CENTENE® Corporation

April 11, 2013

HAND DELIVERED AND
SENT VIA E-MAIL

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Michael Veit, Contracts Administrator
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Re: Bridgeway Protest re AHCCCS Solicitation No YH14-0001

Dear Ms. Harley and Mr. Veit,

This letter is written on behalf of Bridgeway Health Solutions of Arizona, LLC ("**Bridgeway**"), a subsidiary of Centene Corporation. Pursuant to Arizona Administrative Code R9-22-604, Bridgeway hereby protests AHCCCS's April 1, 2013 decision not to award Bridgeway a contract for the Acute Care Program in Maricopa County (GSA 12) under AHCCCS Solicitation No. YH14-0001 (the "**RFP**"). Bridgeway's address and telephone number are as follows: 1501 W. Fountainhead Parkway, Suite 295; Tempe, Arizona, 85282; 866-475-3129. Based on the legal and factual grounds set forth herein, Bridgeway requests that AHCCCS reconsider its decision and award Bridgeway a contract for the Acute Care Program in Maricopa County, which would make a total of seven contracts for this GSA.

A. Timeliness of Protest

Today, April 11, 2013, is the deadline for Bridgeway to protest AHCCCS's decision not to contract with the company for the Acute Care Program in Maricopa County. Pursuant to A.A.C. R9-22-604(D), "a protestor shall file a protest no later than 10 days after the procurement officer makes the procurement file available for public inspection." AHCCCS initially made the procurement file for this RFP available on the AHCCCS procurement site on March 22, 2013. However, the procurement file summary sheet noted that "Per Section H, Paragraph 9, Award of Contract, of the RFP, AHCCCS ***is still evaluating the Maricopa GSA***." (*See* **Tab A**.) As such, as of March 22, the procurement file was not yet complete ***as to Maricopa GSA***.

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On March 22, Michael Veit, AHCCCS's Contracts and Purchasing Administrator, also sent a letter to Patrick Ross, Bridgeway's President, notifying him that "AHCCCS is not awarding a contract to [Bridgeway] for the Acute Care Program ***at this time***." (*See* **Tab B**.) Mr. Veit's March 22 letter requested "a meeting with AHCCCS ***to discuss Geographic Service Area 12 – Maricopa County***," and provided various dates for meetings. Bridgeway and other Centene representatives met with AHCCCS on March 27, 2013. At AHCCCS's request, Bridgeway and Centene provided AHCCCS with a letter on Thursday, March 28, detailing the steps that Bridgeway would take to improve outcomes and the company's overall performance. (*See* **Tab C**.) Thereafter, on April 1, 2013, Mr. Veit sent a follow-up letter to Mr. Ross with the subject line "Notification of Contract Awards RFP YH14-0001," which stated "[t]his letter is to inform you that AHCCCS is not awarding a contract to [Bridgeway] for the Acute Care Program in Geographic Service Area 12 – Maricopa County." (*See* **Tab D**.) This letter also was posted on the AHCCCS procurement website on April 1. As such, it was not until April 1, 2013, that the RFP procurement file was complete as to Maricopa County.

On April 1, AHCCCS also posted a March 29, 2013 letter to Nancy Novick of Phoenix Health Plan, the eighth place finisher in the procurement, notifying Ms. Novick that AHCCCS had decided to offer Phoenix Health Plan a capped contract for Maricopa County, but not Pima County. (*See* **Tab E**.) This letter also contained conditions under which the cap could be lifted for Phoenix Health Plan. Bridgeway notes that this could lead to an outcome where the eighth place finisher could act as the seventh plan in Maricopa, which would be inconsistent with the outcome of the RFP scoring and directly harm Bridgeway.

B. Legal and Factual Bases for Protest

Bridgeway requests that AHCCCS review the AHCCCS Evaluation Team's scoring, and based on the analysis outlined below, determine that Bridgeway's proposal is advantageous to the State and warrants the award of a seventh contract for Maricopa County.

The RFP provides that "the items which are designated for scoring in this RFP shall be evaluated and scored only using the information submitted to AHCCCS by the Offeror, including verbal responses provided as part of the Oral Presentation." (RFP at 289.) The RFP further provides that "the final decision regarding both the number of contractors in a particular GSA and which Offerors are awarded contracts will be made by AHCCCS. The decision will be guided, but not bound, by the scores awarded by the evaluators. However, AHCCCS will ultimately make its decision based on a determination of which proposals are deemed to be most advantageous to the State." (*Id.*)

An objective review of the AHCCCS Evaluation Team's comments reflects that the team erred in its scoring of many of the items in Bridgeway's proposal, specifically Questions 2, 3, 7, 8, and 9. For example, Bridgeway did not receive credit for items that allegedly were not included with its proposal, when, in fact, those items were detailed in the proposal. In other items, the team scored other offerors higher than Bridgeway, even though Bridgeway's responses included comparable information to other offerors. These improperly scored items had an undeniable effect on the outcome of the RFP process. Indeed, had the AHCCCS Evaluation

Team properly scored these questions, Bridgeway would have scored at least as many points as the sixth-place offeror.

The following sections identify the relevant Evaluator Comments and cite to the relevant portions of the Bridgeway proposal, attached as **Tab F**, where Bridgeway provided the requested information.

1. Question 2: Evaluating and Measuring the Network

The Evaluator Comments regarding Question 2 failed to take into account information about how Bridgeway would evaluate and measure the network: *"Offeror described processes for managing its network but did not describe in detail how it would use a comprehensive array of data to make network improvements.*" Bridgeway's response included the following information regarding use of data to make network improvements:

Page 63: These activities include quarterly preparation of network analyses and reports showing travel distance to provider sites, surveying provider sites for appointment availability, and surveying member satisfaction with their primary care provider (PCP). Bridgeway surveys provider performance of appointment availability at least once per quarter using a Site Survey Tool and a statistically valid sampling of PCPs and a random sampling of specialist providers. Member satisfaction information is obtained through complaint/grievance reports, and Member Satisfaction Surveys.

Page 63: Bridgeway measures its network adequacy informally each day and formally at least semi-annually through the preparation, analysis, and submission of network adequacy reports to the QM/PI and AHCCCS. These network reports allow Bridgeway to pinpoint any network gaps quickly within a given county or GSA. Identified gaps are compared against available providers in the same geographic area in order to gain a realistic sense of health care options in the community. If network gaps exist despite every provider in the area participating in Bridgeway's network, we coordinate alternative access to care, such as scheduling transportation to the nearest available provider, using telemonitoring, or ordering home health services for members in rural and remote locations where providers and health care services are scarce.

Page 66: **Centelligence™: Centene's Data Analysis Systems Support for Bridgeway.** In addition to PRM, our award-winning proprietary and comprehensive family of integrated decision support and health care informatics reporting solutions, known as Centelligence™, integrates data from multiple sources (including member and provider data, claims, member responsibility, utilization, authorization, grievances, appeals, etc.) and produces *actionable* information: everything from Care Gaps and Wellness Alerts to Key Performance Indicator (KPI) Dashboards, Provider Clinical Profiling analyses, population level health risk stratifications, operational and state compliance reports. Bridgeway uses the Centelligence™ Insight (Insight) suite of tools for provider data

analysis. Insight gives us desktop reporting and management KPI Dashboards capability, as well as provider practice patterns and clinical quality and cost reporting capabilities. Through Insight, we also have the ability to report all data sets in our platform, including such items as provider network adequacy, HEDIS, EPSDT services, and claims timeliness.

How Bridgeway Identifies and Addresses Network Deficiencies

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

2. Question 3: Care Coordination

Regarding Question 3, the Evaluation Team commented: "*Offeror described future strategies for rewarding quality care, but does not appear to currently employ any of these approaches*." Because two of the three subparts of this question ask about future plans (***i.e.***, "How will the Offeror use data and evidence based decision support tools…" and "How will these tools and data be used…") Bridgeway focused its response on future strategies, however, Bridgeway also included the following information about current approaches:

Page 72: We reach out to our high performing providers to better understand what makes them successful and share best practices across the delivery system. We also recognize providers through additional compensation, at awards dinners, provider meetings, and through the Bridgeway website with a provider profile spotlighting a provider's contribution to care coordination and outstanding patient care.

3. Question 7: Improving Quality and Enhance Cost Containment

The Evaluation Team made two comments in evaluating Question 7 that failed to take into account information found within Bridgeway's response. The first comment found that "*Offeror did not clearly describe how data, such as comparative provider information, will be*

used to improve care." Bridgeway's response, however, included the following information regarding use of comparative provider information:

> **Page 90**: Provider data is used to **compare providers to their peers** and other plan or other industry benchmarks such as HEDIS or utilization measures, develop provider training and education, and implement corrective action plans as needed. Bridgeway's Medical Director and other Provider Relations staff meet with providers regularly to share data, address barriers, and develop appropriate interventions. Bridgeway also uses this data to recognize high performing providers. We reach out to our **high performing providers** to better understand what makes them successful and share best practices across the delivery system. We also recognize providers through additional compensation, at awards dinners, provider meetings, and through the Bridgeway website with a provider profile spotlighting a provider's contribution to care coordination and outstanding patient care.

The Evaluation Team also commented that "*Offeror did not describe how data is used to facilitate continuous quality improvement*." Bridgeway's response included the following information about how data is used to facilitate continuous quality improvement:

> **Page 90**: Our technology systems allow us to analyze data by member, by individual provider/facility, by provider specialty, by type of service, by diagnosis, by place of service, or by comparing services authorized to services received. Health Economics analysts generate monthly trend reports to monitor key utilization measures such as inpatient admissions/days, ER visits, and case management activities. Each of these reports includes a drill down to more specific areas of interest. For example, when analyzing member emergency room visits or inpatient utilization, we look not only at total number of visits or days, but also look at utilization based on the members' recurring admissions, assigned PCP, by service area, by members with no physician office visits, and by members with frequent ER utilization (12 ER visits in six months as detected through ER reports that flag members with 3 or more visits in 6 months). Benchmarks are established using industry standards, HEDIS national Medicaid averages, and/or State mandated thresholds. Particularly when dealing with utilization data, internal benchmarks are developed based on historical data that reflect variances in population demographics, seasonal variations, cultural disparities and regional characteristics of the populations we service.

4. Question 8: Compliance Program

The scoring for Question 8 in particular reflects discrepancies in the Evaluation Team's scoring across proposals. The Evaluation Team gave Bridgeway credit for compliance activities beyond minimum contract requirements, however other higher-ranked offerors were given

additional credit within the evaluation for compliance program activities that Bridgeway also wrote about, but did not receive credit for, including the following:

- **Dedicated FWA Position**. Maricopa (1st) and Mercy (3rd) were given credit for a dedicated FWA position. Bridgeway has a SIU investigator that is dedicated solely to Bridgeway. (*See* Bridgeway Response at 93.)

- **Emphasis on Employee Training to Detect and Report Potential FWA**. Maricopa (1st) was given credit for emphasis on employee training. Bridgeway wrote extensively about its employee training program, but was not given credit in the evaluation including: requiring all new employees to read and provide an attestation on Centene Code of Conduct; computer based training modules; employees required to complete several mandatory compliance courses within 30 days of hire; compliance staff provides additional training to staff who work directly with Medicaid members and providers and educates them on how to detect and prevent FWA (Bridgeway gave an example of how Payment Integrity trains Provider Relations staff on ways to communicate with providers about billing trends etc.); members of the FWA workgroup receive additional training on topics such as current fraud schemes, common coding or billing errors etc.; compliance staff train on identified concerns risks and upcoming changes in regulations or operations. Bridgeway then spoke extensively about its training approaches, which include interactive group, online training, handouts, handbooks, contests and newsletters.

- **Utilization of <u>Multiple</u> Software Applications/Decision Support Tools for FWA Prevention and Identification**. Bridgeway was given credit for having **additional** software and Maricopa (1st) and Care1st (3rd) were given credit for **multiple** software applications, but Care 1st only mentioned two and Bridgeway mentioned three. Also, Maricopa listed its entire claims processing system and CRM.
  - *Maricopa (1st):* Core Claims Processing System GE MCA; TriZetto Medical Data Express for outpatient hospital claims processing; iCES claims editing application; Oracle Siebel CRM FWA analyst receives referrals from Member Services and Med Management uses for retrospective claims review; Cerecons PA management system (note: this does not prevent or identify FWA); e-services provider portal.
  - *Care 1st: (3rd)* ClaimsCheck software; Emdeon's Program Integrity for post adjudication/pre-payment claims review.
  - *Bridgeway (6th):* Claims Xten code auditing software prepayment; Verisk Health pre-payment review; EDI Watch.

- **Creation of a Corporate Special Investigations Unit**. Care 1st, Mercy, Phoenix, and Medisun all had evaluator comments on their Consensus Rationale sheets regarding a Special Investigation Unit (SIU). All ranked higher than Bridgway except for Medisun, which tied with Bridgeway. Mercy was given credit for the Aetna SIU. Bridgeway's evaluator comments did not reference Bridgeway's Special

Investigation Unit, even though Bridgeway mentions the Centene SIU and Payment Integrity division ***19 times*** in its narrative.

- **Application of multiple pre-payment auditing processes**. Mercy (3rd) was given credit for multiple pre-payment auditing processes. Bridgeway was not given credit for this in the Evaluation Team comments, even though there is a section on proactive coding activities, which includes prepayment review. Bridgeway also discusses the Claim Audit Division which assists with pre-payment audits of claims payments.

5. Question 9: Claims Dispute Process

There are three Evaluation Team comments for Question 9 that do not accurately account for the content of Bridgeway's proposal. *First*, the Evaluation Team found that Bridgeway "*failed to describe in detail comprehensive and proactive processes to avoid providers having to file a claims dispute.*" This finding was clearly incorrect, given the many places throughout Bridgeway's proposal where the company detailed its processes for providers to avoid claims disputes:

Page 98: We use several proactive approaches to reduce the claims submission errors and misunderstandings that could lead to a claims dispute or appeal. Our most effective proactive measure is our ***electronic claims management system*** that delivers the functionality, speed and capacity to handle high claims volume and claims complexity for every type of provider and health care service. We ***train providers on how to submit claims*** and ***continually encourage them to submit claims electronically*** to ensure correct claims payment and reduce disputes. Finally, we provide ***timely and attentive service*** support to providers who have questions or concerns regarding claim denials or payment amounts.

Page 98: **Prompt Notice to Providers of Claim Submission Problems.** All claims are pre-adjudicated through EDIFECS and TIBCO middleware using consistent application of common edits to ensure adherence with established claims guidelines, rules and regulations. This pre-adjudication step helps to capture errors, omissions or inconsistencies before the claim proceeds through the next phase of adjudication. If the claim "fails" this initial checkpoint, we immediately alert the submitting clearinghouse or provider so they can correct and resubmit the claims.

Page 99: **Bridgeway's Provider Outreach and Intervention Activities to Reduce Claims Submission Errors**
Bridgeway's Provider Relations Unit, under the auspices of its Network Development and Contracting Unit, delivers effective provider outreach and intervention through a series of communication methods directly with providers. Communication methods include:

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

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

Bridgeway Trains Providers on How to Submit Claims. Bridgeway trains all providers and their billing staff regarding claims submission options and how to submit HIPAA-compliant claims. We also include detailed claims submission instructions on our web-based Provider Portal, in the Provider Manual, and through newsletters, notices and bulletins on an ongoing basis. Our Provider Portal enables providers to view Bridgeway Claims Adjudication logic in detail - using the Clear Claim Connection tool (designed by McKesson Information Solutions, Inc.) that essentially mirrors how the claims software evaluates medical code combinations during the adjudication of a claim resulting in ***cleaner claim submissions and lower error rates.***

Page 100: **Bridgeway's Processes, Interventions and Strategies to Reduce Claims Disputes and Hearing Requests**

If a provider is not satisfied with the initial adjudication, the provider can contact Bridgeway's Claims Research and Support (CRS) Unit – via our toll-free call center - in order to receive high quality, personalized customer service to resolve claims issues. The methods that the CRS Unit uses to reduce claims disputes include effective oversight and monitoring of Bridgeway's claims systems configuration to eliminate claims processing errors in combination with the application of preventive measures through provider training, staff training, and timely dissemination of information relating to changes in guidelines that impact provider billing and claims remuneration.

Recognizing the need to minimize claims disputes in a way that will keep such disputes at a very low level for the long term, Bridgeway restructured portions of its claims management processes to more efficiently and effectively address provider claims dispute issues. A portion of restructuring the CRS unit involved the creation of a subunit staffed by qualified Claims Liaisons who are solely responsible for researching and resolving claims disputes on behalf of providers who have complex claims issues, have a large numbers of claims for which they are inquiring, or who have requested reconsideration of claims payment (via a written appeal). This CRS subunit currently consists of two fully-dedicated Claims Liaisons (Analysts). Providers are connected with an Analyst via referral or query from their dedicated Provider Services Representative; warm-transfer when they call in through the Provider Services call center; or acknowledgement of receipt letter sent in response to appeal letters or faxes received from providers regarding their specific claim dispute, inquiry or request.

Using "First Call Resolution" methodology, the CRS team is responsible for quick identification of the root cause pertaining to the specific issue in question, resolving that specific issue, and then expanding the research to encompass all other impacted providers and claims tied to the same issue. Proactively resolving other impacted providers and claims creates a constant process improvement work flow. For provider and employee training purposes, the nature of the root cause is sorted into four main categories and training occurs as follows:

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

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

1.) Reduced telephone status queries, claims adjustments, claims inaccuracies;

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

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

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

*Data reflects the first 3 quarters of the year

We are pleased with the trends and outcomes achieved since implementing these proactive measures and continue to see a decline in the number of claims disputes and Hearing requests. While the amount of Hearing requests shown in the table above depicts a significant increase from 2011 to 2012, the numbers largely reflect residual cases that have since been resolved and closed. Also, the spike in Hearing requests we experienced in 2012 came from one provider group that requested 23 of the 36 Hearing requests in the first three quarters of 2012 (accounts for 64% of all Hearing requests). There were no Hearing requests in November and December 2012 and we anticipate this downward trend to continue going forward.

Second, the Evaluation Team found that "*Offeror failed to describe in detail processes in place to resolve disputes at the earliest possible stage*." This finding was also incorrect. Bridgeway's response included the following information about resolving disputes at the earliest possible stage:

Page 100: If a provider is not satisfied with the initial adjudication, the provider can contact Bridgeway's Claims Research and Support (CRS) Unit – via our toll-free call center - in order to receive high quality, personalized customer service to resolve claims issues…… Using "First Call Resolution" methodology, the CRS team is responsible for quick identification of the root cause pertaining to the specific issue in question, resolving that specific issue, and then expanding the research to encompass all other impacted providers and claims tied to the same issue. Proactively resolving other impacted providers and claims creates a constant process improvement work flow.

Finally, in evaluating Question 9, the Evaluation Team found: "*Offeror failed to describe in detail how local staff are empowered to assist in resolution of provider claims issues*." This finding overlooked the fact that Bridgeway dedicated an entire section to its local Claims

Research and Support Unit (CRS), detailing the team's ability to address and resolve provider claims issues outside of the claim dispute process:

Page 100: If a provider is not satisfied with the initial adjudication, the provider can contact Bridgeway's Claims Research and Support (CRS) Unit – via our toll-free call center - in order to receive high quality, personalized customer service to resolve claims issues. The methods that the CRS Unit uses to reduce claims disputes include effective oversight and monitoring of Bridgeway's claims systems configuration to eliminate claims processing errors in combination with the application of preventive measures through provider training, staff training, and timely dissemination of information relating to changes in guidelines that impact provider billing and claims remuneration. Recognizing the need to minimize claims disputes in a way that will keep such disputes at a very low level for the long term, Bridgeway restructured portions of its claims management processes to more efficiently and effectively address provider claims dispute issues. A portion of restructuring the CRS unit involved the creation of a subunit staffed by qualified Claims Liaisons who are solely responsible for researching and resolving claims disputes on behalf of providers who have complex claims issues, have a large numbers of claims for which they are inquiring, or who have requested reconsideration of claims payment (via a written appeal). This CRS subunit currently consists of two fully-dedicated Claims Liaisons (Analysts). Providers are connected with an Analyst via referral or query from their dedicated Provider Services Representative; warm-transfer when they call in through the Provider Services call center; or acknowledgement of receipt letter sent in response to appeal letters or faxes received from providers regarding their specific claim dispute, inquiry or request.

Using "First Call Resolution" methodology, the CRS team is responsible for quick identification of the root cause pertaining to the specific issue in question, resolving that specific issue, and then expanding the research to encompass all other impacted providers and claims tied to the same issue. Proactively resolving other impacted providers and claims creates a constant process improvement work flow. For provider and employee training purposes, the nature of the root cause is sorted into four main categories and training occurs as follows:

1.) *Provider Generated (generally coding, coordination of benefits or timely filing):* The provider is educated through an initial outreach from the Claims Liaison. If more thorough explanation is needed, Provider Relations is contacted to support, intervene, or retrain the provider's billing staff.
2.) *Contract Interpretation:* Provider Relations is contacted to review the contract with the provider and address the provider's questions or concerns relating to the contract that impacts the claims in question.

3.) *Plan Generated (generally a configuration issue):* The Contracts Implementation Coordinator is contacted for system configuration changes or updates.
4.) *Claims Center Generated (initial adjudication issue):* Bridgeway contacts the Centene Claims Administration staff to update or augment their processes.

The CRS Unit measures its success in reaching its overarching goal to reduce the number of provider requests for claims review by monitoring trends in the following areas:
1.) Reduced telephone status queries, claims adjustments, claims inaccuracies;
2.) Increased provider satisfaction, claims acceptance rates from AHCCCS (i.e. encounter data); and
3.) Decreased turn-around time frames on payment resolution.

C. Conclusion

In summary, these portions of the Bridgeway proposal show how Bridgeway's responses addressed the purported deficiencies found by the Evaluation Team. Had Bridgeway's proposal been properly scored, Bridgeway's score would have been ***at least*** as high as the sixth place scorer. Moreover, Bridgeway's score would have been that much higher than the eighth place finisher, Phoenix Health Plan, which AHCCCS awarded a capped contract. It is disconcerting that, under the right conditions, the eighth place finisher could end up as the seventh plan in Maricopa County, with Bridgeway being overlooked.

As communicated in the letter from Centene's Chairman and CEO dated March 28th, Centene and Bridgeway are willing to take all actions necessary to meet the expectations of AHCCCS in serving as a leading organization to serve the citizens of Arizona. Again, based on the legal and factual grounds set forth herein, Bridgeway asks that AHCCCS reconsider its decision to award Bridgeway a contract for the Acute Care Program in Maricopa County.

Sincerely,

Mark W. Eggert

Mark Eggert
Senior Vice President,
Contractual and Regulatory Affairs
Centene Corporation

EXHIBIT A

Summary of ACUTE/CRS RFP Awards

	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14	CRS
	Yuma, LaPaz	Apache, Coconino, Mohave, Navajo	Yavapai	Gila, Pinal	Pima, Santa Cruz	Maricopa	Cochise Graham Greenlee	
Bridgeway Health Solutions of Arizona, LLC	S	S	*S	S	S	S	S	
Care 1st Health Plan Arizona	S		S	S	S(1)	*S	S	
Health Choice Arizona	*S	*S	S	S	*S(1)	*S	S	
Health Net of Arizona					S	S		
Maricopa Health Plan managed by University of Arizona Health Plans						*S		
Blue Cross Blue Shield of Arizona / Medisun Community Care Inc. dba Community Care						S		
Southwest Catholic Health Network dba Mercy Care Plan	S	S	S		*S(1)	*S	*S	S
Phoenix Health Plan		*S	*S	*S	*S	*S		
United Health Care Community Plan	*S	S	S	S	*S	*S	S	*S
University of Arizona Health Plans, University Family Care	S		S	*S	*S		*S	
Total Bids Received	6	5	7	6	8	9	6	2

* = Current Contractor
S = Submitted a Proposal
(1) = Award in Pima County Only
= Contract Awarded

Note: Per Section H, Paragraph 9, Award of Contract, of the RFP, AHCCCS is still evaluating the Maricopa GSA.

OFFERORS' RANKINGS BY SUBMISSION REQUIREMENT

	#1 - Network: Medicaid Expansion	#2 - Network Development & Management	#3 - Program: Data Sharing/ Care Coordination	#4 - Program: Disease Management	#5 - Program: Disease Management	#6 - Program: Medicare Integration / Alignment	#7 Organization: IDM	#8 - Organization: Fraud & Abuse	#9 Organization: Grievance	#10 Organization: IT Demo	Oral
Blue Cross Blue Shield of Arizona / Medicaid Community Care Inc. dba Community Care	10	10	7	9	10	10	7	6	9	2	7
Bridgeway Health Solutions of Arizona, LLC	8	8	8	5	2	8	8	4	10	10	10
CareIst Health Plan Arizona	1	5	5	7	1	3	5	3	1	4	6
Health Choice Arizona	7	2	6	4	6	7	6	8	6	5	8
Health Net of Arizona	3	9	9	8	2	3	10	10	8	6	5
Maricopa Health Plan managed by University of Arizona Health Plans	4	2	3	2	7	5	3	1	2	5	1
Southwest Catholic Health Network dba Mercy Care Plan	9	1	2	6	4	1	1	5	7	3	4
Phoenix Health Plan	4	7	10	10	9	9	9	3	4	8	9
United Health Care Community Plan	2	6	1	1	5	2	2	8	5	1	1
University of Arizona Health Plans, University Family Care	4	3	3	2	7	5	3	1	2	7	1

Category Weights	Points
Program	33%
Capitation	33%
Access to Care/Network	17%
Organization	17%
Total	100%

CRS	#11 - Network: Access to Care	#12 Program: Behavioral Health Integration	#13 - Program: Behavioral Health Case Management	#14 - Program Data Exchange Care Coordination	#15 Organization: Ombudsman / Client Advocate
Southwest Catholic Health Network dba Mercy Care Plan	2	1	1	2	2
United Health Care Community Plan	1	2	2	1	1

Category Weights	Points
Program	35%
Capitation	6%
Access to Care/Network	35%
Organization	24%
Total	100%

GSA 2 - Yuma, La Paz

X = Incumbents - Health Choice, United

Total Bids = 6

			X		X	
	Bridgeway Health Solutions of Arizona, LLC	Care1st Health Plan Arizona	Health Choice Arizona	Southwest Catholic Health Network dba Mercy Care Plan	United Health Care Community Plan	University of Arizona Health Plans, University Family Care
Access to Care/ Network	510.00	1,300.00	1,080.00	1,140.00	1,130.00	1,220.00
Organization	818.25	1,360.62	1,024.86	1,393.01	1,276.78	1,463.34
Program	1,550.00	2,125.00	1,660.00	2,400.00	2,890.00	2,265.00
Capitation	1,460.38	1,682.25	2,962.50	787.52	2,468.63	3,288.89
Total Score	4,338.63	6,467.87	6,727.36	5,720.54	7,765.42	8,237.24
Ranking	6	4	3	5	2	1

							Total
Current GSA total membership by Contractor			11,668		36,632		48,300
Potential Transitioning	0	0	11,668	0	0	0	11,668

Note: Gray highlighted columns indicate Contract Award

GSA 4 - Apache, Coconino Mohave, Navajo

X - Incumbents' Health Choice, Phoenix Health Plan

Total Bids = 5

		X		X	
	Bridgeway Health Solutions of Arizona, LLC	Health Choice Arizona	Southwest Catholic Health Network dba Mercy Care Plan	Phoenix Health Plan	United Health Care Community Plan
Access to Care/ Network	510.00	1,080.00	1,140.00	820.00	1,130.00
Organization	818.25	1,024.86	1,393.02	1,067.09	1,276.78
Program	1,550.00	1,660.00	2,400.00	500.00	2,890.00
Capitation	1,071.77	3,286.68	948.93	2,827.59	2,369.21
Total Score	3,950.02	7,051.54	5,881.94	5,214.68	7,666.00
Ranking	5	2	3	4	1

						Total
Current GSA total membership by Contractor		52,712		22,700		75,412
Potential Transitioning	0	0	0	22,700	0	22,700

Note: Gray highlighted columns indicate Contract Award

GSA 6 - Yavapai

X - Incumbent - Bridgeway, Phoenix Health Plan

Total Bids = 7

	X				X		
	Bridgeway Health Solutions of Arizona, LLC	Care1st Health Plan Arizona	Health Choice Arizona	Southwest Catholic Health Network dba Mercy Care Plan	Phoenix Health Plan	United Health Care Community Plan	University of Arizona Health Plans, University Family Care
Access to Care/ Network	510.00	1,300.00	1,080.00	1,140.00	820.00	1,130.00	1,220.00
Organization	818.25	1,360.62	1,024.86	1,393.02	1,067.09	1,276.78	1,463.35
Program	1,550.00	2,125.00	1,660.00	2,400.00	500.00	2,890.00	2,265.00
Capitation	903.37	386.39	3,285.73	1,893.63	2,664.84	2,294.91	3,033.86
Total Score	3,781.63	5,172.01	7,050.59	6,826.64	5,051.94	7,591.70	7,982.21
Ranking	7	5	3	4	6	2	1

								Total
Current GSA total membership by Contractor	16,078				15,084			31,162
Potential Transitioning	16,078	0	0	0	15,084	0	0	31,162

Note: Gray highlighted columns indicate Contract Award

GSA 8: Gila, Pinal

X = Incumbents: Phoenix Health Plan, University Family Care

Total Bids = 6

				X		X
	Bridgeway Health Solutions of Arizona, LLC	Care1st Health Plan Arizona	Health Choice Arizona	Phoenix Health Plan	United Health Care Community Plan	University of Arizona Health Plans, University Family Care
Access to Care/ Network	510.00	1,300.00	1,080.00	820.00	1,130.00	1,220.00
Organization	818.25	1,360.62	1,024.86	1,067.09	1,276.78	1,463.35
Program	1,550.00	2,125.00	1,660.00	500.00	2,890.00	2,265.00
Capitation	883.35	746.46	3,294.45	2,882.38	734.22	1,993.67
Total Score	3,761.60	5,532.08	7,059.31	5,269.47	6,031.00	6,942.01
Ranking	6	4	1	5	3	2

							Total
Current GSA total membership by Contractor				30,026		16,836	46,862
Potential Transitioning	0	0	0	30,026	0	0	30,026

Note: Gray highlighted columns indicate Contract Award

[redacted]

Total Bids = 8

X = Incumbents: Health Choice, Mercy Care, United, Phoenix Health Plan, University Family Care
XX = Contractor also in Santa Cruz County

			XX		X	X	X	XX
	Bridgeway Health Solutions of Arizona, LLC	CareFirst Health Plan Arizona	Health Choice Arizona	Health Net of Arizona	Southwest Catholic Health Network dba Mercy Care Plan	Phoenix Health Plan	United Health Care Community Plan	University of Arizona Health Plans, University Family Care
Access to Care/ Network	510.00	1,300.00	1,080.00	760.00	1,140.00	820.00	1,130.00	1,220.00
Organization	818.25	1,360.62	1,024.86	718.91	1,393.02	1,067.09	1,276.78	1,463.35
Program	1,550.00	2,125.00	1,660.00	1,665.00	2,400.00	500.00	2,890.00	2,265.00
Capitation	1,646.11	679.52	3,137.09	2,246.74	1,390.55	2,680.88	2,228.52	3,197.47
Total Score	4,524.36	5,465.14	6,901.96	5,390.65	6,323.56	5,067.97	7,523.91	8,145.81
Ranking	8	5	3	6	4	7	2 XX	1 XX

									Total
Current GSA total membership by Contractor			41,858		24,834	17,506	60,979	33,980	179,157
Potential Transitioning	0	0	0	0	0	17,506	0	0	17,506

Note: Gray highlighted columns indicate Contract Award

[redacted]

[redacted] X = Incumbents: Care1st, Health Choice, [redacted]

Total Bids = 9

		X	X		X		X	X	X
	Bridgeway Health Solutions of Arizona, LLC	Care1st Health Plan Arizona	Health Choice Arizona	Health Net of Arizona	Maricopa Health Plan managed by University of Arizona Health Plans	Blue Cross Blue Shield of Arizona / Medisun Community Care Inc. dba Community Care	Southwest Catholic Health Network dba Mercy Care Plan	Phoenix Health Plan	United Health Care Community Plan
Access to Care/ Network	510.00	1,300.00	1,080.00	760.00	1,220.00	170.00	1,140.00	820.00	1,130.00
Organization	818.25	1,360.62	1,024.86	718.91	1,438.66	962.50	1,393.02	1,067.09	1,276.78
Program	1,550.00	2,125.00	1,660.00	1,665.00	2,265.00	830.00	2,400.00	500.00	2,890.00
Capitation	2,574.43	1,998.11	2,876.46	2,474.02	3,281.75	1,065.23	1,354.86	1,234.86	2,416.69
Total Score	5,452.68	6,783.73	6,641.32	5,617.92	8,205.41	3,027.73	6,287.88	3,621.96	7,713.47
Ranking	7	3	4	6	1	9	5	8	2

										Total
Current GSA total membership by Contractor		47,500	62,723		47,989		240,791	95,143	138,492	632,638
Potential Transitioning	0	0	0	0	0	0	0	95,143	0	95,143

Note: Gray highlighted columns indicate Contract Award

GSA 11: Cochise, Graham, Greenlee

Incumbents: Mercy Care, University Family Care

Total Bids = 6

	Bridgeway Health Solutions of Arizona, LLC	Care1st Health Plan Arizona	Health Choice Arizona	X Southwest Catholic Health Network dba Mercy Care Plan	United Health Care Community Plan	X University of Arizona Health Plans, University Family Care
Access to Care/ Network	510.00	1,300.00	1,080.00	1,140.00	1,130.00	1,220.00
Organization	818.25	1,360.62	1,024.86	1,393.02	1,276.78	1,463.35
Program	1,550.00	2,125.00	1,660.00	2,400.00	2,890.00	2,265.00
Capitation	1,164.03	2,081.83	3,103.82	1,000.00	2,321.00	3,170.95
Total Score	4,042.28	6,867.45	6,868.69	5,933.02	7,617.79	8,119.30
Ranking	6	4	3	5	2	1

							Total
Current GSA total membership by Contractor				16,520		14,451	30,971
Potential Transitioning	0	0	0	16,520	0	0	16,520

Note: Gray highlighted columns indicate Contract Award

CRS Statewide

X = Incumbent United

Total Bids = 2

		X
	Southwest Catholic Health Network dba Mercy Care Plan	United Health Care Community Plan
CRS Access to Care/ Network	2,250.00	3,000.00
CRS Organization	1,888.02	1,946.78
CRS Program	2,600.00	2,650.00
CRS Capitation	600.00	154.03
CRS Total	7,338.02	7,750.82
Ranking	2	1

Current CRS total membership for January 2012		24,744

Note: Gray highlighted columns indicate Contract Award

EXHIBIT B

Janice K. Brewer, Governor
Thomas J. Betlach, Director

801 East Jefferson, Phoenix, AZ 85034
PO Box 25520, Phoenix, AZ 85002
Phone: 602-417-4000
www.azahcccs.gov

AHCCCS

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ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

March 22, 2013

Bridgeway Health Solutions of Arizona, LLC
Patrick Ross
President
1501 W. Fountainhead Parkway, Ste. 295
Tempe, AZ 85282

Subject: Notification of Contract Awards RFP YH14-0001

Dear Mr. Ross:

This letter is to inform you that AHCCCS is not awarding a contract to Bridgeway Health Solutions of Arizona, LLC (Bridgeway) for the Acute Care Program at this time. It is also to request your presence at a meeting with AHCCCS to discuss Geographic Service Area 12 – Maricopa County. The following dates and times are available for this meeting:

- March 26, 2013 – 11:00 a.m.
- March 26, 2013 – 2:00 p.m.
- March 27, 2013 – 12:00 p.m.
- March 28, 2013 – 1:00 p.m.

It is imperative that representatives from Bridgeway's corporate and local leadership teams attend this meeting and we ask that you limit it to five attendees. Please select a time and date that can accommodate the schedules of all individuals that need to be in attendance. When you have selected a time from those listed above, you may notify Meggan Harley, AHCCCS Procurement Manager, at (602) 417-4538. Ms. Harley is also available to answer any questions that you may have.

Please note that the public will be notified of the awards when the Acute/CRS RFP YH14-0001 Procurement File is made available for public inspection on the AHCCCS website on March 22, 2013. The Offeror may refer to the Procurement File for information regarding contract awards for CYE 2014.

Sincerely,

Michael Veit
Contracts and Purchasing Administrator
Division of Business and Finance

EXHIBIT C

CENTENE® Corporation

March 28, 2013

Mr. Michael Veit
Arizona Health Care Cost Containment System
Contracts and Purchasing Administration
Division of Business and Finance
801 E. Jefferson
Phoenix, AZ 80034

Re: Requested follow-up to AHCCCS meeting held Wednesday, March 27th

Dear Mr. Veit:

I want to thank AHCCCS for meeting with the senior executive group who I selected to attend this important meeting regarding the procurement and our Arizona operations. We had an early morning meeting today and what follows are the actions I directed to be taken to improve outcomes and the overall performance of Bridgeway. Over the next three to six months, I fully expect Bridgeway and Cenpatico to be among the top performers in Arizona. We have a track record of doing this in other markets and Arizona is equally important to us. We fully recognize your reputation for managing a model program.

I would also like to thank AHCCCS for the opportunity to outline our plan to continue strengthening our clinical, operational and contract compliance areas to ensure positive health care outcomes for our members. Several steps have already been taken.

Beginning January 1, 2013, Bridgeway will be reported as a part of Centene's Health Plans Business Segment. Under the leadership of Rob Hitchcock, Centene Executive Vice President, Health Plan Business Unit, Bridgeway is positioned to take greater advantage of Centene's significant Medicaid managed care experience. Rob is charged with achieving the above stated performance objectives. Additionally, I have now assigned Jean Rush, Senior Vice President, Health Plans, who in my judgement is a seasoned and experienced health care executive, to oversee and work with local management. This new structure ensures Bridgeway will better leverage corporate resources and tools to improve our operations. The focus will be on improving AHCCCS Performance Measures and overall plan operations through common corporate oversight with other Centene Medicaid Plans.

The Centene model is based on local plans with strong local management. If a relationship touches a member, a provider, a contractor or a state official, our local president is held accountable to ensure local needs are met. To this model we add corporate oversight and supervision.

At my direction, below you will find a summary of structural and operational initiatives that demonstrate our commitment to Bridgeway's members and AHCCCS contract requirements.

Quality Management/Acute Performance Measures

Bridgeway has increased the number of full-time staff in the Quality Management Department to meet AHCCCS quality management/performance improvement requirements. We will monitor membership and contract requirements and will further increase staffing as needed.

Centene Corporation
Centene Plaza
7700 Forsyth Blvd.
St. Louis, MO 63105
314-725-4477

Centene Internal Audit reports directly to me and the Audit Committee of Centene's Board of Directors, through our Senior Vice President of Internal Audit, Brandy Burkhalter. Brandy will be my direct contact in monitoring appropriate progress and improvements for our Arizona operations.

We are committed to the improvement of member outcomes and ensuring AHCCCS Performance Measures are met. As a result, the following enhancements have occurred or are underway:

- Bridgeway has a Performance Measures Committee with cross functional representation that meets monthly to focus on improving quality measures. Although the impact of this work may not yet be evident, I believe it will be in future reporting periods.
- The Centene Executive Performance Measures Committee will now put additional emphasis on the Health Plan operations in Arizona. The committee provides Bridgeway with additional resources and tools that enhance the development of an effective AHCCCS Performance Measures work plan.
- Centene has recently added a leadership position dedicated to overseeing all Health Plan Performance Measures focused on the oversight of work plans and results.
- Bridgeway will now recruit for an AHCCCS Performance Measures Manager, whose sole focus will be monitoring of Acute Performance Measures. We will meet or exceed these benchmarks, reflecting our commitment to being a first quartile operation. Findings will be reported to executive leadership to identify barriers and recommend process improvements.

Business Systems and Provider Services

As a result of the aforementioned Health Plan alignment, Bridgeway's interactions with personnel responsible for Health Plan systems will result in the following:

- Full participation in all Health Plan system user groups
- Improved access to personnel responsible for system modifications and enhancements
- Improved opportunities to benchmark various performance measures against the experience of other Centene Health Plans as well as benefit from identified best practices

Bridgeway recognizes that providers are an essential partner in the delivery of health care services and will operate in a manner that is efficient and effective for providers and our members. Bridgeway has improved processes to resolve provider inquires and complaints and has seen a significant decline in escalated complaints to AHCCCS over the past six months.

I am directing Don Imholz, Executive Vice President and Chief Information Officer for Centene, to work directly with his staff to fully meet the above stated objectives. We believe these actions will directly improve provider satisfaction, which is expected in all Centene markets.

Additional Staffing

I have directed that Bridgeway immediately recruit for the following additional positions to support the Acute program:

- Vice President of Acute Operations - directly oversee day-to-day operations of the Acute program
- Acute Compliance Manager - coordinates with department leads to ensure accurate and timely deliverable submissions
- Performance Measures Manager - monitors AHCCCS Performance Measures

State Communication and Reporting

To reflect our ongoing commitment to the State of Arizona, we welcome the opportunity to meet with AHCCCS representatives on a regular basis to review our progress in meeting your expectations regarding our operations. These meetings will also provide opportunities to enhance the collaborative nature of our relationship and would include both Centene senior leadership and local management.

Bridgeway is committed to the AHCCCS mission of *Reaching across Arizona to provide comprehensive, quality health care for those in need.* You have our strongest commitment to serve our membership, your recipients, in the State of Arizona using all available Centene resources.

In closing, I want to again express my appreciation for the meeting with AHCCCS leadership that occurred yesterday with my senior executives. At the soonest appropriate time, my office will be in contact with Director Betlach's office to establish a time for Jean Rush, Brandy Burkhalter and myself to meet and review our plans. Please have no doubt that we are completely and fully committed to our Arizona operations and fully expect them to operate at standards of which we can all be proud.

Sincerely,

Michael F. Neidorff
Chairman, President and Chief Executive Officer

EXHIBIT D

Janice K. Brewer, Governor
Thomas J. Betlach, Director

801 East Jefferson, Phoenix, AZ 85034
PO Box 25520, Phoenix, AZ 85002
Phone: 602-417-4000
www.azahcccs.gov

AHCCCS

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ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

April 1, 2013

Patrick Ross
President
Bridgeway Health Solutions of Arizona, LLC
1501 W. Fountainhead Parkway, Ste. 295
Tempe, AZ 85282

Subject: Notification of Contract Awards RFP YH14-0001

Dear Mr. Ross:

This letter is to inform you that AHCCCS is not awarding a contract to Bridgeway Health Solutions of Arizona, LLC (Bridgeway) for the Acute Care Program in Geographic Service Area 12 - Maricopa County.

If you have any questions regarding this letter please contact Meggan Harley, AHCCCS Procurement Manager, at (602) 417-4538.

Sincerely,

Michael Veit
Contracts and Purchasing Administrator
Division of Business and Finance

EXHIBIT E

Janice K. Brewer, Governor
Thomas J. Betlach, Director

801 East Jefferson, Phoenix, AZ 85034
PO Box 25520, Phoenix, AZ 85002
Phone: 602-417-4000
www.azahcccs.gov

AHCCCS

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ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

March, 29, 2013

Nancy Novick
Chief Executive Officer
Phoenix Health Plan
7878 N 16th Street, #105
Phoenix, Arizona 85020

SUBJECT: Notification of Contract Awards RFP YH14-0001, GSA 12, Capped Contract

Dear Ms. Novick:

AHCCCS is exercising its contractual authority to offer a capped contract to an unsuccessful incumbent Contractor in Maricopa County (GSA 12), as outlined in Section H, Paragraph 9, *Award of Contract*, in the RFP document. The capped contract request for GSA 10 Pima County is denied. However, the request with respect to GSA 12 is granted, contingent upon Phoenix Health Plan's agreement to waive and forego any and all rights to file a protest of: (1) the AHCCCS decision to award the capped contract in GSA 12, (2) the AHCCCS decision not to award a capped contract in GSA 10, and (3) the AHCCCS decision not to award Phoenix Health Plan a non-capped contract in any GSA under RFP YH14-0001.

To obtain a capped contract in Maricopa County, Phoenix Health Plan must accept this offer by countersigning this letter and returning it to AHCCCS before the close of business on Monday April 1, 2013. After that date, this offer expires.

If Phoenix Health Plan accepts this offer, Phoenix Health Plan's enrollment in GSA 12. Maricopa County, will be capped effective October 1, 2013. The enrollment cap will not be lifted at any time during the total contracting period specified in Section E, Contract Terms and Conditions unless one of the following conditions exists, in which case AHCCCS may lift the cap:

a. Another Contractor is terminated and increased member capacity is needed, or
b. Legislative action creates an unforeseen increase in the overall AHCCCS population, or
c. Extraordinary and unforeseen circumstances make such an action necessary and in the best interest of the State.

Additionally, AHCCCS does intend to hold an open enrollment for Phoenix Health Plan members in Maricopa County sometime in CYE 14.

If Phoenix Health Plan accepts this offer, then chooses to terminate this contract it may be responsible for the costs associated with all transition expenditures incurred by AHCCCS. See Section E, Paragraph 45, *Term of Contract and Option to Renew* of the contract.

In accordance with Section H, Paragraph 9, *Award of Contract*, in the RFP document, Phoenix Health Plan will be awarded capitation rates that are based on the bottom of the actuarial rate range for the medical component, and the lowest awarded administration rate. The capitation rates are specified in the attached document.

If you have any questions regarding this letter please contact Meggan Harley, AHCCCS Procurement Manager, at (602) 417-4538.

Sincerely,

Michael Veit
Contracts and Purchasing Administrator

I, _____, am authorized to and hereby do accept the offer of a capped contract in GSA 12, subject to all of the terms and conditions in RFP YH14-0001, and the terms and conditions set forth in this letter. By accepting this offer, Phoenix Health Plan agrees to waive and forego any and all rights to file a protest of: (1) the AHCCCS decision to award the capped contract in GSA 12, (2) the AHCCCS decision not to award a capped contract in GSA 10, and (3) the AHCCCS decision not to award Phoenix Health Plan a non-capped contract in any GSA under RFP YH14-0001.

_____ _____
Signed by: Dated
Title:

Acute Care RFP Bid Template - Phoenix Health Plan

Gross Medical Component by Risk Group and GSA

Risk Group	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12 Award	GSA 14
TANF < 1	$ -	$ -	$ -	$ -	$ -	$ 463.43	$ -
TANF 1-13	$ -	$ -	$ -	$ -	$ -	$ 92.76	$ -
TANF 14-44 F	$ -	$ -	$ -	$ -	$ -	$ 210.74	$ -
TANF 14-44 M	$ -	$ -	$ -	$ -	$ -	$ 137.66	$ -
TANF 45+	$ -	$ -	$ -	$ -	$ -	$ 375.78	$ -
SSIW	$ -	$ -	$ -	$ -	$ -	$ 147.57	$ -
SSIW/O	$ -	$ -	$ -	$ -	$ -	$ 746.20	$ -
AHCCCS Care	$ -	$ -	$ -	$ -	$ -	$ 387.44	$ -
Delivery Supp	$ -	$ -	$ -	$ -	$ -	$ 5,447.17	$ -

Administrative Component by Risk Group and GSA

Risk Group	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14
TANF < 1	$ -	$ -	$ -	$ -	$ -	$ 30.12	$ -
TANF 1-13	$ -	$ -	$ -	$ -	$ -	$ 6.03	$ -
TANF 14-44 F	$ -	$ -	$ -	$ -	$ -	$ 13.70	$ -
TANF 14-44 M	$ -	$ -	$ -	$ -	$ -	$ 8.95	$ -
TANF 45+	$ -	$ -	$ -	$ -	$ -	$ 24.43	$ -
SSIW	$ -	$ -	$ -	$ -	$ -	$ 9.59	$ -
SSIW/O	$ -	$ -	$ -	$ -	$ -	$ 48.50	$ -
AHCCCS Care	$ -	$ -	$ -	$ -	$ -	$ 25.18	$ -
Delivery Supp	$ -	$ -	$ -	$ -	$ -	$ 354.07	$ -

These are the awarded rate components. Final adjusted rates including reinsurance, premium tax, risk contingency and any program or other changes, as identified in the RFP, will be issued at a later date.

EXHIBIT F

BRIDGEWAY®
HEALTH SOLUTIONS

E. Narrative Submissions

Table of Contents

2. Evaluating and Measuring the Network

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

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

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

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

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

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

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

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

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

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

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

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

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

Value Based Reimbursement

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

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

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

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

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

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

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

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

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

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

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

8. Compliance Program

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

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

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

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

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

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

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

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

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

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

9. Claims Dispute Process

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*Data reflects the first 3 quarters of the year

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