April 1, 2011

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

Re: Response to the Request for Proposal (RFP) Solicitation No.: YH12-0001 for the Arizona Long Term Care System (ALTCS) Elderly and Physically Disabled (E/PD) Contract for Program Contractors

Dear Ms. Schultz,

We are pleased to respond to the Request for Proposal (RFP) Solicitation No.: YH12-0001 issued by the Arizona Health Care Cost Containment System (AHCCCS) for the Arizona Long Term Care System (ALTCS) Elderly and Physically Disabled (E/PD) Contract for Program Contractors.

Bridgeway is a recognized leader in developing innovative programs and practices that carry out ALTCS' Vision, Values, and Guiding Principles and continuously improve program performance and efficiency. Bridgeway's five years' experience serving ALTCS members has laid the groundwork for a long term relationship with AHCCCS. We self-monitor our performance, design processes that facilitate health plan interdepartmental coordination, maximize use of all stakeholders' feedback, and share best practices with AHCCCS, providers, and other health plans, to promote consistency and accountability in program service delivery. We bring to the table a culture of engagement with members and providers to deliver member-centric, culturally competent, integrated long-term, acute and behavioral health care services. We collaborate with providers, advocates, and other stakeholders as community partners in achieving high quality, efficient and effective services for our members and high satisfaction levels for all stakeholders.

We believe our employees are our strongest asset. We have a seasoned team with significant experience and expertise in long-term care and the ALTCS program. Bridgeway prides itself on being the only contractor with field offices in each GSA where we hold contracts, including both urban and rural markets, and we will continue this approach in any newly awarded GSAs. This approach ensures that we have employees who are familiar with the nuances of each GSA to interact with our members and providers while creating jobs throughout Arizona.

Bridgeway has also, throughout our contract with AHCCCS demonstrated our ability to successfully implement new operations. Since our initial ALTCS contract in 2006 in Maricopa, Yuma and LaPaz counties, we have expanded first in 2008 through an AHCCCS contract for acute care members in Yavapai County and again in 2010 with an expansion of our ALTCS program to include a partnership with the Pima Health System to provide service to the ALTCS enrolled population in Pima and Santa Cruz counties.

As Bridgeway has enjoyed this growth, we are also pleased that we have been able to continue to create additional Arizona-based job opportunities. Bridgeway and our fellow Centene subsidiary organizations currently employ over 500 Arizonians. As we continue to expand our presence, we look forward to the additional employment opportunities this expansion would create.

In addition, as Bridgeway continues to expand, we not only continue to enhance our expertise about the ALTCS program and population, but are also able to take advantage of the resulting economies of scale that have accompanied this growth. We are confident that should we be awarded additional GSAs, this trend would continue, allowing us to achieve further administrative cost savings.

If you have any questions regarding our proposal, please contact me by telephone at 314-566-9591 or through e-mail at rfredrickson@centene.com.

Sincerely,

Richard L. Fredrickson
Chief Executive Officer, Bridgeway Health Solutions

Table of Contents

Section A – General Matters

Amendment 1 2
Amendment 2 3
Offerors Signature Page 4
Oferors Checklist 6
Section G - Representations and Certifications 9

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

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

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

<table>
<tr><td colspan="2">Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.</td><td>This Solicitation Amendment is hereby executed this the 24th day of February, 2011, in Phoenix, Arizona.</td></tr>
<tr><td>Signature [signature]</td><td>Date 3-25-11</td><td>[signature]</td></tr>
<tr><td colspan="2">Typed Name and Title</td><td>Michael Veit</td></tr>
<tr><td colspan="2"></td><td>Contracts and Purchasing Administrator</td></tr>
<tr><td colspan="2">Name of Company</td><td></td></tr>
</table>

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

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

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 11th day of March, 2011, in Phoenix, Arizona.
Signature	Date 3-25-11	
Typed Name and Title		Michael Veit
		Contracts and Purchasing Administrator
Name of Company		

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

Solicitation Contact Person:
Jamey Schultz
Contracts and Purchasing Section
701 E. Jefferson, MD5700
Phoenix, Arizona 85034

Telephone: (602) 417-4629
Telefax: (602) 417-5957
E-Mail: Jamey.Schultz@azahcccs.gov

Issue Date: January 31, 2011

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

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

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

Pre-Proposal Conference:

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

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

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

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

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

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

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

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION.

OFFER

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

Arizona Transaction (Sales) Privilege Tax License No.: 20136826-E

Federal Employer Identification No.: 20-4980818

E-Mail Address: rfredrickson@centene.com

Bridgeway Health Solutions of Arizona, LLC
Company Name

1501 W. Fountainhead Parkway, Suite 201
Address

Tempe	Arizona	85282
City	State	Zip

For clarification of this offer, contact:

Name: Richard L. Fredrickson

Phone: 866-475-3129 or 314-566-9591(cell)

Fax: 866-638-6124

Signature of Person Authorized to Sign Offer

Richard L. Fredrickson
Printed Name

President & CEO Bridgeway Health Solutions of Arizona, LLC
Title

CERTIFICATION

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

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

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

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

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

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

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

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

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

Awarded this ________ **day of** ____________________ **2011**

____
Michael Veit, as AHCCCS Contracting Officer and not personally

OFFEROR'S CHECKLIST

Offerors must submit all items below, unless otherwise noted. In the column titled "Offeror's Page #," the Offeror must enter the appropriate page number(s) from its proposal where the AHCCCS Evaluation Panel may find the Offeror's response to the specified requirement. AHCCCS will only consider the information provided within the allotted page limit and permitted attachments, if any, in response to a specific submission requirement when evaluating the Offeror's proposal. At no time will AHCCCS consider information outside the allotted page limit and permitted attachments, or any other information provided elsewhere in the proposal when reviewing a specific response to an individual submission requirement.

A. GENERAL MATTERS

Subject	*Reference*	*Offeror's Page #*
Offeror's signature page	(Front Page)	N/A
Offeror's Checklist (this attachment)	N/A	N/A
Completion of all items in Section G of the RFP	Section G	N/A

B. CAPITATION

Subject	*Reqmt. #*	*Offeror's Page #*
Capitation Rate Bid (via EFT/SFTP and hard copy)	1	27-47

C. ORGANIZATION

Subject	*Reqmt. #*	*Offeror's Page #*
Moral and Religious Objection	2	49
Organization and Staffing	3	50-82
	4	83
	5	84-86
Sanctions	6	87-89
Claims	7	90-100
	8	101-103
	9	104-106
Encounters	10	107-114
Information Systems	11	115-140
	12	141-143
	13	144-146
	14	147-149
Grievance System	15	150-156
Corporate Compliance	16	157-160

C. ORGANIZATION - CONTINUED

Finance and Liability Management	17	161-162
	18	163
	19	164

D. PROGRAM

Subject	***Reqmt. #***	***Offeror's Page #***
Case Management	20	166-168
	21	169-171
	22	172-174
	23	175-177
	24-A	178-180
	24-B	181-183
	24-C	184-186
	24-D	187-189
Medical Management	25	190-195
	26	196-198
	27	199-201
	28	202-204
Quality Management	29	205-207
	30	208-210
	31-A	211-213
	31-B	214-216
	32	217-219
	33	220-222
	34	223-225
Oral Presentation	35	The Offeror shall submit the names and resumes of the participating individuals via the EFT/SFTP server by 3 p.m. on April 8.

E. PROVIDER NETWORK

Subject	***Reqmt. #***	***Offeror's Page #***
Provider Network	36	227-303
	37	304-306
	38	307-309
	39	310-312
	40	313-315
	41	316-318
	42	319-321
	43	322-324

	44	325-327
Network Summary via EFT/SFTP	45	N/A

SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR

The Offeror must complete all information requested below.

1. CERTIFICATION OF ACCURACY OF INFORMATION PROVIDED

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

2. CERTIFICATION OF NON-COERCION

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

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

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

4. AUTHORIZED SIGNATORY

Authorized Signatory for Bridgeway Health Solutions of Arizona, LLC
[OFFEROR'S Name]

Richard L. Fredrickson	President & CEO Bridgeway Health Solutions of Arizona, LLC
[INDIVIDUAL'S Name]	[Title]

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

5. OFFEROR'S MAILING ADDRESS

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

Richard L. Fredrickson		President & CEO Bridgeway Health Solutions of Arizona, LLC
Name		Title
1501 W. Fountainhead Parkway Suite 201		866-475-3129 (office) 314-566-9591 (cell)
Address		Telephone Number
Tempe	Arizona	85282
City	State	ZIP

6. OFFEROR GENERAL INFORMATION

a. If other than a government agency, when was your organization formed? May 2006

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

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

---

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

---

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

All Centene subsidary companies including subsidiary Bridgeway Health Solutions are required to adhere to our Corporate Policy and Procedure CC.FACL.17 for Building Access for ADA Compliance, which provides guidelines to ensure all office locations adhere to local zoning and state/federal guidelines for the establishment of office space. In accordance with the Corporate Policy and Procedure (provided at the end of Section G), companies that are subcontracted with Centene subsidiaries are contractually required to adhere to ADA requirements and local zoning and state/federal guidelines for the establishment of office space.

---

e. Prior Convictions: List all felony convictions within the past 15 years of any key personnel (i.e., Administrator, Medical Director, financial officers, major stockholders or those with controlling interest, etc.). Failure to make full and complete disclosure shall result in the rejection of your proposal.
None

---

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

---

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

Milliman, Inc.
Name

1301 Fifth Avenue Suite 3800	Seattle	WA
Address	City	State

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

Name

Address City State

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

Our MIS is comprised of numerous, best-of-breed hardware, software, and networking components; that we source from multiple vendors and that we integrate and augment with our own proprietary software. Please see the table located at the end of Section G for a list of the key software components we have in place to serve ALTCS today and for the term of the contract per RFP Solicitation Number: YH12-0001. With the exception of Centene proprietary software, the vendors listed sell and support their products with other health insurance, HMO's, managed care entities and other health plan administrators throughout the US; and are used by managed care companies in the service of multiple Medicaid managed care programs and/or Medicaid state agencies and Fiscal Intermediaries across the country. In the case of Centene, we operate our MIS nationwide, on behalf of 1.5 Million Americans in our Medicaid managed care plans in ten states (including Arizona), and (through Bridgeway) for the Arizona Long Term Care System (ALTCS) since 2006. To the best of our knowledge, none of the vendors listed have anything other than a vendor relationship with AHCCS, other Medicaid plans, HMO's or managed care entities; with the exception of our vendor Ingenix, which is owned by the UnitedHealth Group.

7. FINANCIAL DISCLOSURE STATEMENT

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

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

Name	Address	Percent of Ownership or Control
CenCorp Consulting Company Inc.	7700 Forsyth Blvd. St. Louis, MO 63105	100% owner of Bridgeway and is 100% wholly owned by Centene Corporation
Centene Corporation	7700 Forsyth Blvd. St. Louis, MO 63105	100% ownership of CenCorp Consulting Company, Inc.

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

Name	Address	Percent of Ownership or Control
None		

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

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

None

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

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction
None		

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

Name	Address	Title
None		

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

Name	Address	Description of Debt	Amount of Security
None			

g. Outstanding Legal Actions:

1. Are there any lawsuits, judgments, tax deficiencies or claims pending against your organization?
Yes _☐_ No _☒_ If yes, provide details including the dollar amount.

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

8. RELATED PARTY TRANSACTIONS

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

Name/Title	Address
Richard L. Fredrickson	1501 W. Fountainhead Parkway, Suite 201 Tempe Arizona, 85282
William N. Scheffel	7700 Forsyth Blvd., St Louis MO 63105
Keith H. Williamson	7700 Forsyth Blvd., St Louis MO 63105
Brandy L. Burkhalter	7700 Forsyth Blvd., St Louis MO 63105
Jason M. Harrold	7700 Forsyth Blvd., St Louis MO 63105

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

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

Description of Transaction	Name of Related Party and Relationship	Dollar Amount for Reporting Period Year Ended 9/30/2010
1. Administrative Service Fees (further detailed below)	Centene, CenCorp Health Solutions Parent Company	$9 million
2. Nurse Triage, Call Center Services	NurseWise, Affiliated Subsidiary	$407 thousand
3. Pharmacy Benefit Management – prescription drug benefits	US Script, Affiliated Subsidiary	$18.6 million
4. Behavioral Health Services	Cenpatico Behavioral Health	$312 thousand
5. Vision Benefits	OptiCare	$906 thousand
6. Disease Management Services	Nurtur	$1.1 million

(Numbers reported relate to all Bridgeway contracts held in Arizona)

Justification:

1. Support for Claims processing, IT Systems, Human Resources, Encounters and Finance
2. Covered services provided for eligible members
3. Covered prescription drug benefit provided for eligible members
4. Covered services provided for eligible members
5. Covered services provided for eligible members
6. Covered services provided for eligible members

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

Name	Address	Owner Or Controller	Has Controlling Interest? Yes / No
None			

9. OFFEROR'S OFFSHORE PERFORMANCE OF WORK PROHIBITED

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

There will be no offshore services related to this proposal.

END OF SECTION

6.b. Offeror General Information – License/Certification Attachment

Bridgeway Health Solutions, LLC currently has a contractual agreement with AHCCCS for the ALCTS program contract YH07-0001 and the Acute Care Program contract YH09-0001. Bridgeway maintains Medicare certification and meets all federal and state licensure requirements for the Medicare Special Needs Plan (SNP-H5590) and Medicare Advantage Part D (MAPD) as assessed by AHCCCS. Bridgeway recently obtained behavioral health outpatient licensure for its Behavioral Health Outpatient Facility Clinic in Pima County. The license is with the Arizona Department of Health Services and is effective March 3, 2011 to February 29, 2012.

Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Janet Napolitano, Governor
Anthony D. Rodgers, Director

801 East Jefferson, Phoenix AZ 85034
PO Box 25520 Phoenix AZ 85002
phone 602 417 4000
www.ahcccs.state.az.us

March 5, 2007

Richard Fredrickson
Chief Executive Officer
Bridgeway Health Solutions
1501 West Fountainhead Corporate Park
Suite 201
Tempe, AZ 85282

SUBJECT: Medicare Certification

Dear Mr. Fredrickson:

AHCCCS is granting the attached certification to Bridgeway Health Solutions, as all required certification criteria have been met.

As a reminder, there are financial reporting requirements for the MAPD-SNP plans similar to those required for the ALTCS Program Contractors. Please contact Kathy Rodham at kathy.rodham@azahcccs.gov or 602.417.4568 for detailed information.

Sincerely,

Marc Leib MD

FOR:
Anthony D. Rodgers
Director

cc: Kate Aurelius
Shelli Silver
Matt Devlin
Kathy Rodham
Theresa Harri

C:\Documents and Settings\KXPfiste\Local Settings\Temporary Internet Files\OLK9D\Bridgeway cert awardance ltr 3-5-07.doc

MEDICARE ADVANTAGE (MA)
STATE CERTIFICATION REQUEST

MA applicant should complete items 1-3.

1. MA Applicant Information :(Organization that has applied for MA contract(s))

   Name:_Bridgeway Health Solutions of Arizona, LLC
   D/B/A (if applicable)________________________________
   Address: 1501 W. Fountain Health Parkway, Ste 201
   City/State/Zip: Tempe, AZ 85282
   AZ Business License: L-1285647-2

2. Type of State license or Certificate of Authority currently held by referenced applicant:
   (Check more than one if entity holds multiple licenses)

   ☐ HMO ☐ PSO ☐ PPO ☐ Indemnity X Other_MCO______

   Comments:
   1. Arizona Revised Statute 36-2944- exempts an Arizona Long Term Care System (ALTCS) program contractors from the provisions of Title 20 (Arizona Revised Statutes applicable to the AZ Dept. of Insurance). (Attachment-statute language)
   2. May 1, 2006, CenCorp Consulting Solutions, Inc (CenCorp) was awarded the ALTCS contract with the stipulation that Cencorp will implement a Medicare SNP plan by January 1, 2008 (Letter Attachment).
   3. Bridgeway Health Solutions of Arizona, LLC is a subsidiary of CenCorp, and is licensed (L-1285647-2)to do business in Arizona under the authority of the Arizona Corporation Commission. (Attachment, Web print of Licensure record)

3. Type of MA application referenced applicant has filed with the Centers for Medicare & Medicaid Services (CMS): (Check all that are appropriate)

   X HMO ☐ PPO ☐ MSA ☐ PFFS ☐ Religious Fraternal

   SNP application

(An appropriate State official must complete items 4-7.)

Please note that under section 1856(b)(3) of the Social Security Act and 42 CFR 422.402, other than laws related to State licensure or solvency requirements, the provisions of title XVIII of the Social Security Act preempt State laws with respect to MA plans.

CRT.doc 1-26-2007

4 State official reviewing MA State Certification Request:
Reviewer's Name______Kathy Rodham______________________
State Oversight/Compliance Officer ___Kathy Rodham__________
Agency Name _Arizona Health Care Cost Containment System_
Address__701 E. Jefferson ______________________________
City/State__Phoenix, AZ 85034___________________________
Telephone__602-417-4104________________________________
E-Mail Address ___kathy.rodham@azahcccs.gov_____________

5. Name of other State agencies (if any) whose approval is required for licensure:
Agency____
Contact Person____________________________________
Address____
City/State____
Telephone____
E-Mail Address ___________________________________

6. Financial Solvency:

Does the applicant organization named in item 1 above meet State financial solvency requirements?

X Yes ❐ No

Please indicate which State Agency or Division is responsible for assessing whether the named applicant organization meets State financial solvency requirements.
Arizona Health Care Cost Containment System

7. State Licensure:

Does the applicant organization named in item 1 above meet State Licensure requirements?

X Yes ❐ No

Please indicate which State Agency or Division is responsible for assessing whether this organization meets State licensure requirements.
Arizona Health Care Cost Containment System

State Certification

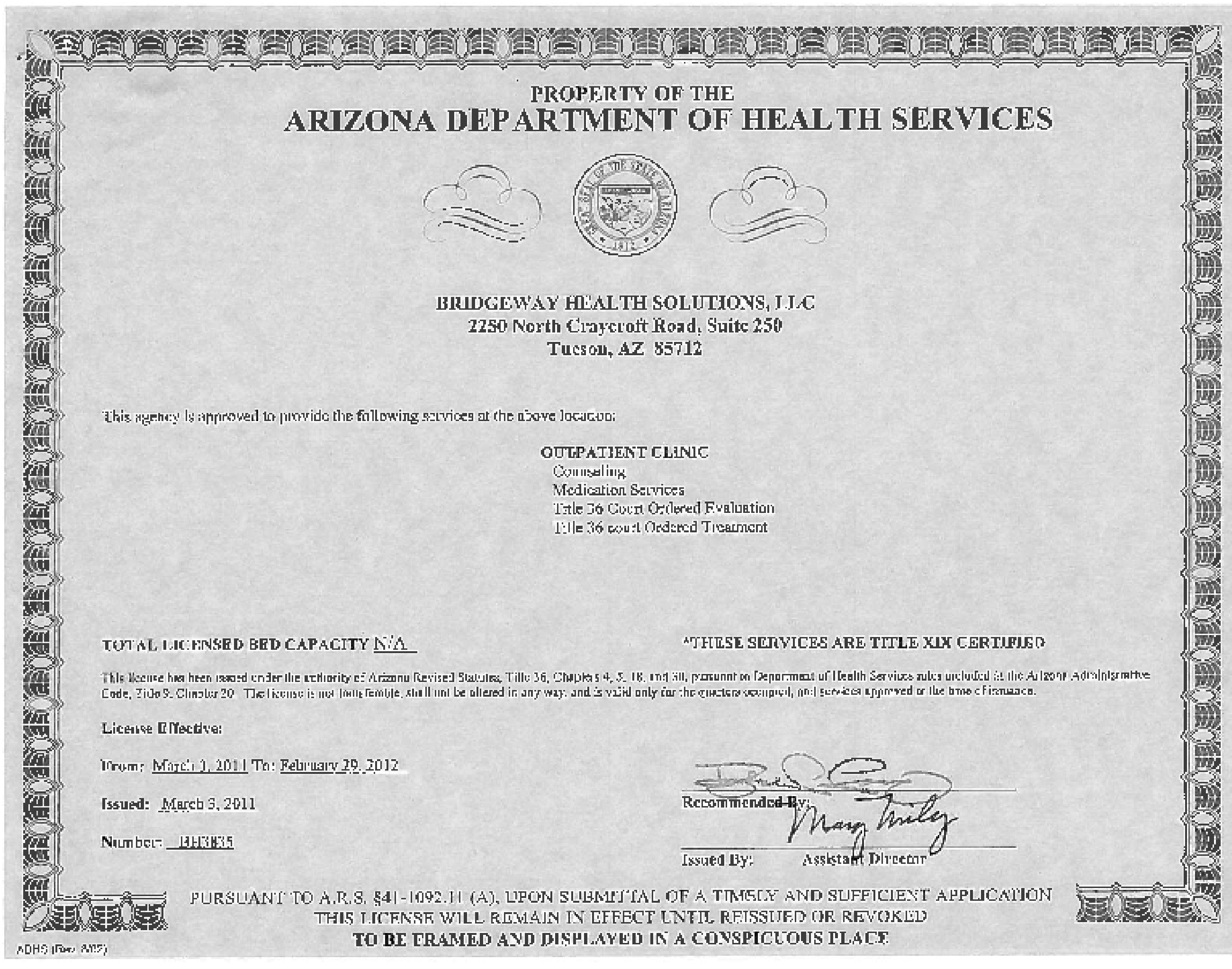
I hereby certify to the Centers for Medicare & Medicaid Services (CMS) that the above organization is licensed as a risk bearing entity in the State of Arizona and that the aforementioned organization is authorized to bear the risk associated with the type of Medicare Advantage contract(s) indicated above.

Arizona Health Care Cost Containment System
Agency

3/5/2007
Date

[signature] Deputy
Signature and Title

CRT.doc 1-26-2007



PROPERTY OF THE
ARIZONA DEPARTMENT OF HEALTH SERVICES

BRIDGEWAY HEALTH SOLUTIONS, LLC
2250 North Craycroft Road, Suite 250
Tucson, AZ 85712

This agency is approved to provide the following services at the above location:

OUTPATIENT CLINIC
Counseling
Medication Services
Title 36 Court Ordered Evaluation
Title 36 court Ordered Treatment

TOTAL LICENSED BED CAPACITY N/A

*THESE SERVICES ARE TITLE XIX CERTIFIED

This license has been issued under the authority of Arizona Revised Statutes, Title 36, Chapters 4, 5, 18, and 50, pursuant to Department of Health Services rules included in the Arizona Administrative Code, Title 9, Chapter 20. The license is not transferable, shall not be altered in any way, and is valid only for the quarters occupied, and services approved at the time of issuance.

License Effective:

From: March 1, 2011 To: February 29, 2012

Issued: March 3, 2011

Number: BH3835

Recommended By:

Issued By: Assistant Director

PURSUANT TO A.R.S. §41-1092.11 (A), UPON SUBMITTAL OF A TIMELY AND SUFFICIENT APPLICATION
THIS LICENSE WILL REMAIN IN EFFECT UNTIL REISSUED OR REVOKED
TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE

ADHS (Rev. 8/07)

POLICY AND PROCEDURE

DEPARTMENT: Planning, Design & Construction	**DOCUMENT NAME:** Building Access for ADA Compliance
PAGE: 12 of 17	**REPLACES DOCUMENT:**
APPROVED DATE: 3/15/06	**RETIRED:**
EFFECTIVE DATE: 3/14/06	**REVIEWED/REVISED:** 3/07; 3/08; 10/08
PRODUCT TYPE: N/A	**REFERENCE NUMBER:** CC.FACL.17

SCOPE:

This policy pertains to all Centene organizations and their affiliates and any subcontractor of Centene or Centene affiliates.

PURPOSE:

This policy provides instructions to assure all office locations adhere to the local zoning and state/federal guidelines for the establishment of office space.

POLICY:

All Centene organizations will adhere to local municipality, state and federal requirements for building, access and compliance to the American Disabilities Act (ADA).

PROCEDURE:

Centene Planning, Design & Construction:

1. Includes requirements that all prospective properties comply and be in accordance with all local, state and federal ordinances and the ADA requirements. Further, Planning, Design & Construction provides that all architects design in accordance with and contractors build in accordance with ADA requirements. These demands are set forth when preparing a RFP for new locations of buildings and office space.

2. Reviews responses to the RFP and assures the responding companies include their plan for ADA compliance or action plan for compliance.

3. Assures the contractor/architect requests appropriate permits for the premises and/or building from the local city authorities for review and approval before any business operations are performed by Centene.

4. Ascertains that all buildings and office space for use by staff and members serviced by Centene health plans meet all local, state and federal regulations for ADA

REFERENCES : American Disabilities Act; Title 41. State Government (Refs & Annos)
Chapter 9. Civil Rights (Refs & Annos)
Article 4. Discrimination in Employment (Refs & Annos)

§ 41-1461. Definitions
§ 41-1492.02. Prohibition of discrimination by public accommodations and commercial facilities
§ 41-1492.03. Incorporation of standards in building codes
§ 41-1492.04. New construction and alterations in public accommodations and commercial facilities

ATTACHMENTS

DEFINITIONS:

REVISION LOG

REVISION	*DATE*
Department Name	10/8/08

POLICY AND PROCEDURE APPROVAL

Please Sign and date on the lines provided (if applicable):

Department Manager: __Approval on file_______________Date: ___3/15/06___

6.i. Offeror General Information – Management Information Systems Attachment

Application	Application Description	Current Version	Support by Vendor	# of Years Version Supported	# Yrs. Product at Centene	Vendor	Vendor Address	Contact Information
Medical Management								
TruCare	Clinical Case Management	4.3	Yes	< 1	< 1	CaseNet	23 Crosby Drive Bedford, MA 01730	Jon Abad (888) 701-0886
InterQual	Medical Necessity Criteria software	4.4	Yes	1	9	McKesson Health Solutions	275 Grove Street Suite 1-110 Newton, MA 02466	Jude Okolie (617) 273-2894
Centelligence Platform								
Enterprise Data Warehouse (EDW)	DBMS Platform for the Enterprise Data Warehouse	13.00.00.22	Yes	2	2	Teradata	10000 Innovation Dr. Dayton, OH 45342	Andy Gilbert (513) 319-7122
Executive Dashboard	Comprehensive dashboard and reporting.	5.15.0	Centene	2	2	Custom	N/A	N/A
XCelsius Enterprise	Dash boarding and Visualizations	2008 SP1	Yes	3	3	SAP	3999 W. Chester Pike Newtown Square, PA 16097	Mike McQuaid (919) 386-5476
Business Objects Crystal Enterprise XI	Compliance reporting and Business Intelligence tolls	XI 3.1	Yes	3	3	SAP		
Impact Intelligence	Utilization, patient outcomes analytics software	1.3	Yes	1	< 1	Ingenix	12125 Technology Dr. Eden Prairie, MN 55344	Jennifer Felt (952) 833-7100
Impact Pro	Predictive modeling and care management analytics software	5	Yes	1	2	Ingenix		
Quality Spectrum Insight (QSI)	Performance measurement and Quality Improvement (QI) reporting - HEDIS	13	Yes	1	2	Med Assurant, Inc.	1559 Janmar Road Snellville, GA 30078	Bill Carden (770) 982-8022 x 6162
Negotiator	Contract modeling software to aid in the analysis of a new or modified provider contract.	1	Centene	N/A	N/A	Custom	N/A	N/A
PowerCenter	Extract, Transform and Load Automation Tools	8.6.0	Yes	2	6	Informatica	100 Cardinal Way	Wayne Dye (310) 643.4522

Application	Application Description	Current Version	Support by Vendor	# of Years Version Supported	# Yrs. Product at Centene	Vendor	Vendor Address	Contact Information
PowerExchange	Updates EDW in near real time with changes from core applications	8.6.1	Yes	2	6		Redwood City, CA 94063	
Web Services								
Provider/ Member Portal	Secure web based portals used for secure transactions with Members and Providers	7	Centene	1	6	Custom	N/A	N/A
Clear Claim Connection	Bridgeway claim auditing rules accessed through the provider portal	5.0	Yes	2	7	McKesson Health Solutions	275 Grove Street Suite 1-110 Newton, MA 02466	Jude Okolie (617) 273-2894
Claims Processing								
Amisys Advance	Eligibility, enrollment, claims processing, Coordination of Benefits	4.0	Yes	2	15	DST Health Solutions	2400 Thea Drive Harrisburg, PA 17110	Kathleen McCarthy (717)703-7188
AWD	Document and workflow management	10	Yes	< 1	< 1			
Outpatient Pricer	Bridgeway outpatient claims pricing	3.0	Yes	1	< 1	Medical Data Express, LLC	908 W Chandler Blvd Bldg A Chandler, AZ 85225	David Abraham (480) 839-0420
ClaimsXten	Medical review and code auditing	CXT.2.0	Yes	4	4	McKesson Health Solutions	275 Grove Street Newton, MA 02466	Jude Okolie (617) 273-2894
MACESS.exp (Includes IMAX and Storage)	Document imaging, OCR and document management	IMAX -4.40	Yes	5	9	SunGard Workflow Solutions	104 Inverness Center Place, Birmingham AL 35242	Terry Clanton 205-408-3480
EXP Form Works/RRI	Image Storage	Form Works 4.0	Yes	5	9			
Encounters								
Xpress Encounter pro	Encounter Processing	3.1	Yes	1	1	Medical Data Express	908 W Chandler Blvd Bldg A Chandler, AZ 85225	David Abraham (480) 839-0420
Member and Provider Relationship Management								
Customer Relationship	Integrated Member/Provider	2011	Yes	<1	< 1	Microsoft	One Microsof	(425) 882-8080

Application	Application Description	Current Version	Support by Vendor	# of Years Version Supported	# Yrs. Product at Centene	Vendor	Vendor Address	Contact Information
Management (CRM)	inquiry, tracking and management					Corporation	t Way Redmond, WA 98052	
Portico	Provider Credentialing, demographics, financial information.	6.1	Yes	3	3	Portico Systems	518 East Township Line Rd., Suite 100 Blue Bell, PA 19422	Connie O'Brien (215) 358-3800
Emptoris	Contract Management and Reporting	7.5.9.1	Yes	< 1	2	Emptoris Inc.	200 Wheeler Road Burlington, MA 01803	Bryan Drumm (952) 473.2600
Enterprise Content Management (ECM)	N/A	N/A	Centene	N/A	N/A	N/A	N/A	N/A
After Hours NurseWise Support								
N Centaurus Telehealth Triage	Nurse triage and call center workflow for NurseWise	2010	Yes	3	<1	LVM	4262 E. Florian Ave. Mesa, AZ 85206	Adan Garcia 480-633-8200 ext 264
Telecom Services								
Avaya Communication Manager (CM)	Delivers world class call routing and applications. Call centers managed through automatic call distribution (ACD) and advanced vectoring.	5.2.1	Yes	1	7	Avaya Inc.	Hdqtrs 211 Mt. Airy Road , Basking Ridge, NJ 07920	(866) Go-Avaya
Avaya Call Management System (CMS) Supervisor	Tracks and reports information processed through the ACD	14	Yes	5	7			
Avaya Voice Portal	Speech-Enabled self-service IVR	5.1	Yes	1	1			
Middleware Services								
BusinessConnect	Data translation software. Supports HIPAA, other ANSI, and proprietary formats.	3.6.0	Yes	2	7	TIBCO Software	3303 Hillview Avenue Palo Alto, CA 94304	Kevin Niblock (650) 846-1000
iProcess Suite	Rules Engine	4.1.1	Yes	2	3			
Edifecs X-Engine	HIPAA Compliance Checking - the translator/validator component of	6.2.1	Yes	1	6	EDIFECS	2600 116th Avenue NE,	Sue Powers (517) 887-0717

Application	Application Description	Current Version	Support by Vendor	# of Years Version Supported	# Yrs. Product at Centene	Vendor	Vendor Address	Contact Information
	EDIFECS.						Suite 200 Bellevue, WA 98004	
EDIFECS Ramp Manager	Automate EDI trading partner administration.	6.4	Yes	1	< 1			
Diplomat Transaction Manager	Used for Enterprise File Transfer. Supports FTP, SFTP, or Local Network Delivery.	3.5.3	Yes	<1	4	Coviant Software	60 Thoreau Street, Concord, MA 01742	Jim Cutler (781) 534-5163
Change Management								
Service-Now	Enterprise Service Desk software - Incident/Problem/Change Management	Fall 2010	Yes	< 1	< 1	Service-Now	120 S. Sierra Ave. Slana Beach, CA 92075	Steven Tito (630) 786-1592

Table of Contents

Section B – Capitation

Actuarial Certification **27**
Capitation Rate Templates.. **41**

1301 Fifth Avenue
Suite 3800
Seattle, WA 98101-2605
USA

Tel +1 206 504 5946
Fax +1 206 682 1295

rob.bachler@milliman.com

March 25, 2011

Actuarial Certification
Bridgeway Health Systems
ALTCS Elderly & Physically Disabled Capitation Bids: GSA 40
October 1, 2011 – September 30, 2012

I, Robert Bachler, am a Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries. I am also a Member of the American Academy of Actuaries and meet its Qualification Standards for Prescribed Statements of Actuarial Opinion. I have been retained by Bridgeway Health Systems (Bridgeway) to provide a certification of the actuarial soundness of its proposed capitation rate for Elderly & Physically Disabled Services in GSA 40 under the Arizona Long Term Care System (ALTCS).

The purpose of this certification is to comply with the Instructions to Offerors contained in the Request for Proposal (including amendments through the date of this certification) issued by Arizona Health Care Cost Containment System Administration (AHCCCS). This certification may not be appropriate for other purposes.

The capitation rate to which this certification applies is shown in the table below. The rate applies to the period October 1, 2011 through September 30, 2012. This rate is inclusive of Case Management, Administration, Risk/Contingency and Premium Tax, and net of Reinsurance and Share of Cost. The bid reflects the AHCCCS-provided HCBS Mix percentage, Share of Cost, and Reinsurance Offset values.

Bridgeway Health Systems
Proposed Capitation Rate for GSA 40

Net Capitation with Premium Tax
$3,223.34

It is my opinion that the above rate is adequate to fund claims and administrative expenses for an average elderly & physically disabled population for GSA 40 during the time period for which it is intended.

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

The costs which underlie the capitation bid are estimates only and include assumptions regarding future experience. In my opinion, the assumptions used are applicable for the purpose of this certification and are reasonably related to the experience of Bridgeway and/or experience provided by AHCCCS and to reasonable expectations. Actual results will differ from the figures indicated in the final offered rates to the extent that future plan experience differs from the assumptions used to develop the figures.

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

Milliman, Inc.
1301 Fifth Avenue, Suite 3800
Seattle, WA 98101-2605

March 25, 2011

1301 Fifth Avenue
Suite 3800
Seattle, WA 98101-2605
USA

Tel +1 206 504 5946
Fax +1 206 682 1295

rob.bachler@milliman.com

March 25, 2011

Actuarial Certification
Bridgeway Health Systems
ALTCS Elderly & Physically Disabled Capitation Bids: GSA 42
October 1, 2011 – September 30, 2012

I, Robert Bachler, am a Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries. I am also a Member of the American Academy of Actuaries and meet its Qualification Standards for Prescribed Statements of Actuarial Opinion. I have been retained by Bridgeway Health Systems (Bridgeway) to provide a certification of the actuarial soundness of its proposed capitation rate for Elderly & Physically Disabled Services in GSA 42 under the Arizona Long Term Care System (ALTCS).

The purpose of this certification is to comply with the Instructions to Offerors contained in the Request for Proposal (including amendments through the date of this certification) issued by Arizona Health Care Cost Containment System Administration (AHCCCS). This certification may not be appropriate for other purposes.

The capitation rate to which this certification applies is shown in the table below. The rate applies to the period October 1, 2011 through September 30, 2012. This rate is inclusive of Case Management, Administration, Risk/Contingency and Premium Tax, and net of Reinsurance and Share of Cost. The bid reflects the AHCCCS-provided HCBS Mix percentage, Share of Cost, and Reinsurance Offset values.

Bridgeway Health Systems
Proposed Capitation Rate for GSA 42

Net Capitation with Premium Tax
$3,124.45

It is my opinion that the above rate is adequate to fund claims and administrative expenses for an average elderly & physically disabled population for GSA 42 during the time period for which it is intended.

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

The costs which underlie the capitation bid are estimates only and include assumptions regarding future experience. In my opinion, the assumptions used are applicable for the purpose of this certification and are reasonably related to the experience of Bridgeway and/or experience provided by AHCCCS and to reasonable expectations. Actual results will differ from the figures indicated in the final offered rates to the extent that future plan experience differs from the assumptions used to develop the figures.

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

Milliman, Inc.
1301 Fifth Avenue, Suite 3800
Seattle, WA 98101-2605

March 25, 2011

1301 Fifth Avenue
Suite 3800
Seattle, WA 98101-2605
USA

Tel +1 206 504 5946
Fax +1 206 682 1295

rob.bachler@milliman.com

March 25, 2011

Actuarial Certification
Bridgeway Health Systems
ALTCS Elderly & Physically Disabled Capitation Bids: GSA 44
October 1, 2011 – September 30, 2012

I, Robert Bachler, am a Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries. I am also a Member of the American Academy of Actuaries and meet its Qualification Standards for Prescribed Statements of Actuarial Opinion. I have been retained by Bridgeway Health Systems (Bridgeway) to provide a certification of the actuarial soundness of its proposed capitation rate for Elderly & Physically Disabled Services in GSA 44 under the Arizona Long Term Care System (ALTCS).

The purpose of this certification is to comply with the Instructions to Offerors contained in the Request for Proposal (including amendments through the date of this certification) issued by Arizona Health Care Cost Containment System Administration (AHCCCS). This certification may not be appropriate for other purposes.

The capitation rate to which this certification applies is shown in the table below. The rate applies to the period October 1, 2011 through September 30, 2012. This rate is inclusive of Case Management, Administration, Risk/Contingency and Premium Tax, and net of Reinsurance and Share of Cost. The bid reflects the AHCCCS-provided HCBS Mix percentage, Share of Cost, and Reinsurance Offset values.

Bridgeway Health Systems
Proposed Capitation Rate for GSA 44

Net Capitation with Premium Tax
$2,794.52

It is my opinion that the above rate is adequate to fund claims and administrative expenses for an average elderly & physically disabled population for GSA 44 during the time period for which it is intended.

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

The costs which underlie the capitation bid are estimates only and include assumptions regarding future experience. In my opinion, the assumptions used are applicable for the purpose of this certification and are reasonably related to the experience of Bridgeway and/or experience provided by AHCCCS and to reasonable expectations. Actual results will differ from the figures indicated in the final offered rates to the extent that future plan experience differs from the assumptions used to develop the figures.

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

Milliman, Inc.
1301 Fifth Avenue, Suite 3800
Seattle, WA 98101-2605

March 25, 2011

1301 Fifth Avenue
Suite 3800
Seattle, WA 98101-2605
USA

Tel +1 206 504 5946
Fax +1 206 682 1295

rob.bachler@milliman.com

March 25, 2011

Actuarial Certification
Bridgeway Health Systems
ALTCS Elderly & Physically Disabled Capitation Bids: GSA 46
October 1, 2011 – September 30, 2012

I, Robert Bachler, am a Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries. I am also a Member of the American Academy of Actuaries and meet its Qualification Standards for Prescribed Statements of Actuarial Opinion. I have been retained by Bridgeway Health Systems (Bridgeway) to provide a certification of the actuarial soundness of its proposed capitation rate for Elderly & Physically Disabled Services in GSA 46 under the Arizona Long Term Care System (ALTCS).

The purpose of this certification is to comply with the Instructions to Offerors contained in the Request for Proposal (including amendments through the date of this certification) issued by Arizona Health Care Cost Containment System Administration (AHCCCS). This certification may not be appropriate for other purposes.

The capitation rate to which this certification applies is shown in the table below. The rate applies to the period October 1, 2011 through September 30, 2012. This rate is inclusive of Case Management, Administration, Risk/Contingency and Premium Tax, and net of Reinsurance and Share of Cost. The bid reflects the AHCCCS-provided HCBS Mix percentage, Share of Cost, and Reinsurance Offset values.

Bridgeway Health Systems
Proposed Capitation Rate for GSA 46

Net Capitation with Premium Tax
$2,949.86

It is my opinion that the above rate is adequate to fund claims and administrative expenses for an average elderly & physically disabled population for GSA 46 during the time period for which it is intended.

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

The costs which underlie the capitation bid are estimates only and include assumptions regarding future experience. In my opinion, the assumptions used are applicable for the purpose of this certification and are reasonably related to the experience of Bridgeway and/or experience provided by AHCCCS and to reasonable expectations. Actual results will differ from the figures indicated in the final offered rates to the extent that future plan experience differs from the assumptions used to develop the figures.

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

Milliman, Inc.
1301 Fifth Avenue, Suite 3800
Seattle, WA 98101-2605

March 25, 2011

1301 Fifth Avenue
Suite 3800
Seattle, WA 98101-2605
USA

Tel +1 206 504 5946
Fax +1 206 682 1295

rob.bachler@milliman.com

March 25, 2011

Actuarial Certification
Bridgeway Health Systems
ALTCS Elderly & Physically Disabled Capitation Bids: GSA 48
October 1, 2011 – September 30, 2012

I, Robert Bachler, am a Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries. I am also a Member of the American Academy of Actuaries and meet its Qualification Standards for Prescribed Statements of Actuarial Opinion. I have been retained by Bridgeway Health Systems (Bridgeway) to provide a certification of the actuarial soundness of its proposed capitation rate for Elderly & Physically Disabled Services in GSA 48 under the Arizona Long Term Care System (ALTCS).

The purpose of this certification is to comply with the Instructions to Offerors contained in the Request for Proposal (including amendments through the date of this certification) issued by Arizona Health Care Cost Containment System Administration (AHCCCS). This certification may not be appropriate for other purposes.

The capitation rate to which this certification applies is shown in the table below. The rate applies to the period October 1, 2011 through September 30, 2012. This rate is inclusive of Case Management, Administration, Risk/Contingency and Premium Tax, and net of Reinsurance and Share of Cost. The bid reflects the AHCCCS-provided HCBS Mix percentage, Share of Cost, and Reinsurance Offset values.

Bridgeway Health Systems
Proposed Capitation Rate for GSA 48

Net Capitation with Premium Tax
$3,275.66

It is my opinion that the above rate is adequate to fund claims and administrative expenses for an average elderly & physically disabled population for GSA 48 during the time period for which it is intended.

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

The costs which underlie the capitation bid are estimates only and include assumptions regarding future experience. In my opinion, the assumptions used are applicable for the purpose of this certification and are reasonably related to the experience of Bridgeway and/or experience provided by AHCCCS and to reasonable expectations. Actual results will differ from the figures indicated in the final offered rates to the extent that future plan experience differs from the assumptions used to develop the figures.

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

Milliman, Inc.
1301 Fifth Avenue, Suite 3800
Seattle, WA 98101-2605

March 25, 2011

1301 Fifth Avenue
Suite 3800
Seattle, WA 98101-2605
USA

Tel +1 206 504 5946
Fax +1 206 682 1295

rob.bachler@milliman.com

March 25, 2011

Actuarial Certification
Bridgeway Health Systems
ALTCS Elderly & Physically Disabled Capitation Bids: GSA 50
October 1, 2011 – September 30, 2012

I, Robert Bachler, am a Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries. I am also a Member of the American Academy of Actuaries and meet its Qualification Standards for Prescribed Statements of Actuarial Opinion. I have been retained by Bridgeway Health Systems (Bridgeway) to provide a certification of the actuarial soundness of its proposed capitation rate for Elderly & Physically Disabled Services in GSA 50 under the Arizona Long Term Care System (ALTCS).

The purpose of this certification is to comply with the Instructions to Offerors contained in the Request for Proposal (including amendments through the date of this certification) issued by Arizona Health Care Cost Containment System Administration (AHCCCS). This certification may not be appropriate for other purposes.

The capitation rate to which this certification applies is shown in the table below. The rate applies to the period October 1, 2011 through September 30, 2012. This rate is inclusive of Case Management, Administration, Risk/Contingency and Premium Tax, and net of Reinsurance and Share of Cost. The bid reflects the AHCCCS-provided HCBS Mix percentage, Share of Cost, and Reinsurance Offset values.

Bridgeway Health Systems
Proposed Capitation Rate for GSA 50

Net Capitation with Premium Tax
$3,424.73

It is my opinion that the above rate is adequate to fund claims and administrative expenses for an average elderly & physically disabled population for GSA 50 during the time period for which it is intended.

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

The costs which underlie the capitation bid are estimates only and include assumptions regarding future experience. In my opinion, the assumptions used are applicable for the purpose of this certification and are reasonably related to the experience of Bridgeway and/or experience provided by AHCCCS and to reasonable expectations. Actual results will differ from the figures indicated in the final offered rates to the extent that future plan experience differs from the assumptions used to develop the figures.

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

Milliman, Inc.
1301 Fifth Avenue, Suite 3800
Seattle, WA 98101-2605

March 25, 2011

1301 Fifth Avenue
Suite 3800
Seattle, WA 98101-2605
USA

Tel +1 206 504 5946
Fax +1 206 682 1295

rob.bachler@milliman.com

March 25, 2011

Actual Certification
Bridgeway Health Systems
ALTCS Elderly & Physically Disabled Capitation Bids: GSA 52
October 1, 2011 – September 30, 2012

I, Robert Bachler, am a Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries. I am also a Member of the American Academy of Actuaries and meet its Qualification Standards for Prescribed Statements of Actuarial Opinion. I have been retained by Bridgeway Health Systems (Bridgeway) to provide a certification of the actuarial soundness of its proposed capitation rate for Elderly & Physically Disabled Services in GSA 52 under the Arizona Long Term Care System (ALTCS).

The purpose of this certification is to comply with the Instructions to Offerors contained in the Request for Proposal (including amendments through the date of this certification) issued by Arizona Health Care Cost Containment System Administration (AHCCCS). This certification may not be appropriate for other purposes.

The capitation rate to which this certification applies is shown in the table below. The rate applies to the period October 1, 2011 through September 30, 2012. This rate is inclusive of Case Management, Administration, Risk/Contingency and Premium Tax, and net of Reinsurance and Share of Cost. The bid reflects the AHCCCS-provided HCBS Mix percentage, Share of Cost, and Reinsurance Offset values.

Bridgeway Health Systems
Proposed Capitation Rate for GSA 52

Net Capitation with Premium Tax
$3,178.18

It is my opinion that the above rate is adequate to fund claims and administrative expenses for an average elderly & physically disabled population for GSA 52 during the time period for which it is intended.

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

The costs which underlie the capitation bid are estimates only and include assumptions regarding future experience. In my opinion, the assumptions used are applicable for the purpose of this certification and are reasonably related to the experience of Bridgeway and/or experience provided by AHCCCS and to reasonable expectations. Actual results will differ from the figures indicated in the final offered rates to the extent that future plan experience differs from the assumptions used to develop the figures.

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

Milliman, Inc.
1301 Fifth Avenue, Suite 3800
Seattle, WA 98101-2605

March 25, 2011

EPD Full Cap Rate Template

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

Service Category	Bridgeway / GSA 40		
	Gross	MIX	Net
Nursing Facility	$ 5,274.00	24.86%	$ 1,311.12
Share of Cost			$ (212.17)
Net Nursing Facility			**$ 1,098.95**
HCBS Home and Community	$ 1,595.00	75.14%	$ 1,198.48
Net HCBS			**$ 1,198.48**
Acute Care Prior to Reinsurance			$ 699.84
Reinsurance Offset			$ (196.76)
Net Acute Care			**$ 503.08**
Medical Component [2]			**$ 2,800.51**
Case Management [3]			$ 115.06
Administration [4]		6.75%	$ 210.08
Sub-Total of Scored Components			**$ 3,125.65**
Risk/Contingency at 1%			$ 33.22
Net Capitation			**$ 3,158.87**
Premium Tax (98% of Final Cap)			$ 64.47
Net Cap w/ Premium Tax			**$ 3,223.34**

Key

user input

user input using AHCCCS provided numbers

formula

Notes

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

EPD Full Cap Rate Template

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

Service Category	Bridgeway / GSA 42		
	Gross	MIX	Net
Nursing Facility	$ 4,905.00	41.20%	$ 2,020.86
Share of Cost			$ (290.22)
Net Nursing Facility			**$ 1,730.64**
HCBS Home and Community	$ 1,149.00	58.80%	$ 675.61
Net HCBS			**$ 675.61**
Acute Care Prior to Reinsurance			$ 500.46
Reinsurance Offset			$ (186.69)
Net Acute Care			**$ 313.77**
Medical Component [2]			**$ 2,720.02**
Case Management [3]			$ 106.40
Administration [4]		6.75%	$ 203.38
Sub-Total of Scored Components			**$ 3,029.80**
Risk/Contingency at 1%			$ 32.16
Net Capitation			**$ 3,061.96**
Premium Tax (98% of Final Cap)			$ 62.49
Net Cap w/ Premium Tax			**$ 3,124.45**

Key

user input

user input using AHCCCS provided numbers

formula

Notes

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

EPD Full Cap Rate Template

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

Service Category	Bridgeway / GSA 44		
	Gross	MIX	Net
Nursing Facility	$ 5,030.00	32.13%	$ 1,616.14
Share of Cost			$ (304.75)
Net Nursing Facility			**$ 1,311.39**
HCBS Home and Community	$ 1,007.05	67.87%	$ 683.48
Net HCBS			**$ 683.48**
Acute Care Prior to Reinsurance			$ 527.82
Reinsurance Offset			$ (106.81)
Net Acute Care			**$ 421.01**
Medical Component [2]			**$ 2,415.88**
Case Management [3]			$ 116.44
Administration [4]		6.75%	$ 178.14
Sub-Total of Scored Components			**$ 2,710.46**
Risk/Contingency at 1%			$ 28.17
Net Capitation			**$ 2,738.63**
Premium Tax (98% of Final Cap)			$ 55.89
Net Cap w/ Premium Tax			**$ 2,794.52**

Key

user input

user input using AHCCCS provided numbers

formula

Notes

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

EPD Full Cap Rate Template

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

Service Category	Bridgeway / GSA 46		
	Gross	MIX	Net
Nursing Facility	$ 4,648.00	39.05%	$ 1,815.04
Share of Cost			$ (343.32)
Net Nursing Facility			**$ 1,471.72**
HCBS Home and Community	$ 1,204.00	60.95%	$ 733.84
Net HCBS			**$ 733.84**
Acute Care Prior to Reinsurance			$ 479.64
Reinsurance Offset			$ (120.27)
Net Acute Care			**$ 359.37**
Medical Component [2]			**$ 2,564.93**
Case Management [3]			$ 107.61
Administration [4]		6.75%	$ 188.51
Sub-Total of Scored Components			**$ 2,861.05**
Risk/Contingency at 1%			$ 29.81
Net Capitation			**$ 2,890.86**
Premium Tax (98% of Final Cap)			$ 59.00
Net Cap w/ Premium Tax			**$ 2,949.86**

Key

user input
user input using AHCCCS provided numbers
formula

Notes

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

EPD Full Cap Rate Template

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

Service Category	Bridgeway / GSA 48		
	Gross	MIX	Net
Nursing Facility	$ 5,178.00	37.04%	$ 1,917.93
Share of Cost			$ (379.10)
Net Nursing Facility			**$ 1,538.83**
HCBS Home and Community	$ 1,548.00	62.96%	$ 974.62
Net HCBS			**$ 974.62**
Acute Care Prior to Reinsurance			$ 472.62
Reinsurance Offset			$ (124.59)
Net Acute Care			**$ 348.03**
Medical Component [2]			**$ 2,861.48**
Case Management [3]			$ 106.88
Administration [4]		6.75%	$ 208.77
Sub-Total of Scored Components			**$ 3,177.13**
Risk/Contingency at 1%			$ 33.02
Net Capitation			**$ 3,210.15**
Premium Tax (98% of Final Cap)			$ 65.51
Net Cap w/ Premium Tax			**$ 3,275.66**

Key

user input

user input using AHCCCS provided numbers

formula

Notes

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

EPD Full Cap Rate Template

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

Service Category	Bridgeway / GSA 50		
	Gross	MIX	Net
Nursing Facility	$ 5,396.00	33.24%	$ 1,793.63
Share of Cost			$ (265.64)
Net Nursing Facility			**$ 1,527.99**
HCBS Home and Community	$ 1,678.00	66.76%	$ 1,120.23
Net HCBS			**$ 1,120.23**
Acute Care Prior to Reinsurance			$ 532.53
Reinsurance Offset			$ (195.45)
Net Acute Care			**$ 337.08**
Medical Component [2]			**$ 2,985.30**
Case Management [3]			$ 113.41
Administration [4]		6.75%	$ 222.36
Sub-Total of Scored Components			**$ 3,321.07**
Risk/Contingency at 1%			$ 35.17
Net Capitation			**$ 3,356.24**
Premium Tax (98% of Final Cap)			$ 68.49
Net Cap w/ Premium Tax			**$ 3,424.73**

Key

user input

user input using AHCCCS provided numbers

formula

Notes

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

EPD Full Cap Rate Template

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

Service Category	Bridgeway / GSA 52		
	Gross	MIX	Net
Nursing Facility	$ 5,630.00	25.82%	$ 1,453.67
Share of Cost			$ (223.08)
Net Nursing Facility			**$ 1,230.59**
HCBS Home and Community	$ 1,416.00	74.18%	$ 1,050.39
Net HCBS			**$ 1,050.39**
Acute Care Prior to Reinsurance			$ 709.07
Reinsurance Offset			$ (229.85)
Net Acute Care			**$ 479.22**
Medical Component [2]			**$ 2,760.20**
Case Management [3]			$ 111.93
Administration [4]		6.75%	$ 209.38
Sub-Total of Scored Components			**$ 3,081.51**
Risk/Contingency at 1%			$ 33.11
Net Capitation			**$ 3,114.62**
Premium Tax (98% of Final Cap)			$ 63.56
Net Cap w/ Premium Tax			**$ 3,178.18**

Key

user input
user input using AHCCCS provided numbers
formula

Notes

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

Table of Contents
Section C - Organization

MORAL AND RELIGIOUS OBJECTIONS ... 49

Question 2: Moral and Religious Objections ... 49

ORGANIZATION AND STAFFING ... 50

Question 3: Resumes ... 50

Question 4: Part-Time Key Positions ... 83

Question 5: Functional Organizational Charts ... 84

SANCTIONS ... 87

Question 6: Sanctions ... 87

CLAIMS ... 90

Question 7: Claims Adjudication Process ... 90

Question 8: Electronic Claims Submission ... 101

Question 9: Clinical Edits ... 104

ENCOUNTERS ... 107

Question 10: Encounters Submission ... 107

INFORMATION SERVICES ... 115

Question 11: Information System ... 115

Question 12: Change Order and Software Process ... 141

Question 13: Software Version ... 144

Question 14: Current and Future IT Federal Mandates ... 147

GRIEVANCE SYSTEM ... 150

Question 15: Grievance System ... 150

CORPORATE COMPLIANCE ... 157

Question 16: Corporate Compliance Program ... 157

FINANCE AND LIABILITY MANAGEMENT ... 161

Question 17: Audited Financial Statements ... 161

Question 18: Performance Bond ... 163

Question 19: Capitalization Requirement ... 164

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

Bridgeway Health Solutions, LLC will provide all covered services, as indicated in Section D, Program Requirements of the ALTCS RFP, for all ALTCS members.

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

Bridgeway Health Solutions, LLC (Bridgeway) has an experienced staff already in place to manage the ALTCS Program. Our key staff have extensive experience working with the Elderly and Physically Disabled population and provide a valuable resource to our members, providers and newer staff members. Please see the table below for a list of the Key Staff positions along with the staff member's name and title. Resumes for all key staff are on subsequent pages.

Required Key Staff	Bridgeway Position Title	Name
Administrator/CEO/COO	President and CEO	Richard L. Fredrickson
Medical Director/CMO	Medical Director	Fred Miller, M.D., Ph.D., CMD
Chief Financial Officer/CFO	Vice President, Finance	Nancy Maurer, CPA
Pharmacy Director/Coordinator	Director, Pharmacy	Duane Angulo, R.Ph, JD
Dental Director/Coordinator	Director, Dental Program	Bruce Nelson, DDS, PC
Compliance Officer	Vice President, Operation Services & Compliance	Nicole Larson
Dispute and Appeal Manager	Manager, Grievance & Appeals	Kitley Ann West
Business Continuity Planning and Recovery Coordinator	Director, Business Continuity	Glen Woita, CBCP, CISA
Contract Compliance Officer	Vice President, Operational Services & Compliance	Nicole Larson
Quality Management Coordinator	Manager, Quality Management Program	Joann Adams, RN, BSN
Performance / Quality Improvement Coordinator	Manager, Quality Improvement	Karen Davis, RN, BSN, CPHQ
Maternal Health / EPSDT (Child Health) Coordinator	Maternal Health & EPSDT Specialist	Maritza Jimenez, LPN
Medical Management Coordinator	Vice President, Medical Management	Susan Benedetti, RN, BSN
Behavioral Health Coordinator	Behavioral Health Coordinator	Kathy Dutridge, LAC
Provider Services Manager	Vice President, Contracts, Member & Provider Services	Elaine Teune
Claims Administrator	Vice President, Claims & Encounters	Ed Gallegos
Provider Claims Educator	Vice President, Contracts, Member & Provider Services	Elaine Teune
Case Management Administrator/Manager	Vice President, Long Term Care Case Management	Mary Reiss, BSW

Administrator/CEO/COO

Richard L. Fredrickson, President and Chief Executive Officer

Summary

Accomplished Government Programs Executive skilled in identifying and executing on process improvements. Strong team leadership abilities reflected by consistent bottom line results while maintaining high customer satisfaction levels. Ability to successfully drive community and provider stakeholders' consensus.

Proficiencies include:

- Long Term Care Policy and Program Operations
- Medicaid Rate Development
- Risk Adjustment Mechanisms
- Quality Improvement Initiatives
- Cultural Competency and Disability Sensitivity
- Provider Relations and Network Development
- Integrated Acute/Behavioral Health Models
- Advocacy and Community Relations
- Disease Management Programs

Career History

Bridgeway Health Solutions — ***Includes Long Term Care Experience***

President and Chief Executive Officer (Tempe, Arizona) — Period: 2006-present

- Directed all operations for Acute, Medicare (SNP), and ALTCS Programs in Arizona

Buckeye Health Plan — ***Includes Long Term Care Experience***

Interim Chief Executive Officer (Columbus, Ohio) — Period: 2008-2009

- Directed all operations for statewide Acute and ABD Medicaid Program in Ohio

Centene Corporation — ***Includes Long Term Care Experience***

Vice President ABD and Special Needs Programs (St. Louis, Missouri) — Period: 2003-2006

- Directed ABD and Long Term Care operating programs and New Business Development
- Led successful implementation of Wisconsin ABD Program in 2005
- Presented expert testimony at Ohio and Missouri Medicaid Reform Commissions hearing on ABD Program redesign
- Originated Centene National ABD Program model which was deployed in Wisconsin and New Jersey
- Led Texas SSI expansion development

Amerigroup Corporation — ***Includes Long Term Care Experience***

Vice President, National SSI Operations (Virginia Beach, Virginia) — Period: 2003

- Executed leadership responsibility for National SSI and Long Term Care Product
- Provided strategic positioning direction for operating models, new business development, and organic growth efforts for 70,000 ABD Members

Vice President, Special Needs (Edison, NJ) — Period: 2000-2003

- Accepted assignment to existing New Jersey based health plan to conduct project for SSI and General Assistance expansion; development included regulatory compliance, CDPS risk adjustment model, network development, medical management, advocacy linkages, marketing and outreach
- Exceeded medical loss ratio expectations and membership targets in first year

Vice President and Executive Director, Star+Plus LTC Program (Houston, Texas) — Period: 1997-2000

- Successfully led multidisciplinary Medicaid product team through RFP to full operational readiness; program generated $170 million revenue on 30,0000 lives
- Exceeded Medical Loss Ratio targets and administrative efficiencies, leading to levels below budget
- Maintained voluntary disenrollment rates at less than one percent monthly
- Exceeded targeted member satisfaction levels
- Developed medical-socio care coordination model; originated provider reimbursement strategy; led a network development team, bringing physical, behavioral, long-term care, and home-community based providers into a fully integrated delivery model
- Selected to facilitate a national service center team through process improvements
- Developed successful Texas "CHIP" bid

United HealthCare Corporation ***Includes Long Term Care Experience***

Manager, ElderCare (Miami, Florida) Period: 1996-1997

- Directed sales, enrollment and provider relations for Nursing Home Diversion Program
- Led sales team to 60% membership growth
- Developed approved network for County COA expansion
- Successfully completed and integrated acquisition of Pacificare Diversion Program

Director of Operations, Workers' Compensation Division (Miami, Florida) Period: 1993-1996

- Led Managed Care Risk Sharing Initiative
- Implemented State certified capitated program with $250 million premium partner
- Served as Senior Account Executive for Florida State Employees Program
- Exceeded budgeted net income for 1994 and 1995 by 25%

Century Financial Service

Senior Consultant (Boca Raton, Florida) Period: 1991-1993

- Served as Lead Practice Partner for Workers' Compensation Division
- Appointed to Advisory Board of group self-insured fund

Education and Credentials

University of Illinois, Bachelor of Science in Finance, 1978
Chicago Board of Underwriters Certification, 1982

Professional and Community Service, Honors, and Awards

Easter Seals Board of Directors. 2001-2003
Camden County Disabled Citizens Advisory Board Member. 2002-2003
HHS National Independent Choices, Symposium Speaker. 2001 and 2000
NJ Association of Community Providers Annual Conference, Workshop Presenter. 2002
Texas Personal Care Task Force Member. 1997-1999
Commissioners Regulatory Advisory Group Member. 1998

Medical Director/CMO

Fred Miller, MD, PhD, CMD, Medical Director

Summary

A dynamic, results-driven physician with a proven background of 31 years of both clinical and administrative roles offering leadership and direction to design focused, effective plans and strategies to support customer healthcare needs and organizational goals. Collaborative leader working closely with medical and legal professionals to resolve complex issues in the clinical, medical administrative and forensic services arenas. Also, having achieved success increasing revenues, reducing overall costs, while mitigating and managing risks in high-risk environments.

Medical Administration	**Medical Director**	**Forensic Services**
Business Development	**Project Management**	**Emergency Medicine**
Vendor Management	**Family Practice**	**Teacher/Professor**
Quality Management	**Geriatric Medicine**	

Career History

Centene Corporation — ***Includes Long Term Care Experience***

Medical Director, Bridgeway Health Solutions, (Tucson, Arizona) — Period: 2011-Present

- Develop, implement, and interpret medical policies and procedures to ensure clinical integrity in the provision of medical care to members
- Provide expertise to all areas of the operation to ensure timely medical decisions, including after hours consultations
- Act as a resource for staff members throughout the operation, including involvement in provider education, in-service training, and orientation
- Oversee all medical and quality management functions of the health plan to ensure the continuous assessment and improvement of the quality of care provided to ALTCS members
- Perform medical review activities pertaining to utilization review, quality assurance, and medical review of complex, controversial, or experimental medical services
- Conduct physician reviews and oversight of all potential adverse determinations including pre-certifications/prior authorizations, concurrent review, and appeals/retrospective review
- Review all network provider applications and submit recommendations regarding credentialing and reappointment of providers prior to contracting to the health plan's provider contracting staff

Pima County — ***Includes Long Term Care Experience***

Chief Medical Director, (Tucson, Arizona) — Period: 2006-2010

- Served as Chief Medical Director for Pima County with medical oversight for county correctional facilities, the Pima County Health Department, and the Pima Health System (PHS)
- Developed, implemented, and monitored the quality/medical management plan for PHS' ALTCS service line
- Collaborated with network development and provider contracting to ensure that adequate staff and resources were available to provide proper medical care to members
- Developed Pima County's Restoration to Competency Program to provide courts with an alternative to the Arizona State Hospital program to determine defendant's competence to stand trial, which resulted in savings of $4.2 million to Pima County
- Developed quality management program for Pima County Jails' juvenile and adult facilities that resulted in 100% compliance with the National Commission on Correctional Health Care survey for 2010 with no deficiencies identified
- Organized the development of the first quality management program for the Pima County Health Department that included the establishment of identifiable goals, with measurable outcomes regarding functioning of clinics and disease management

Posada Del Sol Health Care Center — ***Includes Long Term Care Experience***

Medical Director, (Tucson, Arizona) — Period: 2003-2010

- Served as Medical Director for 156 bed skilled nursing facility
- Developed several quality measures, with participation from the Director of Nursing, Administrator, Social services and, Physical/Occupational Therapy, to develop a more efficient plan of care for nursing facility residents, family members, and staff that led to improved care and outcomes for the long term care of residents

American Physicians, Inc. — ***Includes Long Term Care Experience***

Medical Director, (Phoenix, Arizona) — Period: 2002-2003

- Served as Medical Director for hospitalist group providing medical oversight to gauge appropriateness of care

- Provided direct patient care to patients in both private and Maricopa county skilled nursing facilities, assisted living facilities and private homes

Carebridge ***Includes Long Term Care Experience***

Medical Director, (Phoenix, Arizona) Period: 2001-2002

- Oversaw the delivery of clinical services provided at skilled nursing facilities and assisted living facilities

Plaza Healthcare ***Includes Long Term Care Experience***

Chief of Staff and Medical Director, (Scottsdale, Arizona) Period: 1993-1996

- Served as Chief of Staff and house physician for 179-bed skilled nursing facility
- Provided medical director oversight to the facility to ensure clinical integrity of all medical actions at the facility

FPA Medical Management ***Includes Long Term Care Experience***

Medical Director, (Phoenix, Arizona) Period: 1999

- Continued in role as Medical Director for Phoenix area locations following the acquisition of Thomas Davis Medical Centers by FPA Medical Management

Thomas Davis Medical Centers ***Includes Long Term Care Experience***

Medical Director, (Phoenix, Arizona) Period: 1996-1999

- Started as a primary care physician providing direct patient care to patients visiting the urgent care center before being promoted to Medical Director for the 10 Phoenix-area locations of a multi-specialty medical group

Paradise Valley Hospital

Emergency Medicine Staff Physician, (Phoenix, Arizona) Period: 1983-1993

- Provided direct patient care
- Served as the Director of the Emergency Department from 1983-1993
- Taught and served as course director for Advanced Life Support classes at the facility
- Conducted paramedic tape and chart review

John C. Lincoln Hospital

Emergency Medicine Staff Physician Period: 1981-1983

- Provided direct patient care to patients in the Emergency Department

Phoenix Indian Medical Center

Emergency Medicine Staff Physician, (Phoenix, Arizona) Period: 1979-1981

- Provided direct patient care and clinical services
- Served as Director of Quality Assurance for the Emergency Medicine department

Middlesex Community College

Adjunct Professor, (Middlesex, New Jersey) Period: 1971-1972

- Taught General Biology

Rutgers University

Assistant Professor, (New Brunswick, New Jersey) Period: 1970-1972

- Taught Microbiology, Zoology, Protozoology, and Genetics

National Aeronautics and Space Administration (NASA)

Administrative Operations Specialist, (Washington, District of Columbia) Period: 1968-1970

- Reviewed new and prospective grant applications/proposals submitted by colleges and universities to NASA for possible funding of ongoing research

Education and Credentials

Arizona Medical License, 1980-Present
St. Joseph Hospital & Medical Center, Residency in Family Medicine, 1976-1979
University of Medicine & Dentistry of New Jersey, Doctor of Medicine, 1976
Howard University, Doctor of Philosophy, 1970
Howard University, Masters of Science, 1968
Knoxville College, Bachelor of Science in Biology, 1966
Certified Medical Director, American Medical Doctors' Association, 2005

Professional and Community Service, Honors, and Awards

Grand Canyon University, Member of Board of Directors. 2005-Present
KC Homecare & Physical Therapy, Member of Board of Directors. 2007-Present

Chief Financial Officer/CFO

Nancy Maurer, CPA, Vice President, Finance

Summary

A skilled health care financial executive with 20 years of experience in progressively responsible positions; proven, financial, analytical and managerial skills; effective communication and interpersonal skills used in the motivation of teams to accomplish 'big picture' goals; demonstrated, proven problem resolution abilities with a highly flexible, practical approach to projects

Career History

Bridgeway Health Solutions ***Includes Long Term Care Experience***

Vice President, Finance, (Tempe, Arizona) Period: 2010-Present

- Oversee budgets, forecasts, and monthly business closings for AHCCCS Acute and ALTCS health plans and Medicare Advantage health plan with annual revenue of $265M, while ensuring prompt, accurate monthly financial close
- Perform duties as Chief Liaison between Corporate Finance and the health plan
- Establish financial strategic vision, objectives, policies and procedures in support of the overall strategic plan
- Direct finance, data analysis, encounter, and reinsurance functions
- Oversee Bridgeway's accounting systems and financial reporting
- Train staff on methodologies to increase acceptance rate on encounters and reinsurance
- Ensure timely & accurate completion of periodic regulatory reporting and annual independent audit
- Develop and analyze cost reduction opportunities and areas for further development and improvement

Mercy Care Plan ***Includes Long Term Care Experience***

Chief Financial Officer, (Phoenix, Arizona) Period: 2006-2009

- Managed finance, reinsurance and data analysis functions for AHCCCS and Medicare Advantage health plan with $1.7B annual revenue
- Directed monthly financial statement close for timely and accurate completion of financial statements for multiple lines of business
- Managed relationship with Financial Committee of the Board of Directors via monthly meetings; reported, analyzed, and summarized financial results at quarterly Board meetings
- Maintained actuarial relationships and ensured use of accurate base data for claim reserves
- Directed analysis of health care data for provider contracting and cost savings efforts
- Directed the annual development of medical plan and administrative budgets of $1.7B in annual revenue and performed quarterly re-forecasts
- Managed banking and treasury relationships
- Ensured timely completion of quarterly and annual regulatory reporting and annual independent audit

Arizona Physicians IPA, Inc.

Regional Vice President of Finance, (Phoenix, Arizona) Period: 2003-2006

- Provided overall direction for the daily operations of the health plan finances and analysis departments, and long-term financial strategy with annual revenue of $800M
- Ensured timely completion of annual corporate and plan budgets, all financial regulatory reporting, and monthly financial statements
- Directed analysis of health care claim data for trending and contracting purposes
- Coordinated annual financial and compliance audits
- Oversaw and participated in the monthly calculation of the Issued But Not Reported (IBNR) claims reserve

Colorado Access

Vice President of Finance, (Denver, Colorado) Period: 2001-2002

- Served as Chief Financial Officer of Colorado Access, a non-profit HMO formed by the major safety net providers in Colorado to provide health care access to the medically underserved, with annual revenue of approximately $275M
- Managed all financial activities including development and management of annual budget and forecast activities, internal and external financial reporting, and banking and regulatory relationships
- Supervised 10 staff members consisting of office administration and decision support departments
- Obtained support of corporate sponsors and approval of DOI regulators
- Collaborated with corporate sponsors in development of innovative plan to add capital in lieu of additional sponsor

cash contributions
- Improved IBNR processes and timeliness, providing for decreased financial statement close time period
- Purchased and implemented data warehouse software to replace obsolete in-house analysis system on budget and ahead of completion schedule

Lifemark Corporation ***Includes Long Term Care Experience***

Vice President Decision Support (Phoenix, Arizona) Period: 2000-2001
- Developed capitation revenue rates for new business and contract renewals, as well as payment rates and methodologies for provider contracting
- Consulted with corporate actuaries of national health care companies regarding the development and ongoing reporting of medical costs for health plans managed by Lifemark
- Increased qualitative and quantitative analysis for five owned or managed health plans; departmental budget included 100% staffing increase over 12 months
- Developed and managed the health care reporting system which improved the analytics available to users
- Increased visibility and productivity of internal audit and claims audit departments

Controller Health Plan Services (Phoenix, Arizona) Period: 1996-2000
- Provided full financial management for Medicaid health plans in two states encompassing $290M annual capitation revenue
- Managed compliance reporting to state regulatory agencies
- Developed appropriate internal analysis reports to enable plan management to effect appropriate changes
- Supervised analytical support department to all six health plans owned or managed by Lifemark

Medicus Systems Corporation

Director of Financial Services (San Diego, California) Period: 1990-1996
- Directed financial services for a health care management firm that administered a public sector managed health care program for medically indigent adults, including risk pool analysis, reconciliation, fiscal year-end calculations and payments, management and professional development of finance department, revenue recovery, program eligibility, and administrative staff personnel
- Performed facilities leasing and medical provider contract negotiations
- Developed budget and analysis for new program acquisitions

Ernst & Young

Auditor (New Orleans, Louisiana and San Diego, California) Period: 1984-1990
- Planned and managed all phases of financial statement audits for both public and privately owned companies
- Promoted to Audit Manager 1989

Education and Credentials

San Diego State University, Master of Science in Business, Accounting emphasis, 1985
University of Montana, French, 1976
Certified Public Accountant 1987 (California), 2009 (Arizona)
Certified Management Accountant, 1989

Professional and Community Service, Honors, and Awards

Touchstone Behavioral Health, Board Member. 2007 - current
Arizona Board of Accountancy, Committee Member. 2003 - current
Delta Society and Pets on Wheels of Scottsdale (animal therapy), Community Volunteer. 2008 - current

Pharmacy Director/Coordinator

Duane Angulo, R.Ph, J.D., Director, Pharmacy

Summary

Seasoned pharmacy management professional with expertise in administration, benefit management, regulatory and compliance experience, including Medicaid and Medicare.

Career History

Bridgeway Health Solutions ***Includes Long Term Care Experience***

Director, Pharmacy, Bridgeway Health Solutions, (Tempe, Arizona) Period: 2008-Present

- Oversee and administer the prescription drug and pharmacy benefits for Bridgeway Health Solutions
- Establish the strategic vision, objectives, and policies and procedures for the pharmacy program in support of the health plan's strategic vision
- Develop the health plan's pharmacy utilization committee to review drug utilization, polypharmacy issues, provider prescribing patterns, and individual member cases as appropriate
- Act as the pharmacy contract administrator for the development and implementation of key contracts, manage relationships with key vendors, including pharmacy benefit management and pharmaceutical companies
- Ensure that relevant pharmacy performance standards are met
- Serve as a representative for the health plan to the state's Pharmacy and Therapeutics (P&T) committee
- Collaborate with P&T committee members to develop a single, statewide preferred drug list (PDL) and standardized quantity limit criteria to reduce provider confusion, streamline the prescription ordering and prior authorization process, and enhance timeliness of members receiving their prescriptions
- Worked to develop a process for long term care pharmacies to submit claims for IV medications through the PBM claims processing system. This will help our long term care members located in facilities to obtain these very important IV medications in a timely manner. This will also assist the process of getting the members out of the costly hospital setting and be able to receive these treatments in a long term care facility with no lapse in therapy
- Resolve disputes, grievances, and complaints involving pharmacy program issues
- Participate in external accreditation initiatives
- Support provider education initiatives such as counter detailing and incentive programs
- Manage and analyze operating costs and participate in preparing the annual budget for the assigned work function at both corporate and the health plans
- Collaborate with pharmacy benefit manager (PBM) on a pharmacy process improvement initiative regarding out of state pharmacy authorizations with the purpose of reducing prescription expenditures and identifying members who have moved out-of-state
- Review and analyze reports, records, and directives
- Confer with staff to obtain data required for planning work function activities and prepare reports and records for the health plan management team

Express Scripts

Clinical Program Manager, (Tempe, Arizona) Period: 2008

- Advised Express Scripts clients and consultants on initiatives including benefit design, up-selling of clinical programs, and analysis of client drug mixes and medication spend
- Performed liaison role between the sales and marketing organization, clients, and consultants
- Presented solutions to prospective clients through formal presentations

Pacific Pulmonary Services

Director of Pharmacy, (Tempe, Arizona) Period: 2002-2008

- Managed budgetary, staffing, and human resource-related issues for the pharmacy operations division, consisting of $20 million in revenue
- Responsible for all licensing and regulatory matters for the pharmacy department, including compliance with HIPAA requirements and Medicare, Medicaid, and private insurance guidelines
- Collaborated and performed liaison role with the health plan, corporate counsel, and contracting departments regarding pharmacy patient matters
- Developed a first dose process for prospective hospital discharge dual members needing medications to be administered in a nebulizer machine. Worked with two major retail pharmacy chains to develop a billing mechanism for these medications that are traditionally billed primarily to the members Medicare B coverage and co-insurance balance to the members Medicaid coverage. This new process enabled members to leave the hospital and obtain their

medications, avoiding either a longer hospital stay and/or any lapse in their crucial breathing treatment medications.

Bashas United Drug

Community Pharmacist, (Chandler, Arizona) Period: 2001-2002

- Verified, processed, and filled prescriptions in compliance with all state and federal laws
- Provided drug information and consultation to patients, obtaining prior authorization on non-formulary medications

Renaud, Cook & Drury

Associate, (Phoenix, Arizona) Period: 2002-2003

- Practiced law with areas of focus on pre-litigation, vehicle accident, and basic contracting matters

Dependable Staffing Agency

Managed Care Pharmacist, (Phoenix, Arizona) Period: 1997-2001

- Verified, processed, and filled prescriptions in a managed care setting while maintaining compliance with all state and federal laws
- Provided drug information and consultation to patients, obtaining prior authorization on non-formulary medications

PCS Health Systems, Inc.

Summer Legal Intern, (Scottsdale, Arizona) Period: 1998

- Conducted a variety of projects for the legal staff, including, legal research, regulatory matters, individual state patient confidentiality laws, state prescription dispensing laws as they relate to the pharmacy benefit management industry, and contract provisions

PCS Health Systems, Inc.

Clinical Manager, (Scottsdale, Arizona) Period: 1995-1998

- Provided clinical support for national account clients in four sales offices
- Interacted with clients' medical directors, pharmacy directors, and human resources executives to provide benefit design consultation, drug information, and sales presentations of new products
- Conducted educational visits with medical staff and benefits managers
- Developed disease prevention and management programs

Supervisor-Federal Employee Prior Approval Program, (Scottsdale, Arizona) Period: 1994-1995

- Managed prior authorization (PA) department for managed pharmaceutical care organization
- Led the project and collaborated with various departments to implement a new PA system that incorporated an electronic fax networking system for the largest client in the PCS Health Systems
- Increased turn around times for providing medications to members from five to seven business days to 48 hours with the implementation of the PA system; member satisfaction was increased significantly
- Reduced program operation costs by 10% with the implementation of the PA system; the PA process was so successful that it became part of the suite of clinical programs the company bundled and sold to clients to help manage their member health care needs
- Verified prior approval requests and rendered decisions on appeals for reconsideration
- Updated the program to incorporate current literature and/or standards of care
- Provided drug information services and conducted drug utilization evaluations
- Presented educational sessions to client and internal staff
- Provided clinical support to other departments within the organization

Education and Credentials

Arizona Registered Pharmacist, 1993 - present
University of Arizona, Doctor of Pharmacy, 1993
Arizona State University, Juris Doctor, 2000
Arizona State Bar (Inactive), 2000

Professional and Community Service, Honors, and Awards

Arizona State Bar Association, Member. 2000-Present
University of Arizona Alumni Association, Member. 1993-Present
Academy of Managed Care Pharmacy, Member. 1994-1999
University of Arizona Hispanic Alumni Association, Member. 1993-1995

Dental Director/Coordinator

Bruce Nelson, DDS, PC, Director, Dental Program

Summary

Accomplished Dental Executive with over 30 years providing exceptional dentistry in an Arizona General Dentistry Practice; Proven leader, establishing industry innovations, ensuring compliance, and establishing dental policies and procedures for effective dental services

Career History

Avesis, Inc. ***Includes Long Term Care Experience***

Director, Dental Program, Bridgeway Health Solutions, (Phoenix, Arizona) Period: 2008-Present

- Coordinate all Bridgeway dental activities
- Provide required communication pertaining to dental services between the Bridgeway and the AHCCCS
- Monitor dental network in areas of quality improvement, access, events, and compliance with AHCCCS dental appointment standards
- Ensure timely and accurate processing of dental claims that require dental consultant review
- Ensure that Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program members receive dental treatment in compliance with AHCCCS dental periodicity schedule
- Provide clinical support on programs and communicate with dental offices to ensure compliance with policies and procedures
- Assist with establishing dental claims policies
- Maintain current information on dental practices, materials, and treatments that may affect the health plan
- Train health plan staff and assist with appropriate dental educational materials for members, that is, flyers, brochures and newsletter articles

Ameridontics, LLC

Founding Member, Secretary/Treasurer, (Phoenix, Arizona) Period: 2007-Present

- Serve on the board of directors for a company founded for the marketing of Laser Assisted New Attachment Procedure (LANAP)
- Secure and coordinate website and Internet Uniform Resource Locator as well as organize and coordinate Internet marketing
- Oversee company finances

Bruce L. Nelson, DDS, PC

President/General Dentist, (Phoenix, Arizona) Period: 1982-Present

- Maintain a general dentist practice including all aspects of practice management including coordinating and implementing marketing program, designing and building office facilities, and implementing multi-user/multi-tasking office IT systems

Arizona Dental Health Association

Partner, (Phoenix, Arizona) Period: 1978-1982

- Provided general dental services
- Oversaw management of dental hygienists staff
- Served on the Board of Directors
- Reviewed and prepared the budget for the practice
- Secured and implemented one of the first multi-office, multi-terminal, dental computer systems in the United States, increasing efficiency and accuracy of the practice

Associate Dentist, (Phoenix, Arizona) Period: 1977-1978

- Provided general dental services

Education and Credentials

Northwestern University, Doctor of Dental Surgery, 1977

American Straightwire Orthodontic Association, Post graduate orthodontic training, 1982-1984

University of Arizona, Bachelor of Science in Biology/Pre-Medicine, 1972

Cerec Certification (Design and fabrication of Computer-aided Design and Computer-aided Manufacturing for all ceramic restorations), 2006

LANAP Certification, 2003

Er,Cr:YSGG Laser Certification, 2002

Invisalign® Certification, 1992

Professional and Community Service, Honors, and Awards

American Dental Association, Member. 1972-Present
Arizona Dental Association, Member. 1977-Present
Central Arizona Dental Society, Member. 1977-Present
Arizona Dental Association Peer Review Committee, Member. 2005-Present
Institute for Advanced Laser Dentistry, Member. 2004-Present
World Clinical Laser Institute, Member. 2003-Present
National Dental Electronic Data Interchange (EDI) Council, Member of Board of Directors. 1993-1995
Wellcare Foundation, Volunteer Dentist. 2004-2006
Give Back a Smile, AACD, Volunteer Dentist. 2004-2006
Phoenix Optimist Club, Past President. 1993-1994

Compliance Officer & Contract Compliance Officer
Nicole Larson, Vice President, Operational Services & Compliance

Summary

Accomplished health care executive with 10 years experience in a compliance role and over eight years experience serving the ALTCS population and coordinating with the RHBA and/or AHCCCS; demonstrated ability to forge positive working relationships and foster communication among stakeholders in a managed care environment through strong leadership and management skills

Career History

Bridgeway Health Solutions ***Includes Long Term Care Experience***

Vice President, Operational Services & Compliance (Tempe, Arizona) Period: 2009-Present

- Administer Bridgeway's compliance program
- Serve as Bridgeway's Compliance Officer and liaison with state and federal agencies for all operational issues
- Track and submit all contract deliverables, respond to AHCCCS inquiries, and prepare and execute contract requirements, including Operational and Financial Reviews (OFRs), audits, and ad hoc visits as needed
- Provide oversight of fraud and abuse, grievance and appeals, and member services departments and activities
- Operate as the authority for access to records and make independent referrals to AHCCCS, Office of the Inspector General, regarding suspected fraud and abuse cases
- Conduct compliance audits, develop corrective action plans, and collaborate with contract and department managers to ensure timely completion and compliance with local, state, and regulatory requirements
- Monitor and report on achievement of committed action plans to appropriate management
- Serve as the compliance resource to all employees, provide communication oversight, manage policy development, and ensure accurate and timely communication to all departments
- Develop and implement performance standards for functional areas of the department, with focus on successful audit outcomes
- Develop and execute strategies to enhance the success of the call center operational services functions in collaboration with department, corporate and subsidiary businesses' senior managers
- Ensure all appeals and grievances are processed in accordance with required timeframes and contractual and legal requirements
- Serve on all Bridgeway Quality Committees and Compliance Committee

Director of Compliance (Tempe, Arizona) Period: 2007-2009

- Administered Bridgeway's compliance program
- Served as Bridgeway's Compliance Officer and liaison with state and federal agencies for all operational issues
- Tracked and submitted all contract deliverables, responded to AHCCCS inquiries, and prepared and executed contract requirements, including Operational and Financial Reviews (OFRs), audits, and ad hoc visits as needed
- Provided oversight of fraud and abuse, grievance and appeals, and member services departments and activities
- Operated as the authority to access records and make independent referrals to AHCCCS, Office of the Inspector General, regarding suspected fraud and abuse cases
- Complied with federal and state mandates, achieving 100% timely grievance and appeal reporting
- Supplied required reports to AHCCCS regarding provider claims disputes, notices of action, and hearing requests
- Improved efficiency and quality of service in Member Services department; trained and empowered staff to resolve issues
- Trained employees to identify fraud and abuse actions and adhere to the documentation and notification process
- Provided AHCCCS required Deficit Reduction Act training to all employees, reducing Medicare and Medicaid fraud, abuse, and waste
- Conducted HIPAA training to all employees to ensure the confidentiality of protected health information
- Enhanced relationship between Bridgeway and AHCCCS, focusing on key performance standards such as meeting required timeframes and providing reporting accuracy
- Conducted internal reviews and provided oversight to ensure company management is in compliance with regulations
- Reviewed regulatory requirements related to fraud, abuse prevention, detection and reporting to maintain compliance
- Served on all Bridgeway Quality Committees and Compliance Committee

Manager of Compliance (Tempe, Arizona) Period: 2007

- Implemented Compliance 360 software program that provided a central repository for policies and procedures, electronic tracking of documentation, and monitored various projects including, Corrective Action Plan; this report is sent to AHCCCS monthly, quarterly, semi-annually and annually
- Issued timely Notices of Action letters to AHCCCS, outlining Bridgeway's adherence to required content and formatting
- Analyzed provider services cases and ensured network adequacy
- Served on all Bridgeway Quality Committees and Compliance Committee

Grievance Systems Manager (Tempe, Arizona) Period: 2006-2007

- Ensured that all member and provider services' grievance and appeals were processed in accordance with legal requirements and the investigations were processed according to the contract
- Provided training to provider agencies in compliance with state and federal requirements
- Advised corrective measures needed to prevent recurrences of issues
- Served on all Bridgeway Quality Committees and Compliance Committee

Value Options, Inc.

Paralegal/Consumer Rights Specialist (Phoenix, Arizona) Period: 2004-2006

- Performed initial intake screening of grievances and appeals
- Conducted grievance investigations and appeals mediations
- Facilitated informal conferences and monitored department policies and procedures for compliance

American Mortgage Specialists

Compliance Officer (Mesa, Arizona) Period: 2004

- Ensured office operations were compliant with federal banking regulations and corporate policies and procedures

Schaller Anderson

Paralegal/Grievance Coordinator (Phoenix, Arizona) Period: 2001-2004

- Participated in the development of the grievance and appeals process
- Maintained AHCCCS regulatory compliance of grievance and appeals, including member rights and responsibilities
- Supervised and trained staff on grievance and appeals process

Previous employment history includes:

Contract File Specialist, Provider Services Division (Phoenix, Arizona) Period: 2000
Administrative Assistant, Member Services Division (Phoenix, Arizona) Period: 1999

Education and Credentials

Arizona State University, Bachelors in Justice Studies, Magna Cum Laude, 2008
Phoenix College, Paralegal Certification, 2004

Professional and Community Service, Honors, and Awards

Brain Injury Association of Arizona. Member. 2007-Present
Changes For Children, Team Chances. Contributor/Supporter. 2009-Present
Habitat for Humanity. Contributor/Supporter. 2009-Present
Arizona Human Rights Committee. Participant. 2004-2006
Cystic Fibrosis Foundation. Planning Committee Member, Arizona's Finest Fundraiser/Event. 2002-2003

Dispute and Appeal Manager

Kitley Ann West, Manager, Grievance and Appeals

Summary

Six years experience in health care processing member grievances and provider disputes and appeals, ensuring adherence to AHCCCS and federal regulations and quality guidelines. Proactive approach to seeking resolve and ensuring consistency among staff, members, and providers. Progressive career advancement in responsibilities and achievement.

Career History

Bridgeway Health Solutions *Includes Long Term Care Experience*

Manager, Grievance and Appeals, (Tucson, Arizona) Period: 2011-Present

- Manage and adjudicate member and provider disputes that arise in the Grievance System, including member grievances, appeals and requests for hearing, and provider claim disputes; ensure all appeals, grievances, and requests for hearing are processed in a timely manner and in compliance with AHCCCS, ALTCS, and federal regulations, contract obligations, NCQA provisions, and Bridgeway policy
- Monitor appeals and grievances to provide senior management with accurate monthly reporting on trends; recommend solutions to management based on results of monthly reports
- Identify training opportunities and assist with the development and implementation of new policies and procedures to address regulatory and operational changes
- Interface with members, their representatives, and providers regarding status, process, and outcomes of appeals and claim disputes
- Maintain accurate documentation, including complete files of all grievances and appeals
- Integrate applicable state and federal law changes into Bridgeway's grievances and appeals system
- Provide training and direction to providers through quarterly newsletter regarding how to support the member grievance and appeals process
- Review and process incoming incident and accident reports
- Act as a liaison with the Quality Department to maintain current knowledge of regulations and contract requirements
- Serve on the Grievance and Appeals Committee, Quality Management Process Improvement Committee, and Utilization Management/Medical Management Committee

Pima Health System *Includes Long Term Care Experience*

Health Regulatory and Compliance Coordinator (Tucson, Arizona) Period: 2008-2011

- Maintained current knowledge of Arizona Revised Statues, Arizona Administrative Code, the AHCCCS contract, and Medicare requirements to ensure compliance of Pima Health System's ALTCS Program
- Adjudicated provider claim disputes, member appeals, and grievances in a timely manner
- Streamlined dispute process to reduce necessary staff by half while maintaining 100% compliance with all AHCCCS and other mandated timelines
- Prepared AHCCCS required reports and submitted in timely manner
- Instructed members on the appeals process for denied benefits
- Identified and implemented methods of resolving claims disputes to increase efficiency; trained staff on new methods
- Educated providers on billing procedures to reduce claim denials and disputes; reduced disputes for one provider by 98% over a 4 week period
- Upon internal identification of certain hospital underpayments, notified hospitals to achieve swift resolution and payment and avoid any need for providers to file claims disputes
- Determined the validity of records requests and approved the release of records if HIPAA compliant
- Maintained database of all claim disputes and grievances from receipt through resolution
- Prepared case documentation and represented Pima Health System at State Fair Hearings both by telephone and in person
- Identified quality of care issues from member grievances and sent them to Quality Management for resolution
- Prepared and presented department reports at quarterly Quality Management and Utilization Management meetings to identify areas of improvement
- Presented Grievance and Appeals portion of new employee orientation

Tucson Medical Center *Includes Experience with Long Term Care Program*

AHCCCS Claims Dispute Coordinator (Tucson, Arizona) Period: 2005-2008

- Created position of AHCCCS Dispute Coordinator, which improved efficiency and allowed the AHCCCS billing team to reduce the average account age from 180 days to under 90 days

- Developed policies and procedures to reduce claim denials for plan specific requirements by 90%
- Supervised the claim dispute activities of 8 AHCCCS billers to ensure completeness, correctness, coding accuracy and timeliness of dispute documentation; trained billers on newly developed policies and procedures
- Created and submitted claim disputes to AHCCCS plans using documents submitted by AHCCCS billers
- Created tracking system to ensure disputes, decisions received, and requests for State Fair Hearing were completed in a timely manner
- Evaluated hospital department procedures and recommended changes to increase approval of claims
- Maintained familiarity with Arizona Revised Statutes, Arizona Administrative Code, and AHCCCS and Medicare manuals and policies to assess validity of potential claims disputes and the appropriate course of action, such as a claim dispute, corrected claim, or request for State Fair Hearing
- Represented hospital at State Fair Hearings with no rulings against the hospital
- Researched unpaid claims and filed claim disputes as necessary
- Analyzed the aging of receivables for the Children's Rehabilitation Services account and made process changes to increase the accuracy of financial reporting

Iota Engineering

Buyer (Tucson, Arizona) Period: 1999-2005

- Managed inventory of $1.5 million; reviewed daily and weekly inventory reports against sales orders and forecasts to ensure adequate component levels were maintained for production needs
- Assisted the accounting department with the reconciliation of inventory purchased and received; resolved any discrepancies
- Met with the Quality Control department and vendors to ensure company quality standards were met
- Supervised teams of 8-10 employees during company inventory

Arizona Mail Order

Warehouse Manager (Tucson, Arizona) Period: 1997-1999

- Managed department purchases of all shipping material, companywide office supplies, leasing of trucks and companywide office equipment; ensured expenditures did not exceed approved budget
- Reviewed weekly physical inventory reports and placed orders for shipping supplies in a timely manner to ensure no shortages occurred; oversaw inventory teams during annual physical inventory
- Hired, trained, and supervised a staff of 6

EDI Manager (Tucson, Arizona) Period: 1996-1997

- Established an Electronic Data Interchange (EDI) program at Arizona Mail Order
- Presented workshop on EDI to vendors at vendor open house
- Reviewed transmission/receipt reports to ensure all data sent by vendors and Arizona Mail Order was received and translated properly
- Worked with Information Technology Department to troubleshoot any transmission or receiving issues regarding data

Buyer (Tucson, Arizona) Period: 1993-1995

- Supervised and coordinated the activities of support staff who entered all specifications of items offered in catalog; ensured accuracy of printed catalog
- Assisted vendors regarding changes in required packaging, labeling, shipping, and sizing of selected items
- Attended vendor conventions to preview upcoming lines of merchandise and locate new vendors
- Set work flow priorities of support staff

Sears Telecatalog

Trainer/Supervisor/Customer Service Representative Period: 1988-1993

Education and Credentials

University of Arizona, Bachelor of Science in Business Administration/Finance, 1988
Ferris State University, Associate Degree in Library Science, 1973
Tucson College, Certificate in Medical Billing and Coding, 2005
Institute for Supply Management, Certified Purchasing Manager, 2005

Business Continuity Planning and Recovery Coordinator
Glen Woita, CBCP, CISA, Director, Business Continuity

Summary

Operations and Technical Director with over 18 years of experience in leading information and electronic transaction processing industry cross-functional teams. Background encompasses significant projects and programs in Business Continuity Planning (BCP), New Business Development and Information Technology (IT) Audit Management. Direct and establish process methodology for Operations BCP function and Product Development, a reputation as change agent, quickly delivering quality solutions in both products and processes. Areas of expertise include business impact/risk analysis, enterprise wide – business continuity management, organizational change management, team building / facilitation, business recovery strategies, and incident/crises management delivery

Career History

Bridgeway Health Solutions ***Includes Long Term Care Experience***

Director, Business Continuity (St. Louis, Missouri) Period: 2006-Present

- Manage all phases of disaster recovery planning related to the annual system exercise; update recovery strategies and ensure key IT documents are up-to-date on the Living Disaster Recovery Planning System (LDRPS) for systems supporting multiple Medicaid and Medicare health plans that provide Long Term Care as well as acute and behavioral health care services
- Expanded the role and scope of the Bridgeway Local Response Team (LRT), providing more structure and clarity for responding to crisis events
- Developed corporate strategies and vital business processes to run the business in the event of a disaster
- Developed and implemented a crisis management practice event to educate and train employees on the fundamentals of incident management
- Developed and administer the Crisis Management Plan; oversee training throughout the organization to provide clarity regarding roles and responsibilities so staff understand how to identify, communicate, assess, and assign identified problems toward controlled resolution should the plan be enacted.
- Update and distribute disaster recovery planning manual documentation through a web link as well as distribute hard copy site plans to management
- Improved the risk profile for the organization by adapting business impact analysis principles for all health plans and specialty companies, which includes specific objectives for 76 site locations
- Oversee the review of requirements for system recoverability with the Information Systems (IS) Department management
- Serve as team leader on complex projects and multiple small-scale projects, including developing and publishing project plans and report progress
- Analyze all aspects of the IS program related to crisis management practices and make recommendations to update processes and procedures
- Assist the IT Department with the development and testing of new disaster recovery plans
- Standardize and improve internal processes with business managers, information system managers, and critical third party vendors to ensure successful enterprise-wide execution of the Business Continuity and Disaster Recovery Planning Program using LDRPS
- Manage testing with third party vendors to ensure readiness for disaster recovery
- Conduct regular training programs to increase awareness of business continuity planning issues with senior leadership
- Work closely with Internal Audit, Compliance, Legal and other departments to ensure that existing and proposed disaster recovery regulations are appropriately addressed throughout the organization

A.G. Edwards & Sons, Inc.

Associate Vice President – Manager, Contingency and Disaster Recovery Planning (St. Louis, Missouri) Period: 2003-2006

- Served as project manager for all phases of disaster recovery planning related to the annual system exercise, updated recovery strategies, and ensured up-to-date key information technology documents
- Managed all aspects of recovery activities for the corporate headquarters and over 700 branch locations throughout the United States and Western Europe
- Fostered teamwork by utilizing the Incident Command Management system to lead more than 20 cross-functional teams in all aspects of hurricane, fire, flood, and bomb response
- Established and implemented a crisis management practice event to educate and train employees on the fundamentals

of incident management and identify opportunities for process improvement
- Managed a professional staff of seven with overall budget responsibilities of $2 million

Manager, Information Technology Disaster Recovery Planning (St. Louis, Missouri) Period: 2002-2003
- Led charge to standardize and improve internal process to renew and simplify disaster recovery and information technology facility requirements
- Achieved Sarbanes-Oxley compliance by conducting an application impact assessment which prioritized over 1200 critical business applications to support service level agreements for pre-defined recovery time objectives
- Supervised cross functional team responsible for data center relocation providing crisp communication and escalation of issues throughout the division and consistency with business unit recovery needs
- Established a repeatable framework to review and mitigate third-party vendor contract risk; benefits included analysis on testing, cessation of business, and changes to service levels
- Critiqued over 30 architecture, software and hardware acquisitions, and strategic initiatives to ensure disaster requirements were addressed in support of organization objectives

First Data Corporation

Director, Product General Management (Coral Springs, Florida) Period: 2000-2002
- Served as Chief of Staff for Senior Vice President with responsibility for product management of business unit with annual revenue of $1.5 billion; oversaw customer-focused product solution delivery, managed budgets, monitored implementation of strategic plan, and coordinated human resource management
- Implemented new product process methodology through all phases of project life cycle, including legal requirements, to establish a benchmark of consistency across the organization
- Led teams to improve employee satisfaction through analysis of surveys, holding employee discussion groups, and taking action based on staff input
- Participated in monthly external partner forums to foster good long-term client relations and to identify necessary changes to internal systems, legal documentation, and workflows
- Integrated new Six Sigma techniques, which improved customer service and reduced expenses
- Participated in the development of the annual plan as a key member of the financial planning team

Director, Business Continuity Planning (Coral Springs, Florida) Period: 1996-2000
- Coordinated all business continuity activities for the Operations Division
- Established effective and efficient computer system security policies and procedures
- Examined computer applications to determine compliance with applicable procedures and standards

Manager, Business Continuity Planning & System Compliance (Omaha, Nebraska) Period: 1995-1996

Project Manager, Cardholder Services Group (Omaha, Nebraska) Period: 1995

Senior Information Systems Auditor, Internal Audit Department (Omaha, Nebraska) Period: 1991-1995

Andersen Consulting

Staff Consultant (Chicago, Illinois) Period: 1989-1991
- Ensured all documentation was kept current, wrote technical and procedural bulletins, and trained and supervised programmers for multiple industries including, direct mail shopping services, telecommunication systems, public utilities, and federal government agencies

Education and Credentials

University of Nebraska at Lincoln, Bachelor of Science in Business Administration-Finance, 1989
Certified Information Technology Service Manager, 2003
Certified Business Continuity Planner (CBCP), 2000
Certified Information Systems Auditor (CISA), 1994

Professional Service, Honors, and Awards

Securities Industry Association BCP Planning Committee, Member. 2002-Present
Disaster Recovery Institute International (DRI), Member. 2000-Present
Information Systems Audit and Control Association (ISACA), Member. 1991-Present
First Data Merchant Services (FDMS), Leader of the Pack Award. 1999
FDMS Outstanding Performance Award. 1998
First Data Corporation Team Quantum. 1996
FDC Ovations Players Award. 1994
First Data Corporation Quantum Award. 1993

Quality Management Coordinator

Joann Adams, RN, BSN, Manager, Quality Management Program

Summary

BSN with over 28 years of clinical experience in adult, pediatric and neonatal intensive care and emergency nursing.18 years of administrative experience including quality management (QM), utilization and risk management in hospital and managed care environments. Demonstrated success in compliance with federal, state and national accreditation standards.

Career History

Bridgeway Health Solutions ***Includes Long Term Care Experience***

Manager, Quality Management Program (Tucson, Arizona) Period: 2011-Present

- Assess the quality and appropriateness of Long Term Care (LTC), acute, and behavioral health care service provided to members, establish QM and performance improvement (PI) processes, and integrate quality processes throughout the organization and community to ensure quality of care provided to individual members and the program as a whole
- Develop and monitor ongoing PI projects for all areas; measure performance using objective quality indicators, implement interventions to improve quality, evaluate the effectiveness of the interventions; plan and initiate activities for increasing improvement; report the project status and results to AHCCCS
- Develop/monitor QM and PI programs to achieve, through ongoing measurements and intervention, significant improvements in clinical/non-clinical care, resulting in improved health outcomes and member satisfaction over time
- Track, trend, and resolve member and provider issues, including investigating quality of care grievances, managing the resolution process, documenting communications, and analyzing the effectiveness of interventions
- Oversee the timeliness, accuracy, and submission of the QM quarterly and other AHCCCS s reports, and highlight Bridgeway results from PI strategies and QM activities
- Participate in the Peer Review, Member/Provider Council, MM/UM Committee, and QMPIC and ensure that providers are credentialed and reviewed through the Credentialing Committee

Pima Health System ***Includes Long Term Care Experience***

Quality Management Program Manager (Tucson, Arizona) Period: 2010-2011

- Managed the QM and Credentialing Divisions for both the acute care and LTC lines of business for the AHCCCS managed care plan in the Pima and Santa Cruz Geographic Service Areas
- Developed division's policies and procedures and ensured compliance with AHCCCS QM standards, resulting in a successful outcome with 25 out of 26 LTC quality standards scored as either full or substantial compliance on the 2010 Operational and Financial Review
- Supervised six full-time employees including hiring, scheduling, counseling, and orientation of new staff
- Developed and implemented a system-wide QMPI plan to ensure compliance with AHCCCS, state, and federal standards and regulations in providing services to members, including elderly and physically disabled members
- Developed an internal database designed to meet AHCCCS specifications for quality of care concern data, which resulted in improvement in internal trending of data related to individual and organizational provider performance
- Initiated and implemented transition to paperless documentation for credentialing unit, resulting in improved operational efficiency and simplified compliance with AHCCCS' electronic document submission requirements

CoreSource

Quality Improvement Coordinator (Tucson, Arizona) Period: 2008-2009

- Managed comprehensive quality program including complaints, adverse events, fraud and risk issue tracking, trending, reporting, interventions, and inter-rater reliability audits for utilization, case, and disease management staff
- Monitored compliance with federal, and state regulations and URAC standards; educated and trained utilization, case management, and disease management staff for a third party administrator that provided health care management services to fully-insured and self-funded plans
- Facilitated successful compliance with the URAC audit conducted in February 2009 with 100% compliance for all quality standards and no recommendations or corrective actions required

Carondelet Health System ***Includes Medicare/Senior care experience***

Clinical Documentation Specialist (Tucson, Arizona) Period: 2006-2008

- Performed daily, detailed review of inpatient charts to ensure compliance with Medicare documentation requirements
- Clarified clinical documentation as well as to perform concurrent ICD9 coding of charts and DRG assignment
- Educated medical staff regarding documentation issues, input and tracking of data, trend analysis, and reporting, which facilitated improvement in the case mix index from a baseline of 1.95 to 2.29, resulting in additional income to the facility more than $600,000 per year

- Facilitated the transition from DRG version 24 to 25 with coordination of a task force

Independent Contractor (Richmond, Virginia) Period: 2005-2006

- Audited hospital bills at multiple facilities for third party payers; conducted line-by-line evaluation of itemized bills, preparing bills, performing onsite audits, reconciling over- and under-charges and reporting findings for DiversiMed
- Conducted pre-insurance health exams for Portamedic, including detailed medical history, basic physical exam, collection of blood draws and other specimens, and performing EKGs

Rand Corporation

Nurse Consultant (Los Angeles, California) Period: 2000-2001

- Participated in the team that spearheaded the research study leading to the First National Report Card on Quality of Health Care in America
- Evaluated and revised the computer-assisted medical-record-abstraction software
- Developed, evaluated, and revised the quality indicators for 30 clinical areas, focusing on children and adolescents

Independent Contractor

Nurse Auditor (Los Angeles, California) Period: 1998-2000

- Performed physician office, medical record, and hospital bill audits for COLA and DiversiMed

HealthCare Partners Medical Group

Quality Improvement (QI) Specialist (Los Angeles, California) Period: 1996-1998

- Served as QI Specialist for the Independent Practice Association division of the largest medical group in Los Angeles
- Reviewed and assessed clinical and operational issues related to quality of services provided within the IPA division
- Collaborated with the health plans, Medical Director, managers, and member and provider services to identify ways to improve services and develop and implement related action plans
- Collected, analyzed and reported multiple data sets, including HEDIS, and monitored NCQA compliance

Miraflor & Associates

Quality Improvement Specialist (Los Angeles, California) Period: 1996-1997

- Performed MediCal (Medicaid) managed care site reviews and medical record reviews for Molina medical centers, including the evaluation of Child Health and Disability Prevention (CHDP) requirements

Providence Bay Harbor Hospital ***Includes Long Term Care Experience***

Manager of Quality and Risk Management (Los Angeles. California) Period: 1992-1995

- Coordinated all clinical, operational PI, and risk management activities at a 100 bed acute care community hospital and a 60 bed acute/sub-acute/skilled nursing facility (SNF) rehabilitation hospital
- Facilitated compliance with Title 22 and Joint Commission standards for the acute, sub acute, rehab and skilled nursing services, resulting in a successful 1993 Joint Commission (JCAHO) Survey
- Educated and trained staff regarding Performance Improvement and risk prevention
- Developed a new QI plan to meet new JCAHO standards and focus on quality improvement, rather than assessment

Providence Little Company of Mary Hospital ***Includes Long Term Care Experience***

Quality Review Nurse (Los Angeles, California) Period: 1988-1992

- Provided education regarding quality and peer review process, assisted managers with developing and implementing quality assurance plans, and coordinated medical staff peer review activities

Maxicare HMO ***Includes Long Term Care Experience***

Utilization/Quality Review Nurse (Los Angeles, California) Period: 1987-1988

- Performed concurrent and retrospective review of acute inpatients, prospective review of home health, durable medical equipment (DME), corrective appliances, and other outpatient services
- Provided interpretation of benefits for Commercial, Medicare and MediCal members
- Performed pre-contractual and contractual surveys of medical groups, SNFs and home health providers and acted as a liaison between Maxicare and contracted providers

Clinical Nursing Experience

Ten years of clinical experience including adult, pediatric and neonatal intensive care and emergency nursing in a variety of hospital and trauma center settings Period: 1977-1987

Education and Credentials

Arizona Registered Nurse, 2006 - present
California State University-Los Angeles, Bachelor of Science in Nursing, 1985
Los Angeles Trade Technical College, Associate of Arts in Nursing, 1982
Fredericksburg Area School of Practical Nursing, Diploma in Practical Nursing, 1977

Performance/Quality Improvement Coordinator
Karen Davis, RN, BSN, CPHQ, Manager, Quality Improvement

Summary

Broad experience in quality improvement, including background in health plan accreditation processes, leading performance improvement projects, credentialing of clinical providers, and reporting quality improvement (QI) and performance outcomes. Demonstrated leadership and managerial skills.

Career History

Bridgeway Health Solutions *Includes Long Term Care Experience*

Manager, Quality Improvement (Tempe, Arizona) Period: 2008-Present

Oversee the day-to-day operations of the QI and Credentialing Departments for AHCCCS and ALTCS programs and provide training to staff on quality best practices

- Develop the annual QM/PI work plan and evaluation, addressing ALTCS and acute care services, identify operational responsibilities necessary to support implementation, and submit the work plan and evaluation to the Medical Director, QM/PI committee, and Board of Directors for review and approval
- Monitor the Quality Management (QM)/Performance Improvement (PI) program to ensure compliance with state and federal regulatory, and accrediting agencies' requirements
- Implement and evaluate state and federal performance improvement projects (PIPs)
- Lead HEDIS project team, monitor project progress, develop reports, and report activity to the Performance Improvement Team (PIT) and QM/PI committees
- Coordination, preparation, and follow-up of the QM/PI committee meetings
- Analyze data to develop and implement intervention strategies and processes for improving clinical quality performance measures and outcomes and report performance outcomes to state and federal regulatory agencies
- Develop and implement systematic data collection to include appropriate methodologies and sample sizes; assist in data collection for selected components of the contractual reporting requirements for accrediting bodies and external review agencies
- Perform qualitative and quantitative analysis for QM/PI studies facilitating National Committee for Quality Assurance (NCQA accreditation, Healthcare Effectiveness Data and Information Set (HEDIS reporting, Health Outcomes Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Review and evaluate department reports and QM/PI work plan updates, make recommendations on performance improvement initiatives and program updates, and implement changes across all functional areas
- Oversee resolution of credentialing and re-credentialing issues and identify opportunities for process improvement
- Develop processes to ensure that staff who have direct contact with members or providers are trained on how to refer suspected quality of care issues to quality management
- Conduct and coordinate provider and practitioner medical record reviews
- Coordinated development, documentation, and implementation of the QM/PI Program, QM/PI program evaluation, and work plan
- Developed and implemented the annual "Quality Week" and related quality materials to enhance quality across the organization and into every day activities through interactive training
- Serve on the Bridgeway QMPI, QMIC, Peer Review, Credentialing, PIT, and Pharmacy & Therapeutics Committees

Aetna/Schaller Anderson/Mercy Care *Includes Long Term Care Experience*

Health Care Quality Management Consultant (Phoenix, Arizona) Period: 2007-2008

- Identified, documented, and investigated potential quality of care issues and adverse events; coordinated with the Medical Director and/or Peer Review committee
- Performed provider, practitioner, and facility medical record audits

Southwestern Eye Center

Quality Assurance Coordinator/Compliance Coordinator/Surgical RN (Mesa, Arizona) Period: 2006-2007

- Oversaw clinical operations and regulatory compliance for acute freestanding surgery centers, including the opening of a new surgery center in Casa Grande
- Evaluated and recommended performance improvement initiatives and process changes to all functional areas
- Developed policies and procedures related to QI and compliance, including internal medical record reviews, continuity and coordination of care standards, compliance with NCQA and AAAHC accreditation standards, and state and federal guidelines
- Managed grievance, denial, appeal, and quality of care processes

- Performed data collection for selected components of contract reporting requirements for accrediting bodies and external review agencies
- Conducted compliance and quality training for employees during orientation and on an annual basis
- Served as a community liaison for quality and service initiatives
- Ensured confidentiality of medical information to adhere with HIPAA regulations

Health Net of Arizona

Quality Improvement Specialist II (Tempe, Arizona) Period: 2004-2006

- Assist with the identification and development of QI initiatives and interventions, including assessment, documentation, and evaluation of patient safety
- Developed and implemented interventions and processes for improving clinical quality performance measures, including an extensive mammogram campaign, resulting in an increased number of mammograms from non-compliant members
- Analyzed data to develop intervention strategies to improve outcomes
- Assisted with HEDIS activities, including monitoring project progress, developing reports, and reporting activity to the Quality Improvement Committee
- Facilitated Peer Review Committee activities and performed provider and practitioner medical record reviews
- Performed skilled nursing and assisted living facility audits

Surgical PDI

Contract Nurse Specialist (Upper Saddle River, New Jersey) Period: 2004

- Fostered long term relationships with operating room surgical equipment customers, including ongoing pre-clinical education and educating customer "super users" to troubleshoot product issues
- Assisted client facility physicians and nursing staff with products during actual surgical procedures post-sale

Schaller-Anderson ***Includes Long Term Care Experience***

Medical Claims Review Specialist (Phoenix, Arizona) Period: 2002-2004

- Performed comprehensive medical record and claims reviews for Medicare, Acute, and Long Term Care claims for AHCCCS and other entities
- Made payment determinations based on insurance coverage, coding, and utilization of services and practice guidelines, resulting in savings of $380,000 over a 3-month period
- Entered medical review decisions containing electronic health information, including imaging scans

Independent Registered Nurse (RN) First Assistant

Assistant to OB/GYN, Orthopedic, General Surgery, and Urology Surgeons (Mesa, Arizona) Period: 2000-2008

- Served as the RN First Assistant to the surgeon during surgical procedures
- Provided medical billing for Assistant and Surgeons' services using current procedural terminology (CPT) and ICD-9 medical billing codes utilizing CMS hcfa-1500 medical forms

Casa Blanca Medical Group

Perioperative Nurse (Mesa, Arizona) Period: 1990-2000

- Supervised RN First Assistants and Surgery/Urology Department staff and performed OB/GYN telephone triage
- Performed billing for general and OB/GYN surgeons utilizing proper coding

Education and Credentials

Northern Arizona University, Bachelor of Science in Nursing, 2006
Cochise College, Associate Degree in Nursing, 1974
Certified Professional Healthcare Quality (CPHQ), 2010
Certified Registered Nurse First Assistant (CRNFA), 1999, 2004
Certified Nurse Operating Room (CNOR), 1995 and 2004
Perioperative Plus Associates, Certificate of Completion of Registered Nurse First Assistant, 1992

Professional Service and Honors

National Association for Healthcare Quality (NAHQ). Member. 2008-Present
Arizona Association for Healthcare Quality (AzAHQ). Member. 2008-Present
Sigma Theta Tau, Honor Society of Nursing. Member. 2006-Present
Phi Kappa Phi Honor Society. Member. 2006-Present
Association of periOperative Registered Nurses (AORN), RNFA Special Assembly, Member. 1992-Present
Who's Who in Nursing. 1990

Maternal Health/EPSDT (Child Health) Coordinator

Maritza Jimenez, LPN, Maternal Health & EPSDT Specialist

Summary

Health care professional with diverse experience in clinical and corporate environments; proven ability to create innovative programs, communicate and work well at all levels in an organization, interface effectively with internal and external resources, and motivate individuals and groups to meet organizational goals; areas of expertise include: department/project budgeting, program development/implementation, utilization/medical management, complex case management (CM), development of marketing/communication materials, quality improvement, and compliance auditing

Career History

Bridgeway Health Solutions ***Includes Long Term Care Experience***

Maternal Health & EPSDT Specialist, (Tempe, Arizona) Period: 2008-Present

- Ensure appropriate receipt of preventative services, including EPSDT services and maternal and postpartum care, including identifying members' needs and coordinating assistance as needed
- Interface with community partners to promote preventive health and family planning services, including information about available resources
- Collaborated with Provider Services to ensure successful transition of Arizona Early Intervention Program (AzEIP) services from independent AzEIP contracted companies to Bridgeway managed AzEIP services
- Developed and implemented an internal desktop procedure for the AzEIP request review process and developed an AzEIP policy to streamline the process of managing new members in the program
- Increased the number of providers certified to perform Parents' Evaluation of Developmental Status (PEDS) Tool through targeted provider education and training, resulting in an extension of services available to members
- Targeted individual provider education on EPSDT medical benchmarks and the importance of correct EPSDT form documentation, resulting in a 100% increase in the amount of forms received and increasing compliance with verbal lead assessment and lead testing
- Created and maintained all policies related to EPSDT, including program plan, work plan, and evaluation, for annual submission to AHCCCS
- Serve on the Quality Management Investigative and Quality Management Performance Improvement, Credentialing Committees, and the Member/Provider Council

SCAN Health Plan ***Includes Long Term Care Experience***

Utilization Management/Concurrent Review Nurse, (Phoenix, Arizona) Period: 2007-2008

- Performed concurrent review, discharge planning, Skilled Nursing Facility (SNF) placement, and coordination of hospital admissions/transfers
- Participated in individual complex CM for transplant members and long term care members
- Performed clinical review for inpatient/outpatient prior authorizations
- Transitioned concurrent review from telephonic to hospital visits with chart reviews, improving discharge results and the accuracy of medical information documented
- Served on the Utilization Management, Quality Management, and Credentialing Committees

Arizona Health Care Cost Containment System ***Includes Long Term Care Experience***

Medical Management Specialist, (Phoenix, Arizona) Period: 2005-2007

- Ensured Arizona acute and long term care plans were compliant with state and federal requirements
- Provided ongoing technical assistance in the areas of medical management (MM), utilization management (UM), quality improvement, disease management, and transplants/catastrophic CM
- Managed transplant and catastrophic CM for Fee-For-Service/Indian Health Services
- Surveyed both acute and long term care plans for compliance during operational and financial reviews
- Performed annual evaluation of health plans with respect to UM/MM plans and work plans

Evercare Arizona ***Includes Long Term Care Experience***

Prior Authorization/Utilization Management Coordinator, (Phoenix, Arizona) Period: 2003-2005

- Conducted concurrent review, discharge planning, SNF/acute rehab placement, coordination of hospital admissions and transfers, and individual complex CM for Maricopa County; acted as a liaison for rural counties
- Case managed and transitioned members from acute behavioral health programs to the long term care program
- Collaborated with case managers and other functional departments to implement the best course of care for members
- Performed AHCCCS reporting and program compliance
- Provided clinical review for inpatient/outpatient prior authorizations and Durable Medical Equipment (DME)

coordination; sought medication approval with the Pharmacy Benefit Manager for new and transitioning members

- Developed and implemented policies and procedures, conducted committee meetings, and tracked and trended member and financial statistics related to the department
- Managed hiring, training, education, and supervision of utilization management/prior authorization nurses and staff
- Served on the Utilization Management Committee

TLC/Staff Builders Home Health Care ***Includes Long Term Care Experience***

Reimbursement Quality Assurance Nurse/Intake Coordinator, (Phoenix, Arizona) Period: 2000-2003

- Managed intake department including telephonic customer/patient service, collaboration with hospital and insurance discharge planners, physician order processing, obtaining authorizations from various health plans, interfacing with other home health companies, coordinating patient DME needs, and data processing
- Reviewed all Oasis events and Plan of Treatments (POT's/485's) to assure clinical quality of care and financial compliance with federal and state regulatory agencies
- Assessed diagnosis coding assignment for maximum reimbursement potential
- Developed and presented diagnosis coding in-services for clinical staff

Meridian Healthcare Management

Case Manager/Discharge Planner, (Woodland Hills, California) Period: 1999-2000

- Managed outpatient/inpatient cases for multiple physician groups located in CA, AZ, OR, WA and NJ
- Executed all clinical performance reviews and assessment of group standings as they related to health care contracts
- Managed all UM/QI functions to comply with regulatory standards

Lakeside Medical Group ***Includes Long Term Care Experience***

Care Manager, (Glendale, California) Period: 1998-1999

- Performed inpatient CM and concurrent review for various hospitals
- Managed CM functions, including discharge planning, SNF/acute rehab placement, coordination and CM for out-of-network hospital admissions and transfers, and individual complex CM
- Authorized DME, home health, intravenous (IV) therapy, and inpatient/outpatient procedures

CAP Management Systems

Quality Improvement Manager (Encino, California) Period: 1997-1998

- Reviewed clinical services and physician performance compliance based on federal, state, and NCQA guidelines
- Interfaced with hospitals, physicians, and health plans to assess clinical quality of care issues
- Collaborated with several health plans to assure compliance and quality medical care for patient population by performing QI functions
- Developed and implemented QI policies and procedures in compliance with federal, state, and regulatory guidelines
- Managed peer review and credentialing functions and supervised QI nurse coordinators and member services reps

OB Services Coordinator Period: 1996-1997

- Developed, designed, and implemented patient teaching, CM program, and marketing materials for patients and physicians
- Hired, trained and supervised staff and participated in physician education and recruiting
- Tracked and reported patient and financial statistics

Previous Clinical Experience (Los Angeles, California and surrounding area)

Santa Marta Hospital, Associate Director of Development Period: 1994-1996
Santa Marta Hospital, Comprehensive Perinatal Services Program Coordinator Period: 1992-1994
Medical Office of R. Srinivasan, M.D., Comprehensive Perinatal Services Program Coordinator/Consultant Period: 1995-1996
South Bay Free Clinic, Clinic and Programs Manager, Gardena Branch Period: 1989-1992
Los Angeles County/USC Medical Center, Licensed Vocational Nurse, ED Surgical Admitting Period: 1988-1989
Medical Office of L. Albert, M.D., Medical Office Manager Period: 1984-1988

Education and Credentials

Arizona Licensed Practical Nurse License, 2000; California Licensed Vocational Nurse, 1988
Valley College of Medical & Dental Careers, Licensed Vocational/Practical Nursing Diploma, 1988
Attended University of California, Los Angeles, 1983-1986

Professional and Community Service, Honors, and Awards

TAPI - The Arizona Partnership for Immunization (Community Awareness Committee), Member. 2009-present
Los Angeles Regional Family Planning (LARF) Council, Member. 1989-1995

Medical Management Coordinator
Susan Benedetti, RN, BSN, Vice President, Medical Management

Summary

Managed care and health care executive with experience in public and private sector health care industries, achieving exceptional, positive health and financial outcomes; core professional strengths include: operations, strategic planning, process improvement, team building, problem solving, budget administration, customer service, health plan implementations, and adaptability.

Career History

Bridgeway Health Solutions ***Includes Long Term Care Experience***

Vice President, Medical Management (Tempe, Arizona) Period: 2010-Present

- Oversee and implement all aspects of the Medical Management program, including care coordination, disease management and case management functions
- Direct day-to-day operations and staff regarding prior authorization, medical necessity determinations, concurrent review, discharge planning, retrospective review, utilization of health care services, continuity of care, and other clinical and medical management functions relating to AHCCCS and ALTCS members
- Monitor and ensure that elderly and physically disabled members, and those with Serious and Persistent Mental Illness (SPMI) have direct access to member-centric Long Term Care and acute and behavioral health care services and that those services are delivered in a high quality, cost efficient, and culturally competent manner
- Ensure compliance with AHCCCS policies, rules, accreditation requirements, and contract and with accreditation requirements for medical management, including with NCQA
- Oversee and ensure consistent application and implementation of medical and utilization management (UM) policies and procedures, including consistent application of appropriate medical necessary criteria for inpatient and outpatient stays and overseeing inter-rater reliability assessments
- Manage prior authorizations and referrals by monitoring requests for initial and continuing authorizations and ensure decisions are made in a timely, consistent manner based on clinical criteria and timeliness standards
- Monitor, evaluate, and implement appropriate interventions based on utilization data, including identifying and correcting over- and/or under- utilization of services
- Assist in updating clinical practice guidelines that are based on valid and reliable clinical evidence
- Serve as liaison with the Medical Management/UM Committee to monitor and ensure compliance with timeliness, language, and Notice of Action requirements, and that decisions comply with all coverage criteria
- Monitor and assess medical management, disease management, and pharmacy management activities and report performance to the Medical Management/UM Committee for analysis and recommendations for action;
- Collaborate with Quality Improvement Director to develop, implement, and monitor quality improvement initiatives, with priority on improvements for placing and maintaining members in in-home settings
- Analyze medical management and UM activities, operations, and reports to identify trends, conduct risk assessments, pinpoint opportunities for continuous performance improvement, and implement initiatives and best practices
- Oversee development and submission of the annual written medical management plan and work plan to AHCCCS
- Evaluate new and existing medical concepts and technologies and apply new uses, programs, and tools to improve medical management services and performance
- Restructured polypharmacy utilization committee meetings to focus on actionable items and measurable outcomes
- Serve on the Credentialing Committee (CC) and Quality Management/Performance Improvement Committee (QMPIC)
- Participate in provider education and contracting as appropriate

INSPIRIS ***Includes Experience with ALTCS Members***

Manager of Care Management (Phoenix, Arizona) Period: 2010

- Provided direction and leadership to the nurse practitioner and care management teams
- Supported and educated nurse practitioners and case managers on Medicare, Medicaid and ALTCS and how staff should relate to health plan members
- Identified and developed processes to support cost-effective, high quality outcomes for members
- Implemented a weekly complex care meeting to review and create action care plans for quality outcomes for members
- Served on the Medical Management Committee
- Attended Joint Operating Committee meetings with health plans for which INSPIRIS managed members

Mercy Care Plan/Schaller Anderson/Aetna ***Includes Long Term Care Experience***

Vice President of Utilization Management (Phoenix, Arizona) Period: 2005-2009

- Provided strategic direction to Prior Authorization, Medical Claims Review, Case Management and Concurrent Review Departments, including for ALTCS members
- Served as key member of the executive strategic and health care management teams
- Provided leadership and strategic direction to the health plan for the Medicaid and Medicare program in Arizona
- Managed administrative and clinical operations of the health plan and health care initiatives
- Met budget projections and maintained inpatient utilization medical costs below health plan expectations, while increasing generic pharmacy utilization
- Implemented a program that identified targeted diagnoses that could be managed in an outpatient setting, ultimately decreasing inappropriate inpatient utilization by 17%
- Received a perfect score (100%) on the medical management section of the state's 2008 operational financial review
- Increased employee satisfaction over 15% within the UM Department, in a one-year timeframe
- Partnered with Durable Medical Equipment (DME) vendors to improve customer service and the delivery of health care services, as well as monitoring contract adherence
- Participated in the discussion, design, and implementation of a medical home pilot program
- Chaired the Policy Committee, served on the Quality Management Oversight Committee, System Change Request Committee, and Pharmacy & Therapeutics Committee

Corporate Director of Medical Management (Phoenix, Arizona) Period: 2003-2005

- Directed and monitored activities of all Medical Management Departments across 8 health plans
- Implemented a new health plan successfully within 90 days
- Implemented the standard prior authorization grid to 8 health plans that streamlined the claims payment system, ultimately reducing the number of authorizations entered into the system
- Executed standard policy templates for medical management to 8 health plans
- Participated in the System Change Request Committee and the Corporate Policy Committee

Corporate Manager of Prior Authorization (Phoenix, Arizona) Period: 2001-2003

- Provided leadership and direction for the medical and pharmacy unit for Medicaid and commercial health plans
- Created an after-hours prior authorization unit that provided medical and pharmacy services for Medicaid health plans
- Developed processes that supported cost-effective and quality outcomes
- Developed viable systems for authorization criteria and procedures, contract interpretation, resolving provider and member issues, and maintaining communication between vendors, providers, members, corporate and consultant staff
- Participated in cross-functional teams to successfully implement a QNXT 3.2 software system QNXT 3.2 containing UM and eligibility information from which claims were paid
- Met and exceeded all call center contractual agreements required by each Medicaid and commercial health plan
- Participated on the implementation team for new health plans regarding medical management services

Supervisor of Concurrent Review (Phoenix, Arizona) Period: 1998-2001

Concurrent Review Nurse (Phoenix, Arizona) Period: 1991-1998

Registered Nurse (RN) Case Manager (Phoenix, Arizona) Period: 1991-1993

Prior Authorization RN (Phoenix, Arizona) Period: 1989-1991

Education and Credentials

Arizona Registered Nurse License, 1990

Arizona State University, Bachelor of Science in Nursing, 1990

Professional Service and Awards

Arizona Public Health Association, Member. 2009-2010

Executive Order 2008-25: Reducing the Escalation Health Care Costs for Arizonans. Participated in work groups to give Governor recommendations on how to improve unhealthy birth outcomes, diabetes, respiratory disease, heart disease, and cancer. 2008

Arizona Statewide Independent Living Council (SILC) DME Taskforce. Participated, from the health plan perspective, to make recommendations to the Arizona Legislature for improvement of DME delivery processes. 2008-2009

AHCCCS Notice of Action Work Groups. Assisted with developing language at an appropriate comprehension level for health plans to write an adverse Notice of Action letter to a member. 2008-2009

Aetna Silver Star Award. Recognized for leadership activities. 2008

Behavioral Health Coordinator
Kathy Dutridge, LAC, Behavioral Health Coordinator

Summary

Behavioral health professional with over ten years experience working with Serious Mental Illness (SMI) persons, including eight years serving AHCCCS members. Demonstrated success in assuring the behavioral health program is in accordance with AHCCCS requirements, coordinating services, identifying community resources, integrating behavioral health services into a cross-functional care management team and collaborating with providers to create successful health outcomes for AHCCCS-served populations, including Long Term Care.

Career History

Bridgeway Health Solutions ***Includes Long Term Care Experience***

Behavioral Health Coordinator, (Tempe, Arizona) Period: 2010-Present

- Develop, implement and monitor comprehensive, cost-effective care plans
- Identify and implement best practices for coordinating behavioral health (BH) between PCPs and BH providers
- Educate members and families about services and requirements and ensure members are adhering to the care plan
- Authorize and coordinate referrals for medical and behavioral health services to coordinate BH with medically necessary services
- Ensure provider services are delivered without gaps and identify functional deficiencies in care plans
- Coordinate community based services not covered by Medicaid for dually eligible members
- Collaborate with case managers in discharge planning to identify appropriate placements and conduct post-discharge follow-up to ensure support services are in place
- Provide weekly BH consultations for medical case managers and on an ad-hoc basis as needed
- Participate in utilization reviews when members are admitted into psychiatric inpatient facilities
- Assist members with filing, resolving, and appealing claims
- Forecast potential financial exposure throughout the continuum of care to promote quality, cost-effective outcomes
- Collaborated with BH team to create a comprehensive crisis plan to better serve members in crisis after hours and ensured crisis plan criteria was implemented into the case management (CM) software
- Identify best practices and evidence based practices for BH in a primary care setting and educate BH case managers on implementing those practices for members
- Assess provider resources and continually identify additional provider resources to meet member needs
- Collaborate regularly with the Network Development Manager to expand the network
- Develop a rapport with community providers, ensuring member needs are communicated and met appropriately
- Ensure BH reviews are completed and coordination of care occurs between primary care and BH providers
- Coordinate transitions of care for members coming from the Regional Behavioral Health Authority programs
- Monitor members under court-ordered treatment to ensure appropriate care, treatment, and participation occurs
- Serve on the Pharmacy Utilization Committee and chair the Bridgeway Behavioral Health Team Meetings

Magellan Health Services ***State Contracted Position Through AHCCCS Programs***

Senior Care Manager, (Phoenix, Arizona) Period: 2009-2010

- Authorized and reviewed utilization of mental health and substance abuse services provided in inpatient settings
- Assisted with discharge planning and oversaw implementation of plans including coordinating services with various provider agencies as needed
- Monitored inpatient treatment to ensure medical necessity and effectiveness, resulting in decreased rates for average length of stay and recidivism
- Voted "#1 intervention" by peers and honored twice as “case of the month” for going above and beyond duties
- Staffed CM teams efficiently with attending physicians and social workers, consisting of 10 members per CM team
- Completed retrospective reviews for inpatient stays, monitoring benefit eligibility and appropriateness of service level
- Monitored requests for electroconvulsive therapy to ensure criteria were met and authorized appropriate requests for services following review of the case with a Physician Advisor
- Performed concurrent reviews and telephonic triage

Community Medical Services

Clinician III, (Glendale, Arizona) Period: 2008-2009

- Completed intake assessments to enroll appropriate members in services

- Conducted annual behavioral health assessment updates to monitor appropriateness of ongoing services
- Ensured service planning was individualized, culturally competent, and met the members' needs
- Educated members regarding behavioral health conditions to facilitate improved physical health and well-being
- Provided counseling to increase self-esteem, life fulfillment, and meaningful relationships for members
- Coordinated treatment with additional providers to include Primary Care Physicians and psychiatric clinics

Maricopa Crisis Recovery Network

Crisis Supervisor, (Phoenix, Arizona) Period: 2007-2008

- Provided clinical supervision for 16 crisis specialists
- Monitored floor operations and oversaw console and dispatch operations
- Developed performance evaluation process for start up business and completed evaluations for staff
- Educated local law enforcement on issues pertaining to mentally ill individuals to improve treatment and promote strong community support of crisis services
- Ensured risk assessments were complete and safety plans were clear and concise
- Collaborated with local detox and urgent psychiatric service centers to ensure caller needs were met
- Created standards to determine when additional follow-up services were essential
- Handled emergency calls from police and fire departments
- Implemented triage process resulting in significantly reduced caller hold times

ValueOptions, Inc. ***State Contracted Position Through AHCCCS Programs***

Crisis Supervisor, (Phoenix, Arizona) Period: 2002-2007

- Progressed in the organization, achieving three position advancement promotions
- Performed Crisis Supervisor duties as stated above; provided supervision and training for clinical team
- Managed multi-disciplinary Assertive Community Treatment team in developing and implementing assessments and service plans for SMI members
- Created plans to move persons from supervisory care homes that were unsuitable into more appropriate settings, increasing successfully transitioned members from 2-4 per year to 20 per year
- Developed a fitness and activity group with weekly community activities tailored to SMI members
- Created a "coffee house" for staff, peers and SMI members to perform music, read poetry, obtain proper nutrition information, and improve socialization skills
- Responded to crisis hotline calls for Maricopa County, assessing risk and implementing appropriate interventions
- Served on the Assertive Community Treatment, Supervisory Care Home, and Employee Retention Committees

Life Development Institute

Student Advisor, (Glendale, Arizona) Period: 2001

- Taught functional literacy course, tutoring specific student needs, creating opportunities for skill enhancement, promoting self-awareness, leading to successful outcomes
- Communicated with funding sources and assisted in resource identification
- Created alliances with local businesses, educating them on federal monies available for hiring disabled persons
- Assisted students in job placements to develop skills and progress toward their career goals
- Monitored job performance, providing feedback, on-site job coaching, and support to business partners

Bank of America

Senior Proof Operator, (Tempe, Arizona) Period: 2000-2001

Initial Staffing

Accounting Associate, (Tempe, Arizona) Period: 1998-2000

Education and Credentials

University of Arizona, Master of Arts in Rehabilitation Counseling, specializing in Psychiatric Rehabilitation; 4.0 Cumulative G.P.A, 2007

Arizona State University, Bachelor of Science in Psychology, 2000

Licensed Associate Counselor with Arizona Board of Behavioral Health, 2008

Certified Rehabilitation Counselor, 2007

Professional and Community Service, Honors, and Awards

NAMI events, Active participant and fundraiser. 2005-present

CASS Homeless Shelter and Habitat for Humanity, Volunteer. 2010

Magellan Service Excellence Reward Performer of the Year. 2009

Distinguished Honor Graduate from the Army National Guard Signal School. 1986

Provider Services Manager/Provider Claims Educator

Elaine Teune, Vice President, Contracts, Member & Provider Services

Summary

A healthcare professional with progressively increased responsibilities in management and provider relations over the past 25 years. A strong leader in building long-term relationships with customers, managing staff, and working projects.

Career History

Bridgeway Health Solutions ***Includes Long Term Care Experience***

Vice President, Contracts, Member & Provider Services, (Tempe, Arizona) Period: 2010-Present

- Oversee provider contracting and relations activities to ensure efficiency and maintain compliance with Bridgeway policies and AHCCCS and ALTCS contract requirements
- Serve as primary liaison between Bridgeway subcontractors and Long Term Care/acute care providers to ensure prompt resolution to problems or inquiries, as well as to obtain feedback on claims issues and submission practices
- Educate contracted and non-contracted providers regarding participation in AHCCCS programs, policies and procedures on referrals and claim submission, coding updates, electronic claims transactions, electronic fund transfers, and available Bridgeway resources
- Develop, implement, and maintain a network development plan for serving Medicaid, including ALTCS, members
- Develop and implement performance standards for member and provider services and audit call center performance
- Develop and implement operational processes for provider relations, member affairs, and provider services
- Develop, implement, and maintain production and quality standards for the Contracting Department and identify strategies designed to improve provider satisfaction based on trends
- Integrate new programs and strategies and oversee provider set-up and contract configuration to ensure accurate claims adjudication
- Facilitate the exchange of information between grievance, claims processing, and provider relations systems and providers to ensure integration
- Serve on all Quality Committees, Compliance Committee, Credentialing Committee, Medical Management/Utilization Management, Grievance and Appeals Committee, QMIC, Contracting and Provider Relations Committee, Member/Provider Council, and the Peer Review Committee
- Recruited and satisfied Medicare requirements for network in Maricopa and Yuma counties so that we were awarded to be a Medicare Advantage SNP plan in these counties
- Developed and grew claims liaison department to research claim questions from providers
- Developed a contracting process to ensure consistency in all contracts completed by Provider Relations that ensures for accuracy in loading of provider information and rates in system

Director of Contracting and Provider Services (Tempe, Arizona) Period: 2006-2010

- Assured efficiency and integrity in provider contracting and relations activities, including records and data management, compliance with Bridgeway policies, and AHCCCS and ALTCS contract requirements
- Negotiated contracts with providers utilizing model provider agreements
- Ensured negotiations approximated the state's reimbursement rate for comparable providers
- Achieved compliance with national contracting standards, including the baseline assessment of risk contracts, reimbursement standards, provider set-up rules, exception process, and use of model contract language
- Implemented Emptoris contract management software to streamline monitoring of contract compliance and management
- Developed and implemented a network development plan in line with strategic goals and objectives to identify and initiate contact with providers to support state Medicaid programs, including ALTCS
- Provided oversight to the provider set-up and contract configuration, resulting in accurate claims adjudication
- Analyzed and identified improvement opportunities, developed strategies, and executed contracting strategies to meet contracting goals and objectives

Pinnacle Healthcare Consulting ***Includes Long Term Care Experience***

Network Development Consultant (Phoenix, Arizona) Period: 2006

- Supervised call center for outbound calls to recruit providers and ensure network requirements were achieved
- Coordinated tasks for call center and other consultants and audited database to ensure accuracy of output rosters

Arizona Physicians IPA (APIPA) a UnitedHealth Group Company

Director, Network Development (Phoenix, Arizona) Period: 2003-2005

- Built a strong, dedicated 12-member network development team consisting of contractors, provider relations

representatives, and provider data management personnel, to serve AHCCCS and acute care members
- Led re-contracting effort with hospital network, radiology, and ambulatory surgery centers in urban areas, while increasing the network through cost effective contracts in the rural area, resulting in over $1 million in savings
- Complied with network adequacy requirements and closed gap areas through physician contracting efforts, resulting in a 50% reduction in network gaps
- Led contracting effort that increased the number of contracted urgent care centers to enhance ER diversion
- Provided assistance and collaboration in the transition to a new claims system
- Developed and presented updated provider manual and AHCCCS information at annual statewide provider forums
- Ensured accuracy of quarterly regulatory report of contracted network with less than 3% errors 98% of the time

Manager of Network Management (Phoenix, Arizona) Period: 2002-2003
- Managed contract between APIPA and UnitedHealth Care (UHC) of Arizona for network management services
- Maintained network management metrics for use in quality improvement initiatives and corrective action plans
- Obtained new discounts on per diem rates from contracted network of hospitals resulting in $1 million in annual savings
- Managed provider data maintenance staff
- Served as the APIPA liaison for AHCCCS to ensure completion of the quarterly network report submission
- Developed work plan on new dental processing to increase accuracy of payment and re-contracting efforts of dental network that led to the growth of the dental network; the work plan effectively addressed claims, dental prior authorization, dental recruiting, and re-contracting with standard language and rate configuration

Manager of Network Management, UnitedHealth Care of Arizona (Phoenix, Arizona) Period: 2000-2001
- Managed Network Department for commercial and Medicaid product lines
- Developed work plan to enable UHC to obtain Tier 1 status resulting in enhanced services and lower costs
- Participated in Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) certification process
- Coordinated re-contracting effort with ophthalmology across all product lines resulting in lower reimbursement rates
- Coordinated and implemented model office structure for the Network Department

Manager of Provider Relations, Special Project Coordinator, & Provider Representative, Arizona Physicians IPA (Phoenix, Arizona) Period: 1994-2000
- Recruited and contracted providers to maintain a competitive Medicaid network in size, quality, and cost
- Maintained and updated contracts through extensive communication with the provider and ancillary network
- Redeveloped the policy and procedure for auditing contracted provider network to ensure accessibility
- Contracted with providers for Acute Care services and obtained letters of intent for the AHCCCS RFP
- Participated in HEDIS reporting and NCQA accreditation process

Travelers Managed Care System

Member Services Supervisor, Provider Relations Representative (Phoenix, Arizona) Period: 1990-1993
- Conducted benefit open enrollment seminars and weekly visits to clients to answer benefit questions
- Reviewed and researched grievances and claim problems
- Created and maintained contract tracking system and entered provider referrals into system
- Established departmental policies and procedures

Equicor Health Plan

Member Services Manager (Phoenix, Arizona) Period: 1986-1990
- Managed member calls, questions, and complaints
- Developed methods to improve accuracy of processing grievances; shortened resolution period by 50%

Previous Experience

AFPIPA, Claims Research Period: 1982-1986
Prudential, Claims Processor Period: 1980-1982

Education and Credentials

Attended Dordt College, 1979-1980

Community Service

Palm Lane Christian Reformed Church, President of Deacons, 2010; **Secretary of Deacons,** 2008-2009; **Director of Events,** 1996-2000

Claims Administrator

Edward Gallegos, Vice President, Claims & Encounters

Summary

Over 15 years diversified business experience in managed health care, developing and executing corporate strategies in claims processing, customer service, and human relations; areas of expertise include leading and building high performing teams, building consensus among internal/external stakeholders at all levels, effective communication, complex project management, strategic thinking and planning, negotiating, conflict resolution, and creative problem solving.

Career History

Centene Corporation ***Includes Long Term Care Experience***

Vice President, Claims & Encounters, (St. Louis, Missouri) Period: 2010-Present

- Provide overall leadership and management of the company's claims, encounters, coordination of benefits and third party liability/third party recovery (TPL/TPR), systems benefits configuration, and provider data operations
- Administer the comprehensive claims processing system, AMISYS Advance, overseeing the development and implementation of system updates and customizations to ensure claims payment occurs in accordance with state and federal requirements
- Monitor and ensure effective and efficient claims operations to deliver outstanding service to members, providers and other key external stakeholders while meeting claims processing timelines and minimizing claims recoupments
- Develop processes for cost avoidance
- Ensure Arizona Health Care Cost Containment System (AHCCCS) claims, including Long Term Care claims, are effectively, accurately, and efficiently processed in accordance with claims adjudication requirements and are in compliance with all applicable state and federal laws, rules, and regulations
- Ensure encounter reporting requirements, including AHCCCS requirements, are met
- Provide management and direction to five direct reports, 350+ staff members, and 11 health plans across 11 states
- Manage administration of claims policies and procedures to ensure excellence in service delivery and contract requirements
- Oversee provider set-up, contract configuration, and benefit configuration in the claims processing system to ensure accurate claims adjudication
- Oversee processing, adjudication, and adjustments of all provider claims for covered services, including appealed claims
- Develop and ensure successful implementation of continuous quality improvement initiatives, including new enhancements to business operations to augment service delivery
- Implement and manage effective control mechanisms to measure the quantity and quality of claims and develop remediation plans to quickly address any needed improvements
- Monitor the accuracy and quality of AHCCCS encounter reports in compliance with state requirements
- Ensure members' and providers' claims-related inquiries and disputes are addressed timely and appropriately and that issues are effectively and efficiently resolved
- Collaborate with auditors and external quality review organizations to assess the quality of care and services provided to members by supplying claims data and working with auditors and External Quality Review Organizations (EQROs) to identify opportunities for improvement

Blue Cross Blue Shield of Florida

Vice President, Cultural Competence and Diversity Systems, (Jacksonville, Florida) Period: 2008-2010

- Developed, integrated, and implemented enterprise-wide diversity strategies with core business processes including multicultural consumer engagement and market expansion, internal/external workforce engagement and representation, service innovation, public policy and internal/external education
- Designed strategies to ensure productive, engaged workforce, organizational effectiveness, and facilitate continuous change with minimal disruption to core business processes

Vice President, National Programs and Major Accounts Operations, (Jacksonville, Florida) Period: 2004-2008

- Led and managed company's national claims and call center operations that served over two million members
- Decreased claims backlog 75% during first 90 days through an aggressive inventory reduction effort
- Oversaw achievement of performance guarantees, national performance metrics, governmental key indicators and corporate goals while managing a budget of $85 million and over 1,500 employees

Vice President, Human Resources Operations, (Jacksonville, Florida) Period: 2002-2004

- Led and managed corporate Human Resources functional units, including: Talent Acquisition and Staffing, Executive Recruitment, Organizational Development and Design, Employee Relations, Learning and Development, Equal Employment Opportunity (EEO) / Affirmative Action Program (AAP) reporting, HR Plan and Budget, and the Human Resource Information System (HRIS) – Business Solutions Team
- Oversaw recruiting, hiring, and training of management and staff, including for claims management and processing
- Developed career path and professional goals for management and staff, including those in claims management and processing

Senior Director, Talent Acquisition and Staffing, (Jacksonville, Florida) Period: 2000-2002

- Led a team of 25+ professional recruiters and employment specialists responsible for all internal and external staffing
- Reduced average days to fill for 2,200 annual vacancies by 10% over the previous year while improving quality of hire satisfaction rates
- Initiated, led and managed company workforce planning while successfully placing the 85%+ of the company's impacted employees

Senior Director, National and Major Accounts, (Jacksonville, Florida) Period: 1995-2000

- Led and managed the company's largest national accounts including the Federal Employee Program, General Motors, Ford, Chrysler, Publix and K-Mart
- Provided strategic and tactical execution and operational oversight to a diverse group of over 400 employees in claims, customer service, medical management, training and development and inventory management and control
- Reduced backlog of 750,000 claims to 25,000 during a four month timeframe
- Built and maintained strong relationships with plan contacts by communicating openly and responding quickly to their needs, concerns, and questions
- Served as liaison with local plan leadership to ensure timely and accurate claims payment
- Developed, implemented, and monitored internal performance metrics within all levels of the organization to ensure compliance with corporate goals and objectives

Education and Credentials

University of North Florida, Masters of Public Administration, 1989

State University of New York at Albany, Bachelor of Science in Business, 1986

Professional and Community Service, Honors, and Awards

First Coast Diversity Council, Jacksonville, Florida, President. 2009 – 2010

Florida State University Hispanic Marketing Advisory Board, Member. 2008 – 2010

Project Breakthrough, Jacksonville, Florida, Participant. 2008-2010

Leadership Jacksonville, Class of 2008, Recognition. 2008

Case Management Administrator/Manager

Mary Reiss, BSW, Vice President, Long Term Care Case Management

Summary

A proven health care leader with over 23 years experience in social services and 7 years management/supervisory experience in case management, fostering a holistic approach to service delivery for the ALTCS population

Career History

Bridgeway Health Solutions ***Includes Long Term Care Experience***

Vice President, Long Term Care Case Management, (Tempe, Arizona) Period: 2011-Present

- Manage coordination of statewide case management (CM) functions across all facets of the Arizona Long Term Care System (ALTCS) to maximize the efficient use of resources and minimize negative impacts to member care
- Oversee compliance for case management with state contract and regulations
- Collaborate with the Medical Director to develop, implement, and evaluate the CM program
- Identify trends and root causes of problems and provide recommendations for improvements, documentation, and training related to CM for the ALTCS population
- Oversee staffing for both clinical and non-clinical direct reports, including the development of processes and outcomes in CM that support operational requirements and corporate goals
- Ensure consistency across three geographic service areas of all new and existing CM policies and procedures

Case Management Supervisor - Director, (Tempe, Arizona) Period: 2008-2011

- Provided supervision, education, management of problem resolution, and support to nine case managers performing health care CM activities to ALTCS members
- Identified process and procedural strategies to improve practices and ensured compliance with state and federal policies and procedures
- Maintained effective coordination of covered and non-covered community resources, serving ALTCS members in the most cost effective manner while providing a holistic and respectful approach
- Educated members and their families on reporting issues related to service delivery or other unmet needs to ensure redress of any complaints within the care plan process
- Utilized extensive knowledge of Medicaid, Medicare, Medicaid Advantage, and medical claims payment systems to facilitate case management

Schaller Anderson / Mercy Care Plan ***Includes Long Term Care Experience***

Long Term Care Case Management Supervisor, (Phoenix, Arizona) Period: 2004-2008

- Supervised 12-15 case managers and provided ongoing development and education to the ALTCS CM department
- Developed and revised policies for the CM program to address identified problem areas; implemented solutions/corrective action plans to ensure compliance with state and federal regulations
- Facilitated team meetings, large group training activities, and effective interaction between external providers and internal departments
- Provided guidance and written support to articulate CM activities for the Request for Proposal
- Coordinated CM activities across community health, welfare, and social agencies, providing a holistic approach

Long Term Care Case Manager, (Phoenix, Arizona) Period: 2003-2004

- Provided case management services for elderly and/or physically disabled individuals enrolled in long term care services and assisted other case management team members in completing work assignments as needed
- Coordinated services and health care to assist members in achieving the best quality of life and independently function in the most cost effective manner preferred by the state
- Worked closely with community service providers to initiate, coordinate, and follow through with appropriate community, residential, or skilled nursing care needs
- Empowered members and their families to navigate the health care system to meet their individual needs
- Coordinated with hospital, skilled nursing facilities, and concurrent review nursing staff to provide a continuum of service options necessary for successful discharge planning and reintegration of members into independent living environments

Security National Life Insurance Company

Family Services Counselor, (Phoenix, Arizona) Period: 2002-2003

- Provided pre-need funeral insurance and planning assistance for customers of five funeral homes

South Dakota Division of Mental Health

Community-Based Mental Health Manager, (Pierre, South Dakota) Period: 2001

- Oversaw all programs and services provided by community mental health centers (CMHCs) and personnel functions of CMHC staff to ensure compliance with current state and federal laws, rules, and regulations
- Developed, reviewed, and revised administrative rules and the accreditation process for CMHCs
- Administered all fiscal matters pertaining to CMHCs to ensure compliance with program goals and budgets

Adult Services Program Specialist II/Program Specialist I, (Pierre, South Dakota) Period: 1998-2001

- Oversaw the community-based mental health services provided for individuals with severe and persistent mental illnesses at the states' 11 CMHCs
- Served as the Division of Mental Health (DMH) contact, providing technical assistance to CMHCs as needed
- Conducted accreditation reviews and coordinated discharge planning issues between the state's inpatient psychiatric hospital and the CMHCs
- Led the development of a new residential program that served individuals with co-existing mental illness, substance abuse, and a new program of assertive community treatment
- Completed the grant application and provided oversight for the state's Projects for Assistance in Transition from Homelessness (PATH) program
- Conducted research and completed the grant application for the state's Mental Health State Block Grant (MHSBG)
- Made presentations to the public regarding services available through the state's DMH
- Served on a variety of work groups and committees to improve the overall mental health system in the state; this involvement led to the development of the state's mental health administrative rules and policies and procedures

Child Protection Social Worker, (Pierre, South Dakota) Period: 1993-1998

- Performed child protection services functions including intake referral, investigations, assessments, placement in alternative environments, case management, and participation in the legal process for children experiencing physical, emotional, and sexual abuse
- Educated community groups regarding child abuse/neglect issues

Pierre Indian Learning Center

Dorm Counselor, (Pierre, South Dakota) Period: 1993

- Developed and executed individual education plans and individual treatment plans for Native American children
- Conducted individual and group counseling sessions tailored to the high needs of children in a residential setting

Capital Area Counseling Services

Residential Coordinator & Case Manager, (Pierre, South Dakota) Period: 1990-1992

- Managed a transitional facility for individuals with severe and persistent mental illness, including supervision of full and part-time staff, oversight and development of the facility budget, and overall functioning of the facility
- Provided case management services, medication administration and monitoring, development of treatment plans, and co-therapy for group and individual sessions

South Dakota Human Services Center

Human Services Social Worker, (Yankton, South Dakota) Period: 1989-1990

- Conducted discharge planning activities, referrals to CMHCs, and family therapy and contacts; developed social histories, discharge summaries, and treatment plans for an adult acute psychiatric ward
- Assisted patients with financial needs and identifying community contacts
- Collaborated with CMHCs to assure smooth transitions from the hospital to community settings

Human Services Social Worker, (Yankton, South Dakota) Period: 1988-1989

- Facilitated group and individual therapy sessions, developing treatment, transitional, and aftercare plans for youth in treatment for substance abuse and emotional issues
- Conducted intakes, referrals, social histories, family contacts, and weekend family programs

Education and Credentials

University of South Dakota, Bachelors of Science in Social Work and Psychology, 1988

Professional and Community Service, Honors, and Awards

Planning and Advisory Council for the South Dakota Homeless Consortium, Member. 1998-2001

South Dakota Housing Development Authority. Assisted in writing a grant application for the Housing and Urban Development SuperNOFA. 1998-2001

National Conference on Assertive Community Treatment, Attendee. 2000

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

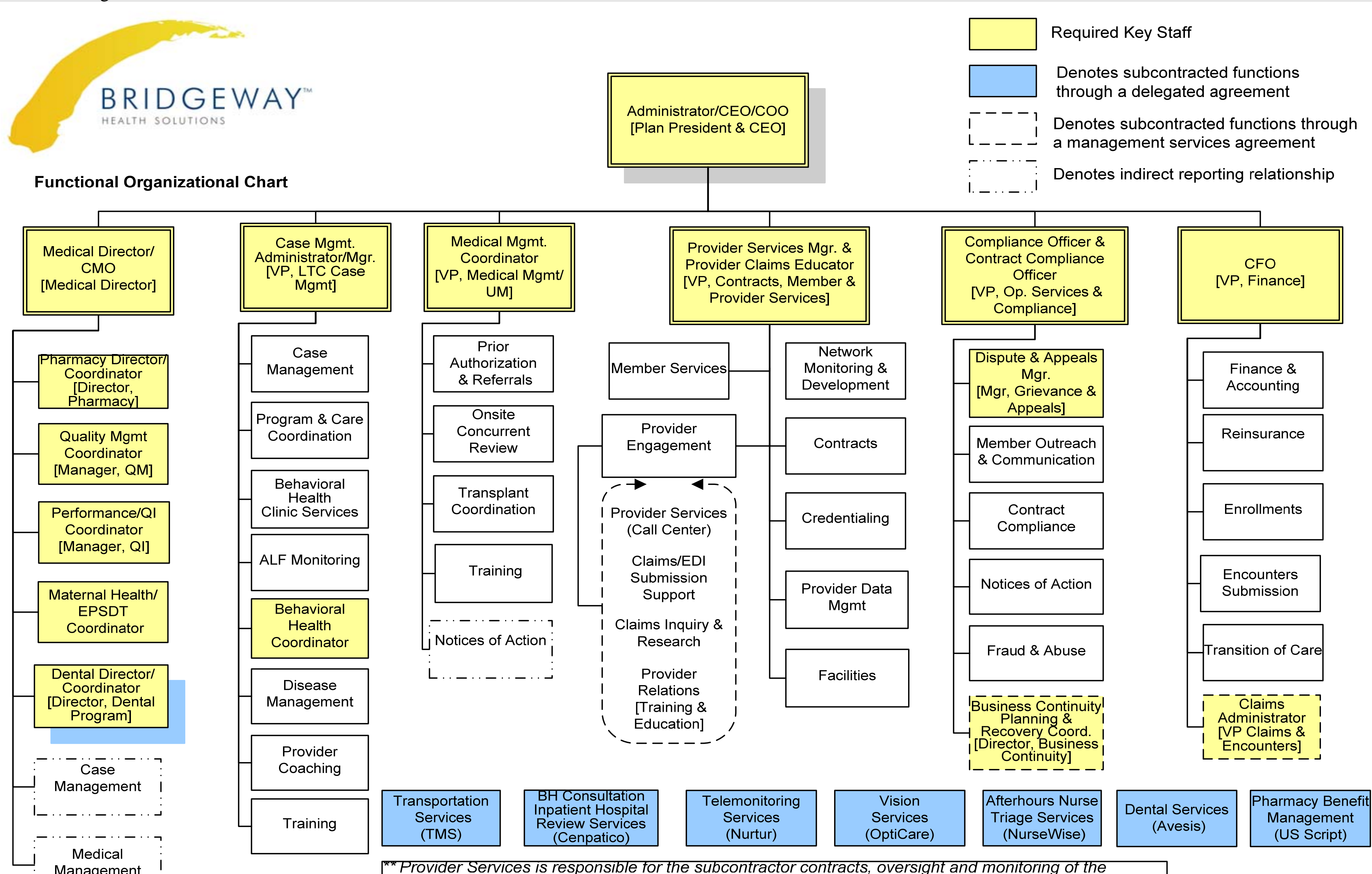
The key positions/employees per Section D, paragraph 25 that are not full-time is as follows:

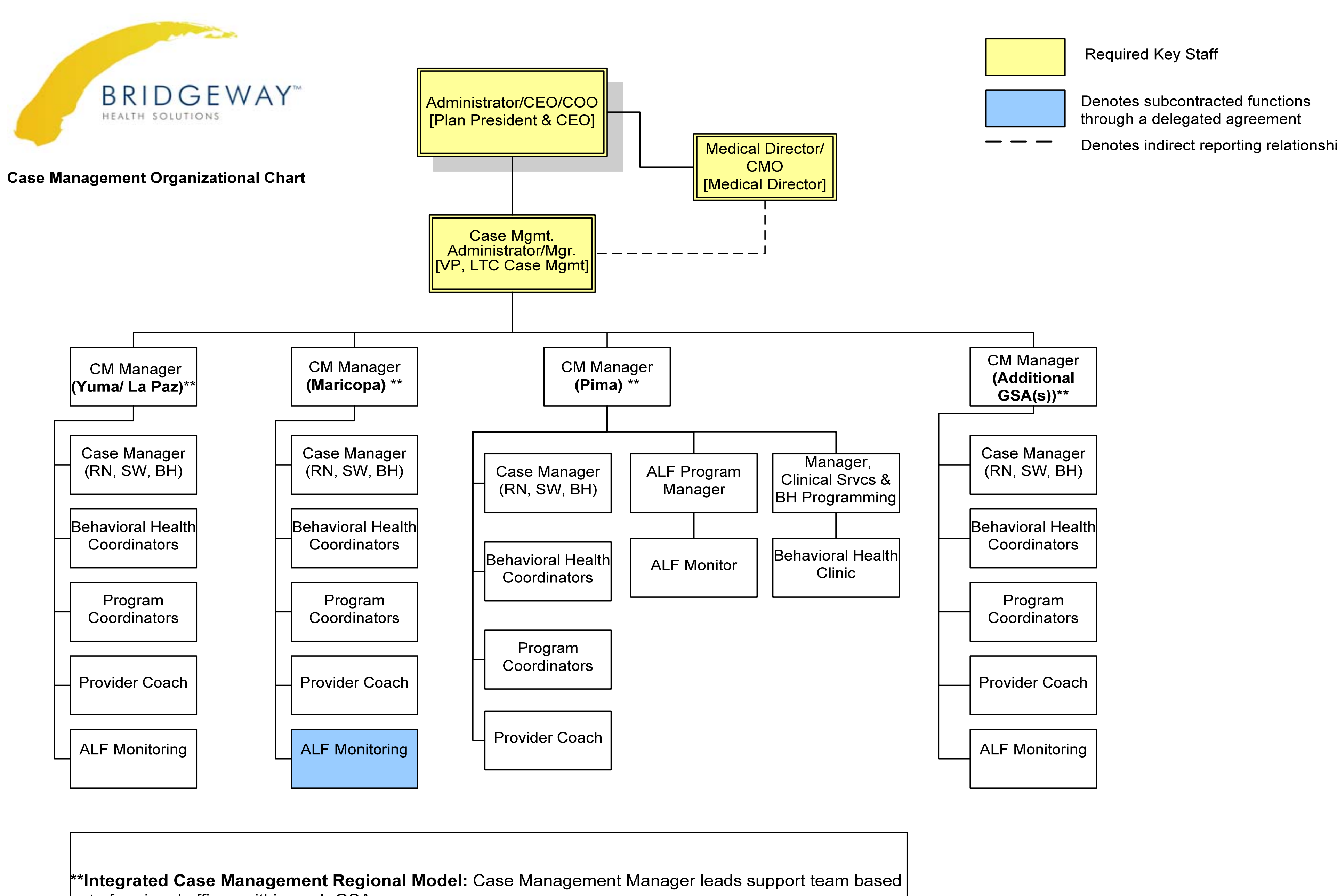
Dental Director/Coordinator: Dr. Bruce Nelson, DDS currently serves as the Dental Program Director for Bridgeway through our dental vendor, Avesis, Inc. Due to the low volume of dental claims received from the Arizona Long Term Care System (ALTCS) population served by this contract, we perform this function with a part-time Dental Director. Historically, less than 1% of Bridgeway's requests for service in our ALTCS population have been for dental services. Furthermore, the majority of dental authorizations have been based on medical necessity, which requires a review by the Medical Director/CMO instead of the Dental Director/Coordinator. Dr. Nelson dedicates the majority of his time to management of his dental practice, but maintains sufficient time to review any dental service requests that fall under his review authority as well as address any dental network issues.

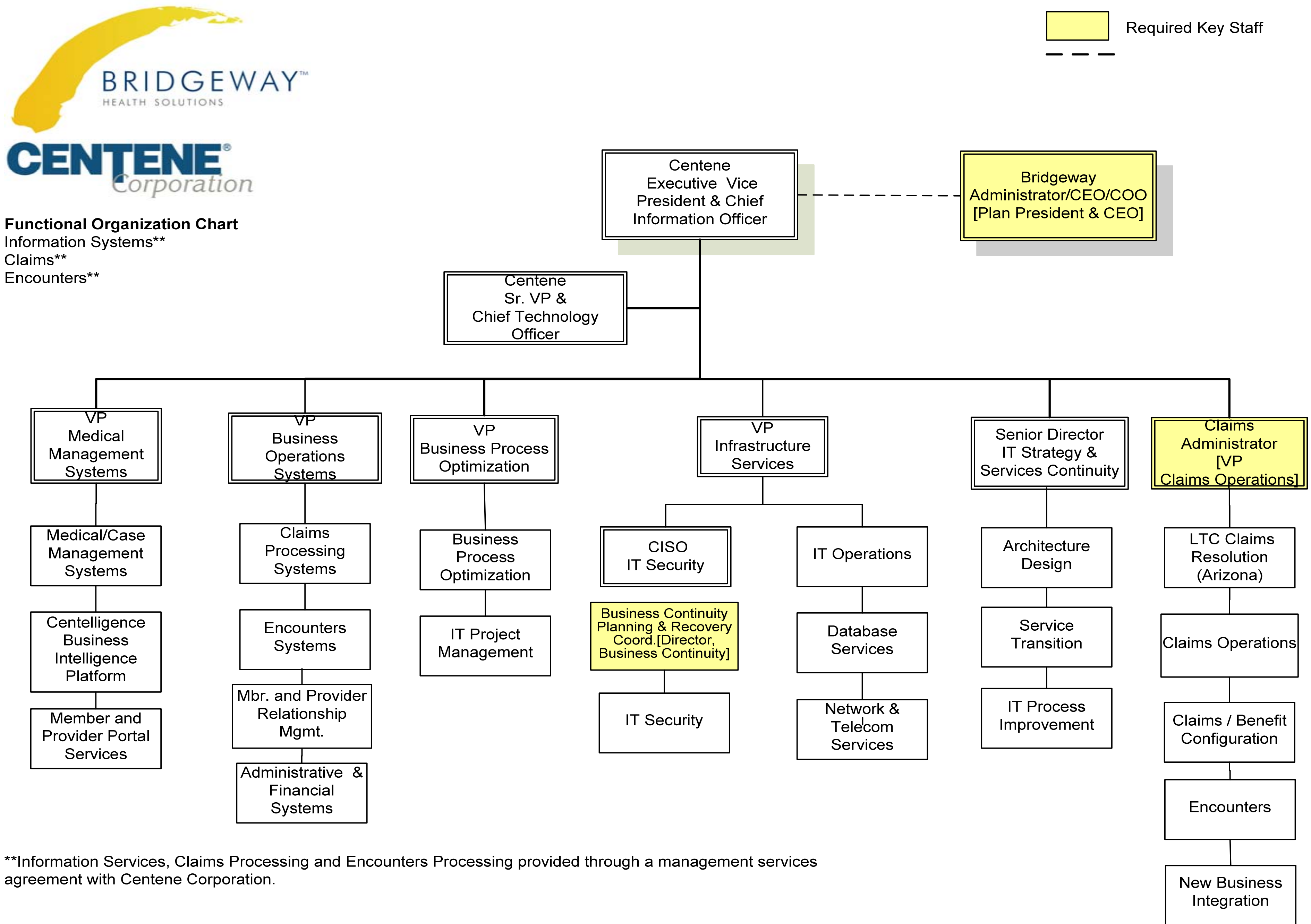
Claims Administrator: Ed Gallegos currently serves as Vice-President, Claims and Encounters for Centene Corporation. While not dedicated exclusively to Bridgeway, in his role, Mr. Gallegos is responsible for claims adjudication operations for all of Centene's subsidiary health plans and specialty companies. Mr. Gallegos has a full complement of managerial and supervisory staff available to provide resources to ensure provider claims are adjudicated appropriately and performance monitoring occurs on a reoccurring basis. Mr. Gallegos' overall duties are similar to his duties under the ALTCS contract, except that his services are provided in connection with other managed care contracts for which Centene conducts claims processing.

Business Continuity Planning and Recovery Coordinator: Glen Woita currently serves as Director, Business Continuity for Centene Corporation. In his role, he oversees all phases of disaster recovery planning across all health plans and specialty companies, including Bridgeway. As Centene's Living Disaster Recovery Planning System is coordinated across all business units, he is not dedicated solely to Bridgeway's operations. Mr. Woita has expanded the role and scope of the Bridgeway Local Response Team (LRT) to provide structure and clarity for an on-site response to crisis events. Mr. Woita's overall duties are similar to his responsibilities under the ALTCS contract, except that his services are coordinates across all managed care contracts for which Centene provides services.

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




BRIDGEWAY
HEALTH SOLUTIONS
Case Management Organizational Chart
Required Key Staff
Denotes subcontracted functions through a delegated agreement
Denotes indirect reporting relationship
Administrator/CEO/COO [Plan President & CEO]
Medical Director/ CMO [Medical Director]
Case Mgmt. Administrator/Mgr. [VP, LTC Case Mgmt]
CM Manager (Yuma/ La Paz)**
CM Manager (Maricopa) **
CM Manager (Pima) **
CM Manager (Additional GSA(s))**
Case Manager (RN, SW, BH)
Behavioral Health Coordinators
Program Coordinators
Provider Coach
ALF Monitoring
Case Manager (RN, SW, BH)
Behavioral Health Coordinators
Program Coordinators
Provider Coach
ALF Monitoring
Case Manager (RN, SW, BH)
Behavioral Health Coordinators
Program Coordinators
Provider Coach
ALF Program Manager
ALF Monitor
Manager, Clinical Srvcs & BH Programming
Behavioral Health Clinic
Case Manager (RN, SW, BH)
Behavioral Health Coordinators
Program Coordinators
Provider Coach
ALF Monitoring
**Integrated Case Management Regional Model: Case Management Manager leads support team based out of regional offices within each GSA



**Information Services, Claims Processing and Encounters Processing provided through a management services agreement with Centene Corporation.

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

The tables below list the sanctions levied on all Centene entities from 01/01/08 to 03/15/11. The first table is for Bridgeway, the second is for all other Centene entities and both tables include any sanctions currently in dispute.

No Centene health plan has ever had enrollment suspended or a Medicaid contract terminated.

Bridgeway Health Solutions, LLC (Bridgeway) – Sanctions levied by Arizona Health Care Cost Containment System (AHCCCS) *Bridgeway has only one sanction that was not waived and for which a fine was levied during this period.*	
Date	**Sanction Description, Specific Reason for It, and Timeline for Resolution/Correction**
Waived Sanctions 2008-2011	Sanction waived for encounters pending over 120 days: 1/18/08 ($915); 01/31/08 ($10,710); 04/01/08 ($40,000); 08/14/08 ($51,400); 11/15/08 ($9,145); 2/10/09 ($34,535); 3/10/09 ($18,973); 09/25/09 ($20,860); 06/30/10 ($215,065: $133,000 for Acute Care Contract and $82,000 for ALTCS); 3/3/11 ($415,525 for Acute Care Contract). Resolution Timeline: On receipt of each notice we worked to clear all pended encounters the same day. For encounters that, due to reasons stated in our monthly risk reporting, could not be cleared timely, and which rolled beyond the period, we prioritized and continue to consistently clear them on a daily basis. We are in the final stages of planning the launch of an updated approach to resolve the encounters accumulation and underlying factors going forward, as follows: 1) Ramping up for a recovery project set for the end of Q2 2011, as well as a focused action plan for reinsurance encounters and pre-scrubs. 2) Implementing targeted outreach through Network Management to certain high volume providers with encounter issues, for billing education and claim correction.
12/09/09	$10,000 sanction for noncompliance with Grievance System requirement to provide a member with specific information on how criteria were not met to receive medication (Acute Care Contract). We reversed the denial one day after issuance and resolved the member's issue by approving the requested medication on the same day. We requested reconsideration of the sanction; it was denied. This reflects one isolated incident; continued training is conducted across departments on notices of action.

Centene Entities Other Than Bridgeway Centene's internal compliance process is to monitor remediation activities for a period of time (over multiple quarters) until they are deemed clearly effective. In addition, states' approaches to issuing sanctions and accepting and closing sanctions or related corrective action plans (CAPs) varies; some states review quarterly, and cases are closed months after resolution or correction of the deficiency. Therefore our approach below is to indicate by when the remediation action taken by each health plan was effective in resolving or correcting the deficiency (including month/year or month/date/year, when possible), and not necessarily the date the sanction or risk was administratively closed by the State or Centene. In several instances, sanctions were based on a study or review of previous quarters or years, so the issue may have been resolved prior to receiving the sanction notice; therefore, the "resolved by" date may be earlier than the sanction notice date in the left column.	
Date	**Sanction Description, Specific Reason for It, and Timeline for Resolution/Correction**
Buckeye Community Health Plan (BCHP), Ohio – Sanctions levied by Ohio Department of Job and Family Services (ODJFS)	
01/15/08	$400 sanction ($100/day) for late responses to a provider (1 day) and member request (3 days). Resolved by 02/18/08.
01/15/08	Sanction reversed on appeal: $10,000 sanction for medical record submission rate < 85%. Appealed 01/23/08; sanction reversed 01/30/08.
02/25/08	$13,700 sanction for untimely response to provider complaint. BCHP revised the process and resolved by 03/31/08.
02/26/08	$2,000 sanction for network deficiencies; a late provider termination made it difficult to obtain State approval of a network exception request by time of evaluation. Resolved by 03/31/2008.
05/08/08	$1,000 sanction for network deficiencies; claims issues caused unexpected provider termination; the late termination made it difficult to obtain State approval of a network exception request by time of quarterly evaluation. Resolved by 06/05/08.
10/09/08	$29,000 sanction for paying sterilization/abortion/hysterectomy claims without the required documentation in SFY07. CAP submitted to ODJFS 10/22/08; CAP approved 10/30/08, however much of the process improvement had already been implemented in 01/08; appeal denied and issue resolved on 12/30/08.
03/05/09	$2,000 sanction for not meeting provider panel requirements in 2 regions in prior quarter; the error was technical and the network not deficient. Corrected records were submitted in 03/09 and the issue resolved.
08/21/09	$1,000 sanction for not meeting provider panel requirements in 1 county in the quarterly measurement. Resolved by 04/30/10.
12/23/09	$1,000 sanction for not meeting provider panel requirements in 1 county. Resolved by 04/30/10.
07/16/10	$48,000 sanction for paying sterilization/abortion/hysterectomy claims without the required documentation in SFY10. CAP submitted to ODJFS 08/10/10 and accepted 08/16/10; portion of CAP completed 08/30/10; remainder of resolution activities continue.
08/10/10	$2,000 sanction (reduced on appeal from $3,000) for not meeting provider panel requirements in 2 counties. The original sanction was reduced on appeal due to issues in the State's system. Resolved by 11/30/10.
Celtic Insurance (Celtic), Illinois – Sanctions levied by State of Florida Department of Insurance	
05/01/08	$13,000 sanction for submitting a hard copy, instead of electronically filing an updated Anti-Fraud plan. Resolved by 05/30/08.
Cenpatico Behavioral Health of Arizona (CBH AZ) – Sanctions levied by Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS)	
02/07/08	$20,000 sanction for Q4 SFY07 noncompliance (84.5%) with 85% minimum standard for routine appointments for ongoing services (7 days of referral) and routine appointments for ongoing services (23 days of initial assessment). *See resolution timeline in next cell.
12/12/08	$36,250 sanction for Q1-Q3 SFY08 noncompliance with 85% minimum standard (as detailed above). *Resolution Timeline: Process improvement implemented 06/01/08 that required all intake specialists to provide the first routine behavioral health (BH) service on the

	day of intake; Clinical Supervisors will audit each intake to ensure the service was provided.
12/12/08	$20,000 sanction for not meeting coordination of care performance standards in Q4 SFY08 in 2 GSAs. *See timeline in next cell.
01/27/09	$10,000 sanction for not meeting the coordination of care performance standards measurement in GSA 4 in Q1 SFY09. *Resolution Timeline: CBH implemented provider re-education and monitored through routine audits. Resolved by 01/31/09.
07/10/09	$5,000 sanction for Q3 SFY09 re not meeting 85% minimum standard for appropriateness of care in GSA 2. Resolved by 07/30/09.
10/01/09	$13,000 sanction for not ensuring the availability of 24 Case Managers to serve children with high needs. Resolved by 12/28/09.
12/28/09	$161,971.48 sanction (reduced from $323,232 due to age of data and improvements made to date) for data errors related to omissions, correctness, and timeliness identified in the Encounter Data Validation Studies of Contract Year 2006; also required to set aside $8,676 for provider education and training. Resolved by 01/07.
Managed Health Services (MHS IN), Indiana – Sanctions levied by Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning	
2009-2010	Sanction for encounter acceptance rate < 98%: 3/18/09 for 02/09 ($600, resolved by 03/09); 11/24/09 for 10/09 ($200)*; 01/25/10 for 12/09 ($200)* and 02/24/10 for 01/10 ($400)*. * Resolution Timeline: A workgroup was created in 11/09; consistent compliant performance was achieved (issue resolved) in the 02/10 aggregate measurement.
Peach State Health Plan (PSHP), Georgia – Sanctions levied by the Department of Community Health (DCH)	
08/07/09	$5,000 sanction for 2 HS&R reports delivered late to the requesting hospitals (Q1 2009). Resolved by 10/02/09; PSHP automated this report process and created dedicated email addresses for incoming requests.
03/18/10	$1,000 sanction for 1 HS&R report delivered 1day late to requesting hospital (in 04/09). Resolved by 10/02/09 (see description above).
09/28/10	Sanction rescinded: $30,000 sanction for dental subcontractor not achieving the 99% cash disbursement journal reconciliation rate in the 06/10 measurement; sanction rescinded on 12/08/10 due to data reconciliation methodology errors.
Sunshine State Health Plan (SSHP), Florida – Sanctions levied by Agency for HealthCare Administration (AHCA)	
09/05/09	Sanction reversed to $0 on appeal: $200 sanction for late submission of Q2 2009 Grievance and Appeals report. Appeal resolved 04/20/10.
03/11/10	Sanction reversed to $0 on appeal: $400 sanction for late submission of Q4 2009 Claims Aging Report. Appeal resolved 04/20/10.
10/18/10	$10,000 sanction for distributing plan specific brochures/material that did not meet definition of community outreach at two events. CAP, approved by AHCA, included employee education and “buddy” monitoring for outreach staff. Resolved by 10/10.
12/03/10	$20,000 sanction for mailing unapproved letter to enrollees (08/27/10) re a hospital contract termination effective 10/31/10; SSHP received Agency approval of letter 10/27/10; CAP submitted 12/22/10 and is pending AHCA response. Sanction currently in dispute (under appeal).
02/24/11	$1,200 sanction for late submission of 80/20 behavioral health IBNR reconciliation report; report not specifically listed in required report tables in State contract. Petitioned the State to add to their defined report list; added to internal report list. Resolved by 03/7/11.
Superior Health Plan, Inc. (SHP), Texas – Sanctions levied by the Health and Human Services Commission (HHSC) for multiple lines of business and service areas (SAs). Note: The resolution timeline for SHP and SHPN sanctions is either included in a parenthetical following the individual item within a sanction or is summarized at the end of the SHPN table below, with the summary reference denoted with a numeric 2 symbol adjacent to the item (symbols range from 1 to 4).	
02/27/09	$50,500 sanction (reduced from $65,650 to compensate for a previous incorrect sanction assessment) re: untimely clean claims 1; provider directory inaccuracies 3; and late BH crisis hotline report (resolved by 03/30/09).
06/04/09	$119,500 sanction for BH subcontractor untimely clean claims 1; provider directory inaccuracies 3 - multiple products/SAs.
09/14/09	$194,500 sanction for multiple service areas re: summer provider directory inaccuracies 3 and untimely claims appeals 2.
11/23/09	$162,660 sanction (reduced on appeal from $982,950) for subcontracted dental vendor noncompliance re: claims reports; clean claims; staff training; provision of pre-appeals process to members; provider and member hotline; inaccurate member complaint, member appeal, and provider complaint reports 4. SHP was also sanctioned $28,900 (reduced to $20,230) for insufficient oversight of dental vendor 4.
12/28/09	$10,000 sanction for not providing required reports of members who agreed to participate in the Smoking Cessation Pilot Program and not adequately monitoring disease management subcontractor’s performance including quality of reported data (resolved by 01/25/10).
12/29/09	$78,500 sanction for Q4 SFY09 in multiple products/SAs: re: untimely claims appeals 2 and provider directory inaccuracies 3.
03/25/10	$110,250 sanction for Q1 SFY10 noncompliance re: claims appeals in multiple products/SAs 2 and STAR Health provider directory 3.
06/28/10	$19,500 sanction for Q2 SFY10 re: exceeding encounter reconciliation report variance (resolved by 07/30/10); member hotline performance below requirements in multiple SAs (resolved 07/30/10); inaccurate provider termination report (resolved by 07/30/10); untimely clean claims 1.
Superior Health Plan Network (SHPN), Texas – Sanctions levied by HHSC for multiple lines of business and service areas (SAs)	
04/09/08	$8,525 sanction for Q1 SFY08 re: late filing of signed contract (one time occurrence, resolved by 04/09/08) and inaccurate provider data reporting (resolved by 08/30/08).
05/07/08	$33,550 sanction (reduced from $93,550) for 04/08 Foster Care (FC) noncompliance re: staffing (resolved by 07/31/08); telemedicine (fine rescinded 06/08); website (resolved by 10/31/08); and reporting requirements (resolved by 08/30/08).
06/02/08	$7,500 sanction for untimely clean claims in Q2 SFY08 1.
07/17/08	$77,675 sanction for FC 05/08 noncompliance re: staffing (resolved 07/31/08); provider directory 3; and website (resolved 10/31/08).
09/09/08	$2,500 sanction for Q3 SFY08 re: untimely clean claims processing 1.
09/09/08	$83,200 sanction for Q3 SFY08 member and provider hotline performance below requirements (resolved by 09/05/08).
09/22/08	$37,675 sanction for FC Q3 SFY08 inaccuracies re: website (resolved by 10/31/08); provider directory 3; vision OON report (resolved by 08/26/09); and acute claims summary and BH provider complaint reports (both resolved by 08/30/08).
12/22/08	$50,500 sanction for FC re: website content in 07/08 and 08/08 (resolved by 10/31/08); vision OON report inaccuracies (resolved by 08/26/09); and provider directory inaccuracies (both printed and online) 3.

12/23/08	$92,100 sanction for Q4 SFY08 re: untimely BH clean claims 1; member and provider hotline performance in multiple products/SAs (resolved by 09/05/08).
02/26/09	$12,800 sanction for FC Q4 SFY08 and Q1 SFY09 re: untimely and inaccurate reporting of THSteps PCP report (resolved by 08/26/09) ; untimely submission of reinsurance agreement (resolved by 08/26/09); provider directory inaccuracies 3.
06/04/09	$18,000 sanction for FC data inaccuracies in spring '09 provider directory 3.
09/14/09	$30,900 sanction for CHIP EPO summer provider directory inaccuracies 3 and untimely claims appeals 2.
12/29/09	$46,000 sanction for FC Q4 SFY09 re: untimely claims appeals statewide 2; fall '09 provider directory inaccuracies 3.
03/25/10	$62,050 sanction for Q1 SFY10 re: CHIP EPO statewide untimely claims appeals 2; and for FC statewide: provider directory inaccuracies 3; untimely claims appeals 2; dental clean claims underperformance 4; untimely dental claims report and inaccuracies 4.
06/28/10	$12,500 sanction for Q2 SFY10 FC statewide untimely dental appealed claims processing 4.
09/22/10	$10,450 sanction for Q3 SFY10 re: FC statewide untimely dental clean claims processing 4 and BH subcontractor noncompliance with inclusion of expedited appeals in the member appeals report (resolved by 08/30/10).
02/03/11	$5,000 sanction for Q4 SFY10 re: statewide untimely BH claims appeals 2.

SHP and SHPN Sanction Descriptions and Resolution Timelines for 1-4. 1 Untimely clean claims processing and 2 untimely claims appeals: HHSC requires 98% of all clean claims and all appealed claims to be processed within 30 days of receipt. This is not an aggregate measurement of the company or each product, but rather a by product/by county (or service area) measurement. In smaller counties, the denominator for these measurements is very small and, in some instances HHSC ignores statistically insignificant data, other times they do not. CAPs typically stay in place until more than one quarter of compliance performance is achieved. Untimely clean claims processing (1) was resolved by the end of 2010 with no sanctions in 2011 to date. SHP and SHPN continue to work diligently to address untimely claims appeals (2) and resolution is pending. 3 Provider Directories: SHP implemented a CAP to improve directory accuracy in 07/08 and also had ongoing discussions with HHSC about revising the audit methodology (measured for 100% accuracy rate in the print directory and for 100% fidelity between the print (produced quarterly) and web directories). HHSC revised their methodology in Q1 2010. SHP has not incurred any further sanction due to directory audit since 03/10; however, SHP has not been officially released from the CAP. 4 Dental subcontractor: SHP terminated the dental vendor contract effective 06/01/10 due to the identified operational deficiencies. SHP reached a settlement agreement with the dental vendor in 12/09 that rescinded their delegated functions, and placed them in an ASO role until 05/31/10. The new dental vendor became effective 06/01/10. Sanctions resulting from the previous vendor's performance received after 06/01/10 represent run-out claims activity and were passed to them for reimbursement. No other Centene health plan uses this dental vendor.

University Health Plan (UHP), New Jersey – Sanctions levied by New Jersey Department of Human Services (DHS)
(Note: Centene's sale of University Health Plan was complete in March 2010.)

2008-2010 EPSDT/ Lead Measures	Sanction for EPSDT and lead measures performance: 05/15/08 for CY05 ($57,762); 04/20/09 for CY06 ($36,201); 05/06/10 for CY07 ($25,650). Resolution Timeline: The State measured lead and EPSDT compliance using only administrative and not medical record data; against the 80% compliance standard, the plan's lead compliance in 2007 using a hybrid HEDIS measurement reached 75.9%.UHP maintained an ongoing corrective action plan and quality improvement plan to increase all aspects of EPSDT screenings (lead, dental, immunizations, and well care).
01/25/10	$15,782 sanction for exceeding maximum monthly duplicate encounter submission rate of 3% in 12/09. Resolved by 02/28/10.

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

An Organizational Focus on Claims Service

Bridgeway Health Solutions, LLC® (Bridgeway) and our parent Centene Corporation (Centene) view claims processing as more than just compliance with payment rules; we see it as a *critical opportunity to offer superior service* to our providers (ensuring a sound provider network). We also view the claims process as arguably the single most important data gathering aspect of our operation, since it supports our quality and utilization monitoring efforts, provider education and outreach initiatives, and supplies AHCCCS with accurate, complete and timely encounter information.

As part of our continuous effort to enhance our claims payment services, Bridgeway is establishing a new team comprised of our local Claims Liaisons, Provider Services staff with specialized EDI expertise, and Network Management staff, coupled with designated Centene Claims, EDI Operations, and Information Systems staff. This **Provider Engagement Team (PET)** will engage providers to work through any issues or barriers they may have with LTC claim submissions and claims resolution, and assist them with navigating changes such as conversion to HIPAA 5010, ICD-10, and the transition from roster billing to electronic HIPAA compliant claim submissions. Locally based PET staff will be empowered to facilitate rapid resolution of provider issues through collaboration with their Centene designated counterparts. This team of talented professionals will assist providers with activities such as conversion to EDI and the initiation of immediate claim adjustments. PET representatives from Bridgeway's dedicated claims team, located in Centene's centralized claims operation, will assist with real time claims resolutions, adjustments, or educational support. Both the local and centralized PET staff are knowledgeable about the unique and complex claims payment needs of the ALTCS Program, and will provide a "high touch" review of these claims to ensure accurate and timely claims payment.

Claims Adjudication Process

Below we describe our fully HIPAA and AHCCCS compliant claims adjudication process and integrated system by following a claim from submission to payment. See ***Attachment C.7-A: Claim Adjudication Process*** for a detailed flowchart that illustrates this process.

Flexible Claim Submission Methods. Centene has the ability to receive Bridgeway claims in four ways: 1) HIPAA 837 Professional and Institutional EDI claims from multiple clearinghouses, such as Emdeon and IGI Health. We will, however, accept claims from any clearinghouse that meets our performance and service quality standards, and which can implement our HIPAA companion guides; 2) via our HIPAA compliant Direct Data Entry (DDE) online claim submission facility. Beginning Q1 2012, claims entry via our online HIPAA compliant LTC Claims Wizard will be available for LTC providers currently accustomed to roster billing who must convert by October 2012; 3) beginning in Q3 2011, providers will be able to submit HIPAA batches directly to us through our secure Provider Portal; or 4) on paper. Paper claims are delivered from the US Postal Service on a daily basis. Within 24 hours, these claims are scanned and converted to data through **MACESS**, our paper document scanning and optical character recognition (OCR) technology. See ***Attachment C.7-B: EDI On Boarding, 5010 Testing and Certification*** which depicts how our PET will work with providers to "get on board" and transition to EDI via EDIFECS Ramp Manager, our support tool that guides providers through testing and certification of 5010 compliance.

Also in Q3 2011, providers will be able to submit required or requested attachments such as emergency room records or an EOB from another insurance carrier online through our Provider Portal. This feature will help to encourage providers to submit EDI claims.

Common Pre-Processing for All Claims. AMISYS Advance, our claims processing system, time stamps both paper and electronic claims with the Julian Date indicating when the claim was received. This "date stamp" is part of the control number used to identify each unique claim, allowing us to link together all available information surrounding a claim. Our integrated EDIFECS **XEngine** (XEngine) software checks for the presence, correct placement and validity of all claims data (paper and electronic) for HIPAA and CMS compliance. Finally, if a claim is clean, our **TIBCO** HIPAA translation software formats the claims data for loading into our AMISYS Advance system for adjudication. If a claim is not clean, it is rejected and a notification is issued to the EDI trading partner or provider conveying the specific AHCCCS-approved edit that did not pass our upfront processing.

Adjudication and Rapid Pend Resolution. All claims that successfully pass the pre-processing edits are loaded for processing into AMISYS Advance. AMISYS Advance performs *six primary steps of adjudication* that a claim must successfully pass through in logical succession to reach a paid, denied, or internally pended status. These steps include:

1) Field and General Edits; 2) Member Eligibility; 3) Provider Eligibility and Status; 4) Preauthorization; 5) Covered Services; and 6) Pricing. If a claim pends because of an adjudication edit, **AWD**, our integrated workflow tool, routes the claim for appropriate processing. AMISYS Advance and AWD provide us flexibility in our configuration of business rules based upon Bridgeway policies, and AHCCCS and federal requirements. For example, to facilitate AHCCCS' request to expedite the adjudication of ALTCS Assisted Living Facility (ALF) and Skilled Nursing Facility (SNF) claims, AWD identifies these claims based upon claim types and procedure code/revenue code combinations, and routes and prioritizes the processing of these claims to meet this request. AWD enables active routing or "pushing" claims to specific Claims Processors (Processors) rather than placing them in a queue. By "pushing" claims in real time to trained Processors who possess a particular area of expertise, we are able to ensure that claims containing multiple pend reasons are distributed based on a hierarchy established through our configuration. For example, if a claim pends for application of Share of Cost (SOC) and COB, the claim would route to a Processor authorized and trained to address both pend situations – in this case, a COB Processor. AWD also provides Processors with immediate access to claim images (including attachments) and supports the communication and routing between departments to resolve a claim pend. For example, in the case of a claim pend due to a prepayment encounter edit, the Processor would route the claim to our Encounter Business Operations Unit (EBO) for review. The EBO would document their findings and route the claim back in AWD to the Claims Team for resolution. AMISYS Advance updates AWD records to reflect the changing claims adjudication status of each claim, allowing any of our authorized Bridgeway staff to view and monitor a claim's status. When the "pend issue" is addressed, we re-adjudicate the claim using the six step process described above.

To help expedite pend resolution, our Processors will have access via their desktop to the Arizona Health Information Exchange (when available), through which they can retrieve required clinical records that were not submitted with the claim. This capability will prevent denials and claims payment delays caused by the need to request records from providers.

Once claims complete adjudication, outpatient claims are extracted out of AMISYS Advance on a nightly basis and processed through our Medical Data Express (MDE) Outpatient Pricer module, which we configure specifically for the rules and pricing supplied by AHCCCS. The price and coding restrictions appropriate for the outpatient facility are then extracted out of the Outpatient Pricer and the claim returned to AMISYS Advance to complete adjudication. At this point, Centene submits a paid claims file to Verisk's HealthCare Insight (HCI) to further evaluate claims to detect clinical coding errors, inaccuracies, and potential fraudulent behaviors in billing. See ***Attachment C.7-C: Proactive Identification of Potentially Fraudulent, Wasteful, or Abusive (FWA) Claims Process***, for a diagram that illustrates this process.

Claims Payment. AMISYS Advance then processes all claims with a status of paid or denied on the next claims payable cycle. The payable cycle determines claims timeliness penalties and if applicable, applies interest payments in accordance with AHCCCS rules. At the provider's option, the Claims Department either mails checks or issues an Electronic Funds Transfer (EFT). Regardless of payment method, we mail an Explanation of Payment (EOP) containing all information as required by AHCCCS to our providers. EOP's are also available on our secure Provider Portal and we offer providers the option of receiving the HIPAA 835 Electronic Remittance Advice (ERA) in lieu of paper EOP's. Refer to ***Attachment C.7-D: EFT and ERA Options*** for a diagram outlining the methods used to orient providers to our various EFT/ERA options. When we deny a claim, we still furnish an EOP (or ERA) to the providers with an explanation of denial and resubmission address, if applicable. Refer to ***Attachment C.7-E: Sample of Remittance Advice***.

Ensuring Accurate and Timely Claim Adjudication

Bridgeway and Centene use internal claim audits as tools to provide all levels of management with an independent assessment of the quality of claims processing performance, and to identify opportunities for system, staff or process improvements. Several departments within Centene conduct our 360-degree evaluation of the claim life cycle from the mailroom to payment disposition. Our internal Claims Department Quality Review Analysts (QRA) conduct ***Staff Audits*** to evaluate the performance of all staff involved in claims processing *before* claims are paid, and staff adherence to job specific guidelines. Our Internal Audit and Compliance (IA&C) Department conducts ***Department Audits*** to evaluate the accuracy of claims payment performance before and *after* claims have been adjudicated and paid. IA&C audits a statistically valid sample for procedural and financial accuracy as well as compliance with contract obligations. IA&C forwards errors to the appropriate department and if necessary, requests a corrective action plan, which IA&C subsequently tracks and monitors. Centene ensures IA&C's audit integrity by organizing the reporting structure to be organizationally *independent* of the Claims Department. IA&C reports results directly to the Claims management team and AHCCCS. To ensure timely claims adjudication, Centene's Centelligence™Insight application provides the Claims management team with real time desktop reporting including Key Performance Indicators (KPI) and standard and ad-hoc

reports. Our Managers monitor KPIs weekly to ensure compliance with AHCCCS timeliness requirements and provide AHCCCS with our claims processing results on a monthly basis in the AHCCCS Claims Dashboard Report.

To ensure timely and accurate claims adjudication, our efforts go beyond monitoring and reporting as we proactively evaluate and identify opportunities well in advance of implementation to mitigate any disruptions in our processing. For example, prior to the implementation of the Pima County transition, a team of Bridgeway representatives collaborated with Pima Health Systems (PHS) to evaluate the provider billing practices, reasons for manual adjudication and encounter submission errors. Our pre-implementation activities included processing hundreds of historical claims in our "test environment" to proactively identify opportunities for provider education that would enhance EDI submission rates and decrease encounter errors. As a result of this exercise and our provider outreach and education, Bridgeway experienced an EDI rate for February 2011 of 67% for claims with dates of service after February 1, compared to an EDI rate of 32% for PHS for dates of service prior to February 1. We realize that it is early in the transition and these results do not reflect the complete picture yet, however we are committed to monitoring and building upon this trend through proactive engagement of our providers.

Detection and Correction of Deficiencies. Bridgeway and Centene are committed to the rapid detection, escalation, and remediation of any deficiencies, and we monitor and audit three primary components - people, process, and systems. Our approach to audit is broader than the identification of errors as we believe that early detection of deficiencies often times results in the avoidance of a future error. Outlined below are several methods employed by our QRAs and IA&C staff to detect and correct deficiencies:

Detection Methods. Critical Claim Inputs. IA&C staff conduct integrity and completeness reviews of all inputs that could potentially affect a claim payment, including provider contract rates, terms and fee schedules, and plan benefits. We conduct these audits on 100% of all inputs to ensure the completeness of source documents, the configuration and entry into respective systems, and the timeliness of implementing these changes.

Claim Edit/Denial Results. QRAs review claim edit and denial reports to detect volume outliers such as high pend or denial rates for an individual Processor or provider. For example, we may detect a particular provider who is consistently billing with unbundled, incidental, or retired codes. We also review 100% of our administrative denials related to authorizations from our LTC providers prior to the check cycle to avoid unnecessary denials, and to identify providers requiring outreach regarding the need to notify one of our Case Managers of a change in a member's LTC status.

Claim Audits. In addition to the staff and department audits noted above, our QRAs and IA&C conduct a variety of other audits such as high dollar threshold audits of professional claims in excess of $5,000 and facility claims in excess of $10,000 on a daily basis to detect and correct any high dollar payments prior to the check cycle.

Correction Methods. Education and Retraining. Deficiencies related to staff or providers are typically remediated through education and retraining. QRAs or IA&C communicate all staff deficiencies to the immediate Supervisor who establishes a retraining plan. Upon completion of training, the QRA or Supervisor may implement a targeted audit to confirm that additional training or action is not warranted. QRAs communicate all Provider deficiencies to Bridgeway's Provider Services Department where outreach and education can be arranged and conducted by their Provider Relations Specialist.

Process Modification. Upon identification of a potential process deficiency, our QRA or IA&C staff notify Centene's Process Quality Department, which employs tools such as Lean Six Sigma to determine root cause. Through analysis and cross-functional dialogue with all affected departments, this team evaluates and recommends a process improvement plan.

Exceeding AHCCCS Timeliness Standards. For the period February 2010 through January 2011, the Bridgeway Claims Team processed over 200K ALTCS claims with an average days on hand of nine days. For this same period, they achieved turnaround times of 95% processed within 30 days and 100% within 60 days, well above the AHCCCS standards of 90% of clean claims processed within 30 days and 99% within 60 days. If, in any month and for any reason, we do not attain our performance standards, we immediately identify the cause and, if applicable, address the issue with appropriate process or technology enhancements. For example, in a recent month we experienced a small number of claims exceeding the 30 day target due to a payment scheduling change. After our subsequent root cause analysis, we implemented additional daily controls to prevent future recurrence of this issue.

Coordination of Benefits (COB) and Third Party Liability (TPL)

When we find evidence of other insurance (OI) for ALTCS members prior to claim payment, we deny the claim with notification to the provider noting the reason for denial and the primary carrier's name and member eligibility dates. Bridgeway employs successful strategies to identify OI as evidenced by our 2010 COB savings of $599,361 and cost avoidance of $11,411,124. These strategies include:

- **OI information provided by AHCCCS on the Eligibility File.** Bridgeway receives and loads OI information provided on the eligibility file by AHCCCS. If we discover that OI exists that AHCCCS does not have on record, or if we detect changes in coverage, we notify AHCCCS of this information within 10 days.
- **OI Information on Claims Received.** Claims may contain OI noted on the claim form itself or on an attachment to the claim, such as an EOB from another carrier. In this case, AWD electronically routes the claim to our COB/TPL Analyst to investigate and validate the existence of OI. Upon confirmation of OI, the COB/TPL Analyst loads the OI information into AMISYS Advance for future determination, adjudicates the claim, and coordinates benefits.
- **Notification from Bridgeway Staff.** Bridgeway staff may become aware of OI during member and provider interactions, chart reviews, etc. When Bridgeway staff learn about OI that is not already included in the member's eligibility record, they submit a notification via AWD to the COB/TPL Analyst requesting that AMISYS Advance be updated with the OI information to ensure accurate handling of future claim submissions.

Coordination of Benefits (COB). Bridgeway captures all results of COB investigations at the member level within the eligibility record in AMISYS Advance. During claims adjudication, AMISYS Advance checks for OI and will pend or deny the claim based on the information contained within the record. When we are aware of other coverage, we coordinate benefits in accordance with AHCCCS' "lesser of the difference between" COB payment methodology. If third party liability cannot be established or third party benefits are not available, we will process the claim. Bridgeway complies with all coordination requirements, including but not limited to federal and state regulations, including those related to Medicare dual eligibles and timely filing rules.

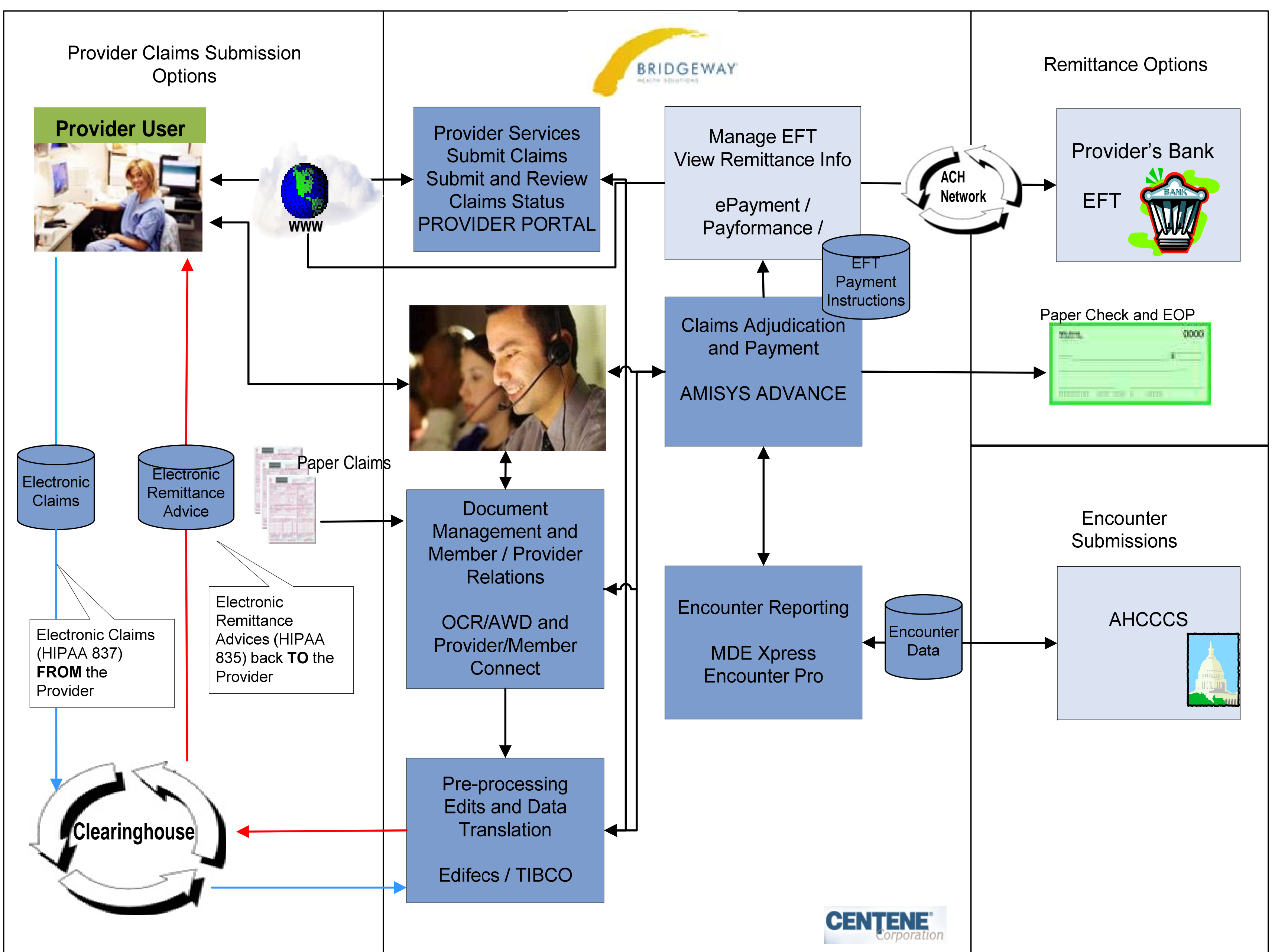
Post Payment Recovery and Third Party Liability (TPL). Bridgeway augments our prepayment COB process, with the post payment recovery services of Health Management Systems, Inc. (HMS) for recoupment when OI is not known at the time we pay the claim, and for subrogation to parties with TPL. On a weekly basis, we provide HMS with a claims detail report of claims processed the previous week. If they determine that a claim is related to OI or subrogation, they initiate steps to recover the overpaid dollars. When HMS confirms that a member has OI and we have paid the claim as primary, they will submit a claim to the primary insurance and request they reimburse Bridgeway for their amount of payment. Our recovery efforts are transparent to the provider, easing the provider's administrative and financial burden, as there is no need for Bridgeway to recoup previous claim payments or request the provider attempt to obtain payment from the primary carrier. Bridgeway and HMS' post payment recovery practices are compliant with all AHCCCS requirements including, but not limited to the ACOM Recoupment Request Policy; review of claims that contain trauma diagnosis codes; recoupment restrictions, settlement negotiations and approval processes; and encounter transaction rules. Centene's Director of Operations Support provides oversight of HMS and monitors adherence to these requirements.

COB/TPL Reporting. Bridgeway provides AHCCCS with a COB Savings/Cost Avoidance report on a quarterly basis and will provide upon request, our HMS monthly report including but not limited to, all active TPL recovery cases, those resolved, and the amounts recovered due to subrogation. Since a significant portion of ALTCS members are dual eligible, and we have information about services that the OI will not cover, such as Medicare non-covered benefits, we pay claims without proof of prior denial, reducing the administrative burden on the provider. In addition, we will offer providers a "one claim filing" for members enrolled in Bridgeway Medicare/SNP and Bridgeway ALTCS, which potentially creates two claim payments from one claim submission. When our system detects this dual situation, we will adjudicate the claim against the Medicare program first, then the Medicaid (ALTCS) program, and issue two payments and remittance advices for the respective payments. See ***Attachment C.7-F: COB/TPL Process*** including our "one claim filing" feature.

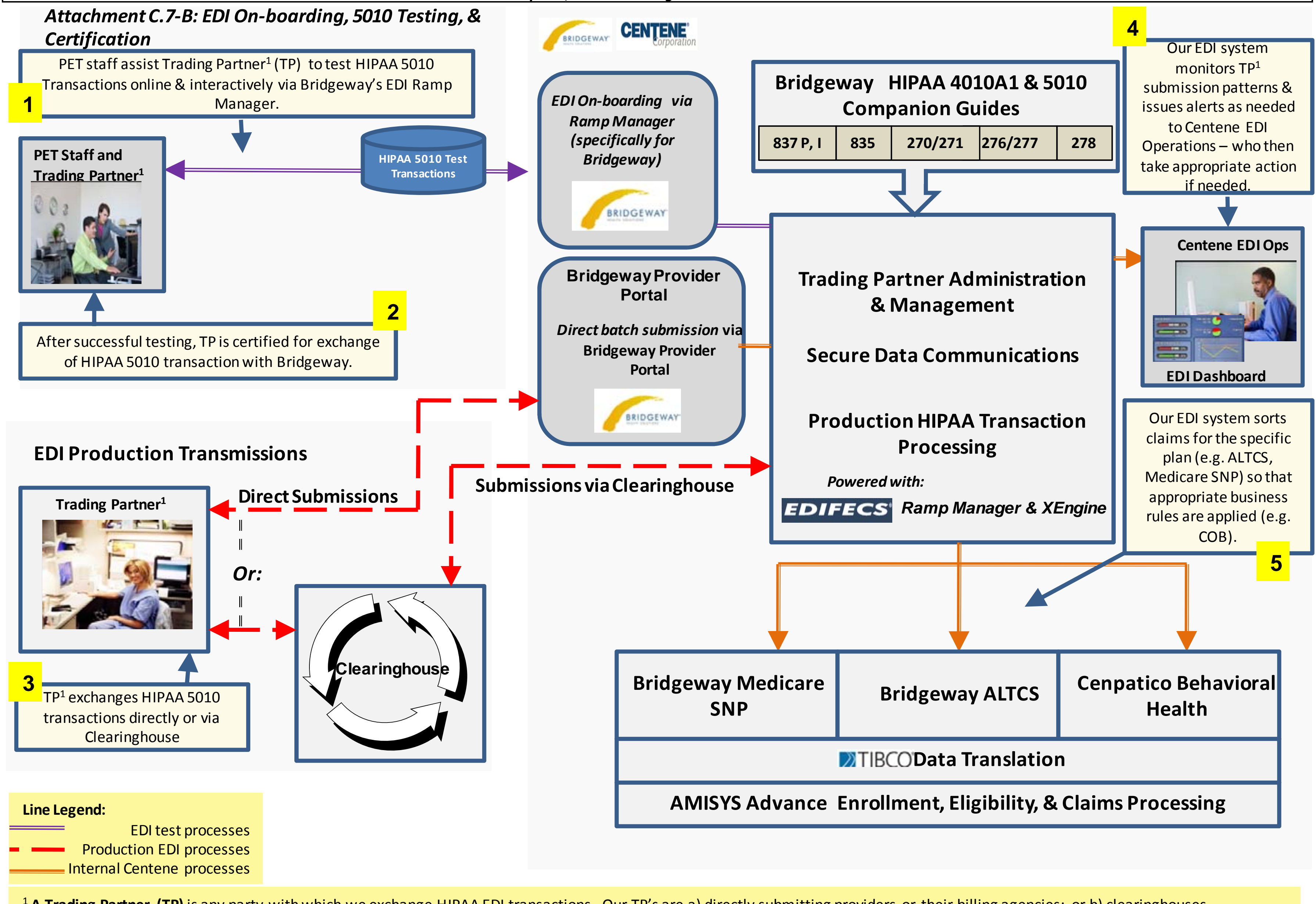
Addressing Claims Inquiries

Bridgeway provides a variety of methods through which providers can initiate a claims inquiry; including online or via telephone. These methods include our **Provider Portal,** which allows a provider to submit inquiries to our Provider Services Department via secure messaging; submit claim adjustments on line, check member eligibility, view claims status and payment information; **Interactive Voice Response System (IVR),** scheduled for a Q2 2011 implementation, with voice activated IVR that will allow providers access 24/7 to information such as member eligibility, PCP information, and claim status including paid date and amount. **Provider Services Representatives (PSR)** located in Bridgeway's call center in Tempe Arizona, are able to offer assistance with claims inquiries, claims submission (paper and EDI) processes, and timely claims resolution. PSRs document all inquiries in Provider Relationship Manager (PRM), our provider services system. If the inquiry requires the attention of an internal Bridgeway department, the PSR will document the request and route the inquiry in PRM. The PSR retains responsibility for the inquiry until all actions are completed and the provider is contacted upon resolution.

Attachment C.7-A: Claim Adjudication Process



Attachment C.7-B: Centene's HIPAA EDI & claims processing infrastructure supports efficient Bridgeway provider testing & certification for 5010 compliance (with assistance from our Provider Engagement Team(PET)), and affords the provider multiple ways to exchange HIPAA transactions with us, and allows one submission point for all Bridgeway, Cenpatico, and other Centene plans; while enabling us to monitor all submissions.



[1] **A Trading Partner (TP)** is any party with which we exchange HIPAA EDI transactions. Our TP's are a) directly submitting providers or their billing agencies; or b) clearinghouses.

Attachment C.7-C: Proactive Identification of Potentially Fraudulent, Wasteful, or Abusive (FWA) Claims Process

We are enhancing our ability to proactively identify potentially Fraud, Waste and Abuse (FWA) claims by complementing our existing FWA capabilities (based on ClaimsXten) – through our data and process integration with HealthCare Insight (HCI), a nationally recognized company specializing in claims integrity for 14 years.

Proactive Identification of Potentially Fraudulent, Wasteful, or Abusive (FWA) Claims Process

CENTENE Corporation

BRIDGEWAY

hci

Paid Claims History

1 Centene sends complete claims history (including the day's batch of claims not yet paid) for all claims for its ALTCS plans (including pharmacy & subcontractor claims – to HCI – from Centene's Enterprise Data Warehouse.

Record of claims pended

6 The Special Investigation Unit (SIU) within Centene Claims Ops investigates claims from HCI with substantiated reasons for suspicious FWA. The rest of claims flagged in (3) are released for payment.

Error report for locked/paid

4 AMISYS Advance pends those claims identified in (3) – all other claims processed.

Pend queue

Daily

Payable Claims

Pend **Flagged** Claims for Analysis

Release, Adjust, or Deny FWA pended claims

Claims Payable

5 Within 12 hours of the HCI process (2), **(a)** HCI transmits file of claims with substantiated reasons for FWA investigation by Centene Special Investigations Unit (SIU); and **(b)** HCI transmits file of claims with results of clinical edit process.

HCI Process

3 Within 2 hours of the HCI process (2), HCI transmits file of claims HCI is substantiating for clinical edits and FWA.

2 HCI processes claims to identify those requiring review by HCI staff for possible FWA.

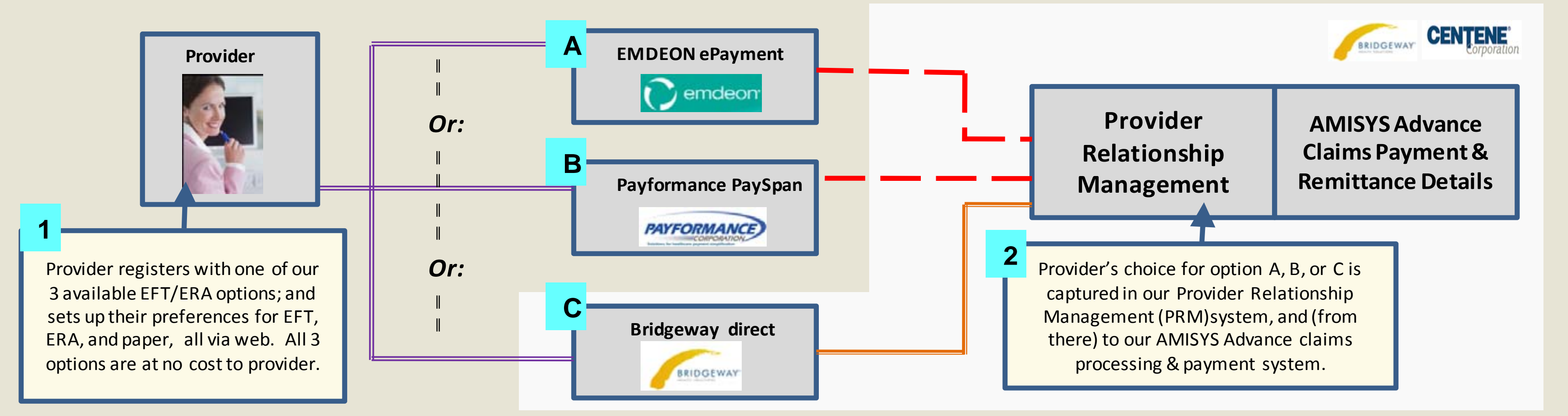
First pass of edits

Clinical & FWA Review

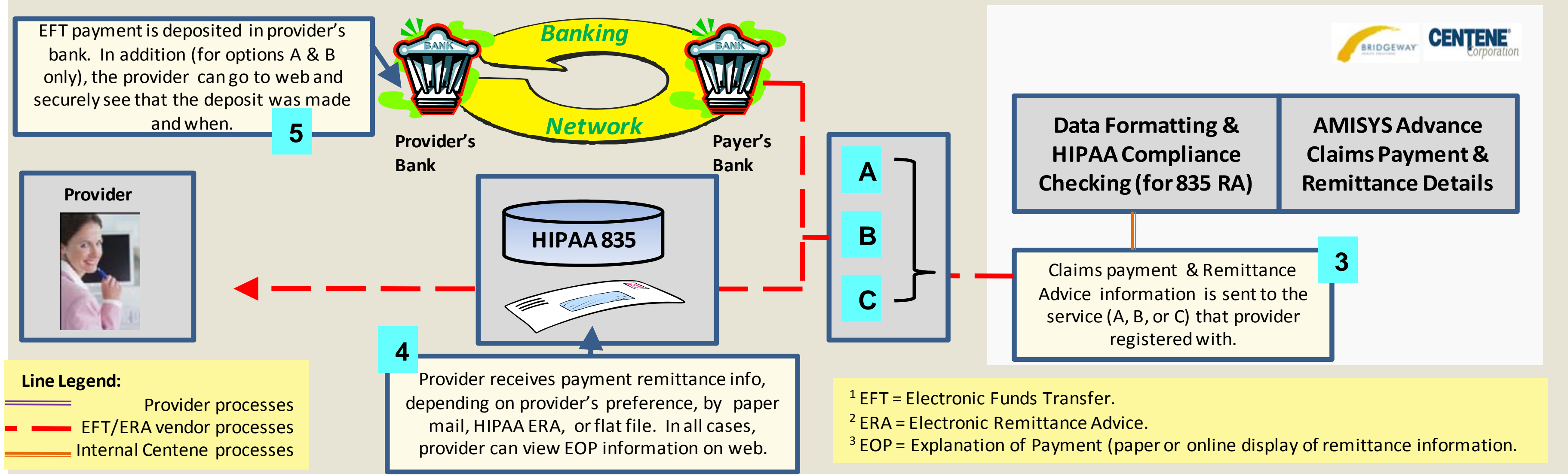
Attachment C.7-D: EFT and ERA Options

Although Centene and Bridgeway offer EFT and ERA support today, we are expanding our providers' EFT / ERA options with the introduction of web based services from EMDEON and Payformance. Both are multi-payer solutions, making financial administration tasks easier for our providers, and shortening their cash flow cycles.

SET-UP: Our Provider Engagement Team (PET) orients the provider to our 3 supported EFT[1] & ERA[2] options. The provider then registers (or changes when needed) EFT information with their designated bank and their chosen method to receive paper EOP[3], ERA, as well as online presentation of remittance details.



OPERATIONS: Provider receives EFT payments in the bank they designated in SET-UP (above); and receives payment remittance information via HIPAA 835 Remittance Advice, or other "flat file" format (at their option), or as paper EOP, and (in all cases) displayed online.



[1] EFT = Electronic Funds Transfer.
[2] ERA = Electronic Remittance Advice.
[3] EOP = Explanation of Payment (paper or online display of remittance information.

P7844028001

Bridgeway Health Solutions
1501 W. Fountainhead Corporate
Park, Suite #201
Tempe, AZ 85282
Electronic Service Requested

CHECK STOCK
2011021001DT
TEST

1-866-475-3129

1 OF 2
ENV 11

SINGLE PIECE
11 0.5486 SP 0.440
MEDICAL SERVICES
PO BOX 111
YUMA, AZ 85366-2325
1

RUN DATE:	01/11/11
WARRANT #:	000000000
PAYEE ID:	2993
IRS#:	123456789

STATEMENT TOTAL

Beginning Negative Services Balance:	.00
Beginning Prepayment Balance:	.00
Total Beginning Balance:	.00
Claims Paid This Run:	16.63
Check Amount:	16.63

Remittance Advice and Explanation of Payment

Policy Information

ALTPOLICY NBR: MDCBXXXXXXXXXD — **CARRIER NAME: MEDICARE PART A**
ALTPOLICY NBR: MEDAXXXXXXXXXD — **CARRIER NAME: MEDICARE PART B**

Insured Name: Member Name — **Member ID#:** AXXXXXXXX — **Claim No:** J2929292929
Patient Name: Patient Name — **PCN:** ZXXXXXXXXXXXX **MRN:** — **Group:** YUMA COUNTY - GSA 42
Service Provider: Dr. Practitioner — **National Provider ID:** XXXXXXXXXX — **Provider ID:** 111111

Serv	Dates	Diag#	Proc# Mod Proc2	Days/ Qty	Cnt	Charged	Allowed	Deduct / Copay	Disallow/ Discount	Interest	Med Allow/ Med Paid	TPP	Denied	Explanation Codes	Payment
0100	091510	37311	99214 25		1	279.00	83.66	.00	262.37 .00	.00	83.79	.00	.00	92	16.63
0200	091510	37311	G8553		1	.00	.00	.00	.00 .00	.00	.00	.00	.00	18 46 7S	.00
0300	091510	37311	99000		1	.00	.00	.00	.00 .00	.00	.00	.00	.00	92	.00
					Sub-total	279.00	83.66	.00 .00	262.37 .00	.00	83.79 67.03	.00	.00		16.63
					TOTAL	279.00	83.66	.00 .00	262.37 .00	.00	83.79 67.03	.00	.00		16.63

Message Code	Description
18	DENY: DUPLICATE CLAIM/SERVICE
46	DENY: THIS SERVICE IS NOT COVERED
7S	DENY: PROCEDURE NOT COVERED ON DATE BY AHCCCS

BRIDGEWAY HEALTH SOLUTIONS

Bridgeway Health Solutions
1501 W. Fountainhead Corporate
Park, Suite #201
Tempe, AZ 85282

BANK OF AMERICA 91-170/1221
TUSCON, ARIZONA USA

Date	Warrant Number
01/11/11	000000000

In payment of approved claim for supplies and /or services
By order of the Board of Supervisors
Pima County, Arizona

Warrant Amount
$*****16.63

PAY Sixteen & 63/100 Dollars
TO THE ORDER OF
MEDICAL SERVICES
PO BOX 111
YUMA, AZ 85366-2325

VOID

111111111 ⑈ 123456789 ⑆ 000000000000

P7844028001

20110211001DT

Bridgeway Health Solutions
1501 W. Fountainhead Corporate
Park, Suite #201
Tempe, AZ 85282

Electronic Service Requested

WHITE STOCK

TEST

RUN DATE:	01/11/11
WARRANT #:	000000000
PAYEE ID:	2993
IRS #:	123456789

ENV 11

Remittance Advice and Explanation of Payment

Continued from Previous Page

Message Code	Description
92	PAID ACCORDING TO CONTRACT / STATE PROCESSING GUIDELINES

In accordance with Arizona Administrative Codes (AAC) R9-28-702, a contractor, subcontractor, or other provider of care or services shall not charge, submit a claim, demand, or otherwise collect payment from a member or eligible person, or person acting on behalf of the member, for any covered service except to collect an authorized co-payment or payment for additional services. This means that a Bridgeway member may not be billed for a covered service.

If a provider has a question or is not satisfied with the information they have received related to a claim, they should contact:
Bridgeway Health Solution Provider Services Department 1-866-518-6843

For Claim Resubmission or Reconsideration, the claim must clearly be marked as "RE-SUBMISSION and [include the original claim number]." Failure to mark the claim as a resubmission and include the claim number or EOP may result in the claim being denied as a duplicate, or for exceeding the filing limit deadline. Resubmitted claims may be sent to the Attention of:

Claims Department
P.O. Box 3040
Farmington, MO 63640-3814

In accordance with Arizona Revised Statute Section 36-2904 (G) and Arizona Administrative Code R9-22-705 (B), you have 12 months from the date of service to file a claim resubmission or request for reconsideration of a claim.

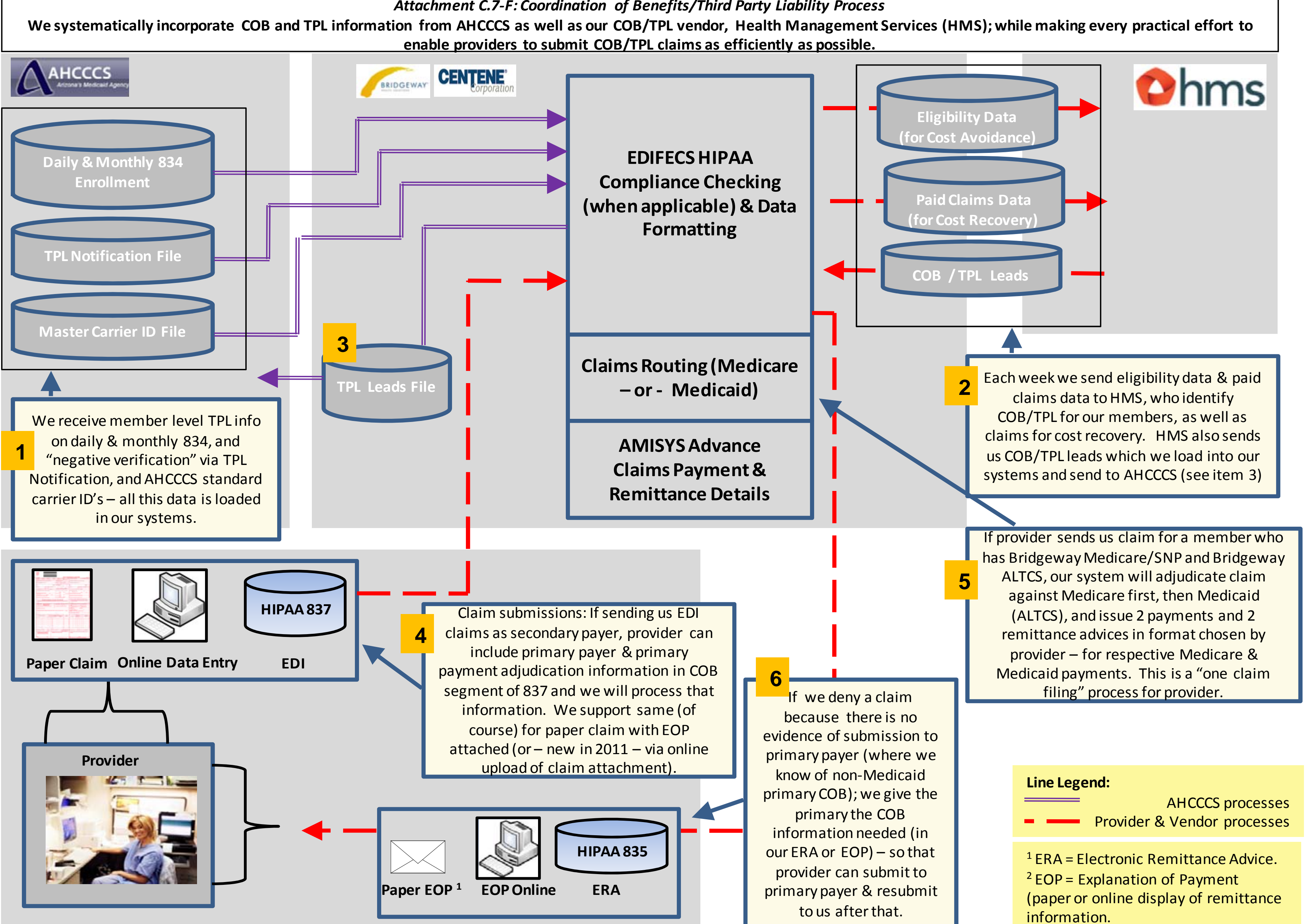
To file a formal appeal of a denial or a payment, it may be made in writing and should state any pertinent information as clearly as possible. Please give names, dates, etc., and any extenuating circumstances which would allow Bridgeway Health Solutions to consider the appeal. The appeal must be received within 60 days of the date of the EOP which contains the denial payment that is being appealed to unless otherwise stated in your contract. Submit your written appeal to the attention of:

Grievance & Appeals Department
Bridgeway Health Solutions
1501 West Fountain Head Parkway, Suite 201
Tempe, AZ 85282

An electronic copy of the Provider Newsletter will be posted quarterly under the News tab on our website or you can request a hard copy by calling 1-866-475-3129.

Attachment C.7-F: Coordination of Benefits/Third Party Liability Process

We systematically incorporate COB and TPL information from AHCCCS as well as our COB/TPL vendor, Health Management Services (HMS); while making every practical effort to enable providers to submit COB/TPL claims as efficiently as possible.



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

Mobilizing To Continue to Increase EDI/EFT Increased Penetration for ALTCS

Bridgeway Health Solutions, LLC (Bridgeway) recognizes that provider capabilities related to submitting electronic claims and receiving payment through Electronic Funds Transfer (EFT) vary significantly based on a provider's technological support and expertise. We also recognize providers face unique challenges given the characteristics of LTC and atypical provider claims. That is why we support a growing variety of online, Electronic Data Interchange (EDI) and EFT options so each provider can select the best approach for their practice. We then actively work with the provider to facilitate participation.

The Provider Engagement Team. To further enhance our collaborative efforts with providers, we are establishing a new multi-disciplinary Provider Engagement Team (PET), comprised of dedicated local Provider Services staff with specialized EDI expertise, and designated Centene Claims, EDI Operations, Encounter Business Operations (EBO), and Information Systems staff. All of these individuals will report in matrix fashion to Bridgeway's VP of Provider Services. The PET will proactively identify high volume paper submitters and directly engage with these providers in the field to educate them about the value of EDI, including the potential impact on their practice. Once the provider transitions to EDI, the PET will continue to monitor their EDI submissions and provide targeted education, when necessary, to help the provider ensure successful EDI transmissions. In addition, PET will provide ongoing support to our existing EDI providers in areas such as the conversion to HIPAA 5010 and ICD-10.

The PET will help Bridgeway identify and develop unique tools in support of EDI and EFT. For example, in Q1 2012, Bridgeway will deploy a new online Long Term Care (LTC) Claims Wizard, which is designed to address the challenges faced by any Nursing Home, Assisted Living Facility (ALF) or Assisted Living Home (ALH) currently submitting roster bills. Our LTC Claims Wizard will leverage familiarity and experience with "roster bills" to provide a natural progression path to full HIPAA compliant electronic claims submission. PET will also leverage best practices and lessons learned from our affiliate health plans, including Cenpatico of Arizona who, in 2010, achieved an EDI Claim submission rate of 97.5%. As illustrated in the table below, through our existing outreach efforts targeted at paper claim submitters, Bridgeway has steadily improved our EDI submission rate from 2007 through February 2011.

Bridgeway Long Term Care EDI Rate by County:

	Maricopa	Yuma	La Paz	Total
CYE 07 Average	10.24%	17.81%	20.48%	**16.18%**
CYE 08 Average	18.28%	32.48%	30.90%	**27.22%**
CYE 09 Average	23.51%	39.76%	27.54%	**30.27%**
CYE 10 Average	32.74%	42.86%	39.65%	**38.42%**
CYE 11 To Date Average	39.32%	38.41%	42.91%	**40.21%**

Enabling Claims EDI and EFT. Bridgeway has deployed resources and is enhancing tools to assist our providers in the submission of electronic claims and acceptance of EFTs, such as:

- ***Bridgeway Provider Portal***. Today, our Portal allows for the HIPAA compliant entry of individual claims via form templates directly through our Provider Portal. Beginning in Q3 2011, we will support the online submission of HIPAA batches directly through the Portal, and providers will be able to submit claim adjustments and additional claim information, such as an EOB from another insurance carrier.
- ***Multiple Clearinghouses.*** Today, Bridgeway supports HIPAA 837 EDI Claims submission through multiple clearinghouses, including Emdeon and IGI Health. In fact, Bridgeway accepts claims from any clearinghouses that meet our performance and service quality standards and can implement our HIPAA companion guides. We will also work directly with larger providers to establish a direct, secure exchange with us.
- ***Electronic Funds Transfer***. To initiate EFT today, all a provider has to do is complete a Bridgeway EFT Agreement. Upon acceptance, Bridgeway will deposit payment for claims directly into the provider's bank account.
- ***Electronic Remittance (ERA).*** Providers can view ERAs through our Provider Portal and can request a printed version of their electronic remittance advice.

Additional Planned Enhancements. Bridgeway, along with our parent company Centene Corporation (Centene), are continuously identifying and developing new tools to further increase EDI and EFT participation rates. In Q2 2011, Bridgeway will provide PET staff with ***EDIFECS Ramp Manager,*** another support tool with which to help providers test

their EDI transactions. This feature enables PET EDI specialists and the provider to interactively test any of the HIPAA 5010 transactions we support. The provider will be able to submit a test HIPAA 837 transaction file, immediately view test submission results and correct any errors. In addition, our EDI Help Desk (described below) will be available, as they are today, to assist with the on-boarding process and address any questions the provider may have. Ramp Manager will also help Bridgeway continuously monitor provider EDI submission patterns and thus help to ensure consistent levels of EDI service. Additional ***EDIFECS*** technology will allow providers to submit only one claim in cases when a member is enrolled in both our ALTCS plan and Medicare Advantage Special Needs Plan. Our system will detect this dual situation, adjudicate the claim against Medicare first, then the Medicaid (ALTCS) program, and issue two payments and remittance advices respectively.

In 2011, Bridgeway will enhance our EFT service offering with two new payment options, ***Emdeon ePayment*** and ***PayFormance***, in addition to ACH direct deposit, without the provider being required to share bank account information with Bridgeway. Providers will be able to review the payment options on our Provider Portal and Bridgeway will assume transaction processing charges. We will educate our providers on these options and the benefits of each so they can make the best selection for their practice. Below is a brief description of each solution:

- ***Emdeon ePayment (ePayment).*** Our providers will be able to go to the ePayment site, register, and set up their bank account for EFT. Once set up, the provider can view remittance information online on the ePayment site and/or download a HIPAA 835 ERA for import and processing as payable information into the provider's practice management system. Providers who use Emdeon's practice management hosted service or submit their claims to us via Emdeon, will also be able to take advantage of the "integration" efficiencies ePayment supports.
- ***PayFormance.*** PayFormance offers our providers a comprehensive payment management solution which is "clearinghouse agnostic." PayFormance supports online EFT enrollment and activation, including bank depository accounts and remittance preferences, and provides online capability for viewing detailed remittance information.

Enlisting, Training, and Supporting Providers

Supplying information technology resources is only part of the solution for engaging and encouraging providers to embrace their use. In 2011, Bridgeway will expand our training and awareness activities through a combination of the following:

PET and Provider Outreach. We have already begun our EDI outreach campaign and will continue to expand this to other providers throughout 2011 and over the contract period. Based on reports identifying high volume paper submitters, our local Provider Relations Specialists (PRS) will contact these providers, listen to their concerns, and educate them about the benefits of EDI and our Portal submission options. In the event the provider requests technical support in deploying their EDI solution, Bridgeway's PET EDI Specialist will provide direct training and technical support.

Outbound EDI/EFT Campaign using Provider Relationship Management (PRM). Bridgeway will launch a provider outreach campaign using our ProviderReach tool (the outbound component of our PRM tool suite) to recruit providers to exchange EDI with us and to make them aware of our EFT capabilities. We can also conduct outbound phone campaigns and complete provider phone surveys using ProviderReach.

Webinars. Bridgeway will deliver training to providers through web seminars or webinars. Our Cenpatico Arizona affiliate has used this method and has received universally positive feedback on this form of training. We have found that provider participants, especially those in the rural areas, appreciate the interactivity webinars offer.

Vendor Seminars for Bridgeway Providers. In 2010, Bridgeway sponsored an electronic submission seminar for Bridgeway providers in Arizona conducted by Emdeon. We will continue to pursue similar opportunities with our vendors for additional training where appropriate.

Training Workshops. We routinely evaluate the need to host workshops to assist provider staff in understanding the benefits of EDI and EFT, and to discuss new policies and procedures regarding claims submission. We also discuss topics such as data omissions, data accuracy, data integrity, and compliance requirements. Prior to implementation in our expansion GSAs, our Provider Services Department will evaluate the need for additional workshops.

Provider Incentives. We are in the process of developing an *Early Conversion Incentive,* which will be a one-time financial incentive for providers who convert to EDI and EFT before 1/1/2012. We are also exploring opportunities with residential and small business Internet Service Providers (ISP's) who have expressed an interest in collaborating with us on our ED/EFT incentive program for qualifying LTC providers.

Provider Online Training and Technical Assistance. Providers and their staff can access Bridgeway's policies and procedures regarding data submission requirements via Bridgeway's Provider Portal. We will continue to evaluate provider feedback and incorporate additional material as necessary. In addition, beginning in 2011, the PET will host quarterly provider Forums (all providers welcome) to solicit input on our current and future Portal functionality.

Provider Call Center Support. Bridgeway's Provider Service Representatives (PSR) are available to offer assistance and education regarding the EDI claims submission process and the options available for EFT enrollment.

EDI Help Desk. Centene offers an EDI Help Desk to communicate directly with providers or clearinghouses that may experience issues or have questions about electronic submissions. EDI Help Desk technicians reach out and work directly with providers who currently submit electronic claims or have high rejection rates and help resolve any issues that cause claim rejections. The EDI Help Desk also offers training or technical expertise to encourage EDI submissions from those providers not yet submitting claims electronically. Beginning in Q2 2011, our EDI help desk will be accessible from the Bridgeway provider services options on our Interactive Voice Response system. EDI Help Desk staff respond to all voice messages and emails within 24 hours, and they are available to participate in conference calls with providers, software vendors and clearinghouses as needed.

Provider Scorecard. We are developing a provider scorecard that will compare a provider's pattern of paper versus electronic claims and reimbursements against all contracted providers. The report will be available via PRM to internal staff who work directly with providers such as Network Managers, Claims Liaisons, PSRs and Case Managers. This report will also be a valuable tool for PET staff as they work one-on-one with LTC providers regarding EDI claims submissions. The data in this report will demonstrate the connection between a provider's claims submission practice and the impact on their business in terms of claims accuracy and reimbursement turnaround. By pulling the data together and presenting it in this format, PET staff will be equipped with powerful and easy-to-understand information that will resonate with providers as we work together to improve EDI participation and reduce administrative costs. The scorecard below is a prototype of what we can demonstrate to providers.

Sample Provider Scorecard:

Healthplan: **Bridgeway ALTCS**

Provider:		Billing Practitioner(s):			
TIN:	999999999	NPI:		Name:	
Name:	Provider Name	NPI:		Name:	

12 Month Claim Summary:

Overall	Paper:	12%			EDI:	88%			Web	0%		
Type	**Reject %**	**Accepted**	**Paid %**	**Denied %**	**Reject %**	**Accepted**	**Paid %**	**Denied %**	**Reject %**	**Accepted**	**Paid %**	**Denied %**
New	**3%**	**153**	**88%**	**12%**	**8%**	**430**	**92%**	**8%**	**0%**	**0**	**0%**	**0%**
Professional	7%	153	88%	12%	8%	430	92%	8%	0%	0	0%	0%
Institutional	0%	0	0%	0%	0%	0	0%	0%	0%	0	0%	0%
Adjustments	**0%**	**29**	**95%**	**5%**	**0%**	**0**	**0%**	**0%**	**0%**	**0**	**0%**	**0%**
Professional	0%	20	95%	5%	0%	0	0%	0%	0%	0	0%	0%
Institutional	0%	0	0%	0%	0%	0	0%	0%	0%	0	0%	0%

Top Reject Reasons:	Top Denial Reasons:
1)	1)

Your Submissions:

Total Paid $ ______ Average Daily Volume $ ______

	Submissions		Date Of Service to Date Received Average		Date Of Service to Date Paid Average		Your Average Receivable	
	You	**Top Quartile**	**You**	**Top Quartile**	**You**	**Top Quartile**	**Days**	**$**
EDI			**days**	**days**	**days**	**days**		
Paper			**days**	days	days	days		
Web			**days**	**days**	**days**	**days**		
Total			**days**	**days**	**days**	**days**		

Opportunity:

Potential Reduction of Receivable with move to Top Quartile: ______ days $ 1.00

Payment and Remit:

Payment Method: Paper Check — Additional Receivable Reduction Potential for moving to EFT: ______

* assumes 3 day delay for mailing and deposit of check

Remittance Advice: Paper EOP — Estimated paper savings for moving to Electronic Remit: ______

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

Bridgeway and our parent company Centene Corporation have delivered accurate and efficient claims processing, payment, reporting, and encounters for the ALTCS Program, and have developed comprehensive clinical and data related edits that may be triggered at varying stages of the claims adjudication process. Each of these stages is supported by various technologies that offer flexible, adaptable, and dynamic configuration rules, allowing us to incorporate AHCCCS specific policies regarding claims submission, adjudication and payment. These technologies integrate Bridgeway and Centene policies and procedures, and are kept current with nationally recognized claim coding guidelines. Below is a description of each edit phase in the cycle, and a general description and specific examples of the edits a claim may experience.

HIPAA Electronic Data Interchange (EDI) Edits

Electronically submitted claims data are validated on all inbound and outbound EDI transactions, including the 837P and 837I claims transactions, using Edifecs XEngine (XEngine) software. XEngine supports HIPAA testing standards as defined by the Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP), and allows us to configure edits, or testing, for our specific business rules. XEngine edits validate data against X12 syntax and rules for data structure; test to ensure conditional rules requiring secondary fields are completed accurately and completely; and ensure all data is in compliance with Bridgeway Companion guides. These upfront edits not only ensure that transactions are compliant with federal mandates and AHCCCS rules, but also allow us to be more efficient in our processing by recognizing and rejecting problematic transactions in the earliest stage of the process, and sending notification to our trading partners through the TA1/997 Acknowledgement transaction. This rapid turnaround allows our providers to correct and resubmit these claims as quickly as possible for adjudication and payment. We continue to augment our upfront edits and will further advance this process with the introduction of Edifecs Ramp Manager in the first half of 2011. Ramp Manager will allow our provider community to test their 837 transactions directly with us through this user friendly application. Ramp Manager validates against our transaction rules and provides immediate feedback on any errors to be corrected. We currently validate through SNIP Level 4 on our inbound claims and are working toward Level 5 SNIP testing leveraging Edifecs XEngine and Ramp Manager tools. These levels include ***Level 1:*** Integrity Testing: general testing of the X12 syntax and rules; ***Level 2:*** Requirement Testing: testing for the HIPAA implementation guide's specific requirements; ***Level 3:*** Balancing: testing for balanced amount fields, etc; ***Level 4:*** Situational Testing: testing of specific segment situations (if A occurs then B is required); and ***Level 5:*** Code Set Testing: in 2011 we will increase front end EDI validation to include code set and code combinations. We will work closely with AHCCCS as we define the timeline and key milestones for our move to Level 5 processing, and we will support this transition through our provider education programs.

Pre-adjudication Edits

Once EDI claims have successfully passed through the HIPAA EDI edits, they are loaded into our pre-adjudication tables. Likewise, claims received on paper and scanned using our Optical Character Recognition software are loaded into these same tables for processing. Centene uses *TIBCO BusinessWorks*™ (BusinessWorks) for this layer of edits before loading the claim into AMISYS Advance. More specific than the EDI edits described above, BusinessWorks validates certain claim data elements against data we currently have in AMISYS Advance. For example, BusinessWorks is configured to look up the member using the Medicaid ID submitted on the claim. If the member is not enrolled in the ALTCS plan, meaning we cannot find the Medicaid ID in AMISYS Advance, the claim would immediately reject with the reason, "Invalid Member." If a transaction is rejected for any of the specific reasons configured in BusinessWorks, a notification is provided to the EDI trading partner or provider outlining the reason for the claim rejection. The types of edits performed in BusinessWorks include:

- Member Eligibility – confirms member eligibility and enrollment in ALTCS Program
- Validate Dates of Service – confirms that the claim date of service is valid and does not contain a future date
- Diagnosis Code Validation/ICD9 tables – confirms the presence and accuracy of ICD9 codes

Adjudication Edits

All claims that successfully pass pre-adjudication edits are loaded for processing into AMISYS Advance. AMISYS Advance performs *six primary steps of adjudication* that a claim must successfully pass through in logical succession to reach a paid, denied, or internally pended status. These steps are listed below along with a brief description of each and specific examples of edits configured within each step for AHCCCS claims:

Step 1: Field and General Edits. AMISYS Advance determines the presence and validity of required claim data such as CPT/ICD9 codes and whether the fields are consistent with the business rules outlined by AHCCCS and federal regulations; as well as age, gender, duplicate, and timely filing edits. Examples include:

- Procedure Code/ICD9 Code inconsistent with member gender
- Procedure Diagnosis Code deleted, incomplete or invalid
- Invalid UB04 Type of Bill

Step 2: Member Eligibility. The system verifies eligibility for service dates and coverage type, and existence of Other Insurance (OI) by comparing to the enrollment data received from AHCCCS. Examples include:

- Medicare EOB missing but member covered under Medicare
- Claim notes other insurance – verification required.
- Member has handicapped status and no Medicare coverage on file

Step 3: Provider Eligibility and Status. The submitting provider's eligibility and status for the dates of service are verified by the presence of the AHCCCS provider number, a certified Medicaid Provider's NPI, or Tax ID. This step also determines provider participating/nonparticipating status and their financial affiliation. Examples include:

- Provider type invalid for procedure
- Provider is under review – all claims require review
- Provider Medicaid number is not a valid AHCCCS provider number or is blank

Step 4: Preauthorization. AMISYS Advance is integrated with TruCare, Bridgeway's integrated, member centric health services management platform where the primary authorization is held. The system determines authorization requirements, verifies the presence of a preauthorization, and confirms that the dates of service are within authorization date spans, limits etc., when applicable. Examples include:

- Authorization not on file
- Procedure does not match authorization
- Authorization requires further review; pend claim to case management

Step 5: Covered Services. To define exactly which services are covered and at what levels, the system determines covered services by applying configured eligibility, provider, and benefit management rules, along with tables of valid procedure codes and ranges; diagnosis codes (HCPCS, CPT-IV, ICD-9-CM diagnosis and procedure codes); service type; member gender and age range; provider type; service location; and benefit limitations. This step determines if a member is eligible for the services rendered, if the service date falls within the effective date of the benefit and meets all the criteria established by AHCCCS for payment. Examples include:

- The service is not covered
- Benefit limit for services without an authorization has been met
- Share of Cost may be applicable

Step 6: Pricing. AMISYS Advance prices the claim by applying any member third party liability (TPL) or coordination of benefits (COB) information, copayments or deductible amounts, and Bridgeway provider specific contractual and financial agreements. This step also applies AHCCCS reimbursement rules such as limiting payment for non contracted in-state and out-of-state providers for emergency services to no more than the AHCCCS rate. Examples include:

- Refer to pricing for DME purchase within rental period
- Manual Pricing Required
- Claim requires high dollar review

Encounter Edits

Bridgeway has implemented a subset of prepayment claim edits specifically for AHCCCS claim encounters to enhance our post payment success rate. We leverage edits in Xpress Encounter Pro, along with reference files and provider files supplied by AHCCCS to configure these prepayment edits in AMISYS Advance. These prepayment edits not only enhance our encounter submission/reconciliation process but also reduce the number of recoupments that might otherwise be needed if the claim is paid inaccurately. Examples of edits occurring during this process include:

- Procedure not covered on date by AHCCCS
- Invalid procedure code modifier combination
- Units of service greater than maximum daily unit

Clinical Edits

Once claims pass adjudication in AMISYS Advance, they are further analyzed by ClaimsXten® (CXT) to determine clinical appropriateness of claim coding. CXT contains a comprehensive set of rules based on nationally recognized coding guidelines (cited below), which address coding inaccuracies such as unbundling, fragmentation, upcoding, duplication, over-utilization standards, invalid codes, and mutually exclusive procedures. These edits are based on generally accepted principles of coding medical services for reimbursement and are not based on medical necessity, nor are they designed to make reimbursement or payment decisions. Instead, CXT offers a recommendation that is applied to the claim when a provider's coding pattern is unsupported by a coding principle. CXT's flexible configuration tools allow Bridgeway to customize these edits by incorporating Bridgeway provider coding/reimbursement policies and AHCCCS benefit criteria into the applicability of these edits. For example, the American Medical Association (AMA) recommends therapy codes be limited to only one unit per day. Bridgeway's policy allows providers to bill more than one unit a day for therapy codes based on the amount of time spent with the member; therefore, this edit is not applicable and would be set to ignore. Standard edits provided by CXT are based on nationally recognized guidelines, including but not limited to:

- American Medical Association (AMA): CXT utilizes the CPT Manuals, CPT Assistant, the AMA website, and other sources
- Centers for Medicare & Medicaid Services' (CMS): In addition to using the AMA's CPT manual, CMS offers a variety of edits including the National Correct Coding Initiative (CCI) for professional and outpatient services
- American Board of Anesthesiology: CXT offers edits based on this and other specialty boards

Below are a few examples of the edits that are performed with ClaimsXten:

- Unbundling: submission of a global CPT/HCPCS code along with other CPT/HCPCS codes that are considered included in the global code billed
- Multiple Surgical Reductions: submission of multiple surgical procedures performed on the same day during the same operative session, which requires price reduction of secondary procedures
- Global Surgical Period: addresses the payment/nonpayment of evaluation and management services billed during the global surgical period of another procedure

Fraud, Waste and Abuse Edits

Centene has entered into a strategic partnership with Verisk's HealthCare Insight (HCI) to further evaluate claims to detect clinical coding errors, inaccuracies, and potential fraudulent behaviors in billing. Through HCI's Physician Claim Insight (PCI) and Fraud Finder Pro (FFP) programs, Bridgeway is able to provide AHCCCS with proactive fraud, waste and abuse detection/prevention services and an additional screening of clinical billing discrepancies, without disrupting claims turnaround time to any material degree. HCI's clinical edits are based on national coding standards as well as some proprietary rules, and augment and compliment those performed by our Claims Xten software. Once a claim passes through all the edits described above and reaches a status of paid, we provide HCI with a paid claims file along with a historical claims file containing our medical and behavioral health, pharmacy, vision and dental claims. By providing the claim history files, HCI can assess claims based on patterns of claims submissions from a provider such as analyzing medications ordered versus substantiating the need for those medications through supporting medical claim data. HCI then evaluates these files utilizing their proprietary code validation and profiling software. HCI conducts an initial sweep of the paid claims file (typically within two hours) and returns notification of claims failing the edits requiring further review and evaluation by HCI's certified coders and licensed nurses. We are then able to release all claims successfully passing the HCI edits and suspend only those requiring additional review as notified by HCI. Upon completion of their review, typically within 12 hours of the claim failing the edits, HCI makes a pay/deny recommendation to Bridgeway based on a review of the immediate claim and the patient's claim history. Prior to finalizing the claim, our Claims Compliance Team reviews and approves or denies all HCI recommendations.

The types of edits typically encountered within PCI and FFP include national correct coding (NCCI) edits; procedure upcoding; and multiple radiology reductions. We generate a notification of Remittance Advice (RA) for any claim failing edits throughout the various stages of claims adjudication. The RA clearly outlines for the provider the reason(s) for claim denial, along with instructions for correction and resubmission, if applicable. In addition, we furnish copies of claims processing and coding guidelines to providers in writing and through our Provider Portal utilizing the Clear Claim Connection tool designed by McKesson Information Solutions, Inc. The tool "mirrors" how Bridgeway's claims software evaluates medical code combinations during the adjudication of a claim allowing providers access to Bridgeway's claim auditing rules and clinical rationale. The result: cleaner claim submissions, quicker claim turnaround time, and successful encounter processing.

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

People, Processes, Continuous Quality Improvement, and Technology Drive Encounter Quality

Bridgeway Health Solutions, LLC (Bridgeway) and Centene Corporation (Centene), our parent company, understand that successful encounter submissions are critical to the AHCCCS program and that AHCCCS relies on accurate, timely, and complete encounter data for a number of purposes including, but not limited to, rate setting, product reconciliation, reinsurance reimbursement, disproportionate share payments, and compliance/performance reporting. As a current program contractor, Bridgeway has almost five years operational experience with encounter submission and reporting to AHCCCS. This experience plus Centene's 27 years of experience submitting encounters nationwide places Bridgeway in a unique position to continually improve our encounter submission process and leverage best practices.

People

We organize our Encounters Team at Bridgeway leveraging the expertise of Centene so that we consistently maintain excellent service to AHCCCS. Together, Bridgeway and Centene resources bring both local and national experience to provide AHCCCS with accurate, timely and complete encounter submissions and an effective error management process.
Local Bridgeway Oversight. Bridgeway provides encounter specialists who are specifically knowledgeable about AHCCCS encounter processing rules, and who are responsible for the overall submission and correction of encounter data. They provide critical feedback into the claims adjudication and encounter reporting processes as they best understand AHCCCS requirements and expectations.
Centene's Encounter Business Operations (EBO) Unit. Centene's Encounter Business Operations (EBO) unit is a centralized resource supporting claim encounters for all Centene health plans. The EBO fosters strong relationships with key functional areas critical to a successful encounters process, such as Finance, Claims, and Information Technology. Within the EBO, Bridgeway has a *dedicated* Senior Encounter Specialist who works with local health plan encounter specialists and where necessary, leverages the expertise of all EBO resources garnered through the encounter submission process with all Centene affiliated health plans.
Provider Engagement Team. To augment and strengthen the teams above, Bridgeway will establish a Provider Engagement Team (PET) in Q2 2011. The PET will focus on Long Term Care (LTC) claim and encounter processing continuous quality improvement (CQI) by working collaboratively and attentively with providers. Since claims represent the starting point for submitting successful encounter data, the PET will work with providers to resolve barriers unique to Long Term Care claims submission. The PET will offer LTC providers a centralized support resource for a wide array of changes that have an impact on encounters including HIPAA 5010 conversion, ICD-10 implementation, roster billing elimination, and general EDI submissions. The PET, led directly by Bridgeway, will include resources from Bridgeway and Centene, including the EBO, to ensure involvement from all functional areas necessary to resolve issues.

Processes - Delivering Results for AHCCCS

Bridgeway views claims processing as not just an exercise in compliance with payment rules, but as a critical opportunity to offer 'best practice' service to our Providers and AHCCCS. We also see the claims process as one of the most significant data gathering aspects of our operation, since it supports our quality and utilization monitoring efforts, and supplies AHCCCS with accurate, timely, and complete encounter information. Please see ***Attachment C.10-A: End-to-End Claims and Encounter Processing Diagram*** for a visual representation of our claims and encounter life cycle. Bridgeway will continue to leverage lessons learned to further improve the accurate, timely, and complete submission of encounters in an open and collaborative partnership with AHCCCS.

Accuracy. To monitor encounter accuracy, the EBO team regularly validates a random sample of encounter records against the source data in AMISYS Advance, our claims processing system. Bridgeway and Centene employ multiple stages of systematically controlled claims and encounter editing and processing to ensure submitted encounter batches are accurate and validated against the most current reference files published by AHCCCS. This allows Bridgeway to remain in compliance with AHCCCS HIPAA compliance and business edits to avoid pended or denied encounters. The table below illustrates Bridgeway's success in submitting accurate LTC encounters to AHCCCS during 2010.

LTC	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Acceptance Rate	97.17%	96.84%	97.27%	95.79%	96.18%	96.20%	96.45%	96.25%	97.60%	94.66%	96.04%	95.84%
Pend Rate	2.83%	3.16%	2.73%	4.21%	3.82%	3.80%	3.55%	3.75%	2.40%	5.34%	3.96%	4.15%

Completeness. Bridgeway encounter submissions include all claims and encounters finalized through adjudication, including those submitted by non-participating providers and subcontractors, for both fee-for-service payments and capitated services. Through continual provider interaction and claims trend reporting, Bridgeway's system verifies providers are submitting valid claims for services provided. Should recurring billing issues be identified, Bridgeway's Provider Services Department works with Centene and the EBO to coordinate provider education on correct billing practices and resolve pended encounters. This may be as specific as having a Provider Relations Representative visit a small provider's office to guide them through a claim billing session so that the provider is aware of appropriate place of service and billing codes.

Timeliness. Bridgeway and our EBO create and submit encounter files to AHCCCS weekly on a fixed schedule, but can easily adjust our submission schedule based on self-monitored metrics (e.g., volume), or at the special request of AHCCCS. Submissions include new day encounters, adjusted claims, and pended encounters that have been resolved and submitted for reconsideration. We routinely monitor the PMMIS mainframe to ensure all files are successfully loaded to and processed through the bimonthly encounter cycles. Bridgeway and our EBO monitor and ensure all standards are met as defined in the AHCCCS Encounter Manual and Encounter Companion Documents. Bridgeway commits to submitting all encounters within 240 days after the end of the month in which the service was rendered.

Automating the Encounter Submission Process

Once AMISYS Advance, our claims processing system adjudicates claims to a finalized status, our MDE Xpress Encounter Pro (Encounter Pro) workflow system ***extracts*** this claims data, then prepares and submits the data as encounters to AHCCCS. Encounter Pro was designed and is supported locally in Arizona. As a company, MDE also has a proven track record within the Medicaid industry of providing the necessary submission and correction functionality to meet AHCCCS encounter submission guidelines.

Encounter Pro. Through the use of Encounter Pro, we are able to submit encounter data that complies with all AHCCCS standards for electronic file submission, file format, file size, submission frequency, and submission method as specified in AHCCCS guidelines, including ANSI ASC X12 and NCPDP Transaction Companion Documents and Trading Partner Agreements; the AHCCCS Encounter Manual; and the AHCCCS Technical Interface Guidelines. Our encounter files capture the same line item detail regardless of the claim type or disposition (e.g., paid or denied), and we also include all rendered services in our encounter submissions. Bridgeway's encounter submissions today include original and adjusted claims, application of retroactive fee or member changes, etc., and adhere to NCQA, AMA coding, UB-04 editor, NCCI, and AHCCCS standards regarding the definition and treatment of certain data elements captured on claims, use of standard codes, counting methods, units, etc.

Specific functionality provided by Encounter Pro includes, but is not limited to:

- Support of AHCCCS-specific business rules to "scrub" data prior to submission
- Automation of client-defined actions, in conformance with AHCCCS guidelines, to correct pends or denials
- Linkage to base claim database, outbound encounters, and inbound acceptance reports to facilitate comprehensive encounter reconciliation efforts
- Automated prioritization of encounter correction activities
- Extensive operational and executive reporting to identify encounter trends, monitor acceptance rates, and proactively correct issues
- Automated extract and delivery mechanisms to minimize bottlenecks and the need for manual intervention.

In addition, Encounter Pro includes a module which provides a 'pre-submission scrub' mechanism to customize and apply edits to encounters prior to AHCCCS submission. Encounter Pro recognizes conditions that will cause an encounter to pend or deny at AHCCCS and holds the claim for review. This allows us to work with providers to correct any issues and reprocess the claims for correct encounter submission.

In 2010, we also implemented MDE's Outpatient Pricing module which has resulted in more accurate pricing of outpatient claims, and also applies coding restrictions appropriate for outpatient facility claims. Since these claims are

processed and paid correctly on initial adjudication, Bridgeway not only realizes an increase in provider satisfaction and a decrease in administrative effort, but also decreased pend error potential for encounters submitted to AHCCCS.

Reconciliation. Each month, Bridgeway balances and reconciles paid claims and encounters through multiple stages to ensure submitted encounter batches are complete. Utilizing our Centelligence platform and reporting tools, on a monthly basis we compare total claims payment amounts to the total payment amounts processed within Encounter Pro. These totals are then compared to the total paid amounts contained in that month's encounter submission. This process accounts for every paid dollar and verifies all finalized claims have been processed as encounters. We have a corresponding process to compare all subcontractor encounters with those submitted to AHCCCS. Bridgeway also utilizes the quarterly AHCCCS encounter re-sync files as an additional control to reconcile with our internal encounter data.

Continuous Quality Improvement (CQI) in the Claims-to-Encounter Life Cycle

Bridgeway submits, on average, more than 24,000 Long Term Care encounters per month to AHCCCS, with an average first time success rate of over 96%. Since 2006, Bridgeway has learned much about AHCCCS encounter submission requirements, both in what we have done right and where we need to improve. We recognize that we have pended encounters past AHCCCS's 120 day compliance reconciliation date and are working to resolve these pends and denials with our providers and AHCCCS as expeditiously and sensitively as possible to ensure continuing, quality partnerships. Equally important as the reconciliation of these pended and denied encounters, are the process improvements we continue to implement to avoid inaccurate encounters upon initial submission to AHCCCS.

Root Cause Analysis and Resolution to Improve Encounter Submissions. Bridgeway follows a systematic approach to identify and resolve the underlying causes of encounter submission errors and not just focus on pended and denied data correction processes. While the latter may be necessary in the short-term, Bridgeway works to resolve root causes and mitigate long-term encounter data submission issues. For a visual representation of this process, please reference ***Attachment C.10-B: Encounter Error.***

Root Cause Analysis and Resolution Flowchart. Bridgeway's CQI approach focuses on the entire life cycle of a claim from inbound claim submission through encounter acceptance. When we identify a provider claim issue that impacts encounter submissions, Bridgeway and Centene staff review electronic claim images, AMISYS Advance configuration, Encounter Pro edits, and even PMMIS reference screens to determine the specific reason behind the issue. Once we have reviewed all of this information, our staff develop the appropriate corrective actions necessary to resolve the issue. For example, based on our highest pend reasons and leveraging the reference and provider files supplied by AHCCCS, we have identified specific edits we have moved to the front end of our claim processing system which will reject or deny inaccurate claims submissions as early as possible in the process so that the claim can be corrected and submitted accurately by the provider. We can then, in turn, submit an accurate, timely, and complete encounter to AHCCCS.

Bridgeway and Centene staff regularly perform a number of tasks designed to identify, quantify, and subsequently resolve potential provider claim issues that might ultimately impact encounter processing. For example, we:

- Conduct a review of weekly check audit results to identify potential areas of concern
- Perform audits for new providers within 90 days of contracting with Bridgeway to identify and resolve claims issues early before they have a significant adverse impact on the provider's operations
- Present AHCCCS-oriented workshops to providers focusing on claims submission and processing, and answering provider questions
- Perform onsite visits and orientations to individual provider offices to specifically discuss claims and encounter processing and resolve any existing problems.
- Attend monthly and quarterly AHCCCS encounter and re-insurance touch-point meetings to assist us in identifying additional areas of concern and opportunities to continuously improve our processes.

Bridgeway also provides materials and resources that help answer questions or provide direction, including, but not limited to: our Provider Services Representatives who staff our provider call center (866-475-3129); our Bridgeway Provider Portal; the Bridgeway Provider Manual; and the AHCCCS Provider manual.

For a graphical representation of our CQI process and additional detail on how we engage our providers, please refer to ***Attachment C.10-C: Encounter Process Continuous Quality Improvement.***

LTC Claims Wizard. In the first quarter of 2012, we will introduce a technology solution specifically designed to assist LTC providers in the migration from roster billing to HIPAA electronic claims submission. Our solution will allow a provider to log-in to our secure Provider Portal and through our LTC Claims Wizard, *review, edit, and complete a pre-*

populated online claims submission form which can then be submitted electronically to Bridgeway. One of the many benefits of this solution is a more accurate and timely submission of encounter data. This solution is an ideal example of how Bridgeway utilizes CQI to define and implement a solution that not only resolves a specific issue (the elimination of roster billing), but presents a solution with a larger purpose and long-term benefit (enabling provider electronic claims submission and more accurate encounters).

Continuous Performance Improvement

Over the past two years, Bridgeway has introduced technology and implemented changes that have improved performance in both claims adjudication and encounter acceptance rates as described above. Bridgeway will further refine the claims payment and encounter submission process as we continue to monitor and analyze our processes. Bridgeway is currently mid-stream in our effort to move edits identified in the 'pre-submission scrub' process that result in a pended or denied encounter to the front end of our claims adjudication process. Several edits have already been incorporated into AMISYS Advance and we anticipate many further edits will be integrated as part of our continual quality improvement process. Additionally, in coordination with AHCCCS, our implementation of HIPAA Level 5 edits will also improve the quality of claims submission resulting in more accurate encounter submissions. As always, we will engage our providers and educate them about these changes in advance so that they are able to quickly correct their system and submit claims in an even more accurate and timely manner. Please reference ***Attachment C.10-D: Encounter Edit/Validation Placement Diagram*** for a depiction of current and future edits.

Partnership with AHCCCS

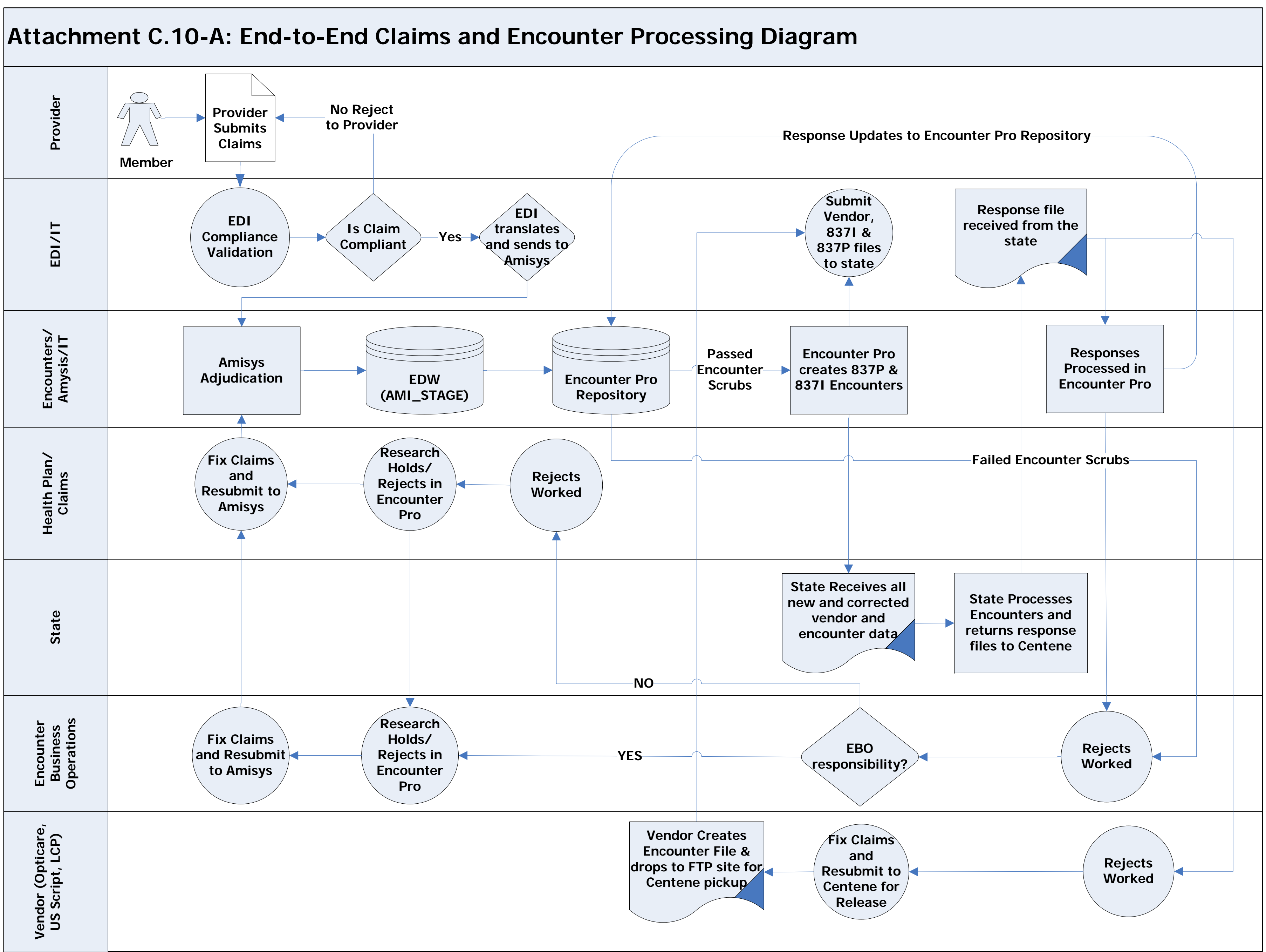
As an established partner in Arizona, Bridgeway will continue to provide timely notification of any changes to our key Claims, Encounter, or IT personnel, as well as any significant changes we make to our systems that could impact the integrity of our claims or encounter data, including new software and strategic partnerships. We communicate all designated contacts to AHCCCS to facilitate efficient standard encounter processing and issue resolution. Bridgeway and Centene resources also attend AHCCCS encounter technical meetings on a regular basis and will continue to report any issues in encounter processing to our designated AHCCCS contact. Bridgeway and Centene view AHCCCS as a partner in the encounter submission process and will continue to work openly and collaboratively to resolve technical issues and to meet any additional requirements that enhance AHCCCS administrative oversight processes.

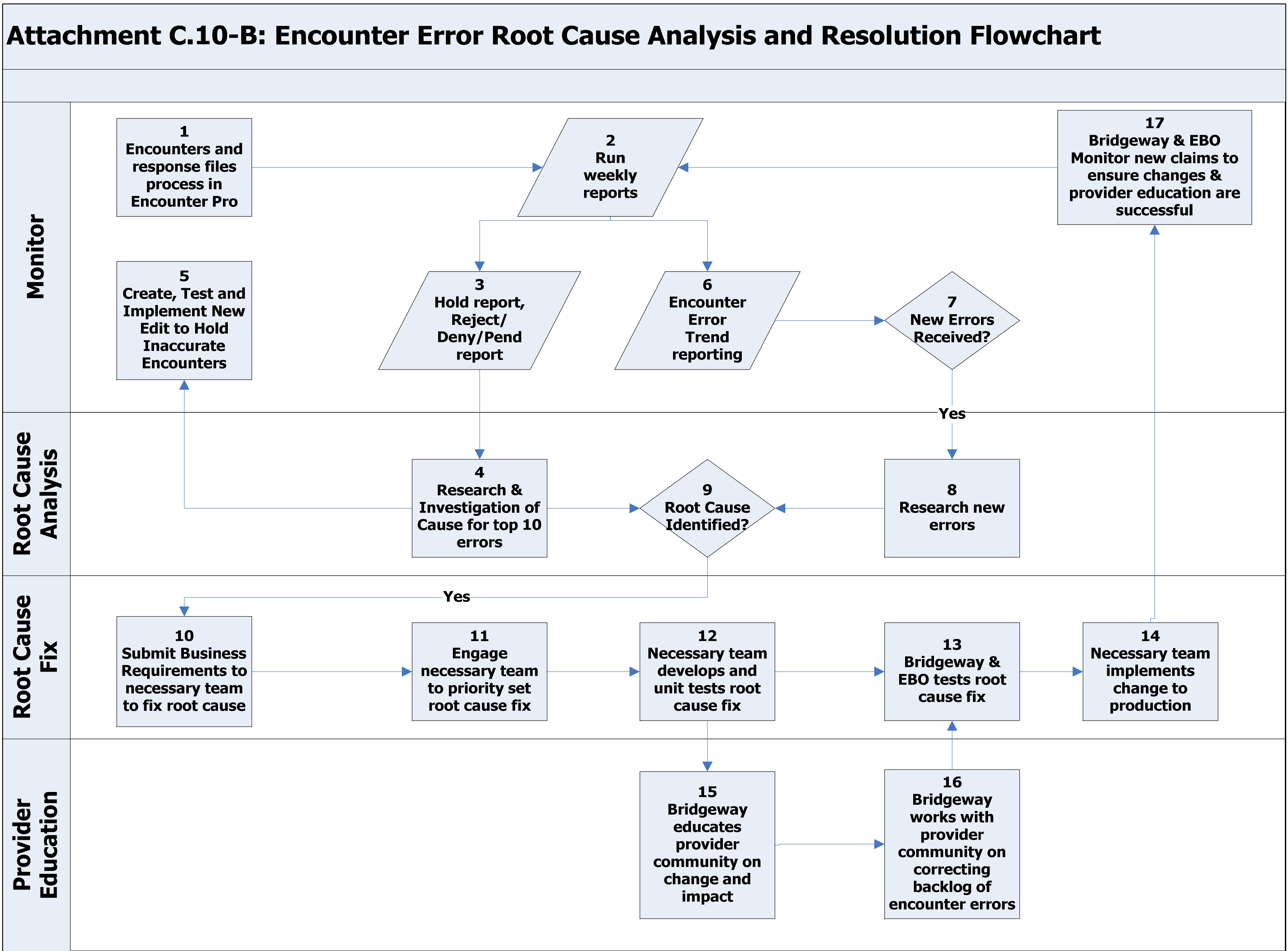
Managing Subcontractor Encounter Submissions

Bridgeway manages our encounter-related contracts and service level agreements with our subcontractors via our established delegation oversight process in close collaboration with Centene. Our vendor contracts call for accurate, complete, and timely encounter submissions to our EBO, where we oversee all aspects of that subcontractor's encounter operations. Our subcontractors are required to comply with the same encounter submission requirements as Bridgeway. In the event a subcontractor does not comply with encounter requirements, we will activate our corrective action processes (which can include monetary penalties) for non-compliance.

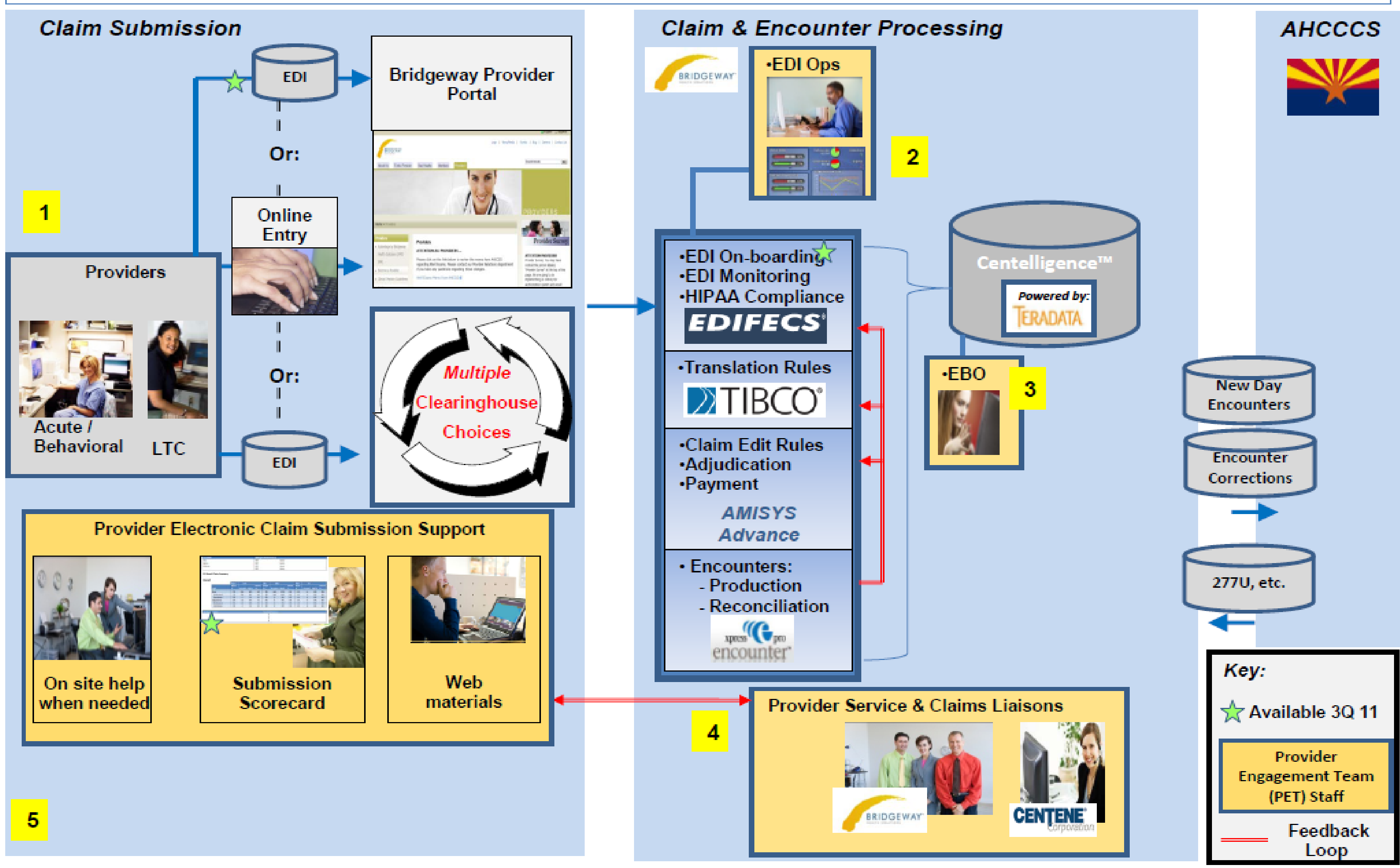
Encounter Data Validation Studies

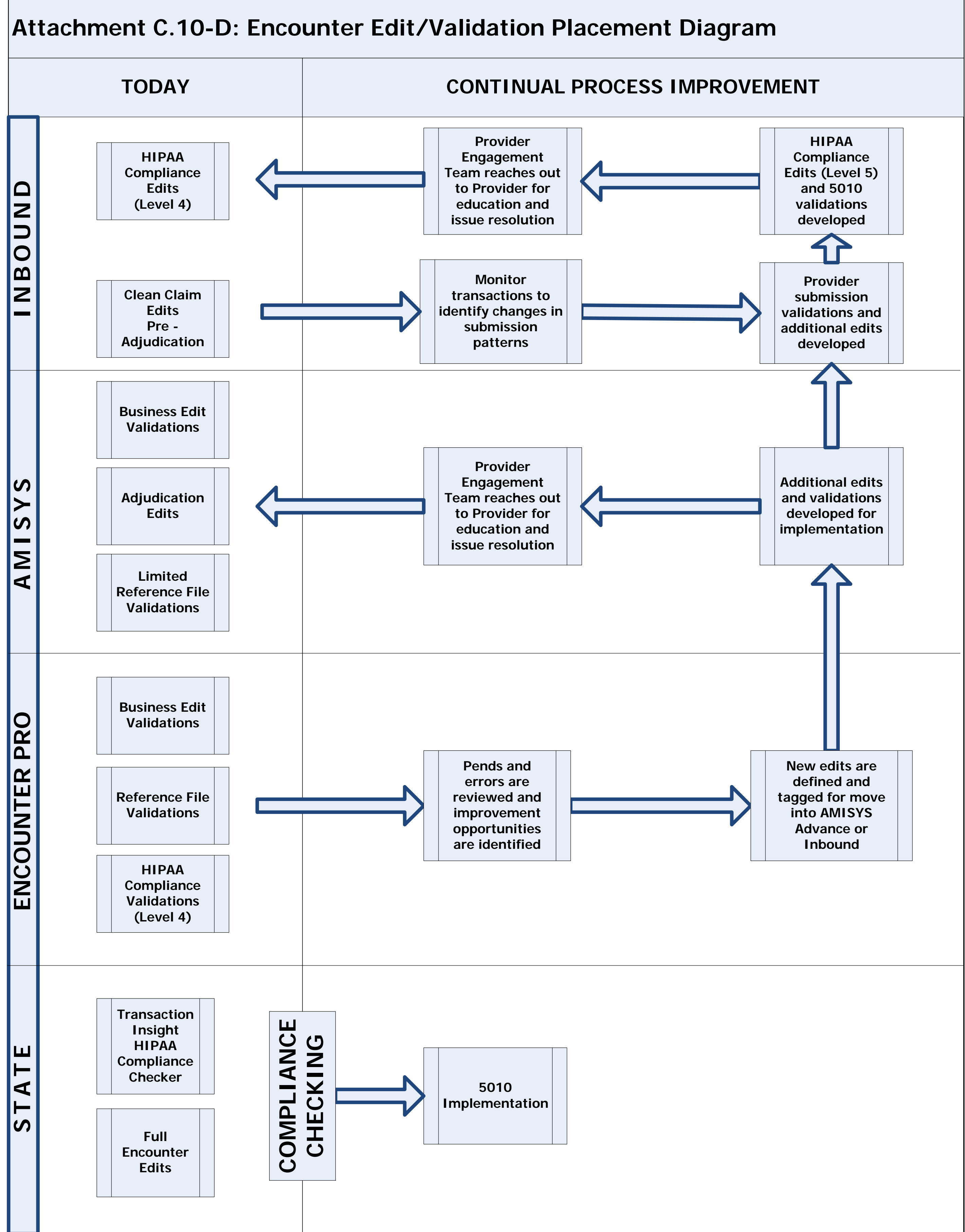
Bridgeway understands that AHCCCS will conduct Encounter Data Validation studies per CMS requirements on at least a yearly basis. Bridgeway will provide the necessary data, resources, and cooperation to support AHCCCS activities to validate encounter timeliness, correctness, and completeness as referenced in the Data Validation Technical Document.


Attachment C.10-A: End-to-End Claims and Encounter Processing Diagram
Provider
EDI/IT
Encounters/ Amysis/IT
Health Plan/ Claims
State
Encounter Business Operations
Vendor (Opticare, US Script, LCP)
Member
Provider Submits Claims
No Reject to Provider
Response Updates to Encounter Pro Repository
EDI Compliance Validation
Is Claim Compliant
Yes
EDI translates and sends to Amisys
Submit Vendor, 837I & 837P files to state
Response file received from the state
Amisys Adjudication
EDW (AMI_STAGE)
Encounter Pro Repository
Passed Encounter Scrubs
Encounter Pro creates 837P & 837I Encounters
Responses Processed in Encounter Pro
Failed Encounter Scrubs
Fix Claims and Resubmit to Amisys
Research Holds/ Rejects in Encounter Pro
Rejects Worked
State Receives all new and corrected vendor and encounter data
State Processes Encounters and returns response files to Centene
NO
YES
EBO responsibility?
Vendor Creates Encounter File & drops to FTP site for Centene pickup
Fix Claims and Resubmit to Centene for Release


Attachment C.10-B: Encounter Error Root Cause Analysis and Resolution Flowchart
Monitor
Root Cause Analysis
Root Cause Fix
Provider Education
1 Encounters and response files process in Encounter Pro
2 Run weekly reports
17 Bridgeway & EBO Monitor new claims to ensure changes & provider education are successful
5 Create, Test and Implement New Edit to Hold Inaccurate Encounters
3 Hold report, Reject/ Deny/Pend report
6 Encounter Error Trend reporting
7 New Errors Received?
Yes
4 Research & Investigation of Cause for top 10 errors
9 Root Cause Identified?
8 Research new errors
Yes
10 Submit Business Requirements to necessary team to fix root cause
11 Engage necessary team to priority set root cause fix
12 Necessary team develops and unit tests root cause fix
13 Bridgeway & EBO tests root cause fix
14 Necessary team implements change to production
15 Bridgeway educates provider community on change and impact
16 Bridgeway works with provider community on correcting backlog of encounter errors

Attachment C.10-C: Encounter Process Continuous Quality Improvement




Attachment C.10-D: Encounter Edit/Validation Placement Diagram
TODAY
CONTINUAL PROCESS IMPROVEMENT
INBOUND
HIPAA Compliance Edits (Level 4)
Provider Engagement Team reaches out to Provider for education and issue resolution
HIPAA Compliance Edits (Level 5) and 5010 validations developed
Clean Claim Edits Pre - Adjudication
Monitor transactions to identify changes in submission patterns
Provider submission validations and additional edits developed
AMISYS
Business Edit Validations
Adjudication Edits
Limited Reference File Validations
Provider Engagement Team reaches out to Provider for education and issue resolution
Additional edits and validations developed for implementation
ENCOUNTER PRO
Business Edit Validations
Reference File Validations
HIPAA Compliance Validations (Level 4)
Pends and errors are reviewed and improvement opportunities are identified
New edits are defined and tagged for move into AMISYS Advance or Inbound
STATE
Transaction Insight HIPAA Compliance Checker
Full Encounter Edits
COMPLIANCE CHECKING
5010 Implementation

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

Information Systems Exclusively For Medicaid Long Term Care, Acute Care, and Medicare Advantage Special Needs Plans. Centene Corporation (Centene) provides local and enterprise level, HIPAA compliant Management Information System (MIS) hardware, software, and communications networking for Bridgeway Health Solutions, LLC® (Bridgeway), including all four of Bridgeway's offices in Yuma, Tempe, Prescott, and Tucson, as well as secure remote laptop and personal electronic device support for all Bridgeway field personnel. Nationwide, Centene's MIS supports the goals of responsive, accountable, and coordinated care for 1.5 million Americans in our Medicaid managed care plans in ten states, and Bridgeway has supported the Arizona Long Term Care System (ALTCS) since 2006. Centene also supports the unique needs of our Medicaid Long Term Care plans in Texas, Florida and Illinois. For 27 years, our MIS and over 250 Information Technology (IT) professionals have focused *solely* on the automation requirements unique to the *integrated* medical, behavioral, and human services needs of Medicaid and Medicare Special Needs Plan (SNP) members.

Continuously Enhancing MIS. As an architected platform comprised of numerous hardware, software and networking components, our MIS is not a static utility - but a constantly evolving system. Every year, we assess our clients' requirements for enhanced member engagement, provider collaboration, improved care, and state client service. We factor in the maturity, "implementation readiness," and interoperability of *new* technologies, and identify when and how to incorporate those technologies in the continuously enhanced service of our constituents. We also compare all components in our integrated MIS portfolio with the latest product versions from our vendors. The output of this effort is our Annual Strategic Technology Refresh Plan, which serves as our roadmap for planned introduction of new or enhanced MIS capabilities. For example, at Bridgeway in 2010 we successfully implemented: (a) a major upgrade of our core enrollment, eligibility, and claims processing system, AMISYS Advance, from Release 1.0 to Release 4.0; (b) converted our prior encounter processing system to our MDE Xpress Encounter Pro application; (c) implemented our integrated Impact Pro predictive modeling application; (d) deployed ClaimsXten clinical editing software - all as part of our Refresh Plan; and (e) introduced the use of Teradata Extreme Data Appliance technology for data warehousing. Our investment in MIS continues to accelerate: over the past year we have committed significant levels of capital and development labor to new applications in member and provider services, data warehousing technology, health care informatics, predictive modeling, clinical profiling, and construction of a second major corporate datacenter, enabling new capacity for growth as well as "hot site" business continuity. We are phasing in these enhancements (several of which are specifically for LTC providers and members) for Bridgeway over the course of 2011and early 2012.

MIS Software Structure and Components: Functionally Rich Yet Integrated Where Needed. Please refer to Figure C-11 below for a diagrammatic overview of our MIS, its integrated components and key data interfaces with AHCCCS, our providers and subcontractors. Figure C-11 shows our communications, functional application and database "layers" and components that represent our MIS in the service of health programs such as ALTCS. Our discussion below walks through these components and, along the way, we highlight how these components support our major operations and where we are enhancing these components in 2011.

Electronic Data Interchange (EDI). Our CoViant Diplomat Transaction Manager (Coviant - item **A** in Figure C-11) handles our automated, scheduled production of HIPAA and non-HIPAA (AHCCCS proprietary) EDI file exchanges with AHCCCS, our subcontractors, and our network of almost 60 EDI Trading Partners. Today we exchange data with AHCCCS using Secure FTP (SFTP), but we can support virtually all industry standard secure file exchange protocols, should AHCCCS desire. CoViant protects Bridgeway's file exchanges with access control, authentication, and secure configuration features, and allows us to support our contractual requirements with AHCCCS as they pertain to data exchanges. Our EDIFECS Ramp Manager and X Engine transaction subsystem (item **B**) provides HIPAA test and production Version 4010A and 5010 compliance checking, automated HIPAA transaction monitoring, and conditional transaction routing driven by transaction specific business rules, ensuring (for example) that a HIPAA *claim* is routed to our AMISYS Advance claim processing system (item **D**). Beginning in the 2nd Quarter of 2011, our Provider Engagement Team (PET: a Bridgeway led multi-disciplinary team with expertise in provider services, EDI operations, and LTC claims and encounter processing) will have interactive access to our Ramp Manager application, allowing our PET staff to assist providers with testing their implementation of HIPAA 5010 transactions (as implemented according to Bridgeway companion guides).

Ramp Manager offers near instant detailed EDI field, segment, and loop feedback for any troubleshooting by the provider or their submitter. Our provider EDI submitters can then certify their status with us as HIPAA compliant, and they will have the option to submit their production HIPAA 837 claim transactions (and receive HIPAA 835 Remittance Advices) directly with us via our Provider Portal beginning in the 3rd Quarter of 2011. Ramp Manager also systematically monitors all HIPAA production transactions, and will alert our EDI Operations staff via dashboard functionality if a particular Trading Partner's submission patterns are deviating from normal, such as if a provider's direct submission volume seems to be dropping off significantly below that provider's norm. We automate processing scheduled runs (e.g. eligibility, claims) on daily, weekly, or monthly cycles through our TIDAL Enterprise Scheduler (TIDAL) job scheduling software. Our TIBCO software suite (item C), provides our HIPAA translation functions and supports a wide range of file transmission acknowledgement protocols, including ANSI standard 997, TA1 ,831, 824, and AHCCCS proprietary formats.

Eligibility Processing. Our TIBCO mapping/translation programs receive eligibility files from AHCCCS, validate and map each data item to the membership input file format of AMISYS Advance (item D). TIBCO also applies edits such as those for duplicate member records, date criteria validity, field data integrity, and valid date spans - all prior to loading into AMISYS Advance. Any member records that trigger edits will default into an Exception Report where they are systematically corrected using data correction routines. Corrected and clean original records are loaded into AMISYS Advance member tables through Add, Delete, and Modify transactions with accurate begin and end dates. Once eligibility data is loaded and processed in AMISYS Advance, it is systematically promulgated to our TruCare integrated health services management platform (item F); our paper scanning and Optical Character Recognition (OCR) system (MACESS - item G); our Automatic Work Distribution claims workflow engine (AWD - item H); and our Enterprise Data Warehouse (EDW) data integration engine (item I) via our Informatica near real time Extract, Transport, and Load (ETL) middleware (J). Through EDW, we also make member eligibility data securely accessible to our providers online via our Provider Portal (K). We transmit member eligibility data to US Script, Bridgeway's Pharmacy Benefit Manager (PBM) affiliate; and our other subcontractors: OptiCare Managed Vision, Inc. (OptiCare), and Avesis (our dental benefits manager). These transmissions, and all our formatted data exchanges, are graphically depicted in Attachment C-11.1: Detail EDI Flow.

Member Services: The Member Relationship Management System. During the 3rd Quarter of 2011, we will introduce *new and powerful* automated member services functionality - through the introduction of our new Member Relationship Management system (MRM - item E) to support all aspects of our members' relationship with Bridgeway. We launched MRM successfully in two of our affiliate plans in late 2010. Please refer to Attachment C-11.2: MRM, in which the three concentric circles represent multiple types of interactions among: MRM (item 1 in Attachment C-11.2), Bridgeway member services staff and outward facing applications (2), such as our secure Member Portal, and members (item 3).

Centene's MRM enables Bridgeway to ***identify***, ***engage***, and ***serve*** our members in a holistic and coordinated fashion, across the breadth of their wellness, clinical, administrative, and financial matters.

MRM is our integrated repository of "all things member" and has three core integrated components:

- **Member Demographics System** (MDS). MDS is similar in design to a Master Patient Index application in that it employs a Master Data Management (MDM) approach to member data. Our MDM design provides processes for collecting, aggregating, matching, consolidating, quality-assuring, persisting, and distributing member data throughout our organization to ensure consistency and control in the ongoing maintenance and application use of member data.
- **MemberReach** automates, manages, tracks and reports on our workflows for *outbound and outreach* member campaigns, as well as targeted outbound interventions (such as engaging high risk members in disease management programs).
- **MemberConnect** is our new Customer Relationship Management (CRM) member services application which greatly expands the efficiency and extent of member and caregiver information that we can collect, transmit, display, route and use.
  - MemberConnect also supports *inbound campaign management*. If a member or caretaker we have been trying to reach happens to call us for any reason, our Bridgeway Member Services Representatives (MSRs) can address the member's immediate issue, then they or another staff member can talk to the member about the issue that is the subject of our outreach attempts. For example, the member's Case Manager may have been trying to reach the member because our Centelligence™ Foresight Predictive Modeling system detected an important gap in care for

that member. Unfortunately, the Case Manager has been unsuccessful because of an incorrect phone number. The Case Manager documented her need to talk to this member in TruCare and the information flowed into MemberConnect. When the member calls about another issue, the MSR can see that the Case Manager needs to talk with the member when they pull up the member record. The MSR addresses the subject of the member's call, then offers to warm transfer the member to their Case Manager.

- MemberConnect supports *co-browsing* or the ability of our MSR to view (with the consent of the member on the phone) what the member or caregiver is viewing on our Member Portal in order to assist them. For example, once MemberConnect is implemented, a member will be able to talk with Bridgeway's call center and while they are online, the MSR can show the member how to view their Service Plan.

Attachment C-11.3 MRM Components: depicts the core technology components of MRM, including MemberReach and MemberConnect. We have built MRM on Microsoft Dynamics MDM (item 1 in Attachment C-11.3) and Customer Relationship Management (CRM - item 2), and Avaya Voice Portal (AVP) Interactive Voice Response (IVR) with Predictive Auto Dialing (PAD) technology (3 - also shown as item AD in Figure C-11). AVP will go into service at Bridgeway for IVR functionality in the 2nd Quarter of 2011. Attachment C-11.3 also depicts how, and for what purpose, MRM integrates with the rest of our functional applications.

Beginning in the 4th Quarter of 2011, and through a partnership with the Microsoft Corporation, we are piloting the extended reach of our MRM system, through the support of on-demand video between Bridgeway equipped selected ALTCS members (with member consent) and Bridgeway's staff of LTC Case Managers. We will not decrease "in person" contacts between our members and our Case Managers. Rather, our LTC In Home Pilot ("pilot") will demonstrate how the viability of on-demand video conferencing can dramatically ***increase*** the frequency and ***augment the quality*** of member contact with our Case Managers. Together with Microsoft, we will integrate our MRM with a combination of Microsoft's Kinect intelligent video system, XBOX console, and Lync Server unified communications software. We are also exploring opportunities with residential Internet Service Providers (ISP's) who have expressed an interest in collaborating with us on our pilot. Our intent would be to offer internet connectivity if a pilot member does not have such access currently (e.g. through their cable TV supplier). Depending on the results of the pilot, we will refine the functional scope and timing of additional capabilities to potentially include support for interactive health content and programs (with supporting reward based incentives), and the secure, HIPAA compliant collection of health data (all with member consent). Please see Attachment C-11.4: In Home Video Pilot for a graphical depiction of the key components and communications flow in our pilot.

Provider Services: The Provider Relationship Management System. Also during the 3rd Quarter of 2011, we will build on existing capabilities to introduce new provider services and data management functionality - our Provider Relationship Management system (PRM - item L in Figure C-11). Attachment C-11.5 PRM Components: graphically depicts PRM's four service components:

- **ProviderConnect** (item 1 in Attachment C-11.5) is our new application for creating, routing, tracking, managing, and reporting provider inquiries. The main users of ProviderConnect are Provider Service Representatives (PSR's - who are part of our integrated Provider Engagement Team), but PSR's also can send and receive provider inquiry work items to and from any other departments (including MSRs and Case Managers), using ProviderConnect.
- **ProviderReach** is our automated outbound Provider campaign management application allowing the efficient and coordinated launch of broad based (Plan level) provider communiqués, notices, and recruitment across multiple communication channels, including telephone, e-mail, fax and web. See item 2 in Attachment C-11.5.
- **Portico** is our provider data management system which integrates provider related information (item 3 and also shown as item AC in Figure C-11) across our other MIS components needing to use provider data. We will be implementing our Portico component for Bridgeway in the 4th Quarter of 2011.
- **Emptoris** is our comprehensive provider contract management software, supporting efficient and collaborative provider contracting, amendment, and re-contracting processes with Bridgeway providers, while ensuring regulatory compliance (item 4 in Attachment C-11.5 and also shown as item AC in Figure C-11).

We developed PRM (which we began implementing in our affiliate health plans in late 2010) using the *same* Microsoft Dynamics CRM platform (5) we have deployed for MRM, integrated with our Portico enterprise provider data management system (6); our Emptoris enterprise contracting system (7); and the *same* Avaya Voice Portal (8) component used in MRM. As Attachment C-11.5 shows, PRM is integrated with our Provider Portal, AMISYS Advance, our Automatic Workflow Distribution (AWD) system, and in the 1st Quarter of 2012, our Enterprise Content Management (ECM) system. This integration provides a comprehensive view for our PSRs to address any provider inquiry quickly,

and/or to route any provider matter to the appropriate Bridgeway department (e.g. Provider Relations on a contracting topic, Case Managers on a clinical subject, Claims Operations regarding a procedure coding question). AVP's voice recognition technology allows provider users to speak identifying information and menu commands for retrieval of eligibility, claim status, and other information. Since we began using voice recognition enabled IVR in early 2011, we have seen a dramatic decrease in IVR callers "pounding out" to a PSR, demonstrating that providers find real utility in this function, while allowing our PSR's to focus on more complex provider calls.

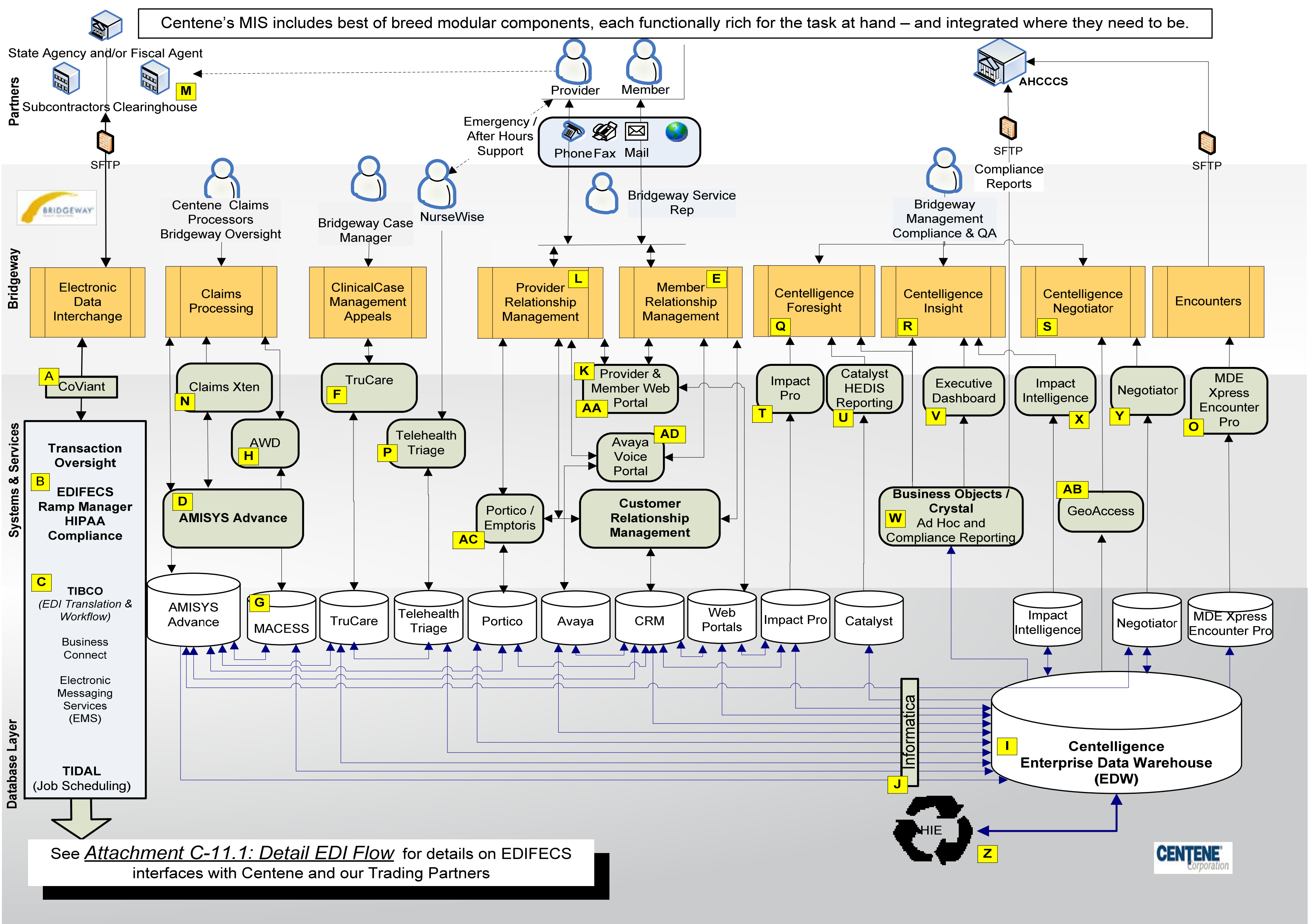
Claims Processing. We accept HIPAA 837 EDI electronic claims from almost 60 EDI Trading Partners (Item **M**), and beginning in the 3rd Quarter of 2011, direct from our providers via our Provider Portal. Today, we also support the online entry of claims via our HIPAA Direct Data Entry (DDE) facility on our Provider Portal. HIPAA EDI format adherence is verified real-time using our EDIFECS X Engine (**B**), which improves our claim auto-adjudication rate and the quality of the downstream encounter data we process and submit to AHCCCS. Providers can submit paper claims, which are scanned using Optical Character Recognition (OCR), indexed and converted to machine readable data through MACESS (**G**). EDI and paper claims are processed thru our TIBCO software (**C**) to map, translate, and validate the data, ensuring that common edits are consistently applied. Component **D** is AMISYS Advance, one of the health care industry's premier transaction processing systems and our core processing system, providing HIPAA-compliant eligibility and claims processing. Our Automatic Work Distribution (AWD) software (**H**) manages workflow of any pended claim in AMISYS Advance in *real time*. If a claim pends in AMISYS Advance, AWD immediately routes an electronic work item to a claims processor skilled to address that type of claim pend. The claim processor can then address the pend issue through AWD, and the appropriate claim change is immediately made in AMISYS Advance. ClaimsXten (**N**) reviews adjudicated claims *prior to payment* for such items as bundling and unbundling of services, incidental services, mutually exclusive codes, global surgery follow-up days, duplicate claims, invalid procedures, bilateral services, and incorrect age/gender validation. Please see our response to C-7 for more information on our proactive strategies to detect fraud, waste or abuse in claim submissions. For payment, Bridgeway offers Electronic Funds Transfer (EFT) and/or Electronic Remittance Advice (ERA) options directly to our providers through a clearinghouse, or through our new provider-friendly Payformance or Emdeon capabilities. Explanation of Payment (EOP) information is also available to providers through our secure Provider Portal (**K**). See our response to C-8 for more information.

Encounter Processing: Once AMISYS Advance adjudicates claims to a finalized status, our MDE Xpress Encounter Pro (Encounter Pro) workflow system (**O**) extracts this claims data, prepares and submits the data as encounters to AHCCCS through TIBCO (for translation to HIPAA 837 format), and (after HIPAA compliance checking) through EDIFECS.

Clinical Management: Beginning in August of 2011, Bridgeway clinical staff will start using CaseNet TruCare (TruCare item (**F**). TruCare is our member-centric health management platform for collaborative care coordination and case, behavioral health, disease, and utilization management. TruCare automates all the clinical components of our case, behavioral, and medical management programs into a single platform, integrated with our other applications to allow us to proactively serve our LTC, chronically ill, acutely ill, and at risk members. TruCare enables a collaborative care partnership among Bridgeway staff and our members, their caregivers, and providers. TruCare affords users a *member centric* view of clinical cases so that our clinical staff can easily see the entire medical and behavioral health status and history of members, and to ensure that coordinated and holistic programs are in place. TruCare's rule based architecture allows us to customize clinical workflow related to clinical decision support criteria, prior authorization, and medical necessity review. For example, TruCare supports the automatic approval of specific types of authorization requests such as when a provider enters an authorization request for "automatically approved" services on our Provider Portal, such as for dialysis or office visits. In such cases, TruCare will acknowledge receipt of the request and issue an authorization approval back to the provider immediately.

TruCare's interface capabilities allow it to transmit authorizations in real time to our AMISYS Advance claims subsystem, and TruCare's data granularity allows authorizations to be issued at the procedure code level, enabling the highest level of specificity for subsequent claim adjudication, and enhancing claim payment turnaround times to our providers. Our TruCare system is integrated with McKesson's industry leading InterQual medical necessity criteria (MNC) software. The integration of TruCare and InterQual gives us evidence-based criteria that provide a consistent, detailed guideline approach to help our staff determine the medical necessity and the appropriateness of covered services requiring prior authorization. McKesson updates their evidence-based clinical guidelines regularly through a development team of over

Figure C-11



60 clinical specialists, and a multi-specialty medical and behavioral panel of over 800 clinicians. InterQual software is grounded in more than 16,000 citations from medical literature and from a variety of acknowledged and accepted sources.

LVM Telehealth Triage (Telehealth Triage - Item **P**) is our clinical content and workflow application supporting Bridgeway's NurseWise nurse advice line affiliate. Telehealth Triage enables our NurseWise Registered Nurses (RN's) to answer ALTCS member health-related questions, refer symptomatic callers to the appropriate level of care, and support members to make informed decisions about their health.

Business Intelligence: Collectively, the integrated items **I**, **Q**, **R**, **S** ,**T**, **U**, **V**, **W**, **X**, **Y**, and **AB** in Figure C-11 represent Centelligence™, our proprietary and comprehensive existing and planned family of integrated decision support and health care informatics solutions. Our Centelligence™ enterprise platform integrates data from multiple sources and produces *actionable* information: everything from Care Gap and Wellness Alerts, to Key Performance Indicator (KPI) Dashboards, Provider Clinical Profiling analyses, population level health risk stratifications, and standard and ad-hoc desktop reports. Please see Attachment C-11.6. Centelligence™ continually analyzes an enormous amount of transactional data (e.g. claims, lab test results, authorizations), producing "business intelligence" and delivering the right information products to the right person (e.g. Case Manager, MSR, Provider, Member) for the right task (e.g. clinical intervention, internal workload adjustments, client reporting) at the right time (e.g. on schedule, or "in real time"). Please see Attachment C-11.7 Centelligence™ Components. The Centelligence™ family includes:

- Item **A** in Attachment C-11.7: Centene's **Enterprise Data Warehouse** (EDW), which integrates medical, behavioral, pharmacy claims (from US Script, Bridgeway's Pharmacy Benefits Manager (PBM) affiliate) lab test data, member and provider demographics, and Health Risk Assessments (HRAs) into a centralized repository. During 2010, we implemented a *significant* upgrade to our Enterprise Data Warehouse (EDW) with the incorporation of the **Teradata®** Extreme Data Appliance. This major capital investment significantly improves our ability to handle truly large amounts of data in much shorter timeframes, resulting in more timely Care Alerts, Dashboards, reports, and other informatics.
- **B**: **Centelligence™ Insight** - our desktop reporting and management KPI Dashboards capability, as well as our implementation of Ingenix's Impact Intelligence. Both of these solutions afford Bridgeway and our providers the practice and peer level profiling information needed for continuous clinical quality improvement.
- **C**: **Centelligence™ Foresight** - incorporating our Impact Pro, Catalyst HEDIS, and Centene proprietary predictive modeling and Care Gap/Health Risk identification applications.
- **D**: **Centelligence™ Negotiator** – our proprietary contract modeling capability that leverages historical market information to aid in the analysis of new or modified provider contracts. The new contract configurations (fee schedule, etc.) can then be electronically fed to AMISYS Advance to accelerate and simplify the implementation of the contract. GeoAccess (item **AB** in Figure C-11), another component of Centelligence™ Negotiator, is our provider network geographic access analysis software.

See Attachment C-11.8: Centelligence™ Insight and Attachment C-11.9: Centelligence™ Foresight for more detailed diagrams of these Centelligence™ components.

Item **Z** in Figure C-11 depicts, wherever applicable to our operations and where supported by our local constituents, our ability to send and receive standards based clinical and demographic data in support of Electronic Health Records (EHR) and Health Information Exchanges (HIE). We support standards such as HL-7, and the XML-based Continuity of Care Document (CCD) as called for in *45 CFR Part 170 Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, Interim Final Rule*, published in July of 2010 by HHS. We also participate wherever possible in local and state wide HIE efforts. For example, Bridgeway participates in the *Health Information Network of Arizona (HINAz)*, a collaborative HIE effort among Arizona health plans, hospitals, large group practices, business leadership, consumers and local administrations. We can integrate TruCare with Virtual Health Record (VHR) systems such as the one planned at HINAz.

Secure Provider Portal: Item **K** in Figure C-11 represents our secure web-based Provider Portal. Our Provider Portal is an increasingly important and strategic component in our ongoing efforts to collaborate with medical, behavioral, and alternative living and other LTC providers for efficient administrative, coordinated care, and clinical quality processes. In addition to the current, well organized reference content on our Provider Portal today, our existing and planned capabilities for the Bridgeway Provider Portal are listed in the table immediately below, in compliance with Section 404 of the AHCCCS Contractor's Operations Manual (ACOM):

Provider Portal Feature	Description	Planned Implementation
Eligibility & Benefits	Verify member eligibility; search for member by last name, date of birth, date of service, or by AHCCCS ID and date of service. Verify benefits coverage, including Third Party Liability (TPL) information.	Currently available.
Member Panel Roster	View, print, or export to Excel all Members under the provider's care.	Currently available.
Online Authorizations	User can submit authorization request online, with immediate acknowledgement.	Currently available.
Claim Entry Online	Enter and submit claim in HIPAA DDE compliant online form.	Currently available.
Claim Status Inquiry	Search for claim status by member, claim, and/or provider name.	Currently available.
View Adjudication Logic	Allows provider to view Bridgeway claim adjudication rules.	Currently available.
Explanation of Payment	Providers can view and download EOP & Payment History.	Currently available.
Batch Claim Submission	Online HIPAA 837 Claim Batch File submission	3rd Quarter 2011
Auth Requirements	User can search by procedure to view pre-authorization requirements.	3rd Quarter 2011
Online Care Gaps	Online alerts about the potential need for interventions, diagnostic and lab tests for certain conditions, or for necessary preventive services whenever a user checks eligibility or their online Member Panel Roster via the Provider Portal.	3rd Quarter 2011
Auto Auth Approvals	For selected services such as dialysis, office and specialist visits, ability for user to get immediate approval in real time while online.	3rd Quarter 2011
Auth/ Claim Attachments	Upload supporting documentation (if needed) for auths & claims.	3rd Quarter 2011
Interactive Formulary	View drug information by searching with NDC code or description.	3rd Quarter 2011
Online Claim Adjustments	Allow providers to complete adjustments on Portal. NOTE: We already allow adjustments via EDI, but Online Claim Adjustments addresses needs of providers who cannot or do not submit adjustments via the EDI process.	3rd Quarter 2011
Member Care Plan	View the member's TruCare service plan online.	3rd Quarter 2011
Enhancements for LTC Providers	We are introducing features specific to LTC providers, including: 1) Allowing "discharge date" on online claim form to be optional 2) Allowing NPI to be optional as not all LTC facilities have NPI	3rd Quarter 2011
New Provider Directory	We are enhancing the Directory by providing Google maps, showing proximity to public transportation, and identifying provider gender.	4th Quarter 2011
Provider Profiling	We will supply provider profiling information for a provider to view on the provider portal.	4th Quarter 2011
LTC Claims Wizard	The LTC Claims Wizard (a version of our existing online HIPAA compliant claim submission capability) is specifically targeted for LTC providers accustomed to "roster billing." LTC Claim Wizard will allow these providers to naturally migrate to HIPAA claim submission. Please see Attachment C-11.10 LTC Claim Wizard for a graphical flow diagram.	1st Quarter 2012

Secure Member Portal: Item **AA** in Figure C-11 represents our secure web-based Member Portal. Today our existing public member website complies with Section 416 of ACOM. In addition, we have recently begun implementation of secure Member Portal functionality in other affiliate plans, and we are on track to implement Bridgeway's Member Portal in the 3rd Quarter of 2011. Our Member Portal will allow Bridgeway ALTCS members and their caregivers to access more content and help them engage more in their care:

Member Portal Feature	Description	Planned Implementation
New Provider Directory (Public site)	We are enhancing the Directory by providing Google maps, showing proximity to public transportation, and identifying provider gender.	3rd Quarter 2011
Claim Information	View information on claims for services rendered to member.	3rd Quarter 2011
Online Care Gap Notification	The member is alerted to potential care gaps, in consumer friendly language, as detected by our Centelligence™ Foresight predictive modeling system.	3rd Quarter 2011
Member Care Plan	View the member's TruCare service plan online.	3rd Quarter 2011
HRA Online	Complete the health risk screening or assessment online.	3rd Quarter 2011
Replacement ID Cards	Order replacement ID Cards online.	3rd Quarter 2011
Demographic Update	Update member demographics online.	3rd Quarter 2011
PCP Change	The member can change his or her PCP online.	3rd Quarter 2011
Replacement ID Cards	Order replacement ID Cards online.	3rd Quarter 2011

Enterprise Class Hardware, Physical Facility, and Network Infrastructure. Centene powers the applications and capabilities described above for Bridgeway with all the requisite processing strength, bandwidth, support, capacity planning, and physical environmentals these applications demand today and in the future. We have engineered a delivery architecture capable of rapidly scaling for both capacity and performance by carefully integrating technologies such as virtualization, clustering, redundancy, and breakthrough performance approaches including Teradata's database technology; enabling us to provide superior service and innovations to our members and providers even as the functional *breadth* of our applications, user audience "reach," and transaction volume grows, particularly on the web.

Scaleable, Reliable Processing Power: Our Hardware Architecture. We use industry standard hardware components for our core processing applications, summarized below in five categories:

Key Hardware Component	Description
Enterprise Servers	For our core UNIX applications (most notably our AMISYS Advance system for enrollment, eligibility, and claims processing), we have five HP 9000 enterprise-class servers running HP/UX Unix. Three application servers operate as a cluster using Veritas Cluster technology and are configured with 4 CPUs and 64 GB of main memory, each scalable to 8 CPUs and 192 GB of memory. Two database servers utilize Oracle 10g Real Application Clustering (RAC) for high availability and are configured with 4 CPU's and 48 GB of main memory, each scalable to 8 CPU's and 192 GB of memory. For our Clinical Applications (such as our TruCare clinical system), we use rack mounted Windows/Intel ("WinTel") blade servers operating in a virtual environment using EMC's VMware virtualization software technology. Our Teradata® Extreme Data Appliance powers our Centelligence™ family of desktop reporting, management dashboard, healthcare informatics, and other decision support applications.
Storage Area Network (SAN)	Our SAN is fully redundant and supports access to two highly available arrays, a NetApp SAN attached Storage Array with Independent Disk (RAID) 5 and RAID 6 configuration and an HP StorageWorks XP24000 configured for RAID 5 storage. All data volumes are striped and mirrored for high-performance, fault tolerant data access. The XP24000 can scale up to 1.13 PB and is currently configured at 146.5 TB. Please refer to Attachment C-11.11: Storage Area Network for a graphical depiction.
Web and Web Portal Servers	We use IBM WebSphere technology operating on Red Hat Enterprise Linux, providing a cost-effective, scalable and flexible solution for our web and portal solutions. We use WebSphere Portal Server (WPS) to set up, operate and integrate our electronic business applications across multiple computing platforms, using Java-based Web technologies. WPS includes both run-time components and application development tools. Red Hat Enterprise Linux includes a comprehensive suite of open source server applications and virtualization capabilities and we have found it ideal for a wide range of applications for our web servers.
Presentation Services	Each application service is securely available to remote users through our Citrix Presentation server. Remote users access application services virtually by use of a secured/encrypted Internet connection.
Network Services	Bridgeway connects to its core applications via Centene's Wide Area Network (WAN): a high-performance, fault-tolerant network architecture designed for stability, interoperability and growth. Data services are provided via a Dedicated OC-12 (622Mbps) SONET Ring Service (DSRS). Primary WAN infrastructure consists of a high-speed, virtual full-mesh, Private IP MPLS network. We have a standard Local Area Network configuration using 100 Mbps T100 Network Interface Cards and Cat5 dual port wiring to each work area. Centene provides Bridgeway offices and field personnel users with Internet access through our OC-3 circuit. The 155Mbps Internet service is transported and terminated on a Cisco access router; connected to redundant corporate firewalls (Cisco 6500s with Firewall Switch Modules). Intrusion Detection Systems (IDS) are located in strategic locations within our trusted and untrusted segments to assist in the detection of security violation attempts. We also have De-Militarized Zones (DMZs) to provide semi-trusted segments for Web Servers, Domain Name System (DNS) Servers, and Secure Access Gateways. We provide remote access to Centene Corporation's network through a Virtual Private Network (VPN) using Cisco's VPN 3000 Concentrator and also through encrypted web access sessions using Citrix Secure Gateways.
End User Clients	Our standard desktop clients are Wyse Viance thin client terminals and our standard for laptops are Dell "E" models.

Virtualization Means Hardware Reliability and Application Availability. Please refer to Attachment C-11.12: Virtualization. Server virtualization reduces our power consumption and air conditioning needs, and optimizes the amount of CPU performance and data storage that we can house in our building space. Virtualization also provides high availability for our applications, and streamlines application deployment and migrations. The servers are automatically load balanced to provide the best performance. If one of the physical nodes were to fail, be taken out of service for maintenance, or experience higher than expected utilization, the application service automatically moves to another node in the server farm without any interruption to the application service (i.e. no impact to the user).

Desktop and Laptop Configurations for Secure Access & Mobility. For all of our staff at Centene, and all Bridgeway field offices and remote field personnel, we configure, provide, and maintain a standardized desktop environment, and each desktop is maintained in compliance with our software upgrade policies. The desktop operating systems include

Desktop Windows Server 2003, SP2 with Citrix XenApp 4.5 for thin clients, and Windows 7 for laptops. The standard configuration package includes Microsoft Office Professional, Minisoft middleware, and McAfee ePolicy Orchestrator Enterprise Agent running McAfee Virus Scan 8.7. The operating system and all files are protected by multiple layers of security including, but not limited to: a desktop image hardened in accordance with established best practices; Active Directory Group Policy; host-based intrusion protection; and restrictive Windows NTFS permissions. Mobile devices have additional security protection to prevent data loss via Safeboot full-disk encryption.

Monitoring Systems Continuously via Automation. Our architecture includes integrated, automated management and monitoring at key points in our overall MIS. All Centene production equipment is monitored for hardware failure, service availability and system performance using Hewlett-Packard's OpenView Operations®, Cisco's CiscoWorks®, and NetScout®. Monitoring of our systems occurs at multiple levels including system availability, service availability, application and transaction performance, system performance, and system capacity. For example, we use OpenView Operations® system to automatically monitor server availability every two seconds, and if one of our servers does not respond to OpenView® for 20 seconds, the OpenView Operations® system automatically shifts resources to an alternate server. We use this same technology to manage scheduled maintenance activities to reduce system downtime.

Enterprise Class Physical Datacenters To Protect Data & Operations. The Centene datacenter houses all the hardware, systems and application software furnished to Bridgeway local offices, field staff, providers and members. The datacenter is equipped with redundant environmental systems for power, cooling, and humidity control. We execute a full power load test quarterly on our backup generators, switching all power loads to the generator to validate the generator's effectiveness. Less than 15 seconds is required to automatically switch to backup generator power resulting in zero downtime for the IT infrastructure. Please refer to Attachment C-11.13: Datacenter Power for a graphical depiction. A redundant chiller plant controls temperature and humidity levels and uses a highly efficient water cooled system backed up by an air-cooled system in the event of loss of water to the facility. Our environmental systems are implemented as an *N+1* design ensuring that the loss of any one unit does not affect our ability to maintain safe temperatures. All environmental systems are tied into Centene's security system and send an audible remote alarm when temperature or humidity falls outside of predefined ranges or water is detected. A Very Early Smoke Detection System (VESDA) provides our datacenter with fire alert capabilities. Our VESDA takes air samples throughout the datacenter sensing particulates that are present in the air prior to actual combustion. Our fire suppression system is an Ecaro-25 Clean Agent Fire Suppression System. A pre-action water sprinkler system provides a second level of protection. Safeguards are in place to minimize the risk of accidental discharge of both the clean-agent and sprinkler suppression systems.

Business Continuity Program (BCP). Centene's IT Department provides comprehensive Business Continuity Planning (BCP) and services to Bridgeway including, but not limited to: disaster recovery, crisis management, plan testing, pandemic response, business impact assessment, and workplace violence preparedness. Bridgeway locations have documented plans, updated yearly, that detail recovery procedures for every critical business process. We use SunGard Mobile Recovery and Metro Center Solutions to provide flexibility in meeting the workspace and business process recovery needs of each location. Should an emergency incident occur affecting communication systems, we use SunGard's NotiFind™ Emergency Notification Service to issue instructions. We perform annual BCP reviews and exercises to maintain a continuous evergreen recovery status. Please see Attachment C-11.14: Business Continuity for a summary diagram.

Centene's Second Datacenter. In the 4th Quarter of 2011, we will complete construction of our new, Tier 3, 19,000 square foot datacenter, with capacity for over 165 IT racks; 6,000 square feet of datacenter floor; and fully redundant environmental, power, and network connectivity systems. Our new datacenter has a seismic importance factor of 1.5 (fully operational following an earthquake); is rated to withstand winds up to 165 MPH (an F3 tornado); and has all HIPAA compliant state of the art security measures. In the 1st Quarter of 2012, we will operate our two fully-redundant enterprise datacenters as mutual "*hot site*" backups. Each datacenter will have the capacity to assume operation of all business critical production systems if the other datacenter is rendered inoperable-within *seconds* of a site disabling outage:

- Fully redundant **networking infrastructure and circuits** between the two datacenter facilities will ensure that an outage by one of our telecommunications providers will not result in our systems being rendered unavailable.
- **Utility power** will flow into each facility via redundant, geographically diverse routes enabling continuous service even if one power feed is severed.

- **Battery backup systems** will be available to keep systems operational in the event of a wide-spread utility power outage.
- Each facility will be equipped with an on-premise **diesel generator** for prolonged power outages.

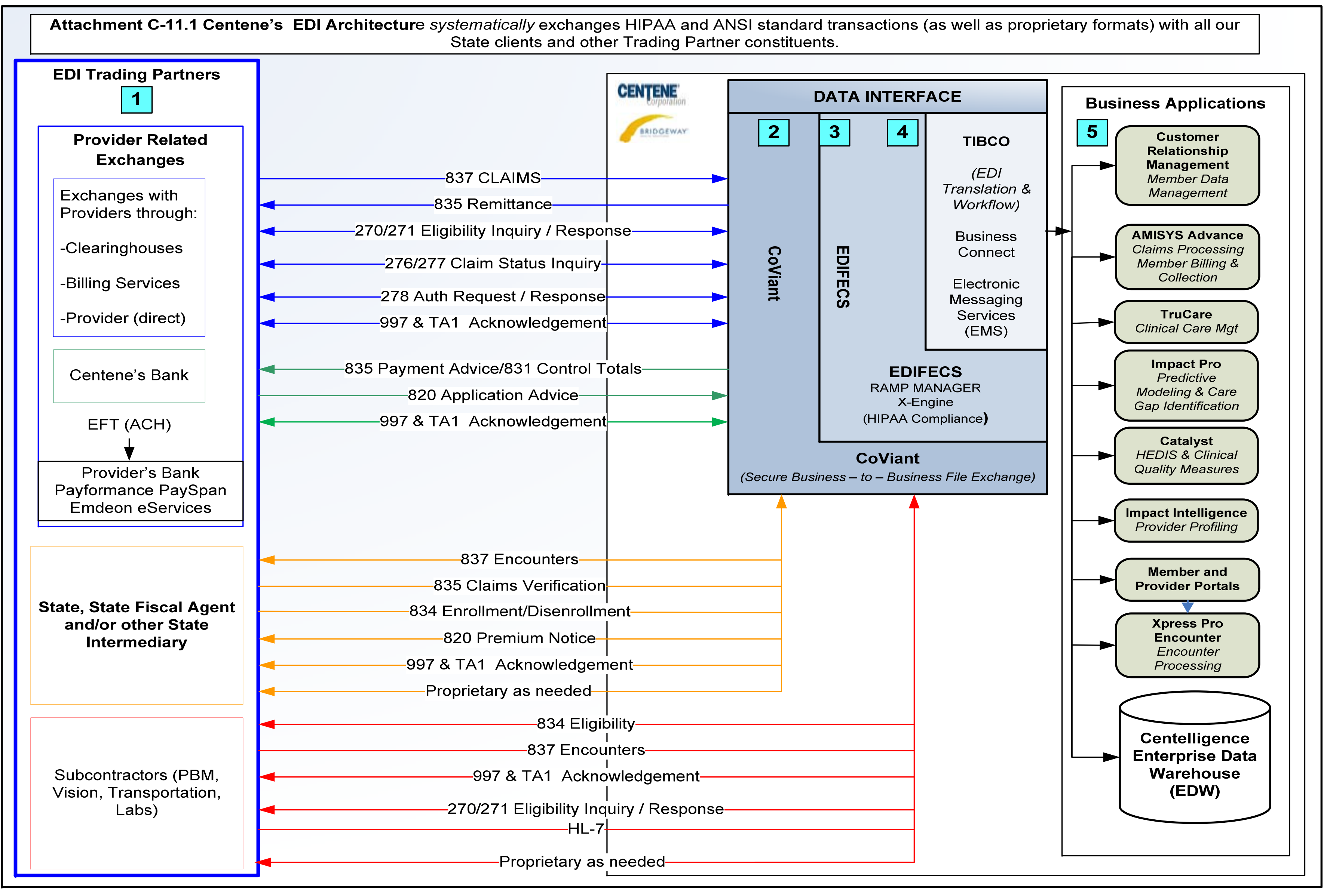
Data and Voice Communications Network Infrastructure. Bridgeway connects to its core applications via Centene's Wide Area Network (WAN): a high-performance, fault-tolerant network architecture designed for stability, interoperability and growth. Data services are provided via a Dedicated OC-12 (622Mbps) SONET Ring Service (DSRS). Primary WAN infrastructure consists of a high-speed, virtual full-mesh, Private IP MPLS network. We have a standard Local Area Network configuration using 100 Mbps T100 Network Interface Cards and Cat5 dual port wiring to each work area. Centene provides Bridgeway offices and field personnel users with Internet access through our OC-3 circuit. The 155Mbps Internet service is transported and terminated on a Cisco access router; connected to redundant corporate firewalls (Cisco 6500s with Firewall Switch Modules). Intrusion Detection Systems (IDS) are located in strategic locations within our trusted and untrusted segments to assist in the detection of security violation attempts. We provide remote access to Centene Corporation's network through a Virtual Private Network (VPN) using Cisco's VPN 3000 Concentrator and also through encrypted web access sessions using Citrix Secure Gateways. Please see Attachment C-11.15: Data Communications.

A Telecommunications Architecture Engineered For Availability and Customer Service. Bridgeway's telecommunications hardware is the Avaya IP Telephony platform with an S8500 Media Server and redundant G650 Media Gateways installed locally with enhanced system critical functionality added by networking to our corporate facility. In 2010, we began implementing the Avaya Voice Portal (AVP) IVR and predictive auto dialing system (see above discussion on our MRM and PRM systems). Please see Attachment C-11.16: Telecommunications Network.

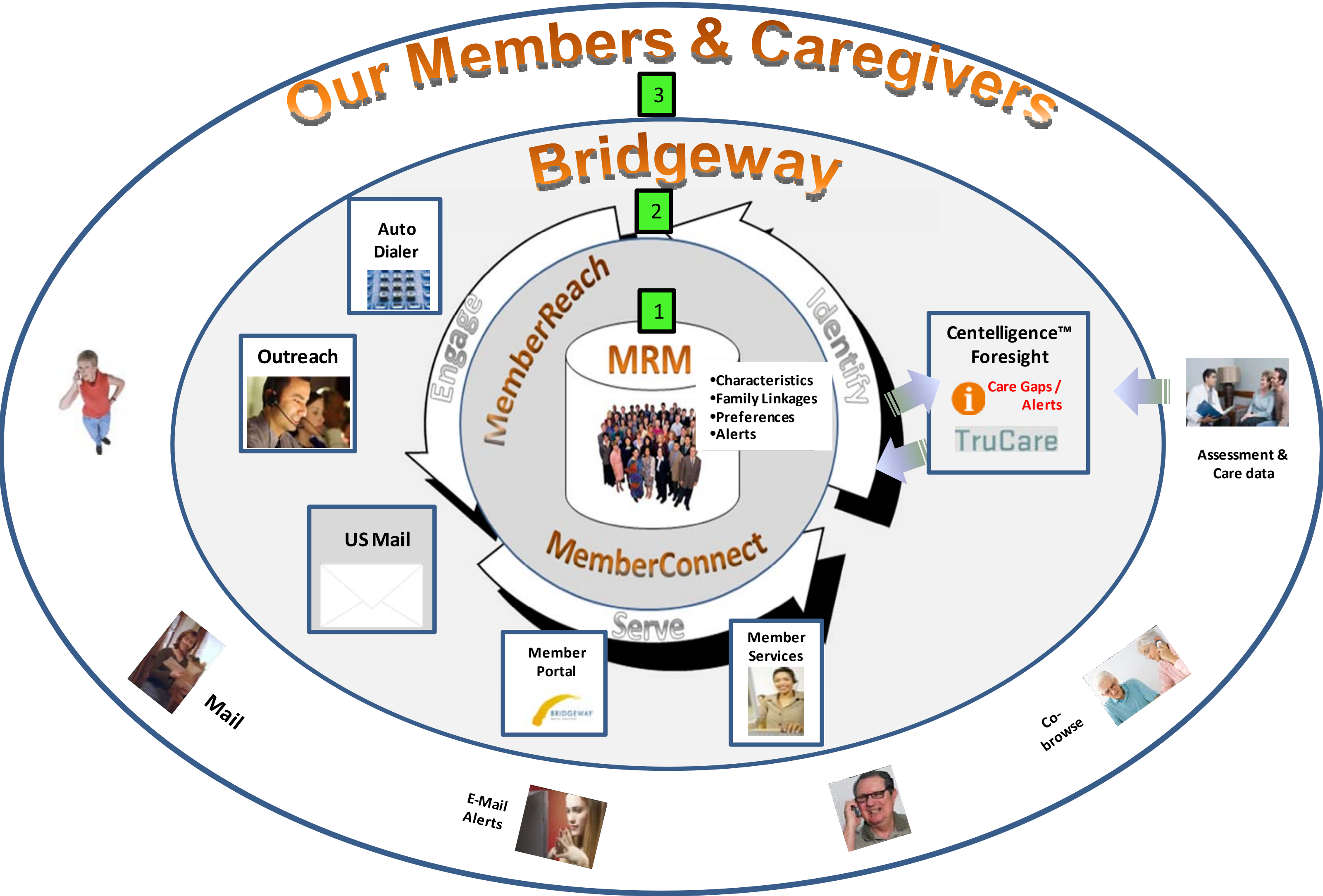
MIS Attuned to ALTCS Goals. In summary, our MIS supports *critical* AHCCCS and ALTCS goals:

- **Member Engagement**: through our MemberConnect and MemberReach applications, our secure Member Portal (with ability to view member care service plans and care gap alerts); we help to ensure that member and caregiver are central participants in our health care and LTC programs. Our "In Home Video" pilot (in partnership with Microsoft Corporation) represents the latest in our ongoing efforts to meaningfully apply new technology in practical ways to ensure a cogent connection to our members.
- **Provider Collaboration**: our Provider Relationship Management (PRM) system coordinates communications with our providers no matter the media (phone, IVR, Fax, e-mail or Web), ensuring rapid and responsive service and efficient contracting support. Our Centelligence™ Insight and Foresight applications will support our providers with secure web access to clinical performance profiling information meaningful to their practices; and provide them with data driven care gaps in their member panels. We are offering two new (free) options in 2011 for provider EFT and ERA support via Payformance and Emdeon.
- **Care Coordination:** our TruCare health management platform, integrated with the CRM technology powering our MRM and PRM enables new levels of interdepartmental coordination. These integrated solutions allow our Bridgeway teams in the office and out in the field to "put the whole member picture" together rapidly for enhanced levels of care coordination.
- **Administrative Efficiencies:** our Provider Portal is expanding significantly in 2011 with new support for direct batch submission of EDI claims, online authorization support (including auto approval for selected procedures), and other features. In addition, our AWD system will significantly decrease the amount of time to process pended claims.

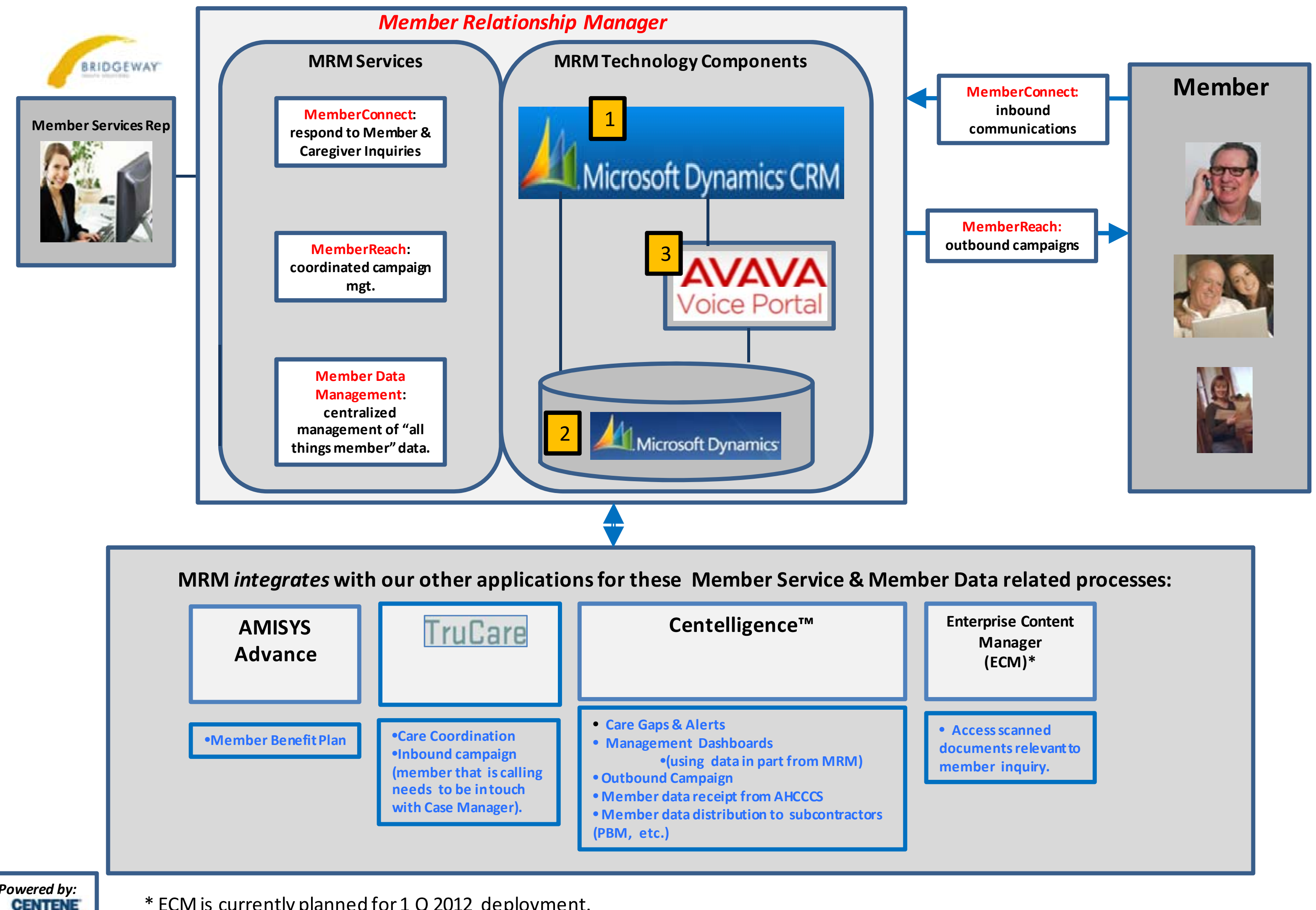
With the exception of Enterprise Content Management (ECM) and the In Home Video pilot, all of the applications discussed in this response are in productive use *today* in at least one Centene health plan, or the application will be in productive use in at least one Centene health plan by October 1st, 2011.


Attachment C-11.1 Centene's EDI Architecture systematically exchanges HIPAA and ANSI standard transactions (as well as proprietary formats) with all our State clients and other Trading Partner constituents.
EDI Trading Partners
1
Provider Related Exchanges
Exchanges with Providers through:
-Clearinghouses
-Billing Services
-Provider (direct)
Centene's Bank
EFT (ACH)
Provider's Bank Payformance PaySpan Emdeon eServices
State, State Fiscal Agent and/or other State Intermediary
Subcontractors (PBM, Vision, Transportation, Labs)
837 CLAIMS
835 Remittance
270/271 Eligibility Inquiry / Response
276/277 Claim Status Inquiry
278 Auth Request / Response
997 & TA1 Acknowledgement
835 Payment Advice/831 Control Totals
820 Application Advice
997 & TA1 Acknowledgement
837 Encounters
835 Claims Verification
834 Enrollment/Disenrollment
820 Premium Notice
997 & TA1 Acknowledgement
Proprietary as needed
834 Eligibility
837 Encounters
997 & TA1 Acknowledgement
270/271 Eligibility Inquiry / Response
HL-7
Proprietary as needed
CENTENE Corporation
BRIDGEWAY
DATA INTERFACE
2
3
4
CoViant
EDIFECS
TIBCO
(EDI Translation & Workflow)
Business Connect
Electronic Messaging Services (EMS)
EDIFECS
RAMP MANAGER
X-Engine
(HIPAA Compliance)
CoViant
(Secure Business – to – Business File Exchange)
Business Applications
5
Customer Relationship Management
Member Data Management
AMISYS Advance
Claims Processing
Member Billing & Collection
TruCare
Clinical Care Mgt
Impact Pro
Predictive Modeling & Care Gap Identification
Catalyst
HEDIS & Clinical Quality Measures
Impact Intelligence
Provider Profiling
Member and Provider Portals
Xpress Pro Encounter
Encounter Processing
Centelligence Enterprise Data Warehouse (EDW)

Attachment C-11.2: MRM Centene's **Member Relationship Manager** (MRM) enables Bridgeway to ***identify***, ***engage***, and ***serve*** our members in a holistic and coordinated fashion – across the breadth of their wellness, clinical care, administrative and financial matters related to their benefit plans.

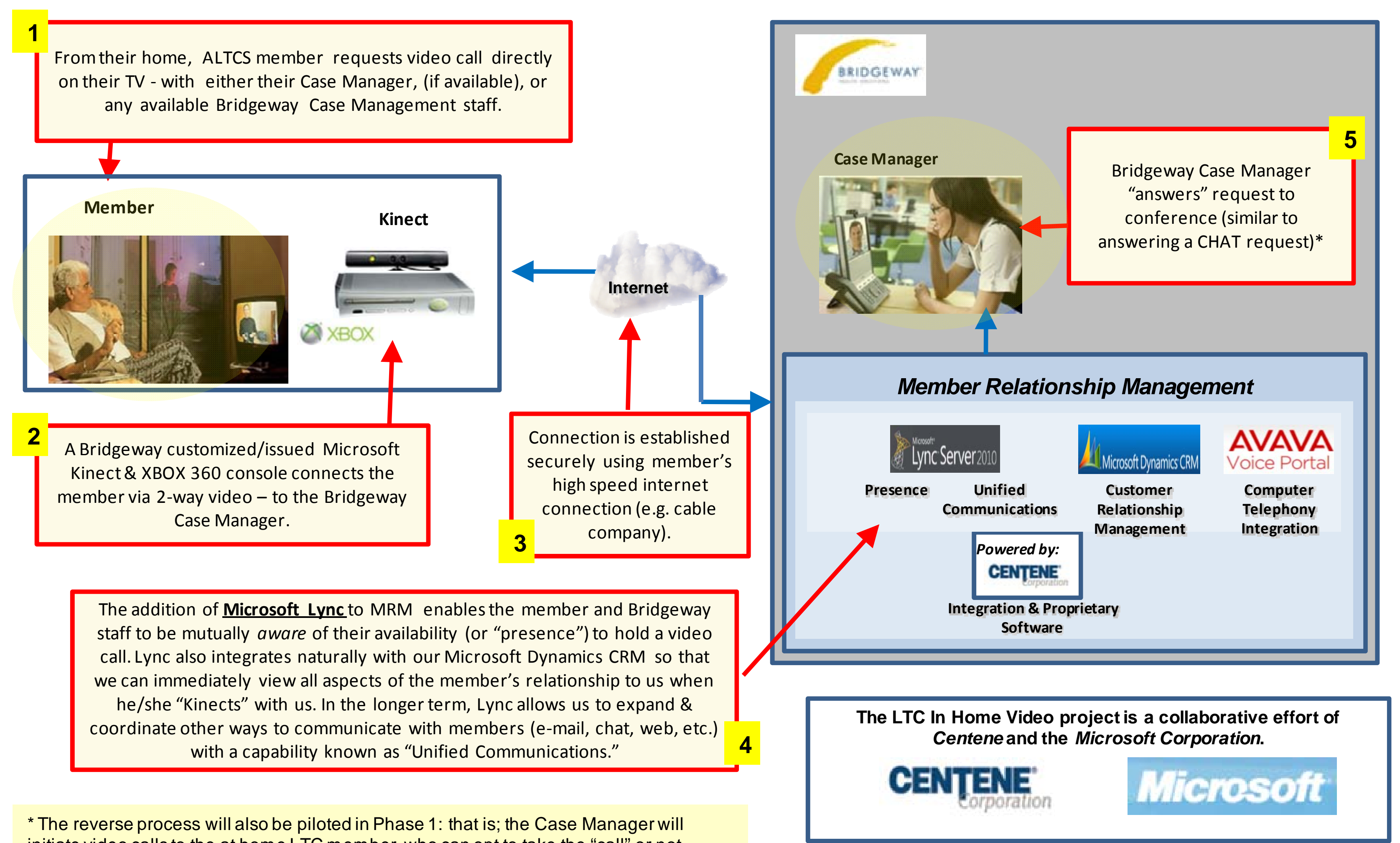


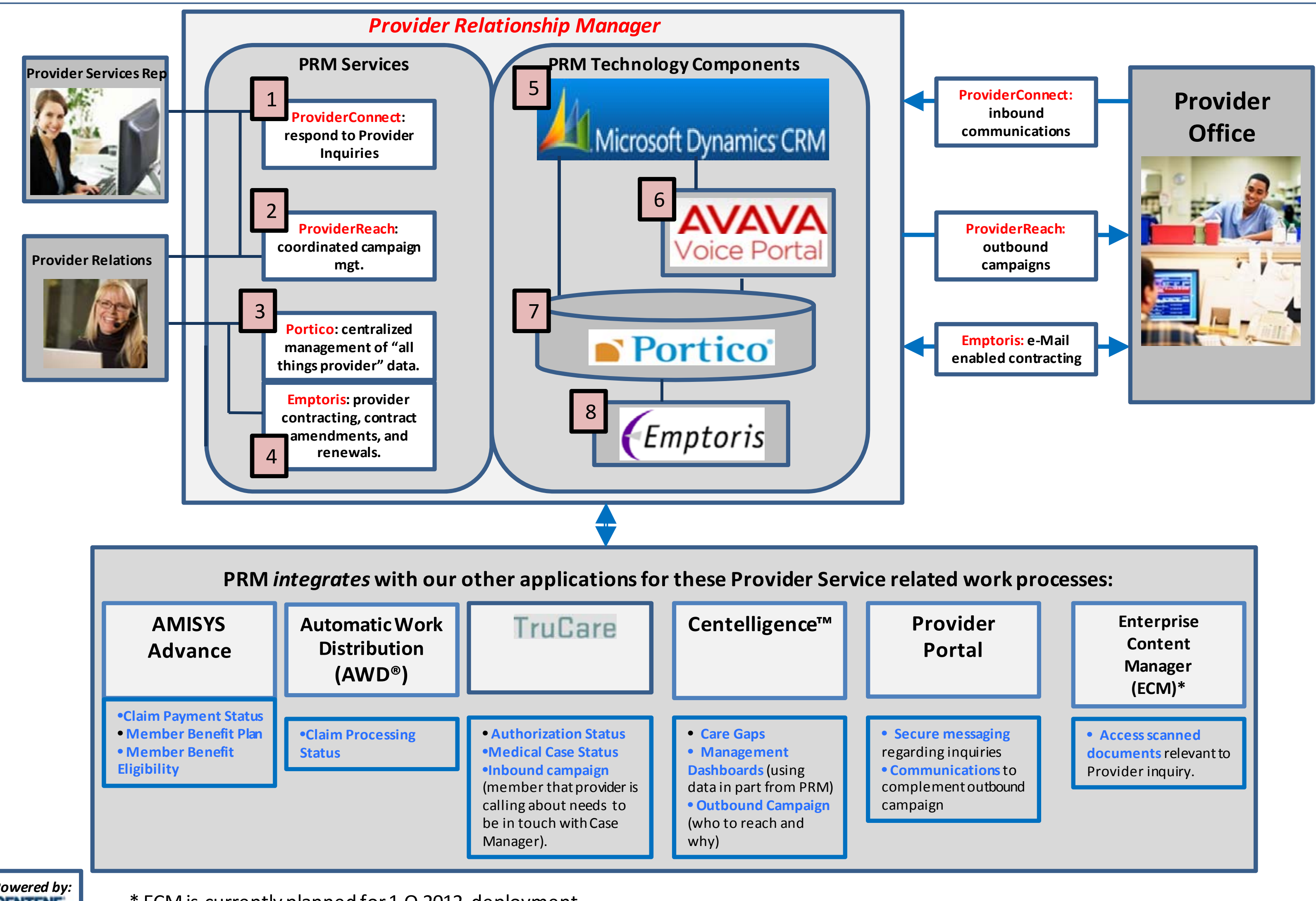
Attachment C-11.3: MRM Components: We have built MRM on best of breed contact relationship management (CRM) and provider data management technologies, customizing service workflow support for our local Plan needs, and integrating with our suite of applications to provide a *holistic service experience* for our providers ...



* ECM is currently planned for 1 Q 2012 deployment.

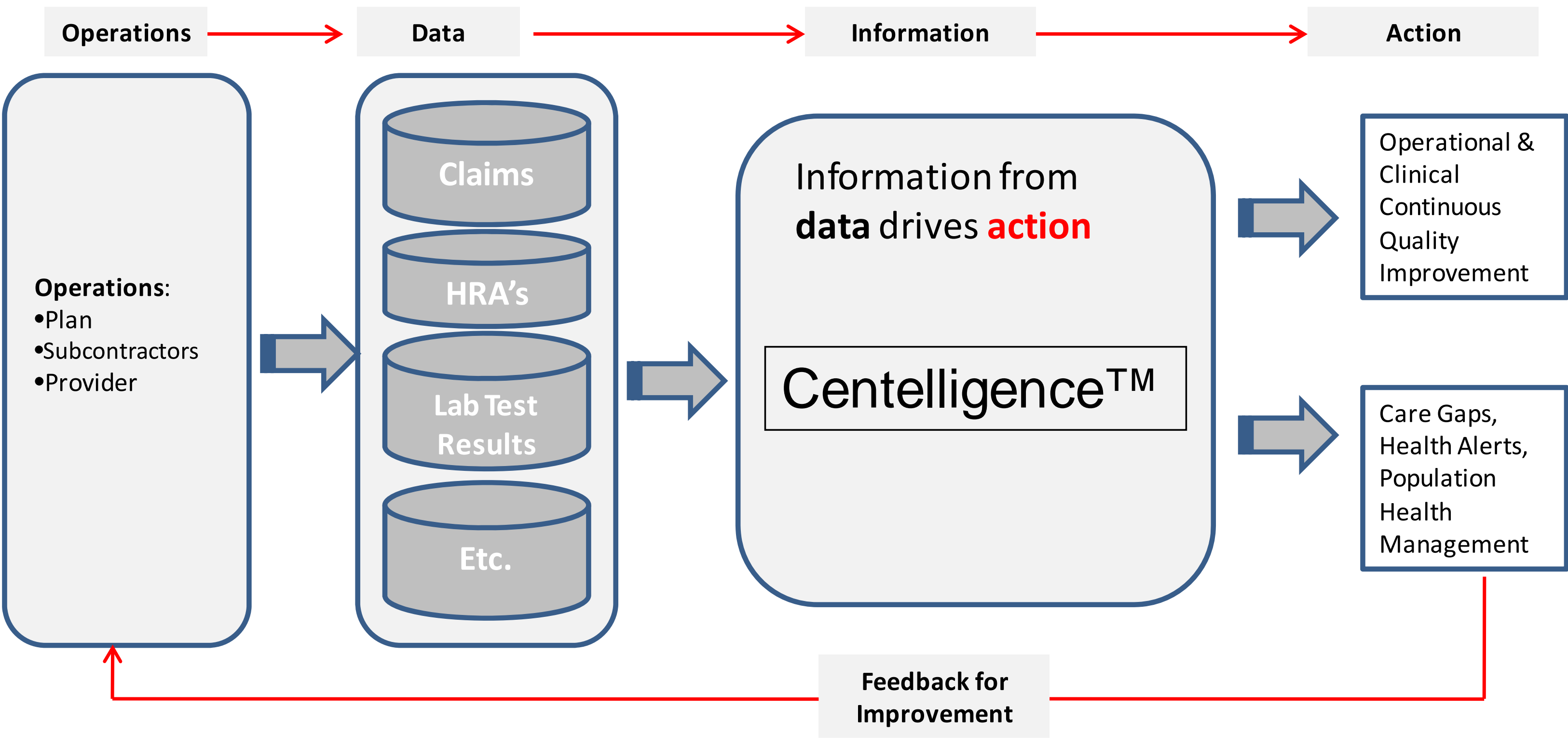
Attachment C-11.4: In Home Video Pilot: During 2011, we are piloting extended reach capabilities in our Member Relationship Management system, through the support of ***on-demand video*** between select Bridgeway equipped ALTCS members and Bridgeway Case Managers. In our Phase 1 pilot, we will demonstrate the viability of in-home video to dramatically increase the frequency and augment the quality of member contact with our Case Managers.




Attachment C-11.5: PRM Components : We have built PRM on best of breed contact relationship management (CRM) and provider data management technologies, customizing service workflow support for our local Plan needs, and integrating with our suite of applications to provide a holistic service experience for our providers …
Provider Relationship Manager
PRM Services
PRM Technology Components
Provider Services Rep
Provider Relations
1 ProviderConnect: respond to Provider Inquiries
2 ProviderReach: coordinated campaign mgt.
3 Portico: centralized management of "all things provider" data.
4 Emptoris: provider contracting, contract amendments, and renewals.
5 Microsoft Dynamics CRM
6 AVAYA Voice Portal
7 Portico
8 Emptoris
ProviderConnect: inbound communications
ProviderReach: outbound campaigns
Emptoris: e-Mail enabled contracting
Provider Office
PRM integrates with our other applications for these Provider Service related work processes:
AMISYS Advance
•Claim Payment Status
• Member Benefit Plan
• Member Benefit Eligibility
Automatic Work Distribution (AWD®)
•Claim Processing Status
TruCare
• Authorization Status
•Medical Case Status
•Inbound campaign (member that provider is calling about needs to be in touch with Case Manager).
Centelligence™
• Care Gaps
• Management Dashboards (using data in part from PRM)
• Outbound Campaign (who to reach and why)
Provider Portal
• Secure messaging regarding inquiries
• Communications to complement outbound campaign
Enterprise Content Manager (ECM)*
• Access scanned documents relevant to Provider inquiry.
Powered by: CENTENE Corporation
* ECM is currently planned for 1 Q 2012 deployment.

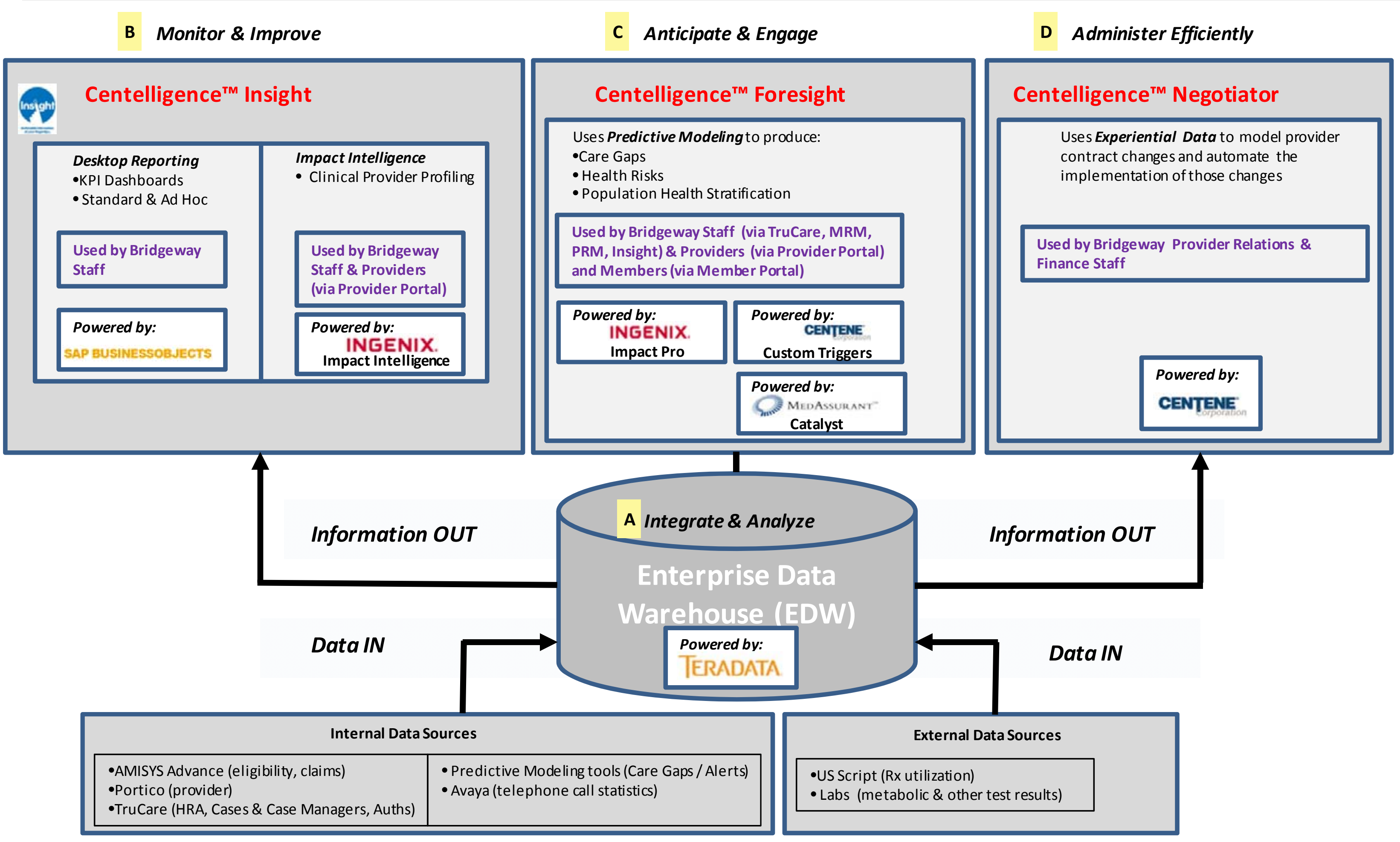
Attachment C-11.6: Centelligence™

Centelligence™ is Centene's trademarked brand name for our existing and *planned* **family** of integrated decision support & healthcare informatics solutions. Our Centelligence™ enterprise platform **integrates data** from multiple sources and produces ***actionable information***: everything from Care Gap and Wellness Alerts, to Key Performance Indicator (KPI) Dashboards, Provider Clinical Profiling analyses, population level health risk stratifications, and standard and ad-hoc desktop reports.



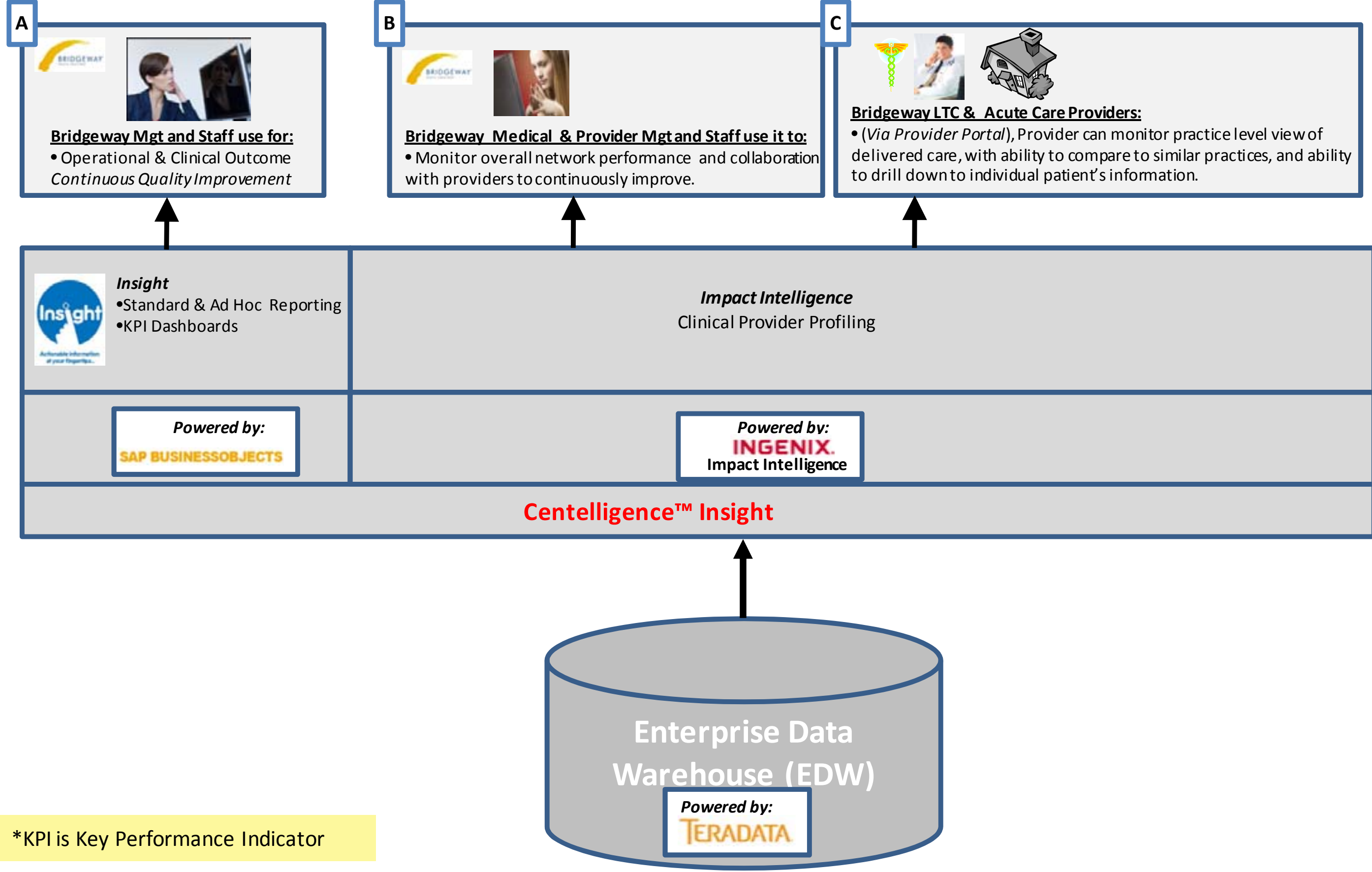
Attachment C-11.7: Centelligence™ Components

The **Centelligence™** growing family of applications allows Centene Plans & Providers to (A) Monitor and Improve clinical & administrative processes, enable Plans, Providers, and Members to (B) Anticipate & Engage in health issues; and allows Plans, Providers and States to (C) efficiently administer contractual changes.



Attachment C-11.8: Centelligence™ Insight

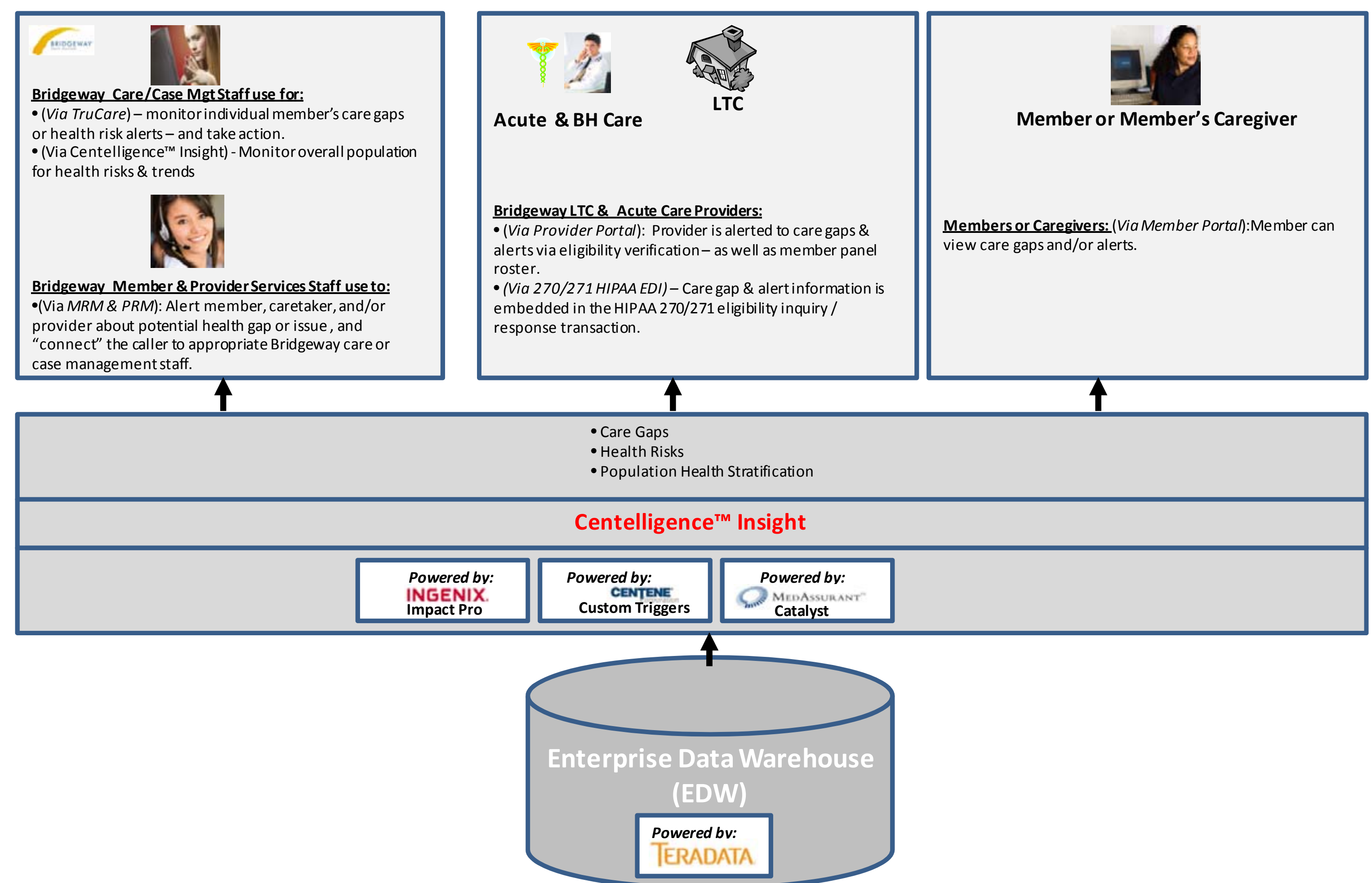
Centelligence™ Insight is our desktop reporting and management KPI* Dashboards capability, as well as our 2011 planned implementation of Ingenix's Impact Intelligence, affording both Bridgeway and Bridgeway's providers the ***practice and peer level profiling*** information needed for continuous clinical quality improvement. Centelligence™ Insight will allow Bridgeway to ***examine and monitor past performance*** - with an eye to continuous operational or clinical process improvement: "*look behind to improve future performance.*"



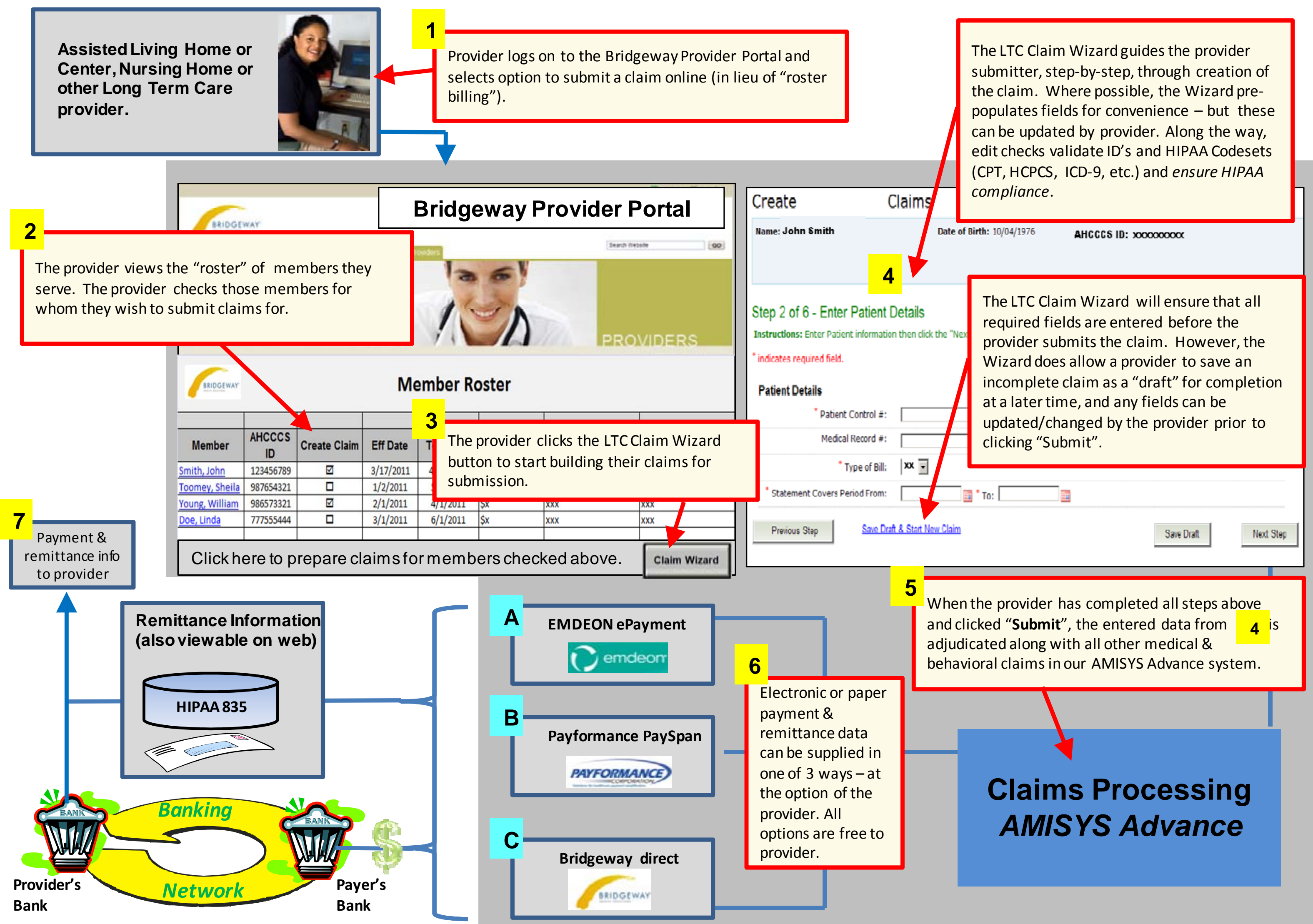
*KPI is Key Performance Indicator

Attachment C-11.9: Centelligence™ Foresight

Centelligence™ Foresight - our Impact Pro, Catalyst HEDIS, and Centene proprietary predictive modeling and Care Gap/Health Risk identification applications. At Bridgeway, Centelligence™ Foresight also encompasses our use of the PopHealthMan service - a complementary health risk identification approach focused on member cases potentially qualifying for Medicare & Medicaid risk adjustment payments.



Attachment C-11.10 : LTC Claim Wizard. We are introducing a version of our existing online HIPAA compliant claim submission capability that is specifically targeted for LTC providers accustomed to "roster billing." Our LTC Claim Wizard will allow these providers to naturally migrate to HIPAA claim submission.



Attachment C-11.11 : Storage Area Network

Data Storage Architecture

Primary Storage Assets

XP 24000

EVA 8000

Backup Storage

ESL 322e

DD880

Production Blade Chassis

SAN Director (Disk)

SAN Director (Disk)

SAN Director (Tape)

Backup Server

Dev/Test Blade Chassis

SAN Edge Switch

SAN Edge Switch

HPUX Physical

Windows Physical

Linux Physical

Backup

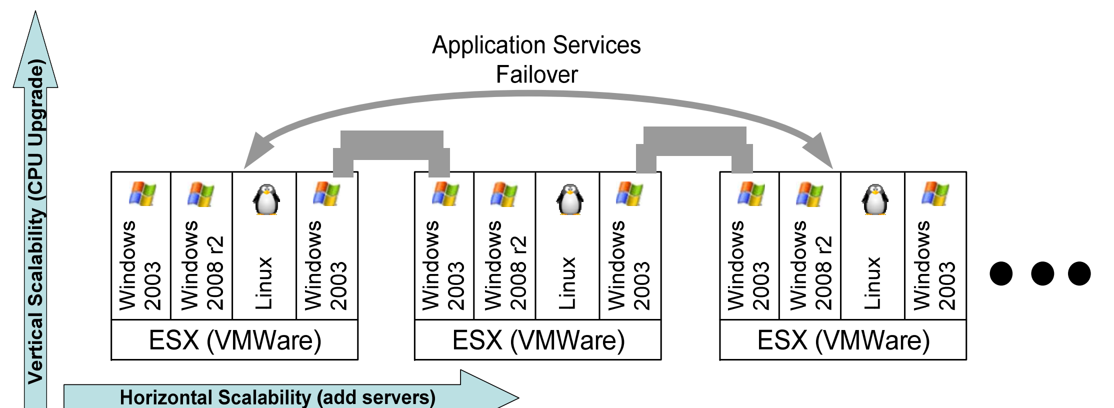
Even Fabric

Odd Fabric

Network

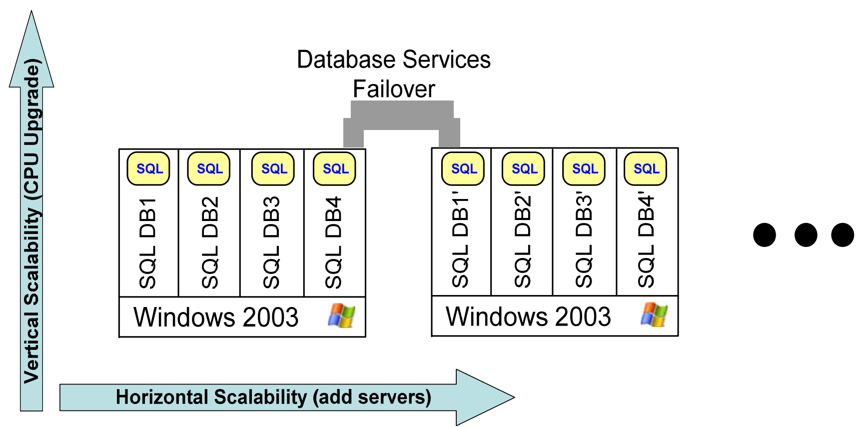
Attachment C-11.12: Server Virtualization

Windows Server Architecture Strategy



Application Services

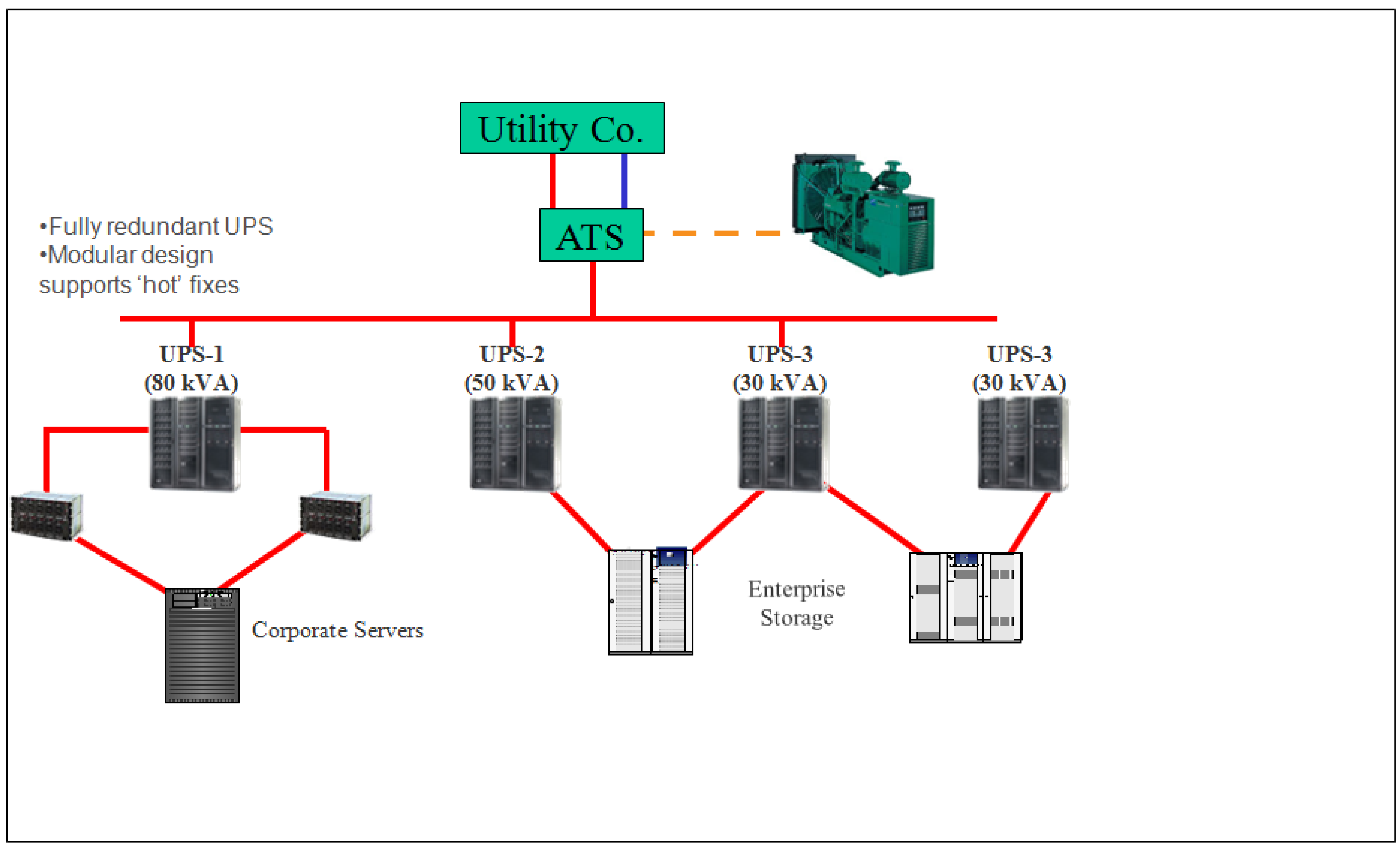
- Virtual Systems
- Any application service can run on any physical (ESX) platform
- Automatic Load Balancing
- Automatic Virtual System migration upon physical failure
- Scalability (vertical & horizontal)
- High Availability / Failover
- Ease of recovery
- Ease of deployment



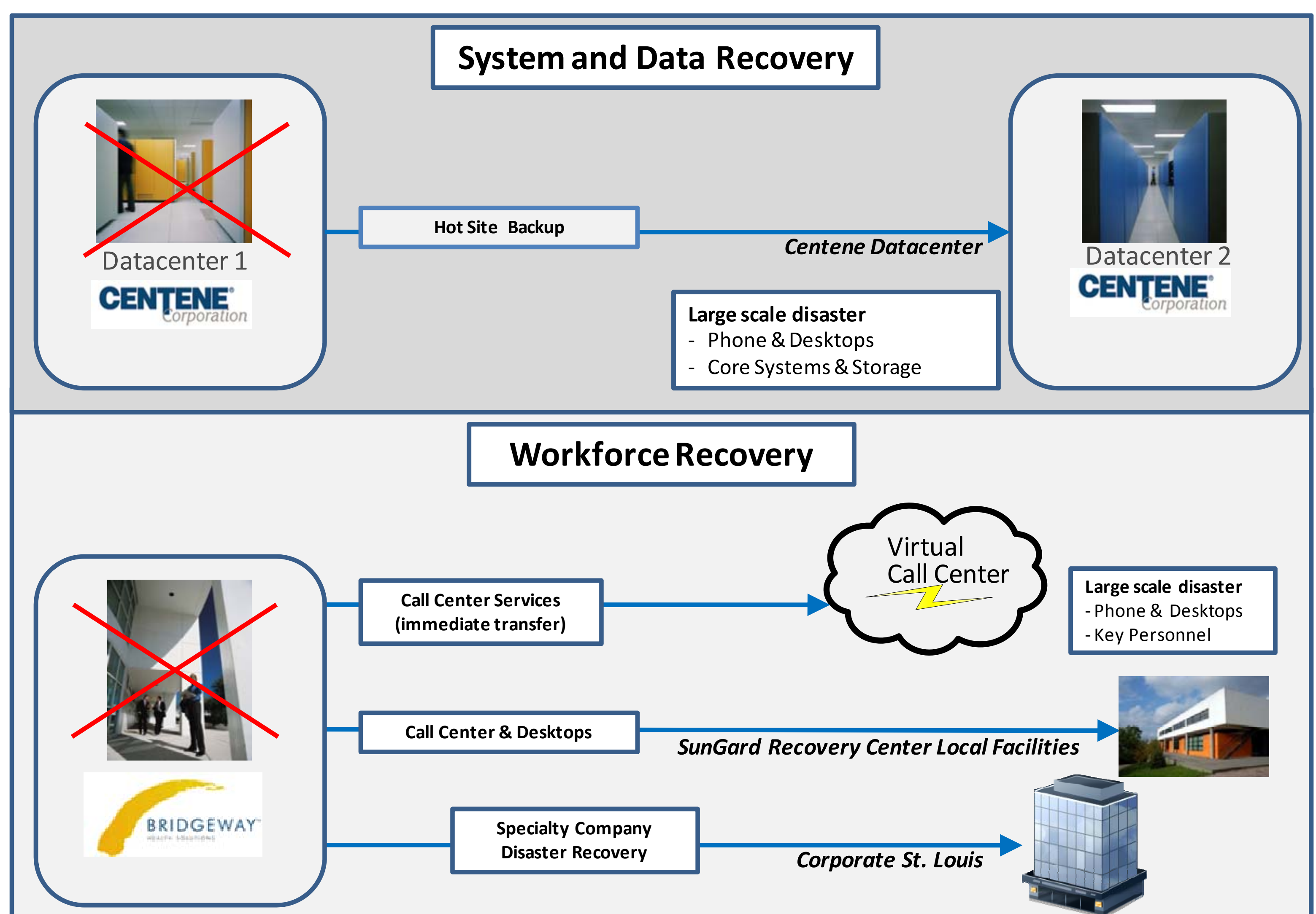
SQL DB Services

- Physical SQL Cluster
- Scalability (vertical & horizontal)
- High Availability / Failover
- Consolidation / Ease of management

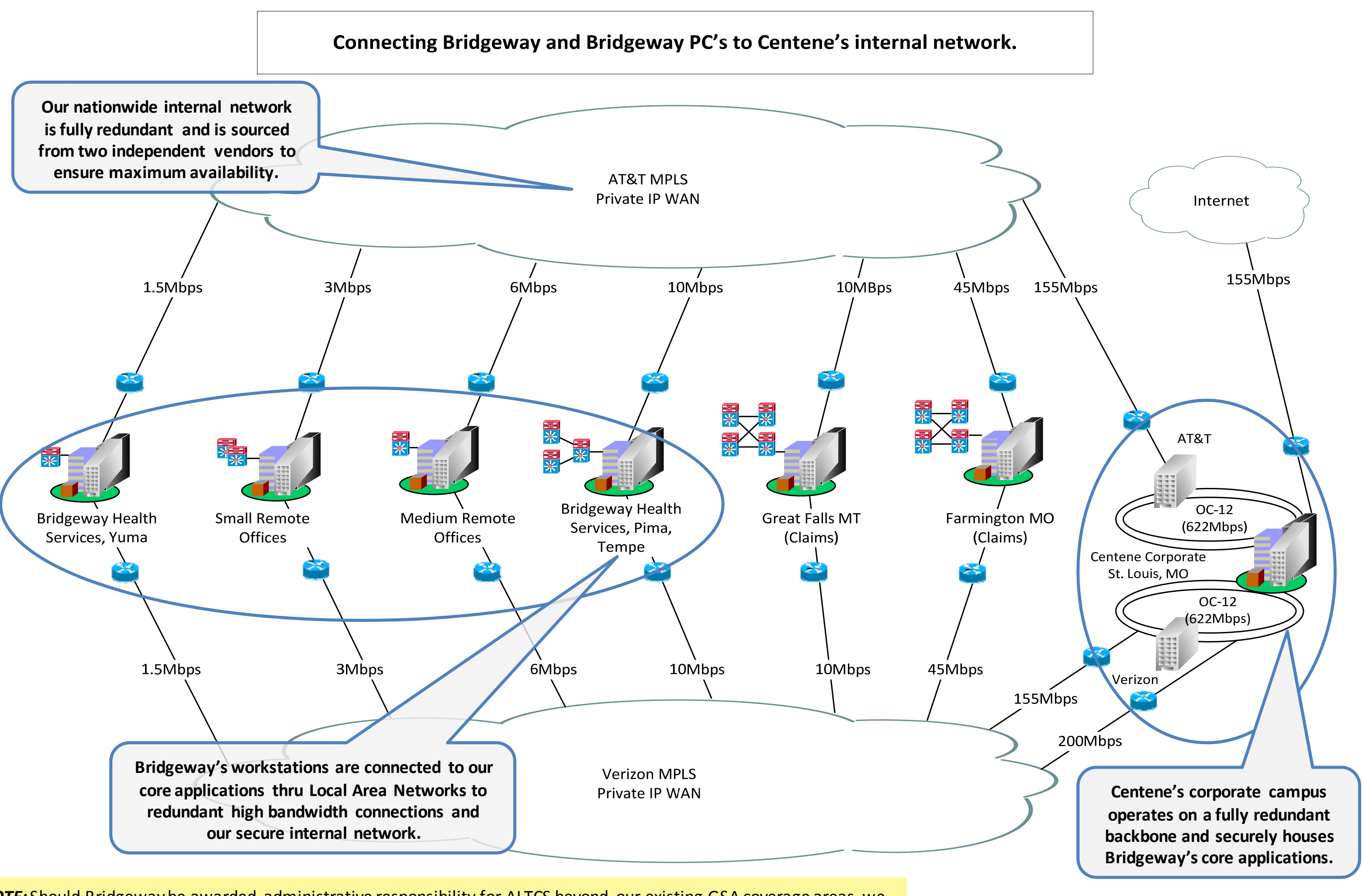
Attachment C-11.13: Datacenter Power



Attachment C-11.14: Business Continuity



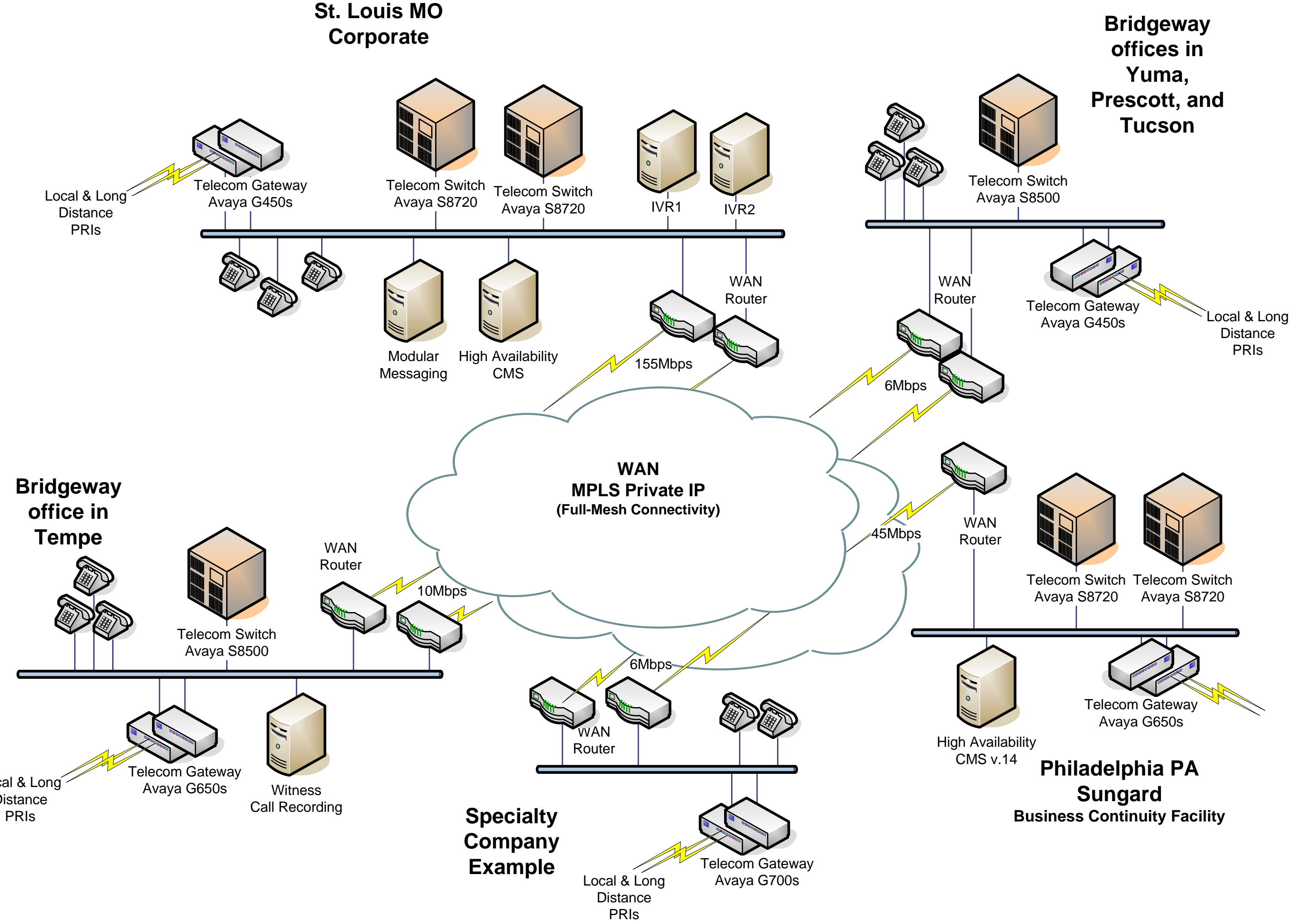
Attachment C-11.15 Data Communications



NOTE: Should Bridgeway be awarded administrative responsibility for ALTCS beyond our existing GSA coverage areas, we will set/up Bridgeway offices in each new GSA and connect them to our network in a manner similar to how we connect our ALTCS offices today.

Confidential and Proprietary: Do Not Reproduce or Distribute

Attachment C-11.16: Telecommunications Network



NOTE: Should Bridgeway be awarded administrative responsibility for ALTCS beyond our existing GSA coverage areas, we will set/up Bridgeway offices in each new GSA and connect them to our network in a manner similar to how we connect our ALTCS offices today.

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

Managing Information System Changes and Modifications through Disciplined Processes & Automation

Bridgeway Health Solution's (Bridgeway) and Centene Corporation's (our parent company) Management Information System (MIS), with its breadth of application functionality, complex business process support, redundancy, and geographic reach, demands self documenting, auditable, yet efficient change order and software modification processes. We need to be *responsive* to MIS change requests in quick fashion, yet *manage* these requests appropriately in terms of business need priority. Coordinating timing of all changes via our software release strategy and impact on MIS performance is critical, keeping in mind the overall imperative of excellent service to AHCCCS, our members, and providers. We achieve a judicious balance of MIS change alacrity and careful change management control through: a) disciplined *identification and validation of required changes*; b) *industry best practice standards* in Six Sigma Continuous Quality Improvement (CQI), Software Development Life Cycle (SDLC) approach and controls; Agile rapid application development; the Information Technology Infrastructure Library (ITIL) process framework; our Enterprise Business Implementation (EBI) Project Management Methodology; and c) our *Service-Now* enterprise software change and release management workflow system. All three aspects of our change management approach are facilitated, continuously refined, and promulgated throughout Bridgeway and Centene by our IT Strategy and Service Continuity Team (Service Team), which reports directly to our Chief Information Officer (CIO). Through the Service Team, our local Bridgeway staff, and our Service-Now system, we are able to communicate and collaborate effectively with AHCCCS and/or our providers for MIS modifications affecting either of these constituents. We keep both parties attuned to project progress and adjust activities in light of any new circumstances that surface during a change or modification project. As we have since initial implementation of the ALTCS contract in 2006, we will continue to notify AHCCCS of any major upgrades to our information systems affecting claims processing, or any other major business component, at least six months prior to our anticipated implementation date.

Identifying and Validating Changes and Software Modifications

MIS software changes always originate from a "Key Business Stakeholder" (KBS) within our organization, at Bridgeway or Centene, who identifies a change or software modification for one of three reasons: 1) to implement new contractual requirements from AHCCCS or from other regulatory agencies; 2) to infuse new capabilities that enhance Bridgeway service to members and providers in an innovative fashion; or 3) to further enhance or reengineer an existing process to enhance overall efficiency and service. In terms of *contractual/compliance driven changes*, the KBS is usually Bridgeway Compliance or Centene's Legal Department that work together to identify needed changes in line with AHCCCS and/or federal mandates, using our Compliance 360 corporate governance and compliance system. A KBS at Bridgeway, in consultation and with the support of an appropriate Centene IT liaison, champions change orders or software modifications to introduce *innovative solutions* for our Bridgeway members and providers. All change and software modification requests are documented and signed off on in our Service-Now system, with appropriate management approval, and are reviewed weekly by the Service Team's interdisciplinary Change Review Board (CRB). The CRB ensures that changes and software modifications are implemented in coordinated release fashion, and that adequate time and resources are assigned for unit, system integration, user acceptance, and regression testing.

Business Process Optimization (BPO). Our Centene BPO Team (BPO Team), which reports directly to the CIO, identifies reengineering opportunities that often drive the *third type* of change order or software modification type. The BPO team works with Bridgeway and uses a Six Sigma approach to continuously measure and analyze operational Key Performance Indicator (KPI) information and seek areas for improvement, often using external benchmarks as a guide. Once we identify a process area for focus, the BPO Team applies root cause analysis to identify underlying problems and a resolution. The BPO Team then identifies key process controls that allow us to measure the impact of our improvement strategies and ensure the resolution is effective in enhancing the target process. Along the way, the BPO Team (working with Bridgeway) may formulate a change order or software modification, and the appropriate KBS sponsors the change in Service-Now for appropriate sign-offs and release scheduling through the CRB. For example, our BPO Team recently uncovered an opportunity for more efficient distribution of member care gap information derived from our predictive modeling software. The BPO Team led a cross functional team with representation from medical management, case management, member and provider services, and our IT organization. This ultimately led to a software modification: the secure search and display of care gaps via our Online Care Gap Notification feature.

Using Industry Best Practices to Effect Changes and Software Modifications

Agile Software Development Life Cycle. Centene and Bridgeway use an Agile Software Development Life Cycle (SDLC) process to deliver higher quality software faster, while maintaining effective business controls. Agile is an industry best practice development and deployment cycle that has a collaborative and evolutionary approach with consistent outcomes in both quality and customer satisfaction. We implement MIS changes as part of an integrated release management process. Each Centene application team (e.g. claims, reporting, case management) works with their business partners to capture requirements and define priorities, and then establishes and publishes a release calendar with controlled releases typically every two to four weeks. This frequency mitigates operational risk by reducing emergency changes. Our SDLC includes the following stages facilitated by our Service Team and the CRB: Stakeholder Input on Release/Change; Development and Unit Testing; Review of Release/Change and Deployment to Test; Integration Testing/User Acceptance Testing; Management Validation; Change Review; Move to Production; and Validation of Production. Each stage has defined tasks and responsibilities to ensure a successful development and change release process.

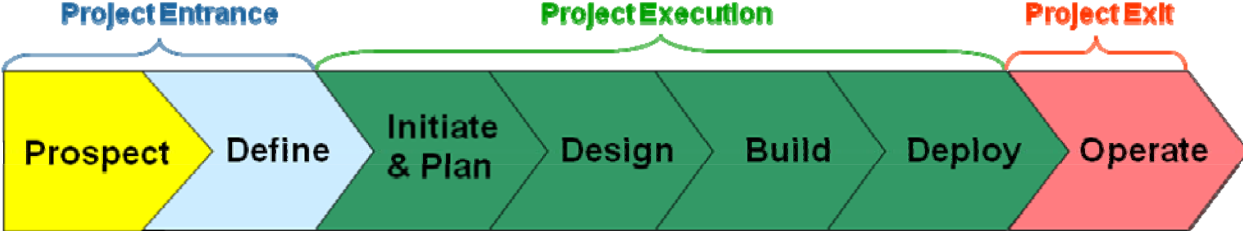
IT Process Improvement. Our Service Team drives our efforts to continuously enhance IT processes through the organization. We have integrated the Information Technology Infrastructure Library (ITIL) process framework into our IT organization. ITIL is a process based, best practice framework for delivering and managing MIS services. Centene requires MIS management to obtain certification in ITIL v3 and incorporate these practices into their service areas. We establish communication channels between Bridgeway and our IT organization by assigning an IT Executive Sponsor who ensures bi-directional communication and coordination at the highest levels between the health plan (e.g. Bridgeway) and Centene IT. This enables a close alignment between Bridgeway priorities and our systems development. In addition to this role, each functional area of Bridgeway: claims, medical management, quality management, encounters, operations, and compliance, has designated IT contacts and liaisons at Centene for immediate tactical and planning support.

Project Management – The Enterprise Business Implementation Model. We use a project management approach called the Enterprise Business Implementation (EBI) Model to ensure effective delivery of software modifications. EBI augments our change order and SDLC processes by providing a structured platform from which we can proactively – and with appropriate risk mitigation - manage the delivery of major software modifications. Our model uses reliable business principles; a proven set of tools and techniques; defined levels of authority; carefully defined procedures and methodologies; and a dedicated, highly specialized team of professionals to launch new health plan products from initiation, through deployment, to full health plan operations. EBI has established standards for, and delivers excellence around, how projects are organized to support the resource planning, fiscal responsibilities and risk management components that are critical to ensuring overall project success. Should Bridgeway expand into more ALTCS GSAs, we will follow this model to leverage Centene Best Practices and implement according to AHCCCS requirements.

Project Life Cycle. The EBI Model provides us with a solid framework for managing new business and key enterprise project implementation activities according to a defined set of standards. This centralized project oversight enables us to more effectively meet tight timeframes, manage cross-functional activities, and establish clear expectations with all stakeholders and project participants. Projects are managed consistently through the project's life cycle by:

- applying **standards and metrics** to each of the key phases in our implementation and development life cycle
- assigning **key milestones** and deliverables to each phase with specific ownership and sign-off points
- reporting **weekly status**, by phase and by function to key stakeholders
- assigning **individual owners** to action items for identified areas of risk to ensure mitigation and resolution, and
- clarifying **escalation paths** at the beginning of each project to facilitate timely response and priority.

Below we illustrate the distinct phases of our EBI project life cycle:



Effectively Using Automation to Power Change Management: Service-Now. To further enable and leverage ITIL methodology, Centene augmented their toolset in 2010 with Service-Now, an ITIL-based application for integrating multiple aspects of MIS service delivery. Centene's initial implementation of Service-Now has leveraged the tool to provide Request Fulfillment (i.e., change order), Incident/Issue Resolution, Problem/Root Cause Analysis, Change Management, Asset/Lifecycle Management, and Configuration Management. Service-Now's comprehensive approach to

service management provides us with the technological toolset to ensure that IT change order and software modification processes can be effectively and consistently managed with higher quality results. Service-Now has already provided Centene and Bridgeway enhanced management oversight of change activities, improved release management control, and a streamlined approach to overall service management administration.

System Conversions-History of Success. Centene and Bridgeway regularly upgrade core systems to take advantage of new technologies or to meet new compliancy requirements. Although the majority of our system upgrades are routine and pose minimal risk to operational processing, **all** upgrades and conversions are closely tracked and managed utilizing the tools and methodologies described above. In those instances during which a major system upgrade or conversion is necessary to leverage highly-desirable system capabilities, stay current on vendor system versions, or meet external requirements, Centene and Bridgeway further augment these methodologies with additional management oversight, extended stakeholder communication, and comprehensive planning which includes extensive testing and contingency planning.

Centene's ability to achieve successful system conversion implementations is a recognized strength, with accomplishments demonstrated throughout Bridgeway's current ALTCS contract. We implemented our most recent significant system conversion in 2010, when Centene and Bridgeway successfully migrated our core eligibility and claims processing application from AMISYS Advance Release 1.0 to AMISYS Advance Release 4.0, primarily to make AMISYS Advance (our central claims and eligibility processing system) HIPAA 5010 compliant. Following appropriate AHCCCS notification of implementation guidelines, Bridgeway submitted a proposed project plan for review including a timeline, milestones, and adequate testing before implementation. Additionally, as required by AHCCCS, we followed the required monthly update communication schedule and provided frequent updates during the course of the conversion. Since conversions can significantly impact the provider community, we took a proactive approach by mailing notices informing providers of the conversion and asking providers to be aware and to notify us with any issues. In fact, although we were prepared internally, we delayed the conversion at one point in the best interest of our members and providers due to potential issues that we foresaw as a result of a previous conversion within another Centene health plan. Bridgeway received positive feedback from AHCCCS regarding the success of our implementation. In similar fashion, we successfully converted our prior encounter processing system to our MDE Xpress Encounter Pro application, our integrated Impact Pro predictive modeling, and ClaimsXten clinical editing software successfully in 2010. During major system conversions, Bridgeway's objective is to make the *right* decision, at the *right* time and to maintain an open, honest communication protocol with all stakeholders.

Carefully Planning New Enhancements and Conversions. Over the next five years, Bridgeway and Centene anticipate the major system upgrades and conversions described in the table below. For each conversion, we will adhere to the methodologies and guidelines outlined above in close collaboration with AHCCCS and other stakeholders.

From	To	Anticipated Date	Subsystems Impacted	Benefits
CCMS	TruCare	August 2011 (AHCCCS has been notified of this conversion)	Centelligence™, AMISYS Advance	TruCare (TC) is our new member centric health services management platform. TC provides real-time feeds of authorization data to AMISYS Advance, and supports the use of our comprehensive Customer Relationship Manager (CRM) toolset.
EDI HIPAA 4010 Transactions	EDI HIPAA 5010 Transactions	January 2012	EDIFECS, TIBCO, AMISYS Advance, Centelligence, TruCare, Provider Portal (online claims submission)	Federal Mandate to enhance EDI transaction capabilities.
AMISYS Advance 4.0	AMISYS Advance 6.0	4th Quarter 2012 or 1st Quarter 2013	EDIFECS, TIBCO, TruCare, Provider Portal, Member Portal, Centelligence™	AMISYS Advance 6.0 incorporates ICD-10 code changes. A wide-ranging list of additional functionality enhancements, which can be provided to AHCCCS upon request, are also included
MACESS	Enterprise Content Management (ECM)	1st Quarter, 2012	Claims Workflow (AMISYS Advance), Provider and Member Portals, MRM, PRM	ECM provides automated paper scanning and correspondence capabilities and more effective publication of static content to web portals.

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

Ensuring reliable operations while continuously introducing meaningful innovation

Centene Corporation (Centene) provides local and enterprise level Management Information System (MIS) hardware, software systems, and communications networking for Bridgeway Health Solutions, LLC® (Bridgeway). Through Centene's 27 years supporting Medicaid managed health programs, we have *carefully* but *continuously enhanced* the individual components and integration of our software architecture. Over the past five years, our MIS direction has increasingly been informed by significant growth in our service of Long Term Care, acute care, and behavioral health managed care plans for members who are elderly and/or have physical disabilities, such as many of our Arizona Long Term Care System (ALTCS) members, as well as similar programs we support in Texas, Florida and Illinois. We balance the demand for software reliability, data integrity, and availability with the need to *carefully* infuse relevant new software versions and innovations, deploying new software and updated software versions through well documented Software Development Life Cycle (SDLC) and MIS operation techniques. Our use of the AGILE method for SDLC allows us to formulate, develop, test and introduce new software versions quickly, yet within the confines of auditable change management, and allowing for total project risk mitigation procedures. For example, we used our AGILE approach in our successful upgrade of AMISYS Advance to Release 4 during 2010. Although we regularly upgrade our AMISYS Advance system, we have extensive operational experience with this "core" application. Specifically, we have over 15 years of operating experience with AMISYS Advance and its predecessor products. In addition, every year, we review and compare all hardware and software components in our integrated MIS portfolio with the latest product versions from our vendors, and overlay the projected needs of our business for the following year. The output of this effort is our Strategic Technology Refresh Plan, which serves as our annual roadmap for planned introduction of new software versions for both Centene proprietary and vendor supported software components. Perhaps the most critical component of our approach to significant software updates and new software integration is our *regular communication with AHCCCS* about any updates related to our Bridgeway operations. Consistent with our approach throughout our administration of the ALTCS Program, we will continue to provide AHCCCS with our system change plan for any major MIS upgrade (including significant software version updates) at least six month prior to our anticipated implementation date.

Below, we have organized our major systems according to the business processes they support:

Application	Application Description	Current Version	Support by Vendor	# of Years Version Supported	# Yrs. Product at Centene	Vendor	Vendor Address	Contact Information
Medical Management								
TruCare	Clinical Case Management	4.3	Yes	< 1	< 1	CaseNet	23 Crosby Drive Bedford, MA 01730	Jon Abad (888) 701-0886
InterQual	Medical Necessity Criteria software	4.4	Yes	1	9	McKesson Health Solutions	275 Grove Street Suite 1-110 Newton, MA 02466	Jude Okolie (617) 273-2894
Centelligence Platform								
Enterprise Data Warehouse (EDW)	DBMS Platform for the Enterprise Data Warehouse	13.00.00.22	Yes	2	2	Teradata	10000 Innovation Dr. Dayton, OH 45342	Andy Gilbert (513) 319-7122
Executive Dashboard	Comprehensive dashboard and reporting.	5.15.0	Centene	2	2	Custom	N/A	N/A
XCelsius Enterprise	Dash boarding and Visualizations	2008 SP1	Yes	3	3	SAP	3999 W. Chester Pike Newtown Square, PA 16097	Mike McQuaid (919) 386-5476
Business Objects Crystal Enterprise XI	Compliance reporting and Business Intelligence tolls	XI 3.1	Yes	3	3	SAP		
Impact Intelligence	Utilization, patient outcomes analytics software	1.3	Yes	1	< 1	Ingenix	12125 Technology	Jennifer Felt (952) 833-

Application	Application Description	Current Version	Support by Vendor	# of Years Version Supported	# Yrs. Product at Centene	Vendor	Vendor Address	Contact Information
Impact Pro	Predictive modeling and care management analytics software	5	Yes	1	2	Ingenix	Dr. Eden Prairie, MN 55344	7100
Quality Spectrum Insight (QSI)	Performance measurement and Quality Improvement (QI) reporting - HEDIS	13	Yes	1	2	Med Assurant, Inc.	1559 Janmar Road Snellville, GA 30078	Bill Carden (770) 982-8022 x 6162
Negotiator	Contract modeling software to aid in the analysis of a new or modified provider contract.	1	Centene	N/A	N/A	Custom	N/A	N/A
PowerCenter	Extract, Transform and Load Automation Tools	8.6.0	Yes	2	6	Informatica	100 Cardinal Way Redwood City, CA 94063	Wayne Dye (310) 643.4522
PowerExchange	Updates EDW in near real time with changes from core applications	8.6.1	Yes	2	6			
Web Services								
Provider/ Member Portal	Secure web based portals used for secure transactions with Members and Providers	7	Centene	1	6	Custom	N/A	N/A
Clear Claim Connection	Bridgeway claim auditing rules accessed through the provider portal	5.0	Yes	2	7	McKesson Health Solutions	275 Grove Street Suite 1-110 Newton, MA 02466	Jude Okolie (617) 273-2894
Claims Processing								
Amisys Advance	Eligibility, enrollment, claims processing, Coordination of Benefits	4.0	Yes	2	15	DST Health Solutions	2400 Thea Drive Harrisburg, PA 17110	Kathleen McCarthy (717)703-7188
AWD	Document and workflow management	10	Yes	< 1	< 1			
Outpatient Pricer	Bridgeway outpatient claims pricing	3.0	Yes	1	< 1	Medical Data Express, LLC	908 W Chandler Blvd Bldg A Chandler, AZ 85225	David Abraham (480) 839-0420
ClaimsXten	Medical review and code auditing	CXT.2.0	Yes	4	4	McKesson Health Solutions	275 Grove Street Newton, MA 02466	Jude Okolie (617) 273-2894
MACESS.exp (Includes IMAX and Storage)	Document imaging, OCR and document management	IMAX - 4.40	Yes	5	9	SunGard Workflow Solutions	104 Inverness Center Place, Birmingham AL 35242	Terry Clanton 205-408-3480
EXP Form Works/RRI	Image Storage	Form Works 4.0	Yes	5	9			
Encounters								
Xpress Encounter pro	Encounter Processing	3.1	Yes	1	1	Medical Data Express	908 W Chandler Blvd Bldg A Chandler, AZ 85225	David Abraham (480) 839-0420
Member and Provider Relationship Management								
Customer Relationship Management (CRM)	Integrated Member/Provider inquiry, tracking and management	2011	Yes	<1	< 1	Microsoft Corporation	One Microsoft Way Redmond, WA 98052	(425) 882-8080

Application	Application Description	Current Version	Support by Vendor	# of Years Version Supported	# Yrs. Product at Centene	Vendor	Vendor Address	Contact Information
Portico	Provider Credentialing, demographics, financial information.	6.1	Yes	3	3	Portico Systems	518 East Township Line Rd., Suite 100 Blue Bell, PA 19422	Connie O'Brien (215) 358-3800
Emptoris	Contract Management and Reporting	7.5.9.1	Yes	< 1	2	Emptoris Inc.	200 Wheeler Road Burlington, MA 01803	Bryan Drumm (952) 473.2600
Enterprise Content Management (ECM)	N/A	N/A	Centene	N/A	N/A	N/A	N/A	N/A
After Hours NurseWise Support								
N Centaurus Telehealth Triage	Nurse triage and call center workflow for NurseWise	2010	Yes	3	<1	LVM	4262 E. Florian Ave. Mesa, AZ 85206	Adan Garcia 480-633-8200 ext 264
Telecom Services								
Avaya Communication Manager (CM)	Delivers world class call routing and applications. Call centers managed through automatic call distribution (ACD) and advanced vectoring.	5.2.1	Yes	1	7	Avaya Inc.	Hdqtrs 211 Mt. Airy Road , Basking Ridge, NJ 07920	(866) Go-Avaya
Avaya Call Management System (CMS) Supervisor	Tracks and reports information processed through the ACD	14	Yes	5	7			
Avaya Voice Portal	Speech-Enabled self-service IVR	5.1	Yes	1	1			
Middleware Services								
BusinessConnect	Data translation software. Supports HIPAA, other ANSI, and proprietary formats.	3.6.0	Yes	2	7	TIBCO Software	3303 Hillview Avenue Palo Alto, CA 94304	Kevin Niblock (650) 846-1000
iProcess Suite	Rules Engine	4.1.1	Yes	2	3			
Edifecs X-Engine	HIPAA Compliance Checking - the translator/validator component of EDIFECS.	6.2.1	Yes	1	6	EDIFECS	2600 116th Avenue NE, Suite 200 Bellevue, WA 98004	Sue Powers (517) 887-0717
EDIFECS Ramp Manager	Automate EDI trading partner administration.	6.4	Yes	1	< 1			
Diplomat Transaction Manager	Used for Enterprise File Transfer. Supports FTP, SFTP, or Local Network Delivery.	3.5.3	Yes	<1	4	Coviant Software	60 Thoreau Street, Concord, MA 01742	Jim Cutler (781) 534-5163
Change Management								
Service-Now	Enterprise Service Desk software - Incident/Problem/Change Management	Fall 2010	Yes	< 1	< 1	Service-Now	120 S. Sierra Ave. Slana Beach, CA 92075	Steven Tito (630) 786-1592

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

Experience in Supporting Federal Mandates

Bridgeway Health Solutions' (Bridgeway) parent company, Centene Corporation (Centene), provides HIPAA and Sarbanes-Oxley (SOX) compliant local and enterprise level Information Technology (IT) hardware, software systems and applications (including software for all HIPAA Electronic Document Interchange (EDI) transactions), and secure data and voice communications networking for Bridgeway and our sister Centene subsidiary health plans serving publicly-funded programs across 10 states. Over 250 Centene IT professionals support Bridgeway staff 365 days a year to deliver technology development, deployment, operations, and compliance experience in Medicaid Long Term Care (LTC), Acute Care, and Medicare Special Needs Plans (SNP) administration. Through 27 years of successful experience in Medicaid, Medicare, and other public sector health plan programs, and as a publicly held entity subject to Federal SOX regulations, we have continuously refined our processes for the systematic and early identification of Federal mandates germane to our health plans. To ensure the coordinated, phased transitioning of mandates to meet compliance effective dates, we expeditiously assess the impact of mandates on our IT infrastructure and operations, develop and implement remediation plans resulting from those assessments, and formulate and execute Level I (internal) and Level II (external) testing plans, working collaboratively with our state clients and providers.

Complying with Current Federal Mandates

Bridgeway and Centene use an integrated combination of safeguards, policies, monitoring tools, and automated business processes to ensure systematic, ongoing, and auditable adherence to HIPAA and SOX mandates; rules and standards per HIPAA Security (42 CFR 164), HIPAA Privacy (42 CFR 160 and 164), HIPAA Transaction and Code Set (TCS) (42 CFR 164); and SOX Section 404. We support all HIPAA Electronic Data Interchange (EDI) formats and protocols, as well as the National Provider Identifier (NPI). For our AHCCCS ALTCS and Acute Care, and Medicare Advantage programs (as with all our affiliate health plans nationally), *we have successfully achieved compliance with all applicable Federal mandates on or before the respective effective dates of each HIPAA rule and SOX mandate*.

HIPAA Security and Privacy Rule Support, and SOX Compliance. We employ administrative, technical and physical security safeguards under the guidance of Bridgeway's and Centene's Compliance Officers, General Counsel, and our Chief Information Security Officer (CISO), to meet or exceed all HIPAA Privacy and Security requirements, and to support the requisite internal controls and management oversight mandated under SOX Section 404. Our CISO holds both Certified Information Systems Security Professional (CISSP) and Certified Secure Software Lifecycle Professional (CSSLP) designations from the International Information Systems Security Certification Consortium (ISC). Our safeguards ensure that only appropriately authorized personnel are granted access to our systems based on specific job roles and in compliance with HIPAA Minimum Necessary Criteria. In addition, physical access is restricted to sensitive computer facilities, and system controls are in place to safeguard data and monitor security events.

Administrative Safeguards. Password length, complexity, and lifetime are strictly controlled to ensure they cannot be easily compromised, and users are forced to change passwords every 42 days. Inactive PC workstations are automatically locked, and after three failed login attempts, users are locked out. IT system administrators maintain an incident reporting file providing the date, time, and comments regarding any unauthorized attempts. Any access identified as inappropriate is immediately addressed. McAfee anti-virus and host-based intrusion prevention software guards against malicious software and hackers. Our IT Department documents changes to the IT environment quarterly, and attests to the impact of any such changes, certifying the effectiveness and adequacy of controls to mitigate risk. Centene requires its subcontractors and business associates to execute HIPAA Business Associate Agreements.

Physical Safeguards**.** The Centene data center in St. Louis, Missouri houses our core data and voice communications systems. In line with HIPAA mandates, proximity cards are required to access any Centene facility, elevator, or entry doors, and the data center has an additional layer of proximity card access restricted to authorized personnel. Access to doors, elevators and the data center is monitored, recorded and audited, and onsite security guards are on duty at all times. We track the receipt, storage, deployment, movement and disposal of all PC workstations, laptops, and Personal Electronic Devices (PEDs) through our Service-Now Asset Management System. When we reassign, dispose, or donate any PC, we erase all data on the machine using secure data erasure software from Blancco, Ltd. Our data erasure tools and methods fully comply with HIPAA Security and US Department of Defense Clearing and Sanitizing Standard 5220.22-M. For any device or media that management approves for disposal, and after all data is removed, our vendor, EPC, Inc. (EPC) picks up the device(s), physically destroys them, and confirms to us that the device(s) have been destroyed. EPC is AAA certified by the National Association for Information Destruction, Inc. (NAID). All Bridgeway and Centene users

who are issued PCs, laptops, and/or a Personal Digital Assistant (PDA) must follow stringent policies on the use of these types of equipment. Desktop machines are physically locked to fixed structures in our offices. Users must attach their laptops to docking stations with cable locks, or lock those laptops in filing cabinets in their offices when not in use. Users are required to store Protected Health Information (PHI) on secured Local Area Network (LAN) servers and not on their desktop PC hard drive, and we equip all of our laptops with MacAfee's Safeboot encryption software. Bridgeway's mobile devices are equipped with Absolute tracking software so that a device (e.g. laptop or PDA) can be physically located when connected to a network. In order to prevent disclosure of PHI, if a device is lost or stolen, access to that device (laptop, Blackberry, etc.) is systematically revoked and data is deleted remotely by authorized MIS staff.

Technical Safeguards. Centene uses Cisco Intrusion Detection Systems (IDS) for internal and external network monitoring. Our IT staff monitor IDS logs daily and act on any unusual activity immediately. Centene ensures that devices are configured in a secure manner before being introduced into our environment, then ensures that the security posture is maintained through regular updates and configuration audits throughout the device life-cycle. We use Rapid 7's Nexpose system to continuously assess our systems, software, devices, and processes against both a library of existing exploits and signatures for new or emerging exploits. Once a vulnerability is identified, it is categorized by risk and addressed accordingly via a number of possible approaches such as vendor update, administrative control, custom development, or a compensating control such as a new firewall rule. Centene uses Public Key Infrastructure (PKI) to encrypt files sent via FTP to protect data in transit. Centene's primary method for securing email communication between systems, sites, and/or domains is Transport Layer Security (TLS), an industry standard protocol for securing electronic communication.

HIPAA Certificate of Coverage and Privacy Notice Compliance. Bridgeway complies with all applicable Certificate of Coverage and data specifications reporting requirements pertaining to HIPAA.

HIPAA Transactions and Code Set Standard Compliance. Today, our HIPAA EDI infrastructure includes an integrated combination of our CoViant secure file exchange management system; TIBCO middleware and EDI translation software; our EDIFECS EDI processing engine with HIPAA compliance transaction checking, validation, self testing and authorization; and AMISYS Advance, our core transaction processing system. Our TIBCO software system supports ANSI X12 HIPAA compliant translation support for the HIPAA 837P, 837I, 270/271, 278, 276/277, 834, 835, and 820 transactions. Bridgeway's Pharmacy Benefit Manager (PBM) affiliate, US Script, supports the HIPAA compliant NCPDP Telecommunication Standard Version 5.1 and NCPDP Batch Standard 1.1. Bridgeway's Dental Administrator, Avesis, supports the HIPAA 837D transaction. Centene and Bridgeway also support several other EDI transactions to help support our SOX financial controls, including the ANSI TA1 (Interchange Acknowledgement), ANSI 997 (Functional Acknowledgement), ANSI 831 (Control Totals), ANSI 824 (Application Advice), and ANSI X12 275 (Electronic Claims Attachment) transactions.

Complying with SOX. As a publicly held company, we are audited annually per Section 404 of SOX for our internal management controls by Ernst & Young, LLP. These controls rely heavily on our IT infrastructure for the confidentiality, integrity, and availability of the data we house. We have successfully passed SOX audits since that law's inception.

Complying with Future Federal Mandates

Preparing for HIPAA Version 5010 (HIPAA 5010). Centene began HIPAA 5010 planning and gap analysis activities in 2008 under the direction of our Manager of EDI Services. We initiated these activities in anticipation of the Final Rule, which was issued by the US Department of Health and Human Services (HHS) in the Federal Register on January 16, 2009, mandating compliance for covered entities of Centene's size on or before January 1, 2012. We completed our internal gap assessment in early 2010, and implemented the HIPAA 5010 compliant version of our core eligibility and claims processing subsystems (AMISYS Advance Release 4) in the fourth quarter of 2009. Throughout the entire upgrade process, we regularly communicated with both AHCCCS and our Bridgeway providers. We completed integrated system Level I (internal) HIPAA 5010 testing in early 2011, and we are beginning Level 2 (external) HIPAA 5010 testing during the first quarter of 2011 with AHCCCS and providers who are ready to test with us. For AHCCCS, Centene has already implemented the 5010 version for the HIPAA 834 transaction for our Cenpatico of Arizona behavioral health affiliate, and we are in the process of implementing the HIPAA 834 and 820 transactions with AHCCCS for Bridgeway, which we expect to "go live" with on April 1, 2011. Centene MIS staff participated in, and will continue to attend, all AHCCCS' HIPAA 5010 / ICD 10 Consortiums, and we review and update our 5010 Health Plan Milestones Report with AHCCCS on a monthly basis. *We remain solidly on target to meet the HIPAA 5010 mandate and deadline*. In addition, US Script has completed their gap analysis for complying with the HIPAA 5010 pharmacy transaction (the NCPDP D.0 standard),

and is currently finishing development and beginning Level 1 testing. US Script will begin Level 2 testing late in the 2nd quarter of 2011 or early in the 3rd quarter. *US Script is also on target to meet the HIPAA 5010 mandate.*

Assisting Our Providers in Meeting the 5010 Mandate. During the second quarter of 2011, we will integrate EDIFECS Ramp Manager (Ramp Manager) with our EDI systems as well as our AMISYS Advance claims subsystem. Ramp Manager will allow Bridgeway's Provider Engagement Team (PET: our multi-disciplinary team of Provider Services and claims support staff, and EDI specialists) to assist providers that wish to directly submit claims to us, and our other trading partners and clearinghouses to rapidly create their own secure EDI accounts with us. In addition, PET staff will use Ramp Manager with providers to test their 5010 transactions; work with the provider to interactively correct errors in real time; and ultimately certify the provider's ability to exchange authorized transactions in compliant 5010 format with us. Our EDI Operations Department staff will continue to support providers with any EDI questions or issues they may have, as they do today. Our entire EDI system (including EDIFECS and our TIBCO system) allows us to support both the HIPAA 4010A1 and 5010 transaction standards as our providers and trading partners transition to the new EDI standard according to their own timeline. To further support our providers' move toward 5010 compliance, our secure Provider Portal offers users a HIPAA compliant Direct Data Entry (DDE) option, enabling them to conduct HIPAA 4010A transactions today, and 5010 transactions effective 1/1/2012.

ICD-10. In 2010, we instituted our inter-departmental, enterprise level ICD-10 compliance initiative led by our Chief Technology Officer (CTO), who reports to our Executive ICD-10 Steering Committee. The Committee is comprised of business leadership from all departments affected by the US Department of Health and Human Services (HHS) Final Rule published on January 16th, 2009 and modifying 45 CFR Part 162 to mandate the use of ICD-10 CM and ICD-10 PCS (ICD-10) codesets in HIPAA transactions effective October 1st, 2013. In late 2012 or early 2013, we will upgrade our AMISYS Advance system to its ICD-10 compliant version, along with requisite upgrades to our TruCare health services management platform; Centelligence™ reporting and decision support system; and MDE Encounter system, in coordination with AHCCCS. We anticipate completing Level 1 testing by the end of 2012, and Level 2 testing by mid 2013. As with our HIPAA 5010 testing initiative, our Ramp Manager system will allow providers, assisted by our PET, to interactively test ICD-10 support.

Federal IT Incentives. Although not Federal mandates, we consider the following to be critical legislation we will analyze and support wherever possible, in order to assist our providers and state clients in improving care delivery and quality through IT: 1) HHS rules stemming from the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009, defining the standardization of health information technology; and 2) Title IV of the American Reinvestment and Recovery Act (ARRA) of 2009, incentivizing eligible providers to "meaningfully use" certified Electronic Health Record (EHR) technology, and for states to promote the establishment of Health Information Exchanges (HIE's). Wherever applicable to our operations and where supported by our local constituents, we implement standards such as HL-7, and the XML-based Clinical Document Architecture as called for in *45 CFR Part 170 Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, Interim Final Rule*, published in July of 2010 by HHS. We also participate wherever possible in local and state wide HIE efforts. For example, Bridgeway participates in the *Health Information Network of Arizona*, a collaborative HIE effort among Arizona health plans, hospitals, large group practices, business leadership, consumers, and local administrations.

Continually Monitoring and Anticipating Future Federal Mandates. Bridgeway's Compliance Department and Centene's Legal and IT Security Departments work closely together to monitor relevant announced Federal mandates *at large* (e.g. published in the Federal Register), IT mandates related to security, and Federal mandates relevant to our contracts with AHCCCS and other Arizona state agencies. We use our Compliance 360 corporate governance, risk management, and compliance system to organize and manage (among other functions) and document our compliance with specific Federal mandates. Our Security Committee, chaired by our Legal Department and comprised of representatives from our Compliance, Internal Audit, Risk Management, Human Resources, IT Security and Physical Security departments, meets monthly and discusses new regulations or rules as they arise. Our Director of IT Security reports to our CISO and is a member of the Information Systems Audit and Control Association (ISACA). ISACA provides our IT Security Director with information/notifications on changes and new regulations and rules at the Federal level, and provides guidance on evidence required for demonstrating compliance with new and existing regulations or rules.

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

Bridgeway maintains written policies and procedures clearly describing the grievance and appeals process. The implementation of our fully developed, member-centric grievance systems processes meet AHCCCS requirements, while promoting and maintaining an internal function dedicated to the identification and prompt resolution of oral and written grievances, member appeals, provider claims disputes and other provider issues.

Bridgeway provides the ACOM Enrollee Grievance Policy and additional information to all providers and subcontractors at the time of contracting, and to members within 10 business days after receiving their notice of enrollment. The policy is provided to new members in the New Member Welcome Packets which is delivered by the Case Manager. We provide at least 30 days advance written notice of any significant policy change to all members, providers and subcontractors.

Written information describing the grievance system, including the grievance and appeals processes, enrollee rights, process requirements and applicable timeframes are provided to Bridgeway members in easily understood language. This information is provided in both English and Spanish, and is available in other languages and alternative formats, as needed. Members are also informed of their right to receive oral interpretation in any language upon request. Bridgeway standards and procedures require provision of vital material and written notices translated into the member's language when that language is spoken by 5% or 1000 (whichever is less) members who also have LEP in that language. As Spanish has been identified as a significant LEP for our membership in two of our GSA (Yuma and Pima), all vital notices are translated into Spanish. These include, but are not limited to: acknowledgement letters, notice of extension letters, notice of action letters, notice of appeal resolution, notice of extension for resolution, notice of extension of notice of action letters, the member handbook and member newsletters.

ALTCS members are given timely notification of denial, reduction, suspension and termination of services and an opportunity to appeal such actions in compliance with AHCCCS policy. The grievance, appeal, expedited appeal and request for hearing procedures are communicated to members in the Member Handbook which is delivered in the New Member Packets and is available on the Member Portal. The Member Handbook contains information about how to contact a Member Service Representative (MSR); how to file a grievance or appeal including timeframes; what to do if a service has been denied, reduced, suspended, or terminated; and how to request a hearing from AHCCCS. Members are also notified of their right to review the file and speak directly with staff in the office if they so choose. The member's ALTCS Case Manager also provides assistance to the member on how to file a grievance or appeal including timeframes and frequently contacts the Grievance and Appeals (G&A) Manager directly to ensure that the member receives the necessary assistance. The grievance and appeals staff frequently provide assistance to ALTCS members and their families/representatives in understanding the appeals process and filing the actual appeal whether by taking the information by phone or meeting with the member in person to obtain all the information.

Member Grievance Process

Bridgeway shares AHCCCS' belief that members should be encouraged to resolve issues at the lowest possible level. Whenever possible, through an informal resolution process, the staff and the member/representative meet to talk about the concerns. Through discussion, education and understanding, a satisfactory resolution is often found. The presence of local Bridgeway offices in the counties of Maricopa, Yuma, Pima and Santa Cruz along with the town of Nogales provides ALTCS members/representatives easy access to their Case Manager if they have questions or issues regarding their service and the process for resolution. Member Service Representatives (MSRs) and case management staff are trained to address/resolve member concerns during this first contact. If the matter is resolved at this point, the Bridgeway staff member who handled the member's concern documents the issue and its resolution, and forwards the matter to the G&A Coordinator for tracking and trending purposes.

A grievance is defined as a member's expression of dissatisfaction, concern or frustration with any aspect of his/her care, other than the appeal of an action. In the event the grievance is a potential quality of care issue, or will require more than 24 hours to resolve, MSR or CM documents his/her attempt at resolution, and forwards the information to the G&A Manager. This procedural training is also extended to all Bridgeway staff who work directly or indirectly with members. All staff are trained to recognize any expression of dissatisfaction, and follow appropriate procedures to ensure the member's issue is addressed. Members may also file a grievance in writing, in which case the document is date-stamped and forwarded to the G&A Coordinator for review and resolution.

Grievances are logged and maintained within an internal database, maintained by Bridgeway's Compliance Department. This database allows the tracking/trending of grievances by category, and facilitates monitoring of the grievance resolution process and timeframes. The G&A Coordinator (under the direction of the G&A Manager) conducts an initial review, which may include contacting the member for additional information or clarification of the issue, and gathering applicable documentation from other Bridgeway departments. For example, the investigation may include the assistance/input of the member's Case Manager, or the Provider Services Department if the matter involves a Bridgeway provider. Clinical issues, including grievances filed as a result of a service denial or a decision to deny a request for an expedited appeal resolution, are forwarded to the Medical Management Department for investigation or review by a physician or other appropriate clinician. If the grievance involves a quality of care issue, it is forwarded to the Quality Management/Performance Improvement (QM/PI) Department for review, resolution and inclusion in the (QM/PI) process. Matters involving privacy concerns or potential fraud and abuse are forwarded to the Compliance Officer for resolution. This individual determines whether the issue should be forwarded to the AHCCCS Office of the Inspector General (OIG).

If the G&A Manager determines that the grievance does not require the involvement of other Bridgeway departments, the issue is forwarded to the G&A Coordinator for investigation and resolution. Once the resolution is determined, the G&A Coordinator drafts a resolution letter which is reviewed and approved by the G&A Manager, then sent via certified/return receipt mail to the member. Although Bridgeway is allowed up to 90 days to resolve a grievance, the health plan makes every effort to resolve member grievances at point of contact. If the matter requires additional follow-up such as in the involvement of different departments, or requires follow up with a provider regarding accessibility issues then we strive to resolve within 10 business days with an internal benchmark of 30 days but not to exceed the 90-day timeframe. Bridgeway considers a member grievance is resolved when the member is satisfied with the resolution and then followed up with a written letter to the member outlining the grievance and the resolution. Regardless of the outcome, Bridgeway does not discriminate or retaliate against a member for filing a grievance, appeal or request for a State fair hearing.

Tracking of Grievances. Enrollee grievances are categorized under the AHCCCS recommended broad categories: Transportation, Medical Service Provision, and Contractor Service Level, Access to Care, and Wheelchairs, and are further defined by sub categories to delineate and trend issues while monitoring and tracking resolution timeframes. On a monthly basis all grievance data is compiled into one Enrollee Grievance Report, which the G&A Manager reviews for identification of trends. Any trending to a specific Department or service is submitted to the department for review and corrective action is taken as appropriate. This data is also submitted monthly to AHCCCS as required, and a report is presented at the Quarterly Quality Management/Performance Improvement Committee (QMPIC) for further review and recommendations as needed. Trending of member expressions of dissatisfaction provides valuable information about what may be problematic for a member and what changes need to occur to provide optimal service to members. Although afforded up to 90 days to resolve a grievance, Bridgeway's Grievance and Appeals Department strives to respond to grievances as promptly as possible, either as a first call contact resolution with a benchmark to resolve matters within 10 days and not to exceed 30 days. **Bridgeway's commitment to resolve issues informally and to track, trend, and improve processes is reflected in our ability to demonstrate a consistent 6 days average resolution time from CYE '07 through the CYE 10.**

Identifying Trends. Over the course of the Contract cycle, Bridgeway continued to capture appropriate data for prompt identification of trends as well as document interventions and outcomes. For example, CYE '07 data reflected a receipt of 72 grievances overall, with a majority of the matters related to transportation issues in Maricopa County all applied to the same provider. Through coordination with our Provider Relations Department, and Quality Management Department, Bridgeway increased the oversight and monitoring of this transportation provider to ensure improved customer service and adherence to policies and procedures. A comparison in the review of CYE '08 grievance data shows a significant reduction in the number of received grievances related to transportation, which is attributed to Bridgeway's interventions following the identified issues from the previous year. Grievance reporting in CYE '08 identified 94 of the total 116 grievances filed for the plan year related to 'Providers Billing Members". Also in this reporting cycle were three "network gap" related issues where members were experiencing difficulty in securing attendant care services. In these cases, we were able to promptly address the needs of the member through assistance of our locally-based Case Manager and Provider Relations Representative and resolve the issue by securing attendant care services for the members. The matters collectively were resolved within five days to the satisfaction of the members, and there were no additional reported grievances in this category through the remainder of the plan year.

Grievance data for CYE '09 reflected a total of 55 filed grievances, with continued low reporting of transportation issues, and continued trending in the "Providers Billing Members" category. Review of grievance data early in CYE '09 in

conjunction with '08 grievance data revealed that in a majority of these instances, the issues was not generally related to a dissatisfaction or frustration, but rather a need for assistance with ensuring the provider's records were updated with the member's current eligibility/enrollment information. Bridgeway responded to this trend by utilizing the Member Services Department to develop a tracking database, and work closely with the Provider Relations and Case Management Departments to either (a) ensure the provider has the appropriate member eligibility/enrollment information, and/or (b) utilize the database as a recruitment tool, identifying non-contracted providers already seeing our members, and contact for potential contracting with Bridgeway.

During CYE '10, there were a total of 36 filed grievances, showing a reduction on the category, 'Providers Billing Members', which was attributed to the intervention efforts from the previous plan year. Bridgeway continues to report a low number of grievances as well as a consistency in prompt resolution turn-around-times, and attributes the increased reporting in various other categories in '2010 to additional trainings provided to staff by the Compliance/G&A Department on identifying and reporting grievances.

Member Appeals Process

An appeal is defined as a request for a review of an action taken by a health plan. A member may file an appeal for a number of reasons including: the denial or limited authorization of a requested service, including the type or level of service; reduction, suspension or termination of a previously authorized service; denial, in whole or in part, of payment for a service; or the denial of out-of-network services for a resident of a rural area with only one health plan. Bridgeway maintains an excellent record of meeting grievance/appeal-related timeframes, and recognizes that failure to provide services in a timely manner or failure to act within the timeframes required for standard and expedited resolution of appeals (and standard disposition of grievances) also constitute an action.

Bridgeway members may request an appeal within 60 days from the date of Bridgeway's Notice of Action (described later in this section), and can submit appeals orally or in writing. A provider may file an appeal on behalf of a member, with the member's written consent. Appeals are either handled through the standard appeal process or on an expedited basis, if requested by the member. Bridgeway follows AHCCCS time-frames and processes for handling expedited and standard appeals, including extending time periods within AHCCCS guidelines, if the extension is in the best interest of the member. The process for appeal timeframes is provided within the flowcharts which are located at the end of this section. Members are encouraged to submit additional documentation, in person or in writing, to support their case and are reminded of the limited time available for expedited appeals. When received, any additional documentation related to the appeal is date-stamped and included in the file for review. Members are informed, in the acknowledgement letter, of the opportunity to provide additional information, as well as the right to review the appeal case file during the appeal process. The G&A Coordinator ensures that the final appeal decision is made by an appropriately licensed health care professional who was not involved in the initial decision-making process. The Bridgeway G&A Manager issues a Notice of Appeal Resolution to the member and all applicable parties within the designated timeframe. In CYE '10, Bridgeway only received seven appeals with the average resolution time being ten days.

The Notice of Appeal Resolution includes the result of the resolution process, supporting citations and authorities and the date the decision was made. If the appeal is not resolved wholly in favor of the member, the Notice of Appeal Resolution also includes language regarding the member's right to request a State fair hearing (including the requirement that the request for hearing must be submitted by the member in writing) no later than 30 days after the date the enrollee received the Notice of Appeal Resolution. This letter also includes instructions on how to request a hearing, that the member may ask for the continuance of previously authorized benefits and how to make a service continuance request.

If the member (or his/her designated representative) requests a State fair hearing, Bridgeway ensures all supporting documentation is forwarded to the AHCCCS Office of Administrative Legal Services (OALS), no later than five business days from the date Bridgeway receives the written hearing request. In CYE '10 Bridgeway did not receive any requests for a State Fair Hearing.

Provider Claims Dispute Process

Bridgeway maintains a written policy that clearly defines the provider/subcontractor (provider) claims dispute process and complies with federal and state laws, regulations and policies. This policy is provided to all Bridgeway providers at the time of contracting. Both Bridgeway contracted and non-contracted providers may access information regarding the provider claims dispute process through the Bridgeway website at www.bridgewayhs.com. All non-contracted providers will have a claims dispute policy mailed with a remittance advice, provided it is sent within 45 days of receipt of a claim. All provider claims disputes are handled by the Bridgeway G&A Department, which is overseen by the Bridgeway Compliance Department.

Bridgeway's provider claim dispute process includes the major steps reflected in the flowchart, which is included as part of this response. Upon receipt of a written provider claim dispute, the G&A Coordinator date stamps all received documentation. The G&A Coordinator assigns a specific docket number to the dispute, and records the following information into the provider claims dispute docket log:

- The docket number and the date the claim dispute was received
- The provider or provider group filing the claim dispute
- The nature of the dispute
- The member name and AHCCCS ID number associated with the claim dispute
- The date(s) of service
- An indicator of whether or not an extension was requested or agreed upon
- The dispute's due date and the date the decision was made
- An indicator of whether or not the provider requested a State fair hearing, and if so, the date the matter was forwarded to AHCCCS

Bridgeway acknowledges all provider claim disputes, in writing, within five business days of receipt. The acknowledgement letter provides a brief description of the nature of the complaint, indicates the expected date of resolution and supplies a contact number for providers to inquire about the status of the dispute. The Bridgeway G&A Coordinator thoroughly investigates each dispute and issues a decision letter to the filing party no later than 30 days from the date the dispute was received, unless both parties agree to an extended timeframe. Each provider claim dispute resolution letter includes:

- The nature of the claim dispute
- A discussion of the issues involved
- The decision and the reason(s) for the decision
- Applicable legal citations, contractual provisions and policy reference
- The provider's right to request a hearing by filing a written request to Bridgeway, no later than 30 days after receipt of the claim dispute decision letter
- If the claim dispute is overturned Bridgeway will reprocess and pay the claim in a manner consistent with the decision within 15 business days of the date of the decision

Claim Disputes are also logged and maintained within an internal database, maintained by Bridgeway's Compliance Department. This database allows the tracking/trending of grievances by category, and facilitates monitoring of the grievance resolution process and timeframes, and assistance in ensuring accurate reporting to AHCCCS.

Trending of ALTCS Claims Disputes over CYE '10 reflected an average of 75 disputes received each month, and an average of 72 resolved each month. Categorical trending over CYE '10 has also reflected that interventions implemented by Provider Relations upon identification of issues appear to have reduced the number of disputes in each respective category in following months. As we continue to appropriately address system issues and work with providers to resolve claims issues/concerns, we anticipate continuing to see a reduction in incoming claim disputes moving into CYE '11.

If the provider files a written request for hearing, Bridgeway ensures all supporting documentation is forwarded to the AHCCCS Office of Legal Assistance (OLA) no later than five business days from the date Bridgeway receives the provider's written hearing request. The file forwarded to OLA contains the following: the written request for hearing by the provider, copies of the entire claim dispute file, Bridgeway's decision and any other information relevant to the Notice of the Decision. Bridgeway will also include a cover letter with the forwarded file that includes the provider's name, AHCCCS provider ID number, the provider's address and telephone number, the date the claim dispute was received, a summary of the actions Bridgeway took to resolve the claim dispute, a summary of the dispute's resolution and the basis for the determination. In efforts to assist AHCCCS in reducing the volume of pending Administrative Hearing Requests, Bridgeway makes every effort to resolve matters before reaching the level of Administrative Hearing. As a result, our requests for Administrative Hearing continue to remain low, accompanied by increased provider satisfaction for the prompt resolution of issues. If a provider's dispute is validated, either by Bridgeway or AHCCCS, Bridgeway will reprocess the claim accordingly within 15 business days of the date of the decision. All claims dispute records are filed in secured locations at Bridgeway and retained for five years after the final decision is made.

Member Grievance Process

Flowchart 1

Member submits oral or written grievance

Grievance acknowledged within 5 business days

Clinical expertise required?

NO

G&A Dept. investigates grievance

YES

Medical Management investigates QOC grievance

BW sends written Notice of Disposition to member within 10 business days whenever possible, but no longer than 90 days of receipt of grievance

Written request for review of Notice of Disposition filed by member within 30 days?

NO

Filed in member's file

YES

BW GC determines request for review

BW sends written determination of review within 45 days of receipt of request

Process Ends

Key Code

BW	Bridgeway
G&A	Grievance & Appeals
MM	Medical Management
BW GC	Bridgeway Grievance Committee
QOC	Quality Of Care

Member Appeals Process

Flowchart 2

Member or representative files appeal within 60 days of NOA

G&A Dept. date stamps appeal

Should it be expedited?

No

Provide written notification the matter will proceed through standard timeframes

No

Standard process within 30 days

Acknowledge within 5 business days

Extension?

YES

May extend time-frames up to 14 additional days

NO

Provide written notification of decision within 30 days

Member prevails?

YES

G&A Dept. forwards to MM to issue authorization

NO

yes

Acknowledge within 24 hours

Extension?

YES

May extend time-frames up to 14 additional days

NO

Provide written notification of decision within 72 hours

Member prevails?

YES

G&A Dept. forwards to MM to issue authorization

NO

Member or designated representative appeals disposition

Yes or No?

NO

Process ends

YES

Member or designated representative may request a SFH

Member requests expedited hearing?

YES

G&A Dept forwards file to OLA within 1 business day

NO

G&A Dept. forwards file to OLA within 5 business days

AHCCCS mails Director's decision to the member no later than 30 days after the date of the Administrative Law Judge's recommended decision.

BW decision overturned

If member or representative prevails (in decision by AHCCCS), BW will promptly provide or pay for services

BW decision upheld

Process Ends

Key Code

BW	Bridgeway
G&A	Grievance & Appeals
SFH	State Fair Hearing
NOA	Notice Of Action
MM	Medical Management
OALS	Office Of Administrative Legal Services

Provider Claims Dispute Process

Flowchart 3

Provider files a claim dispute within 1 year of DOS or 60 days from last adverse action on a timely submitted claim

G&A Dept. date stamps dispute

BW provides written acknowledgement within 5 business day of receipt

BW GAC investigates dispute

An extension of timeframes may be filed providing both parties agree to the extension

If decision is upheld

BW GAC sends written NOD to all parties within 30 days of receipt

Provider may file written request for SFH with BW within 30 days of receipt of the NOD or if NOD is not received within 30 days

Provider prevails?

YES

BW overturns initial decision; Claim is forwarded for reprocessing within 15 days; Provider notified within 30 days

Process Ends

If decision is overturned

NO

BW ensures all supporting documentation is received by AHCCCS no later than 5 business days after receipt of provider's written hearing request

AHCCCS mails a SFH decision to the provider no later than 30 days after the state hearing agency sends the decision to AHCCCS

If BW decision is overturned

If provider prevails (in a decision by AHCCCS),
BW reprocesses and pays the claim in accordance with the decision within 15 business days of the date of the decision

Process Ends

If BW decision is upheld

Provider is notified within 30 days

Key Code

BW	Bridegeway
DOS	Date of Service
GAC	Grievance & Appeals Coordinator
NOD	Notice Of Decision
SFH	State Fair Hearing

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

Corporate Compliance Structure. Bridgeway's Corporate Compliance Program reaches throughout all levels of the organization ensuring a mandatory, robust compliance program that is designed to guard against fraud and abuse and not only meets, but exceeds state and federal requirements. Bridgeway's Compliance Program leverages the resources of our parent company Centene Corporation (Centene) to provide program support and to identify best practices to ensure compliance with our AHCCCS contract. We will continue to maintain our excellent contract compliance record and expand upon current internal controls and processes to ensure timely submission of deliverables and overall compliance. Bridgeway's management team proactively seeks opportunities to collaborate with AHCCCS staff on resolving contract-related issues and continually strives to improve processes and procedures to ensure overall compliance with contract requirements. The organizational chart of the staff involved in compliance is located at the end of the response to this question.

Compliance Officer. Bridgeway's Compliance Officer (CO) serves as the focal point for coordinating and communicating all local compliance activities with Bridgeway staff and is responsible for planning, implementing and monitoring the Compliance Program. The CO reports directly to the CEO as well as to the board of directors (BOD). Bridgeway recognizes the value of having a CO with an independent voice who has direct access to the highest levels of the organization. The Compliance Officer's role includes the oversight and monitoring of the Compliance Program and reporting on a regular basis to Bridgeway's CEO and Compliance Committee on the effectiveness of the program. The Compliance Officer also has the authority to report on all fraud, waste and abuse issues including authority to receive and investigate potential violations of the program.

Bridgeway's Compliance Committee. Bridgeway established our Compliance Committee to assist the CO in monitoring, reviewing and assessing the effectiveness of the compliance program and timeliness of reporting. Comprised of a cross-functional team including the CO, the Vice-President of Finance (as the budgetary official), and employees and managers of key functional areas who have the authority to commit resources to address areas of non-compliance, the committee meets at a minimum on a quarterly basis, as well as on an ad-hoc basis to address any immediate concerns or issues. The Compliance Committee reports directly to Bridgeway's Board of Directors. The Committee's functions include, but are not limited to analyzing the organization's environment, contract compliance, regulatory requirements and specific areas of risk/noncompliance assessing existing policies and procedures and developing new ones to promote compliance. The CO also seeks guidance and assistance from the Compliance Committee including recommending and monitoring, in conjunction with relevant departments, internal systems/controls to carry out Bridgeway's standards, contract requirements and policies and procedures determining the appropriate strategy/approach to promote compliance and detect potential violations, and maintaining a system to solicit, evaluate and respond to concerns, including reports made to Centene's Ethics & Compliance and Waste, Abuse and Fraud (WAF) Helplines and other abuse reporting mechanisms

Centene Contract Compliance Support. In addition to our in-house compliance resources, Bridgeway has a variety of resources available through Centene to assist with contract compliance. Centene oversees the ethics and compliance activities of its entire organization, including Bridgeway. The ethics and compliance program incorporates written standards of conduct, policies and procedures that complement Bridgeway's organizational commitment to program compliance. Centene's Ethics and Compliance (CEC) department meets with Bridgeway on a monthly basis to discuss any potential risks and share best practices. Support provided for Bridgeway by CEC, Legal and Regulatory Affairs departments, includes, but is not limited to:

- Providing state and federal regulatory research and interpretation to support Bridgeway's commitment to compliance with all federal and state standards
- Conducting audits of Bridgeway's contract compliance program and processes prior to implementation and yearly thereafter to ensure contract requirements and subsequent amendments are addressed
- Conducting desk review of the documentation and/or on-site review of compliance functions including claims payment accuracy; state reporting, including quality and accuracy of deliverables submitted and compliance with submission timelines; and staff training
- Benchmarking Bridgeway compliance programs against internal best practices and external resources provided by the Health Care Compliance Association and the Corporate Executive Board's Compliance and Ethics Leadership Council to ensure state-of-the-art methodologies

Centene maintains an Ethics & Compliance Helpline and a WAF Helpline, which are operated by independent, third party companies and are available twenty-four hours a day, seven days a week. Centene's CO is responsible for handling any complaints or issues reported via the Ethics & Compliance and WAF Helplines, and Bridgeway's Compliance Officer is informed of any issues reported pertaining to Bridgeway operations.

Corporate Compliance Program. ***Contract Compliance.*** Prior to the new contract implementation, Bridgeway's CO, with input from AHCCCS as required, will review the contract and develop a comprehensive plan for documenting, monitoring and tracking compliance with contract requirements. This includes, but is not limited to, required operational processes, policies, procedures and reporting deliverables. Once the contract requirements are identified, Bridgeway, with support from CEC department, will input the contract specific requirements, including operational requirements, into the Compliance Workspace module of Compliance 360, Centene's innovative tool for tracking and monitoring compliance with contract requirements. With this robust tool, Bridgeway can perform assessments and monitor compliance by employee, functional area or category; manage AHCCCS deliverables to ensure timely development, quality review, approval and submission; track identified incidents of non-compliance or corrective action and document progress on remediation; track state correspondence; generate multiple variations of reports to track and trend; and produce a contract compliance dashboard and online review/audit process for internal and external surveyors/auditors. All regulatory references associated with AHCCCS (i.e. ACOM, AMPM, Grievance Systems Manual) are included in Bridgeway's internal compliance tool set, as well as comprehensive audit tools that address federal and state Medicaid managed care regulations including HIPAA requirements, the Balanced Budget Act and the Deficit Reduction Act.

Staff Training. Our Corporate Compliance program includes effective training and education programs to ensure employees maintain compliance with all applicable federal and state standards. The CO, in conjunction with department heads, conducts plan-wide in-service training sessions to ensure Bridgeway employees understand the contract requirements that pertain to their job responsibilities. The CO also trains all Bridgeway employees on how to identify and report suspected fraud and abuse. This training includes the Federal False Claims Act provisions, administrative remedies for false claims and statements, state laws relating to civil or criminal penalties for false claims and statements and the whistleblower protections under such laws. Bridgeway has established written policies and procedures, including the disciplinary guidelines for non-compliance which include re-education and written notices up to and including termination, which are included in these training sessions. Training occurs within the first 30 days of employment, and on an annual basis thereafter. Our CO maintains documentation of attendance and participation to allow for verification by AHCCCS. To supplement in-service training, Bridgeway's parent company also offers computer-based training for all employees. The topics of this training change from year to year and have included: speaking up and raising concerns, receiving concerns from employees for managers, appropriate email communications and insider trading. Additionally, department directors are required to hold department-specific training sessions on Bridgeway policies and processes specific to their functional areas.

Provider/Subcontractor Compliance. Bridgeway subcontractors, providers and vendors must comply with relevant provisions of the Centene/Bridgeway compliance program. Failure to comply could result in disciplinary action, including corrective action, discharge, or contract termination. Bridgeway's Board of Directors delegates oversight for compliance with all AHCCCS clinical contract requirements to the Quality Management/Performance Improvement Committee (QMPIC), the Performance Improvement Team (PIT) and the Quality Management Investigative Committee (QMIC). Bridgeway communicates AHCCCS requirements and expectations to all contracted providers and subcontractors through the Provider/Subcontractor (Delegation) Agreement, the Provider Manual and provider newsletters; at provider orientation; and during targeted education for providers/subcontractors found out of compliance. Bridgeway's Quality Management and Performance Improvement (QM/PI) and Medical Management departments provide continuous education and feedback to providers regarding AHCCCS contract requirements and expectations through QM/PI, utilization management (UM), case management (CM) and disease management (DM) program activities, such as the initial and annual delegated audit processes, analysis of subcontractor reports and monitoring of access standards., Bridgeway will also train providers and their staff on the Federal False Claims Act provisions pertaining to administrative remedies for false claims and statements; state laws relating to civil/criminal penalties for false claims and statements; and the whistleblower protections under state and federal laws. Subcontractors who do not meet compliance expectations are subject to quarterly audits, ongoing monitoring and other corrective actions until Bridgeway is comfortable the subcontractor is in compliance.

Monitoring and Auditing. At least monthly, the CO works with functional area leads to review health plan operations and identify any potential contract compliance issues. If issues are identified, the CO immediately notifies and works with the department director to develop and implement a corrective action plan. All incidents of noncompliance, along with status

updates on remediation plans are reported to Bridgeway's CEO, PIT, QMPIC and the Compliance Committee. The CO also ensures that any contract compliance issues that must be reported to AHCCCS are reported as required. In addition, the CO enters any potential contract compliance risks into Compliance 360 which is then reviewed by Centene's CEC department. The CEC Department meets at least monthly with Bridgeway's CO to determine what type of corporate support is needed to mitigate any contract compliance issues. At a minimum, the CO, with support from the CEC department performs annual contract compliance audits for each department using the Compliance Workspace module of Compliance 360. Contract compliance audits are also performed after each amendment to the Contract to ensure that Bridgeway remains in compliance with any new contractual requirements. The robust functionality of Compliance 360 enables the CO to track and review all documentation of compliance, including but not limited to: operational policies and procedures, committee meeting minutes, staff training, state reports and other deliverables. This also allows the CO to target the exact documents that may require updates when the contract amendments occur. Compliance with standards such as claims payment, encounter processing, call center operations and utilization management are monitored by reports from each functional area. If any deficiencies are identified, the CO performs a detailed audit to ensure the functional area is in full compliance with contractual requirements. As part of this audit, the CO also assesses documentation of subcontractor compliance and determines the effectiveness by which the respective departments are providing oversight of delegated entities. During the annual audit, the CO also evaluates the effectiveness of routine operational monitoring and internal controls implemented by individual department directors and managers. For example, Centene's CEC Dept. partnered with Centene's Medical Management (MM) Department and health plan MM staff to develop an Authorization Turnaround Time Report that monitors compliance with health plan authorization timeliness requirements. Bridgeway has implemented this process and the CO periodically reviews this report to ensure the organization is meeting the authorization turnaround time requirements.

Reporting Waste, Abuse and Fraud. Bridgeway takes the detection of waste, abuse and fraud and our responsibility to report and provide a prompt response very seriously. In accordance with federal and state regulations, Bridgeway's Corporate Compliance program requires that employees, subcontractors and providers immediately notify the AHCCCS OIG regarding any suspected fraud or abuse by way of our Corporate Compliance program. Bridgeway's CO will conduct an investigation into the report and inform the OIG in writing of instances of suspected fraud or abuse, including acts that were internally resolved, but involved AHCCCS funds, contractors, or sub-contractors, within 10 business days of discovery. Bridgeway will cooperate fully with OIG, permitting and cooperating with any onsite reviews to ensure program compliance. This cooperation extends to timely response to electronic, telephonic and written requests for information and shall provide documents to representatives of OIG upon request. To enhance our ability to proactively prevent fraud and abuse, Bridgeway utilizes Centene's Special Investigation Unit (SIU). The SIU is located in St. Louis but meets with the Bridgeway team at least quarterly, or as often as needed upon identification of a billing issue trend. The SIU prevents overpayments by employing a code editing software called ClaimsXten (CXT). Last year, CXT prevented the overpayment of approximately $475,000 dollars. CXT reviews claims for a variety of things including, but not limited to: National Correct Coding Initiatives (NCCI), unbundling, age/sex edits, global surgery days, and the correct use of modifiers. To enhance our prepayment efforts, Centene has entered into a strategic partnership with Verisk's HealthCare Insight (HCI) to further evaluate claims. Through HCI's Physician Claim Insight (PCI) and Fraud Finder Pro (FFP) programs, Bridgeway is able to provide AHCCCS with clinically validated proactive fraud, waste and abuse detection/prevention services without disrupting claims turnaround time to any material degree. Using predictive modeling HCI evaluates files utilizing their proprietary code validation and profiling software in order to detect aberrant claims which are then reviewed by an RN. The RN reviews authorizations and claims history to determine if the procedure billed was appropriate or if it should have been billed in another manner. They make a pay/deny recommendation to Centene's SIU who then reviews and accepts or rejects the recommendation. HCI will review the surgeon and co-surgeon bill to ensure they billed for the same procedure; two office visits billed on the same day; providers who appear to be upcoding; excessive amount of services on the same day; and reviewing claims for the appropriate use of modifiers. The SIU also monitors provider billing habits to ensure proper billing. By using a system called Intelligent Investigator, hosted by EDIWatch, the SIU is able to monitor providers billing habits looking for those providers that may be wastefully billing. EDIWatch identifies providers that are upcoding, providing services on weekends, ambulance rides without hospitalizations, and repetitively using modifiers. The SIU works closely with the Bridgeway CO to ensure that providers identified and reviewed for abuse and/or fraudulent patterns are reported in a timely fashion.

Compliance Staff Organizational Chart

Required Key Staff

Denotes indirect reporting relationship

Centene Corporate Ethics, Compliance and Special Investigation Unit

Rick Fredrickson
Administrator/CEO/COO

Bridgeway
Board of Directors

Nancy Maurer
CFO
[VP, Finance]

Nicole Larson
Compliance Officer
[VP, Operational Services & Compliance]

Employees & Managers Of Key Functional Areas

COMPLIANCE COMMITTEE

Lori Johnson
Grievance & Appeals Coordinator

Kitley Ann West
Dispute & Appeals Manager
[Mgr, Grievance & Appeals]

Cheyenne Ross
Director, Medicare Compliance

Virginia Rountree
Director, Compliance

17. Submit the organization's three most recent audited financial statements and the related parent company financial statements if applicable. The Offeror may exceed the three-page limit. Existing ALTCS Contractors which have met this submission requirement through current contract requirements do not need to resubmit the three most recent financial statements.

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

Bridgeway Health Solutions (Bridgeway) is a current ALTCS Contractor. Bridgeway has met the requirement for the three most recent audited financial statements submission through current contractual requirements. Bridgeway submitted the three most recent audited financial statements to AHCCCS on the following dates:

- Audited Financial Statements and Additional Information Year ended 9/30/2010 – submitted January 2011
- Audited Financial Statements and Additional Information Year ended 9/30/2009 – submitted January 2010
- Audited Financial Statements and Additional Information Year ended 9/30/2008 – submitted January 2009

The supplemental information submitted as part of our audited financial statements and additional information includes financial statements specific to Bridgeway's ALTCS business operations. Bridgeway is a wholly owned subsidiary of Centene Corporation (Centene). We submitted Centene's financial statements for the year ended 12/31/2008 in February 2010. Centene's most recent audited financial statements that include the years ended December 31, 2009 and 2010 are submitted as the following attachments:

- ***Attachment C.17-A: 2010 10-K for Centene Corporation***, which includes audited financial statements for both 2009 and 2010

As demonstrated by submission of the documents above and attached to this section, Bridgeway, and its parent company, Centene Corporation, possess sufficient assets and reserves for contingencies, generate sufficient cash flow to pay claims and other obligations timely, and generate positive income to continually boost its reserves and equity.

Attachment C.17-A
2010 10-K for Centene Corporation

18. Submit the organization's plan for meeting the Performance Bond or Bond Substitute requirement including the type of bond to be posted, source of funding and timeline for meeting the requirement.

Bridgeway commits to have the required Performance Bond in place within 30 days after notification by AHCCCS of the amount required. The bond will be placed through Safeco Insurance Company or another carrier of equal rating. Bridgeway understands that the amount of the Peformance Bond is equal to 80% of the total capitation payment expected to be paid in the first month of the contract year or some amount as determined by AHCCCS. Our ability to provide this Performance Bond is evidenced by the Performance Bond we have provided for our current ALTCS Contract. As a current contractor, Bridgeway has maintained compliance with this requirement.

The bond will be funded by Centene Corporation. Centene is authorized to fund such enhanced net worth requirements from its general corporate operating funds and profits.

19. Submit the organization’s plan for meeting the minimum capitalization requirement.

As an existing Contractor, Bridgeway’s equity balance exceeds the equity per member standard for the Maricopa and Yuma/La Paz GSAs that we are currently serving. Bridgeway’s equity as of December 31, 2010 is $7.9 million.

In the event that Bridgeway was awarded additional GSAs and required to fund additional equity, Centene Corporation will fund any additional equity requirements from its general corporate operating funds and profits. Any additional funding would be completed within 30 days after contract award.

As of December 31, 2010, Centene’s consolidated revenue was $4.4 billion. The company has a very strong balance sheet with over $1.9 billion in total assets, including $434.2 million in cash, short-term investments of $21.3 million and long-term investments of $595.9 million. The short-term investments generally consist of highly liquid securities with maturities between three and 12 months. The long-term investments consist of municipal, corporate and U.S. Agency bonds, life insurance contracts, U.S. Treasury investments and equity securities and have maturities greater than one year. Centene manages short-term and long-term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short-term requirements as needed.

Table of Contents
Section D - Program

CASE MANAGEMENT **166**
Question 20: Interdepartmental Coordination 166
Question 21: Monitoring Level of Consistency 169
Question 22: Needs of Complex Members 172
Question 23: Assessment and Care Planning 175
Question 24: Case Management Scenarios 178
MEDICAL MANAGMENT **190**
Question 25: Utilization Data 190
Question 26: Interventions 196
Question 27: Disease Management 199
Question 28: Clinical Criteria 202
QUALITY MANAGEMENT **205**
Question 29: Quality Improvement Opportunities 205
Question 30: Peer Review Committee 208
Question 31: Quality of Care Scenarios 211
Question 32: Improving Quality of Care 217
Question 33: Member and Provider Feedback 220
Question 34: Members Residing in Their Own Home 223

20. Describe how the Offeror has or will implement inter-departmental coordination between case management and other areas of the organization to improve member health and service outcomes. Provide an example of how the Offeror improved member health or service outcomes because of inter-departmental coordination.

Overview

Bridgeway's mechanisms for promoting coordination and communication between Case Management and other departments emphasize, in particular, coordinated approaches between Medical Management and Quality Management, improving both individual member outcomes, and organizational performance. Our integrated systems and affiliate relationships enhance our ability to coordinate across departments as well as with subcontracted functions. This approach has improved our health and service outcomes. For example, the 2010 ALTCS Case Management Survey Review found that 98% of our surveyed members were satisfied with the performance of their Case Manager; and overall satisfaction with our case management services was 96% across all categories, with no category scoring below 90%.

Coordination To Improve Individual Member Outcomes

Care Plan Development, Monitoring and Revision. Bridgeway trains our Case Managers to follow a collaborative process in developing, monitoring and revising care plans. Our multidisciplinary Case Management staff, which include clinicians with medical and behavioral health expertise as well as social workers and non-clinical staff, follow protocols designed to enhance coordination with one another and with staff in other departments as needed to ensure care plans meet the medical, behavioral, functional, social and other needs of each member. For example, we require medical Case Managers to work with our BH Coordinator when a member's assessment indicates a potential BH need, and to coordinate with Member Services staff to assist members in identifying providers. Case Managers consult our Pharmacy Technician for assistance in identifying contraindications and addressing potential and actual medication interactions. Case Managers refer potential provider compliance issues identified during monitoring to the Provider Services Department for follow up. The Medical Director is available 24/7 as well as through our weekly Case Review Team meetings (described below) for any Case Manager who needs input or assistance on a case. Our clinical staff have regular formalized coordination mechanisms as described below, but we coordinate on an hour-by-hour basis, with all necessary staff including the Medical Director pulled in to quickly respond to needs as they arise.

Case Review Team. Our weekly Case Review Team meetings ensure coordination of care and appropriate utilization of services through a collaborative, interdepartmental approach to identifying service options and holistic solutions. The Case Review Team includes the Medical Director, VPs of Case and Medical Management, Director of Medicare, Case Management Supervisors, BH Coordinator, Case Managers, and Prior Authorization Supervisor. Our Quality Improvement Coordinator, Pharmacy Coordinator, and Member or Provider Services staff participate as needed when relevant to the issue(s) to be coordinated. During the weekly meetings, Case Managers present issues to receive cross-department input and assistance. Information presented includes, but is not limited to, the member's medical and behavioral health conditions, social and other needs and goals, and covered and non-covered services on the care plan.

Coordination with ALTCS and Medicare Services. To ensure coordination of ALTCS and Medicare services, our members who receive Medicare services through Bridgeway's Special Needs Plan (SNP) are assigned to one Case Manager for both sets of benefits. Having a single point of accountability for the member's full range of Long Term Care, behavioral health, and acute services through both programs enhances the level of integration. The Case Manager uses the same mechanisms described above to coordinate all aspects of the member's care and service needs among departments. Our SNP's Director of Medicare (DoM), who reports through Bridgeway's VP of Operations and Compliance, is involved in all aspects of management and quality for our dual eligible members (about 85% of our membership). The DoM participates in Case Review Team meetings to provide direction and input on member care and services, general expertise on Medicare regulations, and assistance in working with other Medicare Advantage plans. The VP of Case Management, DoM, and Medical Management Director have bi-weekly Medicare operations meetings and quarterly Medicare compliance meetings which include review of utilization reports related to hospital/ER use, high acuity members, health risk assessments, and notification of transitions. In addition, the DoM provides input to the Quality Management Department on quality initiatives and provides regular training on Medicare issues to all Bridgeway Departments.

Coordination To Improve Aggregate Member Outcomes

Case Management Plan. Our Case Management Plan (CMP) establishes a required framework for interdepartmental coordination to improve both individual and aggregate outcomes. All Case, Medical, and Quality Management staff receive initial and annual training on the CMP to ensure cross-organizational understanding of requirements and processes. The CMP is the foundation for our implementation and monitoring of all case management and administrative

standards, including specialized caseloads, required by the contract and AMPM Chapter 1600. The Vice President of Case Management is responsible for developing, implementing and monitoring the CMP, which includes an annual evaluation of the previous year's CMP, with lessons learned and strategies for improvement. The CMP also includes aggregate data results reviewed by the Quality Management Investigative Committee (QMIC) and Utilization Management/Medical Management Committee in monitoring case management, as well as any performance improvement initiatives. The Case Management Department reviews the CMP with all Case Managers annually to ensure their understanding of Bridgeway's member-centric philosophy, integrated care model, and all case management policies and procedures.

Coordination of Medical Management Issues. Staff from all departments refer all suspected or potential quality of care (QOC) concerns to the Quality Management (QM) Department for further investigation. Provider Service Representatives (PSRs) may learn of potential QOC events during routine site visits to providers and/or facilities. Case Managers may learn of QOC events during onsite member visits, interaction with facility staff and during oversight of care plans. Member Services staff may identify a QOC issue during calls with members. QM and other Bridgeway staff scan news reports for information about quality concerns. The Quality Improvement (QI) Coordinator takes the lead on investigating these reports, coordinating across departments as needed, such as working with Case Management staff to identify all members in a facility who could be affected by the reported QOC issue. The QI Coordinator reports results to the QMIC for necessary follow up action. In addition, the VP of Case Management provides monthly and quarterly results from all Case Management monitoring to the Medical Director and QMPIC for review. This ensures that Bridgeway's clinical leadership stays informed on clinical management issues and addresses them in a coordinated manner. If monitoring indicates a concern, the Medical Director, Medical Management Department, and QMIC work with the Case Management Department to improve processes and outcomes.

Coordination With Bridgeway Leadership. Each Bridgeway Department has weekly meetings to discuss monitoring results and current issues. When a significant issue or opportunity for improvement is identified, including but not limited to those related to member health and service outcomes, the department manager presents the issue to our Senior Leadership Team. Our Senior Leadership Team is comprised of the Bridgeway CEO, the Medical Director, and the Vice Presidents of Case Management, Medical Management, Member and Provider Services, Operations and Compliance, and Finance. The Senior Leadership Team meets weekly to discuss identified issues or opportunities, and advises the Quality Management/Performance Improvement Committee (QMPIC) as necessary. The Team also develops and monitors cross-departmental initiatives to address identified care concerns. Frequent coordination between Case Management and Bridgeway's leadership ensures management decisions incorporate and address issues to improve member outcomes. For example, the Case Management Department identified the timeliness of Case Managers receiving notice of hospital admissions as an area for improvement in discharge planning and preventing readmissions. The QMPIC coordinated the efforts of the Case Management, Medical Management, and Provider Services Departments in developing an automatic notification feature for our medical management system. Pre-Authorization or Concurrent Review Nurses from the Medical Management Department now enter admission information into TruCare, which generates an immediate notification to the Case Manager. This provides early notification of an admission and allows the Case Manager to begin the discharge planning process prior to discharge, increasing the likelihood of preventing readmission.

Performance Improvement Team (PIT). Our PIT includes staff from all Bridgeway departments, including Case Management. This team meets quarterly to monitor performance improvement projects (PIPs) required by AHCCCS. The PIT also develops, implements, and monitors cross-departmental implementation of PIPs directed by the QMPIC to respond to improvement opportunities related to member health and service outcomes identifed through monitoring.

Quality Improvement Process. The VP of Case Management and the Medical Management Director coordinate with QM staff on the development of report cards for institutional and HCBS providers. The QM Data Analyst provides monthly and quarterly reports to QM staff and the Medical Director, who present monitoring results to the QMPIC and CQC and make recommendations for follow-up. The VP of Case Management presents case management reports to the QMPIC and takes the lead on implementing and reporting on performance improvement plans. The QMPIC provides a single point of coordination across Bridgeway Departments for comprehensive, plan-wide monitoring, identification, evaluation, and resolution of problems, and improvement of outcomes.

Integrated System. A central feature of Bridgeway's approach to coordinating among Departments to improve member health and service outcomes is our state-of-the-art Centelligence^{TM} (Centelligence) family of integrated decision support and healthcare informatics solutions. Our Centelligence enterprise platform integrates data from multiple sources and produces actionable information used organization-wide to monitor and improve outcomes. This includes, but is not limited to Care Gap and Wellness Alerts, Key Performance Indicator (KPI) Dashboards, Provider Clinical Profiling

analyses, population-level health risk stratifications, and standard and ad-hoc desktop reports. Centelligence enhances the ability of all departments to collaboratively monitor and improve clinical and administrative processes, and anticipate and address issues and improvement opportunities. For example, Centelligence Foresight allows predictive modeling and health risk analysis to identify members who are at risk for high utilization. Centelligence Insight analyzes actual utilization and trends to track member conditions and progress. This information is integrated through TruCare, our integrated, member-centric health services management system, which is used by all clinical staff. TruCare provides a holistic view of each member's condition, risks and care for all staff involved in a member's care, such as Case and Medical Management staff coordinating a discharge plan or case; and Medical and Quality Management staff analyzing member outcomes to identify opportunities for and to track results of performance improvement initiatives. Centelligence also integrates information on gaps in recommended care as well as other issues (such as the need to identify a member's current phone number) through our Member and Provider Relationship Management systems. This ensures that a Member Services Representative receiving a call from a member/caregiver knows to update the phone number, advise them of the care gap and offer to connect them to a Case Manager for more information or assistance. It also prompts staff to inform providers who call to check member eligibility of a gap in that member's care.

Integrated Affiliate Support. As part of the Centene family of companies, Bridgeway offers a highly integrated approach to the full range of services and supports our members need. Our affiliate specialty companies help us provide enhanced services that touch many areas of our members' lives. For example, Nursewise, our 24/7 nurse advice line, provides after hours call center support. Nurtur, our disease management affiliate supports our telemonitoring program. Cenpatico Behavioral Health, a Regional Behavioral Health Authority in Arizona and behavioral health affiliate in other states, supports our Case Managers and Provider Services staff with additional behavioral health (BH) expertise, and on-the-ground knowledge of BH community resources and the Arizona behavioral health provider community. Opticare provides vision care services and US Script provides pharmacy services to our ALTCS members. Because these affiliates are subsidiaries of the same company, we are able to coordinate and share information and data in ways unrelated companies cannot. By integrating data and applications with our affiliates, and by easy access to staff across companies, we can further support coordinated and timely response to our members' needs. For example, NurseWise documents after hours calls within their Telehealth Triage clinical documentation system, which is loaded into TruCare for Case Manager follow-up the following day. This data exchange allows our Case Managers timely access to after hours concerns and changing member needs, and creates flags for follow up triggered by the issues the member discusses with NurseWise. NurseWise has 24/7 access to our Medical Director and on-call clinical staff so we can immediately address urgent member needs. With services such as our after hours line "in-house," we can coordinate a wide range of efforts, across affiliates and internal departments, and ensure members get what they need when they need it.

One example of how we improved outcomes through coordinating with affiliates is our reduction of inpatient BH admissions by adding outpatient services. Our Case Managers worked with Cenpatico's Provider Network and Medical Management Departments to assist outpatient providers with developing BH-focused programs and services. These efforts expanded access to supports that help members live successfully in the community, such as those available now through Counseling and Consultation and the Mentus Group in Yuma and Maricopa Counties. As a result, BH admissions/1000 fell from 12.5 to 6.8 and BH bed days/1000 from 389.6 to 117.8 from contract year (CY) 2009 to CY 2010.

Example of Improvement in Member Health or Service Outcome

In 2008, our Case Management, Quality, and Medical Management Departments coordinated an initiative to reduce our 30 day readmission rate, which was 26.6% for CY 2007. The QI Coordinator worked with the Medical and Case Management Departments to develop and implement protocols to improve member compliance with post-discharge follow up care. Case Managers began conducting post-discharge calls to members to determine whether members needed assistance following discharge instructions, and to identify and address barriers to doing so. To enhance this effort, the Medical Management Department developed a protocol for concurrent review nurses (CRNs) to notify the Case Manager of the discharge date via our medical management system to assist Case Managers in identifying members for post-discharge calls. Inter-departmental analysis of this initiative later in 2008 identified additional improvements that could be made to the discharge process. As a result, Quality and Medical Management staff developed a discharge transition tool to structure communication between CRNs and hospital discharge/social work staff regarding discharge education for members, including providing members with Case Manager contact information so they know how to quickly access assistance post-discharge. This coordinated initiative reduced our 30 day readmission rate to 18% by CY 2009.

21. Describe the Offeror's plan for monitoring and improving, as needed, the level of consistency among case managers with regard to the assessment of HCBS member needs and service authorizations.

Overview

Bridgeway uses a variety of methods to ensure consistency among Case Managers in assessing HCBS member needs and authorizing services to effectively address medical and behavioral health issues, improve or maintain functioning, and maintain the member in the home or a community-based setting whenever possible. We closely examine individual Case Manager and department performance; follow up on monitoring results with individuals demonstrating inconsistent performance; and implement department-wide initiatives to improve consistency. Our most recent inter-rater reliability testing indicated 95-100% concordance among Case Managers in assessing Level of Care (LOC; see below for detail). We credit this high level of consistency, in part, to our comprehensive initial and ongoing Case Manager training programs, as well as the evidence-based, nationally-recognized guidelines and technology supports we use to evaluate the appropriate types and amounts of services our members need. The 2010 ALTCS Member Satisfaction Survey results indicated 96% satisfaction with our case management services.

Ensuring Consistency

Training. Our dedicated Manager of Training and our experienced Case Management (CM) Supervisors provide intensive training to newly-hired Case Managers which facilitates a consistent approach to assessments and authorizations. This three-week training addresses topics that include, but are not limited to AHCCCS and Bridgeway policies and procedures; assessment instruments and scoring, our strengths-based assessment process; Motivational Interviewing and assessing member/family readiness to change; covered services including self-directed attendant care and spouses/family as paid caregivers; member goal-setting; member-centered care planning; cultural competence and the tools and technology (described below) available to support case management processes and ensure consistency in needs assessment and authorization of services. New Case Managers shadow seasoned Case Managers for hands-on training with initial assessments, reassessments, and care planning in all placement settings, including in-home, assisted living, and skilled nursing facilities. We then test our Case Managers on all aspects of case management policies and procedures, and they must score at least 95% before they can independently take a caseload.

All Case Managers receive ongoing training and targeted training to address inconsistent practices identified through monitoring individual Case Managers or the entire Department. Ongoing training includes, but is not limited to, annual updates on topics covered during initial training such as use of the HCBS Needs Assessment for authorization of service hours; use of the UAT (Uniform Assessment Tool) for individualized assignment of Level of Care (LOC); and training on interviewing techniques necessary to draw information from members during face-to-face assessment visits. Targeted training occurs as discussed below in the Improving Consistency section of this response.

Tools and Technology. Bridgeway uses evidence-based clinical practice guidelines and nationally recognized medical necessity criteria to ensure Case Managers consistently authorize appropriate services that help members achieve the highest possible levels of health, wellness, functioning, and quality of life. These guidelines and criteria are incorporated into TruCare, our integrated, member centric health services management platform. TruCare also houses all our standardized assessment tools and guidelines for authorization of HCBS and other services. This state-of-the art solution supports consistency among Case Managers because the system configuration requires staff to document assessment results in a consistent format. Our CM Supervisors use TruCare's monitoring capability to assess the extent to which Case Managers complete tasks within required timeframes, and can quickly detect and address any variation from these timeframes.

In addition, TruCare analyzes member assessment and other data entered into the system to generate flags for Case Managers, such as disease management eligibility criteria met, member alerts for required follow up, and indicators to facilitate service referrals. These prompts enhance early identification of potential needs and quick authorization of appropriate covered services.

Monitoring Consistency

Bridgeway supervisory staff monitor Case Manager consistency through chart audits, inter-rater reliability testing, and our Case Review Team. We also monitor member and provider feedback to identify potential inconsistencies.

Chart Audits. CM Supervisors complete monthly chart audits to determine whether Case Managers are assessing needs appropriately. Overall chart audit compliance was 95% in 2009-10 and 96% for the first quarter of 2011.

CM Supervisors review for a number of elements (see table below) that indicate whether a Case Manager is using a member-centric approach to ensure the member is involved and satisfied; meeting required timeframes, completing required case management tasks and documentation, and matching appropriate services to member needs. For new Case Managers, 100% of their charts are audited for the first six months of employment. If their results meet standards (95% overall compliance with standards), they are placed on the regular monthly audit schedule used for experienced Case Managers. CM Supervisors select a Case Manager's charts for review randomly, so the Case Manager does not know which chart will be pulled monthly. This encourages excellent Case Manager performance and documentation for all assigned cases. Any audit results that fall below 95% trigger corrective action.

CHART AUDIT CHECKLIST	
Was the initial visit completed in 7 business days (vent)/10 business days (routine)?	If the member received critical services, was there a signed Contingency Plan with member preference levels and back-up plan clearly noted?
Are reviews completed on time? (90 days, 180 days)	Was Self Directed Attendant Care discussed with member within the past year?
Is there a Service Plan completed at each assessment or change in service; does the Plan match identified needs?	Does documentation reflect satisfaction in services and member/representative involvement in determining the treatment plan?
Was a UAT completed at each onsite with changes in member assessment and documented in the chart?	If services are reduced or terminated; does documentation reflect why and if member/representative approved of the change?
If no services for one calendar month, was Member Change Report submitted?	Were authorized services started/ documented within 30 days of initial enrollment?
Was all member contact documented within ten business days or Client Assessment and Tracking System due date?	CM presented spouse attendant care as an option for the HCBS members with spouses?
Are case notes complete and reflect all of the member's identified needs?	If the member was hospitalized, did the CM complete a post hospital assessment and adjust authorizations as needed?

Inter-Rater Reliability (IRR) Testing. Quarterly IRR testing is an important part of our efforts to ensure Case Manager consistency. Our most recent results, from Q4 of 2010, found 100% concordance on LOC assessment among our Case Managers in Yuma and among one of two groups of Case Managers in Maricopa (we split Maricopa into two groups due to the large number of case management staff in that GSA). Results indicated 95% concordance on LOC assessment among our second group in Maricopa.

To conduct IRR testing, a CM Supervisor selects two Case Managers to complete an onsite assessment at the home of a member they have not previously assessed. During the onsite visit, each Case Manager completes the AHCCCS Uniform Assessment Tool (UAT) and the HCBS Needs Assessment. The Case Managers then present the case to a 'peer group' of experienced Case Managers unfamiliar with the case. The presentation includes role-play and each Case Manager provides the group with their completed assessments and documentation. The peer group participants are allowed to ask clarifying questions, then each independently completes the UAT and HCBS Needs Assessment tools to determine Level of Care, and to assess the number of hours that would meet the member's needs. This IRR testing model allows comparison of consistency among Case Managers for a real case. The CM Supervisor aggregates the results and compares each participant's scores to measure assessment consistency and to identify the need for education/training to address any inconsistency. If any Case Manager has assessed the number of hours at +/- 3 or more hours than the CM Supervisor determines is the appropriate number of hours for the member, this discrepancy is discussed among the group and used as a training exercise to increase consistency among the Case Managers in their approach to determining hours.

Case Review Team. Bridgeway's multidisciplinary, interdepartmental Case Review Team meets at least weekly to provide feedback and input to Case Managers on cases that involve high risk conditions, require integration and coordination among multiple areas of expertise and/or departments, or present other challenges. The Case Review Team is comprised of the Medical Director, the Vice President (VP) of Case Management, the VP of Medical Management, the Director of Medicare, our Behavioral Health (BH) Coordinator, Case Management Supervisors, and Case Managers.

Bridgeway requires Case Managers to participate in a Case Review Team meeting at least once each month, even if they do not have a case to present for review. Participation in the Case Review Team meeting provides Case Managers with exposure to the types of questions asked and factors considered by management staff in order to assure appropriate authorization of services. This Case Review enables us to identify services that are at high risk for inconsistency, and implement an effective supervisory review of HCBS Needs Assessments and service authorizations. The CM Supervisor reviews all HCBS member assessment tools completed for Attendant Care, Personal Care, and Homemaker Services, and

provides targeted individual education for staff demonstrating a variance of +/- 3 or more hours from the CM Supervisor's determination of hours for the case.

Member and Provider Feedback. Our annual member satisfaction survey examines areas such as: whether the Case Manager covered required components of assessment and service planning; member involvement in the service planning process; Case Manager responsiveness to member inquiries; coordination of services; and overall satisfaction with our Case Management Program. The Member Services Department conducts the surveys during the 3rd quarter of each Contract Year, and submits the results to AHCCCS within forty-five days of analysis. Our 2010 survey indicates 96% member satisfaction with the customer service provided by our Case Managers.

Our Grievance and Appeals Department analyzes weekly and monthly reports on member complaints and grievances, and provider complaints, and staff attempt to identify issues that indicate potential inconsistency among Case Managers. When a potential inconsistency is identified, the CM Supervisor conducts an investigation, which includes following up personally with the complainant, interviewing the member, conducting a chart review, and conducting additional member reviews to determine whether the issue is confined to a single case or is more widespread. If the issue involves a single Case Manager, the CM Supervisor works with the Case Manager to implement corrective action such as additional training. If the issue is more widespread, the corrective action may involve the entire Department.

The VPs of Case Management and Provider/Member Services, and Compliance staff monitor feedback from our Member/Provider Advisory Council to identify consistency issues. The Council, composed of non-profit agencies, community organizations that serve our members, and members provide feedback quarterly to Bridgeway on a variety of issues related to Case Manager coordination with community resources and non-covered services. Potential inconsistency is investigated and handled as described above for complaints.

Improving Consistency

Individual Case Manager Improvement. When chart audits, IRR testing, or Case Review Team participation indicate an individual Case Manager is not meeting standards for assessments and authorizations, a CM Supervisor discusses the results with the Case Manager during one-on-one Supervisory meetings and/or during the regularly scheduled bi-weekly Case Management Department meetings. For example, Case Managers whose chart audits indicate that they assess member needs and LOC at an unusually low or high level, as well as those with variances of +/- 3 hours from the group mean for authorized hours in IRR testing, receive counseling from the CM Supervisor on how to improve their performance. Case Managers with results below the standard are also required to shadow a seasoned Case Manager on assessment visits for a period of time (determined based on specific monitoring results), and may be required to complete additional training.

Department-Wide Improvement. CM Supervisors and the VP of Case Management analyze aggregated monitoring results monthly to identify department-wide consistency issues. The Case Management Department reports aggregated results for chart audits, IRR testing, and Case Review Team activity quarterly to the Bridgeway Medical Director and our Quality Management/Performance Improvement Committee (QMPIC). If problems are identified, the QMPIC, with the assistance of the Medical Director, Quality Management/Performance Improvement Department, Human Resources, and the Compliance and Operations Officer, develops and monitors a corrective action plan to ensure Case Management Department performance improves. For example, in contract year 2010, Case Management Department monitoring indicated that Case Managers were not consistently educating members about self-directed attendant care (SDAC). In October 2010, we added a question to our monthly Chart Audit checklist to identify and quantify this inconsistency and to signal to Case Managers the importance of this topic. Compliance with educating members about SDAC rose from 85% in November 2009 to 100% in June 2010.

22. Describe the process the Offeror will employ in assessing and meeting the needs of complex care members via service planning and coordination of multiple providers and involved entities specifically for 1) members needing behavior management and 2) members with complex medical care needs.

Bridgeway uses a holistic, member-centric approach that incorporates strengths-based assessment, support of the informal network, and integration of covered services and community resources to maintain members in the least restrictive, most integrated setting appropriate to their preferences and needs. Our assessment, care planning, and coordination processes and innovative approaches improve outcomes and maintain or improve functioning. For example, we achieved 80% reduction in hospitalization for members with complex medical needs participating in our telemonitoring program. Our Case Managers (CMs) spend their time in the field, getting to know members/families and maintaining strong relationships with providers to meet member needs and quickly identify and address issues. We support caregivers with respite services and connect them to community resources to prevent burnout and strengthen the informal support system. We take a holistic 360 degree view of each member, understanding that meeting social and functional needs is as important as meeting medical and behavioral needs in ensuring our members meet their goals for a satisfying life.

Our CMs are supported by our state-of-the-art Centelligence™ family of integrated decision support and healthcare informatics solutions. Centelligence enhances CM ability to anticipate, identify, monitor and address issues and improvement opportunities. For example, CMs can use Centelligence Foresight (Foresight), our predictive modeling and care gap/health risk identification application, to track member conditions; monitor member care gaps or health risk alerts; identify members with co-morbid conditions and persons at risk of developing chronic conditions; identify persons in need of additional services or higher levels of case management; and take action. CMs and other clinical staff access this information with one click through TruCare, our member-centric health management platform for case management, behavioral health (BH), disease management, and utilization management. TruCare allows us to integrate utilization, BH care, case management and disease management efforts; proactively monitor members; efficiently document the impact of our efforts; pinpoint where care is needed; and implement customized intervention strategies. We maintain data for our Medicare Special Needs Plan (SNP) within the same system, providing us a more holistic look at the needs and services of our members who are also in our SNP. In the 3rd quarter of 2011, our CMs' outreach efforts will be supported by the introduction of our new Member Relationship Management (MRM) system. For example, a CM attempts to reach a member because Foresight detects an important gap in care, but is unsuccessful because of an incorrect phone number. The CM can document her need to talk to this member in TruCare, and the information will flow into MRM. When the member calls the member call center about another issue, our Member Service Representative (MSR) can see that the CM needs to talk with the member when they pull up the member record, and offer to warm transfer the member to their CM.

Our assessment, care planning and coordination processes emphasize a holistic view of the member's entire range of needs rather than focusing just on the primary behavioral health (BH) or medical diagnoses. Below we describe these processes, highlighting additional or different processes focused on BH and complex medical needs.

Assessment. Case Management (CM) Supervisors review information from AHCCCS, previous Contractors, BH providers, or other sources to identify members with existing services or immediate needs. New members receive a Welcome Call from a Program Coordinator (PC) who helps the member complete a Health Risk Screening Assessment (HRSA) to identify diagnoses, medications, hospital and emergency room use, activities of daily living, pain, mental health conditions, substance use issues, and use of medical equipment and supplies. The PC enters HRSA data and other information gathered during the call into TruCare. The CM Supervisor uses this information to assign a CM and a timeframe for the initial assessment visit. Depending on the member's condition and needs, the CM may be a nurse, BH clinician or social worker. If enrollment or HRSA information indicates unmet critical needs, the PC immediately contacts a CM, who assesses criteria for urgent initiation of services and schedules an immediate home visit. If there are no unmet critical needs, the PC works with the member to schedule a home visit from the CM within 10 business days of enrollment, or within seven business days of enrollment for ventilator-dependent members. When scheduling the visit, the PC or CM asks who else they would like to have participate, encouraging inclusion of caregivers and informal supports. For dual eligibles in a SNP or Medicare Advantage Plan (MAP), the CM coordinates the initial assessment with the SNP/MAP CM. Members in our SNP have a single CM to coordinate ALTCS and Medicare services.

The CM works with the member and family/caregiver to complete a comprehensive assessment of physical and BH conditions, functioning, social needs, living environment, cultural considerations, informal support system, and financial needs. This includes, but is not limited to the Uniform Assessment Tool (UAT), and the Comprehensive Long Term Care Assessment to determine member needs and level of care. The CM also administers a depression screen, assesses for

medication non-adherence and reviews any psychotropic medications. We require CMs to document medication regimen in TruCare, including purpose, effectiveness, and any adverse side effects. Our 2009 and 2010 chart audits demonstrate 97% overall compliance with this requirement. CMs also assess for history and treatment of substance abuse, psychiatric issues (including hospitalizations), suicide attempts, and aggressive or threatening behavior; as well as legal history, vocational history, ability to care for self, and strengths and goals. For members in NFs and ALFs, the CM assesses ability, desire, and options available to return home (or, for members in a NF, to transition to an ALF). For members in, or desiring to return to the home or community, the CM also assesses availability and strengths of informal supports and caregivers. We assess the member's existing system of care and how it is working for them, and help identify providers with specific expertise as needed. For example, if a member with a BH condition lacks a regular provider relationship, we will discuss the availability of our Integrated Care Program (see below). If members have strong relationships with non-network providers, our Provider Services Representatives will attempt to contract with them to ensure continuity of care and expand availability of expertise within the network in areas such as pain management services.

Care Planning. To ensure that our members can make informed decisions, our CMs uses Motivational Interviewing and other strategies to engage members and their families in the planning process, and provide comprehensive education about services and support available through Bridgeway. This includes, but is not limited to member rights and responsibilities; grievance and appeal procedures; the Member Handbook (in the member's primary language or in an alternative format as needed); ALTCS and Bridgeway; available services and settings; how to contact the CM, the member call center, and our 24/7 nurse advice line; and information about available providers. For dual eligible members, CMs discuss differences between ALTCS and Medicare, and how we coordinate both sets of benefits, including how CMs interface with non-Bridgeway SNPs/MA Plans. CMs educate members living in their own homes about the Self Directed Attendant Care (SDAC) Program, as well as the option to choose their spouse as a paid attendant caregiver and the need to consider how that choice may influence eligibility for other publicly funded programs. To encourage and support members in choosing SDAC, we provide fiscal agent services through Consumer Directed Personal Care in Maricopa and Pima and will expand this service in new GSAs we are awarded. The CM also provides applicable disease management education to enhance the member's control over their own condition and care.

The CM uses assessment information (along with available information from previous Contractors, BH Providers and SNP/MA Plan) to help the member articulate physical health, BH, functional, social and other goals that form the basis of the care plan. Goals are measurable and the CM and member identify a plan of action (including but not limited to timeframes, the member's role in implementing the plan, CM responsibilities and service options) to achieve each goal. As part of this process, the CM discusses the full range of services and settings available through Bridgeway as well as available community resources. The CM encourages member self determination, honoring preferences in types, frequencies and settings of services, emphasizing their right to services provided in the most integrated, least restrictive setting appropriate for and acceptable to them. Respite is provided based on the member's level of medical need as determined by the most recent UAT. For members in ALFs who are assessed to need (but refuse) skilled nursing care, the CM informs the member of possible risks, works with the member/responsible party to complete a Managed Risk Agreement, and notifies the PCP and other providers. For members whose care plans include Attendant Care, Personal Care, Homemaker and/or In-home Respite Care, the CM helps the member/family develop a back-up plan to address gaps in critical services, and educates them about their rights and responsibilities and the process for implementing the back-up plan. The CM also conducts a cost effectiveness study to ensure the care plan meets cost effectiveness requirements. The CM also works with the member and caregiver/family to identify and address community resources and overcome barriers. For example, persons living in their homes in rural areas may need transportation assistance, while those living in ALFs may need a housing specialist to help them move toward supported housing. CMs incorporate non-covered services provided by community resources into the care plan to ensure integration of all services the member receives, and provide a community resource guide to the member/family listing resources in the local area.

Clinical Input. The CM contacts the PCP in a timeframe consistent with member needs to discuss the assessment, member preferences, goals and needs, and the care plan. With member consent, the CM shares clinical information and care options with all applicable providers, and shares each provider's input with other treating providers to ensure coordinated input into the care plan. To obtain additional expertise and input into the care plan, CMs may present complex situations to our multidisciplinary Case Review Team (CRT), comprised of the Medical Director, VPs of Case and Medical Management, CM Supervisors, BH Coordinator, and CMs. A CM Supervisor evaluates all moves from home and community based settings into an ALF for appropriate level of care prior to the move.

Innovative Strategies. Bridgeway's care plans incorporate innovative Bridgeway services that go beyond covered services to meet member needs, maintain them safely in the home/community and enhance our ability to monitor their conditions. Our Integrated Care Program (ICP) will support providers to manage costs and improve outcomes for members with severe and persistent mental illness (SPMI). We will solicit Medicare-certified medical and BH providers in each GSA we are awarded to participate. Our Provider Coaches will provide technical assistance to ICP providers to develop local integrated service delivery connections between medical and BH providers. Since most BH expertise in rural communities is managed through RBHA-funded behavioral health providers, Bridgeway will work with RBHA-contracted BH agencies in our awarded GSAs to forge partnerships between our medical providers and RBHA BH providers. Each County has unique challenges and resources, so partnerships will be developed based upon each area's resources. The partnerships will include the continuum of care in each County including PCPs, BH agencies and ALFs. As part of the ICP, we are transforming our BH clinic in Tucson into a Medical Home with behavioral expertise. Through a partnership with the University of Arizona medical school, its affiliated teaching hospital, and the Arizona Center on Aging, we will provide an integrated continuum of medical services, behavioral health and community supports. We will relocate the BH clinic onto the U of A campus to support coordination of services, provide access to acute medical services through the teaching hospital doctors, and integrate care. We will place a CM onsite to facilitate coordination of care, discharge planning and community re-integration. The hospital will alert us when a member presents in the ER so we can quickly work to resolve the crisis and avoid unnecessary hospitalizations. The AZ Center on Aging will make nurse practitioners available to do home visits for members who require intensive support and oversight.

Other innovative services include telemonitoring services to high-risk members with complex chronic conditions including diabetes, hypertension, chronic obstructive pulmonary disease, and congestive heart failure. We also offer supplemental clinical management of members in NFs through Inspiris registered nurses, who provide onsite oversight and monitoring of member conditions and care, and provide early warning for clinical issues or facility quality problems. Our CMs perform all case management activities and collaborate with Inspiris nurses to monitor care.

Coordination and Monitoring. Once the care plan is finalized and agreed to by the member/family, the CM enters authorizations into TruCare and ensures service initiation. The CM alerts all treating providers, including SNP or MA Plan providers as appropriate to changes in the member's physical, BH or functional status, including any emergency room or inpatient admissions. The CM ensures that any physician who has prescribed medications for the member is made aware of all member prescriptions and how to contact the CM and the PCP to ensure medications are coordinated. The CM advocates for the member as requested, such as facilitating communication between the member and providers, assisting with grievances and appeals, or connecting the member to community-based organizations. CMs share information, obtain required referrals to both BH and medical providers, and coordinate activities which includes notifying all providers of initial service planning and update meetings; obtaining status updates as they occur; attending treatment plan meetings and staffing; receiving incident reports, and following up to ensure the member's treatment plan is updated; providing copies of the service plan to all providers; notifying treatment team members of changes in the member's status (changes in placement, Court Ordered Treatment information); coordinating training and support when a member's behaviors are difficult to manage; and notifying the Provider Relations Department of any administrative issues that may jeopardize a member's placement or ongoing service delivery. The CM also ensures providers know how to access the care plan via Bridgeway's secure Provider Portal, and educates them about Online Care Gap Notifications on the Portal, which alert to them to a member's gaps in recommended chronic and preventive care. For hospitalized members, our onsite concurrent review nurses monitor care, initiate day-one discharge planning with hospital staff and coordinate with CMs to ensure needed post-discharge follow up and services. For ventilator dependent members, the CM phones the member to verify that essential medical supplies are received as reflected in the service plan. If supplies are not delivered timely, the CM contacts a provider to arrange immediate delivery, and documents this failure in TruCare for Provider Services Department follow up. For members in NFs, the CM conducts reassessment of conditions and discharge potential at least every 180 days. If the member desires a HCBS setting and the necessary HCBS would be cost-effective, the CM works with the member, family, providers, Inspiris nurse practitioner and community resources to transition the member to a HCBS setting. For members on psychotropic medications but not stable, or when these medications are being adjusted, the CM reviews the situation with the BH Coordinator at least quarterly. The BH Coordinator contacts the prescriber to discuss and resolve any concerns. Our psychiatric consultant conducts polypharmacy reviews with the Medical Director, Pharmacy Director, BH Coordinator and nurse CMs to identify unneeded, ineffective, or contraindicated medications.

23. Describe the Offeror's process for assessment and care planning of members for home-based services by case managers.

Overview. Bridgeway's assessment and care planning processes ensure home-based services effectively meet member needs and preferences, help them achieve their goals, and maintain them safely in their homes. Our 2010 ALTCS Case Management Survey indicated 98% of home-based members surveyed are satisfied with their Case Manager (CM).

Assessment. All new members receive a Welcome Call from a Bridgeway Program Coordinator (PC). During this call, the PC helps the member complete a Health Risk Screening Assessment (HRSA) to identify service needs. The HRSA includes questions about diagnoses, medications, hospital and emergency room use, activities of daily living, pain, mental health conditions, substance use and use of medical equipment and supplies. If HRSA responses indicate a potential need requiring immediate clinical review, the PC immediately contacts a Case Manager, who reviews ALTCS enrollment and HRSA information, assesses criteria for urgent initiation of services, and schedules a home visit for a comprehensive assessment. If there are no unmet critical needs, the PC schedules a time for a CM to conduct a home assessment visit within 10 business days of enrollment into ALTCS. If the member is ventilator-dependent, the home visit occurs within seven business days of enrollment. In scheduling the visit, the CM asks the member (or legal representative as applicable) who else they would like to have participate in the visit, such as family or informal supports. The CM assigned to the member may be a nurse, BH clinician, or social worker based on the person's individual needs. A Case Management (CM) Supervisor determines the appropriate expertise by reviewing the HRSA and all information provided by ALTCS on the enrollment file to identify whether the member's primary needs are medical or behavioral. The CM works with the member and others involved to complete a comprehensive assessment, which includes the Uniform Assessment Tool (UAT), and the Comprehensive Long Term Care Assessment to determine member needs and level of care. The environmental assessment evaluates potential hazards to health or functioning within the home and home modifications that may be needed. The assessment process also includes a depression screen, and review of cultural needs and how these will impact the member and family's health-seeking behaviors and the effectiveness of services. Our assessment provides a complete picture of the member's strengths; functional abilities; medical conditions; behavioral health (BH) status; social, environmental and cultural considerations; medications; and the existing informal support system.

Our CMs assess all newly enrolled members residing in Assisted Living Facilities using the processes described above for the initial in-home visit and assessment. A central goal of this process is to determine the member's desire and ability to return home. If a move into their own home is not feasible or desired by the member/family at that time, the CM reassesses the member's condition, preferences, and ability to transition to a home environment at least quarterly. We assess members at home or in Assisted Living at least every 90 days.

Care Planning. Care plan development takes into account the full range of the member's goals, preferences, strengths and needs and includes input from the family/caregiver and informal supports to ensure the care plan prevents burn out and supplements but does not supplant those resources. The CM uses assessment information to help the members articulate personal goals as well as desired physical health, BH, functional, social, and other goals that will form the basis of the care plan. Goals are measurable and the CM and member identify a plan of action (including but not limited to timeframes, the member's role in implementing the plan, CM responsibilities, and service options) to achieve each goal. To ensure members and their families can make well-informed decisions, CMs provide comprehensive education about the services and support available through Bridgeway. The CM explains all member rights and responsibilities including grievance and appeal procedures, and provides a copy of the Member Handbook in the member's primary language or in an alternative format as needed. The CM also provides information about the ALTCS program and Bridgeway; available services and settings; how to contact the CM, the member call center and our 24/7 nurse advice line; and available providers. For dual eligible members, CMs discuss differences between ALTCS and Medicare, and how Bridgeway coordinates both sets of benefits, including how CMs interface with our own Medicare Special Needs Plans (SNPs) as well as non-Bridgeway SNPs/Medicare Advantage Plans. CMs educate members living in their own homes about the Self Directed Attendant Care (SDAC) Program, as well as the option to choose their spouse as a paid attendant caregiver and the need to consider how that choice may influence eligibility for other publicly funded programs. Chart audits conducted in contract year 2010 indicated high CM compliance (96-100%) with educating members about SDAC and spouse caregiver options.

The CM determines the member's preferences for types, frequencies, and settings of services, emphasizing that Bridgeway and ALTCS are committed to ensuring that services are provided in the most integrated, appropriate and least restrictive setting acceptable to the member. The CM also works with the member to identify and address barriers, such as lack of transportation. CMs focus on educating the member about what to expect regarding service delivery and their right to receive services according to the care plan.

Holistic Approach. To ensure care plans are holistic and that all services are well-coordinated, we incorporate non-covered services into the care plan. For example, care plans for dual eligibles include Medicare services. Care plans also include non-covered services provided through community resources. Our CMs are knowledgeable about available resources within the community and understand how to locate those resources, and coordinate covered and non-covered services to ensure continuity and comprehensive care planning. The CM provides a community resource guide to the member/family that lists available resources in the local area. Our approach also accounts for cultural, language and other needs that affect member willingness and ability to seek care. For example, to address financial issues that may impact the member's health or ability to access services, the CM may connect the member to social services programs that can assist with such issues as paying utility bills. CMs identify and address other barriers such as lack of transportation. Cultural barriers are addressed with interventions such as providing an interpreter for appointments and identifying providers with the same ethnic background or language. In addition, we support caregivers and families since their ability to provide care and stress level can impact the member's health and care. We provide respite services to prevent caregiver burnout and family support services to help families navigate the system and more effectively support the member. We also connect families and caregivers to support groups and other resources such as the Pima Area Agency on Aging's Community Services System and the AZ Alzheimer's Association.

Innovative Support for Home and Community Living. Care plans incorporate innovative Bridgeway services that go beyond covered services to maintain members safely in their homes and enhance our ability to monitor their conditions. For example, certain members with high risk conditions such as diabetes, hypertension, chronic obstructive pulmonary disease, and congestive heart failure may receive telemonitoring services. We provide telemonitoring devices such as glucometers, blood pressure monitors, weight scales, and pulse oximeters that connect to an electronic transmission center. Transmitted data that fall within certain ranges (which are established for the individual member but based on evidence-based guidelines) trigger an Interactive Voice Response phone call to the member, CM, and the member's provider as an alert to reassess the member's condition. CMs analyze telemonitoring data to identify patterns in the members functioning and compliance with treatment plans. During 2010, we realized an 80% reduction in readmissions for members receiving telemonitoring services. Beginning in the 4th Quarter of 2011, and through a partnership with the Microsoft Corporation, we are piloting our On-Demand In-Home Video Pilot between Bridgeway equipped ALTCS members (with member consent) and Bridgeway's staff of LTC Case Managers. With this exciting pilot, we hope to demonstrate how the viability of on-demand video conferencing can dramatically ***increase*** the frequency and ***augment the quality*** of member contact with our Case Managers.

For members in the Pima service area who have severe and persistent mental illness (SPMI), Bridgeway is developing a unique approach to meet their needs while enhancing their ability to return to or remain in the community. Through a partnership with the University of Arizona medical school, its affiliated teaching hospital and the Arizona Center on Aging, we will provide an integrated continuum of medical services and community support for members with SPMI or other BH conditions. Our Pima BH clinic will be re-located onsite at the hospital to provide a single location for members to access behavioral health and primary care clinic services while also having access to specialty acute medical services through the teaching hospital doctors. Bridgeway will place a CM onsite at the clinic to coordinate all aspects of care, discharge planning and community re-integration. The AZ Center on Aging will make nurse practitioners available to do home visits for members who require intensive support and oversight to remain in the home. This partnership will provide a medical home that supports helping members live successfully in the community. We also enhance member safety and communication through our ConnectionsPlus Program, which was a finalist for URAC's 2009 Best Practices in Health Care Consumer Empowerment and Protection Award. This program provides certain high risk members with cell phones pre-programmed for their PCP, specialist, CM, and 911. This allows the member to immediately communicate concerns and allows us to send targeted health messages and appointment reminders.

Support for BH Needs. We provide peer and family support to facilitate successful transition to and maintenance in the home or community for members with BH disorders. Our peer support program pairs a member with another individual who has experience in recovery and can provide mentoring for transition to the community and recovery. Family support services provide a link to other families who have successfully supported a person with similar issues. This helps families navigate the system and identify appropriate support for themselves as well as their transitioning family member. Since the availability of BH providers to deliver home-based services in very limited in rural areas, Bridgeway collaborates with Regional Behavioral Health Authorities (RHBA) to secure home-based BH services that help members live successfully in their homes and communities. Our relationship with our affiliate Cenpatico provides us with access to providers in eight rural counties in Arizona. We have also partnered with RBHA providers in Yavapai County and will build on these

experiences in all counties awarded to make home-based BH services available to our members. In addition, we contract with Counseling and Consulting, a statewide provider of home-based services, to provide Functional Behavioral Assessments in home settings to help caregivers learn how to assist member's in overcoming problem behaviors.

Cost Effectiveness Study. We evaluate all care plans that include HCBS for cost effectiveness. After the CM completes the assessment during the initial in-person visit, they conduct a Cost Effectiveness Study (CES) to determine whether HCBS can be provided within 100% of the net cost of institutional services for the member's level of care as determined by the UAT. The CM performs the CES before initiation of services unless the member is already receiving services at the time of enrollment, but in all instances, the CM performs the CES within twelve business days of enrollment. The CM enters CES data into CATS within 14 business days of the initial in-home visit, a placement change or significant increase in service costs. The final determination in HCBS placement is the choice of the member, within the cost-effectiveness guidelines set by ALTCS. Any reduction or denial of HCBS due to lack of cost-effectiveness or if we determine a member cannot be maintained appropriately at home or in the community results in Bridgeway sending the member a written notice of action according to state requirements. The CM also educates the member about the appeal process and offers assistance in the process if the member desires.

Gap Planning. CMs assure members have a clear understanding of the right to have back-up services should a gap in services occur. The CM educates the member about what constitutes a gap and provides the Important Member Rights Notice form related to rights pursuant to the **Ball vs. Betlach** order. For members receiving Attendant Care, Personal Care, Homemaker and/or In-home Respite Care, the care plan development/revision process includes development of a written back-up plan to address gaps in services. The CM helps the member complete the Member Service Preference Level on the Contingency Form to identify the member's choice of timeframe for filling a critical service gap. The CM informs members of their right to receive back-up caregiver services within two hours of an identified gap in services. The CM discusses the member's need for assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and other factors such as member preference for accessing informal supports. The CM explains that the member may choose whether to fill the gap using an agency supplied caregiver or unpaid caregiver, and writes the plan to reflect the member's preference. The CM obtains contact information for informal supports that the member designates on the back-up plan, and documents this information on the Contingency Plan. The CM also educates the member about reporting a gap in care. The CM gives the member the Critical Service Gap Report form and instructions for using it; however, the CM explains that the preferred reporting method is via phone, for a quicker response time. Members may call our 24/7 toll-free member call center, the CM, or the Caregiver Agency to report a gap. The handout includes mail and phone steps for reporting service gaps, and shows where to find these steps in the Member Handbook.

Care Plan Implementation, Monitoring and Revision. The CM has the member/representative sign and date the finalized Member Service Plan and Contingency/Back Up Plan (if critical services are part of the care plan), indicating that the information has been explained and that the member understands the information. The CM gives the member a copy of each, scans the documents into TruCare for electronic maintenance, and maintains the signed copy in the member's case file. The CM enters all authorizations into TruCare, and contacts the member to ensure that initiation of and satisfaction with services, including services in the back-up plan, within 30 days of enrollment. If service was not initiated, the CM immediately works with the member to identify another provider to initiate routine or urgent HCBS within 24 hours or back-up services according to back-up plan timeframes or as currently desired by the member. The CM reports non-initiation of service to the Provider Services Department for follow-up and corrective action. The CM regularly monitors the member and services to ensure the care plan continues to meet member needs, making home visits every 90 days or more frequently as indicated by changing needs. During the visits, the CM reviews care plan appropriateness and efficacy, completes a new UAT to verify acuity and level of care, and reassesses the CES. The CM reviews progress toward goals as judged by the member/representative and as reflected in health and functional status and utilization of acute services. The CM also identifies any barriers, needed and member-desired changes to goals, action plans, or the back-up plan. Reassessment includes evaluation of health and functional status and other elements such as the status of informal supports. CMs remind members of their right to appeal any termination, suspension, reduction or denial, as well as how the appeal process works. The CM coordinates with the PCP and other providers to share results of tests and monitoring, and keep all parties informed of member condition, needs and treatments. The CM notifies providers of all care plan revisions, and ensures they know how to access the care plan via Bridgeway's secure provider portal. Our CMs also educate providers about Online Care Gap Notifications through the Portal, which alert them to gaps in recommended chronic and preventive care for each member.

24. The Offeror must submit responses to the following four case management scenarios.
A. Oscar: Age 42. Married with 2 children. Quadriplegic, mostly dependent for all ADLs and IADLs.

The day we receive the enrollment file, a Case Management (CM) Supervisor reviews Pre-Admission Screening and other information provided by ALTCS and assigns Oscar a Case Manager (CM) who is a social worker with experience assisting non-elderly adults with physical disabilities. The CM reviews enrollment information and finds he did not have health insurance prior to ALTCS. The CM calls Oscar to schedule the initial in-person visit and asks who he would like to have participate in the assessment and care plan development. Oscar says he would like his wife April to attend. The CM schedules the visit for the next day when April is off from her part-time job and Oscar's brother can watch the kids.

Assessment. At the initial visit, the CM introduces herself and discusses how Oscar has experienced a life-changing event and that her role is to support Oscar and his family in adjusting to the changes. She also explains that she will find and coordinate the services Oscar selects to meet his and the family's new needs. She explains that assessment and care planning is a member-driven process supported by a whole person, integrated case management approach. She provides information to Oscar and April about Bridgeway and ALTCS including, but not limited to Oscar's rights and responsibilities; how the program works; how to contact the CM and our 24/7 member call center; and how to use our secure Member Portal to access his care plan and other information. She also gives Oscar and April a Member Handbook and Provider Directory. She works with both of them to complete a comprehensive assessment of Oscar's physical and BH conditions, functioning, social needs, cultural considerations, informal support system, financial needs, and other issues. This includes the Uniform Assessment Tool (UAT) and the Comprehensive Long Term Care Assessment to determine acuity and level of care, and a depression screen. Oscar talks about his frustration with the nursing facility (NF), saying he doesn't like being in 'an old people's home.' He also says not being able to take care of his personal needs, particularly bowel care, is bad enough without his caregivers handling him roughly. He also expresses frustration with his rehabilitation progress, and thinks he could be gaining more motor control if he had more therapy. He is embarrassed about the messes he creates while eating. He feels isolated, bored, and alone because he misses his family and is much younger than the other residents. April says that while Oscar is noticeably happier at home, his mood quickly turns to anger when he is frustrated or annoyed. She also says that Oscar was never that way before the accident, and his anger scares her and their children. Oscar says he is worried that he can't provide for his family anymore, and he and April both express concern about their finances since Oscar cannot work in his old job, and April can only work part-time while their children are in school. After obtaining Oscar's permission, she reviews his records at the NF and notes he recently began taking an antidepressant. The CM discusses his records with NF staff to make sure she has current information on his condition and care. She inquires about the confusion that Oscar exhibited and learns that lab testing ruled out infection or metabolic issues that might cause the confusion. She also notes that Oscar completed an Advance Directive during his hospital stay.

Care Plan Development. The CM helps Oscar articulate specific goals that will form the basis of his care plan. He says ultimately what he wants is to feel happy with his life again, go home, and support his family again. Oscar and the CM discuss the need to improve his current experience but agree that the care plan should incorporate immediate steps to facilitate his return home. The CM explains Bridgeway's whole person approach to case management and treatment and describes the importance of coordinating care with all professionals involved in his care. The CM asks Oscar about his previous providers, and he informs her that prior to his accident he did not have a regular provider, and his family used the emergency room (ER). The CM explains how BH services might help Oscar and the family in coping with the recent life changes. Oscar is resistant to this idea because of his cultural beliefs about mental illness, and the CM uses Motivational Interviewing techniques to help Oscar and April talk about this. April reminds Oscar that she and the kids feel loss and anger too, and Oscar agrees to give family therapy a try. The CM says she will arrange for a BH assessment and help the whole family get counseling, including the kids. Recognizing Oscar's struggles in adjusting to the changes and his BH symptoms, the CM introduces the Bridgeway Integrated Care Program (ICP) to Oscar and invites him to get his care through this program. The CM explains that through the ICP, all members of his treatment team have access to all parts of his medical record, including current information on lab work and medications, and will be kept informed and up to date regarding his symptoms, needs, and progress. Oscar says he likes the idea of an integrated approach for his care and agrees to enroll. The CM helps Oscar choose a PCP at Bridgeway Health Solutions, an outpatient BH clinic in Tucson that has experience with non-elderly adults with disabilities. She also says she will arrange for the Medical Director, Pharmacy Director and a Bridgeway psychiatrist to review his medications and contact the prescriber and his PCP to discuss whether his recent confusion might be due to the new antidepressant. She introduces Oscar to Bridgeway's 24/7 nurse advice line, and explains that they can answer any questions he may have about his health. Since Oscar is accustomed to visiting ERs for routine and urgent medical care, she explains to Oscar the merits of first calling the nurse assist line as opposed to

visiting emergency rooms in non-life threating situations. To facilitate an immediate sense of empowerment over his frustration with the NF staff, the CM offers to help Oscar file a complaint with Bridgeway, as well as facilitate a meeting with the Director of Nursing at the NF. The CM also obtains input from the Inspiris nurse located at the NF and our Provider Services Department regarding any history of quality of care concerns. Before the accident, Oscar liked sports and hanging out with friends and family. To address his boredom while he is in the NF, the CM asks April if she can put together a schedule of visits from friends and family as well as visits home. She also lets Oscar know that the NF social worker is available to assist in finding activities he will enjoy while he is there. The CM says she will ask for a PT evaluation of Oscar's rehabilitation schedule and the wheelchair, given the spasticity in his arm, and then focuses on working with Oscar and April to identify immediate steps they can take to facilitate Oscar's return home. She explains that she will assess all home and community based services (HCBS) and other services needed to transition him back home, and encourages him to consider Self Directed Attendant Care services. She asks whether he would like April, another family member, or a friend to provide his attendant care, explaining that he can choose them as paid caregivers. Because of their financial worries and April's work situation, they are interested in having April provide some of his paid care. Oscar also wants to ask his retired brother to help. To address April's request for help getting a wheelchair accessible van, the CM reviews available transportation options, including Bridgeway's medical transportation service, and the possibility of help from the Department of Economic Security's Rehabilitation Services Administration (DES/RSA) to adapt one of the family's current vehicles. In addition, the CM arranges job counseling followed by coaching services once Oscar identifies a new career path. She also explains that they can explore homeowner's insurance for assistance with Oscar's hospital bills, and refers the couple to a financial counselor. The CM also describes the Arizona Bridge for Independent Living (ABIL) Program, which is a peer-to-peer support program that can provide hope and encouragement to Oscar and assist him with many aspects of transitioning back into the community. She explains that the ABIL peers share their own experiences in recovery and provide suggestions for successful outcomes including what is helpful in making home modifications. ABIL also serves as the area's work incentives liaison for the Ticket To Work program, which Oscar shows interest in. Oscar agrees to talk to an ABIL peer to see if he is interested in receiving their services and working with them to transition home. The CM arranges for a physical therapist to evaluate Oscar and April's home for needed modifications such as doorways, ramps and bathroom accessibility, and explains that modifications will be completed while Oscar is finishing facility-based rehabilitation. The CM notes that after moving back home, Oscar might be interested in participating in Bridgeway's new pilot program with Microsoft which provides on-demand video equipment in the home. The project will allow Oscar and the CM to have videoconferences in between regularly-scheduled in-home monitoring visits. She explains that interactive health content and programs will also be available through the technology, and that the family can use the motion-sensing equipment together to play games. Once the CM finalizes the service plan, she reviews it with Oscar and April, obtains their agreement, and has Oscar sign and date it to indicate that the information has been explained and that he understands it. The CM scans the document into TruCare, and maintains the signed original in Oscar's case file. She then enters authorizations into TruCare and all required entries and updates in CATS within fourteen days. **Member Goals.** Oscar's goals are: 1) Be happy again; 2) Live at home; and 3) Support the family. **Care Plan:**

Issue	Plan and Services to Address Issue	Related Goals	Short Term Outcome	Long Term Outcome
Frustration with NF	Facilitate meeting with NF DON. Educate Oscar on difference between expectations for hospital, NF staff frequency of interaction.	1	Complete meeting with NF DON within 3 days.	Increased satisfaction with NF care within 2 wks.
Wheelchair mobility	Referral to PT for chair evaluation Introduction of ABIL peer for assistance	1,2,3	Assess if chair is appropriate and/or training Oscar needs	Smooth, confident use of wheelchair in all situations.
Anger, sleepiness, confusion , forgetfulness	Medical Director, psychiatric consultant review medications and discuss with PCP. Obtain BH assessment. Establish process to coordinate care and share clinical information.	1,2,3	Identify BH /infection/metabolic issue, medication change if necessary. Review impact of trauma. Educate NF staff. Provide calendar of daily events.	Improvement of mood, orientation, and adjustment to losses. Re-established sense of hopefulness.
Financial Stress	Referral to financial counselor, utility assistance, food bank.	1,3	Any possible services implemented within 10 days.	Reduced family/caregiver stress. Improve Oscar's self esteem within 10 days.
Family dynamics	Obtain BH assessment of Oscar and family needs. Coordinate services through behavioral health provider. Identify Caregiver Support Group or individual support for April.	1,2,3	Reinforce /educate NF staff and family re: recommendations of BH provider. Initiate recommended BH services.	Family verbalizes reduction in anger, improvement of dynamics and acceptance in 30 days.
Boredom	CM introduces ABIL peer services for home	1, 2, 3	Establish calendar with activity	Oscar expresses reduced

Issue	Plan and Services to Address Issue	Related Goals	Short Term Outcome	Long Term Outcome
	visits, wheelchair basketball team. April identifies family/friends for visits. Referral to SNF social worker.		schedule.	boredom within 3 weeks.
Control & use of body/messy eating	CM contact with PT/OT providers for update and to establish optimal therapy frequency.	1,2,3	Oscar satisfied with pace of PT/OT within 3 weeks.	Oscar demonstrates increased control within 2 weeks.
Bowel care	Review Oscar's current bowel program with INSPIRIS nurse to determine progress.	1,2,3	Begin nursing bowel training program within 10 days.	Improved efficiency in self bowel care within 30 days.
Home accessibility	Referral to a certified home health PT, OT to complete environmental assessment of Oscar's home. Present evaluations to the Case Review Team for approval.	1,2,3	CM to coordinate and authorize modifications through ABIL program.	Modifications completed within 30 days of order.
Assistance for home visits	CM completes HCBS Needs Assessment with the member, ABIL, and caregivers in the home. Educate April and Oscar's brother in bowel care. Schedule visits for April and Oscar's brother with NF staff feedback.	1,2,3	CM to complete HCBS Needs assessment of home within 5 days. Complete bowel care training for April and brother.	Initiate services to begin upon return home. April and brother demonstrate ability to provide competent care for Oscar.
Transition to home	CM schedules ABIL for peer support, assistance with transition, and a series of home visits w/rehab staff to establish activities and milestones necessary for safe discharge home.	1,2,3	CM to arrange meeting in NF staff for both services within 5 days.	Goals for discharge activities and milestones finalized within 10 days.
Employment	Referral to job coach and ABIL resources to identify employment that Oscar would find meaningful and interesting.	1,2,3	Identify areas of interest for possible employment.	Find employment in satisfying job.
Job skills and training	CM and Oscar explore available services at various state agencies, such as DES/RSA's Independent Living and Vocational Rehabilitation; Housing, Employment and Education; Arizona Freedom to Work program; and ABIL Program.	1,2,3	Identify all available options and costs and review in light of employment and career goals.	Find employment in satisfying job.
Wheelchair accessible van	CM provides information about Access Vehicles/A.D.E./AZ Technology Access Program and Assisted Technology AZ.	1,2,3	Identify all available options, costs; review options against availability of medical and public transportation services.	Implement plan to accommodate all transportation needs.

Gap Planning. The CM helps Oscar develop a Critical Gap Services Plan for the attendant care he will receive during home visits, and gives him and April the Critical Service Gap Report Form and Important Member Rights Notice. She explains the process for notification if the attendant/caregiver does not arrive or arrive on time. She also helps them complete a Contingency Plan and Member Rights and Responsibilities form, and identify Member Service Preference Level for addressing gaps in service, including preference for a back-up plan and the timeline in which services will be provided. She tells them that informal support is not considered the primary source of assistance when a gap occurs, unless that is Oscar's choice. She leaves copies of the completed forms with them and maintains copies in TruCare.

Cultural Competency. Oscar remembers being physically strong and proud of his ability to provide for his family. To address his difficulty accepting assistance and the stigma he associates with receiving BH care, the CM uses Motivational Interviewing when discussing his needs and care. She introduces Oscar to the Disability Resource Center at the University of Arizona and the Tucson Lobos wheelchair basketball group for adults with para/quadriplegia for support. The group holds a wheelchair basketball game every Saturday afternoon, and the CM suggests scheduling a home visit at a time that will allow him to go see a game. She also connects him with an AZ Spinal Cord Injury Association support group.

Coordination and Monitoring. The CM asks Oscar for permission to contact, share information, and coordinate services with his NF, PCP, BH provider, ABIL and other providers (such as HCBS providers) and regular updates as needed. The CM works collaboratively with his providers to implement the care plan, and regularly contacts NF caregivers about care delivery and potential needs. The CM works with Oscar, ABIL, the PCP, the caregivers and the NF to develop and implement a transition plan. Until Oscar is able to transition home, the CM visits Oscar at least weekly to monitor his condition and coordinate services. After his transition home, she will visit every two weeks for one month until he has stabilized and then every 90 days. As Oscar's needs and preferences change, the CM conducts reassessments and works with him and providers to revise the care plan.

B. Magda: Age 83. Diabetes, on dialysis, early stage Dementia, recent falls. Speaks little English. Daughter requested more hours.

Bridgeway's Case Management (CM) Supervisors review 100% of the Home and Community Based Services (HCBS) Needs Assessments Case Managers (CM) complete for our members. In Magda's case, the CM Supervisor notes that the number of caregiver hours recommended by the CM after the recent reassessment is lower than the number of authorized hours in the current care plan. This, combined with the daughter's request for more hours, triggers an automatic review by our inter-departmental Case Review Team (CR Team). This Team consists of the Medical Director, VPs of Case and Medical Management, Behavioral Health (BH) Coordinator, and other clinical staff. In preparation for meeting with the CR Team, the CM Supervisor gathers Magda's monitoring and assessment information, test results, utilization, and existing authorizations which are integrated in TruCare, our health services management platform. The CR Team reviews the information and confirms that a new assessment is warranted. The CM Supervisor assigns our Romanian-speaking nurse CM to conduct a new assessment and revise the care plan.

Preparation for Home Visit. The previous CM contacts Magda and Raquel to explain the need for another assessment and that a decision on hours will be made within 14 days of Raquel's request for more hours. Raquel and Magda choose to schedule the visit early Tuesday morning so Raquel can participate prior to work and Magda would not feel ill from her dialysis. Since the new CM is fluent in Romanian, there is no need for an interpreter. Before the visit, she reviews Magda's file in TruCare. Since Magda's daughter reported difficulty making PCP appointments, the CM reviews visit history, comments from this provider, and communication from Magda's nephrologist and the dialysis team. She contacts the PCP office for updates on Magda's functional and medical status, and to ensure coordination with the dialysis team. She also confirms appointment availability and reminds office staff of related contractual requirements. The office staff tell the CM they have available appointments each day for their complex cases. She asks whether Magda's records reflect information related to the nephrology consult, and learns that the PCP never received follow up documentation. She then coordinates getting this information to the PCP.

Assessment. The CM begins the home visit by introducing herself and explaining her role as a resource to Magda and her family in making decisions about Magda's care and services. She assesses functioning and conditions using the Uniform Assessment Tool (UAT), Environmental Assessment, Comprehensive LTC Assessment, Geriatric Depression screen (GDS-4), and Mini-Mental Status exam. These include information about her medications, blood sugar testing records, dialysis schedule, and functional status. Raquel disagreed with several areas in which Magda previously indicated she was independent in her activities of daily living (ADLs). The previous CM had noted several days in the past month on which Magda's blood sugar was abnormally low. She provides education on dementia and Magda's current health regimen, including focused education about the effect of low blood sugar on Magda's ability to think clearly and care for her own needs. Raquel says that her boss is upset with her because she's been late for work when the caregiver agency is late. She also notes that her 16-year-old daughter is not happy taking care of Magda after school. Raquel reports that they have minimal social life since her mother takes most of the family's free time. Raquel then shares that the "whole family is stressed" taking care of Magda. The CM offers to arrange for the BH Coordinator to visit and assess Magda and the family for services such as family counseling. The CM also assesses the need for attendant care and respite, and evaluates availability of informal caregivers without considering the teenager. Since Raquel works fewer hours to be at home with her mother, the family is having difficulty making ends meet. The CM offers information about the food bank and a local program that can assist with utility bills. She asks about the request to change PCPs and Raquel indicates that they were pleased with him but they could not get an appointment and Magda had difficulty understanding him. The CM offers to assist with making a follow-up appointment when Raquel is off work and arranging for an interpreter if they would like to try again. She also offers to assist with finding an alternative PCP. Magda gives the CM permission to contact the PCP again to investigate the availability of early morning appointments Tuesday or Thursday.

Care Plan Development. Magda likes living with Raquel and the family, but says she is bored and has no one to talk to when they are all at work or school. Raquel and Magda are interested in finding things Magda can do during the day outside the home. The CM recognizes that Raquel has reached a diminished level of coping and offers several interventions. She also refers Raquel to Domestic Older Victim Empowerment and Safety (DOVES), which offers support groups (including one teleconference group). Recognizing that Tucson has a large Romanian community, the CM provides information on the European Multi-Cultural Alliance, and the Pima Council on Aging which may be able to offer a Romanian speaking volunteer to work with the family. The CM educates Raquel how lack of socialization might be contributing to Magda's confusion and agitation, and she suggests having members of Holy Resurrection Orthodox Church, which the family attends, visit Magda or involve her in social outings.

The CM informs Raquel that attendants should provide hands-on assistance with transferring, bathing and mobility to avoid falls. She also educates Raquel that the Homemaker service provider should only clean Magda's general area of the house and laundry, not other areas or laundry for the rest of the family. Eliminating time spent cleaning up after other family members will increase time for Magda's care. She notices an uneven doorstep between the kitchen and living room, and that there are no assistive devices in the bath. She recommends a Physical Therapist to evaluate and determine appropriate home modifications, and discusses interim measures to address these issues to prevent falls, such as removing the throw rugs. The CM determines that the HCBS Needs Assessment tool demonstrates the need for additional caregiver hours. The CM completes a cost effectiveness study (CES) which includes all areas of agreed upon service. She determines that Adult Day Care (ADC) is a cost effective option for care and social interaction on the days Magda does not go to dialysis. Raquel and Magda express concern that being in an unfamiliar environment will confuse her, and that she will not be able to communicate with others there. The CM offers to arrange for a visit to an ADC with an interpreter so they can see what they think. Raquel also asks about getting respite on the weekends. The CM notes that the CES permits some respite hours and that the ADC they will visit also provides respite and provides information about Lend A Hand Senior Outreach, a volunteer organization that provides services such as transportation, errands and friendly visits.

Member Goals. The CM helps Magda develop goals to guide care plan development. Magda's goals are: 1) Spend time with friends; 2) Remain at home with Raquel; 3) Continue church involvement; 4) Get out of house more.

Care Plan. The CM works with Magda and Raquel to develop a plan that addresses Magda's goals, each assessed need, and their preferences for service types and amounts, with short and long term outcomes for each issue to measure progress. To ensure a holistic approach she includes community resources in the care plan. The CM contacts the nephrologist for an update on Magda's condition and obtains input into the care plan. She then contacts the PCP to request an appointment, share the nephrology update, get PCP input into the care plan, inquire about additional cognitive testing, and request diabetes follow-up and a Physical Therapy (PT) evaluation of home safety, patient gait, and bath assistive devices. The CM also discusses Bridgeway's in-home telemonitoring program, and the PCP agrees that the close monitoring of Magda's blood sugar could greatly assist management of her diabetes. Once the plan is finalized, she reviews it with Magda and Raquel, obtains their agreement, signature and date indicate that the information has been explained and that they understand. The CM scans the document into TruCare, maintaining the signed original in Magda's case file, enters authorizations into TruCare, and makes all required entries and updates in CATS within 14 days.

Issue	Plan and Services to Address Issue	Related Goals	Short Term Outcome	Long Term Outcome
Diabetes	PCP to re-evaluate diabetes regimen with collaboration of nephrologist. Review tele-monitoring for management of diabetes	1, 2, 3, 4	Telemonitoring w/in 5 days of PCP agreement. Maintain/ improve status w/in 30 days.	Possible prevention of any other diabetes related problems such as foot neuropathy, etc.
Dementia/Cognitive impairment	PCP to re-evaluate current mental status to determine if medications would be helpful	1, 2, 3, 4	Maintain or decrease symptoms within 90 days	Maintain symptoms on evidence based scales 90+ days
Depression	Psychiatrist to evaluate for depression/cognitive level and agitation	1, 2, 3, 4	Evaluate symptoms within 30 days	50% improvement in symptoms within 90 days
Language/cultural barrier in	CM to identify resources in Romanian community through websites, church	1, 2, 3, 4	CM will introduce source for family w/in 10 days.	Connect with one Romanian of Magda's age within 90 days.
Spiritual needs not addressed	CM to assist family in identifying church resource	1, 2, 3, 4	CM will follow up in 10 days	Magda visited in home by church member within 30 days
Develop peer, social supports & activities	CM to arrange for trips with an interpreter to see 2 Adult Day Care options	1,2,4	Magda & Raquel visit centers w/in 10 days	CM will evaluate feasibility of placement within 30 days
Family conflict	Referral to BH Coordinator for Family Therapy	1, 2, 3, 4	BHC assess w/in 30 days and make referral	50% improvement in family ability to manage conflict.
Family support needs	Attendant care to replace care by teenager. Weekend respite care. Community agency referrals for utility, food support.	1, 2, 3, 4	CM follow up w/in 10 days to verify attendants, respite per care plan.	Maintain family support beyond 90 days
Fall risk Environmental surroundings unsafe	PCP to evaluate diabetes, cognitive functioning. PT evaluate for gait training, assistive device in bath, modification of doorstep.	1, 2, 3, 4	Bath device installed door fixed w/in 30 days of order. Reduce falls, 50% improved mobility w/in 30 days of tx	Falls to decrease by 90% within 90 days
Daily bath/hygiene	HCBS will continue with bath assistance	1, 2, 3, 4	Magda receives assistance with a daily bath	Magda receives assistance with a daily bath
Assistance with Meals	Continue HCBS meal preparation and feeding support to meet nutritional needs	1,2,3,4	Magda receives 2 meals/day through HCBS	Magda receives 2 meals/day through HCBS
Homemaker services	CM reinforce that homemaker service is for Magda's area and laundry only.	1,2,4	Raquel/family understand HCBS expectations	Magda's bedroom, clothes and bedding are clean, organized.

Issue	Plan and Services to Address Issue	Related Goals	Short Term Outcome	Long Term Outcome
Medication adherence	HCBS will continue to support self-administered medication administration	1,2,3,4	Magda will receive daily medications	Magda will receive daily medications

Gap Planning. The CM identifies the critical services in the current care plan, gives Magda and Raquel an updated Critical Gap Services Plan, and ensures they have the Critical Service Gap Report Form and Important Member Rights Notice. She reminds them of the process for notification if the attendant/caregiver does not arrive or arrive on time. She also helps them complete a revised Contingency Plan and Member Rights and Responsibilities form, and identify Member Service Preference Level for addressing gaps in service, including preference for a back-up plan and the timeline in which services will be provided. She reminds them that informal support is not considered the primary source of assistance when a gap occurs, unless that is Magda's choice. She leaves copies of the completed forms with them and maintains copies in TruCare. Because of recent problems with the caregiver showing up on time, the CM contacts the provider to reinforce that the contract requires the agency to provide a back-up caregiver within two hours if the regular worker is unavailable. The CM also notifies the CM Supervisor, who determines that the provider has identified the gap on the Critical Gap Services Report.

Cultural Competency. The CM determines, based on her personal understanding of the Romanian culture, that Magda is experiencing frustration because of cultural expectations about how families support extended family. She believes a 16 year old should take care of her grandmother rather than socializing. The CM explains cultural norms for American teenagers to Magda, and suggests to Raquel that she find other older Romanians Magda can talk to who have immigrated to the US to live with their adult children and families. The CM arranges for Magda to have an interpreter for appointments to ensure clear communication since Raquel's English is still limited and she cannot usually accompany her mother to appointments. The CM helps identify providers who may speak Romanian or have Romanian-speaking staff.

Coordination of Care. The CM advises all providers of care plan revisions and how to access the care plan via our secure Provider Portal. She also explains our Online Care Gap feature, which alerts providers to any gaps in recommended chronic and preventive care. She contacts the attendant care agency to emphasize that Magda should have little to no unsupervised time and that the attendant should consistently provide hands-on assistance with transfers, bathing and mobility in order to eliminate falls. She also inquires about the agency's management of dementia and protocol for reorienting Magda when she becomes confused. The CM coordinates among the PCP and other providers to share test and monitoring results and keep them informed of Magda's conditions, needs and treatment.

Ensuring Case Manager Consistency with Standards. The new and previous CMs meet with the CM Supervisor to compare findings from the follow-up assessment. The previous CM indicates that Magda wanted to meet alone on a day that her daughter was at work, and that Magda self-reported a higher score of independence without the benefit of Raquel's input. The original CM also indicates that she was not aware that the low blood sugars would have such an impact on Magda's strength or ability for self-care. They discuss the difference that not including the granddaughter as an informal support made on the HCBS Needs Assessment. Magda had originally indicated the granddaughter would provide care, but Raquel knew the teen did not want this responsibility. The CM Supervisor educates the previous CM on the importance of accurate informal caregiver assessments in determining needed service hours. The CM Supervisor will review her assessments over the next month to make sure she solicits participation of family and informal caregivers in assessment and care planning. The CM Supervisor also reviews the most recent scores of the previous CM's inter-rater reliability testing and determines that she has otherwise scored comparably to her peers. The CM Supervisor schedules a Department-wide in-service on the effects of poor diabetes management.

Re-Assessment and Monitoring. The CM will follow up with Magda and Raquel every two weeks for the first month to ensure the new plan is meeting Magda's and the family's needs. If there are problems, she will problem solve with Magda and Raquel as indicated to resolve any issues. She will also monitor initiation and provision of services. If Magda and her family remain stable for 30 days, home visit monitoring will occur every 90 days or as indicated by new or changed needs. The CM coordinates among the PCP and other providers to share results of tests and monitoring, and keep them informed of Magda's conditions, needs and treatment.

C. Wanda: Age 66. Diabetes, Peripheral Neuropathy, Hypertension, CHF, pelvic cancer. Requires near-total care. Discharged to ALF.

History. When our Case Manager receives the call from the MAP Concurrent Review Nurse (CRN) about Wanda's hospitalization and discharge plan, he is very familiar with Wanda's history as he has been her Case Manager since she became an ALTCS member. While speaking with the CRN, he reviews the case file. He notes that during his initial review, he assessed Wanda using the Uniform Assessment Tool (UAT), Environmental Assessment, Comprehensive LTC Assessment, Geriatric Depression screen (GDS-4), and Mini-Mental Status exam. Since Wanda's PCP was not in either our Medicaid or Medicare Special Needs Plan (SNP) networks, the Case Manager notified our Provider Services Department, which attempted to contract with the provider to enhance our ability to coordinate Wanda's care. The Case Manager also notes that he had offered education regarding the Advance Directive and given the family a copy of the "Five Wishes" Advanced Planning document to review. Wanda had initially declined to discuss an Advance Directive, however, the Case Manager used Motivational Interviewing techniques to help Wanda and her son think about the type of care Wanda would want should she become unable to indicate her choices. The son told Wanda he would feel more comfortable knowing what her wishes were, and having her make those choices clear while she is still able to communicate them. Wanda agreed and once she completed an Advance Directive giving her son Durable Health Care Power of Attorney, the Case Manager scanned a copy into TruCare, our health services management system. He reviews the Advance Directive as well as the second assessment he performed after Wanda transitioned to an Assisted Living Facility (ALF), Glencroft Retirement Community, a few weeks later.

Preparation for Member Contact. The Case Manager collects information from the MAP Case Manager about the broken nose, the pelvic cancer diagnosis and treatment, and Wanda's heightened confusion. The CRN states that the surgery to remove her pelvic tumor will occur in three weeks, after which they will determine the extent of needed radiation therapy. The Case Manager and CRN agreed that the pain and stiffness typically found with pelvic cancer likely contributed to her recent increase in falls. Upon receiving this update, the Case Manager immediately calls Wanda's son to schedule a comprehensive medical and functional assessment to determine Wanda's level of care (LOC) and to re-assess the appropriateness of her placement. Since Wanda is exhibiting signs of confusion, the Case Manager asks to involve the ALF caregivers in the assessment so he can determine more accurately the extent of her needs and their ability to adequately provide quality services to her. The Case Manager contacts the PCP, the BH provider, and the oncologist to obtain status updates on her conditions. He learns that the oncologist believes Wanda's prognosis is not good, and that a psychiatric evaluation has been ordered by the PCP to assess for level of mental functioning, but it has not yet been completed.

Reassessment. The Case Manager visits Wanda with her son at the ALF to complete a reassessment, which includes the UAT and HCBS Needs Assessment. He includes Wanda's son and the ALF staff in the assessment and discussion. He begins with an interview with Wanda to assess her ability and desire to return home. Wanda is significantly more confused but is aware of where she is and who her son is. Wanda states she thinks she is too sick return to her son's home and her son agrees that he will be unable to care for her there. They discuss whether Wanda has enough socialization or if she would like more activities and Wanda indicates that she is "just too tired for anything else right now."

The Case Manager includes the ALF staff in reviewing her current medications, record of vital signs, any blood sugar testing, and the staff general assessment of Wanda's functioning. The Case Manager learns that the staff have very little record of blood sugar monitoring. The Case Manager inquires about any combativeness, confusion or threatening behavior, and the staff state that when Wanda is confused, she does not want to be touched and occasionally becomes combative. The staff indicate that Wanda does not present any risk to other residents. The ALF staff state that she has had several falls because she is confused and gets out of bed without supervision. The staff also indicate that Wanda does not like to be touched when they remind her to go back to bed. The Case Manager asks the staff to describe the safety features that they have in place to ensure Wanda does not fall. They explain that they periodically monitor Wanda's room when she is alone and when she is in a community area, and help her to her wheelchair or provide her with any other transfer assistance she needs. The Case Manager asks the ALF staff for scenarios such as what happens when Wanda is confused, unsupervised in her room, and she decides to get out of bed. The staff give vague responses that reflect a lack of experience with someone exhibiting Wanda's level of acuity. The Case Manager offers examples to educate them about appropriate supervision, and then assesses for any skilled nursing needs such as poor skin integrity.

Care Planning. Because Wanda's condition has changed significantly from when she first entered the ALF, the Case Manager discusses updated goals with Wanda. Wanda has difficulty staying focused on the conversation, but she says 'I like this place' and notes that she has become close to two of the other residents. The son says he does not want to put her

in a nursing facility, especially since her cancer prognosis is not good, and he would like her to stay in a place where she has friends and is happy. Wanda is worried about the cancer and anxious to begin treatment as soon as possible.

The Case Manager conducts a cost effectiveness survey and determines that due to the increased level of acuity, the ALF is no longer the most cost effective, appropriate level of care. In addition, he is concerned about the appropriateness of the placement due to the severity of her current medical conditions, the need for nearly total care, her non-ambulatory status, and her poor ability to make her needs known. He immediately arranges for our Case Review Team (CR Team) to review the case. (The CR Team includes the Medical Director, VPs of Case and Medical Management, and other clinical staff) The CR Team determines that Wanda's LOC is too severe to remain safely in the ALF and directs the Case Manager to meet with the son and Wanda within 24 hours to recommend transition to a skilled nursing facility. The Case Manager discusses this decision with Wanda and her son, explains the level of supervision required to provide appropriate monitoring for Wanda in order to avoid falls, and provides multiple choices of facilities. The Case Manager informs them that Glencroft also runs a SNF, Glencroft Care Center, which is on the same campus and can meet Wanda's needs. However, Wanda clearly articulates the desire to remain in the ALF, and while it is unclear if she has the mental capacity to make an informed decision, the son supports this decision. The Case Manager explains the risks of her staying, documents Wanda's and her son's desires in the care plan, and helps them complete the Managed Risk Agreement (MRA) which he has both Wanda and her son sign after verifying that the ALF will allow Wanda to stay.

The son asks about counseling to help Wanda and the family deal with a potentially terminal condition, and the Case Manager arranges for the BH provider to assess these needs. The son also asks whether Bridgeway offers hospice and palliative care should those become necessary. The Case Manager explains more about what palliative care and Hospice entail and explains that Medicare covers these services.

The Case Manager reports the falls, broken nose, increased confusion, and cancer treatment plan to the PCP, and obtains input on care plan revisions. He also shares a copy of the Advance Directive, and discusses Wanda's desire to remain in the ALF despite Bridgeway's recommendation that she transfer to a SNF. He explains Bridgeway's telemonitoring program to the PCP, who expresses interest in the intensive monitoring of Wanda's blood sugar and blood pressure through the program. The Case Manager discusses blood sugar monitoring with Wanda and her son, explains that they have not had consistent reliable results for Wanda's blood sugar in several weeks, and offers them information about the diabetes telemonitoring program. He explains that a glucometer attaches to an electronic meter that takes periodic measures of Wanda's blood sugar readings, which are then transmitted to her PCP and the Case Manager. Wanda and her son agree to participate. Once the care plan is finalized, the Case Manager obtains signatures from Wanda and her son to indicate they agree with it. He provides them with a copy, reminds them they can access it online via Bridgeway's secure Member Portal, scans it into TruCare, and maintains the signed copy in Wanda's file.

Member Goals. Wanda's new goals are: 1) stay in the ALF; 2) control chronic conditions; 3) receive cancer treatment.

Care Plan

Issue	Plan and Services to Address Issue	Related Goals	Short Term Outcome	Long Term Outcome
Broken Nose	Follow up visit with PCP.	1	Schedule PCP visit within 1 week.	Recovery with no infection.
Combativeness and Confusion	Refer to BH provider for assessment. CM provides education materials to ALF staff.	1	Receive services for pain management, mental state per BH provider recommendations.	ALF staff , Wanda and son indicate improvement or no decline within 30 days.
Competence	Referral to BH provider for assessment	1,2	CM to followed up with psychiatrist to determine outcome of mental status	Wanda will be able to receive quality care in the event that she is no longer to choose for self.
ADL assistance	Educate ALF staff on appropriate supervision and assistance. Complete Managed Risk Agreement.	1	No falls and ADLs completed consistently	Wanda remains in ALF safely per the MRA as long as condition does not worsen.
Fall Risk	Investigate care provided with ALF, educate ALF staff of need for increased supervision.	1	Inform son of risk and complete Managed Risk Agreement	Maintenance in ALF per Managed Risk Agreement.
Diabetes	PCP monitors condition through Telemonitoring Program. Review BS	2	Implement Telemonitoring program	Stabilization of BS as evidenced by BS within PCP-

Issue	Plan and Services to Address Issue	Related Goals	Short Term Outcome	Long Term Outcome
	regimen and reinforce any changes in diet /meds with ALF staff.			established limits within 30 days.
Cancer Care	Surgery and radiation treatment. Family receive cancer education	3	Surgery to occur within 3 weeks. Radiation therapy to be determined. Case Manager to provide education to family.	Cancer free after radiation therapy. Assess the need for Hospice when further prognosis is available

Coordination. The Case Manager educates ALF staff about Wanda's condition and needs, how to reorient Wanda to where she is and what is going on prior to moving her, in order to avoid combativeness. He also offers suggestions regarding supervising Wanda when she is awake. The Case Manager verifies that the son or ALF staff will escort her to all appointments since her current mental state makes it unlikely that Wanda can consistently provide accurate information to the provider and ensure all recommended follow up occurs per the doctor's instructions. He suggests a schedule that would allow for morning ADLs, then greater use of community time, community meals, with little or no unsupervised time to avoid injury related to falls.

The Case Manager contacts the MAP Case Manager to coordinate delivery of all needed Medicare services with ALTCS services, update her on Wanda's status and notify her that Wanda and her son have expressed interest in palliative care and hospice. He explains what communication has taken place and that they may need further assistance. He also works with the MAP case manager to coordinate ALTCS and Medicare services. He reminds the providers and MAP case manager about how to access the care plan via Bridgeway's secure Provider Portal and explains our Online Care Gap feature which alerts providers to any gaps in recommended chronic and preventive care. He also initiates telemonitoring services. He shares test results, telemonitoring data, and other monitoring information with Wanda's PCP and MAP case manager.

Within 24 hours of learning of the fall that resulted in the broken nose, the Case Manager files a Quality of Care (QOC) concern with Bridgeway's Quality Management Department, which will initiate an investigation of whether the fall resulted from noncompliant care**.** The Case Manager educates Wanda and her son to contact her if Wanda sustains additional injuries during her stay at the ALF.

Reassessment, Monitoring and Follow Up. The Case Manager increases his visits to see Wanda and her son in person weekly to monitor her condition and how well the ALF is meeting her needs pursuant to the terms of the MRA. He also is in frequent contact with ALF staff, the PCP, BH provider, and oncologist to monitor services and cancer treatment and share information among providers including telemonitoring data. As Wanda's cancer treatment progresses, the Case Manager coordinates with the PCP and oncologist to discuss prognosis and treatment recommendations. He learns from the oncologist that Wanda's condition is now terminal. He contacts the BH provider, who determines that Wanda is no longer mentally competent.

The Case Manager contacts the son to schedule a visit to discuss Wanda's needs in light of the terminal diagnosis and the incompetence determination. The son states that he thinks it is time to move her to the SNF. The Case Manager discusses Wanda's Advance Directive (AD) with the son, noting that hospice services are consistent with the AD. He explains the benefits of this service, such as pain management, spiritual advice, and comfort care. The son expresses interest, so the Case Manager schedules a hospice evaluation, which will include a review of whether pain may be contributing to Wanda's combativeness.

The son chooses to move Wanda to the Glencroft SNF and the Case Manager develops a transition plan in consultation with the ALF, SNF, PCP, and MAP case manager. This includes, but is not limited to arranging for transfer of medical records and medications; arranging for TB testing and forwarded results to the SNF, PCP and MAP case manager; and arranging transportation. The Case Manager follows up with the son within two days of transfer to ensure a smooth transition, completes a "Change of Placement" assessment within 10 days of transfer, and follows up with Wanda and her son to ensure hospice services are initiated and being delivered appropriately. The Case Manager continues to monitor Wanda's condition every 30 days or more frequently if her condition changes, and coordinates among the SNF, hospice provider, PCP, BH provider and MAP case manager.

D. Roger: Age 39. Schizoaffective Disorder, TBI, seizures, upper respiratory infections. Lives with sister/guardian. Needs supervision.

Preparing for Home Visit. Upon Roger's enrollment, a Case Management Supervisor reviews his enrollment file and assigns him to a Case Manager with behavioral health (BH) expertise. The BH Case Manager (BHCM) is a clinician who will ensure Roger receives individualized, culturally competent, recovery-oriented services to meet his goals and needs. The BHCM reviews all enrollment, eligibility, demographic, and psychosocial information available, and contacts Joyce to schedule a home visit when both she and Roger can participate.

Home Visit. At the initial meeting, the BHCM reviews information in the Member Handbook with Roger and Joyce, educating them about Bridgeway and the ALTCS Program, including covered services and how to access them, and Roger's rights and responsibilities, such as the right to file a grievance or appeal. The BHCM explains her role is to help them navigate the system, help resolve issues that arise, and ensure that Roger has appropriate access to individualized, member-centric, culturally competent, recovery-oriented services to address his needs and goals. The BHCM gives Roger and his sister contact information, as well as the Bridgeway member call center and nurse advice line numbers, encouraging them to call any time, and that no issue or problem is too small. The BHCM asks Joyce to sign and date a statement indicating that she understands the information that has been provided. The BHCM also asks Roger to sign that he is in agreement as well. The BHCM completes a Uniform Assessment Tool (UAT) to assess level of care, and initiate service planning, and the Comprehensive LTC Assessment of Roger's strengths and needs and a depression screen. The BHCM provides education on schizoaffective disorder, substance use, and TBI, and reviews drug and psychosocial therapies and the use of community supports to successfully treat schizoaffective disorder and TBI.

Care Plan Development. The BHCM discusses with Roger where he would like to live, level of independence he desires, personal strengths, and goals including living environment, education, employment, social, recreational, financial, and spiritual goals. The first is to own his own business. Roger loved helping his father do landscaping as a young man and thinks if he had a successful landscaping business, he could meet his second goal of living independently. The BHCM helps Roger and Joyce review his goals in relation to his job skills, physical health, BH, interpersonal, and independent living needs. She provides information about the Bridgeway Integrated Care Program (ICP) which Roger can access via West Yavapai Guidance Clinic (WYGC), about 20 minutes from Joyce's home. Joyce expresses concern about his substance use and Roger acknowledges it has been an issue. The BHCM explains that WYGC has a substance abuse program, and that the ICP will address all of his medical and mental health challenges, substance use, frequent visits to emergency rooms, repeated hospitalizations and behavioral challenges that have raised concerns about his ability to live at home. She also informs Roger and Joyce that the ICP provides a team of BH and physical health professionals that work together to integrate BH and physical health care, integrate Medicare and Medicaid benefits, help him live as independently as possible and reach his personal life goals. She also notes that WYGC offers a Level 2 residential treatment center for short term treatment stays when needed. They discuss the possibility of Roger living there for 2-4 months to obtain more control over his aggression and behaviors so he can live successfully with Joyce. The BHCM helps Joyce and Roger select a PCP from the ICP with special training in working with persons with TBI. The BHCM schedules an appointment at the PCP's office for Joyce and Roger to meet with the ICP team including the PCP, a BH Professional, and a Specialist in Functional Behavioral Assessment. At that meeting, the team will explore the merits of a potential placement in the WYGC Level 2 treatment center. To address Roger's needs until they make the placement decision, the BHCM arranges for social supports, and educates them about self-directed care and the option to have Joyce serve as a paid caregiver. Because of Roger's aggression and verbal conflict and Joyce's fulltime job, they agree she will not serve as a paid caregiver. They also decide Roger is not ready to oversee attendants. The BHCM suggests revisiting this issue in 12 months as Roger progresses with recovery, and they agree. The BHCM also discusses Nazcare, a peer run program in the area that can support his recovery through peers who are in recovery from mental illness and substance abuse. The BHCM helps Roger problem solve issues that would block his goal attainment using Motivational Interviewing, which leverages his internal motivation through reviewing both successful and unsuccessful activities and behaviors. She offers Joyce the services of a Behavioral Analyst to help her recognize the triggers and functions for Roger's behaviors, teach her how to anticipate behaviors, modify her responses, redirect, prevent inappropriate behaviors and help Roger learn pro-social behaviors. She encourages Joyce to avoid using cigarettes as a reward and provides information on the Arizona Smoker's Help Line (ASHLine). She also educates Joyce on how to identify when Roger may pose a danger to himself or others and how to contact our 24/7 nurse line or the WYGC mobile crisis unit for assistance in a crisis.

The BHCM contacts the PCP to implement Roger's individualized ICP team, discuss the care plan and make arrangements for sharing information about progress and treatment. The BHCM will coordinate and share information with all Roger's providers and arrange care team meetings as appropriate. The BHCM documents all interactions in

TruCare in real-time and makes all required entries and updates in CATS within 14 days. She provides a copy of the care plan to Joyce and Roger, and educates them about how to access the care plan via our Member Portal.

Member Goals. 1) Own neighborhood landscaping business; 2) Live independently. ***Care Plan:***

Issue	Plan and Services to Address Issue	Related Goals	Short Term Outcome	Long Term Outcome
Seizure Disorder	PCP to consult with neurologist for re-evaluation of seizure medications, fall risk.	1,2	Decrease seizures from 2/wk to 1/month within 90 days.	Decrease seizures to 2/year.
Thought Disorder	PCP to consult with a Psychiatrist for evaluation, ongoing medication management.	1,2	Decrease symptoms to mild range on evidence-based scales within 90 days.	Maintain symptoms in mild range on evidence-based scales beyond 90 days.
Mood Disorder	PCP includes Psychiatrist on treatment team for evaluation and ongoing medication management.	1,2	Decrease symptoms to the mild range on evidence-based scales within 90 days.	Maintain symptoms in the mild range on evidence-based scales beyond 90 days.
Behavioral Outbursts and Drug Use	PCP includes Behavioral Health Professional on treatment team for evaluation and ongoing treatment of behavioral issues and substance use.	1,2	Decrease substance use, emotional outbursts to mild range on evidence-based scales within 90 days.	Eliminate substance use and emotional outbursts.
Aggressive Behaviors	PCP includes Behavioral Analyst on care team for evaluation and treatment of anti-social behaviors.	1,2	Decrease aggressive behaviors to mild range on evidence-based scales within 90 days.	Eliminate aggressive behaviors.
Upper respiratory tract infection (by history)	Caregiver monitors, PCP evaluate on an occurrence basis. Initiate HCBS for daily support; teaching appropriate hand washing.	1,2	Increase appropriate hand washing by 50% w/in 45 days. Decrease infections to 2/year.	Increase appropriate hand washing by 95%. Decrease infections to 1 per year.
Risk of Falling	Support neurologist's recommendations for decreasing risks due to falling during seizures.	1,2	Reduce injury threat by 75% within 60 days.	Reduce injury threat by 90% within 12 months.
Smoking	Under supervision of Physician, consider the use of electronic cigarette to reduce pulmonary trauma and serve as an alternative to smoking.	1,2	Replace tobacco with electronic cigarette w/in 10 days of Psychiatrist consult.	Titrate nicotine delivery in electronic cigarette to be nicotine free in 24 months.
Conflict at home	Attend Family Therapy weekly.	1,2	Decrease verbal conflict to 1x/month in 3 months.	Maintain verbal conflict to 1 incident per quarter.
Behavior Management	Behavior Analyst home visit to observe interactions between Roger/Joyce, identify triggers and functions of behaviors, teach Joyce behavioral intervention strategies and principles; monitoring over a 30 day period; provide ongoing coaching.	1,2	Increase positive behavior change through Functional Behavioral Assessment; exclude cigarettes as a reinforcer; target behaviors for change w/in 30 days.	Within 12 months behavioral outbursts will be eliminated. Joyce reports feeling comfortable with Roger living in her home.
Grief/loss	Supportive therapy to address loss of mother and life changes including moving in w/sister.	1,2	Begin working through grief/loss model w/in 30 days	Complete working through grief/loss model in 12 mos.
Poor hygiene	Initiate HCBS to provide daily support for activities of daily living.	1,2	Increase ADL's 35% within 4 months.	Increase ADL's by 75% within 12 months.
Medication compliance	Initiate HCBS to provide daily support of self medication administration using Motivational Interviewing approach.	1,2	Increase daily med compliance to 95% in 60 days.	Increase daily med compliance to 99% in 6 months.
Getting around town independently	Initiate HCBS to provide daily support for supervised trips around town, use of public transit, and safe return to home.	1,2	Safely walk around neighborhood and return home within 6 months.	Safely use public transportation and return home within 12 months.
Cognitive impairment	Initiate day program for cognitive retraining, rehabilitation and coping strategies including use of memory aids, assistive devices.	1,2	Increase the successful use of coping strategies by 30% in 6 months.	Increase the successful use of coping strategies by 60% in 12 months.
Caring for the caregiver (respite)	Set up in home respite on as needed basis and recommend participation with NAMI.	1,2	Initiate 2x/week for 60 days. Then 1/wk. for 10 months.	Initiate on a PRN basis.
Boredom	Initiate HCBS for daily ADL support; TBI day program, supportive therapy for grief/loss.	1,2	Decrease ratings of boredom by 75% within 90 days.	Decrease ratings of boredom by 90% within 12 months.
Independent Living	Refer to Social Rehabilitation provider for independent living skills training to prepare for moving to own apartment.	2	Increase the use of independent living skills by 50% in 12 months.	Move into supported housing within 2.5 years.
Developing friends and peer supports	Day program, peer support, community groups focused on Roger's interests; social rehabilitation, drop-in center, peer support.	1,2	Participation in community activities with friends once/month in 6 months.	Participation in community activities with friends once/week in 12 months.
Job skills development	Referral to supported employment with job coach teaching job readiness, communication,	1,2	Work 4 hr/week in supported employment in 6 months.	Work 10 hr/week in supported employment in 12

Issue	Plan and Services to Address Issue	Related Goals	Short Term Outcome	Long Term Outcome
	behavior at employer site.			months.
Entrepreneurship mentor	Mentor through the Chamber of Commerce; Rotary Club, or other community business organization.	1	Will meet once per quarter to discuss business ideas and strategies in 9 months.	Will meet monthly to discuss business ideas and strategies in 24 months.
Income maintenance	Evaluate the status of Roger's qualification for Medicare.	1,2	Assist w/ application, medical record releases w/in 30 days.	Roger will become eligible for Medicare within 3 years.
Income maintenance	Assist with developing a PASS to protect his benefits as he begins to earn income.	1.2	Submit PASS application to Social Security within 3 months prior to working.	Maintain SSI/SSDI, Medicare while working

Gap Planning. The BHCM explains Roger's rights under the Ball vs. Betlach order, and how to report gaps in critical services, and ensures they understand what critical services are available. The BHCM provides the Critical Service Gap Report Form and the Important Member Rights Notice, and assists Roger in completing the Contingency Plan and Member Rights and Responsibilities form. The BHCM also assists Roger and Joyce in identifying the Member Service Preference Level for addressing gaps in service, including preference for a back-up plan and the timeline for services to be provided. The BHCM explains that informal support is not considered the primary source of assistance when a gap occurs, unless that is their choice. The BHCM gives Joyce and Roger her business card, HCBS Information Sheet, phone numbers for the BHCM, PCP, pharmacy, transportation, urgent care and hospital information. The BHCM also explains that they can contact Bridgeway's member call center 24/7. The BHCM encourages them to contact the provider and/or BHCM to report gaps as they occur so they can be addressed immediately. She notes they can change Member Service Preference Level at any time. The BHCM gives Roger and Joyce the "Welcome to Bridgeway" packet which organizes all of the documents, program descriptions, Member Handbook, phone lists and guides she has discussed in an easily accessible format designed to meet the needs of persons with physical and behavioral challenges. At each 90 day visit, the BHCM will review with them the Contingency Plan and Member Rights and Responsibilities Form, revise the form with them as needed, and give them a copy. The BHCM also gives Joyce and Roger a copy of the Critical Service Gap Report Form at each visit and reviews the process for reporting gaps in service.

Cultural Competency. The BHCM discusses the role of peer support, the philosophy of recovery, and the importance of self-determination. The BHCM arranges for Roger and Joyce to participate in TBI and NAMI support groups. Roger likes spending time with his large extended family but his behaviors have caused some family members to avoid him. The BHCM and Joyce agree to host a family get together in the local park to re-acquaint Roger to his extended family and educate family members about TBI and mental illness. The BHCM also explains to Roger and Joyce the importance of minimizing Joyce's burden and anxiety as a caregiver, and keeping her healthy, as this will positively affect Roger's well-being. Joyce discusses options for sharing caregiver duties with extended family members. The BHCM offers to make training arrangements for extended family members who want to help Roger reach his goals.

Coordination and Monitoring. The BHCM explains how the care team will help Roger reach his goals. This includes the PCP working collaboratively with medical and behavioral providers. The BHCM also explains how the ICP facilitates effective sharing of treatment information among his treating providers. Our provider portal supports provider coordination and allows Roger's care plan to be securely shared. The ICP provides Roger rapid access to his care team, including 24/7 crisis services, and ensures BH and medical providers work together as a team to meet Roger's goals and needs. The BHCM contacts Roger's HCBS providers 24 hours before services are to begin to ensure that services are initiated as planned. She also checks in with Joyce to determine her satisfaction with the services. After Joyce and Roger meet with the PCP and BH provider, they agree the short term placement at WYGC is a good idea. The BHCM authorizes the service and coordinates with the HCBS provider to ensure services remain in place in the home until Roger transitions to WYGC. Once Roger completes the move, the BHCM contacts him and the facility within three days to determine how he is adjusting, then monitors his progress in person every two weeks. The BHCM alerts providers to issues or changing needs identified during monitoring. When his stay is complete, the BHCM conducts an in-person visit with Joyce and Roger to revise the care plan to transition him safely back home. The BHCM contacts Joyce within 24 hours of Roger's return home to verify initiation of and satisfaction with services. She will contact them via phone weekly for the first month then conduct in person visits every 90 days or more frequently as needed to assess progress toward goals, new or changed needs and satisfaction with services.

25. Describe how utilization data is gathered, analyzed, and reported by the Offeror. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. The submission requirement will be a maximum of three pages of narrative. Additionally, the Offeror must include three sample utilization reports that demonstrate how data is gathered, analyzed, monitored and evaluated when a variance has been identified. Each sample should be no more than one page.

How Utilization Data is Gathered, Analyzed, and Reported

Bridgeway's Utilization Management (UM) Program is data-driven and closely **integrated** with our quality management, case management, disease management, and pharmacy functions in the shared process of improving our members' health outcomes. Utilization data is gathered, analyzed, and reported through our Quality Management and Performance Improvement Program. UM data is used to identify under- or over-utilization of services, aberrant practice patterns, and quality of service concerns, many of which can be corrected with education, outreach or other corrective action.

The Bridgeway Board of Directors **oversees** the development, implementation, and evaluation of the UM Program, and approves the Annual UM Program Evaluation. The Board delegates the daily oversight and operating authority for the program through the Quality Management/Performance Improvement Committee (QMPIC) to the Medical Management/Utilization Management (MM/UM) Committee. The MM/UM Committee oversees an integrated management system that is responsible for the assessment, planning, implementation, and evaluation of all UM activities, including, but not limited to, prospective, concurrent and retrospective review, referral management, second opinions, clinical criteria and practice guidelines, medical technology (new and existing), coordination of care, and monitoring for under-or over-utilization. The Medical Director has oversight of the MM/UM Committee, including data reporting and the administration of all UM activities, and chairs the Committee. Members include the Vice President of Medical Management and network providers including behavioral health. Executive leadership and other staff attend as non-voting members. The MM/UM Committee reports to the QMPIC on all UM activities including review of utilization data. The QMPIC is chaired by the Medical Director and includes the Bridgeway Chief Executive Officer, Executive Leadership representing all plan departments, and network providers representing a variety of specialties and provider types.

The MM/UM Committee assures that all medical decisions are **compliant** with AHCCCS coverage guidelines, medical necessity criteria, approved clinical practice guidelines, and timeliness and Notice of Action requirements, at the same time serving the special needs and language requirements of the member. UM staff report initial data analysis, and its accuracy, completeness and consistency, to the MM/UM Committee with particular attention to identification of potential over-and under-utilization. All utilization data is reported to the MM/UM Committee quarterly unless significant variances are identified as needing immediate interventions. In such cases, the Medical Director and the Vice President Medical Management assess the variance and recommend an appropriate action plan. The routine staff report includes a comprehensive analysis of the data including identification of variances or trends, review of outcomes, and recommended interventions based on the findings. The MM/UM Committee makes recommendations that may include additional data analysis, continued monitoring of the process or provider, and/or corrective action. Recommended actions, which may be multi-departmental, may include new or revised disease management programs, revisions to prior authorization requirements, new or revised clinical practice guidelines or medical necessity criteria, additional network development activities, improvements in the utilization monitoring process, or addressing the utilization trends of a particular provider or member.

Centene Corporation (Centene), our parent company, supports the UM Program by providing sophisticated **data management capabilities** for data collection, indicator measurement, analysis, and improvement activities. Information Technology and Health Economics staff provide standard and ad hoc reporting and analysis support to UM staff. Bridgeway captures and analyzes data from internal, subcontractor (vision, behavioral health, pharmacy, dental and clinical laboratory) and external sources, including (starting in 2011) member utilization profiles from the Health Information Exchange of Arizona. Centene uses a Teradata-powered Enterprise Data Warehouse (EDW) as the central hub for service information that allows collection, **integration**, and reporting of clinical claim/encounter data (medical, behavioral health, laboratory, pharmacy, dental and vision; individual and organizational providers); financial information; medical management information (referrals, authorizations, disease management); member information (current and historical eligibility and eligibility group, demographics, member outreach); and provider information (participation status, specialty, demographics) as required by the UM Program. This data is refreshed nightly. Housing all information in the EDW allows staff to generate standard and ad hoc reports from a single data repository, using our Centelligence suite of reporting systems to build and tabulate key performance indicators and provide drill-down capability to the individual provider or member level for investigation of suspected under- or over-utilization. Medical and

behavioral health data are integrated within the same systems facilitating effective integration of utilization management and case management activities. Centelligence Foresight (our predictive modeling application) enables us to not only assess appropriateness of delivered services against evidence-based guidelines, but also against the average risk of members or subgroups of members receiving the services. The software assesses whether the members receiving specific programs or services are the ones who can receive the most value from them.

This information technology infrastructure allows Bridgeway to generate an array of regular, **consistent** utilization reports as well as ad hoc and member and provider level reports. Regular reports that UM staff and the MM/UM Committee review include inpatient measures such as days and admissions per 1,000 members, proportion of unplanned readmissions, and average length of stay, overall and by diagnosis; nursing and assisted living facility, and home and community-based services; outpatient measures such as emergency department (ED) visits per 1,000 members, recommended preventive care exams and screenings, specialty referrals, laboratory, radiology and other ancillary services, behavioral health services, and certain selected procedures (such as hysterectomies); utilization related to ambulatory care sensitive conditions; and pharmacy utilization. We also review quality of service indicators such as the rate of out-of-network care, the rate of notices of actions to reduce or deny authorization of service and the types of services impacted, member and provider satisfaction, including grievances and appeals related to services delivered or denied, timeliness of authorization review, and telephone responsiveness data.

Bridgeway's participation with the Health Information Exchange of Arizona (HIEA) will help overcome current barriers in obtaining full and timely utilization data for all of our members. For example, it has been very difficult to obtain timely and complete data for dual-eligible members who are not covered through Bridgeway's Special Needs Plan. Though we use currently available data in regular reports to identify and outreach to members with high utilization of acute services or low use of preventive services, with more complete data we will be much more effective in offering them additional support. With more timely information, we can be more successful in identifying members with ED visits during the "teachable moment" immediately following the visit. Our current efforts include UM staff reviewing daily call center reports from NurseWise, our 24/7 nurse advice line, and from our behavioral health crisis line listing members who had been directed to emergency services or crisis intervention in the previous 24 hours. Likewise, timely information through HIEA will allow our Concurrent Review Nurses to initiate or participate in discharge transition planning early in the course of inpatient stays for dual-eligible members.

Monitoring for Under- and Over-Utilization

In order to fully understand the utilization **trends** of our members and our providers, as well as the underlying causes, Bridgeway analyzes a variety of different 'snapshots' of our utilization data. The MM/UM Committee monitors and analyzes data at aggregate and detail levels including by member, by individual provider or facility, by provider specialty, by type of service, by diagnosis, by place of service, and by comparing services authorized to services received. Routine monthly trend reports monitor key utilization measures such as inpatient admissions and days, ED visits, and specific preventive care services. Each report includes a drill down capability to more specific areas of interest. For example, when analyzing ED visit or inpatient utilization, we can look not only at total number of visits or days, but also at the utilization in relationship to readmissions, frequent ED utilization, or presence or absence of physician office visits. We can look for patterns of under- or over-utilization by provider, by member, or by GSA. The Committee has established benchmarks using industry standards, national Medicaid HEDIS averages, or AHCCCS mandated thresholds. Particularly when dealing with utilization data, internal benchmarks are developed based on historical data that reflect variances in population demographics, seasonal variations, cultural disparities and regional characteristics of our members.

Monitoring and Evaluating Utilization when a Variance has been Identified in a Provider's Utilization Pattern

Under-utilization by Providers. Bridgeway Quality Management (QM) staff may identify a pattern of under-utilization by a specific provider by reviewing the provider's performance on profile measures for primary and secondary preventive services such as preventive health visits or diabetes care testing, for example. Performance is compared to national benchmarks, when available, and average network performance. Once the provider has been identified, QM or Network Management staff, or the Medical Director, meet one-on-one with the provider to discuss performance, provide education and establish an action plan for improvement. QM staff monitor performance monthly or quarterly, depending on the measure, and report both to the MM/UM Committee and the provider. We continue the higher level monitoring until performance has been corrected and maintained for at least six months. The provider will have direct access to profile performance reports on the Provider Portal.

Over-utilization by Providers. QM or UM staff may identify a pattern of over-utilization by a specific provider by reviewing quarterly profile reports of providers' utilization of inpatient, ED and other services, or of inpatient referral

rates by nursing and assisted living facilities and homes. The Concurrent Review staff may note a trend of unplanned readmissions for a specific hospital. In each case, performance is compared to average network performance or national benchmarks. Network Management staff or the Medical Director meet one-on-one with the provider to discuss performance, provide education and establish an action plan for improvement. UM staff monitor performance monthly and report both to the MM/UM Committee and the provider. We continue the higher level monitoring until performance has been corrected and maintained for at least six months. In certain cases, UM staff refer providers with patterns of over-utilization to Centene's Special Investigation Unit for investigation of possible fraud, waste or abuse. A screening process within our claims processing operations can also generate such referrals. These investigations, which can include review of clinical records, time sheets and other original documentation, are managed jointly with Bridgeway staff.

Monitoring and Evaluating Utilization when a Variance has been Identified in a Member's Utilization Pattern.

Under-utilization by Members. Case Management staff may identify a pattern of under-utilization by a specific member by reviewing routine reports from Centelligence Foresight of members in need of recommended preventive services, for example. Also, members who are identified with a pattern of over-utilization of acute care services may be under-utilizing lower levels of care, preventive services or behavioral health services. The identified member's assigned Case Manager reviews the member's care plan, including a partial or full reassessment of the member's needs, barriers and planned services, and monitors the member more frequently with personal contact, including with caregivers or residential facility staff. Case Managers continue to monitor the monthly Centelligence Foresight reports to identify members persistently listed as having gaps in recommended care, and to identify those members with the highest risk for future acute care utilization, and therefore the highest priority for preventive services. Pharmacy staff may identify members under-utilizing secondary preventive medication, such as asthma controller medications, from routine reports. They contact the prescribing provider with recommendations for appropriate use.

Over-utilization by Members. Bridgeway staff may identify a pattern of over-utilization by a specific member by reviewing routine Centelligence Foresight reports of members with more than four ED visits in the previous 12 months or by reviewing daily call center reports of members referred to the ED for those members with recent previous visits, for example. Concurrent Review staff may identify a member with repeated unplanned inpatient readmissions. The identified member's Case Manager reviews the member's care plan, including a partial or full reassessment of the member's needs, barriers and planned services, including behavioral health services. The Case Manager also reconciles the member's current medications with those on the care plan, and monitors the member more frequently with personal contact, including with caregivers or residential facility staff. Patterns of ED or other utilization may suggest member abuse or neglect. In such cases, Case managers initiate an evaluation of the member in cooperation with Adult or Child Protective Services to ensure the member is in a safe environment. Bridgeway pharmacy staff may identify members with polypharmacy involving therapeutic duplication, or members with high use of controlled drugs from routine pharmacy utilization reports. Our Pharmacy Utilization Review Committee reviews identified members and may make recommendations such as discussion with the prescribing physician(s) or referral of dual eligible members to our Medication Therapy Management Program. For example, in 2010 the Committee reviewed a member who was on two antipsychotic medications (Geodon and Seroquel) and recommended that our psychiatric consultant contact the member's primary practitioner. The provider was unaware of the polypharmacy. Our consultant is currently working with the provider to wean the member off the Seroquel. Pharmacy staff continue to monitor the identified members' drug utilization monthly until the adverse pattern is resolved.

Sample Utilization Reports when a Variance has been Identified

The following sample reports demonstrate Bridgeway's capabilities to analyze, monitor and evaluate utilization data when we suspect under- or over-utilization. If we identify a variance in overall ED utilization, an analysis such as **Sample 1** allows UM staff to compare the utilization of ED **providers**. Further pursuing such a variance, **Sample 2** allows us to identify the primary risk categories (diagnostic groups) for **members** with two or more ED visits in the period. Should we suspect that the variance in ED utilization was driven by members with diabetes, **Sample 3** demonstrates Bridgeway's ability to identify members with non-compliance with diabetes disease monitoring that could be a cause for increased ED utilization.

Sample Report 1. Analysis of Emergency Department Providers by Paid Claims Volume.

http://bit.centene.com:8080/OpenDocument/opendoc/openDocument.jsp - Windows Internet Explorer

Arizona - All Regions LTC Non-Dual-NonPPC Emergency Room All Sub Cost Categories
Claims Drill Down - Top 200 Utilization
Paid Data as of 2/28/2011 - 3 Month LAG

		Utilization Rolling 3 Months								
Top 200 Providers	**Provider #**	SEP 2009 - NOV 2009	SEP 2010 - NOV 2010	% Change	Change	Percent of Total	2009-12	2010-01	2010-02	2010-03
BANNER THUNDERBIRD MEDICAL CENTER	100180	45.76	88.31	92.99%	42.55	7.78%	33.52	101.98	34.19	68.38
JOHN C LINCOLN-NORTH MOUNTAIN	100224	22.88	88.31	285.98%	65.43	7.22%	0.00	33.99	34.19	68.38
MARYVALE HOSPITAL	101010	34.32	58.87	71.55%	24.55	3.56%	33.52	0.00	34.19	0.00
BANNER GOOD SAMARITAN MEDICAL CENTER	100176	34.32	49.06	42.95%	14.74	3.29%	33.52	33.99	34.19	102.56
MARICOPA MEDICAL CENTER	100235	22.88	39.25	71.55%	16.37	2.38%	33.52	67.99	68.38	34.19
MAYO CLINIC ARIZONA	100692	34.32	39.25	14.36%	4.93	2.33%	0.00	0.00	0.00	0.00
!Unknown!		0.00	68.68	0.00%	68.68	1.87%	0.00	0.00	0.00	0.00
CHANDLER REGIONAL HOSPITAL	102130	0.00	19.62	0.00%	19.62	1.80%	0.00	0.00	34.19	34.19
BANNER GATEWAY MEDICAL CENTER	103201	11.44	29.44	157.32%	18.00	1.74%	0.00	33.99	0.00	0.00
MERCY GILBERT MEDICAL CENTER	102348	0.00	39.25	0.00%	39.25	1.63%	0.00	0.00	0.00	0.00
BANNER WALTER BOSWELL MEDICAL CENTER	105914	57.20	58.87	2.93%	1.67	0.84%	67.04	67.99	0.00	0.00
BARBOSA, JOILO C	110174	34.32	49.06	42.95%	14.74	0.79%	0.00	0.00	0.00	68.38
PAULSON, DREW	105837	22.88	29.44	28.66%	6.56	0.65%	33.52	0.00	0.00	34.19
WEST VALLEY HOSPITAL	101255	11.44	9.81	(14%)	(1.63)	0.59%	100.56	0.00	0.00	34.19

Top 200 Diagnosis | Top 200 Procedure | Top 200 Specialties | Top 200 Providers

Refresh Date: March 18, 2011 6:27:37 PM GMT-05:00

Sample Report 2. Analysis of Diagnoses (Primary Risk Categories) for Members with Two or More ED Visits.

Population List - Windows Internet Explorer

http://impactpro/ImpactPro/Aggregate.aspx?TABLE=MEMINFO&GroupBy=110&GroupBy2=291&Grp1=110&Grp2=291&LR=

File Edit View Favorites Tools Help

Population List

CENTENE® Corporation

IMPACT® Pro
Log Off

HOME | MEMBER LIST | POPULATION LIST | REPORTS | ADMINISTRATION

SEARCH Members By Member ID | Enter Search Value

First group by: Primary Risk Category
Then group by: All Population

Print | Save | Export

Centene Population List

Filter Members | Columns

Total Rows: 45

Filter: Current report shows group of members who have Product IN ASO - LTC,LTC Dual-NonPPC,LTC Non-Dual-NonPPC and Plan = AZ.
The report includes only members who have any of the following Care Alerts: "ER Visits - All, 2 or more".

Page: 1 of 1

Primary Risk Category	Distribution	Risk	Risk by TOS	Member Count	Age	Months Enrolled	Future Risk, Costs	Future Costs	Future Risk, Inpatient	Inpatient Stay Probability	Prior Total Costs (Annualized)
Other neurology	✓	✓	✓	85	71	11	6.06	$17,980	7.76	21.6 %	$30,848
Acute and chronic renal failure wo ESRD	✓	✓	✓	73	75	11	10.02	$29,710	11.40	31.7 %	$29,143
Diabetes	✓	✓	✓	45	68	12	8.50	$25,200	11.17	31.0 %	$29,678
Chronic renal failure, with ESRD	✓	✓	✓	43	62	11	36.64	$108,610	19.58	54.4 %	$39,507
Congestive heart failure	✓	✓	✓	33	74	11	11.68	$34,630	14.51	40.3 %	$35,878
Other pulmonology	✓	✓	✓	23	61	11	16.86	$49,980	17.54	48.8 %	$68,583
Other mental health/substance abuse	✓	✓	✓	23	69	12	5.18	$15,340	11.45	31.8 %	$30,853

Local intranet | 100%

start | Citrix XenApp - Applic... | 4 Citrix | 3:06 PM

Sample Report 3. Identification of Members Non-Compliant with HbA1c Monitoring.

Member List Default - Windows Internet Explorer

http://impactpro/ImpactPro/Members.aspx?Table=MEMINFO&LR=LR634360512553241739&MR=1

File Edit View Favorites Tools Help

HOME | MEMBER LIST | POPULATION LIST | REPORTS | ADMINISTRATION

SEARCH Members By Member ID | Enter Search Value

Back to Population List

Print | Save | Export

Centene Corporation Member List

Filter Members | Columns

Total Rows: 160

Filter: Current report shows members who have Product IN ASO - LTC,LTC Dual-NonPPC,LTC Non-Dual-NonPPC, Plan = AZ and All Population = 0.
The report includes only members who have any of the following Clinical Indicators: "**Diabetes**".
The report includes only members who have any of the following Care Opportunities: "EBM - Pt(s) w/o an HbA1c testing in last 12 reported months. ".

Page: 1 of 1

Sex	Link	Months Enrolled	Age	⚠	Future Risk, Costs	Future Costs	Future Risk, Inpatient	Inpatient Stay Probability	✚	Prior Total Costs (Annualized)	Prior Rx Costs (Annualized)	H	Primary Risk Category
Male	✓	12	72	✓	1.48	$4,370	1.71	4.8 %	✓	$2,588	$0		Diabetes
Male	✓	12	59	✓	2.06	$6,100	1.99	5.5 %	✓	$21,442	$0		Diabetes
Female	✓	12	73	✓	2.04	$6,040	1.55	4.3 %	✓	$22,703	$0		Diabetes
Female	✓	12	66	✓	2.75	$8,160	4.00	11.1 %	✓	$17,507	$0		Diabetes
Female	✓	12	65	✓	5.37	$15,920	7.86	21.8 %	✓	$20,567	$0		Diabetes
Male	✓	12	73	✓	13.97	$41,400	20.74	57.7 %	✓	$50,234	$0	✓	Other gastroenterology
Male	✓	12	75	✓	6.41	$18,990	3.02	8.4 %	✓	$15,381	$0	✓	Other major infectious disease

Copyright ©2007 Ingenix, Inc. All rights reserved. | Terms of Use | CPT only ©2006 American Medical Association. All rights reserved.

Report Date: 3/5/2011 | Create Date: 3/15/2011

Local intranet 100%

start | Citrix XenApp - Logge... | Home - Windows Inte... | Member List Default -... | Document1 - Microsof... | 1:21 PM

26. Provide an example of how the Offeror's analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system.

Home Telemonitoring to Decrease Inpatient Readmissions

Identification of Opportunities and Selection of Project. In May 2009, Bridgeway's Medical Management/Utilization Management (MM/UM) Committee reviewed a series of inpatient admission, readmission and emergency department (ED) utilization reports. Their analysis identified a subset of ALTCS members who had frequent ED visits and multiple inpatient admissions and readmissions for the same chronic condition, with a **disproportionate financial impact** on the plan. Case Managers had identified many of these members individually in the past and provided assistance, which was frequently focused on home-based services. These high-risk members often had multiple comorbidities and a complex treatment plan. Follow-up indicated that many of them continued their high utilization of acute care services and were often moved from their natural setting to assisted living or skilled nursing facilities to attempt more consistent monitoring of their chronic conditions. Root cause analysis revealed underlying causes including limited member mobility, transportation barriers, an insufficient natural support system, and limited health literacy.

Target population. ALTCS members who have been diagnosed with diabetes, hypertension, heart failure, or chronic obstructive pulmonary disease (COPD), and who have needed inpatient or ED services recently (see below).

Objectives. Reduce utilization of acute services; improve self-management skills; improve control of the chronic condition; achieve more stability in natural setting (home or assisted living facility).

Intervention. In August 2009, Bridgeway implemented a pilot telemonitoring program designed to improve the clinical stability of high-risk members in their **natural settings**, and bypass barriers such as limited mobility and associated transportation issues (for example, no caregiver available to accompany the member). The monitoring devices available through the program are appropriate for members with diabetes, hypertension, heart failure, and COPD. This program provides in-home telemonitoring devices such as glucometers, pulse oximetry, blood pressure monitors, and weight scales that allow members' biometric information to be tracked, trended, and managed daily via real-time data. The program used patent-pending, FDA-approved technology that is "device-agnostic", interfacing with virtually any medical home monitoring device via wireless or wired modem using land line, cellular or VOIP communications links. Within seconds of a reading being taken in the home, the biometric value was transmitted electronically to our monitoring office and evaluated against patient-specific or national guidelines and analyzed for favorable or unfavorable trends. If the value was outside physician-defined parameters, the monitoring nurse **immediately** informed the member or caregiver, physician and Case Manager as appropriate. The technology is entirely web-enabled; all members were provided a login card that enables them, their family, or their physician to access their biometric information from anywhere in the world at anytime – as long as they have access to the Internet. This technology is **innovative** and sets Bridgeway apart as having the only device-agnostic, real-time biometric monitoring capability among its competitors.

During the initial phase of the intervention, the enrollment criterion was two or more inpatient admissions within a six-month period. Each Bridgeway ALTCS member was assigned a Case Manager, many of whom were social workers. The Social Work Case Managers, in turn, had an assigned Nurse Case Manager to provide support for clinical issues. When Social Work Case Managers noted during evaluations or reevaluations that members met enrollment criteria, they reviewed the assessment results and scheduled a joint home visit to include both the Nurse and Social Work Case Managers, the member and family, or caregiver (and assisted living facility staff when appropriate). The meeting included discussion of the member's chronic condition and how well the member understood it, the potential for improved self-management and, if appropriate, the possible benefits of participating in the telemonitoring program. If the member met criteria and was amenable to the program, the Case Manager contacted the member's primary physician, reviewed the results of the assessment, and discussed a referral to the telemonitoring program as a part of the member's plan of care.

Once there was agreement, a technician delivered and set up the equipment; taught the member, family and caregiver how to use it; and provided a toll-free number to call in case of technical issues with the equipment. If needed, a technician was dispatched to the member's location for troubleshooting. Both Bridgeway Case Managers, and the member's provider, were able to access the member's data at any time on the telemonitoring program web portal. The Nurse Case Managers and the monitoring nurses held bi-weekly case conferences to discuss any member-specific issues, as well as updates on each member's compliance with transmissions and the results. The Nurse Case Manager updated the member's Social Work Case Managers and assisted with any recommendations. The monitoring nurse sent a report to the primary

physician at least monthly, or more often if requested, with a summary of the member's data. If there were any events outside the prescribed parameters, the monitoring nurse immediately contacted the Case Manager and primary physician by phone or email with the transmission results. The Bridgeway Case Manager and monitoring nurse coordinated any interventions or change in monitoring as prescribed by the physician, including assistance with scheduling appointments and arranging transportation, if necessary. Focused coaching at these **teachable moments** improves the members' knowledge of the disease process. Focused goals for self-monitoring help motivate the members.

Our telemonitoring program gives the member's team – member, caregiver, primary physician, Case Manager - actionable opportunities to detect pre-acute conditions and prevent worsening health status with early attention and self-care. The program also provides continuous meaningful information on illness progression in the members' natural setting. It empowers members (or caregivers) to take a more active role in managing their own care. It also makes family members and caregivers more aware of subtle clinical changes in conditions in order to more proactively respond to members' needs.

Evaluation. The MM/UM Committee evaluated the effectiveness of the telemonitoring program, most recently in February 2011. As of February 1, 2011, there were 25 members enrolled in the program, with an average participation period of 10.4 months. These members have had a total of 17 inpatient admissions while enrolled (0.68 admissions per member). These members had a total of 98 inpatient admissions during the 12-month period prior to participation (3.92 admissions per member). The program therefore yielded an annualized **80.1%** reduction in inpatient admissions per year for participating members. As an example, in October 2010, a Case Manager identified a member with co-morbid diabetes, hypertension and cardiopulmonary disease who had 14 ED visits and inpatient admissions in the previous nine months. Previous attempts to stabilize his condition included discharge to a skilled nursing facility for more intense monitoring and subsequent transition home from the nursing facility with home health services. Recognizing that this pattern of need for acute services was persistent, the Case Manager enrolled the member, with his agreement, in the telemonitoring program for home monitoring of blood sugar, blood pressure and oxygen saturation. He has had only one inpatient admission and 0 ED visits in the four months since he enrolled in the program. The program has also demonstrated an improvement in member self-care (or care by caregiver). At members' entry to the program, their average rate of compliance with recommended self-monitoring (blood sugar, blood pressure, weight, blood oxygen saturation) was 27%. It is currently at 63%.

Post-Measurement Activity. The MM/UM Committee completed a six-month interim assessment of the telemonitoring pilot in February 2010, and noted that only 10 members had been enrolled since its inception. They decided that the enrollment process was too restrictive and initiated two **changes** in the intervention. The enrollment criterion was changed from two or more inpatient admissions to two or more inpatient admissions, ED visits, or urgent care visits within a six-month period. Secondly, the Nurse Case Manager Supervisor began receiving a daily census of hospitalized ALTCS members. The supervisor reviews all listed members with their assigned Case Managers for possible program eligibility, considering admitting diagnoses, patterns of past utilization, and any gaps in guideline-recommended care. An additional 15 members were added to the program after these process changes.

Post-Hospital Discharge Follow-Up Calls to Decrease Inpatient Readmissions

Identification of Opportunities and Selection of Project. In 2007, the MM/UM Committee noted a trend of increased rate of readmission of members within 30 days of discharge from an inpatient admission (including behavioral health admissions), particularly for members returning to a home or assisted living residence. The 30-day readmission rate for CYE 2007 was **26.6**%. Root cause analysis for unplanned readmission indicated that many members were not following up with their primary physicians following discharge; that discharge medications, durable medical equipment, medical supplies, and appropriate levels of home or community-based critical services were not consistently being ordered, obtained and utilized; and that the members' assigned Case Managers were not being notified of pending discharges and therefore were not able to initiate proper follow-up. Lack of transportation or caregiver accompaniment for clinical follow-up appointments was also identified as a barrier. ALTCS members with hospital utilization commonly have multiple medical and behavioral health co-morbidities.

Target Population. ALTCS members being discharged home or to an assisted living residence.

Objective. Reduce 30-day readmission rate.

Intervention. In February 2008, Bridgeway implemented a new process and a standardized tool developed by our Quality Management, Medical Management and Case Management staff to improve the effectiveness of case management follow-up

after members are discharged from an inpatient admission. As soon as a member was identified by a Bridgeway Concurrent Review Nurse as a hospital inpatient, the Nurse notified the member's assigned Case Manager and Quality Management Analyst via electronic notification in our health services management system. The same process was followed for dual eligible members covered by Bridgeway's Special Needs Plan. The Case Manager placed a call to the member's home or assisted living facility within two days after the day of discharge. The new tool **standardized** the elements to be reviewed with the member or the member's representative during the telephone call. Those elements, covering both assessment and assistance with barriers, consisted of the following:

- Understanding of discharge instructions
- What medications were ordered and obtained
- What primary or specialty physician or other provider follow-up visits were recommended and scheduled
- Transportation
- What Home and Community Based Services were ordered and arranged
- What durable medical equipment and medical supplies were ordered and delivered.

The Case Managers monitored their assigned members using our health services management system reminder logs and notification process, and a Quality Management Analyst monitored the system to ensure case managers had completed the post hospital call and evaluated the outcome of the calls. In June 2008, the tool was added electronically to the health services management system to facilitate documentation of the calls and data analysis related to the calls.

Evaluation. The MM/UM Committee evaluated the effectiveness of the enhanced post-discharge follow-up call program after five months. The 30-day readmission rate for a stratified random sample of members for that period had improved to **20.3%**. An interim assessment for the period of August through October 2008 revealed an unchanged readmission rate of 20.8%, indicating that the change to electronic documentation had no significant effect on the readmission rate. The MM/UM Committee monitored the initiative quarterly and reported its effectiveness to the Quality Management/Performance Improvement Committee.

Post-Measurement Activity. During the evaluation of the post-discharge call initiative, an additional intervention was implemented to further facilitate the transition process and improve the communication between members and Case Managers immediately after discharge. In September 2008, Quality and Medical Management staff developed and implemented a Discharge Transition Tool, after approval by AHCCCS, to structure communication between Concurrent Review Nurses and hospital discharge/social work staff regarding discharge education for members, including providing members with Case Manager contact information so they know how to quickly access assistance post-discharge. Continuing evaluation indicated a 30-day readmission rate (stratified random sample of members) of **17.8%** for CYE 2009 and **15.9**% for CYE 2010, indicating sustained and increasing improvement.

27. Describe existing or planned Chronic Care/Disease Management programs that are designed to improve health care outcomes for members with one or more chronic illnesses. Describe how the Chronic Care/Disease Management programs' data are analyzed and the results utilized by the Offeror to improve member outcomes.

Traditional Disease Management (DM) programs are built around specific conditions, and the lack of integration in many such programs has led to suboptimal results. Difficulties have included limited integration across programs and services; limited integration with providers, payers and members; lack of tailored or customized information for providers, payers and members; single-disease focus versus integrated solutions recognizing the co-morbidities and psychosocial variables that may impact treatment; and difficulty integrating financial and clinical results to provide a complete picture of program effectiveness. A recent analysis, though limited to Medicaid-only individuals under age 65 with disabilities, reinforced the significance of **multiple co-morbidities**, particularly **behavioral health** conditions. For example, behavioral health co-morbidity was found in 69% of individuals with coronary artery disease and 65% of individuals with diabetes. In each case, behavioral health conditions were also the highest priority co-morbidity based on percent of total cost for the individuals.[1] Based on the unique needs of the ALTCS population, in particular the prevalence of chronic and co-morbid conditions, Bridgeway utilizes an **Enhanced Case Management** (ECM) model for DM. This model integrates the major components of disease management into the intensive case management approach required to manage the LTC population. Objectives of this approach such as accountability for defined measurable outcomes, improvement both in the quality of care for members of the program and in the ECM program, improved member capabilities to self-manage conditions, impact the health care costs of the ALTCS members, and demonstrate a return on investment for the program.

We have incorporated into our ECM Program nationally-recognized protocols and practice guidelines used in traditional DM programs. ECM takes a population-based approach to promoting appropriate health care through member self-care. This concept is a best-practice model for promoting member self-management of chronic disease, and for empowering the member to more effectively utilize the health care system. The model combines aspects of primary care, DM, and case management programs and involves all members with the qualifying diagnoses. The focus is on delivering **personalized** treatment, coordinating services that cut across multiple physical and behavioral health conditions, and on addressing the co-morbidities and the psychosocial factors that influence treatment. A Case Manager (CM) works with each member, providing customized interventions and recommendations based upon the member's unique needs and choice. Traditional disease-specific education and support supplement the individualized program components. Our ECM Program will encompass asthma, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease (COPD), diabetes, and serious and persistent mental illness (SPMI)/dementia/Alzheimer's disease. We selected these conditions due to their prevalence, our ability to affect outcomes, and their financial impact. For example, 21.3% of our ALTCS members have diabetes; 7.6% have cardiac disease; 3.5% have pulmonary disease. About 85% of ALTCS aged or physically disabled enrollees are also eligible for Medicare. Our ECM Program takes a **unified** approach for those members who are also covered through Bridgeway's Special Needs Plan, with the same staff, systems and programs. For other dual eligible members, we coordinate with the other payers, CM to CM, Medical Director to Medical Director, with direct communication. In 2011, Bridgeway will begin participating with the Arizona Health Information Exchange, facilitating comprehensive access to utilization and other data for our dual eligible members.

Program Components

Assessment. Each ALTCS member has an assigned CM who does an initial assessment at the member's home or facility residence within the first 10 days of enrollment, or seven days if the member is ventilator dependent. Members whose primary health risk is serious mental illness or dementia/Alzheimer's are assigned a Behavioral Health CM (BHCM), with training as a clinician, and are supported by Nurse CMs on the team for medical issues. Other members, many of whom have behavioral health co-morbidities, are assigned either a Social Worker or Nurse CM, based on need, and are supported by Behavioral Health Coordinators on the team. During the initial assessment, the CM determines a baseline medical and mental status and identifies disease risk factors. The CM assesses the member's knowledge regarding current health status and diagnoses, health maintenance behaviors, service utilization, medication use, and the member's perception and **preferences** for health care coordination needs. The CM consults with the member's primary provider, and Medicare plan when applicable, to verify the member's medical and behavioral health treatment history, with particular attention paid to issues such as multiple medications, multiple treatment providers, recent hospitalizations or ED visits, recent changes in the member's service plan, past history of surgeries or adverse health events, and demographic

[1] *Clarifying Multimorbidity to Improve Targeting and Delivery of Clinical Services for the Medicaid Population*, Faces of Medicaid Report, Center for Health Care Strategies, December 2010

and lifestyle risk factors for negative disease outcomes. This assessment also addresses stability of housing and past barriers to keeping appointments, particularly for members with SPMI. The CM will use the initial visit to begin empowering the member to become actively involved in the management of his or her care, and will use motivational interviewing while collecting baseline information. The idea is to strengthen self-care capabilities, identify areas in which behavior change is not yet occurring, and move the member from a state of "not ready" toward a state of "readiness" to make needed changes. The member's current **readiness for self-management** is assessed in the following areas of health care:

- Daily monitoring of health indicators for the member's chronic health condition for self-triage
- Consistent self-management of acute clinical symptoms in the home/community setting
- Correct use of all prescribed medications and medication adherence over time
- Appropriate lifestyle decisions based on the member's chronic health condition and physician recommendations
- Management of depression and other mental health correlates of chronic disease
- Access to support for self-management (such as family, friends, and community services)

All members receive education and periodic follow-up from the CM. At a minimum, Case Managers conduct a reassessment visit with members residing at home every three months, and once every six months with members residing in a facility. The frequency and level of intervention is adjusted, whenever necessary, based upon changes in severity of illness; feedback from the treating physician, Medicare plan, or the member; or new risk factors identified by the CM. For existing members, Bridgeway's Centelligence Foresight system provides the CM with algorithm-driven predicted risk scores based on their medical, behavioral health, and pharmacy claims history, as well as AHCCCS eligibility data. The CM will assess and follow members with dual eligibility and **coordinate** any change in condition or risk factors with a Medicare plan or traditional DM Program.

Personalized Plan of Care. Based upon the comprehensive assessment including severity of illness, risk for negative outcomes, capacity for self-management, and community support needs, the CM develops an **ECM plan** and incorporates it into the member's service plan. The ECM Plan is designed to address the member's risk, gaps in their self-management practices, and areas of their treatment that do not comply with evidence-based clinical guidelines, and to coordinate needs across co-morbid conditions and according to those guidelines. Clinical treatment that does not follow these recommended clinical guidelines is discussed with the primary or other treating provider. ECM plans take different approaches based on the member's assessed level of readiness for change using Prochaska's **Stages of Change** model, a reliable tool to match patients with the most effective interventions to promote changes in their behavior (Prochaska & DeClemente, 1986). Members, caregivers and providers are actively involved in the development of the plan. The ECM plan may include other materials such as patient self-monitoring logs or a "questions to ask your doctor" sheet. The CM can modify ECM plans at the time of any interaction with the member, and whenever new information about, or changes related to, risk factors, current functional level, and member health behavior are identified.

Bridgeway uses the following **nationally recognized** clinical guidelines to guide the ECM program. Our Provider Performance Assessment and Profiling Program will monitor compliance with these guidelines.

Clinical Guideline	Source
Asthma	National Heart Lung and Blood Institute
Diabetes	American Diabetes Association
COPD	Global Initiative for Chronic Obstructive Lung Disease
Congestive Heart Failure	American College of Cardiology/American Heart Association
Coronary Artery Disease	American College of Cardiology/American Heart Association
SPMI / Dementia / Alzheimer's Disease	National Institute of Mental Health / Alzheimer's Association of America

Disease specific protocols are the keys to successful ECM, and are based on these guidelines. Each has components in common that can have a significant impact on the health status of the member. These include hospital-based intervention at each admission; education of the member or member's caregiver and providers; physician practices that are consistent with nationally recognized guidelines; member support to improve adherence to medications and to dietary and physical activity guidelines; recommendations regarding self-care and symptom management; and a **self-monitoring plan** for signs and symptoms, including a plan for coping with worsening symptoms that includes guidance on specific actions to be taken. In 2009, Bridgeway added an effective tool for our highest-risk members: a **home telemonitoring** service that transmits to us regularly tested key health data such as blood sugar levels and blood pressure. The member's CM and primary provider can quickly contact the member for real-time, 'teachable moment' support of self-management skills.

Through our ConnectionsPlus® program, the CM can provide preprogrammed cell phones to high-risk members without reliable telephone service. These phones provide ready access to the CM, providers, pharmacy, emergency services, and NurseWise, our 24/7 nurse advice line.

Member Education occurs during the **face-to-face** initial assessment and periodic reassessments as well as through telephone contact, other face-to-face contact, education groups, and educational materials. Members are taught about monitoring daily disease-specific indicators, other actions specific to their condition(s) and the actions to take when these measurements indicate a potential health risk, medications and their side effects, issues specific to their health condition(s), and suggestions about specific actions based on their service plan. If appropriate and available, the CM also will link the member with community-based disease-specific educational programs and support groups. In the 4th Quarter of 2011, and through a partnership with Microsoft Corporation, we will pilot our On-Demand In-Home Video Pilot between Bridgeway equipped ALTCS members (with member consent) and LTC Case Managers. With this exciting pilot, we hope to demonstrate how the viability of on-demand video conferencing can dramatically ***increase*** the frequency of face-to-face member contact with our Case Managers, and further ***expand*** the scope of ***member education*** possible.

Provider Support. To support their ongoing relationship with members, the CM sends the primary provider written progress notes, including all pertinent member-related information, within three days of member contact. When there is sudden or serious change in the member's status, the CM will immediately **communicate** with the provider. To support providers, clinical tools relevant to their practice are provided, including practice guidelines, clinical decision algorithms, desired patient outcomes, and patient counseling materials. Primary providers will also receive aggregate reports about the status of their members. Provider representatives on Bridgeway's Medical Management/Utilization Management (MM/UM) Committee were **involved** in the implementation of the ECM Program and continue to oversee it.

How Chronic Care/Disease Management Program Data are Analyzed and Results Utilized

Bridgeway's Centelligence Insight reporting system captures and reports condition-specific indicators such as HEDIS and utilization measures. Since all members with qualifying conditions are enrolled in the ECM Program, plan-wide indicators are applicable. Additional information may be gathered through provider-completed member checklists and documentation of functional assessments in TruCare, our integrated, member-centric health services management platform. Examples of indicators include HbA1c for diabetes, LDL-C for coronary artery disease, and spirometry for COPD, as well as member-reported quality of life and utilization of acute care services. The MM/UM Committee reviews provider and member-specific reports as well as overall performance. **Outcomes are trended** over time and compared to external benchmarks such as national NCQA Medicaid percentiles. Examples of the improvements demonstrated for members with diabetes include **40%** increase in eye exams and 8% increase in HbA1c screening between 2007 and 2009, both above the national NCQA Medicaid 50th percentile. In addition, inpatient days and ED claims decreased **47%** and 23% respectively comparing January through June 2009 to the same period for 2010 for members with diabetes. Members in the telemonitoring program increased their compliance with self-monitoring such as blood sugars or pulse oximetry from 27% to **63%** over the course of the program, and decreased their inpatient admission rate by **80%** through 2010.

Bridgeway monitors provider compliance with clinical practice guidelines by generating provider-level HEDIS and other utilization measures through Centelligence Insight as part of our provider profiling process. Performance is compared to national benchmarks and average network performance. Quality Management or Network Management staff, or the Medical Director meet one-on-one with non-compliant providers to provide education and establish an **action plan** for improvement. QM staff monitor performance monthly or quarterly, depending on the measure, and report both to the MM/UM Committee and the provider. Providers will have direct access to performance reports on the Provider Portal. Concern about acute care utilization and non-compliance with preventive care services by members with SPMI or with behavioral health co-morbidity led Bridgeway to support the development of medical homes with **integrated physical and behavioral health** services and the increased availability of stable housing, and to provide escort service for members who lack adequate supports to attend appointments independently. Bridgeway also uses data to **improve the ECM program**. For example, past its initial pilot phase, the home telemonitoring program member participation rate remained very low. After analysis, the MM/UM Committee changed the participation criteria to include multiple recent ED or urgent care visits, in addition to multiple inpatient admissions in the previous six months. In addition, a new process was implemented for the ECM Supervisor to review the ALTCS inpatient census daily and discuss each case with the member's assigned CM for possible referral for telemonitoring services. As a result, the home telemonitoring participation rate more than doubled.

28. Describe the process used by the Offeror for the adoption and dissemination of clinical criteria used for decision making that would ensure consistent application of the criteria for clinical decision making.

Overview. Bridgeway improves the delivery of care to our members through the adoption, dissemination and consistent application of standardized medical necessity criteria (criteria) and clinical practice guidelines. We use **evidence-based** criteria and ALTCS requirements to determine medical necessity of covered services requiring authorization. Our criteria ensure timely access to appropriate services that help members achieve the highest possible levels of health, wellness, functioning and quality of life. Criteria are not a substitute for physician judgment; rather, they help staff determine the appropriateness of services and setting, and whether services meet professionally recognized standards of care for the condition. Bridgeway uses McKesson's InterQual medical necessity criteria sets for Adult and Pediatric Acute, Care Planning, Durable Medical Equipment, Adult and Pediatric Home Care, Adult and Pediatric Imaging, Adult Long-Term Care, Adult and Pediatric Procedures, Adult and Pediatric Rehabilitation, and Adult Sub-Acute and Skilled Nursing Facility (SNF) care. We incorporate the AHCCCS Medical Policy Manual for guidance in authorizing inpatient medical and behavioral health services, and Centers for Medicare and Medicaid Services (CMS) guidelines for Medicare services provided through our Medicare Special Needs Plan (SNP). We use medical necessity criteria developed internally by our Arizona behavioral health affiliate, Cenpatico Behavioral Health of Arizona, for all behavioral health and substance abuse services. Bridgeway uses Hayes Technology Assessments and internal guidelines from our parent company, Centene Corporation (Centene), to evaluate new technology**.**

Bridgeway also has adopted clinical practice guidelines (CPGs) for a number of priority acute, chronic and behavioral health clinical conditions relevant to the ALTCS population. QM staff identify CPGs for development by monitoring member attributes, utilization data, and results of quality management and disease management activities. Our CPGs are evidence-based, account for community practice patterns, and reflect specific recommendations published in peer-reviewed literature and by **nationally recognized** organizations (such as the American Heart Association, American Lung Association, and American Diabetes Association) or have been adopted by AHCCCS. Our Medical Management and Utilization Management (MM/UM) Committee reviews CPGs for consistency with utilization criteria, disease management programs, member education and benefit materials. Before distribution to providers, the Medical Director ensures that subsequent authorization decisions, member education, coverage of services, and other affected areas are consistent with CPGs. Bridgeway has adopted the following CPGs:

Condition	Source of Clinical Practice Guideline
Asthma	National Heart, Lung and Blood Institute
CHF	American Lung Association, USDHHS, American College of Cardiology
CAD	American Heart Association, American College of Cardiology, National Cholesterol Education Program
COPD	American Lung Association, USDHHS
Diabetes	American Association of Clinical Endocrinologists, American Diabetes Association
Hypertension	American Heart Association, American College of Cardiology
Adult ADHD	AHCCS
Childhood and Adolescent ADHD	AHCCS
Adult Anxiety	AHCCS
Childhood and Adolescent Anxiety	AHCCS
Adult Depression	AHCCS
Childhood and Adolescent Depression	AHCCS
Alzheimer's Disease	Alzheimer's Association of America

Process for Adoption of Criteria and Clinical Practice Guidelines

The MM/UM Committee annually reviews all utilization criteria sets and CPGs, considers new ones, and updates them as necessary. The Committee also reviews annual InterQual updates upon release. The review process considers relevant, **peer-reviewed** research findings/trials, published best practices and guidelines, new technology or procedures, new uses for existing technology, and current CMS and AHCCCS requirements. We also analyze claims data to identify member needs, identify provider practice pattern variation through utilization review, and track quality of care issues to determine areas for which guidelines may be needed. Our Medical Director chairs the MM/UM Committee, which is comprised of

network providers in a variety of types and specialties including behavioral health, the Vice President of Medical Management, and our Executive Leadership (non-voting). The Committee makes recommendations based on the identified needs of our enrolled population, and variations in network practice patterns. The providers on the Committee provide input on community practices and how to maximize provider acceptance of guidelines. CPGs involving a specialty not represented on the committees are referred to a community specialist for review. The MM/UM Committee sends recommended guidelines and utilization criteria each year to the Quality Management/Performance Improvement Committee (QMPIC) for final approval. The Committees last reviewed and adopted all criteria and guidelines in 2010.

The Centene Clinical Policy Committee (CPC), composed of Centene's Chief Medical Officer, Medical Directors of Centene-affiliated plans and other clinical staff, research, develop and adopt utilization criteria to supplement those available in InterQual, and for new technology. The CPC reviews sources including scientific peer-reviewed literature, government agencies such as CMS, specialty societies, and input from relevant specialists with expertise in the technology or procedure. Bridgeway's Medical Director works with Centene's Chief Medical Officer to ensure the appropriateness of these criteria for Bridgeway's members, and presents them to the MM/UM Committee for approval.

Process for Dissemination of CPGs and Criteria

Criteria. Utilization criteria are available to internal staff electronically through TruCare, our integrated, member-centric health services management platform. The criteria are reviewed by Case Managers and UM staff during initial **training** after hire and during ongoing annual training. Case Managers also receive periodic as-needed training at weekly interdepartmental Case Review Team meetings (See ***Case Review Team*** below). While our license to use InterQual criteria sets does not permit distribution of all criteria to all providers, Utilization Management staff provide relevant utilization criteria to both providers and members as part of our notification of an adverse action.

Clinical Practice Guidelines. Bridgeway undertakes widespread notification of newly adopted or revised CPGs in an effort to achieve consistency of care. We disseminate new or revised CPGs to internal staff and to network providers via orientations and other group sessions, the Provider Manual, the *Provider Report* newsletter, the Bridgeway Provider Portal and company intranet site, and by individual communication by the Quality Management staff or the Medical Director. All CPGs are available to individual members, prospective members and providers **upon request**. When we distribute CPGs to providers, we also provide information related to supporting evidence, case management and disease management programs, and other supportive tools, especially in targeted consultations with providers who do not comply with the guidelines. We also seek high-performing providers to share their best practices with under-performing providers. To help improve the practicality of CPG compliance in busy provider practices, we offer providers toolkits that support CPGs. The toolkits, such as those developed by AHCCCS for behavioral health conditions and one focused on the challenges of depression care in the elderly, provide evidence-based, reproducible decision-making algorithms, symptom rating tools, and therapeutic strategies. Bridgeway also will provide links on our Provider Portal to relevant CME opportunities.

Ensuring Consistent Application of Criteria and Adherence to Clinical Practice Guidelines

Utilization Criteria*.* The Medical Director and the MM/UM Committee ensure that authorization decisions are made in a fair, impartial, and consistent manner using approved utilization criteria. We use the **same processes** and criteria for ALTCS-only and dual eligible members (whether in our SNP, another SNP or Medicare Advantage Plan or traditional Medicare), respecting differences in covered benefits. Staff apply the criteria to make medical necessity decisions for prior authorization, concurrent (initial and continuing stay), and retrospective review of services. Our Prior Authorization, Concurrent Review, and Case Management Nurses use utilization criteria as a resource, considering any circumstances that may require deviation such as age, psychosocial issues, disability, co-morbidities, acute or life-threatening illness, or CPG requirements. UM staff refer requests that do not appear to meet guidelines to the Medical Director or Review Physician. The Medical Director reviews the case and attempts to contact the provider to gather additional clinical information and discuss alternatives prior to issuing a determination. Only the Medical Director and or other qualified staff as specified in AMPM 1010 (C)(6), are authorized to issue an adverse action to deny or limit authorization for services. TruCare provides electronic documentation of InterQual and other utilization criteria and standardized assessment tools, as well as documentation of the review process. TruCare facilitates the workflow for the comparison of member needs with criteria for authorization of services, and supports consistency among reviewers with a consistent format for documenting findings and decisions. It also facilitates data collection for quality monitoring. The MM/UM Committee regularly monitors the consistent application of criteria as well as other performance indicators. At each

meeting, it reviews such indicators as member and provider complaints, authorization line statistics that reflect service levels, and timeliness of determinations. The Committee ensures development and successful completion of an **action plan** for any staff member who does not consistently follow utilization and timeliness criteria. Each quarter, the Committee monitors adverse actions, and the proportion of appeals that uphold those actions, as indicators of accuracy and consistency of decisions. The 2010 goal for actions either without an appeal or with appeal upheld was 95%; actual quarterly average performance was 91%.

***Inter-Rater Reliability*.** At least annually, the Medical Director and the Vice President of Medical Management administer the InterQual Interrater Reliability suite of tests to audit the consistency with which Nurse Case Managers, Review Physicians, Prior Authorization and Concurrent Review Nurses, and Transplant Coordinators apply all sets of InterQual utilization criteria in decision-making. Bridgeway's goal is 85% concordance, though the minimum for an individual to pass is 80%. Our combined score was 96% in 2009 and **95%** in 2010 (the Medical Director's 2010 tests are still pending). We have achieved a 100% pass rate for all staff since 2007 on the InterQual suite and previous instruments. We also perform quarterly audits of the consistency of Case Managers' determination of level of care using the AHCCCS Uniform Assessment Tool. Our most recent results, from the fourth quarter of 2010, indicated 100% concordance among Case Managers in Yuma and Maricopa Team I. Concordance was 95% among Case Managers in Maricopa Team II. IRR testing also includes a quarterly case example to determine Case Manager consistency in determining appropriate number of caregiver hours. Case Managers with a variance of +/- three hours from the CM Supervisor's determination of hours for the case receive targeted education.

Case Review Team. Bridgeway require Case Managers to participate in a Case Review (CR) Team meeting at least once a month, even if they do not have a case to present for review. The CR Team is comprised of the Medical Director, the Vice President of Case Management, the Vice President of Medical Management, the Director of Medicare, our Behavioral Health Coordinator, Case Management Supervisors, Case Managers and others (such as Pharmacy or Quality staff) as needed. The senior staff provide **feedback** and input to the Case Managers on cases that involve high risk conditions, require integration and coordination among multiple areas of expertise and/or departments, or present other challenges. Participation in the CR Team meeting provides Case Managers with exposure to the types of questions asked and factors considered by management staff for the most consistent and appropriate authorization of services. These meetings also allow our clinical leadership to identify services that are at higher risk for inconsistency. For example, to improve consistency in authorized number of caregiver hours, we implemented a policy for Case Management Supervisors to review all HCBS needs assessments completed for Attendant Care, Personal Care, and Homemaker Services.

Clinical Practice Guidelines. We measure compliance with specific CPGs until 90% or more of providers are consistently in compliance. To support provider improvement efforts, we continuously monitor indicators of guideline compliance and include them in annual provider performance profile reports. Many of the indicators will be available to providers on our secure Provider Portal, updated quarterly to provide more continuous provider-level feedback. Bridgeway also supports consistent application of CPGs by encouraging member and caregiver understanding of them. We support member **self-management** of recommended care through member education and other interventions of our Case Management and Disease Management Programs. We will provide reminders to members about services for which they are due or overdue whenever they contact Member Services or any other Bridgeway staff. Our Member Relationship Management system displays a health risk alert for staff whenever the member's name is called up. Case Managers will use TruCare for quick access to member-level utilization, service and disease management data, and will keep providers updated. Our innovative new Provider Portal Care Gap Notification program will give providers real-time, online alerts about members who need CPG-recommended preventive care each time they check member eligibility. Bridgeway Case Managers provide disease management services consistent with approved CPGs for asthma, diabetes and other chronic conditions. The Case Managers contact providers to alert them to identified high-risk members, provide copies of relevant CPGs, offer assistance with contacting members, and support the use of toolkits and other guideline aides.

29. Describe how the Offeror identifies quality improvement opportunities. Describe the process utilized to select a performance improvement project, and the process utilized to implement or enhance multi-departmental interventions to improve care or services. Include information on how interventions will be evaluated for effectiveness.

How Bridgeway Identifies Quality Improvement Opportunities.

Bridgeway participates in Performance Improvement Projects (PIPs) mandated by AHCCCS and recognizes that these topics have been identified taking into account the needs, care, and services for a broad spectrum of members or a focused subset of the population. In addition and upon approval by AHCCCS, Bridgeway also identifies opportunities and selects improvement projects specific to the **needs of our members**. Bridgeway's Quality Management (QM) staff collect and facilitate analysis of data to identify potential areas where improvements in clinical outcomes or service delivery are necessary or desired. Such data may include, but not be limited to:

- Demographic information relevant to health risks
- External data related to conditions or risks for similar populations
- Utilization and condition prevalence trends
- Claims payment statistics
- Access and availability studies
- Performance on standardized clinical measures such as HEDIS
- Member and provider satisfaction survey results and other feedback
- Member and provider grievance or complaint trends
- Quality of care complaint data

QM Staff review qualitative and quantitative data using a variety of QI tools, such as Pareto charts, process control charts and fishbone diagrams, to identify the most prevalent issues and those impacting multiple departments.

Centene Corporation, our parent company, supports our QM Program by providing sophisticated data management capabilities for data collection, indicator measurement, analysis, and improvement activities. Information Technology and Health Economics staff, as well as other needed corporate and health plan resources, provide standard and ad hoc reporting and analysis support to QM staff. Bridgeway captures and analyzes data from internal, subcontractor (vision, behavioral health, pharmacy, dental, and clinical laboratory) and external sources for administration, management, and other reporting requirements. Our systems submit and receive data as well as interface with other systems such as, in the future, the Health Information Exchange of Arizona. Centene uses a Teradata-powered Enterprise Data Warehouse (EDW) as the central hub for service information that allows collection, integration, and reporting of clinical claim/encounter data (medical, behavioral health, laboratory, pharmacy, dental, and vision; individual and organizational providers); financial information; medical management information (referrals, authorizations, disease management); member information (current and historical eligibility and eligibility group, demographics, member outreach); and provider information (participation status, specialty, demographics) as required by the QM Program. Housing all information in the EDW allows staff to generate standard and ad hoc reports from a single data repository, using our Centelligence Insight® suite of reporting applications to build and tabulate HEDIS and other key performance measures, and provide drill-down into metric compliance. Our Centelligence Foresight® suite of analytic and reporting applications supports our health stratification and risk identification activities. Starting with TruCare®, our integrated, member centric health services management platform, all medical and behavioral health data are integrated within the same systems facilitating effective integration of quality management as well as case and care management activities.

Process Utilized to Select a Performance Improvement Project

Select Project and Obtain Quality Management/Performance Improvement Committee (QMPIC) Approval.
Bridgeway's Performance Improvement Team (PIT), supported by QM staff, selects projects they believe address priority issues and present them, and supporting data, for approval by the QMPIC and ultimately by AHCCCS. The PIT is a cross-functional, **multi-departmental** quality management team that facilitates the ongoing integration of quality improvement throughout the organization. It includes the Medical Director and representatives from each involved functional area who conduct or directly supervise the day-to-day activities of their department (Quality Management, Case Management (including behavioral health), Medical Management, and other departments when appropriate, such as Member and Provider Services, Finance or Compliance). The PIT considers the prevalence of a condition among, or the need for a specific service by, Bridgeway members; the identified member demographic characteristics and health risks of the

population; the interests of members, providers, AHCCCS and CMS in the aspect of care or services to be addressed; Bridgeway priorities as expressed in our Annual QMPI Work Plan; and **member input**, whenever possible, in the selection of topics for a PIP and formulation of project goals. The PIT then identifies those health conditions or service issues for which performance improvement will have the greatest impact on the target population of members and providers. Topics may be clinical (preventive or therapeutic, acute or chronic conditions, coordination of care) or non-clinical (network adequacy or accessibility, cultural competency, plan administrative services), and address a spectrum of member needs and services.

The QMPIC includes representatives from the provider community to ensure that local feedback is obtained and resulting recommendations are population or network specific. For example, after the QMPIC reviewed our Advanced Directives PIP and the role of cultural beliefs about illness and death as a barrier, we implemented a training program for our Case Managers about Mexican-American beliefs and a Spanish language video for members to address their concerns. At times PIPs are selected and used to test an innovative strategy and, depending on the improvement, the strategy may be established as a best practice which is then shared with all Centene affiliate health plans.

Select the Target Population. The target populations are determined through careful analysis of utilization, enrollment, claims, encounter, pharmacy, complaint, and satisfaction data, or information acquired through case management assessment or care coordination efforts. QM staff also obtain input from Bridgeway's quality committees and Member/Provider Council. The population studied in each PIP is clearly defined and the methodology indicates if the entire population or a representative sample will be used.

Establish Performance Measures and Goals. The QMPIC evaluates and approves objective, clearly defined, and **measurable** indicators for each project that are derived from clinical practice guidelines or nationally developed clinical or service indicators. We use Medicaid HEDIS measures as well as Medicare and Agency for Healthcare Research and Quality long term care indicators to measure performance due to their relevance to the ALTCS population. Non-clinical service indicators may include, for example, access and availability studies, attendant turnover, claims adjudication and payment statistics, authorization turn-around times, customer service and call center response times, and credentialing statistics. A baseline will be determined and goals will be established for each indicator that reflect the desired level of performance. Goals may be established as "perfection," an industry benchmark, or a projected percentage change from baseline measurement reflective of a demonstrable improvement.

Process Utilized to Implement or Enhance Multi-Departmental Interventions to Improve Care or Services

Develop and Implement Interventions. The PIT solicits input from experts in the field of study, health plan subject matter experts, staff with strong knowledge of statistical analysis, external community resources, and member and provider advisory groups such as the Member/Provider Council, as appropriate. Root causes are postulated, barriers to performance are identified, and interventions are developed that **specifically address** the identified causes and barriers. Causes and barriers that cross various functional areas of the organization are addressed via multi-departmental interventions, which are coordinated among the relevant departments by QM staff, monitored for effectiveness, and reported accordingly. In Bridgeway's experience, nearly all interventions have been cross-departmental. Case Management, Medical Management, Pharmacy, Member Services, Provider Services, and Maternal and Child Health are all involved in current multi-departmental interventions. Clinical interventions may be coordinated by the Case Management Department. The implementation plan includes clearly defining specific tasks to be accomplished by specific departments, identifying persons responsible for the tasks, establishing **timelines** for intervention and determining how and when the effectiveness of the intervention will be measured. The PIT actively tracks all interventions and reports to the QMPIC. The Compliance Department ensures that approval of interventions is obtained from, and periodic reports delivered to AHCCCS when required.

Enhance Interventions. Periodic remeasurement and assessment of success are basic components of Bridgeway's improvement model. We do both interim checks and assessments following full measurement periods. In either case, Bridgeway employs **rapid cycle** PDSA methodology to test changes or additions to the intervention if there is no evidence of improvement. With that methodology we:

- **P**lan the change, the needed data and the goal
- **D**o a trial of the changed intervention, documenting any barriers
- **S**tudy the results, comparing them to the goal

- **A**ct to further refine the intervention based on the results, and
- Repeat the cycle with incremental changes to the interventions until improvement is achieved and sustained.

For example, we planned our project to improve post-hospital discharge follow-up with a call to the member from case management by determining that the baseline 30-day readmission rate was 26.6% for CYE 2007, and that inconsistent follow-up by case management was an underlying factor. The primary goals were to achieve consistent telephonic follow-up by Case Managers and a reduction in the readmission rate. We did a trial with improved notification from concurrent review staff, a standardized tool to structure the follow-up call, and introduced a process for QM staff to monitor the proportion of discharged members receiving calls. After four months, we identified documentation as a barrier to monitoring the calls and added an electronic assessment form in our medical management system. Results after six months indicated an improved readmission rate of 20.3%. We refined the intervention by adding a Discharge Transition Tool that our Concurrent Review Nurses give to hospital staff that included contact information for the member's assigned Case Manager. Reassessment for CYE 2009 indicated sustained improvement and for CYE 2010 demonstrated further improvement in the 30-day readmission rate to 15.9%.

How Interventions are Evaluated for Effectiveness

Measure and Evaluate Improvements. Bridgeway achieves real, sustained improvements in care and service through a continuous cycle of measuring and analyzing performance, and by developing and implementing system-wide improvements. As previously described in ***How the Offeror Identifies Quality Improvement Opportunities*** above, Bridgeway has an innovative and robust capability for accessing and reporting performance measures. We remeasure each project's established performance measures, compare them to the established benchmarks and goals at the intervals determined at the beginning of the project, and test the comparisons for statistical significance. Intervals are based on the timeframe in which an anticipated improvement in performance is expected to occur. The remeasurement methodology is the same as that used for baseline measurement, to ensure comparability. We may also track additional measures related to the project, such as intermediate process indicators or member or provider satisfaction. The PIT evaluates and reports to the QMPIC the success of each project in demonstrating significant improvement and exceeding the established goals (or interim goals specified in a work plan approved by AHCCCS).

Post-Evaluation Activities. If remeasurement does not demonstrate significant improvement and performance exceeding established goals, the quality improvement cycle begins again as described above. In such cases, the PIT, in conjunction with the QMPIC, carefully evaluates each intervention implemented, identifies any additional barriers that may be interfering with the achievement of performance goals, and develops actions to revise the intervention, or replace or supplement it with new interventions also related to identified causes or barriers. Additional remeasurement is conducted at periodic intervals, consistent with the rapid cycle application of Plan-Do-Study-Act improvement methodology, to test the changed or new interventions quickly and further redesign them as appropriate. Bridgeway considers improvement to be **sustained** if the level of performance is maintained or further improved one year after significant improvement has been achieved, and if the improvement likely was a result of the project interventions. We maintain successful interventions, report them to AHCCCS as possible best practices for other contractors, and communicate them as best practices to other Centene plans. Centene also convenes small workgroups with its top performing plan and at least two lower performing plans around a specific quality metric. They discuss best practices and develop work plans for the lower performing plans over the course of three months, and these work plans are shared with all Centene plans.

30. Describe how the Peer Review Committee is structured and utilized by the Offeror and how its reviews/decisions are made and incorporated into the Offeror's quality management process.

Peer review is central to Bridgeway's ability to ensure that the quality of care and services delivered to our ALTCS members is consistent with AHCCCS requirements and professional standards of practice, and that it continuously improves. Issues triggering referral for possible peer review include suspected quality of care issues; non-compliance with approved clinical practice guidelines, medical record documentation standards, or AHCCCS contract requirements; aberrant utilization patterns; patterns of alleged lack of respect or cultural competency, or other unethical behavior; and possibly impaired physical or mental capacity. Peer review may be conducted for all participating providers including, but not limited to, physicians and other individual medical and behavioral health providers, acute care facilities, nursing homes, assisted living facilities, behavioral health facilities, ancillary health providers, and home and community based providers. Peer review may also be conducted for non-participating providers when appropriate. All information used in the peer review process is kept **confidential** and is not discussed outside of the peer review process.

How the Peer Review Committee is Structured and Utilized

The Peer Review Committee reports to the Quality Management Investigative Committee (QMIC) and is scheduled to meet at least quarterly. It is chaired by the Medical Director, includes the other provider members of the Credentialing Committee, and is representative of a variety of network provider types, currently including physicians and long term care nurse practitioners in family practice, OB/GYN, geriatrics and pediatrics. The Vice President of Medical Management, Vice President of Operational Services and Compliance, and Quality Management Manager are non-voting members. Each Committee member is required to sign a confidentiality agreement and conflict of interest statement prior to a Committee meeting in which they review a provider with a potential quality concern. Committee members may not participate in peer review activities in which they have a direct or indirect interest in the outcome. External providers of the same or similar specialty to a provider being reviewed who have been asked to participate in a review are also required to sign confidentiality agreements and conflict of interest statements. Requests for investigation and possible peer review may be referred to the Quality Management (QM) Department through the Pharmacy and Therapeutics, Credentialing or Medical Management/Utilization Management Committees. The Credentialing Committee refers issues that are identified during the periodic **recredentialing** process. Referrals may also be generated by QM and other Bridgeway functional areas through activities such as grievance and quality of care complaint review, UM or QI trend analysis, ongoing case management, concurrent review activities, routine medical record audits, claims reviews, and referrals by AHCCCS or the Arizona Medical Board or other regulatory boards.

How Reviews and Decisions are Made

Investigation. Bridgeway applies a fair and consistent methodology for investigating, reviewing and validating potential quality of care and service events or trends. This process includes a fair and professional review by a qualified medical or behavioral health provider of the **same or similar specialty**, including providers practicing in a long term care setting. The Quality Management/Performance Improvement Committee (QMPIC) maintains ultimate responsibility for oversight of the peer review process. The Medical Director leads the investigation, supported by QM staff who gather all information relevant to the review. Methods used in the investigation may include the following:

- Review of claims data, including diagnostic and utilization trends
- Review of quality of care trends, such as history of adverse events, member complaints or guideline non-compliance
- Review of clinical record audit results
- Review of relevant clinical records
- Consultation with affected members or their representatives
- Consultation with the involved provider or associated facility or agency
- Consultation with other persons who may have knowledge of the issue in question.

Bridgeway offers providers the opportunity to provide **input** regarding a complaint during the course of the investigation. Once all of the pertinent information has been obtained, it is forwarded to the Medical Director for review, assignment of an AHCCCS severity level, and recommendations for action(s) as appropriate. The Medical Director assigns a **severity level** based on the impact of the adverse event and uses that level to assist in determining the appropriate action. The Medical Director (or designee) completes the investigation within 30 days. If the Medical Director feels that the situation warrants immediate action to protect the safety of members, he may summarily suspend the provider pending the outcome of the investigation, and call ad hoc meetings of the QMIC and Peer Review Committee if necessary.

Review. The Medical Director presents issues to the QMIC for review based on criteria including the following:

- A quality of care clinical issue with an AHCCCS severity classification of IV (an identified potential quality of care issue with long-term adverse outcome) or V (a quality of care issue - mortality)
- A quality of care clinical issue that has recurred at a rate (based on visit volume) that exceeds that of like providers
- An issue identified through the credentialing, recredentialing, or other quality review process as one that may have a risk management, legal, or contractual impact on our members or Bridgeway.

The Medical Director may also present providers with **persistent non-compliance** with clinical guidelines or other performance standards. With the approval of the QMIC, the Medical Director presents the finding of the investigation to the Peer Review Committee for review of the current issue and any relevant past issues. When appropriate due to the specialty of the provider to be reviewed or the complexity of the clinical situation, the Medical Director may also arrange a pre-meeting review of the findings by a qualified consultant of the same or similar specialty. The Peer Review Committee is responsible for making recommendations for corrective action or sanctions based on both the severity of the current issue and any past provider quality issues. The recommendations may include, but are not limited to:

- No additional action required
- Formal appearance before the committee
- Expanded review such as mandatory pre-admission review, concurrent review, prompt retrospective review, clinical chart review or focused sampling of administrative data with formal monitoring and evaluation for a specified period of time
- Informal education provided by the Medical Director
- Required formal continuing education in the specific area of concern
- Co-management of patient care with a designated proctor
- Suspension or limitation of new member referrals
- Referral for Fraud, Waste and Abuse investigation
- Sanctions such as suspension or termination of contract or participation privileges
- Referral to Adult or Child Protective Services, or to AHCCCS for further review
- Reporting to the appropriate regulatory or licensing agency, or to hospital/facility quality or peer review for possible action.

Once the investigation and recommendations are finalized, Bridgeway will send the provider **written notice** of the Peer Review Committee's review and recommendations for corrective action. A recommendation for suspension or termination of participation is forwarded to the Bridgeway Credentialing Committee for action. The Medical Director will work closely with the provider to implement any required corrective action. The Medical Director may assign follow-up of corrective actions to appropriate individuals or departments, and reports by those assigned follow-up are presented to the Peer Review Committee at specified intervals. Upon completion of the corrective action plan and achievement of satisfactory behavioral change by the provider, the relationship between Bridgeway and the provider will be normalized. The Medical Director notifies the provider of the **resolution** in writing within 10 business days of completion of the required actions. QM staff reassess the provider's activity in six months, or more frequently depending on the severity of the initial issue, to ensure that improvement has been sustained before reverting to routine monitoring.

Fair Hearing Process. An adverse action or recommendation of the Committee may be appealed or grieved by the provider by written request within 30 days of receipt of the notification of adverse action, as set forth in the Bridgeway Fair Hearing Plan provided with the notification of adverse action. Upon receipt of such a **request** by the Compliance Officer, a Fair Hearing is scheduled before the Hearing Committee within the following 30 days. The Hearing Committee is comprised of five providers who are not in direct competition with or in business with the provider, and have not participated in initiating or investigating the underlying matter at issue. The provider must attend the hearing and is able to call witnesses. The Hearing Committee forwards its recommendations to the Peer Review Committee, which may affirm, modify, or reverse its recommendation or action. The provider has the right to an **Appellate Review** by the Bridgeway Board of Directors in the event of a continuing adverse action. The Appellate Review will determine whether the requirements of the Fair Hearing Plan were met, whether the recommendation of the Hearing Committee was based on substantial evidence of record, and whether the adverse recommendation or decision was justified in light of Bridgeway's duty to the public, and was not arbitrary or capricious. The Board's decision will be final and binding on all parties. If the peer review process results in suspension or termination of a provider's network participation, Bridgeway will report such

action to the appropriate regulatory agencies (appropriate state licensing board, AHCCCS, and/or the National Practitioners Data Bank at the conclusion of the Fair Hearing process.

How Reviews and Decisions are Incorporated into Bridgeway's Quality Management Process

Recredentialing Process. In addition to being tracked at an aggregate level, complete documentation of peer review investigations and outcomes are maintained in the provider's file, which is maintained by the Quality Management Department. Information related to quality issues, including peer review investigations, is monitored on a quarterly basis to identify trends and repeat occurrences. This information is also incorporated into the recredentialing process. If the provider has had any quality issues since he was last credentialed, the information is included in the file presented to the Credentialing Committee for determination of **continuing network status**. The Committee's review may determine that the issues identified do not preclude the provider from being recredentialed; they may also determine that the issues included in the file warrant a change in network participation status. A provider's network participation may be reduced, suspended, or terminated by the Committee for reasons related to the provider's competence or professional conduct. The Committee, as applicable, notifies the appropriate regulatory or licensing agency of their decision to remove a provider from Bridgeway's network. In the event that a provider's participation is reduced, suspended, or terminated, he will be afforded the right to a Fair Hearing as described in **Fair Hearing Process** above.

Tracking, Trending, and Analysis. Peer review information is integrated into Bridgeway's ongoing performance analysis activities, and peer review outcomes are presented to the QMIC as case summaries at regular intervals. The activities of the Peer Review Committee and the QMIC are confidential and only shared outside the Committees as trended aggregate data. The QMPIC reviews and analyzes this data and makes recommendations for the development of **new or revised programs** to improve the quality of care and service provided by network medical and behavioral health providers and facilities, including long term care providers. This analysis includes root cause analysis and barrier identification. For example, if the QMPIC notices a trend related to a particular diagnosis or service, it may recommend the development of new member or provider educational materials or that we modify or expand existing materials. The Committee's analysis of peer review information may also lead to the adoption of new clinical practice guidelines or enhanced dissemination of existing guidelines, for example, sending a targeted mailing to a specific provider specialty, in addition to making materials available online, in the Provider Manual and in our provider newsletter. When the QMPIC identifies a potential opportunity for significant **impact** on clinical or service performance, they may recommend development of a new Performance Improvement Project (PIP). Such recommendations are referred to the Performance Improvement Team (PIT) for development and implementation. The PIT reports progress and results of any recommended PIPs to the QMPIC on a regular basis. Analysis of peer review information may also lead to additional network monitoring, or to change in the referral patterns of our Case Management staff, to ensure that our members are receiving care from our highest quality providers. For example, Case Managers may choose not to refer to a particular home and community-based services agency that is under corrective action until existing quality issues are resolved.

Examples. Bridgeway has successfully used peer review information to identify areas for improvement that impact a broad member population. Based on recent Peer Review Committee activity, two broad issues were identified. Review of events involving electroconvulsive therapy (ECT) for behavioral health conditions revealed the need to provide additional training for network providers regarding the appropriate indications for this therapy. Staff researched a set of evidence-based guidelines that were used to develop provider educational materials and to support a prior authorization requirement for ECT in one GSA. Secondly, review of events involving pain management for non-cancer, non-hospice members revealed the need for additional education for primary practitioners. These members were identified to be a particular challenge for practitioners who do not have pain management training or experience. The Medical Director developed a resource list of primary practitioners who are knowledgeable and experienced with pain management in their practice for one GSA with a shortage of pain management specialists. If a specialist is not available, Member Services can offer names of practitioners who have experience and are willing to see these members. Bridgeway will sponsor a symposium for primary practitioners presented by a recognized pain management expert that will focus on the associated behavioral health issues. Centene Corporation, our parent company, is developing a toolkit for pain management, with the assistance of a practicing national pain management specialist, to help physicians better manage their patients on chronic narcotic and other pain medications. The kit will include a patient-provider pain management contract, up-to-date clinical guidelines, and tools to help physicians with weaning medications as well as other strategies to reduce the amount of pain medications used.

31. The Offeror must submit responses to the following two quality-of-care scenarios.

31.A. Immediate jeopardy at a facility in a rural county that has been operating without a license for several months.

A team of Quality Management (QM), Provider Services (PS), Compliance and Case Management (CM) staff spent several months working with Desert Rose Assisted Living and ADHS to help the facility renew its license. When the owner left town to take care of her mother, her husband had trouble running the home along with his other job. Because of historically good performance and the fact that Bridgeway and ADHS were trying to help the facility address issues preventing license renewal, AHCCCS authorized the continuing stay of Medicaid residents while license renewal was pending. Our Provider Coaches advised new ALF staff of quality standards and trained a new billing clerk to ensure prompt payment. Our PS staff reached out to the Arizona Health Care Association to see if they had resources to help the facility. Our CMs (CM) increased onsite visits to monitor member care and to begin transition planning in case the license was not renewed. Upon learning the other ALF in the area was closing, our PS staff began working with providers in other service areas to encourage their expansion into this service area. We also contacted advocates and professional organizations, and solicited input from our Member/Provider Council. Through this process, we identified a provider interested in buying the closed ALF and began working with them to meet licensure and other requirements to participate in our network.

Early one morning, Desert Rose called the CM to report a partially-collapsed dining room ceiling, which ADHS declared an immediate jeopardy (IJ).

Immediate Response

The CM was very familiar with the members and staff at Desert Rose due to her regular onsite monitoring as well as more frequent visits since the licensure issue arose. She quickly retrieves a census of our four residents along with information about their diagnoses, PCPs and care plans from TruCare, our member-centric health management platform for collaborative case, behavioral health, disease, and utilization management. She calls QM and PS to inform them of the situation. Within10 minutes of the Desert Rose call, a CM and Network Manager are dispatched to protect member care and safety, and to investigate and help resolve the problem. The staff take laptops so they have onsite access to email and our integrated Member and Provider Relationship Management systems (MRM and PRM) which houses all member and facility information, including the assistance we have provided previously to the facility. The QM Manager calls the facility's administrator to verify the situation, inform her of the impending arrival of our staff, assess the steps the facility is taking to address the IJ, and determine how Bridgeway can help. She also calls AHCCCS to inform them of the situation and offer Bridgeway's assistance.

First Response Team. Within minutes of the Desert Rose call, the QM Manager e-mails a description of the situation to our First Response Team (FR Team), comprised of experienced staff from our QM, CM, PS, Medical Management (MM), and Compliance Departments. The QM Manager informs the FR Team she will update them after the first report from onsite Bridgeway staff, which she expects within the hour. While awaiting the first update, FR Team members prepare. The QM Manager downloads our First Response ALF check-list, which identifies the considerations, steps, and responsible parties for handling IJ situations. She arranges a dedicated conference line for updates and strategy sessions among onsite and office-based staff. She also begins documenting the situation in a secure Quality of Care (QOC) file, and reviews QOC logs and other historical information about our interactions with the facility and the facility's QOC track record. CM and MM staff on the FR Team review each member's assessment, care plans, transition plans, and other information, which is integrated in TruCare. They then share relevant information with FR Team members. They also retrieve from TruCare contact information for family members and legal guardians. PS staff begin an inventory of available facilities and home and community-based services (HCBS) providers, including providers in surrounding service areas. This search is facilitated by our recent assessment conducted after the close of the other ALF in the service area, which will soon reopen under new ownership. PS staff contacts the new owner to verify when they expect approval to receive ALTCS members. PS staff also check the ADHS website to see if additional new providers have entered the service area, and emails all provider availability information to the FR Team and onsite Bridgeway staff.

Onsite Activities and Updates. Because we have offices in every GSA we serve, our CM and Network Manager are able to arrive at Desert Rose within 45 minutes of Desert Rose notification even though it is in a rural area. The Network Manager asks the ALF Manager/Owner for an update and inspects the facility. The CM begins meeting with members, asking about their care and well-being and informing them that Bridgeway is looking into the matter. The Network Manager and CM also check on staffing, supplies, food and other operational aspects. First Update. Within 15 minutes of

onsite arrival, the Network Manager calls the QM Manager and says residents are concerned, but no one is hurt. The provider expects a building inspector to arrive shortly to assess the cause and damage. The QM Manager documents the initial report in the QOC file and then updates our FR Team. Second Update. After about an hour, the Network Manager calls in to report that a building inspector found holes in the roof and rot in the joists and rafters, and thinks that a recent heavy rain had contributed to the ceiling's collapse. Neither she nor the provider yet know how substantial and time-consuming the repairs might be. Other Medicaid Contractor staff are not yet onsite. During the wait for the building inspection, the CM began reviewing each member's transition plan and current status to verify all issues are covered and also the list of available placement and service alternatives sent by PS staff.

Response. The FR Team decides to begin informing members and family members/guardians about the need to transition that day–possibly permanently–to an alternative facility or setting. The FR Team develops a response plan that they communicate to our onsite staff. The plan includes the following: Quality Management (QM Manager) recommends a bed restriction via TruCare to prevent additional Bridgeway placements while repairs are being made. She documents the determination to begin transferring members in the QOC file and in our PRM system. She notifies Member Services and the Program Coordinator Supervisors to redirect all incoming calls from members or family/representatives to QM, the member's CM, or the Compliance Officer. Compliance contacts AHCCCS and ADHS to inform them of what we know and get any input they have on our response plan. Case Management begins calling members' family/legal guardians and sends another CM onsite to help implement the transition plans for each member, including help with packing and other arrangements. Because we have been working with the Desert Rose, we know the other Medicaid Contractors with members in the facility, and our CM Transition Coordinator calls them to inform them of our analysis and response, and our desire to collaborate with them. During the discussions with the other contractor arrangements are made to share transportation to an ALF outside of the GSA, if we have multiple members going to the same location. The CM Transition Coordinator can tell from TruCare that we have one such case and offers to coordinate transportation with the onsite CM. Medical Management is on alert to quickly respond to potential CM questions, such as prior authorization approvals for OT/PT or durable medical equipment related to their new placement.

Transition Plan Review. The onsite CMs meet individually with each member, explaining why a move is necessary and to ensure the transition plans developed previously still meet member preferences and needs.

Lucy and Maria: Lucy and Maria are close friends who speak Spanish and have limited English proficiency. During their transition planning, the Spanish-speaking CM learned that they do not want to be separated and would like to go to a place that accommodates their language and cultural preferences, such as traditional holiday observances. These needs can be met with placement at the Nursing Facility (NF) in the area, which has Spanish-speaking staff. The CM discussed with them the option of moving into an apartment together, explaining the available services and community resources that can support them in a less-restrictive environment. She also asked whether Maria's daughter who lives nearby might be a source of informal support. Neither Lucy nor Maria thought the apartment choices were within their financial resources, and Maria said her daughter was unreliable. Lucy and Maria's transition plan included a temporary transition to the nearby NF, while Bridgeway staff continued to explore or develop new affordable housing options and the opening of the new ALF.

Clara: Clara becomes extremely upset and anxious at news of the move. The CM knows from having met frequently with Clara that this behavior is unusual; she is typically calm and independent. Clara says she doesn't think she can handle another change, since she just moved to this facility four months ago after her husband died. The CM tells Clara she will be with her during the transition and move, and check in on her daily. Clara's transition plan included moving to an ALF outside the service area, but since Clara began showing anxiety, the CM informs her of another home about an hour away that offers BH specialty care. Clara doesn't think she belongs with people who have serious BH needs, so the CM offers to arrange a visit to the BH specialty home if Clara wants to explore that option later. Clara agrees, but says she wants to move back to Desert Rose if the situation is remedied. Together they agree that Clara will receive a BH evaluation to make sure medications or other causes weren't heightening her anxiety. The CM arranges for a BH provider to come onsite the next day to provide counseling to help calm Clara.

Joe: Joe loves living at Desert Rose because it is within walking distance of his church and a local café where he has become a favorite of the wait staff. He has no family in the area, and his transition plan included moving to the ALF that was recently closed. However, the new owner indicates it will be another few weeks before the facility re-opens. The CM and Joe review his current health status and begin revising his transition plan. The CM asks if he would like to include one of his friends from church or the cafe in transition planning. Joe gives her Robert's contact information, who often serves as Joe's advocate. Robert is at work but participates in transition planning by phone. Joe and Robert agree to a transition

plan that includes Joe residing temporarily with Robert and that the CM will let him know when the new ALF re-opens or Desert Rose is available again. The CM assesses Joe's need for HCBS services and arranges for an initial evaluation of Robert's home as soon as he gets off work. The evaluation identifies the need for assistive devices in the shower Joe will be using. The CM conducts a cost effectiveness study to ensure the total cost of the care plan necessary to maintain Joe safely in Robert's home is within guidelines. She then expedites installation of grab bars and hand-held shower head so Joe can shower within 24 hours of moving. She also contacts the attendant care agency Joe selects and arranges for initiation of services within 2 hours of Joe's arrival at Robert's house.

Transition. All onsite Bridgeway staff assist in packing and moving member belongings, answering member questions, and documenting additional concerns. CMs ensure medical records are faxed to the appropriate placement and each member's PCP and other treating providers as applicable, and that each member's new placement is documented in TruCare. Bridgeway staff meet the members in their alternative placements, then contact the QM Manager to report transition completion and any remaining issues. All members are transported to their new placement within 4 hours of the building inspector's report.

Ensuring Quality of Care

Member/Family Follow-Up. CMs call each member daily during the first week, and personally visit each member within one week of transition, and again in two weeks. For Clara, the CM visits every day for the first two weeks, until Clara says she feels confident in her new home. Afterward the CM visits Clara bi-weekly, then monthly and eventually no less than every 90 days. The CM also arranges a visit for Clara to the other home. For Lucy and Maria, the CM actively seeks housing arrangements by contacting the local housing authority, and checks in on the progress of the area's ALFs, so that Lucy and Maria can transition to a placement more appropriate to their level of independence. Since Joe is living in a home-based placement, the CM calls or visits him each day for the first two days to make sure all supports are in place and there are no problems with the arrangement. She then calls or visits Joe at least once a week until he selects permanent placement, which may include staying with Robert. For all members, CM staff are alert to any signs of member confusion, and arrange for a BH provider visit if necessary. CMs inform the CM Supervisor of any signs of member health decline or care problems, who can then alert QM and other members of the FR Team to determine next steps in improving care. In addition, the QM Manager mails a letter within two days of the transition to the affected members and their families describing the steps Bridgeway took in ensuring member safety and comfort, and a short questionnaire asking for their assessment of Bridgeway's and Desert Rose's handling of the situation.

Provider Follow-Up. The QM Manager contacts the Desert Rose owner to determine whether he plans to stay in business or close the home permanently. Since he and his wife hope to continue the business, the QM Manager and Medical Director develop and fax to him a Letter of Inquiry for an explanation of the facility's problems and cause, and relevant maintenance records. Upon receipt of this additional information, the QM Manager recommends setting up a time to meet with ADHS and our Quality Management Investigative Committee (QMIC) to collaboratively develop a corrective action plan (CAP) to address building repair and upgrade issues, and achieve successful license renewal. The QM Manager informs the owner that Bridgeway will not resume member placement until the deficiencies are corrected and the license renewed. Once QMIC has approved the CAP, PS staff also offer to help the owner address the issues in the CAP, such as helping him identify low-interest loans for building upgrades. Our QM staff visit or call the facility every two weeks to evaluate progress on the CAP and provide monthly updates to the QMIC.

Other Follow-Up. QM staff update AHCCCS weekly on the facility's progress, usually by email. Within 24 hours of resolution or facility closure, the Compliance Officer, with the help of other FR Team members, develops and submits a summary letter to AHCCCS describing the situation, investigation, monitoring, and member transfers. The QM Manager documents all activities of the FR Team in the QOC file. To support inter-departmental coordination, QM and PS staff document information about Desert Rose status in our PRM system to support network assessments, CM identification of placement options, and Member Services Representative responses to calls. The QM Manager updates the FR Team as frequently as daily during the CAP process and QMIC monthly to ensure effective monitoring of Desert Rose and of FR Team performance. The QM Manager also reports to QMIC all FR Team recommendations for improved responsiveness and will incorporate into its workplan all QMIC-approved or directed recommendations. When Desert Rose successfully completes the CAP, and the QMIC authorizes removing the bed restriction, the VP of Case Management informs all CMs that the bed restriction is lifted. CMs then inform their members who expressed interest in returning to Desert Rose of their option to change placement, and QM or PS staff document the availability in PRM. When the new ALF finally opens, PS staff alert CMs and document its availability in PRM.

31.B. The Offeror is notified of an immediate jeopardy at 4:15 P.M., on a Friday, before a holiday weekend, that a nursing facility in the Phoenix area will not have air conditioning/cooling available for approximately four days. Arizona Department of Health Services licensing staff, local city staff, and the Ombudsman are on site. Reporters are on the way. It is July and currently 116 degrees outside. There are 48 Medicaid members in the facility spread out across several AHCCCS Contractors.

Immediate Response

Immediately upon receiving ADHS notification of the immediate jeopardy (IJ) at Ocotillo Nursing Facility (NF), the QM Manager retrieves a census from our Provider Relationship Management system (PRM) and care plans for our Ocotillo residents from TruCare. She then calls Case Management (CM) and Provider Services (PS) to inform them of the situation and provide information about our members. Within 10 minutes of the ADHS call, a Network Manager, a behavioral health (BH) Case Manager and one Case Manager (CM) for every two Bridgeway residents are dispatched to the facility to protect member care and assist in member transfer and addressing the problem. These staff have onsite access via laptop to all member and facility information via our integrated data systems (Member Relationship Management, PRM, and TruCare) such as care plans and family contact information. The QM Manager calls the facility's administrator or Director of Nursing to verify the situation, inform them of the impending arrival of our staff, and assess the steps the facility is taking to implement its Disaster Plan and how Bridgeway can help. She asks which other Medicaid Contractors have residents in the facility, and calls AHCCCS to inform them of the problem and offer our help as needed.

First Response Team. Within minutes of contacting Ocotillo, the QM Manager e-mails a brief description of the situation to our First Response Team (FR Team), comprised of experienced staff from the following departments: QM, PS, CM, Medical Management (MM), and Compliance. The QM Manager informs the FR Team she will update them when she gets a report from onsite Bridgeway staff. While awaiting the update, Team members prepare: the <u>QM Manager</u> downloads our First Response NF check list, which identifies the considerations, steps and responsible parties for handling IJ situations. She arranges a dedicated conference line for updates and strategy sessions among onsite and office staff. She also begins documenting information in a Quality of Care (QOC) file and reviews QOC logs and other historical information of our interactions with the facility, including its QOC track record which includes no previous reports of cooling issues. <u>CM and MM</u> staff on the FR Team review each member's assessment, care plan authorizations, and other information in TruCare, and share relevant information with the other FR Team members. They also identify contact information for family members and legal guardians and begin informing them of the situation, inviting their participation in transition planning. As appropriate, she asks whether the family would be open to caring for the member at home for a short period of time. <u>PS staff</u> create a list of available beds in network and non-network NFs and ALFs and send the list via email to FR Team members. Because of the population growth in Phoenix, our PS staff performs weekly assessments of network capacity, so they are well-informed and able to quickly create a list.

First Update. Since the Bridgeway office is nearby, our staff arrive at the NF within 30 minutes of the ADHS call. The Case Managers immediately begin assessing member status and NF conditions, including staffing and supplies. The BH Case Manager reassures members who are showing anxiety and emotional distress and assists in transition planning for members with BH needs. The Network Manager meets with the NF Director to determine what actions they have taken so far. Within a half hour of arrival, the Network Manager calls the QM Manager with the following update:

1. The facility is rapidly getting hotter. The east wing hallway is noticeably cooler since it is receiving less direct sun. The facility currently has two large box fans. The NF needs more fans and ice.
2. Case Managers have spoken with NF staff and all Bridgeway members. Members are complaining of discomfort, but so far none have shown any adverse health effects from the heat. Case Managers have identified three particularly vulnerable members and helped them select an alternative facility.
3. The facility is implementing its Disaster Plan, and has asked for Bridgeway help in identifying and transporting residents who are most vulnerable to the heat. Case Managers are coordinating transportation with other Medicaid Contractors.
4. NF staff have advised all residents to wait in the east wing hallway, where staff placed two large box fans. The NF is seeking additional resources for more fans, portable air conditioning units and water while they transition residents.
5. ADHS, licensing staff, local city EMS, police and fire department staff and the Ombudsman are on site. ADHS staff indicate that they have found no other safety issues. The Network Manager offers Bridgeway assistance in any matter ADHS directs. City staff state that no medical emergencies have yet occurred.

6. The NF Director has already fielded several press calls. TV reporters are on their way.

Response. The QM Manager convenes the FR Team and briefs them on the Network Manager's report. FR Team members identify and discuss member needs, including special medical management concerns, transportation, and equipment for the transfer. The FR Team develops a response plan which they communicate to our onsite staff. The plan includes the following: Assistance with Cooling Resources. As part of our disaster preparedness plan, Bridgeway maintains an ongoing relationship with the Office of Emergency Management (OEM), and CM staff contact them for some fans. Compliance staff are familiar with community resources, and identify a grocery store that may be willing to donate ice. Quality Management places a bed restriction via TruCare to prevent additional Bridgeway placements in Ocotillo. QM informs Member Services and the Program Coordinator Supervisors to redirect all incoming calls from members or family/representatives to QM or the member's Case Manager, and all press calls to the Compliance Officer. QM documents all necessary information in the QOC file, Compliance contacts AHCCCS to inform them of what we know and get any input they have on our response plan. Compliance also contacts the Bridgeway CEO, to inform him of the situation, our response plan, and the likely press inquiry. The Compliance Officer instructs the Network Manager to remind staff that any press inquiries should be directed to ADHS or the NF administrator. The CM Transition Coordinator begins contacting the other Medicaid Contractors with members in the facility to inform them of our analysis of the situation and next steps, and offer our collaboration with the transition. She also offers the use of our nearby Bridgeway office, as a place where they can headquarter to enhance transition coordination among health plans. A couple of the plans tell her they need help with transportation, and she tells them that we have already secured additional transportation and puts them in immediate contact with our onsite CMs to coordinate. Provider Services contacts network and non-network BH facilities to identify available placements for our members and those of other Medicaid Contractors who are having difficulty finding open beds. Transportation arranged by Ocotillo is inadequate, so PS staff secure additional vehicles from our transportation provider, and work with the onsite Case Managers to transport our members and those of other Contractors as needed. Case Management assigns a Program Coordinator (PC) to contact any family/legal guardians that Case Managers have not yet been able to reach to explain the situation and obtain participation in transitioning members. The PC also contacts the members' PCPs to inform them of the expected move and to tell them a Case Manager or PS staff will update them upon member transition. The PC also contacts the Medicare Advantage Plans of our dual eligible members to ensure continuity and care coordination during and after the transition. Medical Management (MM) is a consulting resource to onsite CMs in their assessment of member status and transfer options, and to help with expediting transfer, such as by identifying medications that require prior authorization at the new facility and alerting our pharmacy director to pre-program approvals.

Transition Planning. Upon arrival at the NF, the Case Managers immediately begin meeting with each member, checking charts and reviewing assessments to identify needs and any special issues that will complicate moving the member. Case Managers inform members that Ocotillo may re-open once the air conditioning is fixed, but that they must select either permanent or temporary placements, including moving to assisted living or a private residence as appropriate to their needs. Case Managers assist each member in selecting alternative placement, working with family/guardians when a member has these supports and we can reach them, and with the Ombudsman when there is no family/guardian or they cannot be reached. Using care plan information in TruCare and an update from the Transition Coordinator, a Case Manager works to transfer one member back to her home. Her care plan already included an eventual return home, and her family had been training with facility staff in home-care. To facilitate an early move, the Case Manager arranges for in-home skilled nursing, attendant and respite services. Because of the shortage of available BH beds in Phoenix, the family of a member with dementia chooses to move the member to an Assisted Living Facility (ALF) where the Case Manager authorizes additional reimbursement to allow for more intensive staffing as a wrap-around service to protect the member's health and safety. Case Managers arrange for transportation appropriate to each member's needs, such as a regular vehicle for ambulatory members, a van with a lift for members in wheelchairs, and ambulance for bedfast members. For members with dementia or on oxygen, Case Managers arrange for a family member, friend or attendant to accompany them in the vehicle. They also ensure medical records are faxed to the appropriate placement and each member's PCP and other treating providers as applicable, and that each member's new placement is documented in TruCare. Because of their frequent visits to Ocotillo to assess and monitor residents, our Case Managers know the other Contractors' case managers, and share information about bed availability and transportation so that all residents are transferred quickly to the most appropriate placement. Our BH Case Manager and PS staff assist other Contractors' case managers in finding appropriate placements for residents with dementia and other BH conditions.

Transition. Within 2 1/2 hours of ADHS notification, Case Managers finalize transition plans for each member. All onsite Bridgeway staff assist in packing and moving member belongings as needed, answering member questions, and documenting additional concerns. All members are transported to their new placement within four hours of ADHS notification. A Case Manager meets each member in their chosen placement to make sure belongings and medical records are transferred, and the member has needed medications, equipment and services. A Network Manager remains onsite at Ocotillo until all Bridgeway members are safely transferred.

Ensuring Quality of Care

Case Manager Follow-Up. Case Managers follow up with each member's PCP and Medicare plan, as applicable, and document the contacts and all clinical notes about the placement and transition in TruCare. Case Managers check in on each member daily by telephone or in-person until the member is stable in the new placement. During each contact, Case Managers evaluate the setting, verify provision of all medically necessary services, and address any unmet needs. They also assist the member in filing grievances, if requested. Case Managers are particularly alert for any signs of confusion, arrange for a BH assessment if necessary, and inform the CM Supervisor of any signs of member health decline or problems, so she can alert QM and other FR Team members to determine next steps in improving care. For members who have found permanent placement, follow up occurs within 180 days for NF residents and 90 days for members who moved to ALF, in-home, or non-network placements. Follow up occurs weekly for those in a temporary placement. When Ocotillo is authorized to again accept residents, Case Managers alert members and family/guardians to offer this choice.

Facility Follow-Up. First thing Monday morning, the QM Manager faxes a Letter of Inquiry asking Ocotillo to furnish its description of the issues and response, along with records of A/C system age, model, maintenance and repairs, and policies and procedures regarding system maintenance and facility temperature control, including staff training. Late Monday afternoon, the facility faxes all requested information, along with its ADHS-approved corrective action plan (CAP). On Monday, QM and the Medical Director review the report, records and CAP. The QM Manager also confers with the NF Review Collaboration (NFRC) about experiences with Ocotillo to uncover any additional or potential problems. The NFRC consists of QM staff from all four Maricopa-based Medicaid Contractors. Also on Monday, QM reports Ocotillo's situation and CAP to our Quality Management Investigative Committee (QMIC), which determines that the facility was negligent on regular maintenance. Ocotillo's ADHS-approved CAP adequately addresses maintenance issues, but because of staff turnover at the facility, the QMIC directs the staff to include additional measures for staff training, as well as a CAP for improving facility notification to Bridgeway when problems arise. When the QM Manager learns from ADHS/CMS that Ocotillo can resume business, she sends staff onsite to determine facility progress with Bridgeway's CAP and audit the facility on all aspects of operations to uncover any other potential problems. QM shares results with the QMIC for determination in lifting the bed restriction. After the CAP is successfully completed, the QM Manager and CMs conduct a facility audit every quarter, to make sure Ocotillo is upholding all identified practices.

Other Follow-Up. The QM Manager asks the Ombudsman for any complaints received against the NF or Bridgeway. She also mails a letter to affected members and families/guardians describing the steps Bridgeway took in ensuring member safety and comfort, along with a short questionnaire asking for their assessment of how the NF and Bridgeway handled the situation. She tracks CM reports of any member issues that might be related to the transfer or heat, as well as member claims data to determine heightened care needs that may have been a result of the transfer, such as an increase in anxiety as reflected by medication claims or BH provider visits. The QM Manager provides the FR Team updates as frequently as daily during the transition process. The QM Manager also reports to the QMIC monthly on facility responsiveness and Bridgeway actions to ensure effective monitoring of Ocotillo and FR Team performance. She reports to QMIC all FR Team recommendations for improved responsiveness, and incorporates all QMIC-approved or directed recommendations into the QM workplan and First Response checklist.

QM staff update AHCCCS weekly on Ocotillo's progress, usually by email. Within 24 hours of resolution or facility closure, the Compliance Officer, with the help of FR Team members, submits a summary letter to AHCCCS describing the situation, investigation, monitoring, and member transfers. To support continued inter-departmental coordination, the QM Manager documents all activities of the FR Team in the QOC file and information about Ocotillo in our PRM system, making the information available to PS staff assessing network adequacy, to CM staff for placement options, and to Member Services staff who may receive questions prompted by news stories.

32. Describe and provide an example of the Offeror's experience and commitment to improving quality of care and performance in specific measures of health care services. Describe how this commitment is spread throughout the Offeror's program.

Bridgeway's culture, systems and processes are structured around our mission to improve the health of all enrolled members. We employ a **systematic** approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members, including those with special needs. This cyclical model for continuous quality improvement enables us to impact the quality of care and service for our members; **sustain** improvement over time; and increase the effectiveness of initiatives involving preventive health, acute and chronic care, behavioral health, under- and over-utilization, continuity and coordination of care, patient safety, and administrative and network services. The goal of our efforts is to improve the health status of our members. Where the member's condition is not amenable to improvement, Bridgeway implements measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. We identify members at risk of developing conditions, implement appropriate interventions, and designate adequate resources to support the interventions.

Experience Improving Quality of Care and Performance in Specific Measures of Health Care Services

Bridgeway has implemented data-driven initiatives to improve clinical care and service for our ALTCS members during the course of our contract with AHCCCS. Each initiative selected was **relevant** to the population's needs, based on our or AHCCCS' data indicating the need for improvement, and included **targeted** interventions with the greatest potential for improving health outcomes. For example, in 2007 we developed initiatives for Advanced Directives, Diabetes Management, and Initiation of Home and Community Based Services (HCBS), which were all AHCCCS priority areas. We achieved a **32%** increase in members' completing advanced directives between 2007 and 2009 by improving member education materials and adopting an advanced directives form that was easier to understand. We achieved increases in all three diabetes initiative measures between 2007 and 2009 (HbA1c screening 8%; eye exams **40%**; LDL-C screening 6%) by enhancing coordination and facilitation of provider visits, screening, and tracking of results by case management staff, and arranging for onsite retinal exams at nursing and assisted living facilities and homes. We achieved a 6% increase in new members having HCBS initiated within 30 days of enrollment between 2007 and 2009 by sequential improvements in the frequency of monitoring and method of communicating with case management staff. In 2008, Bridgeway developed an initiative to improve the post-inpatient transition of care process by improving and standardizing communication processes, including a case management follow up call that occurs within the first two days after discharge. The 30-day readmission rate decreased **40%** from baseline to 2010. Other initiatives have included increasing the rate of influenza vaccination and increasing EPSDT participation. Our behavioral health initiatives have included improving the transition process for members leaving court-ordered treatment and facilitating transportation to behavioral health outpatient appointments.

Commitment to Improving Quality of Care and Performance in Specific Measures of Health Care Services.

Bridgeway has acted on our commitment to an active, effective QM/PI Program since our inception in 2006. We have consistently aligned our program with **AHCCCS priorities** and goals, focusing our efforts on high-impact shared priorities such as improved member choice and independence. We will continue to draw on the expertise and resources of our parent company, Centene Corporation (Centene), for our QM/PI Program in areas such as project planning, production and printing of member education materials for national QI interventions such as diabetes care initiatives, and preventive health campaigns such as our Fluvention® influenza program. QM staff have access to training and exchange best practices with other Centene-affiliated health plans. Centene also supports the QM/PI Program by providing sophisticated **data management** capabilities for data collection, indicator measurement, analysis, reporting, and improvement activities. Our systems capture, store and analyze data from internal, subcontractor, and external sources and make it available for effective use through our robust Centelligence suite of data informatics and both standard and ad hoc reporting solutions. Our systems submit and receive data, as well as interface with other systems, such as, in the future, the Health Information Exchange of Arizona. Centene uses a Teradata-powered Enterprise Data Warehouse (EDW) as the central hub for service information that allows collection, **integration**, and reporting of clinical claim/encounter data (medical, behavioral health, laboratory, dental, pharmacy, and vision; individual and organizational providers); financial information; medical management information (referrals, authorizations, disease management); member information (current and historical eligibility and eligibility group, demographics, member outreach); and provider information (participation status, specialty, demographics) as required by the QM/PI Program. Housing all information in the EDW allows staff to generate standard and ad hoc reports from a single data repository, using our Centelligence Insight suite of

reporting applications to build and tabulate HEDIS and other key performance measures and provide drill-down into metric compliance. Our Centelligence Foresight suite of analytic and reporting applications supports our health stratification, risk identification, and cap gap identification activities. Medical and behavioral health data are integrated within the same systems facilitating effective integration of quality management as well as case and care management activities. Bridgeway also demonstrates our commitment to quality improvement by widely communicating that commitment as well as information about our methodology, specific initiatives, and outcomes internally to all staff and externally to providers and members.

Example of experience in improving quality of care and performance

Increasing the Use of Advanced Directives. This performance improvement project was mandated by AHCCCS in 2007. Baseline data from 2007 indicated that only 50.6% of Bridgeway ALTCS members had any advanced directive documented. All of the nursing facility residents in the sample had completed advanced directives. Quality Management (QM) and Case Management staff performed a root cause analysis and determined that key barriers included incomplete knowledge about advanced directives by Case Managers, lack of member knowledge, cultural beliefs about illness and death, and difficult-to-understand advanced directive forms.

Target Population. Members of all ages who do not reside in a nursing facility.

Measure. The proportion of members who have any form of advance directives documented in one or more medical record maintained by network providers.

Interventions. In the initial phase, Case Managers educated each new member about advanced directives during the initial assessment and reviewed them at every subsequent reassessment. The Case Manager requested copies of completed advance directives, which when received were scanned into Bridgeway's health services management system. After several months the method used by the Case Managers to document their activity was changed to facilitate data collection. In January 2009, after an **interim evaluation** of the initiative, Bridgeway initiated training with the Case Management staff by an attorney from an outside agency. We adopted the easier-to-understand Five Wishes® advanced directives form and Case Managers provided copies to members and encouraged its use. QM staff began reporting the study measure quarterly and shortly thereafter Case Management Supervisors began reviewing member files for documentation and copies of advanced directives in order to provide more timely feedback to staff. Periodic "refresher" training for Case Managers began in 2010.

Results. The proportion of members with completed advance directives increased **32%** from the 2007 baseline of 50.6% to 66.7% in 2009, a statistically significant improvement ($p = 0.02$).

Improving Diabetes Management. In 2007, AHCCCS mandated performance levels for three measures of effective diabetes management. Baseline data from 2007 indicated that 76.9% of members complied with HbA1c screening, 42.9% complied with eye exams, and 70.3% complied with LDL-C screening, all below the AHCCCS goals. The QM staff led an assessment and determined that key barriers included incomplete data for members also eligible for Medicare, lack of member knowledge, access to transportation, and lack of provider focus.

Target Population. Members with a diagnosis of diabetes.

Measures. The HEDIS Comprehensive Diabetes Care measures for Hb A1c and LDL-C screening and eye exams.

Interventions. In the initial phase, Case Managers provided information sheets to nursing and assisted living facilities and to members that provided contact information for the Case Manager and Bridgeway's contracted transportation provider, as well as information about the importance of timely screening and exams. At each assessment and reassessment, Case Managers requested screening results from members and their providers, reminded both about needed screening, and facilitated scheduling the appointments and needed transportation. In January 2009, QM staff began mailing birthday cards to members reminding them to schedule appointments for the annual screening and eye exams. In 2010, QM staff included diabetes educational articles in both the member and provider newsletters, and initiated educational sessions for the Case Management staff. Case Management staff **arranged access** to a provider willing to perform retinal exams onsite in nursing and assisted living facilities and homes. In 2011, QM staff will begin mailing reminder chart stickers to provider offices or facilities for members' medical charts that indicate the need for screening or exam. Bridgeway will participate, in the future, in the Health Information Exchange of Arizona, which will improve access to service data for dual eligible members. QM staff report the study measures quarterly for non-dual members and members with Medicare coverage through Bridgeway's Medicare Advantage Special Needs Plan.

Results. From 2007 to 2009, compliance with HbA1c screening increased 8%, eye exams increased **40%**, and LDL-C screening increased 6%. Compliance in the Yuma GSA was higher than in Maricopa. Compliance for Hispanic members was higher than for white members.

How our Commitment is Spread Throughout our Program

Consistent with our commitment to improving the quality of care and performance, Bridgeway both advocates and facilitates a data-driven approach to improvement throughout the organization. Executive leadership and network providers anchor that commitment as members of our Quality Management Performance Improvement Committee (QMPIC), which is deeply involved in overseeing Bridgeway's improvement efforts and ensuring that they have adequate resources. Our Performance Improvement Team (PIT), the linchpin of our organization-wide commitment, is an internal, cross-functional, **multi-departmental** QM team that operationally integrates QM throughout our programs. The PIT analyzes performance measures, performs barrier and root cause analyses for indicators that fall below desired performance, and makes recommendations regarding corrective actions or interventions. The PIT also oversees the implementation of initiatives approved by the QMPIC or its supporting subcommittees, monitors the outcomes of the improvement efforts, and reports back to the appropriate committee(s). PIT membership includes the Medical Director and varying levels of staff from Quality Management, Case Management (including behavioral health), Medical Management, Maternal Health/EPSDT and other departments, such as Member and Provider Services, Finance and Compliance, when appropriate. Compliance and QM staff monitor performance metrics and improvement efforts of subcontractors at monthly oversight meetings. Our Provider Coaches will assist HCBS providers in their improvement efforts including direct care workforce development for their staff. Bridgeway facilitates a **team approach** to improving care and services by supporting our staff and providers with sophisticated technology solutions that integrate data across departments, members and providers. For example, MemberConnect (a component of our Member Relationship Management system) will provide any staff member in contact with a member access to a profile of the member, including gaps in care such as diabetes management screening. Centelligence Foresight gives providers or facilities that same care gap information when they check the member's eligibility on the Provider Portal. TruCare, our integrated, member-centric health services management platform, will integrate long term care, medical, behavioral health, and clinical data across case management, disease management, and utilization management, and will give members (or caregivers) access to their care plans via the Member Portal. Our intranet site gives all staff access to company-wide communications and policies and procedures. A separate quality webpage provides a quality news update along with summaries of current improvement projects and project outcomes. Bridgeway also communicates with our members and providers about our commitment to quality improvement. Member information is written in easily understood language and is available in English, Spanish, or alternative formats in print and on our Member Portal. It includes a description of the QM Program and a report on the plan's progress in meeting our AHCCCS Performance Measure and other performance improvement and member satisfaction goals. We also distribute summary information to providers through our secure Provider Portal.

Quality Week. Most recently, the QM department initiated an annual Quality Week Program to involve all Bridgeway staff in our QMPI Program. The staff were engaged with posters and balloons. QM staff provided a daily sequence of materials and training followed by a self-test and course evaluation. The Program covered:

- Bridgeway's commitment to quality: how we define quality, the team approach, and our committee structure
- Our improvement methodology: the Plan-Do-Study-Act improvement cycle
- AHCCCS Performance Improvement Projects and Performance Measures; other quality indicators
- Quality of Care concerns: the AHCCCS categories, the information requested for a referral, and our dedicated email account
- Maternal and Child Health, including EPSDT

Departmental Involvement. All Bridgeway departments are involved with monitoring, evaluating, and improvement activities. The Case Management and Medical Management departments regularly monitor performance indicators and care quality, have annual workplans, and supply clinical data and expertise. They facilitate targeted measures such as advanced directives, falls and injuries, and under- and over-utilization of services. Pharmacy monitors drug utilization and evaluates targeted patterns of utilization. Provider Services regularly monitors network accessibility and availability and identifies barriers. Member Services monitors member satisfaction. Compliance monitors member complaints and grievances and assesses trends. In each case, the department integrates its activities with other relevant departments and with QM. The PIT, with multi-departmental representation, coordinates these activities, and is overseen by the QMPIC, which has overall responsibility.

33. Describe how feedback (complaints, survey results etc.) from members and providers is or will be used to drive changes and/or improvements to the Offeror's operations. Provide a member and a provider example of how feedback was used by the Offeror to drive change.

Bridgeway use a variety of methods such as analysis of grievances and appeals, satisfaction surveys, program satisfaction assessments, direct feedback, enrollment/disenrollment activity, and turnover to assess member and provider satisfaction. Our Quality Management (QM) staff monitor multiple aspects of member and provider satisfaction and report regularly to our Quality Management/Performance Improvement Committee (QMPIC). The QMPIC refers recommendations for interventions related to adverse trends to our Performance Improvement Team (PIT), a **multi-departmental**, cross-functional quality improvement team that facilitates the ongoing integration of quality improvement throughout the organization. It directly manages or coordinates all improvement projects or initiatives. We measure performance of member services and other functions against established benchmarks or goals, and at intervals reflecting when improvement is expected to occur. Data is remeasured at these intervals to allow us to monitor progress and make adjustments to corrective actions. This process can sometimes result in service improvement initiatives that test a pilot program or an innovative approach that, if successful, can be implemented plan-wide. These initiatives are designed to improve the quality of our members' experience with the plan and the ALTCS Program.

How Member Feedback is Used to Drive Operational Changes or Improvements

Member Satisfaction Surveys. Bridgeway's QM staff administered member satisfaction surveys for our ALTCS members in 2008 and 2010 using similar but not identical survey instruments. The surveys assessed satisfaction with the plan and specifically with **case management services**. The surveys were mailed to a sample of members in both contracted GSAs with a response rate that improved from 16% in 2008 to 23% in 2010. Survey results were reviewed by the Leadership Team and presented to the QMPIC for recommendations. QM staff presented the survey results to our Member/Provider Council and published a summary on our website to solicit member and provider feedback for the QMPIC.

Example. An item on both surveys stated: 'My Case Manager has taken time to explain' four specific covered services. In 2008, positive responses (agree and somewhat agree) for the four services ranged from 63% to 77% in Maricopa and 89% to 96% in Yuma. As a result, QM staff reviewed the discrepancy in results between Maricopa and Yuma with Case Management staff, and provided retraining in cultural competency and the importance of ensuring members understand covered services. Case management leadership added focused training in these areas in the department's periodic scheduled training. In 2010, positive responses improved from **90% to 96%** in Maricopa and from **92% to 98%** in Yuma.

Member/Provider Council and other Direct Member Feedback. Bridgeway's Member/Provider Council provides a forum for providers and members to have a **"meaningful voice"** in the development and continuous improvement of our delivery model. The Council meets quarterly and reviews and provides input on member satisfaction, grievance and appeal, and clinical and operational performance data. They also review member materials, new program development and quality improvement outcomes. Participants may be asked to provide personal input on experiences with key areas of service such as timely access to physical and behavioral health services, and timely and appropriate responsiveness from Bridgeway staff related to their issues.

Example. At the December 2008 Council meeting, a Maricopa member mentioning that often caregivers received their training in English; however, she felt that providing training in Spanish would prove to be beneficial to Spanish-speaking caregivers. Network Management staff investigated and found that AccentCare provided training in both English and Spanish and that they were willing to serve as a resource for other agencies. Subsequently we were able to assist a local attendant care agency with providing training in Spanish for Spanish-speaking caregivers that also addressed cultural sensitivity. Bridgeway, a voting member and active participant in the Arizona Direct Care Workforce Committee, has advocated for this training at Committee meetings.

Grievances and Appeals. The Grievance and Appeal (G & A) staff log, track, and trend all member grievances. Tracking categories include, but are not limited to, availability and accessibility of services and providers, utilization and case management services, quality of care, and covered benefits. Each month the G & A Manager reviews all member grievances and discusses them with Bridgeway's Senior Leadership Team. If the G & A Manager identifies adverse trends from quarter to quarter, she convenes the Grievance and Appeal Committee, composed of representatives from all departments. The Committee performs a **root cause analysis** to identify underlying causes and recommends corrective

actions to the QMPIC, which monitors subsequent complaint data for improvement. If we determine through further analysis that a quality of care issue exists, the grievance is forwarded to our QM Department for further investigation. The QMPIC monitors all grievance data quarterly. During the annual QM program evaluation process, the G & A staff and the QMPIC assess grievance data by category to identify trends, identify plan or provider level improvement opportunities, and develop interventions for the annual work plan. The G & A Manager also presents the grievance data to the Member /Provider Advisory Council each quarter for input.

Example 1. In CYE 2007, grievances related to transportation spiked to 43 (60% of all grievances). All originated in the Maricopa GSA and were related to the same provider. We revised our contractor oversight process and recruited additional contractors for the GSA. Transportation-related grievances declined to five in CYE 2008 and have remained low ever since. We also revised our Member Handbook to provide additional information regarding the transportation benefit, including appropriate use of the benefit, how to access services, and contact information for assistance in scheduling transportation.

Example 2. During routine monitoring of member grievance data for CYE 2009, Bridgeway's Leadership Team noted an upward trend in grievances related to providers billing members. There were 94 such grievances constituting 81% of all grievances for the year. The G & A Committee was convened to investigate and perform a root-cause analysis. They identified a major underlying barrier to be provider offices not having accurate member eligibility information. The QMPIC provided recommendations and approved enhancements to the Member Services tracking database, increasing the number of grievance categories to facilitate increased identification and reporting of these grievances. We used the database to coordinate efforts by Case Management staff to ensure that their assigned members' providers had accurate member eligibility information and by Network Management staff to identify non-contracted providers in the database already seeing our members for targeted recruitment efforts. As a result, only 42 grievances related to provider billing were filed in CYE 2009, and only 17 such grievances (47% of all grievances) were filed in 2010. We are continuing to implement interventions to sustain this improvement trend.

Enrollment and Disenrollment Activity. Bridgeway's Finance, Case Management, and Provider Services Departments jointly review member enrollment, disenrollment and 'request to disenroll' data each month, looking for trends within GSAs as potential indicators of member satisfaction or dissatisfaction. They present their analysis to the QMPIC to supplement grievance and appeal trend analysis. This type of data can often drive change in network recruitment processes.

How Provider Feedback is Used to Drive Operational Changes or Improvements

Provider Satisfaction. Bridgeway is developing a new provider satisfaction survey and will use satisfaction data to drive change. Our Pima staff have experience administering provider satisfaction surveys in 2008 and 2009. The surveys were prompted by the implementation of a major systems update that required modification of several claims and prior authorization processes, including processes for Case Manager authorized services. The initial survey questions focused on satisfaction with those processes. The 2009 survey also included queries to elicit providers' interest in receiving a newsletter electronically, attending provider meetings, and setting up electronic billing and fund transfer. In 2008, staff sent the survey to 67 network long term care and home and community-based providers, with a 55% response rate. In 2009, they sent the survey to all high volume network providers, including primary care and specialty providers, long term care and home and community-based providers, ancillary services and transportation providers, and durable medical equipment suppliers, with a 24% response rate. Providers had the option of completing the survey online or by return mail. Survey results were reviewed by the Leadership Team and presented to the QMPIC for recommendations. QM staff presented the survey results to the Member/Provider Council and published a summary in the member and provider newsletters to solicit member and provider feedback for the QMPIC

Example. Based on the 2008 survey results, the QMPIC implemented changes including a temporary increase in staffing, and process redesign encompassing systems analysis, supplemental software and improved accountability. Demonstrated improvement included increases in positive responses from 2008 to 2009: timeliness of claims payments from 65% to 75%; prior authorizations process from 61% to 85%; ability to receive information from Member Services about eligibility from 79% to 94%; and assistance received from Case Managers from 86% to 95%.

Member/Provider Advisory Council and other Direct Provider Feedback. Bridgeway's Member/Provider Council is described in ***Member/Provider Council and Other Direct Member Feedback*** above. We also receive direct feedback from providers on network issues through the secure email on our Provider Portal.

Example. At the December 2010 Council meeting, QM staff presented a comprehensive review and update of Bridgeway's performance improvement projects, including a project to increase member use of advanced directives and our advocacy of the Five Wishes® form. A Provider Council member related his difficulty in obtaining the Five Wishes form for his patients. To supplement the distribution of the forms to members by our Case Managers, we implemented a link to the 5 Wishes forms on the Bridgeway Provider Portal within one week of the meeting. We also implemented a dedicated toll-free "live person" provider inquiry line for authorization and claim status in response to Provider Council members' request for a single point of contact at the plan.

Provider Turnover. Bridgeway Provider Services staff monitor contract terminations as well as retention of individual and organizational providers. QM staff record reasons for provider departures from the network in the credentialing tracking database using reason codes. QM staff also monitor turnover among facility and agency staff such as home health nurses and personal care attendants. The QMPIC regularly reviews turnover data, with input from the Member/Provider Council, and develops recommendations to improve network consistency and promote network provider retention.

Example. As Bridgeway develops our new provider satisfaction survey, we will target survey questions to reflect the five most frequent reasons for provider turnover in our tracking database. The QMPIC will review survey responses, develop root cause analyses, and recommend interventions to address identified causes of provider dissatisfaction.

Provider Complaints and Appeals. A majority of provider complaints received by Bridgeway have been appeals of actions to deny or reduce authorizations for services. The G & A staff log and track the appeals in addition to reporting them to AHCCCS. Because the number of appeals has been small (3% of notices of action were appealed in 2010), the G & A and Medical Management staffs also monitor the frequency and types of actions as additional indicators of potential provider dissatisfaction. Tracking this data may also identify possible changes in practice patterns within the network, or inconsistencies in how Medical Management staff apply medical necessity criteria. G & A staff present action and appeal data each quarter to the Member/Provider Council and the QMPIC for review and recommendations. Provider complaint data can, for example, drive changes in the process of adopting clinical criteria or practice guidelines, as well as changes in the criteria or guidelines themselves. They can also change the process of provider education regarding criteria and the process of training and testing inter-rater reliability for Medical Management staff.

Example 1. In March 2010, a network provider submitted a complaint about repeated denials of prescriptions for medication for hepatitis C. Our prospective pharmacy utilization criteria required that confirmation of hepatitis C should include a positive HCV RNA. The provider's position was that a positive HCV RNA was superfluous if the member had a documented positive liver biopsy and an elevated viral load. Using the provider's input and a review of the evidence base, the Bridgeway Pharmacy and Therapeutics Committee revised our criteria for this medication and removed the requirement for HCV RNA confirmation when the patient had a positive biopsy and viral load.

Example 2. As a result of routine monitoring of provider appeals by the G & A staff in 2009 and of direct feedback from network hospitals, the Medical Management/Utilization Management Committee noted an upward trend in denials, appeals and overturned denials of ALTCS members' inpatient stays. Assessment by the Committee determined that the major contributors were poor communication with and insufficient information from the inpatient facilities to our Concurrent Review staff. The corrective action approved by the Committee was the implementation of onsite Concurrent Review Nurses at our higher volume network hospitals. Concurrent Review Nurses promptly coordinated with hospital staff to arrange access to workspace, patient records, and hospital clinical staff. In some cases, we have received hospital authorization to interact directly with hospitalized members to facilitate transition of care planning for hospital discharge. As a result of this change, the number of denied inpatient admissions has steadily declined from a total of 17 in the fourth quarter of 2009 (4% of admissions) to eight in the fourth quarter of 2010 (1% of admissions). For example, Yuma Regional Medical Center had six denials in the fourth quarter of 2009, but has averaged three per quarter since then; the John C. Lincoln Hospitals in Phoenix had two denials in the fourth quarter of 2009 and none since. We are continuing onsite concurrent review to maintain this improvement.

34. Describe the process that will be utilized by the Offeror to monitor services and service sites of members that reside in their own home. Describe what steps will be utilized if non-compliance is identified.

Bridgeway uses a multi-faceted approach to monitor in-home services that includes regular review of information such as member satisfaction survey results, member complaints and quality of care issues, results from medical record reviews, member grievance data, and key quality measures such as critical gaps in service. Our Case Management, Provider Services, Quality Management, Medical Management, Member Services, Grievance and Appeals and Corporate Compliance Departments all play a part in identifying and addressing service issues and substandard care. We also train all employees to recognize potential abuse and neglect, and to report suspected or alleged instances of abuse or neglect in compliance with ARS §13-3620.A.

Of members surveyed for our 2010 Case Management Service Review, 100% indicated caregivers arrive on time, stay as long as they are supposed to, and do what they are supposed to do. In addition, our internal monitoring of service initiation indicated that for contract year 2010, 92.3% of HCBS providers initiated services within required timeframes, meeting the ALTCS Minimum Performance Standard of 92% for that year.

Case Management Department. Case Managers are our front line for monitoring services provided to members living in their own homes. They ensure members and their families know when and how to contact us with problems so we can quickly handle individual issues as they arise. They also conduct regular monitoring to ensure timely, appropriate delivery of high quality services, and use our technology supports to enhance their ability to monitor and coordinate responses to identified issues.

Monitoring Individual Issues. Case Managers enlist members and their families/representatives as partners in monitoring by educating them on specific expectations for caregivers and other service providers, and how and when to contact us. The Case Manager emphasizes the importance of reporting a critical gap in services, and provides the member with the Critical Service Gap Report form along with instructions for using it. The Case Manager also explains that to ensure a faster response, we prefer that they call the Case Manager or the caregiver agency directly. When the member notifies Bridgeway that a caregiver has not arrived on time, a Case Manager immediately initiates services according to the member's established contingency plan. Of members surveyed for our 2010 Case Management Services Review, 100% indicated that if they spoke to someone about a gap in service, a replacement caregiver arrived within two hours.

Case Managers also educate members and their family/representatives about contacting the Case Manager for assistance when they have concerns about quality or any other complaint about the services being provided. If a family member notifies us with a quality of care concern, the Case Manager collects available information from the member about the issue. If we are notified by phone, the Case Manager may schedule a home visit to obtain additional information. Our Case Managers coordinate with other Bridgeway departments, as needed, to evaluate the situation and take action to address it (the steps we take to address potential and actual noncompliance are described below). If the issue involves services through a Medicare Advantage or Special Needs Plan, the Case Manager notifies the health plan of the concern, shares information as authorized by the member, and coordinates interventions as applicable. The Case Manager also notifies the PCP of any disruption in care or quality of care issue that could affect the member's condition or treatment.

Technology Support. Our Centelligence enterprise platform integrates data from multiple sources and produces actionable information used organization-wide to monitor gaps in care or provider noncompliance. For example, by integrating claims information with authorization data from TruCare, our integrated, member centric health services management platform, Case Managers can compare authorizations to actual dates of service to determine whether services are initiated and being delivered as scheduled. Integrating TruCare with our Member and Provider Relationship Management Systems allows seamless coordination of immediate issues. For example, Centelligence™ Foresight generates alerts that notify Case Managers when a member has a gap in recommended services. The alert also notifies Member Services staff taking a call from the member to forward the member to a Case Manager for follow up. ***Regular Monitoring.*** Case Managers contact members within one day of scheduled service initiation to determine whether services were initiated according to the timeframes in their care plan. In addition, Case Managers conduct home visits every 90 days or more frequently as indicated by the member's condition and needs, to reassess the member and determine if changes to the care plan are needed. At the same time, they evaluate whether services are being consistently delivered according to the care plan and are of acceptable quality; whether the member is satisfied with the services being provided; and if services are being provided in a culturally competent manner. The Case Manager verifies that caregivers providing Attendant Care, Homemaker, and Personal Care/BH Personal Attendant Care services are completing tasks appropriately. For example, if the member is receiving Homemaker services, the Case Manager will determine whether the provider is fulfilling the meal planning, shopping, food preparation, and storage tasks necessary to provide food/meals that meet the nutritional needs of the member. Case Managers also will evaluate delivery of other services, such as whether durable

medical equipment (DME) is delivered as scheduled and whether Attendant Care and Personal Care providers are arriving at scheduled times.

In addition to regular home visits, the Case Management Department monitors services through regular review of complaint data, member satisfaction survey results, and Critical Service Gap reports submitted by members and providers. The VP of Case Management reviews complaints and aggregate results of the Critical Service Gap reports monthly to identify any issues with delivery or quality of services. She also reviews results of our annual Member Satisfaction Survey and Case Management Services Review conducted by ALTCS. Follow up occurs as described below.

Provider Services Department. Our Contracts and Member and Provider Services Department (Provider Services Department) monitors qualifications of providers as well as aggregate information on delivery and quality of services through credentialing, ongoing review of various reports and information, and recredentialing.

Credentialing. Providers must successfully complete credentialing prior to providing services to Bridgeway members. Credentialing staff in the Provider Services Department collect and review information related to qualifications and the quality of Home and Community-based services (HCBS) providers through the credentialing process.

For providers who must be licensed (Adult Day Health, Home Health Agency, Hospice), we:

- Verify licensure with the Arizona Department of Health Services (ADHS)
- Query Medicare/Medicaid, Office of Inspector General (OIG), and the applicable state agency to verify that there have been no sanctions within the past 5 years
- Verify liability insurance for no less than the current state mandated minimum

For Home Health Agencies, we also verify certification by Medicare (or in appropriate instances, compliance with requirements of 42 C.F.R., Part 440, Section 70), and review certification sources such as OASIS for quality information.

For non-licensed providers of Attendant Care, Homemaker, Personal Care/BH Personal Care services, we verify that the agency is in good standing with the OIG, and that the agency verifies that each of their employees is in good standing with the OIG. We also use internally-developed criteria that include verification of the following for each employee:

- Pre-employment screening that includes personal and professional references and fingerprinting
- Training including ADHS-approved training, CPR, first aid and home accident prevention
- Evidence of appropriate supervision
- Annual continuing education

For Personal care/BH Personal Care services, we also verify employee competence certification in all personal care services. Beginning January 1, 2012, Bridgeway will require and review provider documentation that all direct care workers have met the new Direct Care Workforce training and testing standards as required by AHCCCS, unless employed by the agency prior to January 1, 2011. Providers not meeting the requirements will be required to submit a corrective action plan and provide a trained worker until the untrained worker has met the requirements.

For provider types that provide services in a community-based setting to members who live in their own home (such as Adult Day Care services), Quality staff conduct a site visit, using survey tools that are specific to the type of provider being evaluated and based on AHCCCS Medical Policy Manual requirements.

Recredentialing. During recredentialing, we verify information collected for credentialing and review information collected between credentialing cycles related to timeliness, quality, and other aspects of compliant service delivery. This includes, but is not limited to member complaint data, performance against quality measures, utilization information, attendant turnover, no-show rates, and timeframes for initiating services. Credentialing staff also review information from the ADHS Enforcement Actions database to identify quality concerns, and results from annual QM chart audits (see below for details) conducted at provider locations to identify issues that warrant further action before the provider can be recredentialed.

Quality Management Department. Our QM Department conducts regular monitoring to identify issues for immediate follow up, as well as annual profiling to identify and work with providers to improve quality of services for in-home members.

Ongoing Monitoring. QM staff conduct monthly and quarterly reviews of information such as member complaint data, performance against quality measures, and utilization to monitor the delivery of services to in-home members. This includes information related to HCBS agency attendant turnover, no-show rates, and timeframes for initiating services. QM staff identify individual providers who are non-compliant or need improvement, as well as patterns of non-compliance or opportunities for more widespread improvement efforts. QM staff also conduct annual chart audits onsite at the provider's location to verify compliance with requirements relating to caregiver pre-employment screening and/or training; supervisory visits; provision of services in accordance with the care plan; gaps in service; appropriate response when potential gaps occur; and reporting Non-Provision of Service as required by our contract and AHCCCS. For

providers licensed by ADHS, our Quality Improvement (QI) Coordinator queries the ADHS Enforcement Actions database annually and when monitoring indicates a potential issue to identify any concerns or trends that may indicate quality concerns.

Profiling. The QM Department generates annual profiles for each HCBS provider, and the QM staff review profiling results to identify best practices as well as substandard performance. Profile measures include: member satisfaction survey results, complaints, and quality of care concerns; attendant turnover rate; rate of critical gaps in care; rate of initiating services on the care plan within required timeframes; rate of members suffering a fall-related injury; rate of members developing a new stage one pressure sore; and rate of compliance with guidelines for falls and pressure sores

Assisted Living Facility (ALF) Department/Foundation for Senior Living (FSL) Monitoring. In Maricopa, Yuma, and La Paz counties, FSL conducts annual onsite reviews of ALFs and reports results to the QM Department for follow up. In Pima, our ALF Department conducts and follows up on these reviews. We will expand the Pima approach in any new GSAs we are awarded. FSL and the ALF Department both conduct comprehensive reviews to verify compliance with contract requirements, including, but not limited to quality and delivery of care, documentation and posting requirements, and building maintenance and safety. Reviews involve sampling employee files to verify training and other requirements; sampling resident files to review care plans, physician orders, and other quality of care elements; reviewing resident appearance and interaction with caregivers; and interviewing residents about their satisfaction with care and services.

Addressing Noncompliance

When Case Managers learn of a gap in service, they report the incident to the CM Supervisor, who inspects the provider's Critical Services Gap Report to ensure that the incident has been included. If the provider has not reported the service gap, the CM Supervisor sends notification to the assigned PSR who immediately follows up with the provider, reviews the service reporting requirements, and requests an updated report. Case Managers also report identified noncompliance unrelated to critical service gaps and quality of care to the Provider Services Department. In such cases, a PSR follows up to provide education to the provider and develop a corrective action plan (CAP). Our QI Coordinator works with PSRs to track completion of CAPs, and with the Quality Analyst to trend provider compliance with gaps in service and gap reporting. The Provider Services Department refers providers with continued noncompliance to the Quality Management Investigative Committee (QMIC), which reviews the provider and makes recommendations for CAPs or other action. The QM Department assists the QMIC in monitoring CAPs. Failure to successfully complete CAPs may be grounds for limitations on network participation, and/or consideration of continued network status.

When QOC concerns are identified for agency or facility providers, QM staff (or ALF staff for ALF providers in Pima and any new GSAs) conduct unannounced visits to the provider's service site. QM/ALF staff discuss the concern with the provider agency, work with them to develop action steps towards resolution, and schedule a follow up visit to monitor successful CAP completion. In addition, our Medical Director may meet individually with a HCBS provider whose performance falls outside established thresholds. The QI Coordinator communicates any information indicative of potential member abuse, neglect, or substandard care in a facility to Arizona's Long Term Care Ombudsman Program and/or Adult Protective Services (APS) and AHCCCS. The QI Coordinator also refers providers with issues that may affect member health or safety to the Peer Review Committee, a subcommittee of the QMIC comprised of the VP of Medical Affairs, Medical Director, QM Manager, Medical Management Director, network Providers and other staff as appropriate. This Committee reviews provider performance related to quality of care and makes recommendations for disciplinary action, limitations on network participation, and/or consideration of continued network status. The Peer Review Committee ensures that reviews involve peers of the same or similar specialty, using external consultants when that specialty is not represented on the QMIC or Peer Review Committee. Bridgeway notifies the appropriate regulatory/licensing board or agency and AHCCCS when we suspend or terminate a provider due to QOC issues.

Table of Contents
Section E – Provider Network

Question 36: Network Development and Management Plan 227

1. Evaluation of Prior Year's Plan (CYE 2010) 227
2. Current Status of Network 229
3. Current Network Gaps and Methodology Identifying Them 242
4. Immediate Short-term Interventions When a Gap Occurs 245
5. Interventions to Fill Network Gaps, and Barriers to Those Interventions 246
6. Outcome Measures/Evaluation of Interventions 256
7. Ongoing Activities for Network Development 259
8. Interdepartmental Coordination 260
9. External Coordination 267
10. Special Populations 271
11. Tertiary Care Hospital Services 282
12. Not Applicable to ALTCS .... N/A
13. Not Applicable to ALTCS .... N/A
14. Using Feedback on Network Design and Performance 284
15. Not Applicable to ALTCS .... N/A
16. Non-Medicare Certified Home Health Agencies 287
17. Workforce Development Strategies 288
18. Strategies for In-Home Placement with HCBS 291
19. Action Plan for In-Home Placement 293
20. Single Choice Occupancy Waivers 295
21. Nursing Facilities Withdrawn from Medicaid 296
22. Reducing Inappropriate Emergency Services Utilization 297
23. Specialist as PCP 299
24. Network Barriers and AHCCCS' Role 301
25. Reducing Appointment No-Show Rates 302

Question 37: Network Launch for New GSAs 304

Question 38: Communication with Provider Network 307

Question 39: Provider Issues 310

Question 40: Provider Inquiries 313

Question 41: Training Provider Services Staff 316

Question 42: Evaluating Provider Services Staffing Levels 319

Question 43: Potential Loss of Facility in a GSA 322

Question 44: Addressing Provider Performance Issues 325

36. The Offeror must submit a Network Development and Management Plan. The submission may exceed the three page maximum.

1. Evaluation of Prior Year's Plan (CYE 2010)

1. Evaluation of the prior year's Plan including reference to the success of proposed interventions and/or the need for re-evaluation;

Bridgeway Health Solutions (Bridgeway) has conducted a thorough evaluation of the ALTCS Network Development and Management Plan for CYE 2010.

Member/Provider Council and Community Involvement

The Member/Provider Council experienced growth in both member and provider participation during CYE 2010. The Council meets quarterly and includes agenda items for informing members and providers of the status of Bridgeway's network and requesting feedback on the adequacy and accessibility of the network. Another focus of the Council in CYE 2010 was reporting on Bridgeway's expanded community involvement activities and encouraging Council members to recommend ways to enhance our community involvement. Quarterly meetings in 2010 included reporting on Maricopa County Case Management and Network Management's involvement with the Area Agency on Aging's Maricopa Elder Abuse Prevention Alliance (MEAPA), and the Yuma Elder Abuse Prevention Task Force, and community events related to cultural competency. MEAPA promotes public awareness, education, and community outreach for the prevention of elder abuse and late-life domestic violence. (See also the table of sample events provided in Question 9 of the Network Development and Management Plan.)

Throughout the Contract year, member and advocate attendance gradually increased, with the largest attendance reflected in Q4 2010 (8 members in Yuma/La Paz County, and 13 members in Maricopa County). For 2010, we continued to identify ways to recruit members for the Council and to increase their participation. Recruitment efforts will continue to involve Case Managers, along with early distribution of invitations followed up with RSVP phone calls from Bridgeway staff. Provider attendance at Council meetings also steadily increased over the year.

The Yuma Case Management Team recently expanded our community involvement to include pet therapy services, in which a member of our staff brings "Gus," her certified therapy dog, into our contracted homes to visit with members. The pet therapy program has been very well received. It began in the Yuma/La Paz GSA and has expanded to the Maricopa and Pima GSAs.

Performance Improvement

Bridgeway uses both quantitative and qualitative measures to analyze Bridgeway's responsiveness to enrollment growth, members' cultural competency needs, utilization trends, member grievances, provider appointment availability challenges, and to identify areas needing process or operational improvement. For example, the number of provider claim disputes remained low; also, Network Management's interventions that were implemented upon identification of issues appear to have contributed to reducing the number of disputes. We anticipate further reduction in claim disputes moving into CYE 2011, as well as strengthening of our provider relationships.

Throughout CYE 2010, Bridgeway continued to encourage and analyze provider feedback to improve delivery of care. For example, we used feedback from Medical Management Committee meetings to initiate collaborative efforts with Case Management and Network Management to improve our concurrent review and discharge planning processes.

Excellent Member Satisfaction

Finally, we distributed a Member Satisfaction Survey that included questions related to Member Services staff, Case Management Department services, and cultural competency. Member response to the survey collectively averaged 23%. We received 614 survey responses, 455 from Maricopa County and 159 from Yuma/La Paz Counties. This represents an increase of 7% in Maricopa (17% in 2008 to 24% in 2010), and an increase of 5% in Yuma/La Paz (15% in 2008 to 20% in 2010). Members' overall satisfaction averaged 96% across all categories, with no category scoring below 90%. Response patterns in Maricopa County were consistent with responses in Yuma/La Paz Counties. Survey responses averaged 97% satisfaction regarding the responsiveness of Bridgeway's Member Services Department, which included calls being answered promptly, friendliness of staff, and staff's ability to answer questions. Responses also averaged 97% regarding Bridgeway's ability to provide Case Managers and to distribute materials in language that is easily understood by the member.

Expanding Member-Centric Behavioral Health and HCBS Services

Successful Bridgeway interventions for expanding behavioral health and HCBS services included:

- Bridgeway partnered with Community of Providers Enrichment Services/Counseling and Consulting Services (CPES) to create two new Level II behavioral health homes for adults with Serious and Persistent Mental Illness (SPMI) in Yuma. Following our analysis of service gaps and the need for step-down placements from inpatient behavioral health and nursing facility care to community placement, we provided consultation and education to help CPES plan for how to best serve members with SPMI. Both homes provide psychological services to our members in addition to residential treatment services and employ a nurse to support medication management and help coordinate care for members with medical issues.
- Bridgeway reduced Emergency Department utilization by creating a Medical Home for rural members with SPMI. Bridgeway arranged for members with SPMI to receive PCP services at a local behavioral health clinic, and provided an onsite Case Manager to coordinate other services during each visit. We will expand this approach to other GSAs.
- Bridgeway partnered with Maravilla Care Center in Maricopa County and invested significant resources in service delivery and coordination by placing a Bridgeway Case Manager in the facility. The Case Manager works closely with Maravilla's clinical team during care planning and provides staff training and consultation regarding SAMHSA's recovery model. Maravilla has adopted the recovery philosophy and their staff work hard to find alternatives to medication as the primary approach to treatment. They now focus on proactive strategies for dealing with members' difficult behaviors and work with members one-on-one to support them as they work through issues.
- Bridgeway persuaded and assisted a local provider of non-skilled, home based services in Yuma to obtain Medicare certification. The only Medicare-certified provider was no longer accepting members due to their large private pay caseload. We helped the owner work through the financial, infrastructure, and time commitments required as well as projecting future business opportunities. We also provided a start-up loan. The agency passed the Medicare certification survey and began providing skilled nursing and rehabilitative services last summer.

In addition, as part of Bridgeway's Integrated Care Program, Bridgeway has initiated transforming its Behavioral Health Clinic in Tucson into a Medical Home with Behavioral Expertise. Bridgeway is partnering with the University of Arizona to co-locate the Medical Home on their campus in Tucson so that members will have access to the full range of behavioral health and medical services. We expect that this Medical Home will lead to reduced utilization of emergency services and inpatient days for behavioral health reasons.

Re-Evaluation of Interventions

Bridgeway determined to re-evaluate our encounter submission processes, provider training and support on claims submission, and methods for transitioning providers to submitting claims electronically and assisting them in accepting electronic funds transfers. As of March 2011, we have made significant progress in developing interventions that we believe will have a measurable, positive impact on Bridgeway and provider performance in these areas.

2. Current Status of Network

2. Current status of the network by service type (Hospital, Nursing Facility, HCBS, Primary Care OB/GYN, Specialist, Oral Health, Non Emergent Transportation, Ancillary Services, etc.) at all levels including:

a. how members access the system;

b. relationships between the various levels (focus on provider to provider contact and facilitation of such by the Contractor; e.g. PCP, Specialists, Hospitals, RBHAs).

Status of Bridgeway's Network, By Service Type

Bridgeway has described below the current status of the network by the four major service types identified by AHCCCS, for each GSA:

- HCBS Long Term Care – In home services and residential services, including behavioral health homes
- Institutional Long Term Care – Skilled nursing facilities
- Behavioral Health – Outpatient and inpatient
- Acute Care Services – Practitioners and hospitals

Bridgeway also has contracts or letters of intent (LOIs) for ancillary services, as demonstrated by the provider rosters submitted for Question 45. Several subcontractors or providers will serve all Bridgeway members regardless of location. These include:

- Subcontractors with provider networks
    - Dental/oral health
    - Vision
    - Pharmacy
    - Transportation
- Providers
    - Durable medical equipment
    - Home infusion
    - Orthotics and prosthetics

Pinal and Gila Counties, GSA 40

Pinal County is located in the central part of Arizona and has begun to experience growth from the southern part of the Phoenix metropolitan area into the northern parts of Pinal County. The major cities include Casa Grande and the city of Maricopa, with growth patterns of suburban development which are likely to continue southward through the county from Phoenix and northward from Tucson. The county has two distinct regions: the eastern mountainous area (copper mining and tourism) and the western lower valley desert area (manufacturing, distribution and agriculture). Gila County was formed from parts of Maricopa County and Pinal County, with a majority of the population residing in the Globe-Miami area. Payson is part of Gila and growing in population.

Since Pinal County is situated between Maricopa County and Pima County, members have a large choice of providers between the two metropolitan areas. Gila County's main cities are not far from Maricopa County or Flagstaff in Coconino County. In addition, Payson Regional Medical Center offers primary care and a range of physician specialist services.

HCBS Long Term Care

Some of our key home and community based services (HCBS) providers in the Pinal/Gila GSA include Prileo Home Care, ResCare Homecare, Synergy Home Care, The Caring Presence, and Arizona Consumer Direct Personal Care as well as Mom's Meals for home delivered meals.

For residential care, Bridgeway has received an LOI from Faubush Family Homes which has two assisted living homes in Globe that meet the minimum requirement for Gila. Eleven assisted living facilities (ALFs) have signed LOIs for Pinal County. Some are declining to sign an LOI, due to concern that it would negatively affect their relationship with the current contractor; however, if we are awarded the county, we are confident they would contract with us.

Bridgeway Level II behavioral health residential agencies serving Pinal and Gila Counties include Arizona Mentor, Horizon, Southwest Behavioral Health, Park Place, Counseling & Consulting, Intermountain, and Supported Living

Systems. Level III behavioral health residential agencies include Southwest Behavioral Health, Arizona Behavioral Health Homes, Desert Cedar, Successful Journeys, La Paloma, and Intermountain.

Institutional Long Term Care

We have secured three LOIs in Gila County for skilled nursing facilities (SNFs) and continue to work with the other facility in the county. We have met the requirements for skilled nursing in Pinal County with our current contracts in Maricopa and in Pima, along with Apache Junction Care Center for Apache Junction, plus other contracted SNFs in the East Valley for Maricopa.

Behavioral Health

Bridgeway outpatient providers serving Pinal County include Horizon Human Services, Mountain Health & Wellness, Corazon, and Pinal Hispanic. Outpatient providers serving Gila County include Horizon Human Services, Southwest Behavioral Health Services, and Arizona Children's Association. Evaluative services, Medication Monitoring, Individual, Group and Family Counseling, Behavioral Health Day Treatment/Partial Care and Psychosocial Rehabilitation are provided through these providers.

Bridgeway inpatient providers serving Pinal County include Casa Grande Regional, Sonora, Tucson Medical, The River Source (Sub-Acute), University Physicians Hospital (UPH)-Kino, Mountain Health & Wellness Psychiatric Acute Care (Sub-Acute), Haven Senior Horizons, Banner Health System Inpatient units, St. Luke’s, and Tucson Medical Center. Inpatient providers serving Gila County include Casa Grande Regional, Mountain Health & Wellness Psychiatric Acute Care (Sub-Acute), Windhaven Psychiatric, Flagstaff Medical, Banner System, Aurora, Haven Senior Horizons, and St. Luke’s.

Acute Care Services

Practitioners. Bridgeway’s network of LOIs includes the Capstone IPA in Gila County which includes PCPs (General and Family Practice and Internal Medicine) as well as Cardiology, Orthopedic Surgery, Vascular Surgery, Ophthalmology, Geriatrics and General Surgery. We have also secured an LOI with Payson Regional Medical Center in Gila County. Their clinics include PCPs (Family Practice, Internal Medicine), Cardiology, Orthopedics, Gastroenterology, and Otolaryngology. Banner Health signed an LOI and operates a clinic in Payson. The clinic provides the following services: primary care (Family Practice, Family Medicine and Internal Medicine), General Surgery, Orthopedic Surgery, Pediatric Neurology, Pediatric Orthopedics, Rheumatology and Hepatology.

Bridgeway’s network of LOI’s in Pinal County includes Sun Life Family Health Centers, an FQHC with seven locations in the GSA. Their providers include PCPs (Family Practice, Pediatrics), OB/GYNs and one Social Worker. In addition, Banner Health signed an LOI that includes a clinic in San Tan Valley. The services provided at the clinic include primary care (Family Practice, Internal Medicine), General Surgery, OB/GYN, Orthopedic Surgery, Pediatric Surgery, Radiology and Psychology.

Hospitals. Bridgeway’s network of LOIs includes Payson Regional Medical Center (Gila County), and Banner Health in San Tan Valley (Pinal County). In addition, we received a contract from Florence Community Health Care (Pinal County). The other hospital in Pinal County, Casa Grande Regional Medical Center, chose not to sign an LOI. The Administrator has signed other LOIs, and said she was too busy to sign any more. We tried to set up a meeting with her but were refused.

Yuma and La Paz Counties, GSA 42

The Yuma/La Paz GSA is rural and Yuma County, on the border with Mexico, has a high percentage of Hispanic residents. Yuma County includes a military base and large retirement community and has a high rate of growth. La Paz County is less populous and more rural than Yuma County. Yuma offers a much wider range of provider types than does La Paz.

HCBS Long Term Care

Key providers in Bridgeway’s Yuma County network for home based services include Prileo Home Care, AccentCare at Home, and Angels PRN. Key HCBS providers for La Paz County include Comfort Keepers, ABRiO, AccentCare, and RISE, Inc., plus Caring Presence, which serves La Paz as well as other counties. Our Yuma environmental modification

network provider also covers La Paz County and we have a home delivered meals provider in La Paz that specializes in meals for people with diabetes. We provide choice to members through contracts with six HCBS providers besides those listed above, as well as Hospice of Yuma and Hospice Compassus. Therapy needs are currently being met through authorizations with La Paz Regional Hospital.

Although Yuma and La Paz Counties are rural and have a limited number and range of providers, Bridgeway's ALF network meets AHCCCS standards. For Yuma County, Bridgeway has contracted with 13 assisted living facilities; we also have an LOI with an assisted living home in San Luis. In La Paz County, there are no assisted living facilities or Adult Foster Care participating in the AHCCCS program, however we have secured a contract with an assisted living home in Lake Havasu City. Many new assisted living homes have opened over the past five years in Yuma County.

Bridgeway Level II behavioral health residential agencies serving La Paz and Yuma Counties include Community Bridges, Child & Family Services of Yuma, and Community Provider of Enrichment Services (CPES). Bridgeway helped to create the two new CPES Level II facilities, Vista del Rio and Vista del Sol. Level III behavioral health residential agencies serving La Paz and Yuma Counties include Southwest Behavioral Health, Arizona Behavioral Health Homes, Desert Cedar, Successful Journeys, La Paloma, and Intermountain.

Institutional Long Term Care

Bridgeway has secured the participation of all four of the nursing facilities within Yuma County, as well as five nursing facilities between Lake Havasu, Kingman, and Bullhead City, offering more than the required minimum access.

Behavioral Health Services

Bridgeway outpatient providers serving La Paz County include Arizona Counseling and Treatment Services, and Community Intervention Associates. Outpatient providers serving Yuma County include Arizona Counseling and Treatment Services, Community Intervention Associates, Horizon, and Mountain Health & Wellness. Evaluative services, Medication Monitoring, Individual, Group and Family Counseling, Behavioral Health Day Treatment/Partial Care and Psychosocial Rehabilitation are provided through these providers.

Our inpatient providers serving La Paz County include Mountain Health & Wellness (Sub-Acute), Aurora, and Banner Systems. Inpatient providers serving Yuma County include Mountain Health & Wellness (Sub-Acute), Banner Systems, Sonora, Casa Grande Regional, St. Luke's, Palo Verde, The River Source (Sub-Acute), Haven Senior Horizons, and Carondelet.

Acute Care Services

Practitioners. Key acute care providers in Bridgeway's network include the Sunset Community FQHC, which provides primary care at sites in San Luis, Somerton, Yuma, and Wellton, and the Yuma Unified Medical Associates IPA (Yuma IPA), which provides both primary and specialty care services. One physician who stands out is Dr. Sergio Penaherrera, who, along with two physician colleagues and three physician assistants at Southwest Diabetes Center, serves approximately 50 of our members with diabetes. We are in the process of contracting with additional medical providers, which we anticipate will add 10 practitioners (8 physicians and 2 PAs) in Yuma County and 3 rural clinics in Quartzsite, Salome, and Bouse in La Paz County (1 physician and 1 NP). The La Paz providers are currently being credentialed.

Hospitals. For hospital care, we contract with the Yuma Regional Medical Center and have an LOI with La Paz Regional Hospital in Parker.

Bridgeway's Medicare Advantage Special Needs Plan (SNP). Our SNP has contracts with additional providers for acute services in Yuma County, to serve Medicaid and Medicare, or dual eligible members. Bridgeway coordinates these members' care whether they join Bridgeway's SNP or another Medicare Advantage plan, or use the Medicare fee-for-service program. Bridgeway simplifies administration for SNP providers serving dual eligibles by paying co-pays, coinsurance and deductibles for members and minimizing authorization requirements.

Mohave, Coconino, Navajo, and Apache Counties, GSA 44

Mohave County is located in the northwestern corner of Arizona. While the largest city is Lake Havasu City, the most populated community is the Bullhead City/Fort Mohave/Mohave Valley area. Mohave County contains parts of the Grand Canyon National Park and is populated by the Kaibab, Fort Mojave and Hualapai Indian Reservations. Mohave is the

second largest county in the State and most of the land is desert. Designated enterprise zones are located in the four major cities of the county – Bullhead City, Colorado City, Lake Havasu City and Kingman.

Coconino County is in the north central part of Arizona and contains the Grand Canyon National Park. Coconino County has a relatively large Native American population including the Havasupai Nation, parts of the Navajo Nation, and the Hopi Nation. The largest city is Flagstaff. Coconino is the largest county in Arizona yet one of the least populated.

Navajo County also is in northern Arizona and contains parts of the Hopi Indian Reservation, the Navajo Nation and Fort Apache Indian Reservation. The largest population resides in the Show Low/Pinetop/Lakeside area.

Apache County is in northeastern Arizona. Two distinct areas make up the county, divided by the Mogollon Rim. The northern portion is dry and desert-like. The southern section is more mountainous and is forested. Apache County contains parts of the Navajo Indian Reservation, Fort Apache Indian Reservation, and the Petrified Forest National Park. The county has more land, set aside as Indian Reservation (68%) than any other county in the US.

Since the northern area of Arizona is so vast and mostly Native American Reservation land, residents typically travel to Flagstaff or Maricopa County for specialist physician coverage (or in some cases to Las Vegas, Nevada). Two FQHCs have expanded their primary care coverage by establishing clinics in Page, Kaibeto, Fredonia, Keyenta, Littlefield, Flagstaff, Kingman, Holbrook, Williams, Grand Canyon, St. Johns, Show Low, Springerville, and Bullhead City.

HCBS Long Term Care

Bridgeway's LOI network includes HCBS providers such as ABRiO Family Services, Prileo Home Care, Comfort Keepers, Arizona Consumer Direct Personal Care, ResCare Home Care, and Tender Hearts Senior Care. Most of these providers perform services on a statewide basis and hire caregivers from the local community. We also have an LOI from Mom's Meals

We currently have ten LOIs for assisted living facilities, which include four behavioral health homes. Many assisted living facilities in GSA 44 stated they did not want to sign an LOI but are certainly willing to contract with Bridgeway if we are awarded an AHCCCS Contract for this GSA.

Bridgeway Level II behavioral health residential agencies serving all four counties in this GSA include Verde Valley, Mohave Mental Health, The Guidance Center, West Yavapai Guidance Clinic, and SequelCare of Arizona. Level III behavioral health residential agencies serving all four counties in this GSA include Mohave Mental Health, Southwest Behavioral Health, Arizona Behavioral Health Homes, Successful Journeys, and Desert Cedar.

Institutional Long Term Care

Bridgeway's network of skilled nursing facilities includes five that are already contracted with us to serve members who live in La Paz County. These facilities include Havasu Nursing Center, Desert Highlands Care Center, The Lingenfelter Center, The Gardens Rehab and Care Center, and Lake Hills Inn. Bridgeway also has an LOI from Winslow Campus of Care in Navajo County and Chinle Nursing Home in Apache County.

Behavioral Health

Within GSA 44, Bridgeway outpatient providers serving Apache County include Little Colorado Behavioral Health and Sequel TSI of Arizona. Outpatient providers serving Coconino County include The Guidance Center, Sequel TSI of Arizona, and Counseling & Consulting. Outpatient providers serving Mohave County include Mohave Mental Health and Southwest Behavioral Health. Outpatient providers serving Navajo County include Community Counseling Center, Sequel TSI of Arizona. An additional provider we are recruiting is Hopi Guidance (no LOI as yet).

Bridgeway inpatient providers serving Apache, Coconino and Navajo Counties include Flagstaff Medical, Windhaven Psychiatric, Banner Health Systems Inpatient Units, St. Luke's, Haven Senior Horizons, and Aurora. Inpatient providers serving Mohave County include Flagstaff Medical, Mohave Mental Health Psychiatric Healthcare Facility (PHF) (Sub-Acute), Banner Systems, St. Luke's, Haven Senior Horizons, and Aurora. Navajo County has a crisis stabilization unit through Community Counseling Centers.

Acute Care Services

Practitioners. Bridgeway's network includes a number of physicians through our LOI with Western Arizona Regional Medical Center in Mohave County. The practice areas include primary care (Family Practice and Internal Medicine)

General Surgery, Gastroenterology, Orthopedics, Neurology, Otolaryngology and Urology. Through Bridgeway's participation in AHCCCS' acute care in Yavapai, we have contracts in the Flagstaff area (Coconino County) including North Country Community Health Center, an FQHC with 13 locations throughout the GSA. Bridgeway also secured an LOI with Canyonlands Health Care Center, another FQHC with nine clinics, of which six are in GSA 44. Sage Memorial and White Mountain Regional Medical Center signed LOI's that include a number of physicians in Apache County. The service types include primary care (Family Practice and Internal Medicine), Cardiology, Orthopedic Surgery, General Surgery, Ophthalmology, Radiology, Psychiatry, Optometry, Dentistry, Physical Therapy, Occupational Therapy, and Social Work. Banner Health signed an LOI and operates a clinic in Page. The clinic provides the following services: primary care (Family Practice and Family Medicine), Cardiology, General Surgery, Otolaryngology, Emergency Medicine, Radiology, And Anesthesia, and Physical Therapy. Additionally, we have secured LOI's from providers in the following specialties: Orthopedics, Cardiology, Oncology, Ophthalmology, Nephrology, Pulmonology and Dermatology.

Hospitals. Bridgeway secured contracts from Flagstaff Regional Medical Center and Page Hospital (Coconino County), Sage Memorial and White Mountain Regional Medical Center (Apache County), Little Colorado Medical Center and Summit Healthcare Regional Medical Center (Navajo County), and Western Arizona Regional Medical Center (Mohave County). We are still in discussions with Kingman Regional Medical Center, Lake Havasu Regional Medical Center, Hualapai Medical Center, and Valley View Medical Center. They are all reviewing the information and have not decided whether to participate.

Cochise, Greenlee, and Graham Counties, GSA 46

Cochise County is located in the southeastern corner of Arizona, which is the Sierra Vista-Douglas Metropolitan Statistical Area. The major industries in the area are farming, ranching, tourism, and the military. In the past, agriculture was dominant but the local economy is rapidly becoming more diversified. Graham and Greenlee Counties are in southeastern Arizona. Graham County contains part of the San Carlos Apache Indian Reservation. The major city in the area is Safford. The main industries of the county are mining and stock raising.

Sierra Vista is a small community that has PCP coverage and some specialty coverage but members also seek care in Tucson, which offers a much wider choice of providers. Members in Graham and Greenlee Counties also seek care in Tucson as these counties have minimal physician coverage.

HCBS Long Term Care

Bridgeway's network of LOIs includes providers such as ABRiO Family Services, Arizona Consumer Direct Personal Care, ResCare Home Care. Most of these providers perform services on a statewide basis and hire direct care workers from the local community. We also have an LOI from Mom's Meals.

We currently have five LOIs for assisted living facilities.

Bridgeway Level II behavioral health residential agencies serving all three counties in this GSA include Community Bridges, Intermountain, Supported Living Systems, CODAC Behavioral Health Services (CODAC), COPE Community Services (COPE), CPES, La Frontera, and Mary's Mission. Level III behavioral health residential agencies serving all three counties in this GSA include Intermountain and La Paloma.

Institutional Long Term Care

Bridgeway's network of skilled nursing facilities includes six skilled nursing facilities.

Behavioral Health

Bridgeway outpatient providers serving Cochise, Graham and Greenlee Counties include Southeastern Arizona Behavioral Health Services, and Arizona Counseling and Treatment Services. Additional outpatient providers in Cochise County include Community Intervention Associates, Pinal Hispanic, and Corazon. Evaluative services, Medication Monitoring, Individual, Group and Family Counseling, Behavioral Health Day Treatment/Partial Care and Psychosocial Rehabilitation are provided through these providers.

Our inpatient providers serving all three counties in this GSA include Carondelet, Tucson Medical Center, UPH-Kino, Southeastern Arizona Behavioral Health Services PHF (Sub-Acute), Casa Grande Regional, and Palo Verde.

Acute Care Services

Practitioners. Bridgeway secured LOIs with a number of individual Family Practice PCPs throughout the GSA. The FQHC Chiricahua Community Health Centers was unable to get an LOI signed in time; however, they expressed a desire to work with Bridgeway.

Hospitals. Bridgeway's network of LOIs includes Northern Cochise Community Hospital and Sierra Vista Regional Health Center (Cochise County) and Mt. Graham Community Hospital (Graham County).

Yavapai County, GSA 48

Yavapai County is located in the central part of Arizona within a reasonable drive time to Phoenix (100 miles) and Flagstaff (90 miles). Yavapai County is divided geographically by the Mingus Mountains with two routes connecting Prescott and the Verde Valley, about a 50-mile drive. Prescott was the first capital of Arizona.

The largest city in Yavapai is Prescott, which expands into Prescott Valley and offers numerous physician specialties; however many specialties are provided by only one physician. Therefore, members who live in the southern part of the Yavapai County may seek specialty coverage in Maricopa County. Members in Verde Valley, which includes Cottonwood and Camp Verde, may travel to either Flagstaff or Maricopa County for specialty services.

HCBS Long Term Care

Bridgeway's HCBS LOI network includes The Caring Presence, Arizona Consumer Direct Person Care, Tender Hearts Senior Care, Angels on Duty, Home Instead Senior Care, Comfort Keepers, ResCare Homecare, as well as Mom's Meals and CASA Senior Center Meals on Wheels for home delivered meals.

Our LOI network for assisted living facilities includes 4 assisted living centers and 13 assisted living homes.

Bridgeway Level II behavioral health residential agencies serving Yavapai County include Verde Valley, Mohave Mental Health, The Guidance Center, West Yavapai Guidance Clinic, and SequelCare of Arizona. Our Level III behavioral health residential agency is SequelCare of Arizona.

Institutional Long Term Care

Bridgeway's nine LOIs for skilled nursing facilities exceed the minimum requirement of seven. We have a long standing collaborative partnership with Covenant and Lifecare Centers. These organizations have facilities outside of our current GSAs. Matt Luger, CEO of Covenant indicated that he is pleased Bridgeway is bidding for additional GSAs and he has agreed to partner with us in any county that has Covenant facilities.

Behavioral Health

Bridgeway outpatient providers serving Yavapai GSA include Verde Valley Guidance Clinic, West Yavapai Guidance Clinic, Arizona Children's Association, and Southwest Behavioral Health. Evaluative services, Medication Monitoring, Individual, Group and Family Counseling, Behavioral Health Day Treatment/Partial Care and Psychosocial Rehabilitation are provided through these providers.

Our inpatient providers include Flagstaff Medical, Windhaven Psychiatric, Banner Systems, St. Luke's, Haven Senior Horizons, and Aurora.

Acute Care Services

Practitioners. Bridgeway's current contracted network (for our acute care AHCCCS Contract) includes numerous PCPs and specialist physicians. Providers include the Bagdad Clinic, a clinic serving a very rural part of Yavapai County. In addition, we have contracts with Yavapai Community Health Center, the FQHC in Prescott, as well as North Country Community Health Center, which serves the northern part of Yavapai County (Ash Fork and Seligman). We have a very good working relationship with both FQHCs. Our network includes over 90 PCPs as well as many specialist physicians, including but not limited to the specialties of Gastroenterology, Orthopedics, Pulmonary, Oncology, and Cardiology.

Hospitals. Bridgeway's contracted network for hospitals includes Verde Valley Medical Center and Flagstaff Regional Medical Center, which is located in Coconino County but provides much needed services to members in Yavapai County. We have an LOI with Yavapai Regional Medical Center. Even though Yavapai Regional is not currently contracted, we

have worked closely and have a good relationship with them. Yavapai Regional leadership are not unwilling to sign a contract, but rather have no incentive to contract, since out-of-network rates are set by AHCCCS and we have onsite concurrent review in their facility.

Pima and Santa Cruz Counties, GSA 50

Pima County is located in the south central region of Arizona. The vast majority of the county population resides in and around the city of Tucson, which is Arizona's second largest city. Other urbanized areas include the Tucson suburbs of Oro Valley, Marana, Sahuarita, and South Tucson, a large ring of unincorporated urban development, and the growing satellite town Green Valley. The rest of the county is sparsely populated, and the largest towns there are Sells, the capital of the Tohono O'odham Nation, and Ajo in the far western region of the county.

The remaining portions of the GSA, including Santa Cruz County, also are sparsely populated. Santa Cruz County has one main city, Nogales, which is on the border of Arizona and Mexico.

Pima County offers a full array of provider types as well as a major medical training center, at the University of Arizona. Pima also provides specialty coverage for Santa Cruz County.

HCBS Long Term Care

Some of our key HCBS providers in GSA 50 include Dependable Home Health, Nursing Services Inc., PCOA for All (a subsidiary of the Area Agency on Aging), and Arizona Consumer Direct Personal Care. Arizona Consumer Direct Personal Care also offers self-directed attendant care, as does ResCare, for members who elect this option. Two agencies, Accent Care and Dependable, are contracted to provide short notice back-up services to prevent potential gaps in service.

Bridgeway has an assisted living facility network of almost 120 facilities, compared to the requirement of 76 ALF providers for the GSA. The ALF network includes 23 adult foster care, 87 assisted living homes and 8 assisted living centers.

Bridgeway Level II behavioral health residential agencies serving Pima and Santa Cruz Counties include Arizona Children's Association, COPE, CODAC, Community Providers of Enrichment Services (CPES), Intermountain, La Frontera, Supported Living Systems, The Comfort Home, The Haven, The Oasis Home, and Tina Tony Residential Care. Level III behavioral health residential agencies in Pima and Santa Cruz Counties include Intermountain, and La Paloma.

Institutional Long Term Care

The skilled nursing facility network includes 17 nursing homes in Pima County and 1 in Santa Cruz County. Key facilities are Posada del Sol, which provides multiple specialties including behavioral, bariatric, intense rehabilitation, sub-acute and ventilator care, Santa Rosa Care Center which provides several levels of behavioral care, and Devon Gables which operates a challenging dementia unit. Catalina Care and Rehabilitation provides respiratory and ventilator dependent care and will begin providing onsite dialysis effective April 1, 2011. We also partner with and support Holy Cross Hospital Nursing Home in Nogales, Arizona to ensure that there is nursing home available to members in this community.

Behavioral Health Services

Bridgeway outpatient providers serving Pima County include Bridgeway Behavioral Health Clinic, CODAC, COPE, CPES, La Frontera, Intermountain, and Arizona Children's Association. Outpatient providers serving Santa Cruz County include Corazon, Community Intervention Associates, and Pinal Hispanic. Evaluative services, Medication Monitoring, Individual, Group and Family Counseling, Behavioral Health Day Treatment/Partial Care and Psychosocial Rehabilitation are provided through these providers.

Bridgeway inpatient providers serving Pima and Santa Cruz Counties include Carondelet, Sonora Behavioral Health, Tucson Medical Center, La Frontera PHF (Sub-Acute), UPH-Kino, and Palo Verde. In addition, inpatient provider, Southeastern Arizona Behavioral Health Services PHF (Sub-Acute), also serves Santa Cruz County.

Acute Care Services

Practitioners. Bridgeway's network include includes 117 PCP sites and 433 specialist physician sites. The network includes University Physicians Healthcare, Carondelet Medical Group, Arizona Community Physicians, and Northwest Allied Physicians, which provide primary and multi-specialty care at numerous sites. There are also five contracted

FQHCs and Children's Rehabilitative Services (CRS) providers that serve as a medical home for members. Bridgeway partners with a number of providers who offer onsite primary care in SNF's, ALF's and HCBS homes. Key providers include IPC Hospitalists of Arizona, Tucson House Calls, and Providers Direct. Carondelet Medical Group offers onsite primary care at Holy Cross Nursing Home in Nogales.

Hospitals. The contracted network of 15 hospitals includes acute care, long term acute care, rehabilitation and free standing psychiatric hospitals. Bridgeway plans to pursue a contract with Diamond Medical Center, a brand new pediatric hospital in Tucson.

Bridgeway's Medicare Advantage Special Needs Plan (SNP). Our SNP has contracts with additional providers for acute services, to serve Medicaid and Medicare, or dual eligible members. Bridgeway coordinates these members' care whether they join Bridgeway's SNP or another Medicare Advantage plan, or use the Medicare fee-for-service program.

Maricopa County, GSA 52

Maricopa County is Arizona's most populous county, with Phoenix and its suburbs, and numerous towns within easy driving distance of Phoenix. The southern part of the county is largely rural; Gila Bend is the only major town in the southern area, with an estimated population of just over 2,000 residents.

HCBS Long Term Care

To maintain members in their own home or apartment, Bridgeway provides all required home based supportive services, with no network gaps, including home health services, personal care, attendant care, home delivered meals, adult day healthcare, emergency alert, habilitation, homemaker, hospice, personal care and respite. These providers have adequate capacity and geographic coverage for the current and anticipated membership. Several of our key HCBS providers in the Maricopa GSA include the Area Agency on Aging, Arizona Bridge to Independent Living, Comfort Keepers, Creative Networks, and RISE, Inc. We have also secured a contract with Public Partnerships for those members who prefer self-directed care.

For residential care, Bridgeway has a total network of 512 assisted living facility providers, which include 436 assisted living homes, compared to the requirement of 137. [Elaine said yesterday afternoon that she did not use numbers in the new GSAs, but this was in the red team draft for current GSAs (from 2011 Network Plan), so it sounds like it should be verified; it's a strong statement so it would be great to use it. The Pima #s should be current as we rec'd them from Alan last week.] We have a long standing collaborative partnership with Covenant, which manages multiple assisted living facilities, that is different from other health plans. For example, with the active support of Covenant Care CEO, Matt Luger, Bridgeway has met over the past two years with Covenant managed facilities on quality initiatives. In addition, the CEO helped us convince some of the facilities he manages to begin to use EDI for submission of claims.

Bridgeway Level II behavioral health residential agencies serving Maricopa County include Pastalino Manor, Arizona Mentor, Tilda Manor, VEMA Corporation, Baraka House, Destiny for Sober Living, Emmarie Behavioral Home Care, Eureka Imperial Residence, Grace House, Joy Health Care, Prats Residential Behavioral Health Agency, SIMS Behavioral, Mountaintop Behavioral Health Services, and A New Hope Behavioral Health Home. Level III behavioral health residential agencies serving Maricopa County include Arizona Behavioral Health Homes, Desert Cedar, and Successful Journeys.

Institutional Long Term Care

Key skilled nursing facilities include LifeCare Centers of America, Maravilla Care Center, Covenant Care, Ridgecrest, Maryland Gardens, and Plaza Healthcare. Plaza Healthcare capabilities include members with significant medical needs, such as members with a tracheal tube, or who require a ventilator or dialysis. Senior Living Options has five nursing facilities that serve, in particular, members with behavioral health conditions. We have a close working relationship with Bella Vita Health and Rehabilitation (formerly Desert Sky Healthcare and Rehab) (Bella Vita). For example, a Bella Vita representative conducted training for our Case Managers on specific screening protocols they use for referring members from their assisted living facility to their SNF. Unlike many health plans, Bridgeway offers a bariatric unit at Plaza del Rio in Peoria (Zone 6), for members with a Body Mass Index of 40 or more who are either wheelchair or bed bound. We have had discussions with Sun West Choice to support their efforts to open a wing for members with Alzheimer's or dementia, who also have acting out behaviors that are difficult to manage. This would add needed capacity for this type of care in the Far West Valley area.

Behavioral Health Services

Bridgeway outpatient providers in the Maricopa GSA include Southwest Behavioral Health, Marc Center, Arizona Children's Association, Counseling & Consulting, and Mountain Health & Wellness. Evaluative services, Medication Monitoring, Individual, Group and Family Counseling, Behavioral Health Day Treatment/Partial Care and Psychosocial Rehabilitation are provided through these providers. In addition, Southeastern Arizona Behavioral Health Service (SEABHS) is a large provider of behavioral health crisis and outpatient behavioral health services with multiple clinic locations. Arizona MENTOR specializes in creating community based programs that emphasize individualized services and personal choice.

Our inpatient providers include Banner Systems, St. Luke's, Aurora, and Haven Senior Horizons.

Acute Care Services

Practitioners. For members without Medicare (or other primary) coverage, Bridgeway's network includes 81 PCP sites and 326 specialist physician sites. [Verify numbers, per above comment.] The network includes the Arizona State Physicians Association, IPA, a dominant medical group that provides primary and specialty care services. District Medical Group is another large multispecialty physician group that also provides clinical staff to Maricopa Integrated Health System's behavioral health unit. They assist with the court ordered treatment provided for members with serious mental health conditions.

Critical to members who are homebound or in facilities are Geriatric Solutions and INSPIRIS, whose primary care physicians and nurse practitioners go to the home or facility to see members. A number of individual practitioners also provide care to members where they live.

Hospitals. Likewise for nondual coverage members, Bridgeway's hospital network includes IASIS Hospitals (St. Luke's and Tempe St. Luke's), both John C. Lincoln Hospitals (Deer Valley and North Mountain), Select Specialty Hospitals, and Phoenix Children's Hospital. Members also receive services from Banner Good Samaritan, with which we have an LOI, and Maricopa County Medical Center (currently on an out-of-network basis). We recruited major physician groups to align with these key hospitals.

Bridgeway's Medicare Advantage Special Needs Plan (SNP). Our SNP has contracts with additional providers for acute services, to serve Medicaid and Medicare, or dual eligible members. Bridgeway coordinates these members' care whether they join Bridgeway's SNP or another Medicare Advantage plan, or use the Medicare fee-for-service program. Bridgeway simplifies administration for SNP providers serving dual eligibles by paying co-pays, coinsurance and deductibles for members and minimizing authorization requirements.

2a. How Members Access the System

Members and their caregivers access the system through a variety of options. Each member is assigned a Case Manager, who is available to assist members 24/7 by phone or email, and through personal visits to the home or other setting of the member's choice. In addition, members may access the system through their HCBS provider or primary care provider (or specialist serving as a PCP).

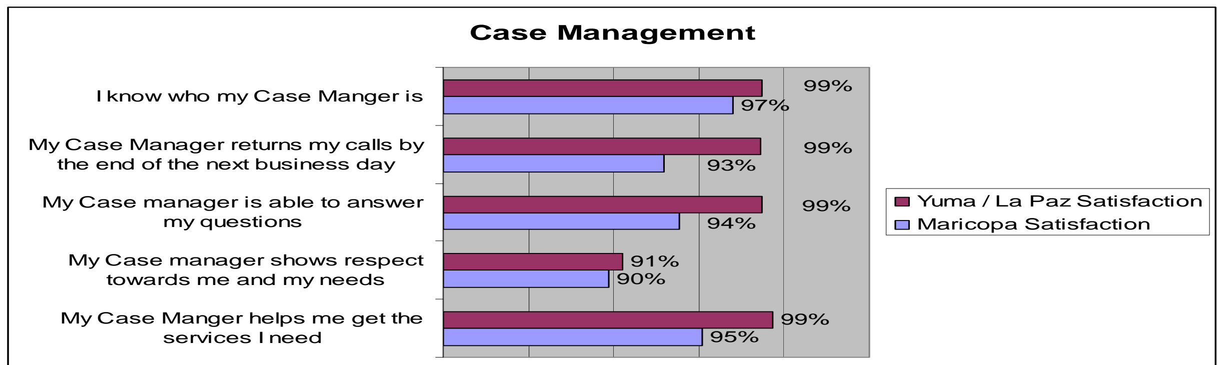
Case Management

Case Managers. Each member is assigned a Case Manager, who is either a nurse, social worker or behavioral health clinician, depending on the member's needs. The Case Manager conducts in-person visits at least every 90 days for members in their own home or assisted living facility and every 180 days for those in skilled nursing facilities (SNFs) and more frequent visits and/or calls as dictated by the member's condition and new or changed needs. For example, Case Managers contact members who are receiving transplant services or have recently experienced a behavioral health crisis more frequently than members whose conditions are stable. Case Managers assess member conditions and needs as well as their goals, service preferences and informal support network. They work with members, families and caregivers to develop a care plan that matches covered services and community resources to their assessed needs and goals, coordinate the entire range of services the member receives, and assist in addressing any barriers to care.

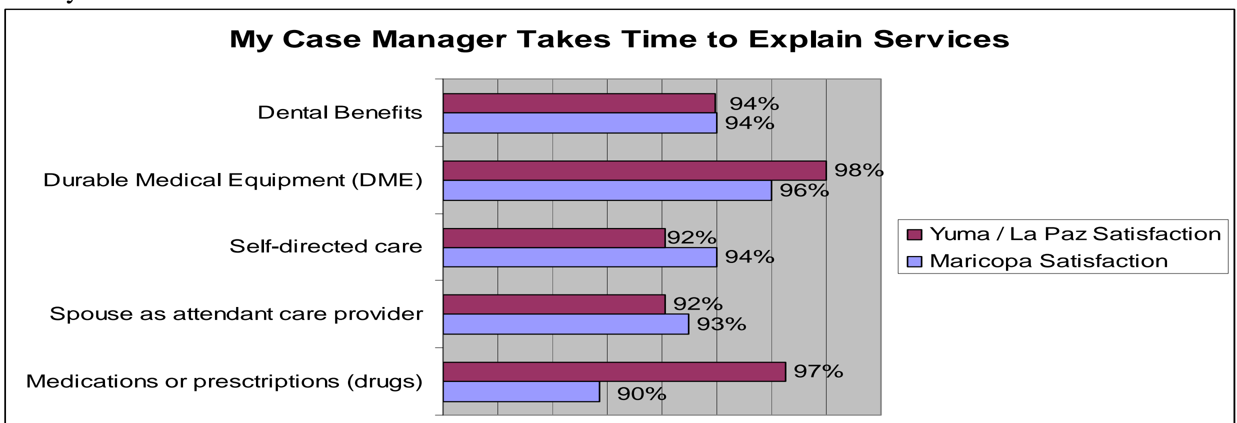
Within five business days of enrollment, all members are welcomed to Bridgeway by a Case Management Program Coordinator. During this encounter, the Program Coordinator educates the member about the role their Case Manager plays in assisting them with identifying and promptly addressing healthcare needs, coordination of benefits, service

implementation, and obtaining care from physicians or other providers. The member is able to access the Bridgeway network by requesting assistance directly through their Case Manager or by obtaining a list of our providers via the Bridgeway website at www.bridgewayhs.com.

Responses from our CYE 2010 Member Satisfaction survey averaged 96% satisfaction regarding case management, including a strong satisfaction response with the customer service provided by their Case Manager.

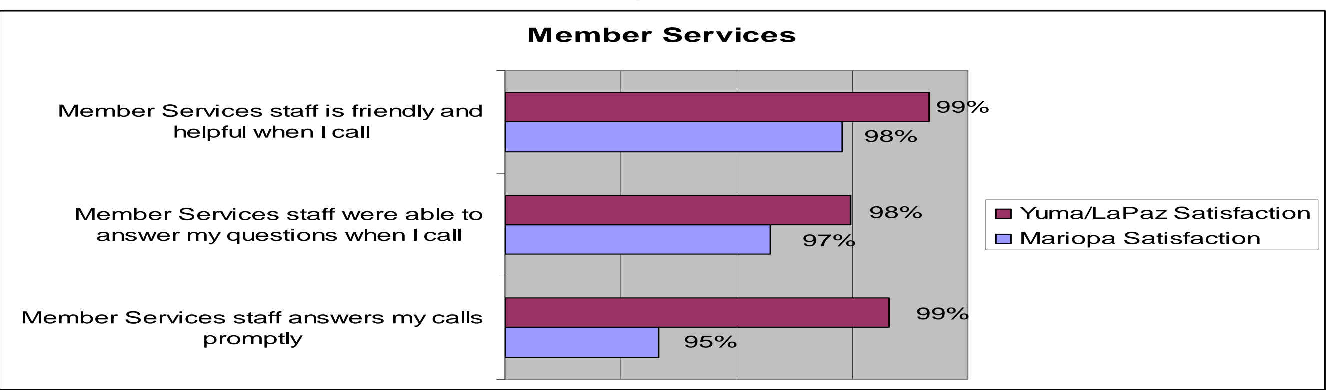


Survey responses averaged 95% member satisfaction regarding Case Managers explaining available services. Some lower percentages may be explained by various placement settings. For example, services such as "spouse as an attendant care provider" or "self-directed care" services would not apply to a member who resides in a nursing facility or assisted living facility.

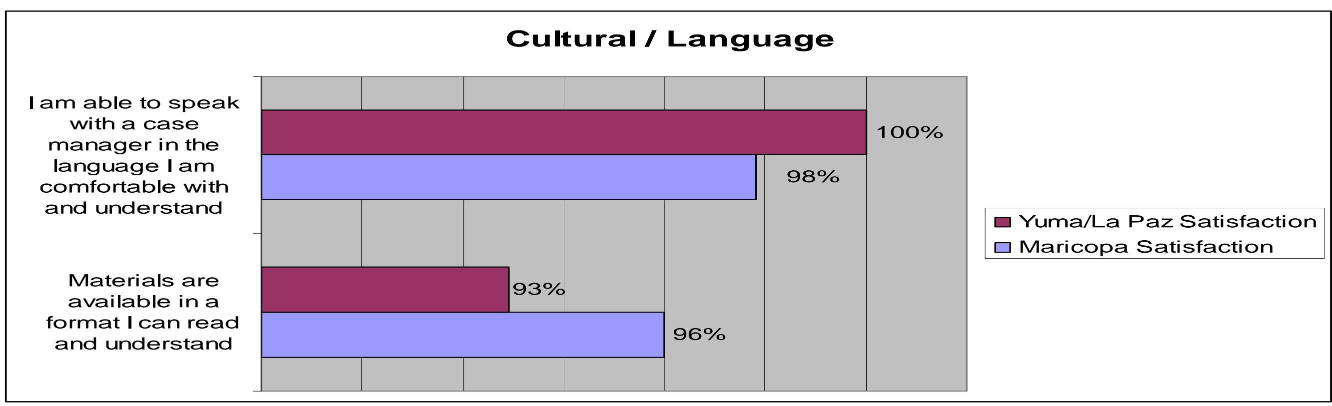


Telephone Accessibility

In addition to direct access to the Case Manager, members may also access the system through Bridgeway's toll-free number (866-475-3129). During business hours, 8 a.m. to 5 p.m., general inquiries are fielded by Member Services Representatives (MSRs) who either promptly answer the member's questions or transfer the member to the Case Manager for further assistance. Using the same number after-hours, members reach NurseWise® RNs and administrative staff who are trained on the same issues as MSRs including handling crisis calls and warm-transferring them to clinical staff when needed. In either case, incoming callers always have the option to speak with a live person who is equipped to address the member's needs. MSRs and after-hours personnel have access to each member's electronic case file and can communicate with members in the member's language through our 24/7 translation service. If a NurseWise Representative cannot address an after-hours need, NurseWise contacts the on-call Case Management Supervisor, who handles all issues. If an after-hours call involves a member's need for emergency medical care, the NurseWise Representative or Case Management Supervisor triages the call and assists in making appropriate arrangements for emergency care. These arrangements may include directions to access Urgent Care, Emergency Departments, other placement as deemed appropriate, or authorization of home and community based services. Members also may file or receive assistance in filing a grievance or appeal from the Grievance and Appeals Coordinator. Annually, Bridgeway conducts a member satisfaction survey to obtain feedback and ensure that we are meeting both the actual and perceived needs of our members.



Survey responses from our Member Satisfaction Survey conducted in 2010 averaged 97% satisfaction regarding the responsiveness of Bridgeway's Member Services Department, which included calls being answered promptly, friendliness of staff, and staff's ability to answer questions. Responses also averaged 97% regarding Bridgeway's ability to provide Case Managers and materials in a language and format that are easily understood by the member.



To promote consistent, culturally competent access to the system, Bridgeway staff and providers are required to complete annual Cultural Competency Training. To ensure that all linguistic and written materials are accurate and sensitive to culturally diverse populations, Bridgeway's Compliance Officer monitors and obtains necessary approvals prior to submission or exposure to Bridgeway members. Bridgeway ensures that members' linguistic and communication needs do not impede their access to the system. Bridgeway staff either speak Spanish or arrange for translation in other languages, and ensure that needed translation services are in place for member contact with their providers. Network HCBS agencies also include personal care attendants and other direct care providers who speak Spanish and other languages. Bridgeway's local and toll-free member numbers have Telecommunications Device for the Deaf (TDD) capability.

Member Handbook, Written Materials, and Provider Portal

Members, as well as their family members, designated representatives, and informal caregivers access the system through written materials such as the Member Handbook, member newsletters, Provider Directory, targeted mailings, health education literature, disease management information, and the Bridgeway Health Solutions Member Portal at www.bridgewayhs.com. Bridgeway materials are specifically written in easily understood language and are available in alternative formats such as audiotapes or CDs, large type, and Braille for people who are blind or visually impaired. The Member Handbook and materials are also available in Spanish. Members who choose to communicate electronically may email their Case Manager or the Case Manager's back-up and may request increased email font size to make reading email easier. All electronic correspondence with members is through secure messaging in accordance with HIPAA requirements.

Bridgeway also reviews member materials at least annually, to ensure the information is the most current information available. In CYE 2009, we developed additional materials specific to ALTCS members, including a brochure entitled, "About Caregiving" and a flyer on fall prevention.

Member/Provider Advisory Council

Bridgeway encourages members and their caregivers to participate in the Member/Provider Council in their own GSA. The Council gives members the opportunity to have a meaningful voice in the delivery of health care services. We inform members about the purpose and functioning of the Council through the Bridgeway Member Handbook, and Case Managers extend personal invitations to members, urging them to express their ideas and thoughts with Bridgeway and to provide feedback on provision of covered services. To encourage members to attend, Bridgeway supplies transportation to and from Council meetings. Throughout the recent plan year, member/advocate attendance gradually increased, with the largest attendance reflected in Q4 2010 (8 members in Yuma/La Paz County, and 13 members in Maricopa County). For 2010, we continued to identify ways to recruit members for the Council as well as to increase member participation in the Council. We mail invitations well in advance of meetings and Bridgeway staff follow up with RSVP phone calls to members. Bridgeway provides an orientation and ongoing training for Council members so they are well informed and well prepared to fully participate in Council activities.

Council meetings are a forum to discuss ways to achieve optimum care coordination and member access to services. Guest speakers have provided information on pharmacy benefits and regarding our Medicare Advantage SNP. Bridgeway encourages provider and member feedback to identify any challenges or gaps in the network or in access to care and addresses any identified deficiencies at quarterly Quality Management/Performance Improvement Committee (QMPIC) meetings.

The Member/Provider Council also addresses Bridgeway's community involvement efforts. Quarterly meetings in 2010 included reporting of Maricopa County Case Management and Network Management involvement and participation in MEAPA (through the Area Agency on Aging). MEAPA promotes public awareness, education, and community outreach for the prevention of elder abuse and late-life domestic violence. The organization has a no-cost membership which includes bi-monthly meetings with guest speakers, subcommittees, program reports, and networking opportunities. Yuma Case Management and Network Management also reported on participation in the Elder Abuse Task Force, which meets monthly and shares information about new legislation, specific cases, current training, and networking. The Elder Abuse Task Force is composed of various agencies and business representatives in the Yuma area. The Yuma Case Management Team has recently expanded our community involvement to include pet therapy services, in which a member of our staff brings "Gus", her certified therapy dog into our contracted homes to visit with members. The "pet therapy" program has been very well received in the homes in the Yuma County area, and Bridgeway has expanded the program to Maricopa and Pima Counties.

2b. Relationships Between the Various Levels

Bridgeway Case Managers facilitate member access to providers and advocate on behalf of members and their caregivers. Case Managers engage members, family and caregivers in all aspects of assessment, care planning and service delivery monitoring to ensure member-driven care.

Programmatic Relationship Building

Bridgeway fosters a network community through open membership to its physician, provider, and community committees. Bridgeway clinical staff build personal relationships with professional peers through committee activities and promote ALTCS' Values and Guiding Principles in expanding collaboration between provider types. In addition, Bridgeway sponsors and conducts training and educational conferences for network providers at all levels that create opportunities for face-to-face interaction.

Member Level Collaboration

Case Managers. The role of the Bridgeway Case Manager is to support member self-determination and ensure integration of appropriate, timely services in the most integrated, least restrictive setting possible. This includes educating and engaging members in assessment, goal setting and care planning; supporting member choice of services, settings and providers; communicating member choice in the care plan to all providers; conducting activities such as case conferences where each provider can see the "whole picture" of the members' status and plan; and monitoring the member's condition and communicating changes to treating providers. Because of the high rate of co-morbid physical and behavioral health conditions in our population, as well as the importance of social and other needs to the member's overall well-being, a key feature of Bridgeway case management is our integrated approach to assessment and care planning. For example, we

screen all members, regardless of primary diagnosis, for depression and other indicators of mental health status and behavioral health needs. Our Behavioral Health Coordinator on our case management staff provides input as needed to other Case Managers to ensure appropriate expertise and assist in connecting members to needed behavioral health services. Case Managers also integrate the informal support network into our process, understanding that the well-being of the member is affected by the well-being of the caregiver(s). In addition, Case Managers identify and incorporate needed non-covered services, including Medicare, and community resources into the care plan to address the entire range of the member's needs. The Case Manager helps the member and family/caregiver access all services and supports necessary to meet the member's goals for a satisfying life.

For members receiving psychotropic medications, the Case Manager reviews the medications at the initial assessment and at subsequent reassessments. Each medication is documented in the electronic case file, including purpose, effectiveness, and any adverse side effects that may have occurred. If the member is not stable on his or her psychotropic medications, or these medications are being adjusted, the Case Manager reviews the case with the Behavioral Health Coordinator at least quarterly or as needed. If the Behavioral Health Coordinator identifies concerns (such as ineffective medications or adverse effects), they contact the prescribing practitioner(s) to discuss their concerns and possible measures to resolve the problem. The Case Manager and/or Case Manager Supervisor document these discussions in the electronic case file. Bridgeway uses a psychiatric consultant to conduct polypharmacy reviews, in collaboration with the Bridgeway Medical Director, Director of Pharmacy, and Behavioral Health Coordinator, in order to ensure that members are not prescribed unneeded, ineffective, or contra-indicated medications. When medication concerns are identified, Bridgeway's medical staff directly contact the prescribing physician(s) to provide feedback and education.

PCP Coordination of Specialty, Hospital, and Other Care. The PCP serves as the Medical Home for the member, and is responsible for all primary care services for Bridgeway members. The PCP identifies members' medical needs, assists in coordinating services from specialists, behavioral health practitioners, and other providers, any needed hospital care, and social services as part of the treatment plan. The PCP ensures that members' desire to live at home, in the community, or in a SNF (consistent with the member's condition) are supported by the member's care plan. The Bridgeway Case Manager serves both as a proponent of the member's choices with the PCP, but also assists the PCP in finding resources and ensuring care is delivered. The Case Manager also assists in ensuring that PCPs understand their responsibilities as PCP and Case Managers collaborate with Network Managers on any PCP training needs. Many Bridgeway ALTCS members have special health care needs and their main health care provider may be a physician specialist rather than a traditional PCP, such as PCPs with family practice credentials.

HCBS. Bridgeway invites HCBS providers to participate actively in ensuring the member's care plan meets member needs. Case Managers use case conferences to update providers on member status and to solicit HCBS providers' feedback and suggestions. Open communication between Bridgeway and HCBS providers is critical.

RBHAs. Bridgeway has developed relationships with RBHAs and their providers particularly in rural areas. We continue to strengthen those relationships in the establishment of Medical Homes for members with primary behavioral health conditions.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Bridgeway supports expanding the use of FQHCs and RHCs to ensure access to care for ALTCS members. We also assist FQHCs and RHCs in providing additional services for members where access is an issue.

3. Current Network Gaps and Methodology Identifying Them

3. Current network gaps and the methodology used to identify them;

Current Network Gaps

Summarized below are current network gaps, which are described in greater detail in Question 5 below, where we address **interventions** to mitigate or eliminate these gaps and related **barriers**.

- GSA 40 – Gila, Pinal: Skilled Nursing Facility, Assisted Living Facilities, Inpatient Behavioral Health, Inpatient Hospital, PCP, Podiatry, Physician Specialists, Pharmacy
- GSA 42 – La Paz, Yuma: Medicare Certified Home Health, Skilled Nursing Facility, Assisted Living Facilities, Inpatient Behavioral Health, Psychiatrists
- GSA 44 – Apache, Coconino, Mohave, Navajo: Skilled Nursing Facility, Assisted Living Facilities, Adult Day Health, Hospice, Inpatient Behavioral Health, Inpatient Hospital, Podiatrist, Physician Specialists
- GSA 46 – Cochise, Graham, Greenlee: Assisted Living Facilities, Adult Day Health, Inpatient Behavioral Health, Inpatient Hospital, PCP, Physician Specialists, Podiatrist, Dentist, Pharmacy
- GSA 50 – Pima, Santa Cruz: Assisted Living Center, Adult Day Health, Inpatient Behavioral Health
- GSA 52 – Maricopa: PCP, Adult Foster Care, Assisted Living Centers

Bridgeway does not have any network gaps in GSA 48, Yavapai.

Methodology to Identify Network Gaps

Bridgeway evaluates the adequacy of its network using AHCCCS minimum standards for all long term care, behavioral health, and acute care provider types. We provide a comprehensive network to ensure that members have access, at least equal to or better than community norms, to covered services that are provided promptly and are reasonably accessible in terms of location and hours of operation.

Member-Specific Network Gaps

Network gaps specific to an individual member most often are identified by Case Managers who are seeking specific provider types in a given geographic area or looking for providers with certain linguistic capabilities or cultural background. The methodology for identifying gaps is assessing the member's health and long term care service needs.

Methodologies Applicable to the Four Major Service Types (for Non-Member-Specific Network Gaps)

We describe below key methodologies we use to identify network gaps that are not specific to an individual member, which staff use each methodology, and with what frequency. We incorporate the results of these gap identification methods in our annual, comprehensive Network Development and Management Plan, which is submitted to AHCCCS and to Bridgeway's Quality Management and Performance Improvement Committee (QMPIC). First, we describe methodologies that apply to all four types of covered services, and second, we describe methodologies that apply to only certain of the four types of services.

Bridgeway uses the methodologies described below to identify network gaps, deficiencies, and limitations for all four service types:

1. HCBS services provided in members homes, and alternative residential services (assisted living facilities and other facility types including behavioral health homes)
2. Institutional care (skilled nursing facilities)
3. Behavioral health care
4. Acute care

The Contracting and Provider Relations Committee reviews monitoring results at monthly meetings and reports to the QMPIC, which reviews monitoring data at quarterly meetings. Bridgeway's CEO and six Vice Presidents participate in both committees, providing cross-functional input on identifying network gaps and the following methodologies.

- **Comparing the Network with AHCCCS Minimum Standards.** At least twice a year, the Vice President (VP) of the Provider Services Department, with support from Network Management staff within the Department, compares Bridgeway's network with AHCCCS minimum standards to verify compliance and identify any potential gaps.
- **Evaluating Membership Growth.** Every month, Case Management staff evaluate member enrollment levels and growth in terms of the provider types and provider capacity needed to ensure that members have prompt access to needed services. Specifically, we evaluate caseload data extracted from our case management platform (currently CCMS, soon to transition to TruCare) in conjunction with ongoing feedback from Case Managers during bi-monthly Case Management Team meetings When staff identify a gap, the VP of Long Term Care Case Management (or her designee) confers with appropriate Network Management staff regarding options for filling the gap. Twice a year, the VP of Provider Services, with support from Network Management staff, evaluates membership growth to determine what types of network changes are needed to continue ensuring member access to care.
- **Member Grievances and Provider Complaints Related to Access**. Each month the VPs of Compliance and Provider Services review Bridgeway's report on member grievances, organized by category, to identify potential network gaps and trends indicating limited access to services. The VP of Compliance reports member grievance and provider complaint statistics and trends quarterly to the QMPIC, for their review regarding potential network gaps and other concerns.
- **Member Satisfaction Surveys.** Bridgeway uses member surveys to identify potential network gaps. For example, our Compliance Department coordinated with our Quality Management (QM) Department, with input from all departments, to conduct a cross-functional member survey in 2008 and a follow-up survey in 2010. A major focus of survey questions is whether members believe they have timely access to the types of services they need, including culturally competent provision of services. On receipt of AHCCCS' approval, our Compliance Department administered the survey and reported results to Bridgeway leadership and the QMPIC. Bridgeway anticipates enhancing the survey process by conducting the Consumer Assessment of Healthcare Providers and Systems, or CAHPS member survey, which facilitates benchmarking against a national repository of CAHPS data.
- **Monitoring Languages Spoken by Members.** On an annual basis, the VP of Compliance reviews the languages reported on members' enrollment file to assess the percentage of members who speak given languages, and also analyzes Bridgeway data on use of the telephonic Language Line and in-person interpreter services. Through credentialing and recredentialing, Bridgeway identifies which languages providers speak. Information on the languages spoken by members and providers helps identify potential network gaps relating to linguistic access and cultural competency.
- **Utilization, Including Out-of-Network (OON) Utilization.** Each month Health Economics staff assemble a comprehensive utilization report using claims data. Bridgeway conducts a monthly meeting to analyze and discuss the report and identify immediate follow-up tasks, including pursuing solutions for any potential network gaps identified. The meeting includes Bridgeway's CEO and the VP of each of our six departments, in particular, Provider and Member Services, Case Management, and QM. In addition, Network Management staff review OON utilization monthly to identify trends in provider types and geographic areas that indicate that network expansion for those types or areas would result in lower OON utilization, and to ensure compliance with AHCCCS' OON standards.

Methodologies Applicable to Certain Service Types (for Non-Member-Specific Network Gaps)

Bridgeway uses the methodologies described below to identify network gaps, deficiencies, and limitations for selected service types, from among the four service types identified above. The service types are underlined in the descriptions below.

- **Gap-in-Critical-Services Reports.** The Bridgeway VP of LTC Case Management and her staff use the monthly gap-in-critical-services reports to identify both underperformance as well as potential network gaps in the <u>critical HCBS services, attendant care, personal care, homemaker, and respite services.</u> CM staff remind members and families at each assessment and reassessment visit how to report gaps, what constitutes a gap in service, and their right to secure a back-up caregiver within two hours of any gap occurring.
- **Percentage of Members in Alternative Residential Settings (ARS).** On a quarterly basis, the VP of LTC Case Management reviews the percentage of members in each GSA in ARS and creates or updates our action plan for

decreasing the number of members in ARS below 25% and increasing the number of members who live in their own homes or apartments or with family members. (The goal is to have less than 20% of members in ARS.) The network gaps most associated with transitioning members from ARS to in-home settings are gaps in wraparound services or supported housing services that help members to live independently, particularly members with behavioral health conditions.

- **Surveys on Compliance with Appointment Access and Waiting Time Standards**. QM staff conduct a rolling survey of PCPs, specialists, and outpatient behavioral health providers to determine whether they meet AHCCCS standards for appointment access and waiting time. (Bridgeway's dental subcontractor monitors dental providers for compliance with appointment standards). QM staff use secret shopper methodology for the appointment access survey. They call the provider's office during normal business hours, posing as a Member Services Representative, and request, for example, an urgent care appointment for a member assigned to the provider. Once the office staff provide an appointment date and time, the QM representative identifies the purpose of the call and provides results based on AHCCCS' standards, and may initiate provider education or corrective action if warranted. A trend of noncompliance with appointment access standards for a given specialty may indicate a network gap regarding that specialty. QM staff conduct the survey with the goal of reaching 100% of applicable providers each year.
- **Surveys on Critical Services' Provision of After-Hours Telephone Access.** Case Management staff conduct telephone surveys on HCBS critical service provider compliance with after-hours telephone access standards at least every six months. If issues arise, more frequent surveys are conducted, in accordance with ACOM and Bridgeway policy, and Bridgeway requires corrective action when appropriate. Critical services are attendant care, personal care, homemaking, and respite care.
- **Percentage of Open PCP Panels.** Twice a year, Network Management staff verify the percentage of open PCP panels, and depending on the results, approach PCPs with closed panels about opening them, and/or begin recruiting additional PCPs to join the network.
- **Use of GeoAccess Software for Network Analysis.** Network Management staff have GeoAccess software that can be used either to create a map of the locations of given network provider types (for example, to visualize the distribution of network ARS and SNFs), or to analyze on average how many miles members are from certain behavioral health or acute care provider types. We use GeoAccess annually to verify compliance with AHCCCS' requirement that 95% of members within metropolitan Phoenix or Tucson are within 5 miles to visit a PCP or pharmacy and that members outside metropolitan Phoenix or Tucson (but within Maricopa or Pima County) are within 10 miles to visit a PCP or pharmacy, if such a provider is located within 10 miles and is willing to contract with Bridgeway.
- Because only 15% of ALTCS members are nonduals, and a majority of Bridgeway dual members do not yet participate in our Medicare Advantage Special Needs Plan, GeoAccess has limited utility for meaningful identification of network gaps other than the PCP and pharmacy standards noted above (instead, we use the AHCCCS zone approach). Nevertheless under certain circumstances GeoAccess is a helpful tool and we use it as needed.

Subcontractors

Bridgeway subcontractors for pharmacy, dental, and vision use similar processes to identify potential network gaps. Bridgeway monitors subcontractors through written delegation agreements that specify the content and frequency of network and access related reporting; provide for Bridgeway involvement in quarterly, joint operational meetings with subcontractors; and require at least an annual onsite delegation audit.

4. Immediate Short-Term Interventions When a Gap Occurs

4. Immediate short-term interventions when a gap occurs, including expedited or temporary credentialing

Immediate short-term interventions Bridgeway uses when a network gap occurs and a member needs prompt access to specific services are described below:

Identify the Nearest Non-contracted Provider and Authorize Out-Of-Network (OON) Services

In the event an ALTCS member requires covered services from a specific provider type or specialty that is not available within the travel standard, the Bridgeway Utilization Management (UM) Department authorizes medically necessary covered services by an out-of-network provider until a suitable network provider is available. For non-HCBS services, Case Managers also may offer the temporary option of a network provider who is geographically further away, for example, when a member prefers a provider with whom Bridgeway has had previous experience.

Network Management staff identify potential providers through sources such as listings from provider associations such as the Arizona Health Care Association, specialty medical societies, Bridgeway Case Managers, Member/Provider Councils, established community relationships, and personal recommendations from network providers in the area. Bridgeway monitors non-contracted providers to assess whether they are reasonably anticipated to provide services at our request more than 25 times during the contract year, and maintains relationships with providers who have declined to join the network, to provide a ready source of potential network providers should a network gap be identified. In most instances, Bridgeway Network Managers invite the out-of-network provider to join the Bridgeway network and offer provisional credentialing so the provider is available to all members (rather than being available only to the member whose services were paid OON or who is the subject of the Single Case Agreement).

Case Managers and Member Services staff also ensure member transportation needs have been addressed when arranging coverage for a temporary network gap.

Bridgeway also reviews providers' reasons for declining to join the network to determine if they have a full understanding of Bridgeway's way of doing business, such as excellent claims payment statistics, and accommodations that can be made that would encourage a given provider to join the network. We are optimistic that over time, OON providers who occasionally serve our members will eventually become network providers. Under all circumstances, Bridgeway staff will help the member locate an appropriate network provider whose service delivery is convenient for the member; has no restrictions (such as age limits) that would affect the member; offers the necessary linguistic access; meets the member's cultural and other preferences; and has hours that accommodate the time it will take the member to get to an appointment or has hours that accommodate the member's needs where he or she lives.

In order to address the challenges in home health agency availability in La Paz County, we negotiated a special reimbursement for a nurse from a physician's office in order to meet the needs of a homebound member.

Ask Providers To Accept More Members

Bridgeway Network Management staff approach PCPs, HCBS providers, and others with limited or closed panels and request that they open their panels to a new member or members. For specialists, staff, in concert with the Bridgeway Medical Director, approach network specialists and request that they expand the number of members they will serve or the scope of their services.

Access Providers Near the GSA Borders

Subject to AHCCCS approval, Bridgeway will contract with providers in adjacent GSAs (or states) who are within the travel standard and include such providers in the Provider Directory.

Subcontractors

Bridgeway subcontractors for pharmacy, dental, and vision use similar processes for immediate short-term interventions when a network gap occurs and a member needs prompt access to specific services. Bridgeway monitors subcontractors through written delegation agreements that specify the content and frequency of network and access related reporting; provide for Bridgeway involvement in quarterly, joint operational meetings with subcontractors; and require at least an annual onsite delegation audit.

5. Interventions to Fill Network Gaps, and Barriers to Those Interventions

5. Interventions to fill network gaps and barriers to those interventions

In this section we address first, barriers and interventions that apply across multiple GSAs. We address second, the GSA-specific gaps that were identified in Question 3 of this Plan, along with related interventions and barriers to those interventions.

Interventions Applicable to Gaps Across GSAs

Bridgeway has described below barriers and interventions that affect multiple GSAs:

1. Model to address barriers to members with significant behavioral health conditions living in the community
2. Strategic use of technology to expand rural access to behavioral health and other services
3. Provider engagement and Provider Coaches to promote ALTCS values and most integrated setting
4. Self directed attendant care and spouse as paid caregiver programs
5. Community Transition Services Program

1. Bridgeway's Model to Address Barriers to Members with Significant Behavioral Health Conditions Living in the Community

Barrier

The most significant subpopulation of ALTCS members who now remain in nursing facilities are members with significant behavioral health conditions, such as severe and persistent mental illness (SPMI), dementia with acting out behaviors, traumatic brain injury, and age-related cognitive conditions, as well as certain substance abuse issues. Frequently, such members have not transitioned to home or community settings because the type of housing they need is rare or does not exist and ensuring appropriate services to keep these members safe and stable has been a challenge. This intervention furthers ALTCS' Guiding Principle on maintaining members in the most integrated, least restrictive setting and providing them choice regarding where they live.

Intervention

Bridgeway has developed its integrated behavioral health model for successfully moving these members into settings where they have the supports they need and we are prepared to expand this model to additional GSAs. In the Maricopa GSA, 76% of our members are living in the community, an increase from 60.5% over the past 4 years. In the Yuma/La Paz GSA, with fewer local providers and resources, we have begun implementing our model, and have increased the percentage of members living in the community from 57.4% to 60.3% over the last 4 years. We are confident that Bridgeway's model will enable us to significantly increase the number of members in GSAs such as Pima/Santa Cruz and Yavapai, where now respectively only 65% and 63% of members are in community based settings.

Bridgeway's integrated behavioral health model has three basic components: supported housing to ensure that members have immediate supports where they live, timely and appropriate primary medical care, and wrap around supports that facilitate members' remaining safe in a community setting. We address first housing, then our approach for integrating primary care and wrap around supports.

Increasing Availability of Housing for Members with Serious Behavioral Health Conditions. A key roadblock to moving such members from inpatient and nursing facilities into the community is the lack of appropriate step-down services. We address this by analyzing, by area, how many members who are in nursing facilities and psychiatric hospitals likely can be transitioned to community living. In areas where there is a critical mass of members (which can be as few as 20), we identify providers willing to come into that area to create community based services (including short term and

transitional residential services). We share our analysis regarding expected utilization, and collaborate with providers to establish housing that meets the needs of members with serious behavioral health conditions. The settings include group homes and small ALFs that focus on people whose primary issues are behavioral. Recognizing that in most rural communities the majority of mental health services are provided through RBHA-funded providers, we actively collaborate with providers in the RBHA system to develop these services. The RBHA funded providers have the infrastructure to leverage their resources to best develop these services.

Bridgeway's recent success with Community of Providers Enrichment Services (CPES) demonstrates the strengths of our model. We partnered with CPES (a Cenpatico RBHA-funded behavioral health provider) to create two, new Level II, behavioral health homes for adults with serious behavioral health conditions in Yuma. First we analyzed key service gaps and the need for step-down placements from inpatient behavioral health and nursing facility care to community placement. We then consulted with Cenpatico (the RBHA for Yuma) who coordinated a meeting with CPES to see if they were interested in addressing the service gaps.

CPES agreed to take on this project and worked closely with our staff for close to a year. We provided consultation and education to help CPES anticipate and plan for how to best serve and accommodate types of members we'd identified. CPES accepted our recommendation for building handicap accessible homes, even though that was not a state licensure requirement. Both homes provide psychological services to our members in addition to residential treatment services and employ a nurse to support medication management and help coordinate care for members with medical issues.

One great example of the quality of care CPES provides is a member with SPMI who needed wound care. The member is now doing better than she was in her previous nursing facility placement, and is able to cooperate and participate in her wound care treatment. An example of CPES' commitment to the community is their proactively providing information and education to area residents on the new homes, the members living there, and the type of services provided.

Bridgeway will continually assess and monitor the availability of housing options for members with serious behavioral health conditions in each GSA. We will work in concert with the RBHA in each region to coordinate efforts to obtain additional affordable housing and supported housing in each GSA as needed.

Integrating Medical and Behavioral Care for Members with Behavioral Health Conditions. We are excited about the opportunity to introduce a new medical and behavioral health integration program for members with behavioral challenges. The Bridgeway Integrated Care Program will provide incentives to providers to manage costs and improve outcomes. Bridgeway will solicit and identify Medicare-certified medical and behavioral health providers in each GSA to participate in the program. Bridgeway Provider Coaches (discussed below) will give technical assistance to providers enrolled in the program to develop local integrated service delivery relationships between medical providers and behavioral health providers in keeping with ALTCS values. Recognizing that the majority of the behavioral health expertise in rural communities is managed through RBHA funded behavioral health providers, Bridgeway will partner with the RBHA-contracted behavioral health agencies in each GSA to forge effective working partnerships between the Bridgeway contracted medical providers and the behavioral health providers in each GSA. As each county is different with unique challenges and resources, we will forge partnerships based on the resources in each community. The partnerships will include the continuum of care in each county, including behavioral health agencies, PCPs, assisted living facilities, and nursing facilities. These medical/behavioral partnerships will be forged, formalized and maintained through the Bridgeway Contracting and Member and Provider Services Department.

Bridgeway has already developed the primary care component of our model for rural communities. We plan to bring physicians into behavioral health clinics to serve as the Medical Home for members with serious behavioral health conditions. We will bring a Case Manager to the behavioral health clinic to facilitate access to services including wrap-around services and coordination of care. Bridgeway has successfully implemented this model in Yavapai County for members with SPMI. Recognizing that ED utilization by members with SPMI was increasing significantly in Yavapai County, Bridgeway arranged with the local RBHA for PCPs to see members with SPMI at a behavioral health clinic (West Yavapai Guidance Clinic). The coordination of behavioral health and medical care reduced ED utilization by these members.

The management of mental health issues plays a critical role in helping people live successfully in non-institutionalized settings. In addition, medical costs are significantly driven by mental health distress. Distressed patients use twice as much health care as non-distressed patients, resulting in increased costs associated with overuse of Emergency Departments, medical tests, prescriptions and hospital stays. Integrating medical and behavioral care has enormous potential to reduce the total cost of care. Since Medicare members can seek care from any Medicare certified provider and about 85% of ALTCS members have Medicare coverage, integrating care can be challenging. Bridgeway will tackle this issue by developing incentives that encourage ALTCS members with behavioral challenges, including SPMI, to seek care through the Bridgeway Integrated Care Program. Bridgeway will incentivize members to enroll in the Bridgeway Integrated Care Program by providing one stop shopping for members, wellness incentives, rapid access to specialists, and enhanced crisis management services. We will incentivize providers to participate in the Bridgeway Integrated Care Program through a higher reimbursement rate, a financial incentive pool tied to reduced utilization of out-of-home care and polypharmacy, and increases in the percentage of persons under their care living in non-institutionalized settings.

As part of Bridgeway's Integrated Care Program, Bridgeway is transforming its Behavioral Health Clinic in Tucson into a Medical Home with Behavioral Expertise. Bridgeway is partnering with the University of Arizona to co-locate the Medical Home on their campus in Tucson so that members will have access to the full range of behavioral health and medical services. This Medical Home will provide an integrated medical and behavioral clinic, offer enhanced crisis services and collaborate with the University of Arizona Tucson Medical Center to reduce utilization of Emergency Department and inpatient days for behavioral health reasons. In addition, we expect the clinic to take a lead in collaborating with the Arizona Health Information Exchange to facilitate comprehensive access to utilization and other data for our dual eligible members.

Our partnership consists of Bridgeway's Behavioral Health Clinic (which was acquired from Pima County on Jan 1, 2011), the University of Arizona Medical School's Dr. William Christ, VP of Health Affairs (leading the collaboration), along with Dr. Francisco Moreno, Chair of the Department of Psychiatry of the University Physicians Healthcare Group (UPH); Diane Rafferty, CEO of the UPH Psychiatric Hospital; Dr. Patricia Harrison-Monroe, Chief of Behavioral Health at the UPH Hospital; Dr. Mindy Fain, Chief, Geriatrics and Gerontology, Co-Director, Arizona Center on Aging; and Honey Pivirotto, Pima County Assistant County Administrator for Health Policy.

This new Medical Home will create a one-stop shop that will allow members to transition out of inpatient psychiatric services after a crisis, and into clinic based services. Our members will have access to acute medical services through the teaching hospital physicians. Our Case Manager will be onsite at the clinic to facilitate service coordination. The Arizona Center on Aging will make psychiatric nurse practitioners available to do home visits for behavioral health needs when appropriate. Together, these entities will provide a Medical Home for members with serious behavioral health conditions. The overarching vision is for this collaboration to become a research center for geriatrics and long term care. At the national level, we expect to become a center of excellence for best practices and outcomes in long term care. Bridgeway will also develop a similar Medical Home in Maricopa County.

2. Strategic Use of Technology to Expand Rural Access to Behavioral Health and Other Services

Barrier

Much of Arizona is rural and some areas are remote. In most rural areas the population is not large enough to support the type of behavioral health provider community needed by many ALTCS members, particularly with regard to psychiatric services.

Interventions

Bridgeway will strategically use technology to expand access to behavioral health services and increase behavioral/medical integration in each GSA served. Technology will include expanded telemedicine capability, video-conferencing and web-based training via laptop, telemonitoring, and our On-Demand In-Home Video Pilot (in partnership with Microsoft Corporation). These interventions will facilitate greater access to psychiatry, preventive and specialty care, and training opportunities, and enhance coordination of care.

National Psychiatric Expertise via Telemedicine. Telemedicine is an important network asset because so much of Arizona is rural. We believe it has great potential to increase access to onsite medication management for members with behavioral health conditions in rural areas. Bridgeway's affiliate Cenpatico has demonstrated the value of psychiatric telemedicine in rural areas over the past four years and we will model our program on their best practices. Cenpatico's network of psychiatrists and psychiatric nurse practitioners currently collaborate through telemedicine to provide services to members of all ages. Cenpatico provides five telemedicine sites in Yuma County, two sites in La Paz County, three sites in Gila County, five sites in Pinal County, four sites in Graham County, four sites in Cochise County and two sites in Graham and Greenlee Counties.

Cenpatico's contractor, Adapt TeleHealth, Inc. connects psychiatrists to rural communities via telemedicine. Adapt Telehealth identifies psychiatrists from around the country with specialized training in behavioral health, helps them get licensed to practice in Arizona, and builds contractual relationships with Cenpatico outpatient providers to deliver psychiatric and consultation services. Many of the psychiatrists are board certified in a behavioral health specialization, bringing expertise to rural areas that would not otherwise be available in those communities. For example, over time we expect that use of telemedicine in nursing homes, especially for oversight of psychiatric medication management, will facilitate a faster transition of our members to community living. Adding Adapt Telehealth psychiatrists to the Bridgeway network will greatly increase the number of psychiatrists available to members and their local providers in rural communities and increase access to experts for all ALTCS members. We also will use telemedicine to connect rural providers to psychiatrists at the planned Geriatric Center of Excellence at the University of Arizona (described above).

Secure Video Conferencing via Laptop for Services and Training. Bridgeway will use secure video conferencing and webinars to provide training and consultation opportunities for members, family members, assisted living centers, nursing facilities, and PCPs. Bridgeway will contract with Recovery Help, LLC to implement a remote access behavioral health and substance abuse services program to assist ALTCS members in living successfully in their communities. Recovery Help provides laptops that use secure video conferencing to bring resources to where the member is living and to staff and family members at times that are convenient to their schedules. Recovery Help, LLC provides opportunities for therapeutic interventions including Functional Behavioral Assessments and Interventions. We can reach any location with an internet connection, and cell phone connections are available in areas that do not have landline internet connections. This technology will help members, families, assisted living facilities, and nursing homes, particularly in rural areas, learn ways to manage behaviors and help reduce the utilization of Emergency Departments, hospitals and other higher levels of care. In addition, Bridgeway will offer training through webinars and web-based training, including in connection with the University of Arizona center of excellence.

Telemonitoring. We use in-home telemonitoring equipment for certain medically fragile members in rural areas, to enable early intervention if their condition deteriorates, prevent unnecessary utilization of emergency services and higher levels of care, improve self-management skills, improve control of chronic conditions, and achieve more stability in natural setting (home or assisted living facility). Bridgeway's Medical Management/Utilization Management Committee evaluated the effectiveness of the telemonitoring program, most recently in February 2011. As of February 1, 2011, there were 25 members enrolled in the program, with an average participation period of 10.4 months. These members have had a total of 17 inpatient admissions while enrolled (0.68 admissions per member). These members had a total of 98 inpatient admissions during the 12-month period prior to participation (3.92 admissions per member). The program therefore yielded an annualized **80.1%** reduction in inpatient admissions per year for participating members.

As an example, in October 2010, a Case Manager identified a member with co-morbid diabetes, hypertension and cardiopulmonary disease who had 14 ED visits and inpatient admissions in the previous 9 months. Previous attempts to stabilize his condition included discharge to a skilled nursing facility for more intense monitoring and subsequent transition home from the nursing facility with home health services. Recognizing that this pattern of need for acute services was persistent, the Case Manager enrolled the member, with his agreement, in the telemonitoring program for home monitoring of blood sugar, blood pressure and oxygen saturation. He has had only one inpatient admission and zero ED visits in the four months since he enrolled in the program. The program has also demonstrated an improvement in member self-care (or care by caregiver). At members' entry to the program, their average rate of compliance with recommended self-monitoring (blood sugar, blood pressure, weight, blood oxygen saturation) was 27%. It is currently at 63%.

On-Demand In-Home Video Pilot, Beginning in the 4th Quarter of 2011, and through a partnership with the Microsoft Corporation, we are piloting our On-Demand In-Home Video Pilot between Bridgeway equipped ALTCS members (with

member consent) and Bridgeway's staff of LTC Case Managers. With this exciting pilot, we hope to demonstrate how the on-demand video conferencing can increase the frequency and augment the quality of member contact with our Case Managers. We expect the pilot will extend our reach to members in rural areas and increase communication and timely opportunities for member education.

3. Provider Engagement and Provider Coaches to Promote ALTCS Values and Most Integrated Setting

Barrier

Many assisted living, nursing facilities, and other providers lack the expertise to put into practice AHCCCS and ALTCS' values of choice, independence, and self-determination, and to collaborate in facilitating members' living in the most integrated, least restricted setting.

Interventions

Bridgeway has a four-prong approach to engage providers to incorporate ALTCS' values in their interaction with members and service delivery. First, at the member-specific level, Bridgeway Case Managers engage members, families and providers in developing individualized treatment planning geared toward helping members live in the least restrictive setting, as independently as possible. Second, our Network Managers provide technical assistance to providers to ensure contract compliance, conduct administrative audits, and assist with billing questions. In addition, Network Managers identify PCPs who want to develop expertise in serving ALTCS members and make arrangements for them to receive clinical and technical assistance to develop that expertise. Third, Bridgeway will employ Provider Coaches who assist providers to put into practice ALTCS' values and provide and develop services, programs, and approaches that help members live in the least restrictive environment possible. Provider Coaches will deliver training, technical assistance, program guidance and "hands on coaching." Fourth, Bridgeway will use evidence based, motivational interviewing techniques to engage providers as individuals to achieve their goals as well as ALTCS' goals. The first two prongs are addressed elsewhere in the Network Development and Management Plan. Here we address primarily the third and fourth prongs.

Provider Coaches. Bridgeway Provider Coaches will report to the Vice President of Case Management. Their initial focus will be on assisted living and nursing facility training, and supporting Bridgeway's Integrated Care Program (discussed above). While Case Managers engage providers at the level of individual members and their needs, Provider Coaches will focus on the residential environment level, across members living in the facility, and on opportunities to improve consistency of provider services with ALTCS values, particularly member choice, independence, and self-determination. Bridgeway has modeled the Provider Coach position on the successful experience of our affiliate Cenpatico in using Provider Coaches to increase and measure behavioral health providers' use of strengths based, culturally competent service delivery methods.

Bridgeway Provider Coaches may assist with direct care workforce development activities. They also will support as needed the Medical Director's peer-to-peer consultation with PCPs who want to develop expertise in serving ALTCS members, including seeing members where they live.

Provider Engagement. Because our Providers' performance is critical to our success, we approach them through a culture of engagement. All staff are trained in provider engagement techniques. We will engage our providers (assisted living and nursing facility, HCBS, PCPs, psychiatrists, and others) using evidence based motivational interviewing techniques, such as expressing empathy and avoiding arguing, rolling with resistance, and supporting self-efficacy (provider's belief they can successfully make a change in the lives of the people we serve). We will use motivational interviewing techniques to help providers and members address chronic conditions such as diabetes, cardiovascular conditions, substance use disorders, and asthma and make positive behavioral changes to support better health. We also will use these techniques to help providers, members and families overcome behaviors that disrupt living environments and cause persons to be placed in higher levels of care. Through supporting our providers we will continue to develop systems that integrate medical and behavioral care and meet our goal of increasing the percentage of persons living in non-institutional settings in each GSA.

One example of Bridgeway's provider engagement involved our persuading and assisting a home health agency in Yuma to obtain Medicare certification. The only Medicare-certified provider was no longer taking members due to their large private pay caseload. We approached a local provider of non-skilled, home based services about filling this gap. The owner was hesitant at first because of the requirements, cost and level of effort to achieve Medicare certification. With our

support, she agreed to proceed. We helped her work through the financial, infrastructure, and time commitments required as well as projecting future business opportunities. We also provided a start-up loan to address capital reserves. The agency, Angels PRN, passed the survey and began providing skilled nursing and rehabilitative services last summer with the award of Medicare certification.

A second example is that Bridgeway has negotiated a quality incentive program for Covenant Network Nursing Home Providers that is based on Medicare Nursing Facility Quality Indicators such as avoidable wounds and resident satisfaction. The Bridgeway quality incentive program rewards Covenant facilities that have statistically significant Bridgeway membership with a year-end bonus payment for exceeding quality targets.

4. Self Directed Attendant Care and Spouse as Paid Caregiver Programs

Barrier

Home care options are more limited in rural than in urban areas. In addition, attendant turnover and the lack of continuity inherent in receiving services from multiple attendants can lead to less consistent care as well as member frustration and dissatisfaction.

Interventions

Bridgeway Case Managers encourage members to participate in shaping their service delivery to the greatest extent possible, including choosing their caregiver and educating them regarding service needs. When members have the option of their spouse or a family member serving as a paid caregiver, or the member functioning as employer of a caregiver of the member's choosing, there is greater potential for members to retain that caregiver for a longer period of time. The Self-Directed Attendant Care Program empowers members to focus on their needs and engage in determining how their needs can best be fulfilled, typically leading to increased satisfaction and sense of well being.

Having a spouse or family member serve as paid caregiver can help relieve stress and enhance and even stabilize the long term personal relationship between the member and caregiver. Because Case Managers use the same assessment tools and approach for family members as paid caregivers as for agency caregivers, we have not experienced an overall increase in use of services since the program began. For the spouse or family member, receiving caregiver training and being part of an agency enhances confidence in providing care and support for modifying how care is provided when the member's needs change.

Both the Self Directed Attendant Care and Spouse as Paid Caregiver Programs serve to fill network gaps in rural areas where the range and availability of HCBS in-home services is relatively limited compared to urban areas. For example, 52% of Bridgeway members receiving attendant care now use paid spouse or family caregivers. In rural areas, this level of utilization increases the availability of traditional agency caregivers for members who do not have family who can provide direct services in the home.

5. Community Transition Services Program

Barrier

Members moving from an institutional setting to their own home or apartment frequently lack funds for important transition expenses such as security or utility deposits, essential furnishings, and other items.

Interventions

Bridgeway fully supports AHCCCS' new Community Transition Program. Our Case Managers are identifying members who meet Program criteria and assessing such members for their potential use of Program benefits. To administer Program benefits in Maricopa County, we will use ABIL, the Arizona Bridge to Independent Living. In the Yuma/La Paz GSA, we will use Accent Care at Home. In Pima County we will use the Pima Council on Aging, and in Santa Cruz County we will use the SouthEastern Arizona Governments Organization, known as SEAGO.

GSA-Specific Network Gaps, Interventions, and Barriers

Described below are GSA-specific network gaps, interventions, and barriers.

Pinal, Gila Counties, GSA 40

HCBS Long Term Care

- **Gap:** Assisted living homes (ALH) in Pinal County. **Specific Interventions:** We have a number of LOIs from Assisted Living Homes across the county. Lita Caring Home and Lita Caring Home II signed a contract however; we have yet to receive it. They are currently out of town and are unable to send an LOI prior to the RFP submission. We expect to have their contract or LOI by April 1, 2011. **Barriers:** There are no barriers as we have a willing provider, just unable to secure agreement prior to RFP deadline.

Institutional Long Term Care

- **Gap:** Skilled nursing facilities (SNFs) in Globe, Miami or Claypool in Gila County. **Specific Interventions**: We have a contract with Heritage Health Care Center (LifeCare) in Globe, along with LOIs with Rim Country Health and Payson Care Center. We have not heard back from Copper Mountain Inn and will continue outreach to secure a contract that would fulfill the requirement for this area. **Barriers:** Limited number of SNFs in the area.

Behavioral Health

- **Gap:** Inpatient services in Gila County. **Specific Interventions**: These services are readily available in Pinal and Maricopa counties. **Barriers:** There is no inpatient psychiatric hospital in Gila County.

Acute Care Services

- **Gap:** PCP in Florence in Pinal County. **Specific Interventions:** We secured LOIs from several PCPs in neighboring San Tan Valley, Eloy and Coolidge. We also have numerous contracts with PCPs in adjacent Maricopa and Pima counties. We will continue to pursue primary care providers in Florence to secure contracts and fulfill this requirement prior to October 2011. **Barriers:** There are a limited number of PCPs in Florence.
- **Gap:** Physician specialists in Gila County (Rectal Colon Surgeon, Endocrinology, Nephrology, Oncology, Ophthalmology, Plastic Surgery, Pulmonology and Urology). **Specific Interventions:** Bridgeway has contracts with a number of specialists in Maricopa, Pinal and Yavapai Counties**.** Members in the southern part of the county have access to specialists in neighboring Pinal and Maricopa County. Members in the northern part of the county have access to providers in neighboring Yavapai County. We will continue to pursue contracts with the above specialists in Gila County to fulfill requirements prior to October. **Barriers:** There are a limited number of specialists in the county.
- **Gap:** Physician specialists in Pinal County (Endocrinology, ENT, Neurology, Nephrology, Plastic Surgery and Rheumatology). **Specific Interventions:** We have contracts with providers in each of the above specialties in neighboring Maricopa and Pima counties to serve members in Pinal County. Additionally, we will continue to pursue contracts with providers in the above specialties prior to October. **Barriers:** There are a limited number of specialists available in this county.
- **Gap:** Podiatrist in Gila County. **Specific Interventions:** Bridgeway is contracted with providers in neighboring Maricopa and Yavapai counties for members to access. **Barriers:** There are a limited number of podiatrists in the county.
- **Gap:** Inpatient hospital in Pinal County **Specific Interventions.** We secured a contract from Florence Community Healthcare and Banner Ironwood Medical Center (San Tan Valley), which both cover the east side of Pinal County. We spoke with Casa Grande Regional Medical Center however, they would not sign an LOI indicating they had already completed LOIs for other health plans and were not interested in signing another. **Barriers:** Casa Grande Regional Medical Center is the only hospital in Casa Grande.
- **Gap:** Pharmacy in Hayden/Winkleman in Gila County. **Specific Interventions:** We will review for mail-order pharmacy. **Barriers:** There are no available pharmacies in these two areas.

La Paz, Yuma Counties, GSA 42

HCBS Long Term Care and Institutional Long Term Care

- **Gap.** Medicare-certified home health agencies in La Paz County. **Specific Interventions.** We have contracted for home health services with Sandra Walters, RN, who is registered with AHCCCS although she is not Medicare certified. In Yuma, Bridgeway assisted a non-Medicare certified home health agency to become Medicare certified. The provider, Angels, PRN, is now able to submit claims for our Medicare primary members (however this provider does not serve La Paz). We continue contract discussions with the only Medicare-certified home health agency in Yuma, however, their capacity is quite full with private pay and commercial insurance patients. **Barriers.** Availability Medicare-certified home health agencies in La Paz County.

- **Gap.** Adult foster care. **Specific Interventions.** We will identify alternative placements for members until this provider type is available in these counties. **Barriers.** There are no adult foster care providers in Yuma or LaPaz Counties.
- **Gap.** ALFs and SNFs in LaPaz County as there are no providers. **Specific Interventions.** We have contracted with SNFs and ALFs in Mohave county in Lake Havasu City and Kingman. We continue with recruiting efforts with an assisted living center in Havasu for our wandering dementia members in La Paz County. We recently helped create and have executed a contract for two behavioral health Level II behavioral health residential homes in Yuma, Vista del Rio and Vista del Sol. One of the ALCs in Yuma is considering building a locked dementia with behaviors unit. **Barriers.** Insufficient LTC provider types in the counties.

Behavioral Health

- **Gap.** Access to sufficient psychiatrists and other behavioral health practitioners. **Specific Interventions.** Community Intervention Associates provides psychiatric services. We have persuaded a Maricopa provider to travel to Yuma to assist in coverage. We are working on a proposed contract with ADAPT, a tele-psychiatry organization, to expand psychiatric services for the Yuma/La Paz GSA. **Barriers.** Insufficient psychiatric providers in these counties.
- **Gap.** Inpatient behavioral health in Yuma and La Paz Counties. **Specific Interventions.** These services are readily available in Maricopa and Pima Counties. **Barriers:** There are very limited inpatient psychiatric services in Yuma and La Paz Counties (72-hour observation has been provided through Mountain Health & Wellness in Yuma).

Apache, Coconino, Mohave, Navajo Counties, GSA 44

HCBS Long Term Care

- **Gap:** Adult day health provider in Coconino, Navajo, and Mohave Counties. **Specific Interventions:** We will open discussions with Lutheran Social Services and Catholic Community services to expand into this county. **Barriers:** Limited number of Adult Day Health providers registered with AHCCCS.
- **Gap:** Hospice is Apache County. **Specific Interventions:** We would open discussions with Hospice Compassus to request expansion of services into Apache County. **Barriers:** There are no available hospice providers.
- **Gap:** Assisted living facilities in Mohave County. **Specific Interventions:** The majority of providers would not sign the LOI but agreed to participate in our network if we are awarded the GSA. We feel confident in our ability to fulfill the network requirements prior to October. **Barriers:** There are no barriers.

Institutional Long Term Care

- **Gap:** SNF in Flagstaff in Coconino County. **Specific Interventions**: The Peaks would not sign an LOI, however, they will consider contracting with Bridgeway if we are awarded the county. **Barriers:** There are no barriers; we anticipate a contract with this provider to fulfill the requirement for two SNFs in the Flagstaff.

Behavioral Health

- **Gap:** Inpatient services in Apache and Navajo Counties. **Specific Interventions:** These services are readily available in surrounding counties. **Barrier:** There is no inpatient psychiatric hospital in Apache and Navajo Counties.

Acute Care Services

- **Gap:** Specialists (Endocrinology, Rheumatology, Plastic Surgery, Ophthalmology and Urology) in Coconino County. **Specific Interventions**: We are contracted with several providers in neighboring Yavapai County. Also, we will continue to pursue contracts with providers in Coconino in the above specialties. **Barriers:** There are no barriers.
- **Gap:** Specialists (ENT, Endocrinology, Oncology, Neurology and Rheumatology) in Mohave County. **Specific Interventions**: We will transport members to closest metropolitan provider for services. We will also continue to pursue any specialists in the area. **Barriers:** There are a limited number of specialists in this county.
- **Gap:** Specialists in Navajo and Apache Counties. **Specific Interventions**: We will transport members to the closest metropolitan provider for services. We will also continue to pursue specialists in the area. **Barriers:** There are a very limited number of specialists in these counties.
- **Gap:** Podiatrist in Apache County. **Specific Interventions:** Bridgeway is contracted with providers in neighboring Navajo county. Also, Bridgeway will continue to pursue contracts with podiatrists in the county. **Barriers:** There are a limited number of podiatrists in the county.
- **Gap:** Inpatient Hospital in Mohave County. **Specific Interventions:** When necessary, we will utilize Havasu Regional Medical Center and encourage their participation in the network. **Barriers:** Havasu Regional Medical Center is the only hospital in Lake Havasu City.

Cochise, Graham, Greenlee Counties, GSA 46

HCBS Long Term Care

- **Gap.** Assisted living facilities in Cochise, Graham and Greenlee County We received a total of eight LOIs from assisted living facilities; others did not want to sign an LOI but agreed that upon award they would discuss contracting with us. **Specific Interventions.** We feel confident that the minimum requirements would be met after Contract award. Providers are very willing to work with Bridgeway. **Barriers.** None if awarded the GSA.
- **Gap.** Adult day care in Cochise, Graham and Greenlee County. **Specific Interventions.** We will open discussions with Lutheran Social Services and Catholic Community Services for their expanding to other counties. **Barriers.** Licensed Adult Day Health providers who are registered with AHCCCS.

Behavioral Health

- **Gap:** For Cochise, Graham and Greenlee Counties, gaps exist for inpatient services. **Specific Interventions.** This service is available in the surrounding counties of Pima, Pinal and Maricopa. **Barriers.** There are no inpatient psychiatric hospitals in any of the three counties.

Acute Care Services

- **Gap.** We have specific gaps in dentistry, podiatry, physician specialists, and hospital in Benson, and PCP in Willcox. **Specific Interventions.** We are confident that these gaps will be filled as most providers stated that they would discuss contracting with the health plan that was awarded the area. **Barriers.** None if awarded the GSA.
- **Gap.** Pharmacy in Greenlee County. **Specific Interventions**: We will work with US Script to secure a pharmacy contract in this county. **Barriers**: None if awarded GSA.

Yavapai County, GSA 48

For Yavapai County, no gap in services exists. Members have access to all services.

Pima, Santa Cruz County, GSA 50

HCBS Long Term Care

- **Gap.** Assisted living center in Northwest Tucson Zone of Pima County. **Specific Interventions.** The network standard is to have two ALCs in this zone. We currently have only one; we have had a long standing relationship with them. We recently contacted all other licensed ALCs in the zone. One is licensed for Supervisory Care only. We explored their willingness to obtain a license at either the Personal Care or Directed Care level, but they were not interested. All other ALCs in the zone indicated that they are strictly for private pay residents, and stated that they did not want to participate in the AHCCCS/ALTCS program at this time. **Barriers.** There is only one ALC in the Northwest Tucson zone that is willing and able to participate in the AHCCCS/ALTCS program. We will continue to survey Northwest Tucson for any willing and qualified ALCs.
- **Gap.** Adult day health center in Santa Cruz County. **Specific Interventions.** There is currently no licensed adult health center located in Santa Cruz County. We are able to offer several other options to members to provide socialization and respite. These include group respite available at one of three contracted assisted living homes, congregate meals program offered by Santa Cruz Council on Aging, and participation in Casa de Esperanza's adult day health program in Green Valley, Arizona which is about 15 miles from Santa Cruz County. For behavioral health services, Southeastern Arizona Behavioral Health Services offers a variety of outpatient behavioral health services in Santa Cruz. Easter Seals Blake provides habilitation services including for members with behavioral health problems. **Barriers:** Availability of a licensed adult day health program in Santa Cruz County. We will continue to partner with stakeholders such as SEAGO (Area Agency on Aging) and prospective providers that may be willing to develop an adult day health center in the area.

Behavioral Health

- **Gap:** Inpatient services in Santa Cruz County. **Specific Interventions.** Members have access to inpatient psychiatric services in Pima County. **Barriers:** There is no inpatient psychiatric hospital in Santa Cruz County.

Maricopa County, GSA 52

HCBS Long Term Care

- **Gap** Inadequate number of adult foster care providers. **Specific Interventions.** We have contracted with 42 AFCs throughout Maricopa County. We will continue with recruiting efforts to secure additional providers. **Barriers.** Several AFCs did not meet insurance liability requirements due to cost; preventing them from participating in the Bridgeway network. Other AFCs re-licensed as an Assisted Living Home, leaving fewer AFCs in the county. One

AFC signed an LOI only to discover their AHCCCS ID was terminated and could not be reinstated in time for the RFP.

- **Gap.** Inadequate number of ALCs in Zone 6 and Zone 7. **Specific Interventions.** We have a considerable number of ALCs contracted in zone 6, however we continue to recruit as there were a few ALCs we have not been able to reach agreement. **Barriers.** In Zone 6 several ALCs are not accepting LTC members, while others indicated they are self pay only. In Zone 7, the remaining ALCs are all private pay.

Acute Care Services

- **Gap.** PCP in El Mirage. **Specific Interventions.** We have a significant number of PCPs contracted in Surprise which is less than 4 miles from El Mirage. Additionally, we have a PCP in Youngtown, approximately 3.5 miles from El Mirage. **Barriers.** Limited availability of PCPs in this city.

Subcontractors

Bridgeway subcontractors for pharmacy, dental, and vision use similar interventions when a network gap occurs to fill the gap and ensure access to covered services. Bridgeway monitors subcontractors through written delegation agreements that specify the content and frequency of network and access related reporting; provide for Bridgeway involvement in quarterly, joint operational meetings with subcontractors; and require at least an annual onsite delegation audit.

6. Outcome Measures/Evaluation of Interventions

6. Outcome measures/evaluation of interventions

Tools for Planning and Evaluating Interventions to Fill Network Gaps

Bridgeway plans and evaluates interventions to fill network gaps primarily through our quality committee structure. Bridgeway conducts monthly evaluation through the **three Bridgeway committees that address network issues,** and quarterly evaluation through the **Quality Management and Performance Improvement Committee** (QMPIC), to which the other committees report.

Regarding the three network related committees, the **Contracting and Provider Relations Committee** (Contracting Committee), addresses HCBS, institutional long term care (LTC), and all acute care services except pharmacy services. The Contracting Committee assesses network adequacy and the effectiveness of interventions, using both data and member and provider feedback from several Bridgeway departments. In addition, the **Behavioral Health Committee and Pharmacy and Therapeutics Committee** address, respectively, behavioral health and pharmacy network adequacy (among other behavioral health and pharmacy issues).

The Contracting Committee membership includes Bridgeway's CEO and the Vice Presidents (VPs) of the six Bridgeway departments (collectively referred to as the Leadership Team, which includes the VP of the Contracts and Member and Provider Services Department (Provider Services Department)), the Manager and Supervisor of the Provider Services Department, and, depending on the agenda, various Network Managers in the Provider Services Department. The QMPIC includes the Leadership Team and designated representatives from the Bridgeway departments, such as the Director of Pharmacy

Annually, the Contracts and Member and Provider Services Department (Provider Services Department) updates its comprehensive, written **Network Development and Management Plan** (Network Plan). One component of the Network Plan is an evaluation of the prior year's Plan, which includes information on the success of interventions and potential need for re-evaluation or modification of those interventions.

Outcome Measures

In addition to comparing the network with AHCCCS standards in the ACOM, Bridgeway measures access using the following key outcome measures

1. Low rates for gaps in service for the four critical HCBS services
2. High percentage of HCBS providers compliant with after-hours phone access standards
3. Less than 20% of membership in ARS
4. Appropriate percentages of members residing in home settings, ARS, and SNFs, in light of population characteristics such as age, medical complexity, and type of behavioral health conditions
5. Low rates for member grievances and provider complaints related to access, including linguistic access and culturally competent services
6. High rates for member satisfaction
7. Low OON utilization rates
8. High percentage of **applicable** providers compliant with appointment accessibility and wait time standards
9. High percentage of open PCP panels

The various Bridgeway departments compile data on these outcome measures, normally, monthly, quarterly, bi-annually, or annually, depending on the nature and use of the data.

Plan for Developing and Evaluating Interventions to Fill Network Gaps

The table below constitutes Bridgeway's plan for evaluating interventions to fill network gaps. The plan shows:

- The frequency for generating specific outcome measures and the department responsible for generating them
- The additional Bridgeway activities, such as key Committee meetings and analysis, conducted to ensure ongoing evaluation of the effectiveness of interventions to fill network gaps, the frequency of those activities, and responsible parties

Frequency	Activity	Main Staff Responsibility
Weekly or Bi-Weekly	Staff Meetings – Provider Services weekly, and Case Management bi-weekly	Provider Services Department and Long Term Care (LTC) Case Management Department; staff from LTC Case Management contact Provider Services Department staff if immediate or prompt action is needed to fill a gap
	Leadership Team meetings – Weekly; the Team addresses network issues on an as needed basis during these meetings	CEO chairs the meetings, which include the VPs from all six Bridgeway departments and Human Resources Director
Monthly	Contracting and Provider Relations Committee meetings	Provider Services Department
	Behavioral Health Committee meetings	LTC Case Management Department and Provider Services Department
	Pharmacy and Therapeutics Committee meetings	Quality Management Department
	Gap-in-critical-services reports	LTC Case Management Department
	Measuring the relative percentages of members in HCBS and institutional levels of care, in light of population characteristics, such as age and complexity of members' condition	LTC Case Management Department
	Member grievances and provider complaints related to access	Operational Services and Compliance Department
	Evaluating membership growth - Case Management Department, monthly, and Provider Services Department, bi-annually	LTC Case Management Department and Provider Services Department
	Utilization analysis, including out-of-network (OON) utilization; recruiting OON providers to join the network	Provider Services Department analyzes OON utilization; other analysis is supported by other departments
Quarterly	Quality Management and Performance Improvement Committee meetings	Medical Director chairs the Committee; VPs from all six Bridgeway departments are on the Committee
	Measuring percentage of members in alternative residential settings (ARS)	LTC Case Management Department
Bi-Annual	Comparing the network with AHCCCS minimum standards	Provider Services Department
	Surveys on HCBS critical service provider compliance with after-hours telephone access standards (if issues arise, more frequent surveys are conducted, per ACOM and Bridgeway policy)	Case Management Department
	Measuring percentage of open PCP panels	Provider Services Department
Annual	Written Network Development and Management Plan, and evaluation of the Plan	Provider Services Department, with support from other departments as appropriate
	Surveys on compliance with appointment access and waiting time standards, for applicable provider types (if issues arise, more frequent surveys are conducted on affected providers)	Quality Management Department
	Member satisfaction surveys	Operational Services and Compliance Department and Quality Management Department
	Monitoring languages spoken by members	Operational Services and Compliance Department
	Measuring Maricopa and Pima Counties PCP and pharmacy access with GeoAccess software (and on an needed basis, conducting any other similar network analysis)	Provider Services Department

Subcontractors

Bridgeway subcontractors for pharmacy, dental, and vision use similar outcome measures and processes for evaluating interventions. Bridgeway monitors subcontractors through written delegation agreements that specify the content and frequency of network and access related reporting; provide for Bridgeway involvement in quarterly, joint operational meetings with subcontractors; and require at least an annual onsite delegation audit.

7. Ongoing Activities for Network Development

7. Ongoing activities for network development based on identified gaps and future needs projection

Bridgeway maintains a strong provider network and continues to pursue additional provider capacity, based on identified gaps and future needs projections, as described in detail in the previous Questions. Current ongoing network development includes:

- Continuing and expanding the key interventions identified in Question 5:
    - Model to address barriers to members with significant behavioral health conditions living in the community
    - Strategic use of technology to expand rural access to behavioral health and other services
    - Provider engagement and Provider Coaches to promote ALTCS values and most integrated setting
    - Self directed attendant care and spouse as paid caregiver programs
    - Community Transition Services Program
- Securing additional specialty providers including behavioral health providers, and physicians who provide care to members in their home or in ARS or SNFs
- Training network providers on administrative processes such as EDI and EFT as well as clinical and case management philosophies
- Obtaining input from its advocacy groups and member representatives for expanding the network
- Using conferences that providers attend as opportunities to recruit providers and to network with providers
- Promoting direct care workforce development and increasing professionalism among long term care workers
- Participating in conferences held by associations and community agencies; arranging for and sponsoring speakers at such conferences; getting to know members of the associations and agencies and understanding their issues and concerns; Bridgeway previously participated with AHCCCS in an ALTCS panel discussion at one of these conferences

Bridgeway's ongoing network activities also include:

- Current gaps in the network are identified in the development plan and receive specific attention until they are resolved. Targeted providers are repeatedly approached until an agreement is reached.
- Capacity of all provider types is compared to existing membership and projected growth.
- Network development incorporates utilization patterns that are relevant to Bridgeway members.
- All Bridgeway network providers accept Medicaid patients in their practices.
- Bridgeway's network has some PCPs whose practice is limited to institutional or home settings, which is taken into account in assessing PCP capacity.
- Bridgeway compares its network to community availability and providers that available to non-Medicaid members, in analyzing potential network needs.

8. Interdepartmental Coordination

8. Coordination between internal departments; including a comprehensive listing of all committees and committee membership where this coordination occurs. Identification of members should include the department/area (i.e., QM, MM/UM, GRV, FIN, CLAIMS) that they represent on the committee.

Bridgeway departments coordinate regarding provider and network issues at both committee and staff levels. Each is addressed below.

Interdepartmental Coordination Through Committees

Bridgeway has six departments: Medical Affairs/Quality Management, Case Management, Medical Management, Contracts and Member and Provider Services (Provider Services Department), Operational Services and Compliance, and Finance. A primary method for coordination among the departments is Bridgeway committees. We describe first the role of committees in interdepartmental coordination regarding network issues, and then provide a comprehensive listing of all committee membership. Bridgeway's Quality Management staff support the Bridgeway committees, including the Member/Provider Council. The Vice President (VP) of Contracts and Member and Provider Services is a member of the committees listed below.

Quality Management/Performance Improvement Committee (QMPIC). The QMPIC, which meets quarterly, ensures that interdepartmental communication initiated at the leadership level flows through all levels of the organization, such as through interdisciplinary work groups. With regard to network issues, the QMPIC monitors network access and provider performance data and recommends interventions promptly as needed. The QMPIC is accountable to the Board of Directors and is the overarching committee that provides oversight, direction, and feedback to all other committees. All committees report to the QMPIC.

Member/Provider Councils in each GSA. Bridgeway's CEO, the VP or a senior manager from the Provider Services Department, and various Network Management staff (that is, field staff from the Provider Services Department), as well as leadership and some staff from other Bridgeway departments attend the quarterly Member/Provider Council meetings. Staff solicit and welcome feedback from members, providers, and local organizations and take responsive action, whenever feasible, promptly after each meeting, as appropriate to specific issues. The Vice President of Operational Services and Compliance coordinates quarterly reporting of Council activities and recommendations to the QMPIC, which analyzes feedback and recommends broad based responsive action to expand network access and performance. The Bridgeway Board, CEO, and senior staff have final responsibility for taking action.

Executive Leadership Team. The Leadership Team includes Bridgeway's CEO, the VP of each of the six departments, and the Human Resources Director. The Team's weekly meetings are an important forum for cross-departmental discussion of current issues, providing department updates, and collaboration, including on network performance and design.

Network Related Committees. Five Bridgeway committees have network specific responsibilities:

- Contracting and Provider Relations Committee
- Behavioral Health Committee
- Pharmacy and Therapeutics Committee
- Credentialing Committee
- Peer Review Committee

The VP of Provider Services chairs the Contracting and Provider Relations Committee and serves on the Behavioral Health and Credentialing Committees.

Contracting and Provider Relations Committee. This committee meets monthly to focus on provider relations, network design, including the dental and vision networks, and addressing feedback on network performance of administrative (as opposed to clinical) functions through cross-departmental collaboration; committee membership includes the Leadership Team. This cross-departmental forum reduces the silo effect that sometimes develops within an operational department and impedes problem solving when issues affect more than one department. The committee also analyzes network access and adequacy indicators, such as member and provider complaints and requests related to access that are received through the call center. The committee incorporates in its planning and evaluation feedback from the Member/Provider Council,

such as local input on utilization patterns, potential provider capacity and travel distance access issues, and recommendations for providers to contract with Bridgeway.

- ***Behavioral Health Committee.*** This multi-departmental committee meets monthly and its main focus is integration of medical and behavioral health care for our members. In addition, the committee addresses network development and all issues relating to behavioral health services. This committee also has focused on developing new service levels for geriatric members in Maricopa, LaPaz and Yuma Counties.
- ***Pharmacy and Therapeutics (P&T) Committee.*** The P&T Committee, which includes a network physician, meets quarterly and as part of its responsibilities, addresses performance of and feedback on the pharmacy network and other pharmacy issues.
- ***Credentialing Committee.*** This committee, which meets quarterly or more often depending on network credentialing needs, is accountable for all credentialing and recredentialing functions for Bridgeway's provider network, including for delegated entities. The committee, which includes contracted AHCCCS providers, also collaborates with other departments and committees as needed regarding provider performance issues that may affect continued network contract status.
- ***Peer Review Committee.*** This committee, which meets at least quarterly, reviews provider performance related to quality of care and makes recommendations for disciplinary action, termination, or limitation of network participation. The Medical Director chairs the Peer Review Committee and it reports to the Quality Management Investigative Committee (QMIC). The committee includes provider members of the Credentialing Committee, is representative of a variety of network provider types and, as needed, includes external providers of the same or similar specialty to a provider being reviewed. Requests for investigation and possible peer review of a network provider may be referred to the Quality Management Department through the P&T, Credentialing, or Medical Management/Utilization Management Committees. Referrals to the committee also may be generated by QM and other Bridgeway functional areas through activities such as grievance and quality of care complaint review. The Peer Review submits its recommendations for provider suspension or termination to the Credentialing Committee for action.

Additional Committees and Their Role in Network Management

The VP of Provider Services serves on all committees listed below.

- ***Compliance Committee.*** This committee meets in conjunction with the weekly Leadership Team and convenes with additional staff on a quarterly basis. The committee's primary network related focus is provider and subcontractor contract compliance. It addresses network performance issues that flow from the Contracting and Provider Relations Committee via the VP of Provider Services, such as provider noncompliance with appointment availability and wait time standards.
- ***Grievance and Appeals Committee.*** This committee meets monthly and includes Provider Services staff representation. The committee analyzes and trends grievances and appeals relating to network access and performance issues.
- ***Medical Management/Utilization Management Committee.*** The committee meets quarterly and as part of its responsibilities analyzes feedback on under- and over-utilization of services and makes related network recommendations.
- ***Performance Improvement Team (PIT).*** The PIT meets monthly to review current Bridgeway performance improvement projects (PIPs). The PIT is a venue for strategizing on PIPs and developing recommendations on how to accomplish the best outcomes, coordinate interventions, and reach targeted goals, including on network performance and design. The recommendations are submitted to the QMPIC on a quarterly and ad hoc basis. Once the QMPIC accepts the recommendations, the PIT is responsible for oversight of the PIP.
- ***Quality Management Investigative Committee (QMIC).*** The QMIC meets quarterly and its network related activities include reviewing quality of care complaints or concerns, investigating member and provider issues, and addressing any contracting issues or needs related to member care and services.

Committees and Committee Membership

The table below lists the committees, internal (Bridgeway staff) members and the departments (functional areas) they represent, external members (if any), and the meeting frequency. The type of interdepartmental coordination for each committee is shown by which department heads participate in each committee. As shown below, Bridgeway committees include representatives from multiple departments. In the table below, the department the Bridgeway staff member

represents is listed before the title of the committee member. Following is the key to Department/Functional Area abbreviations:

• CM – Case Management • CLAIMS – Claims • COMP – Compliance • FIN – Finance • GRV – Grievance	• HP ADMIN – Health Plan Administration • MM/UM – Medical Management/Utilization Management • MS – Member Services • PS – Provider Services

Committee	Committee Members (including department/functional area and title)	
Executive Leadership Team	**Bridgeway's Executive Leadership Team (Leadership Team)** consists of the department head from all functional/operational areas. For any committees listed in the rows below in which all of the department heads attend, the following members are summarized and referred to collectively as the Leadership Team. • HP ADMIN: Chair, President and CEO (Rick Fredrickson) • GRV/COMP Depts: VP Operational Services and Compliance (Nicole Larson) • MS/PS Depts: VP Contracts and Member and Provider Services (Elaine Teune)	• FIN/CLAIMS Depts: VP Finance (Nancy Maurer) • CM Dept: VP Long Term Care Case Management (Mary Reiss) • MM/UM Dept: VP Medical Management (Sue Benedetti) • QM Dept: Medical Director (Dr. Robert Krauss) • QM Dept: ALTCS Medical Director (Dr. Fred Miller) • HP ADMIN: Leadership meetings also include updates from Director of Human Resources (Courtney Freeman) Meeting frequency: weekly
QM Performance Improvement Committee (QMPIC)	• QM Dept: Chair, Medical Director (Dr. Robert Krauss) • HP ADMIN: President and CEO (Rick Fredrickson • QM Dept: ALTCS Medical Director (Dr. Fred Miller) • QM Dept: Manager Quality Improvement (Karen Davis) • QM Dept: Manager Quality Management Program (Joann Adams) • QM Dept: QM Data Analyst (Darren Lynch) • QM Dept: Maternal Health and EPSDT Specialist (Maritza Jimenez) • QM Dept: Director Pharmacy (Duane Angulo)	• MM/UM Dept: Director Acute Medical Management (Robin Johnson) • MM/UM Dept: Director Utilization Management (Diane McMahan) • CM Dept: VP Case Management (Mary Reiss) • CM Dept: Behavioral Health Coordinator (Kathy Dutridge) • MS/PS Depts: VP Contracts and Member and Provider Services (Elaine Teune) • MS Dept: Supervisor Member Services (Elizabeth Nagan) • GRV/COMP Depts: VP Operational Services and Compliance (Nicole Larson) • COMP Dept: Outreach and Communication Specialist (Jennifer Klein) • External members: Cenpatico - Behavioral Health Utilization Manager (Heather Koch) Meeting frequency: quarterly
Behavioral Health Committee	• CM Dept: Chair, VP Long Term Care Case Management (Mary Reiss) • CM Dept: Behavioral Health Coordinator (Kathy Dutridge) • CM Dept: ALTCS Case Management Manager (Debra Tellez) • CM Dept: ALTCS Case Management Supervisors (Rhoda Hernandez, Kimberly Gaunt) • MM Dept: VP Medical Management (Sue Benedetti) • QM Dept: ALTCS Medical Director (Dr. Fred Miller)	• MS/PS Depts: VP Contracts and Member and Provider Services (Elaine Teune) • PS Dept: Provider Services Managers from each GSA • GRV/COMP Dept: VP Operational Services and Compliance (Nicole Larson) • External Members: Cenpatico - Manager, Network Development (Behavioral Health) (Sandra Stamp) and UM Behavioral Health Coordinator (Kari Peel) Meeting frequency: monthly

Committee	Committee Members (including department/functional area and title)	
Compliance Committee	• GRV/COMP Depts: Chair, VP Operational Services and Compliance (Nicole Larson) • COMP Dept: Director of Compliance, Tucson (Virginia Rountree)	• Leadership Team Meeting frequency: Conducted in conjunction with weekly Leadership Team meetings, and on a quarterly basis, often is expanded to include additional department-specific staff to address identified issues or updates.
Contracting and Provider Relations Committee	• MS/PS Depts: Chair, VP Contracts and Member and Provider Services (Elaine Teune) • PS Dept: Provider Services Managers from each GSA • PS Dept: Provider Services Supervisor (Marisa Balbo)	• PS Dept: Network Managers from various GSAs; attendance may vary based on availability and agenda items • Leadership Team Meeting frequency: monthly
Credentialing Committee	• QM Dept: Chair, Medical Director (Dr. Robert Krauss) • HP ADMIN: President and CEO (Rick Fredrickson) • QM Dept: ALTCS Medical Director (Dr. Fred Miller) • GRV/COMP Depts: VP Operational Services and Compliance (Nicole Larson) • MS/PS Depts: VP Contracts and Member and Provider Services (Elaine Teune) • QM Dept: Manager Quality Improvement (Karen Davis) • QM Dept: Manager Quality Management Program (Joann Adams) • QM Dept: Director Pharmacy (Duane Angulo)	• QM Dept: QM Data Analyst (Darren Lynch) • QM Dept: Maternal Health and EPSDT Specialist (Maritza Jimenez) • MM/UM Dept: Director Utilization Management (Diane McMahan) • MM/UM Dept: Director Acute Medical Management (Robin Johnson) • CM Dept: VP Long Term Care Case Management (Mary Reiss) • External members include: INSPIRIS - Nurse Practitioners (Lisa Latto and Karah Norton); Medical Director, contracted (Dr. Charles Dries); network providers (Dr. Abraham Kuruvilla and Dr. Connie Sterling) Meeting frequency: quarterly
Grievance & Appeals Committee	• GRV/COMP Depts: Chair, VP Operational Services and Compliance (Nicole Larson) • Leadership Team • GRV/COMP Dept: Manager Grievance and Appeals (Kitley Ann West) • COMP Dept: Director of Compliance, Tucson (Virginia Rountree) • MS Dept: Supervisor Member Services (Elizabeth Nagan) • PS Dept: Provider Services Managers from each GSA • PS Dept: Provider Services Supervisor (Marisa Balbo) • MM/UM: Director Acute Medical Management (Robin Johnson)	• QM Dept: Manager Quality Improvement (Karen Davis) • QM Dept: Manager Quality Management Program (Joann Adams) • QM Dept: QM Data Analyst (Darren Lynch) • QM Dept: Maternal Health and EPSDT Specialist (Maritza Jiminez) • CM Dept: Behavioral Health Coordinator (Kathy Dutridge) • CM Dept: ALTCS Case Management Manager (Debra Tellez) • CM Dept: ALTCS Case Management Supervisors (Rhoda Hernandez, Kimberly Gaunt) • Additional department supervisors or representatives as needed for specific agenda/discussion items Meeting frequency: monthly
Med Mgmt/UM Committee	• MM/UM Dept: Chair, VP Medical Management (Sue Benedetti) • Leadership Team • MM/UM Dept: Director Acute Medical Management (Robin Johnson)	• MM/UM Dept: Director Utilization Management (Diane McMahan) • QM Dept: Director Pharmacy (Duane Angulo) • FIN, CLAIMS Dept: Director Finance (Mark Brown) Meeting frequency: quarterly

Committee	Committee Members (including department/functional area and title)	
Member / Provider Councils (one per GSA)	• Members, their families and representatives or significant others, providers, member advocacy groups, and community organizations constitute the membership of the Councils • HP ADMIN: Bridgeway's President and CEO (Rick Fredrickson, or his designee) chairs the Council meetings Bridgeway employees who staff and support the Councils and regularly attend meetings include: • MS/PS Depts: VP Contracts and Member and Provider Services (Elaine Teune) • PS Dept: Provider Services Managers from each GSA • CM Dept: VP Case Management (Mary Reiss) • CM Dept: ALTCS Case Management Manager (Debra Tellez)	• CM Dept: ALTCS Case Management Supervisors (Rhoda Hernandez, Kimberly Gaunt) • CM Dept: ALTCS Case Managers (attendance varies based on availability) • GRV/COMP Depts: VP Operational Services and Compliance (Nicole Larson) • COMP Dept: Outreach and Communication Specialist (Jennifer Klein) Other Bridgeway staff may participate depending on the issues on the agenda or requests from Council participants. Meeting frequency: quarterly
Peer Review Committee	• QM Dept: Chair, Medical Director (Dr. Robert Krauss) • QM Dept: ALTCS Medical Director (Dr. Fred Miller) • MM Dept: VP Medical Management, non-voting (Sue Benedetti) • GRV/COMP Depts: VP Operational Services and Compliance, non-voting (Nicole Larson)	• QM Dept: Manager Quality Management Program, non-voting (Joann Adams) • QM Dept: Manager Quality Improvement, non-voting (Karen Davis) • External and network provider members of the same or similar specialty to a provider being reviewed, such as INSPIRIS - Nurse Practitioners (Lisa Latto and Karah Norton) Meeting frequency: quarterly
Performance Improvement Team (PIT)	• QM Dept: Chair, Medical Director (Dr. Robert Krauss) • Leadership Team • QM Dept: ALTCS Medical Director (Dr. Fred Miller) • QM Dept: Manager Quality Improvement (Karen Davis) • QM Dept: Manager Quality Management Department (Joann Adams) • QM Dept: QM Data Analyst (Darren Lynch) • QM Dept: Maternal Health and EPSDT Specialist (Maritza Jiminez) • MM/UM Dept: Director Acute Medical Management (Robin Johnson) • PS Dept: Manager Facilities & Training, (Lisa Erderly)	• CM Dept: Behavioral Health Coordinator (Kathy Dutridge) • CM Dept: ALTCS Case Management Manager (Debra Tellez) • MS Dept: Supervisor Member Services (Elizabeth Nagan) • MS Dept: Supervisor Member Services (Elizabeth Nagan) • Additional department supervisors or representatives attend as needed for specific agenda/discussion items. • External members: Covenant – RN, Judy Sgrillo. Meeting frequency: monthly
Pharmacy & Therapeutics Committee (P&T)	• QM Dept: Chair, Medical Director (Dr. Robert Krauss) • QM Dept: ALTCS Medical Director (Dr. Fred Miller) • QM Dept: Director Pharmacy (Duane Angulo) • QM Dept: Pharmacy Coordinator, non-voting (Dawn Peel) • MM/UM: VP Medical Management (Sue Benedetti) • MM/UM Dept: Director Utilization Management (Diane McMahan)	• MM/UM Dept: Director Acute Medical Management (Robin Johnson) • GRV/COMP Depts: VP Operational Services and Compliance (Nicole Larson) • External members: Medical Director, contracted (Dr. Charles Driess); outside physician (Dr. Donald Nicholson); Affiliate (Pharmacy Benefit Manager) and non-voting member – US Script – Director, Clinical Services (Ken Perrin) Meeting frequency: quarterly

Committee	Committee Members (including department/functional area and title)	
QM Investigative Committee (QMIC)	• QM Dept: Chair, Medical Director (Dr. Robert Krauss) • HP ADMIN: President and CEO (Rick Fredrickson) • QM Dept: ALTCS Medical Director (Dr. Fred Miller) • QM Dept: Director Pharmacy (Duane Angulo) • QM Dept: Manager Quality Improvement (Karen Davis) • QM Dept: Manager Quality Management Department (Joann Adams) • QM Dept: QM Data Analyst (Darren Lynch)	• QM Dept: Maternal Health and EPSDT Specialist (Maritza Jimenez) • MM/UM Dept: Director Utilization Management (Diane McMahan) • MM Dept: Director Acute Medical Management (Robin Johnson) • GRV/COMP Depts: VP of Operational Services and Compliance (Nicole Larson) • CM Dept: VP Long Term Care Case Management (Mary Reiss) • MS/PS Depts: VP Contracts and Member and Provider Services (Elaine Teune) Meeting frequency: quarterly

Interdepartmental Staff Coordination on Provider and Network Issues

Specific Departments. Described below are key points of interdepartmental staff coordination regarding provider and network issues.

- ***Case Management and Network Management.*** Case Managers and Network Management staff communicate regularly, one-on-one, to identify needed providers and enhance member choice, such as identifying both network and prospective network providers with specific types of expertise, such as experience working with persons with traumatic brain injury, or certain types of cultural competence.
- ***Medical Management and Network Management.*** Concurrent review staff in Medical Management request assistance from Network Managers during the discharge planning process, if they cannot locate the type of providers needed to support members where they live after discharge. For example, Network Managers may negotiate a special rate to ensure provision of specific in-home services to a member living in a remote area that has limited HCBS services available. Network Managers also may call various skilled nursing facilities (usually in rural areas) to identify a SNF that has a bed available or specific types of services for a member needing temporary SNF care following discharge.
- ***Quality Management and Network Management.*** QM staff synthesize provider-related performance information from all departments, and disseminate it according to the nature of the information, such as through standardized monthly reports, quarterly committee reports, and the annual Quality Evaluation.
- ***Compliance and Network Management.*** Compliance staff collaborate with Network Management staff in responding to provider complaints and claim disputes, and taking corrective action to ensure contract compliance when needed.
- ***Finance/Claims and Network Management.*** Claims staff notify Network Management staff regarding patterns of errors in claims submission, such as repeated, similar errors from the same provider, so that Network Management staff can educate the provider's office staff on how to file clean claims. Claims staff also run statistical reports such as regarding the top 10 claims errors, to help determine what type of ongoing provider training is needed across the network. Network Management staff also coordinate with Finance staff regarding provider reimbursement rate issues.
- ***Multi-Departmental Coordination.*** On a broader scale, a recent example of interdepartmental coordination is improvements in Bridgeway concurrent review and discharge planning processes, which resulted from collaboration among staff from the Medical Management, Case Management, and Network Management Departments.

Special Purpose Examples of Interdepartmental Coordination.

Case Review Team (CRT). Weekly Case Review Team meetings ensure coordination of care and appropriate utilization of services through a collaborative, interdepartmental approach to identifying service options and holistic solutions. The Case Review Team, comprised of the Medical Director, Vice Presidents of Case Management and Medical Management, Case Management Manager/Supervisors, Behavioral Health Coordinator, Case Managers, and Prior Authorization Supervisor, also may include staff from other departments, such as Network Management, in meetings when network or other expertise is relevant to the issues under review. In some cases, the Case Review Team may confer with Network staff to identify the most appropriate facility or provider for a member's changing needs or to provide feedback on network contracting opportunities. For example, Network staff might collaborate with the CRT when a member's deteriorating condition may require transition from an ALF to a skilled nursing facility or when a member's situation

requires a facility with an environment or more focused services that better address the member's needs. Network staff also help identify facilities within a certain driving range that is convenient for the member's family.

First Response Team. Our interdepartmental First Response Team is mobilized when we are notified of a member in a facility facing immediate jeopardy or a natural disaster or facility closure, in order to investigate, protect member care and safety, and possibly prevent the closure. The team is composed of Network, Quality, Case, and Medical Management, as well as, Compliance department staff who select from among themselves a Lead Coordinator, appropriate to the circumstances, who ensures inter-departmental coordination on all aspects of the issue. As members of the First Response Team, Network Managers assist Case Managers in identifying appropriate facilities or HCBS providers from which members in a facility may choose. Although permanent placement is our priority, Network Managers also identify short-term options such as temporary placement in an acute care or non-participating nursing facility or a family member who could temporarily accommodate the member with the help of HCBS. If a facility outside our network is the most appropriate placement, Network staff follow up to pursue a network contract with the provider.

Employee Council. The purpose of the council is to increase communication and collaboration across departments, between line staff and managers, as well as to make recommendations for processes improvements and workflow changes. The Council has employee representation from each functional work area and membership rotates to increase employee participation and to promote diversity of ideas. Initiatives that resulted from Council recommendations include a job shadowing program in which each member of the Council chooses a different department to shadow, with the objective of learning more about the day to day operations of a department other than the one that in which they currently work, culminating in a department overview presentation to the other Council members. Presentation material ultimately will be incorporated in the new employee orientation and training curriculum. ***Town Hall Meetings.*** Plan President and CEO, Rick Fredrickson hosts Quarterly Town Hall Meetings, which include staff from all four offices (Tempe, Yuma, Prescott and Tucson) with the goal of increasing communication about current and upcoming initiatives or changes that will impact the health plan. ***Cultural Diagnostic Survey.*** All employees participate in an annual Cultural Diagnostic Survey designed to assess employee perceptions of the ethical culture of their organization. The purpose of the survey is to measure the culture of integrity at Bridgeway and we use information from the survey responses to identify areas for improvement in order to continually increase employee satisfaction and the overall work environment. The survey contains the following diagnostic categories: Comfort Speaking Up, Department Climate, Direct Manager Leadership, Tone at the Top, Clarity of Expectations, Openness of Communication, Organizational Justice, Awareness, and Ethical Pressure.

Coordination Between Departments Through Technology

Our technology fosters the collaborative process and promotes robust cross departmental engagement in service of the member. Our new integrated Member and Provider Relationship Management systems will allow our case managers to electronically assign, send, receive, and act on any necessary tasks and follow up with all our operational departments. For example, if a Case Manager identifies a network service gap that requires assistance from Network Management staff, the Case Manager's request is electronically routed and tracked in the system through completion. In addition, our provider and member inquiry tracking and management tools allow the assignment, routing, tracking, follow up and reporting of member and provider inquiries across all operational departments, so that whatever issues the member or provider call center staff cannot address are routed to and addressed by the right functional department.

9. External Coordination

9. Coordination with outside organizations; (ALTCS Contractors shall address member/provider council activities)

Coordination between Bridgeway and outside organizations is conducted primarily by Bridgeway staff, and by Bridgeway committees; both types of coordination are described below.

Staff Coordination with Outside Organizations and Persons on Network Matters

- The **Vice President of Contracts and Member and Provider Services** (VP of Provider Services) is the conduit for all Bridgeway activity relating to the network and providers. For example, the VP of Provider Services coordinates all general communications with and training for providers. The VP or a senior representative from the Provider Services Department participates in the Member/Provider Council meetings, as well as in certain activities with provider associations such as the Arizona Home Health Association and related groups such as the Assisted Living Foundation.
- The **Medical Director** may confer on network issues with the clinical leadership of specialty medical societies and the Arizona Geriatrics Society and other long term care provider associations. The Medical Director plays a visible role in peer-to-peer activities on behalf of Bridgeway.
- Our **Case Managers** are generally the point of contact between members, providers, and community resources. All members have a Case Manager who monitors the member's care plan and facilitates access to covered and non-covered services.
- The Bridgeway **Behavioral Health Coordinator** facilitates monthly Behavioral Health Committee coordination meetings with our affiliate, Cenpatico, to discuss network development and issues related to behavioral health services, target development of new service levels for geriatric and disabled populations, evaluate progress on specific network development initiatives such as recruiting certain psychiatric and behavioral health practitioners and residential facilities, and provide input on and oversight of utilization and reporting of behavioral health services. In addition, the Behavioral Health Coordinator maintains contact with external organizations such as the Brain Injury Association of Arizona and National Alliance for the Mentally Ill (NAMI).
- Our **Transition Coordinator** provides continuity of care for members by coordinating with other plans and non-contracted providers who serve our members before they elect to join Bridgeway (or if they disenroll). The Bridgeway Transition Coordinator ensures that members' care is not disrupted when they change plans.
- **Quality Management staff** support the Bridgeway committees, including the Member/Provider Council, and help engage network providers in performance improvement projects to improve care delivery, such as initiatives to ensure HCBS are provided within the first 30 days of enrollment with Bridgeway, regarding falls and skin care, and to foster direct care workers' professional development.

Memberships and Community Involvement. Bridgeway is a member of many organizations and associations such as the Arizona Health Care Association, Assisted Living Federation of America, Arizona Medical Directors Association, Arizona Non-Medical Home Care Association, and Arizona Geriatrics Society. The Bridgeway CEO and staff participate in these groups' conferences and support the groups by sponsoring speakers or meals at the conferences.

Bridgeway leadership and staff also participate in activities and meetings of the Brain Injury Association of Arizona, Area Agency on Aging's Maricopa Elder Abuse Prevention Alliance (MEAPA), and the Yuma Elder Abuse Prevention Task Force. Our community activities are agenda items at Member/Provider Council meetings, which encourages Member/Provider Council members to make recommendations for expanding our community involvement.

Bridgeway's CEO and leadership coordinate with the Regional Behavioral Health Authorities in our GSAs, to collaborate in areas of common interest such as increasing access to behavioral health services in rural parts of the State.

Committee Coordination with Outside Organizations, Including on Network Matters

Quality Management/Performance Improvement Committee (QMPIC). The QMPIC is composed of Bridgeway's CEO, six departmental Vice Presidents, and designated staff. The QMPIC meets quarterly to ensure cross-departmental coordination and response to and use of member, provider, and other stakeholder feedback in our planning and evaluation

processes. The QMPIC is the overarching entity over all other committees for coordination purposes, including those committees with external membership, such as the Member/Provider Council.

Member/Provider Councils. The primary purpose of the Bridgeway Member/Provider Council (Council) is to ensure the quality and effectiveness of home and community based services (HCBS), assisted living and nursing facility, behavioral health, and acute care services delivered to Bridgeway members.

Overview. The Member/Provider Council meets quarterly. The Vice President of Operational Services and Compliance coordinates quarterly reporting of Council activities and recommendations to the QMPIC. The QMPIC analyzes feedback and recommends responsive action related to network access and performance, among other matters. The Bridgeway Board, CEO, and senior staff have final responsibility for taking action.

The Council is composed of Bridgeway members, their representatives, network providers, advocacy organizations representing Elderly and Physically Disabled members, and other community organizations. At least 50% of the membership consists of members, their families and significant others, and member advocacy groups. We arrange and pay for transportation for ALTCS members to attend Council meetings. There is one Member/Provider Council per GSA and we provide an orientation and ongoing training for Council members. We submit a plan annually to AHCCCS outlining the draft goals and meeting schedule for the Council. Member/Provider Council activities include the following:

1. Advocate for members with diverse backgrounds, with special emphasis on members with disabilities
2. Provide input on program and service delivery model design
3. Provide input on the Bridgeway provider network
4. Review and provide feedback on health care outcomes
5. Review and provide feedback on consumer materials, programs, and services, with primary focus on improving quality
6. Recommend community specific activities and collaborations
7. Educate Council participants on issues, concerns, and information regarding health care delivery for Bridgeway members

Council meetings are chaired by the Bridgeway CEO or VP of Operational Services and Compliance, or their designee. Bridgeway employees from the six departments staff and support the Councils but are not members of the Council. Staff communicate Member/Provider Council recommendations to the QMPIC for cooperative action on any quality or operational issues identified by or presented to the Council that require or would benefit from community involvement (such as health literacy efforts, cultural competence issues, or transportation). The Council also serves as a forum for collaborating on multi-organization initiatives, such as identifying groups or projects for potential sponsorships, obtaining feedback on Case Manager coordination of non-covered services, generating ideas to enhance communication with members, and identifying community problems that members face. The Council and various participants help improve member access by encouraging noncontracted providers to join Bridgeway's network or to begin seeing Medicaid members, improving collaboration among non-network resources, and educating the community at large about issues affecting ALTCS members. Our current Member/Provider Councils meet in Maricopa, Yuma/La Paz, and Pima GSAs. Over the past year, provider turn out for our Maricopa and Yuma Member/Provider Council meetings has been strong, as shown below.

Quarter/Month 2010	Council Provider Attendance Total
Maricopa	
Q1 - March	33
Q2 - June	36
Q3 - Sept	38
Q4 - Dec	45
Yuma	
Q1 - March	17
Q2 - June	11
Q3 - Sept	10
Q4 - Dec	23

New Member/Provider Council Members. Subject to contract award for additional GSAs, we will invite providers and community organizations to the Member/Provider Councils to recommend new providers (including identifying providers who meet ADA disability access standards) and identify any concerns regarding network quality and access. Prior to our having enrolled members, we will encourage advocacy and community groups that have regular contact with ALTCS members to urge such members to attend Bridgeway Council meetings. The following is a sampling, by county, of organizations, including some providers we have contacted with to solicit their participation in Council and other regional Bridgeway activities.

Apache County	Coconino County
1. Area Agency on Aging, Region III – Northern Arizona Council of Governments (NACOG) 2. Reeves Foundation 3. Alpine Chamber of Commerce 4. Apache Public Health Department 5. Catholic Charities	1. Area Agency on Aging, Region III - Northern Arizona Council of Governments (NACOG) 2. Coconino Senior Living Foundation (CSLF) 3. Flagstaff Chamber of Commerce 4. Grand Canyon Chamber of Commerce 5. Coconino Public Health Department 6. Catholic Charities
Gila County	**Mohave County**
1. Pinal-Gila Council for Senior Citizens, Region 5 (Area on Aging) 2. Payson Multipurpose Senior Center Development Association 3. Mogollon Health Alliance 4. Gila County Health Department	1. Area Agency on Aging, Region IV 2. Interagency Council Respite 3. Mohave County Public Health Department 4. Kingman Chamber of Commerce
Navajo County	**Yavapai County**
1. Navajo Area Agency on Aging, Region VII 2. Navajo County Public Health Services 3. Holbrook Chamber of Commerce 4. Catholic Charities	1. Catholic Charities 2. Arizona Bridge to Independent Living (ABIL) 3. Coalition for Compassion and Justice 4. Yavapai County Community Health 5. NAZCARE 6. West Yavapai Guidance Clinic

Recent Bridgeway Community Coordination Activities

Below are some examples of Bridgeway ALTCS community involvement for CYE 2010.

Month	Event/GSA	Sponsoring Organization	Details
Mar	Health Event/Yuma	Yuma County Elder Abuse Task Force	Operation Medicine Cabinet: The quarterly health event provided an opportunity to properly dispose of expired/unused medications. Bridgeway participated/volunteered at this event.
Apr	Health and Wellness Fair/Maricopa	Disability Empowerment Center – ABIL	The event focused on people with disabilities and their care. Bridgeway was an event sponsor and provided health education to attendees while distributing materials/trinkets. Website: http://www.abil.org/disability-empowerment-center-information
May	Women's Health Event/Yuma	Sunset Community Health Center and City of San Luis	The event provided an opportunity for women in San Luis to learn about the importance of good health for themselves and their families. Bridgeway provided health education to attendees and distributed materials/trinkets.
Jul	Community Event/Maricopa	Americans with Disabilities Act – 20th Anniversary	The event celebrated the 20th Anniversary of the Americans with Disabilities Act. Bridgeway was a silver sponsor and conference participant. In addition, we provided health education and distributed materials/trinkets to attendees. Website: http://www.azdac.org/

Month	Event/GSA	Sponsoring Organization	Details
Aug	Community Event/Maricopa	Phoenix Mercury (Women's Basketball Association) and Direct Care Workforce	Caregiver Night: The event for Caregivers provided health care and resource education and information. Bridgeway was an exhibitor and provided health education to attendees while distributing materials and trinkets. Website: http://www.metrocareaz.com/blog/bid/24919/Arizona-Caregivers-Night-with-the-Phoenix-Mercury-August-6-2010
Aug	Health Fair/Yuma	Sun Set Community Health Center and City of San Luis	The event promoted health centers around the city and encouraged use of the health centers for medical treatment. The event highlighted the history and growth of health centers in providing affordable, high quality, cost effective health care to all people, regardless of ability to pay. Bridgeway provided health education and distributed materials/trinkets to attendees.
Aug	Community Event/Yuma	Western Council of Governments (WACOG)	Partnering with the HeadStart Program in Yuma, the poverty simulation allowed participants to experience what it is like to live in a low-income environment. Bridgeway participated in the event and donated folders to be used for resources.
Oct	Community Event/Maricopa	Arizona Latino Caucus Foundation	The event provided education/outreach to the Latino population. Bridgeway made a financial contribution. Website: http://www.azlcf.com/
Oct	Community Event/Maricopa	Benevilla	The event celebrated Benevilla and all of their efforts in helping the elderly in the Northwest Valley. Bridgeway was a silver sponsor and attended the event. Website: http://www.benevilla.org/events.html
Nov	Health Fair/Maricopa	Arizona Asian American Association (AAAA)	The health fair focused on wellness and health for Asian Americans of all ages. Bridgeway was an exhibitor at the event and, in addition, provided health education and distributed materials and trinkets to attendees. Website: http://aaaa-az.org/index.htm

10. Special Populations

10. A description of network design by GSA for the general population, including details regarding special populations. [Non-ALTCS provisions are omitted here.] [ALTCS Program Contractors shall understand these populations to include behavioral health; young adults and children; among others.] The description shall cover:

i. how members access the system,
ii. relationships between various levels of the system
[omitted iii. and iv., which do not apply to ALTCS]
v. (ALTCS Only) the description shall include a list of these providers along with a description of services provided by the program and projected utilization.

Bridgeway Network Design and Local Presence

Bridgeway's network philosophy is to support member choice by contracting with any willing provider that is qualified to serve ALTCS members and accepts a reimbursement rate that is reasonable in the context of AHCCCS' capitation rate. We prioritize recruiting providers that currently serve ALTCS members, to facilitate continuity of care during transition to Bridgeway as a new Contractor. We have evaluated our proposed, comprehensive network to ensure that the projected membership has access at least equal to, or better than community norms, to covered services that are provided promptly and are reasonably accessible in terms of location and hours of operation.

Bridgeway has embraced serving rural areas and, as we do now, we will focus on identifying specific services that do not exist but are needed in rural areas, particularly behavioral health services. We then carefully select provider partners who, with our support and collaboration, are capable of and willing to invest in developing targeted services in certain areas. Using this approach, we facilitated establishment of a Medicare-certified home health agency serving Yuma/La Paz, and two Level II behavioral health homes in Yuma that now serve ALTCS members.

In addition to network development activities of the Contracting and Member and Provider Services Department (Provider Services Department), Bridgeway outreach staff have contacted and met with community organization representatives and advocates in the five proposed new GSAs. These local advocates are most helpful in identifying providers with certain types of expertise in serving members who are elderly or have physical or behavioral disabilities, and we invite the advocates to participate in our Member/Provider Council meetings. We will establish a Member/Provider Council in each GSA shortly after Contract award.

As we do now, Bridgeway will maintain a local presence in all GSAs that we serve, through Network Managers and other staff who reside in each GSA. We also anticipate, as we do now, maintaining an office in each of our GSAs.

Because claims payment supports the livelihood of our providers, and especially small HCBS agencies in our network, it is a Bridgeway priority. For example, for the period February 2010 through January 2011, our Claims Team processed more than 200,000 ALTCS claims with an average days on hand of 9 days. For this same period, they achieved turnaround times of 95% processed within 30 days and 100% within 60 days, well above the AHCCCS standards of 90% of clean claims processed within 30 days and 99% within 60 days. We will soon deploy our new Provider Engagement Team (PET), which is a Bridgeway led multi-disciplinary team with expertise in provider services, EDI operations, and LTC claims and encounter processing, to increase EDI and EFT utilization by providers.

Finally, to strengthen the network, Bridgeway has invested significant resources in long term care workforce development. We are the only ALTCS health plan that is a member of the Direct Care Task Force and are an active participant. In addition, Bridgeway Case Management staff participate in monthly meetings of the Arizona Non-Medical Home Care Association's Legislative Committee, which is drafting legislation to create training and certification requirements as well as background checks for home care workers and agencies. We are providing technical resources to support their initiative.

Key special populations among our ALTCS members include Members with behavioral health conditions, young adults and children, members with traumatic brain injury, and homebound members. We provide details regarding Bridgeway network design by GSA for these special populations under Subsection v. below. Bridgeway builds innovative and collaborative relationships with providers to increase access for member centric, culturally competent, recovery oriented, community based services in order to meet the needs of special populations. Below we describe our key providers, services, examples of innovations, and projected utilization information for the above populations.

i. How Members Access the System

Members and their caregivers access the system through a variety of options. Each member is assigned a Case Manager, who is available to assist members 24/7 by phone or email, and through personal visits to the home or other setting of the member's choice. In addition, members may access the system through their HCBS provider or primary care provider (or specialist serving as a PCP).

Case Managers

Each Member is assigned a Case Manager, who is either a nurse, social worker or behavioral health clinician, depending on the member's needs. The Case Manager conducts in-person visits at least every 90 days for members in their own home or assisted living facility and every 180 days for those in nursing facilities and more frequent visits and/or calls as dictated by the member's condition and new or changed needs. For example, Case Managers contact members who are receiving transplant services or have recently experienced a behavioral health crisis more frequently than members whose conditions are stable. Case Managers assess member conditions and needs as well as their goals, service preferences and informal support network. They work with members, families and caregivers to develop a care plan that matches covered services and community resources to their assessed needs and goals, coordinate the entire range of services the member receives, and assist in addressing any barriers to care.

Telephone Accessibility

In addition to direct access to the Case Manager, members may also access the system through Bridgeway's toll-free number (866-475-3129). During business hours, 8 a.m. to 5 p.m., general inquiries are fielded by Member Services Representatives (MSRs) who either promptly answer the member's questions or transfer the member to the Case Manager for further assistance. Using the same number after-hours, members reach NurseWise® RNs and administrative staff who are trained on the same issues as MSRs including handling crisis calls and warm-transferring them to clinical staff when needed. In either case, incoming callers always have the option to speak with a live person who is equipped to address the member's needs. MSRs and after-hours personnel have access to each member's electronic case file and can communicate with members in the member's language through our 24/7 translation service. If a NurseWise Representative cannot address an after-hours need, NurseWise contacts the on-call Case Management Supervisor, who handles all issues.

Member Handbook, Written Materials, and Provider Portal

Members, as well as their family members, designated representatives, and informal caregivers access the system through written materials such as the Member Handbook, member newsletters, Provider Directory, targeted mailings, health education literature, disease management information, and the Bridgeway Health Solutions Member Portal at www.bridgewayhs.com. Bridgeway materials are specifically written in easily understood language and are available in alternative formats such as audiotapes or CDs, large type, and Braille for people who are blind or visually impaired. The Member Handbook and materials are also available in Spanish. Members who choose to communicate electronically may email their Case Manager or the Case Manager's back-up and may request increased email font size to make reading email easier. All electronic correspondence with members will be through secure messaging in accordance with HIPAA requirements.

Member/Provider Advisory Council

Bridgeway encourages members and their caregivers to participate in the Member/Provider Council in their own GSA, which meets quarterly. The Council gives members the opportunity to have a meaningful voice in the delivery of health care services.

ii. Relationships Between Various Levels of the System

Bridgeway Case Managers facilitate member access to providers and advocate on behalf of members and their caregivers. Case Managers engage members, family and caregivers in all aspects of assessment, care planning and service delivery monitoring to ensure member-driven care.

Programmatic Relationship Building

Bridgeway fosters a network community through open membership to its physician, provider, and community committees. Bridgeway clinical staff build personal relationships with professional peers through committee activities and

promote ALTCS' Values and Guiding Principles in expanding collaboration between provider types. In addition, Bridgeway sponsors and conducts training and educational conferences for network providers at all levels that create opportunities for face-to-face interaction.

Member Level Collaboration

Case Manager. The role of the Bridgeway Case Manager is to support member self-determination and ensure integration of appropriate, timely services in the most integrated, least restrictive setting possible. This includes educating and engaging members in assessment, goal setting and care planning; supporting member choice of services, settings and providers; communicating member choice in the care plan to all providers; conducting activities such as case conferences where each provider can see the "whole picture" of the members' status and plan; and monitoring the member's condition and communicating changes to treating providers.

Because of the high rate of co-morbid physical and behavioral health conditions in our population, as well as the importance of social and other needs to the member's overall well-being, a key feature of Bridgeway case management is our integrated approach to assessment and care planning. For example, we screen all members, regardless of primary diagnosis, for depression and other indicators of mental health status and behavioral health needs. Our Behavioral Health Coordinator on our case management staff provides input as needed to other Case Managers to ensure appropriate expertise and assist in connecting members to needed behavioral health services. Case Managers also integrate the informal support network into our process, understanding that the well-being of the member is affected by the well-being of the caregiver(s). In addition, Case Managers identify and incorporate needed non-covered services, including Medicare, and community resources into the care plan to address the entire range of the member's needs. The Case Manager helps the member and family/caregiver access all services and supports necessary to meet the member's goals for a satisfying life.

PCP Coordination of Specialty, Hospital, and Other Care. The PCP serves as the Medical Home for the member, and is responsible for all primary care services for Bridgeway members. The PCP identifies members' medical needs, assists in coordinating services from specialists, behavioral health practitioners, and other providers, any needed hospital care, and social services as part of the treatment plan. The PCP ensures that members' desire to live at home, in the community, or in a SNF (consistent with the member's condition) are supported by the member's care plan. The Bridgeway Case Manager serves both as a proponent of the member's choices with the PCP, but also assists the PCP in finding resources and ensuring care is delivered. The Case Manager also assists in ensuring that PCPs understand their responsibilities as PCP and Case Managers collaborate with Network Managers on any PCP training needs. Many Bridgeway ALTCS members have special health care needs and their main health care provider may be a physician specialist rather than a traditional PCP, such as PCPs with family practice credentials.

HCBS. Bridgeway invites HCBS providers to participate actively in ensuring the member's service plan meets member needs. Case Managers use case conferences to update providers on member status and to solicit HCBS providers' feedback and suggestions. Open communication between Bridgeway and HCBS providers is critical.

RBHAs. Bridgeway has developed relationships with RBHAs and their providers particularly in rural areas. We continue to strengthen those relationships in the establishment of Medical Homes for members with primary behavioral health conditions.

[iii. and iv. are omitted as they do not apply to ALTCS]

v. Network Design, Providers, Services, and Projected Utilization for Special Populations, by GSA

Significant special populations that Bridgeway serves include the following, each of which is addressed below:

- Members with behavioral health conditions
- Young adults and children
- Members with traumatic brain injury
- Homebound members

Bridgeway builds innovative and collaborative relationships with providers to increase access for special populations to member-centric, culturally competent, recovery oriented, community-based services. Below we provide details on our network design for special populations by describing our key providers, services, examples of innovations, and projected utilization information. In this section Bridgeway has highlighted key providers for special populations; a complete listing of providers is provided as required in response to Question 45.

Behavioral Health Services

Below we describe first behavioral health network design issues relating to all GSAs, and then we address each GSA individually. Within the GSAs, we begin with our experience in the Maricopa, Yuma/La Paz, and Pima/Santa Cruz GSAs, and then describe our providers and services in the proposed new GSAs.

Behavioral/Physical Integrated Care Program. In Question 5, we described Bridgeway's Integrated Care Program, including the rural components of the model and our successful pilot in Yavapai County. To expand our model to other areas, we anticipate approaching the providers on the table below about developing a Medical Home to serve ALTCS members with behavioral health conditions. These providers are currently in different stages of developing behavioral health Medical Homes as part of the RBHA system. Mountain Health and Wellness is opening their new facility in April.

GSA and Counties	Behavioral Health Medical Home Providers
GSA 40	
Pinal	Mountain Health and Wellness, Horizon Human Services
Gila	Southwest Behavioral Health Services, Horizon Human Services
GSA 42	
La Paz	Community Intervention Associates
Yuma	Community Intervention Associates, Arizona Counseling and Treatment Services
GSA 44	
Apache	Little Colorado Behavioral Health
Coconino	The Guidance Center
Mohave	Mohave Mental Health
Navajo	Community Counseling Center
GSA 46	
Cochise	Community Intervention Associates, Southeastern Arizona Behavioral Health Services
Graham	Southeastern Arizona Behavioral Health Services
Greenlee	Southeastern Arizona Behavioral Health Services
GSA 48	
Yavapai	Verde Valley Guidance Clinic, West Yavapai Guidance Clinic
GSA 50	
Pima	Bridgeway Long Term Care Clinic
Santa Cruz	Community Intervention Associates
GSA 52	
Maricopa	Mountain Health and Wellness, Southwest Behavioral Health

Telemedicine – All Rural Areas

As discussed in greater detail in Question 5, telemedicine is an important network asset because so much of Arizona is rural. We believe it has great potential to increase access to onsite medication management for members with behavioral health conditions in rural areas. Bridgeway's affiliate Cenpatico has demonstrated the value of psychiatric telemedicine in rural areas over the past four years and we will model our program on their best practices. Cenpatico's contractor, Adapt TeleHealth, Inc. connects psychiatrists to rural communities via telemedicine. Adapt Telehealth identifies psychiatrists from around the country with specialized training in behavioral health, helps them get licensed to practice in Arizona, and builds contractual relationships with Cenpatico outpatient providers to deliver psychiatric and consultation services. Adding Adapt Telehealth psychiatrists to the Bridgeway network will greatly increase the number of psychiatrists available to members and their local providers in rural communities and increase access to experts for all ALTCS members. We also will use telemedicine to connect rural providers to psychiatrists at the planned Geriatric Center of Excellence at the University of Arizona (described above).

Members Receiving Court-Ordered Treatment

Bridgeway has been successful in stepping down members with court-ordered treatment (COT), and unlike some health plans, we have taken the initiative to obtain court approval for vacating treatment orders after members have made significant progress in treatment. Arizona COT typically lasts about 12 months and does not allow for step-down levels of care. This is a barrier that often keeps members in treatment, even though they are ready to take the next step and transition to an appropriate community placement. Bridgeway has worked with psychiatrists at the District Medical Group to develop the affidavits and other documentation necessary to obtain court approval to discontinue COT when alternative treatment is viable. Although the number of Bridgeway members in COT is low (approximately 10 to 12 at any given time), this special population is important due to their high risk and significant cost of care.

In 2010, our affiliate Cenpatico implemented a secure software service known as Previdence Behavioral Risk Management System. Authorized providers access Previdence through the Cenpatico Provider Portal. Based on Cenpatico's positive experience, Bridgeway plans to adapt Previdence to support long term tracking of members with a high potential to be at risk, and/or persons with a chronic risk level, in particular members in court-ordered treatment. Authorized providers will use Previdence to reassess these members monthly and identify changes in risk level. The software will prompt providers to take appropriate action to maintain resiliency, reduce risk when appropriate, and take appropriate action when risk becomes elevated. Previdence also will give our Case Managers quick access to critical information to effectively manage court orders. We will make Previdence accessible to authorized providers on the Provider Portal and plan to implement it in the 3rd Quarter of 2011.

Maricopa County, GSA 52

In the Maricopa GSA, sufficient numbers of behavioral health providers are well distributed geographically and provide the complete range of services. Selected key network providers and their services are described below, along with examples of our collaboration with them to improve access to and quality of behavioral health and long term care services for our members.

Bridgeway **outpatient providers** in the Maricopa GSA include Southwest Behavioral Health, Marc Center, Arizona Children's Association, Counseling & Consulting, and Mountain Health & Wellness. Evaluative services, Medication Monitoring, Individual, Group and Family Counseling, Behavioral Health Day Treatment/Partial Care and Psychosocial Rehabilitation are provided through these providers. In addition, Southeastern Arizona Behavioral Health Service (SEABHS) is a large provider of behavioral health crisis and outpatient behavioral health services with multiple clinic locations. Arizona MENTOR specializes in creating community based programs that emphasize individualized services and personal choice. District Medical Group is a large multispecialty physician group with a strong psychiatric practice group. They also provide clinical staff to Maricopa Integrated Health System's inpatient behavioral health unit. Bridgeway also has partnered with Bayless Behavioral Health Solutions in serving members with behavioral health conditions.

Greenfields Assisted Living Center is a large **assisted living facility**, with a number of our members who have behavioral health conditions in residence there. In the past year we have worked collaboratively with Greenfields and other ALTCS plans to upgrade the facility's quality of care and prevent the loss of this important network resource. The facility's licensure was in jeopardy and we helped them improve their clinical and administrative capabilities and ensure that quality services were sustainable. For example, our staff provided onsite education and consultation on policy and procedures development.

Bridgeway Level II **behavioral health residential agencies** serving Maricopa County include Pastalino Manor, Arizona MENTOR, Tilda Manor, VEMA Corporation, Baraka House, Destiny for Sober Living, Emmarie Behavioral Home Care, Eureka Imperial Residence, Grace House, Joy Health Care, Prats Residential Behavioral Health Agency, SIMS Behavioral, Mountaintop Behavioral Health Services, and A New Hope Behavioral Health Home. Level III behavioral health residential agencies serving Maricopa County include Arizona Behavioral Health Homes, Desert Cedar, and Successful Journeys.

Key behavioral health **nursing facilities** in the Maricopa GSA include the following:

- Senior Living Options operates five nursing homes that serve members with behavioral health conditions: Ridgecrest Healthcare, Palm Valley Rehabilitation, Maryland Gardens, Encanto Palms, and Scottsdale Village Square. Senior

Living Options also operates All At Home, a Medicare certified home health agency, whose staff are well prepared to provide in home care to members with behavioral health conditions.

- Bella Vita Health and Rehabilitation (formerly Desert Sky Healthcare and Rehab) (Bella Vita) has a single facility in Glendale. Bridgeway has developed a close working relationship with Desert Sky and they have provided training to our behavioral health case managers on specific screening protocols they use for referring members from their assisted living facility to their SNF.
- Sun West Choice Health Care and Rehab is planning a specific wing for persons with Alzheimer's or dementia who also have a behavioral health condition or acting out behaviors. We have committed to increase their rates to incentivize them to complete the project and anticipate that this unit could be operational within a year. The new wing will fill a growing need for this level of care in the Far West Valley area.

Our **inpatient providers** include Banner Systems, St. Luke's, Aurora, and Haven Senior Horizons.

Collaboration with Maravilla Care Center for Members with SPMI. Maravilla Care Center is a large nursing facility with 194 beds divided among 4 different units. The most restrictive unit is locked and the other three provide progressively fewer restrictions. Maravilla serves our most difficult members with SPMI and those requiring court-ordered treatment. The alternative for many of these members would be placement in the Arizona State Hospital.

Bridgeway partnered with Maravilla and invested significant resources in service delivery and coordination by placing a Bridgeway Case Manager in the facility. The Case Manager works closely with Maravilla's clinical team during care planning and provides staff training and consultation regarding SAMHSA's recovery model. It is exciting to see that Maravilla has adopted the recovery philosophy and approach and has incorporated it throughout their organization. Their staff work hard to find alternatives to medication as the primary approach to treatment. They now focus on proactive strategies for dealing with members' difficult behaviors and work with members one-on-one to support them as they work through issues.

One of the most innovative features of Maravilla's program is the daycare facility for the employees' children. Maravilla staff incorporate the children in everyday activities with appropriate members, adding a whole new dimension to the meaning of "community" at Maravilla. To support further community development Bridgeway provided four Wii systems, one for each unit. Our members now increase their social interactions and develop pro-social behaviors through Wii tournaments with their peers and they have organized Wii competitions among the four Maravilla units.

Another innovation is the use of headsets by the nursing staff. These wireless communication devices allow the nurses to spend time on the floor (not behind the desk), interacting with members and providing treatment while receiving alerts, reminders and clinical support. The increased time on the floor helps staff identify members who are escalating and intervene early to avoid a crisis situation.

Yuma/La Paz Counties, GSA 42

Bridgeway **outpatient providers** serving La Paz County include Arizona Counseling and Treatment Services, and Community Intervention Associates. Outpatient providers serving Yuma County include Arizona Counseling and Treatment Services, Community Intervention Associates, Horizon, and Mountain Health & Wellness. Evaluative services, Medication Monitoring, Individual, Group and Family Counseling, Behavioral Health Day Treatment/Partial Care and Psychosocial Rehabilitation are provided through these providers.

Bridgeway Level II **behavioral health residential agencies** serving La Paz and Yuma Counties include Community Bridges, Child & Family Services of Yuma, and Community Provider of Enrichment Services (CPES). As summarized below, Bridgeway helped to create the two new CPES Level II facilities, Vista del Rio and Vista del Sol. Level III behavioral health residential agencies serving La Paz and Yuma Counties include Southwest Behavioral Health, Arizona Behavioral Health Homes, Desert Cedar, Successful Journeys, La Paloma, and Intermountain.

Mountain Health and Wellness (MHW), a sub-acute, **inpatient** behavioral health facility in Yuma, provides urgent psychiatric care, including 72-hour observation for members on court-ordered evaluation. MHW provides the only inpatient behavioral health care available in the GSA. We also access inpatient services in Phoenix and Tucson when needed to ensure our ability to address behavioral health needs of our members, and will arrange transportation to a facility in another GSA if needed. Our inpatient providers serving La Paz County include Mountain Health & Wellness (Sub-Acute), Aurora, and Banner Systems. Inpatient providers serving Yuma County include Mountain Health &

Wellness (Sub-Acute), Banner Systems, Sonora, Casa Grande Regional, St. Luke's, Palo Verde, The River Source (Sub-Acute), Haven Senior Horizons, and Carondelet.

Collaborating to Develop New Services for Members with SPMI and Other Behavioral Health Conditions. As more fully described in Question 5 regarding interventions to fill network gaps, Bridgeway's recent success with Community of Providers Enrichment Services/Counseling and Consulting Services (CPES) demonstrates the strengths of our model for serving members with SPMI in the most integrated, least restrictive setting. In summary, we partnered with CPES (a Cenpatico RBHA-funded behavioral health provider) to create two new Level II behavioral health homes for adults with SPMI in Yuma. Following our analysis of service gaps and the need for step-down placements from inpatient behavioral health and nursing facility care to community placement, our affiliate Cenpatico (the RBHA for Yuma) coordinated a meeting with CPES to determine their interest in collaborating. We provided consultation and education to help CPES to anticipate and plan for how to best serve and accommodate members with SPMI. Both homes provide psychological services to our members in addition to residential treatment services and employ a nurse to support medication management and help coordinate care for members with medical issues.

Pima and Santa Cruz Counties, GSA 50

All required behavioral health services are available through Bridgeway's behavioral health network in GSA 50. The participating providers are well dispersed geographically and provide a complete array of services. Bridgeway operates its own licensed outpatient behavioral health clinic in Tucson, which is dedicated solely to providing services to ALTCS members. In Question 45 we describe our collaboration with the University of Arizona, University Physicians Healthcare Group and Hospital, and Arizona Center on Aging to develop the clinic into a center of excellence for best practices and outcomes in long term care.

Other key providers include SEABHS, providing services in both Pima and Santa Cruz County, and the Aleph Center, which specializes in psychiatric services in LTC settings. La Frontera, CODAC and Community Medical Services provide substance abuse treatment in addition to other services. Arizona Children's Association and Providence offer services for children including day programs, residential care and respite. Finally, agencies such as Easter Seals Blake and Beacon provide habilitation services, which have proven to be of great benefit to members with behavioral health problems.

Additional Bridgeway **outpatient providers** serving Pima County include the Bridgeway LTC Clinic, COPE, CPES, Intermountain, and Arizona Children's Association. Outpatient providers serving Santa Cruz County include Corazon, Community Intervention Associates, and Pinal Hispanic. Evaluative services, Medication Monitoring, Individual, Group and Family Counseling, Behavioral Health Day Treatment/Partial Care and Psychosocial Rehabilitation are provided through these providers.

Within the contracted network, 20 **assisted living home or center** (ALH/ALC) providers are competent in the care of dementia related behaviors and other disorders with specialized behavioral intervention requirements during both waking and normal sleeping hours. In addition, seven **adult foster care** providers have had additional training in behavioral interventions and can meet these needs for members during normal waking hours of 7:00 a.m. to 10:00 p.m. We have an ongoing collaboration with Catalina Village Assisted Living Center in providing a community placement option for younger adults with varying physical and challenging behavioral needs. Additionally, we are in partnership with two assisted living centers that have secured memory care units that provide quality care for members in a secured ALC setting.

Level II **behavioral health residential agencies** serving Pima and Santa Cruz Counties include Arizona Children's Association, COPE, CODAC, Community Providers of Enrichment Services (CPES), Intermountain, La Frontera, Supported Living Systems, The Comfort Home, The Haven, The Oasis Home, and Tina Tony Residential Care. Level III behavioral health residential agencies in Pima and Santa Cruz Counties include Intermountain, and La Paloma. CPES is currently developing a new intensive Level II facility for Pima members that will open in May 2011. The home is being renovated for wheelchair accessibility to provide an option for members with co-occurring physical disabilities.

Bridgeway **inpatient providers** serving Pima and Santa Cruz Counties include Carondelet, Sonora Behavioral Health, Tucson Medical Center, La Frontera PHF (Sub-Acute), UPH-Kino, and Palo Verde. In addition, inpatient provider, Southeastern Arizona Behavioral Health Services PHF (Sub-Acute), also serves Santa Cruz County.

Pinal and Gila Counties, GSA 40

Behavioral Health

Bridgeway **outpatient providers** serving Pinal County include Horizon Human Services, Mountain Health & Wellness, Corazon, and Pinal Hispanic. Outpatient providers serving Gila County include Horizon Human Services, Southwest Behavioral Health Services, and Arizona Children's Association. Evaluative services, Medication Monitoring, Individual, Group and Family Counseling, Behavioral Health Day Treatment/Partial Care and Psychosocial Rehabilitation are provided through these providers.

Bridgeway Level II **behavioral health residential agencies** serving Pinal and Gila Counties include Arizona MENTOR, Horizon, Southwest Behavioral Health, Park Place, Counseling & Consulting, Intermountain, and Supported Living Systems. Level III behavioral health residential agencies include Southwest Behavioral Health, Arizona Behavioral Health Homes, Desert Cedar, Successful Journeys, La Paloma, and Intermountain.

Bridgeway **inpatient providers** serving Pinal County include Casa Grande Regional, Sonora, Tucson Medical, The River Source (Sub-Acute), University Physicians Hospital (UPH)-Kino, Mountain Health & Wellness Psychiatric Acute Care (Sub-Acute), Haven Senior Horizons, Banner Health System Inpatient units, St. Luke’s, and Tucson Medical Center. Inpatient providers serving Gila County include Casa Grande Regional, Mountain Health & Wellness Psychiatric Acute Care (Sub-Acute), Windhaven Psychiatric, Flagstaff Medical, Banner System, Aurora, Haven Senior Horizons, and St. Luke’s.

Mohave, Coconino, Navajo, and Apache Counties, GSA 44

Within GSA 44, Bridgeway **outpatient providers** serving Apache County include Little Colorado Behavioral Health and Sequel TSI of Arizona. Outpatient providers serving Coconino County include The Guidance Center, Sequel TSI of Arizona, and Counseling & Consulting. Outpatient providers serving Mohave County include Mohave Mental Health and Southwest Behavioral Health. Outpatient providers serving Navajo County include Community Counseling Center, Sequel TSI of Arizona. An additional provider we are recruiting is Hopi Guidance (no LOI as yet).

Bridgeway Level II **behavioral health residential agencies** serving all four counties in this GSA include Verde Valley, Mohave Mental Health, The Guidance Center, West Yavapai Guidance, and SequelCare of Arizona. Level III behavioral health residential agencies serving all four counties in this GSA include Mohave Mental Health, Southwest Behavioral Health, Arizona Behavioral Health Homes, Successful Journeys, and Desert Cedar.

Bridgeway **inpatient providers** serving Apache, Coconino and Navajo Counties include Flagstaff Medical, Windhaven Psychiatric, Banner Health Systems Inpatient Units, St. Luke’s, Haven Senior Horizons, and Aurora. Inpatient providers serving Mohave County include Flagstaff Medical, Mohave Mental Health Psychiatric Healthcare Facility (PHF) (Sub-Acute), Banner Systems, St. Luke’s, Haven Senior Horizons, and Aurora. Navajo County has a crisis stabilization unit through Community Counseling Centers.

Cochise, Greenlee, and Graham Counties, GSA 46

Behavioral Health

Bridgeway **outpatient providers** serving Cochise, Graham and Greenlee Counties include Southeastern Arizona Behavioral Health Services, and Arizona Counseling and Treatment Services. Additional outpatient providers in Cochise County include Community Intervention Associates, Pinal Hispanic, and Corazon. Evaluative services, Medication Monitoring, Individual, Group and Family Counseling, Behavioral Health Day Treatment/Partial Care and Psychosocial Rehabilitation are provided through these providers.

Bridgeway Level II **behavioral health residential agencies** serving all three counties in this GSA include Community Bridges, Intermountain, Supported Living Systems, CODAC Behavioral Health Services (CODAC), COPE Community Services (COPE), CPES, La Frontera, and Mary's Mission. Level III behavioral health residential agencies serving all three counties in this GSA include Intermountain and La Paloma.

Our **inpatient providers** serving all three counties in this GSA include Carondelet, Tucson Medical Center, UPH-Kino, Southeastern Arizona Behavioral Health Services PHF (Sub-Acute), Casa Grande Regional, and Palo Verde.

Yavapai County, GSA 48

Behavioral Health

Bridgeway **outpatient providers** serving Yavapai GSA include Verde Valley Guidance Clinic, West Yavapai Guidance Clinic, Arizona Children's Association, and Southwest Behavioral Health. Evaluative services, Medication Monitoring, Individual, Group and Family Counseling, Behavioral Health Day Treatment/Partial Care and Psychosocial Rehabilitation are provided through these providers.

Bridgeway Level II **behavioral health residential agencies** serving Yavapai County include Verde Valley, Mohave Mental Health, The Guidance Center, West Yavapai Guidance, and SequelCare of Arizona. Our Level III behavioral health residential agency is SequelCare of Arizona.

Our **inpatient providers** include Flagstaff Medical, Windhaven Psychiatric, Banner Systems, St. Luke's, Haven Senior Horizons, and Aurora.

Projected Utilization

Bridgeway LTC behavioral health admissions per 1,000 decreased from 12.5 in CY 2009 to 6.8 in CY 2010. Bridgeway LTC behavioral health bed days per 1,000 decreased from 389.6 in CY 2009 to 117.8 in CY 2010. Both these statistics demonstrate dramatic improvement. We project a continued decreasing trend for admissions and bed days, necessarily on somewhat less dramatic scale.

Children and Adolescents

Bridgeway has very few children and adolescents among our ALTCS members. We have 25 child/adolescent members in the Maricopa and Yuma/La Paz GSAs. Since this population is so small, we have one Nurse Case Manager with significant pediatric experience who is the single point of responsibility for coordinating care for these members.

Many child and adolescent ALTCS members qualify for services through Children's Rehabilitative Service (CRS), which has a large statewide network of providers. CRS has a separate benefit plan and covers most of the medical services that eligible children and adolescents require. As a result, Bridgeway does not maintain a comprehensive specialized pediatric medical network. We are contracted with the Phoenix Children's Hospital and their specialist physicians in the event that a member requires specialized pediatric services. We also plan to pursue a contract with Diamond Medical Center, a brand new pediatric hospital in Tucson.

Bridgeway provides primarily in-home support services and behavioral health care services to child and adolescent members, as well as residential care when children cannot remain at home. To a large extent the services most utilized are personal care services, such as bathing assistance, and respite care for family caregivers. Our pediatric Case Manager works directly with the CRS Case Manager to coordinate care for child and adolescent members. Key pediatric providers and services are described below for the Maricopa and Yuma/La Paz GSAs. To the extent that similar specialized pediatric providers are available in other GSAs we will include them in our network.

In the **Maricopa GSA,** in-home HCBS providers that have provided service to Bridgeway child members include Arizona Bridge to Independent Living (ABIL) and Prileo Home Care. We also contract with Los Ninos Hospital, a 15-bed, family oriented hospital specializing in high quality acute and sub-acute care for infants, children and teens. They maintain all RN, LPN and RT staffing with Pediatric Advanced Life Support certifications. Many staff members have previous experience in PICU/NICU settings.

Key outpatient behavioral health providers for children in the Maricopa GSA include Providence of Arizona, Phoenix, whose services include home-based counseling, case management, crisis intervention, and Seven Challenges substance abuse groups, and Arizona MENTOR.

The Phoenix Children's Hospital's Children's Neuroscience Institute plays a key role in providing care to children and adolescents that present with complex and interrelated neurological and behavioral health conditions.

In the **Yuma/La Paz GSA,** the home health agency Nursing Solutions has provided HCBS services to a child member. In addition, key residential providers include:

- The LaCanada Level II Residential Treatment Center is critically important, as it is the only Level II RTC in the Yuma/La Paz GSA. It is part of the Arizona Children's Association.
- The Arizona Children's Association offers five homes in Parker and one home in Yuma that serve children and adolescents.
- Providence offers 12 homes in Yuma that serve children and adolescents.

Key outpatient behavioral health providers in the Yuma/La Paz GSA include:

- EXCEL Children's Outpatient Clinic, which also offers groups for court-ordered adolescents
- Community Intervention Associates (CIA), which provides family-centered treatment and in-home support
- Providence of Arizona, which through both Parker and Yuma sites offer home-based counseling, school-based services, case management, Seven Challenges substance abuse group services, and crisis intervention

Members in the Yuma/La Paz GSA also may access the Children's Neuroscience Institute at the Phoenix Children's Hospital.

Projected Utilization

The number of Bridgeway children and adolescent members is very small (25 in the 2 GSAs combined). In addition, these members have a wide variety of complex conditions. Therefore, it is difficult to make utilization projections with any degree of confidence.

Members with Traumatic Brain Injury

Members with traumatic brain injury are a challenging special population because providers caring for them must be capable of dealing with members' acting out and sometimes violent behaviors. Placements must take into account the potential for members' harming those with whom they live. Unlike the ALTCS population as a whole, members with TBI are primarily adolescents and predominantly young male adults. Providers that specialize in serving members with TBI are described below. Services for members with TBI are available primarily in large urban areas, and there are very limited TBI services available in rural areas. Selected GSA-specific examples of our network for members with TBI follow. We will work with providers in proposed GSAs to support their expanding services for members with TBI.

Maricopa County, GSA 52

Bridgeway's key **outpatient providers** for members with TBI include ELBA Healthcare, LLC and Arizona MENTOR, which provides treatment of brain and spinal cord injuries or other neurological conditions for adults and children. They specialize in working with younger, more physically aggressive individuals and their primary goals are to increase functioning and help members develop the skills needed to live independently and reintegrate into the workforce. We have worked closely with Arizona MENTOR, for example, in helping a member who was then able to move back in with her mother. Arizona MENTOR also recently opened an additional home in Scottsdale.

The Foundation for Senior Living has three **adult day health care** sites that serve young adult members with TBI (and other behavioral health conditions), in Glendale, Phoenix, and Tempe. Young adults, ages 18 and older, who have a closed head injury or other disability, find support within a club-like environment at these centers. Daily activity and fellowship enhance social and recreational skills. Restorative therapy is available to maintain or improve functioning levels. They help our members improve cognitive skills, strengthen reasoning and decision-making, and increase their capacity for community re-entry. Lutheran Social Services provides services for young adult members with TBI at its Day Break site in Apache Junction. Our network also includes 31 **assisted living sites** for members with TBI. They include Adams House with 2 locations, the "Assisted Living" group with 6 locations, Freedom Manor with 5 locations, Liberty Manor with 2 locations, and Young Life with 2 locations.

The **Children's Neuroscience Institute** at the Phoenix Children's Hospital provides both inpatient and outpatient behavioral health and neurological services and has specialty services for children with TBI. In addition, the Barrow Neurological Institute at St. Joseph's Hospital and Medical Center provides TBI services and we have worked with them on an out-of-network basis.

Yuma/La Paz Counties, GSA 42

Bridgeway's key **outpatient providers** for members with TBI include ELBA Healthcare, LLC, which provides neuropsychological assessment and cognitive skills retraining, and Arizona MENTOR, which is described above as they also serve the Maricopa GSA.

Child and adolescent members in the Yuma/La Paz GSA also may utilize TBI services from the **Children's Neuroscience Institute** at the Phoenix Children's Hospital, noted above.

Projected Utilization

We believe that growing public awareness of traumatic brain injury is likely to increase individuals' willingness to seek treatment and consequent overall utilization of TBI services. The estimated subpopulation of ALTCS members with TBI is very small; it is difficult to project whether increased awareness of TBI would affect ALTCS utilization, in light of the functional status that is prerequisite to ALTCS eligibility.

Homebound Members

Bridgeway addresses homebound members as a special population and Contracting and Case Management Department staff are vigilant in identifying physicians and nurse practitioners who will agree to travel to members' homes to provide care. Conditions that may result in members being unable to safely travel to a doctor's office include being dependent on a ventilator, severe obesity, and comorbid, complex physical and behavioral health conditions. Without adequate primary care, such members are at high risk of requiring Emergency Department care, followed by an inpatient hospital stay.

Our main providers for homebound members have been INSPIRIS and Geriatric Solutions, two medical groups that specialize in providing care onsite where members live, including in ALF and SNF settings. INSPIRIS serves both the Maricopa and Yuma/La Paz GSAs, and Geriatric Solutions provides services in the Maricopa GSA.

- INSPIRIS provides intensive primary care services to institutionalized members and members residing in Assisted Living Facilities and also provides services to members living in their own home. Their focus is on elderly, chronically ill, and medically complex patients. INSPIRIS has documented quality measures that demonstrate the clinical value of the program. They have measured as much as a 64% reduction in acute admissions as a result of their programs of care for both long term care and short term episodic events.
- Geriatric Solutions provides primary care services for home-limited and geriatric patients. They specialize in keeping frail elderly members healthy and at home. They manage all aspects of members' health including diagnostic, medical equipment needs, safety in the home, specialist referrals, and prescriptions.

In addition to these two groups, Bridgeway contracts with a number of individual medical practitioners in the Maricopa GSA who provide primary care to members where they live. Some of these practitioners serve exclusively homebound members and no longer maintain office space for seeing patients.

We have identified a PCP who is willing to travel to see members in Yavapai GSA; we have not yet located PCPs willing to do this in the Yuma/La Paz GSA. In rural areas, we seek to identify PCPs, including at FQHCs, who are open to seeing members where they live, and educate them on how Bridgeway Case Managers can support their treatment of members and coordinate care.

On a case by case basis we also may make special arrangements. For example, in La Paz, we arranged for a nurse from a physician's office to travel to the home of a bariatric member who was not ambulatory to do blood draws. In addition, in remote areas, we have placed telemonitoring equipment in the home of members with certain chronic, complex conditions, to monitor their condition and enable timely intervention if their condition changes, and prevent unnecessary use of the Emergency Department.

Projected Utilization

As the number of primary care providers and specialists willing to see members in their home or in alternative residential settings or SNFs increases, we expect utilization of onsite services to increase.

11. Tertiary Care Hospital Services

11. (Acute and ALTCS) A description of the adequacy of the geographic access to tertiary hospital services for the Contractor's membership

Tertiary Hospital Services in Arizona

The health care facilities in Arizona that provide tertiary hospital services[1] are listed below, along with selected, major types of services in which they specialize. There are no tertiary hospital services in the other four ALTCS GSAs. Bridgeway provides in-network pediatric services, although a small percentage of members are children, and much of the acute care provided to such members is through the Children's Rehabilitative Service (CRS) Program. Also, although ALTCS members rarely require obstetric services, they may require from time to time specialized gynecological services.

Tertiary Hospitals by GSA (In alphabetical order)	Selected, High Volume or Specialized Services
Maricopa GSA	
1. Arizona State Hospital, Phoenix	Psychiatric inpatient
2. Banner Desert Medical Center, Mesa	NICU, Trauma
3. Banner Good Samaritan Medical Center, Phoenix	Neuro-Spinal Cord Trauma, Trauma Unit, Fetal Medicine/OB/GYN, Transplants, Cardiology, Oncology/Residency program
4. Banner Thunderbird Medical Center, Glendale	Neurology
5. Cardon Children's Medical Center, Mesa	Oncology, Neurology, Emergency Services, Surgery and a Level III Neonatal
6. Maricopa Medical Center, Phoenix	Trauma, Burn Unit, NICU, OB/GYN
7. Mayo Clinic, Phoenix and Scottsdale	More than 65 medical and surgical specialties
8. Phoenix Children's Hospital, Phoenix	Children's Hospital - Residency Program
9. St. Joseph's Hospital and Medical Center, Phoenix	BNI (Barrow's Neurological Institute), Transplants, Fetal Medicine, Cardiac, Trauma, Gynecologic Oncology, Oncology/Residency Program
10. St. Luke's Medical Center, Phoenix	Cardiology, Orthopedics, Surgical Weight Loss, Emergency Services, Cardiopulmonary Services, Physical Rehabilitation and Wound Care.
11. Scottsdale Healthcare Hospital, Scottsdale	Trauma, Center of Excellence for Bariatric Surgery
Pima, Santa Cruz GSA	
1. Tucson Medical Center (TMC), Tucson	Trauma, Oncology
2. University Medical Center (UMC), Tucson	Trauma Unit, Fetal Medicine/OB/GYN, Transplants
Coconino, Apache, Mohave, Navajo GSA	
1. Flagstaff Medical Center, Flagstaff	Trauma Unit, Fetal Medicine/OB/GYN

Arizona Regional Medical Center (ARMC) in Mesa is the newest hospital in the state of Arizona. The hospital has hired staff, repaired the facilities, obtained new equipment, and is preparing for inspection by the Arizona Department of Health Services and accreditation by the Joint Commission. The hospital will be a multi-specialty tertiary care center with an Emergency Department and intends to integrate clinical research with patient care. Once ARMC is operational, Bridgeway will seek to include the hospital in our network.

Access Patterns for Members

In general, members in the Maricopa and Pima GSAs tend to access tertiary hospital services respectively in Maricopa or Pima Counties, with some exceptions (for example, in light of travel distance, members in the western portion of Pima

[1] Tertiary hospital services are highly specialized health care services encompassing multiple specialties and sub-specialties, sophisticated technology, diagnostic support, and intensive care facilities. McGraw-Hill Concise Dictionary of Modern Medicine. © 2002 by The McGraw-Hill Companies, Inc.

County may use a Maricopa or Tucson facility, depending on their location).

Members in GSAs with no tertiary hospitals normally will be directed to the nearest GSA with a tertiary hospital, unless the closest tertiary facility does not have the appropriate specialty or there are other special circumstances. In these cases, Bridgeway staff will work with the member and caregiver to identify the most appropriate tertiary hospital in another GSA and assist in addressing any transportation issues.

All the facilities on the above table are within Bridgeway's network except Arizona State Hospital, Maricopa Medical Center, Mayo Clinic, St. Joseph's, and Scottsdale Healthcare. For out-of-network tertiary care hospitals, we pay Medicaid rates as provided by AHCCCS. The vast majority of needed tertiary hospital services are available in-state and the need to identify out-of-state services is rare.

Methods for Ensuring Access to Tertiary Hospital Services

Bridgeway ensures that ALTCS members have access to tertiary hospital services regardless of their place of residence or physical or mental condition We assess not only geographical proximity but also which facility offers the most appropriate services and expertise for treating the member's condition, the most appropriate mode of transportation, and any potential geographic barriers (such as in mountainous areas particularly in the winter). Types of tertiary care services that ALTCS members historically have utilized include cardiac care, neurology, oncology, psychiatry and orthopedic surgery.

For members in an emergency or urgent situation in an area distant from tertiary services, facilitation might include stabilization at a local facility and then airlift to a tertiary hospital in the Phoenix area or Tucson or Flagstaff, depending on the member's location. For some members, such as those with cognitive conditions, Case Managers arrange on a case-by-case basis for a qualified caregiver to accompany the member to the hospital and stay in a nearby hotel during the inpatient stay. In these cases, we pay the caregiver's transportation, lodging, and meals. Before a member's stay is concluded, Case Managers conduct thorough and extensive discharge planning to ensure a safe transition and reduce any complications that might necessitate readmission to inpatient care.

14. Using Feedback on Network Design and Performance

14. The methodology(ies) the Contractor uses to collect and analyze member, provider and staff feedback about the network designs and performance. When specific issues are identified, the protocols for handling them.

In our discussion below regarding Bridgeway methodologies for collecting and analyzing feedback on network designs and performance, we address:

- Member and provider feedback
- Bridgeway committees that analyze member, provider, and staff feedback
- Departmental staff feedback
- Protocols for handling provider-specific performance issues

Member and Provider Feedback on Network Issues

Bridgeway uses several methodologies to collect and analyze both member and provider feedback on network issues.

Member/Provider Councils. One of the most important means for collecting and analyzing member and provider feedback on network design and performance is the Member/Provider Councils, of which there is one in each GSA. Bridgeway seeks demographic diversity among Council participants, for example, regarding urban/rural location, ethnicity, gender, and cultural background. The Councils provide specific, current information on member needs, member and provider observations and concerns, recommended solutions to regional challenges, and community insight on what works best in different parts of the State.

The VP of Provider and Member Services or one or more senior staff members attend all Council meetings. Senior staff from all other departments except Finance also attend. Staff welcome feedback on local issues and also solicit feedback on issues that staff have identified. The protocol for addressing issues that Council participants raise is to take responsive action whenever feasible promptly after each meeting, as appropriate to specific issues. The VP of Compliance coordinates quarterly reporting of Council activities and recommendations to the QMPIC, which analyzes feedback and recommends broad based responsive action to expand network access and performance. The Bridgeway Board, CEO, and senior staff have final responsibility for taking action.

Member and Provider Call Center Inquiries and Grievances/Disputes/Complaints. On a monthly basis, Member and Provider Services staff prepare a written report on and trend call center inquiries, and Operational Services and Compliance staff report and trend member grievances, and provider claims disputes and complaints, in order to identify potential network gaps, provider performance concerns, and opportunities for member and provider education on access to care and provider performance. Staff respond immediately to issues amenable to prompt resolution. At weekly staff meetings, staff discuss potential trends as they emerge, and develop proposed solutions as needed, such as onsite provider education to address specific, repeated claims errors from certain providers. The VPs of Member and Provider Services and of Compliance analyze the monthly reports, and they report quarterly to the QMPIC regarding the number of inquiries and complaints, topical categories, and any trends indicating that further action should be taken.

Member and Provider Portals. Both Portals will include secure messaging through which members, their representatives, and providers may submit feedback to Bridgeway. Although email feedback volume currently is low, over time we expect to see increased use of the Portals for obtaining feedback. Member and Provider Services staff will monitor email feedback in a manner similar to monitoring of inquiries and complaints.

Gap-in-Critical-Services Reports. Member feedback on non-provision of services is the basis for providers' gap-in-services reporting that Bridgeway QM staff then audit as required by Ball vs. Betlach. We submit monthly gap-in-services reports to AHCCCS and promptly correct any adverse trends in attendant care, personal care, homemaking, and respite care, largely through additional provider education, and also through corrective action and network expansion when appropriate. We report gap-in-services data to the QMPIC quarterly.

Member and Provider Satisfaction Surveys. The QM Department conducts a cross-functional Annual Member Survey, using input from other departments on the questions in the survey. Many questions address member satisfaction with access to care, and the results provide useful feedback on network design and performance issues. The primary interdepartmental forum for analyzing survey results is the QMPIC. The protocol for responding to issues raised is QMPIC recommendations for action and senior staff implementation. In addition, with support from QM staff of Bridgeway's parent organization Centene, we also periodically conduct a CAHPS survey of members. Our new Member and Provider Relationship Manager software (MRM and PRM) will automate many administrative aspects of developing and conducting member and provider surveys, which will facilitate use of ad hoc surveys to solicit feedback on targeted areas and issues.

Provider Feedback on Network Issues

Onsite Visits With Providers. Network Management staff in the Provider Services Department conduct regularly scheduled monthly, quarterly, or annual onsite visits with network providers, and with providers who request a visit or training. A significant goal of these visits is to gather provider feedback, particularly on network performance expectations and how to meet them. Network Management staff analyze such feedback in weekly staff meetings and take prompt follow action as appropriate.

Joint Operational Meetings with Network Subcontractors. We conduct quarterly joint operational meetings between key Bridgeway staff and our dental, pharmacy, and vision subcontractors for oversight as well as feedback purposes. The VP of Provider Services addresses network specific issues such as contracting and network adequacy, the VP of Compliance monitors overall performance related measures, and staff from other functional areas participate as appropriate. For example, QM staff review each network subcontractor's Quality Management Plan and Utilization Management Plan, and the Pharmacy Director participates in the meetings with our pharmacy subcontractor, US Script. The quarterly meetings are an excellent forum for obtaining feedback on operational and other issues from network subcontractors.

Provider Compliance and Monitoring Surveys. Bridgeway QM staff use secret shopper methodology to assess provider performance against appointment availability standards. QM staff also evaluate compliance with wait time standards. Network Management staff verify the percentage of open panel PCPs. QM staff evaluate feedback on appointment access annually and Network Management staff assess PCP access twice a year, to ensure network sufficiency and compliant performance. In the event that either is deficient, Network staff recruit new providers or conduct provider education to improve performance.

Providers Who Leave the Network. Although provider departure from the network is not a common occurrence, if it happens, a Network Manager or Supervisor contacts the provider to learn what concerns led to the provider's leaving the network. The VP of Provider Services and when appropriate QMPIC use this feedback to prevent similar concerns among other network providers. If appropriate, staff also will re-contact the provider later to encourage them to rejoin.

Bridgeway Committees That Analyze Member, Provider, and Staff Feedback on Network Issues

Bridgeway's committees are a primary means for collecting, analyzing, and especially *integrating* network related feedback from members, providers, and staff. Some committees include providers, who offer their feedback directly by participating in meetings. Committees that do not include providers collect and analyze provider feedback through structured methods such as those described above. Our Committees are an important tool for obtaining feedback from staff who are not in the Tempe office, so that we can ensure that regional issues and views from all GSAs are well represented in Bridgeway Committee deliberations.

The Contracting and Provider Relations Committee is the main committee that focuses on network design, including the dental and vision networks; this Committee also addresses feedback on network performance of administrative functions such as claims submission. Network design issues are a focus of our Behavioral Health Committee, which also addresses means for better integrating BH and medical services and the extent to which providers are achieving integration of

services. The Pharmacy and Therapeutics Committee addresses feedback on the pharmacy network and other pharmacy issues and includes a network physician.

Committees that collect and analyze member, provider, and staff feedback on network performance (and to a lesser extent on network design) include the Grievance and Appeals Committee (network access and performance issues), Medical Management/Utilization Management Committee (including feedback on prior authorization issues), Performance Improvement Team (regarding Performance Improvement Projects), Quality Management and Performance Improvement Committee (the overarching Committee to which most other Committees report), and the Executive Leadership Team.

The remaining Bridgeway committees serve as interdepartmental coordination mechanisms for obtaining and analyzing staff feedback and input from several external committee members, but these committees do not play a major role regarding member and provider feedback or regarding network issues.

Feedback at Provider Services Department Staff Meetings

Weekly Provider Services Department meetings are an important, close to real-time method for ensuring that provider feedback from onsite visits by Network Managers and feedback received through the call center is shared and used promptly to address negative trends and concerns. Weekly meetings enable prompt response and when appropriate, escalation, such as to Bridgeway's Executive Leadership Team.

Protocols for Handling Provider-Specific Performance Issues

When provider-specific performance issues are identified through member or provider feedback or Bridgeway staff monitoring, typically they are compliance matters or potentially sensitive issues. The standard protocol for handling specific provider issues follows, however it may be adjusted for special circumstances (such as allegations of provider substance abuse, depending on the evidence available and circumstances).

- Bridgeway documents the concern in a letter to the provider. In some instances, the Medical Director or Network Manager calls the provider, or Bridgeway staff arrange an appointment with provider leadership representative(s) rather than office staff.
- Appropriate Bridgeway staff meet with the provider to discuss the concern. Since concerns are often compliance related, if substantiated, they usually lead to a corrective action plan (CAP).
- Normally, QM staff monitor CAPs. If compliance is achieved, the CAP is discontinued. If not, providers may be subject to sanctions or contract termination, following submission of the issue to the Peer Review Committee for recommended action.

16. Non-Medicare Certified Home Health Agencies

(For ALTCS Contractors Only)

16. Listing of non-Medicare Certified Home Health Agencies the Contractor is using. The listing is to be provided on the form distributed by AHCCCS and attached to the Plan. (AMPM Policy 1240) (See Attachment A)

We are not using non-Medicare-certified home health agencies.

17. Workforce Development Strategies

(For ALTCS Contractors Only)

17. The strategies the Program Contractor has for Work Force Development. Program Contractors make up the largest payer group for paraprofessionals in the long term care market and must leverage this to ensure adequate resources in the future. Successful efforts to recruit, retain and maintain a long-term care workforce are necessary to meet the needs of the anticipated growth in the ALTCS membership. The Program Contractor must have as part of their network development plan a component regarding paraprofessional work force development in nursing facilities, alternative residential facilities and in-home (attendant care, personal care and homemaker).

Work Force Development is defined as all activities that increase the number of individuals participating in the long-term health care workforce. It includes actions related to the active recruitment and pre-employment training of new caregivers and opportunities for the continued training of current caregivers (i.e. Program Contractor supported/sponsored training). Work Force Development also includes efforts to review compensation and benefit incentives, while providing a plan for the expansion of the paraprofessional network at all levels of client care.

Bridgeway strategies for long term care workforce development include promoting training and standards for direct care workers, engagement with professional associations and community groups, quality incentives, Provider Coaches, and other innovative approaches to enhancing professionalism among HCBS caregivers. Our strategies are described below.

Training and Standards for Direct Care Workers

Direct Care Task Force. Bridgeway is the only ALTCS health plan that is a member of the Direct Care Task Force, and we serve actively on the main Task Force and a subcommittee. Bridgeway has provided input, staff resources, administrative and organizational support and contributions to assist this independent group in creating a universal training and certification program for direct care workers.

Arizona Non-Medical Home Care Association. Bridgeway Case Management staff participate in monthly meetings of the Arizona Non-Medical Home Care Association's Legislative Committee. The Committee is drafting legislation to create training and certification requirements as well as background checks for home care workers and agencies. We are providing technical resources to support their initiative.

National Association of Health Care Assistants. Bridgeway is partnering with the National Association of Health Care Assistants (NAHCA), based in Joplin, MO, to promote long term care facilities' use of NAHCA's Virtual Campus of Care, which provides online caregiver training and a professional development ladder. (NAHCA also collaborates with the Arizona Health Care Association.) Bridgeway has identified and proposed to 11 skilled nursing facilities serving Bridgeway members that their Certified Nurse Assistants and other staff enroll in NAHCA's online training. Bridgeway will pay for the facilities' first month of enrollment. In addition, Bridgeway Case Management staff will take selected courses, as recommended by our Vice President of Long Term Care Case Management.

Pima Health System/Bridgeway Education and Training Center. Under Bridgeway's management agreement with **Pima Health System, the Education and Training Center (Center) provides continuing education to assisted living** facility caregivers and adult foster care sponsors. The continuing education courses are approved and certified by the Board of Examiners of Nursing Care Institution Administrators and Assisted Living Facility Managers, and the Center is ADHS certified as an Assisted Living Training Program. Course examples include the one-day Supervisory and Personal-Directed Care course (offered 3 times a year) and 21-hour Advance Medication Course (offered 2 to 3 times a year). The PHS/Bridgeway Manager of the Center is developing a Fall Risk Prevention Program to submit for certification approval.

Arizona Health Care Association. Bridgeway has the distinction among health plans of collaborating with the Arizona Health Care Association (AHCA) to support their initiatives regarding workforce development for direct care workers. For example, at AHCA's recent annual conference, we provided scholarships for students and interns so they could participate and learn about career opportunities. The Centene Foundation also has contributed to the AHCA Foundation to support their scholarship programs. At AHCA's recent spring conference, our Medical Director, Dr. Fred Miller, was a speaker and addressed techniques for managing care for members with complex conditions.

In addition, Bridgeway has arranged for speakers and financially sponsored professional education sessions for AHCA, including one session at which a network podiatrist spoke on wound care, and another at which a nurse practitioner spoke

on bariatric care issues. We obtained approval for continuing education units for both sessions, which are an excellent incentive for medical professionals' participation.

Legacy Home Care. Bridgeway is developing a partnership with Legacy Home Care to provide training sessions to caregivers. Our goal is to provide caregivers who serve members in their home the skills for observing changes in the member's condition, function, and environment, and responding appropriately. Caregiver response skills include communicating in a timely manner with the member, family, HCBS agency, or Case Manager to arrange for service adjustments to ensure the appropriate types and level of services.

Onsite Staff Training and Assessment Regarding Members with BH issues. Bridgeway Behavioral Health Case Managers currently train staff at network nursing facilities and assisted living facilities on crisis management and how to work appropriately with members who have a behavioral health condition and who exhibit difficult behaviors or need to develop behavior management skills. We have also identified psychiatric professionals who see our members in skilled nursing facilities. For example, we have arranged for a psychologist who is trained in Functional Behavioral Assessment to assess, onsite, members with challenging behaviors. The psychologist also interviews caregivers and family members and helps train them on ways to help extinguish or replace negative behaviors with pro-social behaviors.

Provider Coaches. Bridgeway will establish the position of Provider Coach to address the fact that many assisted living, nursing facilities, and other providers lack the expertise to put into practice AHCCCS and ALTCS' values of choice, independence, and self-determination, and to collaborate in facilitating members' living in the most integrated, least restricted setting. An initial priority for Provider Coaches will be training staff at assisted living and nursing facilities. While Case Managers engage providers at the level of individual members and their needs, Provider Coaches will focus on the residential environment level, across members living in the facility, and on opportunities to improve consistency of provider services with ALTCS values, particularly member choice, independence, and self-determination. Provider Coaches will deliver training, technical assistance, program guidance and "hands on coaching." Bridgeway Provider Coaches will report to the VP of Long Term Care Case Management. Bridgeway has modeled the Provider Coach position on the successful experience of our affiliate Cenpatico in using Provider Coaches to increase and measure behavioral health providers' use of strengths based, culturally competent service delivery methods. Bridgeway Provider Coaches also may assist with other direct care workforce development activities.

Implementation of and Support for State-Required Direct Care Workforce Training. Bridgeway is partnering with several agencies to develop a presentation based on the new State requirements for direct care worker training.
Within our network, for personal care and BH personal care services, we verify caregiver competence certification in all personal care services. Beginning January 1, 2012, Bridgeway will require provider documentation that all direct care workers have met the new Direct Care Workforce training and testing standards as required by AHCCCS, unless employed by the agency prior to January 1, 2011. Noncompliant providers will be required to submit a corrective action plan and provide a trained worker until the untrained worker has met the requirements. For provider types that provide services in a community-based setting to members who live in their own home (such as adult day care services), QM staff conduct a site visit, using survey tools that are specific to the type of provider being evaluated and based on AHCCCS Medical Policy Manual requirements.

Professional Association and Community Support and Involvement

Bridgeway is a current associate member of the **Arizona Health Care Association** and other long term care trade associations such as the **Arizona Association of Homes and Housing for the Aging (AzAHA)** and **Assisted Living Federation of America (ALFA),** and we participate in their leadership conferences. We believe that formation of a professional association for direct care workers (perhaps as an affiliate of an existing long term care association or as a freestanding association) would enhance professionalism and career development opportunities for workers. Bridgeway support for a direct care workers association would include associate membership and offering meeting space and administrative support.

Bridgeway has forged lasting partnerships with other key community stakeholders such as the **Area Agencies on Aging** and the **Yuma Elder Abuse Task Force.** Bridgeway is an active community partner and works cooperatively with other organizations that are dedicated to serving the elderly and physically disabled.

Additional Bridgeway Initiatives and Programs

Quality Incentives. Bridgeway is developing an incentive program to encourage HCBS agencies to enhance the professionalism of their workforce. The program would establish criteria for agencies such as recruiting staff to meet the

cultural competency needs of Bridgeway membership, offering full-time employment and benefits, and offering performance incentives to employees, such as for attendance and timeliness. We are also seeking a partner to implement an HCBS agency incentive based solely on reducing agency staff turnover. Our Illinois health plan affiliate has initiated a similar incentive program that we believe holds great promise.

Meet and Greet Forums for Bridgeway Case Managers and HCBS Direct Care Workers. In new GSAs, before the operational start date and then several months after it, the Bridgeway Case Management Department invites HCBS providers to a local "Meet and Greet" event. The forums are both a listening session for Case Managers to hear directly from local HCBS providers and their staff or workforce, and an avenue for Bridgeway to foster collaboration and a teamwork approach to meeting member needs. One purpose of holding a Meet and Greet session shortly after a new GSA implementation is to solicit feedback on how providers feel the new program is going so we can take action to adjust and improve as needed. For example, for implementation of Bridgeway's recent ALTCS Program management agreement with Pima Health System, we conducted productive Meet and Greet sessions that helped smooth the administrative transition.

Bridgeway will continue to hold Meet and Greet sessions periodically with our HCBS providers in the various GSAs. Recent sessions were held in September 2009 and again in March 2010. In addition to providing Bridgeway Case Managers a different insight into the local long term care community, these ongoing forums help Case Managers communicate to providers, both formally and informally, suggested areas for staff development and potential solutions, such as approaches for improving staff retention.

Member/Provider Council Feedback. Through Member/Provider Council meetings, Bridgeway encourages member and provider feedback and recommendations to improve performance and training of direct care workers, ranging from training topics to possible compensation and benefit incentives for HCBS agencies. We also solicit input on ways to expand our community involvement to support workforce development programs.

Educating Members About Programs Such as Spouse as a Paid Caregiver and Self-Directed Care. Bridgeway Case Managers encourage members to participate in shaping their service delivery to the greatest extent possible, including choosing and educating their caregiver regarding their service needs, and they discuss related programs with members. When members have the option of their spouse or a family member serving as a paid caregiver, or the member functioning as employer of a caregiver of the member's choosing, there is greater potential for members to retain that caregiver for a longer period of time. The self-directed attendant care program empowers members to focus on their needs and engage in determining how their needs can best be fulfilled, typically leading to increased satisfaction and sense of well being.

Having family members serve as paid caregivers can help relieve stress and enhance and even stabilize the long term personal relationship between the member and caregiver. Because Case Managers use the same assessment tools and approach for family members as paid caregivers as they do for agency caregivers, we have not experienced an overall increase in use of services since the program was instituted. For family members, receiving caregiver training and being part of an agency enhances confidence in providing care and support for modifying how care is provided when the member's needs change.

18. Strategies for In-Home Placement with HCBS

(For ALTCS Contractors Only)

18. Strategies the Contractor will take to provide members with "in-home" HCBS versus placing members in Assisted Living Facilities and Nursing Facilities. A priority shall be placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institutional or alternative residential setting.

Bridgeway uses three types of strategies to provide and maintain in-home placement for ALTCS members. The strategies focus on (1) individual members and their providers, (2) contracting with and supporting appropriate types of providers to maintain members at home, and (3) expanding housing options, including through collaboration with community organizations.

Strategies with Individual Members and Their Providers

Case Management Training and Case Reviews. Each member is assigned a Case Manager, who is either a nurse, social worker or behavioral health clinician, depending on the member's needs. Bridgeway Case Managers' primary responsibilities are to assess members and identify the supports needed for members to live at home. We train our Case Managers to view in-home placement as the preferred option, and operate with the expectation that the member will live in-home. If members appear to be capable of living at home but express a preference for an alternative setting, Case Managers explore whether the issue is members' concern about being a burden to their family, and in what ways. Often we can arrange for specific HCBS services or supports that allay members' concerns in this regard. Similarly, family caregivers may themselves feel burdened or stressed, and be unaware of the types of service options that can make in-home placement viable and relieve caregiver stress, including scheduled respite for the caregiver. Sometimes members and families assume that in-home care is out of the question, or simply don't have the time or resources to investigate what may be available. Our Case Managers provide member and family/caregiver education about service options and arrange for those that optimize members' chances of remaining safe at home.

A strategy Case Managers use for members who do not have their own home is to identify siblings and children of members with whom the member may be able to live, or who own a house in which members could live, if they have appropriate home-based supports. Developing a thorough transition plan to assist members who move to a family home is important in order for such an arrangement to get off to a good start and succeed. Case Managers assist members in securing a community based PCP and specialists, as well as finding and authorizing needed services such as attendant care, personal care, homemaker, home health nursing, emergency alert, and other in-home services that may be utilized 7 days per week and as needed throughout a 24-hour period. Case Managers coordinate with all HCBS and other providers and stakeholders, so that the member moves into the home with all necessary and appropriate medical, behavioral, social, peer, personal, and respite supports in place.

Bridgeway conducts Case Reviews with a cross-functional team that includes management as well as staff, to generate additional strategies and direction on care planning and delivery. Case Reviews include collaboration with the member's medical treatment team to identify risk factors that may jeopardize continued in-home placement.

Members in Assisted Living and Nursing Facilities. The Case Manager conducts in-person visits at least every 90 days for members in their own home or assisted living facility and every 180 days for those in skilled nursing facilities (SNFs) and more frequent visits and/or calls as dictated by the member's condition and new or changed needs. At each of these visits, Case Managers evaluate the appropriateness of the placement and the member's interest in living in a less restrictive environment or at home. When the Case Manager determines, along with the member and/or their representative, that a less restrictive environment or in-home placement could be safely and cost-effectively maintained, the Case Manager assists the member in making arrangements to move to their new environment.

Keeping Members in their Homes. Bridgeway Case Managers are the single point of accountability for listening to members, empowering them to participate in decision making about their care, and arranging the necessary supports that reinforce to members that they can remain in-home and enjoy the sense of independence and comfort that in-home living provides. Bridgeway Case Managers work closely with both family members and caregivers to ensure that members have daily support for ADLs and IADLs so that members can remain as fully engaged in all aspects of running their homes and lives as possible. Case Managers assess the need for respite care services to minimize the burden on family caregivers so that the quality of their interactions with and support for members are optimum.

Case Managers maintain contact with members to determine whether their needs are changing; and, if so, Case Managers coordinate any related change in services with the home care staff, PCP, specialists and other providers to ensure that everyone is on the same page with the members' wishes on how to adjust to the change. Case Managers ensure that

members are not isolated and help minimize the chances that loneliness may develop by arranging for peer support, opportunities for social contact, and community activities.

Strategies with Providers

Network Services that Support In-Home Placement. Bridgeway's network provides a wide array of HCBS services to appropriately maintain members in-home (in both rural and urban areas) and ensure their safety, health, and socialization needs are met, such as attendant care, personal care, housekeeping, home delivered meals, adult day care, emergency alerts systems, home health nursing, and therapy services. Key strategies for keeping members in their homes include meeting members' linguistic and cultural needs, providing caregiver respite services (described above), and educating members about their options for self-directed care and the member's spouse or a family member serving as paid caregivers.

- Identifying caregivers who speak the same language as a given member is a priority and can make a significant difference in member satisfaction. Bridgeway Case Managers and Network Managers collaborate in identifying caregivers who speak languages other than English and over the past few years have located caregivers who speak Russian, Bosnian, and Navajo.
- The Self-Directed Attendant Care Program empowers members to focus on their needs and engage in determining how their needs can best be fulfilled, typically leading to increased satisfaction and sense of well being.
- In the Spouse as Paid Caregiver Program, family members who elect to be paid caregivers participate with one of Bridgeway's HCBS providers, receive appropriate training and coaching for the services they provide, and have backup and supervision when temporary issues arise that keep them from serving as a caregiver. The Spouse as Paid Caregiver Program helps to increase the capability and fidelity of family member care, reduces stress, and enhances the comfort and quality of care that members receive.

Monitoring Quality of HCBS Services. Long Term Care Case Management and Quality Management Department staff both play a role in monitoring the consistency and quality of in-home HCBS services and member satisfaction with them. The critical services reports help identify potential problems before they escalate, so that Bridgeway can intervene with providers and improve continuity and timeliness of member care. The VP of LTC Case Management and her staff also monitor member grievances to ensure a prompt resolution that satisfies the member and to identify any negative trends.

Direct Care Workforce Development. Bridgeway has been an active member of the Direct Care Workforce and Arizona Non-Medical Home Care Association and has provided training, support and subject matter expertise to improve quality of care and reduce worker turnover (see specifics in the preceding response, Question 17, Strategies for Work Force Development). An innovative approach Bridgeway will take is creating the position of Provider Coach, to facilitate workforce development and training in assisted living facilities.

Strategies to Expand In-Home Supports and Permanent Supported Housing Options

Increase Capacity for In-Home Supports. Bridgeway is in the process of contracting with Maricopa based Recovery Innovations of Arizona (RIAZ), which provides peer support and self-help, recovery education, peer training and employment, community living assistance, and Another Chance (matching roommates) services. Although this agency has historically worked with RBHA members, Bridgeway has proposed a partnership in an innovative approach to working with ALTCS members in which RIAZ will provide wrap around services to help maintain members in their own homes. Bridgeway's collaboration with RIAZ also supports the principles of AHCCCS' new Housing, Education, and Employment Program.

We will work with our affiliate Cenpatico and community based supported housing agencies and advocates to both adapt current programs for use by ALTCS members and develop additional capacity to serve them. Housing assistance providers in Maricopa with whom Bridgeway will collaborate include the City of Phoenix Housing Assistance Program, HUD, Lutheran Social Ministries, and Catholic Social Services.

Increase Capacity of Permanent Supported Housing. Bridgeway's Behavioral Health Coordinator and Behavioral Health Network Development Manager are collaborating with the Pima County Housing Authority and also working to expand similar supported housing beyond the county, including to the Yuma/La Paz GSA. Pima County received one of the few HUD grants awarded for supported housing in the country, through President Obama's Year of Community Living initiative. This program has begun in Pima County and Bridgeway staff have gained access to it for our members through Pima County's voucher system that is managed by the Housing Authority.

19. Action Plan for In-Home Placement

(For ALTCS Contractors Only)
19. A Contractor who has greater than 25% of their members residing in an Alternative Residential Setting (ARS) per GSA shall develop an action plan that identifies approaches to make placements in in-home settings rather than ARS. The plan must be continuously evaluated for effectiveness and revised as needed. A comprehensive report must be submitted to AHCCCS 15 days after the end of each quarter until the Contractor has less than 25% of their members in ARS for four consecutive quarters. A plan must be developed if a Contractor has two consecutive quarters of 25% of their members in a GSA residing in ARS.

Action Plan for Maricopa GSA

Bridgeway has provided an Action Plan for Maricopa County, where ARS placements are greater than 25%. The VP of LTC Case Management is responsible for implementation, monitoring, and updating the Action Plan. In summary, the Action Plan includes:

- ***Member Evaluation*** – Evaluating new and current members in ARS regarding potential for in-home placement
- ***Prevention*** – Focusing on members living at home who may be at risk of placement in ARS
- ***Wrap Around Services*** – Expanding wrap around services to facilitate in-home placements
- ***Supported Housing*** – Investigating new options for supported housing, to facilitate in-home placement for members who do not have family with whom they can stay or who cannot live at home independently

Quarterly Review. On a quarterly basis, the VP of LTC Case Management will review the effectiveness of steps taken under the Action Plan and require revision of the Action Plan as needed. The review will include analyzing the percentage of members in each type of alternative residential setting.

Additional information on Action Plan components follow.

Member Evaluation

- Case Managers conduct a complete evaluation of new members who reside in ARS regarding their interest in, understanding of, and the potential for in-home placement.
- Case Managers reassess members in ARS at least every 90 days and evaluate whether they could live in a more integrated setting. Case Managers monitor members for improvement and positive changed circumstances, so that as, for example, members with behavioral health conditions or in fragile medical condition stabilize, Case Managers can take every opportunity to inform or remind them of options for living at home.

Prevention

- Bridgeway continues to provide focused reviews of all members who are at risk of moving from their home to alternative residential settings. Our Case Managers routinely assess related risk factors, and they increase the frequency of visits and/or calls for at risk members to enable early intervention and appropriate in-home supports to help the member remain at home.

Wrap Around Services

- We will collaborate with Recovery Innovations of Arizona (RIAZ), which provides peer support and self-help, recovery education, peer training and employment, community living assistance, and Another Chance (matching roommates) services; we believe that additional supports that RIAZ can provide may enable additional members to live at home.

Supported Housing

- Bridgeway Case Managers work with housing assistance providers in Maricopa including the City of Phoenix Housing Assistance Program, HUD, Lutheran Social Ministries, and Catholic Social Services.
- Bridgeway's Behavioral Health Coordinator and Behavioral Health Network Development Manager are actively involved with the Pima County Housing Authority and will endeavor to expand similar supported housing initiatives to other parts of Arizona.

Factors Affecting In-Home Placement Opportunities for Bridgeway Members

Two factors that negatively affect Bridgeway's ability to increase in-home placements are described below.

- **Percentage of New Members Living in ALFs** – A high percentage of Bridgeway members enroll while living in Assisted Living Facilities. The range for the three months in Q1 2010 was from 39% to 47%.
- **Older Population –** Bridgeway continues to have a much older population in relationship to the other ALTCS plans in the Maricopa GSA. Based on demographic data provided in the "ALTCS Members by County, Age, and Gender" Report (November 30, 2010), 76.9% of Bridgeway's membership in Maricopa County is over the age of 65, while the other ALTCS plans in Maricopa County average 66.5%. Also, when comparing members over the age of 80 in

Maricopa County, 47.3% of Bridgeway's membership falls into this category, while the overall average for other ALTCS plans is at 37.8%. We believe that the higher average age of Bridgeway members limits our ability to increase in-home placements due to the higher level and complexity of medical, cognitive, and behavioral issues of older members.

20. Single Choice Occupancy Waivers

(For ALTCS Contractors Only)

20. A listing of Assisted Living Facilities for which the Contractor has already obtained a waiver from the Single Choice Occupancy requirement. Listing must include the name of the facility and the date of the waiver approval. (See Attachment C)

Bridgeway has not obtained Single Choice Occupancy waivers for any assisted living facilities.

21. Nursing Facilities Withdrawn from Medicaid

(For ALTCS Contractors Only)

21. A listing of nursing facilities that have withdrawn from the Medicaid Program but are still being utilized by the Contractor. The listing must include the name of the facility and the number of residents the Contractor has in each facility. (See Attachment C)

Bridgeway is not using any nursing facilities that have withdrawn from the Medicaid Program.

22. Reducing Inappropriate Emergency Services Utilization

(ACOM Page 349, Section e)

e. What interventions has the Contractor implemented to reduce avoidable/preventable ER utilization? What was the outcome of those interventions?

Key Strategies for Reducing Unnecessary ED Utilization

The following strategies are among those Bridgeway uses to reduce unnecessary emergency department (ED) utilization.

- **Physician coverage/call availability after-hours and on weekends –** Such coverage is expected of all physicians. We support physicians with our after-hours call answering service through our NurseWise® capability, should such services not otherwise be available.
- **Onsite triage at ALF and SNF sites** – Network provider INSPIRIS provides onsite triage for members who are having an episode in assisted living centers and nursing facilities to assess whether care can safely be provided at the nursing facility or if the member's condition meets the federal and AHCCCS definition of an emergency.
- **Same day PCP or specialist appointments –** Case Managers also alternatively may arrange same day appointments with a specialist who has treated a member, if it is not possible for the PCP to see the member that day.
- **Nurse call-in center/information lines –** NurseWise® provides members after-hours, toll-free access to customer service representatives and bilingual nurses. (Members dial the Bridgeway toll-free number after-hours and the system transfers the call directly to NurseWise® without delay.) NurseWise® includes crisis capacity with staff trained for handling calls from members with immediate or urgent physical or mental health needs.
- **Urgent care facilities –** Recruitment continues in all counties; we also allow members to use non-contracted urgent care facilities.
- **Transportation -** Bridgeway pays for transportation to an urgent care center after-hours (that is, after PCP offices are closed) without a prior authorization.

Educating Members About Alternatives to Inappropriate ED Use

Motivating Responsible and Prudent Health Care Behaviors and Practices. At the core, encouraging responsible use of health care, including the ED, requires motivating members and caregivers to take actions that they perceive to be in their own interest. Acting in our own interest comes naturally to most individuals; however, members and caregivers may lack the knowledge or the resources they need to effectively access health care services. Bridgeway's goal is to become a trusted source of health care information for members, so that if they aren't sure what to do, the first thing that comes to mind is "Call Bridgeway and ask." Through face-to-face, telephonic, and written word contact with members or their caregivers, we educate them about why and how they should take specific actions that will benefit their health and well-being overall, even though occasionally some effort or inconvenience may be involved.

ALTCS members' Case Managers, through their regular contact with members, are the primary educator regarding appropriate ways to access care and when to use the ED. Member Services Representatives also are trained to educate members on when to use the ED, their PCP or Medical Home, or urgent care options.

Key Messages for Members. Usually, Bridgeway staff educate members on the four resources below (as well as others) that help prevent unnecessary ED utilization. They educate members on how to assess and deal with unexpected health care needs at a calm moment, when members are not in immediate need and are not distracted by their physical or mental condition. Case Managers help members and their caregivers think through in advance and plan what steps they will take if they are confronted with an urgent or emergent health care need.

- **Physician coverage/call availability after-hours and on weekends** – Case Managers explain that PCPs are available by phone or have backup medical coverage 24/7, and that members can call their PCP for direction and assistance after-hours when members have an urgent health care need and don't know what to do about it. They explain that members normally will be called back by the PCP or their covering physician within a short time of reaching the PCP's answering service.
- **Same day PCP appointments** – Case Managers explain that if members have an urgent need while PCP offices are open, it may be possible to obtain an appointment on the same day. Case Managers advise members that the member may call the PCP or may call Bridgeway for assistance in accessing same-day appointments.

- **Nurse call-in center/information lines** – Case Managers continually reinforce with members the message, "If you're not sure what to do about a health care concern, call Bridgeway and ask – anytime of day or night." They stress that members may call the same number day or night and will be able to reach a bilingual nurse (or if the member speaks another language besides English, that the nurse can access a translator for the call). NurseWise staff also educate members, but because members calling after-hours usually are in pressing need, education tends to be call-specific, with staff informing members of options such as a nearby urgent care center, calling the member's PCP, or going to the ED in a true emergency.
- **Urgent care facilities** – Case Managers explain the purpose of urgent care centers, and especially their importance for unexpected health care problems when the PCP's office is not open. Case Managers identify an urgent care center near where members live and tell them about it so they are familiar with its location. Because most members do not have their own cars, Case Managers explain that members may use after-hours transportation to urgent care centers without a prior authorization, and how to access transportation services.

Bridgeway also educates members and their family and informal caregivers about the four resources above and appropriate ED use in general through written materials such as the Member Handbook, Member Newsletters, targeted mailings, health education literature, disease management information, and the Member Portal. The information includes examples of situations that are considered emergency in nature, as well as examples that are generally not considered emergency such as colds, sore throats, and ear aches.

In addition to educating members and their family caregivers, Bridgeway Provider Services staff educate staff at residential providers such as adult foster homes and assisted living on the availability of after-hours assistance. They advise regarding the 24/7 Bridgeway toll-free number, urgent care centers, and after-hours transportation. Thus members who seek assistance from staff where they live receive the essential information they need to use ALTCS health care services responsibly.

Evaluating the Effectiveness of ED Utilization Programs

Bridgeway generates claims data reports identifying members who either are not appropriately using the ED (along with their presenting diagnoses), or are using the ED in excess during a 6-month period. Case Managers then contact or visit such members to educate them on alternative and preferable ways of obtaining needed care. Bridgeway's Medical Director and VP of LTC Case Management Director review ED utilization data to identify patterns that may be useful in designing interventions and also evaluate claims data to identify any correlations between transportation and urgent care utilization versus ED utilization.

As a result of Bridgeway interventions designed to reduce ED utilization, ED claims decreased 23% comparing January through June 2009 to the same period for 2010 for members with diabetes. (Due to claims lag, complete data is not yet available for the full year periods.)

23. Specialist as PCP

(ACOM Page 349, Section f)

f. (**ACUTE and ALTCS**) Are members with special health care needs assigned to specialists for their primary care needs? If so, what general criteria are used to determine if a member should be assigned in this manner?

Specialist as PCP. Many Bridgeway ALTCS members have special health care needs and their main health care provider may be a physician specialist (Specialist) rather than a traditional Primary Care Provider (PCP). Bridgeway does not require traditional PCP "assignment" for ALTCS members, however the Case Manager for each ALTCS member is responsible for explaining the PCP's Medical Home role, helping members select a PCP, and educating members about how to treat the PCP as their Medical Home.

Since members enrolled in Medicare may seek acute care from any Medicare certified provider, and about 85% of ALTCS members have Medicare coverage, many of these members seek care from providers who do not have a contractual network relationship with Bridgeway. Only about 15% or so of Bridgeway's nondual (Medicaid only) members are required to use a network PCP (whether the physician is Specialist or not). In addition, dually enrolled (Medicare/Medicaid) members enrolled in Bridgeway's SNP must use a network PCP. Nevertheless, Bridgeway applies to both nondual and dually enrolled members the same principles to our approach for using Specialists as PCPs.

General Criteria. The general criteria used to determine whether a Specialist should serve as a member's PCP include:

- The Specialist agrees to serve as the member's PCP and is capable of providing primary care services.
- The member agrees that the Specialist will serve as PCP.
- The member's condition is such that a Specialist serving as PCP is likely to increase and improve coordination of the member's care.

Examples of how these criteria are applied follow.

Established Relationship of Specialist Serving as PCP. If a new Bridgeway member has an established, positive relationship with a specialist physician who has essentially served as the member's PCP (prior to the member joining Bridgeway) and the member wants to continue seeing the Specialist, we support the member continuing to receive care from that provider. For a nondual member, if the provider is out-of-network, we seek to contract with the provider to ensure continuity of care for the member.

Identifying Members Who May Benefit From a Specialist Serving as PCP. Case Managers complete their assessment of new members within 10 business days of the member's enrollment (AHCCCS requires 12 days), or within seven business days of enrollment for ventilator-dependent members. They learn as much as possible from the member and their family about which providers the member has been seeing, what type of services the member has been receiving and with what frequency, and how the member is getting to his or her appointments. If the member does not have a PCP, the Case Manager takes the lead in helping the member identify one, and may seek to identify a Specialist as PCP if that is appropriate to the member's condition and needs. Under all circumstances, we encourage and support member choice in selection of a PCP (and all providers).

In addition to the Case Manager's assessment, other means of identifying members with complex medical or special health care needs who might be best served by a Specialist as their PCP, include:

- *ImpactPro* – Impact Pro is a predictive modeling tool that measures risk based on many aspects of the member's health care status. ImpactPro helps to guide Case Managers in their preparation of a customized service plan for the member that includes oversight of care by the member's PCP.
- *Pre-admission Screening Report* – AHCCCS provides this report to Bridgeway at the time of enrollment. The report includes all known diagnoses, anecdotal information about the member's providers, and other health care history about the member.
- *Self referral* – If the member (or in some circumstances member's representative) requests a Specialist as their PCP, we will accommodate the member's request, as indicated above.
- *Physician Referral* – If a member's Specialist asks to serve as PCP, we confirm the member's agreement with this arrangement, then coordinate with all parties involved.

Examples of the types of conditions for which members may benefit from having a Specialist as PCP include HIV, hepatitis C, and end stage renal disease. A nephrologist or urologist would serve as PCP for members with ESRD. An infectious disease Specialist typically would serve as PCP for members with HIV or hepatitis C.

TruCare. The member's Case Manager maintains the member's electronic clinical record in Bridgeway's care coordination management system, TruCare, which includes identification of the member's PCP (currently Bridgeway uses CCMS, but TruCare will replace CCMS in 2011). The TruCare database contains all pertinent and available information about the member including the names, roles (whether PCP or Specialist), and contact information of the member's health care providers. The TruCare database will be accessible to internal staff at Bridgeway for the day-to-day service needs of members and providers.

Provider Contract Provisions. When a Specialist serves as the member's PCP, special provider contract provisions are not needed because Bridgeway's participating provider agreement, credentialing standards, and obligations are the same for PCP and Specialist providers.

24. Network Barriers and AHCCCS' Role

(ACOM Page 349, Section g)

g. What are the most significant barriers to efficient network deployment within the Contractor's service area? How can AHCCCS best support the Contractor's efforts to improve its network and the quality of care delivered to its membership?

Significant Barriers to Efficient Network Deployment

The most significant barriers to efficient network deployment in all GSAs are:

- The rural and remote nature of most parts of Arizona, and the limited provider base available in rural areas, including for long term care, BH, and acute care services, is a barrier.
- High turnover among and limited training opportunities for long term care workers continue to be barriers to consistent, high quality care. Continued focus on direct care workforce development and professionalism is important to address these barriers.
- The ALTCS Program continues to see growth in the number of members with a primary behavioral health condition and in those with secondary cognitive related conditions such as dementia with behaviors. Network development to serve members with these conditions involves attracting providers experienced in behavioral health services in other GSAs, as well as expansion of services for providers currently serving the GSA in question.

How AHCCCS Can Support Bridgeway Efforts to Improve the Network and Quality of Care

The following are ways in which AHCCCS can support Bridgeway efforts to improve the network and quality of care.

- **Medicare Special Needs Plans.** We support AHCCCS' current efforts to obtain an innovation waiver that supports both a passive enrollment approach and enables a more coordinated approach with CMS for Medicare network adequacy standards, provider billing and resolution processes, credentialing and encounter submissions.
- **Area Agencies on Aging.** The AAAs maintain separate entities serving either single GSAs (such as Pima and Maricopa) or blended GSAs (such as Apache and the northern counties and Yavapai). The AAAs often offer as a contracted provider key services such as home modifications and meals on wheels. AHCCCS' support for a more statewide, focused approach to contracting and collaboration on innovation in service delivery with the AAAs would enable the sharing of best practices and standardized approaches to service delivery across all health plans.
- **Encounters.** We would recommend that AHCCCS involve both provider based associations (such as the Arizona Health Care Association and Assisted Living Federation of America) and individual providers in rural areas in listening sessions on the encounter requirements placed on the health plans, in an effort to support the hard edits required by health plans on provider reimbursement requests to meet the State encounter data requirements.
- **Rural Provider Rates.** We would recommend a recalibration of rates for rural providers such as ALFs and SNFs that recognize and promote the limited provider base in rural areas. This would promote the expansion of providers currently serving rural GSAs and attract additional providers.
- **Telemedicine.** AHCCCS and other State support for development of telemedicine infrastructure and protocols for using it accelerates such development and fosters broader use of telemedicine than would be possible under strictly private auspices.
- **Referral Policies.** Bridgeway recommends that AHCCCS collaborate with its contracted health plans to explore development of common prior authorization policies that can be used by all plans.
- **Information Technology.** Bridgeway supports AHCCCS' exploring the feasibility of statewide e-health initiatives. Bridgeway supports development of standards that allow interoperability of systems such as to maximize opportunities for innovation and flexible use of such systems, while ensuring appropriate sharing of valuable data. AHCCCS is in a unique position to encourage development of such standards.

25. Reducing Appointment No-Show Rates

(ACOM Page 349, Section h)

h. **(Acute and ALTCS)** What interventions has the Contractor implemented to address and reduce no-show rates and how is information collected to assess the efficacy of these measures?

Overview

Members' keeping their doctor appointments is important not only to promote members' health and wellness, but also to facilitate provider appointment scheduling. Reasons for appointment "no-shows" vary and are often difficult to identify. Methods of identifying "no-shows" include information received from members and providers, including member grievances and quality of care concerns and provider feedback. Bridgeway seeks assistance from providers in identifying and tracking no-show appointments, and educates providers through training and the Bridgeway Provider Manual to report no-show appointments to the Bridgeway Member Services Department.

Bridgeway has developed a database to log data related to "no-shows" for tracking and trending purposes. The database includes specifics regarding each "no-show" reported in order to ensure that members receive appropriate help in re-scheduling appointments and keeping future appointments.

Interventions

Upon identification of no-shows through provider or member reporting mechanisms, Bridgeway implements interventions to address and reduce re-occurrences. Interventions include a range of activities, from having a Case Manager address the matter immediately with a given member, to systemic approaches such as use of the database. All interventions are reported to the Quality Management and Performance Improvement Committee (QMPIC) and the Member/Provider Council. Examples of interventions include:

- **Case Management.** When a "no-show" is reported to Member Services, they notify the member's Case Manager who contacts the member to determine the reason for the missed appointment. The Case Manager seeks to determine why the member missed an appointment, such as due to dissatisfaction with the provider, distance to the provider, or issues with transportation. The Case Manager assists the member with any issues and if necessary finds a new provider or alternative transportation options. Reasons and outcomes are documented in the tracking database.
- **Monitoring Appointment Accessibility and Availability.** Review of grievances and appeals data may reveal trends regarding difficulties in appointment accessibility or availability. The Quality Department oversees and monitors appointment availability to ensure that members are able to schedule an appointment within AHCCCS required timeframes and do not experience long wait times for appointments.

Outreach. Outreach strategies to educate members on the importance of keeping doctor appointments include:

- **Member Handbook.** The Bridgeway Member Handbook informs members of their responsibility to know who their PCP is, contact their PCP for appointments, keep their appointments, and arrive at appointments on time. Upon enrollment with Bridgeway, Case Managers help members who do not have a PCP to identify an appropriate provider, who in some instances may be a specialist physician. Throughout the Member Handbook members are reminded about Bridgeway transportation services and that transportation to doctor's appointments are covered and free of charge.
- **Member Mailings and Distributed Information.** Bridgeway reminds members of the importance of keeping appointments through periodic mailings such as the Member Newsletter. All member materials are approved by AHCCCS prior to distribution.

Database to Evaluate the Effectiveness of Interventions to Reduce No-Show Rates. Bridgeway initiated the no-show database in January 2011 and it is maintained by the Contracts and Member and Provider Services Department. We will evaluate interventions and processes developed to reduce no-show rates by comparing data in the no-show database with correlated utilization data. Bridgeway is using the tracking database to establish a baseline for no-show reporting. The database includes the following information for reporting purposes: member name and identification number, the provider with whom the appointment was scheduled and missed, specialty, type of appointment, GSA, the reason for the missed

appointment (if available), department(s) involved in addressing the matter, and the actions taken toward resolution. We track and trend the no-show data on a monthly basis.

The QMPIC reviews no-show data quarterly to identify spikes in no-shows within a specific geographic region, recurring instances associated with a specific member or provider, and to analyze correlated utilization data. Recurring instances suggest a need for increased member or provider education. Spikes in a geographic region may indicate the need to address transportation issues or potential gaps in the network. We also report quarterly to QMPIC on interventions to address these issues. We analyze the no-show data as follows:

- **Utilization Data.** We compare no-show data with utilization data in the respective GSAs on a quarterly basis to determine the percentage of no-show appointments in comparison to services delivered.
- **Appointment Availability.** We compare no-show data with appointment availability monitoring data to assess potential causes for any spikes or reductions in no-shows.
- **Grievance and Appeals Data.** We will monitor grievance and appeals data related to provider accessibility and availability and compare it with appointment availability monitoring and no-show reporting to assess any potential correlations.

Bridgeway will analyze the effectiveness of no-show reporting and interventions to reduce no-show rates and report results to the QMPIC annually.

37. Any Offeror who is new to a GSA must submit a description of how it will launch a network capable of supporting its membership by October 1, 2011. Incumbent Contractors that are not new to a GSA are exempt from this requirement.

Current Preparedness for Network Launch

Bridgeway is prepared to launch a network capable of supporting our membership by October 1, 2011 in the following GSAs: 40 – Pinal/Gila, 44 – Apache/ Coconino/ Mohave/ Navajo, 46 – Cochise/ Graham/ Greenlee, 48 – Yavapai, and 50 – Pima/ Santa Cruz. Our outreach for LOIs and contracts in new GSAs is grounded on our extensive, existing relationships with provider communities throughout Arizona. For example, through Bridgeway's management agreement to operate Pima Health System, we have a **fully contracted network** for long term care, behavioral health, and acute care services in the **Pima/Santa Cruz GSA,** with all providers loaded in our claims system, AMISYS Advance. In the **Yavapai GSA,** much of our **acute care network** likewise is contracted and loaded in the system, in connection with our acute care Contract with AHCCCS. Similarly, some of the larger network or statewide providers that now serve our Maricopa and Yuma/La Paz GSAs, such as LifeCare of America and Dependable Home Health, are already loaded in the claims system. In all the new GSAs, we have leveraged the **contracted behavioral health network** of our affiliate Cenpatico to obtain LOIs and Bridgeway will contract directly with these providers. Cenpatico serves as the RBHA in **Yavapai, Pinal, Gila, Cochise, Graham, and Greenlee Counties.** Bridgeway, through its contracted affiliate Cenpatico, has LOIs from all the major behavioral health providers in the **Apache/ Coconino/ Mohave/ Navajo GSA**.

Bridgeway staff in the Contracting and Member and Provider Services Department (Provider Services Department) began network development activities in the new GSAs in September 2010 and now have contracts or LOIs sufficient to provide ALTCS services to members in accordance with AHCCCS standards, with limited need to fill network gaps.

Network Design and Local Presence

Bridgeway's network philosophy is to support member choice by contracting with any willing provider that is qualified to serve ALTCS members and accepts a reimbursement rate that is reasonable in the context of AHCCCS' capitation rate. We prioritize recruiting providers that currently serve ALTCS members, to facilitate continuity of care during transition to Bridgeway as a new Contractor. We have evaluated our proposed, comprehensive network to ensure that the projected membership has access, at least equal to or better than community norms, to covered services that are provided promptly and are reasonably accessible in terms of location and hours of operation. To ensure a successful network launch, between Contract award and October 1st, we will revalidate the network's capability to support the membership.

Bridgeway has embraced serving rural areas and, as we do now, we will focus on identifying specific services that do not exist but are needed in rural areas. We then carefully select provider partners who, with our support and collaboration, are capable of and willing to invest in developing targeted services in certain areas. Using this approach, we facilitated establishment of two Level II behavioral health homes in Yuma that now serve ALTCS members and establishment of a Medicare-certified home health agency serving Yuma/La Paz.

In addition to Provider Services Department network development activities, Bridgeway outreach staff have contacted and met with community organization representatives and advocates in our proposed GSAs. These local advocates are most helpful in identifying providers with certain types of expertise in serving members who are elderly or have physical or behavioral disabilities, and we invite the advocates to participate in our Member/Provider Council meetings. We will establish a Member/Provider Council in each GSA shortly after Contract award.

As we do now, Bridgeway will maintain a local presence in all GSAs that we serve, through Network Managers and other staff who reside in each GSA. We also anticipate, as we do now, maintaining an office in each of our GSAs.

Organizational Structure and Accountabilities for Network Launch

Staff Accountabilities. The Vice President (VP) of Provider Services is the Bridgeway business owner of and has primary responsibility for the ALTCS Contract network launch. Ultimate accountability for successful network launch resides with Bridgeway's CEO. Network development and launch activities are carried out primarily by the Provider Services Department, including field staff (Network Managers) and call center staff (Provider Services Representatives or PSRs). The Behavioral Health Network Development Manager focuses on the behavioral health network. To the extent feasible, the VP of Provider Services assigns individual Network Managers to specific geographical areas that they will continue to serve after implementation, so that as early as possible they begin building strong relationships with network providers and foster continuity in those relationships. However given the expansive and rural nature of many parts of the

new GSAs, and hiring after Contract award Network Managers who live in the GSA they serve, our overriding priority is to ensure that the network for *all* service types in *all* GSAs complies with AHCCCS standards and is credentialed, contracted, and loaded in the system before October 1, 2011, and that providers have received training in a timely manner before that date.

The VP of Provider Services monitors and oversees network development of the four Bridgeway subcontractors that maintain provider networks: US Script for pharmacy, Avesis for dental services, OptiCare for vision services, and TMS for transportation services. The VP of Operational Services and Compliance coordinates with the VP of Provider Services to ensure overall compliance of these subcontractors with AHCCCS Contract requirements.

The Information Technology Department of Bridgeway's parent organization, Centene Corporation, plays a key role in supporting provider set up and system configuration, as well as in auditing the provider set up in sufficient time to correct any identified deficiencies before October 1, 2011. This self-monitoring audit process, conducted by Centene's Internal Audit Department, is a required component of Centene implementations. Centene's Senior VP of Implementations (who reports to the Centene CEO) is the person accountable for IT aspects of the network launch.

Bridgeway Implementation Structure. Bridgeway will complete the network launch in the new GSAs in a manner similar to how we accomplished network review, loading, and provider education for the Pima/Santa Cruz GSA transition under the Bridgeway management agreement with Pima Health System in fall 2010. We will establish a cross-functional Bridgeway Implementation Team that meets weekly under the direction of the Implementation Project Manager to report task status against the implementation schedule, ensure that interdepartmental coordination is occurring appropriately, verify that resources are adequate to complete implementation on time, and escalate any issues of serious concern or that are not reasonably susceptible to timely resolution by the Implementation Team participants. The VP of Provider Services is a member of the Implementation Team and the CEO participates actively in Team meetings as well.

Centene Implementation Support. Centene Corporation provides resources and support for Bridgeway and affiliate health plan implementations through the Centene Project Management Office. Depending on the scope of the implementation, experienced staff from the St. Louis headquarters may work onsite in Arizona alongside Bridgeway staff throughout the network launch period, from shortly after Contract award until one to two months after the October 1, 2011 implementation, or they may provide a more limited level of support if appropriate.

In addition, Centene's Enterprise Implementation Steering Committee (Committee) is responsible for providing oversight for implementation activities across all of Centene's subsidiary health plans. The Committee includes Centene's most senior executive leadership and represents all functional areas, including health plan operations, specialty divisions, information technology, human resources and finance. In addition to providing cross-functional oversight, the Committee helps ensure that we can leverage best practices and efficiencies from other Centene health plan implementations. The Committee meets weekly to discuss current and future implementations to ensure that resources are appropriately allocated for compliant and timely completion of all implementation activities. At each meeting, Bridgeway's CEO presents a standardized report that includes, at a minimum, highlights from the Implementation Team's previous week's activities and progress, overall risk status, key risk areas and mitigation plans, key milestones, and other information as necessary for specific issues.

Steps and Timeframes for Network Launch

Below we have described the major steps and their sequence for network launch from the date of Contract award (on or about May 9, 2011) through the October 1, 2011 Contract implementation date.

May
1. Prepare contract mailing packet 2. Prepare mailing labels from LOIs 3. Develop list of providers who indicated negotiation on rates or language would be needed 4. Mail packets as soon as award is announced (Contract award on or about May 9, 2011) 5. Based on scope of Contract award, implement predetermined plan for hiring and training additional PSRs in Tempe and Network Managers in applicable GSAs 6. Begin follow-up calls regarding packet on May 20 to see if providers have questions, and urge prompt return 7. Establish dates and identify convenient locations for initial Member/Provider Council meetings 8. Submit subcontracts to AHCCCS to obtain prior approval

June - July
1. Conduct one-on-one meetings with providers 2. Begin credentialing providers, as applications are received 3. Prepare agenda and invitations for provider education meetings for August and September 4. Reserve provider-convenient locations for provider education meetings 5. Continue follow up to urge providers to submit credentialing application and contract 6. Begin loading provider contracts, after credentialing and contract execution 7. Begin submitting fee schedule information to configuration team on any rate changes 8. July 1 – Readiness Reviews begin 9. Hold additional Member/Provider Council meetings
August
1. Mail invitations to provider education meetings 2. Begin conducting provider education and EDI meetings 3. Continue follow up to urge providers to submit credentialing application and contract 4. Continue loading provider contracts and configuring new fee schedules 5. Internal Audit Department begins auditing of provider set up and running test claims
September
1. Continue follow up to urge providers to submit credentialing application 2. Continue loading provider contracts and configuring new fee schedules 3. Complete provider education and EDI meetings 4. Waive claims system prior authorization requirements for 60 days, beginning October 1, 2011, to ensure continuity of care for members

Provider Education and Technology Relating to Network Launch

Although we expect that many of our network providers already serve ALTCS members and are familiar with the program, many providers, especially long term care providers, do not currently use EDI to submit claims or EFT to receive payment. Using EDI/EFT is an AHCCCS priority and will be a Bridgeway provider contract requirement on which we conduct extensive, hands-on training of providers, along with providing them tools such as our **LTC Claims Wizard**. The LTC Claims Wizard will target providers who now use roster billing. The Wizard simplifies claim submission, guiding provider office staff through entering the required data elements so that they migrate naturally to HIPAA compliant claim submission. All providers have access to our **Provider Portal,** which supports online submission of a HIPAA file directly to us, or allows entry of individual CMS-1500 and UB04 claims via form templates directly through the Portal. Bridgeway also supports HIPAA 837 EDI claims submission through **multiple clearinghouses, including EMDEON.** Another tool to help providers test EDI transactions is **EDIFECS Ramp Manager.** Beginning in Q2 of 2011, our local Bridgeway EDI specialist will have interactive access to our Ramp Manager application so we can help providers and clearinghouses test their implementation of HIPAA 5010 transactions. With regard to claims payment, in 2011, Bridgeway will enhance our EFT service with two new payment options, **Emdeon ePayment** and **PayFormance,** in addition to ACH direct deposit. Providers will be able to review the payment options on our Provider Portal and Bridgeway will assume the charges for transaction processing regardless of the option selected. Network Managers will train provider office staff onsite at provider offices and commit the time required to ensure that providers of all types and with whatever level of technology expertise are well equipped and prepared to file clean claims that will be paid promptly.

For credentialing, **Portico** is the provider data management system we will use; Portico integrates provider related information across our other MIS components that need to use provider data. **Emptoris** is our comprehensive provider contract management software, which supports efficient and collaborative provider contracting, amendment, and re-contracting processes with Bridgeway providers, and reporting, while ensuring regulatory compliance.

Proven Results

We are confident that by using the structure and methodologies described above for the new GSAs, we will achieve a successful network launch as we did in transitioning the Pima Health System (PHS) network to Bridgeway systems and management. For the Pima/Santa Cruz GSA, within a period of 30 days, we reviewed and accepted all but 9 of PHS' 518 provider contracts, executed 75 fee schedule changes, reviewed and corrected 4,000 provider data elements submitted by PHS and autoloaded them, all with less than a 1% error rate for both the loading and contracts. As demonstrated, Bridgeway stands ready to complete the network launch for the new GSAs to begin serving ALTCS members by October 1, 2011.

38. Describe how the Offeror will communicate with its provider network in explaining the standards for the program, changes in laws and regulations, and changes in subcontract requirements.

Bridgeway explains program standards and regulatory and contractual changes to network providers through training, Member/Provider Council activities, the Provider Manual and Portal, and a variety of other methods described below. Two-way communication with providers is critical to our success and we treat network providers as long-term partners in ensuring AHCCCS' success.

Training. Bridgeway's regionally based Network Management staff explain program standards by training all ALTCS providers and their staff on contract requirements and special needs of members. Group trainings are conducted prior to member enrollment and implementation, as needed during start-up, before new providers begin serving members, and quarterly (for updates and "refresher" priorities such as Ball v. Betlach requirements for responding to gaps in service, transportation services, linguistic access, cultural competency, fraud and abuse, advance directives, and topics requested by providers). Separate initial orientation sessions are held for various types of ALTCS providers, such as home and community based services (HCBS) agencies, adult day care, and others**,** to allow presentation of information that is distinctive to certain provider types. Training is conducted locally in provider offices or convenient venues such as a community center. The Provider Services Manager and Network Management staff partner with local provider organizations to schedule sessions at convenient times and places and solicit feedback from providers to determine how to best motivate providers to participate in ongoing training. For example, serving lunch to provider office staff at noontime programs encourages attendance, provides regional networking opportunities for participants, and does not affect normal business hours. Network Management staff also conduct regularly scheduled, as-requested, and as-needed (such as to improve poor performance) training at providers' offices for new hires and for refresher purposes on program, billing requirements, and how our ALTCS Case Managers can assist them. During initial training sessions we explain how we will communicate promptly changes and updates that occur before, during, and after implementation, as well as throughout the contract period (see below for details). We measure the effectiveness of our provider communications through written evaluation forms of all group trainings, analysis of provider website usage, and scheduled discussion among Network Management staff following provider visits.

Increasing EDI with Providers. On an ongoing basis we train providers on submitting electronic claims either through the Provider Portal or through a clearinghouse. Electronic claims submission training in provider offices is often instrumental in increasing EDI claims filing. Over the past several months, Bridgeway has conducted an outreach program in which we identify providers with the highest paper claim submission volumes and work with them to develop their EDI capability. In 2010 we sponsored an electronic submission seminar conducted by Emdeon for all Bridgeway providers in Arizona. Our outreach and training have steadily improved our EDI submission rate. For example, our Yuma average rose from 17.81% in CY 2007 to 42.86% in CY 2010.

Our new multi-disciplinary Provider Engagement Team (PET), comprised of dedicated local Provider Services staff with specialized EDI expertise, and designated Centene Claims, EDI Operations, Encounter Business Operations (EBO), and Information Technology staff, will take our EDI outreach and education efforts to the next level. All of these individuals will report in matrix fashion to Bridgeway's VP of Provider Services. The PET will proactively identify high volume paper submitters and directly engage with these providers in the field to educate them about the value of EDI, including the potential impact on their practice. Once the provider transitions to EDI, the PET will continue to monitor their EDI submissions and provide targeted education, when necessary, to help the provider ensure ongoing successful EDI transmissions. In addition, the PET will provide ongoing support to our existing EDI providers in areas such as the conversion to HIPAA 5010 and ICD-10. The PET will help Bridgeway identify and develop unique tools in support of EDI and EFT.

We will also leverage best practices and lessons learned from our affiliate health plans, including Cenpatico, which, in 2010, achieved an EDI claim submission rate of 97.5%. As a result, we have identified additional EDI and EFT training and awareness activities for providers that we will conduct in 2011 and over the course of the new contract period under the leadership of our Provider Claims Educator, Elaine Teune, who is VP of Contracts and Member and Provider Services. Elaine has extensive Medicaid and long term care knowledge. She is well prepared to head our training initiatives for educating providers on claims submission and related Provider Portal features while facilitating feedback and provider satisfaction. Our provider claims training will include use of web seminars, using GoToWebinar to deliver interactive content, and which allows participants to pose questions and see in real time the Bridgeway staff member who is responding. This method of training is convenient and efficient for providers as it doesn't require them to leave the office, and following the initial event, can be replayed 24/7 whenever providers may choose.

External Collaboration on Training. To enhance provider training on program standards, Bridgeway also collaborates with local Arizona groups. For example, Bridgeway has arranged for the Arizona Bridge to Independent Living (ABIL) to provide cultural competency and disability sensitivity training for network long term care workers. Bridgeway is the only ALTCS health plan on the Direct Care Task Force and has the distinction among health plans of collaborating with the Arizona Health Care Association to support their initiatives regarding workforce development for direct care workers.

Member/Provider Council Meetings. Bridgeway uses Member/Provider Council meetings to communicate information to providers and members. For example, last year Network Management printed AHCCCS benefit change information as handouts for the meetings and provided time for participants to ask questions. This forum has facilitated many excellent, open discussions from which we identify potential items for future provider communications. Each quarterly meeting begins with review and approval of the previous meeting minutes; then appropriate staff update providers and members on AHCCCS and Bridgeway activities such as quality improvement initiatives, and providers and members provide feedback and recommendations to Bridgeway. We conclude with a question and answer session. Over the past year, provider turn-out for our Maricopa and Yuma Council meetings has been strong, as shown to the left. There is a Council in each GSA.

Quarter/Month 2010	MPC Provider Attendance Total
Maricopa	
Q1 - March	33
Q2 - June	36
Q3 - Sept	38
Q4 - Dec	45
Yuma	
Q1 - March	17
Q2 - June	11
Q3 - Sept	10
Q4 - Dec	23

Provider Manual. Bridgeway's Provider Manual is the repository of program standards and a main tool for explaining these standards to providers. The Manual includes all AHCCCS required elements and provides examples to help providers understand program requirements. We update the Manual as needed and in full at least yearly (dissemination of changes is discussed below). We print the Manual and inform providers that it also is available on the Provider Portal.

Provider Relationship Manager (PRM). Built based on best of class contact relationship management and provider data management technologies, our PRM will allow us to more efficiently coordinate communications with our providers no matter the media (phone, IVR, fax, email, or web). One PRM component is ProviderReach, our automated outbound provider campaign management application for efficient and coordinated launch of provider communications and notices. For example, we will use ProviderReach for an outreach campaign to recruit providers to submit claims via EDI and encourage claims payment through EFT. PRM will integrate with our other provider service applications, such as the Provider Portal.

Provider Web Portal. Bridgeway's Provider Portal houses many tools for our partners, including our Provider Manual, formulary**,** prior authorization requirements and forms, clinical practice guidelines, updates on the AHCCCS program, claims submission and inquiry information, member eligibility verification, and performance measure results. Providers can contact us through secure messaging on the Portal. In addition, we use the Portal for seasonal information such as reminding providers about flu shots during flu season. Bridgeway's secure Portal includes all AHCCCS required elements and functionality, including real-time eligibility and claims look-up capability, specific AHCCCS website links, and a searchable Provider Directory, updated at least monthly. The site explains program standards through the quick reference guides, other tools and training materials that providers can download. Bridgeway anticipates that at some point enough providers will use our secure messaging to make email notices of regulatory and contractual changes an efficient and effective means of delivery. To date, that is not the case. Starting in Q2 2011 and continuing throughout the year, we will enhance the Provider Portal with features such as online care gaps; provider quality profiling information; online authorization submission and authorization/claims supporting documentation upload capability; interactive EDI testing; the ability to view member care plans; and features for certain providers such as allowing the NPI to be optional, as not all LTC facilities have NPIs, and features to address situations such as when a skilled nursing facility and assisted living facility have the same tax ID, but different AHCCCS ID numbers.

Other Methods. Bridgeway uses different methods to disseminate certain information based on the provider type. To achieve clear and effective communication, Bridgeway frequently asks providers what information they would like to receive. In addition to the above, we communicate with providers through newsletters, faxes, mail, explanation of payment stuffers, and quick reference guides.

Newsletters. Bridgeway publishes quarterly provider newsletters for long term care network providers. Because the timing of regulatory changes often is not known in advance, newsletters may remind as well as announce such changes. Newsletters also are effective for explaining program standards and compliance techniques. We include articles on correct billing practices, clinical information, specific Bridgeway outcomes, upcoming code changes, and as we did this past year, benefit changes. We periodically will invite local LTC providers to author guest articles for the newsletter, such as to

highlight their experience with best practices. All Bridgeway employees, especially those working with providers and members on a daily basis, are encouraged to submit suggestions for articles.

BlastFax and Customized Mailings. Bridgeway has found BlastFax to be especially efficient and effective in reaching providers with urgent information about regulatory, contract, or other changes – such as prior to implementation -- as provider staff are accustomed to receiving and acting on faxes. (BlastFax enables our staff to send from their desktop computer a fax to hundreds of providers simultaneously.) Short faxes work best and, when information on changes is less urgent or is lengthier than what is suitable for a fax, we use customized mailings to communicate with providers. Bridgeway's practice for notifying providers of changes is to include a return phone and fax number and other appropriate contact information so that providers can readily ask questions and ensure that communication is a two-way street.

Explanation of Payment EOP Stuffers. Bridgeway has used EOP stuffers a number of times over the past few years as an easy way to quickly circulate information to out-of-network as well as network providers. We use this medium for reminders and information that are not specific to a certain provider type. For example, to encourage providers to move towards submitting claims electronically we included a stuffer on EDI information with the paper checks.

Quick Reference Guides. Bridgeway has found that providers are receptive to concise reference guides that condense complex or voluminous information or summarize important steps or reminders. This format was effective in our recent partnership activities with Pima Health Systems. Within weeks of the expedited implementation, we produced and distributed a Quick Reference Guide to Pima County providers that included a variety of FAQs as well as information on changed processes and billing contact information. We received positive feedback from providers on the Guide.

Notice of Changes in Laws, Regulations, and Subcontract Requirements. Bridgeway's primary goals in communicating regulatory, contractual, and administrative changes to providers is speed and clarity in delivery of the message, monitoring and measuring provider compliance with the changes, and responding to any provider misunderstanding or concerns about implementing the changes or their impact. To further these goals, when time permits, Bridgeway solicits provider input before changes are announced or implemented, in order to design processes that work best for providers. Whenever possible, we give providers advance notice of regulatory and standards changes that is sufficient for them to adapt their business practices without disruption or inconvenience. In the event of a material change in Contractor operations that would impact more than 5% of the total membership and/or the provider network in a specific GSA, we notify providers in writing 30 days in advance (after receiving approval from AHCCCS).

Bridgeway's communication plan for notifying providers of the specified changes includes the following major methods used prior to and during implementation as well as throughout the program Contract period.

Prompt Phone Response. To ensure that providers can readily communicate with Bridgeway regarding regulatory and contractual changes, all staff who take provider calls receive timely training on such changes and are prepared to answer provider questions, troubleshoot, and initiate adjustments to improve how the changes are being handled internally. PRM will promptly display for staff applicable scripts and checklists on specific topics so they can fully respond to callers' inquiries.

Provider Portal Updates. We post regulatory and contractual changes on the Provider Portal for provider convenience and to encourage Portal use, however we do not rely exclusively on the Portal because not all providers yet use the Portal regularly. Posting such changes on the Portal offers providers the advantage of downloading electronic documents related to the change, and using our secure messaging system to ask questions, as an alternative to calling by phone. We use the Frequently Asked Questions page to provide current information on regulatory and contractual changes, because the page can be revised easily if provider feedback indicates that some aspect of mailed information was not clear or if a clarification is received from a regulator.

Provider Office Visits. For significant regulatory or contract changes, Network Managers schedule training with key representatives and staff, as appropriate to the topic, for HCBS in-home providers, ALFs and SNFs, behavioral health providers, physicians, and hospitals.

Mailing. We provide information on legal, regulatory, and standards changes to providers by mail, within newsletters, and sometimes in a separate, special purpose mailing.

Contract Amendments. The Network Management Department sends provider subcontract changes and amendments to providers by certified mail so that we can verify that providers receive the changes. We include an explanatory cover letter and invite questions. When AHCCCS requires changes to the required minimum subcontract provisions, we send changes to the provider on the regular renewal schedule or within six calendar months of the update, whichever comes first.

39. Describe how data and information obtained from throughout the organization are used to manage the network and identify how provider issues are communicated within the organization. Provide an example of how this process has been used in your organization.

How Data and Information From Throughout Bridgeway Are Used to Manage the Network

Addressing Network Gaps. When network gaps are identified, whether through monthly network or member grievance reports or through requests made by internal or external sources (such as Bridgeway Case Managers or based on Member/Provider Council input), Provider Services staff promptly undertake recruiting efforts and may offer providers provisional credentialing when appropriate to expedite network participation.

Building Networks for Special Populations. Within the ALTCS population of Elderly and Physically Disabled members, there are various special populations, such as members with dementia and acting out behaviors, members with Serious and Persistent Mental Illness (SPMI) or traumatic brain injury (TBI), children, members who are homebound and cannot readily be transported to a doctor's office for medical care, members whose condition is complicated by their being obese, and many others. Bridgeway educates Network Managers during their initial orientation on the special populations we serve and the types of providers and specialty services that we seek for our ALTCS network. We have a Behavioral Health Network Development Manager who focuses on our behavioral health network. The Provider Services Department receives feedback from the Long Term Care Case Management and Quality Management (QM) Departments at monthly meetings of the Contracting and Provider Relations Committee on special populations for which provider capacity issues have been identified. Examples of Bridgeway network solutions for special populations include:

- Sun West Choice Health Care and Rehab is planning a specific wing for persons with Alzheimer's or dementia who also have a behavioral health condition or acting out behaviors. We have committed to increase their rates to incentivize them to complete the project and anticipate that this unit could be operational within a year. The new wing will fill a growing need for this level of care in the Far West Valley area.
- Maravilla Care Center is a large nursing facility with four different units, one of which is locked; the other three have progressively fewer restrictions. Maravilla serves our most difficult members with SPMI and those requiring court-ordered treatment. Bridgeway partnered with Maravilla and invested significant resources in service delivery and coordination by placing a Bridgeway Case Manager in the facility. The Case Manager works closely with Maravilla's clinical team during care planning and provides staff training and consultation regarding SAMHSA's recovery model.
- In rural areas, we will expand Bridgeway's Integrated Care Model so that members with behavioral health conditions who are familiar with receiving services at a regional behavioral health center can also receive primary care services at that location, thus increasing the likelihood of their receiving important preventive services in a timely manner.
- Network Managers help identify PCPs who are willing to provide services to ALTCS members in locations other than the PCPs' own offices, including members' homes, alternative residential and nursing facilities, and as above, behavioral health clinics.
- Unlike many health plans, Bridgeway offers a bariatric unit at Plaza del Rio in Peoria (Zone 6) in the Maricopa GSA, for members with Body Mass Index of 40 or more who are either wheelchair or bed bound.

These examples demonstrate how data and information from across Bridgeway has been integrated to develop services that address specific needs of our special populations.

Evaluating Membership Growth and Provider Capacity. Every month, Case Management staff evaluate member enrollment levels and growth in terms of the provider types and provider capacity needed to ensure that members have prompt access to needed services. Specifically, we evaluate caseload data extracted from our case management application (currently CCMS, soon to transition to TruCare) in conjunction with ongoing feedback from Case Managers during bi-monthly Case Management Department meetings. When staff identify a provider capacity concern, the VP of Long Term Care Case Management (or her designee) confers with appropriate Network Management staff regarding options for filling the gap. Twice a year, the VP of Provider Services, with support from Network Management staff, evaluates membership growth to determine what types of network changes are needed to continue ensuring member access to care. If either type of analysis indicates potential concern regarding the network reaching established capacity limits, Network Management staff promptly develop and implement a recruiting plan targeting the applicable provider types and geographic areas. Staff seek interdepartmental input on network development plans from the Contracting and Provider Relations Committee, which meets monthly and includes the Vice Presidents of Bridgeway's six departments.

Avoiding Network Gaps. A key objective of our ongoing provider network monitoring is to eliminate or minimize network gaps. When a network deficiency risk is identified, the Provider Services Department develops and implements an action plan to prevent or fill network gaps. Action plans incorporate the following strategies:

- Targeted Recruitment – Provider Services staff identify and secure contracts with potential providers.
- Panel Size Adjustments – Provider Services staff ask PCPs to open panels to additional members. They also ask specialists to serve more members or expand their scope of services.
- Local Patterns of Care – Primarily in rural areas, if an in-network provider is not available, we identify and recruit providers in adjacent areas that typically serve that community, including across state lines where appropriate.
- Temporary Out-of-Network Care – If we cannot identify a provider who offers specific services in a given locale for a member who needs such services, we approve out-of-network care until a network provider is available or we secure contracts with additional providers in the area.

Technology Support for Making Provider Data Readily Available. In Q2 2011 Bridgeway will launch **Provider Relationship Management (PRM).** PRM is our provider services inquiry system powered by Microsoft Dynamics customer relationship management (aka "CRM") software *and* our Portico enterprise provider data management system. PRM is sophisticated and goes beyond traditional call tracking modules. It combines, integrates, and deploys data from multiple internal systems, such as AMISYS Advance, our claims and eligibility transaction processing system, and TruCare, our integrated, member-centric health services management system, presenting a single view patterned by user type or user need. PRM presents to call center staff all relevant information at their fingertips to quickly and accurately address inquiries without having to access all the systems independently.PRM includes several components such as **ProviderConnect,** our new application for creating, routing, tracking, managing, and reporting provider inquiries. When Network Managers receive provider inquiries during a meeting at a provider's office, they follow the same approach and protocols as our call center staff by accessing PRM remotely via their laptops.

How Provider Issues Are Communicated Within the Organization

The primary mechanism for ensuring that issues and feedback regarding providers and provider availability are communicated to the Provider Services Department (or other appropriate area) is Bridgeway's quality committee structure. Bridgeway conducts monthly evaluation through the **three Bridgeway committees that address network issues,** and quarterly evaluation through the **Quality Management and Performance Improvement Committee** (QMPIC), to which the other committees report. The QMPIC's cross-functional membership includes Bridgeway's CEO and the Vice Presidents (VPs) of the six Bridgeway departments (they are collectively referred to as the Leadership Team, and include the VP of the Contracts and Member and Provider Services Department (Provider Services Department), and designated representatives from the Bridgeway departments, such as the Director of Pharmacy. At meetings the four Committees solicit feedback from all departments on network needs and provider issues. Regarding the three network related committees, the **Contracting and Provider Relations Committee** (Contracting Committee) includes the Leadership Team, Manager and Supervisor of the Provider Services Department, and, depending on the agenda, various Network Managers in the Provider Services Department. The Contracting Committee addresses HCBS, institutional long term care, and all acute care services except pharmacy services. The **Behavioral Health and Pharmacy and Therapeutics Committees** address, respectively, BH and pharmacy network adequacy (among other BH and pharmacy issues). Meeting minutes are posted online so they are accessible to all Bridgeway staff. In addition, at weekly **Provider Services staff meetings,** staff discuss potential trends and develop proposed solutions, such as onsite provider education to address specific, repeated claims errors from certain providers. Another key mechanism for communicating network issues within Bridgeway is the comprehensive, annual, written **Network Development and Management Plan,** which provides a central source for information on network and provider issues as well as on related communication processes.

Feedback to and from a number of sources is particularly important for managing the network. First, the **Medical Director** provides information and feedback to and receives it from the Provider Services Department primarily through meetings of the Contracting and Credentialing Committees, as well as through the weekly Leadership Team meetings, in which the CEO and VPs address any urgent or emerging network issues that should not be deferred to monthly committee meeting. Second, the **Member/Provider Councils,** of which there is one in each GSA, meet quarterly. Provider Services staff report to the Councils on network status and performance, solicit feedback on issues that staff have identified, and receive related member and provider feedback, especially local insight on what works best in different parts of the State. The VP of Provider Services or one or more senior staff members attend all Council meetings. Staff take responsive action whenever feasible promptly after each meeting, as appropriate to specific issues. Third, on a monthly basis, the Dispute and Appeals Manager (in the Operational Services and Compliance Department) prepares a written report on and trends **Member Grievances and Appeals and Provider Claims Disputes.** The Leadership Team and Contracting Committee review such reports monthly to identify potential network gaps, provider performance concerns, and opportunities for member and provider education on access to care and provider performance.

Provider availability and performance issues specific to an individual member most often are identified by **Case Managers.** To meet specific member needs, Case Managers may seek specific provider types in a given geographic area or providers with certain linguistic capabilities or cultural background. If they cannot locate the type of provider needed, they seek help from Network Managers, who identify in or out-of-network providers, and when appropriate follow up by recruiting similar providers. Case Managers report provider-specific, clinical performance issues such as quality of care concerns to the QM Department, who investigate and report to the **Quality Management Investigative Committee.**

We mobilize our interdepartmental **First Response Team** when we learn that members may face immediate jeopardy in a facility such as due to facility quality of care or financial issues. We investigate, protect member care and safety, and on occasion may help prevent facility closure. The example below demonstrates how the First Response Team functions.

Example of Bridgeway Using Information from Across the Organization

In CYE 2009 quality of care (QOC) issues heightened Bridgeway concerns regarding three same-owner assisted living homes where five of our members resided. The homes were within a block of each other. The wife of one member complained to the member's Case Manager that her husband had not been cleaned properly and that she had to ask for clean sheets for the bed. The Case Manager that same day made an unscheduled visit to the assisted living home, confirmed that the member was not being properly cared for, and submitted a QOC concern. Also that same day Quality Management (QM) staff conducted an unannounced onsite audit on which the facility scored slightly less than the minimum acceptable score of 80. Concerns ranged from improper administration of medication to poor sanitation and record keeping. Given the close score, QM staff determined to work with the owner on the issues identified and provided information on specific standards and ways to meet them. Bridgeway Case Management staff facilitated the transition and move for the member whose wife had contacted Bridgeway (the move was at her request) to an alternative facility.

Because the owner had complained to Bridgeway about the Case Manager who investigated the family's complaint and felt that the facility had not been fairly treated, Bridgeway assigned a second Case Manager to visit members there. The second Case Manager's assessment was that improvement was not consistent, and she submitted a QOC concern on behalf of the four remaining members. The owner was verbally abusive and called and faxed QM staff to complain.

Despite renewed efforts and progress in the areas of concern, Bridgeway then discovered what appeared to be the facility's inability to account for certain member funds in a checking account and potential theft of a member credit card. Immediately that day, the Case Manager convened our interdepartmental First Response Team of Case, Network, Quality, and Medical Management, and Compliance Department staff and the Medical Director, who quickly agreed on the decision to move the four members out of the facility. They selected from among themselves the Case Manager as the Lead Coordinator, and planned the logistics of the move. For example, the Network Manager for that area identified other housing options, the Case Manager contacted members or their legal representatives, arranged transportation through our transportation subcontractor, and coordinated with Medical Management to ensure that all authorizations for medication, DME, and so on were in order so that members would arrive in their new residence with all services in place. The VP of Compliance served as the main contact with AHCCCS. QM staff arranged a police escort. The First Response Team agreed on the oral response they would provide to inquiries from the owner or facility staff, in essence, that Bridgeway reserves the right to determine the most appropriate placement for members.

Given the owner's verbal abuse and other circumstances, Bridgeway did not notify the facility of our intent to move the members. Within 24 hours, Case, Network, and Quality Management staff met at the homes along with the Ombudsman, local police, and vehicles from our transportation subcontractor. Our team included a Behavioral Health Case Manager because two members were persons with SPMI. With the police, the Network Manager located and spoke with the owner who was irate, while QM staff observed (for later documentation) members' condition and environment and also helped to pack members' belongings, and the Case Managers facilitated the members' transfer to the vehicles with their belongings and rode with them to the new facility. We found permanent placements for all four members in the same facility, moved them without incident, and terminated the provider contract with cause. The result was that collaborative efforts among Case, Network, Quality, and Medical Management and Compliance staff enabled a prompt and organized transition process in which members were safely relocated with minimal disruption to their lives.

40. Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the claims dispute process.

Bridgeway treats providers as collaborative partners in providing quality care to our members, and we have developed a consistent process for the management of provider inquiries, complaints, and requests for information that ensures prompt resolution and the relay of **accurate** information. We use the information garnered from provider inquiries to make improvements in our policies and processes. Network and non-network providers may submit inquiries, complaints or requests for information by phone, in writing, via email or secure messaging, or in person. For each method of receipt, the staff handling the issue receive training at the time of hire, and on an ongoing basis, to ensure they are able to provide accurate information to providers in a timely manner. Bridgeway operates a toll-free provider call center, located in Tempe, Arizona at Bridgeway's central office, which is staffed Monday through Friday, 8:00 a.m. to 5:00 p.m. Mountain Time, by Provider Service Representatives (PSRs) in our Provider Services (PS) Department. After-hours and on state designated holidays, providers can speak with customer service representatives from NurseWise, our 24-hour nurse advice line, to verify eligibility; obtain benefits, claims and administrative information; and discuss physical or behavioral health issues, including urgent or emergent member issues, with a Registered Nurse. In addition to our call center PSRs, our PS Department employs a team of Network Managers (NM) who are field liaisons working actively with our providers in the communities we serve. To further enhance our service to providers, we are establishing a new multi-disciplinary **Provider Engagement Team (PET)**, comprised of dedicated local Provider Services staff with specialized EDI expertise, and designated Centene Claims, EDI Operations and Information Systems staff. The PET will engage providers to work through any issues or barriers they may have with LTC claims submissions, resolutions and adjustments; identify trends and provide the necessary training. They will be empowered to facilitate rapid resolution of provider issues, such as the initiation of immediate claim adjustments, through collaboration with their Centene designated counterparts.

Innovative and Integrated Technology. Bridgeway's PS Department shares the same call management platform as Bridgeway's Member Services Department, NurseWise, and all internal Bridgeway departments. The Avaya Call Management System (Avaya) provides seamless and efficient call answering capabilities, reporting, and transfers. During the call, staff document all inquiries in our proprietary database, which will be replaced in the second quarter of 2011 by our **Provider Relationship Management** system (PRM). PRM is our provider services inquiry system powered by Microsoft Dynamics CRM® customer relationship management software and by our Portico enterprise provider data management system. PRM is sophisticated and goes beyond traditional call tracking modules. It combines, **integrates**, and deploys data from multiple internal systems, such as AMISYS Advance, our claims and eligibility transaction processing system, and TruCare, our integrated, member-centric health services management platform, presenting a single view patterned by user type or user need. PRM presents staff with all relevant information right at their fingertips so they may quickly and accurately address inquiries without having to access multiple systems independently. PRM has several components to support the activities of our PSRs, such as **ProviderConnect**, our new application for creating, routing, tracking, managing, and reporting provider inquiries. This application provides our PSRs with information and functionality such as:

- ***Member Information*:** Includes contact and eligibility information, other insurance coverage (traditional Medicare or Special Needs Plan, for example), primary physician assignment, languages spoken, any special needs or additional assistance required, and authorized callers who may act on the member's behalf.
- ***Provider Demographic Information*:** Information such as NPI, AHCCCS provider number, affiliation number, participation status, Tax Name, practice number, Taxpayer Identification Number (TIN), practice restrictions, languages spoken, service and billing locations, and panel size.
- ***Claims and Payables:*** PSRs can search for Long Term Care, behavioral health, and acute care claims within ProviderConnect; view detailed claim submission information or related correspondence; respond to status queries about a claim or payment; and, if needed, route the call to a work queue for a Claims Liaison to address.
- ***Authorizations:*** The PSR can view authorization requests submitted by the provider and their status.
- ***Care Gaps:*** If the member at the center of a call from the provider has a gap in recommended care, a visible alert will display prompting the PSR to ask the provider if they would like to speak with the member's assigned case manager.
- ***Provider Inquiry History:*** The system displays a real-time summary of historical inquiries received from providers or their office staff. This summary highlights repeat or similar inquiries and potential provider educational opportunities. For example, if the system detected repeated calls from a LTC provider regarding billing issues, the PSR may offer immediate support or initiate a request to the PET to provide an in depth review and retraining for the provider so they

have a clear understanding of how to address the billing issue. With PRM, PSRs have one data source for all interactions with the provider, giving them a **comprehensive** overview with which to effectively facilitate the call they are handling in real time. For example, they can see what issues the provider has been involved with recently and they can proactively approach these activities with the provider to ensure satisfaction. A sample conversation would be "I see you had a visit from your Network Manager last month regarding this topic. Has the issue been resolved, or would another visit or call from her be beneficial for you and your staff?"

Accepting and Managing Inquiries or Requests for Information. Providers may contact Bridgeway regarding an inquiry or request for information through our provider call center, their Network Manager, submitting an email or secure message via our Provider Portal, or correspondence via fax or US Mail.

General Inquiry Calls to the Provider Call Center. When providers call, the automatic system immediately greets and prompts them to select either Spanish or English. After selecting from the language prompt, callers are presented with additional prompts that immediately connect them to the appropriate department within Bridgeway. Phone prompts offer three options: 1) eligibility verification; 2) medical management; or 3) claims inquiries and provider information. Callers selecting option 3 are transferred to a PSR. Calls are answered promptly, in the order received, and by the first available PSR. If at any point the caller wishes to speak to a "live person," they may bypass the prompts by pressing "0" for immediate connection or they can stay on the line and the system will route them to a PSR at the conclusion of the phone prompts. In the second quarter of 2011, we will be implementing an **Integrated Voice Response** solution with voice activated and touch tone recognition that will allow providers access 24/7 to information such as eligibility, primary physician information, and claim status including paid date and amount. Call transfers to other departments are minimal and generally occur when the inquiry involves clinical or administrative issues that need to be answered by a clinician. For example, if a Nursing Home or Assisted Living provider called questioning the Share of Cost (SOC) applied to a claim, the PSR would be able to confirm the negotiated amount noted in TruCare; however, if questions were related to the SOC negotiation, the PSR would transfer the call to the Case Manager for further explanation. To minimize call transfers, PSR workstations are equipped with resources such as (CPT/ICD-9/UB-04), CMS-1500 and UB Billing Guidelines, industry-coding manuals, Provider Directories, interdepartmental updates, and workflow documents. To ensure calls are handled in a timely manner, our Workforce Analyst monitors real time call activity (for example, calls in queue, average speed of answer, percentage of calls answered within 30 seconds, and call abandonment rate) via an "on line dashboard." If an increase in call volume is detected, the Analyst immediately notifies the PS Supervisor who initiates immediate redistribution of staff among queues to ensure adequate coverage.

Claims Inquiry Calls. PSRs handle most claims inquiries. However when they receive a complex claims inquiry, they advise the caller of the need for research and provide a time estimate within which the provider can expect a response. PSRs route complex claims inquiries to our local Claims Liaisons who are knowledgeable about the unique and complex aspects of LTC and other claims billing, adjudication and payment. The Claims Liaisons complete the research and provide feedback to the PSR regarding necessary next steps. This arrangement frees PSRs to focus on answering other calls, and the caller receives a return call from the same person they initially spoke with who is most familiar with the case. This approach holds the PSR **accountable** for the entire inquiry, from receipt through research to response, offering a seamless customer service experience for our providers. When NMs receive provider inquiries during an onsite meeting, they follow the same approach and protocols as our call center PSRs by accessing PRM remotely via their laptops. If the NM is unable to answer the question during the onsite visit, the NM will contact the provider within three business days with the answer or provide a status report along with the expected timeframe for resolution.

Inquiries Via Secure Messaging, Fax or US Mail. Bridgeway's Provider Portal enables providers to submit inquiries via secure messaging. Using the Portal, providers select from a drop down menu and complete a standard form based on their menu selection. When the provider clicks "submit," the web server time stamps the secure message to allow for tracking of response time. The inquiry is systematically routed to a designated PSR for resolution and, upon completion, the PSR emails the provider that a response is available on the secure Provider Portal and that they must log in to access the response. This notification ensures that we comply with HIPAA security requirements. Correspondence received via fax or US Mail is scanned and attached to the call record in PRM for reference and documentation, and the inquiry is routed to the designated PSR for resolution. Regardless of the method of submission, our PSRs acknowledge all inquiries within three business days and respond with resolution within 10 business days. If unable to resolve an issue within 10 business days, the PSR notifies the provider and gives an estimated date of completion not to exceed 30 days from receipt.

Documenting and Managing Inquiries or Requests for Information. PSRs document all inquiries and requests for information in PRM, assigning a "call type and sub-type" category for inquiry tracking and monitoring purposes.

Examples of these categories include *Provider Updates/Status Information* for inquiries related to provider status and demographics, provider number, TIN or NPI information; *Provider Requests* for information related to requests for manuals, copies of Explanation of Payment forms, and check copies or requests for a NM visit; and *Provider Education* for inquiries related to requests for support with the claims submission, Electronic Data Submission, Electronic Funds Transfer or Authorization processes. Each category has a predefined timeframe within which the inquiry should be addressed and aids in our monitoring of first call contact resolution (FCCR). The Supervisor monitors the rate of FCCR as well as the age of inquiries that require further action and a callback by a PSR to a provider. This ensures that inquiries do not age beyond the predefined timeframes. For example, should assistance from an internal department be needed for a complex claim, the PSR will document the request and systematically route the inquiry to that department via PRM. Should the inquiry remain open beyond the defined timeline for the call category, PRM prompts the PSR to initiate follow up activities and highlights the aged item for the Supervisor.

Accepting, Managing and Documenting Provider Complaints. All PSR staff are trained to receive and document provider complaints that are not related to claims disputes in the same way as for all other provider inquiries or requests for information. PSRs categorize all provider complaints in PRM with sub-type categories, drilling down to the specific type of complaint the provider wants to register, such as related to authorizations or locating a participating specialty provider. Once the complaint is documented in PRM, the PSR routes the complaint to the Compliance Department where it is managed by the Grievance and Appeals Coordinator (Coordinator). The Coordinator mails an acknowledgement letter to the provider within five business days. The Coordinator thoroughly investigates each provider complaint, collecting all pertinent facts from all parties and processing the complaint per Bridgeway policies and procedures. The Coordinator works with the applicable department when researching complaints. For example, complaints regarding a PSR's conduct are coordinated with the Provider Services Department and complaints about preauthorization policies are coordinated with the Medical Management Department. Once a complaint is resolved, the Coordinator issues a resolution letter to the provider and adds the resolution date and description along with all related documents and information to the PRM record. Our standard for complaint resolution is 15 days or less. By monitoring "inquiry age" within PRM, the Provider Services Supervisor ensures adherence to **resolution timeliness**. On a quarterly basis, the Provider Services Department will report identified trends to the Quality Management/Performance Improvement Committee (QMPIC) for review and recommendations for interventions or additional action. The QMPIC will track any implemented interventions, responsible parties, and outcomes.

Monitoring and Reporting

Call Center Monitoring. The Provider Services Supervisor silently monitors a minimum of ten calls per month to evaluate the accuracy and effectiveness of PSR interaction, accuracy of call documentation, and ability of the PSR to identify and pursue opportunities to educate the provider. Accurate call documentation is critical because we use trend analysis of data elements such as the "call type and sub-type" to **drive process improvements**. We rapidly disseminate this information to the staff best suited to analyze each trend and initiate immediate remediation or education. The Provider Services management team reviews reports each month from their proprietary database and presents a quarterly report of trends to the QMPIC for review, along with recommended actions to improve the effectiveness of our provider communications and education. With implementation of PRM, the management team will have an improved ability to manage overall performance of the department, using tools such as ProviderConnect, to provide results of operational metrics, staff performance, call types, routing statistics and volumes; and Centelligence™ Insight, to provide desktop reporting and Key Performance Indicator Dashboard capabilities. These tools will help management quickly identify performance issues, monitor trends, identify opportunities for process improvement, and evaluate the effectiveness of our provider communication.

Self-Monitoring. Provider inquiry activity is further monitored during weekly PS Department staff meetings. All Department staff, including NMs, in all office sites attend (or call in on a conference line) and share occurrences, trends, progress on the previous week's issues and plans for the next week's activities and challenges for their location and GSA, and identify when the assistance of PET should be engaged and/or mobilized. The process facilitates the identification of **emerging trends**, in order to proactively avert potential service problems, and holds each attendee accountable for specific follow up action. Meeting minutes are available to all staff online and are submitted to QMPIC quarterly.

Subcontractor Monitoring. Bridgeway's subcontractors must comply with Bridgeway and AHCCCS requirements and apply similar approaches and protocols for accepting and managing provider inquiries, complaints and requests for information. Our Compliance Department monitors each subcontractor in monthly oversight meetings to ensure compliance.

41. Describe the process for ensuring that provider services staff receive adequate training.

Bridgeway's goal is to attract, develop, challenge, and retain the best and brightest talent available. Bridgeway and Centene Corporation, our parent company, recognize that quality training programs help to create a positive work environment, increase the confidence and capabilities of employees, and improve the ability of the organization to support the members, providers and stakeholders we serve. Our comprehensive initial and ongoing training programs ensure that staff are qualified, professional, and equipped to provide outstanding customer service. To maintain this level of customer service, our training initiatives are continuously implemented, adjusted and improved.

Initial Training Activities

Our Provider Services (PS) Department's training program consists of three phases. **Orientation** introduces the new employee to Bridgeway and Centene's philosophies, mission statements, culture, organizational structure, and Ethics and Compliance. This phase also introduces staff to the role of the Provider Engagement Team (PET), our new multi-disciplinary team composed of experts in Long Term Care (LTC) claim and encounter processing, Electronic Data Interchange (EDI), and provider services. The PET will engage LTC providers to work through any issues or barriers they may have related to LTC claims or encounters. **Fundamentals** focuses on the common tools, techniques and resources available to all staff members including a comprehensive review of the AHCCCS AMPM and ACOM, ALTCS Covered Services, program requirements, populations served, and Geographic Service Areas (GSAs). **Job Functions** targets the specific roles and responsibilities of Provider Service Representatives (PSRs) in the call center, Claims Liaisons, and Network Managers (NM) in the field. In addition, this phase provides guidance on how to escalate issues to and engage the PET to facilitate rapid resolution of provider issues. Training is conducted in a variety of settings, such as classroom and WebEx, and led by the Department Trainer, Supervisor, or a Senior PSR using varying techniques such as oral presentations, computer based training and role playing. Throughout the training program, each participant's comprehension and attainment of skills are evaluated to ensure progression to the subsequent phase training.

At the conclusion of the two-day **Orientation** phase of training, the participants progress to the second phase, **Fundamentals.** This covers the following topics over a three-week period:

- ***Claims.*** Reimbursement models; claims review including filing requirements, and guidelines including unique aspects of Long Term Care (LTC) claims; Share of Cost (SOC) applicability; Medicare primacy rules for dually-eligible members; techniques to detect other insurance; resubmission and resolution processes, including out-of-network; and AMISYS Advance claims processing subsystem; detection and reporting of fraud, waste and abuse.
- ***Clinical Services.*** Case management; prior authorization process and referrals, including out-of-network; and disease management programs.
- ***Covered Services.*** Long Term Care, behavioral health (BH), and acute services; screening and preventive services; differences in services for Medicaid only and dually-eligible Members; pharmacy, transportation, and EPSDT.
- ***Cultural Competence.*** Bridgeway's values and philosophy related to diversity, cultural competence, how our values and philosophy drive operations, how the cultural competence of operations influences health care utilization and outcomes, how the organization is structured to promote these values/philosophies, and how staff are supported and held accountable for cultural competence. Specific topics include community cultural characteristics and effects on access patterns (by GSA); how ethnicity and culture influence utilization of health care services; primary and secondary languages (of members and staff, accessing interpreters via the Language Line, unique skills needed to interpret in a health care environment); disability issues (health care utilization, types of disabilities, and range of member needs, using the TDD line, People First Language); accessing community resources and working with providers to assist members (characteristics of each GSA's providers and effective communication techniques).
- ***Customer Service Tools.*** Customer service and telephone etiquette; active listening; conflict resolution; the Avaya Call Management System; the Provider Relationship Management (PRM) documentation and workflow system; coordinating three-way calls with Language Line Services and TDD line.
- ***HIPAA Compliance.*** Includes review of HIPAA policies, procedures and how to address noncompliance.
- ***Provider Processes.*** Overview of credentialing and recredentialing; the patient centered medical home and roles of specific provider types: PCP (and specialist as PCP), specialist, ancillary, Home and Community Based Services (HCBS), hospital, behavioral health, vision and dental; and member grievance, provider complaints (including how to identify and categorize), claims dispute and State Fair Hearing processes.
- ***Provider Systems Education.*** Features and benefits of Electronic Data Interchange (EDI) for claims submission, Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA); self service tools including Provider

Portal; Integrated Voice Response (IVR); Provider Scorecard; and how to engage PET to educate providers about the value of EDI and EFT and assist the provider with implementing these features.

- ***Resource Materials.*** AHCCCS Medical Policy Manual AMPM and ACOM, AHCCCS bulletins, Bridgeway Provider Manuals and Directories, Newsletters, Member Handbooks, Arizona Health Information Exchange (AHIE); quick reference guides; Member and Provider Portals, and internet map search engines (such as Mapquest and Google).

The third training phase, **Job Functions**, reviews departmental and individual performance goals and expectations for each position. It also targets specific roles and responsibilities including the review of policies, procedures, workflows; any Contract, State and federal requirements that pertain to their position; and how to identify and address any quality of care or service concerns. We also train staff on processes for interdepartmental communication, collaboration, and cooperation in this phase, including the role of the PET. In addition to the topics above, topics for each position include:

Provider Services Representatives (PSR) receive focused training that enhances their ability to provide first call contact resolution or "one and done" service over the phone by quickly determining the nature of the call; documenting and categorizing the type of call for purposes of tracking and trending in our PRM system; responding with accurate and timely information; identifying and warm transferring calls to other staff members such as Case Managers and prior authorization staff; and to identify and provide training assistance. In addition, PSRs are trained on when and how to engage the PET for situations such as when they detect repeat inquiries of the same nature that may indicate a need for focused education or evaluation.

Claims Liaisons (CL) participate in a comprehensive and detailed review of LTC and other claims billing, adjudication and payment, and the related tools available and proven techniques required to quickly and accurately research and resolve complex claims issues, including Coordination of Benefits (COB) and Third Party Liability (TPL). They will actively work with PET representatives from Centene's dedicated claims processing team to address and resolve claims and adjustments real time, and analyze trend data related to claims billing, adjudication, and encounter patterns that may warrant further provider education.

Network Managers (NM) receive enhanced training for their "in-the-field" job responsibilities. NM personnel are seasoned professionals with demonstrated success and years of experience working directly with providers. The enhanced training program for NM staff reflects Bridgeway's expectations for how to conduct onsite meetings with providers and their staff, and how to best assist and teach providers about claims, compliance, and regulatory issues; and how to effectively communicate Bridgeway contracting, credentialing, and Quality Management processes and policies to every provider type within their assigned territory, taking into account the widely varying sizes and different staffing structures of those provider types. NM staff receive training on how to identify and engage the PET to assist in targeted initiatives such as EDI and EFT implementation. NM staff coordinate every aspect of network development within their assigned territories. Therefore, they receive enhanced training on provider contracting and credentialing, onsite survey requirements, and provider enrollment and disenrollment policies and procedures. NM staff also receive training on how to sign on, navigate through, and interpret information found on online programs such as AHCCCS' Department of Administration (DOA) mainframe, PMMIS, to verify provider information housed in AHCCCS records; Centene's provider contracting system, Emptoris, and the National Provider Identification (NPI) registry (www.nppes.cms.hhs.gov) to verify provider NPI status. Near the conclusion of the Job Functions training phase, the Trainer introduces "hands on training" through involvement in real-life and real-time situations for our PSR and NM personnel. Tenured personnel conduct **shadowing**, during which they observe the new staff member's techniques and competence and provide guidance and coaching. The duration of shadowing depends upon the skills and confidence of the new staff member with proficiency demonstrated prior to their graduating from the program and independently performing their jobs. During this phase, newly trained PSR staff are introduced to **silent monitoring** activities regarding phone interactions with callers to ensure accuracy of call documentation, clear communication and cultural appropriateness. Although completing the Job Functions training phase officially concludes the employees' initial on-the-job training, Bridgeway conducts **ongoing training** to keep staff informed of new AHCCCS requirements, modifications to Bridgeway policies and procedures, and the health care industry as a whole. Additionally, the ongoing training described below is designed to ensure staff are capable of performing the tasks associated with those changes.

Monitoring and Oversight Activities

Provider Services Representatives (PSRs). Once initial training is complete, the Provider Services Supervisor continues PSR silent monitoring to evaluate their telephone interaction with providers as well as the effectiveness of our training programs. The volume of calls monitored varies depending upon the tenure of the PSR, with no less than ten calls monitored per month per PSR. The Supervisor shares any negative results or educational opportunities resulting from

silent monitoring with the PSR and initiates retraining for the identified issue in order to avoid recurrence. Positive results that demonstrate "over and above" customer service are shared with staff as examples of exemplary customer service to reinforce Bridgeway's commitment to providing quality customer service to its providers and internal and external clients.

Claims Liaisons (CL). The Provider Services Supervisor solicits feedback from Centene's Claims Department regarding the Claim Liaison's payment decisions and instructions to the Claims Adjustors. In addition, Centene's Internal Audit staff provide feedback when an adjustment error is detected during their audit of the monthly claim sample.

Network Managers (NM). NMs receive hands-on training by pairing new staff with senior staff. During this training, the new NM is accompanied by a senior NM at onsite meetings with providers and their staff. The senior NM observes the new NM as he/she conducts meetings and assists in conducting the meetings when necessary. In most cases, the duration of these monitoring activities is two weeks. Longer shadowing and monitoring may occur if the new NM requests additional assistance or the senior NM recommends additional monitoring and shadowing to ensure the new NM is comfortable with his/her role and responsibilities and capable of performing effectively in the field. The senior NM continually reports back to the department director regarding the new NM's skills and conduct with providers throughout the onsite monitoring phase, to ensure timely attention to any additional training needs the new NM may have and ultimately to ensure smooth transition and consistent customer service for the providers in the new NM's territory. Additionally, the senior NM offers tips to help the new NM develop keen interviewing and listening skills as ways to solicit and obtain feedback from providers and to use the information gleaned to better serve providers. NMs will be trained to use the provider survey tools in PRM to develop and conduct surveys and retrieve survey results for ongoing quality improvement initiatives.

Ongoing Training Activities

Topics for ongoing training are derived from sources such as the results of call category trending, silent monitoring, provider surveys, staff suggestions, and feedback from PET. All staff members are encouraged to continue learning by attending classes offered through Centene's online training program, Centene University, which offers topics related to Medicaid and health care reform, as well as conflict resolution, quality assurance programs and initiatives, and soft skills.

Provider Service Representatives (PSR). Ongoing training activities address new technologies or functionality that impact staff and the provider community, such as the future deployment of our online LTC Claim Wizard, which will provide any nursing home or assisted living facility currently submitting roster bills a tool to help transition to submitting HIPAA compliant electronic claims via our Portal. PSRs will learn the functionality and features of our technological deployments, when and how to introduce them to the provider community, and how to engage PET should the provider require in office training.

Network Managers (NM). Examples of ongoing training activities for NM staff are noted below.

Lunch and Learn. Lunch and Learn sessions are held throughout the year and may be conducted by in-house staff or qualified subject matter experts invited by Bridgeway to present the Lunch and Learn session. Topics cover a variety of subjects such as upcoming changes to benefits for members, tips on customer service skills and techniques, "What's New" at Bridgeway, and similar topics designed to keep our field staff informed of current events relating to Bridgeway and AHCCCS that impact their providers, and provide guidance on how to educate providers regarding the upcoming changes to ensure compliance at all levels.

Conference Attendance**.** Bridgeway encourages field staff to attend local conferences throughout the year in order to be fully informed on issues affecting Medicaid and Medicare providers. Additionally, our field staff gain confidence in assisting HCBS providers and understanding the unique challenges they face regarding turnover and efforts to increase retention, care coordination, and claims submission requirements. Recently, our NM staff attended a conference regarding new RUGs rules and rates along with providers and other health plan personnel. Providers were pleased to see "their Bridgeway rep" at the conference and our NM staff gained a newfound appreciation of the provider's perspective in navigating through complex regulatory changes. Attending conferences and learning alongside providers enables our NM staff to be more engaged with providers and to work in a more collaborative way with providers in their territory.

Subcontractors

Our subcontractors employ similar training programs and monitoring techniques to ensure staff are qualified and equipped to deliver quality customer service in accordance with Bridgeway and AHCCCS requirements.

42. Describe the process for evaluating provider services staffing levels based on the needs of the provider community.

Bridgeway's **Vice President of Contracts and Member and Provider Services (VP of Provider Services)** oversees the enterprise wide activities and strategic planning of the department, along with the staff directly supporting the provider community including, but not limited to the key positions outlined below:

- **Provider Services Manager (PSM)** oversees the call center and field staff to ensure that functions are adequately staffed and can promptly resolve provider problems and inquiries, and provide appropriate education regarding the AHCCCS program and Bridgeway policies. The PSM facilitates interdepartmental coordination between the call center, claims liaisons, and field staff to compile, analyze, and disseminate information relating to provider calls. The PSM also identifies trends and leads the development and deployment of strategies to improve provider satisfaction.
- **Provider Services Representatives (PSR)** staff our call center and are often the first point of contact with our providers. PSRs are able to offer assistance with member eligibility, benefits, claims inquiries; provide assistance identifying and locating network providers; and provide assistance and guidance with administrative tasks such as EDI claims submissions.
- **Workforce Analyst** monitors real time call center volume and adjusts staffing to ensure sufficient coverage for all inbound call queues; analyzes call volumes, call trends, and staff scheduling; participates in the development of forecasting models; and recommends modifications to staff distribution and schedules based on historical patterns.
- **Claims Liaisons (CL)** are knowledgeable in claims billing, adjudication and payment, and support the department in the research and resolution of complex claims inquiries, including COB/TPL and dual eligible claim coordination. They also participate in claims analysis projects to identify systemic or coding problems, about which PSRs in the call center or Network Managers (NM) in the field outreach to and educate provider office staff. In addition, Claims Liaisons are trained and prepared to provide telephonic backup support to the PSRs if the call center experiences a spike in call volume.
- **Network Managers (NM)** are located in or near the communities we serve, and are directly responsible for network development and contracting, provider network retention, provider compliance, provider satisfaction through relationship building and customer service, soliciting feedback from providers and relaying information to them on proposed and implemented process and operational improvements.

Although Behavioral Health (BH) Coordinators and the BH Network Development Manager noted below are *not* members of the Provider Services Department and have a different reporting structure, we highlight them here because they play pivotal roles in our network management of BH providers.

- **BH Network Development Manager** coordinates all contracting and credentialing activities specifically for Bridgeway's BH provider network. This individual reports to the Director of Network Management, and is responsible for all aspects of BH provider contracting paperwork and process completion, and interdepartmental communication with newly contracted BH providers.
- **Behavioral Health Coordinators (BH Coordinator)** are clinical staff responsible for providing all aspects of provider service and program education to Bridgeway's behavioral health (BH) provider network pursuant to AHCCCS requirements. BH Coordinators ensure BH provider satisfaction and network retention through relationship building and coordination of service activities between our Provider Services, Network Management, and BH Case Management functions. BH Coordinators report to the Vice President of Long Term Care Case Management.

Several key positions/individuals listed above will be active members of Bridgeway's new **Provider Engagement Team (PET).** The PET will be a multi-disciplinary team, led by the VP of Provider Services, consisting of experts in provider services, Electronic Data Interchange (EDI), and Long Term Care (LTC) claim and encounter processing. In addition to our Provider Services staff, the team will have dedicated representation from our parent company Centene's Claims, EDI and MIS staff. The PET will focus on LTC claim and encounter processes by collaborating with providers offering educational support, "high touch" real time attention to claims resolution and adjustments; assistance with EDI on-boarding; and helping LTC providers navigate changes such as the conversion to HIPAA 5010, ICD-10 and transition from roster billing to electronic HIPAA compliant claim submissions. Using information captured through our provider inquiries, provider satisfaction surveys, and internal data tools such as our Provider Scorecard and performance metric reports, the PET will meet weekly to discuss issues, identify opportunities, and develop mobilization plans; and meet daily to review priorities of the day and the status of critical work in progress. The VP of Provider Services will coordinate the PET's activities and initiatives with the Arizona Health Care Association and the Assisted Living Federation of America.

The PET concept was conceived while transitioning Pima Health System to Bridgeway operations. We experienced the value of organizing a cross functional team to proactively evaluate and address issues unique to LTC claims billing practices, research causes for manual adjudication, and detect and resolve potential encounter submission errors. This approach armed us with the data we needed to develop targeted support for this LTC provider community and proactively address and engage these providers, understand their concerns, and prevent disruptions well before our implementation.

Provider Call Center Staffing

Staffing levels needed to maintain responsive customer service in the provider call center correlate to the size and specific needs of the network, as well as to distinctive aspects of the ALTCS Program. Such aspects include dual and non dual eligibility and coordination issues, and the level of support required by ALTCS providers in the coding, billing (paper and electronic), and reconciliation of claims payment. Our staffing model factors in a variety of information from multiple reporting sources to ensure adequate staffing and distribution of staff to address the varying ways in which providers engage us. Our Avaya Call Management System provides call center statistics such as call volume, duration, and service levels, and other important information to help us monitor productivity throughout the workday. Our proprietary tracking database (soon to be replaced by our Provider Management System - PRM) tracks correspondence (email, fax and US Mail) volume, and research and response times. Our Workforce Analyst and the Provider Services management team evaluate this data along with contributing factors such as our technology deployment schedules. Considering these schedules is critical so we can anticipate staffing levels for a variety of scenarios such as the initial increase in call duration due to providers requiring additional education and support related to new technology; potential reduction of calls into the call center with the introduction of IVR or enhancements to our Provider Portal; and the overall reduction in call duration with the implementation of PRM. Additionally, we factor in deployment of process improvements identified through our ongoing monitoring, assessments and evaluations of internal processes. For example, past process improvements resulted in the creation of a centralized claims processing team dedicated to Bridgeway, and the expansion of the call center to handle incoming claims inquiries from providers. We prefer this staffing model vs. a traditional call volume to provider ratio model, since we do not impose call duration limits and we view each call as an opportunity to educate the provider or their office staff and help improve their capabilities.

Although we have trained our 4 Claims Liaisons to provide phone support during peak call volumes, we are generally able to maintain adequate phone coverage with our 5 PSRs as evidenced by our call statistics for the period of March 2010 through February 2011. During this time, Bridgeway received 28,516 calls (ALTCS only) with an average speed of answer (ASA) of 45 seconds and an abandonment rate of 4.5%. Our ASA and abandonment rates also improved over the last three months (Dec 2010-Feb 2011) as demonstrated by an ASA of 19 seconds and abandonment rate of 4.2%. This improvement is noteworthy because during these last three months, we experienced an influx of more than 300 additional calls per month due to the expansion of the department to include the ALTCS line of business in the PIMA GSA. We anticipate continued improvements as we move beyond the first days of the expansion to ensure we meet our service goals.

Field Representative Staffing

All Bridgeway Network Managers (NM) live within or near the GSA territories they serve and this will be required of NM staff in the expansion GSAs. ***Locally based Network Managers*** are beneficial to providers in several ways. They have intimate knowledge of the GSA that can be acquired only by living in the community. For example, the community's culture, economy, geography, roads, and weather conditions impact the representative as well as the providers within the community. By living in the same environment, representatives are better prepared to understand and anticipate provider needs, and quickly adjust their schedules and availability to meet ongoing needs. Because representatives live locally, their drive time is shortened and they can be reached through local telephone numbers. This means they are more accessible to providers and better able to deliver efficient and effective service. This community-based staffing approach contributes to a natural comradeship that helps representatives build solid, trusting relationships with providers leading to better service, communication, and access to care for our members.

Bridgeway sets high expectations for its NMs and equips them with the ***technical tools*** they need to stay connected with providers. Each NM has a company issued laptop computer with wireless capabilities that they routinely bring to provider meetings and use to train providers and their staff on how to use Bridgeway's technical support tools, such as the Provider Portal and online prior authorization tools. The laptops also allow a NM to quickly connect to Bridgeway staff to resolve issues while onsite with the provider. This capability provides administrative efficiencies in sending and receiving e-documents, and tracking every form of interaction with providers. This interconnectivity has improved provider satisfaction and contributes to our ability to maintain contractual compliance with timely response to provider needs.

We ***prioritize serving our contracted providers*** and continuously monitor NM assigned account activity and provider satisfaction to adjust staffing levels. We know that some providers have multiple office sites within the same GSA and multiple office sites can be found in one building, such as a medical office building. When provider sites are located in close proximity, the NM needs less travel time and can efficiently plan inservice meetings with several providers in a single location in one day. Conversely, providers in rural communities are generally separated by greater distances and the NM serving rural areas needs more travel time factored into inservice responsibilities. We currently have 12 NMs who are required to conduct a minimum of 20-25 onsite meetings each week. NMs are required to meet with each contracted provider in their assigned territory, with priority given to meeting with nursing facilities and other Long Term Care providers, at least once per quarter. Onsite meetings are a mix of serving existing providers and working through contracts and applications with providers who are interested in joining the network. The topics addressed at onsite meetings include situations or concerns specific to the provider; information regarding changes in AHCCCS, federal or Bridgeway policies or requirements; claims or reimbursement issues; referral and prior authorization requirements; contracting and credentialing; and any other topics related to serving members and complying with Contract standards. Our NMs will collaborate with our ***Provider Coaches*** who support our assisted living and nursing facilities in developing services, programs and approaches to improve consistency of residential living services with ALTCS values, particularly member choice and independence. Provider Coaches report to the VP of Long Term Care Case Management.

Bridgeway is committed to furnishing high quality service to every member of our valued provider community, especially our ***behavioral health provider community***. We currently employ three BH Coordinators who work directly with BH providers in their assigned territories. BH Coordinators are experienced professionals with in-depth knowledge of the AHCCCS ALTCS, Acute Care and Medicare Advantage Special Needs Programs and the integration of BH services within those programs. BH Coordinators are able to quickly answer BH provider questions and assist them with their complex care coordination needs. They conduct regularly scheduled meetings in the BH provider communities they serve. BH Coordinators also provide targeted training programs for BH providers to explain ALTCS versus RBHA requirements and the differences in referral and claims submission procedures. Bridgeway's Provider Services and Case Management staff rely on the availability and expertise of the BH Coordinators as a valuable resource for cases involving BH intervention, care coordination or access to BH services.

Implementation/Expansion Staffing

During implementation or expansion of the GSAs, the Provider Services management team will use our PSR staffing model along with historical implementation call patterns to meet the initial higher call volume we anticipate with new providers in each new GSA. Throughout the initial program implementation, Bridgeway will continuously monitor call volume and Provider Services staff performance, and dedicate the tools and resources necessary to meet organizational customer service goals. After the first 90 days of the Operational Start Date, call volumes typically level off and mirror call volume trends of established GSAs. Our experience in serving current providers in existing GSAs combined with the data we collect during the initial program implementation will guide us during the first 90 days of program implementation and beyond. Based on our existing NM staffing model, we will provide comparable NM staffing with the expansion into new GSAs. Within each GSA, we will consider the current state of the contracted network to determine if additional network development is necessary, and to what degree the NM will need to divide their time between contracting and network management activities. We will recruit, hire, and train new NMs promptly after Contract award, and new PSRs on a schedule consistent with projected increase in provider call volume, based on prior implementations. If there is a greater need for provider contracting than servicing within a given GSA, we typically assign a senior NM staff person to share recruiting responsibilities until goals are met and recruiting efforts can be reduced to a manageable level for the assigned NM. Once initial contracting is completed (providers are credentialed and contracts are executed), we transition provider orientation and in-service functions back to the assigned NM. Throughout this expansion phase, the Manager of the Network Management team monitors activities and outcomes and make staff adjustments, if necessary, to achieve high provider satisfaction in new markets.

In summary, Bridgeway's organizational structure reflects our culture of employee accountability and collaboration. From a functional perspective, the Contracts and Member and Provider Services Department (Provider Services Department) reflects a cohesive blend of common, yet separately defined activities and roles, which when combined, increase teamwork and ensure consistency in our program service delivery, policies, training programs, and technologies.

43. The Offeror must describe how their organization will handle the potential loss (i.e., contract termination, closure) in a GSA of a) a nursing facility and b) an assisted living facility.

Bridgeway proactively monitors our nursing facility (NF) and assisted living facility (ALF) providers to ensure early detection of issues that might result in loss of the provider from our network. When we identify such issues, we handle the potential loss by working with the facilities, Arizona authorities, community leaders, and other health plans to help address problems and prevent the loss whenever possible. We keep members and their family/legal guardians informed of issues and begin transition planning for potential relocation, so that at all times they remain in charge of their care and placement. If contract termination or closure becomes unavoidable, we have procedures in place to quickly and effectively address quality of care, safety and member transition. By maintaining a robust network of both facility and home and community based services providers, we ensure members have alternate, desired placement choices within their GSA.

Identifying Problems Early. We capitalize on the eyes and ears of all Bridgeway staff and our partners in the community, and integrate this information among all affected departments through formal processes, such as our interdisciplinary Case Review Teams. We train our staff to refer all suspected or potential problems with NFs and ALFs to the appropriate department, such as Compliance, Provider Services (PS), Quality Management (QM), and Case Management (CM). Our rapid, coordinated response to facility issues is supported by technology solutions such as our Member and Provider Relationship Management systems (MRM and PRM) and TruCare, our integrated member-centric health management platform. We also identify issues through informal communications, such as among staff in shared offices, and by encouraging feedback and discussion from network providers and members at our Member/Provider Council meetings regarding any identified existing or potential issues. PS Department Network Managers routinely conduct site visits to provider locations to offer education and address questions, and our Provider Services Representatives (PSRs) answer questions and concerns via our provider call center. During these interactions, Network Managers and PSRs may learn about potential or actual issues, including quality of care (QOC) concerns or viability issues. PS staff also review complaints against providers to determine whether issues indicate a trend or one-time occurrence. Our Case Managers (CMs) may learn about facility problems through onsite member visits, interaction with facility staff and other Medicaid Contractor CMs, and identify QOC issues in their oversight of care plans. CMs report identified issues to our QM and PS Departments and to local, state or federal authorities as appropriate. QM staff may conduct joint site visits with CMs to ensure member issues are appropriately addressed. QM and other Bridgeway staff scan news reports for information about financial, legal, or quality concerns in a NF or ALF, share this information in meetings and document the issue in our PRM as warranted to ensure availability to all staff. Our Quality Management Investigative Committee (QMIC) reviews monthly and quarterly reports on member and provider complaints, gaps in services, and QOC issues, and may recommend actions such as training, a corrective action plan (CAP), or additional monitoring to address a problem.

Nursing Facility Oversight. Our QM Department reviews state and federal reports, member complaints and issues reported by staff and providers and makes periodic onsite investigations. For example, QM staff query the CMS Nursing Home Compare tool quarterly to evaluate quality measures, health deficiencies, and inspection results for a random sample of NFs and those with member complaints and QOC issues. QM staff use the AHCCCS-approved NF Review Collaborative tool to annually evaluate quality measures, health deficiencies, and inspection results. QM staff create a file for each QOC issue identified by our staff or reported by members and providers to document investigation activities and findings. Annually, and as indicated by identified QOC concerns, QM staff review the Arizona Department of Health Services (ADHS) database to identify actions against NFs that may indicate potential for closure and query the Medicare/Medicaid exclusion list to identify providers no longer eligible for network participation. QM also reviews complaints about NFs for trends and reports results quarterly to the QMIC and AHCCCS. We require our subcontractor Inspiris, which provides intensive concurrent clinical management of NF members, to inform the CM of QOC or operational issues. The CM then notifies our QM Department by phone, documents the issue in TruCare to facilitate QM follow up, and follows up with affected members. Our Credentialing Committee (CC) reviews member complaints, appeals and sanctions monthly; verifies insurance annually; and reviews information from licensing and accrediting agencies and quality measures every three years. The CC notifies QM of all trends that may indicate problems with a NF's viability or quality of care.

Assisted Living Facility Oversight. Similar to NF oversight, the QM Department reviews ADHS licensure and complaint history, APS history, and the CMS reports noted above to evaluate compliance, quality measures, health deficiencies, and inspection results. For Maricopa, Yuma and La Paz Counties we use the services of the non-profit

organization Foundation for Senior Living (FSL) to provide onsite ALF monitoring. FSL immediately reports negative findings to the QM Department via phone or email, and provides a written report describing its quarterly audits of each facility's quality of care. In the Pima service area (and in any new GSAs we are awarded), we use a specialized ALF Department (within the QM Department) for oversight. QM conducts site visits when we contract with a new facility (prior to contract approval and within 30 days of the first ALTCS placement), in response to a reported concern, and at least annually. CMs review standards of care at least quarterly, and report all deviations to QM via an electronic QOC file. QM, PS, or CM staff coordinate and maintain communication throughout an investigation.

Required Facility Actions To Identify Issues. Bridgeway's contracts require NFs and ALFs to provide written notice (usually within 10 days) of situations involving licensing (such as a report, investigation, or disciplinary action); suspension or exclusion under Medicaid/Medicare or another federal health program; government requests for access to records; and professional malpractice claims against the facility. Facilities also must provide access to CAPs for deficiencies found by state or federal authorities, and must comply with our complaint and QOC investigations. We require facilities to provide immediate written notification when they become aware of financial solvency or licensure/certification issues that necessitate closure. We require them to provide a 90-day advance notification and a 30-day notice to members when they are planning to terminate a contract or to cease operations.

Collaboration With Facilities. Facility closure can be disruptive to care and cause our members stress, confusion or anger. For this reason, when Bridgeway learns of the potential loss of a NF or ALF, or issues that might lead to network loss, we immediately begin working with the facility to address the relevant issues and ensure members continue to receive uninterrupted quality care. This includes forms of assistance unrelated to direct care, such as helping a facility address financial issues by advising them on its billing system, or reaching out for assistance from the Arizona Health Care Association. For example, we provided fall prevention training to staff at a Yuma NF.

Proactive Approach. We do not wait until someone contacts us about a problem. When we detect problems early, before they rise to level of causing potential loss to the network, we approach issues in partnership with the facility, taking on a consultant role to help them identify and implement effective ways to improve performance. For example, we may provide specific training related to the area of concern, such as training on medication administration and documentation, or offer to share best practices used in other facilities, regulatory guidelines, and potential sources of assistance with staffing, building maintenance, and other operational and clinical aspects. Under the new contract, we will begin deploying Provider Coaches to help facilities meet clinical and QOC standards by delivering training, technical assistance, program guidance, and hands-on coaching, and to collaborate with ALTCS, AHCCCS and other plans. When we identify issues, QM, CM or PS staff telephone the facility to discuss the problem and gauge the likelihood of licensure, QOC, or certification issues. We may also conduct an onsite meeting or conference call that includes a cross-departmental representation of Bridgeway staff and other relevant parties, such as ADHS, local licensing authorities, the Ombudsman, and members, to discuss the issue and determine possible solutions. For ownership changes, our Network Managers immediately contact the buyers to offer assistance in registering with AHCCCS or other matters, and our CMs inform members of the change and assist in planning and implementing any desired transitions. Our CM, Network Manager or QM staff also increase onsite and telephonic monitoring to prevent reduction in quality of care and services.

Corrective Action. In the Pima service area, Bridgeway uses our Nursing Facility Quality Resolution Committee (NFQRC) to determine a plan of action for NF compliance, licensing and QOC issues. Membership includes the Medical Director, QM staff, and as appropriate the Compliance Officer and the CM. For ALF issues in Pima, we use our ALF Review Committee for compliance, licensing, or QOC concerns. Membership includes CM, Medical Management (MM) and QM staff, and, as applicable, others such as ALF staff and the Medical Director. For both committees, our QM staff investigate the scope and severity of the cited problems and prepare recommendations. The applicable Committee convenes to determine subsequent actions, including corrective actions plans (CAPs), and whether to place a hold on admissions. The applicable Committee must approve all CAPs and actively monitor the case and direct Bridgeway activity until deficiencies have been corrected. In all other service areas, our QMIC carries out the role of the Committees, overseeing and directing QM staff investigations and subsequent plan of action, and monitoring facility progress in correcting the problems. QM staff (in coordination with PS and CM staff as applicable) help the facility create a CAP that fully addresses the problem. If a facility is unable to successfully complete the CAP and correct deficiencies, the applicable committee will recommend terminating the contract.

Natural Disasters/Immediate Jeopardy/Closure Notifications. When we are notified of a facility facing potential or probable closure, our inter-departmental First Response Team (FR Team) immediately investigates and helps address the problem to protect member care and safety and, if possible, prevent closure. The team is comprised of PS, QM, CM, MM

and Compliance staff, who select from among themselves a Lead Coordinator appropriate to the situation's circumstances. The Lead Coordinator ensures inter-departmental coordination and documents all issues and actions, including barriers, challenges, interventions, outcomes, and responsible parties, in a QOC file and TruCare. Our FR Team uses a prepared checklist of essential activities and staff responsibilities, and develops a transition plan that meets the unique circumstances of each closure. The plan includes member/family notification; increased facility monitoring and/or assistance; communications and collaboration with Arizona authorities and other plans with resident members; helping members select their desired, appropriate placement, including returning home or to a more integrated care setting; and the smooth transfer of member belongings, medical records, prescriptions and medical supports. During instances of immediate jeopardy, at least one Bridgeway staff member (such as a CM or Network Manager) remains in the facility at all times to ensure member care. The FR Team also assists facilities in complying with disaster response plans and finding emergency help, such as staffing, food, fluids and shelter. For closure notifications, the FR Team may assist facilities such as by offering strategies for retaining staff, and CM staff will conduct daily onsite monitoring to assure quality care**.**

Collaborating with Others. By collaborating with members, Arizona authorities, and other plans, we safeguard member care and safety and find optimal solutions to facility issues that could result in closure or termination.

Members. As soon as we identify a significant issue, the CM immediately notifies the members and their family/guardian/Power of Attorney of the pertinent facts so that they may remain in charge of their care, and to prevent or eliminate rumors that heighten fear and confusion. The CM will provide daily updates by telephone or in person until the issue is resolved, and encourage them to call the CM if they have further questions. When there is the potential for a closure or contract termination, we will begin transition planning with members *prior to* the determination for closure/termination. In such situations, we assess the member's desire and ability to return to the community or home and work with them as applicable to ensure a safe, successful transition. Regardless of the facility issue or problem, we will honor and facilitate at all times the wish of a member to transfer to another placement. When members choose to remain in a facility that we determine may be unsafe, we will ask them to sign a Managed Risk Agreement that documents our concerns, the options we presented, the member's choice, and the possible outcomes of their choice.

Arizona Authorities. In addition to complying with all AHCCCS/ADHS requirements on notifications of facility problems, we also work with Arizona authorities to obtain input and guidance and assist in preventing closures or terminations. For example, we contact AHCCCS when we find and help fix a problem, such as training ALF staff on medication documentation, and may ask AHCCCS or ADHS for input and review on CAPs. We may update and confer with AHCCCS and Ombudsman staff in the development and enactment of our FR Team's action plan, and work with the Ombudsman in resolving issues concerning other residents. We also assist Arizona authorities with additional information or other help. For example, we train and require all Bridgeway staff with member contact to identify and report any case of suspected and alleged abuse and neglect to the appropriate state health professional licensing board. In addition to increasing facility monitoring in these cases as needed or requested, we will assist board investigations as requested.

Other Contractors. To ensure the safety of all residents, we work with Medicaid Contractors and those responsible for non-ALTCS members to coordinate our efforts to resolve facility problems or make arrangements in the event of a closure. For example, Bridgeway is a member of the Nursing Facility Review Collaboration, which consists of QM staff from all Maricopa-based Medicaid Contractors, who meet regularly to share and resolve provider quality issues. To address an identified decline in cleanliness at Greenfields NF, Collaboration members trained NF staff on how to keep the facility clean. During any situation which requires the transition of members, we work with other Contractors, NF Ombudsmen and others responsible for non-members to secure appropriate placement and transportation for all residents.

Network Development and Maintenance. Our provider network meets the needs of almost 7,000 members in our current service areas, and has sufficient capacity to offer member choice should we lose a NF or ALF. We also maintain a strong network of HCBS agencies to support members who decide to move to a home or community setting. Finding permanent placement is our priority, but if the member needs more time to decide, PS staff assist CMs and members in identifying short-term options such as acute care or non-participating facilities, or a family home with support services. We help develop capacity in rural and underserved areas by informing providers, often in other service areas, or through professional organizations, of the demand for services, and work with them to develop needed services. For example, the most significant subpopulation of members in NFs has severe and persistent mental illness (SPMI). We partnered with Community of Providers Enrichment Services (CPES - a Cenpatico RBHA funded behavioral health (BH) provider) to create two new Level 2 BH homes for adults with SPMI in Yuma. We also work with housing authorities and advocates to adapt current programs and develop additional capacity. For example, we are now working with Pima County Housing Authority to expand availability of housing appropriate for ALTCS members.

44. Describe the process for addressing provider performance issues, up to and including contract termination.

Provider Performance Improvement Culture

Bridgeway takes a measured approach to addressing provider performance issues, preferring to support providers' efforts to improve before considering other actions. Below, we provide details on our processes for monitoring and assessing provider performance; providing targeted feedback to providers; motivating providers through non-financial and financial incentives; and facilitating provider performance improvement. Later in this narrative we provide details on the process(es) we follow to address provider performance issues. When necessary, we take swift and appropriate action to protect the health and safety of our members. Such actions may include referring the provider to the Peer Review Committee for investigation of potential quality of care issues or, in the case of ongoing non-compliance, consideration of continued network status.

Monitoring and Assessing Provider Performance

The Bridgeway Medical Director is responsible for our provider Performance Assessment and Reporting Program (Performance Assessment Program), and reviews provider performance data on key quality and utilization indicators on a quarterly and annual basis with the Quality Management/Performance Improvement Committee (QMPIC). In addition, we will supplement our current provider performance assessment activities in 2011 with a state-of-the-art provider profile report program. This program will be a critical component of our approach to supporting providers in their efforts to continuously improve. It will compare each element of provider performance to normative data, so that providers can improve their practice patterns or care processes and quality of care in alignment with evidence-based clinical practice guidelines and AHCCCS standards. Our approach is multi-dimensional, and will assess clinical, administrative, and member satisfaction aspects of performance.

Our QMPIC, which includes a variety of provider specialties and types, including behavioral health, will review the profiling elements and other aspects of the Program. The Committee will determine the specialties and provider types, such as endocrinology and cardiology specialists, to include in the profiling program based on the needs of ALTCS members. The providers on our QMPIC also will help determine the profile indicators, and help providers understand and use feedback to improve care. This collaborative effort will foster provider acceptance of profiling results, and help Bridgeway motivate providers to continuously improve performance in targeted areas.

The Committee will establish inclusion criteria, such as threshold numbers of assigned members or member encounters, designed to achieve statistically valid comparisons of performance, as well as maximum participation by providers. Performance indicators will be measurable, reliable, and valid; have available benchmark data; be relevant to members, providers, and our Quality Management (QM) Program; and be actionable by providers. Different provider types will have unique sets of indicators relevant to the services rendered by those providers and that reflect compliance with approved practice guidelines and AHCCCS standards. They may include HEDIS clinical measures; inpatient, emergency department, pharmacy or other utilization measures; quality of care concerns; member satisfaction; and medical record (or behavioral health treatment record), access and appointment availability, and wait time audit results. Indicators for long term care providers, including home and community-based services providers, might include, for example, personal attendant no-show and turnover rates, timeliness of initiating services, rates of falls or pressure sores, and medication compliance. The QMPIC will establish benchmarks for each indicator that may reflect AHCCCS goals, national HEDIS Medicaid percentiles, or average network performance. Chosen profile measures will differentiate providers with superior performance.

Centene Corporation, our parent company, will support our Performance Assessment Program by providing sophisticated data management capabilities for data collection, indicator measurement, analysis, and reporting. Our Teradata-powered Enterprise Data Warehouse is the central hub for service information that will allow the collection, integration, and reporting of clinical claim/encounter, financial, medical management, member, and provider data. Our Centelligence Insight suite of reporting systems generate HEDIS and other performance indicators, which will encompass both ALTCS and Bridgeway Special Needs Plan data. QM staff will monitor provider performance at least quarterly and will produce annual profile reports for provider review, at least three months after the end of each year to account for claims lag. Providers may also review their performance status on our Provider Portal, with HEDIS performance updated quarterly. After each profiling year, QM staff will file profile copies in credentialing folders for review by the Credentialing Committee (CC).

PROPRIETARY

Targeted Feedback

Bridgeway will mail or hand deliver profile reports to providers, and we will encourage providers to contact the Medical Director or Provider Services personnel with any questions related to their profile. The Medical Director, Quality Management or Provider Services staff will meet personally with each underperforming or noncompliant provider to review expectations and AHCCCS standards, and jointly develop an action plan for improving identified measures to a target level of performance. They may also help the provider identify additional resources such as the Advancing Excellence in America's Nursing Homes Campaign educational programs and quality improvement monitoring tools; the National Center for Assisted Living clinical practice guidelines and in-service training tools; or the American Psychology Association continuing education on evidence-based practice. Part of the discussion will focus on identifying actions we can take to support the provider's improvement efforts. QM staff will re-evaluate the provider's performance every three to six months until an acceptable level of performance in the selected measure(s) is achieved. When non-compliance with standards is identified during an onsite visit, Provider Services staff will immediately review contractual performance requirements with the provider and initiate development of an action plan.

Motivating Providers

Bridgeway's strategy for improving network provider performance will depend, in part, on the credibility of our Performance Assessment Program and the indicators we measure. When providers believe that performance indicators and benchmarks are valid and relevant, we can more fully engage their analytic skills and competitive spirit. Self-motivated providers often ask for more data and, as a result, discover additional improvement opportunities on their own. Since peer influence can be a potent motivator, Bridgeway will include average network performance for each profile measure, which will allow providers to compare their performance to their peers. We will also give them access to rolling 12-month HEDIS performance measures through the Provider Portal.

Pay-for-Performance (P4P) programs have been recognized as a promising strategy to improve health care quality and access in Medicaid programs. We will employ both non-financial and financial incentives to recognize providers for their outstanding performance and consistent support of our QM efforts. Bridgeway will focus our P4P program on network long term care providers in view of their vital role in meeting the needs of ALTCS members. Our **Long Term Care Champion** Award is aimed at promoting better health outcomes by recognizing quality long term care providers of all types. Providers with the highest scores for the elements in the annual performance profile will be eligible for this annual non-financial award. Awardees are featured in national and local press, and receive an engraved crystal award and catered luncheon for them and their office staff. In addition, our **Community Contribution Award** will recognize providers, nominated by other providers, members or staff, who make a significant contribution to the health and well-being of their communities. Winners will receive recognition in the press and our newsletters, and will be eligible to direct a contribution from Centene to an approved charity of their choice. We will also publicly recognize providers who receive external recognition or certification related to quality of care, or best practices and we will highlight them and their recognition/certification in our online Provider Directory. We will offer a **Long Term Care Quality Incentive Program** to home and community-based services providers**.** This financial incentive will include an attendant care rate enhancement to recognize superior quality of care and service. Rate enhancement will be based on the degree to which the provider's score indicates above network average performance on the quality measures in the performance profile. For example, the attendant turnover rate measure would recognize agency retention efforts such as training and certification programs, health insurance, and vacation time to improve recruitment and retention of direct care workers. Other measures might include timeliness for initiating services; percent of members with advanced directives; skilled nursing facility, ED, and inpatient admission rates for members receiving services; Quality of Care events; member complaints; members enrolled in Consumer Directed Services; and medication compliance rate for members receiving services. Bridgeway also has experience with more focused incentives to providers, such as eligibility for drawings for iPods® as an incentive for provider offices to submit encounter or other data for HEDIS performance.

Facilitating Provider Performance Improvement

Bridgeway collaborates with providers in support of their improvement activities and accountability for members served. Our Medical Director and QM staff offer consultations about improvement strategies through face-to-face visits or by phone with interested providers. Our case and disease management functions also actively support provider efforts to improve health outcomes. We provide information about best practices through the Provider Newsletter, Provider Portal, and provider orientations, and we facilitate clinical practice guideline compliance by providing access to practical resources such as provider toolkits. For example, Bridgeway has AHCCCS toolkits for common behavioral health conditions available on our Portal. Other examples include Fluvention packets with influenza prevention posters and

brochures and a pain management toolkit, currently under development, to help physicians better managed their patients on chronic narcotics and pain medications. To facilitate accountability, we will supply providers with periodic reminder lists of members due or overdue for preventive services such as women's health screening and diabetes monitoring, along with chart stickers and mailing labels. Additionally, the online Care Gap Notification feature on our Provider Portal, powered by the Centelligence Insight reporting system, will alert providers about the need for recommended services when they check member eligibility online. To improve communication and coordination, our Provider Portal will provide features such as online access to member reminder lists and the ability to submit corrections; both practice and individual member views of delivered care; an interactive formulary; and read-only access to care plans from TruCare, our integrated, member-centric health services management platform. Bridgeway also will provide direct member outreach through our Case Managers and MemberConnections® community outreach program.

Addressing Provider Performance Issues

Providers with lagging performance who have not improved their performance or who are not in compliance with performance standards must submit a corrective action plan. The Medical Director and the Quality Management Investigative Committee (QMIC) review the plan to ensure it is acceptable. The QMIC is chaired by the Medical Director and includes the Vice Presidents of Operational Services and Compliance, Contracts, Member and Provider Services, Case Management, Medical Management, and the Director of Quality Improvement. QM staff continue to monitor provider performance every three to six months to verify implementation of the action plan and sustained improvement in performance. The QMIC refers providers who have persistent non-compliance to the Medical Director for further investigation, if necessary, and presentation to the Peer Review Committee. The Medical Director also reviews quality of care incidents or trends and other serious quality concerns. Requests for review may be referred through the Pharmacy and Therapeutics or Medical Management/Utilization Management Committees; from Grievance and Appeal, Medical, Case, or Quality Management staff; or by AHCCCS or the Arizona Medical Board or other regulatory boards. The CC refers issues that are identified during the periodic recredentialing process.

For potential quality of care issues, the Medical Director leads the investigation, supported by QM staff who gather all information relevant to the review, including both internal and external records, data or trends and input from the provider in question and other persons with knowledge of the issue. If the Medical Director feels that a referred situation warrants immediate action, he/she may summarily suspend the provider pending the outcome of an investigation. The Medical Director assigns AHCCCS severity levels to quality of care incidents, develops recommendations for actions based on the investigation results, and presents level IV and V incidents and other concerning issues or trends to the QMIC for approval for referral to the Peer Review Committee.

The Peer Review process includes a fair and professional review by a qualified medical or behavioral health provider of the same or similar specialty, including providers practicing in a long term care setting. The provider may attend the Committee session. The Medical Director presents the finding of the investigation or trend of non-compliance for review. The Peer Review Committee is responsible for making recommendations for corrective action or sanctions based on both the severity of the current issue and any past provider quality issues. Possible recommendations may include, for example, no additional action, expanded ongoing utilization review, formal professional education or coaching by the Medical Director, or suspension or limitation of new member referrals. When appropriate, the Committee may recommend referral or reporting to Adult or Child Protective Services, AHCCCS, the appropriate regulatory or licensing agency, or to a hospital or facility quality or peer review for further review or action. It may also recommend referral to Centene's Special Investigation Unit for Fraud, Waste and Abuse investigation. The Medical Director will work closely with the provider to implement any required corrective action. Upon completion of the corrective action plan and achievement of satisfactory behavioral change by the provider, the relationship between Bridgeway and the provider will be normalized. QM staff reassess the provider's activity in six months, or more frequently depending on the severity of the initial issue, to ensure that improvement has been sustained before reverting to routine monitoring.

Contract Termination. The Peer Review Committee may forward a recommendation for suspension or termination of participation to the CC for action. The provider receives written notice of the CC's review and recommendations and may appeal any adverse action of the CC, as set forth in the Bridgeway Fair Hearing Plan. The appeal is reviewed by a Hearing Committee comprised of providers who have not previously participated in the investigation of the matter at issue. The provider has the right to an Appellate Review by the Bridgeway Board of Directors in the event of a continuing adverse action. If the review process results in suspension or termination of a provider's participation, Bridgeway will report such action to the appropriate regulatory agencies (appropriate state licensing board, AHCCCS and the National Practitioners Data Bank at the conclusion of the fair hearing process.