EXHIBIT A: OFFEROR'S CHECKLIST

The Offeror must complete the Offeror's Checklist. The Offeror's Checklist must be submitted with the Proposal and shall be the initial pages of the Proposal. The Offeror's Checklist includes all submission requirements for the Proposal. It is the Offeror's responsibility to ensure it has submitted all requirements in the RFP notwithstanding the items included in the Offeror's Checklist.

In the column titled "Offeror's Page No.," the Offeror must enter the appropriate page number(s) from its Proposal where AHCCCS may find the Offeror's response to the specified requirement. Refer also to the **Submission Requirements** outlined in RFP Section H: Instructions to Offerors.

OFFEROR'S CHECKLIST		
Submission Requirement	**RFP Section**	**Offeror's Page No.**
Offeror's Bid Choice Form	RFP Exhibit B Refer to Bidders' Library	2
Offeror's Completed and Signed RFP Solicitation Page	RFP Section A	3
Offeror's Signed Signature Page(s) for each Solicitation Amendment	Refer to Bidders' Library	5
Capitation Bid Submission		
Capitation Bid Template/Tool(s)	Instructions to Offerors	13
Capitation Actuarial Certification(s)	Instructions to Offerors	14
Executive Summary and Disclosure		
Executive Summary	Instructions to Offerors	17
Moral or Religious Objections	Instructions to Offerors	20
Narrative Submission Requirements		
Program #1	Instructions to Offerors	21
Program #2	Instructions to Offerors	26
Program #3	Instructions to Offerors	31
Program #4	Instructions to Offerors	36
Program #5	Instructions to Offerors	41
Program #6	Instructions to Offerors	46
Access to Care/Network #7	Instructions to Offerors	51
Access to Care/Network #8	Instructions to Offerors	56
Access to Care/Network #9	Instructions to Offerors	61
Administrative #10	Instructions to Offerors	66
Administrative #11	Instructions to Offerors	71
Administrative #12	Instructions to Offerors	90
Oral Presentations		
Names and Titles of Participating Individuals	Instructions to Offerors	91
Resumes of Participating Individuals	Instructions to Offerors	92
A.R.S. §35-393.01 Attestation		
Completed and Signed Attestation	RFP Exhibit F Refer to Bidders' Library	109

GENERAL SUBMISSION REQUIREMENTS

OFFEROR'S BID CHOICE FORM
EXHIBIT B

EXHIBIT B: OFFEROR'S BID CHOICE FORM

ALTCS E/PD YH18-0001 BID CHOICE

BRIDGEWAY HEALTH SOLUTIONS OF ARIZONA, INC. Offeror's Name is bidding on the ALTCS E/PD Program in the GSA(s) checked below:

GSA North: Mohave, Coconino, Apache, Navajo and Yavapai Counties
GSA South: Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma Counties
GSA Central: Maricopa, Gila, and Pinal Counties

PERMISSABLE BIDS BY GSA		
N/A	Central Only	No
N/A	Central and South Only	No
☐	North Only	Yes
☐	South Only	Yes
☐	North and South Only	Yes
☐	Central and North Only[1]	Yes
☒	Central and North and South[2]	Yes

[1]In order to be considered for award in the Central GSA, the Offeror must submit a competitive bid in the North GSA as well. A submission for the Central GSA that does not include a proposal for the North GSA will not be considered. However, AHCCCS may choose not to award a contract for both GSAs to a single Offeror. For award of GSAs see Paragraph 9, Award of Contract.

[2]AHCCCS does not intend to award contracts for all GSAs to a single Offeror. For award of GSAs see Paragraph 9, Award of Contract.

Authorized Signature — Date: 11/15/2016

PAUL BARNES — Print Name
PLAN PRESIDENT AND CEO — Title

OFFEROR'S COMPLETED AND SIGNED RFP SOLICITATION PAGE SECTION A

AHCCCS Arizona Health Care Cost Containment System	Notice of Request for Proposal
	SOLICITATION # YH18-0001
	Arizona Long Term Care System (ALTCS) Elderly & Physical Disability (E/PD) Program Contract for Contractors

SECTION A: SOLICITATION PAGE

Chief Procurement Officer
Meggan Harley
Chief Procurement Officer
AHCCCS
701 E. Jefferson, MD5700
Phoenix, Arizona 85034

Telephone: (602) 417-4538
E-Mail: EPDYH18_QuestionstoRFP@azahcccs.gov
Issue Date: November 1, 2016

LOCATION: **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION (AHCCCS)**
Procurement Office (First Floor)
701 E. Jefferson, MD 5700
Phoenix, AZ 85034

DESCRIPTION: **ARIZONA LONG TERM CARE SYSTEM (ALTCS) ELDERLY & PHYSICAL DISABILITY (E/PD) PROGRAM CONTRACT FOR CONTRACTORS**

PROPOSAL DUE DATE: **January 23, 2017** **AT 3:00 P.M. ARIZONA TIME**

Pre-Proposal Conference: A Pre-Proposal Prospective Offerors' Conference has been scheduled for Tuesday, November 8, 2016 starting at 9:00A.M. Arizona Time. The Conference will be held in the following location:

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

QUESTIONS CONCERNING THIS SOLICITATION SHALL BE SUBMITTED TO THE PROCUREMENT OFFICER NAMED ABOVE, IN WRITING, VIA E-MAIL, AS SPECIFIED IN SECTION H, INSTRUCTIONS TO OFFERORS. QUESTIONS MUST BE SUBMITTED ON THE RFP YH18-0001 QUESTIONS AND RESPONSE TEMPLATE LOCATED IN THE BIDDERS' LIBRARY. ANSWERS TO QUESTIONS WILL BE POSTED IN THE AHCCCS WEBSITE IN THE FORM OF A SOLICITATION AMENDMENT FOR THE BENEFIT OF ALL POTENTIAL OFFERORS.

In accordance with A.R.S. §36-2906, which is incorporated herein by reference, competitive sealed Proposals will be received at the above specified location, until the time and date cited. Proposals received by the correct time and date will be opened and the name of each Offeror will be publicly read.

Proposals must be in the actual possession of AHCCCS on or prior to the time and date and at the location indicated above.

Late Proposals shall not be considered.

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

Persons with a disability may request a reasonable accommodation, such as a sign language interpreter, by contacting the person named above. Requests should be made as early as possible to allow time to arrange the accommodation.

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION.

OFFER

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, amendments, and final Proposal revisions (if any). Signature also certifies Small Business Status.

Arizona Transaction (Sales) Privilege Tax License No.:

20136826

Federal Employer Identification No.:

20-4980818

E-Mail Address: pabarnes@centene.com

BRIDGEWAY HEALTH SOLUTIONS OF ARIZONA, INC.
Company Name

1850 W. RIO SALADO PARKWAY, SUITE 201
Address

TEMPE	ARIZONA	85281
City	State	Zip

For clarification of this offer, contact:

Name: PAUL BARNES

Title: PLAN PRESIDENT AND CEO

Phone: 480-567-9011

Signature of Person Authorized to Sign Offer

PAUL BARNES
Printed Name

PLAN PRESIDENT AND CEO
Title

CERTIFICATION

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

1. The submission of the offer did not involve collusion or other anti-competitive practices.
2. The Offeror shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 2009-09 or A.R.S. §§ 41-1461 through 1465.
3. The Offeror 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.
4. The Offeror 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, amendments and final Proposal revisions (if any), contained herein, is accepted. The Contractor is now bound to provide all services listed by the attached Contract and based upon the solicitation, including all terms, conditions, specifications, amendments, etc., and the Contractor's Offer as accepted by AHCCCS. The Contractor is cautioned not to commence any billable work or to provide any material or service under this Contract until Contractor receives written notice to proceed.

This Contract shall henceforth be referred to as Contract No. YH18-0001.

Award Date: _____

MEGGAN HARLEY, AHCCCS Chief Procurement Officer

OFFEROR'S SIGNED SIGNATURE PAGE(S) FOR EACH SOLICITATION AMENDMENT
AMENDMENTS 1 - 6

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

SOLICITATION AMENDMENT #1		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: **January 23, 2017** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@azahcccs.gov

A signed copy of this amendment must be submitted with your solicitation response.

This Solicitation is amended as follows:

RFP Section I: Exhibits, Exhibit E: Medicare Requirements:
Participation as a Medicare Advantage Special Needs Plan
All ALTCS E/PD Contractors will be required to provide Medicare benefits to dual eligible members as a D-SNP in all awarded counties. Contractors will be required to implement Medicare business on **January 1, 2018** and thus all Offerors are required to submit a non-binding Notice of Intent to Apply (NOIA) as a D-SNP to CMS no later than ~~**November 10, 2016**~~ November 14, 2016. Additional information and exact submission dates for 2017 can be found here: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/.

To comply with the statute A.R.S. §36-2906.01, the NOIA must be submitted under the Medicare entity name. D-SNPs must have a contract with AHCCCS to enroll ALTCS E/PD full benefit dual eligible members and must have a D-SNP subset that matches this Contract. All Offerors must also submit D-SNP applications to CMS by ~~**February 2017**~~ February 15, 2017. Additional information on D-SNPs can be found at: http://www.cms.gov/SpecialNeedsPlans.

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE:
TYPED NAME: PAUL BARNES	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: PLAN PRESIDENT AND CEO	TITLE: Chief Procurement Officer
DATE: 11/15/2016	DATE: 11/7/2016

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

SOLICITATION AMENDMENT #2		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: **January 23, 2017** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@azahcccs.gov

A signed copy of this amendment must be submitted with your solicitation response.

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 ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE:
TYPED NAME: PAUL BARNES	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: PLAN PRESIDENT AND CEO	TITLE: Chief Procurement Officer
DATE: 12/14/16	DATE: 11/21/2016

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

SOLICITATION AMENDMENT #3		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: **January 23, 2017** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@azahcccs.gov

A signed copy of this amendment must be submitted with your solicitation response.

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 ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE:
TYPED NAME: PAUL BARNES	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: PLAN PRESIDENT AND CEO	TITLE: Chief Procurement Officer
DATE: 12/28/2016	DATE: 12/19/2016

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

SOLICITATION AMENDMENT #3		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: **January 23, 2017** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@azahcccs.gov

A signed copy of this amendment must be submitted with your solicitation response.

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 ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE: SIGNATURE ON FILE
TYPED NAME: PAUL BARNES	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: PLAN PRESIDENT AND CEO	TITLE: Chief Procurement Officer
DATE: 1/9/2017	DATE: 01/06/2017

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

SOLICITATION AMENDMENT #4		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: **January 23, 2017** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@azahcccs.gov

A signed copy of this amendment must be submitted with your solicitation response.

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 ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE: M Harley
TYPED NAME: PAUL BARNES	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: PLAN PRESIDENT AND CEO	TITLE: Chief Procurement Officer
DATE: 1/9/17	DATE: 1/4/2017

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

SOLICITATION AMENDMENT #4		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: **January 23, 2017** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@azahcccs.gov

A signed copy of this amendment must be submitted with your solicitation response.

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 ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE: SIGNATURE ON FILE
TYPED NAME: PAUL BARNES	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: PLAN PRESIDENT AND CEO	TITLE: Chief Procurement Officer
DATE: 1/9/17	DATE: 01/06/2017

SOLICITATION AMENDMENT #5		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: **January 23, 2017** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@azahcccs.gov

A signed copy of this amendment must be submitted with your solicitation response.

This Solicitation is amended as follows:

1. The attached IT Demo Calendar revisions are incorporated as part of this solicitation amendment.

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE:
TYPED NAME: Paul D. Barnes, PhD	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: President	TITLE: Chief Procurement Officer
DATE: 1/12/17	DATE: 01-11-2017

SOLICITATION AMENDMENT #6		
YH18-0001 ALTCS E/PD RFP	Solicitation Due Date: **January 23, 2017** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: EPDYH18_QuestionstoRFP@azahcccs.gov

A signed copy of this amendment must be submitted with your solicitation response.

This Solicitation is amended as follows:

Section D: Program Requirements, Paragraph 80 – Value- Based Purchasing

Value-Based Purchasing Initiative: The purpose of the VBP initiative is to encourage Contractor activity in the area of quality improvement by aligning the incentives of the Contractor and provider through VBP strategies, as delineated by ACOM Policy 318 CYE 16 and CYE 17 and as specified in Attachment F3, Contractor Chart of Deliverables. Quality distributions to Contractors will be funded by assessing 1 percent of Prospective Gross Capitation (Quality Contribution) exclusive of Acute Care Only payments. One hundred percent (100%) of the Quality Contribution will be distributed to one or more Contractors according to the Contractors' performance on selected Quality Management Performance Measures relative to minimum performance standards established by CQM and the Contractors' ranking on QMPMs. Quality contributions and quality distributions will be settled through a reconciliation performed annually on a Contract Year basis. It is the intent of AHCCCS to require that the Contractor move to the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model Framework with a focus on Categories 2, 3 and 4 effective October 1, 2017. Additionally, AHCCCS intends to update ACOM Policy 318 CYE 16 and CYE 17 requirements regarding the percentage of payments that must be governed by VBP strategies. That language shall require that both the ALTCS E/PD Contract, and the MA-DSNP Contract for ALTCS E/PD Duals, each reach 35% and 50% of total payments governed by VBP strategies for CYE 18 and CYE 19 respectively. Inclusion of payments for Room and Board for members residing in Nursing Facilities (which are included in per diem payments and not separately identifiable) are permissible when computing the percentage of total payments that are governed by VBP strategies.

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE: SIGNATURE ON FILE
TYPED NAME: PAUL BARNES	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE: PLAN PRESIDENT AND CEO	TITLE: Chief Procurement Officer
DATE: 1/17/17	DATE: 01-17-2017

CAPITATION BID SUBMISSION

CAPITATION BID TEMPLATE/TOOLS(S)

ALTCS/EPD RFP Bid Template - Bridgeway Health Solutions of Arizona, Inc.

Scored Rate Components by Risk Group and GSA

Dual	North	South	Central
Medical Component	$2,593.32	$2,782.09	$2,847.45
Case Management Component	$141.33	$139.83	$142.44
Administrative Component	$178.68	$151.77	$139.90
Sub-Total of Scored Components	$2,913.33	$3,073.69	$3,129.79

Non-Dual	North	South	Central
Medical Component	$5,238.19	$5,628.30	$6,227.87
Case Management Component	$152.45	$145.95	$147.20
Administrative Component	$365.77	$295.82	$305.96
Sub-Total of Scored Components	$5,756.41	$6,070.07	$6,681.03

1/18/17 12:28

CAPITATION ACTUARIAL CERTIFICATION(S)

Milliman

1301 Fifth Avenue
Suite 3800
Seattle, WA 98101-2605
USA
Tel +1 206 504 5676
jason.nowakowski@milliman.com

January 18, 2017

Actuarial Certification
Bridgeway Health Solutions
Arizona Long Term Care System
Elderly & Physical Disability
Capitation Bids for Time Period: October 1, 2017 – September 30, 2018
Regarding: Solicitation # YH18-0001

I, Jason T. Nowakowski, am a Principal and Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries. I am also a Member of the American Academy of Actuaries and meet its Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States. I have been retained by Bridgeway Health Solutions (Bridgeway) to provide a certification of the actuarial soundness of its proposed capitation rates for Elderly & Physical Disability Services under the Arizona Long Term Care System (ALTCS).

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

Bridgeway is opting to provide bids in each of the Geographic Service Areas (GSAs): North, South, and Central. While AHCCCS does not intend to award contracts for all GSAs to a single offeror, the RFP instructions permit a bid for all three GSAs. This certification covers all three GSAs. Per the instructions in the RFP, a single certification covering all three GSAs is permissible.

The capitation rates to which this certification applies are on a per-member-per-month (PMPM) basis and are shown in the table below. The rates apply to the time period October 1, 2017 through September 30, 2018. There are three rates for each combination of GSA (e.g., North, South, and Central) and risk type (e.g., Dual and Non-Dual). The three rates are for medical, case management, and administrative expenses.

Per the RFP instructions, the medical rate is based on the state's prescribed mix of Home and Community Base Services (HCBS) members and Nursing Facility (NF) members and is gross of member Share of Cost (SOC) and reinsurance.

Per the RFP instructions, the bid rates do not reflect premium tax or risk margin loads.

Bridgeway Health Solutions - Capitation Bid effective 10/1/2017 - 9/30/2018						
GSA	North		Central		South	
Risk Type	Dual	Non-Dual	Dual	Non-Dual	Dual	Non-Dual
Bid Prescribed HCBS Mix:	69.00%	75.61%	76.25%	75.86%	72.00%	74.50%
Medical Expense	$2,593.32	$5,238.19	$2,847.45	$6,227.87	$2,782.09	$5,628.30
Case Management Expense	$141.33	$152.45	$142.44	$147.20	$139.83	$145.95
Administrative Expense	$178.68	$365.77	$139.90	$305.96	$151.77	$295.82

Based on my review of the available data and other information, it is my opinion that the above proposed rates are actuarially sound, in consideration of the population covered under this RFP.

For the purposes of this certification, Medicaid capitation rates are defined being "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows (not applicable in this case), governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, and administrative expenses. Please note that this certification is made with the understanding that provisions for taxes and risk margin will be added to the above rate by AHCCCS.

I have relied upon the financial results, eligibility data, historical utilization and cost data, and rate development assumptions provided by AHCCCS in the RFP information. In addition, I have relied on financial results, eligibility data, historical utilization and cost data, and other representations made by Bridgeway. This information has been supplemented with Milliman research and my judgment. I performed no independent audit of the underlying data, but did perform appropriate reasonableness checks.

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

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

Jason T. Nowakowski, FSA, MAAA
Milliman, Inc.
1301 Fifth Avenue, Suite 3800
Seattle, WA 98101-2605

January 18, 2017

EXECUTIVE SUMMARY
AND DISCLOSURE

EXECUTIVE SUMMARY

AZ REQUEST FOR PROPOSALS SOLICITATION # YH18-0001

EXECUTIVE SUMMARY AND DISCLOSURES

***Executive Summary:* The Offeror must provide an Executive Summary that includes an overview of the organization…**

OVERVIEW OF ORGANIZATION

Bridgeway Health Solutions® (Bridgeway) is pleased to have the opportunity to respond to the Request for Proposal for Arizona Long Term Care System (ALTCS) Elderly & Physical Disability (E/PD) Program YH18-0001. Bridgeway is an established, Arizona based company providing care to Arizona members through the ALTCS program and complying with AHCCCS regulations since 2006. Collectively, our executive leadership team has an average of 12 years of experience in the ALTCS program and average 9 years of DSNP experience. We are a recognized leader in maintaining a member-centric focus, developing innovative programs and practices and collaborating with local practitioners and service providers to carry out the ALTCS Program Vision, Values, and Guiding Principles while continuously improving program performance and efficiency.

Bridgeway's more than 10 years of experience 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. We bring to the table a culture of engagement with members and providers to deliver member-centric, culturally competent, integrated long-term, acute and behavioral health care services. We collaborate with providers, advocates, and other stakeholders as community partners in achieving high quality, efficient and effective services for our members and high satisfaction levels for all stakeholders.

RELEVANT EXPERIENCE

Bridgeway provides managed care services for approximately 5,300 ALTCS members in Maricopa, Pinal, Gila, Cochise, Graham, and Greenlee counties. Through this program, we manage members' medical, behavioral, pharmacy, vision, dental, and transportation services as well as both facility and home and community-based (HCBS) services. Bridgeway's affiliated Regional Behavioral Health Authority, Cenpatico Integrated Care, provides whole person health care including medical and behavioral health services to members in Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma counties. Additionally, Bridgeway has prior experience in serving members under the Acute Care Program in Yavapai County.

Bridgeway Experience

Central Region: Maricopa, Pinal, Gila

South Region: Graham, Greenlee, Cochise Pima, Santa Cruz, Yuma (DSNP 2008-2010)

North Region: Yavapai (Acute 2008-2013)

Cenpatico Integrated Care Experience

Central Region: Pinal

South Region: Cochise, Graham, Greenlee, LaPaz, Pima, Santa Cruz, Yuma

Provider Partnerships. Bridgeway recognizes the importance of partnering with our providers to ensure integrated, high quality care for our members. Bridgeway is committed to recognizing providers that support creative programs addressing member care within our Arizona communities. For example, in September 2016 we announced our Behavioral and Physical Health Integration award recipients from the Transitioning Care Awards Luncheon. Helping Hearts and COPE were awarded 1st ($10,000) and 2nd ($5,000) place respectively while The Bridge Group of Arizona received an Honorable Mention ($1,500). Bridgeway also funds provider partners and stakeholders to increase public awareness of direct care and to promote workforce development. Bridgeway is currently the **only platinum level sponsor of the Arizona Direct Care Workforce Initiative**. We also sponsor entities like the National Diversity Council, the Arizona in Home Care Association, and participate in community events such as "Cochise Serving Veterans" to share information about becoming a direct care worker or behavioral health paraprofessional. We would continue to seek out targeted key partnerships throughout the contract to increase the supply of workers to meet our members' needs.

Since the launch of ACCCHS VBP initiative Bridgeway has had a strategic focus on and are actively engaged in designing and implementing VBP initiatives with our provider networks. We have designed VBP initiatives ranging from pay for performance to gain sharing models to meet providers where they are, and provide the education, training, and data necessary to advance their readiness. For example, we have VBP arrangements with Optum, Banner and Ensign.

Improved Health Outcomes. Bridgeway has demonstrated experience supporting individuals in need of LTC to: 1) receive higher quality care in long term facilities, 2) ensure least restrictive community settings, and 3) provide access to reliable and member-driven community-based LTC to avoid facility placement. For example, our Enhanced Care Transition Program, which focuses on members as they are facing vulnerable transitions of care from a hospital, Skilled Nursing Facility (SNF), acute rehab, or LTC stay to home achieved a **6% reduction in our all-cause readmission rate and a 5% reduction in our rate of same-cause readmissions** among participants in this initiative. After implementing a home testing kit program in 2014, Bridgeway's colorectal screening rates for our DSNP members increased 8% in just one year. Similarly, after implementing a gift card incentive program, our rate of mammograms for DSNP members rose 11%. Bridgeway's Health Fairs have proven highly successful in closing care gaps for members, ultimately improving their health. We have hosted larger health fairs in urban settings and mini-health fairs for smaller communities, such as Douglas and Sierra Vista. In one case, a retinal exam performed at the health fair screened positive for glaucoma and we were able to refer the member to an appropriate provider for treatment.

Leveraging National Experience. Bridgeway's parent company, Centene, is a national leader in LTC managed care programs, having the largest LTC membership across the nation. Centene manages LTC in six states for individuals diverse in age and disability, including elders with chronic conditions and individuals with physical disabilities, intellectual disabilities, and brain injuries. Combined, Bridgeway and its affiliate health plans have almost 30 years of experience supporting LTC members to access the high quality, member-driven support they require.

Bridgeway is committed to:

- Our Members
- Our Providers
- Our Customers (regulators)
- Our Communities
- Our Coworkers

PROPOSED APPROACH TO MEETING REQUIREMENTS

Bridgeway's approach to meeting the needs of ALTCS members will draw from its existing experience and the experience and success of Centene and its affiliate health plans that currently serve all segments of the Medicaid population including five affiliate health plans supporting members who receive long-term services and supports. Each of Centene's LTC health plans work directly with our dedicated Corporate LTC product team with industry leadership experience to share best practices and to develop systems of care unique to each of our state contracts.

Operating with the same philosophy as our parent company: quality health care is best delivered locally, Bridgeway's local presence allows us to better understand the barriers that both members and providers face in receiving and providing quality health care services. Our local approach enables us to provide accessible, high quality and culturally/linguistically sensitive health care services to our members. Our managed care model uses integrated programs that can be delivered effectively only by a local staff, resulting in meaningful job creation within Maricopa County. Because staff is local, all Centene health plans have a strong connection with the communities they serve. This approach to managing health plans ensures that members, providers, state agencies and community resource agencies are able to partner with trusted individuals from their communities and that all stakeholders have direct access to local, accountable health plan staff.

Our proposed solutions for the ALTCS Program begin with effective member engagement and a robust, well-supported provider network. We provide the support and information members need to take charge of their health and access services appropriately, through a member-centric, whole health approach. A dynamic health care system requires frequent changes and we recognize the need to continually re-focus to make the necessary adjustments that will result in the most beneficial quality outcomes for our members.

BRINGING ADDED VALUE TO THE PROGRAM

Bridgeway is a trailblazer, both in Arizona and for Centene, in developing crucial LTC community partnerships, such as supporting Centers for Independent Living and Area Agencies on Aging to assume key roles within managed care and participating in community taskforces to enhance the direct care workforce. Bridgeway also has a long history of establishing trusting relationships with facility providers as seen in their partnership with the National Association of Health Care Assistants to promote use of online worker training and worker career ladders.

Current and Proposed Innovations. As further illustrated in our responses to the scenarios herein, Bridgeway has implemented a variety of innovative programs to improve quality health outcomes, contain program costs and increase member satisfaction. For example, Bridgeway is piloting technology innovations to improve outcomes such as

our **Passive Sensor Pilot**, which, upon agreement from the member, uses passive sensors installed in members' homes to remotely monitor patterns in activities of daily living and sends information on changes in activity to their case manager and caregiver as appropriate. Bridgeway has also begun working with Fire Departments and Emergency Medical System agencies participating in the **Treat & Refer Community Paramedicine Program**, starting with Chandler Fire Department, to identify our members who are at risk for emergency room utilization or hospital admission. Through this program, participating EMS providers create a treatment/referral plan to address the needs of individuals who call an emergency number but do not require transport to the ED based on their clinical condition. Working with the EMS providers, Bridgeway case managers can identify our members who contacted emergency services and follow up to connect them to their PCP, as needed, and address any barriers to care.

Centene's affiliate health plans have also piloted effective interventions focused on dual members that Bridgeway will be able to adopt. The **Palliative Care Pilot** (Compassionate Connections®) in Ohio, which Bridgeway will be rolling out for our members, resulted in a significant reduction ($p < 0.05$) in the ED spend when comparing the three month period prior to the member's initial palliative care visit to the three months following this visit. Bridgeway will also implement an **Electronic Pill Box** program for improved medication adherence, currently being piloted by our Texas affiliate. This technology will especially help members with cognitive issues as it reminds the member to take their medication. Bridgeway will implement Centene's new diabetes management program, **On.Demand**, which monitors blood glucose data real-time through cellular enabled blood glucose meters and web-based technology. On.Demand provides proactive and reactive health coaching, population health reporting, and customizable interventions. In our affiliate plan in Mississippi, On.Demand program helped reduce all cause readmissions by 58% and ED visits by 55% for participants compared to control group.

With approval from AHCCCS, Bridgeway also proposes to implement Centene's **CentAccount Health Rewards** program. Members will be provided a re-loadable rewards card, which can be used to purchase items and products to drive healthy behaviors and healthy outcome. Members can earn dollar rewards by staying up-to-date on comprehensive diabetes screenings. Members will be able to buy things like groceries, as well as certain over-the-counter drugs (allergy, cold meds, etc.) and other personal care items (deodorant, soap, shampoo, etc.). Members will be able to use their reward card at a select number of retailers including Wal-Mart, Dollar General and Family Dollar stores.

Several Bridgeway affiliates have implemented an Interactive **Community Resources Referral Connections** system powered by technology from one of the nation's leading social service search, referral, and workflow systems. With approval from AHCCCS, this tool allows us to connect members to community organizations who serve members in both urban and rural areas. The Community Resources Referral Connections system provides an expanded resource database which can connect members with resources to overcome barriers such as food insecurity, substandard housing, and limited access to affordable transportation. A dedicated data team reviews and approves newly identified social service programs to increase resource availability and help ensure access across urban and rural areas.

MEETING MEDICARE REQUIREMENTS

Since its 2008 entry into the Arizona Medicare DSNP market in Maricopa County, Bridgeway has demonstrated success in improving outcomes and experiences for dual members – achieving a Medicare 4 Star rating in 2016. In addition to Maricopa, Bridgeway now operates DSNP programs in Graham, Greenlee, Cochise and Gila counties effective 1/1/2016. For Pinal County, Bridgeway established a DSNP look-alike plan which began operations 1/1/2017 to ensure members receive the full suite of integrated Medicare and Medicaid services until Bridgeway is able to begin operations of its formal DSNP program effective 1/1/2018. Bridgeway currently serves over 1,650 members in our DSNP plans. Additionally, Bridgeway previously operated DSNP programs in Pima, Santa Cruz, and Yuma counties from 2008 – 2010.

Bridgeway acknowledges the requirement to offer a Medicare Advantage DSNP in all awarded counties and have submitted our Notice of Intent to Apply to CMS for expansion of our DSNP program to additional counties awarded under this RFP. As part of the application process, Bridgeway has been actively developing provider networks in service expansion counties in accordance with CMS and AHCCCS adequacy standards.

In summary, Bridgeway brings more than 10 years of experience in both urban and rural areas, our established provider partnerships, and innovative health programs that together have resulted in improved health outcomes.

MORAL OR RELIGIOUS OBJECTIONS

AZ REQUEST FOR PROPOSALS SOLICITATION # YH18-0001

EXECUTIVE SUMMARY AND DISCLOSURE

Moral or Religious Objections

The Contractor shall notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. The Contractor may submit a Proposal addressing members' access to the services. AHCCCS does not intend to offer the services on a Fee-For-Service basis to the Contractor's members. The Proposal shall be submitted to AHCCCS in writing as part of this submission. This submission will not be scored.

Bridgeway Health Solutions has no moral or religious objections to covered services; will provide or reimburse for covered services; and is not submitting a Proposal to address members' access to the services.

NARRATIVE SUBMISSION REQUIREMENTS

AZ REQUEST FOR PROPOSALS SOLICITATION # YH18-0001

NARRATIVE SUBMISSION REQUIREMENTS

Program #1: An 85 year old American Indian member currently enrolled with the Offeror, with Medicare Part A and Part B, and unknown tribal affiliation resides alone in Parker…

Bridgeway Health Solutions®' (Bridgeway) person-centered approach for this member, *whom we will call Mary throughout this scenario*, aims to maintain her safely in her home and maximize her quality of life through a variety of Bridgeway services and supports for health and activities of daily living, as well as significant, proactive cross-system coordination to connect her to needed non-Bridgeway services and achieve integration of care. We seek to sustain her connections to her circle of support and community, which will promote aging in place and quality of life, and support her cultural needs through helping her to continue accessing covered and non-covered Tribal services as she desires. In addition to addressing her clinical needs, we understand the critical nature of addressing cognitive issues. While evaluating medications is a key first step to dealing with her memory and confusion, these issues may result from cognitive decline which will require education and support not only for Mary, but also her caregiver(s)/circle of support.

Below we discuss how we manage care to achieve the best outcomes for Mary including: ensuring continuity of care during transition back to Bridgeway and preparation for initial contact after she re-enrolls; conducting person-centered assessment and planning; a sample care plan and how we coordinate services and supports; and monitoring services and supports to ensure progress and member satisfaction. We also discuss how we integrate data across systems and spans of eligibility to ensure a holistic picture of each member's needs and care so that we can provide timely, appropriate interventions to maximize member outcomes.

ENSURING CONTINUITY DURING TRANSITION AND PREPARATION FOR MEMBER VISIT

Upon receipt of enrollment transition information (ETI) from the relinquishing plan or, if no transition information is received, upon enrollment, the Transition Coordinator (TC) immediately initiates care coordination by outreaching to the relinquishing plan and providers to obtain additional information about existing ALTCS, IHS, and 638 services. The TC provides authorizations for ongoing covered services to existing providers (regardless of network status) for at least 30 days or through the end of the duration of active treatment, as applicable, and notifies the Case Management Supervisor of the new enrollment to initiate the Case Management process and assign a Case Manager (CM). The CM contacts Mary via phone within 7 days of enrollment to welcome her to Bridgeway, verify immediate needs and existing services/providers (including 638 and traditional healing services), and educate her to continue accessing covered services with no change until a new care plan is authorized. The CM determines that Mary would like her daughter to participate in the person-centered planning process, and schedules a visit with Mary and her daughter at Mary's home within 12 days of enrollment. The CM reviews transition information as well as information from Mary's previous spans of enrollment to prepare for the initial meeting. Through review of Case Management notes and authorizations from her previous spans of eligibility with Bridgeway, the CM sees that Mary's condition has deteriorated over time, including increased confusion. The CM also contacts providers, including Medicare and Tribal providers, for updates on Mary's status and services.

PERSON-CENTERED ASSESSMENT AND CARE PLANNING MEETING

During the home visit, the CM uses natural dialogue to assess Mary's functioning and conditions using the Uniform Assessment Tool and Comprehensive LTC Assessment, which includes but is not limited to the PHQ-4 (depression and anxiety), a home environment evaluation, and quality of life-related National Core Indicators. The CM asks to see all prescriptions and attempts to determine what Mary is actually taking, how much, and how often. The CM facilitates a discussion of Mary's goals for her health and quality of life using Motivational Interviewing to promote active engagement in identifying what is important to her. Mary's goals and wishes drive the discussion, and the CM capitalizes on opportunities that arise naturally to educate Mary and her daughter in order to further support their ability to evaluate Mary's needs and determine how best to address them.

They discuss Mary's memory issues and confusion taking medications. The CM asks if Mary would consent to a neuropsychological exam to evaluate decision-making capability. When the daughter expresses interest in pursuing power of attorney for health care, financial, and other decisions, the CM indicates that since Mary lives in the area of Parker that is on reservation land, they will need to work through the Tribal court system. The CM will connect them to

that system and coordinate to ensure all necessary information is available for the Tribal court. The CM notes that Mary has a completed advance directive (AD), and will verify at each visit whether it still reflects Mary's wishes.

This leads to discussion of the availability of family or friends to support Mary due to her cognitive issues. The daughter visits twice a week to do laundry, grocery shop, and cook but does not have time to provide daily assistance. Mary feels bad asking her daughter for help but doesn't have anyone else she feels comfortable asking. She wants to remain in her home but, because she knows she is forgetful and doesn't like to drive anymore, she is worried that she will have to go to a nursing facility. The CM educates them about Mary's right to remain in her home as the least restrictive setting, and they discuss HCBS services available to support her safely. The CM also discusses the availability of traditional, as well as, Self Directed and Agency with Choice attendant care options. Since the daughter is not available every day to help oversee the attendant, they select the traditional option.

Bridgeway will leverage the experience of our affiliate, Cenpatico Integrated Care (CIC), in developing relationships with Tribes and collaborating with Tribal providers. CIC has an agreement with the Colorado River Indian Tribes (CRIT) that allows CIC and its providers to deliver services on the CRIT reservation.

Mary mentions that, prior to developing panic disorder and agoraphobia, she enjoyed spending time at the Mo-Chem-Ho-Na Senior Citizen Center and attending Tribal events with her family. She would like to resume these activities once her panic disorder is controlled because the connection to her culture is very important to her. The CM asks whether Mary's multiple transitions between Bridgeway and Tribal ALTCS are related to this. The daughter indicates that she changes to Tribal ALTCS when she needs to access the Primary Care Provider (PCP) at Parker Indian Hospital but switches back to Bridgeway to go to La Paz Regional Hospital. The CM educates them that Mary may access both providers while enrolled with Bridgeway, regardless of network status. The CM also corrects their erroneous belief that Mary must be in Tribal ALTCS to access 638 and traditional healing services. The CM coordinates with our Provider Relations staff to outreach to Parker Indian Hospital to educate the facility about how to contact us when Mary presents for services to ensure continuity and coordination of care. We also educate the facility that ALTCS members may access Tribal/638 services.

The CM verifies whether Mary desires to remain with her current providers across ALTCS, Medicare, and Tribal systems or select new ones. Mary likes her providers, but neither she nor her daughter understands the differences between the systems. The CM educates Mary and her daughter on how the systems differ, which providers and services are accessed through each, Mary's rights with respect to each system, and how the CM can assist in coordinating across systems.

The CM works with Mary and her daughter to develop the care plan, including the service plan and quality of life plan, to help Mary remain safely in her home and make progress toward her goals. They also develop a Contingency Plan to indicate how any service gaps will be addressed. Mary signs the plan to indicate agreement. The CM shares the plan, assessment results and Mary's goals with our internal Interdisciplinary Team (IDT). The team behavioral health (BH) clinician provides recommendations to address depression, panic disorder and agoraphobia. The team social worker provides input on community services for Mary's social and economic needs. Our pharmacy staff provide input on medication issues. IDT recommendations reflect the importance of culture in addressing health care needs.

Prior to service initiation, or within 12 business days of enrollment if Mary is already receiving services, the CM completes a cost effectiveness study (CES) to ensure the HCBS in Mary's service plan are within 100% of the net cost of institutional services for her level of care as determined by the UAT, and enters CES data in the Client Assessment Tracking System within ten business days of the action.

The CM shares all recommendations, assessment results, and Mary's goals with her treating providers and PCP to obtain their input on the care plan. The CM discusses any provider-recommended changes with Mary and her daughter to obtain approval and sign-off. To assist them in keeping track of appointments and medications, the CM provides Mary with our *My Care Planner* booklet and our *My Caregiver Journal* booklet to the daughter.

PERSON-CENTERED CARE PLAN

Mary's care plan, highlighted in the table below, includes the following services and support, based on goals that, in our experience, would be typical for the member described in this scenario.

MEMBER GOAL	PERSON-CENTERED CARE/SERVICE PLAN	FOCUS AREAS
Feel safe leaving house	• Evaluation/treatment from Medicare psychiatrist • Bridgeway depression disease management program • Peer support services for agoraphobia • Therapeutic BH services	**Depressive Disorder** **Panic/Agoraphobia**
Prevent another stroke	• Evaluation/treatment from Medicare neurologist • Preventive visit, flu shot via Medicare PCP	**CVA/Ischemic History** **Preventive Care**
See clearly	• Evaluation/treatment from Medicare ophthalmologist	**Cataracts**
Be safe taking medications and take as ordered by prescriber	• Medication management via Medicare home health • Electronic pill box to help ensure and track adherence	**Medication Support**
Remain living alone in the home	• Attendant care for activities of daily living assistance • Life Alert to access emergency assistance • Bridgeway passive sensor program to detect risks • Bridgeway Connections Plus® Program for phone access	**Functional Supports**
Return to Tribal senior center activities and participate in traditional healing services	• Caregiver support, social opportunities through Region 8 Inter Tribal Council of Arizona Area Agency on Aging (ITCA-AAA) • ITCA-AAA fall prevention program • Caregiver support via ITCA-AAA • Traditional healing services via Tribal provider • IHS Community Health Representative program	**Social Supports**

Coordination Across Systems. Since Mary receives traditional Medicare and has no Medicare case manager, our CM proactively connects Mary to needed Medicare services as described below. This includes helping to schedule appointments and arrange transportation. The CM alerts her Medicare providers who do not participate in our ALTCS or DSNP networks as well as her IHS/Tribal providers that they may register to access Mary's ALTCS care plan and utilization history via our Provider Portal. The CM also shares contact information among all of Mary's providers to facilitate communication, and educate them about the assistance Bridgeway can provide to support coordination, such as facilitating joint service planning across all Mary's providers regardless of system. We will leverage the relationships of our affiliate, CIC, the South Region Regional Behavioral Health Authority, in engaging IHS/Tribal providers in coordination and joint service planning. The CM also talks to Mary and her daughter about the benefits of enrolling in a DSNP, as well as enrolling the same plan for both ALTCS and Medicare. If they express interest, the CM provides a referral to our DSNP to learn how to enroll.

BH Conditions. The CM connects Mary to a BH provider of her choice for clinical evaluation and treatment of her depression, panic disorder, and agoraphobia. Potential providers include Community Health Associates (CHA) in Parker, which offers in-home BH telemedicine services (ensuring Mary can get care even if she is unable to go to CHA's clinic due to her agoraphobia) and peer support services. CHA also offers primary care services which would give Mary the choice to address both BH and primary care needs in a single location, which may help prevent panic attacks from going to multiple locations, as well as enhance integration. Another possible provider is Colorado River Indian Tribes Behavioral Health Department, which has licensed staff and a visiting psychologist onsite twice a month, as well as peer support. Our affiliate, CIC, is working with CRIT BHD to develop telemedicine capabilities and/or provide telemedicine at their site via a CIC provider. The CM ensures initiation of Therapeutic Home Care Services to provide additional BH support in the home. The CM links Mary to our Depression Management Program, introducing her via phone to the Health Coach, who will provide ongoing coaching and assistance to promote self-management and medication adherence, identify potential side effects, and support the provider's treatment plan.

CVA/Ischemic History. The CM connects Mary to her current neurologist for clinical evaluation and treatment of her CVA. The CM assists in coordinating any rehabilitation referral and arranging transportation as needed.

Cataracts. The CM connects Mary to one of the multiple ophthalmologists available in and near Parker to discuss treatment for her cataracts. If the provider recommends surgery, the CM assists with transportation to and from the procedure, and coordinates with the provider to ensure any necessary home care services are in place following the surgery. Bridgeway covers all Medicare coinsurance and deductibles for the consultation exam, procedure, and related services including any intraocular lenses.

Medication Support. The CM provides an immediate referral to the Limited Income Newly Eligible Transition (NET) Program which provides interim prescription drug coverage for low-income beneficiaries who do not yet have Part D. The CM also educates Mary about Part D benefits and how to enroll. The CM discusses Mary's medication issues and other assessment results with her Medicare PCP to obtain home health services for medication management and a medication set up. The CM provides Mary with an electronic pill box that the home health nurse will set up. The pill box makes it easy for Mary to remember what medications to take when, and allows the nurse and the CM to track adherence. If Mary receives eight or more prescriptions monthly, we will conduct a medication review to optimize or discontinue medications using a whole-person approach that takes into account all medications across prescribers.

Functional Supports. The CM authorizes and arranges for initiation of attendant care services to assist with activities of daily living. We provide an emergency alert system so Mary can quickly request help in emergency situations. If Mary lacks phone access, the CM assists her to obtain a Safelink phone or, if she is not eligible, provides a phone via our Connections Plus program to ensure ability to communicate with the CM, providers, our 24/7 nurse line, and 911. The CM offers to enroll Mary in our Healthsense Passive Sensor Program to support aging in place through early detection of emerging risk. Security-system style motion and contact sensors (no cameras or microphones) placed throughout the home monitor daily activity patterns. A proprietary algorithm identifies changes that indicate potential condition changes (such as an increase in time spent in bed which may indicate worsened depression or an ischemic event, or increased toilet use which may indicate medication side effects) and send an alert to the CM who will check on Mary to evaluate for needed intervention.

In a 12 month study (2014-15), Healthsense reduced:

- ED costs 34%
- LTC costs 68%
- Acute Hospitalizations 32%

for participants compared to a matched historical control group

Preventive Care. The CM connects Mary to her Medicare PCP for preventive services, such as flu shots and preventive screenings. At each CM follow up, the CM will complete our CM Performance Measure tool which tracks member receipt of key preventive services such as flu shots and chronic condition preventive services to prevent and address any care gaps.

Social Supports. Based on cultural background and her preferences, the CM connects Mary to Tribal providers. Bridgeway can leverage the experience of our affiliate, CIC, which received Substance Abuse & Mental Health Block Grant funds from AHCCCS to pay for traditional healing. The grant requires CIC to make funding available to other AHCCCS plans for these services. While a sweat lodge is the most common type of traditional healing service, this may not be appropriate given Mary's health conditions. We would coordinate between her PCP and traditional healers to ensure access to appropriate traditional healing services and Tribal peer support. The CM also connects her to an IHS Community Health Representative from the CRIT Health Department for additional support. The CM provides the daughter with a referral to the Family Caregiver Support Program through the Region 8 Inter Tribal Council of Arizona Area Agency on Aging. Once Mary's panic disorder and agoraphobia are more controlled, the CM assists her to access socialization opportunities through the Mo-Chem-Ho-Na Senior Citizen Center.

MONITORING AND REASSESSMENT

The CM contacts Mary and providers to ensure services were initiated within required timeframes and that she is satisfied with her services and providers. Ongoing, the CM monitors Mary's utilization to identify new or changed needs and track prescription adherence. The CM works closely with providers across systems to monitor and share information about changes in Mary's physical, behavioral health, or functional status, including any emergency department or inpatient admissions. If Mary receives psychotropic medications, is not stable on the medication, or the provider adjusts the medication, the CM reviews Mary's case with our BH Coordinator and Pharmacist at least quarterly. If they identify concerns (such as ineffective medications, adverse effects), they contact the prescriber(s) to discuss the concerns.

As noted above, the CM is supported by our IDT and our interdisciplinary review process for any problems or complex issues that arise. For example, the IDT may examine the impact of Mary's BH medications on her confusion.

The CM conducts an in-person reassessment at least every 90 days and any time there is a condition change or Mary requests care plan changes. The CM reviews established goals, including quality of life goals, with Mary at each visit and determines the extent to which they are being met, as reported by Mary and her daughter and reflected in her health and functional status and utilization of acute services. The CM documents progress toward goals, which includes identifying strengths, and member-desired changes to goals, action plans, or the back-up plan, and justification for service continuation. Service adjustments are based on changes in overall condition and her strengths, needs, and goals. The CM initiates the Notice of Action Policy and Procedure for service reduction, termination or suspension.

INTEGRATING INFORMATION TO ACHIEVE CONTINUITY AND INTEGRATION OF CARE

This scenario reflects a key challenge to achieving the best outcomes for American Indian as well as dual eligible members, who can access care from multiple systems, which is that the full picture of their utilization and needs is not available via a single repository. We meet this challenge through our Centelligence® healthcare informatics system (an integrated component of our enterprise MIS) which can receive and integrate data from multiple sources, including non-participating providers and other systems.

Bridgeway would be continually aware of the member's history, risk level, and needs, including services from Medicare and Tribal ALTCS, via the AHCCCS Blind Spot data, which we integrate into Centelligence, and our use of the Arizona Health-e Connection (AzHeC) Health Information Exchange (HIE). We have integrated AzHeC into our workflow for several years, accessing medical data and Admission/Discharge/Transfer (ADT) alerts and other information, and continue to expand our use and integration with the HIE. We would have been accumulating claims and treatment history proactively from these sources in our core data warehouse, as well as engaging the member's non-network providers directly as needed to backfill details. Each time the member re-enrolls with us, our system immediately identifies her for Case Management due to her known history.

The VP of Information Technology of our BH affiliate, Cenpatico Integrated Care, is on the AzHeC board of directors, giving us additional insight into clinical data connectivity in Arizona.

Our Unified Member View technology allows our CM staff to view existing data on the member's previous spans of enrollment with Bridgeway (including with our ALTCS and Medicare plans, and if applicable, with CIC) along with HIE, blind spot, and other data from non-Bridgeway systems and non-network providers (including 638 and Medicare) through our TruCare clinical management application. This provides a comprehensive picture of member history and services that enhances our ability to identify immediate needs and ensure continuity of care.

We are encouraging Tribal providers to participate in the AzHeC HIE, but are also working with them to develop agreements for direct electronic data sharing with us, as well. This would better facilitate information exchange during transitions and allow Tribal providers to access our Provider Portal for information on our members they are serving. Since American Indian members may access any 638 provider regardless of Tribal affiliation, having agreements with as many Tribes as possible (such as the Colorado River Indian Tribes in Parker) will enhance our access to all member information, maximizing our ability to support integration of care across systems.

PROGRAM #2

AZ REQUEST FOR PROPOSALS SOLICITATION # YH18-0001

NARRATIVE SUBMISSION REQUIREMENTS

Program #2. A 71 year old Hispanic member, residing in Kingman, diagnosed with schizophrenia, Opiate Use

OVERVIEW

Throughout this scenario, we refer to the member as "Juan." Bridgeway Health Solutions® (Bridgeway) is dedicated to meeting the holistic health care needs of members through an integrated, person-centered approach to service and care coordination. In 2016, Bridgeway facilitated 25 transitions of care with Regional Behavioral Health Authorities (RBHAs) demonstrating our experience with members like Juan. Our staff engage and advocate for members with consideration to the unique strengths and needs of each member. For Juan, we are sensitive to several aspects of his story including but not limited to his age, culture, and preferred language, his behavioral health (BH) and physical health (PH) conditions, his living conditions and preferences, familial support, and the legal aspects of his care. For Juan, we know that his dementia diagnosis and potential for continued cognitive decline will impact both our short term and long term care planning as we work closely with Juan and his chosen family supports for transition of care arrangements, ongoing assessment for suicidal ideation, mental health, and opioid treatment as well as ensuring monitoring of his diabetes and primary care needs. With these considerations in mind, we describe our approach to initiating and managing Juan's care, including services, supports and treatment options as he transitions from the Health Choice Integrated Care (HCIC) RBHA to Bridgeway. Our approach to achieving the best outcomes for Juan includes, but is not limited to, the following initiation and management of care:

- Coordination for the transition from HCIC to Bridgeway to ensure there is no disruption in care (to include the transition between placements from Kingman to Flagstaff)
- Gathering history from Juan's previous treatment providers and HCIC to fully understand Juan and his BH/PH treatment history including but not limited to his diabetes and advancing dementia
- Coordination with the County Courts to continue the Court Ordered Treatment (COT) and transfer jurisdiction to Coconino County from Mohave County
- Address Juan's opioid use, suicidal ideation history, schizophrenia, and coordinate treatment
- Establishing an individualized plan to meet the needs of Juan taking into account his preferences, his family's preferences, and the legal aspects of his treatment
- Coordination of services for Juan's treatment in the least restrictive environment
- Coordination of services with thoughtful consideration to Juan's cultural/ethnic background

IDENTIFICATION OF ENROLLMENT AND TRANSITION FROM THE RBHA TO BRIDGEWAY

Upon receiving notification of Juan's new enrollment status from AHCCCS, Bridgeway initiates coordination with HCIC within the next business day for a smooth and uninterrupted ***transition of care*** from the RBHA to the ALTCS program. These activities are conducted concurrently with our initial outreach and welcome call as well as the initiation of discharge planning (described in the next sections). Bridgeway's BH Coordinator outreaches to the Inter-RBHA Liaison from HCIC to expedite receipt of the member's RBHA Transition Packet. Our BH Coordinator immediately requests the RBHA Transition Packet, to ensure it is received within seven days of enrollment so that we have access to Juan's clinical history such as current BH providers (psychiatrist, therapist, peer support specialist, etc.), provider notes, medication list, COT documents and/or other information that may positively impact the member's BH/PH conditions, quality of life, and/or quality of care. During this initial outreach to the Inter-RBHA Liaison, we are working to ensure continuity of care by coordinating authorization of services for Juan's continued stay at the psychiatric facility and follow up care post discharge. The Bridgeway BH Coordinator works with the Inter-RBHA Liaison and our Bridgeway CM to ensure services are streamlined and without barriers. This includes consideration of the 30 day transition period in which Juan's eligibility with the RBHA transitions to Bridgeway. Additionally, the BH Coordinator contacts all providers identified in Juan's RBHA Transition Packet to gather Juan's treatment history. Juan's BH/PH treatment history is also sourced from his past/current treatment providers and/or facilities to obtain additional member information.

Initial Welcome Call. Upon receipt of Juan's RBHA Transition Packet, Bridgeway notes that Juan is bilingual but prefers Spanish-speaking providers. Due to his Spanish-speaking preferences, as well as his most recent presenting issues of suicidal ideation with schizophrenia and opioid abuse disorder, Juan is assigned to a Spanish-bilingual Bridgeway Case

Manager (CM) with BH expertise for ongoing case management. The Bridgeway CM is the primary contact for Juan (and his family) and coordinates the services needed to support the all of Juan's BH/PH conditions, ongoing needs, and facilitate a successful transition. The Bridgeway CM reviews the medical records obtained for Juan including the online Pre-Admission Screening (PAS) to retrieve additional information about Juan such as medical summaries and/or Juan's level of care score. The PAS indicates that Juan's adult niece Leticia is an authorized representative and source of familial support. In reviewing the available information, our Bridgeway CM determines that Juan has not experienced suicidal ideation since his conditions were stabilized. The Bridgeway CM also views that Juan has a history of using street opioids and heroin, and notes that until recently Juan was estranged from his family due to his medication non-compliance and substance use. Juan's CM at Bridgeway contacts Juan's niece Leticia, that same day, to establish contact and build rapport during a Welcome Call. During the Welcome Call, the CM schedules an initial face to face onsite visit with Juan and Leticia to administer a comprehensive assessment that occurs as soon as the family is available for the visit (Juan's family is available the day after the welcome call) and within 12 days of Juan's effective date of enrollment.

Initial Face to Face Visit. During the initial face to face visit, the CM explains to Juan that in order to continue working with his niece, we will need his written consent and the CM provides an Authorization to Disclose Protected Health Information form in Spanish, which Juan signs, allowing Leticia to be a part of his care planning team. Juan shares that he was homeless off and on for years prior to contact with his family and expresses gratitude for his family's support. Leticia tells the CM that taking care of elders is important to her and important to the memory of her father (Juan's brother). The CM, recognizing the complexities of his BH and PH conditions, COT, and his overall challenges, discusses with Leticia options such as pursuing legal authority to act for Juan, such as becoming his payee, guardian, and/or a conservator, careful not to interfere with Juan's autonomy but cognizant of his declining capacity. The CM provides education to Juan and Leticia about these options. Details such as the requirement of a family member (such as Leticia) to petition the court for guardianship at the end of the COT and the requirement of an evaluation by an independent provider for COT rollover are discussed with Juan and Leticia. The CM provides education to Juan about establishing a healthcare and BH power of attorney (POA). Our CM works with Juan (as able) to determine who he feels is the appropriate family member to designate as his POA. Juan indicates to Leticia that he would like to designate her formally as his healthcare and BH POA. Advance directives are also discussed with Juan to determine his healthcare preferences in the event he is unable to make healthcare decisions. The CM completes Bridgeway's Integrated Assessment Tool with Juan as he is assessed for the current status including but not limited to his diabetes, substance use treatment, and functional/social needs. Additionally, the CM screens Juan for Special Assistance as required by AMPM 320-R and also screens for Medicare eligibility. The CM interviews Juan and Leticia about specific symptoms related to his dementia including but not limited to his memory, focus level, and reasoning. The CM notes during the assessment that Juan's communication/use of language appears to be difficult for him. He appears to struggle to find the right words to express himself and repeats phrases. Juan's history of schizophrenia and suicidal behaviors is assessed and his history of using street opioids, including heroin is reviewed. The CM speaks with Juan and Leticia to determine if there are times of day, days of the week, and/or events in which memory loss, cognitive functioning, and emotional status improves or worsens for him. The CM also learns at this time that a Neuropsychological Evaluation has been completed.

During the assessment, Juan's psychiatrist is confirmed as his BH medication prescriber and the CM verifies that Juan's psychiatrist is within our Provider Network. As Juan still resides in Kingman, all of his providers including his Primary Care Physician (PCP) are also identified and verified to be participating providers for Bridgeway. Juan's assessment and history are securely documented in ***TruCare***, our clinical management application. As part of Juan's transition of care, the CM initiates the completion of the following activities:

- Assisting Juan and his family in securing an appointment with his prescribing psychiatrist within 7 days to ensure no disruption in services
- Arranging any needed transportation or other resources to ensure Juan attends his appointments
- Ensuring an RBHA Transition Letter is sent to HCIC once Juan has attended his appointment with a Bridgeway provider and his prescriptions are filled without barriers. The BH Coordinator will send this letter to the Inter-RBHA Liaison indicating that Juan has successfully transitioned into Bridgeway.
- Sending a Letter of Intent, signed by our BH Coordinator and our Medical Director, to the Inter-RBHA Liaison due to his COT, that details Bridgeway's intentions to assume Juan's health care responsibility as it relates to the COT

Initial Resource Linkage. Our CM offers resources to Juan's niece Leticia to help build immediate connections to supports for Juan and for herself as a caregiver. These include linkages to MyStrength: Our online resource self-managed support that provides education about BH/PH diagnoses; and Nursewise: our 24/7 Nurse Advice Line. Additionally, the CM informs Leticia that her family is able to access family counseling services (covered by Bridgeway) if additional support is needed. The CM provides education to Leticia about these resources (verbally and via pamphlet) as they have access to the internet for MyStrength. Resource linkage to additional educational sources for familial support include but are not limited to the Alzheimer's Association, National Alliance on Mental Illness (NAMI AZ) and/or AZPIRE for family support group options, and Help for Alzheimer's Families. In addition, Juan' family is offered family support services through NAZCARE, a peer and family run organization serving northern Arizona.

PERSON-CENTERED PLANNING AND DISCHARGE PLANNING

The CM coordinates Juan's discharge with the transition coordinator at the Psychiatric Level I Facility in Kingman. The CM verifies Juan was not in an Institution for Mental Disease (IMD) facility and subsequently, is able to remain in the psychiatric facility beyond 15 days. Additionally, the CM works with Juan and Leticia to disseminate the transition of care information as it occurs in real time. An example of Juan's care plan during his transition is shown below.

Table 1. Person-Centered Care Plan

Member Goals	Person-Centered Care Plan and Service Plan	Focus Areas
I want to live closer to my family	• Assistance with coordination transition between facilities • Assistance with transportation to new facility • Placement to the appropriate setting • No disruption in care • Transition of COT to Coconino County	• Placement • Transportation • Least Restrictive Setting • Bridgeway Eligibility • Medicare Eligibility • Network Coordination • Legal Aspects of Care
I want to feel good	• Supporting Juan's schizophrenia, opiate use disorder, diabetes, and dementia • Supporting medication treatment with consideration to effectiveness and side effects • Supporting other needed treatments such as dental care due to substance use • Nutritional and Dietary Support for Juan's diabetes • Coordinating treatment; including MAT coordination • Safety planning due to history of suicidal thoughts • Provider Team Consultations • Integrated Care Team Reviews • Family support and engagement	• Holistic and Integrated Care • Management of evolving PH and BH conditions • Treatment History • Coordinating Care • Reassessment • Multidisciplinary Team • MAT Treatment • Resource Linkage • Cultural Competency • Language considerations

As Juan is ready to be discharged from Psychiatric Level I Facility in Kingman, the CM schedules a BH Interdisciplinary Team (IDT) meeting to occur the day after the initial face-to-face visit to address placement in Kingman, if needed. The IDT meeting for Juan is attended by our interdisciplinary care management team which includes BH professionals, Registered Nurses, supervisors/managers, the Pharmacy Director, our Network Development BH Manager, and our Medical Director. During the meeting, Juan's CM presents information about Juan's BH/PH conditions, opioid use, functional/social history, current needs, and the goals for care expressed by Juan/his family. The team also discusses Juan's current placement, future housing and level of care options, COT guidelines, providers involved (including Medication-Assisted Treatment (MAT) providers), medications prescribed (to ensure Juan does not run out of medications at any time), and Juan's current cognitive/BH/PH state. Juan's (and his family's) preferences are discussed as well as his request to move to Flagstaff directly from his current facility in Kingman. The BH Network Manager assists with identifying potential placement opportunities in Flagstaff such as *Brookdale Senior Living Solutions and Austin House Assisted Living in Cottonwood.* In contact with Juan and his niece Leticia, the CM learned and expressed to her colleagues that Juan recognizes the state of his BH/PH conditions and his progressive dementia. Juan has confirmed to Leticia that he would like to move to Flagstaff to be closer to his family.

Juan has fully transitioned into Bridgeway and is working with his CM on a routine basis with Leticia's support and participation. Juan has expressed to his niece that he would like to move to Flagstaff as soon as possible and the CM works with Leticia to facilitate the transition. Prior to the move to Flagstaff, the CM develops the member's care plan to include planning for his provider team, treatment facility, community resources, and additional requests Juan may have prior to the move. Our CM works proactively with Leticia to make arrangements for Juan's move from the Psychiatric Level I Facility in Kingman to a facility in Flagstaff. Throughout this process, the CM continually assesses (by observation, discussions with providers, and ongoing follow-up with his niece/family) if Juan has retained the cognitive capacity to make determinations related to medical decisions. Bridgeway recognizes the importance of Juan's participation in his healthcare decisions and service planning. However, we also understand that Juan at any moment due to his diminishing health, may not have the ability to make decisions, sign legal documents, and/or communicate at all. This includes an assessment of Juan's willingness and/or ability to engage his care in treatment on a voluntarily basis. His CM at Bridgeway offers Juan a judicial review visit every 60 days and connects with him every other week telephonically to assess for risk, follow-up, and check-in about any concerns.

In relation to a living facility for Juan, his CM shares and offers a list of potential facilities in Flagstaff and the surrounding areas (identified during the IDT meeting) to Leticia that would fit Juan's personal needs. The CM talks with Leticia about her goals for Juan and the possibility of Juan returning to her home. Leticia indicates that with the right care and respite, she may be open to that option in the future, but at this time she just wants a smooth transition to Flagstaff for her uncle. The CM offers her support to Leticia and reminds her that she is available for questions at any time. Moving forward, Juan will remain in the Kingman facility until the appropriate placement is determined to meet Juan's needs. Potential facilities (as mentioned above) that could benefit Juan would be Brookdale Senior Living Solutions (Brookdale) in Flagstaff, which has a Memory Care Unit to support his dementia condition as it advances. Another facility that could support Juan is Austin House Assisted Living in Cottonwood, which offers services and support for both dementia and SMI placement. Each potential facility is discussed with Juan and Leticia, and with our CM's assistance arrangements are made for them to tour facilities to help them make their decision. Our CM will support Juan throughout this process to ensure he is placed in an appropriate living facility for his specific needs. Ultimately, Juan and Leticia select Brookdale in Flagstaff. As Brookdale has been identified as Juan's new facility, the CM arranges for a "doc-to-doc" meeting between Juan's former treating psychiatrist overseeing the COT and Juan's new psychiatrist at Brookdale in Flagstaff.

As Juan's move to Flagstaff gets closer, his CM will work with Juan and Leticia to coordinate locating his provider team in Flagstaff and arrange transportation for Juan's facility transfer. This includes but is not limited to: Locating an in-network PCP, a neurologist (dementia), endocrinologist (diabetes), psychiatrist (schizophrenia, SI risk), MAT provider (opioid use disorder), peer support provider (SMI/Substance Use Disorder), and a family support provider. Given, Juan's combined BH/PH health conditions, we recommend an integrated health clinic to serve Juan such as the Guidance Center of Flagstaff and North Country Healthcare. The CM provides education to Juan and Leticia about the benefits of receiving services through an integrated clinic as this type of clinic will treat Juan's PH and BH symptoms holistically. The CM will coordinate with our BH Coordinator and Network Development staff to ensure all physicians and staff who we will work with Juan are Spanish-speaking (or have access to interpretation capabilities) and are of reasonable distance to Brookdale. Once these providers are identified, the CM offers Leticia assistance in scheduling appointments prior to the date of Juan's move to establish care.

ONGOING SUPPORTS AND SERVICES

Bridgeway will provide ongoing care coordination for Juan and Leticia. For example, due to Juan's move to Flagstaff and his COT history, his CM asks the BH Coordinator to engage Bridgeway's attorney to draft and file a *Change of Venue* with both Mohave and Coconino counties to facilitate the transfer of the COT. We stay consistently engaged with Juan's care, and will notify the court should a status change occur that is pertinent to his COT. Other care coordination activities include but are not limited to locating a provider in Flagstaff that can specifically prescribe psychiatric medication and adhere to the COT guidelines. Additionally, we arrange for Juan to receive MAT at *Southwest Behavioral Health Services* for his opioid use disorder to ensure management of opioid-related symptoms and maximize his recovery opportunities. To fully support Juan, his CM engages resources available through Bridgeway to help him achieve better health outcomes. For example, an individual with Juan's diagnoses may have used opiates as a way to self-medicate, and with his age and dementia, may not respond or be appropriate for a traditional opioid treatment program. Our CM would proactively engage Bridgeway's Pharmacy Consultation program to increase support for the appropriate medication

regimen that will reduce his symptoms and that he and his caregivers will be able to maintain for both BH/PH conditions. We recognize that many atypical antipsychotics can have adverse effects such as weight gain, diabetes onset/complications, and/or sudden cardiac death in older adults. With Juan's metabolic conditions in mind, his CM would work with our BH Coordinator to coordinate a ***Medication Review*** with pharmacy, our Medical Director, his psychiatrist/PCP, and his MAT provider. For ongoing care, these reviews would be offered quarterly but at the beginning of the process Juan's team may meet more frequently to ensure Juan's medication regimen is appropriate for his BH/PH conditions and his medication compliance history.

Our care coordination extends beyond coordination of health care services and benefits. For Juan, our CM would discuss with him interest in social supports such as activities or perhaps his spiritual beliefs, all of which could help him to feel engaged. Based on his preferences our CM will connect him with social or environmental supports that meet his needs. For example, if Juan is able and willing, we will connect Juan and Leticia with the Joe C. Montoya Community and Senior Center in Flagstaff for socialization and activities for older adults with the attendance of a family member. Additionally, in Juan's area AZPIRE (A NAZCARE facility) offers peer support, skills training and development that could benefit Juan and family support services for Leticia or other family members.

REASSESSMENT

Reassessment occurs 90 days after the initial face to face visit and every 90 days thereafter. Juan's present needs related to his schizophrenia, opiate use disorder, diabetes, and dementia are reassessed by checking in with Juan (as his condition allows) about his wellness as well as any additional needs. The CM then follows up with Juan's facility providers to inquire about Juan's progress. Following those discussions, the CM interviews Leticia about Juan's evolving health care needs during a scheduled appointment. The CM specifically asks questions about provider appointments and reviews the information against documents sent from providers after Juan's previous appointments. The results of those appointments are also reviewed to monitor for care gaps and/or problems needing solutions. Juan's reassessment entails the CM's routine meetings with the IDT to ensure an integrated approach to Juan's health care needs. Topics such as Juan's medication effectiveness and/or related side effects, progression of dementia, his opioid use, schizophrenia, and the state of his other conditions in relation to his overall health such as his diabetes are discussed. With Leticia's consent, the CM also maintains regular contact with Juan's current providers to speak about their recommendations to avoid care gaps and address any barriers. The CM checks in with facility staff when completing scheduled onsite visits with Juan and Leticia to assist both the family and facility with any identified coordination needs during the transition period. During this reassessment time period, the CM also informs Leticia/Juan that the family will be receiving a Bridgeway's annual Case Management Member Satisfaction Survey in the mail to complete as the family is able to discuss their experiences as they transition Juan's care. The CM provides education about the importance of this tool as it captures our member's experiences and informs Bridgeway on what we are doing right and where we need to improve in the future.

MEMBER FEEDBACK

Juan has moved to Flagstaff and is now comfortably living in Brookdale of Flagstaff. The CM has been meeting with Juan and Leticia in person every 90 days and following up telephonically with Brookdale staff as needed. Additionally, the CM completed a Change in Placement assessment within 10 days of Juan's move. Juan has attended his first appointments with his provider team and has effectively established care. During one visit, the CM provides support to Juan and Leticia as she discusses the difficulty of observing her uncles dementia advance over this time and assists her in obtaining family support services. The CM listens intently and reminds Leticia of her option for family counseling through Bridgeway and also discusses Bridgeway's Caregiver Journal Tool which she can use to write down her feelings and also contains information about the importance of self-care when caring for a family member. A few days later, Leticia receives Bridgeway's annual Case Management Member Satisfaction Survey in Spanish by mail to complete with Juan (as he is able). The Member Satisfaction Survey solicits feedback from members/families about their personal experiences of various aspects of care including but not limited to experiences with providers, access to providers, and utilization of services. The CM provides support to Juan and Leticia and engages them in discussions about goals for Juan as his health continues to evolve. To achieve the best outcomes for Juan, this may include but is not limited to continuing to monitor his person-centered care plan with identified goals, proactively engaging his family/Leticia to assure Juan's needs are met, and ensuring that Juan is in the least restrictive environment possible for his specific conditions.

PROGRAM #3

AZ REQUEST FOR PROPOSALS SOLICITATION # YH18-0001

NARRATIVE SUBMISSION REQUIREMENTS

Program #3 - Provide a description of the Offeror's past experience as a Medicare DSNP Plan…

BRIDGEWAY HEALTH SOLUTIONS' EXPERIENCE AS A MEDICARE DSNP PLAN

Bridgeway Health Solutions® (Bridgeway) has demonstrated success in improving outcomes and experiences for dual members since its 2008 entry into the Arizona Medicare DSNP market. Bridgeway first served dual members through a DSNP in Maricopa, Yuma, Pima and Santa Cruz Counties. In 2016, we expanded the DSNP business to most counties in which we served the Arizona Long Term Care System (ALTCS) population – Maricopa, Cochise, Graham, Greenlee, and Gila. For Pinal County, Bridgeway established a DSNP look-alike plan in 2017 to ensure members receive the full suite of integrated Medicare and Medicaid services while Bridgeway pursues CMS approval to operate a formal DSNP effective 2018. In November 2016, we submitted our Notice of Intent to Apply as a DSNP to CMS in all potential counties in preparation for a 2018 implementation. Bridgeway currently serves over 1,650 members in our DSNP plan.

In designing its DSNP program, Bridgeway draws on over ten years of experience in the ALTCS market. Through targeted and consistent improvement efforts and engagement of the resources of our parent company, Centene Corporation, the Bridgeway DSNP now has a four star summary rating for Medicare Part C and Part D in 2017. Four Part C measures that were rated at a three or lower in 2015 moved up to a five for 2017. To achieve this success, Bridgeway fostered a culture of continuous quality improvement that engaged every staff member. Tactics included:

- Garnering the buy-in of Bridgeway leadership, to recognize the need for improvement and direct organizational resources to achieve good outcomes for dual members
- Training staff and educating providers on the value of maintaining high quality and member satisfaction, using Medicare Star rating and AHCCCS measures to monitor progress
- Using data to identify where quality initiatives could have the biggest impact on member outcomes
- Soliciting feedback from staff in every functional area on what initiatives were needed to catalyze improvement, including where we needed to target network expansion
- Gathering feedback directly from members, through focus groups, to tailor approaches to their needs

In 2014, Bridgeway also included member care gap completion as an element of Case Management staff performance evaluation, which improved our Medicare Star rating performance. Bridgeway continues to strive for excellence in the care of all our members and will continue these focused improvement tactics, building on lessons learned, throughout the course of the contract.

Bridgeway participates in national conferences to share our expertise in care coordination for dual members and to gather best practices, such as the National Association of States United for Aging and Disabilities National Home & Community Based Services Conference. AHCCCS also recently invited Bridgeway to contribute as a model plan for published research on successful integration strategies for long term services and supports.

Leveraging Centene's Resources. In addition to its 32 years of serving the Medicaid population, Centene began serving Medicare members in 2008 and now offers Medicare Advantage (MA) plans in five states, DSNP plans in nine states and Financial Alignment Demonstrations in six states. Centene holds the nation's second largest membership across Financial Alignment Demonstrations with nearly 50,000 members as of the beginning of 2017. With its Health Net acquisition, Centene now has over 300,900 total Medicare and dual members. Centene also serves on the National Quality Forum's Measures Application Partnership Dual Eligible Beneficiaries workgroup to approve new quality measures for that population. In addition to expertise in the care of dual members, Centene offers Bridgeway a laboratory for duals case management and benefit coordination practices across all of its states and can offer insights into successful and less successful practices. For example, when Centene uncovered a palliative care practice in its Financial Alignment Demonstration in Ohio that produced positive, evidence-based results, it expanded the initiative, described further below, to Bridgeway and Centene's other affiliate plans to allow more members to benefit from the innovation.

Bridgeway DSNP Approach. Bridgeway provides a fully integrated solution for our duals members, so the member can focus on their health and not on navigating the confusing world of Medicare and Medicaid benefits. For example, we

offer a single identification card for dual members so they do not have to maintain separate cards. Our LTC and DSNP activities are integrated in common program processes to ensure the best quality outcomes for the member.

Aligning Members with our DSNP. Bridgeway collaborates with AHCCCS and CMS to identify optimal strategies for aligning members with our DSNP. We implemented successful CM recognition program in rural counties to encourage them to refer members to our DSNP and ensure that as a member came on board, the member had all the information and materials they needed to experience continuity of care. Bridgeway was also one of the first plans to employ a "seamless enrollment" process, which allows Bridgeway ALTCS members enrolling in Medicare to automatically enter the integrated DSNP and keep their current primary care provider.

Focus on alignment. Bridgeway also recognizes the importance of alignment across members' Medicaid and DSNP plans and proactive coordination where the plans are not currently aligned. The number of Bridgeway ALTCS members also enrolled in our DSNP plan increased by 48% between 2011 and 2016. Our LTC CMs are accountable to drive coordination across acute medical and long term care benefits, with a focus on improving overall outcomes and member experience. In addition to referring eligible members to the DSNP, our LTC CMs assist with scheduling appointments to resolve care gaps and coordinate with providers as needed. As a result, Bridgeway has maintained four Medicare Star rating or above on key chronic disease prevention measures (e.g. controlling blood pressure) and satisfaction measures (e.g. complaints about the health plan). For the relatively small number of our dual members who have a ALTCS plan other than Bridgeway, our Case Managers seek to proactively contact the members' ALTCS plan care team to establish communication channels and exchange pertinent information fostering better health outcomes.

Supporting providers to improve member experience. Our experience has shown that developing good relationships with providers supports dual member experience and quality of care. Recognizing the need, Bridgeway placed a provider outreach representative in Cochise County. The representative serves as a contact for providers if they have questions, helps to educate providers on complex benefits questions and attends member council meetings to identify any potential issues.

Bridgeway also helps providers navigate the dual benefits and improve care for these complex members through education. In 2015, Bridgeway's Director of Pharmacy launched a campaign to provide member and provider education on high risk medications, recognizing the increased risk of adverse drug events for our dual members over the age of 65. After the intervention, the high risk medication rate dropped from 15% in 2014 to 9% in 2015 and now to 8% in 2016. The Director of Pharmacy also provided education to pharmacies on how to appropriately bill Part B covered items to Medicare so the member has no out of pocket cost. This resulted in fewer member issues at the point of sale and a reduction in call volume on provider issues, which indicates an improved member experience.

EXAMPLES OF EFFECTIVE INITIATIVES

Bridgeway and Centene have implemented successful initiatives to target both improved outcomes and dual members' experience. Below each initiative description, a table indicates associated implementation dates, number of members impacted, the metrics used to measure success, and the resulting improvement in health outcomes and experience. Bridgeway's interventions have focused on targeted goals, directly linked to Medicare and AHCCCS quality metrics and our dual members' most critical needs: reducing care gaps and avoiding unnecessary hospital admissions.

An excellent example is the **Enhanced Care Transition Program**, which focuses on members as they are facing vulnerable transitions of care from a hospital, Skilled Nursing Facility (SNF), or acute rehab stay to home. Bridgeway implemented this initiative after data indicated that dual members were experiencing a high rate of hospital readmissions and required more comprehensive management. The initiative consists of focused telephonic outreach and meticulous follow-up of identified concerns and issues, including conducting member assessments, scheduling follow-up Primary Care Provider (PCP) appointments, performing medication reconciliation, and sending discharge information to the PCP. The nurse CM leading the transition maintains close coordination with the members' LTC CMs and PCPs, consulting the CM on the clinical care plan and advising the CM when the member is enrolled in the program, when the transition is complete, and when the PCP is contacted. The LTC CMs are also able to access the member's related medical records through the TruCare clinical management application. Since implementation, program participants' all-cause and same-cause readmission rate dropped by over 5%, strongly suggesting this initiative is having a positive impact on dual member outcomes. Given the telephonic modality of this intervention, it will be easy for Bridgeway to expand the program to other geographies.

Implementation Dates and Members Impacted	Metrics and/or Measurement Process	Health Outcomes/Improved Experience
Implemented **May 2013 – Present** **660 members referred to the program from May 2015- April 2016**	• Hospital readmission rates (HEDIS) • Avoidable complications • Quality of care • Post-hospital appointment verification • Completion of Medicare-required HRA/IHRA • Completion of Individual Care Plans (ICPs)	• After two years of operation, the Bridgeway all-cause readmission rate has dropped 6% (22% in the first year to 16% in the second). • Moreover, the rate of same-cause readmissions among participants in this initiative decreased by 5%, from 12% in year 1 to 7% in year 2.

Our **Beech Home Care Program** is an extension of the Enhanced Care Transition Program that uses attendant care workers to visit and assess both the member and the home. Upon notification that the member is ready for discharge, the attendant care worker conducts an assessment to ensure the member has food, appropriate heat/air conditioning, clean clothes, medications, and other necessities to be safe in their home. They also help the member with transportation and making PCP and other provider appointments. The attendant care worker coordinates with the nurse doing the post-discharge call and can even send pictures of the member's medication so the nurse can evaluate appropriateness and adherence. If the attendant care worker notices anything concerning, they contact the CM immediately to intervene. This initiative has led to an increased rate of in-home assessments, improving the likelihood of dual members' successful transition from an institution to home.

Implementation Dates and Members Impacted	Metrics and/or Measurement Process	Health Outcomes/Improved Experience
April 2015 – Present **172 members referred to the program from May 2015- April 2016**	• Completed return-home assessments in the hospital or home	Example for June 2016: • 86% of members referred had a visit while still in the hospital • 95% of members referred had an in-home assessment

Bridgeway's **Health Fairs** have proven highly successful in closing care gaps for dual members, ultimately improving their health. We have hosted larger health fairs in urban settings and mini-health fairs for more rural communities, such as Douglas and Sierra Vista. Members can either schedule an appointment or walk in to complete care gaps, designed around Medicare and AHCCCS quality measures. In one case, a retinal exam performed at the fair screened positive for glaucoma and we were able to refer the member to an appropriate provider for treatment. Our health fairs include non-health related features, such as haircuts and manicures, which draw members to the site. We also provide member education on topics affecting dual members at our Member Council meetings, such as a recent meeting in Casa Grande that included a presentation on good nutrition.

Initiative	Implementation Dates and Members Impacted	Metrics and/or Measurement Process	Health Outcomes/Improved Experience
Large health fairs	Annually, starting in Sep 2013 187 members in 2016	• Attendance • Care gap status (AHCCCS, Medicare, and both) • Completed tests	Closed 710 of 802 total AHCCCS and Medicare gaps at the 2016 Health Fair. This is 88.53%, up from 84.27% last year.
Mini health fairs (Douglas and Sierra Vista)	Annually, starting in June 2016 40 members (Sierra Vista) and 24 (Douglas)	• Attendance • Care gap status (AHCCCS, Medicare, and both) • Completed tests	Closed 245 of 265 total AHCCCS and Medicare care gaps, or 92.45%. A total of 297 tests were completed across the two health fairs.

Our **Performance Measurement Tool** is a web-based shared resource for CMs and their supervisors to track, by member, when both Medicare and AHCCCS care gaps are needed and fulfilled. Bridgeway implemented the tool to

ensure that we were capturing a full picture of care gaps and completion for dual members, without relying on claims data in the case that the member is not enrolled in our aligned DSNP. The tool also allows supervisors to track care gap completion rates by CM and use that information for quality assurance. This tool helps Bridgeway proactively monitor its progress towards HEDIS, Medicare Star rating and AHCCCS-specific performance goals to confirm it is on track to exceed benchmarks. Our CMs identify members who have care gaps, follow up with the member and the member's PCP to obtain the needed service, and set up the appointment, successfully addressing needed preventive services for dual members.

Implementation Dates and Members Impacted	Metrics and/or Measurement Process	Health Outcomes/Improved Experience
October 2013 – Present **All members**	Care gaps needed and completed: • Advanced directives • Flu Shots • HbA1c • LDL-C • Diabetic Retinal Eye Exam	Completion rates as of the end of the contract year: • Advanced directives- 93% • Flu Shots- 61% • HbA1C- 99% • LDL-C- 98% • Diabetic Retinal Eye Exam- 89%

To try to improve rates of preventive care completion for its dual members, Bridgeway implemented incentive programs like the **Gift Card Incentive Program** and the **Home Lab Test Kit Program**, both targeted to members who had persistent care gaps. The Home Lab Test Kits offer the option for the member to complete a preventive screenings (colorectal cancer, HgbA1c, and nephropathy screening) in their own home, minimizing barriers to completion. Bridgeway provides incentives to attendant care agencies to confirm that the member completes the kit and mails in the result. These initiatives resulted in improved screening rates to help promote early detection of significant chronic conditions that plague dual members, such as cancer, diabetes and heart disease.

Initiative	Implementation Dates and Members Impacted	Metrics and/or Measurement Process	Health Outcomes/Improved Experience
Gift Card Incentive Program	2015-Present 530 members in 2015 and 505 in 2016	• Completion of key preventive services: colorectal screening and mammograms	• Colorectal screening rates increased 8% in just one year (from 46% in 2014 to 54% in 2015). • Mammogram rates rose 11% in the same period (from 34% to 45%).
Home Lab Test Kits	2015-present 311 in 2015 and over 2,000 in 2016	• Completion of key preventive services: colorectal screening, HbA1c, LDL, nephropathy (program expanded beyond colorectal in 2016)	• As noted above, colorectal screening rates increased from 46% in 2014 to 54% in 2015. The impact of kits for other services implemented after 2015 are currently being evaluated.

Bridgeway also implemented a program, **Initiation of Services**, to monitor that all members entering Bridgeway are seen in a timely manner, that initial contact is completed on time and that services are started within 30 days. After designing and applying the improved monitoring process to replace manual tracking, all of these metrics demonstrate 99-100% completion. This program is especially important for our dual members given the complexity of their condition. The sooner Bridgeway can help them obtain services and begin managing chronic conditions, the better their outcomes.

Implementation Dates and Members Impacted	Metrics and/or Measurement Process	Health Outcomes/Improved Experience
October 2014 – Present **Approx. 120 members per month**	Implemented initiative to: • Ensure timely initial telephonic contact • Ensure timely initial face to face visits	• 99% of members had a timely initial telephonic contact. • 99% of members had a timely initial face to face visit.

	• Ensure services are started within 30 days	• 100% of members received services within 30 days.

Promising New Initiatives. Bridgeway is piloting technology innovations to improve outcomes such as our **Passive Sensor Pilot**, which started with dual members. Eighty of our members agreed to and are currently enrolled in the program and have sensors installed in their homes to remotely monitor their eating, sleeping and toileting patterns and send information on unusual activity to their CM and caregiver as appropriate. With our dual members, this technology allows Bridgeway to immediately identify needs and address acute medical and long term care services in parallel. We are currently evaluating this initiative to assess its impact on hospital admission rates and SNF placements.

Bridgeway has also begun working with Fire Departments and Emergency Medical System agencies participating in the **Treat and Refer Community Paramedicine Program**, starting in Chandler, to identify our members who are at risk for emergency room utilization or hospital admission. Through this program, participating EMS providers create a treatment/referral plan to address the needs of individuals who call an emergency number but do not require transport to the ED based on their clinical condition. Working with the EMS providers, Bridgeway CMs can identify our dual members who contacted emergency services and follow up to connect them to their PCP, as needed, and address any barriers to care.

Centene's affiliate health plans have also piloted effective interventions focused on dual members that Bridgeway will be able to adopt. The **Compassionate Connection® Palliative Care Pilot** implemented by our affiliate in Ohio, which Bridgeway will be rolling out for our dual members, helped members avoid the ED and remain in a more comfortable setting, measured by a significant reduction ($p < 0.05$) in the ED spend from the period three months prior to the member's initial palliative care visit to the three months following this visit, as well as promising trends in the increase of Advanced Care Directive completion. Pharmacy interventions started this year, such as an **Electronic Pill Box** for improved medication adherence, are also being evaluated for impact on dual members' health and scalability to Bridgeway's GSAs. This technology will especially help dual members with cognitive issues as it reminds the member to take their medication.

REPLICATING INITIATIVES ACROSS AWARDED GSAS

The initiatives described above will be replicated in all awarded GSAs based on demonstrated success, lessons learned, and community input/need. Bridgeway's current experience in both urban and rural counties in two of the three GSAs in Arizona gives us great insight into how to successfully expand our current practice to other regions in the state.

For example, in setting up the health fair in Cochise County, we reviewed care gaps for those members and noted that several members needed eye care so we sent a mobile provider to the fair to offer that service. Where there was not enough volume to draw a mobile provider to provide mammograms, we worked with the local hospital that had regular mammogram events and helped members get scheduled in the hospital's clinic. We also take advantage of the Non-Emergency Medical Transportation (NEMT) benefit for dual members in rural communities who need to travel to visit their Medicare provider. Because of the large Spanish speaking population in Cochise, Bridgeway also brought in translators and bilingual CMs to translate the presentations into Spanish. Bridgeway would follow this process in any of the GSAs we serve, identifying the members' needs in that community, working with local providers and leveraging our network of mobile providers and culturally appropriate staff to bring services to members.

In more urban regions, Bridgeway partners with local providers to maximize our ability to serve a larger population. For example, at the Maricopa County health fair, nurse practitioners from Optum assisted Bridgeway staff in providing services. Our relationships with area providers play a significant role in the success of our initiatives and our members' experience, so we will start any expansion with an assessment of member needs as well as provider outreach. Bridgeway already has experience serving members in Yuma and La Paz counties as well as Pima and Santa Cruz counties through Cenpatico Integrated Care.

Many of the initiatives described above rely on remote technologies, such as phone calls and remote in-home monitoring. These technologies, along with education programs, can be easily scaled across geographies. To implement the other in-person initiatives, Bridgeway will hire staff, adapt existing protocols to community needs, and develop relationships with local providers, as indicated, to ensure access to needed services.

PROGRAM #4

AZ REQUEST FOR PROPOSALS SOLICITATION # YH18-0001

NARRATIVE SUBMISSION REQUIREMENTS

Program #4: Approximately 20% of the ALTCS E/PD population dies annually representing a significant percentage of the membership...

Bridgeway Health Solutions® (Bridgeway) has supported decision-making and care needs related to life transitions such as declining health, aging, and terminal illness in the ALTCS population since 2006. Our focus in serving members during life transitions has been to improve quality of life using a person-centered approach that identifies and addresses each individual's unique needs and preferences (including caregiver needs) during this sensitive time. We empower members and their caregivers to make decisions through continual education and bi-directional interaction. This helps the member and their chosen circle of support determine when and how to access end of life care services and how the member can best utilize these services and supports to maximize their quality of life. Our Compassionate Connections® Program, which reflects our experience and leverages best practices, will serve as the umbrella under which we will implement new innovative strategies to support decision making and care needs during life transitions.

EXPERIENCE SERVING MEMBERS DURING LIFE TRANSITIONS

We take a person-centered approach that prioritizes the member's dignity and perceived quality of life. In our experience, members experiencing life transitions have high avoidable utilization, such as readmissions and Emergency Department (ED) visits, due to their deteriorating condition which negatively impacts quality of life. We understand the particular importance of close monitoring and quickly identifying needed care plan modifications to reflect sudden changes to member needs and preferences, which are common. As we implement and monitor the care plan for these members, the Case Manager (CM) evaluates member satisfaction and the extent to which services are maximizing quality of life, and collaborates with the member, caregiver/family, Primary Care Provider (PCP) and other treating providers to revise the care plan as needed.

Our CMs track member age and also use member and caregiver/family contact as well as data to identify members whose health may be declining and those with a terminal illness. We train CMs to understand the *sensitive nature of this topic and cultural factors* that impact member willingness to engage on the topic, and to use an individualized, person-centered approach to determine the appropriate point at which to begin discussions about end of life care services. We understand the importance of supporting members and their families to make decisions about their care and services throughout the aging process as well as when health declines and after a terminal diagnosis, all of which can be confusing and very emotional for the member and their circle of support. For example, our Pharmacy staff meet in person with members and their families when appropriate to discuss medication recommendations as well as the rationale for those recommendations, to equip them with the information needed to drive their care in a manner consistent with their goals. CMs assist members to understand what advance directives are and how to complete them, as well as their options for curative care, hospice, home and community-based services and supports to enable them to remain in the least restrictive setting, and caregiver and other supportive services. Our over-riding goal is to maximize member quality of life throughout the aging process and during the end of life.

Below we discuss our experience providing:

- End of life care services, including advance care planning, hospice, palliative care, and supportive services
- Medication management, including monitoring/addressing medication utilization and working with prescribers

Experience Providing End of Life Care Services. We identify members experiencing a life transition as early as possible, as a declining health condition can be an early indicator of the need to assess for end of life care needs. When we identify a member, we quickly assess their needs and when indicated, we offer, coordinate, and monitor end of life care services, which include all health care and supportive services provided at any age or stage of illness, and encompass advance care planning, palliative care, hospice, and supportive services. These members may opt to receive curative care until they choose to receive hospice.

Advance Care Planning. Bridgeway maintains all required written policies related to advance directives (ADs) for adults. ***93% of our members have completed an AD***. We have achieved this through educating and assisting members and family/representatives, CM training and monitoring, and provider education and monitoring.

Member Education/Assistance. We provide all required written information to adult members and, when the member is incapacitated or unable to receive information, the member's family or surrogate. We provide information via the Member Handbook in our Welcome Packet and on our Member Portal. CMs educate members during assessment and care planning, and reinforce the importance of ADs by bringing forms and offering education when there is a change in condition. Our CM Performance Measure tool, reviewed during each member visit, includes a measure for ADs which serves as a prompt for the CM as well as a monitoring method. For members with completed ADs, the CM reviews it when a condition changes to determine whether the AD still reflects the member's current wishes. We track members without completed ADs so that any staff speaking with the member knows to educate, encourage, and assist the member to complete an AD. For incapacitated members, we follow up via the CM to provide the information to the member directly at the appropriate time. Of the remaining 7% of members who do not have a completed AD, some erroneously believe an AD means rejecting life-saving treatment. We address this through communicating that an AD is simply the expression of the member's wishes. For those whose cultural beliefs result in a reluctance to discuss death, the CM attempts to discuss ADs with family, who may be able to broach the topic with the member.

CM Training/ Monitoring. We train CMs on all AD requirements, cultural beliefs related to ADs, and how to educate and encourage completion in a culturally appropriate manner. We track completed ADs by CM, identify staff with lower completion rates among their caseload, and provide additional training to address issues that may impact completion rates. Some CMs hold cultural beliefs that affect their comfort level with AD education. To address this, we provide additional training to address CM cultural beliefs. For CMs receiving retraining in 2015, completed AD rate increased from 55% in Q3 to 78% in Q4. Our CM Performance Measure tool, completed at each member visit, includes an AD-related measure. A Supervisor reviews results bi-weekly to identify and provide additional training to staff not meeting standards. The Case Management Department reviews and addresses department-wide results quarterly.

Provider Requirements and Monitoring. Our hospital, nursing facility, hospice, home health, primary care and specialist providers and personal care provider contracts comply with all Federal and State laws and regulations regarding ADs for adult members. This includes but is not limited to requirements to maintain written policies and providing written information to adult members regarding their right to make decisions about care; document in the medical record whether the member has been provided AD information and has executed an AD; not discriminate against the member due to their AD-related decisions; educate their staff on all AD requirements; and to provide a copy of the member's AD or documentation of refusal to the member's PCP for inclusion in the medical record.

Experience with Hospice Care. For non-dual eligibles, we provide hospice services to meet member needs related to the hospice-qualifying condition through contracted hospice providers that meet Medicare requirements. The CM works with the member and family/representative, hospice staff, and PCP to develop a care plan and coordinate care. When we identify hospice services, the CM works with the member, caregiver, and providers to adjust the member's care plan accordingly. The CM obtains the election of benefits form from the hospice provider as well as the quarterly certificate of terminal illness. In all cases, the CM facilitates access to needed durable medical equipment and our pharmacy staff monitors drug utilization (as described below). We track members receiving hospice, including the date of hospice enrollment and diagnosis, and their hospice services to prevent duplication of services. However, we recognize attendant care is not considered a duplicative service. We encourage and support members to remain in the least restrictive setting, particularly at this sensitive time, by incorporating attendant and other non-curative, non-duplicative covered services such as homemaker services and respite to ensure member comfort and support for caregivers/family. We pay Medicare coinsurance and deductibles for covered services provided to dual eligible members.

Experience with Palliative Care. We adopted Centene's Compassionate Connections Program (described below) based on two factors. First, we have found that hospice enrollment usually occurs within the last two weeks of life, although we find that costs tend to balloon during the last six months. This suggests unmet palliative needs prior to the end of life. Second, results of an analysis of readmissions in our enhanced post-discharge program indicated a high proportion of these readmissions were members in the end of life period who were rejecting hospice. The program is informed by our experience with a palliative care pilot through Hospice of the Valley (HOV). We identified home and community-based members with dementia, psychotic/schizophrenic disorders, and mood and other cognitive disorders. HOV provided services focused on the caregivers. Key lessons learned were that caregivers send members to the emergency department (ED) or hospital to meet needs that can appropriately be met through home and community-based

palliative services, and that members want to remain with their doctor during a life transition. Thus, our program will include a focus on caregiver education as well as ensuring continued access to the member's doctor throughout participation in the program.

Our Compassionate Connections Palliative Care Program, which is designed to improve quality of life while respecting member choice not to receive hospice as well as to reduce readmissions for these, also draws on our Ohio affiliate's experience implementing a palliative care program. While palliative care is not a covered service in Arizona, initial Ohio results include a statistically significant reduction ($p < 0.05$) in ED spend PMPM from the period 3 months prior to the initial palliative care visit to the 3 months following this visit, suggesting the program may potentially pay for itself. Other early results that are not statistically significant but promising include: an increase in Members reporting that personal care goals are identified and discussed with physicians and caregivers (29% ->86%); an increase in advanced directives completed and communicated (29% ->71%); and reductions in monthly ED visits (50%), inpatient admissions (58%), PMPM inpatient spend ($450), and overall PMPM spend ($1500) in the three months following the initial palliative care visit compared to the six month prior to the visit. A key lesson learned in Ohio is that members may react negatively to the term palliative care. Thus, even though our Compassionate Connections Program will encompass more than just a palliative care component, as described below, we will use the Compassionate Connections name to refer to this component to improve member receptivity.

Experience with Supportive Services. We provide and connect members to psychological, social, spiritual and practical support to improve comfort and quality of life. This includes both covered services as well as natural supports and community resources. We understand that the member's circle of support can go beyond the caregiver and immediate family, and takes on heightened importance toward the end of life. Our comprehensive assessment process uses a person-centered approach to identify and address needs in all domains including supportive services provided directly to the member as well as those that will address caregiver and family needs to maximize the support they can provide to the member. For example, a care plan may incorporate both individual therapy and counseling as well as group and family therapy and counseling to assist the entire family unit through the transition. The CM provides the member and family information on and connects them to community resources such as the Arizona Caregiver Coalition's caregiver support groups. We provide CMs with a comprehensive Community Resource Guide which lists resources by community, as well as the Area Agency on Aging's Elder Resource Guide. Our online Caregiver Resource Center offers caregivers such information as local support groups and tips for preventing burnout.

Experience Providing Safe, Appropriate Medication Management. Pain management is a key aspect of supporting members through life transitions and maximizing quality of life, especially during the end of life period. However, Arizona has the 6th highest rate of prescription drug abuse in the nation, and a dramatic increase in recent years in opioid-related ED visits and deaths. Bridgeway staff, led by our Pharmacy Director (PD), have been working with the ALTCS Program in 2016 to develop policies to ensure safe opioid utilization. Our experience also includes monitoring and addressing controlled and non-controlled medication use, and working with our providers to improve controlled substance prescribing. Our providers have welcomed this assistance, as we are able to provide access to information about the member's needs and care received from other providers/prescribers and support whole-person care. For example, our Centelligence® system can integrate Medicare Part D and other Blind Spot data as well as information available through the HIE to gain a comprehensive understanding of the member's prescriptions and identify potentially harmful polypharmacy.

Monitoring and Addressing Medication Use. Bridgeway monitors controlled and non-controlled medication use to ensure members receive clinically appropriate prescriptions. To identify and screen high-risk members and providers who may facilitate drug diversion, as well as to determine potential misuse, our Pharmacy Department conducts quarterly reviews of utilization, prescribing, and dispensing patterns for atypical antipsychotics, benzodiazepines, hypnotics, muscle relaxants, opioids and stimulants. Our reviews examine prescription claims data; Arizona State Board of Pharmacy Controlled Substances Prescription Monitoring Program (CSPMP) data; Indian Health Service (IHS) and Tribal 638 pharmacy data; RBHA/TRBHA prescription claims data; and other pertinent data. When we identify a potential mis/overuse pattern, our PD alerts the prescriber and collaborates to develop a plan to address it, with assistance from the CM for any needed member assistance.

We also monitor drug utilization and needs for assigned members on an ongoing basis and coordinate with pharmacy staff to identify and address potential mis/overuse. This includes not just review of data but also indicators such as changes in conditions and member/caregiver requests for additional services or medications. The CM brings such

information to our interdisciplinary case review process, which includes other Case Management staff as well as pharmacy and UM staff and our Medical Director. When indicated, this process may include a medication review. For example, if a member is already prescribed narcotics for pain but expresses a need for further pain control, pharmacy staff review the member's case including all medications, and coordinate with the CM and PCP/prescribers to safely address the member's needs. In some cases, we have found situations such as family members sneaking pills (causing the member to run out of the medication before it can be refilled) or a member scared to take opioids and not receiving the intended relief. Pharmacy staff collaborate with prescribers to ensure appropriate dosages and reduce unnecessary and/or dangerous utilization, and coordinate with CMs to work with members/family on appropriate utilization and address issues such as safe opioid regimens.

Working With Providers to Improve Prescribing. CSPMP has been in place since 2012 as part of the state's Prescription Drug Misuse and Abuse Initiative. However, only 34% of Arizona prescribers are registered to use it, which allows a practitioner or delegate to view all the member's filled controlled substance prescriptions. Bridgeway has participated in state efforts to increase CSPMP use through educating our providers about the CSPMP and the new requirement that PCPs register for and use it. Our PD conducted prescriber education during 2016 at conferences and provider meetings about how to use the CSPMP, including encouraging providers to pull the member's information and put it into the medical chart prior to a member office visit. Provider feedback included not having time to access the system, which our PD addresses by educating them that they can register staff to use the system on their behalf. We include CSPMP information in our Provider Quality of Care Guide; have provided information via mailers, newsletter articles, and via our Provider Portal; and Provider Representatives educate at every provider visit. Our PCP contracts will reflect the new requirement to use the CSPMP.

NEW INNOVATIVE STRATEGIES TO SUPPORT MEMBERS WITH DECISION-MAKING AND CARE NEEDS

We will implement new innovative strategies to support member decision-making and care needs through our Compassionate Connections Program. The Program will reflect best practices set out in the Center to Advance Palliative Care's (CAPC) 2014 *Improving Care for People with Serious Illness through Innovative Payer-Provider Partnerships: A Palliative Care Toolkit and Resource Guide.* In addition to other end of life care services we already provide as described above, new innovative strategies we will implement through our Compassionate Connections Program will include:

- Palliative care services
- A medication review to identify and address over/mis-prescribing

Identifying Members for Compassionate Connections. To improve quality of life and outcomes for members with palliative needs who reject or do not qualify for hospice, we implemented our Compassionate Connections Program January 1, 2017. We identify members using a proprietary algorithm that incorporates claims data, health risk assessment information, and the Charlson Comorbidity Index (CCI). As we have found that members experiencing life transitions often do not meet high cost or high need criteria until the last six months of life, our goal is to identify those with diagnoses or other indicators that suggest a potential to become high cost or high need. Dual eligible members enrolled in our DSNP who reside at home or in assisted living who meet all of the following criteria are eligible: 1) CCI score greater than 5 OR has ALS, Parkinson's, ESRD, Huntington's, or multiple sclerosis; 2) Two hospitalizations within the previous 12 months; 3) Three office visits within the previous 12 months. (Note that while we will not use emergency department utilization as part of the criteria, because we found in our Ohio experience that is not a good predictor for palliative needs, our CMs will look at the member's ED utilization as part of the overall picture of their needs.) We systematically identify members meeting program criteria through our Centelligence analytics and predictive modeling platform. Centelligence processes large data sets to generate timely, impactful insights and actionable care alerts and interventions for our case management staff and our providers. Of the Members we identified for initial program eligibility, the most prevalent primary diagnoses are: acute/chronic renal failure (23% of identified members); diabetes (12% of identified members); other neurology (12% of identified members); heart failure/cardiomyopathy (9% of identified members).

Partnerships for End of Life Care. We are partnering with Hospice of the Valley (HOV) and Arizona Palliative Care (APC) to provide services. Participants may choose the model provided through HOV, which focuses on intensive caregiver education and support, or the APC model, which provides more direct member education and support from a nurse practitioner who makes in-home palliative care visits as appropriate. All participants receive an in-home palliative care assessment, which includes depression screening, and advance care planning education. During the assessment, the CM

educates the member that they may continue to receive curative treatment while enrolled in the program. The CM collaborates with the member, caregiver/family, PCP, the palliative care provider, and other treating providers to develop and monitor an individualized plan for end of life services (integrated with the overall care plan) based on the member's unique goals and situation. A key element of the care plan is respite for caregivers based on assessment of their willingness and ability to provide care. CMs educate members and caregivers about the 600 hour respite benefit and the importance of preventing and addressing caregiver burnout. We also provide caregiver training and support such as connecting the member to community support groups. In addition, the CM outreaches to other important 'players' in the member's life, such as churches and Tribal organizations, to educate and involve the member's entire circle of support in helping the member through their life transition, including supporting the caregiver(s). Reassessment and care plan revision occur every 90 days, when there is a new or changed condition, and upon member request. Program evaluation will examine ED visits, inpatient admissions, pain scores, completed ADs, and member/caregiver satisfaction. To promote an evidence-based, best practice approach to palliative care, we will adopt CPGs such as the National Consensus Project for Quality Palliative Care's Clinical Practice Guidelines (CPGs) for Quality Palliative Care. We will educate and support providers on CPG use through initial training, ongoing monitoring of guideline implementation, and additional training and technical assistance to ensure members receive high quality services that align with the CPG. We will also provide CPG information on our online Provider Portal.

Medication Review. In October 2016, Bridgeway implemented a new innovative strategy to reduce polypharmacy and promote safe prescribing of controlled substance medications, which is a key way to improve quality of life for those experiencing a life transition while reducing avoidable ED and hospital use. Through our Medication Review Program (MRP), a *specialized long term care consultant pharmacist* (SRx Consulting Group) assists our PD to review drug utilization and make recommendations when indicated to deprescribe or change medications that may be harmful or no longer necessary due to member age or conditions, or in conflict with other prescribed medications or clinical practice guidelines. Dosages need to be reduced and monitored closely for members at an advanced age or with chronic conditions, as they may not metabolize medications as quickly or have additional conditions which the dosage could adversely affect. The inappropriate or overuse of opioids is of particular concern as they can exacerbate dementia and increase confusion among those with Alzheimer's; increase fall risk; cause constipation which can lead to bowel obstruction; and cause respiratory distress in those with COPD. While skilled nursing facility residents receive a pharmacy review every 30 days, such a review is not required or reimbursed for the approximately 75% of our members who live in the community. Yet these members are just as, if not more, likely to be taking many prescriptions including multiple controlled medications. To address this gap, we developed our program using guidelines from the American Society of Consultant Pharmacists. We will identify members with potentially significant polypharmacy (8+ prescriptions) using all available data, including Medicare Part D data available via the Blind Spot Data provided by AHCCCS. When we identify a member, our pharmacists work with the PCP to optimize or discontinue medications using a whole-person approach that considers all medications across prescribers as well as the full range of health and behavioral health conditions and needs, including but not limited to pain control. Our pharmacist provides the guidelines on which our recommendations are based, and follows up about a week later to discuss the recommendations. We plan to conduct this comprehensive review on at least 30 members per month in 2017. Of the 10 members for whom we conducted reviews in October 2016, we made 31 recommendations for medication changes (e.g., dose reductions, medication changes, lab/clinical monitoring). Prescribers accepted 81% of our recommendations. Program evaluation will examine ED, hospital, and prescription utilization and cost, overall medical cost, and member-reported changes in quality of life.

We are also creating prescriber report cards which we will use to monitor CSPMP use and provide prescriber feedback to spur provider improvement efforts. Our Pharmacy and Quality Departments will collaborate to develop the report cards quarterly and annually. When we identify a prescriber not using the CSPMP as required, the PD or Medical Director will outreach to the provider with education and if appropriate develop a corrective action plan (CAP). The Quality Department will monitor the CAP until the prescriber demonstrates compliance.

To further support appropriate controlled substance prescribing, we will increase provider awareness of the Substance Abuse and Mental Health Services Administration's free mobile application, MATx, developed as part of the agency's Opioid Initiative. Released in October 2016, MATx provides prescribers with instant access to critical information about medication-assisted treatment of opioid use disorder. We will include information on MATx in our Provider Manual and on our Provider Portal. We will also educate prescribers about MATx during interactions about members identified via the MRP.

PROGRAM #5

AZ REQUEST FOR PROPOSALS SOLICITATION # YH18-0001

NARRATIVE SUBMISSION REQUIREMENTS

Program #5- The Offeror has a newly-enrolled 32 year old male with a Traumatic Brain Injury who temporarily resides in a Skilled Nursing Facility…

Bridgeway Health Solutions® (Bridgeway) is dedicated to providing a holistic, member-driven and strength-based approach to serving members with an array of complex needs and conditions, including members with Traumatic Brain Injury (TBI). We work directly with members, family, community partners, and providers to understand members' quality of life goals; personal, family, and community assets; and behavioral health (BH), long-term rehabilitation, and functional needs. We provide members with the timely support they require to attain their goals through individual skill development and a mix of informal and formal supports. As summarized in the table below and discussed in more detail throughout this response, we share our process for working with this member, whom we will call Martin throughout this response, a newly-enrolled 32 year old male with TBI and obesity. We work with Martin and his self-identified circle of support to map Martin's future and the interventions necessary to achieve his goals. We intervene immediately to address Martin's Stage 3 pressure ulcer while also encouraging hope and long-term recovery by supporting Martin's goal to be become active again. Bridgeway identifies and swiftly addresses the Skilled Nursing Facility's (SNF) Quality of Care incident, and as a result, ensures lessons learned from this incident inform future training and provider improvement activities for the SNF and our wider SNF network.

Member's Goals	Person-Centered Care Plan and Service Plan	Focus Areas
I want to be active (SNF)	▪ Bariatric Care and Equipment ▪ Specialized Wound Care ▪ Sleep Apnea Treatment and Equipment ▪ Nutrition/ Wellness Assistance and Meal Planning ▪ Neurological Consult ▪ Occupational, Physical, Cognitive, Speech Therapies ▪ BH Consult and Individual and Group Therapies	▪ Wound Care ▪ Weight Loss ▪ Improved Sleep ▪ Increased Mobility ▪ Increased Exercise ▪ Continued BH/TBI Recovery
I want to move into my own home	▪ Housing Specialist Consult and Housing Assessment ▪ Housing Application and Eligibility Assistance ▪ Community Transition Program ▪ Brain Injury Alliance Referral for Education, Peer/ Family Supports ▪ Ability360 Referral for Education and Peer Supports ▪ Community Resource Referral Connection ▪ Medical and Community Transportation	▪ Housing ▪ Transition ▪ Home Modifications ▪ Community Integration ▪ Transportation
I want to be a Freelance Writer	▪ Vocational Profile and Employment Goals ▪ Rehabilitation Services Administration (RSA) Vocational Referral ▪ Personal Journal for Memoirs ▪ Employment Services and Assistive Technology ▪ Job Accommodation Network (JAN) Referral ▪ Ability360 Referral for Education and Peer Supports	▪ Employment ▪ Assistive Technology ▪ Accommodations

INITIAL MEMBER CONTACT AND VISIT

Meeting Preparation. Martin's Bridgeway Case Manager (CM) is assigned to support Martin in addition to all of the members we serve in Martin's SNF, which allows the CM to be onsite many times within a week, routinely attend rounds, and establish a rapport with the facility's administration and staff. Martin's CM, like all our CMs, is trained on the unique characteristics of the members we serve, including supporting members with TBI and who are obese. Prior to meeting Martin in-person, the assigned CM reviews Martin's electronic medical record through the Client Assessment and Tracking System (CATS) and Arizona's Health-e Connection (AzHeC) to begin understanding Martin's historical care. The CM finds that Martin was hospitalized after a motor vehicle accident at which time he received acute TBI treatment

and rehabilitation services. Martin was subsequently discharged to a SNF that specializes in TBI close to his sister's home (per her request) for post-acute care.

Our CM informs the facility, during routine rounds, that Martin has been enrolled in our health plan and discusses Martin's needs with the SNF social worker. The SNF social worker indicates that Martin has no interest in leaving his bed. She also reports that he is on a calorie restricted diet, has moderate family involvement, and does not engage much with the other residents or staff. Our CM reviews Martin's facility-based medical record while onsite, including his hospital transition notes, existing treatment plan, Minimum Data Set (MDS) findings, and progress notes. Following his TBI, Martin reportedly had cognitive, motor, perceptual, and communication deficits as well as personality changes. His pre-existing morbid obesity and depression, already limiting his mobility and functioning, were reported to be exacerbated by the accident. Martin was diagnosed with sleep apnea while in the SNF and uses a CPAP at night.

Initial Visit. Our CM visits Martin's room during one of her routine visits to the SNF (no more than 7 business days from enrollment) to welcome Martin. The CM provides Martin with a Member Handbook and other vital materials in his language of choice (English) and provides Martin with a brief overview of Bridgeway's mission and member-driven approach; his benefits; and how to reach his CM if he needs assistance. During the visit, Martin expresses frustration with being in the SNF and his strong desire to walk again. He also shares that he is an avid reader and writer, but he has done very little since his accident. The CM asks Martin who he would like to engage in his discharge and life planning. Martin reports that his sister and her young family live close by and mean a lot to him; so, he would like to engage his sister. The CM has Martin sign an Authorization of Disclosure form so the CM can speak to Martin's sister, when needed. On the way out, the CM assures Martin that she will be back to conduct an assessment and to work with Martin and his sister to plan for his next steps.

The CM follows up with Martin's sister the next day, who indicates that Martin has experienced trouble concentrating and becomes easily frustrated since his accident. She advises the CM that Martin's best times for visits are mid-day and that meetings are best if they are kept brief. Martin's sister expresses concern that while Martin is receiving speech and physical therapy, his depression and obesity are not being addressed. She fears that without the right services, her brother's health may never improve. Our CM ensures Martin's sister that Bridgeway will quickly assess Martin's needs and work with Martin and his circle of support to encourage his continued recovery. Martin's sister says she will participate in meetings to support Martin's recovery. Our CM uses TruCare, our clinical management application to document all communication with Martin, his sister, and SNF staff. All documentation occurs, as soon as possible, but always within 10 days..

MEMBER ASSESSMENT

Martin's CM schedules an assessment time, within the required ten days, that meets both Martin and his sister's needs. During this assessment, our CM reviews Martin's Member Handbook and vital materials in further detail, including his ALTCS benefits, Member Rights, and Advance Directives policy. The CM uses our online Integrated Assessment Tool, in combination with AHCCCS' required tools and forms, to assess Martin's medical, BH, and functional needs. Our CM, informed by recovery principles and person-centered planning mapping techniques, facilitates the assessment process to understand Martin's assets, vision for the future, and short and long-term goals.

Sample Findings. Our CM learns that prior to Martin's accident, he was a successful freelance writer who was well respected for his written pieces on the latest computer gadgets. The CM also learned that Martin was divorced and temporarily living with his sister in Maricopa County when he was in a motor vehicle accident. While he is appreciative of his sister, Martin does not want to be a burden and wants to live independently. Martin blames his obesity as the cause of his "string of bad luck" and hopes that, in time, he can lose weight, become active, and return to being a writer. Martin's sister adds that Martin, since his accident, fatigues quickly and is often discouraged, making his goal to lose weight challenging. Recognizing that depression is the number one symptom following a TBI, the CM completes a depression screening. Martin is clearly discouraged and demonstrates symptoms of depression. Our CM introduces peer support to Martin, and although he expressed reluctance at first, he agreed to give it a try as soon as he feels better.

Martin reports that he dislikes spending so much time in his bed, which he feels is too small for his body and is causing his pain and incontinence. Our CM completes the majority of the assessment with Martin and his sister, but after one hour, it is clear Martin is physically uncomfortable and exhausted. The CM reports the pain to the SNF lead nurse and requests an immediate skin integrity assessment given his risk for skin break down. Our CM completes the remaining components of the assessment over a two hour span based on the meeting discussions, written information available,

and follow up interactions with the facility social worker, Martin, and Martin's sister. The assessment identifies Martin's need for a more in-depth psychiatric evaluation and a nutrition consult to address his diet and exercise needs.

The CM also finds, through a detailed review of Martin's medical record, that neurological consults are recommended by his physician to inform Martin's TBI recovery; the CM documents this need in the assessment to ensure the appropriate follow-up. Our CM completes the Uniform Assessment Tool (UAT) to determine Martin's acuity and level of care. Martin's level of care, found to be a Class 2, aligns with his existing SNF setting. The CM's findings are added to the CATS within 12 days of enrollment and are made available online for all authorized staff.

Assessment Follow Up. The SNF discovers that Martin has developed a Stage III pressure ulcer on his buttocks. The SNF informs Martin and his sister. The CM determines, through further SNF medical record review, the SNF failed to recognize Martin's bariatric needs during the Resident Assessment, thus failing to implement preventative procedures, such as recording routine skin checks and implementing a formal skin integrity management plan. The pressure ulcer appears further complicated by Martin's lack of bariatric durable medical equipment, his immobility, and his incontinence. The CM contacts the CM Supervisor to discuss the Quality of Care concern. The CM reports the Quality of Care concern in accordance with health plan and AHCCCS policy.

INTERDISCIPLINARY TEAM AND PERSON-CENTERED CARE PLANNING

The CM, with direct engagement of the CM Supervisor, CM Manager, and Medical Director, determines that an immediate transfer to a SNF with expertise in bariatric treatment (receiving a bariatric rate for bariatric knowledge, staffing, and equipment) is in Martin's best interest. Both Martin and his sister agree to this solution and the CM works with them to determine which of his local choices can best meet Martin's needs and help him progress towards his short and long-term goals. Martin chooses North Mountain Medical and Rehabilitation Center in Maricopa County, which is close to his sister and has a dedicated Certified Wound Care Specialist, bariatric care, and rehabilitation therapies that can support his TBI needs. The CM moves forward with completing the ALTCS Member Change Report, and due to the urgent situation, obtains authorization to transfer Martin to the new SNF that same evening. The CM shares critical information between providers through our online Provider Portal. The CM calls Martin and his sister the day after the move to ensure he and his sister are satisfied with the new SNF and to schedule a visit within 10 days of placement.

As Martin proceeds with the transition, our CM ensures nutrition, mobility, and neuro-rehabilitative consults are conducted and that specialized mental health support is provided to address Martin's needs. Our CM ensures appropriate coordination between Martin's neurologist and our health plan's BH Director to inform the care plan. Martin's CM engages Bridgeway's interdisciplinary team (IDT) and SNF treatment providers through routine case reviews, inclusive of a BH Specialist trained in TBI treatment to ensure that Martin receives the crucial neuro-rehabilitative services and BH support required to sustain optimal recovery. Our CM also facilitates, with Martin, his person-centered planning team, which meets at the SNF routinely to understand Martin's vision for the future and the short and long-term interventions required to support his quality of life, medical, and BH goals. Per Martin's request, his circle of support includes his sister, SNF Social Worker, Nutrition Specialist, Physical Therapist, Occupational Therapist, BH Specialist, and Wound Care Specialist. The CM invites, with Martin's permission, additional team members over time to address his quality of life and transition goals, including Bridgeway's Housing and Employment Specialists and Martin's widening circle of peers.

PERSON-CENTERED CARE PLAN AND SERVICE PLAN

Becoming Active. The care plan includes aggressive wound care treatment provided by the SNF's Certified Wound Care Specialist with frequent skin integrity checks, a well-defined incontinence care routine, and male nurse staff (per Martin's request) to provide bathroom assistance. Martin also works with a Nutrition Specialist to understand his nutritional needs and to develop a meal plan that works for him and his weight loss goals. As his wound heals, the SNF implements Martin's mobility plan to support his increased mobility over time. While Martin's psychiatric consult indicates that he is demonstrating depressive symptoms, he refuses a prescription to treat his symptoms, indicating that he thinks he will feel better once he is walking. The CM finds a peer support provider with a history of traumatic brain injury through Ability360 and introduces him to Martin. The CM also introduces caregiver and family resources to Martin's sister, but the sister declines at least for now. The BH Specialist recommends Martin participate in individual and group therapies to support his recovery. North Mountain Medical and Rehabilitation Center has extensive experience supporting members with TBI to increase their activity through a continuum of therapeutic work. The SNF provides rehabilitative therapies, including physical therapy to strengthen his safe transferring and walking; occupational

therapy to support his self-care skills (e.g., recognizing his hygiene needs and performing activities of daily living); speech therapy to address his struggles with communication; and cognitive therapy to improve his concentration.

Live Independently. Martin has communicated, repeatedly, his desire to transition to the community and to live independently. The CM conducts, with guidance from our Housing Specialist, an enhanced assessment to identify with Martin and his circle of support his independent living options and available housing resources. The CM facilitates a person-centered planning team discussion, with Martin and his circle, about the benefits, obstacles, and risks of transitioning to a home setting and ways in which Bridgeway can support Martin to reach his goals. The CM shares information on the ALTCS Community Transition program, a program created to assist members in facilities to transition to a home setting. The CM also educates Martin and his circle on the various settings of care that are available to meet his needs if he is not ready to transition home, including Alternative HCBS Settings for members with needs similar to his. The CM informs Martin that Bridgeway is prepared to support his independent living goals, and with our Housing Specialist and community-based partners, we can assist Martin to identify transition obstacles and to develop innovative solutions, if he chooses to transition home. Martin's decision, after further discussions with his treatment partners, is to transition out of the SNF into an apartment close to his sister. With assistance from Martin's person-centered planning team, Martin develops an attainable plan to live independently. The CM initiates Martin's application for HUD Section 8 Housing and identifies Low Income Housing Tax Credit projects in the area for housing dedicated specifically for people with disabilities.

Be a Freelance Writer. With guidance from our Employment Specialist, the CM discusses with Martin and his circle of support, the Arizona Rehabilitation Services Administration (RSA) Vocational Rehabilitation (VR) program and ALTCS' supportive employment services, both of which (if he is determined eligible) include employment supports tailored to meet the needs of individuals with brain injury. In the short-term, Martin is encouraged by all who are engaged in his treatment to keep a journal and to start his own written memoirs. When Martin is ready, the Employment Specialist partners with the CM to schedule an orientation session with RSA to understand the services and assistive technology offered through the VR Program to meet the unique needs of Martin and his TBI. The CM also connects Martin and his team to the Job Accommodation Network (JAN) and JAN's TBI expert consultation to understand the resources available to Martin to ensure his employment success. As a result, Martin is introduced to the Writers' Corner at PSA Art Awakenings' to meet more people, express his talents, and explore career opportunities.

Care Education and Support. Martin's goals require that Martin be informed of his needs and the role he (and possibly his sister) will play in his long-term health and recovery. The CM refers Martin and his sister to the Brain Injury Alliance of Arizona (BIAAZ) to access a wide range of informational materials and to access peer and family support groups. Through the BIAAZ, Martin is introduced to a peer support specialist who visits with Martin in the facility weekly to share his experiences and to provide Martin hope for the future. Martin and his sister also participate in groups held at the SNF, which are facilitated by Nutritional Specialists and Rehabilitation Therapists on staff. As Martin builds trust with his group leaders, his sister, and his peers, he is able to work with them to develop positive coping strategies and skills to ensure his progress, especially with the complex interaction between his obesity, depression, and brain injury. To prepare for transition, the CM works with Martin and his circle to identify partners through our Community Resource Referral Connection system, including nearby meal programs and local Lend-a-Hand projects that specialize in supporting individuals with needs similar to Martin's. The CM also links Martin to Ability360 to socialize with peers, learn about community resources, and access freelance writing opportunities (including Ability360's newsletter*).*

REASSESSMENT, MONITORING AND FOLLOW UP

The CM remains engaged with Martin, his sister, and his circle of support through monthly SNF case rounds and quarterly in-person visits and reassessments. Martin's pressure ulcer was treated rapidly and he sustains skin health integrity. With his focus on improved diet, exercise, and sleep, Martin has consistently lost 8-10lbs per month and has regained enough strength to transfer with limited assistance. Martin has developed a strong bond with the peer who visits weekly, and he is relieved to know someone who has gone through similar experiences. Martin is looking forward to participating in more BIAZZ and Ability360 activities with his friend once he is discharged. His personal memoir is coming out nicely, and once he is discharged, Martin plans to contribute to BIAAZ and Ability360's newsletters. Four months post admission, Martin's acuity and level of care has decreased to a Class 1 and he is ready for discharge to his own apartment. Martin's CM assists Martin to identify a local Primary Care Provider who meets his needs, and the CM ensures timely transfer of Martin's records upon discharge. Martin receives assistance with one time deposits,

purchases, and home modifications through the Community Transition Program (e.g., kitchen equipment and a larger bed) and the CM ensures his required medical equipment is delivered to his home in time for his discharge (e.g., CPAP and transfer aids). Once discharged, Martin receives outpatient rehabilitation therapies, personal care (he was educated on his self-directed personal care options through our self-direction training video), and RSA VR services (to determine Martin's Vocational Profile and to match him to employers). The CM coordinates all of Martin's transportation to medical appointments and supports Martin to obtain an ADA Platinum Pass to attend his weight loss group, brain injury support group, and book club. Martin's new personal care worker also consistently supports Martin's weight loss goals.

CONTINUOUS QUALITY IMPROVEMENT PROCESSES

Quality of Care Investigation. The CM, under the guidance of the CM Manager, submits a Quality of Care (QOC) Concern to the Bridgeway's Quality Management Department regarding the stage 3 pressure ulcer. The Quality Improvement (QI) Coordinator reviews all relevant case notes, assessments, and treatment plans in TruCare and the medical records received from the hospital and SNF. The QI Coordinator completes a QOC investigation, and the investigation summary is reviewed by the QM Director and Medical Director. According to the investigation, the first SNF was in violation of the AHCCCS Medical Policy Manual (AMPM). According to the AMPM, the Resident Assessment Instrument (RAI) is intended to identify the member's risk of pressure ulcers and the preventative treatment and equipment required. While the SNF performed the RAI, it was not completed accurately to reflect the member's current needs and risks. The SNF, as a result, failed to provide the member with the medically necessary equipment included in their per diem rate (such as alternating pressure mattress, lifts, cushions, and geri-chairs). The SNF, aware of the prior authorization process, also did not request customized DME for the member's bariatric needs.

Corrective Action Plan. The Quality Management Department, in partnership with the first SNF, develops a Corrective Action Plan (CAP) to address the SNF's QOC violations. After conducting trend analysis, Bridgeway schedules a series of technical assistance meetings with Bridgeway's Medical Director, QM Director, VP Long-Term Care, Provider Relations, and the SNF administrators to develop work plans to address the SNF's identified deficiencies, including inadequate screening, assessment, and documentation practices as well as inconsistent wound care protocols. Bridgeway partners with wound care experts to provide the SNF with technical assistance and works with the SNF to ensure wound care training is provided to the SNF nursing staff. Our Quality Management team conducts an onsite visit within three months of the CAP implementation and monitors the SNF ongoing to ensure sustained compliance according to AMPM. As a direct result of this process, the SNF takes significant strides towards improved wound care service delivery as demonstrated through Medicare Star rating data, MDS data, and our Centelligence® enterprise analytics system. Bridgeway is exploring with the SNF, at the SNF's request, the requirements for and benefits of a bariatric rate and model of care moving forward.

Provider Training and Development. Through Medicare Star rating and Centelligence data, Bridgeway identifies SNFs that are emerging as leaders in wound care prevention and treatment as well as SNFs that have higher rates and progression of ulcers. Our Medical Director partners with our Provider Services Manager, emerging Provider leaders in wound care, and wound care experts to develop a comprehensive Wound Care Prevention and Treatment Training Program to improve Providers' quality of care outcomes. The Training Program, informed by national and Arizona best practices and clinical practice guidelines, is piloted and then fully implemented with our SNF Provider network through our online training platform (and through onsite technical assistance and training, when needed). Providers also receive access to our online Practice Improvement Resource Center, which includes best practices, clinical practice guidelines, and tools to support pressure ulcer screening, prevention, and treatment. The Training Program is subsequently offered annually to our Providers. Our lessons learned, from the QOC investigation and Provider trainings, inform our provider improvement activities across the SNF network, including our existing pressure ulcer measure as part of our Value-Based Payment arrangement with facilities.

AZ REQUEST FOR PROPOSALS SOLICITATION # YH18-0001

NARRATIVE SUBMISSION REQUIREMENTS

Program #6- A young male Veteran with a service connected spinal cord injury and Post Traumatic Stress Disorder (PTSD) is currently residing in an Assisted Living Facility…

EXPERIENCE AND OVERALL APPROACH

Veteran Experience and Readiness. Bridgeway Health Solutions® (Bridgeway) will support veterans through a multidisciplinary, person-centered approach that recognizes the role of members, peers, family, veteran service organizations (VSOs), and state and federal entities in holistic and well-coordinated care. Building on the success of our affiliates, Cenpatico Integrated Care (CIC) and Health Net Federal Services (HNFS), we will work with the Veteran's Administration (VA), Veteran Health Care Systems, and community organizations to conduct outreach and to coordinate care. We will abide by Centene's Collaborative Protocol with Arizona Veterans Affairs, initiated by CIC, which includes protocols for outreach, assessment, crisis response, and problem resolution. We also will build on HNFS' more than 28 years of experience providing health care to 2.9 million TRICARE beneficiaries and 1.7 million veterans through Department of Defense and Veteran Affairs contracts. For instance, we will adopt secured clinical data exchange practices being tested by HNFS with the VA, when appropriate and allowed by the VA. Bridgeway also will participate in Arizona Coalition for Military Families' technical assistance and training to acquire Supportive Employer Status as well as their Veteran Navigator training to ensure our Case Managers (CMs) successfully support veteran members. Our CMs also will receive enhanced veteran training coordinated by our internal Veteran Expert and informed by our Veteran partners. Our training will include veteran-tailored content in Mental Health First Aid; member culture; trauma and recovery; VA eligibility, programs and services; VA/ health plan collaborative protocols; and innovative VSO partnerships.

Scenario Approach. As summarized in the table below and discussed in more detail throughout this response, we share our process for working with David, a 26 year-old African American with a spinal cord injury and Post Traumatic Stress Disorder (PTSD). We provide direct insight into how our health plan will support veteran members through well-coordinated medical care, behavioral health (BH) care, and long-term care (LTC), including services provided by non-covered entities. The CM partners with David and his support system to identify his assets, quality of life goals, and care gaps so Bridgeway can work with David, our interdisciplinary team, and his person-centered planning team to address his unmet needs. The CM identifies early on, through a mix of investigative work, in-person assessment, and member interaction, that David has veteran-provided services and works with David and his VA CM to address his gaps in care. Our CM uses a trauma-informed approach to support David to widen his circle of support and to link David to a mix of Veteran and non-Veteran employment and housing resources to meet his quality of life goals. Our CM also works with our Veteran Expert and our Housing and Employment Specialists to provide David with timely information to address his fear of benefit loss while also supporting his long-term financial independence.

Member's Goals	Person-Centered Care Plan and Service Plan	Focus Areas
I want to work	• Vocational Profile and Employment Goals • Disability Benefits 101/ Benefit and Work Calculators • DIRECT Center for Independence Referral • Arizona Rehabilitation Services Administration (RSA) Referral • Kino Veterans' Workforce Center Referral • Employment Accommodations through ALTCS and VA • Transportation for Employment Readiness Activities; Free Bus Passes; Ability360 Referral for Vehicle Purchasing • Peer Engagement through VSOs and ALTCS Peer Support Providers • Freedom to Work Program through Social Security Administration • Arizona's Wounded Warrior Job Placement Program	• Non Covered (VA) Benefit Coordination • Employment Training and Support • Isolation Risk • Functional Independence • Transportation • Benefit Planning

I want to move into my own home	• Primary and Routine Preventative Care, Neurology, and Rehabilitation through the VA (Spinal Cord Clinic) • Specialized PTSD Treatment through the VA, As Needed • Routine BH Appointments and Peer Supports through ALTCS • Wounded Warrior Project (Alum) Peer Support, As Needed • Prescription Management by ALTCS • VA Guaranteed Home Loan and Adapted Housing Grant Programs • Free Bus Passes; Ability360 Referral for Vehicle Purchasing Community Transition Plan and Related Services and Equipment • Agency with Choice Personal Care through ALTCS Upon Transition • Contingency Plan for Attendant Care	• Functional Independence • Non Covered (VA) Benefit Coordination • Prescription Coordination • PTSD/ Trauma • Transportation • Personal Care
I want to do things outdoors	• Peer Engagement through Wounded Warrior Project and ALTCS • University of Arizona Adaptive Fitness Center Membership • Ability360's Sports Clinics for Veterans and Adaptive Climbing • New Adaptive Climbing Group with Local Wounded Warrior Alum	• Comm. Integration • Transportation • Health and Wellness • PTSD/ Trauma

INITIAL MEMBER CONTACT AND VISIT

David's CM reviews David's electronic medical record, inclusive of his Pre-Admission Screening (PAS), prior to contacting David. Our CM learns that David is a 26 year-old African American with a spinal cord injury and PTSD living in a Tucson-based Assisted Living Center (ALC). The CM also determines, through the PAS, that David has VA funding. Our Program Coordinator (PC) contacts the ALC to inform them of the transition. The ALC reports that David has no unmet needs.

Initial Welcome Call and Visit. The PC contacts David to welcome him to Bridgeway within 7 business days of enrollment. The PC provides David a brief overview of our mission and values; member benefits; and how to reach his CM and our 24/7 help line if he needs assistance. The PC asks David who he would like to engage in the assessment and care planning process, if anyone. David reports, with some frustration, that he has two case managers (one at the VA and one at the ALC), a neurologist, a primary care provider (PCP), and a psychiatrist. The PC validates for David the frustration associated with trying to navigate complex systems of care and communicates that a Bridgeway's CM can assume a helpful role in coordinating across his covered and non-covered benefits. David seems appreciative and reports that he would like his father engaged in the assessment. The PC tells David that she is mailing a Member Handbook and documents her communication with David in TruCare, our clinical management application. During a routine visit to the ALC, the assigned CM knocks on David's door to introduce herself and asks David to sign an Authorization of Disclosure form to allow the CM to engage David's father and non-covered providers (at which time she learns he receives VA-based primary care, psychiatric care, and rehabilitation therapies).

MEMBER ASSESSMENT

Assessment Process and Tools. The CM meets David and his father at the ALC at a time convenient for both of them (and within 12 business days of enrollment) to conduct the initial in-person assessment. After introductions, the CM reviews David's Member Handbook and vital materials in his preferred language, including ALTCS benefits, Member Rights, and Advance Directives policy. To assess David's medical, BH, and functional needs, the CM uses our online Integrated Assessment Tool, which includes questions specific to members' veteran status. The CM, sensitive to David's PTSD, informs David about the purpose of the assessment, the type of questions that will be asked, and his option to stop the assessment at any point. The CM also is trained on trauma-informed practice and how to identify signs that a member is experiencing trauma-related stress (e.g., a visual appearance of terror, hyperarousal, etc.). The CM modifies the assessment approach to be respectful of David's experiences, as needed.

Veteran Benefits. The CM learns from David that he was in the Marines when he was injured by an improvised explosive device, which lodged shrapnel into his upper back and caused a C6 spinal cord injury. David reports that he was honorably and medically discharged after this injury for which the VA has currently deemed him 75% disabled. David voluntarily, but cautiously shares his VA paperwork and reports that he receives $1,500 per month from the VA for his care expenses. The CM assures David that his VA services and funds will not influence his ability to access the care and support he needs from ALTCS. David demonstrates trust in the CM as the assessment progresses and begins to fill in the

missing pieces of the provider puzzle. David reports that he is receiving his primary and routine preventative care, neurology, and rehabilitation therapies through the VA. He reports that he receives (and very much likes) his Tucson-based outpatient primary care coordination from the Spinal Cord Clinic and Disorders Team at the Southern Arizona VA Health Care System. David also reports that he receives occasional outpatient psychiatry and individual BH counseling through the VA, but that obtaining his desired appointment times can be challenging. The CM reviews concrete ways in which our health plan can coordinate David's services, regardless of the funding stream, to ensure David receives the comprehensive care needed to live as independently as possible in the community. The CM recognizes that David, given his service-related injury, may have access to an array of veteran resources. The CM reports that Bridgeway can work with veteran partners (with David's permission) to ensure David is accessing services for which he is eligible, to the extent he chooses, while also providing medical, BH, and LTC he needs through Bridgeway.

Functioning. David indicates that he has some upper body movement and partial hand movements to grasp and release light objects, but that his lower body is paralyzed. He confirms that he receives ALC assistance for transferring, dressing, and meals, but that he has been working hard to regain as much functioning as possible because he wants to do things on his own. David's father, who remains quiet for most of the assessment, indicates that David is a highly motivated person who does not want handouts and does not allow set-backs to keep him from reaching his goals. While David has moderate PTSD symptoms, his BH screening indicates he has no signs of risk to himself or others.

Pharmacy. The CM has some concern about David's risk for addiction given his prescriptions, which according to the labels, include two pain medications prescribed by more than one physician. One prescription, a low dose of oxycodone, is for neuropathic and musculoskeletal pain, and David reports that his doctor has been working to reduce the medication over time. The CM documents, for follow-up, prescriptions' names, dosage, usages, prescribers, and efficacy.

Social Supports. David has frequent contact with three local friends from high school and one friend from his service days. David's father, who lives locally, also appears invested in David's life. Even so, the assessment indicates that David has minimal involvement with community organizations and may be isolated socially. David's father would like to see David, "get out more often." The assessment also points to David's PTSD symptoms (e.g., anxiety and avoidance of crowds) possibly impacting his interest in trying new tasks and engaging socially.

Quality of Life. David reports he wants to eventually "work, own his own home, and have fun." He is confused about what the VA offers, what ALTCS offers, and what he may lose for support if and when he seeks employment. He would prefer to have one or two personal care workers he can trust rather than multiple workers he does not know. His current ALC coordinates his meals and social activities, but David reports he would like to "eat on my own and do my own thing." The ALC provides transportation to David's medical appointments and to occasional activities, but he eventually wants to drive his own car, "if that is possible." The assessment identifies David's recreational interests, which include biking and climbing (although he personally doubts these activities are possible.)

Assessment Conclusions and Follow-Up. The CM finds that David has many assets, including being a hard worker, resilient, socially engaging, and funny. David also has a strong informal support network inclusive of friends and family. With copies of David's Veterans-related paperwork and documented consent, David's CM works tirelessly to identify David's VA CM and to schedule a call to discuss any existing care gaps, including those related to his rehabilitation and BH care. The CM recognizes that David is ready and interested in transitioning to a less restrictive environment, but that David wants to move to the right place rather than just any place. The CM uses ALTCS' Uniform Assessment Tool (UAT) to determine David's acuity and level of care and the HCBS Needs Tool (HNT) to determine the estimated time needed to support David in his own home. David's level of care is found to be at a Level 1, and the HNT indicates that David will require approximately 15 hours of personal care a week to live in his own home.

INTERDISCIPLINARY TEAM AND PERSON-CENTERED CARE PLANNING

David's CM engages Bridgeway's Medical, Behavioral Health, and Pharmacy leadership, as needed, through weekly Interdisciplinary Team (IDT) reviews to ensure an integrated approach to David's care. David's CM also engages the health plan's VA Expert, Employment Specialist, and Housing Specialist, as well as, David's VA CM and PCP from the Spinal Cord Clinic, through the IDT process to support coordination of David's non-covered benefits. With David's consent, the CM contacts David's VA CM and all of David's providers (covered and non-covered, including the Spinal Cord Clinic) no less than quarterly to identify David's gaps in care and to address his unmet coordination needs. While David's VA CM is extremely busy, Bridgeway's ongoing outreach has paved the way for consistent communication and problem solving among David, his VA CM, and Bridgeway. David's CM works with David, as a part of the assessment

process and ongoing, to identify David's circle of support. His circle of support, which meets no less than quarterly and in-person, assists David to recognize his assets, supports his recovery, and participates in innovative problem solving. David's chosen circle of support includes his father and friends he has made through the Wounded Warrior Project and recreational activities.

Sample of Care Coordination Success. As a follow-up to the CM's assessment, Bridgeway's Pharmacy Director reviews the *Controlled Substances Prescription Monitoring Program Database* to identify David's prescribers and to develop, with covered and non-covered Providers, a therapeutic pain management program that addresses David's risk for opioid addiction. The CM's discussion with David's VA BH provider finds that he has accessed the PTSD Clinical Team for short periods of time, and through further conversations with David, the CM refers David to a BH provider that meets David's needs. The BH provider assesses David's trauma and chooses evidence-based practices that meet his needs, including peer support. The CM also reviews, with the IDT, David's eligibility for Medicare given his two-year waiting period (post-disability) and informs David of his Medicare eligibility and options, when appropriate.

PERSON-CENTERED CARE PLAN AND SERVICE PLAN

David's goals are to: 1) be employed, 2) own his home, 3) live independently, and 4) be active outdoors. His initial Plan, built on David's personal assets and skills, addresses his immediate needs specific to employment, maintenance of benefits, and recreation as well as initiates support for his long-term goal of home ownership. David's Plan is fluid to respond to his changing needs and is modified based on re-assessments at least every 90 days or when there is a change in status. The CM supports David to meet his goals through a mix of authorized Provider services, Veteran services, and community referrals. Below, we highlight the services provided to meet David's personal goals. Please see the table above for the comprehensive Person-Centered Care Plan and Service Plan.

Our Employment Specialist, trained by the Work Incentive Information Network and active in workgroups and conferences, will train CMs on Arizona's Employment First policy.

Employment. Bridgeway's Employment Specialist is engaged in IDT meetings to support David's employment goals. The CM meets with David to create his Vocational Profile inclusive of his personal assets, knowledge, skills, and career interests. The CM works with David and his chosen allies, through the person-centered planning process, to document his employment goals, access employment supports, and discuss his progress. The CM meets with David to access *Disability Benefits 101 (Disability101)* and its Benefit and Work Calculators to demonstrate how employment may or may not affect his benefits. The CM then refers David to DIRECT Center for Independence, which provides David a Work Incentive Consultant to learn about Ticket to Work (Social Security work incentives), the Job Accommodation Network (free and confidential employment guidance), and Az Job Connection (Arizona@Works affiliated registry to match individuals to employers). The CM also informs David of Vocational Rehabilitation (VR) services provided by the Arizona Rehabilitation Services Administration (RSA) and supports David's access to post service career support. While waiting for VR eligibility determination, the CM introduces David to the Kino Veterans' Workforce Center for peer relationship building, employment training (e.g., resume development and interview preparation), VA benefit education (including information on Education and Training funds), and referrals to employers hiring veterans. The CM works with David to identify his accommodation and assistive technology needs, such as a speech recognition program for typing. The CM works with David to learn from the hiring process and to avoid discouragement.

Maintaining Benefits. The CM, informed by our Employment Specialist, participates in ongoing communication with David to address his fear of benefit loss. David's CM informs David of opportunities for saving even with his Medicaid asset limits and of the *Freedom to Work* Medicaid buy-in option for when his income rises above Medicaid thresholds. David's CM also works with David and the Employment Specialist to develop a Plan for Achieving Self Sufficiency (PASS) to effectively prepare for if/when his Social Security disability benefits are decreased or eliminated.

Transportation. The CM works with David to identify and access a wide range of transportation resources to meet his short-term needs, including medical transportation through his ALTCS benefit and Veterans Transportation Services. David's CM also informs David that the health plan can provide transportation assistance for his employment and community integration goals, including transportation for employment readiness activities and free bus passes for local Sun Tran's accessible buses. David's long-term transportation goal is to drive independently using his own modified vehicle. Our CM introduces David to Ability360 to access a wide range of vehicle purchasing, modifying, and financing resources, such as Arizona Technology Access Program (includes a database of vehicles for purchase), VA's Automobile

Adaptive Equipment Vehicle Modification Programs (includes equipment and reimbursements for vehicle conversions), and the Veteran Driver Rehabilitation Program (provides training to safely operate new vehicles).

Recreation. After they explore local recreational activities, the CM authorizes David's paid access to the University of Arizona Adaptive Fitness Center. The DIRECT Center for Independence also informs David of Ability360's adaptive programs in Phoenix, including Veteran Sports Clinics and adaptive climbing groups. David attends many of these events with his father and eventually starts a local adaptive climbing group with his local Wounded Warrior Alum.

Housing. David's CM supports David to make informed decisions about his independent living options, including setting his housing goals, understanding his obstacles, and developing innovative solutions for success. David's CM refers David to Old Pueblo Housing Development to explore all VA and non-VA funded housing options, including loan programs and grants that provide veterans with no payment down and affordable and accessible home options. The CM, in partnership with Old Pueblo Housing Development, also explores with David the benefits of accessing the Arizona Department of Housing Pathways to Purchase program, which assists with home purchasing costs. David's CM, trained and supported by our Housing Specialist, will be informed of housing laws, including Fair Housing laws and the Arizona Residential Tenant Act. David's CM also will be informed of local housing best practices and state and federal initiatives through our Housing Specialist's active engagement in community events, workgroups, and conferences.

Transition Supports and Attendant Services. In preparation for David's transition, the CM works with David and his circle of support to develop a Community Transition Plan. The CM ensures David has all the equipment and services needed before the transition (e.g., a trapeze system, continence supplies, and pharmacy home delivery). David's CM authorizes the required Home Modifications unavailable through other funding sources, including a ramp and grab bars. Through the re-assessment and Cost Effectiveness Study, the CM finds that David, as a Level 1, can access 15 hours of Attendant Care per week to meet his home and employment needs. The CM educates David on his Self-Directed Attendant Care options through multi-media tools, and David chooses Agency with Choice to allow more time for his career and sports interests. David supplements his personal care through his VA disability benefits and receives peer support to assist with his PTSD (beyond what is offered through ALTCS) from the Wounded Warrior Project.

Contingency Planning. In preparation for David's transition, the CM facilitates David's Contingency Plan with David to mitigate any disruption of his Attendant Care. The CM works with David to review the "Member Service Preference Level" component during each visit, which identifies when, how, and by whom service gaps will be reported and filled. David's CM also assists David to develop and continuously review his disaster plan for if/when he loses heat and/or water, requires back-up electricity, requires shelter, and/or requires a back-up supply of medications. David's CM reviews with David, in light of his PTSD, how to recognize a BH crisis and access Community Bridges for crisis services through NurseWise, our 24/7 help line. The CM reviews with David his PERS as well as the importance of calling upon his circle of support (including his BH peers) when he is feeling isolated or is experiencing heighted PTSD symptoms.

REASSESSMENT, MONITORING AND FOLLOW UP

During his 90-day reassessment, David seems upbeat and describes his recent biking trips with friends. With support from his CM and peers, David has been completing vocational assessments and exploring his employment interests. David's medical needs are stable, his confidence is growing, and he is socializing more often. Six months later, David is employed with Old Pueblo Community Services providing support to veterans who are experiencing homelessness. While still living in the ALC, David is completing financing applications with his CM and would like to transfer from the ALC to his own home, if possible. David visits the gym at least once per week and is considering trying out for the University of Arizona adaptive road racing team. David also is a new member of the Bridgeway's Member Council and provides guidance on how we can better support veterans. One year later, David is engaged, living in his own home, attending church frequently, and preparing for his first social work college course.

ACCESS TO CARE/
NETWORK #7

AZ REQUEST FOR PROPOSALS SOLICITATION # YH18-0001

NARRATIVE SUBMISSION REQUIREMENTS

Program #7
It is estimated one in four Arizonans will be over the age of 60 by 2020…

BRIDGEWAY HEALTH SOLUTION'S PERSPECTIVE ON THE ARIZONA PARAPROFESSIONAL LABOR MARKET

Paraprofessionals provide critically important services that impact Bridgeway Health Solutions® (Bridgeway) members' health and quality of life. For the significant majority of Bridgeway members who live in a residential home or assisted living facility, paraprofessionals provide homemaker services, personal care, coordination of services, general supervision and assistance, socialization and skills development. These services allow members to live comfortably in the least restrictive setting and deliver needed social supports. For the 25% of Bridgeway members who live in a Skilled Nursing Facility, paraprofessionals extend the reach of clinicians, providing our members with improved access to care and addressing the non-clinical aspects of health and wellness.

As our member population continues to age, in parallel with the state's population, the demand for paraprofessional services will increase. According to the Arizona Department of Health Services' 2014-2018 Arizona Health Aging Plan, by 2025 there will be as many people over 65 as under age 15 living in Arizona. The population is also growing more ethnically diverse, with every racial and ethnic group over age 65 at least doubling in size between 2005 and 2025. To adequately care for the aging population in our state, the community will need to come together to build a sustainable and diverse paraprofessional workforce pipeline. Given the role paraprofessionals play in our members' health and wellness, Bridgeway has a vested interest in convening this effort and contributing resources to ensure a successful outcome.

Arizona is Facing a Paraprofessional Shortage

Despite the growing demand for paraprofessionals, recruitment and retention remains a challenge. As noted in *Aging 2020: Arizona's Plan for an Aging Population*, the state will need 10,362 new home health aides by 2025 to maintain the current ratio of 149 home health aides for every 1,000 individuals over 85 years of age. Yet difficult working conditions, relatively low compensation, and limited opportunities for upward mobility all contribute to a workforce with high rates of turnover. Worker shortages are even more acute in rural areas, where it is more difficult to recruit skilled staff and providers. Greater reliance on paraprofessional staff in areas where providers are scarcer warrants a higher level of skills training to maximize scope of practice.

Through Bridgeway's relationships with the 57 attendant care agencies in our current network and the institutions that employ paraprofessional staff, we are intimately aware of their struggle to maintain a quality workforce and the risks if we do not act quickly to build up the pool of paraprofessionals. Providers are concerned that younger individuals in the state are not primed to seek out this type of employment without a change in values or incentives that make the roles competitive with other opportunities. Despite the recent minimum wage increase and AHCCCS fee schedule adjustment, our providers note that workers still face unstable working conditions and limited job growth potential, which will continue to drive turnover without action. They note that due to the characteristics of the work and the workforce, successful strategies will likely focus on increasing the pipeline and retention of short term workers rather than trying to retain current workforce over the long term.

The Solution Must be Broad and Community-Wide

No one entity can solve the paraprofessional shortage in Arizona. Similarly, no one strategy will address all of the challenges to recruitment, hiring and retention. In a recent study of the Arizona health care workforce, health care leaders felt that better recognition, training, and wages for the paraprofessional workforce would help improve care and retention. Other studies have validated these approaches – for example, the CMS National Direct Service Workforce Resource Center published evidence on linkages to training and job satisfaction, better benefits and lower turnover, and positive impacts of efforts to improve the work environment and culture. Therefore, a multi-faceted solution will need to be developed, that engages educational institutions, policymakers, health plans, providers, workers and members across the state, to advance the supply of high quality paraprofessionals to serve our members.

BRIDGEWAY'S ANTICIPATED PARAPROFESSIONAL LABOR NEEDS

Bridgeway will be ready to serve our members on day one of the Contract. We recognize that as the population ages and our membership grows, the need for paraprofessionals to sustain our members in the least restrictive setting will increase. Because over 40% of our members receive assistance from Direct Care Workers (DCWs), our proposed solutions below are targeted to these workers.

We will also need to ensure that the workforce continues to reflect the cultural and language preference of the members we serve in our communities. We recognize that we cannot do this alone and will look to strategic partners, including those listed below, to help build up the supply.

PURSUING A COMMUNITY-WIDE SOLUTION TO RECRUITMENT, HIRING AND RETENTION

As a fully invested stakeholder in the long term care health care space in Arizona, Bridgeway recognizes the need to help organize a community-wide strategy on the long term care paraprofessional workforce that addresses core challenges our providers and members face. Bridgeway will drive the creation of and help fund an **Arizona Workforce Development Consortium** that will establish specific goals for paraprofessional volume in Arizona and set up processes to achieve the goals and measure progress. We intend to take a leadership role in this Consortium along with the following partners.

- **Educational institutions**. High schools, community colleges and universities that could develop certification programs and higher education opportunities for workers.
- **Provider associations.** Associations such as the Arizona In-Home Care Association and the Arizona Association of Providers for People with Disabilities can help provide perspective on the feasibility of solution implementation for various paraprofessionals and agencies relative to business needs.
- **AHCCCS**. AHCCCS can provide intelligence on the history of efforts to build the paraprofessional workforce in the state as well as weigh in on potential policy levers to improve opportunities for paraprofessionals.
- **Bridgeway and other ALTCS Plans.** Bridgeway and other plans can provide feedback on what is working with their populations and direct more concentrated, pooled resources to solutions that work across the community.
- **Members.** We want to include the member perspective in any convening to ensure the solution will meet their needs.

An example of an initiative that the Consortium could define and execute would be providing an incentive to paraprofessional workers to receive educational credits in exchange for retention in the industry. For example, if a paraprofessional worker works for an AHCCCS provider for at least 12 months they can begin to qualify for a certain number of education credits for online courses that will allow them to achieve a higher degree. This would provide needed education for individuals, present a career path, improve the quality of care provided to ALTCS members and offer workers more value for staying in their job. If a pilot was successful, the Consortium would work with AHCCCS to determine how broadly the initiative could be implemented. Another potential strategy would be to establish different tiers of paraprofessional reimbursement based on the amount of training the worker obtains.

Bridgeway will contribute seed capital and leadership for the Consortium to implement these and other creative solutions to make a bigger impact on the problem than any one entity or field could alone. The group would need to tackle both financial needs of paraprofessionals as well as their non-financial needs, such as gaining a sense of mission and a higher level of responsibility from their job.

BRIDGEWAY-DRIVEN STRATEGIES TO INCREASE PARAPROFESSIONAL SUPPLY

Through the Consortium, Bridgeway will also take steps to develop workforce through incentive programs, innovative technologies, and targeted partnerships. Given that Certified Nursing Assistants tend to have more of an established career path, our efforts will focus on paraprofessionals outside of institutions. These strategies will align with the following goals that address known challenges:

- Assist in identification of a broad pipeline for recruitment
- Support the start-up and ongoing costs to serve as an agency
- Provide support and incentives to agencies to support retention of workers

Bridgeway will also articulate these strategies as part of the workforce development component of its Network Management and Development Plan.

Ensuring a Broad Pipeline for Recruitment

Family members can be an obvious choice to provide long term care services for their aged and disabled relatives. However, many members do not have family capable to serve or the family cannot or does not desire to provide care. Therefore, Bridgeway will encourage agencies to recruit from a variety of underutilized populations in the state who may be seeking alternative forms of employment. These include:

- Veterans groups
- Retired populations
- Temporary Assistance for Needy Families (TANF) and other able members
- Community Health Workers
- Peers

We will work through our contracted agencies to expand their recruitment strategies to reach these groups and partner with associations that work with the targeted population groups to advertise paraprofessional roles. We will also ensure our case managers (CMs) are trained to offer opportunities to members who are capable and desire to care for others. For example, a member who is alert and oriented is able to provide supervision to another member for a few hours until a family member comes home from work.

Partnering with associations to obtain a diverse workforce. Bridgeway is currently the only platinum level sponsor of the Arizona Direct Care Workforce Initiative. Funds are used to increase public awareness of direct care and to promote workforce development. We also sponsor entities like the National Diversity Council, the Arizona In Home Care Association, and participate in community events such as "Cochise Serving Veterans" so that they can share information about becoming a direct care worker or behavioral health paraprofessional. In our leadership role of the Consortium we would encourage other ALTCS plans participate at commensurate levels.

Empowering our members to recruit and take advantage of natural supports. Our members often prefer to have help from those with whom they are familiar but these individuals may not be accessible through Bridgeway's contracted agencies' traditional recruitment channels. Bridgeway gives our members the resources they need to select, hire and retain these workers. Our CMs encourage members to seek member-directed or Agency with Choice options for attendant care, where appropriate, as the member is more engaged and has more control over their care.

We also help members incorporate natural supports available to help them navigate the system, which decreases the demand for trained workers. Hosting Peer Support Groups is one way to help members gain information about how to access benefits in the community and increase quality of life.

Maximizing use of current worker supply. It has been our experience that in some parts of Arizona the paraprofessional workforce may not be fully utilized due to lack of awareness of available services within the community the agency operates. Specifically, we have heard from workers in Maricopa, that in order to fill their schedule each week they may have to drive well outside their area. While this may help address a need for surrounding communities, it is challenging for the workforce as the worker may spend more time driving to members than actually serving them. However, Bridgeway has been partnering with these agencies to connect the workers to local members. This helps ensure greater connection between the local workforce and the members in their communities, thus improving access and availability for members and improving retention for the agencies employing the paraprofessional workers. As we work with the Consortium to improve access and further help ensure that the current supply of trained workers is being utilized to its full extent, Bridgeway will direct the Consortium to promote the communication of worker availability, such as through existing state registries including Arizona Respite Locator. We will ensure our contracted agencies and members know of and use these resources to identify potential hires, as appropriate to our members' needs. We will also work with those agencies that may have been sending workers out of their area to identify patterns in care and the need to support the agency in recruiting and training workers in rural communities.

Decreasing Start-up and Ongoing Costs of Care Provision

Many direct care worker agencies are small businesses that struggle with the costs of operating. To the extent that Bridgeway can leverage its size and expertise to help reduce the start-up and ongoing costs of direct care work, we can help support a new supply and retention of agencies and their employees.

Training and technical assistance programs. Obtaining the training needed to be competent in providing long term care services can be a barrier to entry. Bridgeway will partner with existing programs, including the AHCCCS Direct Care Worker Training Program, HOSA Arizona, Community College training programs, and others to maximize worker access to training and identify any needed gaps in content. For example, the 2015 Maricopa County Community College District Allied Health Needs Assessment revealed a need for training in integrated behavioral and physical health care.

To extend our reach, Bridgeway will offer web-based Relias Learning Management System (RLMS) to support low or no cost remote training and education on behavioral health topics for our contracted providers who cannot afford to offer a training on their own. Users will have access to provider created trainings as well as the RLMS behavioral health library. The RLMS can track online trainings as well as live events, and many courses offer Continued Educational Credits (CEUs.)

Bridgeway will build on its current knowledge of the business pressures facing direct care agencies and help them tailor trainings to meet the need. For example, assist lay persons in identifying when a member they are caring for is in distress. We also know that cultural competence will grow in importance as the aging population in Arizona diversifies. Given Bridgeway's size and expertise, we can provide agencies with content to support their administrative and staff training needs, allowing them to focus on providing quality direct care. We will also provide agencies access to our Provider Portal to assist with claims submission.

Bridgeway and the Consortium can also spread best practices we identify across our network. For example, if we see one agency is having notable success recruiting paraprofessionals through certain channels, we will share that information with other agencies and help them replicate the initiative in other areas of the state.

Certification programs. Modeled off of the successful Behavioral Health Aide program in Alaska for the tribal population, Bridgeway will promote certification of direct care workers to enhance the level of training and ideally increase workers' payment. The training must be tailored to the knowledge base and service needs of the particular geography served. Bridgeway will also help advertise the certification to help communicate the value of the training to agencies and members.

Agency support. We currently hold regular provider meet and greets to further build relationships with agencies and proactively identify and resolve issues and challenges. In an effort to support the maintenance and growth of agencies, we will explore new and expanded relationships. One of the concerns we hear from our agencies is about having consistent volume to keep their employees busy and engaged. Bridgeway can help direct volume to agencies that are in need in cases where working with that agency will be beneficial to the member. We can also help provide intelligence on where agencies could expand to increase volume. Where Bridgeway observes a gap in needed paraprofessional service, we will work with agencies to expand capacity in other services areas. For example, we have contracts with multiple home care agencies (such as Beech Home Care) who will work with us to expand their services to the North GSA if we identify capacity concerns and need additional workforce.

Empowering Home Care Workers. Centene's affiliate plan in Illinois is piloting the use of smartphones to help home care aides report the changing health conditions of members to CMs and providers via the caregiver's supervising agency, allowing the caregiver to share important observed changes in the physical, mental and environmental conditions of participants. Home care aides receive training from their supervising agency on how to identify changes in condition and how to report the changes. By providing this resource, Bridgeway will help to engage caregiver agencies to empower their workers to share critical information about the member's condition, to reach out when the aide feels they need more advice to act, and to take on a more meaningful role in the member's care, ideally improving retention.

Passive home health monitoring. Increasing the efficiency of the existing workforce helps to mitigate the need for more workers. To help extend the reach of a limited number of paraprofessionals, Bridgeway will expand our HealthSense pilot, which uses passive "in home" monitoring technology. The technology incorporates sensors, with authorization from the member, that monitor member's eating, sleeping and toileting patterns. By expanding this pilot, home care workers will have actionable data that makes their time with the member more efficient and effective.

Offering Caregiver Supports

Given the difficulty of the job, caregivers are subject to caregiver burnout that can threaten retention. To lower the risk of caregiver burnout, Bridgeway will promote the use of community-based caregiver support groups across the GSAs we are serving, including, but not limited to, the following:

- Area Agency on Aging Family Caregiver Support Group: Family Caregivers Forums offer educational sessions for caregivers held at locations throughout Maricopa County. Provides caregiver support
- Neighbors Who Care (Chandler): Offers a peer support group for caregivers of older adults who are homebound.
- PCOA Caregiver Support Groups (Tucson): Provides monthly support groups for family and informal caregivers.
- Navajo Family Caregiver Support Program: Offers support groups for caregivers of elders.

Addressing Retention within the Workforce. Bridgeway's affiliate plan in Pennsylvania will be piloting a solution to use an algorithm to identify home care workers who are at risk for departure, and implement interventions that improve the worker's job satisfaction and therefore retention. Bridgeway will monitor outcomes of this innovation to determine whether to expand it to Bridgeway's network.

Bridgeway currently has a value-based payment initiative targeting staff retention for attendant care agencies as one of the key performance measures that impact payment. Bridgeway will expand this initiative to other paraprofessional agencies and make adjustments to the incentive where retention may be waning.

Proactive response to agency closure. Bridgeway proactively works to prevent potential service gaps for members due to agency closure. For example, when Bridgeway learned of a pending agency closure due to the owner's retirement, we sought out another agency that hired all the caregivers from the closing agency to ensure there were no gaps in service. Bridgeway will continue this proactive monitoring and outreach work throughout the course of the contract.

Measurement and Monitoring

Bridgeway will implement a monitoring plan to measure what strategies work and what do not, and to ensure we are using the most effective tactics throughout the contract. This monitoring plan will include the following elements:

- ***Satisfaction survey for paraprofessionals.*** On an annual basis we will survey paraprofessionals who serve our members to understand the biggest threats for retention and what resources they need to provide quality care.
- ***Agency survey.*** Similar to the paraprofessional survey, we would survey all of the contracted paraprofessional agencies to identify shortages and other resource concerns across the GSAs. We will gather feedback on what is helping relieve concerns and what support is still needed.
- ***Member feedback.*** We will continue to gather feedback from members in terms of the quality of care they receive from providers to monitor and quickly resolve gaps in service.
- ***Rapid initiative evaluation.*** For each of the new initiatives Bridgeway implements to promote hiring and retention of paraprofessionals, we will perform rapid cycle evaluation to closely monitor their results in terms of outcomes and costs to know whether the investment is truly benefiting our members or if our resources are better invested elsewhere. We will feed these findings into our value-based incentive model to maximize the gains.

ACCESS TO CARE/
NETWORK #8

AZ REQUEST FOR PROPOSALS SOLICITATION # YH18-0001

NARRATIVE SUBMISSION REQUIREMENTS

Program #8
A 16 year old male who is paraplegic secondary to a gunshot wound to the spine is currently enrolled with the Offeror. The member is currently receiving treatment in a Behavioral Health Residential Facility for inappropriate sexual behaviors perpetrated against a sibling and previous exposure to drug and alcohol abuse in the family home. In recent months, he has met all of his treatment goals and is ready for discharge. Due to his history of inappropriate sexual behaviors, the Child and Family Team recommends he not return to the family home. The family has heard about and visited an out of state group home where they would like to see the member placed. Describe how the Offeror will address the appropriate placement and service needs for this member.

OVERVIEW

In this scenario, we refer to this plan member as "Joseph." Bridgeway Health Solutions® (Bridgeway) prides itself on its robust ability to provide Case Management and coordination using a person/ family centered approach. For Joseph's case, we prioritize our participation in the Child and Family Team (CFT) and its ability to meaningfully engage both Joseph and his family in discharge planning and the development of his care plan, and ensure that he gets the right placement, services and care that are targeted to his goals and needs. Viewing the entire family as an inter-related unit, our Case Manager (CM) works closely with Joseph, his family and the stakeholders of the CFT to design a plan that offers him the best opportunities to meet his social-emotional and educational goals, improve his family relationships and family member skills, as well as minimize his risk for sexual re-offense, substance use, and unnecessary health care utilization. Bridgeway benefits from a rich network of community providers that can address Joseph's specific needs.

DISCHARGE PLANNING

Current Status

Joseph's discharge planning began the moment he entered the Behavioral Health Residential Facility (BHRF) with the assistance of our LTC CM. Throughout Joseph's treatment at the BHRF, our CM, with support from our Behavioral Health Coordinator, has maintained engagement with Joseph, his family and Joseph's probation officer to remain an integral part of the CFT. Joseph and his family have forged a team comprised of Joseph's family, friends, Juvenile Probation Officer, and clinical staff at the BHRF. Although Joseph has met his treatment goals during his 12 month stay, we recognize that he requires ongoing support to address a complex variety of needs. Our CM has supported the CFT to meet with Joseph, his family and probation officer regularly over the past several weeks to discuss Joseph's current status and plan the approach to the discharge. To inform our meetings, we enlist support from internal resources such as our Justice System Liaison, EPSDT Coordinator and Housing and Education experts. For example, once we confirm Joseph's next placement setting, our Education expert will reach out to the local school district for a representative to assist our CFT with learning the best educational and/or vocational options for Joseph.

Our CM performs a follow-up trauma assessment that addresses status of his social-emotional functioning, as well as a functional assessment that informs the current performance level of his daily living activities. Our Behavioral Health Coordinator arranges a follow-up psychosexual assessment, which includes use of the Level of Service/Case Management Inventory (LS/CMI). This evidence-based assessment measures the risk and need factors of late adolescent and adult offenders and functions as a case management tool. This single application provides all the essential tools needed to aid professionals in the treatment planning and management of offenders in justice, forensic, correctional, prevention and related agencies. Offender risk will match the level of service, i.e., the higher the level of risk, the higher the level of service and support. Our CM also assesses Joseph's level of engagement in his treatment, as well as with his family. We also gather status information regarding his educational progress, well visit/ EPSDT adherence, medication needs, if any, and physical health status.

All Bridgeway's assessments are stored in our clinical management application, TruCare, which houses all clinical information, assessments, notes, treatment and service plans for our members. Any assessments, notes and/or diagnostic information not captured directly by our staff in our platform are gathered at the discharge planning stage to ensure that Joseph's clinical and care portfolio is complete as he enters a new phase of care.

Approach to Conducting Discharge Planning Meeting

Our CM works collaboratively to create a plan that accounts for his youth status, trauma history and physical health and any other cultural and linguistic considerations. We aim to create a developmentally appropriate, trauma-informed plan that includes opportunities for Joseph to express himself, learn to communicate effectively, problem-solve, identify positive role models and make informed, safe choices. We treat the family as a unit for the discharge/service planning process. His family's preference for out of state placement hints at a possible opportunity for more family work facilitating reunification goals. We recognize the difficulty in finding a least-restrictive placement that will accommodate his physical condition as well as safety precautions related to his history of sexual offenses. His trauma history and exposure to family substance use increase his risk for substance use and repeat sexual offenses. Bridgeway supports the CFT toward the creation of a care plan that mitigates these risks and recognizes Joseph's goals and preferences.

Discharge planning meetings began 45 days prior to planned discharge and have continued weekly with additional meetings scheduled as requested by Joseph, his family, his school district and/or his probation officer. At the meetings, the CFT facilitates a discussion that elicits Joseph and his family's goals, aligns them with his new care plan and encourages active family and member participation in the CFT. Because our team recognizes the unique challenges related to this family, we will work with our affiliated RBHA and its infrastructure (which includes protocols, assessment tools and toolkits for creating a trauma-informed environment within organizations) to ensure that our staff engage with families with a trauma-informed orientation. Our CM works to clarify roles for family involvement in Joseph's new phase of care and help to define decision-making processes. Our staff is highly skilled in motivational interviewing techniques and the person-centered approach to encourage Joseph to identify his own strengths and his goals for family reunification, education, career, social relationships, and physical health. We facilitate a similar discussion with his family members, asking them about their expectations and role in supporting Joseph's future. We also assess for any family support resources that may be needed to facilitate family communication and visitation scheduling that can support reunification.

Crisis Prevention and Safety Planning

Our CM will collaborate with the CFT, including Joseph, his family, schools system representatives and probation officer, to identify potential crises, sexual and behavioral triggers, successful coping and safety planning strategies and interventions. We will also help elucidate ways to prevent crisis events and sexual maladaptive behaviors as well as defined roles and activities to prevent behavioral crises and sexually inappropriate behavior. Joseph's crisis plan will be integrated with his Individual Service Plan (ISP).

PLACEMENT

Options

Bridgeway recognizes the challenge of finding a placement for Joseph that can accommodate his level of care, accessibility, and behavioral health needs, as well as one that is appropriate relative to his sexual offense history. Throughout the discharge planning process, our CM respectfully reviews all placement and service options for Joseph and presents those that are the least-restrictive and the most conducive to continuing his healing and development, championing his goals, and cultivating his progress toward becoming a successful member of society. We collaborate closely with Joseph, his family, the CFT, and the Juvenile Probation Officer in our research, to ensure their buy-in to the reasonable options we present.

Out-of-State Group Home. In our conversation with Joseph's family, our CM explores in detail the features of the out-of-state group home that appealed to them, and the reasons for their preference for out-of-state placement. We also elicit Joseph's reaction and feelings toward his family's preference. We explain the challenges of locating Joseph out of state, juxtaposed with the evidence-based, socio-emotional importance of nurturing family attachments for healthy adolescent development. We are aware that Joseph's family may resist our suggestion, since they devoted significant effort toward finding an out of state placement. Our Manager of Network Development and LTC CM both visit this facility to fully understand its resources and inform discussions with the CFT, Probation Officer, Joseph and his family about placement options. We recommend that even an in-state adolescent group home is not the ideal setting due to his sexual offense history and potential risk to other children. We also highlight that an out of state placement can only last six months and multiple short-term transitions could unravel the progress that Joseph has achieved while in the BHRF. Our consensus aims toward prioritizing family and environmental stability as critical to sustaining and advancing

Joseph's recovery and development. With consultative support from Bridgeway team members, our CM offers Joseph, his family and probation officer the option of partnering with a provider and offering in-state services comparable or better than the family's out of state choice. An in-state option gives the family the opportunity to remain actively involved in Joseph's treatment and enhances his opportunities to return to his community. The following options are considered and discussed with Joseph and his family.

Kinship Placement. Our CM explores with Joseph and his family whether there are any other family members or friends who could offer their home to him. If a kinship placement is feasible, we collaborate with the Juvenile Probation Officer to ensure that the family member has the appropriate behavioral and personal health training that will help facilitate the nurturing home environment that Joseph needs.

Remain in BHRF. This presents as an option, since Joseph's family and the CFT do not want him to return home, and the current BHRF has proven their ability to accommodate his accessibility and behavioral health needs. However, since Joseph has achieved his treatment goals in the BHRF, he shows readiness for a less-restrictive environment. His next setting is not envisioned as just a placement, but a stepped-down level of treatment intervention.

Assisted Living with Behavioral Health Services. While this type of facility may fulfill Joseph's accessibility needs, it lacks the expertise around youth/trauma-oriented behavioral health and adolescent development that will support Joseph's recovery.

Home Care Training for the Home Care Client (HCTC). HCTC is a viable option for a non-institutional, home-based environment. In this specialized therapeutic home setting, Bridgeway can provide the comprehensive wraparound supports for Joseph that address personal care, continued behavioral health and family-oriented support services, psychosocial rehabilitation and skills training/development. HCTC also allows the opportunity for Joseph to succeed in a family setting and participate in public school education, thus optimizing chances for family reunification, if that goal becomes part of his care plan. A specialized HCTC home would be developed to meet Joseph's unique treatment needs. Through HCTC, Joseph's family will be able to participate in shared parenting with the HCTC foster parent, and Joseph will be housed in an environment that cultivates safe connections, continued family engagement and communication. This setting can also accommodate any activities/services related to transition to adulthood, should reunification with his family prove to be not possible, and his treatment needs require him to remain in HCTC until he reaches age eighteen. In addition, this setting would make it possible for the sibling victims to participate in treatment to help them overcome their trauma and facilitate family reunification.

Supporting Joseph's Placement Selection

Based on the options presented, and with a full understanding of their rights, Joseph and his family agree to the HCTC. Joseph's family continues to show concern for Joseph's sexual behavior, for which the out of state placement described a comprehensive program eased their fears. Recognizing the programs offered, and feeling confident in our ability to replicate the services in state, our CM presents an option that provides the same level of service and anticipated outcomes promised by the out-of-state option. HCTC further meets Joseph's personal goal of moving into a home environment where he feels safe and accepted, while continuing to work on building a new relationship with his family.

We recognize that for any new placement, Joseph needs a setting fitted with adaptations so that he can easily maneuver around with his wheelchair. We work with the family member or HCTC parent to adapt the home to meet his accessibility needs. This includes coordinating with community resources for donation and/or payment for any necessary home adaptations. For Joseph's HCTC residence, we provide durable medical equipment (DME) which includes: portable threshold ramp, shower bar, grab bars, transfer bench, hospital bed with trapeze bar. These are purchased through a DME vendor and installed prior to Joseph's arrival.

Finding placements and preparing for Joseph's transition undoubtedly takes time. With Joseph and his family's agreement, he remains at the BHRF (no longer than 14 days from the time of identifying an HCTC placement) until his placement is ready and we will work closely with them to initiate the services in his new service plan while waiting.

Through Cenpatico Integrated Care (Cenpatico), Bridgeway has a connection with Devereux Advanced Behavioral Health, an established national organization offering children's behavioral health and child welfare services in Pima and Maricopa Counties. We are able to deem this contract through Cenpatico so that Joseph can receive HCTC through Devereux. We find an HCTC placement for Joseph in Buckeye. Bridgeway also has contracts with Arizona's Children and Pathways for HCTC homes, which can offer additional options should Devereux prove insufficient.

SERVICES

Bridgeway is keenly aware of the social determinants of health that have already put Joseph at risk for long term health conditions. His physical disability and behavioral health history qualify him as having special health care needs for which we construct an individualized clinical and behavioral treatment plan with multi-disciplinary supports. Our CM offers these services to Joseph and his family as locally available, quality options that can be incorporated into his care plan, based on their agreement and consent.

Bridgeway works with specialist support and rehabilitation providers like Touchstone Health Services, which offers therapeutic integrated child behavioral health services in Phoenix, Mesa, Avondale and Tucson. Touchstone offers an evidence-based Multi-Systemic Therapy (MST) for Problem Sexual Behaviors Program, which provides therapeutic services that would build on Joseph's strengths to combat sexual misconduct, build coping strategies and work jointly with his family to rebuild their relationship in a healthy way. This therapeutic model has been proven to lower recidivism risk for juvenile sex offenders. The model is flexible enough to be provided in multiple settings (not just in an office) and requires multiple contacts with the member across family, school, peer, and individual systems. MST interventions can enhance parenting skills, and promote positive, caring relationships. Bridgeway has worked with Touchstone in the past as a non-participating provider for another child member. For Joseph, we reach out and contract with this provider to ensure his service continuity.

To address the history of alcohol and drug abuse in Joseph's home, our CM also recommends a family referral for participation in Substance Abuse Counseling.

As another potential concern for Joseph, Bridgeway is aware through our national affiliate experience that overuse of psychotropic medications is a nationally recognized issue for foster care children. We will leverage this experience in implementing Psychotropic Medication Utilization Review for all children, which has demonstrated success in reducing psychotropic medication prescriptions and polypharmacy. Joseph's high risk circumstances would make him a prime candidate for this review program, to prevent overprescribing if he is on any medications.

Our CM engages home health services to teach Joseph and his caregiver proper bladder/bowel care, bathing, dressing and other personal care needs. In collaboration with the CFT, we facilitate choice of the most appropriate personal care provider for Joseph, with sensitivity to his adolescent developmental stage and the intention to model dignity and self-respect through this learning period.

Bridgeway also offers outpatient physical rehabilitation services, i.e., physical therapy and occupational therapy to help support his activities of daily living up to the current benefit limit.

Our CM also evaluates Joseph's need for and offers non-emergency transportation services to facilitate his access to services. In Maricopa County where Joseph lives, Valley Metro can provide Joseph with ADA-compliant wheelchair access to services across the region.

During our care planning meetings, our LTC CM identified that Joseph was a good student and while at the BHRF had been taking online classes. Joseph would like to continue his education at a public school to obtain his high school diploma. After his placement in the HCTC, our LTC CM engages our Education expert to identify local high school options from which Joseph can choose.

For services over the longer term, beyond the first six months of discharge, our CM assesses for any needs related to Joseph's transition to adulthood, including vocational rehabilitation services, independent living skills, educational goals and employment planning. We work closely with Joseph to complete the Casey Life Skills Assessment and ensure that he has a strong foundation of natural supports that bolster his development of self-determination skills. System partners are engaged throughout Joseph's care to ensure that service planning and transition is collaborative process that prioritizes Joseph's well-being and goals.

At Bridgeway we recognize the importance of maximizing opportunities for family involvement to help Joseph on his recovery journey. With Joseph and his family's consent, we also provide a family support referral to Family Involvement Center, a family-run organization serving Phoenix and Northern Arizona that helps parents to access information, support, community resources, and parent education about raising children with emotional, physical and behavioral healthcare needs. Parent training and workshops help Joseph's family learn communication, collaboration and advocacy skills while participating in a community of support. Their motto, "parents helping parents" may resonate for Joseph and his family so that they do not feel isolated in navigating this joint recovery journey.

SUPPORTS

Community supports can play vital role in helping Joseph and his family to navigate a path toward their collective goals. We want to provide Joseph and his family with a range of options for family and youth oriented programs that will enhance service engagement and recovery progress. Bridgeway uses our comprehensive online Community Resource Referral Connection system, powered by technology from one of the nation's leading social service search, referral, and workflow systems, to help our Interdisciplinary team (IDT) identify, refer, and follow-up with members in need of social or behavioral services. This system enhances service coordination with a customizable interface that identifies community resources (e.g., local housing, food, health, work, goods, education, transportation, etc.) that meet member needs and help address social determinants of health. It facilitates communication with members and caregivers (at their option) for text or e-mail resource recommendations and referral reminder prompts. Through this resource, we can help Joseph, his family and his HCTC caregiver to find youth programs/activities that target member engagement and self-determination toward their own goals and peer support programs for trauma-affected and disabled youth. Ability360, one of the five Centers for Independent Living in the State, has an array of programs that include peer mentoring, social and recreational opportunities, and youth transition to adulthood programs that would give Joseph opportunities to learn from others with similar disabilities and their approaches to self-efficacy. Our LTC CM also offers to facilitate registration for the Arizona Assistive Technology Exchange, hosted by the Arizona Technology Access Program at the Institute for Human Development at Northern Arizona University. This program aims to put Assistive Technology (AT), adapted equipment or Durable Medical Equipment (DME) that is not currently being used into the hands of someone who can benefit from it. This program may be helpful in supplying Joseph's HCTC placement.

TRANSITION/ ACCESS TO CARE/ ONGOING COORDINATION OF CARE

Once Joseph, his family and the CFT have reached agreement on Joseph's care plan, the team members initiate steps in authorization, referral and engagement in services, and placement transition. As part of our operations, our LTC CMs authorize all covered services reflected in the service plan as part of Joseph's care plan. They also serve as the single point of contact to coordinate communication among family, the CFT, stakeholders and the service providers. While awaiting HCTC placement, the CFT helps Joseph to initiate individual/family behavioral health services while at the BHRF. In order to minimize any delays or barriers to care, our CM maintains regular phone contact with service providers and 90-day member visits post-discharge to ensure that his needs are being met and provide opportunities to calibrate his plan as he adjusts to his new environment. We work closely with CFT team members to ensure that Joseph receives timely access to care by finding ADA-accessible providers that can handle prompt referral appointments. Our online Provider Directory lists specific accessibility indicators for each network provider, which can facilitate provider searches. Part of the standard monitoring will include confirmation of timely service delivery, member/family/caregiver/system partner satisfaction, coordination of appointments and continuous communication and progress tracking with family, providers and CFT members.

Bridgeway has IT applications in place that support and facilitate care coordination, which is particularly useful for members like Joseph, who have complex needs. In 2017, we are deploying enhanced service plan functionality in our Provider Portal, offering providers expanded online access to securely submit, view, and attach notes and other supporting information to Joseph's service plan, supporting collaborative and coordinated support of Joseph's goals and health outcomes. Our EPSDT Planner is also available through our Provider Portal and gives primary care providers a view of Joseph's EPSDT service needs and gaps. Through our Caregiver Portal, Joseph, his family, caregiver(s) and CFT members support engagement in and direction of care. With Joseph's consent, the birth and/or HCTC parent(s) could use the portal to access contact information, medical, BH, and pharmacy information, see Joseph's Care Plan and care gaps, and send secure e-mail to Bridgeway.

On an ongoing basis Bridgeway commits to collaborating with the CFT to use a strengths-based approach to track needs and adapt services for Joseph and his family. These activities include: tracking progress and outcomes, keeping the child's and family's vision of the future in mind; adapting the service plan as necessary to address challenges, or new situations; completing/updating person-centered care plans including Quality of Life Care Planning; including Joseph, family members other caregivers and providers in the Care Plan process; coordinating care needs so that Joseph receives timely services; reviewing and updating the provider CASII every 6 months; and tracking task assignments and their completion.

ACCESS TO CARE/
NETWORK #9

AZ REQUEST FOR PROPOSALS SOLICITATION # YH18-0001

NARRATIVE SUBMISSION REQUIREMENTS

Program #9: The Offeror holds an ALTCS E/PD Contract for both the Central and North GSAs and receives $280 million

BRIDGEWAY HEALTH SOLUTION'S CORE COMMITMENT TO AND EXPERIENCE WITH VALUE-BASED PURCHASING

Bridgeway Health Solutions® (Bridgeway) shares AHCCCS' commitment to Value-Based Purchasing (VBP) as a foundational strategy for driving the health system toward improved quality of care and reduced costs. Bridgeway began our VBP approach as a pilot starting with only a few nursing facilities and has grown to having **48% of provider payments from our ALTCS E/PD contract under VBP arrangements and 32% of provider payments from our DSNP contract under VBP arrangements.** Bridgeway's journey to achieving this percent of provider payments through VBP agreements began with assessing provider readiness and total cost of care for our members with that provider. Through this process we worked with nursing and assisted living facilities through VBP contracts that include upside-gainshare (LAN Category 3) with the remaining agreements falling into the category of Fee-for-Service (FFS) linked to quality and value (LAN Category 2). Based on our success, we are confident we will achieve 50% or more for our ALTCS E/PD contract by April 2017, and we are on track to achieve 50% by September 2017 for our DSNP contract.

Bridgeway already has **VBP models in all 3 counties in the Central GSA, where we are the only incumbent ALTCS plan in Pinal and Gila, and 3 rural South GSA counties**. At the heart of our approach to VBP are the Core Principles outlined below; the launching point for Bridgeway to achieve the objectives identified in this Question.

- Aligning incentives to improve member outcomes for whole-health and wellbeing, while reducing unnecessary costs
- Driving our members to providers with demonstrated performance and VBP contracts while always honoring choice, and working with all providers to improve and enhance performance
- Tailoring risk and reward to the current provider capabilities, while developing provider's capabilities over time
- Utilizing a structured communication to share data, solve mutual problems and strengthen the overall relationship.

Experience with VBP. Today, Bridgeway's service areas include all 3 counties that make up the Central GSA: the urban communities of Maricopa County as well as more rural (such as Gila County) and suburban to rural communities (such as Pinal). Bridgeway has established VBP arrangements in all 3 counties in the Central Region. In addition, our experience developing and implementing VBP arrangements in the rural counties of the South GSA provides valuable techniques that will support our ability engage in VBP contracts in the rural North region. While we have achieved success in developing VBP contracts with providers, we will continuously work to increase the percent of provider payments through VBP and move these agreements from LAN 2 arrangements to gainsharing and risk based arrangements (LAN 3), as well as population-based payment methodologies (LAN 4) based on provider readiness.

Our VBP models for ALTCS E/PD and DSNP have focused on four key provider types: attendant care providers, nursing facilities, hospitals, and primary care providers. These providers encompass a broad spectrum of care and can impact both quality and costs of care. Our efforts to advance VBP have focused in particular on crafting arrangements tailored to long-term care (LTC) services as members receiving LTC services have high needs and a higher cost of care. In addition, the provider delivery system for LTC is distinct from that of hospitals or other physical and behavioral health (BH) providers, and reflects varied levels of readiness to participate in VBP models.

Local and National Medicaid VBP Leadership. In addition to Bridgeway's local experience with VBP specific to ALTCS E/PD and D-SNP providers, in Arizona we are able to leverage the experiences of our affiliate companies. Specifically engaging BH providers in VBP strategies moving them from block payment, to FFS, to P4P and continuing to work with providers through the Alternative Model Payment framework as appropriate to each provider's readiness. Through our parent company, Centene Corporation (Centene), we leverage the experiences of our Medicaid health plan affiliates in more than 20 states who operate Medicaid and LTC VBP models. **By the end of 2016, 70% of Centene's Medicaid membership were served through a value based contract.** Centene's innovative analytic tools, dashboards and scorecards will help Bridgeway to facilitate communication, engagement and alignment with providers to enhance VBP performance. Thus we can build on Bridgeway's strong VBP experience in Arizona with our overall company's experience and expertise when it comes to Medicaid managed care and a broad spectrum of VBP models (LAN category 2, 3, and 4) across provider types and geographies.

MEETING CYE19 REQUIREMENTS. Bridgeway views VBP as a continuous improvement process where performance measures are enhanced over time. To date, a majority of our VBP arrangements fall within LAN category 2. However, some of our VBP contracts include gainsharing provisions (LAN 3). We will implement infrastructure supports for

providers (outlined below) to ensure success as we move providers to increased gainsharing opportunities, upside and downside risk and population-based payment approaches (LAN 4). We have 2 PCPs, Optum and PopHealth Care that are on track to move to LAN 4 arrangements in the near term. In our Arizona organization, we have already implemented Medicare Advantage contracts with LAN 4 VBP, and will leverage this experience as we support our providers to improved performance.

Infrastructure to Support Provider Performance and VBP: Success in VBP contracting and continuous quality and cost improvements are possible with strong relationships with engaged providers. We will meet providers where they are and equip them with the education, training, and data necessary to improve performance and increase their capacity for risk based arrangements in order to advance their readiness. Bridgeway has developed infrastructure and capacities through staffing, leadership engagement and actionable performance data to meet the goals described in this scenario.

Leadership Engagement and Resources. Leadership teams from Bridgeway and individual VBP providers engage in semi-annual Strategic Alliance Meetings (SAMs). SAMs provide a structured forum for collaboration, furthering strategic initiatives and addressing barriers to improving outcomes for members. Bridgeway has developed an expert team focused on provider engagement and improving VBP. This team is led by our Provider Network Vice President, with day-to-day support from our Provider Performance Senior Manager and Data Analyst staff. This team is dedicated to VBP implementation, ongoing training and technical assistance, performance monitoring, and analytics.

Actionable Performance Data: In our experience, when providers have easy to understand data that is actionable, they are better able to improve performance at the individual level and at the contract/system level. Our secure Provider Portal allows providers' access to Centelligence® Patient Analytics (CPA), which provides critical information to better identify evidence-based care gaps, understand quality improvement opportunities, and improve their Case Management functions. Our Centelligence Analytics Insights (CAI), available in the Portal, produces provider-facing dashboards that bring together a collection of the most important medical cost and utilization, pharmacy, emergency department, potentially avoidable events, clinical, population health, and quality data to help health plans and providers form a cohesive understanding of provider performance and membership trends. As we bring up new providers in the Central and North GSA, we will provide hands on training of these tools to ensure providers maximize their capabilities.

Steering Members to High Value Providers: Bridgeway is enhancing our ability to steer membership to value-based providers who achieve a higher level of performance through a system-based solution. As we gather sufficient data over time to draw justifiable conclusions about quality performance, Bridgeway will increasingly refer our highest performing providers within our overall group of VBP providers.

VBP approaches for Medicare versus Medicaid Lines of Business. One key distinction relevant to how we implement our VBP contracting approaches for ***new*** Medicaid versus ***new*** Medicare VBP contracts focuses on different services covered by each contract, recognizing that Medicaid VBP arrangements focus more on LTC services, and Medicare VBP focuses more on hospitals, physicians and acute care providers. In our Medicare DSNP contract our highest spend is attributed to hospital services (as opposed to nursing facilities and attendant care in our ALTCS Medicaid contract). Hospitals tend to be better prepared to engage in VBP and risk arrangements with multiple payers, but require critical mass to ensure success. With a relatively small DSNP member base, we will leverage other lines of business including Acute Medicaid, Medicare Advantage, Marketplace and Group Commercial to achieve VBP with hospitals that may not be interested in stand-alone DSNP. Another difference between managing a VBP contract for Medicaid vs. Medicare has required us to address how to fund VBP incentives on the ALTCS E/PD side when Bridgeway is not otherwise accruing the DSNP savings for non-aligned dual eligible members for whom we have responsibility for acute care spending.

Urban vs. Rural Experience. In our experience, urban service areas have more organized systems of care (that include primary care, attendant care, skilled nursing facility and hospital) working towards common performance measures with greater adoption of electronic health records, are more likely to participate in health information exchange, and have capacity to take risk in VBP. When working in rural communities the concentration of members does not support organized systems, impacting the effectiveness of integrated coordination of care. Rural areas may have fewer community resources and social supports to augment the person-centered service plan and impact quality of life performance measures. In rural areas, moving members to a high value provider may be a challenge due to lack of choice, making the technical assistance and support from our Provider Network staff even more critical to improve overall performance in that rural community. Additionally, we have found that having local network staff that reside in the community, such as our current team member in Cochise County, increases access to support and enhances the

relationship with the provider. Bridgeway will hire network staff for Coconino near Flagstaff, another in Mohave, and an additional hire for Apache and Navajo counties together to support VBP contracting in rural areas.

STRATEGIES TO ACHIEVE 50% OF PAYMENTS UNDER VBP ARRANGEMENTS. Based on the facts set forth by RFP Question 9, we detail in this response our strategies to achieve 50% of ALTCS E/PD payments and 50% of DSNP payments under VBP arrangements in the Central and North GSAs. To achieve these goals, Bridgeway will maintain and deepen our current VBP strategies (discussed above) in the Central GSA, while expanding these efforts to reach our VBP goals in the North GSA.

Strategies to Achieve 50% Value-Based Purchasing – ALTCS E/PD: In the Central GSA, Bridgeway's strategies to achieve 50% of ALTCS provider payments under VBP arrangements by CYE 19 would build on our **demonstrated success of 48%** of provider payments already under VBP arrangements (LAN Category 2c) as of CYE16. In the North GSA, Bridgeway's strategies will focus on expanding our provider relationships in this region and tailoring the model as needed to meet the unique VBP issues faced by rural providers.

Highest Area of Spending First. Our overarching strategy to achieve 50% of spending under VBP will focus first on highest areas of spending for the ALTCS E/PD contract. Using the AHCCCS databook spending figures for the Central and North GSAs, we calculated that **nursing facilities comprise approximately 45% of total spending under the ALTCS E/PD contract,** and **Attendant Care comprises 20%** of total ALTCS spending assuming: 72% of members in HCBS settings, 28% in HCBS (including 18% in Alternative HCBS); and 10% revenue retention. Our strategies to ensure 50% of ALTCS E/PD spending under VBP arrangements would therefore prioritize Nursing Facilities and Attendant Care providers, building on Bridgeway's current VBP models for each of these provider types, as outlined below.

Nursing Facilities: Bridgeway's current nursing facility VBP model is pay-for-performance (LAN category 2c) with the built in capability to move to LAN 3 when the facility is ready. The contract incentivizes facilities to ensure access to preventative and other critical health services that promote members' improved health outcomes and wellbeing, and help avoid unnecessary and costly emergency care and preventable inpatient admissions. We currently have 11 performance measures, and providers may earn financial incentives based on performance targets for each measure. In the most recent performance year (2015), Bridgeway paid $116,040 in performance incentives to providers in 2015. Bridgeway projects an expected payout of $450,000 to Value–Based Providers over the next 2 years. We will build on our existing VBP arrangements with nursing facilities and develop capacity to transition to greater risk/reward for providers such as Covenant Health Network, Ensign, Haven and Life Care Centers of America systems. Specifically:

Central GSA*:* Under Bridgeway's current ALTCS E/PD contract, VBP payments to nursing facilities comprise 25.8% of overall payments to providers. We now have VBP arrangements with 44 nursing facilities within our Central GSA network. Our success started with a few nursing facilities in our VBP pilot in 2014. Together with our pilot sites, we developed performance metrics and targets that were aggressive, yet attainable, and their internal capacities to achieve these goals. In 2015, we expanded to additional facilities in the Central GSA. A key challenge faced by facilities interested in VBP is ensuring that providers have a member base large enough for valid performance measurement. To address this issue, we worked with nursing facilities to create GSA-based measures that pool provider performance across the GSA. In Gila, for example, nursing facilities successfully met GSA-level performance targets, but we continue to work with providers to address challenges of measuring performance for providers with small patient populations and other barriers to VBP. To reach the 50% target, we plan to expand our program to include: Immanuel Caring Ministries ($2.4 mil, 4% NF Spend), Plaza HC Holding ($2.1 mil, 3.48% NF Spend), Renaissance West ($1.88 mil, 3.13% NF spend), Radiant Hills Health Assoc. ($1.75 mil, 2.9% NF spend) and Windsor Ridgecrest ($1.6 mil, 2.76% NF Spend).

North GSA*:* Bridgeway will deploy multiple strategies to expand VBP in the North GSA. We will initially focus provider outreach on our nursing facilities already on VBP contracts that have locations in the North GSA, for example, Ensign with 4 locations in Flagstaff, Haven Health Group with 6 locations and 2 Covenant facilities in Yavapai County. Our Provider Network team will evaluate existing VBP arrangements with the incumbent ALTCS plan and outreach to those providers. We will engage associations such as Arizona Health Care Association, to better understand key challenges to VBP and identify strategies to mitigate. Examples of nursing facilities we will engage for VBP include but are not limited to: The Peaks, Havasu Nursing Center and Prescott Nursing and Rehab Center.

Attendant Care: Bridgeway's attendant care VBP model is pay-for-performance (LAN category 2c), with the built in capability to move to LAN 3 and incentivizes attendant care providers to identify potential care gaps and ensure members are accessing preventive and other critical health services. We currently have 9 performance measures

included in attendant care VBP arrangements, and providers earn financial incentives based on performance targets for each measure. Specific strategies to increase VBP:

Central GSA*:* Currently, VBP payments to attendant care providers comprise 16.9% of our overall payments to ALTCS E/PD providers. We have VBP arrangements with 18 of 62 attendant care agencies serving the Central GSA region. We achieved this success by engaging attendant care providers through a six-month, collaborative process. Attendant care providers generally have limited experience with VBP, so our approach is to support providers in building capacities needed to measure, track, and report quality of care measures. We also convened in-person meetings with all our VBP attendant care providers for group discussion of VBP challenges and best practices. This meeting included a presentation from provider champions highlighting development of effective quality improvement systems to realize VBP financial incentives. To reach the 50% target, we plan to expand our program to include: Arizona Consumer Direct Personal Care ($2.6mil spend), Del Lago Medical ($1mil spend), Covenant Consumer Direct ($620k spend), Instant Care of AZ ($450k spend) and MGA Home Healthcare ($389k spend).

North GSA*:* We will first target providers through currently contracted entities; 4 of our 18 currently contracted VBP attendant care providers in Maricopa County extend into the North GSA. We have contracts with home care agencies (such as Beech Home Care) who will work with us to expand services to the North GSA to address any capacity or additional workforce needs. Our Provider Network team will engage providers with VBP arrangements under the existing ALTCS plan. We will use stakeholder feedback to help guide our VBP outreach and contracting efforts specific to the most rural/frontier areas of the North GSA through discussions with associations such as: AzNHA and other leaders in the Attendant Care provider community.

Strategies to Achieve 50% Value-Based Purchasing – DSNP: With a $75 million DSNP contract serving the Central and North GSAs, we estimate serving approximately 2,700 DSNP members.

In the Central GSA, Bridgeway's strategies to achieve 50% of DSNP provider payments under VBP arrangements by CYE 19 would build on our strong foundation of 32% of provider payments already under VBP arrangements (LAN Category 2c) as of CYE16. In the North GSA, Bridgeway's strategies will focus on expanding our provider relationships in this region and tailoring the model as needed to meet the unique VBP issues faced by rural providers.

Our overarching strategy to achieve 50% of spending under VBP will focus first on highest areas of spending for the DSNP contract. Based on the facts presented for the DSNP payments in the Central and North GSA, Bridgeway's VBP strategies would target the following areas: hospitals (44% of total payments: 37% inpatient, 3% emergency room, 4% outpatient), and physicians (22% of total payments).

Hospitals: In 2016, Bridgeway launched a VBP arrangement (LAN category 2c) with one of our major hospital system partners, Banner Health. Based on this experience we are expanding VBP arrangements to all new, and renewal contracts with our network hospitals in 2017. Our initial focus has been on reducing hospital readmissions, and we plan to expand performance measures under these contracts. We will also expand hospital performance measures within our VBPs, including measures such as hospital acquired condition rates, patient satisfaction surveys, discharge instruction rates, and medication reconciliation. To maximize VBP arrangements with hospitals in the Central and North GSAs, we will engage the following:

Central GSA: In Bridgeway's current DSNP contract, VBP payments to hospitals comprise 23.5% of overall payments to providers. In 2017, we are including VBP provisions in all new contracts and contract renewals with hospitals. By the beginning of 2018, we anticipate VBP payments to hospitals will comprise 62% of our total DSNP payments. We will continue to enhance these arrangements through *increasing the quality metrics evaluated*. Tenet, Dignity, and Oasis will be entering into a VBP in early 2017.

North GSA: In the North GSA, we will first target currently contracted entities for VBP. Banner Health, for example, has an affiliated site in Page, Arizona*. In addition, our Provider Network team will conduct extensive outreach to engage and develop relationships with hospitals (including integrated behavior health facilities), including:*

- Flagstaff Medical Center, Kingman Regional, Havasu Regional, Summit Healthcare Regional, Yavapai Regional, Tuba City Regional Health Care Corporation, Little Colorado Medical Center, Hopi Health Care Center, Sage Memorial Hospital, Fort Defiance, Northern Arizona VA Health Center, and Verde Valley Medical Center.

Physicians: Bridgeway's current VBP model focuses on primary care providers (PCP), and recognizes the opportunity for these providers to ensure members receive preventive services, appropriate care to manage chronic conditions, and reduce emergency and inpatient care. We currently have P4P (LAN category 2c) VBP arrangements with two of our major PCP providers (Optum and PopHealth Care) who provide services where the member lives. In addition, we are on

track to move to LAN 4 with both providers, including a shared savings arrangement to incentivize better management of prescription drugs and pharmacy spending for members. In addition, Bridgeway plans to expand VBP to specialists and to a new network of BH providers to promote physical and BH integration. To maximize VBP arrangements with physicians in the Central and North GSAs, we will engage the following:

Central GSA*:* In Bridgeway's current DSNP contract, VBP payments to physicians comprise only .7% of overall payments to providers. Bridgeway will approach hospital-based provider groups that include PCP and Specialist to include in a VBP to cover physical and BH quality indicators. Bridgeway will enter into a gainshare agreement with Optum by Q2 2017

North GSA: We will engage current providers of PCP services, Optum and PopHealth Care, to expand with Bridgeway's expected growth into the North GSA. PopHealth Care is providing home services in Mohave County and Optum operates its NP/PCP model in Yavapai County. We will also engage hospital-based PCP and specialist provider groups such as YRMC Physician Care and Midwest Internal Medicine (Internal Medicine, Neurology, Gastroenterology, Oncology, Cardiology) into VBP agreements to cover physical and BH quality indicators.

PERFORMANCE AND OUTCOME MEASURES ACROSS ALL VBP CONTRACTS. Enhancing quality is a critical component of our VBP model, and we have collaborated with our providers to identify key performance measures for attendant care providers, nursing facilities, hospitals, and PCPs. Table 1 below lists examples of these measures, which reflect a range of clinical and operational measures that align with AHCCCS and Medicare STAR measures.

Table 1: Summary of Current Bridgeway VBP Performance Measures across Provider Types for ALTCS E/PD and DSNP

Performance Measure	AC	NF	H	PCP
Flu shots *(AHCCCS): percentage of members receiving flu shots*	X	X		X
HgbA1C *(AHCCCS): percentage receiving test as defined by measure*		X		X
Readmission rate *(AHCCCS): readmission rate within 30 days of discharge*		X	X	X
ER visits *(AHCCCS): number ER visits per 1,000 members*		X		X

Behavioral Health and Physical Health Integration: Bridgeway has worked with BH providers like Heritage Lane since we first initiated VBP to increase care coordination and support for members with both BH and LTC needs. Bridgeway is working to incorporate Care Integration measures to include in our current ALTCS and DSNP contracts that incentivize our current VBP providers (nursing facilities, attendant care, PCP) to ensure coordination and integration of member physical and BH services. This Integrated BH/PH model applies to all of Bridgeway's members residing in community and institutional settings, and builds an overarching and foundational strategy for identifying and addressing our member BH needs. Similarly, Bridgeway and our affiliate RBHA (Cenpatico), have developed VBP models that support BH integration to improve whole health outcomes. Cenpatico has experience working with providers to develop integrated services at community mental health centers and providing LAN 2a support, moving into 2c and 2d.

With this experience in mind, in the first quarter of 2017, we will launch our newest phase of VBP contracting for integrated BH and physical health services. Through this model, our Bridgeway Case Managers will conduct clinical depression screenings (using the PHQ-4) for all our members on a quarterly basis. Members who screen positive for BH needs will be referred to high-performing BH providers within our network such as Empact SPC. With these new VBP arrangements, we will incentivize coordination between the member's PCP and Bridgeway assigned case manager, reduction in emergency department and avoidable inpatient care, and will fast track referred members to receive appointments within 14 days (at a maximum) of referral. As our Integrated BH/PH VBP model matures, we anticipate gaining performance data to steer members to high-value providers while always honoring choice. Additionally, we will work with integrated clinics such as Terros to support whole-health care, and will incentivize providers that serve our members in other capacities, i.e. counseling, peer services or skills training. We will incentivize integrated health VBP providers to evaluate members using an integrated health assessment looking at holistic member needs and matching to services through the providers' integrated clinic. We will engage Wellness Connections a highly utilized peer and family run provider in Cochise County in VBP contracting to enhance members' social and environmental supports. We have successfully utilized this provider in Cochise, Graham and Greenlee counties to engage members in peer services and skills training. By incentivizing Wellness Connections to evaluate members for referral to vocational and/or educational services and for coordination with PCPs, we anticipate greater participation in programs that will support engagement and prevention.

ADMINISTRATIVE #10

AZ REQUEST FOR PROPOSALS SOLICITATION # YH18-0001

NARRATIVE SUBMISSION REQUIREMENTS

Program #10
The Offeror recently received an authorization request for an increase in attendant care hours for a member…

OVERVIEW

Throughout this scenario we will refer to the member as Bernice and her spouse caregiver as Steven. Bridgeway Health Solutions® (Bridgeway) is committed to ensuring that each member has the adequate number of attendant care and skilled care hours to maintain health and wellbeing in the least restrictive setting possible. Based on Bridgeway's experience with the Long Term Care (LTC) population, we have proactively implemented a member-centered process to identify and resolve concerns early on to meet our members' needs. This process has proven effective, **reducing requests for a State Fair Hearing from 59 in 2015 to only 19 in 2016.**

In this case, our member Bernice's condition began to decline and her representative Steven submitted an authorization request for an increase from 20 to 45 care hours. While the case manager (CM) was reviewing the request with her supervisor, Steven contacted five different agencies, including the legislature, in an attempt to secure approval of the request. Through this response we outline how our case management team evaluates and addresses the request to meet the member's need, keeps AHCCCS apprised of all developments, and ensures that Steven and other agencies know the appropriate channels to direct future requests.

ANTICIPATING AN AUTHORIZATION REQUEST

The assigned CM visited Bernice and Steven on February 9, 2016, 68 days prior to his request, and presented Steven with a service plan allocating 20 attendant care hours for Bernice. Steven told the CM he was comfortable with the plan and signed the plan to indicate his agreement.

According to Bridgeway's policy and Bernice's specific care plan, the CM assigned to Bernice would have contacted Bernice and Steven at least every 90 days, or upon any service event such as an admission or visit to the emergency department (ED), to assess whether any changes in services are required. In this situation, between the CM's regular assessments, Bernice's condition began to decline. She experienced a Urinary Tract Infection, for which she sought treatment from her Primary Care Provider (PCP). Following that treatment, Bernice became incontinent, leading to additional care needs and work for Steven to keep Bernice safe and comfortable in the home.

Our CMs work to maintain good relationships with members as well as their caregivers and the caregivers' employers, to establish a direct and open line of communication about the member's needs. In most cases, the relationships the CMs forge with their members, caregivers and agencies ensure that the CM is the first line of contact for any concern. This includes contacting the CM regarding unplanned visits to the PCP and any change or suspected change in health status.

In this case, despite the CM's efforts to encourage Steven to contact her immediately with any changes in Bernice's condition, Steven became overwhelmed by the increased demand for his caregiver services and went directly to the Member Services Department and multiple other agencies to request an increase in hours.

RECEIPT OF AN AUTHORIZATION REQUEST AND INITIAL REVIEW

When our Member Services Department receives Steven's authorization request for additional attendant care hours, they immediately refer the request to the LTC CM assigned to the member. The assigned CM then contacted Steven that same day to discuss his request for an increase in attendant hours and to understand what conditional changes may be impacting Bernice's activities of daily living. Steven explained that due to Bernice's incontinence he was now having to do multiple loads of laundry every day and move and tend to Bernice more often which was taking more time. The CM stated she heard and understood Steven's concerns and confirmed that Steven still felt capable of adequately caring for Bernice. After documenting Steven's concerns, the CM informed Steven that she would speak to her supervisor about the request and would follow up with Steven the next day.

The CM also encouraged Steven to contact either her or his traditional attendant care employer, Ability 360, if he notices any further change in Bernice's condition as the CM and agency were both advocates for Bernice and Steven. She also told Steven to contact Bernice's PCP with any conditional change. As an active participant on the Care Team, the PCP is also instructed to notify the CM of changes in health status.

The CM completed the Home and Community Based Services Need Tool, based on the information gleaned from her conversation with Steven, and shared the findings with her supervisor to discuss potential needed changes to the service plan. The CM also told her supervisor that Steven is a spousal caregiver, knowing that members with spouses as their caregiver cannot have more than 40 hours of attendant care or similar services in a seven day period.

Based on the CM's assessment and the requested increase in hours, the supervisor assigned the request to case review.

MEMBER-CENTERED INTERDISCIPLINARY TEAM CASE REVIEW

The Interdisciplinary Team (IDT) includes a Medical Director, a registered nurse Case Manager, a behavioral health coordinator, managers of case management, a supervisor of case management, the Pharmacy Director, nurse CM and Bernice's assigned LTC CM. This broad interdisciplinary team allows for an objective review of the situation, including strong representation of the member's perspective.

Bernice's CM advocated for Steven and Bernice at the case review meeting, explaining the change of condition and the reason Steven is requesting 45 hours. The IDT agreed that they needed additional information due to the decline in condition. They felt the living environment needed to be reevaluated by a CM. In the interim, given the increase in caregiver effort that Bernice's condition demanded, the IDT immediately approved 40 hours, the maximum allowable for Steven to continue serving as the caregiver, while further assessment is being conducted.

The nurse CM also contacted Bernice's PCP to get additional information about the change in condition. She advised the PCP to contact the CM if the PCP observes any further change in Bernice's condition.

CONDUCTING A REASSESSMENT

The IDT recognized the opportunity to send two CMs to conduct the reassessment. This is a process improvement that Bridgeway has incorporated over the last five years to promote inter-rater reliability between CMs for improved assessment accuracy.

Both CMs go to Bernice and Steven's home, at a time that is convenient for them, and conduct a full change of condition assessment. The following tools are used to inform their assessment of Bernice's current needs: (1) the Home and Community Based Services Needs Tool, (2) the Uniform Assessment Tool, and (3) the Bridgeway Health Solutions Integrated Assessment. Our CMs take a member-centered approach in their review, seeking to identify and resolve the root of the member's problem. They listened to Steven's concerns and validated them to ensure Steven recognized the CMs as his advocates.

After completing these three tools, reviewing the living environment, and talking with Bernice and Steven, the CMs agreed that Bernice's condition may in fact require more hours than Steven requested, up to 48 hours of attendant care. The assigned CM explained to Steven that if he remains as the spousal caregiver, he cannot provide more than 40 hours of service in a seven-day-period. Steven stated he would strongly prefer to remain as the caregiver and perform the 48 hours of service. Given the CM's history with Steven and Bernice, she knew that Bernice had expressed anxiety about having a different caretaker and recognized maintaining Steven's role as the caretaker was a priority for the member.

The CMs notify Steven and Bernice that they will take this information back to the IDT and assure them they will hear a response within 14 days of their request, but to contact the CM directly with any concerns. If the assessment were to take more than 14 days, the CMs would have directed the Grievance & Appeal (G&A) Coordinator to send a Service Request – Notice of Extension to Steven and Bernice, explaining the reason for the decision to extend the timeframe.

Given the new information, the case was presented to the IDT for a secondary review. The CMs again advocated for Bernice and Steven, indicating that the results of their assessment suggested that 48 hours of attendant care were required given Bernice's change in condition and that Steven strongly desired to remain the caregiver.

The nurse CM also reported the results of her review and confirmed that the PCP ordered a skilled nursing assessment. Per the Bridgeway Skilled Nursing Need Standard Policy, the AHCCCS registered home health agency in Bernice's community, Valley Home Health Care, conducted the assessment. The assessment revealed that Bernice's change of condition did not warrant skilled nursing.

The IDT agrees to approve the case for 40 hours with Steven as the attendant, while they would approve 48 hours for an attendant care worker that is not the spouse. Given that Steven and Bernice already strongly expressed their goal for Steven to remain the sole caregiver, the Team approved the request at 40 hours. The Team developed a revised service plan that reflects the 40 hours of approved attendant care and the assigned CM asked Steven to sign the service plan,

explaining how to document on the plan if he disagrees with the hours allocated. The CM also made sure that Steven re-signed the Spousal Attendant Care Acknowledgement Form to demonstrate he understands how additional hours may impact certain benefits Steven and Bernice receive, such as food stamps.

Given that the 40 approved attendant hours is below the 45 requested, the action taken is a formal denial. The supervisor directs the G&A Coordinator to prepare a Notice of Action to be sent to Bernice and Steven, following Bridgeway and AHCCCS policy. The Notice of Action clearly explains the reason for denial, focusing on information about Bernice's condition and Steven's request that informed the decision, as well as instructions on how to file an appeal, in addition to the other required elements as outlined in the AHCCCS ACOM Policy 414.

In addition to the mailed notice, the assigned CM contacted Steven to inform him of his rights to appeal if he still feels the decision is not in the best interest of Bernice. The CM also explained how to file a formal appeal if he had further concern.

Recognizing the IDT would have approved more hours for a non-spouse attendant and noting Steven's stress, the CM recommends that Steven attend a caregiver support group in his community to help him manage the stress and develop productive coping strategies in the company of his peers. Bridgeway CMs maintain a list of these and other community resources to support caregivers and, in turn, our members. Knowing Steven did not like to drive far, the CM pointed out the groups that would be most convenient for Steven to attend.

The CM also reminded Steven and Bernice that they have the option for respite care to allow Steven a break from his caregiver duties while still giving Bernice the assurance of having a caregiver to assist in Steven's absence. In Bridgeway's experience, respite care and caregiver support groups are critical instruments to combat caregiver burnout. Another option that may be discussed is palliative care if Bernice's condition warrants those services.

ADDRESSING A COMPLAINT TO THE LEGISLATURE

Bridgeway's case management program encourages CMs to serve as an advocate for members, to maintain a supportive relationship, and have regular check-ins with members and their representatives. Case management supervisors serve as a backup in the rare case that this relationship breaks down for any reason. This arrangement typically allows the CM or supervisor to resolve any issues before they rise to the level of a complaint and anticipate any member needs. However, in this case, despite the CM's efforts, Steven's stress drove him to voice his concern elsewhere.

As soon as AHCCCS notifies Bridgeway that Steven contacted a member of the legislature, the Corporate Compliance Officer immediately follows up, with a goal to keep AHCCCS informed at every step of the process until resolution. The Corporate Compliance Officer follows up with her AHCCCS contact every day to inform the contact as to the status of the situation, actions that Bridgeway has taken and the process moving forward to resolution.

In addition, to promote ongoing system education, the case management supervisor calls each of the caregiver agencies Steven contacted to inform them that they should contact the CM immediately to relay any concern they hear and that they should serve as advocates for Steven and Bernice. Similarly, as noted earlier, the CM advises the PCP to communicate with the CM if the PCP anticipates a concern from the member or her representative. This creates one point of contact – the CM – so she can monitor the requests and follow up on them as opposed to creating multiple points of contact that may cause requests or complaints to slip through the cracks.

The CM supervisor also contacts Steven directly, to identify any potential issues he faced contacting the CM. The supervisor makes sure Steven is aware that if Steven cannot reach his assigned CM or the CM is not resolving his request, he is always able to contact the supervisor to get his concern resolved. The goal is to give Steven an option for escalation within Bridgeway before seeking help from external parties. The supervisor also explains that should Steven want the assistance of a third party, he has access to external resources that are designed to hear his concerns and help him further understand the policies and the process, including the Long Term Care Ombudsman and legal aid through the Elder Law team at Jackson White.

To further address these instances, Bridgeway follows a written Member Management Policy that proactively provides care coordination for those who have multiple complaints regarding services or the AHCCCS program. Bridgeway has had success with this policy with the ALTCS population.

PERSON-CENTERED CASE CONFERENCE

After talking with the CM and receiving the Notice of Action, Steven is still unsure if the decision is right for the family and requests an appeal. Bridgeway sends Steven a written acknowledgement of receipt of the appeal within five business days.

Bridgeway has implemented a case conference process as an additional step to find resolution on denied requests without having the case go to a State Fair Hearing. As noted above, implementing this case conference process has prevented cases from even being scheduled for a State Fair Hearing. However, members are always informed of their right to request a State Fair Hearing according to Bridgeway policy.

From 2015 to 2016 the number of State Fair Hearings requested dropped from 59 to only 19, demonstrating the effectiveness of Bridgeway's process.

In this case conference process, the case management supervisor assembles additional member advocacy information from Bernice and Steven, the CMs, as well as any information the nurse CM and PCP can provide to inform the appeal decision. We do this to ensure the member's perspective is well represented in the appeal.

APPEAL PROCESS

The supervisor provides all the information gathered in the case conference for the medical director to review the case. The case management team always pulls in a new medical director to review the case on appeal so that the medical director can provide an opinion that is unbiased from the prior levels of case review.

After reviewing the information provided, the medical director confirms that the denial was sound and that the alternative care plan of 40 attendant care hours is the appropriate allocation given Steven's request to be the sole caregiver. He directed Grievances & Appeals to send a Notice of Appeal Resolution, no later than 30 calendar days from the date of receipt of the appeal, explaining the outcome of the appeal and notifying Bernice and Steven of their right to file for a State Fair Hearing.

The CM sits down with Steven and Bernice again and explains the reasoning behind the decision and how it may benefit Bernice more than the original request for 45 hours, given the potential impact of a disruption in caregiver and loss of other benefits. After hearing these arguments, Bernice and Steven agree to the new care plan and decide not to file for a hearing.

Should Steven and Bernice have exercised their right to a fair hearing, Bridgeway would commence our formal process for documenting and demonstrating to the Administrative Law Judge (ALJ) that we have made every effort to resolve the issue before coming to the ALJ and coming prepared with all the facts necessary to support our assessment. **All cases brought to a State Fair Hearing in 2015 and 2016 have so far been adjudicated in Bridgeway's favor.**

PROACTIVE FOLLOW-UP AND MONITORING

Although this case was able to be resolved without a State Fair Hearing, Bridgeway recognizes the need for follow-up so that future requests are anticipated and resolved efficiently. After the request is resolved, the CM sets up a more frequent contact schedule with Bernice and Steven to make sure the transition to the new care plan goes smoothly. The CM reminds Steven of the options available to him to provide relief, including caregiver support groups, respite care and even palliative care and helps him determine how to take advantage of those services.

The case review process also allows for continuous quality improvement. With every case, the IDT takes a learning approach to determine how a member complaint could have been avoided. They look across cases and across supervisors to determine the most effective path to pursue with members and caregivers going forward.

Bridgeway also takes a broader plan-level look at service requests and outcomes in an effort to continuously improve our processes. The Quality Management Department keeps a log of all cases that go to case review to identify any trends in why the cases are brought to review and how they are resolved. This information is provided on a regular basis to the CM supervisors so they can communicate to their team how to anticipate and respond to future service requests. The data is also reported to the Quality Committee for analysis and review.

ADDRESSING GRIEVANCES AND APPEALS FROM MEMBERS WITH A SERIOUS MENTAL ILLNESS (SMI)

Although SMI was not a factor in this case, Bridgeway recognizes the requirement to implement and administer an SMI Grievance and Appeal system in addition to a Title XIX/XXI Grievance and Appeals system. Bridgeway will build upon its existing Grievance System to incorporate the additional grievance system procedures for persons with an SMI, as

referenced in Section J, Paragraph 3 of the RFP. These additional procedures include an SMI Grievance Investigation process and an SMI Appeal process. Bridgeway's behavioral health partner, Cenpatico, has well-established policies and desktop manuals and has significant experience with these processes.

If Bernice was a member in the SMI Program, she would have the option to follow either the SMI Appeal process or the Title XIX/XXI appeal process as provided for in AHCCCS ACOM 444 since the services in question are covered by Title XIX/XXI. Both the SMI Appeal process and the Title XIX/XXI appeal process center around the member. However, pursuant to the SMI Appeal process, Bridgeway would convene an Informal Appeal Conference with Bernice and Steven within seven days of receipt of an appeal, which would include authorized or designated representatives, CMs, representatives from service providers, or others as applicable. Bridgeway would screen any appeal for possible expedited resolution as required by AHCCCS policy and render a decision as expeditiously as the member's condition required. Our appeal process is designed to ensure the member's voice is heard and disputes about service planning are resolved at the earliest possible time.

AZ REQUEST FOR PROPOSALS SOLICITATION # YH18-0001

NARRATIVE SUBMISSION REQUIREMENTS

Program #11. A provider who is a specialty surgeon, filed a claim dispute contesting the Offeror's recent recoupment of the entire payment amount for a claim it paid 26 months earlier…

BRIDGEWAY HEALTH SOLUTIONS' CLAIM DISPUTE POLICIES AND PROCEDURES

Bridgeway Health Solutions®' (Bridgeway) Claim Dispute Policy is consistent with AHCCCS policy as described in RFP Attachment F2 and in accordance with AHCCCS Contractor Operations Manual Policy (ACOM) 412. Bridgeway provides information about covered benefits, prior authorization and claim dispute policies and procedures to our providers through our public website, which includes a copy of the Bridgeway Provider Manual and is available to both contracted and non-contracted providers.

Organization and Accountability. All Grievances and Appeals, including claim disputes are assigned to a Bridgeway Grievance and Appeal (G&A) Coordinator upon receipt. The G&A Coordinator reports directly to Bridgeway's Dispute & Appeal Manager, who is responsible for managing and resolving provider disputes including requests for State Fair Hearings. The Dispute & Appeal Manager has authority to require plan corrective action and has requisite experience to administer the claims dispute process. The Dispute & Appeal Manager reports directly to the Vice President of Operations, who as direct access to Bridgeway's ALTCS Program Administrator. This organizational structure allows the Dispute & Appeals Manager to elevate any concerns to the attention of Bridgeway leadership, as needed. The Dispute & Appeal Manager and all staff reporting to this position are located at Bridgeway's office in Tempe, Arizona.

CLAIM SCENARIO BACKGROUND

Although Bridgeway has never encountered a situation in which we initiated a recoupment so significantly outside of the allowable timeframes, we present our assumptions and processes below related to the scenario as presented in the RFP.

Original Claim Payment. A Bridgeway member was directly admitted to the hospital on May 21, 2014 from her provider's office with acute symptoms. During the first 24 hours of the admission, the member's urgent/emergent status was stabilized and a non-participating surgeon, Dr. Chavez, was called in for a surgical consult. The surgeon recommended that an elective ureteroscopy be performed to remove the stone. On May 23, 2014, Dr. Chavez performed the procedure and also conducted a reversal of the member's previous sterilization. The member was discharged from the hospital on May 25, 2014. Bridgeway received and auto-adjudicated claim #26785 on June 9, 2014, and issued payment in the amount of $854.00 as part of a group of claims for services provided to the member during her hospital stay.

Identification of Claim Payment Error and Notice of Recoupment. Bridgeway routinely audits claims configuration to ensure proper set up for all services. On June 1, 2016, Bridgeway conducted an analysis of non-covered service codes and found that the code for reversal of sterilization was not set up as a non-covered benefit. Bridgeway then reviewed all paid claims with this service type. Our claims auditor identified that claim #26785, billed by Dr. Chavez, had been paid incorrectly. In addition to paying for the non-covered service, it was discovered that the non-par physician had not obtained prior authorization for the elective ureteroscopy performed on May 23, 2014. Dr. Chavez's claim for consultation was appropriately paid.

Bridgeway followed all required processes as outlined in ACOM 412 regarding recoupment of a payment greater than 12 months from date of original payment. Bridgeway staff initiated and obtained AHCCCS approval for the recoupment using the AHCCCS-approved form (see Att.11.a). Bridgeway staff also reviewed our internal Recoupment Tracking Log and determined Bridgeway had not recouped over $50,000 cumulatively from Dr. Chavez during the AHCCCS contract year, and therefore did not require further reporting as part of the AHCCCS claims dashboard. Following receipt of AHCCCS approval to proceed with recoupment (see Att.11.b), a Notice of Recoupment was mailed to Dr. Chavez on July 18, 2016 (see Att.11.c), which included the summary statement highlighted in the scenario in addition to the following information: how the need for recoupment was identified; the process that was utilized to recover the funds; the anticipated timeline for the recoupment; the provider's right to file a claim dispute; total recoupment amount, total number of claims and ranges of dates for the claims being recouped; and listing of impacted claim numbers. Because Dr. Chavez was a non-par provider and had no pending claims from which Bridgeway could recoup the claim payment, our

Notice of Recoupment requested that Dr. Chavez refund the initial payment with instructions as to where and when the check should be remitted.

CLAIM DISPUTE PROCESS

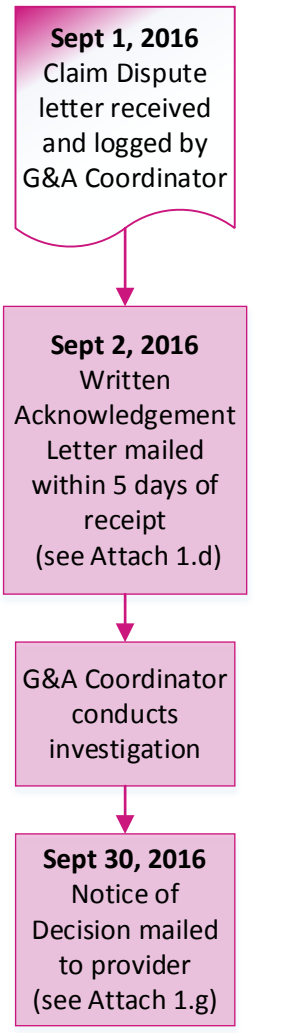
Step 1: Receipt and Documentation of Claim Dispute. On September 1, 2016, Bridgeway receives a written claim dispute from Dr. Chavez. The claim dispute letter is date stamped upon receipt, assigned a docket number, and entered into the Bridgeway tracking log for claim disputes. The tracking log contains sufficient information to identify the complainant, date of receipt, nature of the claims dispute, resolution of the claims dispute, interest payment, date of check issued for overturned disputes, and the date of resolution. All documentation received by Bridgeway during the claim dispute process is also date stamped upon receipt and stored in an electronic, secure case file.

Dr. Chavez's claim dispute is assigned to a G&A Coordinator, who remains the single point of contact for reviewing the claim dispute and communicating with the provider until resolution of the case. The G&A Coordinator reviews Dr. Chavez's request to confirm that it is submitted within the required 60 days from the date of the Notice of Recoupment as required per policy. The G&A Coordinator also reviews the request to ensure the dispute notes the factual and legal basis for the relief requested, and whether it includes the minimum necessary information needed to process the dispute such as the Explanation of Payment, medical records, or claims. Dr. Chavez's claim asserted that the "services were critically necessary" and the recoupment was improper, therefore establishing a factual and legal basis for the dispute. Dr. Chavez's claim also made reference to the medical records submitted with the original claim, but did not include additional documentation.

Step 2: Acknowledgement Letter. Bridgeway's G&A Coordinator sends Dr. Chavez a written Letter of Acknowledgement (see Att.11.d) on September 2, 2016 notifying her that the dispute request was received and would be investigated and resolved within 30 days of receipt.

Step 3: Investigation of the Claim Dispute: The G&A Coordinator thoroughly investigates the claim dispute using applicable statutory, regulatory, contractual and policy provisions, ensuring that relevant facts were obtained from all parties. Because Dr. Chavez was a non-contracted provider, Bridgeway's G&A Coordinator defers to the Bridgeway Provider Manual, Bridgeway Policy and Procedures, AHCCCS contract provisions and policies, and applicable state and federal laws. The G&A Coordinator researches the history of the claim payment and steps leading to the request for recoupment.

Bridgeway Claim Dispute Process



Clinical review: Bridgeway's Medical Director refers back to the medical records submitted with the original claim and determines that the member was a direct admit to the hospital on May 21, 2014 through referral by a Bridgeway contracted primary care provider (PCP) as a result of severe flank pain, inability to stand, vomiting, and fever. The PCP reported that the member had a known history of kidney stones and had been trying to manage as outpatient, but the pain became severe and unrelenting and fever and vomiting developed to the point that the member was unable to keep fluids down and had become dehydrated. The PCP therefore recommended direct admission to the hospital to provide hydration, control of pain, nausea and vomiting, and diagnostic tests. On the second hospital day (May 22, 2014), the member was stabilized by hospital staff but had not passed the stone, and the CT scan results revealed that the size and location of the stone was not amenable to lithotripsy (a medical procedure that uses external shock waves to break up kidney stones into smaller pieces that may pass through the urine). The attending physician ordered a consultation by a surgical urologist (Dr. Chavez), who confirmed that the size and location of the stone was not amenable to lithotripsy, and recommended that an elective ureteroscopy be performed to remove the stone. The following morning (May 23, 2014), Dr. Chavez performed the procedure.

Based on Bridgeway's Medical Director's review, the member clearly presented to the hospital with an emergency medical condition, given the manifestation of acute symptoms. However, the member's emergency condition was stabilized by hospital staff within the first 24 hours of admission through intravenous (IV) fluids and pain management. The ureteroscopy was performed on day three of the admission *after* the member had been stabilized and therefore

was not considered an emergency surgery. Per Bridgeway's policy and procedures, non-emergent services provided by a non-contracted provider require prior authorization. Additionally, Bridgeway's Medical Director noted that following the ureteroscopy, Dr. Chavez performed a reversal of the member's previous sterilization, a non-covered benefit under the ALTCS Program.

Request for Additional Information and Extension of Timeframe. If the G&A Coordinator had identified the need for additional information or needed additional time to make a determination, we would have sent Dr. Chavez a Request for Additional Information and/or Notice of Extension for Resolution (see Att.11.e and Att.11.f).

Step 4: Notice of Resolution Mailed to All Parties: The G&A Coordinator develops a draft Notice of Decision that included information as required by ALTCS RFP, Attachment F2, paragraph 11, and submits it for review and approval by the Dispute & Appeals Manager. The G&A Coordinator mails Dr. Chavez the Notice of Decision by certified mail on Sept 30, 2016 (see Att.11.g). This notice includes Dr. Chavez's right to a State Fair Hearing.

STATE FAIR HEARING PROCESS

Dr. Chavez exercises her right to a State Fair Hearing on October 21, 2016, within the 30-day timeframe after receipt of the Notice of Decision. Bridgeway's G&A Coordinator takes the following actions:

Request for State Fair Hearing. On October 26, 2016, within five business days of the date Bridgeway receives the Dr. Chavez's written hearing request, Bridgeway sends by certified mail to both AHCCCS Office of Administrative Legal Services (OALS) and Dr. Chavez an identical file including the following information:

- Notice of State Fair Hearing Cover Letter
- Written request for hearing filed by the provider
- Copies of the entire file including pertinent records and Bridgeway's Decision
- Other information relevant to the Decision

Second Medical Review. In preparing for the State Fair Hearing, the G&A Coordinator would obtain a second, independent medical review from a Bridgeway staff physician or a board certified consultant of a same or similar specialty who has previously not been involved in the case. The goal of this review would be to confirm that there is agreement among Bridgeway's physicians that the services in dispute involved poststabilization rather than emergency care. Assuming Bridgeway's physicians are in agreement, Bridgeway will proceed with the State Fair Hearing process. If there is not agreement, Bridgeway would move forward to resolve the matter with Dr. Chavez prior to the scheduled hearing date.

Factual and Legal Arguments. Bridgeway's factual and legal arguments will focus on the same issues highlighted in the Notice of Decision to the Dr. Chavez. Specifically, Bridgeway will argue that the ureteroscopy qualify as poststabilization care. Poststabilization care provided by a non-contracted provider requires prior authorization, with the exception of three limited circumstances outlined by state and federal rule. Dr. Chavez did not provide information demonstrating any of the circumstances in which poststabilization services are paid to non-contracted providers without prior authorization. Additionally, the reversal of sterilization was not a covered benefit. Bridgeway followed appropriate processes and procedures to carry out the recoupment. Bridgeway therefore appropriately recouped the claim in full.

Preparation of State Fair Hearing Exhibits. Upon receipt of a hearing date and hearing docket number from OALS, the G&A Coordinator prepares hearing Exhibits that provide additional information relevant to the claim dispute. These include: Request for AHCCCS Approval of Recoupment; Provider Notice of Recoupment letter. Each Exhibit is titled and includes the hearing appointment date. All State Fair Hearing Exhibits are scanned and electronically submitted to both OALS and the provider in advance of the hearing date to allow all parties time to review.

Attendance at State Fair Hearing: The G&A Coordinator and Bridgeway's Medical Director responsible for reviewing the claim dispute would attend the State Fair Hearing. If Bridgeway's decision were reversed at the State Fair Hearing, in full or in part, Bridgeway would reprocess and pay the claim within 15 business days of the date of the State Fair Hearing Decision.

Retention of files: All files are retained in our secure, electronic filing system for at least five years following the Notice of Decision, AHCCCS decision, judicial appeal or close of the claims dispute, whichever is later.

SYSTEM LEVEL ACTIONS TO REDUCE PROVIDER RECOUPMENTS AND CLAIMS DISPUTES

Bridgeway understands and takes seriously AHCCCS' priority to minimize provider recoupments and claims disputes. Toward this end, we undertake several system-level actions to minimize recoupments and claims disputes as discussed in this scenario. These actions include:

Quality Monitoring and Process Improvement (QMPI) Program: Bridgeway's Quality Monitoring and Process Improvement (QMPI) program to evaluate system flaws. Bridgeway's Provider Claims & Appeals staff report at monthly QMPI meetings all provider disputes, including the type of disputes received, volume, trends, and overturned denials. If concerns are identified, Bridgeway's QMPI program revises relevant process and audit reviews to avoid future recurrence of the issue. In this scenario, the QMPI program would address the following opportunities for improvement:

- Benefit configuration: Bridgeway identified that reversal of sterilization was not configured appropriately. To improve the timeliness of identification, Bridgeway will increase the frequency of quality control audits of claims configurations, including benefits.
- Payment of Non-par Services: Bridgeway identified that a Claims Examiner had inappropriately overridden the system logic for requiring prior authorization of non-par services. Bridgeway's Claims Manager conducted education with the Claims Examiner on this issue and evaluated the possibility of reducing the Examiner's latitude in overriding system logic.
- Provider Education: Based on Dr. Chavez's claims volume, Bridgeway would evaluate the benefit of providing education to this non-par provider and/or contracting with Dr. Chavez.

Health Information Systems/Claims System Processes: Bridgeway maintains a health information system that ensures accurate collection and processing of claims, analysis, integration, and reporting of data, including information regarding provider claim disputes and member appeals. Bridgeway's Claim Liaisons analyze trends for reprocessing requests from providers. If they note patterns of similar denials being reprocessed to correctly pay, they can originate an inquiry into accuracy of system set up. In addition, Bridgeway's parent company's, Centene Corporation (Centene), internal audit department reviews claims each month. If audit review finds a systems error that results in incorrect claim payment, Centene's audit department requires Bridgeway to correct the claims system set up.

Quarterly Reports AHCCCS - Provider Claim Disputes: Bridgeway submits quarterly reports to AHCCCS detailing provider claim disputes, type of dispute, volume, and resolution. This allow us to identify and address any trends in provider claims disputes.

Attachments: Copies of Dr. Chavez Case Communications

Att.11.a Request for AHCCCS Approval of Recoupment

Att.11.b AHCCCS Approval of Recoupment

Att.11.c Provider Notice of Recoupment letter

Att.11.d Provider Acknowledgement Letter

Att.11.e Provider Request for Additional Information

Att.11.f Provider Notice of Extension

Att.11.g Provider Notice of Decision Letter

Att.11.h Office of Administrative Legal Services (OALS) Cover Letter for State Fair Hearing Request

Att.11.a Bridgeway Request for AHCCCS Approval of Recoupment

Request for AHCCCS Approval of Recoupment

June 6, 2016

Jay Dunkleberger
Operations and Compliance Officer
Arizona Health Care Cost Containment System (AHCCCS), DHCM

Re: Claim Recoupment – More than 12 Months from the Date of Original Payment

Dear Mr. Dunkleberger:

Under ACOM Policy 412 III A and C, this letter serves as notification that the plan has identified a claim recoupment project that will result in individual recoupments greater than 12 months from the date of original payment:

Project #: 021222
Health Plan: Bridgeway Health Solutions

Information required under the Section III A of the policy is as follows:

A. How the need for recoupment was identified

On June 1, 2016, Bridgeway conducted an analysis of non-covered service codes and found that the code for reversal of sterilization was not set up as a non-covered benefit. Bridgeway then reviewed all paid claims with this service type. Our claims auditor identified that claim #26785, billed by Dr. Chavez, had been paid incorrectly. In addition to paying for the non-covered service, it was discovered that the non-par physician had not obtained prior authorization for the elective ureteroscopy performed on May 23, 2014. Dr. Chavez's claim for consultation was appropriately paid.

B. The system causes resulting in the need for a recoupment

Code for reversal of sterilization was not set up as a non-covered benefit in our claims payment system. Bridgeway also identified that a Claims Examiner had inappropriately overridden the system logic for requiring prior authorization of non-par services.

C. The process that will be utilized to recover the funds

Bridgeway will request that Dr. Chavez refund the entire payment with instructions as to where and when the check should be remitted.

D. Methods to notify the affected provider(s) prior to recoupment

Because of the non-par status, the provider will be notified via a letter that the claim will be recouped through request for refund from the provider.

E. Anticipated timeline for the project

The provider will be notified of the recoupment within ten days of approval of the recoupment by AHCCCS. The non-par provider will be requested to submit the refund within two weeks of notification.

F. The corrective action plans that will be implemented to avoid future occurrences

Bridgeway will increase the frequency of quality control audits of claims configurations, including benefits. Bridgeway's Claims Manager conducted education with the Claims Examiner on this issue and evaluated the possibility of reducing the Examiner's latitude in overriding system logic.

G. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of Providers impacted:

Total Number of Providers Impacted: One

Impacted Provider	TIN	Provider AHCCCS ID	Total Recoupment Amount	Total Number of Claims Impacted	Range of Dates for Claims Being Impacted
Julia Chavez, MD	94xxxxxx	123654	$854.00	1	5/23/2014

Please also find attached the following:

1) An electronic file that includes the following fields as described in ACOM 412:
   - AHCCCS Member ID
   - Date of Service
   - BW Original Claim Number
   - AHCCCS CRN (if available)
   - Date of Payment
   - Amount Paid
   - Amount to be recouped

2) A copy of the written communication to the impacted provider(s) including:
   - How the need for the recoupment was identified
   - The process that will be utilized to recover the funds
   - The anticipated timeline for the recoupment
   - The provider's right to file a claim dispute
   - Total recoupment amount, total number of claims and ranges of dates for the claims being recouped
   - Listing of impacted Claim numbers

Please review and approve this request, or contact me if you have additional questions.

Sincerely,

Susan Gilkey
Arizona Compliance Director

Attachments:

Excel Spreadsheet with Claim Detail
Draft Letter to Impacted Providers

cc: Cheyenne Ross, Arizona Vice President Compliance & Regulatory Affairs
Nancy Maurer, Arizona Vice President Operations
Trista Loops, Arizona Vice President Finance
Mike Flynn, Arizona IS Administrator
Terri Speaks, Arizona Encounters

Attachment 11.b. AHCCCS Approval of Recoupment

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

[redacted]

Cheyenne L. Ross, CCEP, CHC, CHPC
Vice President Compliance & Regulatory Affairs
Bridgeway Health Solutions
1501 W. Fountainhead Parkway Suite 295
Tempe, AZ 85282

RE: [redacted] Claim Recoupment (Over 12 Months)

Dear Ms. Ross:

The Division of Health Care Management (DHCM) has reviewed Bridgeway Health Solutions (Bridgeway) Claim Recoupment for [redacted] (more than 12 months from the date of original payment) that was submitted on [redacted]. The documents were reviewed against the ALTCS Contract and AHCCCS Contractor Operations Manual (ACOM) Policy 412 Claims Reprocessing.

Based on this review, Bridgeway's Claim Recoupment for [redacted] in the amount of $[redacted] is approved.

Please contact me if you have any questions. I can be reached at brenda.gobeli@azahcccs.gov or 602-417-4586.

Sincerely,

Brenda Gobeli
Operations and Compliance Officer
AHCCCS Division of Health Care Management

Att.11.c Provider Notice of Recoupment

Provider Notice of Recoupment

July 18, 2016

Dr. Julia Chavez
2020 SW Provider Parkway
Tempe, Arizona 85022

Re: Claim reference number 26785 for Amy T. Williams will be recouped in the next payment cycle. Not all services are covered. No prior authorization obtained.

Dear Dr. Chavez,
You were inadvertently overpaid for certain claims. Under AHCCCS Policy, we are required to provide the following information to you:

A. How the need for recoupment was identified
On June 1, 2016, Bridgeway conducted an analysis of non-covered service codes and confirmed that the code billed is a non-covered benefit. In addition you did not obtain prior authorization for the elective ureteroscopy performed on May 23, 2014.

B. The process that will be utilized to recover the funds
Bridgeway requests that you refund the entire payment of the claim, in the amount of $854.00, to the address noted below within 14 days of this notice.

C. The anticipated timeline for the project
Refund is requested within 14 days of this notice.

D. Total recoupment amount, total number of claims and range of dates for the claims being recouped
Total recoupment amount of $854.00 for single claim (#26785) for date of service May 23, 2014.

E. Listing of impacted claim CRNs
Claim reference number #26785.

If you believe that reimbursing Bridgeway the overpayment amount as outlined above will cause undue financial hardship, or if you have any additional questions or concerns please contact Michael Klassen at 1-866-475-3129 ext. 456.

As a reminder, please refer to The False Claims Act (FCA), 31 U.S.C. §§ 3729 – 3733 for additional information related to eliminating fraud, waste and abuse in Medicaid.

Claim Dispute Filing

You have the right to file a formal claim dispute. Please note: all claim disputes challenging claim payments, denials or recoupments must be filed in writing with Bridgeway no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later. Claim Disputes should be submitted to:

Bridgeway Provider Claim Disputes
1850 W. Rio Salado Parkway Suite 201
Tempe, AZ 85281

Thank you for your continued participation as a Bridgeway partner.

Sincerely,

Bridgeway Health Solutions
Provider Relations

Attachment: Claim detail

Att.11.d Provider Acknowledgement Letter

Provider Acknowledgement Letter
Provider Claim Dispute

Date: 9/2/2016

Attn:
Dr. Julia Chavez
2020 SW Provider Parkway
Tempe, Arizona 85022

Re: Claim Dispute: PCD246
Member Name: Amy T. Williams
Member ID: 122333444
Date of Service: May 23, 2014

Dear Dr. Chavez,

Bridgeway Health Solutions has received your claim dispute on 9/1/2016. Bridgeway will investigate your claim dispute and may request additional information or clarification of the issues as necessary.

Bridgeway will notify you in writing of our decision no later 9/30/2016. If you have any questions regarding the Provider Claims Dispute process, please contact the Bridgeway Grievance and Appeals Department at 1-866-475-3129.

Sincerely,

Norma Morales
G&A Coordinator
Bridgeway Health Solutions

cc: file

Att.11.e. Provider Request for Additional Information

Request for Additional Information
Provider Claim Dispute

Date: SAMPLE

Attn:
Dr. ABC
2020 SW Provider Parkway
Tempe, Arizona 85022

Re: Claim Dispute: PCD123
Provider Name: Dr. ABC
Member Name: John Doe
Member ID: 122333444
Date of Service: May 23, 2014

Dear Provider ABC,

Bridgeway Health Solutions received your claim dispute regarding the above referenced matter on 9/1/2016. We are completing a thorough investigation of the matter and are requesting the following information:

- Documentation or other verification of your efforts to obtain prior authorization of the services.

Please submit this information to the address below, or by contacting us at 1-866-475-3129.

Respectfully,

Norma Morales
G&A Coordinator
Bridgeway Health Solutions

cc: file

Att.11.f. Provider Notice of Extension

Notice of Extension for Resolution
Provider Claim Dispute

Date: SAMPLE

Attn:
Dr. ABC
2020 SW Provider Parkway
Tempe, Arizona 85022

Re: Claim Dispute: PCD123
Provider Name: Dr. ABC
Member Name: John Doe
Member ID: 122333444
Date of Service: May 23, 2014

Dear Provider ABC,

Bridgeway Health Solutions received your claim dispute regarding the above referenced matter on 9/1/2016.

We would usually issue a Notice of Decision within 30 days of 9/1/2016. However, Bridgeway has requested additional time and needs to request a delay of 14 days to evaluate the additional information before we make a decision. You will receive notification of our decision by 10/7/2016. If you do not agree to this extension or have any additional questions, please call us at 1-866-475-3129.

Respectfully,

Norma Morales
G&A Coordinator
Bridgeway Health Solutions

cc: file

Att.11.g. Provider Notice of Decision

Notice of Decision
Provider Claim Dispute

Date: 9/30/2016

Attn:
Dr. Julia Chavez
2020 SW Provider Parkway
Tempe, Arizona 85022

Re: Claim Dispute: PCD246
Provider Name: Dr. Julia Chavez
Member Name: Amy T. Williams
Member ID: 122333444
Date of Service: May 23, 2014
Issue: Bridgeway Health Solutions (Bridgeway) recoupment of full payment for claim originally adjudicated (paid) on 6/9/2014

Dear Dr. Chavez:

Bridgeway has completed a review of the claim dispute submitted regarding the above referenced matter. Our decision is to uphold the appropriateness of the recoupment action based on Arizona Administrative Code R9-22-705. Pursuant to A.A.C. R9-22-705(H)(1), "A contractor [Bridgeway Health Solutions] may conduct a review of any claim(s) submitted and recoup any payments made in error." Furthermore, subsection (3) states that regardless of prior authorization or concurrent review activities, [Bridgeway Health Solutions] may make prepayment or post-payment review of all claims."

Upon review of the documentation provided, it was determined claim #26785 was appropriately recouped in full. On 6/09/2014 Bridgeway adjudicated claim #26785 and issued payment in the amount of $854.00 (check #123ABC). On 6/1/2016 Bridgeway conducted a post-payment review of the adjudicated claim and determined that the original claim payment was made in error. The recoupment was conducted for the following reason:

In Bridgeway's review, the member clearly presented to the hospital with an emergency medical condition, given the manifestation of acute symptoms (severe flank pain, inability to stand, vomiting, and fever) that a prudent layperson would reasonably expect to place the member's health in serious jeopardy in the absence of immediate medical attention (ALTCS E/PD Contract YH18-0001, Part C. Definitions). The member's emergency condition was stabilized on Day 1 through administration of fluids and pain management. The ureteroscopy was performed on Day 3 *after* the member had been stabilized, and is therefore a poststabilization care service. A poststabilization care service is defined as a service related to the emergency medical condition, and provided after the member's condition is sufficiently stabilized in order to order to maintain, improve or resolve the member's condition so that the member could be alternatively safely discharged or transferred to another location (ALTCS E/PD Contract YH18-0001, Part C. Definitions).

Prior authorization is not required for emergency services, regardless of whether the provider is contracted or not. However, pursuant to A.A.C. R9-28-202 and 42 CFR 438.114; 42 CFR 422.113(c); and 42 CFR 422.133, Bridgeway requires

prior authorization of poststabilization services provided by a non-contracted provider, except for the following situations:

1. "Poststabilization care services that were pre-approved by the Contractor, or,
2. Poststabilization care services that were not pre-approved by the Contractor because the Contractor did not respond to the treating provider's request for pre-approval within one hour after being requested to approve such care or could not be contacted for pre-approval.
3. The Contractor representative and the treating physician cannot reach agreement concerning the member's care and a Contractor physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the member until a Contractor physician is reached or one of the criteria in 42 CFR 422.113(c)(3) is met." (ALTCS E/PD Contract YH18-0001, Part D.10 Scope of Services)

The medical records and other Bridgeway documentation reviewed as part of the claim dispute does not demonstrate that you met any of the three circumstances in which poststabilization services are paid to non-contracted providers without prior authorization. CMS requires that Medicaid managed care plans follow Medicare policy with respect to coverage of poststabilzation services. As an AHCCCS contractor, Bridgeway is required to follow federal Medicaid Managed Care guidelines regarding coordination of poststabilization services (ALTCS E/PD Contract YH18-0001, Part D.10). The intent of these requirements is to ensure proper coordination of poststabilization services after an emergency condition has been stabilized [42 CFR 438.114; 42 CFR 422.113(c)].

Additionally, pursuant to A.A.C R9-28-102, R9-28-201 and the ALTCS E/PD Contract YH18-0001, Part C. Definitions provides definition of Covered Services. AAC R9-28-101 General Definitions, "Covered services" means the health and medical services described in Articles 2 and 11 of this Chapter as being eligible for reimbursement by AHCCCS. AAC R9-28-102. Covered Services Related Definitions "Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:.. "Scope of services" means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter." Article 2. Covered Services, R9-28-201. "General Requirements, In addition to the exclusions and limitations specified in this Article, services provided to a member are covered services if:

1. Medically necessary, cost effective, and federally reimbursable;
2. Coordinated by a case manager in accordance with requirements specified in R9-28-510;
3. The provider obtains prior authorization as required by a member's program contractor or by the Administration:
   a. Failure of the provider to obtain prior authorization is cause for denial.
   b. Services provided during prior period coverage are exempt from prior authorization requirements;
4. Provided in facilities or areas of facilities that are licensed or certified under Article 5 of this Chapter, or meet other requirements described in Article 5 of this Chapter;
5. Rendered by AHCCCS registered providers as permitted under this Chapter and within their scope of practice; and
6. Provided at an appropriate level of care, as determined by the case manager or the primary care provider."

YH18-0001 Covered Services state, "The health and medical services to be delivered by the Contractor as described in Section D, Program Requirements or the Scope of Work Section. 42. Claims Payment/Health Information System… All payments are subject to other limitations that apply, such as provider registration, prior authorization, medical necessity, and covered services." In accordance with these definitions and review of the medical records, Bridgeway has determined that reversal of sterilization is not a medically necessary covered service under these definitions.

Bridgeway maintains claims processes, prior authorization processes and concurrent review processes to minimize the likelihood of having to recoup already-paid claims. In this case, we inadvertently issued payment and initiated recoupment upon discovery. The recoup occurred greater than twelve (12) months from the date of the original claim payment. Bridgeway followed all required process as outlined in the AHCCCS Contractor Operations Manual Policy

(ACOM) Policy 412- Claims Reprocessing for recouping payments over twelve (12) months from the date of original payment including the pre-approval of our written communication to you dated 7/18/2016 outlining the following:

- How the need for the recoupment was identified,
- The process that was utilized to recover the funds,
- The anticipated timeline for the recoupment,
- Right to file a formal claim dispute,
- Total recoupment amount, total number of claims and ranges of dates for the claims being recouped, and
- Listing of impacted claim numbers

Reference: https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/412.pdf

Based on the legal and regulatory references outlined above, Bridgeway maintains that the recoup action taken was appropriate and therefore, uploads its original actions related to recoupment activities. If you are dissatisfied with Bridgeway Health Solution's decision regarding this claim dispute, you may submit a request for a "State Fair Hearing" to the AHCCCS Administration. To do so, please submit your request in writing and send it with any additional supporting documentation to:

Bridgeway Health Solutions
Attention: Claim Disputes
1850 W. Rio Salado Parkway
Suite # 201
Tempe, Arizona 85281

Please note that Bridgeway Health Solutions must receive your request no later than 30 days from the date you receive this final decision letter, in accordance with Arizona Administrative Code, Title 9, Chapter 34, Section 405. Bridgeway will then forward the request directly to AHCCCS, Office of Legal Assistance no later than five (5) business days from the date Bridgeway receives your request.

If you have any questions regarding this decision or the appeals process, please feel free to contact the Grievance and Appeals Department at 1-866-475-3129.

Respectfully,

Norma Morales
G&A Coordinator
Bridgeway Health Solutions

cc: file

Att.11.h Cover Letter for Request for Hearing

REQUEST FOR HEARING COVER LETTER
Provider Claim Dispute
Bridgeway Health Solutions

October 26, 2016

AHCCCS
Attention: Office of Administrative Legal Services
701 E. Jefferson
MD6200
Phoenix, Arizona 85034

Re: Request for State Fair Hearing

Provider's Name: Dr. Julia Chavez
Provider's Address: 2020 SW Provider Parkway, Tempe, Arizona 85022
Provider's Telephone #: (480)333-6699
Provider's AHCCCS ID#: 123654

Member: Amy T. Williams
ID#: 122333444
DOS: May 23, 2014
Date of Receipt of Claim Dispute: 9/1/2016
Bridgeway Dispute #: PCD246

Dear Hearing Officer:

Bridgeway Health Solutions (Bridgeway) has received a written request for a State Fair Hearing from the provider listed above. Bridgeway received the original claim dispute on (9/1/2016); issued a Notice of Decision to the provider on (09/30/2016); and received the request for a State Fair Hearing was received on (10/21/2016).

Bridgeway has taken the following actions to resolve the claim dispute:

Bridgeway conducted a thorough investigation of the claim dispute, obtaining relevant facts from all parties, and evaluating applicable statutory, regulatory, contractual, and policy provisions. Based on this review, Bridgeway upheld the recoupment action and determined that the claim was appropriately recouped in full.

Page 2

Bridgeway's decision was based upon the following:

In Bridgeway's review, the member clearly presented to the hospital with an emergency medical condition, given the manifestation of acute symptoms (severe flank pain, inability to stand, vomiting, and fever) that a prudent layperson would reasonably expect to place the member's health in serious jeopardy in the absence of immediate medical attention (ALTCS E/PD Contract YH18-0001, Part C. Definitions). The member's emergency condition was stabilized on Day 1 through administration of fluids and pain management. The ureteroscopy was performed on Day 3 *after* the member had been stabilized, and is therefore a poststabilization care service. A poststabilization care service is defined as a service related to the emergency medical condition, and provided after the member's condition is sufficiently stabilized in order to order to maintain, improve or resolve the member's condition so that the member could be alternatively safely discharged or transferred to another location (ALTCS E/PD Contract YH18-0001, Part C. Definitions).

Pursuant to A.A.C. R9-28-202 and 42 CFR 438.114; 42 CFR 422.113(c); and 42 CFR 422.133, Bridgeway requires prior authorization of poststabilization services provided by a non-contracted provider, except in limited situations allowed under state and federal rules. The intent of these requirements is to allow Bridgeway to ensure proper coordination of poststabilization services after an emergency condition has been stabilized.

Additionally, pursuant to A.A.C R9-28-102, R9-28-201 and the ALTCS E/PD Contract YH18-0001, Part C. Definitions which defines Covered Services as services that must be medically necessary as well as the definition of medical necessity. Reversal of sterilization is not a medically necessary covered service under these definitions.

Please find attached to this letter, the complete provider claims dispute file which includes all pertinent records and information. If you have any questions, please contact me at 1-866-475-3129.

Sincerely,

Norma Morales
G&A Coordinator
Bridgeway Health Solutions

cc: file
Dr. Julia Chavez
2020 SW Provider Parkway
Tempe, Arizona 85022

Attachments:

- Original Claim Dispute
- Acknowledgement letter
- Decision Letter for Claim Dispute
- Written Request for Hearing filed by the provider

State Fair Hearing Exhibits

1. Request for AHCCCS Approval of Recoupment
2. Provider Notice of Recoupment letter

ADMINISTRATIVE #12

AZ REQUEST FOR PROPOSALS SOLICITATION # YH18-0001

NARRATIVE SUBMISSION REQUIREMENTS

Program #12
Information Technology (IT) Systems Demonstration
By participating in mock Information Systems scenarios over a 10-day period, the Offeror shall…

Bridgeway Health Solutions® (Bridgeway) acknowledges that its participation in the IT Systems Demonstration beginning on January 24, 2017, constitutes fulfillment of Submission Requirement #12. Bridgeway acknowledges that it will comply with the stated guidelines and calendar for this process. Bridgeway acknowledges that the IT Systems Demonstration will be scored as part of the Offeror's Proposal.

ORAL PRESENTATIONS

NAMES AND TITLES OF PARTICIPATING INDIVIDUALS

AZ REQUEST FOR PROPOSALS SOLICITATION # YH18-0001

ORAL PRESENTATIONS

Oral Presentations

Offerors shall participate in a scheduled oral presentation pertaining to key areas of the ALTCS E/PD Program. The duration of the oral presentation session will be limited to three hours, which shall include allotted time for discussion and preparation. All presentations will be scheduled to occur during the weeks of January 30 and February 6, 2017. Presentations will be audio-taped by AHCCCS for the Agency's use in the evaluation process. Audio-taped oral presentations will be published to the AHCCCS website once the Contract awards have been made. AHCCCS shall notify each Offeror of its scheduled presentation no later than 5:00 pm Arizona Time on January 26, 2017.
The Offeror shall bring no more than six individuals to the meeting. All participants must be employees of the Offeror; no consultants may participate. Among these six individuals, the Offeror shall include persons with expertise in:

- ***Medical/Clinical Management,***
- ***Case Management, and***
- ***Behavioral Health***

The Offeror shall submit with its Proposal a list of names and titles along with resumes of the participating individuals.

The Offeror will not be permitted to bring electronic devices into the room, including but not limited to, laptops, cellular or smart phones, and tablets. Outside communication will be prohibited, including but not limited to, use of cell phones, telephones or text messaging. The Offeror will not be permitted to distribute previously-prepared presentations or materials to AHCCCS. The Offeror will be permitted to utilize any hard copy reference material brought with them, including copies of policies and procedures to assist with preparing for the presentation. AHCCCS will provide a white board or flip charts and markers for Offeror use in preparing for the Oral Presentation.

AHCCCS will have staff in the room for the duration of the oral presentations to ensure compliance with these requirements.

The following employees of Offeror will participate in the Oral Presentations:

1. Paul Barnes, Ph.D, Plan President and CEO
2. Susan Benedetti, RN, BSN, ALTCS Program Administrator
3. Dr. Robert Krauss, DO FACOG, Chief Medical Director
4. Alan Nesbit, MSW, LCSW, Behavioral Health Coordinator
5. Dan Koesser, LTC Case Management Manager
6. Terri Morales, Senior Contract Negotiator

The resumes of each of the employee participants follow this page.

RESUMES OF PARTICIPATING INDIVIDUALS

ARIZONA PLAN PRESIDENT AND CEO
Paul Barnes, Ph.D.

PROFESSIONAL SUMMARY:

Chief Executive for Medicaid and other managed care programs in state of Arizona. Over 30 years of senior executive experience with both managed care and provider organizations. Extensive experience with fast growth, innovative companies in both operational and business development roles. Held leadership roles in both physical and behavioral health organizations with a strong interest in their integration. Earned Ph.D. in Clinical Psychology with practice experience in community mental health.

EXPERIENCE:

ARIZONA CENTENE HEALTH PLANS **TEMPE, AZ**
Plan President and CEO
JUNE 2014 - PRESENT

- Responsible for oversight of Medicaid, Medicare and commercial health plans for Centene in the state of Arizona, representing over $2B in revenue. Eightfold growth (by revenue) in responsibilities since assuming role with membership and employees covering central and southern Arizona. Have successfully integrated Arizona Health Net business lines into pre-existing Centene business in Arizona. Oversight includes physical and behavioral health organizations.

ORTHOARIZONA **PHOENIX, AZ**
Chief Executive Officer
JUNE 2009 – MAY 2014

- Responsible for largest orthopedic practice in Arizona. Merged seventeen practices with 58 physicians into single practice in May 2010. Have grown organization to over 70 physicians, 35 locations and over $75M in annual revenue. Developed ancillary revenue streams, including imaging, service line co-management and IT portal for workers' compensation.

NAVITAS CANCER REHABILITATION **WESTMINISTER, CO**
President and Chief Executive Officer
MAY 2006 – JUNE 2009

- Responsible for early-stage cancer services company. Venture-backed company that began with unique focus on rehabilitation services for cancer patients and survivors in free-standing centers. Modified business model to expand into hospital-based cancer centers and rehabilitation programs. Company also expanded into telephonic-based health coaching for cancer patients, with a focus on disease management and survivor services. Company acquired by Triveris, another venture-backed healthcare company. Ensure effective care is delivered to members while achieving utilization management goals

ACTIVEHEALTH MANAGEMENT **NEW YORK, NY**
Executive Vice President and Chief Marketing Officer
FEBRUARY 2003 – MAY 2006

- Responsible for sales and marketing for health management company offering innovative disease management and data analytics services. Privately-held company that was acquired by Aetna in May 2005 for over $400M. Revenue grew from $18M (Feb 2003) to over $100M. Developed and implemented marketing plan for build out of sales team and marketing unit. Responsible for executive relationships with multiple health plan customers, including contract and rate negotiation. Responsible for senior-level integration issues with Aetna related to sales, marketing, public relations and product development. In February 2006, also became responsible for service center operations.

APS HEALTHCARE **SILVER SPRING, MD**
President and Chief Operating Officer
NOVEMBER 2000 – JANUARY 2003

- Responsible for all Profit and Loss as well as other operational areas for physical and behavioral management company offering risk and ASO services to health plans, employers and public sector customers. Products included disease management, behavioral care management and other medical management. Company grew from $60M to almost $200M during tenure, including organic growth and acquisitions. Managed medical costs for risk contracts tied to over 60% of company revenues. Responsible for integration of multiple acquisitions, including customer retention, cost synergies and personnel decisions. Provided oversight of operations, claims, information technology, account management and human resources.

MAGELLAN HEALTH SERVICES **COLUMBIA, MD**
Executive Vice President and Chief Marketing Officer
OCTOBER 1991 – OCTOBER 2000

- Responsible for sales and marketing for behavioral health company offering risk and ASO services to health plans, employers and public sector customers. Grew over $100M on $1.5B base in final year. Oversaw team of over 12 sales people and 30+ marketing staff. Developed new branding and marketing approach for market leader in behavioral health. Responsible for cross-marketing approach between behavioral and medical services.

Executive Vice President, Operations (under Merit Behavioral name)

- Responsible for all Profit and Loss areas for behavioral health company. Oversaw six geographic regions and national accounts for $600M business line. Responsible for over 20 service centers across country. Managed medical costs for risk contracts tied to over 75% of company revenues. Implemented new business initiatives in Medicaid and military markets.

Senior Vice President, Western Region

- Responsible for all Profit and Loss for regional operations of behavioral health company. Oversaw four local operations covering Colorado, Arizona, California and Hawaii. Responsible for new business growth, including state employee and Medicaid business.

LINCOLN NATIONAL CORPORATION **FORT WAYNE, IN**
Director, Mental Health Services
AUGUST 1988 – SEPTEMBER 1991

- Responsible for development and management of behavioral health programs for health insurance company. Developed internal program and external carve-out relationships as part of overall strategic to introduce managed care.

UNITED CLINICS OF COUNSELING **LOUISVILLE, KY**
Executive Director, Louisville Operation
JANUARY 1988 – JULY 1988

- Responsible for management of risk program for a behavioral health company.

HEALTH AMERICA OF KENTUCKY **LOUISVILLE, KY**
Director of Mental Health
JUNE 1986 – JULY 1988

- Responsible for development and management of behavioral health program for a staff-model Health Maintenance Organization.

METRO HEALTH **INDIANAPOLIS, IN**
Clinical Psychologist
MAY 1985 – MAY 1986

- Responsible for providing clinical psychology services for a staff-model Health Maintenance Organization.

CUMMINS MENTAL HEALTH **DANVILLE, IN**
Clinical Psychologist
OCTOBER 1983 – APRIL 1985

- Responsible for providing clinical psychology services for a Community Mental Health Center.

EDUCATION:

Florida State University
M.S., Ph.D., Clinical Psychology

Wheaton College
B.A., Psychology

LICENSES AND CERTIFICATIONS:

- Licensed Clinical Psychologist (not current)

PROFESSIONAL AND COMMUNITY SERVICE, HONORS, AND AWARDS:

- Arizona Arthritis Foundation Leadership Board, 2015-2016
- OrthoForum (industry group of large orthopedic practices) Board of Directors, 2013-2014

ALTCS PROGRAM ADMINISTRATOR
Susan Benedetti RN, BSN

PROFESSIONAL SUMMARY:

Managed Care and Health Care Executive with experience in public and private sector health care industries looking for opportunities to influence change and achieve exceptional positive health and financial outcomes. Core professional strengths include:

- Operations
- Strategic Planning
- Process Improvement
- Team Building
- Problem Solving
- Budget Administration
- Customer Service
- Health Plan Implementations
- Flexibility

EXPERIENCE:

CENTENE CORP. **TEMPE, AZ**
Arizona Vice President Long Term Care
OCTOBER 2016- PRESENT

- ALTCS program administrator that oversees the Bridgeway operations, and has the authority to direct and prioritize work, regardless of where performed.

CENTENE CORP. **TEMPE, AZ**
Arizona Vice President Medical Management
JULY 2016- PRESENT

- Direct and coordinate activities of department with the Chief Medical Director and aid the Chief Executive Officer of the health plan and appropriate corporate staff in formulating and administering organizational and departmental policies.
- Review analyses of activities, costs, operations and forecast data to determine department progress toward stated goals and objectives.
- Serve as a member of Health Plan management committees
- Administer and ensure compliance with Regulatory Agencies
- Participate in, attend and plan/coordinate staff, departmental, committee, sub-committee, community, State and other activities, meetings and seminars.

- Participate in provider education and contracting, as necessary.

BRIDGEWAY HEALTH SOLUTIONS (CENTENE CORP.) **TEMPE, AZ**
Vice President Medical Management
NOVEMBER 2010- JUNE 2016

- Direct and coordinate activities of departments with the Chief Medical Director and the Chief Executive Officer of the health plan in formulating and administering organizational and departmental policies for Medical Management, Pharmacy, Quality Management and Long Term Care Case Management
- Review analyses of activities, costs, operations and forecast data to determine progress toward stated goals and objectives
- Monitor performance results against established metrics and benchmarks and recommend improvement opportunities
- Serve as the subject matter expert and participate in all new implementations
- Oversee utilization and care management across all business programs
- Participate in, attend and plan/coordinate staff, departmental, committee, sub-committee, community, State and other activities, meetings and seminars
- Oversee the production of all clinical reports required by the business program
- Participate in provider education and contracting.
- Ensure effective care is delivered to members while achieving utilization management goals
- Oversee annual budget for clinical operations
- Create and maintain collaborative partnerships with providers/organizations

INSPIRIS **PHOENIX, AZ**
Manager of Care Management
JANUARY 2010- NOVEMBER 2010

- Provided direction and leadership to the Nurse Practitioner and care management team.
- Identified and develop processes that support cost-effective and quality outcomes for the patient.
- Implemented a weekly Complex Care Meeting to review and create action care plans for quality outcomes for our patients.
- Supported and educated nurse practitioners and case managers on Medicare, Medicaid and the ALTCS programs and how they relate to our patients.
- Attended JOC meetings with Health Plans whose members INSPIRIS manages.

MERCY CARE PLAN **PHOENIX, AZ**
Vice President Utilization Management
MARCH 2005- NOVEMBER 2009

- An active member of the executive strategic team and health care management team responsible for providing leadership and strategic direction to the health plan for the Medicaid and Medicare program in Arizona; manage administrative, clinical operations, and financial management of the Health Plan and the health care initiatives while meeting budget projections and holding inpatient utilization medical costs below health plan expectations and increasing generic pharmacy utilization.
- Implemented a program that identified targeted diagnoses that could be managed in an outpatient setting. Decreased inappropriate inpatient utilization by 17%.

- Received a 100% on Medical Management section of the State's Operational Financial Review for 2008.
- Provided strategic direction to Prior Authorization, Medical Claims Review, Case Management and Concurrent Review departments.
- Increased employee satisfaction within Utilization Management over 15%, within one year.
- Partnered with DME vendors to improve the customer service, the delivery of health care services and monitor adherence to contracts
- Participated in the discussion, design and implementation of a pilot of a medical home program.
- Chair of the Policy Committee

MERCY CARE PLAN/ SCHALLER ANDERSON/ AETNA **PHOENIX, AZ**
Corporate Director Medical Management
JANUARY 2003- MARCH 2005

- An action oriented, decision making member of the management team to provide direction and perform monitoring activities of all medical management departments in Health Plans managed by Schaller Anderson.
- Participated and implemented the standard prior authorization grid to all Health Plans
- Implemented standard policy templates for medical management to all Health Plans
- Successfully implemented new health plan in another state within 90 days
- Active member of the System Change Request Committee
- Active member of the Corporate Policy Committee

MERCY CARE PLAN/ SCHALLER ANDERSON/ AETNA **PHOENIX, AZ**
Corporate Manager Prior Authorization
SEPTEMBER 2001- JANUARY 2003

- Provide leadership and direction for the medical and pharmacy unit for Medicaid and commercial health plans. Develop processes that support cost-effective and quality outcomes. Develop viable systems for authorization criteria and procedures, contract interpretation, resolving provider and member issues, and maintaining communication between vendors, providers, members, corporate and consultant staff.
- Participated in cross-functional teams to implement a software system successfully
- Created an after-hours prior authorization unit that provided medical and pharmacy services for Medicaid Health Plans within Schaller Anderson
- Met and exceeded all call center contractual agreements required by each Medicaid and commercial health plan
- Participated on the implementation team for new health plans for medical management services
- Participated in the RFP process for potential new clients

MERCY CARE PLAN **PHOENIX, AZ**
Supervisor Concurrent Review
JULY 1998- SEPTEMBER 2001

MERCY CARE PLAN **PHOENIX, AZ**
Concurrent Review Nurse
JUNE 1993 JULY 1998

MERCY CARE PLAN **PHOENIX, AZ**
RN Case Manager
OCTOBER 1991 JUNE 1993

MERCY CARE PLAN **PHOENIX, AZ**
Prior Authorization RN
MAY 1989 OCTOBER 1991

EDUCATION:

Arizona State University Tempe, Arizona
Bachelor of Science
Majors: Nursing

LICENSES AND CERTIFICATIONS:

- Arizona Registered Nurse License #RN073262

PROFESSIONAL AND COMMUNITY SERVICE, HONORS, AND AWARDS:

- 2009- Current: Arizona Public Health Association Member
- 2011- Current: Maricopa County Oral Health Leaders Advocates & Resources Collation: Board Member, Treasurer
- 2013-2014: Maricopa County Community Health Improvement Plan Initiative – Participant in the Healthcare Work Group
- 2009: Arizona Statewide Independent Living Council (SILC) DME Taskforce.
- 2008-2009: AHCCCS Notice of Action Work Groups
- 2008: Executive Order- Reducing the Escalation Health Care Costs for Arizonans
- 2008: Aetna Sliver Star Award

CHIEF MEDICAL DIRECTOR
Robert Krauss, DO FACOG

PROFESSIONAL SUMMARY:

Administrative
- Medical Director - large managed health care plan
- Senior Medical Director of Clinical Operations health insurance plan

Clinical
- 25 years in solo practice of obstetrics and gynecology
- Delivered over 7500 babies
- Provided health care to thousands of women
- Actively involved in clinical resident education at two major teaching hospitals in Phoenix

Hospital
- Hospital committee chairman
- Hospital Executive committee
- Served on multiple hospital committees

Legal
- Expert witness in malpractice cases
- Health plan medical representative in administrative hearings

Political
- ACOG Arizona Section Chairman
- Lobby for ACOG annually for women's health issues

EXPERIENCE:

BRIDGEWAY HEALTH SOLUTIONS (CENTENE) **TEMPE, AZ**
Medical Director
JUNE 2009- PRESENT

Arizona-licensed physician is actively engaged in all major clinical and Quality Management and Medical management components of the health plan. Ensures timely medical decisions, including after-hours consultation as needed

SCHALLER ANDERSON, AN AETNA COMPANY **TEMPE, AZ**
Senior Medical Director of Clinical Operations
MARCH 2008- MARCH 2009

MERCY CARE PLAN MANAGED BY SCHALLER ANDERSON **PHOENIX, AZ**
Medical Director
SEPTEMBER 1999- MARCH 2008

PRIVATE SOLO CLINIC PRACTICE OB/GYN **PHOENIX, AZ**
MARCH 1977- JANUARY 2000

EDUCATION:

Maricopa County Medical Center Re-entry Program, Phoenix, Arizona
Clinical Medical Management in Gynecology, June-September 2012

The Wharton School Leonard Institute of Health Economics, Pennsylvania
The Wharton Executive Development Program for Managed Care Medical Directors
November 2004

Saint Joseph's Hospital and Medical Center, Phoenix, Arizona
Residency Program Obstetrics and Gynecology 1974-1976

Doctor's Hospital, Columbus, OH
Internship, 1970-1971

Des Moines University, Des Moines, IA
D.O Degree, 1966-1970

Brooklyn College, Brooklyn, New York
BA Biology, 1962-1966

LICENSES AND CERTIFICATIONS:

- Arizona License #1283
- Missouri License #32938

PROFESSIONAL AND COMMUNITY SERVICE, HONORS, AND AWARDS:

- 2006- Present: American College of Medical Quality
- 1993- Present: ACOG Key Designee
- 2002-2005: ACOG District VIII, Arizona Section Vice Chairman
- 1999-2002: ACOG District VIII, Arizona Section Treasurer
- 1997-2000: Saint Joseph's Hospital and Medical Center Medical Ethics Committee
- 1997-2000: Saint Joseph's Hospital and Medical Center Medical Informatics Committee
- 1993-2008: ACOG District VIII Arizona Section Legislative Workshop and Lead
- 1991-2003: Phoenix OB-GYN Society Treasurer
- 1994-1999: Maricopa Foundation Board of Directors Vice President
- 1995-1999: Maricopa Foundation Chairman Reimbursement Committee

- 1994: Saint Joseph's Hospital and Medical Center, PHO Board of Directors
- 1994-1998: Saint Joseph's Hospital and Medical Center, PHO Utilization Review Committee

PUBLICATIONS:

- Jennett, Tarby and Krauss. Erb's Palsy Contrasted with Klumpke's and Total Palsy: Different Mechanisms are Involved Am J Obstet Gynecol 2002:Vol186 Number 6

BEHAVIORAL HEALTH COORDINATOR
Alan Nesbit, MSW, LCSW

PROFESSIONAL SUMMARY:

Extensive experience in the coordination of member behavioral care needs including active involvement in all out of state placement decisions. Managed care experience includes the review and enhancement of health plan network systems to reduce out of state placements and process development for the coordination of behavioral health care and physical health care between all service providers

EXPERIENCE:

BRIDGEWAY HEALTH SOLUTIONS (CENTENE) **Tempe, AZ**
Behavioral Health Coordinator
APRIL 2012- PRESENT

Assists with the implementation, monitoring and directing of behavioral health care needs. Participates in care management rounds to assist in identifying behavioral health care needs and integration. Provide resource and education to non-licensed behavioral health staff. Schedule and make follow up calls to provide care facilitation. Promote recovery concepts and inspire hope. Work with other internal and external agency personnel to meet member needs. Provide professional assessments, interventions within scope of position. Provide information and behavioral health education when appropriate to internal staff. Management responsibilities for the behavioral health team of case managers.

PRIVATE PRACTICE **Mesa, AZ**
Therapist
March 2011- PRESENT

Operating private practice of outpatient therapy for trauma related disorders and general mental health with a Cognitive Behavioral and Structural Family therapy focus.

TOUCHSTONE BEHAVIORAL HEALTH **Phoenix, AZ**
Multisystem Treatment Therapist
APRIL 2006- APRIL 2012

Practiced Structural and Strategic Family therapy models along with Cognitive Behavioral Therapy to adolescents and their families with substance abuse, legal involvement, problem sexual behaviors, and other out of control behaviors. Responsible for assessment, treatment planning and creation of safety and behavioral modification plans.

LDS FAMILY SERVICES **Mesa, AZ**
Outpatient Therapist
MAY 2009- MARCH 2011

Provided outpatient general mental health counseling with a Cognitive Behavioral Therapy focus.

SOCIAL WORK PRN **Phoenix, AZ**
Office Coordinator
MAY 2007- APRIL 2008

Coordinated recruitment of staff and filling orders for temporary and permanent social work positions throughout the Phoenix, Flagstaff and Tucson areas. Provided supervision for field placements. Maintained monitoring of working staff and relationship with work settings. Oversaw marketing and advertising of services.

JEWISH FAMILY AND CHILDREN'S SERVICES **Mesa, AZ**
Intensive Case Manager
MAY 2005-APRIL 2006

Provided case management for children and their families experiencing behavioral disruptions. Facilitated child and family team meetings and coordinated services from a variety of behavioral health systems. Created treatment plans and crisis/safety plans.

FLORENCE CITTENTON SERVICES OF ARIZONA **Phoenix, AZ**
Behavioral Health Technician
OCTOBER 2004- AUGUST 2005

Modeled and developed healthy interpersonal relationships with clients and their families. Responsible for enforcement of rules, conflict resolution, and flow of the daily schedule for clients.

NEW HAVEN RTC **Spanish Fork, UT**
Shift Supervisor
OCTOBER 2000- AUGUST 2004

Directly supervised three other health care assistants. Provided trainings on building healthy relationships, conflict resolution, and interventions to other employees and client families. Participate in weekly interdisciplinary treatment team. Modeled and developed healthy interpersonal relationships with clients and their families.

EDUCATION:

Master of Social Work
Arizona State University, Tempe, AZ
Major: Social Work

Bachelor of Arts
Brigham Young University, Provo, UT
Major: Marriage, Family and Human Development

Minor: Business Management

Associate
Ricks College-Idaho, Rexburg, ID
Major: Mathematics

LICENSES AND CERTIFICATIONS:

- AZ LCSW License #13046

LTC CASE MANAGEMENT MANAGER
Daniel Koesser

PROFESSIONAL SUMMARY:

- Contributor of over 21 years of health care administration and management experience.
- Established provider of quality cost effective Arizona Long Term Care Services for 15 years.
- Successful in training & mentoring case managers and supervisors for the ALTCS program.
- Excellent problem solving skills, with the ability to manage independently or facilitate as a team.
- Licensed Registered Respiratory Therapist with outstanding assessment and evaluation skills.
- Extensive knowledge of durable medical equipment, medical supplies and environmental needs.
- Proficient in the AHCCCS Client Assessment Tracking System, Microsoft Office and Case Management software.
- Superior understanding and implementation of the AHCCCS Medical Policy Manual.

EXPERIENCE:

BRIDGEWAY HEALTH SOLUTIONS (CENTENE) **Tempe, AZ**
LTC Case Management Manager
SEPTEMBER 2013- PRESENT

Direct **o**versight and responsibility of the day-to-day operations of LTC Case Management Services. Ensure compliance with ALTCS – AHCCCS rules and regulations and Bridgeway Policy and Procedures. Ensure timely response to AHCCCS for LTC deliverables. Review and evaluate LTC operational systems for quality and cost effectiveness. Review and direct the implementation of LTC services.

- Ensure case management compliance with the AHCCCS/ALTCS program
- Monitor cost effectiveness by plan, supervisor team and case manager
- Create tools to improve time management, performance measures and outcomes
- Collaborate with Quality Management, Medical Management, Network Development, Behavioral Health Professionals, Providers Services and Corporate Compliance as an integrated team to improve member outcomes.
- Share and implement ideas for improved quality with peers

BRIDGEWAY HEALTH SOLUTIONS (CENTENE) **Tempe, AZ**
LTC Case Manager Supervisor
SEPTEMBER 2011-AUGUST 2013

- Provide supervision to 14-17 employees
- Ensure case management compliance with the AHCCCS/ALTCS program
- Monitor cost effectiveness
- Identify areas for improvement
- Implement methods to make employees successful

- Share ideas for improved quality with peers

PINAL/GILA Long Term Care **Florence, AZ**
Long Term Care (LTC) Case Management Supervisor
JANUARY 2003- SEPTEMBER 2011

- Supervise, train and assign work to case managers including satellite office staff in Gila County.
- Monitor timeframes and performance measures to improve AHCCCS deliverables.
- Facilitate inter disciplinary team meetings to problem solve resolution activities.
- Staff specialty placements (ventilator, tracheostomy, wound care and dialysis).
- Write Policy and Procedure including criteria for services.
- Annually completed the Case Management Plan.
- Assisted in writing RFP
- Participate in Quality Management, reporting of initial contact, visit and start of service.

Pinal/Gila Long Term Care **Florence, AZ**
Long Term Care (LTC) Case Manager III
SEPTEMBER 2001- JANUARY 2003

- Performed medical and behavioral health assessments, care planning, and authorizations.
- Completed assessment visits at the home, assisted living facilities and nursing facilities.

VENCOR/INTEGRATED HEALTH SERVICES **Phoenix, AZ**
Area Manager/ Supervisor
JANUARY 1995-JULY 2001

- Provided supervision for respiratory programs in skilled nursing facilities
- Monitored Budget Information
- Provided in-services to licensed medical staff
- Manage ventilator dependent individuals to return to a least restrictive environment

EDUCATION:

Apollo Collage
Associate Degree
Majors: Respiratory Therapy

LICENSES AND CERTIFICATIONS:

- Arizona State University Tempe, AZ-Certified Public Manager
- Registered Licensed Respiratory Therapist 1994- Current

SENIOR CONTRACT NEGOTIATOR
Terri Morales

PROFESSIONAL SUMMARY:

Extensive experience in home & community based, hospital, specialist, primary care and facility contract negotiations and relationship management for Medicare and Medicaid populations.

EXPERIENCE:

BRIDGEWAY HEALTH SOLUTIONS (CENTENE) **TEMPE, AZ**
Senior Contract Negotiator
NOVEMBER 2015- Present

- Identify and close network gaps in the Bridgeway provider network utilizing Quest Analytics to ensure compliance with State and Federal requirements.
- Contract and establish new provider networks in accordance with State and Federal requirements.
- Establish a network or performance based contract providers.
- Collaborate with the Network Team to ensure provider needs are being met and all contract requirements are compliant.

BRIDGEWAY HEALTH SOLUTIONS (CENTENE) **TEMPE, AZ**
Network and Provider Relations Supervisor
SEPTEMBER 2014- NOVEMBER 2015

- Developed, trained and managed Network/Provider Relations team.
- Collaborated with operational departments to improve processes in an effort to improve network management and member experience.
- Established a network of incentive based contracted providers.
- Led Network Team in identifying and closing network gaps in the network by utilizing CMS methodology including time and distance.

BRIDGEWAY HEALTH SOLUTIONS (CENTENE) **TEMPE, AZ**
Provider Relations Specialist
MAY 2012- SEPTEMBER 2014

- Responsible for network development and contracting.
- Educated provider to ensure compliance with all Federal and State requirements and regulations.
- Conducted on site visits and ongoing program training with provider office staff.
- Developed and coordinated group trainings at the health plan.
- Participated in Quarterly Member Council meetings.
- Participated in Quarterly Provider Educational Conferences.

LIFE LINE ABULANCE **PRESCOTT, AZ**
Accounts Receivable Manager/ Compliance Officer
DECEMBER 2006-MAY 2012

- Managed a staff of nine (9) employees.
- Ensured all billing statements and invoices were accurate and submitted in a timely manner.
- Developed, audited and maintained billing compliance.
- Tracked remits to ensure accurate and timely payments.
- Maintained billing for contracted providers.
- Developed, audited and maintained billing and compliance plan policies and procedures that ensured compliance with Federal, State and Local regulations.
- Monitored staff performance and attendance as outlined in policy and procedures.

LIFE LINE AMBULANCE **PRESCOTT, AZ**
Receptionist/ Rate Specialist
AUGUST 2005-DECEMBER 2006

- Reviewed all ambulance call sheets for accuracy.
- Entered procedures, medications and supplies into tracking software.
- Determined level of care provided to patient.
- Distributed call sheets to patient representatives for billing.
- Answered multi-line phone system.
- Answered customer questions regarding membership.
- Collected over the counter payments, posted and prepared daily bank deposits.

LUCAS OIL PRODUCTS **CORONA, CA**
Human Resources Director
AUGUST 2005-DECEMBER 2006

- Developed Human Resources forms and procedures.
- Processed employee benefit enrollments and terminations within required timeframes including COBRA notifications.
- Processed and reconciled payroll for five (5) locations utilizing Intuit Payroll software and Excel spreadsheets.
- Developed safety training program for office, warehouse and fleet staff.

EDUCATION:

Yavapai College
Management Certification

LICENSES AND CERTIFICATIONS:

- Certified Ambulance Coder, National Academy of Ambulance Coding 2009

A.R.S. §35-393.01
ATTESTATION

EXHIBIT F: A.R.S. §35-393.01 ATTESTATION

Recognizing legislation has been enacted to prohibit the State from contracting with companies currently engaged in a boycott of Israel, to ensure compliance with A.R.S. §35-393.01, this form must be completed and returned with the response to the solicitation and any supporting information to assist the State in making its determination of compliance.

As defined by A.R.S. §35-393.01:

1."Boycott" means engaging in a refusal to deal, terminating business activities or performing other actions that are intended to limit commercial relations with Israel or with persons or entities doing business in Israel or in territories controlled by Israel, if those actions are taken either:
(a) In compliance with or adherence to calls for a boycott of Israel other than those boycotts to which 50 United States Code section 4607(c) applies.
(b) In a manner that discriminates on the basis of nationality, national origin or religion and that is not based on a valid business reason.
2. "Company" means a sole proprietorship, organization, association, corporation, partnership, joint venture, limited partnership, limited liability partnership, limited liability company or other entity or business association, and includes a wholly owned subsidiary, majority-owned subsidiary, parent company or affiliate.
3. "Direct holdings" means all publicly traded securities of a company that are held directly by the state treasurer or a retirement system in an actively managed account or fund in which the retirement system owns all shares or interests.
4."Indirect holdings" means all securities of a company that are held in an account or fund, including a mutual fund, that is managed by one or more persons who are not employed by the state treasurer or a retirement system, if the state treasurer or retirement system owns shares or interests either:
(a) together with other investors that are not subject to this section.
(b) that are held in an index fund.
5."Public entity" means this State, a political subdivision of this STATE or an agency, board, commission or department of this state or a political subdivision of this state.
6. "Public fund" means the state treasurer or a retirement system.
7. "Restricted companies" means companies that boycott Israel.
8. "Retirement system" means a retirement plan or system that is established by or pursuant to title 38.

All Offerors must select one of the following:

__X__ My company **does not** participate in, and agrees not to participate in during the term of the contract a boycott of Israel in accordance with A.R.S. §35-393.01.

_____ My company **does** participate in a boycott of Israel as defined by A.R.S. §35-393.01. :

By submitting this response, proposer agrees to indemnify and hold the State, its agents and employees, harmless from any claims or causes of action relating to the State's action based upon reliance on the above representations, including the payment of all costs and attorney fees incurred by the State in defending such an action.

BRIDGEWAY HEALTH SOLUTIONS OF ARIZONA, INC.
Company Name

1850 W. RIO SALADO PARKWAY, SUITE 201
Address

TEMPE ARIZONA 85281
City State Zip

PEOB 11/13/16
Signature of Person Authorized to Sign

PAUL BARNES
Printed Name

PLAN PRESIDENT AND CEO
Title