OCTOBER 30 RESPONSE ON TRANSITION PLAN

HNA must provide a final anticipated acquisition date. AHCCCS acknowledges this date is contingent on regulatory approval and activities in other jurisdictions impacted by the acquisition. This date should be provided when these contingencies are resolved.

- *The anticipated acquisition date is subject to approvals by relevant state insurance and health care regulators, and satisfaction of other customary closing conditions. Under the terms of the merger agreement, the closing will most likely occur between three and sixteen business days after receipt of the final required approvals. This time frame allows for the placement of debt prior to closing. Therefore, as an example, if the final approvals and closing conditions are achieved on December 31, 2015 then the transaction would likely close between January 4 and 26, 2016.*

1. Clearly indicate if a new Tax ID will be needed for HNA. The handling of the Tax ID is critical to AHCCCS operations and planning for any Contractor change of ownership. The September 25, 2015 cover letter stated that the Transition Plan addresses how a new Tax ID will be handled, however the Tax ID is not addressed in the Transition Plan.
   - *A new Tax ID will not be needed for Health Net Access. The current Tax ID will continue to be used after closing.*

2. AHCCCS is concerned about the overall leadership structure for both HNA and Bridgeway Health Solutions (Bridgeway) both during the transition and ongoing post acquisition.

   a. The Transition Plan outlines the structure with Paul Barnes, Chief Executive Officer, dividing his time with 45% being devoted to Bridgeway and 55% to HNA. Nancy Maurer, VP of Operations, and Sue Benedetti, VP of Medical Management, will similarly split their time 80% and 20% to Bridgeway and HNA respectively, for an indefinite period of time. The new organizational structure will also significantly increase the number of staff reporting directly to Mr. Barnes. AHCCCS is concerned that this structure will dilute the effectiveness of these three key leaders for both AHCCCS Contractors throughout the transition and on an ongoing basis. Please address the current, as well as, any additional managerial supports that Centene will offer to these individuals both during the transition and ongoing to ensure Bridgeway's operational effectiveness is not impacted and HNA has the leadership structure required to operate a compliant health plan. Please provide an organizational chart for Bridgeway highlighting any staff that will be involved in the transition as well as any additional positions anticipated as a result of the acquisition.
      - *The organization charts and descriptions submitted in the Transition Plan for both Bridgeway and Health Net Access will be effective as of the transaction closing. However, the first three months after closing will be spent in analysis of people, processes and structure to drive decisions for*

the long term. In terms of people, there will be an assessment of all management staff to determine their optimal roles in the long term organization. Processes will be compared between the acute care and long term organizations to identify opportunities for best practice and common focus across the Arizona Centene acute care and long term care programs. All of this will then facilitate decisions about the long term organizational design for Health Net Access and Bridgeway as well as common functions across both organizations.

Specifically, the twelve direct reports for Paul Barnes will only be in place for that initial period of three months. It is expected that Mr. Barnes will have 6-8 direct reports between the Health Net Access and Bridgeway organizations after that initial period. As those decisions are reached, AHCCCS will be provided notice as well as the rationale for the ultimate organizational design.

Since the submission of the Transition Plan on September 25, a number of Centene resources have been identified to lead and support activities during the transition. Valerie Eaton has been hired as Implementation Director reporting to Paul Barnes with 100% of her time dedicated to the Health Net Access transition. Ms. Eaton is an experienced operational professional with extensive experience in implementations and change management. Her resume may be found in Attachment A.

In addition, a number of Centene corporate resources have been identified who are already driving and supporting various aspects of the Transition Plan. Here is a list of those individuals including their functional area of responsibility:

- *Jean Wilms, VP Business Development – corporate coordination*
- *Keith Hibbard, VP, Information Technology – corporate IT*
- *Ainette Martinez, VP, Provider Data Management – provider data management and credentialing*
- *Jason Delimitros, VP, Operations – provider network*
- *Rob Davis, VP, Operations – back office operational support*
- *Peggy Dietrich, Senior Director of Corporate Compliance – health plan compliance*
- *Rob Duchild, Project Lead System Implementation – IT lead for Arizona*

In addition to Paul Barnes, Sue Benedetti and Nancy Maurer, the Bridgeway VP of Compliance (Cheyenne Ross) will be devoted 10% to Health Net Access at the point of closing. The following resources have been engaged to allow each of these individuals to give appropriate attention to both Health Net Access and Bridgeway:

- *Crystal Hemmenway – Senior Manager, Corporate Compliance who supports Bridgeway issues at the corporate level (for Cheyenne Ross).*
- *Jenny Clark - Staff Vice-President Complex Care who is based in Arizona and very familiar with AHCCCS programs with past five years with Centene and former VP position with Health Choice (for Sue Benedetti).*
- *Mike Tullo – Finance Director who has taken over lead financial executive role for Bridgeway in the past month (for Nancy Maurer).*

The keys for Paul Barnes to have the capacity on this expanded role are based on the following factors:

- *The addition of Valerie Eaton as Implementation Director – allows delegation of operational activities related to the transition activities of both organizations.*
- *The complete on-boarding of Ken Yergey as VP, Provider Network for Bridgeway – has allowed Mr. Barnes to transition many provider network leadership activities held when Bridgeway had an interim network Vice President.*
- *The initiation of recruitment for two senior level management positions planned for the combined organization. Although these positions cannot be finalized in this stage of the transaction, the expected scope of Arizona's Centene organization has dictated the decision to begin recruitment of two executives reporting to Mr. Barnes in the long-term organization. These positions are contemplated in the 6-8 direct reports for Mr. Barnes in the long-term organization.*

b. The Transition Plan outlines numerous significant system transitions that will require pre-close, as well as, post-close activities up to as many as 180 days from post-close date. However, the Plan does not identify a key responsible person for ensuring system migration and implementation of all these critical transitions nor additional staff or resources required to support this transition. Please identify the following related to these activities:

   A lead person responsible for these transitions and an outline of all associated responsibilities. Provide a resume for this person.

   - *The lead executive for the system transitions is Keith Hibbard, VP, Information Technology. Mr. Hibbard is a senior IT executive with over 25 years of experience in health care technology. He is currently the identified IT lead for Bridgeway and was the senior IT executive in the Cenpatico Integrated Care implementation. In the Health Net Access system transition, Mr. Hibbard will be accountable for all IT activities related to medical management, member/provider call centers, Centene's web presence (Public and Secure portals), enrollment/billing/eligibility management, and related business/vendor partner collaborations. His resume may be found in Attachment A.*

The system transition is part of the overall Implementation Plan for Health Net Access which also includes the operational changes outlined in the Transition Plan. Mr. Hibbard is joined on the Health Net Access overall Implementation Leadership Group by the following individuals:

***Paul Barnes, Plan President and CEO** – As the Executive Champion and CEO, Paul Barnes is responsible for the overall project to ensure its success. As part of this role, the Executive Champion will make key decisions, such as budget allocations, major project activities, and identification/approval of resources for the project. The Executive Champion reports into the Enterprise Implementation Steering Committee.*

***Jean Wilms, VP of Business Development** – Supports the Executive Champion according to the defined scope, schedule, and timeline. Ms. Wilms will assure project compliance with corporate policies and procedures and will work with the implementation director to promote open communication and project integration.*

***Rob Duchild, Project Lead System Implementation** – Oversees the IT system migration project scope, timeline and deliverables. Mr. Duchild will lead and manage the IT work group teams. Will partner with Health Plan leadership and deliver application and infrastructure functionality in member/provider call center, enrollment, benefits and pricing configuration, claims processing and provider payments, medical management, and web portal functionality.*

***Valerie Eaton, Implementation Director** - As Implementation Director, Valerie Eaton will be fully dedicated to manage the day-to-day implementation activities with support from the corporate implementation team. Ms. Eaton will be responsible for overseeing and coordinating the setup of project tools and resources, managing the project according to the defined scope, schedule, and timeline, assure project compliance with State requirements, facilitate communication across all levels of the organization and monitor implementation status and results.*

***Karen Richardson, Implementation Director** – Karen Richardson will be the corporate liaison for the project by providing best practices from prior implementations, engaging corporate resources, and readiness review assistance. Ms. Richardson served the same role in the Cenpatico Integrated Care implementation.*

Overview of other key staff and/or teams assigned to and supporting these activities:

- *The system transition is part of the overall Implementation Plan for Health Net Access which also includes the operational changes outlined in the Transition Plan (e.g., location change for call center). The overall methodology and structure for the implementation may be found in Attachment B.*

Under this Plan, Health Net, Centene and Bridgeway resources are organized into work groups grouped by functional operational and/or IT areas. A complete listing of the work group members may be found in Attachment C.

c. Update the HNA Organizational Chart to include the additional staff/positions and reporting lines of key staff responsible for transition activities.
    - *As compared to the previously submitted Transition Plan, there is a change in the projected Health Net Access organization as of closing. Kay Ziegler will serve as Operations Director with responsibility for the functions of IT, claims, encounters, and call center. She is involved with those functions currently at Health Net Access and has been engaged with the plan since its onset. Ms. Ziegler's resume may be found in Attachment A. Gay Ann Williams will continue with the organization at closing in a staff role reporting to Mr. Barnes to ensure continuity with legacy Health Net functions. The organizational chart reflecting this change as well as the reporting lines for staff involved in transition activities may be found in Attachment D.*

d. On Attachment B - Organizational Chart (at closing), there is a dotted line from Trista Loops, Chief Financial Officer, to Paul Barnes Chief Executive Officer. Please clarify who Ms. Loops will directly report to and address the direct and indirect reporting lines. Please update the organizational chart to identify Ms. Loops direct reporting line.
    - *At closing, Ms. Loops will continue to have a direct reporting relationship to Brian Tweten (Vice President, Finance) as she does presently. Mr. Tweten will continue to provide oversight from a technical financial perspective for Ms. Loops work as well as ensuring corporate consolidation of Health Net Access' financials. From an operational perspective, Paul Barnes will provide oversight for Ms. Loops for all Health Net Access operational matters, including the integration of financial area with provider network, compliance, medical management and other operational functions. The direct/dotted line reporting relationship for Ms. Loops will be evaluated over the first three months to determine the optimal structure for the long-term organization. Attachment D shows the direct and dotted line reporting relationships for Ms. Loops.*

e. Under the discussion of the Board Composition, "Peer Review" is identified as a function of the QMPI Committee, which in turn reports to the Board of Directors. This structure is not in compliance with AMPM Policy if the Plan is referring to a Peer Review Committee. As required by AHCCCS Medical Policy Manual (AMPM) Chapter 910, the Peer Review Committee is directly responsible to the Chief Medical Officer. Further, the Committee's activities are confidential and must be carried out as a standalone committee or in executive session of the Contractor's Quality Management Committee as outlined in the AMPM.

- *The Peer Review Committee is part of each plan's Quality Management (QM) function. Both plan QM programs meet AHCCCS requirements as outlined in the AHCCCS Medical Policy Manual (AMPM) chapter 910. Although the Boards maintain ultimate fiduciary oversight responsibility for both entity operations and compliance programs, the Peer Committee structures and compositions meet all requirements outlined in Arizona Revised Statute 36-2403 and the AMPM, including but not limited to:*
  - *The Peer Committees are chaired by each plan's Chief Medical Officer (CMO)*
  - *All Peer Committee materials are kept confidential and "protected" as required in the AMPM and by statute*
  - *All Peer Review committee activities are carried out in confidential executive sessions of the broader QM committees.*

3. The Transition Plan should provide additional details on the major systems being migrated from Centene to HNA. The Transition Plan identifies six information systems, including its claims system that will be implemented for HNA operations.

    a. The Transition Plan must address how it will meet contract reporting requirements related to major system changes. The six systems referenced in the Transition Plan are likely to qualify as "System Changes and Upgrades" for HNA as identified in the AHCCCS Contract YH14-0004, Section D, paragraph 64. These types of system migrations have specific reporting and submission requirements.
        - *The Health Net Access to Centene information system conversion consists of the following six integrated components:*
            1. *Member and Provider Services (Customer Relationship Management)*
            2. *Provider Data Management, including Contract Management*
            3. *Care & Utilization Management*
            4. *Claims Payment and Adjudication*
            5. *Analytics (including predictive modeling), reporting, and decision support)*
            6. *Member and Provider Portals*

        In addition to the detail provided in the transition plan documents dated September 25, 2015; Health Net Access will submit to AHCCCS a detailed System Conversion Notification and Plan for all applicable components under separate cover. Health Net Access will submit the System Conversion Notification and Plan to AHCCCS the week of November 2, 2015. The System Conversion Notification and Plan will address all required information, including but not limited to:
            - *A proposed timeline*
            - *Milestones*

- *A description and outline of testing to be completed before implementation*

Centene and Health Net Access will work collaboratively with applicable AHCCCS staff to address all issues and concerns, and to ensure that complete end to end testing is completed prior to the system go live date.

b. The Transition Plan must identify how it will address HNA claims submitted prior to the migration. The Transition Plan does not clearly address whether the data on these claims will be migrated to the Centene claims processing system, or whether the claims will continue to use the HNA system after the migration for their life cycle including but not limited to payments, adjustments, recoupments, claim disputes etc. If the HNA system will be retained, the Transition Plan must provide a timeline and clearly address the staff, resources and support necessary to maintain the system for complete run out.
    - *For the Systems Migration, claims with Dates of Service (DOS) before the migration <u>will be processed on the present Health Net Access system (ABS) including but not limited to payments, adjustments, recoupments, and claim disputes.</u> The ABS system will remain intact and fully functional for other lines of Health Net business. Thus ABS will be functional for the Health Net Access line of business to allow for full claims run out to be completed.*

      The Systems Migration will minimize the impact on providers and members. There will be no change to where a provider submits a paper or EDI claim at the time of the Migration. Health Net and Centene will perform electronic routing of claims behind the scenes to the appropriate claims payment system based upon DOS. Member and Provider toll free service numbers also will not change.

      Health Net Access currently has a dedicated claims team to support all functions of claims processing including, but not limited to claim adjudication, COB determination, recoupments, and claims auditing. This dedicated team will provide run out services to meet all contractual requirements and timelines. Currently there are 75 FTEs on this dedicated team. As the claims volume decreases, it is expected that individuals will migrate to other functions within the overall claims unit. It is projected that this reduction will not begin until 90 days after the DOS cutover. After 90 days, it is projected that the team will be reduced by about 8 individuals per month over the following 8 months. The timing for the remaining 10 – 12 staff will be based on the specific claims activity at that time.

All AHCCCS files will continue to be uploaded into ABS, as well as any calendar year contract changes/updates that may be needed to continue to process claims in an AHCCCS compliant manner. This will ensure that all claims adjustments, recoupments, and claim disputes will be handled by the current trained Health Net Access staff to provide consistent, timely and uninterrupted service.

4. Further clarification is required related the Call Center and member and provider services. The Transition Plan estimates 11 FTEs for member services and 12 for provider services to operate the Call Center function for HNA, and 14 FTEs for the Pre- Authorization function. The Transition Plan indicated staff estimates for claims processing were being developed.

    a. The Transition Plan should clearly indicate whether these FTEs represent additional or the total staff needed to carry out these functions. Existing FTEs for these functions should also be included for clarity.
        - *To support Health Net Access' call volume we anticipate using 10 FTEs to support Members, and 16 FTEs to support Providers. Additionally, current staffing requirements for Bridgeway's call volume are 6 FTEs to support Members and 12 FTEs to support Providers.*

          The current FTE requirements for supporting Bridgeway are a subset of a larger "pod" of 34 Arizona Service Center agents who support Bridgeway Members and Providers in addition to also supporting Members and Providers from Centene health plans in California and Washington. With the addition of Health Net Access, all Arizona Service Center agents currently in the Bridgeway/CA/WA pod will be re-assigned to support only Bridgeway and Health Net Access callers. This will allow agents to leverage their Arizona Medicaid experience and focus solely on Bridgeway and Health Net Members and Providers.

          The current BW/CA/WA pod includes 12 agents trained for Member calls and 22 agents trained for Provider calls. Total Health Net Access and Bridgeway call volumes will require 16 agents trained for Member calls and 28 agents trained for Provider calls. By reassigning our current employees, the call center agents supporting Members will include 75% current staff/25% new hires, and the call center agents supporting Providers will include 78% current staff/22% new hires. At the point of the transition, we plan to bring over 7 trained staff agents to address the increased call volume possible during the transition.

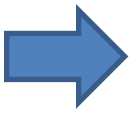
          The Arizona Service Center will provide call center coverage for Health Net Access members from 7:30 am to 6:00 pm local time,

Monday through Friday, with 24/7 afterhours coverage provided by Centene's NurseWise specialty company. Health Net Access will be submitting documentation for approval of the NurseWise services in a separate submission.

b. If the revised Transition Plan is still unable to provide FTE estimates for claims processing, it should address why this estimate is unavailable.
   - *The required analysis has been completed to determine the necessary FTEs for claims processing. Centene claims staffing projections are driven by the product (e.g., Medicare, Acute Medicaid, LTC Medicaid) that is being implemented. The staffing model allows Centene to use historical trend data to determine auto adjudication, claims per member, and adjustments to estimate the required number of FTEs to service a given membership volume. This yields an expected claims volume on a monthly basis. Applying EDI percentages to the expected claims volume yields a paper volume that needs to be accounted for in our "front end" department. The Auto Adjudication (AA) rate and an adjustment rate yields the amount of claims that are pended and have to be staffed to be worked by claims analysts.*

     In the case of Health Net Access, the current metrics for EDI, AA and adjustment were compared to the Book of Business for comparable Centene populations and providers. The resulting assumptions are a blend of current experience of Centene Book of Business.

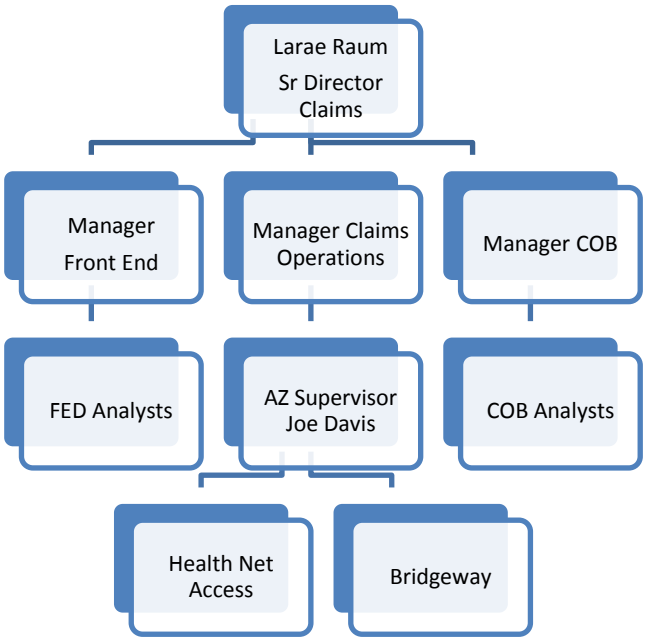
Model Variables/Assumptions	
Product Line	ACUTE
# Members	65,000
# Claims PMPM	1.06
Auto Adjudication %	40%
EDI Submission Rate	85%
Adjustment %	6%



Claims Processing Staffing Needs	
Claims Analyst	23
Front End Analyst	2
COB Analyst	1
Supervisor	1
Total Staff	**27**

Health Net Access claims will be processed by a team dedicated to this program. The current manager for the Bridgeway dedicated team will also oversee the Health Net Access team thus providing continuity for Arizona Medicaid issues. The Health Net Access claims staff will come from existing seasoned and trained Centene Claims Analysts who currently process similar type of claims for other Centene health plans. These health plans will be transitioned to a different claims processing center. Transitioned staff will be cross-trained 2 weeks in advance of go-live on issues

specific to Arizona Medicaid. The organizational chart for the Health Net Access claims team may be found below:



c. The Transition Plan should address the factors that were considered in developing the FTE estimates. It should also describe timelines for hiring and training additional staff, and the hiring strategy – particularly with respect to existing HNA staff.

- *FTE staffing estimates rely on multiple criteria including health plan membership, expected member utilization of the call center, Erlang C modeling, and shrinkage/overhead. Health plan membership is a key factor, along with the member utilization percentage based on current experience in supporting all Centene Medicaid lines. This data provides the initial estimate for month-over-month call volumes.*

  Erlang C logic is then applied to ensure projected call volumes can be answered within the defined Service Level and ASA criteria, while also ensuring a low caller abandon rate. We use the base requirements from the Erlang formulas and apply shrinkage to ensure coverage for employee vacations, coaching sessions, training sessions, etc. The final results ensure sufficient and cost-effective staffing, while providing a responsive and positive caller experience when contacting the service center.

  A total of 60 days will be needed to hire and train new call center employees; 30 days for recruiting and hiring, and 30 days for onboarding and classroom training. For current call center employees

who will be moved from other assigned work to support Health Net Access members and providers, a maximum of 30 days will be needed for Health Net specific training.

See Attachment E for the Arizona Service Center Training Program.

d. With respect to the Call Center, the Transition Plan should outline all lines of business that are supported by the Call Center and the overall staffing of the Center as it relates to the lines of business it supports. The Plan must address the extent that the additional staff required may be called upon to support other lines of business, such as Bridgeway, Cenpatico Integrated Care and other health plan related calls.

- *The Arizona Service Center currently supports the following types of callers: Providers (34% of agents), Marketplace Members (52% of agents), Medicaid Members (13% of agents). The Centene health plans currently supported by the Arizona Service Center include the following:*

  Medicaid Health Plans: AZ, CA, GA, IL, KS, MO, MS, NH, SC, WA, WI

  Marketplace Health Plans: FL, GA, IL, IN, MA, MS, OH, TX, WA, WI

  The Arizona Service Center is currently staffed by 110 call center agents. An additional new hire group planned for November will increase this number to 125. With the additional agents to support Health Net Access and to backfill for support to Centene's California and Washington health plans, the count of Arizona Service Center call center agents will increase to 151. In January 2016, the Arizona Service Center will be relocating to a new location in Tucson with total seating capacity for 164 agents.

  The Arizona Service Center is led by director Mitch Bushnell (see attachment A for his bio). His onsite leadership and support staff includes 1 Human Resources manager, 6 Call Center Supervisors, 1 Quality Specialist, 2 Trainers, 2 Workforce Management Analysts and 1 Office Services Coordinator. Centene is currently hiring an additional Call Center Supervisor and 3 additional Quality Specialists, who will be in place by December 1, 2015. This staff will be augmented in 2016 with additional leadership positions, specifically to support the growth from Health Net Access.

5. The Transition Plan must address the assumptions (narrative) related to the pro forma financial statements – particularly enrollment projections. Also, the Transition Plan should elaborate on the systems and staffing assumptions used to develop the pro forma statements. HNA should consider providing a timeline.

a. *Assumptions, including enrollment projections, may be found in the footnotes of the pro-forma submitted as part of the Transition Plan. However, there is additional detail that can be provided to better understand the reduction of the administrative expense from 2015 to 2016.*

In the submitted pro forma, it was assumed that Centene would complete the acquisition of Health Net on February 1, 2016. Please note that this assumption was only to use a specific date for the purposes of financial modeling and the actual date will be driven by regulatory approvals and closing conditions. At the point of acquisition, an administrative services agreement will take effect between Centene Management Company and Health Net Access, which includes claims processing, IT, management services and other deliverables. This agreement will be submitted for approval by AHCCCS separate from the Change in Ownership filing.

Consistent with the methodology used with other Centene plans (including Bridgeway), this Agreement has a financial structure based on a percentage of revenue (adjusted for different types of Medicaid programs). The 3 year pro forma submitted assumes that the Centene Agreement will take effect on February 1, 2016 and that the current services agreement with Health Net will be superseded by the Centene Agreement at that time. The reduction in administrative expenses reflected from 2015 to 2016 in the pro forma is driven by the reduced charges under the Centene agreement. Besides the difference in methodology between the Health Net and Centene agreements, the larger revenue base of Centene Medicaid programs (including the acquired Health Net programs) and the greater efficiencies of Centene systems (e.g., increased auto adjudication rates for claims) are supporting factors to the lower rates under the Centene agreement.

There is no assumption of reduced direct services FTEs in Arizona used in development of the pro-forma.

6. While the Transition Plan anticipates little to no changes to HNA subcontracts, it must address the following specific issues:

a. HNA currently utilizes at least 10 administrative services subcontracts, including several that process specific claim types for HNA. While the Transition Plan indicates it anticipates no changes to these subcontracts, it also addresses migrating all claims administration to the Centene Claims Center. The Transition Plan should confirm its intent with regard to these subcontracts.

- *A review of current Health Net Access claims processing subcontractors has been completed. These subcontractors will*

stay in place for "run out" phase for existing Health Net Access claims related subcontracts.

Health Net Access will be submitting a System Change Notification to the State as required in contract and policy. There are no other planned claims processing related subcontract changes expected related to the acquisition.

Health Net Access is preparing the submission of two delegated agreements for AHCCCS review and approval in accordance with ACOM 438 to be submitted in November 2015:

- *Centene and Health Net Access Management Services Agreement*
- *NurseWise Call Center Agreement*

There are other Health Net Access delegated functions with subcontract agreements being considered that will be submitted to the State for review and approval. As additional subcontracts are identified for change, Health Net Access and Centene will follow all AHCCCS policy requirements, including ACOM 438, related to subcontract service agreement submissions and approvals.

b. The Transition Plan also anticipates no changes to the HNA provider network other than those changes that occur in the ordinary course of business. The Transition Plan must address whether new contracts will be required or changes/amendments to the current HNA provider contracts are necessary to reflect the acquisition.
    - *Neither new contracts nor changes/amendments will be required for current Health Net Access provider contracts related to the acquisition.*

7. The Transition Plan did not specifically address current HNA and Bridgeway compliance issues that impact the acquisition. AHCCCS' September 4, 2015 letter indicated it "has continued concerns regarding HNA's non-compliance with contract requirements and will look for and evaluate specific strategies and actions in the Transition Plan to be implemented by Centene to remediate the existing outstanding HNA compliance issues and ensure compliance going forward."

    a. The revised Transition Plan must include strategies to address all HNA open compliance actions.
        - *Centene is aware of the current Health Net Access non-compliance actions as well as the Corrective Action Plans submitted to AHCCCS. However, the legal constraint of operating as separate companies dictates that Centene can have no direct influence or*

impact on resolution of open corrective action plans prior to closing. At the point that the acquisition is completed, Centene will intervene with urgency on all Health Net Access compliance issues open at that point in time. In the first week post acquisition, Centene Corporate Compliance management as well as local Centene and Health Net Access operational and compliance management will convene a meeting to complete a robust review of all Health Net Access compliance actions. All open CAPs will be reviewed to determine if additional Centene or Health Net resources and/or escalation are required to fully resolve the issue. As needed, CAPs will be revised and/or supplemented to meet all State requirements. Revised CAPs will be submitted to AHCCCS after that process. Centene and Health Net Access will request a meeting with applicable AHCCCS personnel for approximately 3 weeks post acquisition to review the outcome of the analysis and subsequent revised CAPs to ensure that all issues are fully addressed for resolution.

On a broader level, the Health Net Access Compliance program structure will transition at closing to align with the Centene Corp. Compliance program structure. The Health Net Access Compliance Officer will report directly to the CEO with dotted line reporting to the plan's Board of Directors. The Compliance Officer will continue to be responsible for ensuring that Health Net Access is in compliance with all state and federal program and regulatory requirements. The Health Net Access Compliance Officer will maintain independent access to the Plan President & CEO and Plan Board of Directors to escalate any concerns for prompt resolution.

The Health Net Access Compliance Officer will receive additional support and guidance from Centene's Corporate Compliance unit including the identification, tracking, and when appropriate, the escalation of contract non-compliance risks associated with the Medicaid contract. All functional leads will maintain accountability for the identification and prompt resolution of any identified contract compliance gaps in coordination by the Health Net Access Compliance Officer. Reporting of contract non-compliance is disseminated to the Plan President & CEO, the plan Compliance Committee, the Plan Board of Directors and when appropriate and necessary, to the highest level of the parent organization for mitigation and resolution.

The Health Net Access Compliance Officer will be responsible for conducting full contract assessments as part of its Compliance Program and upon acquisition to identify any risks or instances of

noncompliance. The Health Net Access Compliance Program will be revised accordingly.

Health Net Access will implement utilization of the Centene software, Compliance 360 for compliance program oversight monitoring auditing. Compliance 360® is a comprehensive software solution that streamlines governance, compliance and risk identification.

The Compliance 360 suite includes:

- *Policy Management: Full life-cycle management of policies and procedures including customizable workflow for collaboration and approval processes as well as comprehensive document management including version control and audit trails.*
- *Compliance Management: Ensure up-to-date regulatory compliance with proactive monitoring and alerts coupled with compliance assessments to identify and remediate gaps.*
- *Incident Management: Collect incident information using integrated hotline options. Store, and collaborate on all incidents (cases) using automation to streamline the management of investigations. Track the progress of investigations and resolution of potential issues and compile proof of remediation and preventative measures.*
- *Contract Management: Enable proactive management of all contracts including those with the State, vendors, service providers, and more.*
- *Risk Management: Identify, prioritize and manage risk areas across the enterprise. Automate the assessment of risks and testing of controls using a highly customizable scoring methodology. Link risks to strategic objectives and compliance programs and manage risk mitigation projects.*
- *Third Party Risk Management: Proactively identify potential third party risks, verify that business partners and their employees are compliant, monitor for changes that might create new risks or compliance gaps, and manage the investigation and remediation of incidents. Apply a systematic, ongoing, and risk-based approach to due diligence for anti-bribery and anti-corruption.*
- *Compliance and Ethics Training: Inspire ethical decision-making through compliance and ethics training and awareness that engages employees and business partners with relevant content.*
- *Disclosures Management: Collect, store, and track disclosure information relating Conflicts of Interest and Gifts and Hospitality via online forms submitted by employees or other business*

associates, creating a centralized database of all disclosures that is auditable and searchable. Improve communication as disclosures are automatically routed to the proper individual(s) who can approve, deny or request more information in a timely manner. Use the configurable online dashboards and reports for monitoring activity and trends.

b. In addition, since the acquisition will result in HNA claims being processed on Centene's system, the open items from the Bridgeway CYE 2014 Operational Review must also be addressed. Specifically, Bridgeway must address AHCCCS' findings regarding the Bridgeway remit, manual interest calculation and application of the provider category of service edit.
    - *Bridgeway Health Solutions has submitted an updated CAP response for outstanding CY14 issues related to Claims and Information Systems (CIS) findings as of October 27, 2015. Please refer to Attachment F for a summary of the three (3) open CAP items. All outstanding CAP items are scheduled to be fully resolved by November 30, 2015.*

8. Finally, the Transition Plan should provide additional details on the draft member and provider letters submitted (Attachments M and N). Before AHCCCS can approve the letters, the Transition Plan should address the timeline for distribution of these letters and posting to the website and any additional planned letters/notifications and distribution timeframes.
    a. *It is critical that Health Net Access members and providers remain informed about the expected acquisition while reassuring both groups that they will not experience change in processes, benefits or access points (e.g., toll-free numbers, website). Several factors were considered in developing the communication plan timeline including a transaction close date which cannot be specified, the upcoming holiday season, and the pending AHCCCS review/approval process. Considering all applicable factors, the notification letters have been modified to permit distribution before all regulatory approvals (including AHCCCS) has been issued. See Attachments G, H and I for the modified notifications. The targeted timeframe for formal notification to HNA members and providers are as follows:*
        - *November 13, 2015: member and provider notifications distributed to Health Net Access staff including call center and provider relations to prepare to address any incoming member and/or provider inquires*
        - *November 16, 2015: member notifications mailed via US Postal Service*
        - *November 16, 2015: provider notifications mailed via US Postal Service*
        - *November 16, 2015: member notification uploaded to Health Net Access website member section*

- *November 16, 2015: provider notification uploaded to Health Net Access website provider section*