

Suzanne K. Richards
Direct Dial (614) 464-6458
Direct Fax (614) 719-4920
Email skrichards@vorys.com

July 18, 2012

Lewis C. George, Esq.
Chief Legal Counsel
ODJFS Office of Legal & Acquisition Services
30 East Broad Street, 31st Floor
Columbus, OH 43215-0423

Re: Community Insurance Company d/b/a Anthem Blue Cross and Blue Shield (“Anthem”) Protest of the Awarding of Request for Application (RFA) Number: R1213078038

Dear Mr. George:

Attached please find Anthem’s timely protest of the scoring of Anthem’s response to Request for Application (RFA) Number: R1213078038 Ohio Integrated Care Delivery System. We and Anthem appreciate your attention to this matter and look forward to a prompt resolution.

I. Introduction

Pursuant to section III.F. of the Request for Applications (RFA) Number: R1213078038, Community Insurance Company d/b/a Anthem Blue Cross and Blue Shield (“Anthem”) files this protest of the scoring decisions concerning Anthem’s submission in response to this RFA. The scoring decisions were announced by the Ohio Department of Job and Family Services (ODJFS) on June 28, 2012.

Anthem is making this protest for the following reasons:

1. Anthem’s Medicare Healthcare Effectiveness Data and Information Set (HEDIS) results in Appendix C, Section 1 were improperly disqualified (see page 4 below).
2. Anthem’s response to quality improvement initiative number 1 in Appendix C, Section 2 was improperly disqualified (see page 6 below).

Lewis C. George, Esq.
July 18, 2012
Page 2

3. A portion of Anthem's response to quality improvement initiative number 3 in Appendix C, Section 2 was improperly disqualified (see page 10 below).
4. Anthem's response to quality improvement initiative number 4 in Appendix C, Section 2 was improperly disqualified (see page 11 below).
5. Anthem's response to Appendix D, Part A, question 8(a) Care Management was improperly scored (see page 14 below).
6. Anthem's response to Appendix E, Section E-1 was improperly disqualified for not addressing its experience in the form of an essay (see page 15 below).
7. Anthem's response regarding reporting individual incidents in Appendix E, Section E-2 was improperly disqualified (see page 16 below).
8. Some of Anthem's responses to Appendix F, Section 2 were inappropriately scored (see page 17 below).

Anthem submits that the improper decisions noted above should be reversed in order to ensure that the RFA process is administered in accordance with OAC 5101:3-26-04 and in a manner consistent with the notions of fairness, transparency, and open and honest competition that underlie public contracting in Ohio.

For those reasons, and as further explained below, ODJFS should rescore Anthem's application and consider Anthem for selection as a health plan to provide services to Ohioans under Ohio's proposed Integrated Care Delivery System on the basis of the correct scores.

Lewis C. George, Esq.
July 18, 2012
Page 3

II. Required Information

A. Name, Address, and Telephone Number of Protestor

Community Insurance Company d/b/a Anthem Blue Cross and Blue Shield

c/o Jacqueline Macias
Acting President and General Manager
Medicaid
WellPoint, Inc.
One WellPoint Way
Thousand Oaks, California 91362
(805) 557-6336 (office)
(805) 557-6362 (fax)
Jacqueline.macias@wellpoint.com

B. Name and Number of the RFA

REQUEST FOR APPLICATIONS
Ohio Integrated Care Delivery System (ICDS)
RFA Number: R1213078038

C. Detailed Statement of Legal and Factual Grounds for Protest

1. This Protest Is Timely And Must Be Considered By ODJFS.

The RFA provides that “A protest may be filed by an Applicant objecting to the scoring resulting from this RFA.” (RFA, Section III.F., page 21) The RFA further provides that “A timely protest shall be considered by ODJFS if it is received by ODJFS’ Office of Legal & Acquisition Services no later than 3:00 p.m. EDT of the tenth business day following the date of issuance of the results from Step Three of the Selection Methodology.” (RFA, Section III.F., page 21) (emphasis added).

ODJFS issued the results from Step Three of the Selection Methodology on June 28, 2012. The tenth business day following the date of issuance was July 13, 2012. Thus, according to the instructions for protest in the RFA, protests originally were to be filed on or before July 13, 2012. However, as a result of a delay in the provision of vendor applications and their corresponding scores, ODJFS extended the protest period from July 13, 2012, to July 18, 2012. (ODJFS Website, Request for Proposals, <http://jfs.ohio.gov/rfp/R1213078038ICDS.stm>)

Lewis C. George, Esq.
July 18, 2012
Page 4

The RFA's use of the mandatory term "shall" means that any timely protest must be considered by ODJFS. *See Miller v. Miller*, 2012-Ohio-2908 P28, 2012 Ohio LEXIS 1673 (Ohio S. Ct. July 3, 2012). Because this protest is being filed on or before the July 18, 2012 deadline, ODJFS is required by the terms of the RFA to consider the protest.

2. The Legal and Factual Grounds For This Protest Require ODJFS To Rescore Anthem's Application.
 - a. Anthem's Medicare Healthcare Effectiveness Data and Information Set (HEDIS) results in Appendix C, Section 1 were improperly disqualified.

On April 24, 2012, ODJFS issued the RFA, which included Appendix C. The RFA stated that: "The purpose of Appendix C is to evaluate an Applicant's success at improving and/or sustaining high levels of positive health outcomes. ODJFS is using the Healthcare Effectiveness Data and Information Set (HEDIS) clinical measures and satisfaction surveys, as well as structured quality improvement initiatives to evaluate the Applicant's ability to impact health outcomes for Medicare and/or Medicaid individuals." (RFA, Appendix C, page 1)

The instructions for completing Section I.a. of Appendix C instruct the Applicant on how to submit Medicare HEDIS scores. Those instructions indicate, in part, that "An Applicant must report Medicare Advantage HMO/PPO results from the State referenced in Appendix B with the largest number of Medicare Advantage HMO/PPO member months for CY 2010 for which there are HEDIS/CAHPS results that meet the requirements set forth in (1) and (2) above." (RFA, Appendix C, page 1)

Initially, Anthem reported Medicare Advantage HMO/PPO results from the State of California because that is the state that had the largest Medicare membership months in CY 2011. When reviewing Anthem's response to Section I.a., ODJFS identified a need for clarification regarding the information Anthem submitted for Appendix C. In a letter issued by ODJFS to Anthem on June 4, 2012, ODJFS requested clarification regarding the information Anthem originally submitted. The letter to Anthem, which resulted in additional information being submitted, included the statement that the additional information was needed "in order for the state to award the appropriate score." (ODJFS Letter to Anthem dated June 4, 2012 attached as Exhibit A) ODJFS required Anthem to submit clarifying information no later than June 6, 2012. On June 5, 2012, Anthem submitted to ODJFS a letter indicating that, in response to the questions posed by ODJFS in the letter of June 4, 2012, and upon further analysis of the requirements set forth in the RFA and in the ODJFS Question and Answer document, Anthem identified an error in reporting HEDIS and CAHPS scores for the Medicare line of business for

Lewis C. George, Esq.
July 18, 2012
Page 5

the State of California. This June 5, 2012 letter is attached as Exhibit B. Anthem included these scores because this is the state that had the largest Medicare membership months in CY 2011. Upon further review, Anthem recognized that it should have reported its 2011 Medicare HEDIS and CAHPS scores for its Medicare line of business in the state of Ohio, which was the state that had the largest Medicare member months in CY 2010. (Exhibit B, Anthem Letter to ODJFS dated June 5, 2012)

Section III.D. (Applicant Scoring) of the RFA indicates that “Scoring of the Applicants will be based upon the criteria specified in this RFA. Any applications not meeting the requirements established herein will not be scored or may be held pending receipt of required clarifications.” (RFA, Section III.D., page 18) (emphasis added). Further, “ODJFS may, at its sole discretion, waive minor errors, omissions, or other defects in applications when those defects do not unreasonably obscure the meaning of the content.” (RFA, Section III.D., page 18)

ODJFS did, in fact, request clarification from Anthem regarding the information Anthem submitted under Section I.a, so that the state could “award the appropriate score.” (Exhibit B, ODJFS Letter to Anthem dated June 4, 2012) Anthem supplied this information, as requested, in a timely fashion — on June 5, 2012, one day before the June 6, 2012, deadline imposed by ODJFS. In short, Anthem’s timely response was a “required clarification” for purposes of the RFA, Section III.D., and once ODJFS was in receipt of the requested clarifying information, it was required to consider Anthem’s clarification. Moreover, Anthem’s original submission of California data was a “minor error” that ODJFS should waive, as it does not “unreasonably obscure the meaning of the content.” (RFA, Section III.D., page 18)

The failure to consider Anthem’s timely response to the ODJFS request not only would be inconsistent with the terms of the RFA, but also would impermissibly render the ODJFS request for clarification, and Anthem’s response to that request, vain acts. *See also State, ex rel. Associated Builders & Contractors of Central Ohio v. Franklin County Board of Commissioners*, 125 Ohio St. 3d 112, 2010-Ohio-1199 P24 (2010) (“once a public authority has adopted supplemental evaluation criteria, it is then obligated to follow and apply those criteria within its permitted zone of discretion.”).

Finally, Anthem notes that Aetna was also asked for clarification regarding its HEDIS scores. Aetna, however, was permitted to submit information for its state with the second largest number of Medicare Advantage HMO/PPO member months. Its response indicated that Aetna did not submit the information for its largest Medicaid state for a HEDIS Compliance Audit, and so had submitted its second largest Medicaid state. Aetna provided no explanation as to why it surprisingly did not submit its largest Medicaid state scores for compliance review. See Exhibit D, Aetna’s response to ODJFS’ request for clarification.

Lewis C. George, Esq.
July 18, 2012
Page 6

ODJFS' acceptance of Aetna's data from its second-largest Medicaid state further supports Anthem's right to have ODJFS accept and score Anthem's application based on the data Anthem supplied in response to ODJFS' request for clarification. In light of these facts, Anthem requests that ODJFS rescore Appendix C, Section I. a. and award Anthem up to 6800 points.

- b. Anthem's response to quality improvement initiative number 1 in Appendix C, Section 2 was improperly disqualified.

Appendix C, Section II of the RFA asks each Applicant to describe components of each structured quality improvement initiative the Applicant highlights in its application. Section II also provides that:

“The Applicant may submit an essay for a maximum of three out of the following four structured quality improvement initiatives:

1. Preventing unnecessary long term institutionalization by re-directing Medicaid individuals to community settings and using community-based long term care services and supports.
2. Transitioning Medicaid individuals who have resided in nursing facilities for longer than 90 days into community settings by arranging and providing for home and community based services and supports.
3. Improving health outcomes or quality of life indicators for Medicaid and/or Medicare members with severe and persistent mental illness.
4. Decreasing inappropriate and avoidable hospital admissions and reducing inappropriate use of high-cost acute care services for Medicaid and/or Medicare members.” (RFA, Appendix C, pages 6-7)

Anthem chose to describe a quality improvement initiative under number 1. Specifically, Anthem described a project undertaken by our CareMore Dual Eligible Special Needs Plan (D-SNP) that operates in California and that serves individuals who are enrolled in both Medicaid and Medicare. “CareMore set out to answer the question, ‘What services and supports are needed for members with complex medical, social, and psychological needs to avoid placement in inpatient and institutional settings?’” (Anthem Application, Appendix C, page 6). The goal of this project was to prevent unnecessary institutionalization by providing access to community-based services and supports.

Lewis C. George, Esq.
July 18, 2012
Page 7

In scoring Anthem's application, ODJFS awarded Anthem 0 points for this response because ODJFS mistakenly believed that Anthem provided information applicable to only Medicare, and not Medicaid. ODJFS, therefore, decided that the response should not be considered. (Anthem Scoring Sheet, page 24) Anthem's scoring sheet is attached as Exhibit C.

The ODJFS scoring decision was erroneous because the population to which CareMore applied its research and implemented measures to improve access to community-based services was in fact a population of Medicaid individuals. There are several types of special needs plans. CareMore is a D-SNP, which means the population it serves is enrolled in Medicaid in addition to Medicare. According to the Centers for Medicare and Medicaid Services, "Since only individuals who are dually eligible for Medicare and Medicaid can enroll in D-SNPs, the plans provide a more integrated experience for the dual eligible population." (Centers for Medicare and Medicaid Services, State Resource Center, <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/StateResourceCenter.html>) Because Anthem's application indicates that the CareMore project falls under Anthem's Medicare Advantage Plan line of business, ODJFS apparently concluded that the population served was not a Medicaid population. However, by definition, a D-SNP serves a Medicaid population, and therefore Anthem's submission was proper and fully responsive to the RFA request.

In addition, Anthem's response was consistent with a reasonable reading of the RFA request. As ODJFS knows, there is often considerable overlap in Medicaid and Medicare populations – particularly in populations that would be potentially prone to "long-term institutionalization," which was the target population identified in item number 1 in RFA Appendix C, at 6-7. Anthem's interpretation of item number 1 to permit description of quality improvement project for a D-SNP program that included individuals who are enrolled in both Medicaid and Medicare therefore was appropriate and responsive, because it was consistent with a reasonable, plain meaning reading of the RFA's request. *See also State, ex rel. Associated Builders & Contractors of Central Ohio v. Franklin county Board of Commissioners*, 125 Ohio St. 3d 112, 2010-Ohio-1199 P29 (2010) (applying "plain sense" interpretation to term used in evaluation criteria for public contract award).

Because Anthem did, in fact, describe a quality improvement initiative that prevented "unnecessary long term institutionalization by re-directing Medicaid individuals to community settings and using community-based long term care services and supports," ODJFS should rescore Appendix C, Section II, quality initiative number 1 and award Anthem up to 1600 points. The additional points should be allocated as follows:

Lewis C. George, Esq.

July 18, 2012

Page 8

- **400 points for properly discussing how the initiative targeted improvement and for discussing how the initiative specifically related to Anthem's membership.** Anthem described how the initiative targeted improvement by explaining that CareMore's utilization review indicated that only 20 percent of members were utilizing 60 percent of the medical resources. As a result, CareMore determined that quality improvement resources would be well-spent investigating the characteristics of those 20 percent to determine what interventions could be developed to ensure that services, both medical and non-medical, were delivered in the right amount, at the right time, and in the right setting. CareMore determined that specific interventions were needed to address any social and environmental barriers to its members achieving identified health care goals.
- **400 points for properly discussing one or more selected quality indicators that were used to track performance and improvement over time, discussing how the quality indicators were meaningful to monitoring success of the intervention, and discussing the benchmarks and goals to which the quality indicators were compared throughout the initiative.** Anthem discussed three quality indicators: inpatient acute admissions, skilled nursing facility admissions, and inpatient admissions for psychiatric conditions. These quality indicators were meaningful for monitoring success of the intervention because each indicator represents potentially avoided admissions to institutional settings and therefore measured how well the additional supports and services were working. Knowing that admissions are not avoidable in all cases, the project goal was to see a decrease in the admissions over the measurement period. The pre-implementation rate for each indicator served as the benchmark for the project. CareMore also calculated the amount of cost avoidance achieved with each indicator.
- **400 points for properly defining the intervention for the quality improvement initiative and for discussing how the intervention was expected to change behavior at either an institutional, provider, and/or enrollee level.** Anthem described that the intervention was the development of the CareMore Intervention Team (CIT) to address the needs of complex members and to improve patient outcomes and compliance with health care interventions by using several tactics including coordinating with home and community-based resources. The CIT is comprised of a licensed clinical social worker, a nurse case manager, a mental health clinician, a physician,

Lewis C. George, Esq.
July 18, 2012
Page 9

hospice and palliative personnel, and other health care professionals such as pharmacists and dieticians. The intervention aimed to change behavior by focusing the multidisciplinary team on the member from different angles to better address the member’s medical and social issues.

- **400 points for properly presenting pre- and post-results for the quality indicators listed and for showing—for each quality indicator—improvement that was statistically significant.** Anthem presented pre- and post-results for each of the three quality indicators and showed significant improvement for the days per thousand, in the aggregate. See chart below provided in Anthem’s response to Appendix C, section 2, quality initiative number 1. (Emphasis added)

Type of Admit	PreCIT (12 month) Days per Thousand	PastCIT (12 month) Days per Thousand
Inpatient	6,006	2,222
Skilled Nursing Facility	10,250	3,431
Psychiatric	547	581
TOTAL	16,803	6,234

Additionally, Anthem notes that CareSource’s response to Appendix C, section 2, quality improvement initiative number 1 also describes a project focused on a Medicaid population that “targets dual eligible members who are at risk for nursing facility placement.” (CareSource Application, Appendix C, section 2, page 7). Like Anthem, CareSource described an initiative focused on improving quality for a Medicaid population that is also eligible for Medicare. However, *unlike* Anthem, CareSource’s response was scored. Because there is no distinguishable difference between Anthem’s description of a project that serves a Medicaid population also eligible for Medicare and CareSource’s description of a project that serves a Medicaid population also eligible for Medicare, Anthem’s response should also be scored.

Lewis C. George, Esq.
July 18, 2012
Page 10

- c. A portion of Anthem's response to quality improvement initiative number 3 in Appendix C, Section 2 was improperly disqualified.

Anthem also described in its application a quality improvement initiative under number 3, which addressed "Improving health outcomes or quality of life indicators for Medicaid and/or Medicare members with severe and persistent mental illness." Specifically, Anthem discussed a project undertaken by WellPoint in Indiana to improve coordination of aftercare prior to discharge for its members hospitalized for a behavioral health disorder. The purpose of the project was to increase the rate of behavioral health coordination prior to member discharge from the hospital. In order to measure success, WellPoint used as a quality indicator "the percentage of members hospitalized with a behavioral health diagnosis who have a care coordination plan established prior to discharge that includes an aftercare appointment scheduled to occur within 7 days post hospitalization." (Anthem response to Appendix C, page 11)

In its scoring of quality improvement initiative number 3, ODJFS did not award Anthem points under subsection 3.b., finding that Anthem failed to discuss "how the quality indicators were meaningful to monitoring the success of the intervention" and failed to "discuss the benchmarks and goals that the quality indicators were compared to throughout the initiative." (Anthem Scoring Sheet, page 28)

Measuring "the percentage of members hospitalized with a behavioral health diagnosis who have a care coordination plan established prior to discharge that includes an aftercare appointment scheduled to occur within 7 days post hospitalization" is meaningful to the success of the intervention because, without the indicator, WellPoint would not be able to detect whether its initiative was having a positive or negative impact on hospitalization rates for its members with serious and persistent mental illness.

Additionally, "the indicator used the standard for follow-up in the HEDIS measure, Follow-Up after Hospitalization for Mental Illness, which was developed through a robust public process, using the best available clinical evidence in the industry." (Anthem response to Appendix C, page 11) Anthem collected and analyzed the data monthly so that WellPoint could understand whether the intervention was affecting utilization. WellPoint had a clearly stated goal of ">=90% of members having an established care coordination plan prior to discharge." (Anthem response to Appendix C, page 11) Thus, WellPoint established a benchmark against which its monthly performance was measured, and it clearly defined a goal of at least 90% of its members with serious and persistent mental illness having a care coordination plan before discharge.

Lewis C. George, Esq.
July 18, 2012
Page 11

Anthem therefore requests that ODJFS rescore Appendix C, Section II, quality improvement initiative number 3 and award Anthem an additional 400 points.

d. Anthem's response to quality improvement initiative number 4 in Appendix C, Section 2 was improperly disqualified.

Anthem also described in its application a quality improvement initiative under number 4, which addressed “decreasing inappropriate and avoidable hospital admissions and reducing inappropriate use of high-cost acute care services for Medicaid and/or Medicare members.” Specifically, Anthem discussed a project undertaken by Anthem Blue Cross in California to “reduce inappropriate ER use following a review of member and provider survey data that indicated a high rate of ER visits for one non-emergent condition, upper respiratory infection (URI).” (Anthem Application, Appendix C, page 16)

In its scoring of quality improvement initiative number 4, ODJFS indicated that Anthem's application only discussed emergency room (ER) use. (Anthem Scoring Sheet, page 29). Ostensibly, ODJFS concluded that the project Anthem described only addressed inappropriate use of high-cost acute care services, but did not address decreasing inappropriate and avoidable hospital admissions.

Such a reaction ignores the reality of ER use. Indeed, commentary regarding the nexus between outpatient and inpatient care indicates that “the Emergency Department is increasingly the gatekeeper of inpatient admissions.” (The Emergency Department will Grow as a Means to Reduce Hospital Admission, Joshua Tamayo-Sarver, MD, PhD) Dr. Tamayo-Sarver further observes that “now greater than half of all inpatient hospitalizations are originating in the [emergency department] ED.” Additionally, “Researchers at the University of Southern California estimated that *by closing the emergency department, a hospital would lose one-third or more of its inpatient admissions*, which would cost the hospital much more than the savings generated by closing the emergency department.” (Emphasis added) (Nonurgent Use of Hospital Emergency Departments, Statement of Peter Cunningham, Ph.D. Senior Fellow and Director of Quantitative Research Center for Studying Health System Change (HSC), before the U. S. Senate Health, Education, Labor and Pensions Committee Subcommittee on Primary Health and Aging, Hearing on —Diverting Non-urgent Emergency Room Use: Can It Provide Better Care and Lower Costs? May 11, 2011) See Exhibit E—Hospital Admission Rates Through the Emergency Department: An Important, Expensive Source of Variation—for additional information.

Further, as indicated and highlighted in Exhibit E, slide number 9, in discussing the evidence related to admissions and admitting decisions from an emergency department,

Lewis C. George, Esq.
July 18, 2012
Page 12

“Emergency physicians [are] more likely to admit than family physicians or internal medicine physicians”. (Hospital Admission Rates Through the Emergency Department: An Important, Expensive Source of Variation, Slide 9)

Because the ER often serves as the gatekeeper for hospital admissions, because a substantial percentage of all inpatient hospitalizations originate in the ER, and because decisions to admit are more likely from an emergency room physician as compared to other types of physicians, appropriately diverting individuals away from the ER — as Anthem’s submission demonstrates that its project did — will, necessarily, “decreas[e] inappropriate and avoidable hospital admissions,” as the RFP requested. For this reason, the project Anthem described answers both aspects of item number 4 – it both decreases avoidable hospital admissions and reduces inappropriate use of high-cost acute care services (i.e., services rendered in an emergency department).

Anthem therefore requests that ODJFS rescore Appendix C, Section II, quality improvement initiative number 4 and award Anthem up to 2000 points. The additional points should be allocated as follows:

- **400 points for properly discussing how the initiative targeted improvement and for discussing how the initiative specifically related to Anthem’s membership.** Anthem described how the initiative targeted improvement by indicating that Anthem Blue Cross joined a collaborative quality improvement project in July 2007 to reduce inappropriate ER use following a review of member and provider survey data that indicated a high rate of ER visits for one non-emergent condition, upper respiratory infection (URI). The project targeted all plan members aged 1 to 19 and was guided by the following study question: “Do targeted interventions decrease the rate of avoidable ER visits during the measurement year?”
- **400 points for properly discussing one or more selected quality indicators that were used to track performance and improvement over time, discussing how the quality indicators were meaningful to monitoring success of the intervention, and discussing the benchmarks and goals to which the quality indicators were compared throughout the initiative.** Anthem discussed two quality indicators: HEDIS ambulatory care – ER visits and HEDIS-like avoidable ER visits. These quality indicators were meaningful to monitoring success of the intervention because each indicator measures the overall rate of ER utilization but then drills down to those ER visits that are avoidable. This

Lewis C. George, Esq.
July 18, 2012
Page 13

is an important distinction because the desired rate of ER use is not zero. True emergent conditions are expected, are typically not predictable or avoidable, and should be treated in an ER. Anthem identified benchmarks and goals to which these quality indicators were compared. This entailed identifying barriers, developing interventions to address identified barriers, and implementing a structured methodology to collect and analyze data appropriate to the study question and indicators.

- **400 points for properly defining the intervention for the quality improvement initiative and for discussing how the intervention was expected to change behavior at either an institutional, provider, and/or enrollee level.** Anthem's barrier analysis showed that the reasons for non-emergent ER use are complex and that interventions would be needed to change the behavior of both members, by encouraging care in other settings, and of Primary Care Providers, by encouraging better outreach, education, and availability.
- **400 points for properly presenting pre- and post-results for the quality indicators listed and for showing—for each quality indicator—improvement that was statistically significant.** Anthem presented pre- and post-results for each of the three quality indicators and showed significant improvement for each. Consistent with the goals of the Quality Improvement Project, avoidable ER visits went down. After an initial increase in the first year, the rate of avoidable ER visits decreased in each subsequent year. The overall rate of ER visits increased, but there are many factors that influence the ER rate – most importantly, conditions that legitimately require an ER visit. Stanislaus County showed a statistically significant decrease two years in a row. Focused efforts on the avoidable ER rate led to a decrease in the number of avoidable ER visits. Anthem's member-specific live phone calls and self-care book (Healthwise Handbook) in conjunction with CRC visits to provider offices have been continued as a best practice. Because these are avoidable visits, members could be seen in a doctor's office and so probably avoided additional case management. According to Health Services Advisory Group (HSAG), California's External Quality Review Organization, in their Statewide Collaborative Quality Improvement Remeasurement Report (September 2011), "Anthem Blue Cross–Stanislaus County was the only plan with sustained improvement." Twenty-four plans were

Lewis C. George, Esq.
July 18, 2012
Page 14

reviewed by HSAG for the project. See chart below that presents data for Anthem Blue Cross in Stanislaus County, provided in Anthem’s response to Appendix C, section 2, quality initiative number 4.

Reporting Year	Measurement	ER Visits (per 1,000 MM)	Avoidable ER Visits (%)
2007	Baseline	47.59%	13.36%
2008	Re-measurement 1	50.59%	22.22%
2009	Re-measurement 2	53.00%	21.14%
2010	Re-measurement 3	64.37%	18.39%

- **400 points for properly reporting that the results of the quality improvement initiative were independently validated.** Anthem reported that the project was independently validated by California’s External Quality Review Organization, Health Services Advisory Group.
- e. Anthem’s response to Appendix D, Part A, question 8(a) Care Management was improperly scored.

Appendix D, Part A, question 8(a) prompts “Does the Applicant have at least 12 months of experience as of March 31, 2012 with conducting **home visits** with enrollees to either observe or assess them in their residential environment?” (RFA, Appendix D, page 7) (emphasis added) The applicant was instructed to indicate yes or no and the state and line of business for which the activity is indicated. Anthem was penalized 180 points for failing to indicate the state and line of business for which home visits were completed in 8(a) yet, in the response to the very same question, Section d, Anthem provides the statistics for **home visits** and its answer clearly indicates the state and line of business as CA Medicare Advantage. (Anthem Scoring Sheet, page 35)

Lewis C. George, Esq.
July 18, 2012
Page 15

A fair reading of Anthem's submission clearly shows that all required information was in fact provided for this question. Anthem therefore requests that ODJFS rescore Appendix D, Question 8(a) and award Anthem 180 points.

- f. Anthem's response to Appendix E, Section E-1 was improperly disqualified for not addressing its experience in the form of an essay.

Appendix E, Section E-1 of the RFA asks "Does the applicant have more than 12 months' direct experience, since January 1, 2007, at contracting with, and reimbursing, community-based long term care providers serving Medicaid populations such as the following? Mark all that apply and reference the form(s) submitted in Appendix B for which the experience applies." (RFA, Appendix E, page 2) Under this question, there is a chart in which the applicant is to mark whether it has more than 12 months experience providing certain services. Section E-2 also asks the applicant to mark in a chart whether the applicant has 12 months experience providing certain functions/services. Under this second chart, there is an instruction to applicants indicating "For each element marked and for each state/line of business referenced, describe in a brief essay the Applicant's experience including sources and definitions/types of incidents and the Applicant's responsibility and experience." (RFA, Appendix E, page 3)

Because of the placement of this instruction after the E-2 chart and because the instruction does not explicitly indicate that it applies to both E-1 and E-2, Anthem interpreted this provision to mean that it must provide an essay only for its response to E-2. In scoring Anthem's response to E-1, ODJFS awarded Anthem 0 points and indicated on the scoring sheet the reason: "no essay provided". (Anthem Scoring Sheet, page 61)

ODJFS clarified in its Question and Answer document that "The essay requirement includes both E1 and E2. The essay portion will validate the responses scored in E1 and E2." (ODJFS Question and Answer Document, page 26) (Emphasis added) However, the requirement still was interpreted in different ways by the various applicants. For example, in reviewing another applicant's (WellCare's) response to E-1, Anthem noticed that WellCare provided two essays. However, these essays did not separately address E-1 and E-2, but addressed both E-1 and E-2 together for two different WellCare experiences (one in New York and one in Hawaii). Moreover, WellCare addresses E-1 in the essays by simply stating that WellCare has experience in providing the services marked in the E-1 chart. For example, WellCare states "Since October 2007, we have had direct experience contracting with and reimbursing the community-based long term care provider types indicated in Table E-1." (WellCare of Ohio response to RFA, page 110) This passing reference to E-1 does not, in reality, "describe . . . the Applicant's experience". (RFA, Appendix E, page 3)

Lewis C. George, Esq.
July 18, 2012
Page 16

Moreover, Anthem addresses many of the services identified in the E-1 chart in essay/narrative form in various places throughout its application. For example, in Appendix D, Anthem provides support for its assertion in E-1 that it provides non-medical transportation by explaining that Anthem will arrange transportation services for members, as needed. (Anthem response, Appendix D, page 22) Similarly, also in Appendix D, Anthem discusses arranging for in-home care and durable medical equipment. In reviewing Anthem's application as a whole, ODJFS had a great deal of evidence about the provision of the services indicated in E-1.

Lastly, Anthem submitted a signed attestation statement pursuant to Appendix A confirming that the information it provided in its application is accurate. Attesting to the accuracy of the information in E-1—and all other parts of Anthem's application—also accomplishes the purpose stated in the ODJFS Question and Answer Document, page 26, of validating the response.

Anthem therefore requests that ODJFS rescore Appendix E, Section 1, and award Anthem up to 2002 points. Please note that 2002 points is the number of points *awarded to Anthem for its response* to E-1 before the scorer crossed out that score and instead made the score a zero. (Anthem Scoring Sheet, page 62)

g. Anthem's response regarding reporting individual incidents in Appendix E, section E-2 was improperly disqualified.

Appendix E, Section E-2 of the RFA asks "Does the applicant have more than 12 months' direct experience, since January 1, 2007, with reporting and/or investigating individual incidents related to the health and welfare of community long term care service providers and individuals?" (RFA, Appendix E, page 3)

In scoring Anthem's application, ODJFS awarded Anthem 0 points for the portion of its response related to "Investigating individual incidents reported by individuals, providers and other entities and reporting outcomes to the state/oversight agency." (Anthem Scoring Sheet, page 64) Further, the scorer indicated that the "essay does not support experience in investigation." (Anthem Scoring Sheet, page 64) This is not accurate.

Anthem's response does indicate that CareMore staff — which includes providers who deliver care directly to our members under the CareMore HMO staff model — do undertake face-to-face assessments and visits to facilities and members' homes in order to assess and detect potential abuse, neglect, and exploitation. (Anthem Application, Appendix E, page 4) The act of speaking with and observing individuals in-person in order to determine whether there has been an incident that has affected the individual's health or wellbeing is an act of investigation.

Lewis C. George, Esq.

July 18, 2012

Page 17

Moreover, if a CareMore employee detects potential abuse, neglect, or exploitation, the provider works closely with the ombudsman and adult protective services to ensure resolution of issues for the individual. (Anthem Application, Appendix E, page 4)

Because Anthem did, in fact, address provider experience investigating incidents related to individuals' health and welfare, Anthem requests that ODJFS rescore Appendix E, Section E-2, and award Anthem up to 834 additional points.

- h. Some of Anthem's responses to Appendix F, Section 2 regarding the vision for innovative payment in Ohio were inappropriately scored.

Appendix F, section 2 asks applicants to "describe their vision for implementing specific innovative payment methods in Ohio that would help achieve the goals of this project." (RFA, Appendix F, page 1) Further, ODJFS directed applicants to "describe one innovative payment method the Applicant would employ in Ohio to help achieve the goals of this project." (RFA, Appendix F, page 5) The applicant was allowed to describe an innovative payment method for up to five provider types from a list of eight provided by ODJFS.

The scoring instructions for Appendix F, Section 2 indicate that ODJFS should "award 500 points for each innovative payment method described for a specific provider type (for a maximum of 2,500 points)." (RFA, Appendix F, page 8) ODJFS should "award additional points based on the overall strength of each Applicant's vision for Ohio and the alignment of the proposed models with the State's goals." (RFA, Appendix F, page 8) In order to award additional points, ODJFS used a set of evaluation criteria and indicated whether, for each, the applicant's response did not meet expectations, partially met expectations, met expectations, or exceeded expectations. ODJFS then awarded points — 0, 50, 100, or 150, respectively — for each criterion. If, for example, ODJFS determined that the applicant's response "met expectations" in terms of describing how it envisioned "keeping people living in the community" (one of the evaluation criteria), ODJFS would award the applicant an additional 100 points. The evaluation criteria ODJFS used are as follows, and are referenced by number in describing Anthem's responses:

1. Keep people living in the community
2. Increase the individuals independence
3. Improve the delivery of quality care
4. Reduce health disparities across all populations
5. Improve health and functional outcomes

Lewis C. George, Esq.
July 18, 2012
Page 18

6. Reduce preventable hospital stays, nursing facility admissions, and/or emergency room utilization
7. Improve transitions across care settings
8. Increase identification of depression and other mental health conditions
9. Increase or improve care coordination
10. Increase the accountability and responsibility of the primary care provider to maintain the individual's overall health

(RFA, Appendix F, page 9)

In its description of an innovative payment method for **Provider Type 1 (Innovative Payment for HCBS Case Management Providers)**, Anthem describes an initiative built on a very strong clinical approach that is individualized to every person's transition from the nursing home to the community. It includes paying providers for their clinical expertise and their hands-on assistance with (and oversight of) the actual transition. The initiative utilizes current Area Agencies on Aging and Money Follows the Person providers — who know what it takes — to work with the member from the beginning of the transition all the way through the transition. The initiative also relies on the expertise of the nursing home staff — who will have the most current, active, twenty-four-hour-a-day picture of the member's needs and functioning — to serve as a consulting resource. For individuals transitioning from nursing homes, it is less about “coordinating,” educating, and monitoring; it is about *doing*. In Anthem's description of this innovative payment method, two clinical teams will transition each member, and the providers will be paid for this clinical time and expertise. This is what the Money Follows the Person experience has taught policy makers — success takes hard work and is accomplished one person at a time.

ODJFS awarded Anthem 750 points for this initiative. For the reasons stated above, ODJFS should award Anthem an additional 300 points—as follows—for a total of 1050:

- An additional 50 points for evaluation criterion three — improving the delivery of care. Anthem's model of a community transition team and using the nursing facility as a consulting resource virtually ensures that there will be no gap in the information associated with the member's care, and nothing related to the member's preferences will be lost in the transition.
- An additional 50 points for evaluation criterion six — reducing preventable

Lewis C. George, Esq.
July 18, 2012
Page 19

hospital stays, nursing facility admissions, and/or emergency room utilization. While hospital admissions, emergency room use, or readmission to the nursing facility cannot be eliminated in all cases, there is no better way to prevent this than Anthem's strategy of an active hand-off coupled with the communication and knowledge/experience of the provider.

- An additional 50 points each for evaluation criteria seven and nine — improving transitions across care settings and increasing or improving care coordination, respectively — for a total of 100 additional points, as this clinically-based, affirmative following and handing-off of the member and his or her case is the best and only way to ensure success.
- An additional 100 points for evaluation criterion 10 — increasing the accountability and responsibility of the primary care provider to maintain the individual's overall health. It is possible that ODJFS overlooked the responsibility of the community case manager team to enter the assessment and transition information into the "member's EMR [electronic medical record] in order to integrate the entire continuum of care." (Anthem response, Appendix F, page 19) This fact alone makes a request for an additional 100 points appropriate.

In its description of an innovative payment method for **Provider Type 2 (Innovative Payment for Nursing Facilities and Assisted Living Facilities)**—as well as in its description of an Innovative Payment Method for HCBS Case Management Providers, discussed above — Anthem indicates that the Area Agencies on Aging and Money Follows the Person providers will be responsible for developing and driving transition planning, and for including it in the member's electronic medical record. These actions particularly relate to evaluation criterion 10, as well as to criteria three, seven, and nine.

It appears as though ODJFS' scoring did not take into account some important realities and the essential need to work with and engage the nursing homes — as providers and clinicians — in the transition planning process. Of particular note is that some applicants did not even address nursing facilities as one of their target strategies.

In order to achieve points for all four criteria identified below, but especially for the first three, it is important that nursing homes are not working *against* the transition, even if not assisting *affirmatively* with the member's successful discharge and transition. Anthem's strategy reflects both realism and practicality: Anthem will try to engage the nursing facility to the greatest extent possible and will particularly work with the nursing facility to identify

Lewis C. George, Esq.
July 18, 2012
Page 20

financial incentives to be created for their benefit. The obvious clinical benefits of this strategy are expressed fully in Anthem's proposed initiative, though we request that you reconsider the importance of working *with* nursing facilities to fashion financial incentives that will be meaningful to them.

ODJFS awarded Anthem 600 points for this initiative. For the reasons stated above, ODJFS should award Anthem an additional 300 points as follows, for a total of 900:

- An additional 50 points for evaluation criterion three — improving the delivery of quality care
- An additional 50 points for evaluation criterion seven — improving transitions across care settings
- An additional 50 points for evaluation criterion nine — increasing or improving care coordination
- An additional 150 points for evaluation criterion 10 — increasing the accountability and responsibility of the primary care provider to maintain the individuals' overall health

In its description of an innovative payment method for **Provider Type 3 (Innovative Payment for Physicians)**, Anthem indicates that it “created a model to maximize the use of physician extenders to deliver the preventive and chronic care services that members may need.” (Anthem response, Appendix F, section 2, page 27) Among other responsibilities described in the initiative, the physician extender is “required to administer a battery of comprehensive assessments to each member.” (Anthem response, Appendix F, section 2, page 28) The assessments include screening for behavioral health and cognitive issues. The extender is also tasked with arranging for or providing services that will meet these particular needs of the member. (See Anthem response, Appendix F, section 2, page 28) Requiring a battery of comprehensive assessments, including behavioral health screening, and arranging for or providing—not simply referring members to—needed follow-up services is the most cost effective and person-centric strategy to accomplish evaluation criteria six and eight—reducing preventable hospital stays, nursing facility admissions, and/or emergency room utilization; and increasing identification of depression and other mental health conditions, respectively. For this reason, ODJFS should award Anthem at least 50 points for each of these criteria, for a total of at least 100 additional points.

Lewis C. George, Esq.
July 18, 2012
Page 21

The Innovative Payment to Physicians initiative also includes a bonus program “to encourage physicians to refer members to extenders for comprehensive preventive care and education.” (Anthem response, Appendix F, section 2, page 29) ODJFS awarded Anthem 0 points for evaluation criteria one and two — keeping people living in the community and increasing individuals’ independence, respectively — for this portion of the initiative. The most effective and empowering strategy to enable individuals to maintain their independence and to maintain their life in their home is to educate them about their health, with an emphasis on prevention. Anthem’s bonus program is proposing an initiative that will keep individuals in their communities and increase their independence, and is providing an incentive for physicians to help accomplish this. For this reason, ODJFS should award Anthem at least 150 points for each of these criteria, for a total of at least 300 additional points.

ODJFS awarded Anthem 750 points for this initiative. For the reasons stated above, ODJFS should award Anthem an additional 400 points, for a total of 1150 points.

In its description of an innovative payment method for **Provider Type 4 (Innovative Payment to Pharmacies)**, Anthem identified research on key problems with medication adherence and proposes action to help alleviate these problems. Specifically, Anthem proposes “two initiatives for Ohio dual eligible members designed to improve medication compliance: reminder calls and enhanced payment to pharmacies for home delivery of medication.” (Anthem response, Appendix F, section 2, page 32) Anthem also proposes a strategy to identify the ongoing need for home delivery of medications. This is done by assessing the need for home delivery or the initiation of services with a three part strategy of information, analysis, and adding individuals who will benefit from home delivery.

Another applicant — CareSource — received 800 points for a less responsive essay. Specifically, in its description of an innovative payment method for pharmacies, CareSource parroted back the evaluation criteria provided by the state without connecting them to its initiative or describing related action steps. The CareSource initiative specifies two measurements — the Preferred Prescription Usage — and Mean Possession Ratio — and identifies three “strategies”—medication therapy management (MTM), preferred prescription usage, and medication adherence. However, CareSource doesn’t describe what MTM actually *does*, except to indicate that it relies on a software program that less than 20% of pharmacies use. Additionally, the preferred prescription usage strategy requires little more than using CareSource’s drug formulary. Lastly, CareSource’s statement that “Pharmacists will assist in monitoring” the member’s compliance with medication refills is not much of a strategy at all. (CareSource response to Appendix F, page 55) Pharmacist compliance will be monitored and some money “will be applied to the pharmacy model.” (CareSource response to Appendix F, page 52)

Lewis C. George, Esq.
July 18, 2012
Page 22

Anthem's initiative will cost money; the money will be spent on client services, i.e., making it easier for the client to remain in his or her home and independent. By comparison, the CareSource response received 800 points, yet there is no active engagement of pharmacies (i.e., they will "assist" and the pharmacy will be "monitored").

ODJFS awarded Anthem 550 points for this initiative. For the reasons stated above — especially as compared to the CareSource initiative — ODJFS should award Anthem an additional 250 points, for a total of 800 points: 100 additional points for evaluation criterion one, 50 additional points for evaluation criterion two, 50 additional points for evaluation criterion three, and 50 additional points for evaluation criterion six.

In its description of an innovative payment method for **Provider Type 5 (Innovative Payment for Hospitals)**, Anthem proposes "to build upon the success of our hospital fixed per day rate program by identifying one or more hospitals in Ohio to participate in an unique financing strategy that will improve overall financial viability while supporting improved health outcomes for their patients and our members. The model puts Anthem at contractual risk for the hospital to achieve lower variable costs." (Anthem response, Appendix F, Section 2, page 36)

Hospital costs — along with nursing home costs — are significant drivers of the total cost of health care, and important places to look for achieving payment innovation and payment reform. In terms of controlling costs, consider the following spectrum of interventions and innovation from least or "lightest" impact to the most powerful:

1. Designation/recognition — Identifying providers whose patterns of care are most "preferred" for a variety of reasons.
2. Data sharing and whether the data is real time or shared infrequently.
3. Sharing savings and how significant is the pot of money available to be shared.
4. Sharing risk

Consider the following innovative payment methods for hospitals submitted by other applicants and their location on this continuum of financial impact/innovation described above:

Lewis C. George, Esq.
July 18, 2012
Page 23

- Molina received 800 points. Their strategy includes:
 - Recognizing certain hospitals as Centers of Excellence, and
 - Sharing a pool of savings, based on preventable readmissions and reductions in emergency department utilization and hospital acquired conditions
 - Sharing data annually on prevention quality
 - Sharing data annually on inpatient quality
 - Sharing data annually on patient safety indicators
- CareSource received 950 points. Their strategy includes:
 - Sharing savings in an unspecified manner across all components/all providers participating in their initiative; not specified or targeted to hospitals
 - Developing data sharing (that is not currently in place)
 - Decreasing readmissions and follow-up with individuals hospitalized for mental illness.
- United received 950 points. Their strategy is further along the impact/innovation continuum and includes:
 - Reimbursement changes to utilize a *fee-for-service structure plus shared savings*
 - A pool of savings to be shared with hospitals accrued from decreasing avoidable and duplicative savings
- Anthem received 800 points — equal to Molina and less than United and CareSource. Consider that Anthem is proposing a reimbursement method that is:
 - Currently in place and operating in California

Lewis C. George, Esq.

July 18, 2012

Page 24

- Recognized by the U.S. Department of Health and Human Services, Agency for Health Care Research and Quality (<http://www.ahrq.gov/>)
- Anthem's initiative puts Anthem *at risk* and *shares risk with the hospital* by partially unbundling the hospital care and shifting parts of the inpatient bundle toward community providers for certain components of the care.

Anthem's initiative is the only proposal of all those submitted to offer a truly innovative financing mechanism, with a recognized track record, that demonstrates real payment reform. Rather than asking the hospital to do something that may not be in its financial best interest, this initiative inserts community expertise to do what the community does best, and drives hospital efficiencies at the same time.

ODJFS awarded Anthem 800 points for this initiative. The state's initial scoring suggests that other proposals may have been written more creatively; however, the scoring should also reflect substance and not form, and recognize that Anthem is offering the most innovative and powerful financial mechanism of all those considered. Especially in light of page limitations, ODJFS should consider Anthem's financing initiative as "exceeding expectations" and award additional points in the following areas:

- Improve the delivery of quality care;
- Improve health and functional outcomes;
- Reduce preventable hospitalization and ER use;
- Improve transitions across care settings; and
- Improve care coordination.

In light of this, ODJFS should consider awarding additional points of up to 1300 points.

D. Request for Ruling by ODJFS

Anthem requests that ODJFS issue a written ruling that this protest has merit and that Anthem is entitled to the relief requested.

Lewis C. George, Esq.
July 18, 2012
Page 25

E. Statement as to the Form of Relief Requested From ODJFS

Anthem requests that ODJFS rule on the substance and merits of this protest, scoring Anthem's application in response to the RFA based on the information that Anthem has provided to ODJFS in connection with this matter, as discussed in this letter.

Very truly yours,

A handwritten signature in cursive script that reads "Suzanne K. Richards".

Suzanne K. Richards

SKR/dms

Exhibits

- Exhibit A ODJFS Letter to Anthem Requesting Clarification (dated June 4, 2012)
- Exhibit B Anthem Response Letter to ODJFS (dated June 5, 2012)
- Exhibit C Anthem Scoring Sheet
- Exhibit D Aetna Response Letter to ODJFS
- Exhibit E Hospital Admission Rates Through the Emergency Department:
An Important, Expensive Source of Variation

Exhibit A

Ohio

Department of Job and Family Services

John R. Kasich, Governor
Michael B. Colbert, Director

June 4, 2012

Jacqueline Macias
Acting President and General Manager,
Anthem Blue Cross and Blue Shield
One WellPoint Way
Thousand Oaks, California 91362

Dear Ms. Macias:

Thank you for submitting your response to the Ohio Department of Job and Family Services (ODJFS) Request for Applications number: JFSR1213078038, for the Integrated Care Delivery System. While reviewing the applications received, it was determined that there was a need for a clarification of information submitted in your Appendix C. in order for the state to award the appropriate score. Specifically, the following information is required:

(1) Do HEDIS measure results for CY 2010 exist for any Ohio Medicare population; and (2) if so, have the particular results undergone a HEDIS Compliance Audit conducted by an NCQA-Certified HEDIS Compliance Auditor (CHCA) and reported to NCQA's Interactive Data Submission System?

Your clarification must be received no later than Wednesday, June 6, 2012 by 9AM. Faxed responses are acceptable, but hard copy must follow. Please address the hard copy and fax to:

ODJFS
Fax number: 614-995-4876
Office of Contracts and Acquisitions
RFP/RLB Unit
30 East Broad St., 31st Floor
Columbus, Ohio 43215

Sincerely,



James Tassie, Esq.
Assistant Deputy Director
Legal and Acquisition Services

30 East Broad Street
Columbus, Ohio 43215
jfs.ohio.gov

An Equal Opportunity Employer and Service Provider

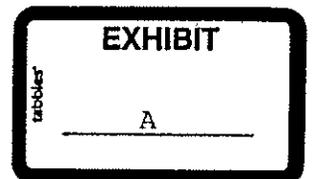


Exhibit B



June 5, 2012

Mr. James Tassie
Assistant Deputy Director
Ohio Department of Job and Family Services
Office of Contracts & Acquisitions
ATTN: RFA/RLB Unit
30 E. Broad Street, 31st Floor
Columbus, Ohio 43215-3414

RE: Clarification for Appendix C for the Ohio Integrated Care Delivery System (ICDS), RFA Number: R1213078038

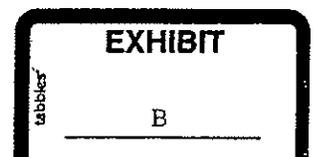
Dear Mr. Tassie:

Per the letter from the Ohio Department of Job and Family Services (ODJFS) dated on June 4, 2012, Community Insurance Company d/b/a Anthem Blue Cross and Blue Shield (Anthem) is providing clarification for our response on Appendix C.

Specifically, in our review of the questions posed by ODJFS in the letter and upon further analysis of the requirements set forth in the Request for Application (RFA) and in ODJFS' questions and answers, we identified an error in our reporting of HEDIS and CAHPS scores for our Medicare line of business for the State of California in Appendix C. We had included the scores for California because this is the State that had the largest Medicare membership months in CY 2011, and is consistent with our response for our Medicaid HEDIS and CAHPS scores. However, upon further review, we recognize that we should have reported our MY 2011 Medicare HEDIS and CAHPS scores for our Medicare line of business in the State that had the largest Medicare member months in CY 2010, which would have been Ohio.

We recognize that the error in reporting California data is likely to result in different scores for our total score for Appendix C. Given this, we are submitting our Ohio HEDIS and CAHPS scores for ODJFS' review and consideration to include as part of our score for Appendix C and for our overall RFA score. This oversight was an unintentional one, and we regret any delay that the discovery of this oversight may have caused ODJFS in its evaluation of this RFA opportunity.

As reflected in the HEDIS and CAHPS scores in the attached table, the difference in scores between those reported for California and Ohio does not vary significantly. Our independent evaluation of the score for Section 1.a. for Appendix C is 6680 points when using our Ohio Medicare HEDIS and CAHPS scores. This is compared to 7844 points when using our California Medicare HEDIS and CAHPS scores. We have also included





the Interactive Data Submission System (IDSS) report for our Ohio Medicare plan, as well as the 2011 Medicare Advantage CAHPS Results report that is issued by the Centers for Medicare and Medicaid Services.

We would greatly appreciate ODJFS' consideration of our request to use this updated data in ODJFS' evaluation of our response on this important initiative for the State of Ohio. We believe that we can be a strong partner with the State on this significant transformation to the health care delivery system for dual eligible members, and we hope that this error does not preclude us from participating in this important program.

If there are any questions or concerns, or if you require additional data or information, please do not hesitate to contact me at (805) 557-6336 or at jacqueline.macias@wellpoint.com

Sincerely,

A handwritten signature in black ink, appearing to read "JM", followed by a long horizontal line extending to the right.

Jacqueline Macias
Acting President and General Manager, Medicaid
WellPoint, Inc.

APPENDIX C
 CLINICAL PERFORMANCE

MEDICARE RESULTS ONLY

Table 1: Comparison of HEDIS/CAHPS Medicare Results for CA Medicare and OH Medicare

#	Measure ID	Element ID	HEDIS Measure	Report for Medicare Advantage HMO/ PPO	Report for Medicare SNP	CY/MY 2010 Result for CA Medicare	CY/MY 2010 Result for OH Medicare
1	PNU		Pneumonia Vaccination Status for Older Adults ≥ 65 Years of Age (HEDIS CAHPS Medicare Health Plan Survey)	X		73.00	72.00
2	COA	rateacp	Care for Older Adults: Advance Care Planning		X	43.55	N/A
3	COA	ratemr	Care for Older Adults: Medication Review		X	57.49	N/A
4	COA	ratefSa	Care for Older Adults: Functional Status Assessment		X	60.63	N/A
5	COA	rateps	Care for Older Adults: Pain Screening		X	64.11	N/A
6	AAP	ratetot	Adults' Access to Preventive/Ambulatory Health Services: Total	X		96.46	97.51
7	OMW	rate	Osteoporosis Management in Women Who Had a Fracture	X		36.30	14.25
8	MRP	rate	Medication Reconciliation Post-Discharge		X	0.00	N/A

#	Measure ID	Element ID	HEDIS Measure	Report for Medicare Advantage HMO/PPO	Report for Medicare SNP	CY/MY 2010 Result for CA Medicare	CY/MY 2010 Result for OH Medicare
9	DAE	rate1p	Use of High-Risk Medications in the Elderly: At Least One High-Risk Medication	X		27.11	25.79
10	DAE	rate1p	Use of High-Risk Medications in the Elderly: At Least Two or More Different High-Risk Medications	X		6.53	6.74
11	AMM	rateeap	Antidepressant Medication Management - Effective Acute Phase Treatment	X		60.47	56.99
12	AMM	rateccp	Antidepressant Medication Management - Effective Continuation Phase Treatment	X		52.45	40.67
13	FUJH	rate7	Follow-Up After Hospitalization for Mental Illness within 7 Days of Discharge	X		41.82	38.58
14	CDC	ratebp90	Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)	X		77.13	66.67
15	CDC	rateade	Comprehensive Diabetes Care - HbA1c control (<8.0%)	X		66.18	74.77
16	CDC	rate100	Comprehensive Diabetes Care - LDL-C control (<100 mg/dL)	X		60.10	53.6
17	CPB	ratefot	Controlling High Blood Pressure	X		71.05	70.74
18	CMC	rate100	Cholesterol Management for Patients with Cardiovascular Conditions- LDL Control <100	X		68.13	64.56

#	Measure ID	Element ID	HEDIS Measure	Report for Medicare Advantage HMO/ PPO	Report for Medicare SNP	CY/MY 2010 Result for CA Medicare	CY/MY 2010 Result for OH Medicare
19	PBH	rate	Persistence of Beta-Blocker Treatment After a Heart Attack	X		85.16	78.35
20	PCE	ratecort	Pharmacotherapy Management of COPD Exacerbation: Dispensed a Systemic Corticosteroid Within 14 Days of the Event	X		75.91	68.43
21	PCE	ratebron	Pharmacotherapy Management of COPD Exacerbation: Dispensed a Bronchodilator Within 30 Days of the Event	X		84.76	70.4
22	IET	rini18	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation of AOD Treatment (18 + Years)	X		9.53	68.03
23	IET	reng18	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Engagement of AOD Treatment: (18 + Years)	X		0.77	0.86
24			Rating of Health Plan (HEDIS CAHPS Medicare Health Plan Survey)	X		9.00	8.50
TOTAL SCORE FOR APPENDIX C, SECTION 1.a.						7844	6680

Measure/Data Element	Report Measure	Benefit Offered	Rate	Reportable	Comment
<p>Adult Review Table Community Insurance Company dba Anthem Blue Cross and Blue Shield in Ohio (Org ID: 137, SubID: 6012, Medicare, Spec Area: None, Spec Proj: CMS), Measurement Year - 2010</p> <p>The Auditor lock has been applied to this submission.</p>					
Adult BMI Assessment (obs)	Y		58.16%	R	Reportable
Breast Cancer Screening (bcs)	Y		64.12%	R	Reportable
Colorectal Cancer Screening (col)	Y		58.45%	R	Reportable
Glaucoma Screening in Older Adults (gso)	Y		62.01%	R	Reportable
Care for Older Adults (coa)	N				
Adverse Care Planning Medication Review			NR	NR	
Functional Status Assessment			NR	NR	
Pain Screening			NR	NR	
<p>Effectiveness of Care (Quality Categories)</p>					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (sptr)	Y		30.06%	R	Reportable
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y			
Systemic Corticosteroid Administration			68.43%	R	Reportable
			70.40%	R	Reportable
<p>Effectiveness of Care (Quality)</p>					
Cholesterol Management for Patients With Cardiovascular Conditions (cinc)	Y				
LDL-C Screening Performed			87.14%	R	Reportable
LDL-C Control (<100 mg/dL)			64.56%	R	Reportable
Controlling High Blood Pressure (cbp)	Y		70.74%	R	Reportable
Persistence of Beta-Blocker Treatment After a Heart Attack (aha)	Y	Y	78.35%	R	Reportable
<p>Effectiveness of Care (Quality)</p>					
Comprehensive Diabetes Care (cdc)	Y				
Hemoglobin A1c (HbA1c) Testing			90.54%	R	Reportable
HbA1c Poor Control (>9.0%)			16.89%	R	Reportable
HbA1c Control (<8.0%)			74.77%	R	Reportable
Eye Exam (Retinal) Performed			85.06%	R	Reportable
LDL-C Screening Performed			96.71%	R	Reportable
LDL-C Control (<100 mg/dL)			83.80%	R	Reportable
Medical Attention for Nephropathy			87.34%	R	Reportable
Blood Pressure Control (<140/90 mm Hg)			50.23%	R	Reportable
Blood Pressure Control (<130/80 mm Hg)			66.67%	R	Reportable
<p>Effectiveness of Care (Quality)</p>					
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ard)	Y	Y	78.16%	R	Reportable
Osteoporosis Management in Women Who Had a Fracture (fsw)	Y	Y	14.25%	R	Reportable
<p>Effectiveness of Care (Quality) (HHS)</p>					
Antidepressant Medication Management (ama)	Y	Y			
Effective Acute Phase Treatment			58.98%	R	Reportable

Effective Combination Phase Treatment Follow-Up After Hospitalization for Mental Illness (tbl)	Y	Y	40.67%	R	Reportable
30-Day Follow-Up			58.53%	R	Reportable
7-Day Follow-Up			35.5%	R	Reportable
Effectiveness of Care Medication Management					
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y			
ADE Inhibitors or ARBs			92.04%	R	Reportable
Diagnosed Diabetes			93.62%	R	Reportable
Adverse Events			92.35%	R	Reportable
Toler?			66.77%	R	Reportable
Medication Reconciliation Post-Discharge (mp)			91.63%	R	Reportable
Potentially Harmful Drug-Device Interactions in the Elderly (ide)	N		NR	NR	
Falls + Tricyclic Antidepressants or Antipsychotics	Y	Y			
Dementia + Tricyclic Antidepressants or Antipsychotics			6.92%	R	Reportable
Anticholinergic Agents			18.80%	R	Reportable
Chronic Renal Failure + Nonsteroidal NSAIDs or COX-2 Selective NSAIDs			5.67%	R	Reportable
Total			14.54%	R	Reportable
Use of High-Risk Medications in the Elderly	Y	Y			
One Prescription			25.78%	R	Reportable
All Less Than Two Prescriptions			6.74%	R	Reportable
Adult Access to Preventive/Ambulatory Health Services (ap)	Y				
20-44 Years			85.32%	R	Reportable
45-64 Years			86.41%	R	Reportable
65+ Years			87.69%	R	Reportable
Total			87.51%	R	Reportable
Initiation and Engagement of AOD Dependence Treatment (it)	Y	Y			
Initiation of AOD Treatment: 13-17 Years			NA	R	Discontinued fewer than 30
Engagement of AOD Treatment: 13-17 Years			NA	R	Discontinued fewer than 30
Initiation of AOD Treatment: 18+ Years			68.03%	R	Reportable
Engagement of AOD Treatment: 18+ Years			68.03%	R	Reportable
Initiation of AOD Treatment: Total			0.86%	R	Reportable
Engagement of AOD Treatment: Total			0.86%	R	Reportable
Call Answer Timeliness (tbl)	Y		86.01%	R	Reportable
Call Abandonment (tbl)	Y		2.33%	R	Reportable
Use of Services					
Frequency of Scheduled Procedures (fep)	Y			R	Reportable
Ambulatory Care (tbl)	Y			R	Reportable
Inpatient Utilization-General Hospital/Acute Care (ipua)	Y			R	Reportable
Identification of Alcohol and Other Drug Services (tbl)	Y	Y		R	Reportable
Mental Health Utilization (tbl)	Y	Y		R	Reportable

Auth Infr. Utilization (abbr)	Y	Y	Y	R	Responsible
Plan All-Cause Hospitalizations (nc)	Y			R	Responsible
Cost/1000					
Relative Resource Use for People With Diabetes (cc)	N				
Inpatient Facility: Per Member Per Month				NR	NR
E & M Inpatient: Per Member Per Month				NR	NR
E & M Outpatient: Per Member Per Month				NR	NR
Surgery Inpatient: Per Member Per Month				NR	NR
Surgery Outpatient: Per Member Per Month				NR	NR
Pharmacy: Per Member Per Month				NR	NR
Inpatient Facility Discharges per 1,000 Member Years				NR	NR
ED Visits per 1,000 Member Years				NR	NR
Relative Resource Use for People With Cardiovascular Conditions (cc)	N				
Inpatient Facility: Per Member Per Month				NR	NR
E & M Inpatient: Per Member Per Month				NR	NR
E & M Outpatient: Per Member Per Month				NR	NR
Surgery Inpatient: Per Member Per Month				NR	NR
Surgery Outpatient: Per Member Per Month				NR	NR
Pharmacy: Per Member Per Month				NR	NR
Inpatient Facility Discharges per 1,000 Member Years				NR	NR
ED Visits per 1,000 Member Years				NR	NR
Relative Resource Use for People With Hypertension (ny)	N				
Inpatient Facility: Per Member Per Month				NR	NR
E & M Inpatient: Per Member Per Month				NR	NR
E & M Outpatient: Per Member Per Month				NR	NR
Surgery Inpatient: Per Member Per Month				NR	NR
Surgery Outpatient: Per Member Per Month				NR	NR
Pharmacy: Per Member Per Month				NR	NR
Inpatient Facility Discharges per 1,000 Member Years				NR	NR
ED Visits per 1,000 Member Years				NR	NR
Relative Resource Use for People With COPD (cc)	N				
Inpatient Facility: Per Member Per Month				NR	NR
E & M Inpatient: Per Member Per Month				NR	NR
E & M Outpatient: Per Member Per Month				NR	NR
Surgery Inpatient: Per Member Per Month				NR	NR
Surgery Outpatient: Per Member Per Month				NR	NR
Pharmacy: Per Member Per Month				NR	NR
Inpatient Facility Discharges per 1,000 Member Years				NR	NR
ED Visits per 1,000 Member Years				NR	NR
Top 10 Drug Discharges and Utilization					
Board Certification (cc)	Y			R	Responsible
Enrollment by Product Line (enp)	Y			R	Responsible

2011 Medicare Advantage CAHPS Results

Report for: Community Insurance Co (H3655)

Issued November 2011
by the Centers for Medicare & Medicaid Services

Community Insurance Co (H3655)

Table of Contents

Part 1: Executive Summary iii

 Overview iv

 How this Report is Organized iv

 What's New For 2011 iv

 How Results are Adjusted vi

 Other Public Reporting of Medicare CAHPS Data vi

 How Scores are Compared vi

 How to Use this Report vii

 Summary Tables viii

 General Assessment of Your Medicare Advantage Prescription Drug Contract's Performance x

 Consumer Reports xi

Part 2: Detailed Results 1

 Getting Needed Care Composite 2

 Getting Needed Care: Getting Appointments With Specialists 4

 Getting Needed Care: Getting Needed Care, Tests, or Treatment 6

 Getting Care Quickly Composite 8

 Getting Care Quickly: Getting Care Needed Right Away 10

 Getting Care Quickly: Getting Appointments 12

 Getting Care Quickly: Getting Seen Within 15 Minutes of Your Appointment 14

 Doctors Who Communicate Well Composite 16

 Doctors Who Communicate Well: Providing Clear Explanations 18

 Doctors Who Communicate Well: Listening Carefully 20

 Doctors Who Communicate Well: Showing Respect for What Patients Have to Say 22

 Doctors Who Communicate Well: Spending Enough Time With Patients 24

 Health Plan Customer Service Composite 26

 Health Plan Customer Service: Give Information Needed 28

 Health Plan Customer Service: Courtesy and Respect 30

 Health Plan Customer Service: Forms Were Easy to Fill Out 32

 Overall Rating of Health Plan 34

 Overall Rating of Care Received 36

 Overall Rating of Personal Doctor 38

 Overall Rating of Specialist 40

 Getting Needed Prescription Drugs Composite 42

 Getting Needed Prescription Drugs: Ease of Getting Prescribed Medicines 44

 Getting Needed Prescription Drugs: Ease of Filling Prescriptions (combined item) 46

 Getting Needed Prescription Drugs: Ease of Filling Prescriptions at a Pharmacy 48

 Getting Needed Prescription Drugs: Ease of Filling Prescriptions by Mail 50

Community Insurance Co (H3655)

Getting Information From the Plan About Prescription Drug Coverage and Cost Composite.....	52
Getting Information From the Plan About Prescription Drug Coverage and Cost: Customer Service Give Information About Prescription Drugs.....	54
Getting Information From the Plan About Prescription Drug Coverage and Cost: Customer Service Treat You With Courtesy and Respect.....	56
Getting Information From the Plan About Prescription Drug Coverage and Cost: Which Medicines Covered.....	58
Getting Information From the Plan About Prescription Drug Coverage and Cost: Out-of-Pocket Costs.....	60
Overall Rating of Prescription Drug Coverage.....	62
Willingness to Recommend Plan for Drug Coverage.....	64
Medicare-Specific and HEDIS Measures: Influenza Vaccination.....	66
Medicare Specific and HEDIS Measures: Pneumonia Shot.....	68
Medicare Specific and HEDIS Measures: Getting Medical Equipment.....	70
Medicare Specific and HEDIS Measures: Follow-up with Test Results.....	72
Single Item: After Hour Calls.....	74
Single Item: Answer as Soon as Needed.....	75
Single Item: Timing of Callback.....	76
Frequency Tables.....	78
Part 3: Background and Methodology.....	101
Background.....	102
Methodology.....	102
Data Collection.....	105
Sample Selection and Eligibility Criteria.....	105
Survey Implementation.....	105
Sample Disposition.....	106
Data Analysis.....	107
Differences Between CAHPS and NCOA Scoring Methodology.....	115
Survey Item Crosswalk for 2011 - 2010 MA-PD Questionnaires.....	116
Appendix.....	122

Community Insurance Co (H3655)

Overall Rating of Health Plan

Question 37: Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

For each contract, the table shows: the number of members who answered this question, the distribution of responses, the mean score, and whether the contract was significantly better than (↑), significantly worse than (↓), or not significantly different from (no arrow) the national average for MA contracts. If your score appears in italics, it means that the score has low reliability (below 0.75 in a 0 to 1.0 range). N/A means either too few beneficiaries answered the question to permit reporting or the score had very low reliability. This item is adjusted for case-mix.

		0-6	7-8	9-10	
		↑ = Significantly better than the national average ↓ = Significantly worse than the national average			
National Distribution	n=159797		26%		8.60
State Distribution - Ohio	n=6212	12%	29%		8.51
2011 Community Insurance Co (H3655)	n=881		32%		8.50
2010 Community Insurance Co (H3655)	n=919	18%	31%		8.21
MA Contracts in Your Market Area					
Aetna Medicare (H3623)	n=410	12%	30%		8.50
Aetna Medicare (H5521)	n=426	17%	30%		8.20 ↓
Anthem Insurance Co (R5941)	n=414	13%	29%		8.40 ↓
CareSource (H6178)	n=169	12%	27%		8.50
Community Insurance Co (H5529)	n=388	13%	33%		8.40 ↓
HealthAmerica (H8980)	n=378	18%	30%		8.10 ↓
Hometown Health Plan (H3672)	n=421		23%		8.90 ↑
Humana (H3619)	n=342	14%	27%		8.30 ↓
Humana (H0953)	n=332	13%	28%		8.40 ↓
Humana (R5826)	n=341	15%	29%		8.20 ↓
Kaiser Foundation HP (H8360)	n=411		28%		6.60
MediGold (H3668)	n=459		18%		9.10 ↑
SecureHorizons by UnitedHealthcare (H3659)	n=360		36%		8.40
SummaCare (H3660)	n=305		22%		8.90 ↑
WellCare (H0117)	n=309	22%	32%		7.70 ↓

Community Insurance Co (H3655)

Other MA Contracts in Ohio

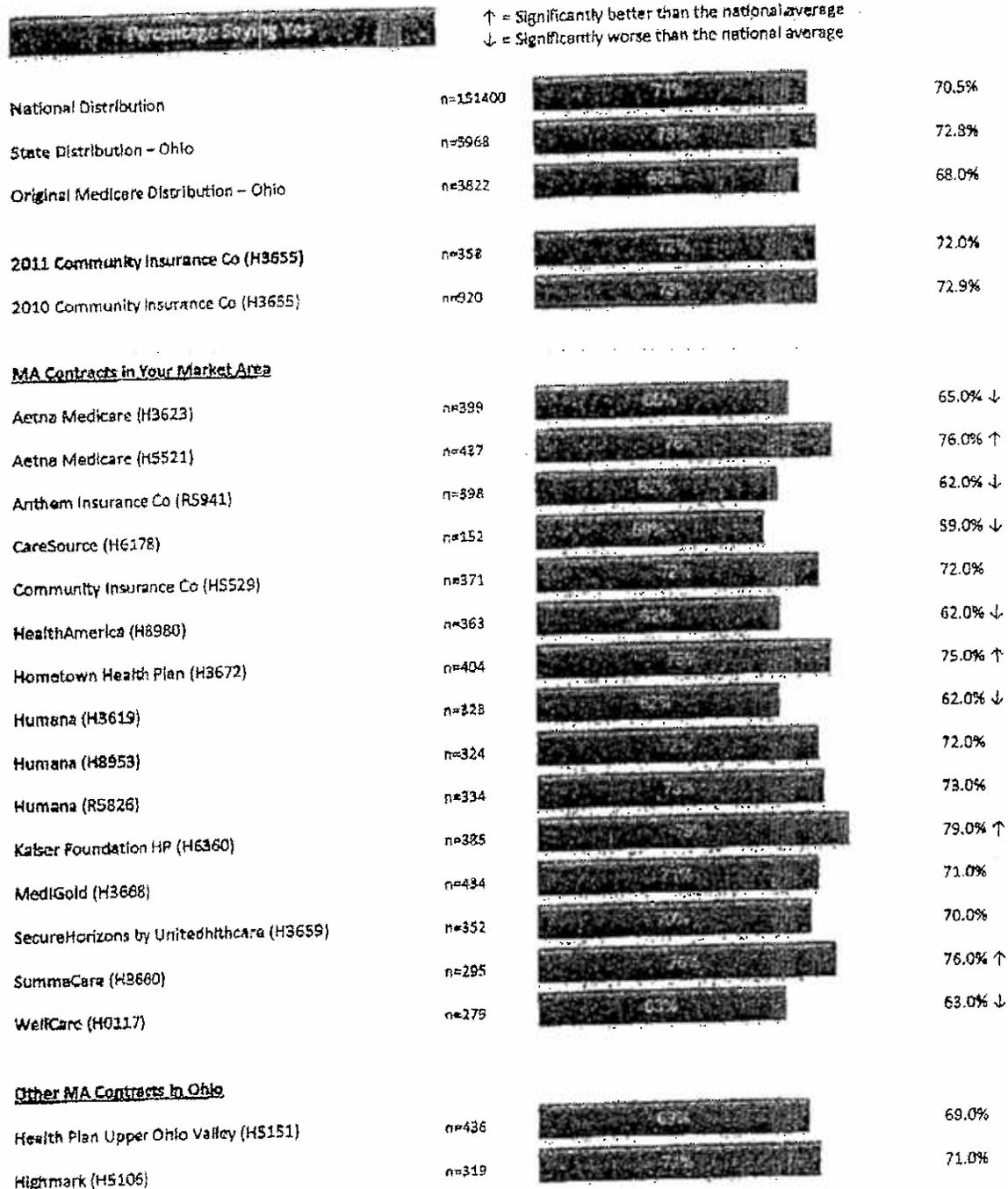
Health Plan Upper Ohio Valley (H5151)	n=450	21%		8.90 ↑
Highmark (H5106)	n=326	18%	27%	8.30 ↓
Paramount Care (H3653)	n=414		27%	8.60
PrimeTime Health Plan (H3620)	n=293		25%	8.90 ↑
PrimeTime Health Plan (H3664)	n=414		20%	8.90 ↑

Note: Percentages may not add to 100 due to rounding. For information on how we defined your market area, calculated significance for the up and down arrows, and adjusted for case-mix, see Part 3 of this report.

Community Insurance Co (H3655)

Medicare Specific and HEDIS Measures: Pneumonia Shot

Question 71: Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from a flu shot. It is also called the pneumococcal vaccine.



Community Insurance Co (H3655)

Other MA Contracts in Ohio

Paramount Care (H3653)	n=402		74.0%
PrimeTime Health Plan (H3620)	n=284		76.0% ↑
PrimeTime Health Plan (H3664)	n=408		75.0% ↑

Note: Percentages may not add to 100 due to rounding. For information on how we defined your market area and calculated significance for the up and down arrow, see Part 3 of this report. Note that this item is not adjusted for case-mix.



Medicaid

FAX COVER SHEET

PAGES 17 (Including Cover)

TO: ODJFS-Office of Contracts and Aquisitions DATE: June 5, 2012 FAX: 614.995.4876 TELE:
--

FROM: Jacqueline Macias LOCATION: Thousand Oaks, CA PHONE:805-557-6336 FAX:

Due to the length of the 2011 Medicare Advantage CAHPS Results report, we are only faxing over the relevant pages of the report. We will provide the entire report to ODJFS via hard copy.

Thank you

Jackie

IMPORTANT WARNING:
 This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**. If you have received this message by error, please notify us immediately and destroy the related message. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.

Exhibit C

Scoring Sheet 1

Item 1: Applicant Name: ANTHEM

Item 2: State: California

Item 3:	Calendar Year: At least 3 Months	CY 2009		CY 2010		CY 2011	
		Months:	12	Months	12	Months:	12
Item 4:	Hospital Care	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Primary/Specialist	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Home Health	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Pharmacy	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Dental	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Vision	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
Behavioral Health	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	
	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	
LTC Institutional	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	
	Medicare	<input type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	
HCBS	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	
	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	
DME	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	
	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	

Subtotals: 720 1,170 1,950

Item 5: ABD Medicaid 20.0% 20.0% 20.0%

Subtotals: 864 1,404 2,340

Item 6:	Member Months				
	Medicaid		9,265,489	9,034,317	9,132,286
	Medicare		1,156,456	1,438,185	2,051,109
	Total	0.0%	10,421,945	0.0%	10,472,502
				0.0%	11,183,395

Subtotals: 864 1,404 2,340

Sum of All Calendar Year Scores 4,608.0

Item 7:					
Admin Exp Ratio		0.0%	OK	Medicaid	10.1%
			OK	Medicare	7.9%

Antheim-1
P. 2 of 2

Subtotal:		4,608.0	
Item 8:	Part. Directed Care	0.0%	1 - 12 months <input type="checkbox"/>
			Greater than 12 months <input type="checkbox"/>

Subtotal: 4,608.0

Item 9:	NCQA Accreditation	5.0%	None <input type="radio"/>	Group Box: <input type="radio"/> <input type="radio"/> <input checked="" type="radio"/> <input type="radio"/>
			Accredited <input type="radio"/>	
Commendable <input checked="" type="radio"/>				
Excellent <input type="radio"/>				

Subtotal: 4,838.4

Item 10:	Action Revoking License	0.0%	Check if "Yes" <input type="checkbox"/>

4,838.4

Items 11, 12, 13 & 14	CY 2009		CY 2010		CY 2011	
	New Member Freeze	<input checked="" type="checkbox"/>	-30.0%	<input type="checkbox"/>	0.0%	<input type="checkbox"/>
Proposed Contract Term/ Nonrenewal	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%
Contract Denial/Term/ Norenewal	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%

Value -30.0%
Subtotal: 3,386.9

Final Score (capped at Max Amount) **3,387**

Scoring Sheet 2

Item 1: Applicant Name: ANTHEM

Item 2: State: (none) Indiana

Item 3:	Calendar Year: At least 3 Months	CY 2009		CY 2010		CY 2011	
		Months:	12	Months	12	Months:	12
Item 4:	Hospital Care	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Primary/Specialist	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Home Health	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Pharmacy	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Dental	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>
		Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>
	Vision	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
Behavioral Health	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	
	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	
LTC Institutional	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	
	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	
HCBS	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	
	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	
DME	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	
	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	

Subtotals: 700 990 1,650

Item 5: ABD Medicaid 0.0% 0.0% 0.0%

Subtotals: 700 990 1,650

Item 6:	Member Months	CY 2009		CY 2010		CY 2011	
	Medicaid		2,147,110		2,391,772		2,858,555
	Medicare		289,293		476,803		683,069
	Total	0.0%	2,436,403	0.0%	2,868,575	0.0%	3,541,624

Subtotals: 700 990 1,650

Sum of All Calendar Year Scores 3,340.0

Item 7:	Admin Exp Ratio	0.0%	OK	Medicaid	9.3%
			OK	Medicare	4.4%

Cuthem J.
p2 of 2

Subtotal: 3,340.0

Item 8:	Part. Directed Care	0.0%	1 - 12 months	<input type="checkbox"/>
			Greater than 12 months	<input type="checkbox"/>

Subtotal: 3,340.0

Item 9:	NCQA Accrediation	5.0%	None	<input type="radio"/>
			Accrediated	<input type="radio"/>
			Commendable	<input checked="" type="radio"/>
			Excellent	<input type="radio"/>

Subtotal: 3,507.0

Item 10:	Action Revoking License	0.0%	Check if "Yes"	<input type="checkbox"/>
-----------------	-------------------------	------	----------------	--------------------------

3,507.0

Items 11, 12, 13 & 14	CY 2009		CY 2010		CY 2011	
	New Member Freeze	<input checked="" type="checkbox"/>	-30.0%	<input type="checkbox"/>	0.0%	<input type="checkbox"/>
Proposed Contract Term/ Nonrenewal	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%
Contract Denial/Term/ Norenewal	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%

Value -30.0%

Subtotal: 2,454.9

Final Score (capped at Max Amount) 2,455

Scoring Sheet 3

Item 1: Applicant Name: ANTHEM

Item 2: State: Ohio

Item 3:	Calendar Year. At least 3 Months	CY 2009		CY 2010		CY 2011	
		Months:	12	Months	12	Months:	12
Item 4:	Hospital Care	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Primary/Specialist	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Home Health	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Pharmacy	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Dental	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>
		Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>
	Vision	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
Behavioral Health	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	
	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	
LTC Institutional	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	
	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	
HCBS	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	
	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	
DME	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	
	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	

Subtotals: 420 630 1,050

Item 5: ABD Medicaid 0.0% Medicare 0.0% 0.0%

Subtotals: 420 630 1,050

Item 6:	Member Months			
	Medicaid			
	Medicare			
	Total	0.0%		

Subtotals: 420 630 1,050

Sum of All Calendar Year Scores 2,100.0

Item 7:	Admin Exp Ratio			
		0.0%	OK	Medicaid <input type="text" value="0.0%"/>
			OK	Medicare <input type="text" value="5.6%"/>

Question - 3
p 2 of 2

Subtotal:		2,100.0
Item 8:	Part. Directed Care	0.0% 1 - 12 months <input type="checkbox"/>
		Greater than 12 months <input type="checkbox"/>

Subtotal:		2,100.0
Item 9:	NCQA Accrediation	10.0%
		None <input type="radio"/> Accrediated <input type="radio"/> Commendable <input type="radio"/> Excellent <input checked="" type="radio"/>

Subtotal:		2,310.0
Item 10:	Action Revoking License	0.0% Check if "Yes" <input type="checkbox"/>

		2,310.0					
Items 11, 12, 13 & 14		CY 2009		CY 2010		CY 2011	
	New Member Freeze	<input checked="" type="checkbox"/>	-30.0%	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%
	Proposed Contract Term/ Nonrenewal	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%
	Contract Denial/Term/ Norenewal	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%

Value -30.0%
Subtotal: 1,617.0

Final Score (capped at Max Amount) 1,617

Scoring Sheet 4

Item 1: Applicant Name: ANTHEM

Item 2: State: Virginia

Item 3:	Calendar Year: At least 3 Months	CY 2009		CY 2010		CY 2011	
		Months:	12	Months:	12	Months:	12

Item 4:	Hospital Care	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Primary/Specialist	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Home Health	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Pharmacy	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Dental	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>
		Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>
	Vision	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
Behavioral Health	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	
	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	
LTC Institutional	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	
	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	
HCBS	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	
	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	
DME	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	
	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	

Subtotals: 700 1,050 1,650

Item 5:	ABD Medicaid	20.0%	<input checked="" type="checkbox"/>	20.0%	<input checked="" type="checkbox"/>	20.0%	<input checked="" type="checkbox"/>
	Subtotals:	840		1,260		1,980	

Item 6:	Member Months					
	Medicaid		2,218,754		2,535,550	2,689,580
	Medicare		143,948		136,830	208,673
	Total	0.0%	2,362,702	0.0%	2,672,380	2,898,253
	Subtotals:	840		1,260		1,980

Sum of All Calendar Year Scores 4,080.0

Item 7:	Admin Exp Ratio	0.0%	OK	Medicaid	4.3%
			OK	Medicare	6.9%

Authem 4
p. 2 of 2

Subtotal: 4,080.0

Item 8:	Part. Directed Care	0.0%	1 - 12 months	<input type="checkbox"/>
			Greater than 12 months	<input type="checkbox"/>

Subtotal: 4,080.0

Item 9:	NCQA Accrediation	10.0%	None	<input type="radio"/>
			Accrediated	<input type="radio"/>
			Commendable	<input type="radio"/>
			Excellent	<input checked="" type="radio"/>

Subtotal: 4,488.0

Item 10:	Action Revoking License	0.0%	Check if "Yes"	<input type="checkbox"/>
-----------------	-------------------------	------	----------------	--------------------------

4,488.0

Items 11, 12, 13 & 14	CY 2009		CY 2010		CY 2011	
	New Member Freeze	<input checked="" type="checkbox"/>	-30.0%	<input type="checkbox"/>	0.0%	<input type="checkbox"/>
Proposed Contract Term/ Nonrenewal	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%
Contract Denial/Term/ Norenewal	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%

Value -30.0%

Subtotal: 3,141.6

Final Score (capped at Max Amount) 3,142

Scoring Sheet 5

Item 1: Applicant Name: ANTHEM

Item 2: State: Wisconsin

Item 3:	Calendar Year: At least 3 Months	CY 2009		CY 2010		CY 2011	
		Months:	12	Months	12	Months:	12
Item 4:	Hospital Care	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Primary/Specialist	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Home Health	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Pharmacy	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Dental	Medicaid	<input type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Vision	Medicaid	<input type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
Behavioral Health	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	
	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	
LTC Institutional	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	
	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	
HCBS	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	
	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	
DME	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	
	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	

Subtotals: 620 1,140 1,900

Item 5: ABD Medicaid 0.0% 0.0% 0.0%

Subtotals: 620 1,140 1,900

Item 6:	Member Months	CY 2009		CY 2010		CY 2011	
	Medicaid		367,493		401,664		428,710
	Medicare		430,638		305,672		133,666
	Total	0.0%	798,131	0.0%	707,336	0.0%	562,376

Subtotals: 620 1,140 1,900

Sum of All Calendar Year Scores 3,660.0

Item 7:	Admin Exp Ratio	0.0%	OK	Medicaid	10.9%
			OK	Medicare	6.5%

Continuation 5
p. 2 of 2

Subtotal: 3,660.0

Item 8:	Part. Directed Care	0.0%	1 - 12 months	<input type="checkbox"/>
			Greater than 12 months	<input type="checkbox"/>

Subtotal: 3,660.0

Item 9:	NCQA Accrediation	0.0%	None	<input checked="" type="radio"/>
			Accrediated	<input type="radio"/>
			Commendable	<input type="radio"/>
			Excellent	<input type="radio"/>

Subtotal: 3,660.0

Item 10:	Action Revoking License	0.0%	Check if "Yes"	<input type="checkbox"/>
----------	-------------------------	------	----------------	--------------------------

3,660.0

Items 11, 12, 13 & 14		CY 2009		CY 2010		CY 2011	
		New Member Freeze	<input checked="" type="checkbox"/>	-30.0%	<input type="checkbox"/>	0.0%	<input type="checkbox"/>
Proposed Contract Term/ Nonrenewal	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%	
Contract Denial/Term/ Norenewal	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%	

Value -30.0%

Subtotal: 2,562.0

Final Score (capped at Max Amount): 2,562

Anthem 6

Individual Score Sheet Blending

Name: ANTHEM

<u>Sheet</u>	<u>CY</u>	<u>Member Months</u>	<u>Weight</u>	<u>Score</u>	<u>Weighted Score</u>
1	11	11,183,395	55.42%	3,387.0	1,877.2
2	11	3,541,624	17.55%	2,455.0	430.9
3	11	1,992,849	9.88%	1,617.0	159.7
4	11	2,898,253	14.36%	3,142.0	451.3
5	11	562,376	2.79%	2,562.0	71.4
		<u>20,178,497</u>	100.00%		

Total Blended Score

2,990.5

Anthem

PART II: Scoring Methodology

Applicants will be individually scored for each region. For each region an applicant may not score more than the maximum points of 15,000. For each region, if the applicant checked only one of the three boxes for a county (Medicare Advantage, Medicaid, and Commercial) then the score associated with the check box is the score for the county. If the applicant checked multiple boxes for a county then the checked box that awards the highest score is counted. For example, if applicant for the Central region checked the Medicare Advantage, Medicaid, and Commercial boxes for Delaware County then the Applicant would receive a score of 3,000 for Central region/Delaware County. The county points are totaled for a total score for Part II of this appendix for the specific region.

Region: Central

County	Region	Area(s) of Coverage		
		Medicare Advantage	Medicaid	Commercial
Delaware	CEN	3,000	2,400	1,500
Franklin	CEN	3,000	2,400	1,500
Madison	CEN	3,000	2,400	1,500
Pickaway	CEN	3,000	2,400	1,500
Union	CEN	3,000	2,400	1,500

15,000

15,000

Region: East Central

County	Region	Area(s) of Coverage		
		Medicare Advantage	Medicaid	Commercial
Portage	EC	3,750	3,000	1,875
Stark	EC	3,750	3,000	1,875
Summit	EC	3,750	3,000	1,875
Wayne	EC	3,750	3,000	1,875

15,000

15,000

Region: Northeast

County	Region	Area(s) of Coverage		
		Medicare Advantage	Medicaid	Commercial
Cuyahoga	NE	3,000	2,400	1,500
Geauga	NE	3,000	2,400	1,500
Lake	NE	3,000	2,400	1,500
Lorain	NE	3,000	2,400	1,500
Medina	NE	3,000	2,400	1,500

15,000

15,000

Authem

Region: Northeast Central

County	Region	Area(s) of Coverage		
		Medicare Advantage	Medicaid	Commercial
Columbiana	NEC	5,000	4,000	2,500
Mahoning	NEC	5,000	4,000	2,500
Trumbull	NEC	5,000	4,000	2,500

15,000

15,000

Region: Northwest

County	Region	Area(s) of Coverage		
		Medicare Advantage	Medicaid	Commercial
Fulton	NW	3,750	3,000	1,875
Lucas	NW	3,750	3,000	1,875
Ottawa	NW	3,750	3,000	1,875
Wood	NW	3,750	3,000	1,875

15,000

15,000

Region: Southwest

County	Region	Area(s) of Coverage		
		Medicare Advantage	Medicaid	Commercial
Butler	SW	3,000	2,400	1,500
Clermont	SW	3,000	2,400	1,500
Clinton	SW	3,000	2,400	1,500
Hamilton	SW	3,000	2,400	1,500
Warren	SW	3,000	2,400	1,500

15,000

15,000

Region: West Central

County	Region	Area(s) of Coverage		
		Medicare Advantage	Medicaid	Commercial
Clark	WC	5,000	4,000	2,500
Greene	WC	5,000	4,000	2,500
Montgomery	WC	5,000	4,000	2,500

15,000

15,000

SCORING METHODOLOGY

The remainder of this Appendix is a description of the process that will be used by ODJFS in scoring an Applicant's responses to the questions in this Appendix. Applicants are not to fill in and return this section with their applications. However, ODJFS strongly encourages applicants to use these pages to evaluate the quality and responsiveness of their application packets prior to submission.

Appendix C Clinical Performance

Scoring: Section I.a.

- (1) For each individual measure, a score shall be assigned according to the values set forth in Appendix C Scoring Instructions (located at the end of this Appendix).
- (2)
 - a) If the Applicant was a Medicare Advantage HMO/PPO and was not a Medicare SNP in the given State, the applicable nineteen (19) measures as marked with an "X" in Table 1 per Instructions in Section I.a. above are added together to get a final score for Section I.a. of Appendix C.

Scoring Questions:

- 1) Did the Applicant report Medicare Advantage HMO/PPO results from the State referenced in Appendix B with the largest number of Medicare Advantage HMO/PPO member months for CY 2010 with HEDIS/CAHPS results? This will require a check of Appendix B and the Applicant's final, auditor-locked IDSS data-filled workbook and audit designation table for self-reported audited HEDIS data.
 - a. If not, the Applicant will receive 0 points for this section.
 - b. If yes, proceed with the following questions.
- 2) Was the Applicant a Medicare Advantage Plan HMO/PPO and not a Medicare SNP in the State as referenced in Appendix B?
 - a. If yes, proceed with filling in scores in Table 1.
 - b. If not, go to next question.
- 3) Was the Applicant a Medicare Advantage Plan HMO/PPO and a Medicare SNP in the State as referenced in Appendix B?
 - a. If yes, proceed with filling in scores in Table 2.

Anthem

Table 1: Medicare Advantage Plan

Scores	Measure ID	Element ID	Score	Score Validation
1	Pneumonia Vaccination Status for Older Adults ≥ 65 Years of Age (HEDIS CAHPS Medicare Health Plan Survey)			
2	Adults' Access to Preventive/Ambulatory Health Services: Total			
3	Osteoporosis Management in Women Who Had a Fracture			
4	Use of High-Risk Medications in the Elderly: At Least One High-Risk Medication			
5	Use of High-Risk Medications in the Elderly: At Least Two or More Different High-Risk Medications			
6	Antidepressant Medication Management - Effective Acute Phase Treatment			
7	Antidepressant Medication Management - Effective Continuation Phase Treatment			
8	Follow-Up After Hospitalization for Mental Illness within 7 Days of Discharge			
9	Comprehensive Diabetes Care - Blood			

Anthem

	Pressure Control (<140/90 mm Hg)			
10	Comprehensive Diabetes Care - HbA1c control (<8.0%)			
11	Comprehensive Diabetes Care - LDL-C control (<100 mg/dL)			
12	Controlling High Blood Pressure			
13	Cholesterol Management for Patients with Cardiovascular Conditions- LDL Control <100			
14	Persistence of Beta-Blocker Treatment After a Heart Attack			
15	Pharmacotherapy Management of COPD Exacerbation: Dispensed a Systemic Corticosteroid Within 14 Days of the Event			
16	Pharmacotherapy Management of COPD Exacerbation: Dispensed a Bronchodilator Within 30 Days of the Event			
17	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation of AOD Treatment (18 + Years)			
18	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment:			

Anthem

	Engagement of ADD Treatment: (18 + Years)			
19	Rating of Health Plan (HEDIS CAHPS Medicare Health Plan Survey)			
TOTAL Score				0

Step 2: Validate each score with 1) the final, auditor-locked IDSS data-filled workbook and audit designation table for self-reported audited HEDIS data; and 2) the Medicare-only CAHPS results with an attestation from their CMS-approved Medicare CAHPS vendor verifying the accuracy of each set of Medicare HEDIS results reported in Appendix C (note that this is due on June 4). If the Applicant did not submit the final, auditor-locked IDSS data-filled workbook and audit designation table for self-reported audited HEDIS data for the Medicare HEDIS results reported in Appendix C, then the Applicant will receive 0 points for the HEDIS results. If the Applicant did not submit the Medicare-only CAHPS results with an attestation from their CMS-approved Medicare CAHPS vendor verifying the accuracy of each set of Medicare HEDIS results reported in Appendix C, then the Applicant will receive 0 points for the HEDIS/CAHPS results.

- b) If the Applicant was both a Medicare Advantage HMO/PPO and a Medicare SNP in the given State, the applicable twenty-four (24) measures as marked with an "X" in Table 1 per instructions in Section I.a. above are added together to get a final score for Section I.a. of Appendix C.

Table 2

Scores	Measure ID	Element ID	Score
1	Pneumonia Vaccination Status for Older Adults ≥ 65 Years of Age (HEDIS CAHPS Medicare Health Plan Survey)		
2	Care for Older Adults: Advance Care Planning		
3	Care for Older Adults: Medication Review		
4	Care for Older Adults: Functional Status Assessment		
5	Care for Older Adults:		

Authem

	Pain Screening		
6	Adults' Access to Preventive/Ambulatory Health Services: Total		
7	Osteoporosis Management in Women Who Had a Fracture		
8	Medication Reconciliation Post-Discharge		
9	Use of High-Risk Medications in the Elderly: At Least One High-Risk Medication		
10	Use of High-Risk Medications in the Elderly: At Least Two or More Different High-Risk Medications		
11	Antidepressant Medication Management - Effective Acute Phase Treatment		
12	Antidepressant Medication Management - Effective Continuation Phase Treatment		
13	Follow-Up After Hospitalization for Mental Illness within 7 Days of Discharge		
14	Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)		
15	Comprehensive Diabetes Care - HbA1c control (<8.0%)		
16	Comprehensive Diabetes Care - LDL-C		

Andersen

	control (<100 mg/dL)		
17	Controlling High Blood Pressure		
18	Cholesterol Management for Patients with Cardiovascular Conditions- LDL Control <100		
19	Persistence of Beta-Blocker Treatment After a Heart Attack		
20	Pharmacotherapy Management of COPD Exacerbation: Dispensed a Systemic Corticosteroid Within 14 Days of the Event		
21	Pharmacotherapy Management of COPD Exacerbation: Dispensed a Bronchodilator Within 30 Days of the Event		
22	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation of AOD Treatment (18 + Years)		
23	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Engagement of AOD Treatment: (18 + Years)		
24	Rating of Health Plan (HEDIS CAHPS Medicare Health Plan Survey)		

Andersen

TOTAL Score

0

END

Step 2: Validate each score with 1) the final, auditor-locked IDSS data-filled workbook and audit designation table for self-reported audited HEDIS data; and 2) the Medicare-only CAHPS results with an attestation from their CMS-approved Medicare CAHPS vendor verifying the accuracy of each set of Medicare HEDIS results reported in Appendix C (note that this is due on June 4). If the Applicant did not submit the final, auditor-locked IDSS data-filled workbook and audit designation table for self-reported audited HEDIS data for the Medicare HEDIS results reported in Appendix C, then the Applicant will receive 0 points for the HEDIS results. If the Applicant did not submit the Medicare-only CAHPS results with an attestation from their CMS-approved Medicare CAHPS vendor verifying the accuracy of each set of Medicare HEDIS results reported in Appendix C, then the Applicant will receive 0 points for the HEDIS/CAHPS results.

Antkem

Scoring: Section I.b.

- (1) For each individual measure, a score shall be assigned according to the values set forth in Appendix C Scoring Instructions (located at the end of this Appendix).
- (2) The five (5) highest scored measures above are added together to get a final score for Section I.b. of Appendix C.

Scoring Questions:

- 1) Did the Applicant report Medicaid results from the State referenced in Appendix B with the largest number of Medicaid member months for CY 2010 for which there are HEDIS/CAHPS results? This will require a check of Appendix B and the Applicants final, auditor-locked IDSS data-filled workbook and audit designation table for self-reported audited HEDIS data and the NCQA HEDIS Survey Results Report as downloaded from NCQA's IDSS for CAHPS results.
 - b. If not, the Applicant will receive 0 points for this section.
 - c. If yes, proceed with the scoring.

Measures	Measure ID	Element ID	Score	Score Validation
1	Adults' Access to Preventive/Ambulatory Health Services: Total		0	✓
2	Antidepressant Medication Management - Effective Acute Phase Treatment		0	
3	Antidepressant Medication Management - Effective Continuation Phase Treatment		0	
4	Follow-Up After Hospitalization for Mental Illness within 7 Days of Discharge		0	
5	Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)		380	✓

Anthem

6	Comprehensive Diabetes Care - HbA1c control (<8.0%)		380	✓
7	Comprehensive Diabetes Care - LDL-C control (<100 mg/dL)		380	✓
8	Controlling High Blood Pressure		380	✓
9	Cholesterol Management for Patients with Cardiovascular Conditions- LDL Control <100		190	✓
10	Persistence of Beta-Blocker Treatment After a Heart Attack		0	✓
11	Pharmacotherapy Management of COPD Exacerbation: Dispensed a Systemic Corticosteroid Within 14 Days of the Event		570	✓
12	Pharmacotherapy Management of COPD Exacerbation: Dispensed a Bronchodilator Within 30 Days of the Event		380	✓
13	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation of AOD Treatment (18 + Years)		0	
14	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Engagement of AOD Treatment: (18 + Years)		0	

Anthem

15	Rating of Health Plan-Adult (HEDIS CAHPS Medicaid Health Plan Survey)		0	✓
----	---	--	---	---

END

Step 2: Validate each score with 1) the final, auditor-locked IDSS data-filled workbook and audit designation table for self-reported audited HEDIS data; and 2) the NCQA HEDIS Survey Results Report as downloaded from NCQA's IDSS for CAHPS results. If the Applicant did not submit the final, auditor-locked IDSS data-filled workbook and audit designation table for self-reported audited HEDIS data for the Medicaid HEDIS results reported in Appendix C, then the Applicant will receive 0 points for the HEDIS results. If the Applicant did not submit the NCQA HEDIS Survey Results Report as downloaded from NCQA's IDSS for CAHPS results, then the Applicant will receive 0 points for the HEDIS/CAHPS results.

From the above Table, select the 5 highest scores.

Top Five Highest Scores	Measure ID	Element ID	Score
1	# 11		570
2	# 5		380
3	# 6		380
4	# 7		380
5	# 8		380
TOTAL Score			2090

Section II

Section II is worth a maximum of 6,000 points.

- (1) For the three individual structured quality improvement initiatives for which the Applicant reports a response, a score shall be assigned according to the instructions set forth below. The Applicant will be scored on no more than three responses. If the Applicant submits more than three structured quality improvement initiatives, only the first three submitted will be scored.

Quality Improvement Initiative 1:

Does the quality improvement initiative address preventing unnecessary long term institutionalization by re-directing Medicaid consumers to community settings and using community-based long term care services and supports?

Yes ___ No *(gave M'Care not M'Care info - therefore not considered)*

The Applicant will be scored on 1.a.-1.e. if the answer is Yes. The Applicant will receive 0 points for 1.a. through 1.e. if the answer is No.

1.a.

- 1. Did the Applicant discuss how the initiative targeted improvement?

Yes ___ No ___

- 2. Did the Applicant discuss how the initiative specifically related to the organization's membership?

Yes ___ No ___

The Applicant will receive 400 points if the answer to both questions is Yes. The Applicant will receive 0 points if the answer to either question is No.

1.b.

- 1. Did the Applicant discuss one or more selected quality indicators that were used to track performance and improvement over time?

Yes ___ No ___

- 2. Did the Applicant discuss how the quality indicators were meaningful to monitoring success of the intervention?

Yes ___ No ___

- 3. Did the Applicant discuss the benchmarks and goals that the quality indicators were compared to throughout the initiative?

Anthem

Yes ___ No ___

The Applicant will receive 400 points if the answer is Yes to all three questions. The Applicant will receive 0 points if the answer is No to any of the above questions.

1.c.

1. Did the Applicant define the intervention for the quality improvement initiative?

Yes ___ No ___

2. Did the Applicant discuss how the intervention was expected to change behavior at either an institutional, provider and/or enrollee level?

Yes ___ No ___

The Applicant will receive 400 points if the answer to both questions is Yes. The Applicant will receive 0 points if the answer to either question is No.

1.d.

1. Did the Applicant present pre- and post-results for the quality indicators listed in 1.b.?

Yes ___ No ___

2. Did the results for each quality indicator show improvement that was statistically significant?

Yes ___ No ___

The Applicant will receive 400 points if the answer to both questions is Yes. The Applicant will receive 0 points if the answer to either question is No.

- 1.e. Did the Applicant report that the results of the quality improvement initiative were independently validated?

Yes ___ No ___

The Applicant will receive 400 points if the answer is Yes. The Applicant will receive 0 points if the answer is No.

Quality Improvement Initiative 2:

1. Does the quality improvement initiative address transitioning individuals who have resided in nursing facilities for longer than 90 days into community settings by arranging and providing for home and community based services and supports?

Yes ___ No ___

Authem

The Applicant will be scored on 2.a.-2.e. If the answer is Yes. The Applicant will receive 0 points for 2.a. through 2.e. if the answer is No.

2.a.

1. Did the Applicant discuss how the initiative targeted improvement?

Yes___ No___

2. Did the Applicant discuss how the initiative specifically related to the organization's membership?

Yes___ No___

The Applicant will receive 400 points if the answer to both questions is Yes. The Applicant will receive 0 points if the answer to either question is No.

2.b.

1. Did the Applicant discuss one or more selected quality indicators that were used to track performance and improvement over time?

Yes___ No___

2. Did the Applicant discuss how the quality indicators were meaningful to monitoring success of the intervention?

Yes___ No___

3. Did the Applicant discuss the benchmarks and goals that the quality indicators were compared to throughout the initiative?

Yes___ No___

The Applicant will receive 400 points if the answer is Yes to all three questions. The Applicant will receive 0 points if the answer is No to any of the above questions.

2.c.

1. Did the Applicant define the intervention for the quality improvement initiative?

Yes___ No___

2. Did the Applicant discuss how the intervention was expected to change behavior at either an institutional, provider and/or enrollee level?

Yes___ No___

The Applicant will receive 400 points if the answer to both questions is Yes. The Applicant will receive 0 points if the answer to either question is No.

Anthem

2.d.

1. Did the Applicant present pre- and post-results for the quality indicators listed in 1.b.?

Yes ___ No ___

2. Did the results for each quality indicator show improvement that was statistically significant?

Yes ___ No ___

The Applicant will receive 400 points if the answer to both questions is Yes. The Applicant will receive 0 points if the answer to either question is No.

2.e. Did the Applicant report that the results of the quality improvement initiative were independently validated?

Yes ___ No ___

The Applicant will receive 400 points if the answer is Yes. The Applicant will receive 0 points if the answer is No.

Quality Improvement Initiative 3:

Does the quality improvement initiative address improving health outcomes or quality of life indicators for Medicaid and/or Medicare members with severe and persistent mental illness?

Yes No ___

The Applicant will be scored on 3.a.-3.e. if the answer is Yes. The Applicant will receive 0 points for 3.a. through 3.e. if the answer is No.

3.a.

1. Did the Applicant discuss how the initiative targeted improvement?

Yes No ___

2. Did the Applicant discuss how the initiative specifically related to the organization's membership?

Yes No ___

The Applicant will receive 400 points if the answer to both questions is Yes. The Applicant will receive 0 points if the answer to either question is No.

3.b.

1. Did the Applicant discuss one or more selected quality indicators that were used to track performance and improvement over time?

Yes No

2. Did the Applicant discuss how the quality indicators were meaningful to monitoring success of the intervention?

Yes No

3. Did the Applicant discuss the benchmarks and goals that the quality indicators were compared to throughout the initiative?

Yes No

The Applicant will receive 400 points if the answer is Yes to all three questions. The Applicant will receive 0 points if the answer is No to any of the above questions.

3.c.

1. Did the Applicant define the intervention for the quality improvement initiative?

Yes No

2. Did the Applicant discuss how the intervention was expected to change behavior at either an institutional, provider and/or enrollee level?

Yes No

The Applicant will receive 400 points if the answer to both questions is Yes. The Applicant will receive 0 points if the answer to either question is No.

3.d.

1. Did the Applicant present pre- and post-results for the quality indicators listed in 1.b.?

Yes No

2. Did the results for each quality indicator show improvement that was statistically significant?

Yes No

The Applicant will receive 400 points if the answer to both questions is Yes. The Applicant will receive 0 points if the answer to either question is No.

3.e. Did the Applicant report that the results of the quality improvement initiative were independently validated?

Auttem

Yes No

The Applicant will receive 400 points if the answer is Yes. The Applicant will receive 0 points if the answer is No.

Quality Improvement Initiative 4:

Does the quality improvement initiative address decreasing inappropriate and avoidable hospital admissions and reducing inappropriate use of high-cost acute care services?

Yes No — only discussed ER use

The Applicant will be scored on 4.a.-4.e. if the answer is Yes. The Applicant will receive 0 points for 4.a. through 4.e. if the answer is No.

4.a.

1. Did the Applicant discuss how the Initiative targeted improvement?

Yes No

2. Did the Applicant discuss how the initiative specifically related to the organization's membership?

Yes No

The Applicant will receive 400 points if the answer to both questions is Yes. The Applicant will receive 0 points if the answer to either question is No.

4.b.

1. Did the Applicant discuss one or more selected quality indicators that were used to track performance and improvement over time?

Yes No

2. Did the Applicant discuss how the quality indicators were meaningful to monitoring success of the intervention?

Yes No

3. Did the Applicant discuss the benchmarks and goals that the quality indicators were compared to throughout the initiative?

Yes No

The Applicant will receive 400 points if the answer is Yes to all three questions. The Applicant will receive 0 points if the answer is No to any of the above questions.

Authem

4.c.

1. Did the Applicant define the intervention for the quality improvement initiative?

Yes ___ No ___

2. Did the Applicant discuss how the intervention was expected to change behavior at either an institutional, provider and/or enrollee level?

Yes ___ No ___

The Applicant will receive 400 points if the answer to both questions is Yes. The Applicant will receive 0 points if the answer to either question is No.

4.d.

1. Did the Applicant present pre- and post-results for the quality indicators listed in 1.b.?

Yes ___ No ___

2. Did the results for each quality indicator show improvement that was statistically significant?

Yes ___ No ___

The Applicant will receive 400 points if the answer to both questions is Yes. The Applicant will receive 0 points if the answer to either question is No.

4.e. Did the Applicant report that the results of the quality improvement initiative were independently validated?

Yes ___ No ___

The Applicant will receive 400 points if the answer is Yes. The Applicant will receive 0 points in the answer is No.

Five Components of the Three Reported Quality Improvement Initiatives	Score
1.a.	<i>0</i>
1.b.	
1.c.	
1.d.	
1.e.	

Anthem

QI #3

Total for First Quality Improvement Initiative	0
2.a.	400
2.b.	0
2.c.	400
2.d.	400
2.e.	400
Total for Second Quality Improvement Initiative	1600
3.a.	0
3.b.	0
3.c.	0
3.d.	0
3.e.	0
Total for Third Quality Improvement Initiative	0

QI #4

1600

1,600

Anthem

The remainder of this Appendix is a description of the process that will be used by ODJFS in scoring an Applicant's responses to the questions in this Appendix. Applicants are not to fill in and return this section with their applications. However, ODJFS strongly encourages applicants to use these pages to evaluate the quality and responsiveness of their application packets prior to submission.

Appendix D – Care Coordination
Scoring Instructions and Worksheet

Total Points for Appendix D: 30,000

Part A: Care Management

Total possible points for Part A are 27,000.

Reviewers are to fill in the appropriate points based on the information submitted on the Appendix D form. Points will be awarded for each response based on the instructions provided for each question.

Questions:

1. Does the Applicant have at least 12 months of experience as of March 31, 2012 with providing and coordinating the following benefits as part of its care management program?

State and Line of Business	Points Possible			Points Awarded	
	Benefit	Yes	No		
Entry 1: <i>Calif</i> State: Line of Business: <i>Medicare</i>	Acute care	100	0	<i>100</i>	
	Behavioral health care	100	0		
	Long term services and supports (only one entry may be selected)	Community and institutional	<i>200</i>	0	<i>200</i>
		Community only	100	0	
		Institutional only	100	0	
Add 50 points if the Line of Business is Medicare-Medicaid or Medicare.				<i>+50</i>	
Total Points Awarded for Entry 1 (may not exceed 450):				<i>450</i>	
Entry 2: State: <i>Ohio</i>	Acute care	<i>100</i>	0		
	Behavioral health care	<i>100</i>	0		
	Long term services and supports	200	0		
	Community and institutional				

Clutham

State and Line of Business	Points Possible			Points Awarded	
	Benefit	Yes	No		
Line of Business:	and supports (only one entry may be selected)	Community only	100	0	
		Institutional only	100	0	
Add 50 points if the Line of Business is Medicare-Medicaid or Medicare.				450	
Total Points Awarded for Entry 2 (may not exceed 450):				350	
Entry 3:	Acute care		100	0	100
State: <i>Ind</i>	Behavioral health care		100	0	100
Line of Business:	Long term services and supports (only one entry may be selected)	Community and institutional	200	0	
<i>Medicare</i>		Community only	100	0	100
		Institutional only	100	0	
Add 50 points if the Line of Business is Medicare-Medicaid or Medicare.				450	
Total Points Awarded for Entry 3 (may not exceed 450):				350	
Total Points Awarded for Question 1					
Sum of entries 1-3 shall not exceed 1,350 points.					1150

2. Does the Applicant have at least 12 months of experience as of March 31, 2012 providing comprehensive care management for enrollees receiving long term institutional care (i.e., enrollees resided or remained long term in an institutional setting)?

State and Line of Business	Points Possible		Add 30 points if the Line of Business is Medicare-Medicaid or Medicare	Points Awarded
	Yes	No		
Entry 1 State: <i>Calif</i> Line of Business: <i>Medicare</i>	150		+ 30	150
Entry 2 State: <i>Oh</i> Line of Business: <i>Medicare</i>	150	X		

Autbor

Entry 3 State: <i>Calif</i> Line of business: <i>M Care</i>	150	X		
Total Points Awarded for Question 2: Sum of entries 1-3 shall not exceed 540 points.				150

3: Does the Applicant have at least 12 months of experience as of March 31, 2012 with using the following mechanisms to identify enrollees for care management?

Identification mechanism	Entry 1 State: <i>Calif</i> Line of business: <i>M Care</i>		Entry 2 State: <i>Calif</i> Line of business: <i>M Care</i>		Entry 3 State: <i>Calif</i> Line of business: <i>M Care</i>	
	Points Possible	Points Awarded	Points Possible	Points Awarded	Points Possible	Points Awarded
a. Health risk assessment Award zero points for any entry for which the Applicant did not attach a copy of the HRA(s) as requested.	35		35		35	
b. Administrative data assessment	30		30		30	
c. Predictive modeling software Award zero points for any entry which the Applicant did not provide the name of the predictive modeling software.	40		40		40	
	Provide name of predictive modeling software used: <i>Impact Pro</i>		Provide name of predictive modeling software used: <i>CC</i>		Provide name of predictive modeling software used: <i>CC</i>	
	<i>DXC.G</i>		<i>CC</i>		<i>CC</i>	
d. Provider, enrollee, or service agency referrals	35		35		35	

Autism

Identification mechanism	Entry 1		Entry 2		Entry 3	
	State: Line of business:					
	Points Possible	Points Awarded	Points Possible	Points Awarded	Points Possible	Points Awarded
e. Functional assessment that evaluates activities of daily living Award zero points for any entry for which the Applicant did not attach a copy of the functional assessment(s) as requested.	35		35		35	
Total Points Awarded for each entry (points may not exceed 175):		175		175		175
Sum of total points awarded for entries 1 – 3. (points may not exceed 525)	525					
Add 15 points if the Line of Business is Medicare-Medicaid or Medicare.	+15					
Total Points Awarded for Question 3: Sum of total points may not exceed 540.	540					

4. a. Does the Applicant have at least 12 months of experience as of March 31, 2012 with assessing the following domains for enrollees?

Assessment Domains	Entry 1	Entry 2	Entry 3
	State: Line of business:	State: Line of business:	State: Line of business:
	Cal Medicare	OH Medicare	Cal Medicare

Authora

Note: If the Applicant did not submit a copy of the assessment or did not highlight the location of each domain(s) for the applicable entry, award zero points for that domain and entry.	Calif		Chic		Louisiana	
	Yes	No	Yes	No	Yes	No
	Medicare		" "		" "	
i. Medical and behavioral health history	30	0	30	0	30	0
ii. Behavioral health needs	30	0	30	0	30	0
iii. Medical needs	30	0	30	0	30	0
iv. Functional needs	30	0	30	0	30	0
v. Cognitive needs	30	0	30	0	30	0
vi. Social needs	30	0	30	0	30	0
vii. Nutritional needs	30	0	30	0	30	0
viii. Long term services and supports	30	0	30	0	30	0
ix. Individual goals and preferences	30	0	30	0	30	0
x. Environmental or residential assessment	30	0	30	0	30	0
xi. Activities of daily living and/or instrumental activities of daily living capabilities	30	0	30	0	30	0
xii. Ability of the enrollee to self-direct community-based long term services and supports	30	0	30	0	30	0
xiii. Willingness/readiness to change	30	0	30	0	30	0
xiv. Discharge/transition plans	30	0	30	0	30	0
xv. Health and welfare	30	0	30	0	30	0
xvi. Natural supports, including family and community	30	0	30	0	30	0
xvii. Caregiver capabilities	30	0	30	0	30	0
xviii. Special communication needs	30	0	30	0	30	0
xix. Health literacy	30	0	30	0	30	0
Total Points Awarded for Each Entry Sum of points may not exceed 570.	570		570		570	

XX

On point-by-point review, team could not validate for item i in this entry or for (had entry) the 400 points not awarded for the 2 items.

540 540

Authem

Assessment Domains	Entry 1		Entry 2		Entry 3	
	State: Line of business:		State: Line of business:		State: Line of business:	
	Yes	No	Yes	No	Yes	No
Note: If the Applicant did not submit a copy of the assessment or did not highlight the location of each domain(s) for the applicable entry, award zero points for that domain and entry.						
Sum of total points awarded for entries 1-3. Total points may not exceed 1,710.					710 1650	
Add 190 points if line of business is Medicare-Medicaid or Medicare.					+190	
Total Points Awarded for Question 4a. Sum of total points may not exceed 1900.					1900 1840	

b. Does the Applicant have at least 12 months of experience as of March 31, 2012 with conducting an assessment using the following data sources?

Data Source	Entry 1		Entry 2		Entry 3	
	State: <i>Cal</i> Line of business: <i>McCare</i>		State: <i>Pa</i> Line of business: <i>U</i>		State: <i>Ill</i> Line of business: <i>U</i>	
	Yes	No	Yes	No	Yes	No
i. Enrollee	15	0	15	0	15	0
ii. Family/caregiver	15	0	15	0	15	0
iii. Medical records	15	0	15	0	15	0
iv. Administrative data (pharmacy, inpatient, emergency department, etc.)	15	0	15	0	15	0
v. Primary care providers	15	0	15	0	15	0
vi. Specialists	15	0	15	0	15	0
vii. Long term service and support providers	15	0	15	0	15	0
Total points awarded for each entry. (Sum of points may not exceed 105.)	105		105		105	

Antkowi

Data Source	Entry 1:		Entry 2:		Entry 3:	
	State:	Line of business:	State:	Line of business:	State:	Line of business:
	Yes	No	Yes	No	Yes	No
Sum of total points awarded for entries 1-3. (Sum of points may not exceed 315.)	315					
Add 35 points if a line of business is Medicare-Medicaid or Medicare	+ 35					
Total Points awarded for Question 4b. (Sum of total points may not exceed 350.)	350					

c. Does the Applicant have at least 12 months of experience as of March 31, 2012 with conducting an assessment using the following methods of collecting information from the enrollee?

Methods of data collection	Entry 1:		Entry 2:		Entry 3:	
	State:	Line of business:	State:	Line of business:	State:	Line of business:
	Yes	No	Yes	No	Yes	No
Home visit	60	0	60	0	60	0
Telephone	30	0	30	0	30	0
Form completed by the enrollee	10	0	10	0	10	0
Total points awarded for each entry. (Sum of points may not exceed 100.)	100		100		100	
Sum of total points awarded for entries 1-3. (Sum of points may not exceed 300.)	300					

Authem

Methods of data collection	Entry 1:		Entry 2:		Entry 3:	
	State: Line of business:		State: Line of business:		State: Line of business:	
	Yes	No	Yes	No	Yes	No
Add 50 points if a line of business is Medicare-Medicaid or Medicare.	+50					
Total Points awarded for Question 4c. (Sum of total points may not exceed 350.)	350					

Total Points for Questions 4a - 4c. Points may not exceed 2,600.	$1840 + 350 + 350 = 2540$
--	---------------------------

5. a. Does the Applicant have at least 12 months of experience as of March 31, 2012 with assigning enrollees to a risk/acuity level based on the results of the identification and/or assessment processes?

Response	Points Possible	Did Applicant indicate one state and line of business as reported in Appendix B? Insert yes or no. If no, then award zero points for Question 5a.	Points Awarded (0 or 100)
Yes	100		100
No	0		

- b. Does the Applicant have at least 12 months of experience as of March 31, 2012 with communicating the results of the assessment and the risk/acuity level assignment to enrollees?

Response	Points Possible	Did Applicant indicate one state and line of business, as reported in Appendix B? Insert yes or no. If no, then award zero points for Question 5b.	Points Awarded (0 or 135)
Yes	135	✓	135
No	0		

- c. Does the Applicant have at least 12 months experience as of March 31, 2012 with communicating the results of the assessment and the risk/acuity level assignment to enrollees' primary care providers?

Response	Points	Did Applicant indicate one state and line of	Points
----------	--------	--	--------

Author

	Possible	business as reported in Appendix B7. Insert a yes or no. If no, then award zero points for Question 5c.	Awarded (0 or 135)
Yes	135		135
No	0		

Total Points for Questions 5a - 5c. Points may not exceed 370.	= 370
---	-------

6. Does the Applicant have at least 12 months of experience as of March 31, 2012 with developing integrated, person centered care plans that address the components specified below?

Care Plan Component	State: <i>Cal</i> Line of business: <i>W/Case</i>		State: <i>Cal</i> Line of business: <i>"</i>		State: <i>Cal</i> Line of business: <i>"</i>	
	Yes	No	Yes	No	Yes	No
a. Established goals, interventions, and anticipated outcomes, with specified timeframes for completion that address clinical and non clinical needs (i.e., medical, behavioral, environmental, social, functional, long term services and supports, nutrition, etc.) and services identified in the comprehensive assessment. The goals, interventions and outcomes must reflect the individual's preferences.	165	0	165	0	165	0
b. Involvement and engagement of the enrollee and his/her support system in the development of the care plan. The enrollee's agreement with the initial and revised care plans shall be documented in the care plan.	165	0	165	0	165	0
c. Established communication plan, including anticipated frequency of contacts, with the enrollee, the primary care provider and, as appropriate, other providers.	165	0	165	0	165	0
d. A comprehensive approach to transitional care across settings to ensure communication among providers, primary care follow up, medication reconciliation, and timely provision of formal and informal supports.	165	0	165	0	165	0
e. Referrals for the enrollee to access social and community support services and validation that the enrollee received the necessary services.	165	0	165	0	165	0

Autism

Care Plan Component	State: Line of business:		State: Line of business:		State: Line of business:	
	Yes	No	Yes	No	Yes	No
f. A review of the initial and revised care plan with the enrollee, family/ caregiver, primary care provider, and specialists, as appropriate, while actively seeking input from them.	165	0	165	0	165	0
g. Continuous monitoring of service delivery and enrollee's adherence to the care plan to identify gaps between care recommended and care received, along with implementation of strategies to address the gaps in care.	165	0	165	0	165	0
h. Ensuring the care plan is accessible to the enrollee and all providers involved in managing the enrollee's care.	165	0	165	0	165	0
Total points awarded for each entry. Sum of total points may not exceed 1,320.	1320		"		"	
Sum of total points awarded for entries 1 – 3. Points may not exceed 3,960.	3,960					
Add 90 points if a line of business is Medicare-Medicaid or Medicare.	+ 90					
Grand Total points awarded. Sum may not exceed 4,050.	4050					

7. a. Does the Applicant have at least 12 months of experience as of March 31, 2012 with assigning a single accountable point of contact (i.e., a care manager) to each enrollee who helps the enrollee obtain medically necessary care, assists with health related services, coordinates care for the enrollee; disseminates information to the enrollee; and implements and monitors the care plan?

Response	Points Possible	Did Applicant indicate one state and line of business as reported in Appendix B? Insert yes or no. If no, then award 0 points for Question 7a.	Points Awarded (0 or 270)
Yes	270	✓	270
No	0		

b. Does the Applicant have at least 12 months of experience as March 31, 2012 with forming a trans-disciplinary team consisting of the enrollee, primary care provider, care manager and, as needed, specialists to effectively manage the enrollee's needs?

Authem

Response	Points Possible	Did Applicant Indicate one state and line of business as submitted in Appendix B? Insert yes or no. If no, then award 0 points for Question 7b.	Points Awarded (0 or 270)
Yes	270		
No	0		270

Total Points Awarded for 7a and 7b	= 540
------------------------------------	-------

8. a. Does the Applicant have at least 12 months of experience as of March 31, 2012 with conducting home visits with enrollees to either observe or assess them in their residential environment?

But no state & LOB given.

Response	Points Possible	Did Applicant Indicate one state and line of business as submitted in Appendix B? Insert yes or no. If no, then award 0 points for Question 8a.	Points Awarded (0 or 180)
Yes	180		
No	0		0

pts

- b. Does the Applicant have at least 12 months of experience as of March 31, 2012 with delivering care management services (e.g., medication reconciliation, health education, health coaching, etc.) in person with an enrollee in a residential setting or outpatient/inpatient facility?

Response	Points Possible	Did Applicant Indicate one state and line of business as submitted in Appendix B? Insert yes or no. If no, then award 0 points for Question 8b.	Points Awarded (0 or 180)
Yes	180		
No	0		180

Authem

- c. Does the Applicant have at least 12 months of experience as of March 31, 2012 with developing and implementing a communication plan to meet an enrollee's needs that included a combination of home visits, point-of-care visits (e.g., hospital, provider's office, etc.), email or internet communication, and telephonic outreach?

Response	Points Possible	Did Applicant Indicate one state and line of business as submitted in Appendix B? Insert yes or no. If no, then award 0 points for Question 8c.	Points Awarded (0 or 180)
Yes	180		180
No	0		

- d. Provide the following information related to home visits for one state and line of business as reported in Appendix B:

Inquiry:	Response
State/Line of Business/Population submitted for Appendix B:	Informational only. No points will be awarded for response.
Number of enrollees in care management in CY 2011:	Informational only. No points will be awarded for response.
Average number of home visits per enrollee in care management for CY 2011: Numerator: Total number of home visits conducted in CY 2011 Denominator: Total number of enrollees in care management in CY 2011	Informational only. No points will be awarded for response.
Average frequency of home visits per enrollee in care management for CY 2011: Numerator: Average number of home visits per month Denominator: Total number of enrollees in care management	Informational only. No points will be awarded for response.

Total points awarded for 8a – 8c. Points may not exceed 540.	## = 360
---	---------------------

Catherine

Catherine Appx D item #9 mislabeled as #5 - minor error overlooked

9. Does the Applicant have experience with contracting and delegating care management functions to a community-based entity (e.g., Center for Independent Living or Area Agencies on Aging) for long term services and supports?

Response	Points Possible	Did Applicant include the community based entity contact information? Insert yes or no. If no, then award 0 points for Question 9.	Points Awarded (0 or 540)
Yes	540		
No	0		540

by PRT

10. a. Does the Applicant have at least 12 months of experience as of March 31, 2012 in supporting a participant-directed care model for enrollees receiving home and community based long term services?

Response	Points Possible	Did Applicant Indicate one state and line of business as submitted in Appendix B? Insert yes or no. If no, then award 0 points for Question 10a.	Points Awarded (0 or 450)
Yes	450		
No	0		

b. If the response to Question 10.a. is YES, does the Applicant have at least 12 months of experience as of March 31, 2012 with evaluating whether the participant-directed care model was effective, as defined by criteria such as volume of services received, increased enrollee/family satisfaction, etc., for enrollees using this model?

Response	Points Possible	Did Applicant Indicate one state and line of business as submitted in Appendix B? Insert yes or no. If no, then award 0 points for Question	Points Awarded (0 or 450)
----------	-----------------	---	---------------------------

Cather

		10b.	
Yes	450		0
No	0		

c. If the response to Question 10.b. is YES, but the Applicant determined that the participant-directed care model was not effective for certain enrollees, does the Applicant have at least 12 months of experience as of March 31, 2012 with transitioning the enrollee to a traditional model of using providers who are employed by a home health or home care agency?

Response	Points Possible	Did Applicant Indicate one state and line of business as submitted in Appendix B? Insert yes or no. If no, then award 0 points for Question 10c.	Points Awarded (0 or 450)
Yes	450		0
No	0		

Total Points Awarded for Questions 10 a – c. Sum of points may not exceed 1,350.	0
--	--------------

11. Does the Applicant currently have an electronic care management system that collects the results of the assessment and the care plan, including goals, actions and completion dates and is linked to other databases or systems that the Applicant uses to maintain enrollee information?

Response	Points Possible	Did Applicant Indicate one state and line of business as submitted in Appendix B? Insert yes or no. If no, then award 0 points for Question 11.	Points Awarded (0 or 270)
Yes	270	✓	270
No	0		

Authem

12. a. The reviewer should evaluate information reported for a care management program for a Medicaid non-Long Term Care population for which the Applicant provided care management services:

Provide the following information for the Applicant's care management program that was evaluated:	Total Points Possible	Total Points Awarded
Date of care management program implementation: MM/YY	Informational only.	No points will be awarded.
Pre implementation measurement period: MM/YY to MM/YY	Informational only.	No points will be awarded.
Post implementation measurement period (must have occurred in CY 2010 or CY 2011): MM/YY to MM/YY	Informational only.	No points will be awarded.
Total number of individuals enrolled in the care management program during the post implementation measurement period.	Informational only.	No points will be awarded.
Percent of the overall population enrolled in the care management program during the post implementation time period. (Include the numerator and denominator.)	Informational only.	No points will be awarded.
Acuity/risk levels of individuals enrolled in the care management program	<input checked="" type="checkbox"/> Low – 0 points <input checked="" type="checkbox"/> Medium – 25 points <input checked="" type="checkbox"/> High – 50 points Total points may not exceed 50.	+ 50
<u>Indicator 1: Rate of hospital readmissions:</u>	Award 125 points if there was a decrease in the rate of hospital readmissions from the pre-implementation period to the post-implementation period. Award 0 points if the Applicant did not report a rate or did not report the numerator and denominator for the indicator.	+ 125

Caution

Provide the following information for the Applicant's care management program that was evaluated:	Total Points Possible	Total Points Awarded
<p><u>Indicator 2: Rate of emergency department visits</u></p> <p><i>No pre-implementation reported % rate of decrease cannot be determined</i></p>	<p>Award 125 points if there was a decrease in the rate of emergency department visits from the pre-implementation period to the post-implementation period.</p> <p>Award 0 points if the Applicant did not report a rate or did not report the numerator and denominator for the indicator.</p>	<p>0</p>
<p>Sum the total points. Points may not exceed 300.</p>		<p>175</p>

b. The reviewer should evaluate information reported for a care management program that was conducted for a Medicaid Long Term Care population for which the Applicant provided care management services:

Provide the following information for the Applicant's care management program that was evaluated:	Total Points Possible	Total Points Awarded
Date of care management program implementation: MM/YY	Informational only.	No points will be awarded.
Pre implementation measurement period: MM/YY to MM/YY	Informational only.	No points will be awarded.
Post implementation measurement period (must have occurred in CY 2010 or CY 2011): MM/YY to MM/YY	Informational only.	No points will be awarded.
Total number of individuals enrolled in the care management program during the post implementation measurement period.	Informational only.	No points will be awarded.
Percent of the overall population enrolled in the care management program during the post implementation time period.	Informational only.	No points will be awarded.

Arthem

Provide the following information for the Applicant's care management program that was evaluated:	Total Points Possible	Total Points Awarded
Acuity/risk levels of individuals enrolled in the care management program	___ Low – 0 points ___ Medium – 30 points <input checked="" type="checkbox"/> High – 60 points Total points may not exceed 60.	+60
<u>Indicator 1: Rate of hospital readmissions:</u>	Award 125 points if there was a decrease in the rate of hospital readmissions from the pre-implementation period to the post-implementation period. Award 0 points if the Applicant did not report a rate <u>or</u> did not report the numerator and denominator for the indicator.	0
<u>Indicator 2: Rate of emergency department visits</u>	Award 125 points if there was a decrease in the rate of emergency department visits from the pre-implementation period to the post-implementation period. Award 0 points if the Applicant did not report a rate <u>or</u> did not report the numerator and denominator for the indicator.	+125
<u>Indicator 3: Percent of individuals who reside in a nursing facility</u> <u>Indicator 4: Percent of individuals who reside in a community setting</u>	Award 200 points if the following two statements are true: The percent of individuals residing in a nursing facility decreased from the pre-implementation period to the post-implementation period. The percent of individuals residing in a community setting increased from the pre-implementation period to the post-implementation period.	0
Sum the total points. May not exceed 510 points.		= 185

Cutham

Part B: Patient-Centered Medical Home

Total points possible for Part B are 3,000.

Fill in the appropriate points based on the information submitted on the Appendix D form. Points will be awarded for each response based on the instructions provided for each question.

Question	Points Possible	Did the Applicant provide the contact information as requested? Insert yes or no. If no, then zero points will be awarded for the question.	Points Awarded
1	750	Not applicable.	750
2	450	Not applicable	450
3	300	Not applicable.	300
4	300	Not applicable.	300
5	150	✓	150
6	450	✓	450
7	150	✓	150
8	450	✓	450
Total Points			3,000

Answer

Sum of total points for 12 a and b. Total points may not exceed 810.	= 360
---	-------

13. Responses will be evaluated on whether the Applicant's submitted ICDS care management model does not meet, partially meets, meets, or exceeds the expectations expressed in the Appendix D form and the ICDS proposal and will assign the appropriate point value, as follows:

0 Does not meet expectations	40 Partially meets expectations	70 Meets Expectations	100 Exceeds Expectations
---------------------------------	------------------------------------	--------------------------	-----------------------------

The total score for question 13 will be the sum of the point value for all of the evaluation criteria.

Proposal acceptance criteria:

Was the Applicant's response in accordance with the following: 1) the submission guidelines specified in Section III.B.3, Essay Requirements, of this RFA; 2) the 20, double spaced page limitation; and 3) organized according to the instructions specified in this Appendix, Question 13 with sections clearly referenced and labeled?

Yes No

If the response is yes, proceed with evaluating the Applicant's response.

Evaluation Criteria	Weight	0 Doesn't Meet	40 Partially Meets	70 Meets Expectations	100 Exceeds Expectations	Points Awarded
Identification strategy						
The Applicant provided a description of the strategy to identify and prioritize the timeframe by which individuals will receive an initial comprehensive assessment.	4.5				✓ 100	450
The Applicant provided a description of the data that will be reviewed.	4.5			✓ 70		315
The Applicant provided a description of the criteria that will be used for case selection.	4.5				✓ 100	450
Comprehensive assessment						
The Applicant described its process for completing a comprehensive assessment of	5.4			✓ 70		378

Timeframes
Expedient
Strong
strategy
for
prioritiz
ing

1215

Comprehensive criteria - good review of polypharm cost

Antheim

Evaluation Criteria	Weight	0 Doesn't Meet	40 Partially Meets	70 Meets Expectations	100 Exceeds Expectations	Points Awarded
the enrollee's medical, behavioral health, long term services and supports, environmental and social needs with input from the enrollee, family members, caregiver, and providers.				✓ ↑		↑
The Applicant provided a summary description of the assessment tool.	5.4			✓ 70		378
The Applicant described the data sources that will be used.	5.4			✓ 70		378
The Applicant described how the assessment information will be collected.	5.4			✓ 70		378
The Applicant described the process for determining when to re-evaluate the enrollee's needs.	5.4			✓ 70		378
Risk/Acuity Levels						
The Applicant indicated the structure of the levels by providing number of levels and if they will be risk or acuity based.	2.25			✓ 70		157.5
The Applicant described the criteria for each of the risk/acuity levels.	2.25		✓ 40			90
The Applicant described how an enrollee will be assigned to the appropriate risk/acuity level.	2.25		✓ 40			90
The Applicant described how the risk/acuity level will be communicated to the enrollee.	2.25			✓ 70		157.5
The Applicant described how the risk/acuity level will be communicated to the primary care providers/specialists.	2.25		✓ 40			90
The Applicant indicated the minimum frequency of contacts—including face to face visits (in the residence or at the point of care), telephonic, etc.--established for each risk/acuity level.	2.25		✓ 40			90
Care Plan						
The Applicant described the process for developing and implementing an integrated,	5.5			✓ 70		↓

1890

6751

Authem

Evaluation Criteria	Weight	0 Doesn't Meet	40 Partially Meets	70 Meets Expectations	100 Exceeds Expectations	Points Awarded
person-centered care plan with the enrollee, family members, caregiver(s) and provider(s) that addresses needs identified in the comprehensive assessment with corresponding goals, interventions and outcomes.				✓		385
The Applicant described how the enrollee's preferences and preferred role in decision-making will be considered when developing the care plan.	5			✓ 70		350
The Applicant described how the enrollee and his/her supports will be included in the development and implementation of the initial and revised care plans.	5			✓ 70		350
The Applicant described how the enrollee's providers will be included in the development and implementation of the initial and revised care plan.	5			✓ 70		350
The Applicant identified how a communication plan will be established with the enrollee.	5			✓ 70		350
The Applicant described a process to monitor the care plan to determine: the quality of services provided in order to achieve progress toward person-centered goals and outcomes, adherence to evidence-based practices, existence of barriers to care, the need to manage transitions across settings, appropriate service utilization, etc	5			✓ 70		350
The Applicant described how gaps in care for an enrollee will be identified and addressed.	5			✓ 70		350
The Applicant described how the care plan will be continuously reviewed and revised.	5		✓ 40			200
Care Manager and Care Management Team						
The Applicant described the strategy to formulate a trans-	2.7					

2685

Rathem

Evaluation Criteria	Weight	0 Doesn't Meet	40 Partially Meets	70 Meets Expectations	100 Exceeds Expectations	Points Awarded
disciplinary care management team led by a care manager (i.e., accountable point of contact) designed to effectively manage the individual's services. The team shall consist of the beneficiary, the primary care provider, the care manager, LTSS service coordinators, and other providers, as appropriate.				✓		189
The Applicant described how the team composition and the care manager for each enrollee will be decided with examples of who may serve as members of the team and the care manager.	2.7		✓	70		189
The Applicant described the role of the care manager;	2.7		40	✓		108
The Applicant indicated whether care managers or members of the team will be field-based, centralized, or both.	2.7			✓	70	189
The Applicant identified the care management staffing ratios for each of the proposed acuity/risk levels.	2.7			✓	70	189
Communication Methods						
The Applicant described the use of innovative communication methods that are culturally and linguistically appropriate.	3.25			✓	70	227.5
The Applicant described how it will employ innovative communication methods that consider the unique needs of the enrollee.	3.25			✓	70	227.5
Managing Care Transitions						
The Applicant described a strategy to aggressively manage care transitions, including admissions and discharges from hospitals, nursing facilities, and other settings to ensure communication among providers, primary care follow up, medication reconciliation, timely provision of formal and informal in-home supports, etc.	7				100	700

864

455

100 ←

detailed role of clinicians need defined active role

Authem

Evaluation Criteria	Weight	0 Doesn't Meet	40 Partially Meets	70 Meets Expectations	100 Exceeds Expectations	Points Awarded
Medication Reconciliation						
The Applicant described a process to perform ongoing-medication reconciliation and employment of advanced pharmacy management programs, including medication therapy management, to increase adherence and eliminate contra-indicated drug use;	2.7			✓ 70	100	189
Care management system						
The Applicant described a care management system that captures the assessment and care plan content.	1.8			✓ 70		126
The Applicant described a care management system that links to other internal databases or systems that are used to maintain information about the enrollee.	1.8			✓ 70		126
The Applicant described a care management system that has the capability to produce a copy of the care plan when requested by the enrollee and the provider.	1.8			✓ 70		126
Program Evaluation						
The Applicant described a strategy to evaluate the impact of the care management program on Ohio's Medicare-Medicaid population with regard to health outcomes, enrollee satisfaction, enrollee's independent living status, functional status, and other quality indicators.	5.4			✓ 70		374
Grand Total of Points Awarded						9429

378

374

**Appendix D: Care Coordination
Summary Scoring Sheet**

Applicant Name: Autken

Part A: Care Management

Question	Points Possible	Points Awarded
1.	1,350	1150
2.	540	180
3.	540	540
4.	2,600	2,600 2540
5.	370	370
6.	4,050	4,050
7.	540	540
8.	540	360
9.	540	540
10.	1350	87
11.	270	270
12.	810	360
13.	13,500	9429
Total	27,000	20,329

Part B: Patient Centered Medical Home

Question	Points Possible	Points Awarded
1.	750	750
2.	450	450
3.	300	300
4.	300	300
5.	150	150
6.	450	450
7.	150	150
8.	450	450
Total	3,000	3,000

Grand Total for Appendix D:

Part A	20,329
Part B	3,000
Total Points	23,329

**Applicant Name: Anthem
Question 13 a - Scoring Table**

	Weight	0	40	70	100	Points Awarded
Identification Strategy						
Description of strategy to identify and prioritize the timeframe by which individuals will receive an initial comprehensive assessment	4.5				100	450
Description of the data that will be reviewed	4.5			70		315
Description of criteria that will be used for case selection	4.5				100	450
Comprehensive Assessment						
Description of process to complete a comprehensive assessment of the enrollee's medical, behavioral health, long term services and supports, environmental and social needs, with input from the enrollee, family members, care giver, and providers	5.4			70		378
Summary description of the assessment tool	5.4			70		378
Description of the data sources that will be used	5.4			70		378
Description of how the assessment information will be collected	5.4			70		378
Described the process for determining when to re-evaluate the member's needs	5.4			70		378
Risk/Acuity Levels						
Indicated the structure of the levels by providing number of levels and if they will be risk or acuity based	2.25			70		157.5
Described the criteria for each of the risk/acuity levels	2.25		40			90
Described how an enrollee will be assigned to the appropriate risk/acuity level	2.25		40			90
Described how the risk/acuity level will be communicated to the enrollee	2.25			70		157.5

Described how the risk/acuity level will be communicated to the primary care providers/specialists	2.25	40			90
indicated the minimum frequency of contacts	2.25	40			90
Care Plan					
Described process for developing and implementing a person-centered care plan with the enrollee, family members, caregivers, and providers that addresses needs identified in the comprehensive assessment with corresponding goals, interventions and outcomes.	5.5	70			385
Described how the enrollee's preferences and preferred role in decision making will be considered when developing the care plan	5	70			350
Described how the enrollee and his/her supports will be included in the development and implementation of the initial and revised care plans	5	70			350
Described how the enrollee's providers will be included in the development and implementation of initial and revised care plan	5	70			350
Identified how a communication plan will be established with the enrollee	5	70			350
Described a process to monitor the care plan to determine: the quality of services provided in order to achieve progress toward person centered goals and outcomes, adherence to evidence based practices, existence of barriers to care, the need to manage transitions across settings, appropriate utilization, etc.	5	70			350
Described how gaps in care will be identified and addressed	5	70			350
Described how the care plan will be continuously reviewed and revised.	5	40			200

Care Manager and Care Management Team							
Described the strategy to formulate a trans-disciplinary team led by the care manager (i.e., accountable point of contact) designed to effectively manage the individuals services. The team shall consist of the beneficiary, the primary care provider, LTSS service coordinators, and other providers as appropriate.	2.7			70		189	
Described how the team composition and the care manager for each enrollee will be decided with examples of who may serve as the members of the team and the care manager.	2.7		40	70		189	
Described role of the care manager.	2.7					108	
Indicated whether care managers or members of the team will be field based, centralized or both	2.7			70		189	
Identified the care management staffing ratios for each of the proposed acuity/risk levels.	2.7			70		189	
Communication Methods							
Described the use of innovative communication methods that are culturally and linguistically appropriate.	3.25			70		227.5	
Described how it will employ innovative communication methods that consider the unique needs of the member.	3.25			70		227.5	
Managing Care Transitions							
Described a strategy to aggressively manage care transitions, including admissions and discharges from hospitals, nursing facilities, and other settings to ensure communication among providers, primary care follow up, medication reconciliation, timely provision of formal and informal home supports, etc.	7				100	700	
Medication Reconciliation							

Described a process to perform ongoing medication reconciliation and employment of advanced pharmacy management programs, including medication therapy management, to increase adherence and eliminate contra-indicated use	2.7				70	189
Care Management System						
Described a care management system that captures the assessment and care plan content	1.8				70	126
Described a care management system that links to other internal databases or systems that are used to maintain information about the enrollee.	1.8				70	126
Described a care management system that has the capability to produce a copy of the care plan when requested by the enrollee and the provider	1.8				70	126
Program Evaluation						
Described a strategy to evaluate the impact of the care management program on Ohio's Medicare-Medicaid population with regard to health outcomes, enrollee satisfaction, enrollee's independent living status, functional status, and other quality indicators.	5.4				70	378
Grand Total						9429

Summary Scoring Sheet

Part A: Care Management

Question	Points Possible	Points Awarded
1	1350	1150
2	540	180
3	540	540

Anthem

4	2600	2540
5	370	370
6	4050	4050
7	540	540
8	540	360
9	540	540
10	1350	0
11	270	270
12	810	360
13	13500	9429
Total	27000	20329

Part B: Patient Centered Medical Home	Points Possible	Points Awarded
1	750	750
2	450	450
3	300	300
4	300	300
5	150	150
6	450	450
7	150	150
8	450	450
	3000	3000

Grand Total for Appendix D	
Part A	20329
Part B	3000
Total	23329

**Appendix E
TOTAL SCORE**

Enter scores from E-1 and E-2 below, and calculate the total score for Appendix E:

Applicant Anthem BlueCross/BlueShield

Section	Score
Total Score from E-1 (Cannot Exceed 2,500 Points)	Score 0 No essay provided
Total Score from E-2 (Cannot Exceed 2,500 Points)	1,668
TOTAL SCORE for Appendix E (Cannot Exceed 5,000)	Score 1,668

Applicant Anthem

Mark "X" if Applicant Indicated more than 12 months experience	Community-Based LTC Provider/Service Type	Enter 150 Points if Applicant Indicated a State and Line of Business Submitted in Appendix B (0 or 150 points)	Enter 163 Points if Applicant Indicated a second State and Line of Business Submitted in Appendix B (0 or 163)	Total Points (0, 150, or 313 per row)
	Adult Day Health Services			
	Assisted Living Services			
	Emergency Response Systems			
	Home Delivered Meals			
X	Homemaker/Housekeeping services	X		150
	Minor Home Modifications			
X	Non-Medical Transportation	X	X	313
X	Nurses affiliated with a Home Health Agency	X	X	313
X	Independent Nurses not affiliated with an agency	X		150
	Independent Aides not affiliated with a Home Health Agency			
X	Nutritional consultation	X	X	313
X	Out of Home Respite Services	X		150
X	Personal care aide services	X		150
X	Social work/Counseling	X	X	313
X	Supplemental Adaptive and Assistive Devices (i.e. lift chair, bath seat, grabber)	X		150
TOTAL (limited to a maximum of 2,500 points)				2002

Required Essay was not provided to validate these responses.

Ops

Anthem
2002

Anthem

Anthem did not provide an essay for E1 as required in the Q&A document page 26, Item 183.

E-2 - Incident Mgmt/Reporting - Plan says they have ~~Calif. MA.~~ - all 3 types - However, essay for E-2 does not validate plan's ~~past~~ ^{experience} of incident reporting -

~~Walden~~

Applicant Arthem

Mark "X" if Applicant indicated more than 12 months of each type of experience	Experience Type	Mark "X" if a State and Line of Business is indicated and this corresponds with information provided in Appendix B	Enter 834 points if the plan indicated at least 12 months experience and cited a State and Line of Business from Appendix B (0 or 834 per row)
<input checked="" type="checkbox"/>	Documenting and reporting individual incidents to the State or other oversight/investigative agency	<input checked="" type="checkbox"/>	834
<input checked="" type="checkbox"/>	Investigating individual incidents reported by individuals, providers and other entities and reporting outcomes to the state/oversight agency	<input checked="" type="checkbox"/>	— <i>Essay does not support experience in investigation</i>
<input checked="" type="checkbox"/>	Prevention planning or risk management for individuals receiving long term care services in community settings	<input checked="" type="checkbox"/>	834
(limited to a maximum of 2,500 points)			1,668

Appendix F
TOTAL SCORE

Applicant Cuthbert

Enter scores from F-1 and F-2 below, and calculate the total score for Appendix F:

Section	Score
Total Score from F-1 (Cannot Exceed 10,000 Points)	9,000
Total Score from F-2 (1)	2,500
(Cannot Exceed 10,000 Points) (2)	3,450
TOTAL SCORE for Appendix F (Cannot Exceed 20,000 Points)	14,950

14,950

F-1 Scoring Worksheet
Worksheet for Experience with Innovative Payment Methods
(Complete for each Method described)

Applicant Centim

Based on the sequence presented in the Application, which Innovative Payment Method is this:

First Second Third Fourth Fifth

A) Based on the description, answer the following questions:

a. What did the innovative payment method attempt to encourage? (Check all that apply)

- Preventative Care
- Care Coordination
- Health Promotion
- Individual Safety
- Quality of Care
- Improved Health Outcomes
- Accountable Care organizations
- Primary Care for Chronically Ill or High-Risk Individuals
- Effective Discharge Planning
- Avoidance of Unnecessary or Duplicative Services
- Other _____

b. What type of financial mechanism was used? (Check all that apply)

- Incentive Payments
- Penalties or Sanctions
- Shared Savings
- Comprehensive Care and Episode-Based Payments
- Global Payments
- Multi-Payer Collaborations
- Bundled Payments
- Risk-Adjusted Sub-Capitation
- Fee-for-Service
- Other _____

Anthem

If you indicated "Fee-for-Service" only, the method described does not qualify as an Innovative Payment Method for the purposes of this Appendix and no points may be awarded.

- c. If you checked, "Risk-Adjusted Sub-Capitation" above, were other financial mechanisms also used other than "Fee-for-Service"?

Yes No

- d. If you checked, "Risk-Adjusted Sub-Capitation" above, was this mechanism used as part of a comprehensively structured innovative approach that attempted to control costs, improve quality, or improve access to medically necessary services?

Yes No

If you answered "No" to both questions above, the method described does not qualify as an Innovative Payment Method for the purposes of this Appendix and no points may be awarded.

If you answered "Yes" to either question above, continue.

- e. Which provider types were affected by this Payment Method? (Check all that apply)

- Hospitals
- Nursing Facilities
- Physicians and other Clinicians
- Home- and Community-Based Service Providers
- Assisted Living Facilities
- Providers of Durable Medical Equipment
- Pharmacies
- Other _____

If none of the Provider types are checked above, the method described does not qualify as an Innovative Payment Method for the purposes of this Appendix and no points may be awarded.

Anthem

Based on your review thus far, if the method described: 1) was intended to promote efficiency or positive clinical outcomes, 2) relied on an acceptable financial mechanism, and 3) affected at least one of the provider types listed, the applicant scores: 1,000 points:

(Must be 0 or 1,000)

Look at the number of Provider Types checked under item "e." above. The applicant scores 500 points for each Provider Type checked:

(Must be 0 or a multiple of 500) [NOTE: Total Points across all Innovative Payment Methods Described will be limited to 2,500]

B) Did the Applicant indicate that the method associated with a line of business described in Appendix B?

Yes

No

If "Yes," which one? _____

per the Q&A, this would not be verified

C) Did the applicant indicate that the method resulted in Improved Clinical Outcomes?

Yes

No

If the answer above is "Yes," the applicant scores: 300 points:

(Must be 0 or 300)

D) Did the applicant indicate that the method resulted in a positive Return on Investment?

Yes

No

If the answer above is "Yes," the applicant scores: 200 points:

(Must be 0 or 200)

2,000

F-1 Scoring Worksheet
Worksheet for Experience with Innovative Payment Methods
(Complete for each Method described)

Applicant Ortman

Based on the sequence presented in the Application, which Innovative Payment Method is this:

First Second Third Fourth Fifth

A) Based on the description, answer the following questions:

a. What did the innovative payment method attempt to encourage? *(Check all that apply)*

- Preventative Care
- Care Coordination
- Health Promotion
- Individual Safety
- Quality of Care
- Improved Health Outcomes
- Accountable Care organizations
- Primary Care for Chronically Ill of High-Risk Individuals
- Effective Discharge Planning
- Avoidance of Unnecessary or Duplicative Services
- Other _____

b. What type of financial mechanism was used? *(Check all that apply)*

- Incentive Payments
- Penalties or Sanctions
- Shared Savings
- Comprehensive Care and Episode-Based Payments
- Global Payments
- Multi-Payer Collaborations
- Bundled Payments
- Risk-Adjusted Sub-Capitation
- Fee-for-Service
- Other _____

At Home

If you indicated "Fee-for-Service" only, the method described does not qualify as an Innovative Payment Method for the purposes of this Appendix and no points may be awarded.

- c. If you checked, "Risk-Adjusted Sub-Capitation" above, were other financial mechanisms also used other than "Fee-for-Service"?

Yes No

- d. If you checked, "Risk-Adjusted Sub-Capitation" above, was this mechanism used as part of a comprehensively structured innovative approach that attempted to control costs, improve quality, or improve access to medically necessary services?

Yes No

If you answered "No" to both questions above, the method described does not qualify as an Innovative Payment Method for the purposes of this Appendix and no points may be awarded.

If you answered "Yes" to either question above, continue.

- e. Which provider types were affected by this Payment Method? (Check all that apply)

- Hospitals
 Nursing Facilities
 Physicians and other Clinicians
 Home- and Community-Based Service Providers
 Assisted Living Facilities
 Providers of Durable Medical Equipment
 Pharmacies
 Other _____

If none of the Provider types are checked above, the method described does not qualify as an Innovative Payment Method for the purposes of this Appendix and no points may be awarded.

Attham

Based on your review thus far, if the method described: 1) was intended to promote efficiency or positive clinical outcomes, 2) relied on an acceptable financial mechanism, and 3) affected at least one of the provider types listed, the applicant scores: 1,000 points:

1,000 (Must be 0 or 1,000)

Look at the number of Provider Types checked under item "e." above. The applicant scores 500 points for each Provider Type checked:

500 (Must be 0 or a multiple of 500) [NOTE: Total Points across all Innovative Payment Methods Described will be limited to 2,500]

B) Did the Applicant indicate that the method associated with a line of business described in Appendix B?

Yes No

If "Yes," which one? _____

C) Did the applicant indicate that the method resulted in Improved Clinical Outcomes?

Yes No

reduced utilization (ED or inpt stays)

If the answer above is "Yes," the applicant scores: 300 points:

is used by PRT to indicate improved clinical outcomes

300 (Must be 0 or 300)

D) Did the applicant indicate that the method resulted in a positive Return on Investment?

Yes No

If the answer above is "Yes," the applicant scores: 200 points:

200 (Must be 0 or 200)

2,000

F-1 Scoring Worksheet
Worksheet for Experience with Innovative Payment Methods
(Complete for each Method described)

Applicant Autism

Based on the sequence presented in the Application, which Innovative Payment Method is this:

First Second Third Fourth Fifth

A) Based on the description, answer the following questions:

a. What did the innovative payment method attempt to encourage? (Check all that apply)

- Preventative Care
- Care Coordination
- Health Promotion
- Individual Safety
- Quality of Care
- Improved Health Outcomes
- Accountable Care organizations
- Primary Care for Chronically Ill or High-Risk Individuals
- Effective Discharge Planning
- Avoidance of Unnecessary or Duplicative Services
- Other _____

b. What type of financial mechanism was used? (Check all that apply)

- Incentive Payments
- Penalties or Sanctions
- Shared Savings
- Comprehensive Care and Episode-Based Payments
- Global Payments
- Multi-Payer Collaborations
- Bundled Payments
- Risk-Adjusted Sub-Capitation
- Fee-for-Service
- Other _____

Anthem

If you indicated "Fee-for-Service" only, the method described does not qualify as an Innovative Payment Method for the purposes of this Appendix and no points may be awarded.

c. If you checked, "Risk-Adjusted Sub-Capitation" above, were other financial mechanisms also used other than "Fee-for-Service"?

Yes No

d. If you checked, "Risk-Adjusted Sub-Capitation" above, was this mechanism used as part of a comprehensively structured innovative approach that attempted to control costs, improve quality, or improve access to medically necessary services?

Yes No

If you answered "No" to both questions above, the method described does not qualify as an Innovative Payment Method for the purposes of this Appendix and no points may be awarded.

If you answered "Yes" to either question above, continue.

e. Which provider types were affected by this Payment Method? (Check all that apply)

- Hospitals
- Nursing Facilities
- Physicians and other Clinicians
- Home- and Community-Based Service Providers
- Assisted Living Facilities
- Providers of Durable Medical Equipment
- Pharmacies
- Other _____

If none of the Provider types are checked above, the method described does not qualify as an Innovative Payment Method for the purposes of this Appendix and no points may be awarded.

Anthem

Based on your review thus far, if the method described: 1) was intended to promote efficiency or positive clinical outcomes, 2) relied on an acceptable financial mechanism, and 3) affected at least one of the provider types listed, the applicant scores: 1,000 points:

(Must be 0 or 1,000)

Look at the number of Provider Types checked under item "e." above. The applicant scores 500 points for each Provider Type checked:

(Must be 0 or a multiple of 500) [NOTE: Total Points across all Innovative Payment Methods Described will be limited to 2,500]

B) Did the Applicant indicate that the method associated with a line of business described in Appendix B?

Yes No

If "Yes," which one? _____

C) Did the applicant indicate that the method resulted in Improved Clinical Outcomes?

Yes No

If the answer above is "Yes," the applicant scores: 300 points:

(Must be 0 or 300)

D) Did the applicant indicate that the method resulted in a positive Return on Investment?

Yes No

If the answer above is "Yes," the applicant scores: 200 points:

(Must be 0 or 200)

= 2,200

F-1 Scoring Worksheet
Worksheet for Experience with Innovative Payment Methods
(Complete for each Method described)

Applicant Cathern

Based on the sequence presented in the Application, which Innovative Payment Method is this:

First Second Third Fourth Fifth

A) Based on the description, answer the following questions:

a. What did the Innovative payment method attempt to encourage? (Check all that apply)

- Preventative Care
- Care Coordination
- Health Promotion
- Individual Safety
- Quality of Care
- Improved Health Outcomes
- Accountable Care organizations
- Primary Care for Chronically Ill or High-Risk Individuals
- Effective Discharge Planning
- Avoidance of Unnecessary or Duplicative Services
- Other _____

b. What type of financial mechanism was used? (Check all that apply)

- Incentive Payments
- Penalties or Sanctions
- Shared Savings
- Comprehensive Care and Episode-Based Payments
- Global Payments
- Multi-Payer Collaborations
- Bundled Payments
- Risk-Adjusted Sub-Capitation
- Fee-for-Service
- Other _____

Anthem

If you indicated "Fee-for-Service" only, the method described does not qualify as an Innovative Payment Method for the purposes of this Appendix and no points may be awarded.

- c. If you checked, "Risk-Adjusted Sub-Capitation" above, were other financial mechanisms also used other than "Fee-for-Service"?

Yes No

- d. If you checked, "Risk-Adjusted Sub-Capitation" above, was this mechanism used as part of a comprehensively structured innovative approach that attempted to control costs, improve quality, or improve access to medically necessary services?

Yes No

If you answered "No" to both questions above, the method described does not qualify as an Innovative Payment Method for the purposes of this Appendix and no points may be awarded.

If you answered "Yes" to either question above, continue.

- e. Which provider types were affected by this Payment Method? (Check all that apply)

- Hospitals
- Nursing Facilities
- Physicians and other Clinicians
- Home- and Community-Based Service Providers
- Assisted Living Facilities
- Providers of Durable Medical Equipment
- Pharmacies
- Other _____

If none of the Provider types are checked above, the method described does not qualify as an Innovative Payment Method for the purposes of this Appendix and no points may be awarded.

Anthem

Based on your review thus far, if the method described: 1) was intended to promote efficiency or positive clinical outcomes, 2) relied on an acceptable financial mechanism, and 3) affected at least one of the provider types listed, the applicant scores: 1,000 points:

(Must be 0 or 1,000)

Look at the number of Provider Types checked under Item "e." above. The applicant scores 500 points for each Provider Type checked:

(Must be 0 or a multiple of 500) [NOTE: Total Points across all Innovative Payment Methods Described will be limited to 2,500]

B) Did the Applicant indicate that the method associated with a line of business described in Appendix B?

Yes No

If "Yes," which one? _____

C) Did the applicant indicate that the method resulted in Improved Clinical Outcomes?

Yes No

If the answer above is "Yes," the applicant scores: 300 points:

(Must be 0 or 300)

D) Did the applicant indicate that the method resulted in a positive Return on Investment?

Yes No

If the answer above is "Yes," the applicant scores: 200 points:

(Must be 0 or 200)

= 1,800

F-1 Scoring Worksheet
Worksheet for Experience with Innovative Payment Methods
(Complete for each Method described)

Applicant Centem

Based on the sequence presented in the Application, which Innovative Payment Method is this:

First Second Third Fourth Fifth

A) Based on the description, answer the following questions:

a. What did the innovative payment method attempt to encourage? (Check all that apply)

- Preventative Care
- Care Coordination
- Health Promotion
- Individual Safety
- Quality of Care
- Improved Health Outcomes
- Accountable Care organizations
- Primary Care for Chronically Ill or High-Risk Individuals
- Effective Discharge Planning
- Avoidance of Unnecessary or Duplicative Services
- Other _____

b. What type of financial mechanism was used? (Check all that apply)

- Incentive Payments
- Penalties or Sanctions
- Shared Savings
- Comprehensive Care and Episode-Based Payments
- Global Payments
- Multi-Payer Collaborations
- Bundled Payments
- Risk-Adjusted Sub-Capitation
- Fee-for-Service
- Other _____

Arthur

If you indicated "Fee-for-Service" only, the method described does not qualify as an Innovative Payment Method for the purposes of this Appendix and no points may be awarded.

c. If you checked, "Risk-Adjusted Sub-Capitation" above, were other financial mechanisms also used other than "Fee-for-Service"?

Yes No

d. If you checked, "Risk-Adjusted Sub-Capitation" above, was this mechanism used as part of a comprehensively structured innovative approach that attempted to control costs, improve quality, or improve access to medically necessary services?

Yes No

If you answered "No" to both questions above, the method described does not qualify as an Innovative Payment Method for the purposes of this Appendix and no points may be awarded.

If you answered "Yes" to either question above, continue.

e. Which provider types were affected by this Payment Method? (Check all that apply)

- Hospitals
- Nursing Facilities
- Physicians and other Clinicians
- Home- and Community-Based Service Providers
- Assisted Living Facilities
- Providers of Durable Medical Equipment
- Pharmacies
- Other _____

If none of the Provider types are checked above, the method described does not qualify as an Innovative Payment Method for the purposes of this Appendix and no points may be awarded.

Anthem

Based on your review thus far, if the method described: 1) was intended to promote efficiency or positive clinical outcomes, 2) relied on an acceptable financial mechanism, and 3) affected at least one of the provider types listed, the applicant scores: 1,000 points:

(Must be 0 or 1,000)

Look at the number of Provider Types checked under item "e." above. The applicant scores 500 points for each Provider Type checked:

(Must be 0 or a multiple of 500) [NOTE: Total Points across all Innovative Payment Methods Described will be limited to 2,500]

B) Did the Applicant Indicate that the method associated with a line of business described in Appendix B?

Yes No

If "Yes," which one? _____

C) Did the applicant indicate that the method resulted in Improved Clinical Outcomes?

Yes No

If the answer above is "Yes," the applicant scores: 300 points:

(Must be 0 or 300)

D) Did the applicant indicate that the method resulted in a positive Return on Investment?

Yes No

If the answer above is "Yes," the applicant scores: 200 points:

(Must be 0 or 200)

= 1,500

Anthem

Appendix F
Innovative Payment Methods

Scoring: Section F-2

- (1) ODJFS will award 500 points for each innovative payment method described for a specific provider type (for a maximum of 2,500 points)
- (2) ODJFS will award additional points based on the overall strength of each Applicant's vision for Ohio and the alignment of the proposed models with the State's goals. Each proposed method must be within the parameters set forth by ODJFS in the ICDS demonstration proposal.

Additional points will be awarded based on how well each proposed innovative payment method meets expectations to promote specific goals of this project. The ratings used will be: "does not meet," "partially meets," "meets," or "exceeds" expectations with points awarded as follows:

0 Does Not Meet Expectations	50 Partially Meets Expectations	100 Meets Expectations	150 Exceeds Expectations
---------------------------------	------------------------------------	---------------------------	-----------------------------

The total score for question F-2 will be the sum of the point value for all the evaluation criteria with some limits for maximum scores.

F-2
(1)

Provider Type	500 Points if a Provider-Specific Initiative was Described (0 or 500 per row)
Hospitals	✓
Nursing Facilities	✓
Physicians and Other Clinicians	✓
Home- and Community-Based Service Providers	✓
Assisted Living Facilities	✓
Providers of Durable Medical Equipment	✓
Pharmacies	✓
Other	✓
TOTAL	2,500

F-2, (1)

Authem

Innovative Payment Method for <u>HCBS</u> (first provider type addressed)					
Evaluation Criteria	0 Doesn't Meet	50 Partially Meets	100 Meets Expectations	150 Exceeds Expectations	Points Awarded (max per row is 150)
Keep people living in the community			100		
Increase individuals' independence			100		
Improve the delivery of quality care			100		
Reduce health disparities across all populations	C				
Improve health and functional outcomes			100		
Reduce preventable hospital stays, nursing facility admissions, and/or emergency room utilization			100		
Improve transitions across care settings			100		
Increase identification of depression and other mental health conditions		50			
Increase or improve care coordination			100		
Increase the accountability and responsibility of the primary care provider to maintain the individuals' overall health	D				
TOTAL (cannot exceed 1,500)					750

Authem

Innovative Payment Method for NF + (Center for Facil) (second provider type addressed)

Evaluation Criteria	0 Doesn't Meet	50 Partially Meets	100 Meets Expectations	150 Exceeds Expectations	Points Awarded (max per row is 150)
Keep people living in the community			100		
Increase individuals' independence			100		
Improve the delivery of quality care	0				
Reduce health disparities across all populations	0				
Improve health and functional outcomes			100		
Reduce preventable hospital stays, nursing facility admissions, and/or emergency room utilization			100		
Improve transitions across care settings			100		
Increase identification of depression and other mental health conditions	0				
Increase or improve care coordination			100		
Increase the accountability and responsibility of the primary care provider to maintain the individuals' overall health	0				
TOTAL (cannot exceed 1,500)					600

Innovative Payment Method for Physicians (third provider type addressed)

Evaluation Criteria	0 Doesn't Meet	50 Partially Meets	100 Meets Expectations	150 Exceeds Expectations	Points Awarded (max per row is 150)
Keep people living in the community	0				
Increase individuals' independence	0				
Improve the delivery of quality care			100		
Reduce health disparities across all populations	0				
Improve health and functional outcomes			100		
Reduce preventable hospital stays, nursing facility admissions, and/or emergency room utilization			100		
Improve transitions across care settings			100		
Increase identification of depression and other mental health conditions			100		
Increase or improve care coordination			100		

Centura

Increase the accountability and responsibility of the primary care provider to maintain the individuals' overall health				150	
TOTAL (cannot exceed 1,500)					750

Innovative Payment Method for <u>Pharmacies</u> (fourth provider type addressed)					
Evaluation Criteria	0 Doesn't Meet	50 Partially Meets	100 Meets Expectations	150 Exceeds Expectations	Points Awarded (max per row is 150)
Keep people living in the community		50			
Increase individuals' independence			100		
Improve the delivery of quality care			100		
Reduce health disparities across all populations	0				
Improve health and functional outcomes			100		
Reduce preventable hospital stays, nursing facility admissions, and/or emergency room utilization			100		
Improve transitions across care settings	0				
Increase identification of depression and other mental health conditions	0				
Increase or improve care coordination			100		
Increase the accountability and responsibility of the primary care provider to maintain the individuals' overall health	0				
TOTAL (cannot exceed 1,500)					550

Anthem

Innovative Payment Method for <u>Hospitals</u> (fifth provider type addressed)					
Evaluation Criteria	0 Doesn't Meet	50 Partially Meets	100 Meets Expectations	150 Exceeds Expectations	Points Awarded (max per row is 150)
Keep people living in the community			100		
Increase individuals' independence			100		
Improve the delivery of quality care			100		
Reduce health disparities across all populations	C				
Improve health and functional outcomes			100		
Reduce preventable hospital stays, nursing facility admissions, and/or emergency room utilization			100		
Improve transitions across care settings			100		
Increase identification of depression and other mental health conditions	C				
Increase or improve care coordination			100		
Increase the accountability and responsibility of the primary care provider to maintain the individuals' overall health			100		
TOTAL (cannot exceed 1,500)					800

750
 600
 750
 550
 800

 3450

TOTAL POINTS (Cannot exceed 7,500) 3,450
--

Exhibit D

7400 W Campus Rd.
Mail Code: F494
New Albany, Ohio 43054

Phone: (207) 200-0178
Fax: (860) 902-7758

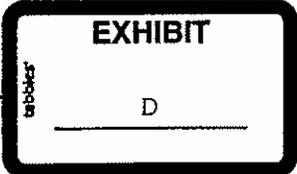
**Aetna Better Health
of Ohio**

Fax

To: Ohio Department of Job and Family Services Office of Contracts & Acquisitions RFA/RLB Unit 30 East Broad Street, 31st Floor Columbus, Ohio 43215	From: Jason Smith Aetna Better Health of Ohio 7400 W Campus Rd. Mail Code: F494 New Albany, Ohio 43054
Fax: 614-995-4876	Pages: 2 (Including Fax Cover Sheet)
Phone: N/A	Date: 6/05/2012
Re: RFA-Ohio Integrated Care Delivery System- Request for Clarification	cc: N/A

Urgent **For Review** **Please Comment** **Please Reply** **Please Recycle**

• **Comments:** The attached document includes Aetna Better Health of Ohio's response to the ODJFS Request for Clarification in reference to Integrated Care Delivery System RFA Number JFSR1213-07-8038.





Ohio Department of Job and Family Services
Fax Number: 614-995-4876
Office of Contracts & Acquisitions
RFA/RLB Unit
30 East Broad Street, 31st Floor
Columbus, Ohio 43215

June 6, 2012

Jason Smith
Senior Business Development Executive
Phone: 207-200-0178

7400 W Campus Rd. - Mail Code: F494
New Albany, Ohio 43054
SmithT6@AETNA.COM

AETNA BETTER HEALTH[®] OF OHIO

RE: RFA-Ohio Integrated Care Delivery System - Request for Clarification

Dear Mr. Tassie:

Aetna Better Health Inc., d/b/a Aetna Better Health of Ohio is pleased to respond to your request for clarification regarding our response to RFA Number JFSR1213-07-8038 for the Ohio Integrated Delivery System.

Our response to the following:

1. Do HEDIS measure results for CY 2010 exist for any Arizona Medicaid population?
Response: Yes, HEDIS results exist for a limited set of measures for CY 2010 for our Medicaid Arizona population.
2. If so, have the particular results undergone a HEDIS Compliance Audit conducted by an NCQA-Certified HEDIS Compliance Auditor (CHCA) and reported to NCQA's Interactive Data Submission System?
Response: No, the HEDIS results have not undergone a HEDIS Compliance Audit conducted by an NCQA-Certified HEDIS Compliance Auditor and reported to NCQA's IDSS.

Thank you for the opportunity to provide this clarifying information. If you have any questions, please contact me via phone at (207) 200-0178 or via email at SmithT6@aetna.com. Aetna Better Health of Ohio looks forward to working with ODJFS in supporting the State's vision for meeting the needs of Ohioans through the Ohio Integrated Care Delivery System.

Sincerely,

Jason Smith
Senior Business Development Executive

Exhibit E

Hospital admission rates through the emergency department: An important, expensive source of variation

Jesse M. Pines, MD, MBA, MSCE
 Mark Zocchi
 George Washington University
 AHRQ Annual Meeting

Disclosures / Funding

- AHRQ
- Robert Wood Johnson Foundation
- National Priorities Partnership on Aging
- Department of Homeland Security
- Kingdom of Saudi Arabia

Study team

- Ryan Mutter (AHRQ)
- Mark Zocchi (GWU)
- Andriana Hohlbauch (Thomson-Reuters)
- David Ross (Thomson-Reuters)
- Rachel Henke (Thomson-Reuters)

Introduction

- HCUP Data: 125 million ED visits in 2008
 - 15.5% admission rate
 - 19.4 million hospitalizations
 - ED visit growth outpacing population growth
- Why are EDs so popular?
 - Variable outpatient primary care availability
 - High-technology care has become the standard
 - Patient preferences / convenience

Introduction

- EDs are becoming the hospital's front door
- 2008 v. 1997
 - 43% of U.S. hospital admissions originated in the ED v. 37%
 - Mean charge per hospital stay - \$29,046 v. \$11,281.

Introduction

- Why are ED admissions important?
 - Variation in inpatient charges are one of the major drivers of cost variation



Welch NEJM 1993

Introduction

- Hospital Care Intensity (HCI)



www.dartmouthatlas.org

Introduction

- The perspective of the ED
- Why admit someone?
 - Requires hospital resources
 - Critically ill
 - Is unable to access a timely resource outside the hospital
 - Has a high-risk presentation
 - Other reasons

Introduction

- Variation in the decision to admit from the ED
 - 2-3 fold variation in the decision for primary care practices to hospitalize on emergency basis
 - Individual ED physician admission rates vary in Canada: 8% - 17%
 - Emergency physicians more likely to admit than family physicians or internal medicine physicians.
 - Differences in risk tolerance by individual physicians
 - Malpractice fear
 - Differences in patient & community resources

Introduction

- Three categories
 - Clear cut admissions
 - AMI, stroke, severely-injured trauma
 - Clear cut discharges
 - Minor conditions
 - The remainder
 - Shades of gray

Specific Aims

- Explore the regional variation in hospital-level ED admission rate across a wide sample of hospitals.
- Determine predictors the hospital-level ED admission rate
 - Hospital-level factors, ED case-mix, and age-mix, and local economic factors that may drive differences in admission rate
- Determine the contribution of local standards of care to explain hospital-level variation in admission rate

Methods

- HCUP Data from 2008
- All ED encounters from the 2,558 hospital-based EDs in the 28 states
 - Had a SID and a SEDD to HCUP in 2008
- Calculate an admission rate for each ED
 - Transfers Included as admissions

Methods

- Exclusions
 - EDs removed "atypical characteristics"
 - 639 EDs removed with an annual volume < 8,408, the 25th percentile
 - Removed 4 EDs with admit rate > 49%
 - HCUP requirements
 - Counties < 2 hospitals not appear in a map
 - Additional exclusions
 - Empirical analysis of the effects of local practice patterns on a facility's ED admission rate
 - Excluded 483 facilities that had the only ED in the county
- 1,376 EDs: Final sample

Methods

- Calculated variables
 - County-level ED admission rate
 - Age-mix proportions
 - Insurance proportions
 - Case-mix: 25 most common CCS categories
- Other characteristics
 - Hospital factors (2008 AHA survey)
 - Trauma-level (2008 TIEP survey)
 - Community-factors (2007-8 ARF)

Methods

- Mapped of ED admission rates at the county level.
- Each ED's admission rate was weighted by its annual volume
- Counties that did not have a sufficient number of EDs or which are in states that did not provide a SID and a SEDD are in gray

Methods

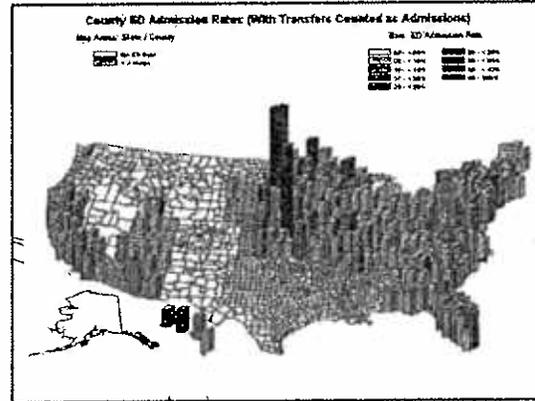
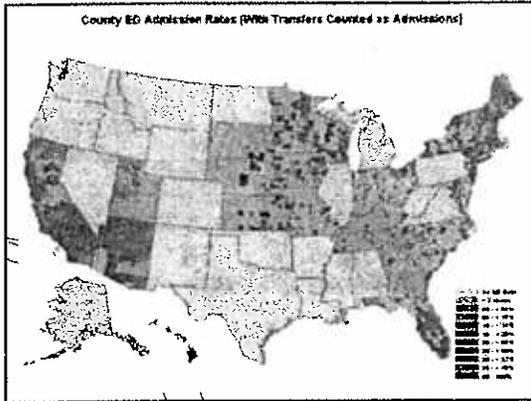
- Adjusted analysis
 - Other factors associated with variations in ED admission rates using multivariate analysis
 - Hospital-level ED admission rate (dependent variable).
 - Natural log of the dependent variable and the continuous independent variables so that the coefficients on the regressors are elasticities.
 - Clustered at the hospital-level

Results

Variable	Mean	Std. Dev.
Patient Characteristics of EDs		
% of ED encounters resulting in admission or transfer	17.5	6.5
% of ED encounters paid by Medicaid	21.7	7.18
% of ED encounters paid by Medicare	26.8	13.0
% of ED encounters paid by private insurance	24.8	13.8
% of ED encounters by the uninsured	18.9	9.0
% of ED encounters paid by other source	4.8	4.5
% of ED encounters aged 0 to 17	18.8	7.5
% of ED encounters aged 18 to 34	26.2	9.1
% of ED encounters aged 35 to 54	25.4	8.8
% of ED encounters aged 55 to 74	9.1	1.7
% of ED encounters aged 75+	18.4	7.0

Results

Hospital Characteristics of EDs	Mean	Std Dev
Number of hospitals beds	263.5	225.0
ED volume	40,804.8	26,482.8
% of EDs at teaching hospitals	31.8	46.3
% of EDs in an urban location	67.2	39.3
% of EDs at public hospitals	11.7	31.6
% of EDs at for-profit hospitals	15.3	36.8
% of EDs at non-profit hospitals	72.4	44.7
% of EDs at Level 1 trauma centers	8.9	28.3
% of EDs at Level 2 trauma centers	9.7	29.7
% of EDs at Level 3 trauma centers	2.6	24.4
% of EDs at long-term care centers	73.8	44.8
Geodemographic and Socioeconomic Characteristics of EDs		
% of ED encounters resulting in admission, county level with subject ED excluded	18.0	7.3
Per capita income, county level	\$29,954.1	11,264.7
General practice MDs providing primary care per 100,000, county level	29.1	19.8



Adjusted analysis

Variable	Coefficient	t-statistic
Intercept	1.746**	4.62
Patient Characteristics of EDs		
% of ED encounters paid by Medicare	0.236**	6.61
% of ED encounters paid by Medicaid	0.009	0.19
% of ED encounters by the uninsured	0.007	2.13
% of ED encounters paid by other source	0.012	1.50
% of ED encounters aged 0 to 17	0.001	0.04
% of ED encounters aged 18 to 34	-0.181*	-2.37
% of ED encounters aged 35 to 64	0.009	0.20
% of ED encounters aged 65 to 84	0.015	0.30

* p < .05
 ** p < .001
 *** p < .0001

Adjusted Analysis

Variable	Coefficient	T-Statistic
Intercept	1.746**	4.62
Hospital Characteristics of EDs		
Number of inpatient beds	0.000**	-4.08
ED volume	-0.000**	-4.08
Teaching hospital	0.081*	1.72
Urban location	0.004	0.13
Peripartograph	0.004*	1.76
Non-profit hospital	-0.013	-0.58
Level 1 trauma center	0.134**	4.66
Level 2 trauma center	0.014	0.64
Level 3 trauma center	0.006	0.27
Community- and Patient Characteristics of EDs		
% of ED encounters resulting in admission, county level with subject ED included	0.146**	4.78
Per capita income, county level	0.007	0.21
Population per 1000 primary care physicians per 100,000, county level	-0.002**	-3.85

* p < .05
 ** p < .001
 *** p < .0001

- ### Discussion
- Patient-level characteristics
 - % Medicare (higher -> higher)
 - % 18-34 (higher -> lower)
 - Hospital-level characteristics
 - Number of inpatient beds (higher -> higher)
 - ED volume (higher -> lower)
 - Teaching hospital (Yes -> higher)
 - Level 1 trauma center (Yes -> higher)

- ### Discussion
- Community-level characteristics
 - County-level admission rate (higher -> higher)
 - Number of primary care doctors (higher -> lower)

Conclusion

- There is tremendous variability in ED admission rates across 28 states
 - May be the most expensive, regular discretionary decision in U.S. healthcare
- Patient & Hospital-level factors predict admission rates
 - Medicare & hospitals more likely to receive admissions (trauma, teaching, larger)



Conclusion

- Community-factors
 - Significant standard of care effect
 - Impact of local primary care MDs



Future Directions

- Exploring specific diagnoses that may drive this impact
 - Pneumonia, DVT, Chest pain, others
- Testing solutions to control variation
 - Clinical decision rules
 - Enhancing care coordination

