EXHIBIT A: OFFEROR'S CHECKLIST

The Offeror's Checklist must be submitted with the proposal and shall be the first pages in the binder. Offerors must submit all items below, unless otherwise noted.

The Offeror must complete the Offeror's Bid Choice Form, Section A1 identifying the program(s) for which the Offeror is submitting a proposal. In addition, when bidding on the Acute Care Program, the Offeror must indicate the Geographical Service Area(s) (GSAs) for which the Offeror is submitting a proposal.

In the column titled "Offeror's Page No.," the Offeror must enter the appropriate page number(s) from its proposal where the AHCCCS Evaluation Team may find the Offeror's response to the specified requirement.

A. GENERAL MATTERS

Subject:	*Page Number Reference*	*Offeror's Page No.*
Offeror's Checklist *(This Exhibit)*	Exhibit A	1 - 3
Offeror's Bid Choice Form *(Form provided below in this Exhibit and submitted with the checklist)*	See A1 below	N/A
Offeror's Signature Page	1 and 2	~~4 - 5~~ 5-6
Signed Cover Sheets of Solicitation Amendments, if any	289	7-12
Completion of all items in Section G: Representations and Certifications of Offeror	Section G	~~6 - #~~ 13-39

A1: OFFEROR'S BID CHOICE FORM

ACUTE CARE PROGRAM

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

Bridgeway Health Solutions of Arizona, LLC
Offeror's Name

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

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

Authorized Signature — Date: 1-28-13

Patrick J. Ross — Print Name

President — Title

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

Authorized Signature	Date
Print Name	Title

NOTE: The "Requirement No." shown in Parts B, C, D, E, and F below refers to the **Submission Requirements** outlined in *Section H: Instructions to Offerors* of this RFP.

B. *ATTESTATION*

Attestation	*Requirement No.*	*Offeror's Page No.*
	1-34	41-45

C. *CAPITATION SUBMISSION*

Capitation	*Requirement No.*	*Offeror's Page No.*
Acute Care Program Capitation Bid Submission Including Actuarial Certification	1	47-50
CRS Program Capitation Bid Submission Including Actuarial Attestation	2	N/A

D. EXECUTIVE SUMMARY AND DISCLOSURE

Executive Summary and Disclosure	*Requirement No.*	*Offeror's Page No.*
	1	52-55
	2	56

E. *ACUTE CARE NARRATIVE SUBMISSIONS*

Access to Care/Network	*Requirement No.*	*Offeror's Page No.*
	1	58-62
	2	63-67

Program	*Requirement No.*	*Offeror's Page No.*
	3	68-72
	4	73-77
	5	78-82
	6	83-87

Organization	*Requirement No.*	*Offeror's Page No.*
	7	88-92
	8	93-97
	9	98-102
	10	103

F. CRS NARRATIVE SUBMISSIONS

Access to Care/Network - CRS	*Requirement No.*	*Offeror's Page No.*
	11	N/A

Program - CRS	*Requirement No.*	*Offeror's Page No.*
	12	N/A
	13	N/A
	14	N/A

Organization - CRS	*Requirement No.*	*Offeror's Page No.*
	15	N/A

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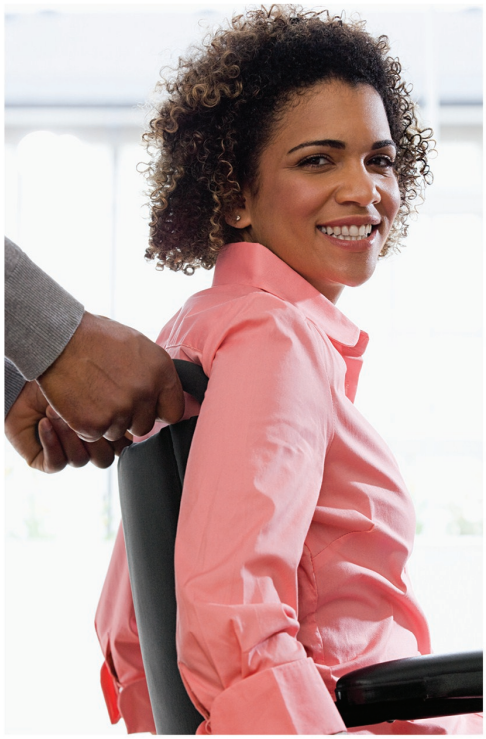

A. General Matters

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Offeror's Signature Page

30 years 1982 - 2012	**Notice of Request for Proposal**		**AHCCCS** Arizona Health Care Cost Containment System
	SOLICITATION NO.: **YH14-0001**	PAGE 1	701 East Jefferson, MD 5700
		OF 337	Phoenix, Arizona 85034

Solicitation Contact Person

Meggan Harley
Contracts and Purchasing Section
701 E. Jefferson, MD 5700
Phoenix, AZ 85034

Telephone: (602) 417-4538
Telefax: (602) 417-5957
E-Mail: Meggan.Harley@azahcccs.gov
Issue Date: November 1, 2012

LOCATION: **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)**
Contracts and Purchasing Section (First Floor)
701 E. Jefferson, MD 5700
Phoenix, AZ 85034

DESCRIPTION: **ACUTE CARE / CHILDREN'S REHABILITATIVE SERVICES (CRS)**

PROPOSAL DUE DATE: **January 28, 2013** **AT 3:00 P.M. Arizona Time**

Pre-Proposal Conference: A Pre-Proposal Offer's Conference has been scheduled for **Friday, November 9, 2012** starting at **9:00 A.M. Arizona time**. The Conference will be held in the following location:

AHCCCS
Gold Room, Third Floor
701 E. Jefferson
Phoenix, AZ 85034

QUESTIONS CONCERNING THIS SOLICITATION SHALL BE SUBMITTED TO THE SOLICITATION CONTACT PERSON NAMED ABOVE, IN WRITING VIA E-MAIL AS SPECIFED IN SECTION H, INSTRUCTIONS TO OFFERORS. QUESTIONS MUST BE SUBMITTED ON THE ACUTE CARE AND CRS PROGRAM RFP YH14-0001 QUESTIONS AND RESPONSES TEMPLATE LOCATED IN THE BIDDERS' LIBRARY.

The Solicitation Process shall be in accordance with the "RFP and Contract Process" Rules set forth in Title 9 Chapter 22 Article 6 and effective November 11, 2012. These rules are posted on the AHCCCS website at:

http://www.azahcccs.gov/reporting/Downloads/UnpublishedRules/NOFR22_6.pdf

The RFP and Contract Process Rules were also published on October 5, 2012 in the Arizona Administrative Register at:

http://www.azsos.gov/public_services/Register/contents.htm

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 package with the Solicitation Number and the Offeror's name and address clearly indicated on the 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.

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

OFFER

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

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

Federal Employer Identification No.: 20-4980818

E-Mail Address: pross@centene.com

Bridgeway Health Solutions of Arizona, LLC
Company Name

1501 W. Fountainhead Parkway, Ste. 295
Address

Tempe, AZ 85282
City State Zip

For Clarification of this offer, contact:

Name: Patrick J. Ross

Phone: 1-866-475-3129 Ext.: 26743 or 602-743-8304 (cell)

Fax: 866-638-6124

Signature of Person Authorized to Sign Offer

Patrick J. Ross
Printed Name

President
Title

CERTIFICATION

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

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

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

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

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

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

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

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

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

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

_____
Michael Veit, as AHCCCS Contracting Officer and not personally

Signed Cover Sheets of Solicitation Amendments

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

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

This solicitation is amended as follows:

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the **27th day of November, 2012**, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date** 1/17/13	**Signature**
Typed Name Patrick J. Ross		**Typed Name** Michael Veit
Title President		**Title** Contracts and Purchasing Administrator
Name of Company Bridgeway Health Solutions of Arizona, LLC		**Name of Company** AHCCCS

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	SOLICITATION AMENDMENT	AHCCCS
30 years 1982 - 2012	Solicitation No.: **RFP YH14-0001** Amendment No. 2 (Two) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

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

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

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

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

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

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

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

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 19th day of December, 2012, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date** 1/17/13	**Signature**
Typed Name Patrick J. Ross		**Typed Name** Michael Veit
Title President		**Title** Contracts and Purchasing Administrator
Name of Company Bridgeway Health Solutions of Arizona, LLC		**Name of Company** AHCCCS

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

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

This solicitation is amended as follows:

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

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 4th day of January, 2013, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date** 1/17/13	**Signature**
Typed Name Patrick J. Ross		**Typed Name** Michael Veit
Title President		**Title** Contracts and Purchasing Administrator
Name of Company Bridgeway Health Solutions of Arizona, LLC		**Name of Company** AHCCCS

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

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

This solicitation is amended as follows:

1. Section H: Instructions to Offerors, Paragraph 16, Capitation, *Acute Care Program Capitation Bid Submission (Submission Requirement No. 1)*, page 302 is amended as follows:

***Acute Care Program Capitation Bid Submission* (Submission Requirement No. 1)**
All GSAs for which an Offeror bids will require a capitation rate bid submission for each risk group. Each bid will encompass two components; a gross medical component and an administrative component. Each component will be scored separately. In addition, the combined components (i.e. the gross medical and administrative components) may be scored for each risk group and GSA. The lowest bid within each GSA and risk group will receive the maximum allowable points. However, AHCCCS may award the maximum allowable points to any bid for the administrative component equal to or below a minimum threshold considered by AHCCCS to be reasonable, either for the scoring of the administrative component and/or the combined components. ~~Conversely, the highest bid will receive the least number of points.~~

Bid component requirements:

1. Offerors will submit a gross medical component PMPM bid for each risk group by GSA. Neither reinsurance offsets nor capitation withheld for payment reform initiatives should be considered in the medical component bid. Prior to October 1, 2013 AHCCCS will develop projections for reinsurance offsets and will adjust awarded capitation rates accordingly.
   - Capitation bids submitted with a medical component outside of the published ranges (described below) will earn a medical component score of zero points.
2. Offerors will submit an administrative component PMPM bid for each risk group by GSA. The administrative component is limited to a maximum of 8%. The administrative component percentage shall be calculated as: Administration / Gross Medical Component.
   - Capitation bids submitted with an administrative component exceeding 8% will earn an administrative component score of zero points.
3. In the event that AHCCCS elects to score the combined components, in any instance where zero points are awarded for either the medical or administrative component, the combined component score will be zero.
4. In any instance where zero points are awarded for either the medical or administrative component and the Offeror is awarded a contract, the awarded capitation rate for the impacted GSA/risk group will be as follows:
   - For a medical component score of zero points: the bottom of the actuarial rate range for the medical component for that GSA/risk group (as adjusted by Section D, Paragraph 53, Compensation and Section D, Paragraph 55, Capitation Adjustments); and
   - For an administrative component score of zero points: the lowest awarded administration rate for that GSA/risk group.

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

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

***CRS Program Capitation Bid Submission* (Submission Requirement No. 2)**
The Offeror will submit a capitation rate bid submission for the administrative component. The lowest bid will receive the maximum allowable points. However, AHCCCS may award the maximum allowable points to any bid for the administrative component equal to or below a minimum threshold considered by AHCCCS to be reasonable. ~~Conversely, the highest bid will receive the least number of points.~~

Bid component requirements:

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 10th day of January, 2013, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date** 1/10/13	**Signature**
Typed Name Patrick J. Ross		**Typed Name** Michael Veit
Title President		**Title** Contracts and Purchasing Administrator
Name of Company Bridgeway Health Solutions of Arizona, LLC		**Name of Company** AHCCCS

	SOLICITATION AMENDMENT	AHCCCS
30 years 1982 - 2012	Solicitation No.: **RFP YH14-0001** Amendment No. 5 (Five) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person. A signed copy of this signature page must be received by AHCCCS no later than the Solicitation due date and time. Notwithstanding, Section H: Instructions to Offerors, Paragraph 15, *Contents of Offerors Proposal*, for Amendment No. 5 only, one copy of signed Amendment No. 5 is required which may be submitted separately from the remainder of the proposal. However, the signed Amendment No. 5 must still be submitted by 3:00PM (Arizona Time) on the January 28, 2013 deadline. Offerors may submit the signed amendment electronically to the Offeror's SFTP folder noted in Section H: Instructions to Offerors, Paragraph 15, *Contents of Offerors Proposal*, or by hard copy to the Solicitation Contact Person.

This solicitation is amended in response to the following question which was received by the Technical Support Help Desk regarding the Capitation Bid Template:

> *It appears that macros within the Bid Template are rounding unit costs entered with more than two decimal places to two decimal places. Are we limited to two decimal places for unit cost entry?*

AHCCCS Response:

> Offerors are not limited to two decimal places when entering unit cost. The first time you enter and store a risk group/GSA you have unlimited decimal places. However, if you retrieve that same risk group/GSA the model will round to two decimal places for unit cost.

No questions will be accepted by the Technical Support Help Desk regarding the Capitation Bid Template on or after January 25, 2013 at 12:00PM (Arizona Time).

OFFEROR		AHCCCS
Signature	Date 1/25/13	Signature
Typed Name Patrick Ross		Typed Name Michael Veit
Title President		Title Contracts and Purchasing Administrator
Name of Company Bridgeway Health Solutions		Name of Company AHCCCS

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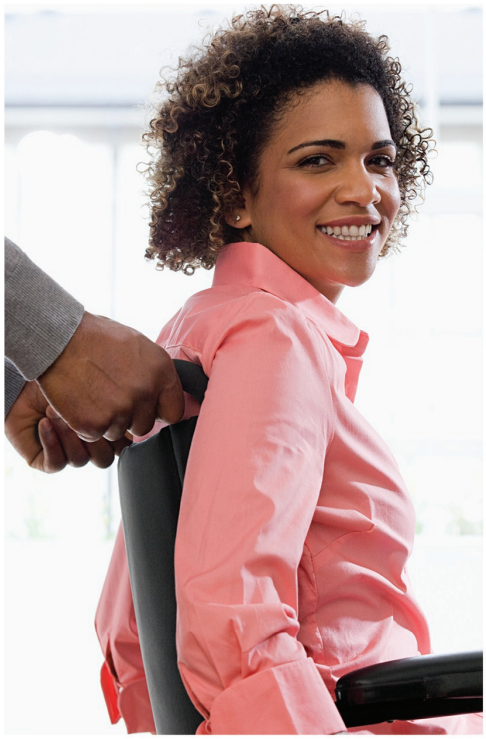

B. Attestation

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Attestation 41

Attestation

EXHIBIT C: ATTESTATION FORM

In order to be considered a responsive offer, the Offeror must attest to each element below by indicating with a check mark in the box next to each requirement. Failure to check any box will result in automatic disqualification of the offer.

If the Offeror is submitting a proposal for both the Acute Care and CRS Programs, the attestation of each element shall apply to both Programs. If the Offeror is submitting a proposal for the Acute Care Program only, the attestation of each element shall apply to that Program only.

In addition to complying with all contractual requirements, the Offeror specifically acknowledges the importance of the following provisions and their critical value to the Arizona Health Care Cost Containment System program. The statements in the attestations are not intended to alter or amend the contractual obligations set forth elsewhere in the Request for Proposal. In the event of any inconsistency or ambiguity regarding the meaning of an attestation, the provisions of the Request for Proposal are controlling.

AHCCCS has identified the general references for each element as a convenience for the Offeror; however, all references may not have been identified. It is the responsibility of the Offeror to identify all relevant sources for each element.

Corporate Compliance	
AHCCCS is committed to protecting the public from fraud, waste and abuse. As part of this commitment, AHCCCS Contractors must comply with all applicable Federal and State program integrity requirements. The Offeror attests that it will:	
1. ☑	Have a corporate compliance program and plan consistent with 42 CFR 438.608, and practices which comply with program integrity requirements specified in 42 CFR 455, and the AHCCCS requirements described in ACOM Policy 103 and the contract, by the contract start date *RFP Section D, Paragraph 62, Corporate Compliance*
Staffing	
The Offeror will demonstrate by the start date of the contract that all staff shall be fully qualified to perform the requirements of the contract. The Offeror attests that it will:	
2. ☑	Maintain a local presence within the State of Arizona as outlined in Section D, Paragraph 16, Staffing Requirements and Support Services, of the contract *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
3. ☑	Limit Key Staff to occupying a maximum of two of the Key Staff positions *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
4. ☑	Have local staff available 24 hours a day, seven days a week to work with AHCCCS and/or other State agencies on urgent issue resolutions *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
5. ☑	Not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities *RFP, Section D, Paragraphs 16, Staff Requirements and Support Services and 62 Corporate Compliance*

SECTION I: EXHIBITS
EXHIBIT C: ATTESTATION FORM

Contract/RFP No. YH14-0001

Staffing - continued	
6. ✓	Screen all employees and subcontractors to determine whether any of them have been excluded from participation in Federal health care programs *RFP, Section D, Paragraphs 16, Staff Requirements and Support Services and 62 Corporate Compliance*
7. ✓	Require all staff members to have appropriate training, education, experience and orientation to fulfill the requirements of the position *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
8. ✓	Have sufficient staffing levels to operate in compliance with the terms of the contract *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
9. ✓	Have an Administrator/Chief Executive Officer (CEO) who shall have the authority and ability to direct Arizona priorities. *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
Information Systems	
The Offeror will demonstrate by the start date of the contract that its information system has clearly defined change control processes. The Offeror attests that it will:	
10. ✓	Maintain a change control process which includes the Offeror's ability to participate in setting and modifying the priorities for all information systems including those of the Parent Company, subcontractors and vendors *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
11. ✓	Maintain system upgrade and conversion processes which include appropriate planning and implementation standards *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
12. ✓	Have structures in place to ensure and support current and future IT Federal mandates *RFP, Section D, Paragraph 64, Systems and Data Exchange Requirements*
Claims/Encounters Processing	
The Offeror will demonstrate by September 1, 2013 that its systems and related processes can support the following key components of the AHCCCS Medicaid claims processing lifecycle. The Offeror attests that the entity and its IT system will:	
13. ✓	Accept and process both paper and electronic submissions *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*
14. ✓	Allow for the proper load of provider contract terms, support processing of claims within timeliness standards, incorporate coordination of benefit activities, and generate claims payments and HIPAA compliant remittance advices *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*

SECTION I: EXHIBITS
EXHIBIT C: ATTESTATION FORM

Contract/RFP No. YH14-0001

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

BRIDGEWAY HEALTH SOLUTIONS

SECTION I: EXHIBITS
EXHIBIT C: ATTESTATION FORM

Contract/RFP No. YH14-0001

Medical Management - continued	
23. ✓	A process that ensures that practice guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in that field and disseminated to providers *RFP, Section D, Paragraph 24, Medical Management (MM)*
24. ✓	A process in place to provide emergency services without prior authorization regardless of contract status of the provider *AMPM Chapter 310F*
25. ✓	A process to analyze utilization data and use the results to implement medical management changes to improve outcomes and experience *RFP, Section D, Paragraph 24, Medical Management (MM)*
26. ✓	Disease and chronic care management programs that are designed to coordinate evidence based care focused on improving outcomes for members with one or more chronic illnesses which may include behavioral health conditions *RFP, Section D, Paragraph 24, Medical Management (MM)*
Behavioral Health	
The Offeror attests that it will have:	
27. ✓	A process for identifying members with behavioral health care needs and assisting members in accessing services in the Regional Behavioral Health Authority system *RFP, Section D, Paragraph 12, Behavioral Health Services; AMPM Chapters 400 and 1000*
Access to Care *(Only Offerors submitting a proposal for the CRS Program must attest to #29)*	
The Offeror attests that it will have:	
28. ✓	A comprehensive network that complies with all Acute Care network sufficiency standards as outlined in RFP YH14-0001 and ACOM Draft Policy, Acute Network Standards, no later than August 1, 2013 *RFP, Section D, Paragraph 27, Network Development*
29. ☐ ***CRS Only***	A comprehensive network that complies with all CRS network sufficiency standards as outlined in RFP YH14-0001 (see Section D, Paragraphs 10, Scope of Services and 27, Network Development), no later than August 1, 2013 *RFP, Section D, Paragraph 27, Network Development*
30. ✓	A process for researching, resolving, tracking and trending provider inquiries/complaints and requests for information that includes contacting providers within three days and resolving issues within 30 days *RFP, Section D, Paragraphs 27, Network Development and 29, Network Management*
31. ✓	A process for monitoring and addressing provider performance issues up to and including contract termination *RFP, Section D, Paragraphs 27, Network Development and 29, Network Management*

SECTION I: EXHIBITS
EXHIBIT C: ATTESTATION FORM

Contract/RFP No. YH14-0001

Finance	
The Offeror attests that it will:	
32. ✓	Have a separate entity established for purposes of this contract within 120 days of the contract award if the Offeror is a non-governmental *New Contractor*. *RFP, Section D, Paragraph 51, Separate Incorporation*
33. ✓	Meet the minimum capitalization requirements within 30 days of the contract award if the Offeror is a *New Contractor;* or, fund through a capital contribution the necessary amount to meet the equity per member requirement within 30 days of the contract award if the Offeror is a *Successful Incumbent Contractor.* *RFP, Section D, Paragraph 45, Minimum Capitalization; Section H, Instructions to Offerors-Paragraph 14, Minimum Capitalization*
34. ✓	Secure a performance bond as defined in amount and type in Section D, Paragraphs 46, Performance Bond or Bond Substitute and 47, Amount of Performance Bond, and ACOM policies 305 and 306 no later than 30 days after notification by AHCCCS of the amount required. *RFP, Section D, Paragraphs 46, Performance Bond or Bond Substitute; 47, Amount of Performance Bond*

ATTESTATION SIGNATURE

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

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

Authorized Signature — **Date** 1/17/13

Patrick J. Ross — President

Individual's Printed Name — **Title**

C. Capitation Rates

C. Capitation Rates

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Capitation 47

Milliman

January 25, 2013

Actuarial Certification
Bridgeway Health Solutions
AHCCCS Acute Care Capitation Bids: GSA 2, 4, 6, 8, 10, 12, and 14
Rates Effective October 1, 2013 – September 30, 2014

I, Jason T. Nowakowski, am a Principal and Consulting Actuary with Milliman, Inc. I am a Member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. I am also a Fellow of the Society of Actuaries. I have been retained by Bridgeway Health Solutions to provide a certification of the actuarial soundness of its proposed capitation rates for Acute Care Services in GSA 2, 4, 6, 8, 10, 12, and 14 under the Arizona Health Care Cost Containment System (AHCCCS).

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

The Gross Medical Component and Administrative Component rates to which this certification applies are attached in AHCCCS's required Bid Template sheets and shown in Table 1 and Table 2 below. The rates apply to the period October 1, 2013 through September 30, 2014.

Table 1
Gross Medical Component by Risk Group and GSA

Risk Group	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14
TANF < 1	$399.21	$435.09	$452.83	$455.25	$429.38	$463.43	$419.51
TANF 1-13	$84.96	$91.69	$103.58	$90.71	$79.32	$92.76	$88.86
TANF 14-44 F	$180.92	$228.74	$275.67	$236.59	$189.70	$210.74	$216.25
TANF 14-44 M	$105.12	$155.46	$175.75	$147.75	$117.73	$137.66	$146.59
TANF 45+	$294.38	$383.69	$401.72	$407.21	$320.75	$375.78	$354.88
SSIW	$153.18	$106.27	$99.89	$118.38	$114.45	$147.57	$129.38
SSIW/O	$800.14	$849.69	$883.52	$693.57	$733.80	$746.20	$845.04
AHCCCS Care	$319.35	$408.09	$448.45	$389.09	$299.70	$387.44	$353.04
Delivery Case Rate	$4,684.40	$5,192.20	$5,368.46	$5,339.56	$5,248.54	$5,447.17	$5,103.71

Offices in Principal Cities Worldwide

Table 2

Administrative Component by Risk Group and GSA

Risk Group	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14
TANF < 1	$31.93	$34.80	$31.69	$36.42	$30.05	$34.75	$33.56
TANF 1-13	$6.79	$7.33	$7.24	$7.25	$5.55	$6.95	$7.10
TANF 14-44 F	$14.47	$18.29	$19.29	$18.92	$13.27	$15.80	$17.30
TANF 14-44 M	$8.40	$12.43	$12.30	$11.82	$8.24	$10.32	$11.72
TANF 45+	$23.54	$30.69	$28.11	$32.57	$22.45	$28.18	$28.39
SSIW	$12.25	$8.50	$6.99	$9.47	$8.01	$11.06	$10.34
SSIW/O	$64.01	$67.97	$61.84	$55.48	$51.36	$55.96	$67.60
AHCCCS Care	$25.54	$32.64	$31.39	$31.12	$20.97	$29.05	$28.24
Delivery Case Rate	$374.75	$415.37	$375.79	$427.16	$367.39	$408.53	$408.29

It is my opinion that the above rates are adequate, in the aggregate, to fund claims and administrative expenses for an average Medicaid population for GSA 2, 4, 6, 8, 10, 12, and 14 during the time period for which they are intended. AHCCCS has recommended that bidders submit rates reflecting the average monthly cost of a member utilizing the Data Book provided in the Bidders' Library; my opinion reflects this recommendation.

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 Health Solutions, and my judgment. In performing my analysis, I relied on data and other information provided by AHCCCS and Bridgeway Health Solutions. 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.

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

I also relied on Bridgeway Health Solutions provider reimbursement descriptions without audit. My opinion that the rates are actuarially sound is based on the assumption that Bridgeway Health Solutions's capitated providers are financially stable and have the financial resources to absorb capitation risk. I did not review the financial resources or medical management abilities of any provider to confirm their ability to assume financial risk.

The utilization rates and average costs in the attached Bid Template sheets 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 Health Solutions 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 deviates from expected experience.

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.

Jason T. Nowakowski

Jason T. Nowakowski, FSA, MAAA
Principal & Consulting Actuary
January 25, 2013

Acute Care RFP Bid Template - Bridgeway Health Solutions

Gross Medical Component by Risk Group and GSA

Risk Group	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14
TANF < 1	$399.21	$435.09	$452.83	$455.25	$429.38	$463.43	$419.51
TANF 1-13	$84.96	$91.69	$103.58	$90.71	$79.32	$92.76	$88.86
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AHCCCS Care	$319.35	$408.09	$448.45	$389.09	$299.70	$387.44	$353.04
Delivery Supp	$4,684.40	$5,192.20	$5,368.46	$5,339.56	$5,248.54	$5,447.17	$5,103.71

Administrative Component by Risk Group and GSA

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TANF 1-13	$6.79	$7.33	$7.24	$7.25	$5.55	$6.95	$7.10
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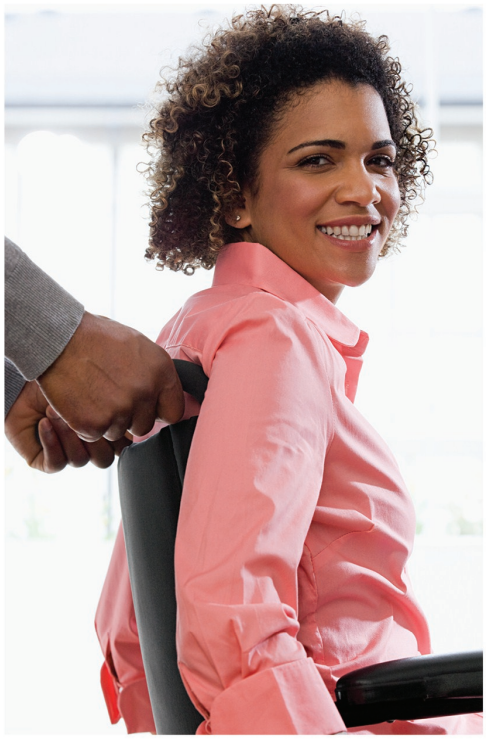

D. Executive Summary And Disclosure

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Executive Summary and Disclosure

1. Executive Summary

1. The Offeror must provide an Executive Summary that includes an overview of the organization and its relevant experience, a high-level description of its proposed approach to meeting contract requirements and a discussion of how it will bring added value to the program. In the final portion of the Executive Summary, the Offeror must describe how it will meet the requirements specified in Section I, Exhibit D, Medicare Requirements, Section 2. The Executive Summary will not be scored, but may be used in whole or part by AHCCCS in public communications, following contract awards. (4 page limit)

Overview

Bridgeway Health Solutions, LLC (Bridgeway) is a recognized leader in developing innovative programs and practices that carry out the AHCCCS Mission and Vision and continuously improve program performance and efficiency. Bridgeway's over four years of experience serving Acute Care Program members and over six years of experience in the ALTCS Program 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 hire from within the communities we serve; our local staff build relationships with members, providers and community organizations. It is by building these relationships that we are able to provide a level of service that goes beyond contract requirements. We bring to the table a culture of engagement with members and providers to deliver member-centric, culturally competent, integrated care. 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.

Experience and Approach to Meeting Contract Requirements

Bridgeway has been serving as the managed care contractor for the Acute Care Program in Yavapai GSA since October 2008. Bridgeway serves over 17,000 members and is contracted with 137 PCPs and 301 Specialists within the Yavapai GSA. We have always been sensitive to maintaining a local presence in the communities we serve and operate administrative offices located in rural and urban settings. Bridgeway currently operates offices in Bisbee, Casa Grande, Prescott, Tempe, and Tucson where members and providers appreciate our local presence. In fact, our local presence in Yavapai County has been a key success factor in serving Acute Care members in this semi-rural area and ensuring continuity of care. Our history of working with AHCCCS, stakeholders, members and providers has given us a comprehensive understanding of how to meet member needs and increase service delivery effectiveness and efficiency. Our medical home model, combined with effective member management approaches and a robust, well-supported provider network, is the foundation of our approach. We provide the support and information our members need to take charge of their health and access services appropriately, and a seamless experience of care for each member. A dynamic health care system requires frequent changes and we continue to re-focus to make the necessary adjustments that will result in the most beneficial quality outcomes for our members and for the Acute Care Program.

From a technology standpoint, our parent company Centene Corporation (Centene), who will provide the Management Information System (MIS) for Bridgeway, has won national awards for use of information technology. In 2012, for the second year in a row, Centene was the top Managed Care Company focused on Medicaid based programs on Information Week's 500 Most Innovative Business Technology list. Ours is a scalable, proven, and mature MIS, supporting industry standard and HIPAA compliant data and application interfaces, assuring secure support for information access, reporting, and support of meaningful and impactful health care support.

Bringing Added Value to the Acute Care Program

Focusing on the Member. Bridgeway recognizes that our members are the core focus of why we do what we do every day. We view our members as customers and strive to provide service that goes above and beyond with every member interaction. A member has to place only one call to one number to connect with a live person to assist them with requests such as finding a PCP, assistance with transportation, a connection to a community program for assistance with paying the electric bill, or assistance with managing health issues from their case manager.

Our *Member Advisory Council* meetings are held quarterly and are well attended by Bridgeway members and the advocate community. In these meetings we are able to hear direct feedback from the member and advocate community. For example, in one meeting a member expressed concern with what she felt was a limited number of contracted Bridgeway providers in a certain area. This feedback was then brought back to the leadership team and the provider relations team. Gap analysis reports were run and although we did meet contract requirements, we responded by ramping up efforts to expand the network and obtain additional provider contracts. Bridgeway intends to continue our focus on the member and find new and innovative ways to engage members in making their health a priority.

"The Bridgeway Advisory Council was really great! Juanita does a super job. Everyone there is very comfortable and open to share issues and services. There is no hint of anything other than total comradery. Your organization should be complimented on providing this great vehicle to bring organizations together and support those who need it in Yavapai County."

Casey Knight
Chief Professional Officer
Boys and Girls Club of Central Arizona

Programs that Educate and Promote Member Engagement.

Bridgeway offers programs that help educate members and provide solutions that may prevent members from seeking unnecessary care. Below are a few examples of the programs that bring added value to the Acute Care program. Bridgeway will continue to offer these programs and continue to develop programs that are specific to our member needs.

Start Smart for Your Baby® (Start Smart). Start Smart promotes education and care management techniques designed to reduce the risk of pregnancy complications, premature delivery, and infant disease which can result from high-risk pregnancies. The program offers support for pregnant women and their babies through the first year of life by providing educational materials as well as incentives for going to prenatal, postpartum, and well child visits. The ***Start Smart® Baby Shower Program*** is designed to educate pregnant members about prenatal and postpartum care for themselves and their newborn. "Baby Showers" are conducted in a class environment by Bridgeway staff. Led by a registered nurse and assisted by MemberConnections, the classes cover the basics of prenatal care, including nutrition, the risk of smoking and benefits of smoking cessation, the progress of a fetus throughout pregnancy, the importance of regular follow-up with medical providers, common health issues that occur during pregnancy, and a review of the Bridgeway Start Smart® and MemberConnections programs. Upon completion of the class, members are given a diaper bag filled with an assortment of baby items.

MemberConnections. Bridgeway hires MemberConnections Representatives (MCRs) from within the communities we serve to ensure staff are knowledgeable about the cultural, geographic, demographic, and other aspects of our members' communities, and the resources available within the various communities. MCRs establish relationships with members and deliver personalized service that engages them in their health and in the community. Outreach occurs in a variety of settings, including by phone, in the member's home, and in provider offices. Bridgeway MCRs have accompanied members to their doctor appointment and generally provide that in-person support to the member that cannot be accomplished remotely. For example, through data analysis Bridgeway noted higher transportation costs due to members being transported to remote pharmacies in rural areas to pick up medications. Our MCR was able to identify community pharmacies that had the capacity to

deliver medications to members living in remote areas; providing convenience for our members and a reduction in transportation costs.

Connections Plus. Through our ConnectionsPlus® Program, we provide pre-programmed cell phones to high risk members who lack reliable phone access, allowing them to make and receive calls from providers, their Case Manager, NurseWise, and 911. Members are educated on observing their health status and calling promptly for advice rather than waiting until the next appointment. The Case Manager can send the member a text message with health information targeted to the individual member's condition. In rural areas, increased telephonic communication helps overcome the barrier to care that travel distances sometimes pose for members.

Telemonitoring. Bridgeway's telemonitoring program uses communications technology to provide real-time information on health conditions from a distance. Our affiliated disease management contractor, Nurtur, provides this innovative technology with our best-in-class disease management coaching. Telemonitoring provides a way to facilitate patient adherence to treatment plans, improve care coordination between members and their care teams (including providers), and remove barriers to care such as lack of mobility or social supports. The wireless technology enables biometric readings to be taken in the home and transmitted electronically to the member's Case Manager and/or provider within seconds. The telemonitoring software compares the data against established thresholds noting favorable or unfavorable trends and provides an automatic data reading report to readily share any unexpected results with the provider. Members are given a URL and password information (HIPAA compliant) to share with their physician and/or family members to access their biometric data further supporting coordinated care efforts.

Care Coordination. 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 case manage members with special healthcare needs and to coordinate care for those that need additional assistance identifying community support. Through this model, the full range of covered and non-covered services each member needs is integrated into a seamless, holistic experience of care that improves outcomes and enhances quality of life.

Integrating Behavioral Health. We realize that many members with special healthcare needs often require behavioral health services support. Bridgeway has strived to improve the integration of behavioral health. We have a full time BH coordinator on staff that acts as the bridge between the RHBAs and Bridgeway. The BH coordinator also educates PCPs on the importance of communicating with the BH providers and has led training sessions on the process for making referrals to the RHBA. We have hosted collaboration sessions with the RBHA- and developed streamlined communication processes. We intend to continue hosting these sessions and brainstorm on ways we can all collaborate better incorporate behavioral and physical health services. We have also found ways to partner with behavioral health providers to better integrate care for our SMI members. For example, in 2010 Bridgeway identified that many of our SMI members with chronic medical conditions were using the emergency rooms for PCP services. Failure to obtain routine preventative care in turn led to an increase in hospitalizations for these members. As a result of this finding, discussions opened up with the West Yavapai Guidance Center to establish a partnership and co-manage those members with an SMI diagnosis and chronic medical illnesses. A pilot program was initiated in June 2011 in which the Bridgeway medical CM met with the member immediately following their BH appointment at either of the two BH clinics. As a result, the Bridgeway medical CMs are now invited to the weekly BH CM "staffing meetings" so as to be included in the development of the member's custom designed plan of care. These staffings include the participation of a psychiatrist from the clinics. With this new integrated approach, the case managers from each organization are able to utilize each other's expertise. A documented referral process and form has been created by both teams to further enhance communication.

Partnering with Providers. More than ever, Bridgeway is actively communicating and meeting with providers as part of its overall health services improvement initiatives among Physical Health (PH) and Behavioral Health (BH) providers. Last year, we invited pain management specialists, behavioral health specialists and PCPs in our network to attend meetings we held in Yavapai County where we invited an Addictionologist to talk about pain management issues that plague providers and care coordinators across the nation. Bridgeway's care coordinators also attended these meetings. Providers were given tools and information about local resources. Scenarios were presented to delineate when providers should contact or refer a patient for behavioral health versus pain

management services and for assistance with managing patient care. The providers who attended these meetings expressed their appreciation to Bridgeway for hosting such a valuable and informative event, bringing everyone together, and providing information they can apply to their overall practices, not just to Bridgeway members. Since these meetings took place, we have seen a marked improvement and increase in communication and interchange of ideas and care options between providers and their peers and between providers and our care coordination staff. Most recently, we worked with providers and AHCCCS to expand patient access to flu shots for our 9-18 year old members who previously could only obtain flu shots through providers using the Vaccines for Children (VFC) program. This removed access barriers and burdens for providers and increased member choice and likelihood of obtaining flu shots. This year, *we have increased outreach to PH and BH providers* and plan to host more workshops with additional topics designed to increase communication and interchange of ideas between BH and PH providers and their peers and to help providers in managing administrative services as well as managing care coordination in collaboration with our care coordination teams for both BH and PH services. New topics in 2013 include: how to improve care coordination for members with severe co-morbidities; using Bridgeway's online Care Gaps tools to improve patient adherence to obtaining preventive services (focus on dental care, childhood immunizations and prenatal care) and best practices and tips for EDI and EFT use. Bridgeway invites network providers to attend its monthly Care Management meetings where they can present topics to their network peers and our Care Management teams, answer questions, and share ideas geared toward serving patients more effectively. We also continue to invite providers to participate on our peer advisory committees and empower them to be more actively involved in developing solutions that will increase their ability to deliver quality care in an administratively efficient, unobtrusive and cost-effective manner. In addition, Bridgeway will continue to meet at least semi-annually with RBHA providers to assess their BH coordination efforts with PH providers and to develop initiatives aimed at improving BH and PH interactions and coordination efforts even more.

Monitoring Quality. Improving performance and monitoring quality is a function within all departments. 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. We will continue to monitor quality and address through our Performance Improvement Team (PIT) to implement interventions to improve operational performance and outcomes for our members.

Medicare Requirements

Bridgeway is currently an established corporation in the State of Arizona and operates a D-SNP for the ALTCS program in the Maricopa GSA. Bridgeway has filed a NOIA for the Acute Care Program as a D-SNP and a Medicare Demonstration plan in all GSAs. Bridgeway utilizes the same branding strategy and logo for our Medicare product as we do for the ALTCS and Acute Care Program ensuring brand recognition across all products for members and providers. **Medicare/Medicaid Integration.** Bridgeway currently has an integrated Medicare/Medicaid product in the ALTCS program and intends to offer the same level of integration with the Acute Care Program and the D-SNP or Dual Demonstration. Members only have to call one number to contact Member Services with questions regarding either their Medicaid or Medicare benefits. Even if the member is not with our Medicare plan we are able to provide the member with information regarding Medicare benefits and provide wrap around support services through case management for non-covered services. Our Corporate Compliance department utilizes the Compliance 360 suite which houses all contract requirements as well as provides a tool for implementing and monitoring the seven elements of the Compliance Program for both Medicaid and Medicare. We have implemented procedures, including crossed trained personnel, to ensure that the Grievance System is seamless to the beneficiary while adhering to the respective CMS and State requirements. Our Quality Management program is robust and includes the following domains: safer patient care, patient centered care, effective care coordination, effective prevention and treatment, promotion of healthy living, effective communication and improving affordability.

2. Moral or Religious Objections

2. The Contractor must notify AHCCCS if, on the basis of moral or religious grounds, it elects not to provide or reimburse for a covered service. The Contractor may propose a solution not already contemplated by this Contract to allow members to access the services. The Contractor must identify solutions pertinent to the Acute Care Program and the CRS Program if submitting proposals for both. AHCCCS does not intend to offer the services on a fee-for-service basis to the Contractor's enrollees. The proposal must be submitted to AHCCCS as part of this submission. This submission will not be scored.

Bridgeway Health Solutions, LLC will provide all covered services, as indicated in Section D1, Acute Care Program Requirements for the Acute Care Program.

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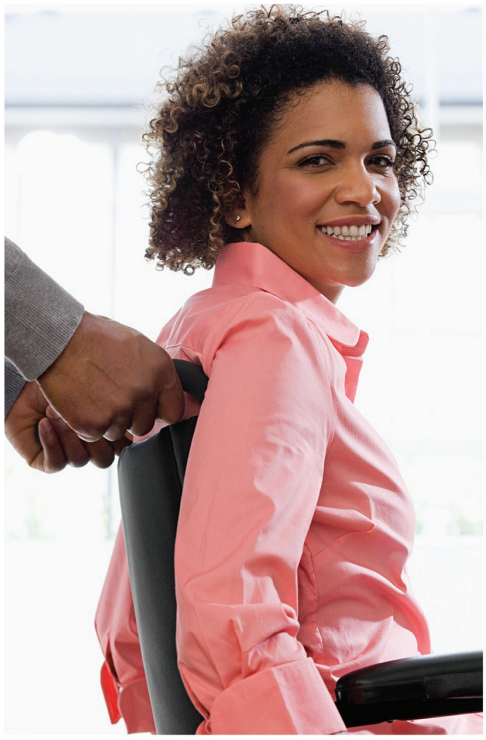

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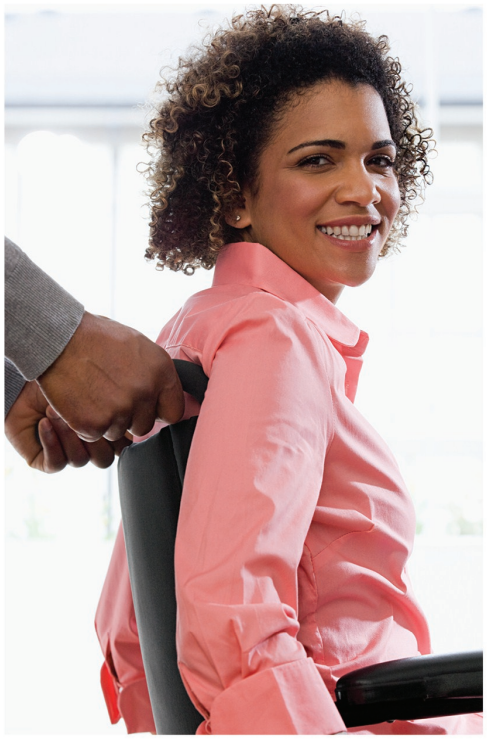

E. Narrative Submissions
Access to Care / Network

Access to Care/Network

1. Implementation of the Affordable Care Act (ACA)

1. AHCCCS anticipates that is membership will grow as a result of implementation ……..

Bridgeway's Administrative Operations Fully Support Significant Membership Growth

Bridgeway Health Solutions (Bridgeway) is well-established in Arizona and has been serving AHCCCS members and managing provider networks in Arizona since 2006. We have always been sensitive to maintaining a local presence in the communities we *serve* and operate administrative offices located in rural and urban settings. Bridgeway currently operates offices in Bisbee, Casa Grande, Prescott, Tempe, and Tucson where providers and members appreciate our local presence. In fact, our local presence in Yavapai County has been a key success factor in serving Acute Care members in this semi-rural area and ensuring continuity of care. All Bridgeway offices have the business continuity protection and technological support of our parent company, Centene Corporation (Centene). Therefore, Bridgeway is ready to successfully accommodate significant membership growth during program implementation and for the long term.

How Bridgeway Ensures Network Adequacy and Access to Care during Enrollment Growth

Bridgeway ensures network adequacy for our members across Arizona by continuously reaching out to providers for participation in our program. We also contract with network extenders, such as nurse practitioners and physician assistants, to enable participating PCPs to extend their service capacity. Traditional Medicaid and Safety Net providers, such as FQHCs and RHCs, are staples in our provider network. During times of expansion, we will ease out-of network authorization requirements in order to maintain the continuum of care during the member's transition to in-network services. Also, our ER diversion program effectively identifies persons who need assistance in establishing a PCP relationship or obtaining services at the appropriate level. Our overarching network development goal is to ensure timely access to quality health care services for all members. Bridgeway's team of seasoned professionals manages our Acute and Long Term Care programs and provider networks. Their proven ability to establish and maintain trusting relationships with local providers that focus on continuity of care for members will contribute to our success in carrying out this expansion plan. In addition, Bridgeway's technological platforms, administrative tools and systems functionality within its customer service, claims management, and 24/7 care coordination and case management systems are:

- *applied* to the daily interactive service support activities carried out by qualified and experienced Bridgeway staff for members, providers and AHCCCS;
- *fully functioning* with the capacity to handle additional volume resulting from expansion; and
- *integrated* among all Bridgeway administrative office sites.

Centene affords Bridgeway quick expansion capabilities and scalability of critical administrative functions and services that ensure smooth transition during enrollment growth or rapid service area expansion along with systems back-up protection for business continuity. Since 1984, Centene has operated government-sponsored managed care plans, such as Bridgeway, and currently operates health care programs in 18 states serving more than 2.5 million people who are Medicaid and/or Medicare beneficiaries. With Centene's quality systems solutions and support, Bridgeway's business operations, equipment and infrastructure are fully functional and ready to accommodate a large influx of members and providers in a seamless fashion. **Organizational Areas of Greatest Impact.** Bridgeway's foundational operations and systems infrastructure are intact, scalable and well-managed. The areas that process claims, conduct systems transactions, and oversee quality management and Contract compliance have the capacity to handle a large influx of new members and providers. Operational areas most impacted by enrollment growth and service area expansions include member Services, Provider Services, and Care Coordination. Bridgeway has dedicated appropriate personnel and resources to these areas to enable their ability to serve members and providers before, during and after program implementation. We have performed initial high-level assessments based on data gathered regarding future enrollment growth expectations due to AHCCCS, ACA and CMS (dual eligible and special needs programs) program initiatives that guide our strategies for managing growth in an environment where change is oftentimes the only constant. With future growth in mind, Bridgeway has deployed internal expansion operations in much the same way as was applied last spring when Bridgeway successfully transitioned SCAN Health Plan long-term care (LTC) members to Bridgeway. The successful process that Bridgeway carried out for the SCAN transition included the following action items:

- **Customer Service *Call Center Expansion*** – additional staff added 90 days prior to go-live date to handle increase in call volume while meeting call center performance standards

- **24/7 Medical Advice Line *Collaboration*** – included nurse advise line in the communication chain and in system integration procedures so they could effectively prepare for call volume increases and address caller questions
- **Personalized *Transition Assistance*** – set up a triage system for members receiving health care services during the transition to ensure outreach to each member took place
- ***Communication*, *Training*, Website Tools and Resources** – added notices, updates, and instructions relating to the transition for persons accessing Bridgeway's website for information

The results of this transition were very positive: members were pleased with the caring way they were treated during the transition. There were no care gaps and no delays in obtaining service. Providers were cooperative and truly engaged in the process of transitioning patients from one health plan to another. There was no negative media attention or criticism from external agencies or member advocacy groups regarding Bridgeway's performance during the transition.

Bridgeway's Operational Structure to Support MEMBERS Bridgeway's Member Services and Integrated Care Team includes a local customer service center staffed by Member Services Representatives, a Maternity Health/EPSDT Coordinator, a Behavioral Health Coordinator, and teams of Case Managers, Clinical Resource Specialists, Program Transition Coordinators, Referral Specialists and Pharmacy Coordinators. These teams assist members in obtaining services in a timely manner and in the most appropriate setting for their unique health care needs. Bridgeway Members Services staff are caring professionals experienced at serving Medicaid, LTC and Special Needs populations in a managed care environment. All Bridgeway Member Services staff have been furnished with - and are fully trained on the confidential and culturally sensitive use of - Bridgeway's policies, technological systems and tools for documentation of member data relating to items such as authorizations, eligibility verification and care coordination.

Bridgeway's Local Customer Service Call Center. Bridgeway's Member and Provider Services call center is located at its Tempe, Arizona headquarters. In times of high call volume, our call triage plan will ensure a superior level of customer service support for members at all times. For example, provider calls relating to claims inquiries may be routed to our auxiliary customer service center in order to keep lines open for member calls. Customer service center hours of operation are Monday through Friday from 8:00 am to 5:00 pm. Calls received after normal business hours and on weekends are routed to NurseWise, Bridgeway's affiliated 24/7 nurse advice and triage call center that is also located in Tempe, Arizona.

Customer Service Center Staffing. Using its staffing model, Bridgeway assures the customer service center is staffed by an adequate number of experienced Member Service Representatives (MSRs) who have been thoroughly trained regarding AHCCCS and Bridgeway program requirements. Although Centene oversees all enterprise-wide systems support activities, Bridgeway maintains oversight and approval authority of its policies and procedures in order to ensure cross-functional integration among all operational areas and consistency in use of technology and interface protocols that are compliant with Contract requirements and AHCCCS policies. **Training Programs for All Staff Interacting with Members.** In addition to the activities listed above, all Bridgeway employees and subcontracted vendor employees who interact with Bridgeway members (such as NurseWise and Nurtur representatives) will receive training about AHCCCS' Acute Care Program prior to the October 1, 2013 start date. Employee training will be conducted and completed 60-90 days prior to the program start date and will include "train the trainer" curriculum specific to AHCCCS' Acute Care Program. **Successfully Managing Transitions for New Members.** Bridgeway's methods to ensure continuity of care truly address the unique needs of members and ensure smooth transition with no disruption in services. Members continue to get the services they need while we work to improve coordination among multiple providers to effectively manage care for members with chronic and complex health conditions. Our processes address many transition scenarios, such as members changing health plans or members transitioning from fee-for-service, entering our Integrated Care Program, or transitioning from an inpatient stay. We honor and automatically provide authorization of existing treatment authorizations prior to the member's effective date with Bridgeway for an initial period of 30 calendar days, regardless of the provider's network participation status. We allow continuation of medically necessary services with non-network providers for up to 90 days or until the member's care may reasonably and safely be transferred to an in-network provider. We educate members about the transition process through the Member Handbook, Member Portal, Welcome Calls, and through our locally staffed Case Managers. We keep providers informed of the transition process through the Provider Manual, Provider Portal and Case Managers working with members in active care. The information provided emphasizes the importance of notifying Bridgeway when a member requires transition assistance.

Transitioning Members Who Were Previously Uninsured or Underserved. Bridgeway recognizes that many new members we gain due to this expansion will be uninsured or underserved people who need services right away. As a

proactive measure to ensure every new member receives the right care, at the right time, and in the right setting, we will continue to attempt to perform Health Risk Assessments (HRAs) for every new member within 30 days of their enrollment in Bridgeway. Bridgeway supplies HRA forms to members, as required, via the new member Welcome Packet. We also conduct outreach calls to perform HRAs for members who did not complete the HRA form and return it to us in order to quickly identify their needs and to guide them to appropriate services. Information gleaned from the HRA supplements information supplied by AHCCCS (i.e. enrollment reports regarding diagnoses or prior health conditions) and ensures Care Gaps are quickly identified and shared with the PCPs and specialist providers serving these new members as a way to help individuals to "catch up" in receiving critical services as well as preventive care.
Prenatal Care and Out-of-Network Access. Bridgeway's policy emphasizes the importance of consistent prenatal and postnatal care. We go beyond Contract requirements for pregnant members, regardless of their gestational age, by offering them the option to remain with their out-of-network OB/GYN for the duration of their pregnancy and postpartum visit. Additionally, we do not require medical necessity review for prenatal or postpartum care. Any pregnant member is eligible to participate in our Start Smart for Your Baby pregnancy program which provides education and clinical support to members and providers (whether in- or out-of-network). ***Members Held Harmless.*** Bridgeway makes provisions for members to receive services out-of-network for as long as an appropriate in-network provider is unavailable and at no additional cost. **Bridgeway's Operational Structure to Support PROVIDERS** Bridgeway's Provider Services units consist of local teams of Provider Relations Specialists, Contract Implementation Specialists, Credentialing Specialists, Claims Liaisons and a Provider Services call center staffed by Provider Services Representatives. Provider Services teams routinely interact with providers and deliver ongoing service support to providers and their office staff in the provision of health care services for Bridgeway members. Provider Relations field staff live in or near the communities they serve. Additionally, all Bridgeway Provider Services staffs have been furnished with - and are fully trained on the use of - Bridgeway's technological systems and tools for data management pertaining to providers, such as documentation, claims, authorizations, reports, and eligibility verification.
Claims Management and Service Support for Providers. Bridgeway's claims management center located in Farmington, Missouri, processes and adjudicates claims based on systems configuration data supplied by Bridgeway claims and contract management staff. In this way, Bridgeway assures its compliance with all state-mandated rules, regulations and policies regarding claims management processes. The center is a state-of-the-art facility with sophisticated claims adjudication systems that provides business continuity and will support enrollment spikes as well as network and service area expansions among Centene health plans (such as Bridgeway). The center's claims management functionality is integrative and enables Bridgeway Provider Services staff to access claims data in a secure, HIPAA compliant manner, which facilitates seamless claims service support for providers at a local level. ***Encouraging Provider Participation in Bridgeway's Electronic Claims Submission Program.*** To ease administrative burdens and speed up reimbursement turnaround times for providers, Bridgeway continually encourages network providers to submit claims electronically via Electronic Data Interchange (EDI). Providers must register for this program in writing or through Bridgeway's website. Registration is quick and easy. Provider Relations Specialists routinely assist providers and verify their registration information in order to avert any risk of errors once the provider's data is released for systems entry, thus ensuring each provider can confidently use EDI at the onset. Bridgeway keeps track of provider participation and use of EDI and as of September 2012, EDI use exceeded AHCCCS' standard of 60%. We continue to encourage all providers to use EDI and "go paperless." ***First Call Resolution and Rep of the Day Program.*** Bridgeway introduced its "Rep of the Day" program in 2009 in order to deliver outstanding service to providers. This program is similar to a "Help Desk" wherein providers with complex or time-consuming administrative issues (beyond routine call center inquiries) can have their issues addressed immediately by the Rep of the Day. The Rep of the Day program has been well-received by providers and allows us to work together in resolving the situation. The "Rep of the Day" program also facilitates cross-training for staff in a live setting within territories outside of their own assigned service area, which gives them a broader understanding and perspective of the overall health care needs of members in Arizona. Since this program was introduced, call volume has decreased, which indicates to us that providers have gained a sense of security in terms of Bridgeway's quick and effective response to their concerns. In turn, provider time is freed to focus on the health needs of members versus tied up with administrative issues.
Bridgeway's Provider Support and Education Programs to Ensure Network Readiness. We evaluate the current state of our network management program as a measure of our ability to support providers and members before, during and after the implementation event. This self-evaluation sets the stage for our network development plan over the course of the

12-18 months pre- and post-implementation that includes a variety of planning activities for our staff and the readiness of our providers to accommodate the expected influx of new members. A thorough description of our network preparedness and network development activities is provided in Section E.2. In addition to network development and provider contracting activities, all Bridgeway contracted providers, including providers in subcontracted provider networks will receive training prior to the October 1, 2013 start date. Provider training is conducted at provider offices and in group settings at locations and times that are most convenient for providers to attend. Training regarding the Acute Care Program will be completed 30-60 days prior to the program start date and will include "train the trainer" curriculum specific to AHCCCS' Acute Care Program. ***Simplifying Administrative Processes for Providers during Growth and Expansion.*** During peak times of enrollment growth or service area expansion, Bridgeway relaxes certain authorization rules by extending grace periods, increasing service allowance times, authorizing out-of-network services (including execution of single-case agreements), and delaying authorization expiration dates to provide flexibility with increased membership or to allow new providers time to familiarize themselves with Bridgeway policy. We also increase the number of available phone lines and customer service representatives in order to handle the expected influx of provider calls and inquiries that often go hand-in-hand with significant enrollment increases or program changes. Bridgeway also increases the frequency of provider credentialing committee meetings in order to expedite the credentialing process for providers in expansion areas. Simultaneously, Provider Relations Specialists increase the frequency of provider orientation and training sessions in expansion areas, ensuring all providers have been thoroughly trained, informed and equipped with the materials and tools they need to serve Bridgeway members from day one of their enrollment with Bridgeway. ***Encouraging Providers to Use Bridgeway's Provider Portal.*** Bridgeway's secure Provider Portal offers providers and their office staff quick and easy access to member data (HIPAA compliant) that truly enables efficient service for members. The Provider Portal's key features include Secure Messaging, Care Gap alerts, online Provider Manual, Provider Directory, Eligibility Verification, Benefits and Coverage Information, Patient Roster, Claims Submission, Claims Status and Claims Adjudication Logic Information (including batch claim capabilities), Authorization Requests/Verification, and provider profiles. To our knowledge, Bridgeway is the only AHCCCS health plan that has a Provider Portal with Care Gap alert AND Member Profile features. Care Gaps notify providers of the member's need for care interventions, such as diagnostic tests and preventive services, whenever any provider checks eligibility via our Provider Portal. Member Profiles on the Provider Portal include claims data from the past 18 months, including pharmacy claims. We encourage and monitor provider use of the Provider Portal and continuously look for ways to improve features and increase provider awareness and use of this valuable care coordination tool.

Ensuring Preparedness of Subcontractors with Provider Networks. Bridgeway contractually obligates all delegated subcontractors that manage certain provider networks in Arizona to ensure adequacy and readiness of their provider networks. Bridgeway's subcontracted vendors include the following organizations:

- *US Script* - administers and manages pharmacy programs, claims and pharmacy provider networks on behalf of Centene health plan affiliates, like Bridgeway. Bridgeway does not contract directly with pharmacies or pharmacists. US Script is a fully-owned subsidiary of Centene Corporation.
- *OptiCare Managed Vision (OptiCare)* - administers and manages vision care programs and provider networks on behalf of Centene health plan affiliates, like Bridgeway. Bridgeway does not contract directly with non-clinical vision care providers, such as opticians, optometrists and eyewear providers that are found in OptiCare's provider network. OptiCare is a fully-owned subsidiary of Centene Corporation.
- *DentaQuest* – administers and manages a dental care program and provider network. Bridgeway does not contract directly with dental care providers. DentaQuest is neither owned nor operated by Centene or Bridgeway. DentaQuest manages dental claims and Bridgeway oversees DentaQuest's quality management and provider services programs in accordance with our agreement.
- *Transportation Management Services (TMS)* – administers and manages a non-emergency medical transportation (NEMT) program and NEMT network on behalf of Bridgeway. Bridgeway does not contract directly with NEMT providers. TMS is neither owned nor operated by Centene or Bridgeway. TMS manages NEMT claims and Bridgeway oversees TMS' quality management and provider services programs in accordance with our agreement.

Bridgeway has informed all subcontractors of its expansion plans and has required each to supply bi-weekly network status reports to ensure their expansion preparedness stays on target for the October 1, 2013 start date. *All subcontractors operate statewide provider networks and are well-prepared to handle an influx of new Bridgeway members.*

Bridgeway's Operational Structure to Support CARE COORDINATION **Technology Used by Care Coordinators - TruCare.** The TruCare module of our integrated Management Information System (MIS) is a member-centric health management platform for collaborative care coordination of medical, behavioral health, disease, and utilization management. Used by our Integrated Care Team (ICT) and utilization management staff, TruCare provides one consolidated, workflow enabled window into medical and behavioral health risks, services and authorizations. TruCare also incorporates fully integrated authorizations workflow support, whether the authorization originates from phone, fax, or directly through our Provider Portal, all authorizations are documented and managed in TruCare. **Bridgeway's Integrated Care Coordination Programs to Support the Continuum of Care.** Bridgeway's system integration capabilities facilitate the continuum of care in a confidential and convenient manner - especially during periods of significant enrollment growth. With oversight by Bridgeway's Medical Director and Vice President of Medical Management, care coordination occurs in collaboration with internal case management teams, subcontracted vendors, provider partners, and Interdisciplinary Teams. Bridgeway routinely works in collaboration with its subcontracted vendors and Arizona's RBHAs to maintain open lines of communication regarding the daily needs of members in the midst of treatment. Communication venues include face-to-face meetings, teleconferences, report sharing, task force development, and a myriad of day-to-day interactions between case managers, providers, members, subcontracted vendors, and specialty companies. Bridgeway builds partnerships with local providers and stakeholders to deliver outstanding service and quality care to our members before, during and following their unique health care episode.

NurseWise: 24/7 Medical Advice Line. Bridgeway has partnered with NurseWise since 2006 to assist with the provision of health assessments and outreach to members and providers during peak activity phases of program expansions and implementations. NurseWise is a medical triage phone service staffed by qualified nurses and physicians providing 24/7 health assistance. A wholly owned subsidiary of Centene, NurseWise operates call centers in Arizona, Florida, Georgia, Missouri, and Texas and offers medical advice to Medicaid recipients in 15 states. NurseWise has full accreditation from URAC for compliance with Health Call Center Standards. ***Triage for Emergent, Urgent and Routine Medical Care.*** In addition to routine health care advice, NurseWise provides effective clinical triage services for our Behavioral Health affiliate, as well as academic institutions, physicians, hospitals, military facilities and managed care organizations. NurseWise triage nurses are experienced professionals armed with the knowledge and ability to assist people in accessing care at the appropriate place and time. ***24/7 Authorization Services.*** During normal business hours, authorization services are managed by Bridgeway. On weekends and after normal business hours, providers requesting authorization can submit their request to Bridgeway via phone, facsimile or the Provider Portal. Providers who reach our call center after normal business hours to obtain authorization are assisted by NurseWise. NurseWise gathers information from the provider and submits a complete report of all authorization requests received during the after-hours "shift" to Bridgeway's care management unit for follow up the next business day. It is important to note that *Bridgeway does not require prior authorization for urgent or emergency care*. **Nurtur: Disease Management and Telemonitoring Services.** Care Coordination is enhanced through Nurtur, Bridgeway's partner for telemonitoring and disease management services. Since 2008, Nurtur has coordinated and implemented disease management programs for Bridgeway members resulting in improved health for members. In 2009, Bridgeway added Nurtur's successful telemonitoring coordination services. With clients in 16 states, Nurtur is NCQA and URAC accredited for Asthma, COPD, CAD, Diabetes and Heart Failure. Nurtur recently opened a new office in Tempe, Arizona, which gives Bridgeway the added ability to expand statewide. We will rely on - and are looking forward to - applying Nurtur's award-winning programs for disease management to a broader segment of AHCCCS members as we continue to grow. **Summary.** With an established, local employee base and administrative offices located throughout Arizona, Bridgeway is capable of successfully accommodating significant membership growth and ready to serve an influx of AHCCCS members. Our quick expansion capabilities and scalability of critical administrative functions and services are also made possible through the experience, local presence, operational efficiencies and expansion capabilities our subcontracted vendors bring in support of Bridgeway's overall operations. Working together to serve members, and bolstered by Centene's technological support, we await the opportunity to serve more AHCCCS members in 2013 and beyond.

Bridgeway's system integration capabilities support timely access to care that facilitates the continuum of care in a caring, confidential and convenient manner.

2. Evaluating and Measuring the Network

2. Describe how the Offeror evaluates and measures its network in order to ensure timely access to care to underserved populations, identify deficiencies in the network, manage the network, make improvements to the network and sustain an adequate network.

Bridgeway Health Solutions (Bridgeway) measures and monitors its provider network continuously, not only to evaluate network adequacy and timely access to care, but also to evaluate provider performance in the delivery of quality care to our members. Our network monitoring activities include site visits, on-site surveys, performance report cards, secret shopper surveys, member and provider satisfaction surveys, credentialing and recredentialing, claims audits, prior authorization audits and a multitude of similar activities. Survey and audit results along with credentialing, recredentialing, and contracting information are reported to AHCCCS and to the Quality Management/ Performance Improvement Committee (QM/PI) at least once per quarter. The Network Development Plan guides our network evaluation activities and procedures using measurable benchmarks, thresholds and goals that align with nationally-recognized access to care indicators, such as NCQA, HEDIS and URAC, as well as AHCCCS and CMS standards. Our annual plan also outlines goals for performance improvement metrics in comparison to previous years as a means for quantifying success from year to year.

Bridgeway Continually Measures and Monitors Timely Access to Care. Bridgeway has been managing a provider network in Arizona since 2006 to serve SSI, LTC, Medicare SNP and Acute Care populations (including dual eligibles). Our provider network is loyal, stable and consists of a comprehensive list of qualified providers and facilities to support the continuum of care for our members across Arizona. Timely access to care is assured for Bridgeway members through network analysis exercises and provider monitoring activities that are conducted on an ongoing basis. These activities include quarterly preparation of network analyses and reports showing travel distance to provider sites, surveying provider sites for appointment availability, and surveying member satisfaction with their primary care provider (PCP). Bridgeway surveys provider performance of appointment availability at least once per quarter using a Site Survey Tool and a statistically valid sampling of PCPs and a random sampling of specialist providers. Member satisfaction information is obtained through complaint/grievance reports, and Member Satisfaction Surveys. Survey results regarding appointment availability are reported to AHCCCS and Bridgeway's QM/PI every quarter. Providers found to be out of compliance with appointment access standards are placed on a Corrective Action Plan (CAP) until compliance can be verified for a minimum of 30 days after the CAP has been lifted. Bridgeway did not impose any CAPs relating to appointment standard compliance in 2012.

Additional Access to Care Monitoring Activities. Bridgeway manages its provider network largely through the efforts of the local Contract Implementation, Provider Services and Provider Relations staffs that interact directly with providers within their assigned territories on a day-to-day basis. Bridgeway employs Provider Relations Specialists (PRS) who travel throughout Arizona and are responsible for initial and ongoing provider training and in-service meetings, conducting site surveys, coordinating management of any CAPs, monitoring provider appointment and capacity level (panel size) and assisting providers with any claims or service items. Provider Relations Specialists are required to meet with PCPs in their assigned GSA at least once every quarter. All of these activities impact the access to care experience for our members and help us, organizationally, to better assist providers in delivering quality services in a timely manner.

Bridgeway's Comprehensive Network Development and Management Plan. Bridgeway measures its network adequacy informally each day and formally at least semi-annually through the preparation, analysis, and submission of network adequacy reports to the QM/PI and AHCCCS. These network reports allow Bridgeway to pinpoint any network gaps quickly within a given county or GSA. Identified gaps are compared against available providers in the same geographic area in order to gain a realistic sense of health care options in the community. If network gaps exist despite every provider in the area participating in Bridgeway's network, we coordinate alternative access to care, such as scheduling transportation to the nearest available provider, using telemonitoring, or ordering home health services for members in rural and remote locations where providers and health care services are scarce. In order to ensure Bridgeway's network adequacy and expansion readiness for all lines of business (i.e. Acute, ABD, SNP, LTC), we are taking a number of steps now that are designed to improve operational efficiencies and reduce administrative burdens for the long term. These steps include:

developing a statewide provider network and measuring network adequacy using the most stringent time and distance standards, which happen to be the CMS (Medicare) standards that AHCCCS has also adopted for the Acute Care Program;

- using contract documents for providers new to the Bridgeway network that includes language, rates, guidelines, etc. for existing as well as potential line of business additions;
- adding addendums to existing provider agreements that include language, rates, guidelines, etc. for new and potential line of business additions;
- participating in the AzAHP Credentialing Alliance to reduce administrative burdens for providers
- notifying participating and potential providers of the impending changes via newsletters, bulletins, BlastFax, and the Provider Portal on Bridgeway's website;
- encouraging all providers to utilize the secure web portal for electronic claims submission (EDI);
- requiring our subcontracted vendors to be ready for our anticipated membership increase in the coming years;
- encouraging all providers to utilize Bridgeway's secure Provider Portal for most administrative functions; and
- Increasing network development and provider relations staff size in relation to network expansion activities and provider needs in the coming years.

Estimating Enrollment Growth by GSA. Bridgeway's approach to preparing for substantial enrollment growth takes into consideration the highest estimated number of new members known or expected to enroll in our program then setting implementation performance standards, timelines and goals that align with the highest number of expected new members within each county and each GSA. Our goal is to expand our service area statewide for the Acute Care Program. Therefore, initial estimates we have calculated have given us reasonable expectations on which we built our overarching organizational goals for each GSA. Using the maximum number of new members provided in Section E.1.of the RFP (430,000), an example of how we derive membership expectations by GSA is shown in the table below:

GSA	Counties in GSA	Acute Care Enrollment by GSA*	Enrollment % by GSA	Max RFP Awardees	Additional Member Potential per Awardee
2	LaPaz, Yuma	50,463	5%	2	11,000
4	Apache, Coconino, Mohave, Navajo	76,850	7%	2	16,000
6	Yavapai	31,817	3%	2	7,000
8	Gila, Pinal	47,588	5%	2	11,000
10	Pima, Santa Cruz	182,812	18%	5	16,000
12	Maricopa	641,044	63%	7	39,000
14	Cochise, Graham, Greenlee	31,787	3%	2	7,000
		1,062,361	**100%**	***	**107,000**

*As of October 2012; calculations rounded up to nearest % and 1,000

Statewide Expansion Activities. Since 2006, Bridgeway and its subcontracted vendors for dental, pharmacy, and transportation services have been managing provider networks serving Medicaid and Medicare beneficiaries throughout Arizona. We know Arizona and understand the dynamics of health care delivery in its urban and rural regions. More importantly, we are experienced at building and managing provider networks that serve underserved populations. Bridgeway's provider networks rival those of our competitors in size, but surpass them in terms of provider satisfaction, and network loyalty.

Bridgeway's Network Development Strategies for Each GSA. Bridgeway's Network Development team is building provider networks in new GSAs and expanding provider networks in existing service areas. Network Development activities have been underway since the spring of 2012 in preparation of AHCCCS' Acute Care Program RFP release for 2013 and the ACA initiatives in 2014. Due to the multiple product lines for which we are developing provider networks (Acute Care, Dual Eligible, Medicare Advantage), Bridgeway's Network Development team is measuring network adequacy using the time and travel standards that AHCCCS has adopted from CMS. We are measuring network adequacy using CMS standards in correlation to the Health Services Delivery (HSD) tables for the Dual Demonstration program for which Bridgeway is intending to file in February 2013. Below we describe Bridgeway's comprehensive network development plan for each GSA that will ensure timely access to care.

GSA 2: Bridgeway manages a provider network that served its LTC members in LaPaz and Yuma counties from 2006 through 2011. Therefore, we only need to update contracts with providers in GSA 2 by adding the Acute Care line of business. Provider response to updating the contract has been very positive and this network development effort is mainly

an administrative exercise. PRSs have been meeting face-to-face with providers, educating them of the upcoming changes relating to the Acute Care Program, CMS and ACA, and completing contract paperwork in preparation for Bridgeway's expansion plans. We anticipate full network adequacy and readiness in GSA 2 for the October 1, 2013 start date.
GSA 4: Bridgeway is developing provider networks in Apache, Coconino, Mohave, and Navajo Counties. Network development has been underway since the spring of 2012. To date, network development has been most successful in Coconino County. We expect full network completion in Coconino County by February 2013. Providers have shared their positive feedback with us regarding participation in the Bridgeway provider network for both Acute Care and dual eligible beneficiaries. With Coconino's close proximity to Yavapai County, we have been able to connect providers across county lines to the provider hubs in Flagstaff and Prescott. PRSs are concentrating in Apache and Navajo Counties in the areas of Chin Le, Holbrook, Springerville, St. Johns, Kayenta and Heber/Overgaard. We anticipate full network adequacy and readiness in GSA 4 for the October 1, 2013 start date.
GSA 6: Bridgeway has been managing an Acute Care program and provider network in Yavapai County since 2008. Network development is complete, with the exception of plastic surgery. In anticipation of the 2013 expansion, we have developed an addendum for provider signature that adds any additional lines of business to the provider's agreement. Doing this now will reduce the administrative burden during program implementation of any new lines of business in the future. There are no PCP network gaps in Yavapai County. Providers have expressed support of Bridgeway's expansion plans. We anticipate full network adequacy and readiness in Yavapai County for the October 1, 2013 start date.
GSA 8: Bridgeway has been managing a LTC provider network in GSA 8, Gila and Pinal Counties, since 2011. In anticipation of the 2013 expansion, we have developed an addendum for provider signature to add lines of business to the provider's agreement. Doing this now will reduce the administrative burden during program implementation of any new Bridgeway member segments to be served in GSA 8 in the future. The provider network is fully developed and there are no networks gaps of concern. A recent win includes a contract with Cobre Valley Hospital in Gila County. The provider network is adequate and ready for the October 1, 2013 start date.
GSA 10: Bridgeway has been managing a provider network in Pima and Santa Cruz Counties since 2010. In anticipation of the 2013 expansion, Bridgeway has been converting Pima Health System contracts to Bridgeway paper including all lines of business. Currently there are very few provider gaps in either county. Contracting efforts have been largely face to face. Bridgeway met with Carondelet Health Systems and is in the process of finalizing an agreement. We have full network adequacy and readiness in Pima County for the October 1, 2013 start date and are working with Carondelet Health Systems to complete the network in Santa Cruz County with targeted completion by February 2013.
GSA 12: In Maricopa County, Bridgeway has been managing a LTC provider network since 2006 and a special needs provider network since 2008. In anticipation of the 2013 expansion, we have developed an addendum for provider signature that effectively adds any additional lines of business to the provider's agreement that will reduce the administrative burden during program implementation of any new Bridgeway member segments to be served in Maricopa County in the future. Providers have shared their positive feedback with us regarding participation in the Bridgeway provider network for both Acute Care and dual eligible beneficiaries. Network build-out is nearly complete. We have full network adequacy in Maricopa County and are ready for the October 1, 2013 start date.

GSA 14: Bridgeway has been managing a LTC provider network in GSA 14, Cochise, Graham and Greenlee Counties, since 2011. In anticipation of the 2013 expansion, we have developed an addendum for provider signature that adds any additional lines of business to the provider's agreement that will reduce the administrative burden during program implementation of any new Bridgeway member segments to be served in GSA 14 in the future. Bridgeway has filled almost all network gaps and is finalizing a contract with a much needed dialysis provider. We anticipate full network adequacy and readiness in GSA 14 for the October 1, 2013 start date.
Centene's legacy and support for its health plans, like Bridgeway, in establishing and maintaining comprehensive and stable provider networks - ***that spans three decades and covers 18 states*** - are testimonies to Centene's ongoing support that has enabled Bridgeway to develop provider networks quickly even in the most challenging settings. We are pleased with our provider recruitment activities in Arizona to date and confident Bridgeway's expanded provider network will meet all AHCCCS network sufficiency standards by the Acute Care Program start date of October 1, 2013.
How Bridgeway Will Use Technology to Manage Its Provider Networks
PRM: Centene's Technological Support for Bridgeway. Bridgeway's network sufficiency throughout Arizona is fortified and further supported by Centene's highly scalable Provider Relationship Management (PRM) system, powered

by Microsoft Dynamics contact relationship management (CRM) software. PRM is an integrated suite of systems for provider services inquiry. PRM is the data source system for provider data exchange processes and our online Provider Directory Search. The ***ProviderConnect*** component of PRM allows us to create, route, track, manage, and report on provider call services while ***ProviderReach*** enables efficient and coordinated launch of plan level provider communiqués, notices, and recruitment across multiple communication channels. PRM also integrates provider related information across Bridgeway's other Management Information System (MIS) components including our Provider Portal, our claims system and our Avaya Voice Portal (AVP - for voice recognition enabled IVR and outbound campaigns).

Centelligence™: Centene's Data Analysis Systems Support for Bridgeway. In addition to PRM, our award-winning proprietary and comprehensive family of integrated decision support and health care informatics reporting solutions, known as Centelligence™, integrates data from multiple sources (including member and provider data, claims, member responsibility, utilization, authorization, grievances, appeals, etc.) and produces *actionable* information: everything from Care Gaps and Wellness Alerts to Key Performance Indicator (KPI) Dashboards, Provider Clinical Profiling analyses, population level health risk stratifications, operational and state compliance reports. Bridgeway uses the Centelligence™ Insight (Insight) suite of tools for provider data analysis. Insight gives us desktop reporting and management KPI Dashboards capability, as well as provider practice patterns and clinical quality and cost reporting capabilities. Through Insight, we also have the ability to report all data sets in our platform, including such items as provider network adequacy, HEDIS, EPSDT services, and claims timeliness.

How Bridgeway Identifies and Addresses Network Deficiencies. Network deficiencies are identified chiefly by front-line Network Development Representatives keenly aware of the provider availability and health care climate within their given territories. They routinely research the AHCCCS provider database, local provider directories, and the State's registry of board certified physicians to assemble a target list of qualified providers to reach out to and invite for participation in Bridgeway's network. At times, internal Bridgeway staff will also identify network gaps and will submit provider contracting requests to the Network Development department for follow up. Additional recruitment requests may come from the Quality Management and/or Medical Management Teams. Network requests and recruitment leads, whether initiated internally or externally, are addressed and follow up activities along with outcomes are reported back to the requesting individual, department, or committee. In addition, Network Development Representatives document all recruitment activities and submit activity reports weekly to the VP of Network Development and Contracting for ongoing analysis, planning and outcomes measurement purposes.

How Bridgeway Makes Improvements to Its Provider Network. Bridgeway proactively manages its provider network to make adjustments and improvements in preparation of anticipated service area expansion, increased enrollment or changes to Covered Services that would impact utilization. Bridgeway will also make network improvements in response to requests from staff or when provider gaps have been identified. Bridgeway's network improvement activities for 2012 focused on dental care and non-emergency transportation services with ongoing service improvements to be enjoyed in 2013 and beyond. Our strategies for improving these networks are described below.

Augmenting Bridgeway's Dental Provider Network. To address network adequacy and improve access to care for dental care services, we recently changed vendors and selected DentaQuest for the provision of dental services. This new contract was executed on November 1, 2012. DentaQuest administers and manages a dental care program and provider network, including provider credentialing and claims adjudication, throughout Arizona on behalf of Bridgeway. Bridgeway does not contract directly with general dentists. A key component of our agreement with DentaQuest requires development of a comprehensive, statewide dental network in preparation for Bridgeway's anticipated service area expansion plans in 2013 and beyond. DentaQuest submits network data, including credentialed, participating providers, to Bridgeway every other week. Dental Care provider files are uploaded into Bridgeway's provider database management system which enables care coordination, systems integration and administrative functionality between Bridgeway and DentaQuest staff and program managers. Bridgeway currently manages a comprehensive, statewide dental provider network, and we have full dental network adequacy and readiness in all GSAs for the October 1, 2013 start date.

Improving Transportation Services. Bridgeway has implemented quality improvement initiatives geared toward improving its non-emergency transportation program and ensuring *consistently high quality customer service* is being delivered by our subcontracted transportation vendor. The main areas of our focus are call center performance and on-time delivery to appointments. We have been monitoring the vendor's performance in these areas and have initiated frequent communication with the vendor as a proactive troubleshooting mechanism to address member concerns immediately. The vendor's performance has improved substantially in both areas, which is evidenced by a decrease in member complaints

and very good call center performance. We are pleased with these improvements and will continue to closely monitor performance quality, complaint reports, and outcomes data indefinitely to ensure sustained high-quality performance. In the event our current vendor fails to consistently deliver high quality performance, we intend to seek other avenues for the provision of high-quality non-emergency medical transportation services for our members.

How Bridgeway Sustains an Adequate Network. Sustaining network adequacy is a function of proper network management and adjusting outreach and intervention efforts when new programs are introduced, benefits or service areas change, or access to care issues arise. Bridgeway sustains network adequacy using a combination of network measures – as described above – and by delving deeper to discover root causes that impact a provider's ability to sustain desired performance levels or add our members to their patient panels. We find that most providers in urban and suburban locations can sustain desired levels because health resources are plentiful and readily available to them. However, providers in rural and frontier regions of Arizona can encounter difficulties in the provision of services due to vast distances between available services, harsh weather conditions, rugged terrain (sometimes no paved roads), and sparsely populated areas. Therefore, much of our outreach efforts relating to sustaining network adequacy focused on rural communities and the providers serving these communities. Bridgeway assists rural providers, and members living in rural areas, in a number of ways. Provider support activities are designed to help providers sustain a high level of service and access to care. Examples of Bridgeway's provider support activities include:

- Assisting providers in sustaining open panels through face-to-face in-service visits to ensure providers are pleased with their panels and Bridgeway's service support
- Hosting Town Hall meetings (2012 examples below)
- Pain Management Consortium
- Bridgeway's technical tools and programs for care coordination
- Developing Member Advisory Committees
- Developing Provider Advisory Committees
- Advising providers of wrap around support services, like telemonitoring, nurse advice line, member connections
- Encouraging use of Provider Portal for EDI, eligibility verification and authorization services
- Pay for Performance opportunities for providers

Ongoing Network Adequacy Measurement. Like its affiliate health plans, Bridgeway will continuously monitor its provider network to ensure it is made up of the right mix of providers to serve members in a timely manner and in the right setting. Our network adequacy self-analysis goes beyond counting numbers and comparing our network to other plans or the State's network. We review quality indicators, such as the monthly complaint report, requests for long distance transportation, and out-of-network utilization to get a clear picture of how our existing network is performing and to determine what we can do to improve services and access for our members through further development of our network.

Summary. Bridgeway offers a solid, well-managed network of providers across the care continuum that will reach every part of Arizona. As of December 2012, the Bridgeway provider network consists of over 5,000 individual providers at nearly 1,300 locations (PCPs and specialists), over 300 dental care providers in 348 locations; at least 111 routine vision care providers, and 1,117 pharmacies. In addition, at any given time applying providers are in the midst of credentialing or contract completion. Provider response has been quite favorable and we are confident that we will meet or exceed expectations regarding network adequacy for both the Acute Care and Dual Demonstration programs. We will be glad to deliver additional progress reports to AHCCCS as we prepare for network readiness over the next few months.

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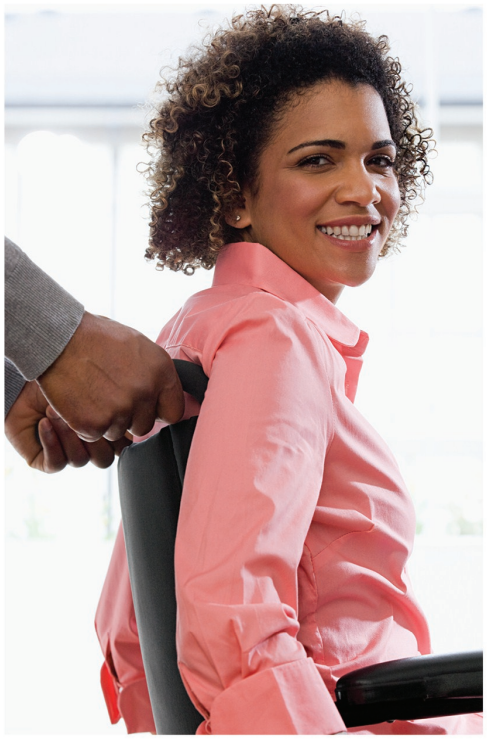


E. Narrative Submissions Program

Program

3. Care Coordination

3. AHCCCS supports efforts to reward desired care outcomes attained through care coordination and the provision of the best and most appropriate evidence-based care that results in lower costs. How will the Offeror use data and evidence based decision support tools, both within its organization and in working with providers and stakeholders, to maximize care coordination for members, improve outcomes, and create cost efficiencies? How will these tools and data be used to implement outcome – and value-oriented payment models?

Bridgeway shares AHCCCS's vision and value placed on informed decision making and value-based payment. We have designed many of our programs and systems around these concepts with the ultimate goal of improving clinical, operational, and financial outcomes. At the heart of these efforts is our Care Management System and Centene's Centelligence enterprise platform which integrates data from multiple sources, and provides actionable population and member level information to the right person for the right task at the right time.

Decision Support Tools

Bridgeway's modular Management Information System (MIS), provided through our parent company, Centene Corporation (Centene), offers the greatest possible latitude for interoperability in the service of care coordination.

TruCare. Our Member-centric health management platform for collaborative care and utilization management, TruCare is used by clinical and case management staff. TruCare provides one consolidated window into health risks, services and authorization, as well as appeal history. Among its clinical operations workflow support features, TruCare includes a fully integrated authorizations workflow. TruCare is integrated with nationally recognized, and industry leading McKesson's evidence based medical necessity criteria (MNC) software. Bridgeway utilizes InterQual adult and pediatric guidelines, and internal guidelines, to determine medical necessity for non-emergency inpatient/outpatient services. Together, the integration of TruCare and InterQual provide a consistent, detailed guideline approach to help our utilization managers and case managers, in conjunction with our Integrated Care Team (IC Team), to determine the appropriateness of covered services. IC Teams ensure coordinated, integrated care for our members and include the member, PCP, nurse case manager, pharmacist, behavioral health coordinator and Bridgeway medical director, plus other care participants as appropriate.

Centelligence™ Informatics Solution. The cornerstone of our tracking system is our proprietary Centelligence™ enterprise reporting platform. Centelligence provides a comprehensive family of integrated decision support and health care informatics solutions offering 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. The Centelligence™ family includes our Enterprise Data Warehouse, Centelligence Insight, and Centelligence Foresight.

Centelligence™ Enterprise Data Warehouse (EDW). Bridgeway uses a Teradata-powered EDW as the central hub for service information that allows collection, integration, and reporting of clinical claim/encounter data; 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). 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 tools to build and tabulate key performance indicators and provide drill-down capability to the individual provider or member level to track screenings, diagnosis, and treatment adherence.

Centelligence™ Insight (Insight). Using Insight, our family of decision support tools, Bridgeway monitors an array of key performance indicators across its functional areas allowing us to track and trend performance over time, monitor progress towards goals and identify outliers that require further investigation and intervention. Insight includes advanced capabilities for provider practice pattern and utilization reporting (what we refer to as "Patterns of Care" reporting for providers), which will support our Quality Improvement (QI) staff and providers via summary and detailed views of clinical quality and cost profiling information. This capability gives our providers the practice and peer level profiling information needed for continuous clinical quality improvement. A component of our Insight is our Inovalon HEDIS Advantage™ (formerly known as QSI Catalyst) reporting system. HEDIS Advantage is an NCQA Certified Software system that produces results for HEDIS®, state specific measures, Pay for Performance measures, internally designed Quality Improvement studies, and Provider Reporting studies. We use HEDIS, HEDIS-like, and other performance

measures, both for standard and ad-hoc reporting, to support ongoing monitoring of the quality, safety and appropriateness of care and service. We analyze performance data to monitor for disparities, comparing members by region, gender, and age group and we generate HEDIS-like measures when specifications like age are not appropriate for a targeted population. We compare our HEDIS results across all of our health plans in 18 states, as well as across national averages.

Centelligence™ Foresight (Foresight). Using claims information from the EDW, Foresight is a predictive modeling application used to identify Care Gaps, Wellness Alerts, health risks and a growing array of other predictive tools such as forecasting operational metrics based on prior historical data. For example, Bridgeway has configured the system to identify members who are due or past due for assessments or services and distribute Care Gap alerts when a screening is due or past due. Care Gap alerts are essential to tracking and ensuring member access to and compliance with required assessments and points of care coordination. Care Gap alerts are available through our secure Provider Portal. When a provider checks the member's eligibility or views their member panel through our secure provider portal, they will receive a Care Gap alert that the member is due or past due for assessment or services. This portal is a critical source of information in the care of our members and its use is constantly promoted within our provider communities at Advisory Meetings, provider trainings, individual and group provider meetings, and by our Medical Directors, Case Managers, Member Services Representatives, and NurseWise staff.

Web Portal. In addition to Care Gaps and other Wellness Alerts, our Member Portal and Provider Portal give our members and providers 24/7 access to important information to help make decisions. Information available through our portals includes utilization history, approved health education materials, preferred drug lists and other information to assist member and providers in informed health care decision making. The Provider Portal specifically improves care coordination, eliminates redundancy, and reduces provider errors by providing secure access to the member's treatment history including prescription drug utilization, immunization history, reported allergies, past doctor visits, behavioral health history, laboratory tests, vital signs and patient demographics.

Evidence and Value-Based Practice and Performance

As part of Bridgeway's data and outcomes driven method of approach is the incorporation of evidence and value-based practices. To promote this culture throughout our delivery system, we rely on clinical practice standards and other best practices to ensure quality, consistency and efficiency. Evidence-based health care supports the triple aims of improving population health, improving the care of individuals, and reducing the cost of care. We use clinical evidence from controlled and other clinical trials, observational studies, and expert consensus to drive objective guidelines and performance measures for prevention, clinical practice, and appropriate utilization of services. These guidelines and measures serve as the core for the collaboration between providers, members, and plan staff to improve healthy behaviors and self-management of chronic conditions, measure progress, and administer incentives to both members and providers for improved compliance with recommended care.

Clinical Practice Guidelines. The Centene Clinical Policy Committee (CPC) in conjunction with the Bridgeway Medical Management Committee (MMC) develops and distributes clinical practice guidelines for the provision of acute, chronic and behavioral health services relevant to the population served. Providers are expected to adhere to Bridgeway's published guidelines and are monitored for compliance through chart audits and monthly reporting which are presented at the MMC which reports up to the Quality Management and Performance Improvement (QM/PI) Committee. Guidelines are distributed to providers and members as appropriate given the subject through provider orientation materials, the Provider Manual, Provider Newsletters, special mailings, Bridgeway Website, Medical Management/Case Management materials, the Member Handbook, Member Newsletters and through Bridgeway's Member Services Department by request from either a provider or member.

Disease Management Programs. In order to offer our members access to disease management programs with a proven track record of success, Bridgeway has partnered with our affiliate Centene subsidiary, Nurtur Health, Inc. (Nurtur). Nurtur has been a leading innovator in behavior change and disease management since the mid-1990s, offering best-in-class programs for such conditions as coronary artery disease, congestive heart failure, diabetes, asthma, COPD, smoking cessation, hypertension and hyperlipidemia. All of Nurtur's DM programs are accredited by the National Committee for Quality Assurance (NCQA) and URAC. Nurtur also recently received the Population Health Impact Institute's Methods Evaluation Process (MEP) accreditation, which denotes data measurement transparency and an efficient continuous quality improvement process. To facilitate communication between Bridgeway and Nurtur, Nurtur enters all DM activities and patient information in Bridgeway's TruCare system and communicates directly with the Case Manager as needed.

Each member participating in disease management works with their assigned Case Manager or Nurtur health coach to establish both short and long-term goals that include modifying unhealthy behaviors and targets for achieving improvements in health outcome measures. In addition, each of Bridgeway's disease management programs includes disease-specific measurable goals that allow us to measure the effectiveness of our programs and make any necessary program changes to ensure that we maximize our ability to favorably impact health outcomes for our members. Bridgeway has witnessed significant improvements in health status and reduction in inpatient and ER utilization for several of its disease management programs, resulting in improved utilization and overall cost savings. For example:

- For participants in Bridgeway's diabetes program, there has been an 81% increase in program participants exercising > 150 minutes per week between baseline and outcome. Participants in the Back Pain program reported a 23% decrease in pain level and 60% increase in exercise > 150 minutes/week.
- Adult Asthma program participants had significantly higher rates in asthma medication compliance (32%), Pulmonary Function Tests (26.4%) and Influenza Vaccination measures (26.2%) as compared to their non-participant counterparts.
- Adult program participants with Heart Failure had lower rates of All Heart-Related Admissions (-44.3%), All Heart-Related Emergency Room Visits (-51.4%), Heart Failure-Related Emergency Room Visits (-28.3%) and All Cause Emergency Room Visits (-41.0%) when compared to the matched non-participants.
- Bridgeway has also seen improvements in health related to our participation in Nurtur's telemonitoring pilot. A July 1, 2011 to June 30, 2012 retrospective cohort study consisting of 454 Medicaid members across three Centene health plans, including Bridgeway, suggested that participating in telemonitoring had decreased the likelihood of disease-specific utilizations, including inpatient admissions and ER visits. For example, heart failure members were 64% less likely to incur a readmission than the control group.

START SMART for Your Health. Start Smart for Your Health™ is a medical management program designed to help members manage a series of health conditions. The program provides members with tools to empower them to be active participants in their healthcare team including wellness programs, educational information and access to care management. The objective of the Start Smart for Your Health program is to increase the quality of life and reduce the need to access the healthcare system for complications from the condition.

Data-Driven Decision Making

Bridgeway utilizes the information obtained through our robust data systems, as well as our Advisory Councils, to help improve quality, health outcomes and program efficiency; maximize care coordination for members; and support provider performance. This information is utilized across all of our departments, who are all responsible for ensuring quality and efficiency throughout the system. Internal departments and network providers receive support and guidance from our Quality Management (QM) Department through reporting, policy development, special programs and training on the Quality Management and Performance Improvement (QM/PI) Program. The Bridgeway Board of Directors (BOD) oversees development, implementation and evaluation of the QM/PI Program and has the ultimate authority and accountability for oversight of the quality of care and services provided to members. The BOD delegates the operating authority of the QM/PI Program to the QM/PI Committee and Chief Medical Director. Employing a philosophy of data-driven continuous quality improvement to guide our programs, the QM structure creates the framework for ensuring quality throughout our system. The QM/PI Committee is at the center of this robust quality process, with multiple sub-committees responsible for addressing specific QM concerns and providing regular feedback to the QM/PI Committee. Data-driven decisions and interventions are inherent in our business and occur at the system level, the member level and the provider level.

System Level. Through our committee structure, Bridgeway monitors medical and utilization data in order to identify under, over and inappropriate utilization trends. As areas of concern are identified, Bridgeway may implement a new training curriculum, policy or program intervention that impacts the entire delivery system or changes an existing process. For example, recognizing a need for better collaboration and integration between physical and behavioral health, Bridgeway implemented an approach to facilitate and support the exchange of information between Bridgeway and Northern Arizona Regional Behavioral Health Authority (NARBHA), the RBHA in Yavapai County. This effort includes a standing collaboration with the RBHA behavioral providers and sharing data to assist in identifying members with behavioral health service needs so they are appropriately referred, care coordination, joint participation on interdisciplinary care teams, and ensuring we do not duplicate services. Through coordination, collaboration, education,

and forming positive community relationships through Advisory Council meetings, provider meetings, and PCP educations sessions***, Bridgeway has been able to increase provider care coordination participation by over 30%.*** Bridgeway also identifies areas for system improvement based on Standard Performance Measures which are tracked and monitored monthly. For example, to meet Bridgeway's internal standard goal of 90% for Timeliness of Prenatal Care, we are working to improve performance through ***Start Smart for Your Baby® (Start Smart)***, a medical management program where case managers monitor pregnant members for compliance to scheduled appointments during telephone outreach and assist with appointment scheduling and transportation as needed. The program provides educational materials as well as incentives for going to prenatal, postpartum, and well child visits. As seen in our Centene affiliate health plans, Start Smart, which started in 2006, has succeeded in improving key indicators of birth outcomes, including statistically significant decreases in NICU admission rates and NICU days/1000 births, and decreases in all three measures of low birth weight, all from 2007 to 2010. ***In 2010, Start Smart won a Platinum Award for Consumer Empowerment at the URAC Quality Summit, and the inaugural URAC/ Global Knowledge Exchange Network International Health Promotion Award.*** In 2009 it was named an NCQA Best Practice. Strategies for identification of pregnant members to enroll into this program rely heavily on data, including mining pharmacy data for prenatal vitamins or other indications of pregnancy, reviewing lab data for pregnancy tests and looking at visits and coding of office visits for OB/GYN providers.

Member Level. Member level interventions may occur as a result of data mining activities that are standard in our medical management departments. For example, designated Case Management staff run monthly reports utilizing HEDIS data, Health Risk Assessment (HRA) data, predictive modeling, and the AHCCCS Continuity of Care PIP to help identify members scoring at-risk and borderline risk levels, to identify members appropriate for case management or complex case management. Once identified, a Case Manager will reach out to the member by phone to engage in care management activities. Since Bridgeway implemented Centelligence™ Forsight to help identify these high need members, the percentage of members more appropriately placed in case management increased by 17%. The member's PCP is also notified to ensure appropriate coordination of care and services. Similarly, Disease Management staff look at this data to identify members with chronic care needs for enrollment in the appropriate Disease Management program.

Also targeted for member level interventions are our high risk/high need members. For example, Bridgeway looks at Emergency Department (ED) utilization of chronic pain members. Once identified, Bridgeway reaches out to the member and redirects them to a pain management clinic, in coordination with the member's PCP. Bridgeway identified a specific issue in Yavapai County with substance abuse and pain management. We collaborated with the RBHA and identified a pain management provider that had experience with patients with substance abuse that we could refer to.

More generally, after seeing an increase in outpatient utilization, we delved deeper into the data to discover root causes. Standing out were high transportation costs, which we traced back to a high frequency of 911 calls. In response, we identified the top 20 members found to have frequent calls to 911 for non-emergent services and contacted them all by telephone. Our outreach goals were to educate members about the options available to them when they need transportation and to identify and address any barriers to care they are experiencing. Out of 20 members identified: 3 members termed after case management involvement, 3 members had 1 more ER visit from 7/30/12- 11/30/12, 1 member had 2 more ER visits (7/30/12-11/30/12) and 13 members had no more ER visits. As a result, we have now implemented a process where this data is pulled and this process is repeated on a quarterly basis. Through the HRA process, we identified some members lacking appropriate primary care, talked with PCPs, and enrolled the member into case management or applied the appropriate intervention. Case Managers utilize TruCare to monitor Care Plans and ensure members are compliant and receiving needed services. Case Managers, Member Services staff, Nurse Advice Line, Providers and others involved in a member's care also have access to Care Gap Alerts. Members with missing screenings will be automatically flagged in the system and care gap alerts will be sent to providers and members through the Web Portal. This information is visible to Bridgeway staff who are trained to review this information and provide verbal reminders to members during any routine contact or outreach. If a member does not have access to the internet we will offer a voluntary texting service that members can opt into to receive alerts and other health education information as approved by AHCCCS.

Provider Level. Through the monitoring of medical and pharmacy utilization data, grievance and appeals, and HEDIS data, providers may be identified as outliers for high ED utilization, under-utilization of well-child visits or other areas of non-compliance. Provider data is used to compare providers to their peers and other plan or other industry benchmarks such as HEDIS or utilization measures, develop provider training and education, and implement corrective action plans as needed. Bridgeway's Medical Director and other Provider Relations staff meet with providers regularly to share data, address barriers, and develop appropriate interventions. Bridgeway also uses this data to recognize high performing

providers. We reach out to our high performing providers to better understand what makes them successful and share best practices across the delivery system. We also recognize providers through additional compensation, at awards dinners, provider meetings, and through the Bridgeway website with a provider profile spotlighting a provider's contribution to care coordination and outstanding patient care.

Value Based Reimbursement

Based on demonstrated success in other Centene markets, Bridgeway is currently engaged in discussions with internal staff and providers to develop P4P programs specific to the Arizona acute member and provider populations designed to improve outcomes and create efficiencies in the system. These value-based payment models will be built around appropriate critical mass and aligned with the goals of the state and the community. For example, we have identified c-section rate as an issue and will work with providers and hospitals to identify barriers to safe vaginal or VBAC deliveries, designing payment methodologies to support best practices in this area. Examples of alternative payment arrangements from our Centene affiliates are as follows:

Encounter-Based incentives. During the initial years of a new health plan, Centene affiliated health plans often use a "per encounter incentive payment reimbursement for specified codes" where the health plan may not have adequate claims or quality data available to offer other incentive options. This methodology is also useful in provider offices that have a smaller panel size or overall smaller office base where there may not be sufficient membership volume to measure quality-based metrics, such as HEDIS, appropriately. Health plans typically offers this form of enhanced fee-for-service on preventative or well-child visits, immunizations, or visits for ongoing, chronic diseases like diabetic well checks. This methodology is typically utilized as a short term effort in new markets or pilot areas in efforts to build towards a longer term risk-sharing arrangement with the providers.

Shared Savings. This provider reimbursement model is an incentive program paid in addition to the fee-for-service payment and is designed to share financial savings with primary care providers. The provider is eligible for a bonus if the provider has achieved the mutually agreed upon minimum applicable cost savings target and point change for HEDIS Measurements and/or improvements in other measures such as percent of eligible members successfully enrolled in applicable disease management programs, percent decrease in unnecessary ER visits or percent increase in pharmacy adherence. The cost reduction is linked to improved outcomes in order to ensure that providers are not merely incentivized to reduce costs by reducing care but are incentivized to both reduce costs and improve outcomes.

The provider is eligible for a bonus based on the provider's ability to improve health outcomes resulting in lower medical expenses if the provider: (1) has achieved the specified medical expense thresholds as set forth in the provider incentive agreement; (2) meets all other thresholds and requirements set forth in the agreement; and (3) is in compliance with the terms and conditions of the agreement. Bonus incentives earned are distributed on a quarterly schedule with an annual reconciliation based on the primary care provider's year end results. Centene health plans support providers with critical resources, tools and processes such as reporting, member compliance innovations, Predictive Modeling, and care management tools.

Shared Risk Reimbursement Model. For Medical Home Providers who are interested in a compensation model that directly rewards them for impacting quality outcomes, Centene's "Model One Lite" reimbursement methodology may be an appropriate option. This model requires an adequate volume of membership, typically at least 250 members on a PCP panel. Model One Lite is a variation of professional services capitation that is designed to encourage appropriate use of health services and to achieve highest quality outcomes for our members. Providers are reimbursed on a fee-for-service or enhanced fee-for-service basis, while a percentage of the premium for their members is allocated to a Professional Services Fund (PSF). The PSF includes PCP and specialty services, ER services, free-standing outpatient laboratory and radiology services, therapies, and other non-institutional services. Providers who positively impact these services (such as through reduced ER utilization) are eligible to receive a percentage of the surplus of the PSF; however, the Provider does NOT bear any financial risk for deficits in the PSF or increases in other service.

4. Mr. Andrews Scenario

4. Mr. Andrews is a member in your plan. He is extremely overweight, and spends long periods in bed due to ill health and complete exhaustion. He has no family. He cannot walk 100 feet without resting. His medical diagnosis is COPD and he has a chronic cardiac condition following two heart attacks and stent insertions. When he becomes short of breath, he becomes very anxious and calls 911 to take him to the ER. He has been to the ER 12 times in the last six months. His PCP has referred him to the health plan for disease management. Please describe how the Offeror would address the needs of Mr. Andrews. Describe what systemic processes the Offeror will use to improve health care outcomes for members with one or more chronic illnesses.

Members with co-occurring conditions are complex and pose many challenges. Clinical guidelines and disease management programs traditionally focus on a single condition, although the experience of multiple chronic illnesses is the reality for many patients. Bridgeway's approach for these members, such as Mr. Andrews, is to use a biopsychosocial approach that looks at the member as a whole person, and looks at each member individually, taking into account their needs and preferences. Based on Mr. Andrews' scenario presented, we are making the following assumptions:

Mr. Andrews recently joined our plan; Mr. Andrews is a middle aged, white male

Mr. Andrews has issues with medication adherence; Mr. Andrews does not have a serious mental illness

Mr. Andrews suffers from social isolation, anxiety and depression; Mr. Andrews is enrolled in the RHBA but does not have an active episode; Mr. Andrews' PCP considers him noncompliant

Mr. Andrews has limited mobility preventing him from getting out and eating fresh, healthy foods

Bridgeway's Care Management Toolbox As described in Table 4.1 below, Bridgeway has well-established process, programs and dedicated resources to improve health care outcomes for members with chronic conditions, including complex members like Mr. Andrews. ***Table 4.1: Systematic Tools***

Health Risk Assessment (HRA)
Definition and Purpose: A comprehensive member assessment conducted upon enrollment into Bridgeway to identify special needs, including cultural, social and environmental; appropriately allocate care management resources; and engage members in primary care and appropriate care management programs based on health status and risk. An HRA is also used when a referral to case management is made or when a member is identified that may benefit from case management.
Process: Bridgeway proactively identifies members with special needs upfront by ensuring every member has a completed HRA. Beyond just including an HRA in all member welcome packets, Bridgeway's Nurse Advice Line, NurseWise, conducts outbound calls to all members within thirty days of enrollment to complete the HRA. If NurseWise doesn't reach the member after 3 attempts they are referred to a case manager and the program coordinator does outreach calls. If the program coordinator cannot get in touch with the member and the member is suspected as being high risk through utilization reports, we send a MemberConnections Representative (MCR) out to visit the member.
Predictive Modeling and Reporting
Definition and Purpose: Bridgeway continuously identifies members for engagement in care management programs; targeted education; and referral to appropriate community resources and services through predictive modeling, regular reporting and staff interaction. Predictive modeling is run at least monthly to proactively identify members at high risk. Predictive modeling looks at high IP, ER or pharmacy utilization, complex or co-morbid diagnosis, and other indicators of high risk behavior (e.g. lack of primary care).
Process: Bridgeway uses Centelligence Foresight, our multidimensional, episode-based predictive modeling and care management analytics tool, which uses clinical, risk, and administrative profile information obtained from medical, behavioral and pharmacy claims data and lab value data to identify members who may need case management or other specialized services. This allows us to identify members who may not yet have a diagnosis or identified condition that would trigger assessment for case management. Bridgeway also tracks utilization through regular reports that detect inappropriate utilization and/or non-compliance. For example, we track ER services utilized to identify those members with 3 or more ER events within a 6 month period. These reports identify members who used the ER, the date of the visit(s), and their diagnoses. This information is used to reach out to members and providers to identify service gaps, barriers to care and develop interventions to prevent future inappropriate ER use.
System Encounters
Definition and Purpose: Any interaction with a member is an opportunity to review member records and identify potential issues that would warrant referral to care management and/or disease management. Member encounters can occur by

accessing services or calling Bridgeway's member services line, including after-hours calls.

Process: For members admitted as an inpatient, our concurrent review staff review the member's chart to see if they are regularly visiting their PCP, identify needs and make a case management referral as appropriate. PCPs are encouraged to notify Bridgeway any time they refer members to the ER. Based on these notices, we contact the member to determine and resolve barriers and to educate about self-management, prevention and appropriate ER use. Bridgeway staff review daily reports from NurseWise regarding the previous day's calls. Bridgeway's care management staff contact members who NurseWise referred to the ER to determine the member's post- ER health status, and to provide education and/or assistance with follow-up care, as needed.

Individual Care Plan (ICP)

Definition and Purpose: ICPs are based on each member's individual needs and contain measurable goals related to each co-occurring condition, wellness and prevention, and overall health and quality of life. ICPs are developed in partnership with the member/caregiver and PCP. ICPs are holistic in approach, dealing with physical, behavioral and social issues.

Process: The nurse case manager works with the member, PCP and other care participants to develop and disseminate the ICP to be used as a roadmap to ensure integrated and coordinate care and alignment and consistency across providers and services. Each ICP includes steps to achieve established goals, such as health education, self-management tools and training, medication management and community resources, and is geared toward providing services that allow the member to be in the most integrated, least restricted setting that is appropriate for and acceptable to them. The ICP is continuously monitored and updated based on member health status.

Nurse Case Manager

Definition and Purpose: The single point of contact assigned to help members navigate the system, develop personal goals, remove barriers and achieve success. The nurse case manager engages the member; develops, documents, and disseminates the ICP; and assembles and leads the IC Team with the member at the center, ensuring appropriate integration and coordination across all services and disciplines. Case management is a high touch program and nurse case managers will participate with the members face to face, when necessary. They go to the member where the member is, including accompanying the member to appointments.

Process: The nurse case manager is the single point of contact for the member, providers and all IC Team participants. Individual case managers are assigned to members based on the member's cultural, clinical and social needs and preferences. Frequency of nurse case manager visits and phone outreach is established upfront based on member condition and preferences. The nurse case manager is available for members to call anytime. Monitoring is achieved through member outreach, provider outreach, and care management reports that look for non-compliance, including referrals with no associated claims, lapses in prescription refills, lack of PCP visits and follow up care, as well as utilization reports that monitor ED visits, admissions and re-admissions.

Member Connections Representative (MCR)

Definition and Purpose: MCRs are health outreach workers hired from the community to engage members in care. MCRs ensure that our outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area

Process: MCRs make home visits to members we cannot reach by phone. They assist with outreach, coordinate with social services, and attend community functions to provide health education. MCRs receive comprehensive training and become an integral part of our Member Services and Care Management teams which benefits our members and increases our effectiveness.

Behavioral Health (BH) Coordinator

Definition and Purpose: Bridgeway's BH Coordinator is the liaison between the RHBA, RHBA providers, PCP and Bridgeway's nurse case manager to help coordinate needed behavioral health resources.

Process: While the nurse case manager remains the single point of contact, the case manager engages a Bridgeway BH Coordinator to participate on the IC Team and help coordinate behavioral health services with the RBHA.

Integrated Care Team (IC Team)

Definition and Purpose: A member-driven care team that includes the member, PCP, nurse case manager, pharmacist, behavioral health coordinator, MCR and Bridgeway medical director, plus other specialists or care participants as appropriate.

Process: All members in case management have an assigned IC Team. Facilitated by the nurse case manager, the IC

Team meets regularly to ensure effective coordination, member compliance and ICP achievement. They support the process by coordinating services across multiple providers and disciplines, making recommendations, monitoring information between the PCP and specialists, alerting the nurse case manager and/or PCP to new or changed needs, and providing assistance in accessing services.

Care Management Programs

Definition and Purpose: Care Management Programs include Case Management, Care Coordination, Disease Management, Telemonitoring, and Medication Management. The programs provide additional resources that are matched to the member's level of risk and needs to ensure access to self-management tools and other health education to manage their condition; ensure appropriate coordination and integration of services; promote primary care; and reduce or eliminate unnecessary services.

Process: Members are identified for Care Management Programs through the HRA, predictive modeling, reporting and referrals. Once identified, Bridgeway staff reach out to the member and the PCP to engage the member in the program.

Web Portal

Bridgeway's secure web-based Member Portal offers members online access to health plan information and supporting "self-service" functions such as ability to view their utilization, change PCPs, update contact information, access health education information, view health alerts or Care Gap information (for due or overdue preventive screenings or immunizations), and communicate with Bridgeway plan staff. Bridgeway's Provider Portal equips providers with clinical information to assist in care coordination. The portal offers a well-organized view of Member Care Gaps, full member-specific clinical profiles including lab and pharmacy data, HRA and ICP information, and Bridgeway's clinical practice guidelines and other clinical quality improvement information.

Provider Training, Clinical Practice Guidelines and Screening Tools

All network providers receive appropriate training regarding members with chronic and co-occurring conditions. Bridgeway educates PCPs on topics such as how to refer members for care management programs and best PCP practices in coordination and treatment. We provide additional information about coordination and quality initiatives through Provider Newsletters, the Provider Manual, and group trainings. We also support PCPs by providing clinical practice guidelines and practice management toolkits. A member suffering from untreated bh issues may have more difficulty managing a chronic or acute condition. To help identify service needs and other contributing factors to a member's medical treatment, providers are given access to screening tools such as depression screening or substance abuse screening.

Integrated Care Delivery

As the medical plan working to provide holistic care and services to our members, Bridgeway acts as a convener, promoting the integration of services including physical, behavioral and social. For example, Bridgeway hosted its first Behavioral Health Care Coordination Luncheon in Prescott, AZ on September 27, 2012 for the local RHBA providers to promote better coordination and identify ways to collaborate to ensure more integrated care for the members. The session was a success and, based on positive feedback, Bridgeway is planning additional provider meetings in 2013 to include possible interdisciplinary panel discussions providing BH and PCP providers the opportunity to dialogue and collaborate. Coordinating with the RHBAs is particularly significant for our members with chronic and co-occurring conditions

Bridgeway's Approach to Member Identification and Health Risk Assessment Given Bridgeway's proactive care management approach, had Mr. Andrews been an actual member in our plan, we would have identified him as a high risk/high needs case based on the initial HRA, or at a minimum his high ER utilization through frequent flyer reports and predictive modeling. Specifically, the presence of co-morbid conditions or the multiple ED visits would have triggered a referral to case management. Had Mr. Andrews not been successfully identified through the HRA process, he would have been flagged and followed based on: 12 ER visits in six months as detected through ER reports that flag members with 3 or more visits in 6 months; Presence of co-morbidities as identified through predictive modeling software (COPD, chronic heart condition and behavioral health/anxiety diagnosis); Non-compliance with medications and/or PCP follow up as identified through pharmacy reports that reconcile prescriptions submitted, filled and picked up and/or lack of PCP encounters as identified through utilization reports

Bridgeway's Individual Care Plan Development Based on the Disease Management (DM) referral from Mr. Andrews' PCP, Mr. Andrews' case would be reviewed and he would first be referred to case management where a nurse case manager would be assigned and an ICP developed. The first step in Mr. Andrews' care planning process would be to establish a relationship with Mr. Andrews, ensuring he is the focus and the driver of the ICP development. The nurse case

manager is the facilitator of this process and would work with Mr. Andrews to help him identify barriers and goals. For example, one of Mr. Andrews goals may be to first call Bridgeway's nurse advice line, NurseWise, any time he feels the need to dial 911 for shortness of breath. The ICP would also include action steps for how to help manage his COPD, helping to reduce anxiety around the condition. Once goals have been identified and evaluated, Mr. Andrews is given a choice in services and providers to be included in the action plans for the goals and the care team as appropriate. Once Mr. Andrews has agreed to the ICP, it is shared with the PCP and all applicable specialists, including BH providers. The ICP is always available to Mr. Andrews, his PCP and all applicable specialists through Bridgeway's web portal. **Bridgeway's Nurse Case Managers, Community Health Workers and IC Teams** Based on his co-morbidities and high ER utilization, Mr. Andrews would be enrolled in case management and assigned a personal nurse case manager. The nurse case manger reaches out and arranges to go to Mr. Andrews' home where they jointly establish a schedule, including frequency and method of interaction, and identify an IC Team. In addition to Mr. Andrews and his case manager and PCP, recommended participants on his IC Team would include a pulmonologist, a cardiologist, a dietician, a health educator or disease management coach, and a behavioral health specialist. The nurse case manager is responsible for the continuous monitoring and evaluation of Mr. Andrews and his successful achievement of ICP goals. When his status changes or an issue is identified, the nurse case manager reaches out to Mr. Andrews and his PCP to identify and address barriers and update the ICP as appropriate. Average time in case management is 9 months. For Mr. Andrews we would initiate weekly or more frequent contact as agreed to by Mr. Andrews. As more services are put into place and Mr. Andrews is adhering to the plan agreed upon, contact would reduce in frequency. If Mr. Andrews has an inpatient admission or goes to the ER, we would resume the higher level of contact until compliance is maintained. While Mr. Andrews presents with potential social issues, with no family supports and limited social interaction, Bridgeway would also assign a Community Health Worker or MemberConnections Representative (MCR). MCRs go into the community to work with members one-on-one to educate them, engage them in the community and address barriers to appropriate care. For Mr. Andrews, the goal would be to involve him in the community to get him out of the house and socially engage with friends and neighbors. The nurse case manager would ensure that the IC Team fully understood the behavioral and social needs and had access to the appropriate clinical practice guidelines, representatives and resources to coordinate and integrate all of Mr. Andrews' care and services. In addition to identifying needed clinical specialists, the case manager or IC Team would arrange for community resources, such as a behavioral health counselor or support group. Likewise, if Mr. Andrews requires special accommodations such as an oversized exam table, the team could assist him in locating a provider that could meet this need. **Bridgeway's Care Management Programs** Bridgeway has extensive experience managing members through multiple care management programs and services. With multiple, co-occurring conditions, in addition to complex case management, Mr. Andrews would be a candidate for several of these programs including DM, Medication Management, and Telemonitoring. **Disease Management.** The overarching goal of Bridgeway's disease management program is to help members achieve the highest possible levels of wellness, functioning, and quality of life. Our programs are person-centered with a focus on improved health outcomes, enhanced access and improved safety, while engaging the member every step of the way. Disease Management Coaches work with members to develop self-management plans grounded on evidence-based guidelines and condition-specific, measurable goals. Based on his conditions, Mr. Andrews would be invited to participate in our COPD, coronary artery disease and weight management programs, all coordinated through his nurse case manager. Given his weight, he would also be screened for diabetes and behavioral health issues. With Bridgeway's integrated approach to care, and Mr. Andrews' co-occurring conditions, these program elements would be integrated and encompassed into our care management efforts and a tailored Disease Management approach designed specific to Mr. Andrews. Example goals for Mr. Andrews might include: ***Coronary artery disease:*** Promote member adherence to treatment guidelines and improve self- management skills in order to prevent subsequent cardiac events and optimize quality of life. ***COPD:*** Reduce the need for rescue inhalers; Reduce ED visits and inpatient admissions; Achieve improvement in self-management of disease; improve quality of life; and promote member adherence to treatment guidelines and improve self- management skills to delay disease progression and optimize quality of life. ***Weight Management:*** Weight loss of 10% of body weight (may need to recommend bariatric surgery based on member's motivation and BMI); Improve Physical Activity (Duration 150+ min/week); Healthier food choices (Increased number of fruits, vegetables and whole Grains); and Improved self-awareness and knowledge of healthy weight loss methods. **Medication Management.** Medications play an increasingly important and complex role in treatment regimens for both acute and chronic conditions. Given Mr. Andrews' co-occurring conditions, it is important to integrate prescribing activities with all providers to avoid issues such as polypharmacy, therapeutic duplication or drug-drug interactions.

Likewise, it is important that Mr. Andrews understands the role of medications in his treatment plan and how to use them correctly, is empowered to ask prescribers questions, and that his providers prescribe medications consistent with evidence-based guidelines. Mr. Andrews' nurse case manager will facilitate communication of his medication lists between providers to encourage safe, consistent prescribing through periods of joint care coordination and across transitions between levels of care. Through Bridgeway's web portal, all registered providers, members and caregivers have access to a historical record of prescription use. The nurse case manager also reviews medications at each assessment or reassessment, maintains documentation of them in TruCare, and resolves barriers to compliance with medication regimens, for example by arranging transportation or delivery needed to obtain prescriptions from the chosen pharmacy. **Telemonitoring.** Telemonitoring uses communications technology to provide real-time information on health conditions from a distance. The wireless technology enables biometric readings to be taken in the home and transmitted electronically to the member's nurse case manager and/or provider within seconds. The telemonitoring software compares the data against established thresholds noting favorable or unfavorable trends and provides an automatic data reading report to readily share any unexpected results with the provider. For example, a member with heart failure may have inadvertently ingested a high-sodium content food or beverage earlier in the day which resulted in an unfavorable weight reading. This provides an opportunity for a "teachable moment" that can result in healthier behaviors and improved member self-management in the future. For Mr. Andrews, given his mobility and tendency to resort to calling 911, telemedicine may be an effective measure to engage him in his care and give him a sense of control and security that could address some of his anxiety. This is also an opportunity to keep him engaged with his PCP. **Bridgeway's Integrated Service Delivery** Critical to treating Mr. Andrews' holistic care needs, the nurse case manager addresses behavioral and social needs through matching him with appropriate services, community resources and supports and removing any barriers to service, such as cost and transportation. We would ensure Mr. Andrews receives a behavioral health assessment and the behavioral or pharmaceutical intervention his condition requires. While Mr. Andrews does not suffer from a serious mental illness (SMI), if we can get him into the RHBA they can provide peer support services that can be a valuable resource for many of his conditions. For example, CDSMP, Stanford University's Chronic Disease Self-Management Program developed by Dr. Kate Lorig, is a peer support program that could help Mr. Andrews gain self-confidence in his ability to control his symptoms and learn how his health conditions affect his life. Small-group workshops are generally 6 weeks long, meeting once a week for 2.5 hours and are led by lay leaders living with chronic conditions. The meetings are highly interactive, focusing on building skills, sharing experiences and individual/group support. To facilitate his participation, Bridgeway would pay for Mr. Andrews' transportation to and from these sessions, accommodating his weight and health circumstances. We would also arrange for meals on wheels or other service to ensure delivery of healthy food choices. Other programs for Mr. Andrews may include: ***People Who Care***. People Who Care provides caring volunteer assistance for elderly, chronically ill or disabled adults helping them maintain their sense of independence and quality of life. Volunteers through this organization can provide needed social support for Mr. Andrews, helping him with grocery shopping for fresh fruits and vegetables, ensuring his home environment is safe, and making a friendly visit to his home each week or calling him just to chat several times a week. ***Neighbor to Neighbor***. A volunteer caregiving organization that assists individuals in maintaining quality of life and independence in their homes, including transportation, friendly phoning and visiting, basic handyman work, personal safety units, and caregiver relief. ***Aqua Therapy***. Aqua therapy might be a good exercise option for Mr. Andrews given his weight and COPD. Bridgeway uses two organizations who provide Aqua Therapy that offer scholarships which we assist in securing. Finally, with regard to Mr. Andrews' physical health needs, the nurse case manager will ensure he is referred to the appropriate specialists such as gastroenterology, pulmonology and cardiology. Recognizing difficulty for Mr. Andrews getting around and a potential reluctance to use transportation, the case manager arranges for transportation to his appointments, taking into consideration his weight and any special needs, and accompanying him to the appointment if he chooses. Assuming Mr. Andrews has not been getting to the PCP because he is not comfortable going outside of the home, we would identify a PCP that does home visits until Mr. Andrews is more comfortable going out. The nurse case manager maintains open communication with the PCP and all specialists and all registered providers can view Mr. Andrews' profile and ICP on Bridgeway's Web Portal as instructed by the nurse case manager and reviewed in provider trainings, Provider Advisory Council meetings, and through BH coordinators. Bridgeway's Web Portal is our technology solution for ensuring the coordination of care across providers and disciplines. The portal allows for consolidation of important medical and demographic data to aid the provider in making informed medical decisions, and identify potential gaps in patient care. This information is also available to members to ensure active member engagement.

5. George Robertson Scenario

5. George Robertson, a 29 year old AHCCCS member, was involved in a motor vehicle accident on March 1, 2012. After immediate stabilization at the scene, George was rushed to the Arizona General Hospital and treated in the emergency room as a trauma patient. George sustained multiple injuries including a fractured femur, internal bleeding, and trauma to the sternum. After surgery to resolve the internal bleeding, and internal fixation of the fractured femur, George was transferred to the hospital floor.
George has been an AHCCCS member for five years. George has a history of substance abuse which may have been a contributing factor in the accident. George is in active substance abuse treatment with a Regional Behavioral Health Authority provider but is not consistent in participating in treatment. After 21 days in the hospital, George is discharged home. George lives alone in a run-down apartment complex in Phoenix. George must navigate two flights of stairs to reach his apartment.
Four weeks after discharge, George was found by a maintenance worker at the bottom of the stairs. Paramedics were called and George was rushed to the emergency room. George was diagnosed with a head injury, later determined to be a traumatic brain injury, and broken ribs that were sustained from the fall down a flight of stairs. George was fund to be in possession of illegal substances by the paramedics, resulting in police involvement at the hospital. After an additional four day inpatient stay, George is transitioned by the hospital Social Worker to a skilled nursing facility that specializes in TBI patients. The skilled nursing facility is not a contracted provider.
Describe what processes would be used to coordinate care for George as he moves through the continuum of care related to these documented health issues. What does the Offeror see as the greatest setback risks/challenges for George and how will the Offeror proactively address these concerns?

Mr. Robertson presents as a complex member with further complicating substance abuse issues. Bridgeway's approach is similar to Mr. Andrews, including a Health Risk Assessment (HRA), Individual Care Plan (ICP), nurse case manager and Integrated Care Team (IC Team), but the specific interventions and community supports are tailored for Mr. Robertson. The additional aspect of substance abuse also presents challenges which need to be specifically addressed. Based on Mr. Robertson's scenario presented, we are making the following assumptions:

- Mr. Robertson has no family support
- Mr. Robertson initially refused placement other than his home and refused case management upon discharge following his motor vehicle accident
- Mr. Robertson's legal consequences include probation
- As a result of these two latest incidents, Mr. Robertson is now expressing an interest in his health care
- Mr. Robertson suffers from a long standing substance abuse problem, history of depression and anxiety
- Mr. Robertson's TBI is not debilitating

With his most recent fall, there were two evident failures in the system. The first is an insufficient discharge plan given his living environment, no family engagement and continued substance abuse. The second is the inability to engage Mr. Robertson in an active substance abuse program. Through Bridgeway's approach to care transitions, integration of physical and behavioral health services and member and family engagement, in addition to care management programs and access to community resources and supports, we would develop an ICP for Mr. Robertson that addresses the full continuum of care and anticipates and plans for challenges and risks proactively.

Care Transitions Program. Referring to resources such as the National Transitions of Care Coalition (NTOCC) and care transition programs such as Project RED, Project BOOST, and Care Transitions as best practices, Bridgeway has enhanced its Care Management program to encompass transition in care processes, leveraging existing resources such as the No Place Like Home Campaign. No Place Like Home is a collaborative effort to reduce avoidable hospital readmissions, improve the patient experience and ensure appropriate follow up. Elements critical to effective care transitions that Bridgeway has incorporated into our approach include:

- Coordinated communication during transitions between providers, members and caregivers, the local RBHA, and other involved agencies that includes a single point of contact responsible for all communication, most frequently the Bridgeway nurse case manager.
    - In the case of Mr. Robertson this would include his nurse case manager as the primary/lead contact, the hospital, nursing home, PCP, TBI and other identified specialists, a pain management specialist, a pharmacist, the RBHA and his probation officer. Based on the severity of his TBI, this may also include a

guardian or power of attorney. All communication would be facilitated through the designated nurse case manager.

- Documentation and access to information across the system.
  - Bridgeway's Web Portal is our technology solution for integrating and sharing information. Through engagement in case management, Mr. Robertson would have an ICP available via Bridgeway's Web Portal. Providers across the system are highly encouraged to utilize the portal via provider meetings and trainings. The nurse case manager would also ensure that all providers involved in Mr. Robertson's care were registered for and had access to the portal and the ICP. All members have a member profile which can be accessed by providers, specialists, hospitals and emergency rooms to get needed patient historical utilization and pharmacy data at the point of care.
- Establishment of a single point of contact accountable for coordinating care.
  - Mr. Robertson's nurse case manager would be the identified single point of contact and would reach out to hospitalists, SNFists hospital case managers and nursing home staff, the PCP, Bridgeway's Concurrent Review Nurse, Bridgeway's BH Coordinator, and other identified specialists to establish expectations and engage these providers and staff in the care planning and IC Team activities.
- Facilitation of case management, disease management, care coordination and follow up activities directed by the nurse case manager.
  - For Mr. Robertson, the nurse case manager would coordinate with the Concurrent Review Nurse to understand the discharge planning process and be able to communicate with the member and facilitate the follow up services, such as PCP appointments, transportation, home health visits, transitioning to a SNF, obtaining prescriptions and DME, and Provider Service needs as required to engage non-contracted providers. The nurse case manager would follow up with Mr. Robertson by phone within one business day of discharge, and face to face within 7 days as indicated and arranged with the member prior to discharge. The nurse case manager would visit Mr. Robertson in the hospital during his stay and try to engage the family. Due to the impact of substance abuse issues on Mr. Robertson's physical health and current condition, coordination with the RBHA and legal system is critical, led by the Bridgeway BH Coordinator in collaboration with the nurse case manager. Symptom recognition and self-management relating to recent injuries will be promoted through the use of health coaching techniques, helping Mr. Robertson understand and address TBI issues, challenges and frustrations.
- Strong community ties and a local presence to match members with appropriate subsidy programs, providers, community resources, such as waiver programs, support groups, meals and other personal care services.
  - Bridgeway has a local presence with local staff that know the resources available, the culture, conditions in the community, and have face to face relationships with providers. While in the SNF, we would work with the RBHA to pull in the necessary rehab and counseling services to start addressing Mr. Robertson's substance abuse issues. The nurse case manager would also identify and leverage TBI resources such as Arizona Governor's Council on Spinal and Head Injuries. Upon discharge home, Bridgeway's nurse case manager arranges available community services to support the member in his home and help him apply for SSI disability and ALTCS benefits in case his condition does not stabilize or improve. We would engage Rehab without Walls, an agency that provides intense therapy in an outpatient setting to assist with any additional needs. Through the BH Coordinator, the nurse case manager works with the RBHA to identify and arrange continuation of substance abuse services, including the option of inpatient services within the benefit limit.
- Performance measures to encourage better transitions of care.
  - As part of monitoring Mr. Robertson's ICP, we would include measures specific to transitions of care, such as re-admissions and ER utilization.

Concurrent Review. After Mr. Robertson's motor vehicle accident (MVA) on March 1, 2012, Bridgeway would be notified that Mr. Robertson was an inpatient and our Concurrent Review Nurse would follow him through his stay and work with Mr. Robertson, his family, the hospital discharge planning staff, and his PCP to develop a Discharge Plan. Contracted hospitals are required by contract to notify Bridgeway within 24 hours that our member is in the facility. Hospitals notify Bridgeway via fax, phone or in some cases we can access their EHR directly. The concurrent review process provides for:

- Assessment of the clinical status of the member at admission and throughout an institutional stay
- Medical record review for gaps in care and referral to care management program(s)
- Verification of the need for continued hospitalization or ongoing residential care
- Provision of timely services in accordance with the member's ICP
- Determination of the appropriateness of the level of care and treatment rendered
- Evaluation of the quality of care to verify professional standards of care are met

Based on the Concurrent Review Nurse's assessment of the situation, a history of substance abuse, lack of family support and extensive injuries, Mr. Robertson would be referred to case management and a nurse case manager would be assigned to effectively coordinate his care across multiple providers and disciplines, including care transitions. Following Mr. Robertson's fall which led to a second inpatient admission, Concurrent Review is again notified and the concurrent review process initiated and coordinated with the assigned nurse case manager.

Discharge Planning. Part of the discharge planning process is an evaluation of Mr. Robertson's social supports and physical environment. With a nurse case manager now engaged, the nurse case manager or an assigned MemberConnections Representative (MCR) would attempt to engage Mr. Robertson's family to determine if they could provide needed support. The MemberConnections Program allows Bridgeway to provide a level of in-person, "boots on the ground" interaction with our members. MCRs are health outreach workers hired from within the communities we serve to ensure that our outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area. MCRs receive comprehensive training and become an integral part of our Member Services and Care Management teams. MCRs will make home visits to members we cannot reach by phone. They will assist with member outreach, coordinate with social services, and attend community functions to provide health education and outreach. If family supports are not available, the Concurrent Review Nurse in coordination with the nurse case manager and BH Coordinator would identify and arrange the appropriate community supports to help keep Mr. Robertson as independent as possible. Mr. Robertson's Discharge Plan will need to address DME needs, PCP follow up appointments, specialist follow up appointments, coordination with the RBHA to ensure re-engagement in substance abuse treatment, and assessments including special health care needs and apartment environment. The risks involved in Mr. Robertson's home environment include the two flights of stairs and a potentially enabling substance abuse situation given the condition and location of his apartment complex. The ultimate goal is to have the member in the least restrictive setting of care with the member's consent. Member decision is first and foremost. For his MVA hospital stay, we note that the member refuses safe placement any other place other than his home. We arrange home health as a follow up to ensure he is compliant with his medications and properly caring for his injuries. Our BH Coordinator outreaches to the local RHBA to ensure the RHBA is assisting with effectively transitioning him with his behavioral health issues and let them know he has been discharged. Following hospitalization relating to his fall, the Discharge Planning process would need to focus on his TBI and his substance abuse issues, presumably the root cause of this stay. Bridgeway knows there are limited TBI facilities in the area and would work to match him with a nursing home that will accept members with TBI and substance abuse issues. For SNFs not in our network, Bridgeway executes a single case agreement while working with our Provider Services Department to pursue a permanent contract.

Care Management. Following Bridgeway's standard care management approach, specific efforts for Mr. Robertson would include:

- Frequent face to face interaction with member, weekly or more often as mutually agreed to by member.
- Development of ICP in person with member, looking at what motivates him and his goals.
- Engagement of PCP, specialists, behavioral health providers and others involved in Mr. Robertson's care through an IC Team process facilitated by the nurse case manager with the member at the center.
- Outreach to and engagement of member's family. Assessing Mr. Robertson's relationship with his family as a result of his substance abuse and helping him demonstrate a willingness to actively participate in a substance abuse program may re-engage them in his care and service support.
- Engagement in Bridgeway member programs. For example, facing substance abuse issues, medication management is critical in the provision of pain management. Mr. Robertson would also qualify for Connections Plus which provides him a pre-programmed cell phone allowing us to communicate with him through phone outreach and text reminders and allowing Mr. Robertson to communicate with his PCP, specialists, peer support, a Narcotics Anonymous sponsor, a probation officer, BH case managers and others involved in his care.

- Coordination with PCP to have Home Health conduct an evaluation, including a safety evaluation of Mr. Robertson's apartment, his PT/OT and DME needs and available benefits, and his understanding of discharge plans, expectations, and ability to comply.
- Nurse case manager to obtain Mr. Robertson's medical records to understand the total picture including what has happened in the hospital, PCP records, RBHA service utilization, and other specialist referrals.
- Coordination with RBHA. Collaboration with the RBHA to engage Mr. Robertson using Motivational Interviewing and working together to avoid duplication and coordinating and co-managing all of his needs, including physical, behavioral, social and environmental. Effective sharing of information is achieved through the exchange of records including assessment and case management notes, joint IC Teams, and use of a Bridgeway BH Coordinator who acts as a liaison between the RBHA and the Bridgeway nurse case manager.
- Coordination with Bridgeway's Provider Services Department to identify the "right" provider based on Mr. Robertson's unique needs and cultural preferences, including peer to peer with medical director and provider. For example, we will need to identify a provider with experience treating members with substance abuse issues as well as TBI.
- Coordination of follow up appointments with Mr. Robertson's PCP, identified specialist(s), and behavioral health. The nurse case manager will also help arrange transportation and accompany the member to appointments as requested.
- Identification and coordination with community resources and supports. Mr. Robertson's nurse case manager will evaluate availability of section 8 housing, low income housing, assisted living or group homes for transition. Bridgeway will coordinate with the RHBA to find a peer support partner and engage him in participating in a TBI support group and substance abuse support group (Narcotics Anonymous). An MCR may be designated to get him involved in the community and engage him in meaningful relationships. His nurse case manager will identify and explore other potential resources and supports such as veteran's benefits or Indian Health Services, as applicable, and Brain Injury Alliance of Arizona.

Risk Mitigation

Challenge	Risk Mitigation	Outcome Measure
Ensuring integrated and coordinated physical and behavioral health services	Bridgeway facilitates communication between the medical plan and the RBHA through a Bridgeway BH Coordinator. To help promote continued integration of care and services for Mr. Robertson, Bridgeway would introduce him to TERROS Health Home. TERROS Primary Care Physicians is an integrated care setting that utilizes the SBIRT (Screening and Brief Intervention and Referral to Treatment) approach to identify and provide intervention for patients with substance use disorders. TERROS patients requiring further SUD treatment are immediately referred to treatment on-site, which includes a comprehensive assessment, as well as an ASAM (American Society of Addiction Medicine) screening to determine the appropriate level of treatment.	• Increased PCP utilization • Decreased ER utilization • No preventable inpatient admissions • Active RBHA episode of care
Member Engagement	While in the hospital or SNF, Bridgeway would notify the RBHA to assign a specially trained peer support specialist (Peer Bridger) to meet with Mr. Robertson and help explain processes, share experiences and help "bridge" him to a peer support system in the community for ongoing support. Should Mr. Robertson continue to refuse out of home placement or substance abuse treatment, we would work with the RBHA to engage him through Motivational Interviewing and try to engage the family to have some influence. Substance abuse will be one of the greatest risks and challenges, which will require close coordination with the RBHA. Bridgeway has a strong history of collaborating with our local RBHAs to effectively support these efforts.	• Increased PCP utilization • Decreased ER utilization • No preventable inpatient admissions • Active RBHA episode of care

Challenge	Risk Mitigation	Outcome Measure
Member Compliance	To promote adherence to his ICP, the assigned nurse case manager continues to be engaged until all goals have been met and Mr. Robertson demonstrates compliance and stability. We would coordinate and co-manage with the RBHA and regularly communicate with everyone involved in his care, such as a probation officer. Bridgeway recognizes the importance of maintaining contact with Mr. Robertson as his medical situation improves. While case management for the acute side lessens we would have the BH coordinator keep in touch with his case through the RHBA and communicate any setbacks to the nurse case manager for in person follow up.	• Progress toward ICP goals
Social Support and Cultural Dynamics	With the assumption that Mr. Robertson is expressing an interest in his health and well-being, the nurse case manager or an MCR would reach out to his family to engage them in his recovery. Based on the family circumstances and cultural sensitivities, this may be attempted in coordination with the RBHA, utilizing a peer support specialist. Prior to this outreach, Mr. Robertson would need to demonstrate a renewed commitment by establishing goals and initiating treatment activities that signify a positive change in behavior. These goals and activities would be documented and signed by Mr. Robertson through the ICP process. If family support could not be enrolled, we would identify community services to assist in provided needed social support.	• ICP Development • Progress toward ICP goals • Active RBHA episode of care
Illegal Activity	To keep Mr. Robertson from greater legal battles and better monitor his legal situation, his probation officer would be engaged in the care planning process. The purpose of this relationship is to ensure Mr. Robertson is receiving a consistent message, and that he is not allowed to manipulate the situation by playing one against the other. The nurse case manager can ensure he understands any legal consequences he faces and the probation officer can better support his treatment efforts. This effort would also require Mr. Robertson's active engagement in substance abuse treatment.	• Probation obligations fulfilled
Pain Management	Given risks involved in managing pain for members with substance abuse issues, we would ensure the participation of a pain management specialist on the IC Team. The role of this practitioner would be to help identify and secure the necessary contracts and services warranted by Mr. Robertson's co-occurring conditions. Mr. Robertson would be part of our lock-in program. The purpose of this program is to address and contain member over-utilization of services such as pharmacy or non-emergent care based on state regulatory guidelines. This program provides case management and care coordination, restricted hospital and pharmacy choice, and a single narcotic prescriber.	• Appropriate pharmacy utilization • Decreased ER utilization • No preventable inpatient admissions

6. Medicare Advantage and/or Medicare Special Needs Plans

6. Describe the Offeror's experience with Medicare Advantage and/or Medicare Special Needs Plans. Describe the processes that will be utilized to enhance and maximize care coordination and improve member experience for members being served for both Medicare and Medicaid services by the Offeror and for members who will only be served for Medicaid by the Offeror. What strategies will be used to increase and maintain aligned Medicaid and Medicare enrollment.

Bridgeway Experience Serving Dual Eligible and Acute Care Populations. Since 2006, Bridgeway Health Solutions, LLC (Bridgeway) has been a contractor for Arizona in a variety of business lines and service areas. In Yavapai County we are a service provider for acute care; in Gila, Pinal, Cochise, Graham, Greenlee and Maricopa a provider for the Arizona Long Term Care System; and we offer a Medicare Advantage Special Needs Plan in Maricopa. Bridgeway has been a Special Needs Plan since 2008, and has recently been recognized by CMS as a Fully Integrated Dual Eligible Plan. The overall CMS Quality Star rating for Bridgeway in Arizona is a three. CMS conducted an official on-site audit of our Model of Care (MOC) for our dual SNP population. The Model of Care is Bridgeway's approach to managing our SNP members. The audit focused on verification of what we wrote and what we actually do for members. The Bridgeway score was 89%-92% which is an "Above Average/Superior Performing Plan".

We support the conclusion the State came to while designing the demonstration program for individuals eligible for both Medicare and Medicaid, that better alignment between those two payers and the services they provide, along with enhanced care coordination will improve clinical outcomes, add system efficiencies, and improve member satisfaction. Our processes for coordinating care for dual eligibles and providing Medicaid wrap-around services are based on the successful experience of Bridgeway and other Centene affiliate health plans in Florida, Illinois, Kansas, Ohio, South Carolina, Texas and Wisconsin. We train our case managers and providers on all protocols for each line of business and coverage scenario because members may be receiving services through our Medicare Special Needs Plan (SNP), another company's Medicare Advantage plan/SNP (MA Plan), or fee for service (FFS) Medicare. Bridgeway staff provides value to this population through understanding of benefits administration for Medicare and Medicaid, care coordination among covered and non-covered services, ease of navigation among both program rules and benefits, and the reduction of barriers to care.

Bridgeway's operational and administrative infrastructure extends to its four administrative offices located in Prescott, Tempe, Tucson, Bisbee, and Casa Grande. Bridgeway's technological systems, customer service centers, claims management functions, and 24/7 care coordination and case management systems are supported by its parent company, Centene Corporation (Centene). Since 1984, Centene has operated government-sponsored managed care plans, such as Bridgeway, and currently operates health care programs in 18 states serving more than 2.5 million people who are Medicaid and/or Medicare beneficiaries. Centene affords Bridgeway quick expansion capabilities and scalability of critical administrative functions and services that ensure smooth transition during enrollment growth or rapid service area expansions along with systems back-up protection to ensure business continuity at all times. With Centene's quality systems solutions and support, Bridgeway's business operations and infrastructure are fully functional and ready to accommodate a large influx of members and providers at any time.

Enhanced Care Coordination

Bridgeway fully realizes the importance of coordinating the care of dually-eligible members between their Medicare and Medicaid health plans. To ensure maximum coordination of benefits, Bridgeway identifies the Medicare plans for all members identified in our eligibility files as dually eligible. This coordination, whether Bridgeway is the SNP or if we are working with another Medicare Plan, creates a collaborative framework which includes:

- A mechanism that identifies concurrent dually eligible members
- A coordination process that incorporates inpatient concurrent review, inpatient discharge planning and outpatient utilization review services
- A mechanism that ensures case management and disease management programs are provided in a seamless fashion
- Facilitation of claim processes that ensure appropriate and accurate payment of Medicare wrap-around services and copayments and deductibles
- The origination of programs that provide for the highest levels of support for dually-eligible members living in the community or at home

- Coordination of quality programs including member satisfaction and delivery excellence
- Coordination of drug formularies to ensure appropriate coverage of prescription drug benefits.

Processes to Ensure Coordination of Care. Bridgeway successfully uses a process in the Acute program to identify members in a Medicare plan. Information about Medicare health plan membership is initially gathered from State enrollment files, identifying if a member has Medicare Part A, Part B, Part A and B, Part C, or Part D. Verification is also accomplished through the Health Risk Assessment (HRA) and case management contact, and with our Coordination of Benefits Department (COB). The COB department is located within Centene's Claims Department and reviews Medicare Explanation of Benefits –to ensure Third Party Liability information is appropriately identified within the member's eligibility record.

Bridgeway's Coordination of Benefits Claims Unit maintains direct relationships with Medicare Health Plans. Bridgeway identifies and coordinates services for members reaching lifetime inpatient limits, Medicare Health Plan deductible or co-payment thresholds, Medicaid wrap-around benefits, SNF limits, claims for deductibles or co-payments in excess of Medicaid fee schedules, Plan D pharmacy formulary coordination requirements, and authorization requirements.

Bridgeway will send an introductory mailer to the case management departments at the Medicare Plans who share our member. This mailer will include contact information for our case managers, benefit coverage available through Bridgeway for Medicare members, a copy of our Member Handbook, and services and processes we have available to facilitate the coordination of care for dually-eligible members enrolled in their health plan(s).

We believe that collaboration and communication is key to better coordination. For example, Bridgeway took the lead to streamline and simplify care coordination tools with the behavioral health providers in Yavapai, creating a new form for better communication; all providers agreed to participate and now utilize the form. To build upon this experience, Bridgeway will invite Medicare Advantage plans to a semi-annual luncheon to collaborate and share successes/barriers and challenges in coordinating care.

Coordination processes with other plans across the service spectrum include, but are not limited to the following.

- Bridgeway receives information such as the current Medicare Case Manager (if any), disease management programs in which the member is enrolled, current plan of care, treating providers, and pharmacy regimen. With the permission of the treating physician, the information is reviewed with the member. Following this initial communication, any subsequent changes are shared between parties. When a member is identified that has high-risk co-morbid conditions or high utilization of services and is enrolled with another MA Plan, the Integrated Care Team (IC Team) contacts the MA Plan to refine care plans and ensure services are coordinated and not duplicated.
- The IC Team will establish care conferences that enable discussion of global processes and specific members based on trigger criteria such as member complaints, joint disease management programs, risk of institutional placement, compliance with care plans, and/or quality of care concerns. More formal meetings will be hosted by Bridgeway, if applicable, with Medicare plans to discuss Medicare cross-over claims, pharmacy and encounter data sharing, streamlining eligibility information, coordinating community resources and education, and any organizational staff changes.
- Inpatient and outpatient utilization services will be discussed with the Medicare plans. Once notified of any emergent inpatient admission or upon scheduling of a non-emergent planned admission, Medicare plan UM staff will be asked to contact Bridgeway. Subsequently, BW's CM will be alerted and will update TruCare, our medical management system, so that the admission is established within our Daily Census Report. The CM will contact the member, the Medicare plan CM, and hospital staff to ensure the member receives appropriate services in his/her home after discharge. The CM will also notify the PCP of non-compliance or frequent and inappropriate use of the ED.
- The CM will work with the Medicare plan to coordinate discharge services, for example home health care, the need for durable medical equipment, transportation assistance, and scheduling of follow-up appointments.
- Member and provider communications including health education information are available through the Member Portal. Other printed health education materials will be developed to educate the dual member on benefits, services, and resources available to them.
- US Script, our affiliated pharmacy benefits manager in coordination with Bridgeway's Pharmacy Director coordinates with Medicare FFS, and any Medicare Advantage, SNP, or stand-alone Medicare Prescription Drug Plan a Bridgeway member belongs to in accordance with AHCCCS and CMS rules and regulations.

Coordination with PCPs. Bridgeway proactively supports the Medicare PCP to oversee the member's full range of care, including both Medicare and Medicaid services, regardless of their status with our SNP network. Case managers consult via phone, fax and email with PCPs during care plan development and modifications. We use Centelligence™ Foresight to help identify and anticipate potentially significant health risks and care needs. Our in-home telemonitoring services facilitate close PCP monitoring of very high-risk members. PCPs in our SNP network have additional support to integrate care. Each time a PCP in our SNP checks member eligibility, our innovative Provider Portal Online Care Gap Alert system gives them real-time, online alerts about members who need preventive care, including recommended preventive care for chronic conditions.

We provide PCPs in our SNP with toolkits and clinical practice guidelines to promote evidence-based care. This includes but is not be limited to information about screenings for depression such as use of the Patient Health Questionnaire (PHQ9) and our depression and Substance Use Disorder programs. Our SNP contracts require PCPs to provide overall clinical direction and manage both Medicaid and Medicare services for dual members. We educate our Medicaid providers about billing Medicare for members receiving FFS Medicare. We also educate Medicare providers not contracted with our SNP on how to bill appropriately for Medicaid members. The training explains our role in coordinating Medicaid and Medicare services and how the physicians should continue to bill Medicare for services provided to dual eligibles.

Technology To Track Care Coordination. Case Managers document and track care plans in TruCare, our member-centric health management platform, which integrates care coordination, disease management, and authorization information. TruCare is integrated with Centelligence™, our enterprise data analytics platform that consolidates medical, behavioral, and pharmacy claims, lab results, member and provider demographic data, assessments, authorizations, and other information into a central repository. This repository feeds our multiple analytics engines, such as Centelligence™ Foresight, our predictive modeling, health risk identification, and HEDIS reporting application, and other proprietary predictive modeling and care gap identification software. The integration of TruCare within Centelligence™ gives CMs a broad range of proactive alerts, data, and multiple tools to quickly identify and respond to potential and actual care needs.

Coordinating and Ensuring Quality of Care. Bridgeway will continue to participate in joint quality improvement initiatives with Medicare plans. The QIO, Health Services Advisory Group, has several initiatives that impact the dual Medicare Medicaid members. Bridgeway is currently involved in two of these initiatives:

- The *No Place Like Home Campaign* is an 18-month collaborative through June 2013 that engages hospitals and other community providers in an effort to reduce avoidable hospital readmissions that occur within 30 days of a discharge. The goals are to prevent 4,000 readmissions; reduce the readmission rate for Medicare clients by 20%; and to decrease healthcare expenditures related to readmissions.
- SNF Quality initiatives that are addressing critical areas for quality improvement including:
  - Reduction of unnecessary antipsychotics for residents with dementia
  - Avoidable hospital admissions and readmissions
  - Falls
  - Pressure ulcers
  - Staff turnover/stability
  - Consistent/permanent assignments
  - Urinary tract infections.

Improving the Member Experience. The Member Services Department is the first point of contact for individuals enrolled in both Medicare and Medicaid. Member service staff are trained in Medicare and AHCCCS benefits and processes. They answer questions the dual member may have or identify the correct department to address the concerns or questions. We educate members through the Member Handbook, Member Portal, Welcome Calls, and through our locally staffed Case Managers. We keep providers informed through the Provider Manual, Provider Portal and Case Managers working with members currently in active care. Bridgeway conducts Health Risk Assessments with new members to identify needs and to quickly engage the member with providers and case managers. Our goal is to provide high quality, efficient services to our members that improve their experience with our plan, but also improves their experience with the healthcare system as a whole. The HRA includes assessment of medical, social, and functional status, and the member's assessment and perception of their overall quality of life.

When a member is identified or referred to case management and has agreed to be managed, the **Case Manager is the single point of coordination** for the full range of Medicaid and Medicare services, as well as any other needed services.

The Case Manager asks members in FFS Medicare for information about all of their current Medicare providers and involves those providers in coordinating care in the same manner they involve our SNP providers. With member consent, case managers share assessment information and Member goals and needs with all treating providers to obtain input into the care plan. Case Managers provide the necessary information providers need to initiate services quickly, and the IC Team monitors timely provision of all services including the member's condition, sharing monitoring information, with member consent, with all treating providers regardless of network status. The IC Team works with the Medicare physician and/or pharmacy as needed to resolve problems members have filling prescriptions, such as for medications that are not on the Part D formulary. The IC Team monitors utilization data and reviews our highest-risk SNP members to evaluate needs and care, and makes recommendations for new or changed services. The Case Manager shares recommendations with the Member's PCP and revises the care plan with Member input as needed.

Case Managers work with the member, family and others they choose to involve, and treating providers to complete a comprehensive assessment of medical and behavioral health (BH) conditions and needs, medications, activities of daily living, social needs, availability of informal supports, the home environment (as applicable), and other issues. The assessment includes the Medicare services the member is receiving. The Case Manager supports member self-determination in assessment and care planning to encourage engagement. Those processes integrate member strengths, needs and goals to produce an individualized, cost-effective care plan that meets medical, functional, BH, social and other needs and preferences to improve the member experience with the health plan and with the overall healthcare system. The care plan is strengths-based and individualized, addresses all assessed needs and identifies the Member's long- and short-term goals. The care plan incorporates: member action steps toward goals; caregiver, family, and informal support participation; service types, date ranges, and authorized units; a plan for addressing barriers; Case Manager responsibilities; non-covered Medicaid, Medicare and other medical/BH services and providers; and linkages for social and other needs such as food stamps, housing, or utility assistance.

Technology Designed with Integration and Service in Mind. The tools used by Bridgeway to support the level of customer service described above include Member Relationship Management (MRM), Centene's member services inquiry and member data management application. This application is powered by Microsoft's Dynamics contact relationship management (aka "CRM") software, and integrated with our Member Portal, Amisys Advance, TruCare and our new Centene Document Management System (CDMS) automated document capture, workflow and retention management system. MRM provides the technology to **effectively integrate Medicare and Medicaid information for dual eligible members** by enabling health plans to: (a) handle more inquiries more efficiently and accurately; (b) systematically reach out to members and intervene appropriately; and (c) manage a broader range of member data in a more holistic and integrated fashion. MRM has three components:

- **MemberConnect** our application for creating, routing, tracking, managing, and reporting (via Centelligence™ Insight) inquiries.
- **MemberReach** an automated outbound Member campaign management application; allowing the efficient launch of broad based (Plan level); or targeted outreach campaigns (e.g. disease management outreach).
- **Member Data Management (MDM)** MRM's database that contains "all things member" related information - including Member demographic and choice information.

Local Care – Local Services. Bridgeway staff use a comprehensive and integrated approach to case management, while also acknowledging the need to respect local preferences and approaches to service delivery. Unique features of our approach include:

- By having a local presence in communities the people who serve our members know what resources are available and they have established relationships with individuals in those other organizations. They understand the culture and conditions in the community, and they know who to call to make things happen.
- Case Management team members have worked in the healthcare industry in their community and have established relationships with PCPs, specialists, and staff in local hospitals. They treat providers as partners.
- Bridgeway holds regular PCP meetings in local communities so providers have formal opportunities to network, give us input and feedback, and can partner with the plan to solve problems and improve services for members.
- Because we have a local presence, members and providers have greater accessibility to Bridgeway staff; they can literally stop into the office and meet with us face-to-face if they prefer that to phone, email, or mail.
- Local CMs and Member Connections are able to quickly make a home visit to members; they can go to physician appointments when requested; and Member Connections can be deployed to "find" a member if other forms of

outreach have not been successful. Member Connections is a unique program within Bridgeway that provides home visits; routine checks on the status of the member; and through Connections Plus provides cell phones to certain high risk members with key phone numbers pre-programmed into the phone including numbers for NurseWise and the member's PCP, CM, specialists, and family support team.

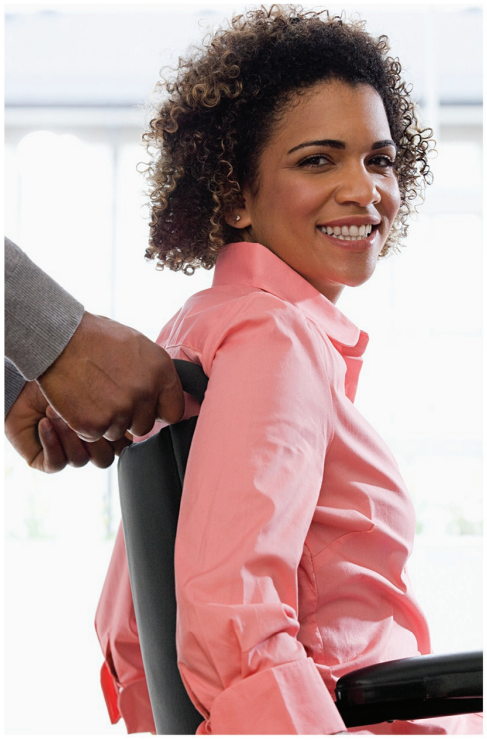
- By having a local presence we can better collaborate with RBHA in person. Bridgeway has developed communication processes and effective working relationships with BH providers, and local staff meet regularly with the most utilized BH providers and RBHA to ensure ongoing coordination and continuous quality improvement of services.

Increasing and Maintaining Enrollment. Bridgeway believes that a personal touch, especially for the dually eligible population, with the goal of exemplary customer service is essential. We educate all of our staff to ensure that they have the correct information at their fingertips, and that they give the right information to members the first time. Once a member is identified as someone who is Medicare eligible, a licensed agent will make contact and offer to set up a personal visit either in the home or a clinical setting. The agent will explain the choices for Medicare and compare the differences between original, FFS Medicare and what Bridgeway offers in the way of benefits and care coordination. Comparison documents are provided to assist the member with decision-making, and the agent remains available to answer questions and address the unique needs of the member.

Local Bridgeway staff will attend community health events including health fairs and public education seminars, partner with senior centers and local agencies on aging, co-sponsor events with organizations such as the American Cancer Society, and conduct Member Provider Advisory Council meetings which are posted on the website. Our experience has shown that engagement with community partners provides valuable education and outreach to current and prospective members, and develops stronger partnerships between Bridgeway, primary care providers, and community resource providers to enhance the quality of life for our members.

Another successful technique to increase and maintain enrollment is to educate the providers in the network, offer ongoing training and continuing education, and support their ability to serve the dually eligible members. Our quarterly provider forum has a standing agenda item that provides new and updated information regarding the Medicare plan and special services and benefits for dually eligible members. The Provider Portal has numerous features that ease the administrative burden on providers and gives them access to information and data to better serve their patients.

Finally, Bridgeway is able to identify member needs through other data sources and standard reports. When the CM and other providers identify members who are not adhering to medications, are being readmitted to a hospital or overusing the ED, or are high utilizers of transportation we can intervene and provide additional case management that can improve quality and outcomes, reduce unnecessary expenditures, and increase member satisfaction. When those "triple aim" goals are realized – improved outcomes, reduced costs, and better consumer experience – we are more likely to increase and maintain the enrollment of members who are eligible for both Medicaid and Medicare.



E. Narrative Submissions Organization

E. Narrative Submissions Organization

Organization

7. Improving Quality and Enhance Cost Containment

7. The health care system in the United States is currently on an unsustainable path. The projected growth of Medicare and Medicaid based on demographics and historical trends result in public programs that consume an excessive portion of the U.S. Gross Domestic Product. There have been numerous studies that document that while having some of the highest costs in the world, the U.S. health care system based on some measures does not have the best outcomes. Recently the Institute of Medicine (IOM) released a report titled Best Care at Lower Cost that estimated$750 billion nationally is "wasted". This includes $210 billion in unnecessary services, $130 billion in inefficient care - $190 billion in excess administration - $105 billion in inflated prices - $55 billion in prevention failures and $75 billion in fraud. The same IOM study also identified various strategies that should be pursued to improve care and lower costs.
As one of the single largest payers in the state of Arizona, AHCCCS has an important role to play in helping to move the health care system to a more sustainable model that improves outcomes. As a participant in the AHCCCS program, provide specific initiatives and efforts your organization will pursue to deal with "waste" that exists within the existing system and improve outcomes. Provide specific information describing the initiatives that would be pursued to improve quality and enhance cost containment including but not limited to the stakeholders involved, the timelines for implementation and the desired outcomes.

Commitment to Culture Change. Of all the recommendations and conclusions put forward in the IOM report, perhaps the most important and overarching recommendation has to do with the need to change the culture of the health care delivery system. This includes the need for consumers to learn how to use new tools and information, and how to be better users of the healthcare system. The Bridgeway model of care is designed for, and supports true patient-centered care, where the relationship and encounter between a provider and a member is supported by all parts of the company. We listen to our members, providers, and stakeholders and adapt our models and interventions regularly to meet their needs. Changes in the system also need to happen at the provider level. More and more providers understand the value of becoming partners with their patients, and focusing on outcomes that resolve immediate health concerns but also that improve the overall quality of life. Bridgeway is dedicated to providing tools for providers allowing them to communicate in modern ways to share information, and avoid duplication of services and waste of healthcare resources. As a health plan, Bridgeway believes that if all key stakeholders have access to the right tools and incentives to promote and reward high performing systems and healthy behaviors, we can continue to move toward a system that rewards quality and outcomes, not just volume and transactions. We have numerous programs and initiatives, recognized and award winning, to offer to the AHCCCS member population that cover everything from prenatal care and pregnancy outcomes, to childhood obesity prevention, to intensive case management for people with chronic conditions.

Bridgeway understands the value of **healthy communities** as well, and we believe in being good partners and corporate citizens in the communities where we serve individual members. We engage communities and our Members through events that can lead to the overall improvement of the community including health fairs and other initiatives directed at disease prevention and management. We have member council meetings offering two-way communication and interaction that both educates and empowers members, giving Members an opportunity to give us feedback on how to improve our services. Members have easy access to educational materials from our website, and we encourage Members, their providers, and other family caregivers to use those resources to guide them in making good health care choices. Bridgeway offers ongoing education opportunities for providers so they learn effective ways to use all of the technology and education tools available, including the web portals, printed and on-line materials, and quality improvement tools.

Breaking Down Silos. Bridgeway believes that efforts to eliminate waste in the health care system require multi-layered and multi-faceted approaches to prevent and reduce the use of unnecessary services, improve coordination of services between payers and providers, engage providers, and increase the focus on prevention of disease and early intervention to manage chronic illnesses once they are diagnosed. There are many programs and initiatives available and underway to address specific areas of waste in the system, and Bridgeway will continue to partner with AHCCCS to ensure a return on investment in those efforts and to develop new approaches to improving quality and lowering costs of care. Technology allows us to collect and amass immense quantities of data that can be analyzed, interpreted, and used to develop interventions, monitor progress quickly and make rapid cycle improvements, and to evaluate effectiveness in shorter periods of time. Bridgeway is constantly making adjustments in our systems to enhance data accumulation and analysis: with more knowledge about members' needs and provider behaviors, we create more opportunities to effect positive

change in the system and improve outcomes for individuals. Making data driven decisions is one important step to improving the healthcare system and reducing waste.

Partnering with Behavioral Health. It is no secret that some waste in the healthcare system is attributed to the difficulties that often surround ***serving individuals with both physical and behavioral health problems***. The primary care and behavioral health systems are often funded separately, and use networks of providers that are not aligned in the same systems or plans and in fact, more commonly, have little or no relationship to one another. Integrating or coordinating primary care and behavioral health (BH) is considered to be one of the main areas of opportunity to reduce waste, but also to improve outcomes and quality of care for the individual.

In 2010, Bridgeway identified that many of our SMI members with chronic medical conditions were using the emergency rooms for PCP services. Failure to obtain routine preventative care in turn led to an increase in hospitalizations for these members. As a result, discussions opened up with the West Yavapai Guidance Center to establish a partnership and co-manage those members with an SMI diagnosis and chronic medical illnesses. In the pilot program the Bridgeway medical Case Manager meets with the member immediately following their BH appointment at either of the two BH clinics. Bridgeway identified staffing and training needs and increased the number of CMs, established training programs on confidentiality and sharing information, and the teams conduct weekly case management team meetings. These staffings include the participation of a psychiatrist from the clinics. With this new integrated approach, the case managers from each organization are able to utilize each other's expertise. As a further evolution of this process, a NP was hired by one of the clinics to perform PCP services for their SMI and BH Bridgeway population.

Our behavioral health coordinator has been reaching out to our PCP providers in Yavapai to educate them on their responsibilities to communicate with our member's behavioral health providers. Over the past six months Bridgeway has hosted two major PCP meetings in which this message has been advanced. In February 2012, our guest speaker was an addictionologist who spoke to our providers on pain management. Bridgeway has conducted medical record audits so as to identify any lapses in behavioral health documentation and has provided education to the providers to enhance reporting. Bridgeway's behavioral health coordinator met with NARBHA providers, and will take the lead to coordinate more outreach and meetings to discuss how processes can be refined to further enhance communication between the behavioral and physical health providers.

Prevention and Public Health. Perhaps nothing will eliminate waste in the system in the long run more than putting more resources into ***primary prevention and early intervention***. Bridgeway staff are participating in a new effort in Maricopa County, sponsored by the public health department to develop a Community Health Improvement Plan. There will be a focus on strategies to impact health outcomes in five priority areas: Obesity, Diabetes, Cardiovascular Disease, Lung Cancer, and Access to Care. Bridgeway is committed to supporting this effort and providing staff resources and expertise. Once the strategies and goals for these five areas are developed, we will introduce efforts into our own initiatives to ensure that we are contributing through our models of care and education programs to help reach these public health goals. Many of these priorities are addressed already on an individual member basis through our disease management programs, and in our quality management and performance improvement program.

Effective **member education** is pivotal to improving member health outcomes. Bridgeway will offer an expansive array of health education content to inform members and their families about health issues, self-care, and how to access Medicare and Medicaid benefits and support. The website offers health sheets with up-to-date information about immunizations, flu shots, prenatal care, and chronic disease management to name a few. Education must be patient centered and delivered to the member in the most effective way possible – sometimes in person, face-to-face; in writing or via the website; through and with a caregiver; and always in a culturally competent way at the appropriate level of literacy. Members have easy access to their own member profiles and their care plans and goals are developed in partnership with their Case Manager and other appropriate family caregivers. Bridgeway CMs and Member Connections representatives assist members in finding community resources when they have needs that are not covered by AHCCCS. One example of a successful education campaign is ***Fluvention,*** an annual coordinated campaign for all members who are educated on preventing transmission of the influenza virus by encouraging them to get seasonal flu vaccines and take everyday precautions to prevent illness. The campaign includes detailed booklets for the general population and for households with children, posters for provider offices and pharmacies, pamphlets with stay-healthy tips, pamphlets that list symptoms, reminder postcards, and Health Education Sheets. The educational approach also includes phone calls, providing information via our Member Portal, and collaborating with community groups to host events at which we provide flu prevention information to participants.

Materials encourage self-management with headlines like "How can I protect my family?" and "Is there a medication to treat the flu?" with detailed answers. Colorful posters give flu prevention tips and remind high-risk groups of the value and safety of the vaccine. Households with children, in particular, are reminded about the nasal-spray vaccine option and how to get it. The repeated messaging at different levels of detail, along with a coordinated look, encourages personal responsibility and provides a foundation for health literacy on other topics.

Effective Utilization of Services. Key to reducing waste in the healthcare system is ensuring that patients get the **right care, at the right time, by the right provider**. Sometimes even one or two key services in the healthcare system drive excessive costs. A program was created to address and contain member over utilization of services including pharmacy and non-emergent care. The Bridgeway program is based on our experience in other Centene health plans and provides case management and care coordination, hospital and pharmacy choice, and a single narcotic prescriber (while adhering to state and federal guidelines). Bridgeway's affiliate health plan in Georgia, Peach State Health Plan's Pain Medication Management program was awarded the Case In Point Platinum Award for their successful lock-in program. Data showed that for the 4,733 members identified during baseline period as having 10 or more ER visits, only 1,009 of these members continued to have high ER utilization following implementation of the program. The results also showed a decline in overutilization of services related to drug-seeking behaviors and associated negative outcomes. Overall savings comparing the total spend of members in 2009 vs. 2010 was $2.3 million.

Prior Authorization. The use of prior authorization policies and procedures is a common way health plans and systems manage utilization and address the overutilization, or provision of **unnecessary services**. We review our prior authorization policies and procedures at least annually and often suggest to our state clients that some requirements be added, removed, or modified. Our data collection and analysis tell us when a policy has the potential for eliminating waste, or if in fact there may be unintended consequences that actually drive members to using inappropriate services. We use workgroups of providers to monitor these policies, and we keep providers educated and updated on the policies and procedures. Providers can submit prior authorization requests online, and through the provider portal they can check the status of the authorization and claims history. Providers always have access to the individual member profile, and to retrieve historical information about prior authorizations and claims.

Members and providers are supported through technology by TruCare, our member-centric health management platform for **collaborative care and utilization management** which provides one consolidated window into health risks, services and authorization, as well as appeal history. Among its clinical operations workflow support features, TruCare includes a fully integrated authorizations workflow. Whether the authorization originates from fax, or our Provider Portal, integrated through Centene Document Management System (CDMS),or through our Provider Relationship Management (PRM), all authorizations are documented in TruCare.

Our technology systems allow us to **analyze data by member**, by individual provider/facility, by provider specialty, by type of service, by diagnosis, by place of service, or by comparing services authorized to services received. Health Economics analysts generate monthly trend reports to monitor key utilization measures such as inpatient admissions/days, ER visits, and case management activities. Each of these reports includes a drill down to more specific areas of interest. For example, when analyzing member emergency room visits or inpatient utilization, we look not only at total number of visits or days, but also look at utilization based on the members' recurring admissions, assigned PCP, by service area, by members with no physician office visits, and by members with frequent ER utilization (12 ER visits in six months as detected through ER reports that flag members with 3 or more visits in 6 months). Benchmarks are established using industry standards, HEDIS national Medicaid averages, and/or State 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 the populations we service.

Engaging Providers. Through the monitoring of medical and pharmacy utilization data, grievance and appeals, and HEDIS data, providers may be identified as outliers for high ED utilization, under-utilization of well-child visits or other areas of non-compliance. Provider data is used to **compare providers to their peers** and other plan or other industry benchmarks such as HEDIS or utilization measures, develop provider training and education, and implement corrective action plans as needed. Bridgeway's Medical Director and other Provider Relations staff meet with providers regularly to share data, address barriers, and develop appropriate interventions. Bridgeway also uses this data to recognize high performing providers. We reach out to our **high performing providers** to better understand what makes them successful and share best practices across the delivery system. We also recognize providers through additional compensation, at

awards dinners, provider meetings, and through the Bridgeway website with a provider profile spotlighting a provider's contribution to care coordination and outstanding patient care.

Bridgeway is also committed to ensuring **administrative efficiencies** that guarantee we attract and retain qualified, high performing providers in our health plans to serve our members. In addition to engaging providers in clinical quality improvement, prevention of fraud and abuse, and to increase our focus on prevention of illness and disease we will continue to implement administrative efficiencies that benefit both the provider and the system as a whole. As Bridgeway continues to expand its network, enrolling the provider into Electronic Funds Transfer as well as signing the provider up for either our secure web portal or verifying that the provider utilizes an electronic clearinghouse is now a standard part of our welcome process for providers. Our goal is to further target provider groups that are still submitting paper claims and work through the barriers to electronic claims transmittal, with **a goal of having 75% to 80% of providers submitting claims and receiving payments electronically.**

Managing the Chronically Ill. Bridgeway uses communications technology to provide real-time information on health conditions from a distance. **Telemonitoring** provides a way to facilitate patient adherence to treatment plans, improve care coordination between members, their care teams (including providers), and remove barriers to care such as lack of mobility or social supports. Nurtur combined this innovative technology with our best-in-class disease management coaching as a pilot program in 2009. The resulting outcomes proved so dramatic that the program is now available to more than 800,000 Medicaid members in five states served by our parent company, Centene Corporation. When Bridgeway first offered telemonitoring, we found that ABD member participation in their home telemonitoring program remained very low after its initial pilot phase. To improve ABD member participation, Bridgeway's Utilization Management Committee expanded program participation criteria to include multiple recent ER or urgent care visits and multiple inpatient admissions in the previous six months. In addition, a new process was implemented for the program supervisor to review the inpatient census daily and discuss each case with the member's assigned Case Manager for possible referral for telemonitoring services. As a result, the home telemonitoring participation rate more than doubled. Our comprehensive telemonitoring solution begins when the health plan, in coordination with the member's physician, refers eligible **high-risk Members with CAD, heart failure, hypertension or diabetes** to Nurtur to initiate device setup. The wireless technology enables biometric readings to be taken in the home and transmitted electronically to the member's Nurse Health Coach and/or provider within seconds. The telemonitoring software compares the data against established thresholds noting favorable or unfavorable trends and provides an automatic data reading report to readily share any unexpected results with the provider. Members are given a URL and password information (HIPAA compliant) to share with their physician and/or family members to access their biometric data further supporting coordinated care efforts.

Members are more engaged and empowered to **improve self-management skills** and self-efficacious behavior and have an increase in program compliance, medication adherence and physician office visits. For example, an adolescent member thought she could control her diabetes and refused her mother's help. Her case manager initiated a referral to our telemonitoring disease management program, whereby the member's diabetes readings were automatically and regularly sent to her health coach. With readings in-hand, the young woman's coach provided suggestions on pre-medication and reactive steps she should take to help control her blood sugar levels. Twice weekly, the health coach provides blood sugar readings to the nurse practitioner. Through these coordinated efforts, she now has her diabetes in check.

Using this innovative technology enables Health Coaches to contact the member within minutes of an adverse reading and immediately intervene to address the value as it relates to the patient's recent behavior. For example, a member with heart failure may have inadvertently ingested a high-sodium content food or beverage earlier in the day which resulted in an unfavorable weight reading. This provides an opportunity for a "teachable moment" that can result in healthier behaviors and improved member self-management in the future. Real-time alerts of potentially dangerous values result in timely interventions that, in turn, avoid unnecessary – or "avoidable" Emergency Department (ED) or hospital utilization or readmissions.

Nurtur tested this theory by conducting a retrospective cohort study consisting of 454 Medicaid members in three states. Members had participated in the telemonitoring pilot; had medical claims data available for two years prior to participation, and medical claims data in the 12-month period following the implementation of telemonitoring. Due to the high level of participation (93%) of those who were considered candidates for the program, an adequate control group

could not be generated from within those states' membership. We selected a similar Medicaid plan that did not employ telemonitoring but whose membership had a similar case mix to those who were on telemonitoring.

Our results suggested that participating in telemonitoring had decreased the likelihood of disease-specific utilizations, including inpatient admissions and ER visits. For example, heart failure members were 64% less likely to incur a *readmission* than the control group; 79% for acute myocardial infarctions (AMI); and 42% for diabetes. Also, we noted that members on telemonitoring were less likely to have an inpatient *admission:* heart failure 56%; AMI 70%; and diabetes 35%. We concluded that telemonitoring appears to be an effective tool in reducing inpatient utilization among Medicaid members with chronic disease. Based on these findings, we estimated a **return on investment** (ROI) of 3.09:1. This translates into better access to care and improved health care outcomes for members and cost savings due to appropriate utilization and averted hospitalization events.

Quality Reduces Waste. A key strategy to improving outcomes and quality is built into the Bridgeway philosophy about managing and coordinating care throughout the healthcare system. Care management in and of itself offers more opportunity than a traditional fee-for-service environment to improve outcomes and quality, and eliminate waste. Bridgeway's culture, systems and processes are structured around its **mission to improve the health of all enrolled members**. The Bridgeway Board of Directors (BOD) oversees development, implementation and evaluation of the QM/PI Program and has the ultimate authority and accountability for oversight of the quality of care and services provided to Members. The BOD delegates the operating authority of the QM/PI Program to the QM/PI Committee and Chief Medical Director. Bridgeway utilizes the information obtained through our robust data systems, as well as our Advisory Councils, to help improve quality, health outcomes and program efficiency; maximize care coordination for members; and support provider performance.

The Bridgeway Quality Workplan. Some waste in the healthcare system is generated by poor quality of services, and a lack of focus on assuring that people get the right care at the right time – care that will lead toward improved health. Bridgeway develops an annual Quality Management Workplan that includes specific **performance improvement measures** and projects. The 2013 workplan focuses on cholesterol management and BMI assessments; management of asthma and diabetes; reducing unnecessary hospital readmissions; and, improved care coordination with behavioral health providers. Activities include provider and Member education, employee training, monitoring and auditing the compliance of providers, analysis of claims and other data sets, use of tools such as predictive modeling and hospital reports, and pairing up of providers with CMs for high needs populations including individuals with serious mental illness**. Data-driven decisions and interventions** are inherent in our business and occur at the system level, the member level and the provider level. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services.

8. Compliance Program

8. The Offeror is required to develop a compliance program designed to guard against fraud and abuse. Beyond the requirements outlined in the RFP and AHCCCS policies, describe additional activities your compliance program will take to limit, identify, and address fraud and abuse. Describe the Offeror's experience using these methods and include examples of successful application.

Overview. Bridgeway Health Solutions (Bridgeway) leveraged the experience of its parent company, Centene Corporation, in the creation of a Compliance Program that guards against fraud, waste and abuse among employees, subcontractors, providers and members in accordance with AHCCCS Contract requirements and all applicable State and federal regulations, including ACOM Policy 103 and A.R.S. §36-2918.01. Centene has operated a Fraud, Waste and Abuse (FWA) program supporting its subsidiary health plans and Bridgeway's approaches, policies and procedures are grounded in that expertise and accumulated knowledge. Centene and Bridgeway take a proactive approach in detecting FWA and remain committed to exceeding State requirements in limiting, identifying and addressing FWA.

Corporate and Bridgeway FWA Structure. Bridgeway executes its FWA Program largely through its local Compliance staff and the Payment Integrity team, which is located in Centene's corporate headquarters in St. Louis, Missouri. Centene's Internal Audit also plays a role in monitoring the effectiveness of our FWA operations. Centene and Bridgeway work in accordance with ACOM Policy 103 and acknowledge that Arizona's Officer of Inspector General (OIG) has absolute authority in determining fraud and conducting investigations regarding FWA. Bridgeway and Centene conduct the preliminary reviews, referring those cases of potential FWA to the OIG within 10 days of discovery.

Bridgeway's Compliance Officer works closely with the Vice President of Payment Integrity to report all suspected fraud allegations to State and federal agencies as required. The Compliance Officer, in collaboration with the FWA Workgroup, reports to the Compliance Committee any Special Investigation Unit (SIU) cases that have broad implications for Bridgeway operations in a manner that preserves confidentiality and protects investigations.

Payment Integrity Division. The Payment Integrity Division includes our Special Investigations Unit (SIU) and Compliance Coding teams. The Vice President of Payment Integrity reports to Centene's Vice President of Ethics and Compliance. One Investigator is specifically assigned to Bridgeway.

The SIU oversees and assists Bridgeway's FWA activities by conducting reviews/audits based on analytics, information identified by Bridgeway, internal audits or through referrals. SIU also conducts systematic testing, reviews regulatory requirements, tracks investigations, and works with State and federal agencies as necessary. SIU reports the results of its reviews to Bridgeway's Compliance Officer and the FWA Workgroup. SIU also assist as necessary in reporting or discussing the review/audit findings with Bridgeway executives and AHCCCS.

Additional Activities to Limit, Identify and Address FWA. In addition to having a dedicated, onsite Compliance Officer, Bridgeway utilizes a Centene best practice by expanding the role of its Compliance Committee and including an additional FWA Workgroup.

Compliance Committee. Bridgeway's commitment to reducing FWA begins with its Compliance Committee that consists of executive leadership, including the CEO, COO and Vice Presidents and at least one representative from each functional area. This cross-functional representation allows us to address issues holistically for all stakeholders.

FWA Workgroup. This group meets every 4 to 6 weeks and is comprised of Bridgeway's Compliance Officer and staff, Chief Medical Director, Vice President, Network Development and Contracting and Centene's SIU. This group's function provides opportunities to review and monitor provider data and provide input on additional education and training opportunities for providers who are experiencing difficulties with proper coding or billing. The meeting agenda's always include discussion around opened/identified cases, closed cases, current status etc. The goal of the meeting is to collaboration between the SIU and health plan and identify areas for additional opportunities. **Successful Applications.** As the result of an identified trend, the SIU worked with Provider Relations Specialists (PRS) at Bridgeway to conduct targeted training on common and easily correctable coding errors that include, but are not limited to: the proper components needed for an evaluation and management service to prevent upcoding, appropriate billing regarding surgery and follow-up office visits, not including minor procedures that are included in the evaluation and management services, such as ear wax removal.

Claim Audit Division. Centene's Claim Audit Department (CAD) assists with pre-payment (preventive) and post-payment (detective) audits of claim payments and related systems. Centene created this department in 2001 to provide

continuous feedback to management on processing, payment, and financial accuracy of claims processing. The department is independent from Claims and the Payment Integrity Division and reports directly to the Senior Vice President, Internal Audit. The main goal of CAD is to ensure that payments are being made in accordance with the appropriate rates and that all State and federal claim processing rules are followed, including but not limited to - prompt payment and interest calculations. Results are summarized in monthly reports to claims and plan management and quarterly results are shared with plan leadership and corporate executives.

Proactive Coding Activities. Prepayment Review. Centene has made a significant commitment and technology investment to move to a more efficient, prepayment, *prospective* model across all affiliate health plans opposed to the traditional "pay and chase," or retrospective post-pay fraud identification model. Prepay Compliance Coding staff conduct pre-payment reviews to monitor for FWA and ensure claims are processed in accordance with coding guidelines and State requirements. As necessary, they refer specific providers to the SIU for in-depth retrospective review or investigation. Once claims have been adjudicated to a paid, denied or pend status, we analyze their coding for clinical appropriateness. Our processes reduce "false positives" that many pure data mining software solutions produce, thus making our identification more efficient.

ClaimsXten ®. Using code-auditing software ClaimsXten**,** a McKesson LLC product, Centene's Prepay Compliance Unit reviews outpatient facility and physician claims post-adjudication, prepayment. ClaimsXten ensures the claims comply with State guidelines as well as national coding guidelines published by CMS, the American Medical Association, and various specialty organizations, such as the American Board of Anesthesiology. The software helps identify and address coding inaccuracies, such as unbundling, fragmentation, upcoding, duplication, over-utilization standards, invalid codes, and mutually exclusive procedures. These edit rules are based on generally-accepted principles of medical services coding and are not based on medical necessity, nor are they designed to make reimbursement or payment decisions.

Successful applications. In 2011, a pre-pay review of laboratory services identified excessive units being billed for adrug screen for multiple drug types. Through research of the provider, it was identified that the provider did not have the proper level of CLIA certification to be performing these drug screens. As a result, Bridgeway denied claims totaling approximately $54,000. PRS staff provides targeted training to the provider for proper billing and coding. The providers are continually monitored to ensure that services are coded and bundled correctly.

Verisk Health (VH)®. Bridgeway and Centene have entered into a strategic partnership with Verisk Health (VH), to proactively identify FWA. VH uses predictive modeling, coding analysis and skilled clinical review to identify coding errors and aberrant claims. VH's value in identifying aberrant claims is based upon its nationwide and multi-payer database of claims experiential data, which offers them a holistic view of provider billing patterns.

By using specially trained registered nurses to review system-detected reimbursement issues and claim history, VH evaluates the claim from a clinician's perspective and makes a recommendation to pay or deny the claim. This additional evaluation prevents unnecessary resubmission of claims and provides consistent and logical claims processing. Examples of some of the issues this process identifies include keying errors, unbundled/fragmented services and inappropriate use of modifiers. In addition, if ClaimsXten allows a procedure billed with an incorrect modifier to pay because it appears to be appropriate, VH nurses can create a detailed clinical picture using the member's history to determine if the procedure code was appropriately modified.

Due to our education efforts, an affiliate health plan employee recently reported concerns that a home health agency may have been billing for services that the Foster Parent was providing to their Foster Child. A record review validated the allegation and identified a potential overpayment of $1.3 million. The provider was reported to OIG for potential fraud.

After review by ClaimsXten, Centene automatically and securely transmits all submitted and adjudicated claims data to VH for analysis. VH will identify claims that warrant additional clinical or FWA review, and Centene will process the remaining claims for payment. VH then proceeds with detailed analysis of the identified claims, applying analytics informed by its national database of provider billing patterns, which provides VH the vantage point of assessing a provider's billing practices against national, all-payer practice trends. Within 12 hours of receiving the claims data from

Centene, VH will notify the Payment Integrity Unit of claims suspected of FWA. Coding Unit staff will review the flagged claims against State guidelines, Contract provisions, historical information, and other factors and will either release the claim for payment or refer the claim to SIU for preliminary review.

Successful applications. A Bridgeway provider was identified as up-coding standard office visits to a level 4 or 5. The Verisk Code Validator software allows for two standard deviations from a provider's peers; however, it was determined that this particular provider's office visits were higher than normal, prompting notification to the provider and an opportunity for our Provider Relations Specialists (PRS) to conduct targeted training for proper coding rules. In another instance, a provider was identified as unbundling for non-fetal stress testing that should have been included in the initial evaluation code. As noted above, once the provider is notified, our PRSs provide targeted training to ensure proper coding standards are met.

Post-Payment Reviews. EDIWatch Intelligent Investigator™. Quarterly, the SIU uses Intelligent Investigator to identify potentially fraudulent billing patterns for further investigation and provides a quick analysis of suspicious claims. This tool is also used to train new investigators. It contains hundreds of edits based on CMS and AMA guidelines to identify outliers, such as diagnoses/procedures incompatible with age/gender, mutually exclusive codes billed together, ambulance upcoding, add-on codes billed without primary CPT codes, and non-emergency procedures billed on Sundays or holidays. Furthermore, Intelligent Investigator identifies instances where unbundled procedures are billed on separate claims; however, if billed on one claim, the subcode would have denied as a component of the primary code.

Successful Applications. Centene identified an outlier OB-GYN group who billed extreme charge variances over time and also had a high utilization of repeat diagnostic testing and unbundling of obstetrical services and office visit upcoding. These billing errors and immediate targeted training by PSR staff saved Bridgeway and estimated overpayment of $219,000.

Claim Sampling Audits. During the first 90 days of a new product or market launch, CAD will audit a sample of claims from the trial check runs (prepayment) using judgmental selection process, with the intent of identifying claim errors prior to payment. CAD also performs audits of critical claim inputs (such as fee schedules, pricing, and benefits) to assess the accuracy and completeness of claims payment set-up. CAD forwards errors to the appropriate department and if necessary, requests a corrective action plan, which CAD subsequently tracks and monitors.

CAD performs a statistically valid quality audit (based on a random sample) of processed claims, assessing claims for processing, payment and financial accuracy, as well as compliance with contract obligations. The sample provides for a 99% confidence level, plus or minus 2.5% on a quarterly basis. Random samples are selected from each check run, which includes paid, denied, appealed and adjusted claims. CAD reviews a wide range of attributes to assess accuracy, including but not limited to:

- Review for outliers/unusual practices
- Trace claim dollars in the audit sample to the specific underlying source documents (e.g. provider contracts, fee schedules, benefit grids)
- Claims accurately entered into the system, including: diagnosis, charges, provider, claimant, and procedure codes (accuracy of claim data entry)
- Contracted providers paid in accordance with contractual rates (allowed payment agrees with contracted rate)
- Ensure duplicate claim submissions were identified and denied
- Proper coding was consistent with provider credentials

Upon completion of the audit, the results are compiled and reported monthly and quarterly to executive leadership. They also work closely with SIU by communicating irregularities for further review. While results are compiled monthly, errors are posted on a daily basis and management is responsible for performing root-cause analyses of exceptions identified and submissions of corrective actions. The monthly sampling provides an in-depth view on the accuracy of claims processing and opportunities to identify potential FWA incidences. The monthly reporting also provides feedback for internal continuous process improvement and staff training needs.

Other Targeted Audits. Based on previous experience and emerging fraud trends, Bridgeway, in collaboration with Payment Integrity, developed provider and member claim audit plans. Audits may address a random group of providers or targeted providers with billing pattern issues. In addition, we validate encounter data through Plan Focus Studies, annual provider medical record reviews, provider profiling, reconciliation of detail encounter data, and targeted reviews of a provider's utilization. For example, the SIU conducted targeted audits based on national FWA trends in both Durable Medical Equipment (DME) and Laboratory frequency. The SIU is continuing to educate providers and create policies

based on best practices but has currently saved over $7 million dollars as a result of these reviews. To prevent overpayments going forward, additional authorizations are required and unauthorized services will be denied. The review revealed two issues: 1.) frequency of lab testing, with some patients receiving a complete lab panel up to 5 times a week when the national standard is once per month; 2.) Incontinence supplies were being provided based on benefit limits verses patient necessity. At times, some patients were receiving over 500 incontinence supplies a month for night time bed wetting, when most patients only require100-200. The SIU recently conducted a review of home health services which identified over $1.2 million dollars paid inappropriately to providers. The review identified unqualified individuals providing and billing for services. As a result, the case was reported to the appropriate state agency and action pending their review.

Explanation of Benefits (EOBs). Based on CMS recommendations, Bridgeway also surveys a random sample of members by mailing an Explanation of Benefits (EOBs). The EOBs clearly state the document is not a bill, but is to verify that the services listed were received. In the event a member did not receive the services, we request that they call Member Services. We are careful not to survey members using EOBs that would create a violation of member privacy related to women's health care, family planning, and behavioral health services.

Additionally, every member over the age of 18 has secure access to their claims history (medical, lab, pharmacy and vision) on the Member Portal, which protects the confidentiality of member health information. Claim histories are updated weekly. The claims history screen also directs members to contact Bridgeway when they find services listed that they did not receive.

Medical Management. Medical management staff will conduct quality control audits by reviewing various reports on a regular (usually monthly) basis. Examples of these reports include providers with a high number of referrals, providers that provide outdated treatments, and member Emergency Department utilization. For example, staff may detect potential FWA in monitoring a provider's use of surgery against the provider's use of a more appropriate and cost-effective treatment**.**

Educating, Hiring and Training Qualifications. Bridgeway meets all Contract requirements for staffing, educating and training health plan staff and Board Members. Program Integrity begins with highly qualified staff and rigorous training standards and Bridgeway strives to meet these goals in its operation.

Qualified Staff. The Payment Integrity department maintains high standards for department staff. New hires come from a variety of backgrounds in healthcare and law enforcement, with many having prior FWA experience. Additionally, almost 50 percent of current staff are Certified Professional Coders (CPC). This additional expertise demonstrates our proactive commitment to reducing FWA. We require all new employees and Board members upon hire or engagement to read our Code of Conduct, which includes an overview of relevant laws and Bridgeway policies. We also require them to provide an attestation that they have read, understand and will abide by the Code. They are asked whether they:

After its 2011 review of our Code, Corpedia reported that Centene's Code fall within the 79th percentile of Health Care Industry Codes reviewed by Corpedia and the 84th percentile against Corpedia's entire Code review database to date.

- Are they aware of any violations of State, federal or health plan requirements
- Have any direct or indirect interest in any Bridgeway or Centene transactions
- Have ownership in any companies that do business with Bridgeway or Centene
- Have any relatives employed by Bridgeway or Centene, or who are members of outside boards

In addition to requiring staff and the Board to read the Code of Conduct, we use computer-based training modules on compliance, privacy, security, and FWA. All employees must complete several mandatory compliance courses within the first 30 days of hire and additional training course annually thereafter. All training is documented in our Compliance 360 software, allowing easy management for reporting and adherence. All compliance and FWA training is a condition of employment.

In 2012, 99% of Centene's 6,000 employees completed the annual BECP Survey within 9 weeks of distribution.

Targeted Employee Training. Some employees are required to complete additional annual education, as appropriate to their position. For example, Compliance staff provides targeted training to staff who work directly with Medicaid members and providers, such as staff in Claims, Medical Management, Quality Improvement, Credentialing, Member Services, and Provider Services.

Compliance staff educates these employees on the special role they play in detecting and preventing FWA and raise awareness about indicators or red flags they may come across in the course of their work. For example, Payment Integrity department staff trains Provider Relations staff on ways to communicate with providers about billing trends or anomalies identified through audits and reviews. Members of the FWA Workgroup (the Medical Officer and the Vice President, Network Development and Contracting) receive special training from SIU staff on FWA topics such as current fraud schemes, common coding or billing errors, and CMS-focused audits. In addition to annual training, compliance staff train all or appropriate subgroups of staff on identified concerns, risks and upcoming changes in regulations or operations. For example, managers may identify areas that require additional FWA detection training, and Compliance staff will provide or help arrange the training.

Staff Training Approaches. Bridgeway uses a variety of training methods, such as interactive group and individual training, online training, handouts, handbooks, contests, and newsletters. The Compliance Officer conducts trainings in a live forum to foster participant engagement, strengthen working relationships, and promote our open door policy for reporting compliance concerns.

We also test participant knowledge and foster understanding and retention after each training session using a question and answer format within the training modules. For example, our computer based modules on "Ethics and Compliance" and "Insider Trading" require staff to pass the test questions with a score of 80% or higher.

An example of intranet training is Centene's module on "Speaking Up: How and When to Speak Up With a Concern." This course uses a scenario that walks employees through the steps of speaking up to a manager about a potential conflict of interest, including the proper way to make a report, how the manager should handle the situation, our zero-tolerance non-retaliation policy for a good-faith report, and what to expect from an investigation and follow up. Other online program integrity sessions include HIPAA topics and courses for supervisors on handling employee complaints.

Question: *I noticed some unusual things on a claim submitted by a provider. The services provided don't appear to match the provider's specialty or the member's condition. I'm not sure if this provider is committing fraud. Should I report it?*
Answer: *Yes, all concerns about potential fraud, waste and abuse should be immediately reported to the Special Investigations Unit (SIU). The SIU will evaluate the situation and, if needed, request documentation from the provider to support the information submitted on the claim. While it might not be necessarily be fraud, the Company wants to stop any wasteful or abusive billing. In addition, reviewing the appropriate information could also identify issues with the quality of care being provided to our members.*

An innovative example of in-person training is Centene's modules, "Who Wants to Be a Compliance Millionaire?" and "Compliance Jeopardy," in which we use game-show formats and staff participation to promote retention and appropriate application of compliance and ethics standards in an entertaining and interactive way. We use real life examples as recommended by CMS in our Code of Conduct (see call-out box) and training scenarios. For example, we may depict situations an employee might encounter and ask them to identify the compliance or FWA violations. We also post FAQs on fraud, waste and abuse on our intranet site. In addition to intranet resources cited above, Centene, Bridgeway's parent company, continuously posts current resources for all Centene and health plan employees, including but not limited to:

- ***Receiving Employee Concerns Reference Guide*:** A resource for managers; provides transparency to all employees regarding the handling of their concerns
- ***Decision Making Process Resource*:** A document for managers and employees to assess compliance issues
- ***Resources for Reporting Compliance Issues:*** A guide describing who staff can contact for guidance on ethics or compliance issues or to report suspected violations
- ***FWA Referral Form***: Helps employees report potential fraud, waste or abuse, anonymously if they prefer

9. Claims Dispute Process

9. Describe in detail the ongoing processes and strategies the Offeror will implement to minimize the need for providers to utilize the claims dispute process to obtain proper reimbursement. In addition, describe the interventions and strategies the Offeror will employ to resolve claims disputes without resorting to the hearing process.

Bridgeway's Proactive Approach to Minimizing Claims Disputes. Bridgeway Health Solutions (Bridgeway) claims are adjudicated at a claims adjudication center owned and operated by Bridgeway's parent company Centene Corporation (Centene). All claims are adjudicated following Medicare National Correct Coding Initiative (NCCI) edits, State of Arizona (AHCCCS) mandated guidelines and Contract specific carve outs. By adhering to these specified oversight guidelines, Centene assures Bridgeway's provider claims are processed properly and in a timely manner. Provider appeal rights are included with every claim remittance advice and Bridgeway acknowledges, in writing, receipt of formal appeals. Providers can request review of their claims at any time. We use several proactive approaches to reduce the claims submission errors and misunderstandings that could lead to a claims dispute or appeal. Our most effective proactive measure is our *electronic claims management system* that delivers the functionality, speed and capacity to handle high claims volume and claims complexity for every type of provider and health care service. We *train providers on how to submit claims* and *continually encourage them to submit claims electronically* to ensure correct claims payment and reduce disputes. Finally, we provide *timely and attentive service* support to providers who have questions or concerns regarding claim denials or payment amounts. Bridgeway's ongoing strategies for minimizing the provider's need to utilize the claims dispute process are described below.

Bridgeway's Electronic Claims Management Systems Effectively Reduce Errors and Uncertainty

Bridgeway's fully integrated, HIPAA-compliant claims adjudication practices and sophisticated claims processing systems are configured in accordance with state and federal specifications to ensure provider compliance with AHCCCS and federal requirements at all times. We accept claims in electronic and paper formats in order to accommodate claims submitted from providers regardless of the submission option they choose. These options include:

- ***Electronic Data Interchange (EDI) Multiple Clearinghouses.*** We accept claims from any clearinghouse that meets our performance and service quality standards and can implement our HIPAA companion guides and send an acknowledgement response to the clearinghouse, which then notifies the provider of the successful receipt or rejection of the claim file.
- ***Batch Files from Providers***. Providers can submit HIPAA EDI 837 batch files through our secure web based Provider Portal, where we acknowledge receipt of that batch and return a response to the provider, in near real time, indicating whether the transaction was a valid HIPAA file.
- ***Direct Data Entry* (DDE)** using the Provider Portal. This functionality is especially convenient for our smaller provider offices, yet offers the same EDI validation as our batch claim submission processes. In addition to our DDE claim form, we also offer a Long Term Care (LTC) Claim Wizard, which further guides providers through the claim submission processes, thus avoiding incorrect or incomplete claims submissions that otherwise might have led to claims disputes.
- ***Paper Claims.*** Within one business day of receipt, paper claims (CMS 1500 or UB04) are scanned and converted to electronic format.

Each claim, including adjustments, received through any of the above methods is systematically given a unique internal control number including the date of receipt. Each claim within the batch is labeled with the batch number and sequence within the batch for easy reference and tracking.

Prompt Notice to Providers of Claim Submission Problems. All claims are pre-adjudicated through EDIFECS and TIBCO middleware using consistent application of common edits to ensure adherence with established claims guidelines, rules and regulations. This pre-adjudication step helps to capture errors, omissions or inconsistencies before the claim proceeds through the next phase of adjudication. If the claim "fails" this initial checkpoint, we immediately alert the submitting clearinghouse or provider so they can correct and resubmit the claims. Claims that "pass" this initial check instantaneously proceed through the next series of pre-adjudication edits, including member and provider validation. If the claim fails this level of processing, we issue a detailed HIPAA 277U to the claim submitter, within ***one business day*** of claim receipt. The adjudication process is completed for all claims that pass initial edits, thus ensuring timely and accurate payment while virtually eliminating claims disputes.

Bridgeway Encourages Providers to Use EDI Submissions. When providers submit claims electronically, the time from service to submission is shortened by more than *half* the time compared to claims submitted on paper. We obtain data sooner, can process claims faster, Case Managers can utilize information sooner in the care of our members, and we can display the information sooner on the Provider Portal. We strongly encourage network providers to submit claims electronically and thoroughly educate and support our providers on the benefits and methods of EDI claim submission. From 2011 to 2012, Bridgeway's EDI submission rates increased by 7%. As Bridgeway continues to expand its provider network, our standard practice is to encourage new providers to enroll in our EDI and Electronic Funds Transfer (EFT) programs or we verify their use of an electronic clearinghouse. Our ongoing strategy is to continue targeting provider groups that are submitting paper claims and working through barriers to their use of EDI and EFT. Our goal for 2013 is to achieve at least 75% EDI and EFT use among providers for the Acute Care program. ***EDI/EFT Task Force Formation.*** Bridgeway would participate in and support the formation of a task force made up of AHCCCS personnel and health plan personnel to explore ways in which we can align and streamline processes even further so that more providers will use EDI and EFT.

Bridgeway's Provider Outreach and Intervention Activities to Reduce Claims Submission Errors

Bridgeway's Provider Relations Unit, under the auspices of its Network Development and Contracting Unit, delivers effective provider outreach and intervention through a series of communication methods directly with providers. Communication methods include:

- Sending official written notices, memorandums, bulletins, BlastFax and newsletters to network providers
- Stuffing remittance advice envelopes with notices, memorandums or bulletins describing the claims situation in question and appropriate billing procedures, rules and regulations
- Uploading applicable forms, information and announcements to Bridgeway's website and in Provider Manuals
- Notifying all internal departmental managers of critical issues or changes and providing comprehensive information, as well as guidelines for their use in training their departmental staff about the claims or billing topic and how to respond to questions from members and providers relating to the topic
- Inviting providers to attend provider training sessions relating to specific topics. These training sessions are conducted in a group setting, at multiple locations, and on multiple dates in order to ensure high provider attendance.

All of these activities depict the team effort and collaboration that occurs between the various departments within Bridgeway as we work together to improve processes that will lead to lasting change, better outcomes and renewed support among providers that align with AHCCCS health care delivery initiatives.

Bridgeway Trains Providers on How to Submit Claims. Bridgeway trains all providers and their billing staff regarding claims submission options and how to submit HIPAA-compliant claims. We also include detailed claims submission instructions on our web-based Provider Portal, in the Provider Manual, and through newsletters, notices and bulletins on an ongoing basis. Our Provider Portal enables providers to view Bridgeway Claims Adjudication logic in detail - using the Clear Claim Connection tool (designed by McKesson Information Solutions, Inc.) that essentially mirrors how the claims software evaluates medical code combinations during the adjudication of a claim resulting in *cleaner claim submissions and lower error rates.* **Bridgeway's Claims Management Processes are Scalable and Ready for Rapid Growth.** The process changes Bridgeway rolled out this year were implemented not only to reduce claims disputes and Hearing requests for the short term, but were also designed to be manageable during times of service area expansion and substantial enrollment growth. Because Bridgeway has been operating in Arizona since 2006, the foundational infrastructure of our organization is solid, well-maintained, and extends to all of Bridgeway's administrative offices. Because Bridgeway's technological systems, customer service centers, claims management functions, and 24/7 care coordination and case management systems are supported by its parent company, Centene Corporation (Centene), Bridgeway has always had expansion capabilities and scalability of critical administrative functions and services built-in to its operational and administrative foundations. This scalable functionality ensures smooth transition during enrollment growth or rapid service area expansions along with systems back-up protection to ensure business continuity at all times. With Centene's quality systems solutions and support, Bridgeway's business operations and infrastructure pertaining to claims management are fully functional and ready to accommodate a large or sudden influx of claims resulting from enrollment growth.

Bridgeway's Processes, Interventions and Strategies to Reduce Claims Disputes and Hearing Requests

If a provider is not satisfied with the initial adjudication, the provider can contact Bridgeway's Claims Research and Support (CRS) Unit – via our toll-free call center - in order to receive high quality, personalized customer service to resolve claims issues. The methods that the CRS Unit uses to reduce claims disputes include effective oversight and monitoring of Bridgeway's claims systems configuration to eliminate claims processing errors in combination with the application of preventive measures through provider training, staff training, and timely dissemination of information relating to changes in guidelines that impact provider billing and claims remuneration. Recognizing the need to minimize claims disputes in a way that will keep such disputes at a very low level for the long term, Bridgeway restructured portions of its claims management processes to more efficiently and effectively address provider claims dispute issues. A portion of restructuring the CRS unit involved the creation of a subunit staffed by qualified Claims Liaisons who are solely responsible for researching and resolving claims disputes on behalf of providers who have complex claims issues, have a large numbers of claims for which they are inquiring, or who have requested reconsideration of claims payment (via a written appeal). This CRS subunit currently consists of two fully-dedicated Claims Liaisons (Analysts). Providers are connected with an Analyst via referral or query from their dedicated Provider Services Representative; warm-transfer when they call in through the Provider Services call center; or acknowledgement of receipt letter sent in response to appeal letters or faxes received from providers regarding their specific claim dispute, inquiry or request. Using "First Call Resolution" methodology, the CRS team is responsible for quick identification of the root cause pertaining to the specific issue in question, resolving that specific issue, and then expanding the research to encompass all other impacted providers and claims tied to the same issue. Proactively resolving other impacted providers and claims creates a constant process improvement work flow. For provider and employee training purposes, the nature of the root cause is sorted into four main categories and training occurs as follows:

1) *Provider Generated (generally coding, coordination of benefits or timely filing):* The provider is educated through an initial outreach from the Claims Liaison. If more thorough explanation is needed, Provider Relations is contacted to support, intervene, or retrain the provider's billing staff.
2) *Contract Interpretation:* Provider Relations is contacted to review the contract with the provider and address the provider's questions or concerns relating to the contract that impacts the claims in question.
3) *Plan Generated (generally a configuration issue):* The Contracts Implementation Coordinator is contacted for system configuration changes or updates.
4) *Claims Center Generated (initial adjudication issue):* Bridgeway contacts the Centene Claims Administration staff to update or augment their processes.

The CRS Unit measures its success in reaching its overarching goal to reduce the number of provider requests for claims review by monitoring trends in the following areas:

1) Reduced telephone status queries, claims adjustments, claims inaccuracies;
2) Increased provider satisfaction, claims acceptance rates from AHCCCS (i.e. encounter data); and
3) Decreased turn-around time frames on payment resolution.

A comparison of the first three quarters of 2011 to 2012 Provider Claims Disputes and Hearing Requests depicted in the table below reveals that Bridgeway's recently implemented process changes and proactive methods to reduce provider claims disputes have been effective in achieving goals and improving provider satisfaction.

	2011*	2012*
Claims Disputes	1,317	969
Disputed Claims: Provider Error	41%	62%
Disputed Claims: Plan Error	59%	38%
Hearing Requests	12	36

*Data reflects the first 3 quarters of the year

We are pleased with the trends and outcomes achieved since implementing these proactive measures and continue to see a decline in the number of claims disputes and Hearing requests. While the amount of Hearing requests shown in the table above depicts a significant increase from 2011 to 2012, the numbers largely reflect residual cases that have since been resolved and closed. Also, the spike in Hearing requests we experienced in 2012 came from one provider group that requested 23 of the 36 Hearing requests in the first three quarters of 2012 (accounts for 64% of all Hearing requests). There were no Hearing requests in November and December 2012 and we anticipate this downward trend to continue going forward. **How Bridgeway Responds to Provider Claims Disputes and Hearing Requests.** Bridgeway complies with all timely response and turnaround times as mandated by AHCCCS, the State and applicable CMS standards. The

procedures and processes we follow in responding to provider claims disputes and Hearing requests are supported by written policies that are reviewed, revised, and/or updated by our Quality Management /Performance Improvement Committee (QM/PI) at least once per year. When any provider, whether in- or out-of-network, requests a review of their claims or requests a Hearing, Bridgeway responds immediately to the provider's request and documents the interactions and activities that Bridgeway and the provider perform in resolving and closing the issue in a timely and equitable manner. Bridgeway's processes for responding to claims disputes and Hearing requests are described below.

Bridgeway's Process for Responding to Provider Claims Disputes. Bridgeway includes provider appeal rights with every remittance advice in order to ensure every provider is aware of the proper process to follow in the event they wish to dispute the claim decision. Providers will typically contact Bridgeway first by calling the Provider Services call center and inquiring about the claim denial they received. If the Provider Services Representative cannot resolve the claims inquiry to the provider's satisfaction, they will warm transfer the call to one of two Analysts (i.e. stay on the line with the provider until a live person answers the phone). If neither Analyst is able to take the "live" call, then the call is warm transferred to the on-call "Rep of the Day" who will assist the provider with their claims concern. If the provider indicates that they disagree with the claims decision and request reconsideration of payment, then the provider is instructed, per AHCCCS guidelines, to submit their appeal request in writing (can be mailed or faxed to Bridgeway). Once we receive the written appeal, we will in turn send written acknowledgement of receipt of the review request (i.e. Claims Dispute) to the provider. Along with the written acknowledgement we send to the provider, we typically request additional information from the provider, when appropriate, to expedite the review process. A claims dispute record is "opened" in the claims tracking system (collectively referred to as CRM) on the same day the acknowledgement letter is sent to the provider. Once Bridgeway formally requests additional information from the provider, the following steps occur:

A. If the provider submits the additional information within the requested time frame and the information supports the original claim submission, then the Analyst:

1. Date Stamps, scans and uploads the documents to the open dispute record in CRM for logging, inventory, and assignment of a docket number.
2. Documents investigation findings in the open claims dispute record in CRM.
3. Resubmits the claim on the provider's behalf for reconsideration of payment.
4. Sends written notice to the provider regarding the determination and right to request a Hearing if provider disagrees with the decision.
5. Changes the dispute status to "closed" in CRM.

B. If the provider submits additional information, but it is not sufficient to warrant a change, then the Analyst:

1. Scans the notes and uploads them to the open dispute record in CRM in order to date-stamp and document receipt of the information.
2. Documents investigation findings in the open claims dispute record in CRM.
3. Sends a letter to the provider of the decision and the reason(s) the original decision has been upheld and the right to request a Hearing if the provider disagrees with the decision.
4. Changes the dispute status to "closed" in CRM.

C. If additional information was not provided at all or was not provided within the requested time frame, then the Analyst:

1. Documents investigation findings in the open claims dispute record in CRM.
2. Sends a letter to the provider of the decision and the reason(s) the original decision has been upheld and the right to request a Hearing if the provider disagrees with the decision.
3. Changes the dispute status to "closed" in CRM.

Bridgeway documents and tracks all provider appeals and claims disputes and reports outcomes information to AHCCCS on a monthly basis via the Claim Dispute Report. This information is also submitted to the QMPIC at least quarterly as part of Bridgeway's quality management and performance improvement programs.

Bridgeway's Response to Provider Requests for a Hearing. All provider requests for a Hearing must be made in writing to Bridgeway. Providers can mail or fax the Hearing request to Bridgeway. Until the day of the Hearing, Bridgeway will continue to work in good faith with the provider and try to resolve the issue and avert a Hearing. Nevertheless, if the provider prefers to have his/her case heard by state authorities, Bridgeway enables the provider to exercise their right to request a Hearing using the following process:

1. If the provider verbally indicates their wish for a Hearing, but has not already submitted a written request for a Hearing, Bridgeway will advise the provider that they must submit a formal written request for a Hearing to Bridgeway.
2. Once Bridgeway receives a written request for a Hearing, Bridgeway:
   a. Date stamps the provider's written request
   b. Makes a copy of the provider's written request for a Hearing, along with copies of the claims and other documents relating to the case (to be sent to the State)
   c. Within 5 days of receiving the Hearing request, Bridgeway mails copies of the provider's Hearing request and records pertaining to the case to the State's Office of Legal Assistance as notice of the provider's Hearing request
3. Upon receiving the State's "Notice of Hearing," Bridgeway will submit a written request to the State (with copy to provider) for the Hearing to be conducted telephonically.
4. As the Hearing date approaches, Bridgeway will re-review the case to ensure every reasonable effort has been made to resolve the claims dispute and to be fully prepared for the Hearing.
   a. If upon re-review, Bridgeway is able to resolve the case to the provider's satisfaction, Bridgeway will notify the provider verbally and in writing of the decision. Written notification will include the remittance check number and payment amount along with a request and instructions for the provider to withdraw their request for a Hearing.
   b. If the provider (whose case has been resolved) fails to withdraw their request for a Hearing, Bridgeway will file a "Motion for Dismissal" with the State. The Motion for Dismissal will include proof of payment to the provider along with copies of written notices and letters sent to the provider regarding the case and steps taken to resolve the situation.
5. If a Hearing takes place, Bridgeway's next actions are dictated by the determination decision as follows:
   a. *Case Upheld* – this means determination was made in Bridgeway's favor.
      1) No further action occurs on Bridgeway's part in terms of communication with the provider (State sends written notice to provider and Bridgeway of its determination).
      2) The case is closed in the CRM system.
   b. *Case Modified* – this means some portion of the provider's claims are found to be payable.
      1) Bridgeway will make payment within 10 days of receiving the State's determination notice.
      2) Bridgeway will send a follow up notice to AHCCCS showing proof of the claim payment.
      3) The case is closed in the CRM system.
   c. *Case Overturned* – this means determination was made in the provider's favor.
      1) Bridgeway will make payment within 10 days of receiving the State's determination notice.
      2) Bridgeway will send a follow up notice to AHCCCS showing proof of the claim payment.
      3) The case is closed in the CRM system.

Bridgeway documents and tracks all provider requests for Hearings and reports outcomes information to AHCCCS on a monthly basis via the Claim Dispute Report. This information is also submitted to the QMPIC at least quarterly as part of Bridgeway's quality management and performance improvement programs. **Summary: Bridgeway Cooperates with AHCCCS to Maintain a Healthy Balance** Bridgeway understands the administrative burden that Hearings represent to the State of Arizona. Our due diligence in reducing Hearing requests is truly a function of our desire to be faithful stewards in managing the Acute Care Program on behalf of AHCCCS. While ideally we would like requests for Hearings to be zero, the reality is that some providers believe in utilizing to the fullest potential the tools afforded them via a Hearing request to get claims paid. Bridgeway will continue to do its part in properly managing claims, overseeing claims adjudication processes, training providers and staff, and monitoring activities among providers and members that could be indicative of fraud, abuse, and waste. We view AHCCCS as our partner and ally in ensuring program funds are distributed to providers for services rendered in accordance with applicable State statutes and Federal laws, rules and regulations and we remain steadfastly committed to maintaining a healthy balance of provider satisfaction while holding ourselves and our providers accountable for strict compliance with claims filing and processing rules.

10. Information Technology Systems Demonstration

10. Information Technology (IT) Systems Demonstration
Demonstrate, by participating in mock Information Systems scenarios over a 10-day period, that the Offeror will understand how to, and have the capability to, accurately and timely:
• Process data exchanged with AHCCCS
• Administer actions based on the data processed
Supplemental materials to assist in preparation for this demonstration are available in the Bidders' Library under the heading "Information Technology (IT) Systems Demonstration," and include:
• Guidelines
• 10-day Calendar
• User Guides and Manuals
These mock scenarios will begin on Tuesday, January 29, 2013. For this Submission Requirement, the Offeror shall provide written acknowledgement as follows:
• <Offeror> acknowledges that its participation in the IT Systems Demonstration beginning on January 29, 2013, constitutes fulfillment of Submission Requirement No.10
• <Offeror>acknowledges that it will comply with the stated guidelines and calendar for this process.
• <Offeror> acknowledges that the IT Systems Demonstration will be scored as part of the Offeror's Proposal

Bridgeway Health Solutions of Arizona, LLC acknowledges that its participation in the IT Systems Demonstration beginning on January 29, 2013, constitutes fulfillment of Submission Requirement No.10

Bridgeway Health Solutions of Arizona, LLC acknowledges that it will comply with the stated guidelines and calendar for this process.

Bridgeway Health Solutions of Arizona, LLC acknowledges that the IT Systems Demonstration will be scored as part of the Offeror's Proposal

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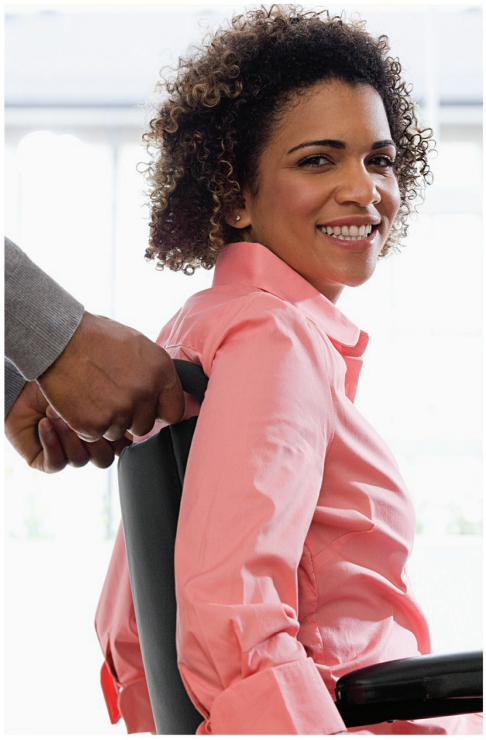

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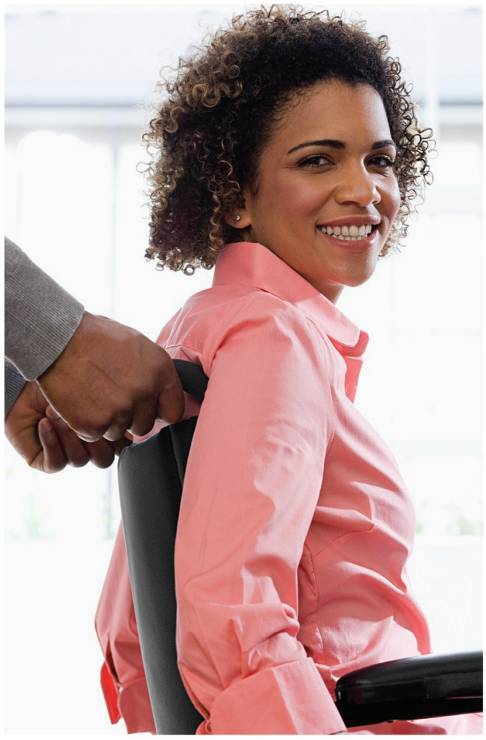
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