims in error due to G code fee schedule issue	Fee schedule in system was updated and all claims have been reprocessed correctly	Completed – 11/4/2015	February / July Semi-annual site visits
2. Mountain Park Health Center	Provider opened new location, did not notify Health Choice of the changes, causing claim denials	Address, NPI and TIN updates were inputted into the system and claims were reprocessed, no outstanding claims issues.	Completed – 11/01/2015	January, April, July, October Quarterly JOC
3. Old Pueblo Anesthesia	Claims denied due to billed codes not approved for the POS on the AHCCCS Prov File	Provider updated their file with AHCCCS to have procedure codes added for their POS	Completed – 11/17/2015	June - Annual site visit
4. Dignity Health Care – St. Joseph’s Medical Center	Delays in processing HIP/HOP admit notification	Health Choice implemented a dedicated fax line for hospital admit referrals/notification, no outstanding issues	Completed – 10/27/2015	JOC’s Second Thursday of each month
5. St. George Surgical Center	Claims denied due provider not being a registered provider under AHCCCS	Assisted the provider with their AHCCCS registration and Health Choice updated its system with current provider demographics and all claims were reprocessed, no outstanding issues	Completed – 10/21/2015	July – Annual site visit

Green shading under “Status” Column = completed. **Yellow shading** = In Process

Items 1-22:

AHCCCS (i) received these provider complaints, which cover the period from JUN 2015 through the end of JAN 2016 and (ii) referred them to Health Choice for review and disposition.

Items 23-31:

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Provider	Description of Issues	Current Status	Status	Mtg Schedule
6. The CORE Institute	Claims denied due to providers that were not registered and/or were terminated with AHCCCS	Health Choice is currently assisting provider with AHCCCS registration for all providers under this TIN and are reprocessing claims, most issues have been resolved	In Process – Expected 3/15/2016 completion date	April / September Semi-annual site visit
7. Therapy Group of Tucson	Claims denied due to processing error	Provider submitted denied claims report which was used to reprocess the claims, no outstanding issues (claims processors were identified and re-educated)	Completed – 10/20/2015	May - Annual site visit
8. White Mountain Sleep Lab	Health Choice declined providers request to contract with health plan due an initial determination of 'lack of need'	Health Choice reevaluated and assessed network need and proceeded with an executed contract effective 11/1/2015	Completed – 11/1/2015	October – Annual site visit
9. My Doc Now	Claim denials and disputes due to untimely notification of PCP assignment changes	On 1/29/2016 Health Choice responded to AHCCCS regarding resolution of this matter. All outstanding claims were re-adjudicated and the provider was educated regarding PCP change request, COB, and claims denials. No outstanding issues.	Completed – 2/6/2016	Second Tuesday of January, April, July, October, Quarterly site visits

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10. Arizona Associated Surgeons	Claims denied due to billed codes not approved for the POS on the AHCCCS Prov File	Provider in process of updating their file with AHCCCS to have procedure codes added for their POS	In Process – Expected completion date of 3/15/2016	May / November Semi-annual site visits
11. Arizona Dermatology	Untimely turn-around times for prior authorization requests	Health Choice reviewed and modified the prior authorization process and staffing; communicated improvements to provider, no outstanding issues	Completed – 9/22/2015	March / September Semi-annual site visit
12. Dr. Valpiani	Changes to prior authorization requirements and untimely turn-around times for prior authorization requests	Initial training and education on the PA guidelines provided. Health Choice will continue train the practice about the PA requirements and process.	Completed - 1/15/2016	Weekly JOC every Friday Portal training in progress JAN, APR, JUL, OCT – Quarterly site visits
		In addition we are working with the practice manager on educating and training the office staff in the use of the provider portal to submit and track PA requests more efficiently	In Process – Estimated completion date of portal project 3/15/2016	

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Listing of Providers with Escalated Issues

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13. People Empowering People	Provider did not understand contracted reimbursement for Mid-Levels after the 10/1/15 GMH/SA transition	Health Choice provided education on the 10/1 GMH/SA transition and contracted reimbursement to Mid-levels, no outstanding issues	Completed – 10/8/2015	Third Wednesday - Monthly JOCs
14. Dr. Thuy Ngo	Provider was denied authorization and payment for dentures after they were given a verbal approval via phone	Health Choice honored the verbal commitment approved the course of treatment and processed the claim, no outstanding issues	Completed – 10/15/2015	September – Annual site visit
15. Marana Health Center	Claims were denied due to providers not being loaded in the system	Health Choice obtained a current roster with demographic data and system was updated and claims have been paid, no outstanding issues	Completed – 11/16/2015	Forth Tuesday - Monthly JOCs
16. Dr. Spiess – Casa Grande Pediatrics	Provider asked for higher reimbursement and Health Choice could not agree to higher rates	Health Choice and Dr. Spiess were not able to come to terms on rates, subsequently the provider terminated his contract	Completed – 6/11/15	N/A
17. Around The Mountain	Contract dispute – requesting higher rates	Health Choice and provider were able to agree on rate terms and rescinded the contract termination in September of 2015	Completed – 9/31/2015	July – Annual site visit

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Attachment B
Listing of Providers with Escalated Issues

Provider	Description of Issues	Current Status	Status	Mtg Schedule
18. Greater Anesthesia Solutions	Claims denied/rejected due to providers showing termed in PMMIS	Health Choice determined that several providers were being termed with AHCCCS due to billing inactivity. Health Choice assisted provider with re-registering the appropriate terminated providers and reprocessed claims. No outstanding issues	Completed – 7/15/2015	Provider outreach needed for non-contracted
19. Dr. Kara Tiffany	Claims denied due to billing issue - office injections in conjunction with rendering and referring provider were incorrect on submitted claims	The Health Choice Claims Provider Educator met with and assisted Dr. Tiffany with her billing issues and worked through her billing system limitations to resolve the rendering and referring provider issues to submit correct claims. No outstanding issues	Completed – 8/15/2015	April / September - Semi-annual site visit
20. Cardiovascular Consultants	Prior authorization denials	Health Choice re-educated provider on the MSI network and prior authorization process. No outstanding issues.	Completed – 8/13/2015	February / August - Semi-annual site visit
21. Kool Smiles	Credentialing turn-around times	Health Choice received a spreadsheet of providers and escalated them in the credentialing process. No outstanding issues	Completed - 8/15/2015	August – Annual site visit
22. Enticare	Claims denied in error	Health Choice reprocessed claims. No outstanding issues	Completed – 8/25/2015	June - Annually site visit

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Provider	Description of Issues	Current Status	Status	Mtg Schedule
23. Barnet and Delaney	Claims denied due to ASC location not being contracted nor loaded	Health Choice is in the process of credentialing the ASC and amending the current contract to add the ASC location. System will be updated when credentialing and contract is completed	In Process – with target date of 3/31/2016	Will notify the practice when process is complete
24. Maricopa Integrated Health System	Errors in clearing house and electronic claims submission	Assisted provider with remediating clearing house to clearing house issues, which have now been resolved; in this process we also discovered inconsistencies with provider rosters and subsequently are updating all provider demographic information for MIHS.	In Process – Initial electronic filling issue resolved. Full remediation with roster update by 4/1/2016	Third Friday – Monthly JOC's
25. Tucson Medical Center	Timeliness of claims payment	Health Choice worked with provider to identify all outstanding claims; reprocessed claims and they are in the queue to drop to check/EFT	Completed – 2/2/2016	Forth Thursday - Monthly JOC's
26. Obstetrix/Pediatrics	Claims paid inappropriately for Mid-Level reimbursement	Health Choice identified a fee schedule error and has updated the system. Claims are currently being reprocessed	In Process – 3/15/2016	Second Wednesday – Monthly JOC's

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Listing of Providers with Escalated Issues

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27. Goodman & Partridge (Mom Doc)	Claims processor error impacting OB pkgs and postpartum visits	Provider submitted denied claims report which was used to reprocess and adjust the claims payment (claims processors were identified and re-educated). No outstanding issues	Completed – 1/15/2016	January, April, July, October – Quarterly site visits
28. Nationwide Vision	Claims denied and/or rejected due to provider not notifying Health Choice of new locations	Health Choice reached out to provider for a complete list of locations. We are currently in the process of adding and loading all locations	In Process – 3/30/2016	May / November Semi-Annual JOC's
29. Dr. Chad Hartley	Prior authorization requirements for a multi-specialty clinic not known by provider - subsequent claims issues due to not requesting PA.	Health Choice reached out to the provider and has educated them on the PA requirements for a multi -specialty clinic. Additionally the Claims have been reprocessed. No outstanding issues	Completed – 1/26/2016	February / September Semi-annual site visit
30. Dr. Dana Balderama	Claims denied due to invalid provider specialty type for practice loaded in the Health Choice system	Health Choice in process of updating our system so PA requests and claims will process correctly	In Process – to be completed by 3/15/2016	April / October Semi-annual site visits

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31. Dr. Andre Alvarado	Provider was dissatisfied with the turnaround time for prior authorization requests	Health Choice reached out to provider and identified that provider was submitting PA requests to multiple fax numbers. Provider has been educated and given current fax and portal information for submitting prior authorization requests. Monitoring PA Department to ensure we are turning around the requests within the 14 day time period. No outstanding issues.	Completed 2/1/2016	April / October Semi- annual site visits

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Items 1-22:

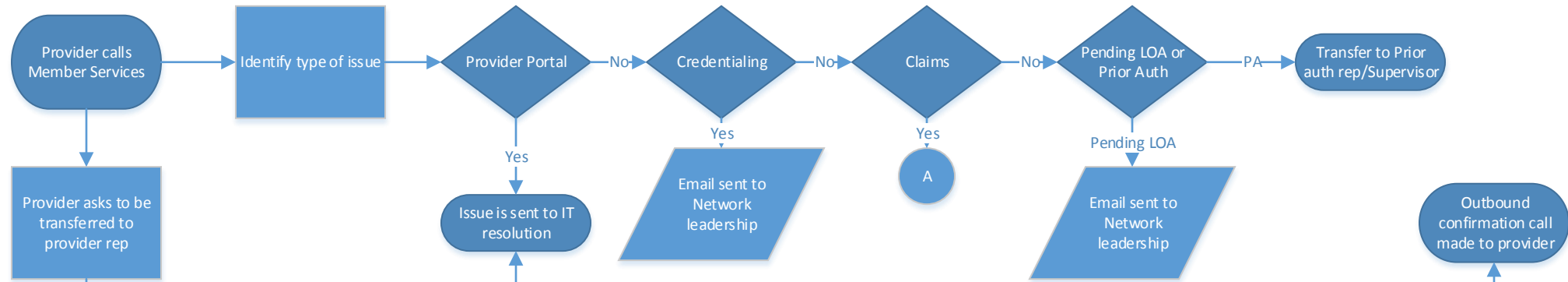
AHCCCS (i) received these provider complaints, which cover the period from JUN 2015 through the end of JAN 2016 and (ii) referred them to Health Choice for review and disposition.

Items 23-31:

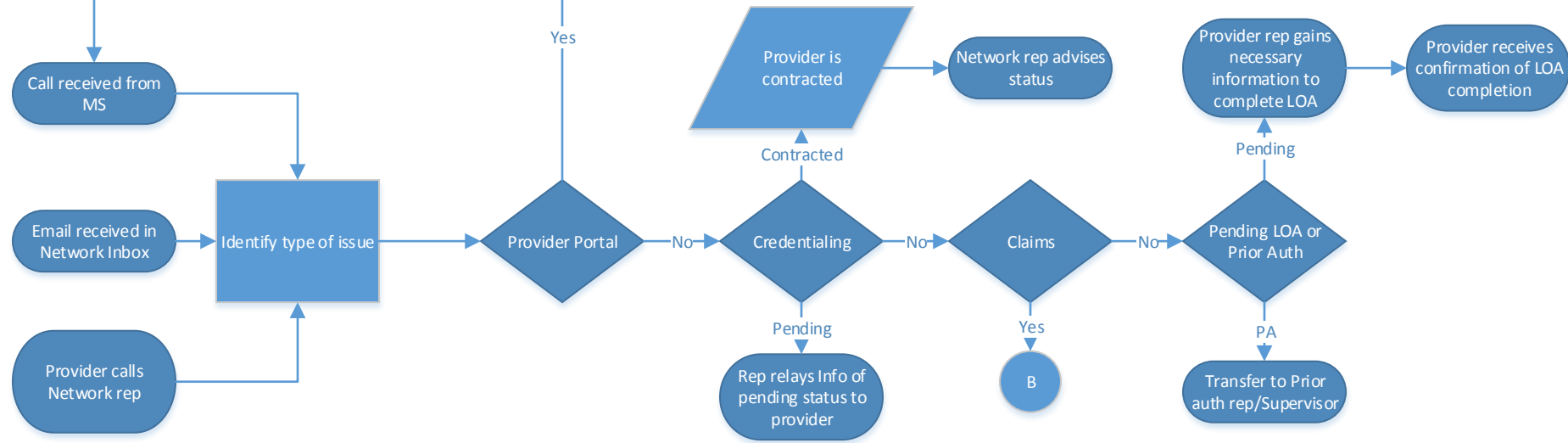
Health Choice received these escalated issues directly from providers, which were resolved or set to be resolved based on projected closure date.

Provider Issue Resolution Flow

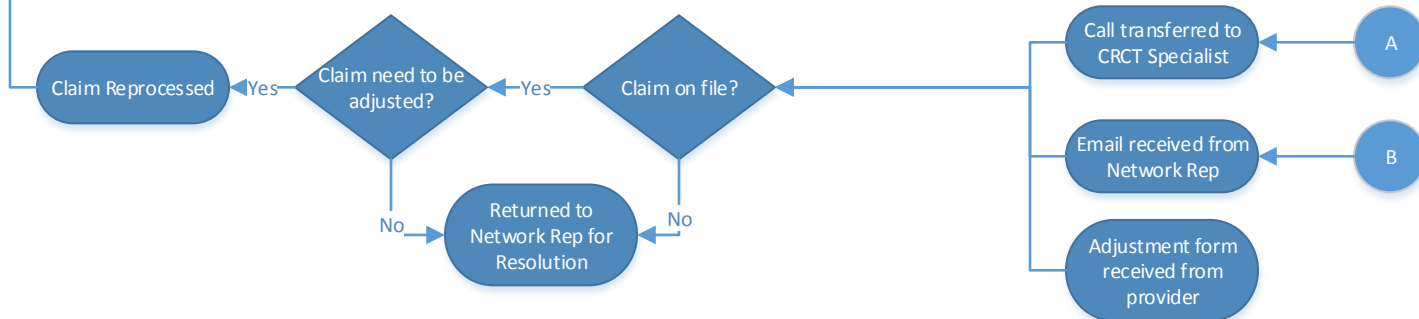
Customer Service Call Center



Network / Credentialing



Claims Adjustment Team



Compliance



