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July 18, 2012

VIA HAND DELIVERY

Chief Legal Counsel
ODJFS Office of Legal & Acquisition Services
30 East Broad Street, 31st Floor
Columbus, Ohio 43215-0423

**Re: Written Protest of Scoring and Selection Methodology
Request for Applications Number: R1213078038**

Dear Mr. Spitzer:

We are writing on behalf of our client, WellCare of Ohio, Inc. (the "WellCare"), to respectfully protest the Ohio Department of Job and Family Services ("ODJFS") scoring of applications received in response to Request for Applications Number R1213078038 ("RFA"). The RFA was issued for the purpose of implementing a proposed Integrated Care Delivery System ("ICDS") for dually-eligible Medicare-Medicaid beneficiaries in the State of Ohio.

On July 3, 2012, ODJFS completed "Step Three" of its Selection Methodology following its publication of a grid of applicant scores which are separated into seven regions. Consistent with Section III.F. of the RFA and the extension of the protest period announced by ODJFS on July 6, 2012, this written protest is being submitted prior to 3:00 pm on Wednesday, July 18, 2012.

I. Required Information

Regions in Dispute:	All seven regions.
Protestor Contact Information:	WellCare of Ohio, Inc. 6060 Rockside Woods Boulevard North Suite 300 Independence, Ohio 44131 (216) 901-4141
Name / Number of RFA:	Request for Applications Number R1213078038 Ohio Integrated Care Delivery System

Request for Ruling / Form of Relief Sought: WellCare requests a ruling by ODJFS in response to this written protest. Regarding the form of relief sought, WellCare requests scoring corrections which are consistent with the information and analysis provided below.

All additional required information, including the detailed statement of the legal and factual grounds for this protest, is provided in the remaining portions of this letter. Copies of relevant documentation are also attached for reference purposes where appropriate.

II. Legal and Factual Grounds

ODJFS's Participating Plan Selection Team ("Selection Team") was charged with the difficult and arduous task of reviewing and scoring nine applications received in response to the RFA. WellCare appreciates the challenges which are inherent in conducting a large evaluation involving such a considerable amount of review, verification, analysis, and discussion.

By submitting this written protest, WellCare intends to engage the protest process set forth in the RFA pursuant to state and federal law. *See, e.g.*, 45 C.F.R. 92.36; Ohio Adm.Code 5101:3-26. Under such laws, the RFA procurement process must provide for full and open competition and avoid any actions which are arbitrary. 42 C.F.R. 92.36(c). The idea being, provide a full and open competition which results in the selection of responsible contractors who demonstrate integrity, relevant historical performance, and adequate resources. *Id.*

Consistent with state and federal law, WellCare believes ODJFS must (1) correct several scoring errors found within the Selection Team's final calculations, and (2) take steps to ensure WellCare's fair treatment in relation to several errors in the scoring of other applicants under Appendix B. Following WellCare's own in-depth review, it has been determined that WellCare should have been awarded higher scores and received a higher final ranking, especially within the Northeast Region. As the revised scores and rankings will demonstrate, WellCare is a responsible and highly-qualified selection for ODJFS. WellCare and its employees remain eager to support and assist ODJFS in the implementation of the new ICDS, which will help bridge the gap between two historically uncoordinated federally-funded programs in the State of Ohio.

1. Requested Scoring Corrections Relating to Calculation Errors by Selection Team

A. Appendix C, Table 1

Reference	Measure ID	ODJFS Selection Team Response	The Basis of WellCare's Protest
Appendix C, Table 1, Measure 1	Pneumonia Vaccination Status for Older Adults >= 65 Years of Age (HEDIS CAHPS Medicare Health Plan Survey)	Not validated.	The information submitted is correct and validated.
Appendix C, Table 1, Measure 24	Rating of Health Plan (HEDIS CAHPS Medicare Health Plan Survey)	Not validated by submission of additional CAHPS information.	The information submitted is correct and validated.

Appendix C provided applicants with the opportunity to submit HEDIS/CAHPS measure results to demonstrate experience with Medicare. Regarding WellCare, the Selection Team inaccurately scored Measures 1 (Pneumonia Vaccination) and 24 (Rating of Health Plan) under Appendix C, Table 1. (See WellCare Scoring Sheet, pp. 17, 19) (attached as Exhibit A). The information submitted by WellCare in relation to these measures is correct and validated, yet the Selection Team provided WellCare with zero points for both measures.

Regarding Measure 1, WellCare submitted a score of 68%. (WellCare's Executed Application, p. 35). Please refer to the Final Report for WellCare of Florida, Inc CAHPS Survey (Nov. 2011) (the "CMS CAHPS Report") (Tab 3 to WellCare's Executed Application) (attached as Exhibit B). The CMS CAHPS Report contains the Florida Medicare Advantage CAHPS results as reported by WellCare to the Centers for Medicare & Medicaid Services ("CMS"). WellCare's submitted score of 68% for Measure 1 came directly from the CMS CAHPS report. (CMS CAHPS Report, p. 68).

Regarding Measure 24, WellCare submitted a score of 2.43. (WellCare's Executed Application, p. 37). Please refer to the Survey Results for MA CAHPS for WellCare of Florida, Inc. (Oct. 2011) (the "CMS Survey Report") (Tab 4 to WellCare's Executed Application) (attached as Exhibit C). The CMS Survey Report contains the Florida NCQA 3 point score of 2.43, the same

number which was reported on WellCare's Executed Application. (CMS Survey Report, p 3; WellCare's Executed Application, p. 37).

On May 24, 2012, ODJFS released an alert containing its Clarification and Revision to Appendix C., Clinical Performance, Section I.a., Item 4, Instructions ("Appendix C Revision") (attached as Exhibit D). The Appendix C Revision states, in pertinent part:

Applicants must submit * * * (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 for Appendix C.* Applicants must obtain this information from their CAHPS vendor, and then directly submit this information to ODJFS. (Appendix C Revision, p. 1).

Consistent with the Appendix C Revision, WellCare provided an attestation letter dated May 25, 2012, from the Nicole Brown, Director of Quality and Compliance Myers Group ("WellCare's Attestation") (attached as Exhibit E). The Myers Group is WellCare's CMS-approved Medicare CAHPS vendor. WellCare's Attestation verifies the accuracy of the raw data provided to CMS by the Myers Group on WellCare's behalf, which is the same data reported to ODJFS in WellCare's Executed Application.

WellCare emphatically disagrees with the Selection Team's conclusion that Measures 1 and 24 were not validated. As described above, the results were official and final when originally submitted to CMS. Those results were subsequently verified through WellCare's Attestation.

WellCare's requested scoring correction is further supported by ODJFS's scoring of responses provided by CareSource. Like WellCare, CareSource reported scores in response to Measures 1 and 24 which were subsequently validated by an attestation letter dated May 24, 2012, also from Nicole Brown, Director of Quality and Compliance at the Myers Group ("CareSource's Attestation") (attached as Exhibit F). The only minor difference is that the CareSource's Attestation verifies the accuracy of the results submitted to ODJFS, whereas the WellCare Attestation verifies the accuracy of results submitted to CMS, and then directly submitted to ODJFS verbatim. The information submitted to CMS is identical to the information submitted to ODJFS. It is unclear why attestations were drafted differently by the Myers Group. Nevertheless, the result is the same. WellCare, like CareSource, submitted correct and validated scores in relation to Measures 1 and 24. WellCare's Attestation is from its CMS-approved Medicare CAHPS vendor, which has properly verified the accuracy of each set of results reported for Appendix C. Accordingly, WellCare respectfully requests that ODJFS award WellCare all available points in relation to Measures 1 and 24.

B. Appendix C, Section II

Appendix C, Section II provided applicants with the opportunity to submit details about experience with implementing structured quality improvement initiatives. Regarding WellCare, the Selection Team inaccurately scored WellCare’s recited experience with such initiatives.

Reference	ODJFS Evaluation/Scoring Criteria	ODJFS Selection Team Response	The Basis of WellCare’s Protest
Appendix C, Section II, 1.b.3.	Did the Applicant discuss the benchmarks and goals that the quality indicators were compared to throughout the initiative?	Two marks. Crossed out “Yes.” Check mark next to “No.”	Benchmarks and goals were discussed in WellCare’s Executed Application, pp. 41–42.
Appendix C, Section II, 1.d.2.	Did the results for each quality indicator show improvement that was statistically significant?	Check mark next to “No.”	Statistically significant improvements were discussed in WellCare’s Executed Application, pp. 42–43.
Appendix C, Section II, 3.a.2.	Did the Applicant discuss how the initiative specifically related to the organization’s membership?	Check mark next to “No.”	The initiative’s relationship to Florida Medicaid members was discussed in multiple instances in WellCare’s Executed Application, p. 46.
Appendix C, Section II, 3.b.2.	Did the Applicant discuss how the quality indicators were meaningful to monitoring success of the intervention?	Check mark next to “No.”	WellCare discussed how the quality indicators were meaningful to monitoring success in WellCare’s Executed Application, p. 47.
Appendix C, Section II, 3.b.3.	Did the Applicant discuss the benchmarks and goals that the quality indicators were compared to throughout the initiative?	Check mark next to “No.”	Benchmarks and goals were discussed in WellCare’s Executed Application, pp. 46, 49–50.

Appendix C, Section II, 3.e.	Did the Applicant report that the results of the quality improvement initiative were independently validated?	Check mark next to “No.”	WellCare reported that the SF-BH™ measurement tool has been independently validated, as discussed below.
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i. Section 1.b.3 (Initiative 1)

The Selection Team inaccurately scored WellCare under Section 1.b.3. (WellCare Scoring Sheet, p. 24). The Selection Team placed a check mark after “No” to indicate that WellCare did not discuss the benchmarks and goals which were used in relation to the initiative. This is an error.

Contrary to the scoring sheet, WellCare discussed benchmarks and goals. WellCare recounted its experience with a Hawaii-based initiative in which a WellCare subsidiary sought to reduce the number of nursing home admissions and stays and increasing the number of members receiving home and community based services (“HCBS”). (WellCare’s Executed Application, p. 40). WellCare identified two quality indicators, including (1) the total number of Hawaii Medicaid members who reside in a nursing facility, and (2) the total number of Hawaii Medicaid members receiving HCBS. (WellCare’s Executed Application, pp. 40–41).

As outlined in WellCare’s Executed Application, the benchmark and goal was “to achieve at least a 10 percent decrease in the total number of members residing in a NF and a corresponding increase in the total number of members receiving HCBS.” (WellCare’s Executed Application, p. 41). The narrative continues by providing detail on implementation steps which were undertaken to achieve the stated benchmarks and goals. This included, by way of example, setting up “comprehensive person-centered care plans,” “aggressive NF discharge planning,” and a process for ensuring that care plans “included an array of services to meet * * * medical, behavioral, functional, and psychosocial needs and forestall NF placement.” (WellCare’s Executed Application, pp. 41–42).

Interestingly, the Selection Team originally and correctly marked “Yes” in response to Section 1.b.3., indicating that WellCare appropriately discussed benchmarks and goals. Subsequently, “No” was checked. Based on the information provided above, ODJFS must revise the response in Section 1.b.3. by marking “Yes,” just as the Selection Team originally decided, and by awarding WellCare all available points.

ii. Section 1.d.2. (Initiative 1)

The Selection Team inaccurately scored WellCare under Section 1.d.2. (WellCare Scoring Sheet, p. 25). The Selection Team placed a check mark after “No” to indicate that WellCare’s results for the initiative’s quality indicators did not show statistically significant improvements. (Id.) This is an error.

To the contrary, WellCare reported data which demonstrated that the number of members who lived in a nursing facility dropped from 69% to 55% from 2009 to 2011, an impressive decrease equaling 14 percentage points. (WellCare's Executed Application, pp. 42–43). That decrease is well in excess of the stated benchmark and goal of 10%, discussed above. With respect to Section 1.d.2., WellCare has provided statistically significant results, as WellCare was servicing 60% of the Hawaii Medicaid beneficiary population. Accordingly, ODJFS must revise the Selection Team's response in Section 1.d.2. to a selection of "Yes" and award WellCare all available points.

iii. Section 3.a.2. (Initiative 3)

The Selection Team inaccurately scored WellCare under Section 3.a.2. (WellCare Scoring Sheet, p. 27). The Selection Team placed a check mark after "No" to indicate that WellCare did not discuss how the initiative specifically related to the organization's membership. (Id.). This is an error.

WellCare plainly discusses how the initiative relates to the membership. (WellCare's Executed Application, p. 46). Specifically, the initiative "targets members with acute psychiatric conditions who are at heightened risk for readmission, including members with" severe and persistent mental illness ("SPMI"). (WellCare's Executed Application, p. 46). The "Project Topic," after all, was the improvement of "health outcomes or quality of life indicators for WellCare of Florida Medicaid members* * * *" (Id.). The "Study Question" was also directly related to the membership, i.e., in attempting to answer whether the "implementation of intensive case management (ICM) intervention resulted in improved emotional health and a reduction in hospital readmissions for Florida Medicaid members with" SPMI. (Id.). Based on this information, ODJFS must revise the response in Section 3.a.2. to a selection of "Yes" and award WellCare all available points.

iv. Section 3.b.2. (Initiative 3)

The Selection Team inaccurately scored WellCare under Section 3.b.2. (WellCare Scoring Sheet, p. 28). The Selection Team placed a check mark after "No" to indicate that WellCare did not discuss how the quality indicators were meaningful to monitoring success of the intervention. (Id.). This is an error.

Contrary to the Selection Team's decision, WellCare discussed its use of members' self-reported health status, which was captured through SF-BH™, a measurement tool which allows members and providers to receive progress reports over time, which is meaningful to monitoring the overall success of the intervention. (WellCare's Executed Application, p. 47).

As discussed, "SF-BH™ is maintained in Magellan's secure web-based outcomes measurement system, which enables members to self-report their mental and physical health status and have current outcome summary reports available to themselves and their providers in order to monitor

progress over time.” (Id.). Using “the SF-BH™ assessment supports behavioral health outpatient treatment planning and outcomes measurement.” (Id.). Based on this information, ODJFS must revise the response in Section 3.b.2. to a selection of “Yes” and award WellCare all available points.

v. Section 3.b.3. (Initiative 3)

The Selection Team inaccurately scored WellCare under Section 3.b.3. (WellCare Scoring Sheet, p. 28). The Selection Team placed a check mark after “No” to indicate that WellCare did not discuss the benchmarks and goals which were used in relation to the quality improvement initiative. (Id.). This is an error.

Once again, WellCare discusses benchmarks and goals in its application. Most obviously, WellCare notes that implementation of the initiative is specifically geared towards “improved emotional health and a reduction in hospital readmissions for Florida Medicaid members with” SPMI. (WellCare’s Executed Application, p. 46). The initiative involved working closely with members to “identify care gaps and develop an Intensive Care Management plan with specific goals and interventions agreed to by the member.” (WellCare’s Executed Application, p. 49). This allowed for more detailed measurements of health outcomes, specifically in relation to emotional health improvement and hospital readmission rates. (WellCare’s Executed Application, p. 50). Of the 160 Florida Medicaid members who had assessments completed upon their intake and discharge, 75% experienced emotional health improvement. (WellCare’s Executed Application, p. 49). With respect to hospital readmissions, the rate declined by 27%. (WellCare’s Executed Application, p. 50). WellCare discussed its goals and met them. ODJFS must revise the Selection Team’s response in Section 3.b.3. to a selection of “Yes” and award WellCare all available points.

vi. Section 3.e. (Initiative 3)

The Selection Team inaccurately scored WellCare under Section 3.e. (WellCare Scoring Sheet, p. 28). The Selection Team placed a check mark after “No” to indicate that WellCare did not report that the results were independently validated. (Id.).

As discussed above, WellCare reported and discussed its use of the SF-BH™ measurement tool. (WellCare’s Executed Application, p. 50). WellCare specifically indicated that SF-BH™ is a “scientifically validated assessment instrument.” (Id.). The SF-BH™ measurement tool is based upon the QualityMetric Short Form (SF)-12® Health Survey, a nationally recognized instrument which has been scientifically validated.¹ WellCare’s results were validated by virtue of the underlying design of SF-BH™ itself. Based on this information, ODJFS must revise the response in Section 3.e. to a selection of “Yes” and award WellCare all available points.

¹ A Case Study: Magellan Health Services, Using the SF-BH Assessment to Measure Success and Prove Value, available at <http://www.qualitymetric.com/Portals/0/Uploads/Documents/Public/MagellanCaseStudy2.pdf> (stating “[i]t is a practical, reliable, and valid measure that is particularly useful in large populations.”)

C. Appendix D

Appendix D provided applicants with an opportunity to describe an “innovative” approach for providing the type of care management services which would be capable of monitoring and coordinating care for Ohio’s dually-eligible Medicare-Medicaid beneficiaries. The Selection Team inaccurately scored WellCare’s essay on the topic.

Reference	ODJFS Evaluation/Scoring Criteria	ODJFS Selection Team Response	The Basis of WellCare’s Protest
Appendix D, 13.b.	The applicant describes the process for determining when to re-evaluate the enrollee’s needs.	Partially Meets	The process is described in WellCare’s Executed Application, pp. 86–88, and 91–92.
Appendix D, 13.c.	The applicant described how the risk/acuity will be communicated to the enrollee.	Partially Meets	The communication or risk/acuity is described in WellCare’s Executed Application, pp. 88–89.
Appendix D, 13.d.	The applicant identified how a communication plan will be established with the enrollee.	Doesn’t Meet	The establishment of the communication plan is identified and described in WellCare’s Executed Application, pp. 85, 88–90.
Appendix D, 13.e.	The applicant described how the care plan will be continuously reviewed and revised.	Doesn’t Meet	The process is described in WellCare’s Executed Application, pp. 84, 86, 87–88, and 91–92.
Appendix D, 13.j.	The applicant described a care management system that links to other internal databases or systems that are used to maintain information about the enrollee.	Doesn’t Meet	WellCare’s Executed Application, pp. 82–84, 86, 90–92, and 99–100.

i. Appendix D, 13.b.

The Selection Team inaccurately scored WellCare under Appendix D, 13.b. (WellCare Scoring Sheet, p. 50). The Selection Team erroneously indicates that WellCare only “Partially Meets” the criteria that it must describe the process for determining when to re-evaluate the enrollee’s needs. (Id.). This is an error.

WellCare’s application directly addresses the process for determining when to re-evaluate enrollee needs. WellCare specifically explains the use of the PercolatorSM system and its role in combining data from over 800 algorithms to produce a daily output file that re-prioritizes intervention based on a member’s risk level and acuity. (WellCare’s Executed Application 86–88, 91–92). Further, WellCare noted that “Care Managers and Care Coordinators address identified triggers; and, depending on member health status, Care Managers may then administer additional assessments or conduct evaluations of the member’s social needs (stable housing, transportation, health literacy, caregiver support, community resources). (WellCare’s Executed Application, p. 88). The explanation of WellCare’s process for determining when to re-assess, re-stratify, and re-evaluate members is thorough and harnesses both modern computing/technology and human capital. The following passages from WellCare’s essay support a scoring correction by ODJFS:

We analyze the entire population daily to prioritize interventions.
(WellCare’s Executed Application, p. 86).

* * *

APS [APS Healthcare, Inc.] currently maintains over 800 algorithms that are available for use with the Percolator, such as HEDIS® performance measures and public domain measures such as the Prevention Quality Indicators published by the Agency for Healthcare Research and Quality. Application of these algorithms creates “triggers” that elevate the risk score for the individual member, prioritizing that member for interventions. * * * After stratification, CareConnection® and PercolatorSM work in unison to provide daily workflows for outreach. CareConnection® provides a workflow queue so Care Managers can begin outreach calls in the order of member need. (WellCare’s Executed Application, p. 87).

* * *

The reason why a member is prioritized through PercolatorSM vary from complex socioeconomic issues that impact members’ access to appropriate care to simpler needs for condition-specific education. Care Managers and Care Coordinators address

identified triggers; and, depending on member health status, Care Managers may then administer additional assessments or conduct evaluations of the member's social needs (stable housing, transportation, health literacy, caregiver support, community resources). By running the Percolator™ process *daily*, we continually reprioritize members for outreach. (WellCare's Executed Application, pp. 87–88) (Emphasis in original).

* * *

Because members' environments can change on a daily basis in ways that change their risk level and need for interventions, we re-stratify the population on a daily basis to take into account differences in care needs for every member. The Percolator™ then creates daily workflow queues for evidence-based clinical and non-clinical interventions. (WellCare's Executed Application, pp. 91–92).

WellCare's essay supplies a comprehensive description which details a thorough, impressive, and innovative, continuous, and real-time process for member re-evaluation. Based on this information, ODJFS must revise the Selection Team's response to "Meets Expectations," at a minimum, or "Exceeds Expectations," and correspondingly award WellCare all available points.

ii. Appendix D, 13.c.

The Selection Team inaccurately scored WellCare under Appendix D, 13.c. (WellCare Scoring Sheet, p. 50). The Selection Team erroneously indicates that WellCare only "Partially Meets" the criteria that it must describe how risk/acuity will be communicated to the enrollee. (Id.). This is an error.

Contrary to the Selection Team's decision, WellCare fully describes how risk/acuity will be communicated to the enrollee. The following passages from WellCare's essay support a scoring correction by ODJFS:

Helping members understand risk is important. We communicate directly with the member during a call or visit with Care Managers who are trained to discuss complex health issues. (WellCare's Executed Application, p. 88).

* * *

To communicate with members, we use Tier 1 (low risk), Tier 2 (moderate risk) and Tier 3 (high risk). These terms help members

understand their health status and priorities or care management. The table below shows proposed contacts by risk/acuity level.

Level	Minimum Frequency of Contact
Tier 3	Monthly Face-to-face - Care Manager Telephonic with Care Coordinator
Tier 2	Quarterly Telephonic - Care Manager/Care Coordinator
Tier 1	Semi-Annual Telephonic - Care Manager/Care Coordinator

Care Managers contact members based on members' individual needs with more frequent 'touches' for higher risk members. (WellCare's Executed Application, p. 89) (Emphasis in original.).

In the above excerpts, WellCare describes how a trained care manager will communicate directly with members during calls or visits. To further assist, WellCare communicates to members whether they are considered Tier 1 (low risk), Tier 2 (moderate risk), or Tier 3 (high risk). WellCare then supplies the above-referenced table which details the contact frequency according to an enrollee's risk/acuity level.

WellCare's essay supplies a comprehensive description of how risk/acuity will be communicated to the enrollee. ODJFS must revise the Selection Team's response to at least "Meets Expectations" and award WellCare all available points.

iii. Appendix D, 13.d.

The Selection Team inaccurately scored WellCare under Appendix D, 13.d. (WellCare Scoring Sheet, p. 50). The Selection Team erroneously indicates that WellCare "Doesn't Meet" the criteria that it must identify how a communication plan will be established with the enrollee. (Id.). This is an error.

WellCare's application identifies how the communication plan will be established and the medium through which enrollees will be contacted (phone, face to face, or electronic / digital exchanges). The following passages from WellCare's essay support a scoring correction by ODJFS:

We notify individuals of opportunities for assessment so members are aware of the activity and that it is authorized by their health plan. We contact members by telephone to schedule interviews, making at least three attempts. After three attempts, we work with

Member Services and members' physicians to obtain consent from the member to participate in an assessment. We track members' status and report on those who cannot be reached or who decline. Assessments are scheduled and conducted for members agreeing to participate, conducted by licensed clinical personnel trained in the assessment tool. For high and moderate risk members, a face-to-face assessment is optimal. Assessment of low risk members is conducted through a telephone interview. High and moderate risk members are offered this method if that is their preference. (WellCare's Executed Application, p. 85).

* * *

We communicate directly with the member during a call or visit with Care Managers who are trained to discuss complex health issues. (WellCare's Executed Application, p. 88).

* * *

Our approach incorporates evidence-based strategies to communicate with members, such as recommendations from the Academy of Family Practice, which include:

- Schedule discussions in the morning.
 - Present information clearly, in person, using lay language to convey medical concepts.
 - Summarize key points in writing as "leave behinds."
- (WellCare's Executed Application, p. 89).

* * *

Member interventions include but are not limited to the following:

- Face-to-face communication with individual members as appropriate based upon risk and diagnoses for which members are receiving care.
- Telephonic and other electronic and digital exchanges with APS [APS Healthcare, Inc.] Care Management Team (Care Managers, Utilization Management staff, care coordination staff) as appropriate.
- IVR or mailed campaigns to selected individual members.
- Face-to-face, telephonic, web-based (email or exchanges) or written communication with the member's provider based on need.

- Face to face, telephonic, web-based (email or exchanges) or written communication with the member's caregiver/social worker/ other representatives based on need and permissions. (WellCare's Executed Application, p. 90).

WellCare's essay identifies how a communication plan will be established with the enrollee. ODJFS must revise the Selection Team's response to at least "Meets Expectations" and award WellCare all available points.

iv. Appendix D, 13.e.

The Selection Team inaccurately scored WellCare under Appendix D, 13.e. (WellCare Scoring Sheet, p. 51). The Selection Team erroneously indicates that WellCare "Doesn't Meet" the criteria that it must describe how the care plan will be continuously reviewed and revised. (Id.). This is an error.

To the contrary, WellCare's essay describes a process that provides for continuous review of the care plan by ensuring that member health status indicators are analyzed daily and prioritized for intervention based on real-time information. WellCare also explains that if the member's health status indicator does not trigger a re-evaluation or a review of the care plan, then re-assessments will be performed on an annual basis. The following passages from WellCare's essay support a scoring correction by ODJFS:

We maintain evidence-based assessments for chronic conditions that are prevalent in this population. These assessments are updated as needed, and we conduct a comprehensive assessment on an annual basis that is used to evaluate the impact of the Care Management program. (WellCare's Executed Application, p. 84).

We analyze the entire population daily to prioritize interventions. (WellCare's Executed Application, p. 86).

* * *

APS [APS Healthcare, Inc.] currently maintains over 800 algorithms that are available for use with the Percolator, such as HEDIS® performance measures and public domain measures such as the Prevention Quality Indicators published by the Agency for Healthcare Research and Quality. Application of these algorithms creates "triggers" that elevate the risk score for the individual member, prioritizing that member for interventions. * * * After stratification, CareConnection® and PercolatorSM work in unison to provide daily workflows for outreach. CareConnection® provides a workflow queue so Care Managers can begin outreach calls in

the order of member need. (WellCare's Executed Application, p. 87).

* * *

The reason why a member is prioritized through PercolatorSM vary from complex socioeconomic issues that impact members' access to appropriate care to simpler needs for condition-specific education. Care Managers and Care Coordinators address identified triggers; and, depending on member health status, Care Managers may then administer additional assessments or conduct evaluations of the member's social needs (stable housing, transportation, health literacy, caregiver support, community resources). By running the PercolatorTM process *daily*, we continually reprioritize members for outreach. (WellCare's Executed Application, pp. 87–88) (Emphasis in original.).

* * *

Because members' environments can change on a daily basis in ways that change their risk level and need for interventions, we re-stratify the population on a daily basis to take into account differences in care needs for every member. The PercolatorTM then creates daily workflow queues for evidence-based clinical and non-clinical interventions. (WellCare's Executed Application, pp. 91–92).

WellCare provides a comprehensive description which details a thorough, continuous, and real-time process of how the care plan will be continuously reviewed and revised. ODJFS must revise the response to at least "Meets Expectations" and award WellCare all available points.

v. Appendix D, 13.j.

The Selection Team inaccurately scored WellCare under Appendix D, 13.j. (WellCare Scoring Sheet, p. 53). The Selection Team erroneously indicates that WellCare "Doesn't Meet" the criteria that it must describe a care management system that links to other internal databases or systems that are used to maintain information about the enrollee. (Id.). This is an error.

To begin, WellCare identifies and describes a care management system which will be known as APS CareConnection®. The following passages describe the system and its ability to communicate and gather information from other internal databases and systems:

APS CareConnection® is the care management system we propose for this project. It is a web-based, HIPAA-compliant system used

to administer risk stratification, assessment, and care planning. CareConnection® houses all relevant care management tools – data, guidelines and criteria, ICSPs [Integrated Care and Service Plans], health status assessments, communications, and interventions – in a single site accessible to all providers and the Care Team. Outreach policies and procedures are documented in CareConnection® and record each contact with members, providers, and other community resources. (WellCare’s Executed Application, pp. 99–100).

* * *

Information from a variety of sources is added to CareConnection® on a daily basis, including updates of claims data, utilization review results, assessment data, results of interventions, feedback and input from providers, and Care Manager/Care Coordinator notes and data. Because members’ environments can change on a daily basis in ways that change their risk level and need for interventions, we re-stratify the population on a daily basis to take into account differences in care needs for every member. The Percolator then creates daily workflow queues for evidence-based clinical and non-clinical interventions* * * *. Our integrated approach means we will have daily UM results. (WellCare’s Executed Application, pp. 90–92).

An abundance of additional detail about the integrated analytic approach is set forth in WellCare’s essay. (WellCare Executed Application, pp. 82–84, 86). WellCare’s provides a detailed description of the chosen care management system which will link to other internal databases and systems. ODJFS must revise the response to at least “Meets Expectations” and award WellCare all available points.

D. Appendix F, Section F-2 (Innovative Payment Methods)

Appendix F provided applicants with an opportunity to submit experience with implementing innovative payments systems and to detail their vision for implementing innovative payment proposals in the State of Ohio. The Selection Team inaccurately scored WellCare’s essay on the topic.

In relation to the initiatives reported by WellCare, the Selection Team erroneously evaluated WellCare’s essay under Appendix F, Section F-2, by choosing to award zero points in relation to the initiatives’ ability to “Increase Individuals’ Independence.” (WellCare Scoring Sheet, p. 82). WellCare’s innovative payment proposals for two provider types included specific structural features which demonstrate the ability of such initiatives to increase individuals’ independence.

To begin, consider WellCare's Innovative Payment Proposal 3, which involves nursing facilities. (WellCare's Executed Application, pp. 140–145). Under the proposal, nursing facilities would earn incentive payments for assisting in the transition of residents back home or to another community setting. (WellCare's Executed Application, p. 144). This transition would clearly result in greater independence for the affected members. In addition, nursing facilities could earn incentive payments for achieving a rating of four stars or higher on the CMS Star Quality rating system. (Id.). The rating system takes into consideration factors which have a direct impact on a resident's level of independence, including accidents, physical functioning, nutrition, and skin care. Finally, note that "Increase Independence" is listed as an "Integrated Care Quality Objective" for the same proposal. (WellCare's Executed Application, p. 143).

WellCare's Innovative Payment Proposal 4 involves HCBS providers. (WellCare's Executed Application, pp. 146–151). In this instance as well, one of the primary missions is to strive for individual independence. (WellCare's Executed Application, pp. 146, 148). Under the proposed methodology, WellCare provided a further incentive by rewarding providers for strong performance in the areas of fall prevention and ulcer prevention. (WellCare's Executed Application, p. 150). Both areas directly affect the independence of enrollees receiving HCBS.

WellCare's Innovative Payment Proposals 3 and 4 have structural features which demonstrate an ability to "Increase Individuals' Independence" as contemplated in Appendix F, Section F-2. ODJFS must revise the Selection Team's response to at least "Meets Expectations" and award WellCare all available points.

2. Requested Scoring Corrections Relating to Errors in the Scoring of Other Applicants Under Appendix B, Item 4

Appendix B provided applicants with an opportunity to submit experience and compliance histories which are relevant to dually-eligible Medicare-Medicaid beneficiaries. Part 1 to Appendix B requests information regarding current statewide operational experience for Medicare and Medicaid.

Under Appendix B, Part 1, Item 4, ODJFS requests that applicants check all applicable boxes for experience with relevant lines of business. WellCare responded accurately to Item 4 in relation to its lack of qualifying Medicaid experience for the Behavioral Health and LTC Institutional lines of business. Numerous other applicants, however, submitted the same non-qualifying Ohio-based Medicaid experience for the same lines of business and were erroneously awarded points by the Selection Team. This is an error in scoring and must be corrected.

The RFA definition of "Behavioral Health" includes several elements, including "partial hospitalization." (RFA, Appendix B, p. 2). Pursuant to Appendix G (Coverage and Services) of the ODJFS Managed Care Plan Provider Agreement, Ohio-based managed care plans were not providing partial hospitalization, which was listed as an excluded or limited item, not a coverage

or service which is part of the beneficiary benefit package.² No managed care plans operating in Ohio during the time periods specified in the RFA should have received any points for “Behavioral Health” experience.

The same is true in relation to the RFA definition of “LTC Institutional.” This service line is defined to mean long-term nursing facility services which are designed to meet an individual’s medical, personal, social, and safety needs. (RFA, Appendix B, p. 3). Pursuant to Ohio Adm.Code 5101:3-26-03(H) (attached as Exhibit G), when any member of a managed care plan is placed in a nursing facility, the managed care plan only has a very limited and abbreviated payment obligation, i.e., covered services until the last day of the month following admission. This obligation in Ohio cannot be characterized as qualifying experience with a comprehensive line of nursing facility services which meet residents’ medical, personal, social, and safety needs. This is simply not the role of managed care plans in Ohio under current law. No managed care plans operating in Ohio during the time periods specified in the RFA should have received any points for “LTC Institutional” experience.

These interpretations are supported by the Question and Answer dated May 10, 2012 (“Official Q&A”). The Official Q&A includes a question from WellCare which asks “If an Applicant provides a portion of services listed within a definition (e.g., dental exams but not orthodontia), should the box be checked?” (Official Q&A, p. 11). In response, ODJFS answered “No. The service being rendered must include all the core services listed in the definition.” (Id.).

Buckeye, United, CareSource, Molina, and Paramount received points erroneously for “Behavioral Health” experience in Ohio. United and Paramount also received points erroneously for “LTC Institutional” experience Ohio. All of these applicants submitted non-qualifying Medicaid experience and were erroneously awarded points by the Selection Team. ODJFS must correct these scoring errors by making scoring reductions where appropriate.

3. Requested Validation of Molina’s Reported Medicare Membership on Appendix B, Part II

Appendix B, Part II, provided applicants with an opportunity to report information regarding current health plan operations for Medicare Advantage, Medicaid, and commercial insurance in those regions for which an applicant is applying. WellCare respectfully requests that ODJFS validate information supplied by Molina in relation to its reported Medicare membership in the three regions. Specifically, WellCare is seeking validation of Molina’s reported Medicare membership for Pickaway, Madison, and Union Counties in the Central Region; Butler, Clermont, and Warren Counties in the Southwest Region; and Clark and Greene Counties in the West Central Regions.

² Ohio Department of Job and Family Services Ohio Medical Assistance Provider Agreement for Managed Care Plan, available at http://jfs.ohio.gov/ohp/bmhc/documents/pdf/Combined_Final_Generic_PA_7-01-09.pdf.

Based upon the CMS Enrollment File for April, 2012, it appears that Molina does not have active Medicare members in the above-referenced counties.³ To the extent that ODJFS is unable to validate Molina's reported Medicare membership, ODJFS must correct the scoring by make reductions as appropriate.

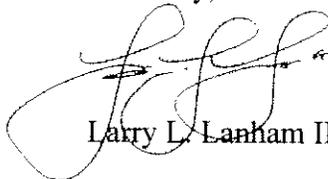
III. Conclusion

The information and analysis provided above demonstrate that scoring errors contained in the Selection Team's final calculations reduced WellCare's final score in all seven regions. The errors, considered as a whole, significantly decrease WellCare's final score and ranking. Moreover, the Selection Team awarded scores to numerous other applicants who submitted non-qualifying or nonexistent experience in response to the RFA. Had WellCare been properly awarded points, and other applicants not received points erroneously, WellCare would be well situated to be awarded a contract, especially within the Northeast Region.

WellCare respectfully requests that it be awarded all available points as outlined above or otherwise discovered by ODJFS during its protest review process. WellCare also respectfully requests that ODJFS make scoring appropriate reductions in relation to any points which have been erroneously awarded to other applicants by the Selection Team.

Should you have any questions or require additional information or clarification, please contact us at your earliest convenience.

Sincerely,



Larry L. Lanham II, Esq.

Enclosures

CC: William C. Epling
President, Ohio Region
WellCare of Ohio, Inc.

Donald A. Antrim, Esq.
Dinsmore & Shohl LLP

Robert C. Khayat, Jr., Esq.
Gregory K. Smith, Esq.
King & Spalding, LLP

³ CMS Medicare Advantage/Part D Contract and Enrollment Data, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDENrolData/Monthly-MA-Enrollment-by-State-County-Contract-Items/MA-Enrollment-by-SCC.html>.

LIST OF ATTACHMENTS

- Exhibit A:** WellCare Scoring Sheet
- Exhibit B:** Final Report for WellCare of Florida, Inc CAHPS Survey (Nov. 2011)
- Exhibit C:** Survey Results for MA CAHPS for WellCare of Florida, Inc. Based on NCQA Scoring Methodology
- Exhibit D:** Clarification and Revision to Appendix C., Clinical Performance, Section I.a., Item 4, Instructions.
- Exhibit E:** WellCare Attestation Letter from Nicole Brown, Director of Quality and Compliance at Myers Group (May 25, 2012).
- Exhibit F:** CareSource Attestation Letter from Nicole Brown, Director of Quality and Compliance at Myers Group (May 24, 2012).
- Exhibit G:** Ohio Adm.Code 5101:3-26-03

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EXHIBIT A

A

Scoring Sheet 1

Item 1: Applicant Name: WELLCARE

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 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 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"/>
	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 checked="" 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: 820 1,230 2,050

Item 5: ABD Medicaid 0.0% 0.0% 0.0%

Subtotals: 820 1,230 2,050

Item 6:	Member Months					
	Medicaid	1,177,191	1,218,381	1,221,185		
	Medicare	37,384	32,519	36,089		
	Total	0.0% 1,214,575	0.0% 1,248,900	0.0% 1,257,274		
Subtotals:		820	1,230	2,050		

Sum of All Calendar Year Scores 4,100.0 2,050

Item 7:	Admin Exp Ratio		OK	Medicaid	11.0%
		15.0%	Over	Medicare	21.4%

2011/2012

Subtotal:		3,485.0	
Item 8:	Part. Directed Care	0.0%	1 - 12 months <input type="checkbox"/> Greater than 12 months <input type="checkbox"/>

Subtotal:		3,485.0	
Item 9:	NCQA Accreditation	0.0%	None <input checked="" type="radio"/> Accredited <input type="radio"/> Commendable <input type="radio"/> Excellent <input type="radio"/>

Subtotal:		3,485.0	
Item 10:	Action Revoking License	0.0%	Check if "Yes" <input type="checkbox"/>

		3,485.0					
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: 2,439.5

Final Score (capped at Max Amount) **2,440**

Scoring Sheet 2

Item 1: Applicant Name: WELLCARE

Item 2: State: Florida

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 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 checked="" 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: 820 1,230 2,050

Item 5: ABD Medicaid 20.0% 20.0% 20.0%

Subtotals: 984 1,476 2,460

Item 6:	Member Months						
	Medicaid	4,655,549		4,234,981		4,093,154	
	Medicare	934,550		741,689		735,411	
	Total	0.0% 5,590,099		0.0% 4,976,670		0.0% 4,828,565	
	Subtotals:	984		1,476		2,460	

Sum of All Calendar Year Scores 4,920.0

Item 7:	Admin Exp Ratio				
		0.0%	OK	Medicaid	9.3%
			OK	Medicare	13.7%

WellCare
2

Subtotal:		4,920.0
Item 8:	Part. Directed Care	0.0% 1 - 12 months <input type="checkbox"/> Greater than 12 months <input type="checkbox"/>

Subtotal:		4,920.0
Item 9:	NCQA Accreditation	0.0% None <input checked="" type="radio"/> Accrediated <input type="radio"/> Commendable <input type="radio"/> Excellent <input type="radio"/>

Subtotal:		4,920.0
Item 10:	Action Revoking License	0.0% Check if "Yes" <input type="checkbox"/>

		4,920.0					
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: 3,444.0

Final Score (capped at Max Amount) **3,444**

Scoring Sheet 3

Item 1: Applicant Name:

Item 2: State:

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 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 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 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"/>
	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 checked="" 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: 820 1,230 2,050

Item 5: ABD Medicaid 0.0% Medicare 0.0%

Subtotals: 820 1,230 2,050

Item 6:	Member Months	CY 2009	CY 2010	CY 2011
	Medicaid	6,183,314	6,493,779	6,648,119
	Medicare	67,235	71,593	112,950
	Total	0.0% 6,250,549	0.0% 6,565,472	0.0% 6,761,069

Subtotals: 820 1,230 2,050

Sum of All Calendar Year Scores 4,100.0

Item 7:	Admin Exp Ratio	OK	Medicaid	9.8%
		Over	Medicare	17.7%

wellcare
3

Subtotal: 3,485.0

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

Subtotal: 3,485.0

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

Subtotal: 3,659.3

Item 10:	Action Revoking License	0.0%	Check if "Yes"	<input type="checkbox"/>
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3,659.3

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/ Nonrenewal	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%	<input type="checkbox"/>	0.0%

Value -30.0%

Subtotal: 2,561.5

Final Score (capped at Max Amount) **2,561**

Scoring Sheet 4

Item 1: Applicant Name: WELLCARE

Item 2: State: (none) HAWAII

Item 3:	Calendar Year: At least 3 Months	CY 2009		CY 2010		CY 2011	
		Months:	11	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 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 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"/>	
HCBS	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" 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: 900 1,350 2,250

Item 5: ABD Medicaid 20.0% 20.0% 20.0%

Subtotals: 1,080 1,620 2,700

Item 6:	Member Months	CY 2009		CY 2010		CY 2011	
	Medicaid	249,355		274,247		284,828	
	Medicare	6,800		7,503		21,302	
	Total	0.0% 256,155		0.0% 281,750		0.0% 306,130	
	Subtotals:	1,080		1,620		2,700	

Sum of All Calendar Year Scores 5,400.0 2,700

Item 7:	Admin Exp Ratio	15.0%	OK	Medicaid	4.0%
			Over	Medicare	9.7%

WILLIAMS
4

Subtotal:		4,590.0
Item 8:	Part Directed Care	20.0% 1 - 12 months <input type="checkbox"/>
		Greater than 12 months <input checked="" type="checkbox"/>
Subtotal:		5,508.0

Item 9:	NCQA Accrediation	2.5%	None <input type="radio"/>
			Accrediated <input checked="" type="radio"/>
			Commendable <input type="radio"/>
			Excellent <input type="radio"/>
Subtotal:		5,645.7	

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

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: 3,952.0

Final Score (capped at Max Amount): **3,952**

Scoring Sheet 5

Item 1: Applicant Name: WELLCARE

Item 2: State: New York

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 type="checkbox"/>	Medicaid	<input 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 checked="" type="checkbox"/>
		Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>	Medicare	<input checked="" type="checkbox"/>
	Dental	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"/>
	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 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"/>	
HCBS	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" type="checkbox"/>	Medicaid	<input checked="" 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: 860 1,290 2,350

Item 5:	ABD Medicaid	20.0%	<input checked="" type="checkbox"/>	20.0%	<input checked="" type="checkbox"/>	20.0%	<input checked="" type="checkbox"/>
Subtotals:		1,032		1,548		2,820	

Item 6:	Member Months						
	Medicaid	1,136,929		988,660		896,316	
	Medicare	293,817		232,465		246,114	
	Total	0.0% 1,430,746		0.0% 1,221,145		0.79 1,142,430	
Subtotals:		1,032		1,548		2,820	

Sum of All Calendar Year Scores 5,400.0

Item 7:	Admin Exp Ratio						
			15.0%	OK	Medicaid	9.5%	
				Over	Medicare	15.0%	

WELLS-FARGO
5

Subtotal: 4,590.0

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

Subtotal: 4,590.0

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

Subtotal: 4,590.0

Item 10:	Action Revoking License	0.0%	Check if "Yes"	<input type="checkbox"/>
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4,590.0

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: 3,213.0

Final Score (capped at Max Amount): **3,213**

Individual Score Sheet Blending

Name: WELLCARE

<u>Sheet</u>	<u>CY</u>	<u>Member Months</u>	<u>Weight</u>	<u>Score</u>	<u>Weighted Score</u>
1	11	1,257,274	8.79%	2,440.0	214.6
2	11	4,828,565	33.78%	3,444.0	1,163.3
3	11	6,761,069	47.30%	2,561.0	1,211.2
4	11	306,130	2.14%	3,952.0	84.6
5	11	1,142,430	7.99%	3,213.0	256.8
		<u>14,295,468</u>	100.00%		

Total Blended Score

2,930.5

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

3,000

3,000

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

7,500

7,500

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

Wellcare

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

10,000

10,000

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

3,750

3,750

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

12,000

12,000

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

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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.

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			

	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.			

wellcare

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

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)		141,4474 not calculated
2	Care for Older Adults: Advance Care Planning		350 ✓
3	Care for Older Adults: Medication Review		175 ✓
4	Care for Older Adults: Functional Status Assessment		0 ✓
5	Care for Older Adults:		175 ✓

	Pain Screening		
6	Adults' Access to Preventive/Ambulatory Health Services: Total		339,473.7
7	Osteoporosis Management in Women Who Had a Fracture		226,315.8
8	Medication Reconciliation Post-Discharge		560
9	Use of High-Risk Medications in the Elderly: At Least One High-Risk Medication		226,315.8
10	Use of High-Risk Medications in the Elderly: At Least Two or More Different High-Risk Medications		226,315.8 ✓
11	Antidepressant Medication Management - Effective Acute Phase Treatment		113,157.9
12	Antidepressant Medication Management - Effective Continuation Phase Treatment		113,157.9 not submitted
13	Follow-Up After Hospitalization for Mental Illness within 7 Days of Discharge		226,315.8
14	Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)		226,315.8
15	Comprehensive Diabetes Care - HbA1c control (<8.0%)		339,473.7
16	Comprehensive Diabetes Care - LDL-C		226,315.8

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	control (<100 mg/dL)		
17	Controlling High Blood Pressure		226 3158
18	Cholesterol Management for Patients with Cardiovascular Conditions- LDL Control <100		226 3158
19	Persistence of Beta-Blocker Treatment After a Heart Attack		226.3158
20	Pharmacotherapy Management of COPD Exacerbation: Dispensed a Systemic Corticosteroid Within 14 Days of the Event		113.1579
21	Pharmacotherapy Management of COPD Exacerbation: Dispensed a Bronchodilator Within 30 Days of the Event		113 1579
22	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation of AOD Treatment (18 + Years)		0
23	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Engagement of AOD Treatment: (18 + Years)		113 1579
24	Rating of Health Plan (HEDIS CAHPS Medicare Health Plan Survey)		

~~197 4474~~
not validated
by Medicare
CAHPS
198

wc

TOTAL Score		4711.30
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END

(- 141,4474)
(- 141,4474)

4428.4212

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.

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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		570	✓
2	Antidepressant Medication Management - Effective Acute Phase Treatment		380	✓
3	Antidepressant Medication Management - Effective Continuation Phase Treatment		380	✓
4	Follow-Up After Hospitalization for Mental Illness within 7 Days of Discharge		760	✓
5	Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)		380	✓

welfare

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

W & H care

15	Rating of Health Plan-Adult (HEDIS CAHPS Medicaid Health Plan Survey)		350	✓
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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	#4		760
2	#1		570
3	#2		380
4	#3		380
5	#5		380
TOTAL Score			2470

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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

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?

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

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.

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?

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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

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.

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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.	400 (Handwritten: 400)
1.b.	0 (Handwritten: 0)
1.c.	400 (Handwritten: 400)
1.d.	0 (Handwritten: 0)
1.e.	0 (Handwritten: 0)

welfare

	Total for First Quality Improvement Initiative	
3	2.a.	6,573 (110 d. 12, 11/11/11)
		0
3	2.b.	0
		0
3	2.c.	400
		0
3	2.d.	0
		0
3	2.e.	0
		0
	Total for Second Quality Improvement Initiative	400
		0
4	3.a.	0
		0
4	3.b.	0
		0
4	3.c.	0
		0
4	3.d.	0
		0
4	3.e.	0
		0
	Total for Third Quality Improvement Initiative	0

TL. 1,200

Well Care

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:

- 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>Hawaii</i> State: <i>Medicaid</i> Line of Business:	Acute care	100	0	400	
	Behavioral health care	100	0		
	Long term services and supports (only one entry may be selected)	Community and institutional	200		0
		Community only	100		0
		Institutional only	100		0
Add 50 points if the Line of Business is Medicare-Medicaid or Medicare.				400	
Total Points Awarded for Entry 1 (may not exceed 450):					
Entry 2: <i>NY</i> State: <i>Medicaid</i>	Acute care	100	0	400	
	Behavioral health care	100	0		
	Long term services and supports	Community and institutional	200		0

Wellcare

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	400	
	Institutional only	100	0		
Add 50 points if the Line of Business is Medicare-Medicaid or Medicare.				/	
Total Points Awarded for Entry 2 (may not exceed 450):				400	
Entry 3: State: <i>Oh</i> Line of Business: <i>Medicaid</i>	Acute care	100	0		
	Behavioral health care	100	0		
	Long term services and supports (only one entry may be selected)	Community and institutional	200	0	
		Community only	100	0	
		Institutional only	100	0	
Add 50 points if the Line of Business is Medicare-Medicaid or Medicare.				/	
Total Points Awarded for Entry 3 (may not exceed 450):				200	
Total Points Awarded for Question 1				1,000	
Sum of entries 1-3 shall not exceed 1,350 points.					

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 Total points awarded for each row may not exceed 180.
	Yes	No		
Entry 1 State: <i>Hawaii</i> Line of business: <i>Medicaid</i>	150		/	150
Entry 2 State: <i>NY</i> Line of business: <i>Medicaid</i>	150		/	150

Wellness

Entry 3 State: <i>IL</i> Line of business: <i>M'Care</i>	150	<i>/</i>		<i>0</i>
Total Points Awarded for Question 2: Sum of entries 1-3 shall not exceed 540 points.				<i>300</i>

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		Entry 2		Entry 3	
	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.	<i>35</i>		<i>35</i>		<i>35</i>	
b. Administrative data assessment	<i>30</i>		<i>30</i>		<i>30</i>	
c. Predictive modeling software Award zero points for any entry which the Applicant did not provide the name of the predictive modeling software.	<i>40</i>	<i>/</i>	<i>40</i>		<i>40</i>	
	Provide name of predictive modeling software used: <i>X</i>		Provide name of predictive modeling software used: <i>CDPS</i>		Provide name of predictive modeling software used: <i>CDPS</i> <i>CDPS</i>	
d. Provider, enrollee, or service agency referrals	<i>35</i>		<i>35</i>		<i>35</i>	

11/20/09

Identification mechanism	Entry 1		Entry 2		Entry 3	
	State: Line of business:		State: Line of business:		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):		135		175		175
Sum of total points awarded for entries 1 – 3. (points may not exceed 525)	485					
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.	500					

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: <u>Hawaii</u> Line of business: ←	State: <u>NY</u> Line of business: ←	State: <u>OH</u> Line of business: ← <u>Medicaid/Medicare</u>

Wellcare

<p>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.</p>	Yes	No	Yes	No	Yes	No
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
<p>Total Points Awarded for Each Entry Sum of points may not exceed 570.</p>	450	0	420	0	360	0

450

420

360
= 1230

not calculated for Ohio
not calculated in further
67CH

not calculated for NY

William

Assessment Domains	Entry 1		Entry 2		Entry 3	
	State:		State:		State:	
	Line of business:		Line of business:		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.	1570 1230					
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.	1710 = 1420 1,700					

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: GA		State: Hawaii		State: OH	
	Line of business: M. Card & M. Care		Line of business: u *		Line of business: R H	
	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.)	90		105		105	

William

Data Source	Entry 1:		Entry 2:		Entry 3:	
	State:		State:		State:	
	Line of business:		Line of business:		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.)	300					
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.)	= 335					

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:		State:		State:	
	Line of business:		Line of business:		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.)	90		100		100	
Sum of total points awarded for entries 1-3. (Sum of points may not exceed 300.)	= 290					

Wellcare

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.)	= 280					

Total Points for Questions 4a – 4c. Points may not exceed 2,600.	$1420 + 335 + 280 = 2035$
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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
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Well care

	Possible	business as reported in Appendix B? 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
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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: Line of business: <i>So</i>		State: Line of business: <i>Stone</i>		State: Line of business:	
	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

11/11/11

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		1320		1320	
Sum of total points awarded for entries 1 - 3. Points may not exceed 3,960.	3960					
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		
No	0		270

- 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?

Wellcare

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		270
No	0		

Total Points Awarded for 7a and 7b	540
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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?

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		180
No	0		

- 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		180
No	0		

2.11.11

- 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		
No	0		180

- 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.	
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Willow

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	✓	540
No	0		

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	✓	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)
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Wellcare

		10b.	
Yes	450	✓	450
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	✓	450
No	0		

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

WellCare

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
Indicator 1: Rate of hospital readmissions:	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 <i>decrease</i>

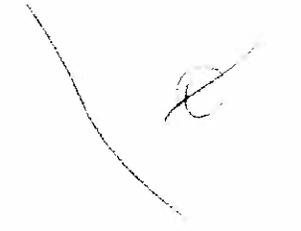
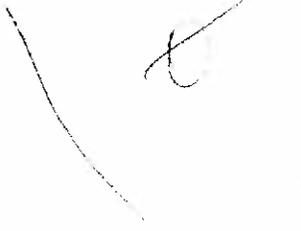
11/20/11

Provide the following information for the Applicant's care management program that was evaluated:	Total Points Possible	Total Points Awarded
Indicator 2: Rate of emergency department visits	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 or did not report the numerator and denominator for the indicator.	125 decrease
Sum the total points. Points may not exceed 300.		300

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.

Willow

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	<input checked="" type="checkbox"/> Low - 0 points <input checked="" type="checkbox"/> 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 or did not report the numerator and denominator for the indicator.	
<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 or did not report the numerator and denominator for the indicator.	
<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.	200
Sum the total points. May not exceed 510 points.		260

Well care

Sum of total points for 12 a and b. Total points may not exceed 810.	560
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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
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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			✓ 70		315
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			✓ 70		315
Comprehensive assessment						
The Applicant described its process for completing a comprehensive assessment of	5.4					

Willow

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.				✓ 70		378
The Applicant provided a summary description of the assessment tool.	5.4			✓		378
The Applicant described the data sources that will be used.	5.4			✓		378
The Applicant described how the assessment information will be collected.	5.4			✓		378
The Applicant described the process for determining when to re-evaluate the enrollee's needs.	5.4		✓ 40			216
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			✓		157.5
The Applicant described the criteria for each of the risk/acuity levels.	2.25		✓			90
The Applicant described how an enrollee will be assigned to the appropriate risk/acuity level.	2.25			✓		157.5
The Applicant described how the risk/acuity level will be communicated to the enrollee.	2.25		✓ 40			90
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			✓ 70		157.5
Care Plan						
The Applicant described the process for developing and implementing an integrated,	5.5					

Wellness

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.			40 ✓			220
The Applicant described how the enrollee's preferences and preferred role in decision-making will be considered when developing the care plan.	5		40 ✓			200
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		40 ✓			200
The Applicant described how the enrollee's providers will be included in the development and implementation of the initial and revised care plan.	5		40 ✓			200
The Applicant identified how a communication plan will be established with the enrollee	5	0				0
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		40 ✓			200
The Applicant described how gaps in care for an enrollee will be identified and addressed	5		40 ✓			200
The Applicant described how the care plan will be continuously reviewed and revised.	5	0				0
Care Manager and Care Management Team						
The Applicant described the strategy to formulate a trans	2.7					

Wellcare

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.				✓ 70		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		✓			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		✓ 40			135
The Applicant described how it will employ innovative communication methods that consider the unique needs of the enrollee.	3.25		✓ 40			130
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			✓ 70		490

WellCare

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		✓ 40			105
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	0				0
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		378
Grand Total of Points Awarded						

Wells

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			3,200

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

Applicant Name: Wellcare

Part A: Care Management

Question	Points Possible	Points Awarded
1.	1,350	1,000
2.	540	300
3.	540	500
4.	2,600	2,035
5.	370	370
6.	4,050	4,050
7.	540	540
8.	540	540
9.	540	540
10.	1350	1,350
11.	270	270
12.	810	560
13.	13,500	6,987.5
Total	27,000	19,042.5

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	19,042.5
Part B	3,000
Total Points	22,042.5

Applicant Name: Wellcare

Question 13 a - Scoring Table

Identification Strategy	Weight	0	40	70	100	Points Awarded
Description of strategy to identify and prioritize the timeframe by which individuals will receive an initial comprehensive assessment	4.5			70		315
Description of the data that will be reviewed	4.5			70		315
Description of criteria that will be used for case selection	4.5			70		315
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
Description of the process for determining when to re-evaluate the member's needs	5.4		40			216
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			70		157.5
Described how the risk/acuity level will be communicated to the enrollee	2.25		40			90

Described how the risk/acuity level will be communicated to the primary care providers/specialists indicated the minimum frequency of contacts	2.25			40				90
	2.25				70			157.5
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			40				220
Described how the enrollee's preferences and preferred role in decision making will be considered when developing the care plan	5			40				200
Described how the enrollee and his/her supports will be included in the development and implementation of the initial and revised care plans	5			40				200
Described how the enrollee's providers will be included in the development and implementation of initial and revised care plan	5			40				200
Identified how a communication plan will be established with the enrollee	5		0					0
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			40				200
Described how gaps in care will be identified and addressed	5			40				200
Described how the care plan will be continuously reviewed and revised.	5		0					0

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 individual's services. The team shall consist of the beneficiary, the primary care provider, LTSS service coordinators, and other providers as appropriate.							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				70		189
Described role of the care manager.	2.7			40			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.							
Described how it will employ innovative communication methods that consider the unique needs of the member.	3.25			40			130
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.							
Medication Reconciliation							
	7				70		490

4	2600	2035
5	370	370
6	4050	4050
7	540	540
8	540	540
9	540	540
10	1350	1350
11	270	270
12	810	560
13	13500	6987.5
Total	27000	19042.5

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	
Total	3000	3000	

Grand Total for Appendix D	
Part A	19042.5
Part B	3000
Total	22042.5

**Appendix E
TOTAL SCORE**

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

Applicant Willcare

Section	Score
Total Score from E-1 (Cannot Exceed 2,500 Points)	2,500
Total Score from E-2 (Cannot Exceed 2,500 Points)	2,500
TOTAL SCORE for Appendix E (Cannot Exceed 5,000)	5,000

Applicant Wellcare

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)
X	Adult Day Health Services	150	163	313
X	Assisted Living Services	150		150
X	Emergency Response Systems	150	163	313
X	Home Delivered Meals	150	163	313
X	Homemaker/Housekeeping services	150	163	313
X	Minor Home Modifications	150	163	313
X	Non-Medical Transportation	150	163	313
X	Nurses affiliated with a Home Health Agency	150	163	313
X	Independent Nurses not affiliated with an agency	150		150
X	Independent Aides not affiliated with a Home Health Agency	150		150
X	Nutritional consultation	150	163	313
X	Out of Home Respite Services	150	163	313
X	Personal care aide services	150	163	313
X	Social work/Counseling	150	163	313
X	Supplemental Adaptive and Assistive Devices (i.e. lift chair, bath seat, grabber)	150	163	313
TOTAL (limited to a maximum of 2,500 points)				4,206

2,500

Well Care

APPX E

E-1 - Provided 2 essays, one for ea. LOB., both validate all services claimed in both states -

E-2 Essay validates all 3 incident reporting services claimed

Applicant Wellcare

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)
X	Documenting and reporting individual incidents to the State or other oversight/investigative agency	X	834
X	Investigating individual incidents reported by individuals, providers and other entities and reporting outcomes to the state/oversight agency	X	834
X	Prevention planning or risk management for individuals receiving long term care services in community settings	X	834
(limited to a maximum of 2,500 points)			2582

**Appendix F
TOTAL SCORE**

Applicant McLoone

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)		8,700
Total Score from F-2 (Cannot Exceed 10,000 Points)	(1) 2,500	
	(2) 3,500	
	Total for F-2:	6,000
TOTAL SCORE for Appendix F (Cannot Exceed 20,000 Points)		14,700

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

Applicant Wellcare

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 _____

Wellcare

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.

Wilkens

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 Wellcare

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 Reducing ED use

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 _____

Wellcare

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.

Welfare

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 Wellcare

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 reduce med costs

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 tiered payment per diagnosis

Wellcare

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.

Wellcare

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

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

Applicant Wellcare

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 _____

Welfare

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.

W. S. H. H. H.

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)

1500

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

Applicant William

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 _____

Wellcare

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 FLHC

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.

Wellcare

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

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.

(i)

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 <u>FGHC</u>	✓
TOTAL	2,500

(F-2 (i))

well care

Innovative Payment Method for <u>Hospital</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	E				
Improve the delivery of quality care			100		
Reduce health disparities across all populations	E				
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	X	50			
Increase or improve care coordination			100		
Increase the accountability and responsibility of the primary care provider to maintain the individuals' overall health	X	50			
TOTAL (cannot exceed 1,500)					700 700

Plan used same initiative, but described its application for each of the 5 provider types discussed.

Willow

Innovative Payment Method for Pharmacy & Therapeutics Administration (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		50			
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		50			
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			100		
TOTAL (cannot exceed 1,500)					650

Innovative Payment Method for NE (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			100		
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		50			
Increase or improve care coordination			100		

Wellcare

Increase the accountability and responsibility of the primary care provider to maintain the individuals' overall health		50			
TOTAL (cannot exceed 1,500)					700

Innovative Payment Method for <u>HCBS</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			100		
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		50			
Increase or improve care coordination			100		
Increase the accountability and responsibility of the primary care provider to maintain the individuals' overall health		50			
TOTAL (cannot exceed 1,500)					700

wellcare

Innovative Payment Method for <u>Behavioral Health</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	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		
Increase the accountability and responsibility of the primary care provider to maintain the individuals' overall health		50			
TOTAL (cannot exceed 1,500)					750

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

EXHIBIT B

**FINAL REPORT FOR WELLCARE
OF FLORIDA, INC. CAHPS
SURVEY**

2011 Medicare Advantage CAHPS Results

Report for: WellCare (H1032)

Issued November 2011
by the Centers for Medicare & Medicaid Services

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Part 1: Executive Summary

Overview

The CAHPS survey is conducted annually to assess the experiences of beneficiaries in Medicare Advantage and Prescription Drug Plans. This report provides results from the 2011 CAHPS Survey of Medicare Advantage Prescription Drug (MA-PD) Plans. The 2011 survey was conducted in the first half of 2011 and measured members' experiences with your plan over the previous six months. The survey sample was drawn from all individuals who had been members of your plan for at least six months. Although beneficiaries provide ratings of their "plans," the unit of analysis is not a health and/or prescription drug plan but rather a health and/or prescription drug plan contract. This report refers both to plans and to contracts. In the context of this report, the terms refer to both health and/or prescription drug plan contracts.

How this Report is Organized

This report provides your results from the 2011 CAHPS survey. The remainder of this summary suggests how to use the report, and describes your contract's performance on several summary measures, overall ratings, and a set of measures mandated for public reporting. Part 2 of the report presents detailed results, including your contract's performance on the individual dimensions that make up the summary measures and frequency tables that display the unadjusted (i.e., not adjusted for case-mix) and unweighted responses to all survey items. For comparison, the detailed results are shown for other MA contracts in your market area. Part 3 describes sampling and other methodological topics and provides some background about the surveys.

What's New For 2011

This report retains much of the content and features from 2010. The following describes what is new for 2011.

1. **Changes to survey content.** There were significant changes made to the survey in 2011 to shorten the questionnaire. The following 17 questions from the 2010 survey were dropped:
 29. In the last 6 months, how often did you feel that the specialists you saw had all the information they needed to provide your care?
 39. Each fall your health plan sends you a notice that describes any changes in covered services. Since September 2009, has your plan sent you this kind of notice?
 40. Has your plan ever given you a document with this kind of information?
 41. Did an insurance agent or broker ever call you without your asking them to, to tell you about insurance for health care or prescription medicines?
 42. Did an insurance agent or broker ever visit your home without your asking them to, to tell you about insurance for health care or prescription medicines?
 43. Did an insurance agent or broker ever switch you to a different health care plan without your permission?
 68. Have you signed up for this extra help program?
 69. In the last 6 months, how often were you able to use Medicare's extra help program when you refilled a prescription for a medicine you had taken before?
 70. In the last 6 months, did pharmacy staff tell you that you needed to provide proof that you qualify for Medicare's extra help program?
 71. In the last 6 months, have you ever gone without a prescribed medicine because the pharmacy's records did not show you were signed up for Medicare's extra help program?
 74. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?
 75. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?
 81. How confident are you that you can identify when it is necessary for you to get medical care?
 82. Because of any impairment or health problem, do you need the help of other persons with your personal care needs, such as eating, dressing, or getting around the house?
 83. Because of any impairment or health problem, do you need help with your routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?
 84. Do you have a physical or medical condition that seriously interferes with your independence, participation in the community, or quality of life?
 98. Because of a health or physical problem are you unable to do or have any difficulty doing the following activities?

WellCare (H1032)

Two items were reworded to incorporate a 6-month lookback period:

- “In the last 6 months, was there a time when you believed you needed care or services that your health plan decided not to give you?” replaced “Was there ever a time when you believed you needed care or services that your plan decided not to give you?”
- “In the last 6 months, have you ever asked anyone at your health plan to reconsider a decision not to provide or pay for health care or services” replaced “Have you ever asked anyone at your health plan to reconsider a decision not to provide or pay for health care or services?”

In 12 items, the text “your health plan” was replaced with “your prescription drug plan” (See items 47-50 and 52-59 in the crosswalk shown in Part 3).

And finally, two other items were slightly changed:

- “Would you recommend your prescription drug plan for coverage of prescription drugs to other people like yourself?” replaced “Would you recommend your plan for coverage of prescription drugs to other people like yourself?”
- “In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider?” replaced “In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?”

All changes to the survey instrument are documented in Part 3 of this report (see Methodology: Survey Item Crosswalk for 2011-2010 MA-PD Questionnaires), and frequency distributions for all items are presented in Part 2.

2. **Consumer reported items and measures.** In advance of this detailed report, participating MA contracts received a memo with results reported to consumers. These results are also published in the *Medicare & You* handbook, on the Medicare web site, and later in this section of the report. Note that the composite measure “Doctors who communicate well” was dropped from the set of results that were made publicly available in the *Medicare & You* handbook and *Medicare Plan Finder*. Results for this measure are provided as usual in Part 2 of this report and the rules for assigning stars are described under “Consumer Reports” in a later section in this part of the report.
3. **Item about test results.** An item about how often the doctor’s office follow-up with test results is reported for the first time: Q23 “In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your doctor’s office follow up to give you those results?”. The results for this item is shown in the Summary Tables at the end of this section as well as in Part 2: Detailed Results.
4. **Fee-for-Service benchmarks.** This year, the FFS comparison area scores are based on “FFS Only” beneficiaries (those without PDP coverage), rather than a mixture of FFS beneficiaries with and without PDP coverage, with the exception of scores for Part D measures (which are based on beneficiaries with PDP coverage). Analyses of the previous year’s data demonstrate that the FFS Only scores on these items are very similar to those from a mixture of FFS beneficiaries with and without PDP coverage.
5. **Maps and Fee-for-Service Results.** For comparison purposes, the Appendix includes the Consumer Report measures and items from the 2011 Fee-for-Service survey -- excluding those measures related to prescription drug coverage. The Fee-for-Service results are displayed adjacent to your contract’s results along with state-level maps. In some states where there is significant enrollment in both Fee-for-Service and in your contract, Fee-for-Service ‘sub-state’ level results are displayed for certain geographic areas. Note that some sub-state areas may have been eliminated since they were last reported in 2010 because the differences among areas were no longer statistically reliable. As many as two state maps (states in which your contract has significant enrollment) and associated FFS results may be shown.
6. **Change in data collection.** Through 2010, the Medicare CAHPS surveys had been conducted by a single survey vendor. In 2011, seven different CMS-approved vendors administered the Medicare CAHPS surveys following data collection specifications and guidelines established by CMS. These specifications and guidelines are available at <http://www.ma-pdpcahps.org>.

How Results are Adjusted

Analyses of CAHPS data have shown that beneficiaries with certain characteristics tend to report systematically higher or lower scores, even when they are members of the same contract and therefore exposed to the same level of contract quality. Notably, older patients, healthier patients, less educated members and those with lower socio-economic status (SES) tend to give higher scores than younger, sicker and more educated members and those with higher SES. Different contracts do not have the same distribution (“case mix”) of enrollees with these characteristics, so these tendencies can bias comparisons among contracts.

We perform a procedure called “case-mix adjustment” to correct for these effects using a statistical model (linear regression) to estimate the scores that would be obtained by each contract if every contract had the same distribution of member characteristics, equivalent to the average across all contracts. Because the overall national mean is the same before and after adjustment, scores for some contracts (those with beneficiaries who tend to give more favorable scores) will be adjusted downwards, and others will be adjusted upwards. A more detailed explanation of these procedures is available in Part 3 of this report. Note that the HEDIS measures on immunizations are not adjusted for case-mix.

Other Public Reporting of Medicare CAHPS Data

It is important to recognize that this report is but one of several venues in which CAHPS data on MA contracts are publicly reported. There are sometimes important differences in how the results are organized and displayed in different venues as a function of their different purposes. For example, CMS reports these data on its web site, www.medicare.gov. In that venue, however, CMS assigns stars to contracts based on the mean of the distribution. Your contract’s scores and star ratings from this venue are presented at the end of Part 1, and in more detail in the Appendix to this report. The National Committee for Quality Assurance (NCQA) also collects CAHPS results about MA contracts, but uses a different method for calculating results for accreditation purposes. See Part 3 for more information about NCQA’s scoring methodology. It is important to keep these distinctions in mind when comparing data from these different venues.

How Scores are Compared

Contract scores are reported on www.medicare.gov and in the *Medicare & You* handbook using a 1-to-5 star scale. The algorithm for assigning stars combines information about the comparison of the plan to a standard based on the distribution of scores, the *ranking* of the contract case-mix adjusted mean score relative to other contracts, the *reliability* with which the mean is estimated in comparison to the distribution of means, and the *statistical significance* for the test of the difference of the contract mean from the national mean. In this plan report, the up and down arrows accompanying scores reflect only the last of these factors, the test for statistical significance.

Some apparently paradoxical results can occur with this system. These are unavoidable, especially with the 5-star scale, for two reasons: (1) several pieces of information are combined into a display that varies along only a single dimension, and (2) continuous results are broken down into a few discrete categories. Consequently, each year we occasionally observe some of the following phenomena:

- Two scores that are extremely close receive different star ratings: one was just above a cutoff between categories and the other just below;
- Contract A has a higher score than Contract B, but Contract B is significantly above the mean and Contract A is not: Contract B might have had more data and therefore a more precise estimate than Contract A, so even a smaller numerical difference from the mean is statistically significant, indicating a greater degree of confidence that it is above average. These differences in statistical significance can then be reflected in the star ratings, or in the assignment of up and down arrows in this report.
- All contracts in one area receive 4 or 5 stars, while all contracts in another area receive 1 or 2: all comparisons are to national means and distributions, not local ones.
- A contract’s mean score went up but received fewer stars than last year: it may be that the national mean went up as well, and the contract did not keep up with this shift.

How to Use this Report

MA-PD contracts can use the information in this report for many purposes. Some of the most common uses include the following:

- **Identify program strengths and opportunities for improvement**

Part 2 of this report [Detailed Results] presents an analysis of your contract's performance on a variety of dimensions and compares your performance to the mean performance of other MA contracts nationally. It also displays results for comparable contracts in your market area.

The *CAHPS Improvement Guide* provides practical strategies that organizations can use to improve the aspects of performance measured by CAHPS. This Guide describes specific strategies for improving the quality of health care services and the beneficiaries' experience of care. The *CAHPS Improvement Guide* is a web-based resource that enables users to identify pertinent strategies and resources more efficiently. This resource is available at www.cahps.ahrq.gov. Over time, the contents of the guide will be updated to reflect changes to the Health Plan Survey and new information about effective strategies for improving performance in the domains measured by CAHPS surveys.

- **Give feedback to providers**

Some MA-PD contracts present summary results to physicians and other contracting providers, primarily through newsletters or presentations. This feedback may be a good way to provide information about how beneficiaries perceive their experiences with physicians and with MA-PD overall.

- **Track trends**

You may want to see how your performance has changed over time by comparing the 2011 survey results to those of previous years.

Summary Tables

Below are the summaries for your health plan composite measures, overall health plan ratings, prescription drug composite measures, overall ratings of drug coverage, Medicare-specific and HEDIS measures collected through CAHPS, and three single item measures.

Health Plan Composite Measures - Responses to individual survey questions were combined to form four composite (summary) measures of members' experiences with their health plans. For each measure, the table below shows the national average for all MA contracts, your contract's case-mix adjusted mean score on a 1-4 scale, and whether your contract's score was significantly greater than, less than, or equal to the national average.

Health Plan Composite Measures	National	Your Contract	↑↓
Getting Needed Care	3.57	3.52	↑↓
Getting Care Quickly	3.28	3.13	↓
Doctors Who Communicate Well	3.71	3.64	↓
Health Plan Customer Service	3.63	3.52	↓

Overall Health Plan Ratings - Survey respondents used a 0-10 scale to rate their health plan, care received from their plan overall, their personal doctor, and the specialist (if any) they had seen most frequently in the past 6 months. For each measure, the table below shows the national average for all MA contracts, your contract's case-mix adjusted mean score on a 1-4 scale, and whether your contract's score was significantly greater than, less than, or equal to the national average.

Overall Health Plan Ratings	National	Your Contract	↑↓
Health Plan Overall	8.60	8.40	
Care Received Overall	8.62	8.50	
Personal Doctor	9.07	8.90	
Specialist	8.91	N/A	

Prescription Drug Composite Measures - Responses to individual survey questions about prescription drugs were combined to form two composite (summary) measures of members' experiences. For each measure, the table below shows the national average for all MA-PD contracts, your contract's case-mix adjusted mean score on a 1-4 scale, and whether your contract's score was significantly greater than, less than, or equal to the national average.

Prescription Drug Composite Measures	National	Your Contract	↑↓
Getting Needed Prescription Drugs	3.74	3.70	
Getting Information From the Plan About Prescription Drug Coverage and Cost	3.41	3.28	

Note. An up arrow (↑) indicates that your contract scored significantly better than the national average, a down arrow (↓) that it scored significantly worse than the national average, and the absence of an arrow means that it was not significantly different from the national average. Scores in italics have 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. For more detailed results of your contract and other contracts in your market area, see Part 2.

Summary Tables (continued)

Overall Ratings of Drug Coverage - Survey respondents were asked for an overall rating of their plan's drug coverage on a 0-10 scale, and about their willingness to recommend the plan for drug coverage on a 1-4 scale. For each measure, the table below shows the national average for all MA-PD contracts, your contract's case-mix adjusted mean score on a 1-4 scale, and whether your contract's score was significantly greater than, less than, or equal to the national average.

Overall Ratings of Drug Coverage	National	Your Contract	↑↓
Overall Rating of Drug Coverage	8.52	8.50	
Willingness to Recommend Plan for Drug Coverage	3.50	3.46	

Medicare-Specific and HEDIS Measures - Survey respondents were asked whether they received an influenza vaccination recently and whether they had ever received a pneumonia vaccination (yes or no). They were also asked about getting needed medical equipment and whether the doctor's office provided test results on a 1-4 scale. The table below shows your contract's percentage of "yes" responses or mean score for these four items and the national average for all MA Contracts. The vaccination items are not adjusted for case-mix but the item about medical equipment is.

Medicare-Specific and HEDIS Measures	National	Your Contract	↑↓
Influenza Vaccination	69.7%	67.0%	
Pneumonia Vaccination	70.5%	68.0%	
Getting Medical Equipment	3.35	N/A	
Follow-up with Test Results	3.49	3.43	

Single Item Measures - Survey respondents were asked if they phoned a doctor's office or clinic with a medical question after hours (yes or no) in the past six months. Those responding "yes" were also asked how often they received a call back as soon as needed and how long it took for a callback. The table below shows your contract's percentage of "yes" responses for making an after-hours call, the proportion of "always" responses for call backs as soon as needed, the proportion of "less than 1 hour" responses for timing of the callback, and the national average for all MA contracts. The results for these items have not been case-mix adjusted, and statistical tests against the national average were not performed.

Single Item Measures	National	Your Contract
After-hours call	9.5%	10.5%
Callback as soon as needed	45.6%	50.0%
Timing of callback	35.4%	23.1%

Note: An up arrow (↑) indicates that your contract scored significantly better than the national average, a down arrow (↓) that it scored significantly worse than the national average, and the absence of an arrow means that it was not significantly different from the national average. Scores in italics have 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. For more detailed results of your contract and other contracts in your market area, see Part 2.

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

In total, 33 MA plans in Florida participated in the 2011 CAHPS Survey of MA Plans, conducted from March 2011 through June 2011.

The response rate for your contract was 37.6%, compared with 40.3%, the average response rate for all MA contracts in Florida.

Strengths

Your MA-PD contract performed above the national average on the following composite measure(s):

Your contract did not perform above the national average on any composite measure.

Opportunities for Improvement

On other measures, your contract performed below the national average. The following list shows those measures and references strategies for improving performance as described in the *CAHPS Improvement Guide*. The Guide is available on the CAHPS web site at www.cahps.ahrq.gov.

Customer Service	https://www.cahps.ahrq.gov/Quality-Improvement/Improvement-Guide/Browse-Interventions/Custom-Service.aspx
Getting Care Quickly	https://www.cahps.ahrq.gov/Quality-Improvement/Improvement-Guide/Browse-Interventions/HP-Interventions/Getting-Care-Quickly.aspx
How Well Doctors Communicate	https://www.cahps.ahrq.gov/Quality-Improvement/Improvement-Guide/Browse-Interventions/HP-Interventions/Doctors-Communicate.aspx

Consumer Reports

The results of the Medicare CAHPS survey are published in the *Medicare & You* handbook and on the Medicare web site: <http://www.medicare.gov>. These publicly reported results help beneficiaries choose a Medicare health and/or prescription drug plan, and allow the public and research community to assess Medicare program performance. Survey measures that are reported in the *Medicare & You* handbook and on the Medicare web site are not directly comparable to the ones presented in this report. The handbook and web site provide stars to indicate contract performance rather than showing response distributions. Your contract's results as they will appear in these consumer reports are shown in Table 2. Note: If your contract is not renewing for 2012, information about your contract will not be available on the Medicare web site.

The CAHPS base star cut points. The CAHPS survey responses are case-mix adjusted to take into account differences in the characteristics of enrollees across contracts that may potentially impact survey responses, and then mapped to a 0-100 scale to create the measure scores. The cut points for determining the number of base stars from these scores are listed in Table 1 below. These cut points do not take into account statistical significance and reliability; your final star rating may be higher or lower after these factors are considered.

Table 1: CAHPS Base Star Cut Point Values

Reporting Composite or Item	1 Star	2 Star	3 Star	4 Star	5 Star
Ratings of Health Plan Responsiveness and Care					
Getting Needed Care	0-80	81-83	84	85-86	87-100
Getting Appointments and Care Quickly	0-70	71-72	73-74	75-78	79-100
Overall Rating of Health Care Quality	0-82	83-84	*	85-87	88-100
Overall Rating of Health Plan	0-81	82-83	84	85-87	88-100
Customer Service	0-83	84-85	86-87	88-89	90-100
Vaccines					
Flu Vaccination	0-59	60-64	65-70	71-75	76-100
Pneumonia Vaccination	0-56	57-63	64-69	70-77	78-100
Member Experience with Drug Plan					
Getting Needed Prescription Drugs	0-87	88-89	90	91-92	93-100
Getting Information from Plan About Prescription Drugs	0-76	77-79	80-81	82-85	86-100
Overall Rating of Prescription Drug Plan	0-80	81-82	83	84-85	86-100

*Due to rounding and the placement of the predetermined 4-star cutoff, no contracts were assigned 3 base stars; all contracts meeting the cutoff for 3 base stars also met the cutoff for 4 base stars. However after application of the further criteria of significance and reliability, some plans with fewer than 3 base stars may have been assigned 3 final stars.

Consumer Reports (continued)

Definitions and Statistical Significance. This section describes the contents of Table 2 and how statistical significance and reliability are taken into account in determining the final star rating.

Reporting Composite or Item – The name of the measure.

Mean Score – The mean score for the measure (the flu and pneumonia vaccination measures are not case-mix adjusted, the rest are).

Base Star – The rating prior to significance and reliability testing.

Statistical Significance – Indicates if the statistical significance of the base star was above or below the national average CAHPS measure score (blank entries are not statistically significant).

Reliability – A blank entry means good reliability of the reported data. An entry of “Low” means that the data had low reliability due to a small number of measure completes. An entry of “Very Low” means that the data reliability was too low to report the results.

Final Measure Star – The final star rating the contract received for this measure.

Assigning Final Star Values. The following rules are applied to the base star values to arrive at the final CAHPS measure star values:

5 base stars: If significance is NOT above average OR reliability is low, the Final Star value equals 4.

4 base stars: Always stays 4 Final Stars.

3 base stars: If significance is below average, the Final Star value equals 2.

2 base stars: If significance is NOT below average AND reliability is low, the Final Star value equals 3.

1 base star: If significance is NOT below average AND reliability is low, the Final Star value equals 3; if significance is not below average OR reliability is low (but not both), the Final Star value equals 2.

Table 2: CAHPS Consumer Reports

Reporting Composite or Item	Mean Score	Base Star	Statistical Significance	Reliability	Final Star Measure
Ratings of Health Plan Responsiveness and Care					
Getting Needed Care	84	3	No Difference		★★★
Getting Appointments and Care Quickly	71	2	Below Average		★★
Overall Rating of Health Care Quality	85	4	No Difference		★★★★
Overall Rating of Health Plan	84	3	No Difference		★★★
Customer Service	84	2	Below Average		★★
Vaccines					
Flu Vaccination	67%	3	No Difference		★★★
Pneumonia Vaccination	68%	3	No Difference		★★★
Member Experience with Drug Plan					
Getting Needed Prescription Drugs	90	3	No Difference		★★★
Getting Information from Plan About Prescription Drugs	76	1	No Difference		★★
Overall Rating of Prescription Drug Plan	85	4	No Difference		★★★★

More detail on how these scores are calculated as well as state- or substate-level comparisons with Original (Fee-for-Service) Medicare may be found in Part 3 and in the Appendix to this report.

Part 2: Detailed Results

In the following pages, we provide detailed results of the 2011 MA-PD CAHPS Survey, including your contract's performance on the individual performance dimensions that make up each of the summary measures. Frequency tables that display unadjusted responses (not case-mix adjusted) to all survey items are also shown.

Getting Needed Care Composite

This table shows how your contract and other MA contracts in your area performed on "Getting Needed Care," a composite of survey questions 26 and 31. For each contract, the table shows: the number of members who answered at least one of these questions, 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. All statistics are adjusted for case-mix. Results for the individual questions included in this composite are on the following pages.

			Never + Sometimes	Usually	Always		
						↑ = Significantly better than the national average	↓ = Significantly worse than the national average
National Distribution	n=118207		26%		68%		3.57
State Distribution – Florida	n=7785		26%		68%		3.56
Original Medicare Distribution – Florida	n=6572		27%		67%		3.61
2011 WellCare (H1032)	n=216		9%	29%	62%		3.52
2010 WellCare (H1032)	n=675		13%	27%	60%		3.45
<u>MA Contracts in Your Market Area</u>							
Aetna Medicare (H5414)	n=328		30%		64%		3.55
Amerigroup (H8991)			N/A				
BC & BS of Florida (R3332)	n=269		30%		62%		3.52
BC&BS of Florida (H5434)	n=308		26%		67%		3.61
Care Plus Health Plan (H1019)			N/A				
Citrus Health Care (H5407)			N/A				
Coventry Health Care of Florida (H1076)			N/A				
Coventry HP of Florida (H1013)	n=191		12%	23%	65%		3.49
Coventry Summit Health Plan (H5850)	n=234		26%		64%		3.49
Freedom Health Plan (H5427)	n=322		26%		64%		3.52
Health First Health Plans (H1099)	n=277		29%		66%		3.61
Health Options (H1026)	n=259		9%	31%	60%		3.49 ↓
HealthSpring of Florida (H5410)	n=201		14%		85%		3.82 ↑
Humana (H1036)	n=203		25%		66%		3.55
Humana (R5826)	n=260		9%	27%	63%		3.52

WellCare (H1032)

MA Contracts in Your Market Area

Humana AdvantageCare Plan (H5426)	n=245		3.55
Optimum HealthCare (H5594)	n=318		3.49 ↓
Physicians United Plan (H5696)	n=251		3.46 ↓
Preferred Care Partners (H1045)	n=257		3.55
Quality Health Plans (H5402)	n=296		3.43 ↓
SecureHorizons by Unitedhlthcare (H1080)	n=235		3.64
SecureHorizons by Unitedhlthcare (H5532)	n=253		3.64 ↑
SecureHorizons by Unitedhlthcare (R5287)	n=297		3.52
Universal Health Care (H5404)	n=244		3.52
Universal Health Care (H5429)		N/A	

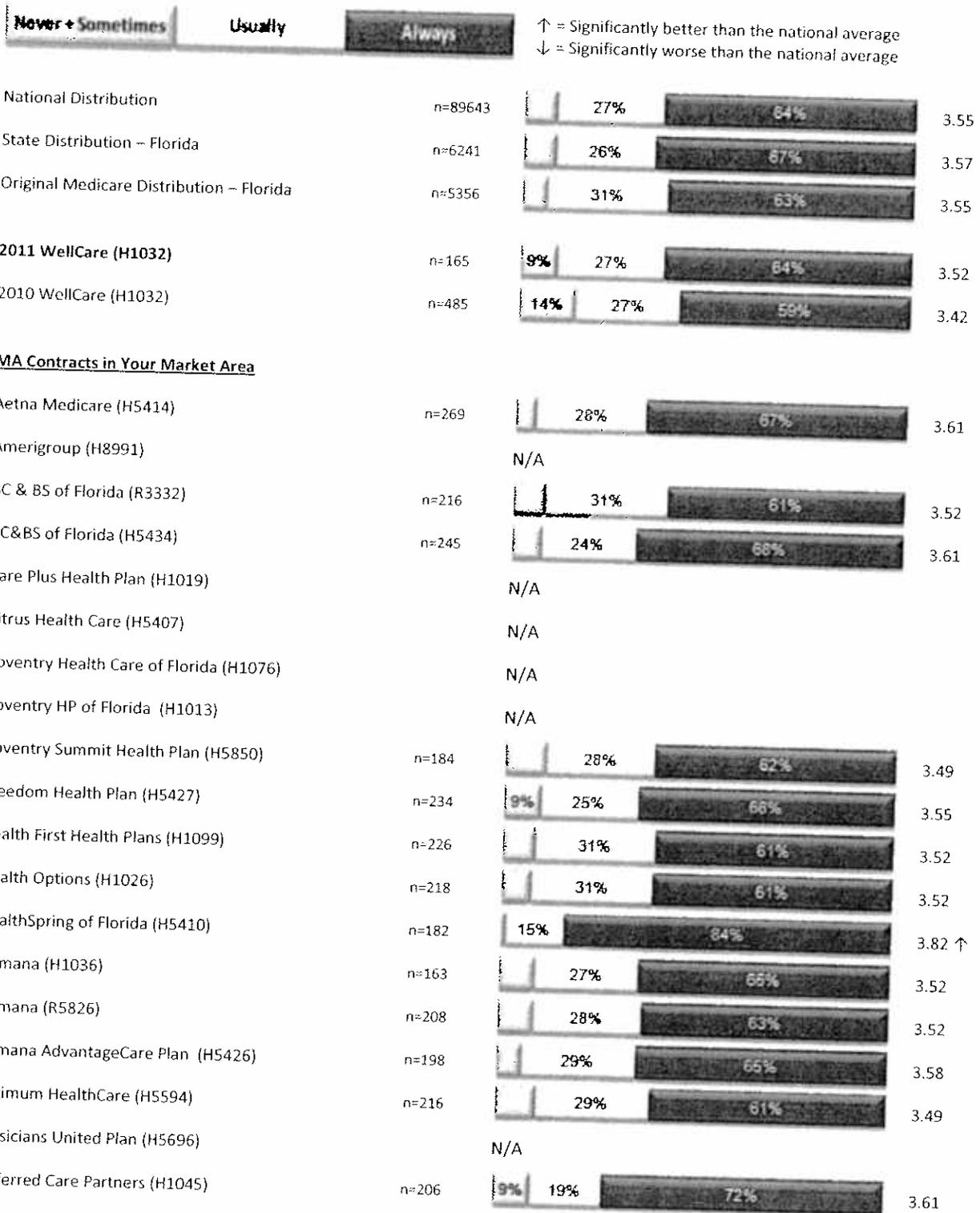
Other MA Contracts in Florida

AvMed Inc. (H1016)	n=296		3.61
Capital Health Plan (H5938)	n=363		3.64 ↑
Florida Health Care Plan (H1035)	n=296		3.58
Healthsun Health Plans (H5431)		N/A	
JMH Health Plan (H4155)		N/A	
Medica Healthcare Plans (H5420)	n=208		3.67 ↑
SecureHorizons by Unitedhlthcare (H9011)	n=239		3.34 ↓

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.

Getting Needed Care: Getting Appointments With Specialists

Question 26: In the last 6 months, how often was it easy to get appointments with specialists?



WellCare (H1032)

MA Contracts in Your Market Area

Quality Health Plans (H5402)	n=227	27%	64%	3.52
SecureHorizons by Unitedhlthcare (H1080)	n=190	20%	69%	3.58
SecureHorizons by Unitedhlthcare (H5532)	n=207	28%	66%	3.61
SecureHorizons by Unitedhlthcare (R5287)	n=237	30%	63%	3.55
Universal Health Care (H5404)	n=184	23%	66%	3.52
Universal Health Care (H5429)				N/A

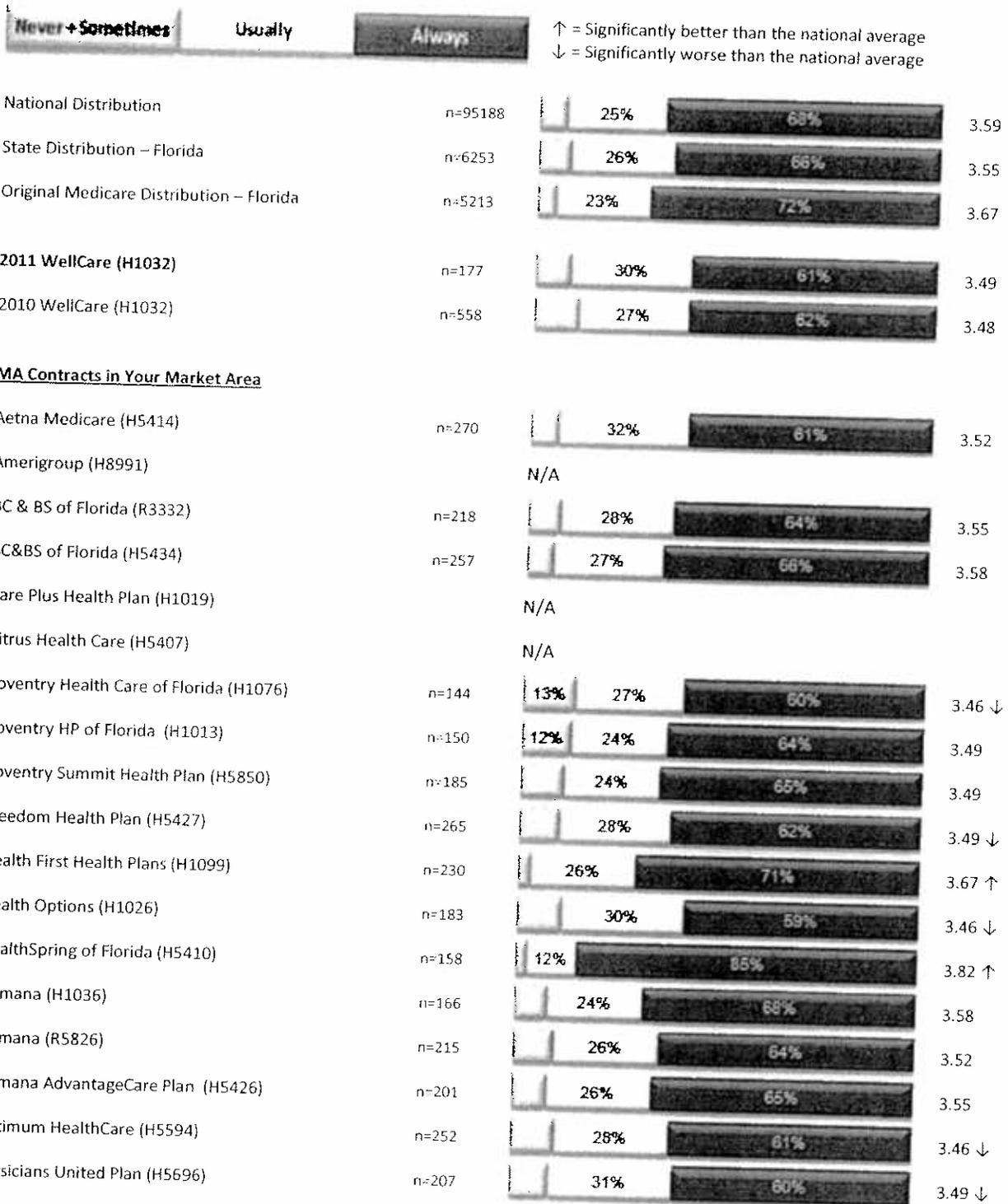
Other MA Contracts in Florida

AvMed Inc. (H1016)	n=248	23%	70%	3.64 ↑
Capital Health Plan (H5938)	n=293	28%	64%	3.55
Florida Health Care Plan (H1035)	n=247	24%	66%	3.61
Healthsun Health Plans (H5431)				N/A
JMH Health Plan (H4155)				N/A
Medica Healthcare Plans (H5420)	n=180	26%	70%	3.64 ↑
SecureHorizons by Unitedhlthcare (H9011)	n=202	14%	26%	3.43 ↓

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.

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

Question 31: In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?



WellCare (H1032)

MA Contracts in Your Market Area

Preferred Care Partners (H1045)	n=209	29%	62%	3.49	
Quality Health Plans (H5402)	n=233	16%	31%	53%	3.34 ↓
SecureHorizons by Unitedhlthcare (H1080)	n=190	25%	72%	3.67 ↑	
SecureHorizons by Unitedhlthcare (H5532)	n=200	25%	73%	3.70 ↑	
SecureHorizons by Unitedhlthcare (R5287)	n=236	34%	80%	3.52	
Universal Health Care (H5404)	n=198	23%	67%	3.52	
Universal Health Care (H5429)				N/A	

Other MA Contracts in Florida

AvMed Inc. (H1016)	n=231	22%	70%	3.61	
Capital Health Plan (H5938)	n=280	19%	78%	3.73 ↑	
Florida Health Care Plan (H1035)	n=234	22%	60%	3.58	
Healthsun Health Plans (H5431)				N/A	
JMH Health Plan (H4155)				N/A	
Medica Healthcare Plans (H5420)	n=163	19%	74%	3.67	
SecureHorizons by Unitedhlthcare (H9011)	n=198	18%	33%	49%	3.28 ↓

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.

Getting Care Quickly Composite

This table shows how your contract and other MA contracts in your area performed on “Getting Care Quickly,” a composite of survey questions 4, 6 and 8. For each contract, the table shows: the number of members who answered at least one of these questions, 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. All statistics are adjusted for case-mix. Results for the individual questions included in this composite are on the following pages.

			Never + Sometimes	Usually	Always		
National Distribution	n=146695		19%	27%	54%	3.28	
State Distribution – Florida	n=9196		22%	26%	52%	3.22	
Original Medicare Distribution – Florida	n=7639		25%	26%	49%	3.16	
2011 WellCare (H1032)	n=269		24%	30%	46%	3.13	↓
2010 WellCare (H1032)	n=806		26%	23%	52%	3.16	

↑ = Significantly better than the national average
 ↓ = Significantly worse than the national average

MA Contracts in Your Market Area

Aetna Medicare (H5414)	n=378		19%	27%	54%	3.28	
Amerigroup (H8991)	n=231		21%	24%	55%	3.25	
BC & BS of Florida (R3332)	n=317		23%	31%	46%	3.16	↓
BC&BS of Florida (H5434)	n=347		22%	29%	49%	3.19	↓
Care Plus Health Plan (H1019)	n=119		24%	27%	49%	3.16	
Citrus Health Care (H5407)	n=190		27%	25%	48%	3.10	↓
Coventry Health Care of Florida (H1076)	n=227		23%	22%	55%	3.22	
Coventry HP of Florida (H1013)	n=228		27%	20%	53%	3.16	↓
Coventry Summit Health Plan (H5850)	n=277		24%	26%	50%	3.16	↓
Freedom Health Plan (H5427)	n=387		22%	27%	51%	3.19	↓
Health First Health Plans (H1099)	n=345		19%	30%	51%	3.25	
Health Options (H1026)	n=288		24%	26%	50%	3.16	↓
HealthSpring of Florida (H5410)	n=206		12%	21%	67%	3.52	↑
Humana (H1036)	n=250		21%	24%	55%	3.25	
Humana (R5826)	n=329		22%	26%	52%	3.25	
Humana AdvantageCare Plan (H5426)	n=288		20%	27%	53%	3.25	

WellCare (H1032)

MA Contracts in Your Market Area

Optimum HealthCare (H5594)	n=383	25%	23%	62%	3.19 ↓
Physicians United Plan (H5696)	n=307	26%	29%	45%	3.10 ↓
Preferred Care Partners (H1045)	n=291	23%	23%	64%	3.25
Quality Health Plans (H5402)	n=383	22%	27%	51%	3.19 ↓
SecureHorizons by Unitedhlthcare (H1080)	n=301	19%	28%	53%	3.28
SecureHorizons by Unitedhlthcare (H5532)	n=305	17%	30%	53%	3.31
SecureHorizons by Unitedhlthcare (R5287)	n=338	22%	28%	50%	3.19 ↓
Universal Health Care (H5404)	n=305	19%	31%	50%	3.22
Universal Health Care (H5429)	n=203	17%	26%	57%	3.34

Other MA Contracts in Florida

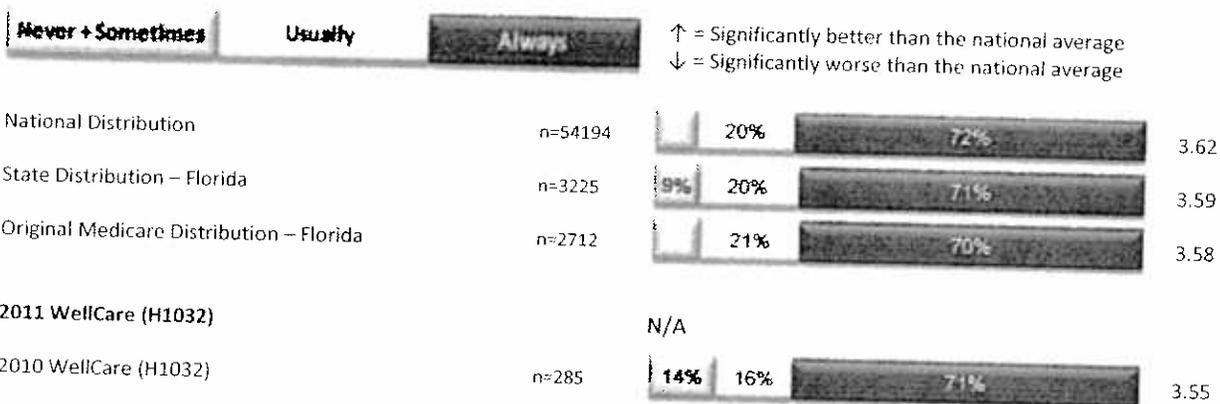
AvMed Inc. (H1016)	n=325	25%	23%	62%	3.16 ↓
Capital Health Plan (H5938)	n=414	20%	27%	53%	3.28
Florida Health Care Plan (H1035)	n=351	17%	28%	55%	3.34
Healthsun Health Plans (H5431)	n=158	23%	23%	64%	3.22
JMH Health Plan (H4155)	n=190	30%	23%	47%	3.04 ↓
Medica Healthcare Plans (H5420)	n=230	27%	22%	51%	3.13 ↓
SecureHorizons by Unitedhlthcare (H9011)	n=270	30%	27%	43%	3.01 ↓

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.

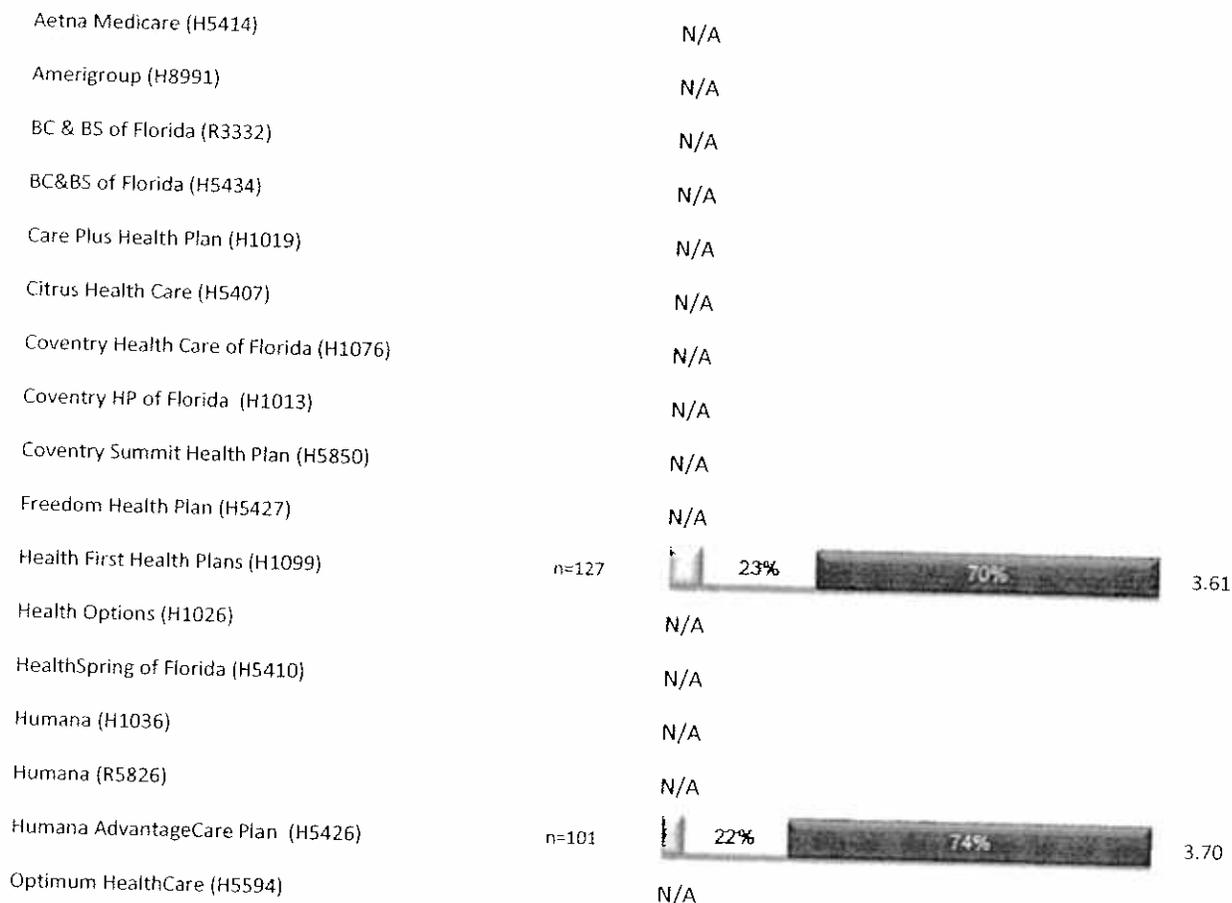
Getting Care Quickly: Getting Care Needed Right Away

Question 4: In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?

[Scored only for those who needed care right away in the last six months.]



MA Contracts in Your Market Area



WellCare (H1032)

MA Contracts in Your Market Area

Physicians United Plan (H5696)	N/A
Preferred Care Partners (H1045)	N/A
Quality Health Plans (H5402)	N/A
SecureHorizons by UnitedHlthcare (H1080)	N/A
SecureHorizons by UnitedHlthcare (H5532)	N/A
SecureHorizons by UnitedHlthcare (R5287)	N/A
Universal Health Care (H5404)	N/A
Universal Health Care (H5429)	N/A

Other MA Contracts in Florida

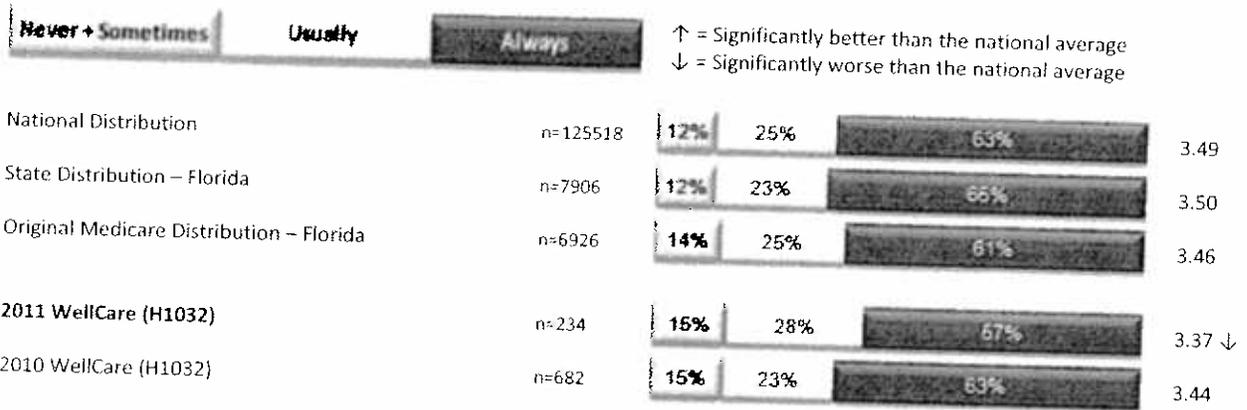
AvMed Inc. (H1016)	N/A		
Capital Health Plan (H5938)	n=146		3.64
Florida Health Care Plan (H1035)	N/A		
Healthsun Health Plans (H5431)	N/A		
JMH Health Plan (H4155)	N/A		
Medica Healthcare Plans (H5420)	N/A		
SecureHorizons by UnitedHlthcare (H9011)	N/A		

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.

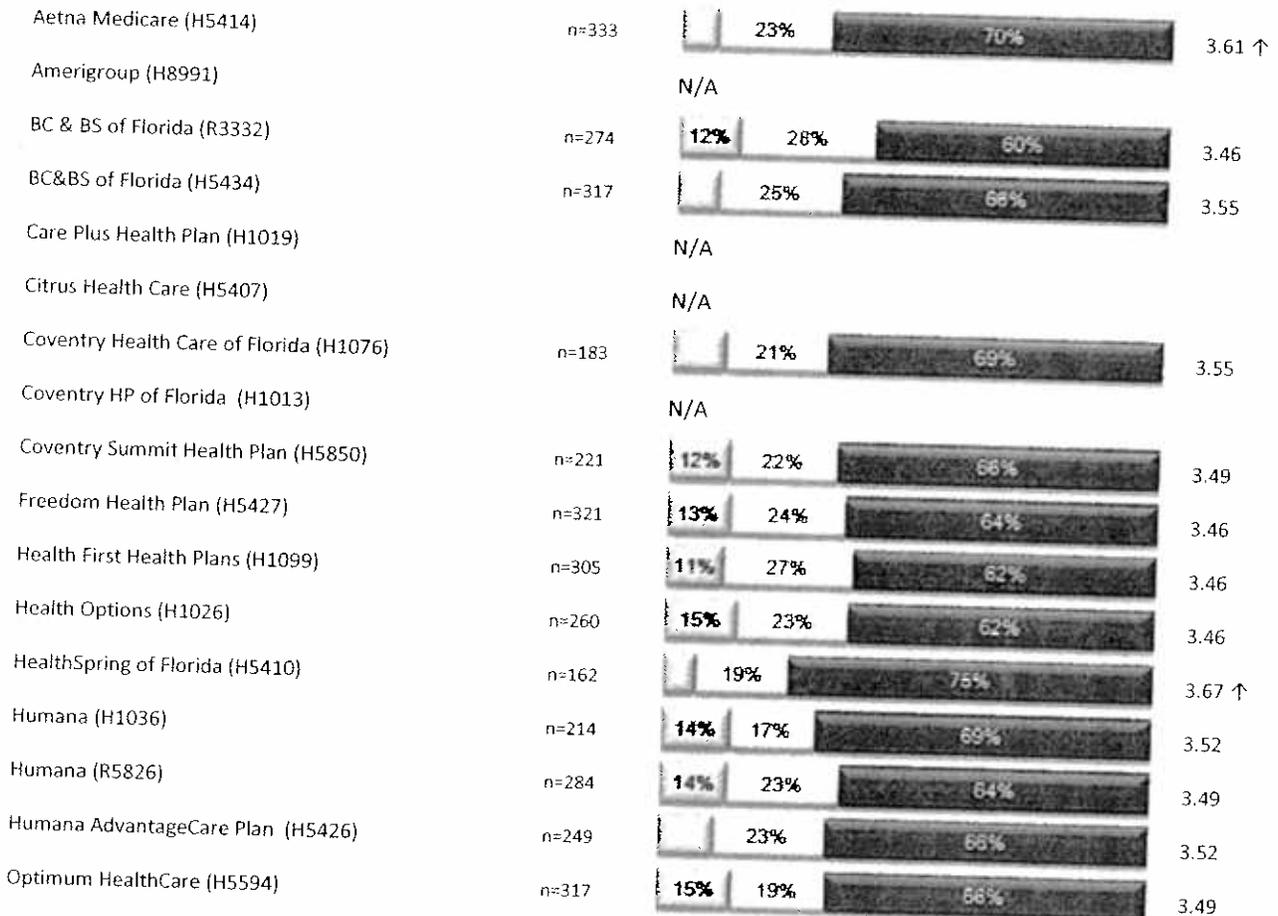
Getting Care Quickly: Getting Appointments

Question 6: In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?

[Scored only for those who needed an appointment for health care in the last six months.]



MA Contracts in Your Market Area



WellCare (H1032)

MA Contracts in Your Market Area

Physicians United Plan (H5696)	n=264	9%	30%	61%	3.49
Preferred Care Partners (H1045)	n=250		25%	65%	3.55
Quality Health Plans (H5402)	n=322	13%	24%	63%	3.46
SecureHorizons by UnitedHlthcare (H1080)	n=254		25%	64%	3.52
SecureHorizons by UnitedHlthcare (H5532)	n=269		20%	70%	3.58 ↑
SecureHorizons by UnitedHlthcare (R5287)	n=309		28%	62%	3.49
Universal Health Care (H5404)	n=261		23%	69%	3.58
Universal Health Care (H5429)	n=173		24%	66%	3.55

Other MA Contracts in Florida

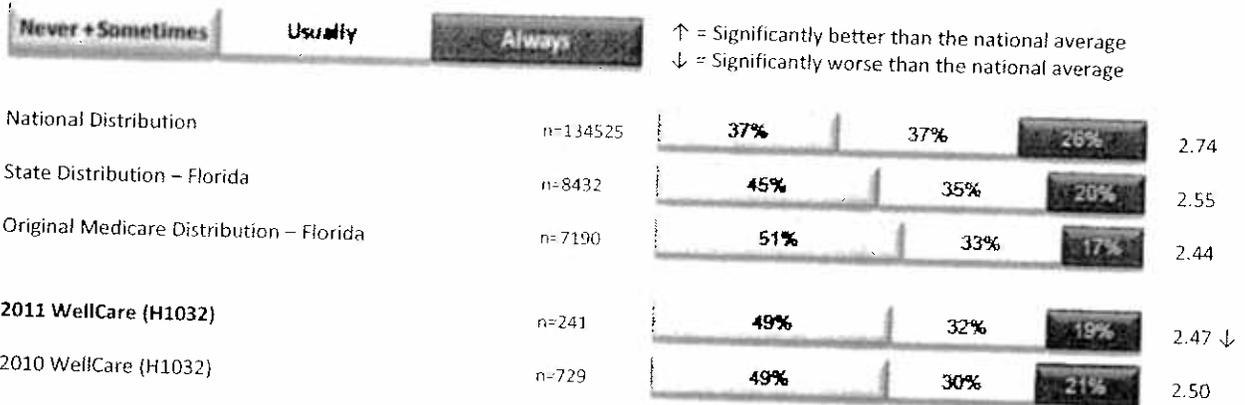
AvMed Inc. (H1016)	n=277	12%	21%	66%	3.52
Capital Health Plan (H5938)	n=372		24%	68%	3.58 ↑
Florida Health Care Plan (H1035)	n=302		23%	67%	3.55
Healthsun Health Plans (H5431)		N/A			
JMH Health Plan (H4155)		N/A			
Medica Healthcare Plans (H5420)	n=206	13%	20%	68%	3.52
SecureHorizons by UnitedHlthcare (H9011)	n=232	18%	28%	54%	3.34 ↓

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.

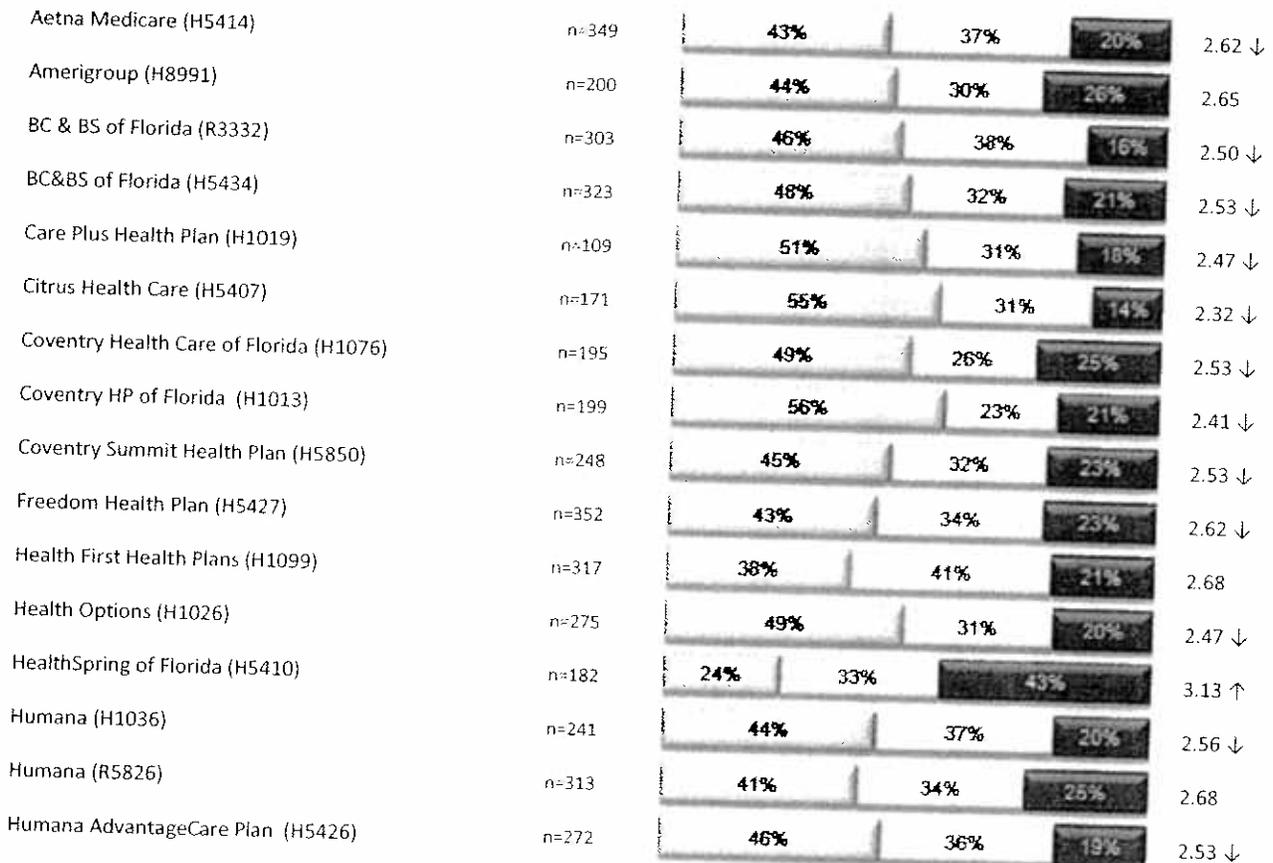
Getting Care Quickly: Getting Seen Within 15 Minutes of Your Appointment

Question 8: In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

[Scored only for those who went to a doctor's office or clinic for care in the last six months.]



MA Contracts in Your Market Area



WellCare (H1032)

MA Contracts in Your Market Area

Optimum HealthCare (H5594)	n=347	45%	35%	20%	2.56 ↓
Physicians United Plan (H5696)	n=284	53%	31%	16%	2.41 ↓
Preferred Care Partners (H1045)	n=268	50%	28%	23%	2.53 ↓
Quality Health Plans (H5402)	n=344	44%	34%	21%	2.56 ↓
SecureHorizons by UnitedHlthcare (H1080)	n=280	37%	39%	24%	2.71
SecureHorizons by UnitedHlthcare (H5532)	n=290	35%	46%	19%	2.74
SecureHorizons by UnitedHlthcare (R5287)	n=319	46%	37%	17%	2.56 ↓
Universal Health Care (H5404)	n=287	37%	43%	20%	2.68
Universal Health Care (H5429)	n=188	36%	36%	28%	2.77

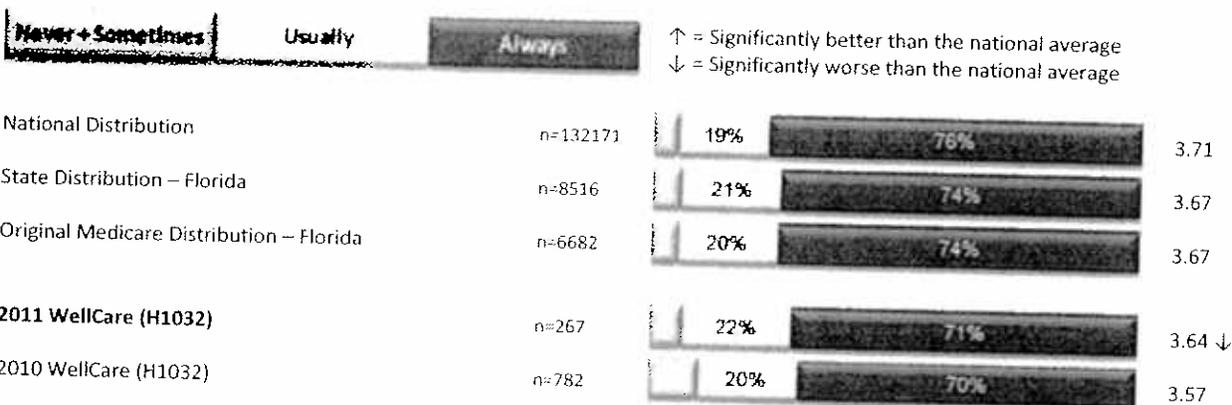
Other MA Contracts in Florida

AvMed Inc. (H1016)	n=291	53%	32%	15%	2.35 ↓
Capital Health Plan (H5938)	n=390	43%	36%	21%	2.65 ↓
Florida Health Care Plan (H1035)	n=328	32%	43%	25%	2.80
Healthsun Health Plans (H5431)	n=140	46%	29%	25%	2.59
JMH Health Plan (H4155)	n=170	61%	25%	14%	2.26 ↓
Medica Healthcare Plans (H5420)	n=208	59%	26%	15%	2.29 ↓
SecureHorizons by UnitedHlthcare (H9011)	n=234	57%	26%	16%	2.29 ↓

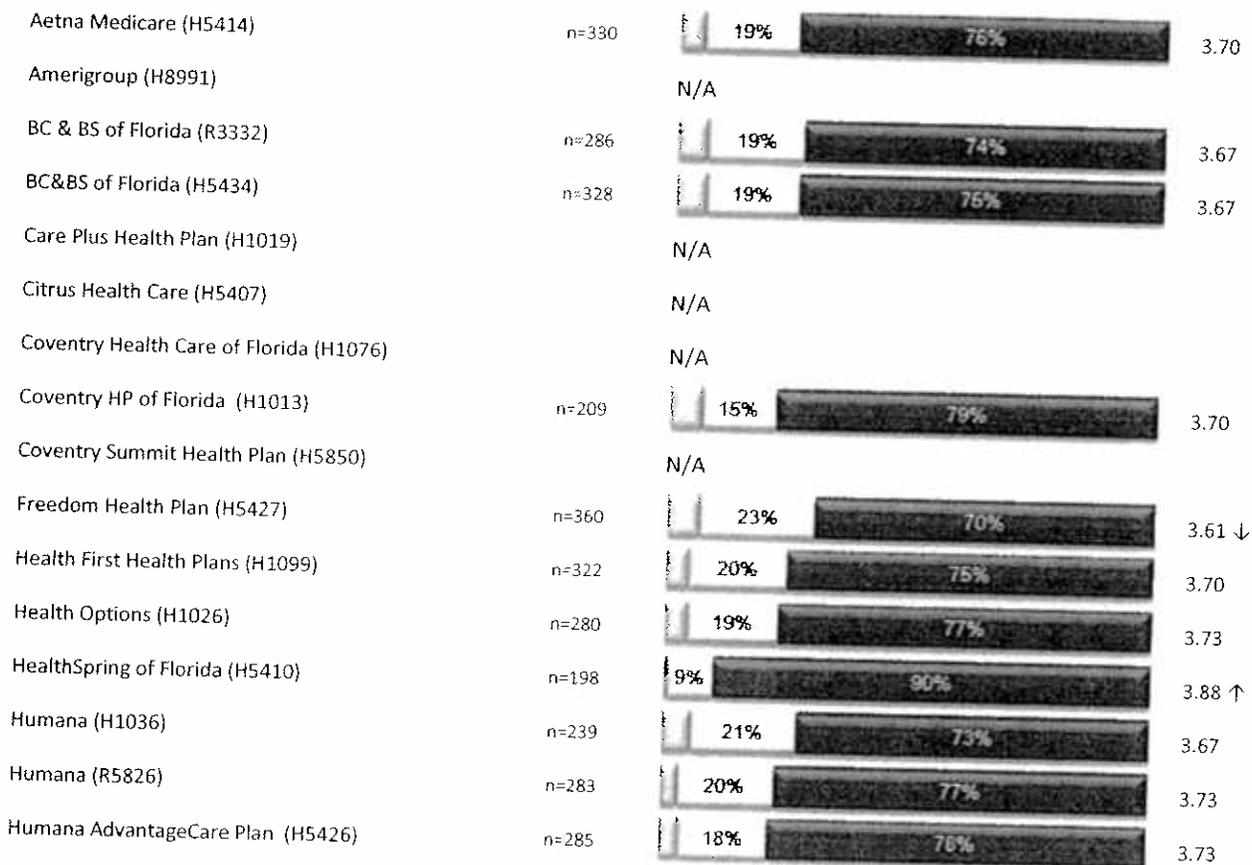
Note: Percentages may not add to 100 due to rounding. For information on how we defined your market area, calculated significance for the up and down arrows, and adjusted for case-mix, see Part 3 of this report.

Doctors Who Communicate Well Composite

This table shows how your contract and other MA contracts in your area performed on “Doctors Who Communicate Well,” a composite of survey questions 17, 18, 19 and 20. For each contract, the table shows: the number of members who answered at least one of these questions, 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. Results for the individual questions included in this composite are on the following pages.



MA Contracts in Your Market Area



WellCare (H1032)

MA Contracts in Your Market Area

Optimum HealthCare (H5594)	n=355	21%	70%	3.58 ↓	
Physicians United Plan (H5696)	n=300	9%	22%	68%	3.58 ↓
Preferred Care Partners (H1045)	n=275	18%	76%	3.70	
Quality Health Plans (H5402)	n=338	23%	72%	3.67	
SecureHorizons by UnitedHealthcare (H1080)	n=282	19%	77%	3.73	
SecureHorizons by UnitedHealthcare (H5532)	n=293	19%	76%	3.73	
SecureHorizons by UnitedHealthcare (R5287)	n=321	21%	74%	3.67	
Universal Health Care (H5404)	n=284	17%	77%	3.70	
Universal Health Care (H5429)	n=173	25%	70%	3.64	

Other MA Contracts in Florida

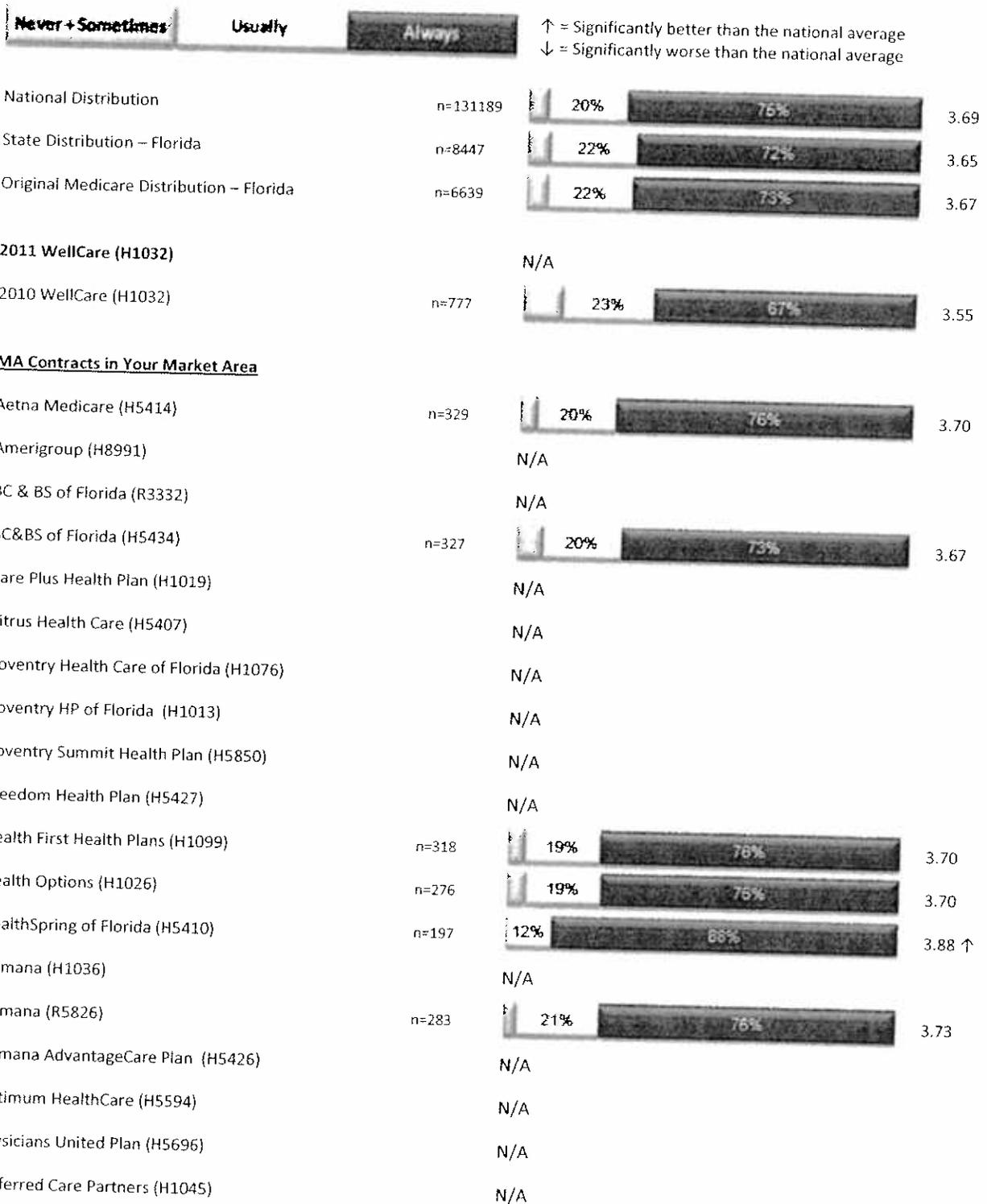
AvMed inc. (H1016)	n=280	18%	75%	3.67
Capital Health Plan (H5938)	n=371	18%	76%	3.70
Florida Health Care Plan (H1035)	n=311	21%	73%	3.67
Healthsun Health Plans (H5431)	n=149		88%	3.85 ↑
JMH Health Plan (H4155)		N/A		
Medica Healthcare Plans (H5420)	n=220	16%	80%	3.76
SecureHorizons by UnitedHealthcare (H9011)	n=243	18%	76%	3.70

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. We continue to provide results for this measure. However, this measure is no longer published in the Medicare & You handbook or displayed on Medicare Plan Finder.

WellCare (H1032)

Doctors Who Communicate Well: Providing Clear Explanations

Question 17: In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?



MA-PD CAHPS Results

WellCare of Ohio

WellCare (H1032)

MA Contracts in Your Market Area

Quality Health Plans (H5402)	n=337	25%	71%	3.67
SecureHorizons by Unitedhlthcare (H1080)	n=277	19%	78%	3.73
SecureHorizons by Unitedhlthcare (H5532)	n=289	21%	76%	3.70
SecureHorizons by Unitedhlthcare (R5287)	n=313	21%	74%	3.67
Universal Health Care (H5404)	N/A			
Universal Health Care (H5429)	N/A			

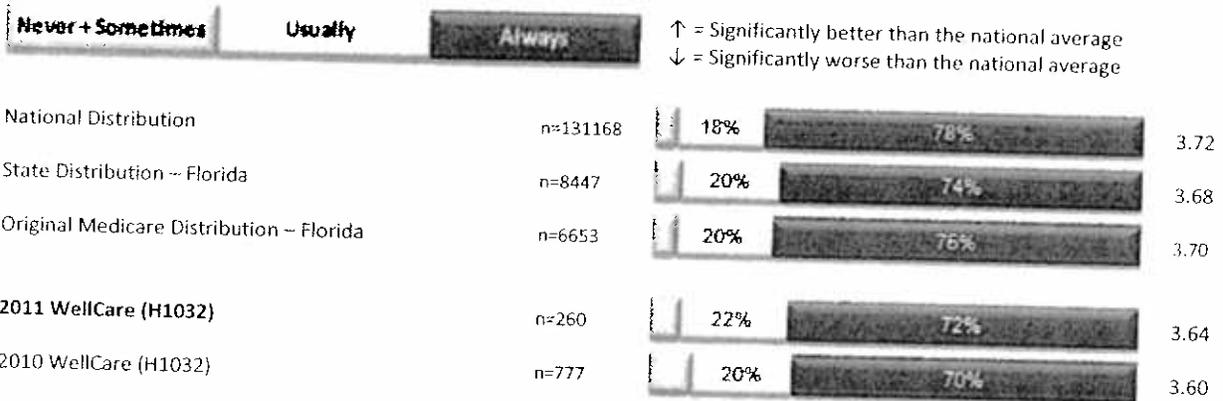
Other MA Contracts in Florida

AvMed Inc. (H1016)	N/A			
Capital Health Plan (H5938)	n=368	18%	77%	3.70
Florida Health Care Plan (H1035)	n=310	22%	72%	3.67
Healthsun Health Plans (H5431)	N/A			
JMH Health Plan (H4155)	N/A			
Medica Healthcare Plans (H5420)	N/A			
SecureHorizons by Unitedhlthcare (H9011)	N/A			

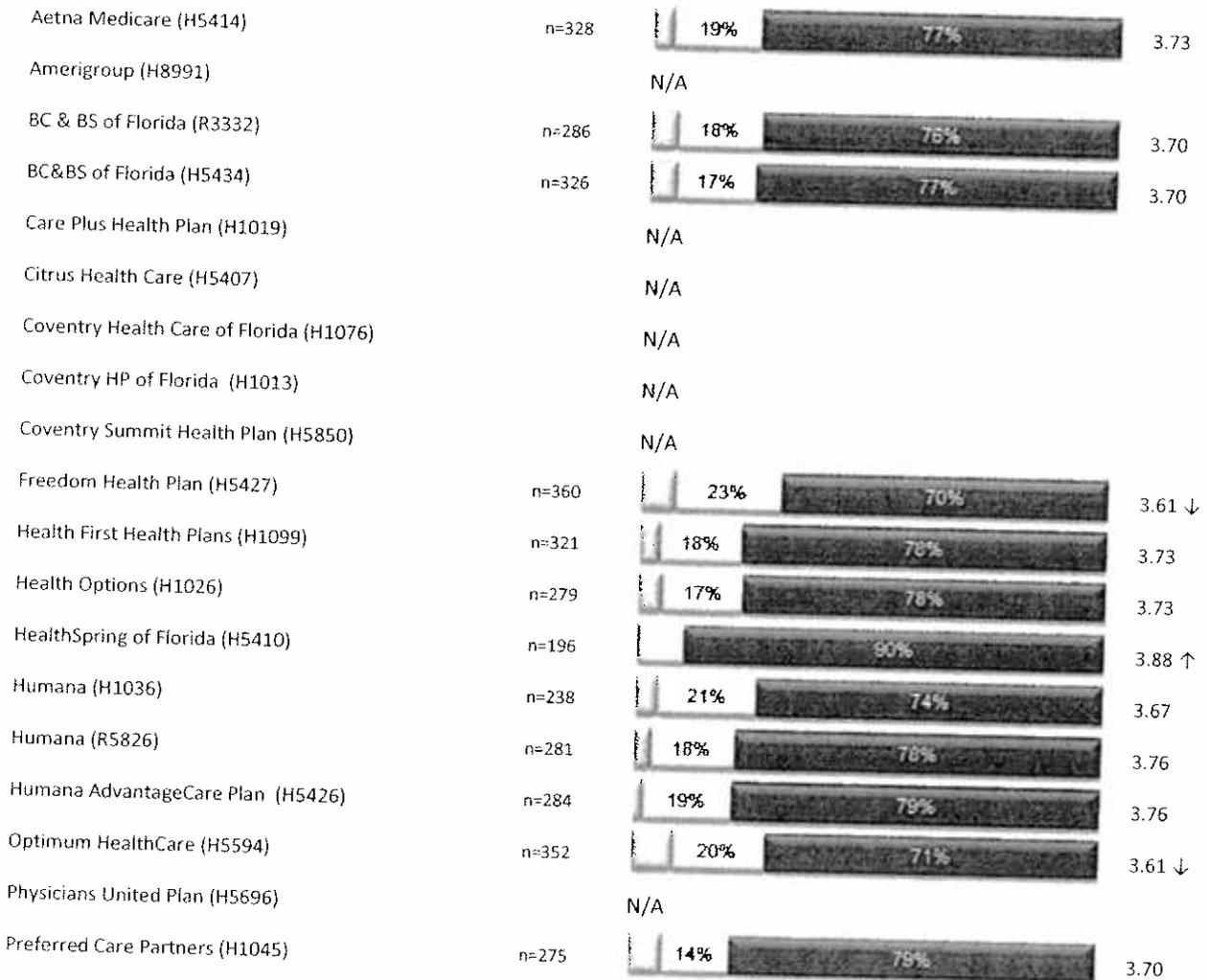
Note: Percentages may not add to 100 due to rounding. For information on how we defined your market area, calculated significance for the up and down arrows, and adjusted for case-mix, see Part 3 of this report.

Doctors Who Communicate Well: Listening Carefully

Question 18: In the last 6 months, how often did your personal doctor listen carefully to you?



MA Contracts in Your Market Area



WellCare (H1032)

MA Contracts in Your Market Area

Quality Health Plans (H5402)	n=338	26%	70%	3.67 ↓
SecureHorizons by Unitedhlthcare (H1080)	n=277	18%	77%	3.73
SecureHorizons by Unitedhlthcare (H5532)	n=293	20%	76%	3.73
SecureHorizons by Unitedhlthcare (R5287)	n=315	21%	74%	3.67
Universal Health Care (H5404)	n=277	16%	79%	3.73
Universal Health Care (H5429)	n=171	25%	73%	3.70

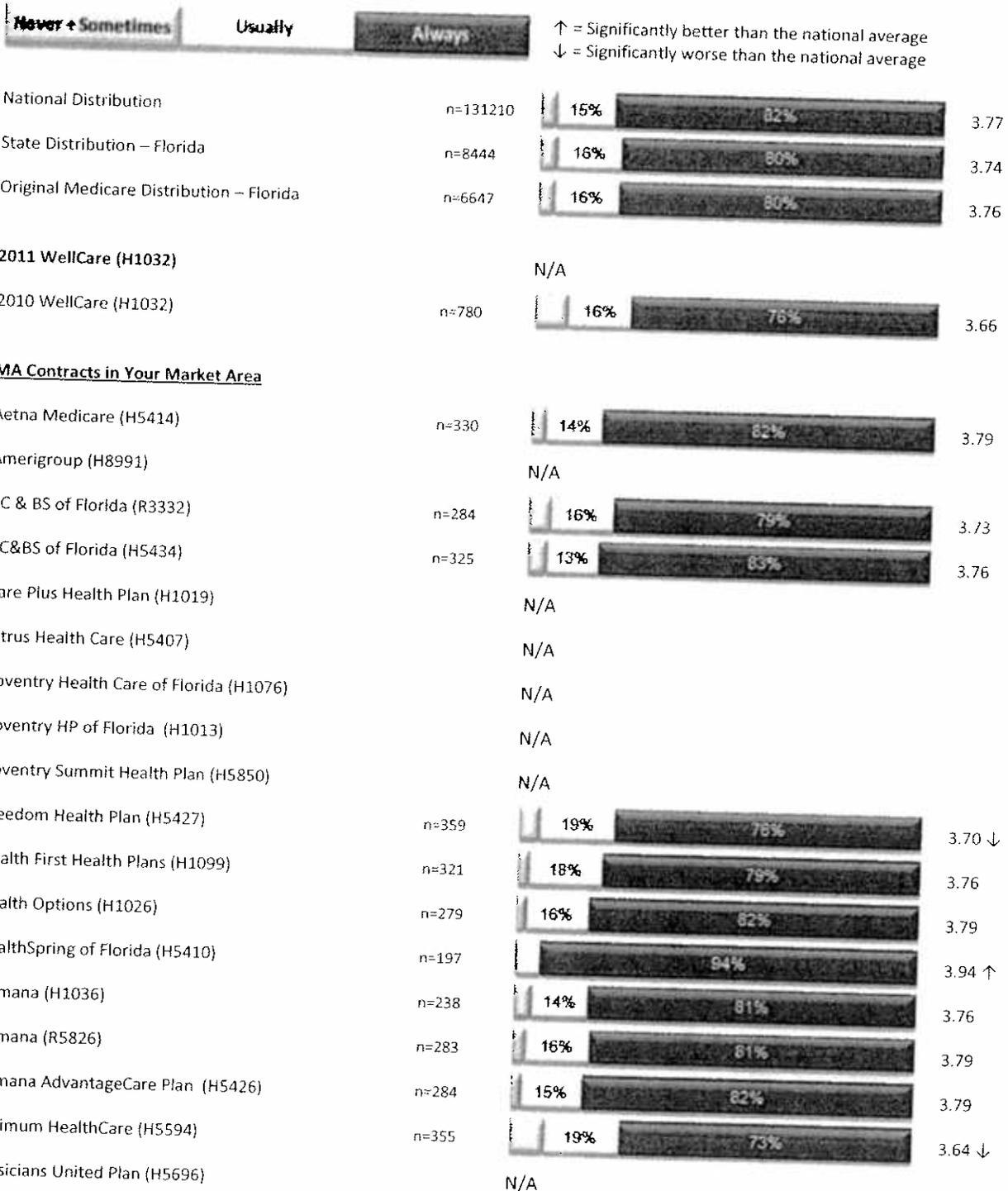
Other MA Contracts in Florida

AvMed Inc. (H1016)	n=277	16%	78%	3.70
Capital Health Plan (H5938)	n=369	17%	77%	3.70
Florida Health Care Plan (H1035)	n=309	22%	73%	3.67
Healthsun Health Plans (H5431)	n=142		90%	3.88 ↑
JMH Health Plan (H4155)		N/A		
Medica Healthcare Plans (H5420)	n=217	15%	81%	3.76
SecureHorizons by Unitedhlthcare (H9011)	n=240	19%	76%	3.70

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.

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

Question 19: In the last 6 months, how often did your personal doctor show respect for what you had to say?



WellCare (H1032)

MA Contracts in Your Market Area

Preferred Care Partners (H1045)	n=274	15%	81%	3.76
Quality Health Plans (H5402)	n=337	19%	77%	3.73
SecureHorizons by UnitedHlthcare (H1080)	n=279	14%	82%	3.79
SecureHorizons by UnitedHlthcare (H5532)	n=291	17%	79%	3.76
SecureHorizons by UnitedHlthcare (R5287)	n=317	18%	78%	3.73
Universal Health Care (H5404)	n=279	15%	81%	3.76
Universal Health Care (H5429)		N/A		

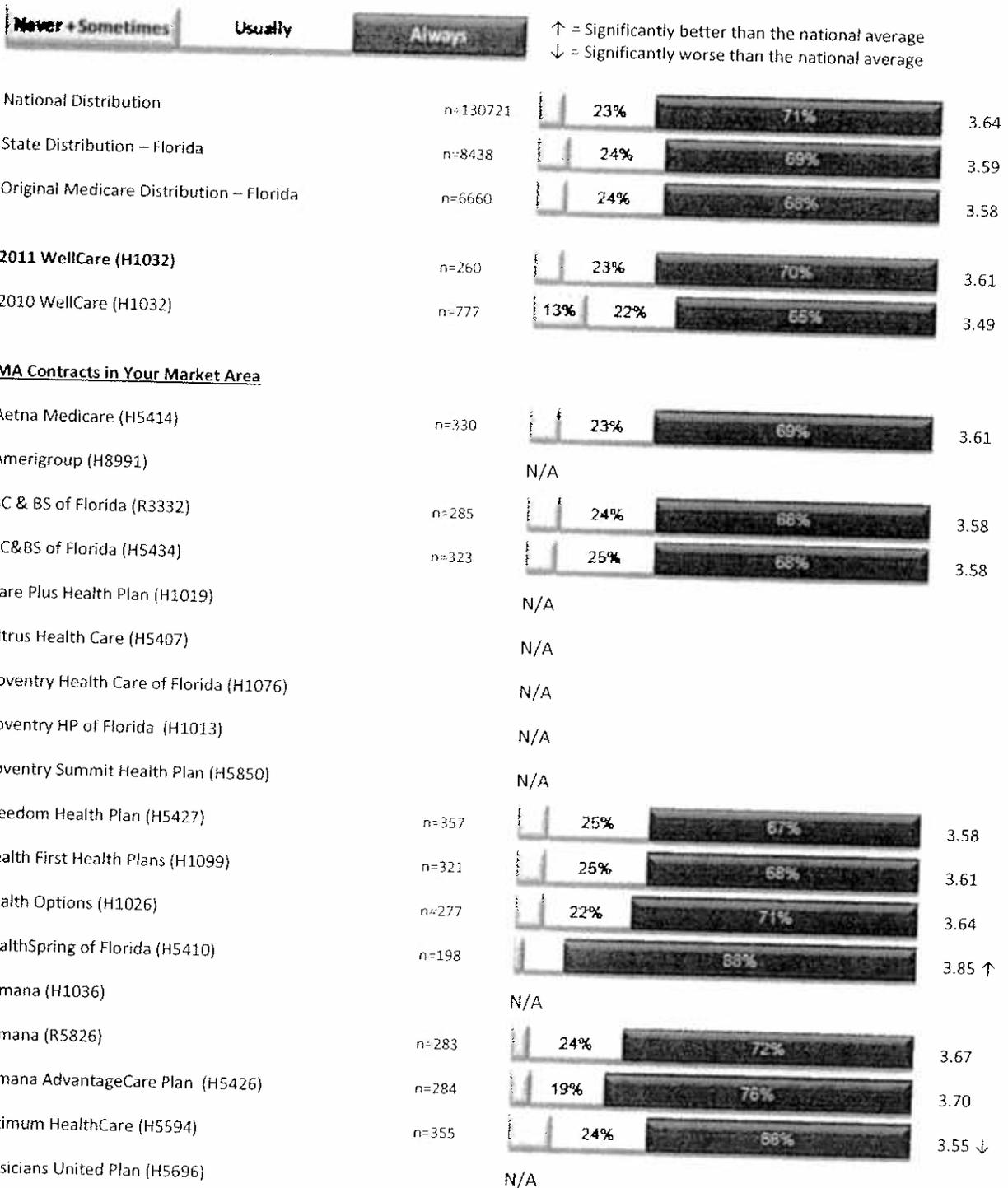
Other MA Contracts in Florida

AvMed Inc. (H1016)	n=278	16%	80%	3.76
Capital Health Plan (H5938)	n=367	15%	81%	3.76
Florida Health Care Plan (H1035)	n=310	18%	78%	3.73
Healthsun Health Plans (H5431)	n=142		95%	3.94 ↑
JMH Health Plan (H4155)		N/A		
Medica Healthcare Plans (H5420)	n=218	13%	84%	3.82
SecureHorizons by UnitedHlthcare (H9011)	n=237	13%	82%	3.76

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

Doctors Who Communicate Well: Spending Enough Time With Patients

Question 20: In the last 6 months, how often did your personal doctor spend enough time with you?



WellCare (H1032)

MA Contracts in Your Market Area

Preferred Care Partners (H1045)	n=273	20%	73%	3.64	
Quality Health Plans (H5402)	n=338	23%	70%	3.61	
SecureHorizons by UnitedHlthcare (H1080)	n=280	26%	69%	3.64	
SecureHorizons by UnitedHlthcare (H5532)	n=293	20%	75%	3.67	
SecureHorizons by UnitedHlthcare (R5287)	n=316	24%	69%	3.61	
Universal Health Care (H5404)	n=277	9%	20%	71%	3.58
Universal Health Care (H5429)				N/A	

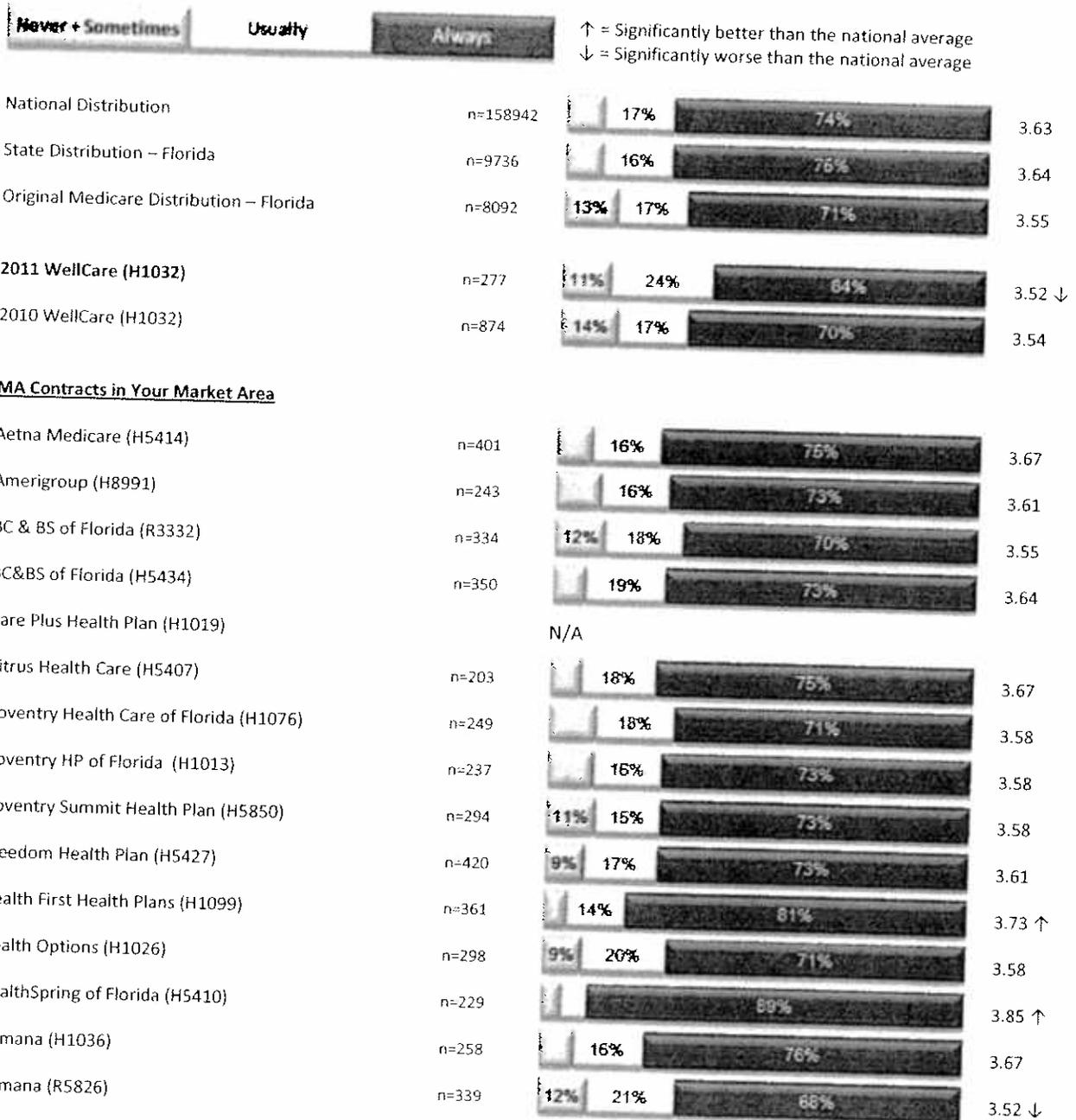
Other MA Contracts in Florida

AvMed Inc. (H1016)	n=278	20%	72%	3.61
Capital Health Plan (H5938)	n=366	22%	69%	3.61
Florida Health Care Plan (H1035)	n=310	23%	69%	3.61
Healthsun Health Plans (H5431)				N/A
JMH Health Plan (H4155)				N/A
Medica Healthcare Plans (H5420)	n=219	17%	77%	3.73 ↑
SecureHorizons by UnitedHlthcare (H9011)	n=241	23%	71%	3.64

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.

Health Plan Customer Service Composite

This table shows how your contract and other MA contracts in your area performed on “Health Plan Customer Service,” a composite of survey questions 33, 34 and 36. For each contract, the table shows: the number of members who answered at least one of these questions, 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. All statistics are adjusted for case-mix. Results for the individual questions included in this composite are on the following pages.



WellCare (H1032)

MA Contracts in Your Market Area

Humana AdvantageCare Plan (H5426)	n=310		3.64
Optimum HealthCare (H5594)	n=412		3.67
Physicians United Plan (H5696)	n=337		3.67
Preferred Care Partners (H1045)	n=321		3.76 ↑
Quality Health Plans (H5402)	n=400		3.67
SecureHorizons by UnitedHlthcare (H1080)	n=318		3.61
SecureHorizons by UnitedHlthcare (H5532)		N/A	
SecureHorizons by UnitedHlthcare (R5287)	n=362		3.55
Universal Health Care (H5404)	n=319		3.64
Universal Health Care (H5429)	n=220		3.61

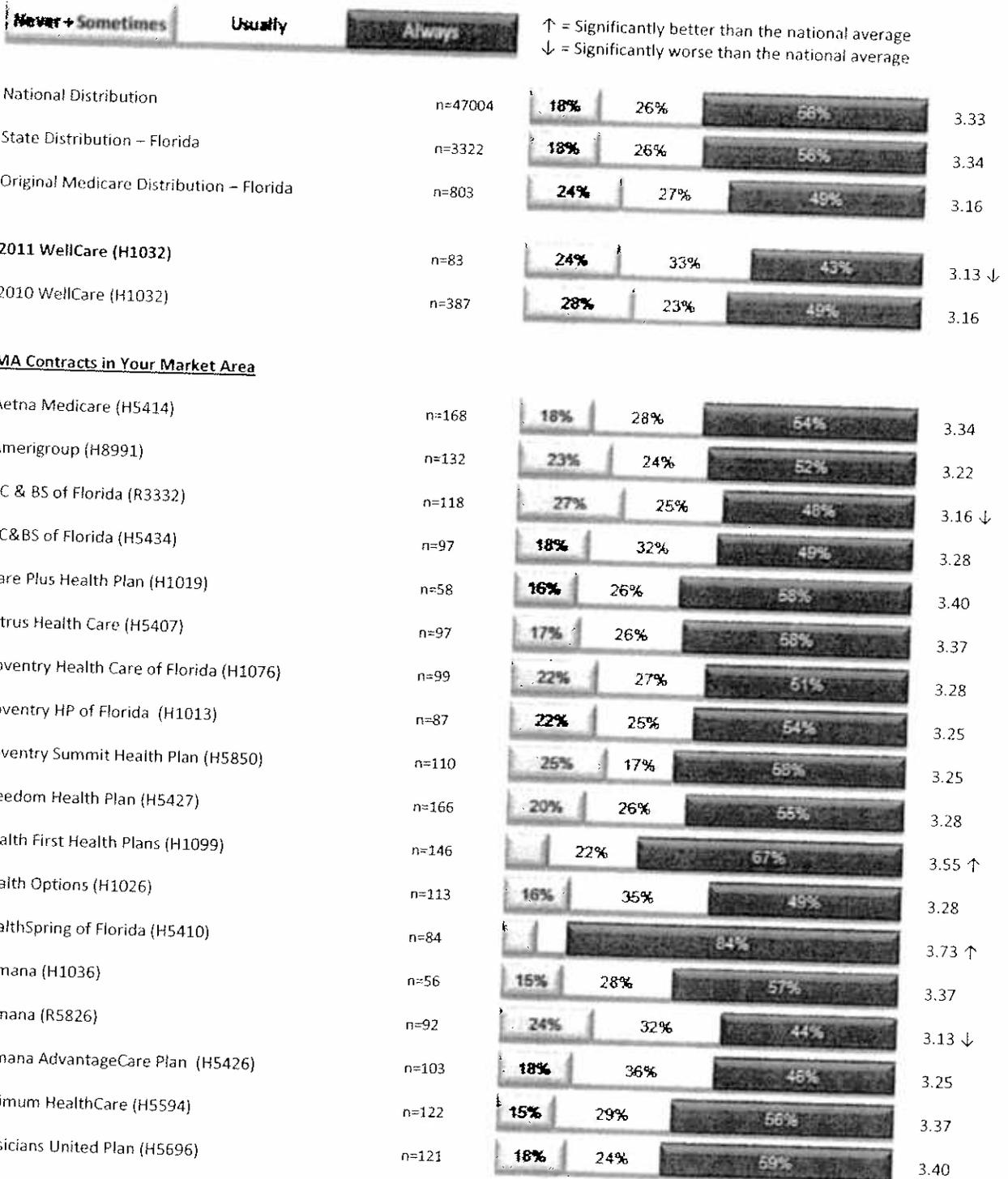
Other MA Contracts in Florida

AvMed Inc. (H1016)	n=341		3.73 ↑
Capital Health Plan (H5938)	n=431		3.88 ↑
Florida Health Care Plan (H1035)	n=371		3.67
Healthsun Health Plans (H5431)		N/A	
JMH Health Plan (H4155)		N/A	
Medica Healthcare Plans (H5420)	n=244		3.76 ↑
SecureHorizons by UnitedHlthcare (H9011)	n=293		3.52 ↓

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.

Health Plan Customer Service: Give Information Needed

Question 33: In the last 6 months, how often did your health plan's customer service give you the information or help you needed?



WellCare (H1032)

MA Contracts in Your Market Area

Preferred Care Partners (H1045)	n=120	23%	67%	3.55 ↑
Quality Health Plans (H5402)	n=142	19%	58%	3.34
SecureHorizons by Unitedhlthcare (H1080)	n=64	21%	52%	3.28
SecureHorizons by Unitedhlthcare (H5532)		N/A		
SecureHorizons by Unitedhlthcare (R5287)	n=92	23%	43%	3.13 ↓
Universal Health Care (H5404)	n=94	20%	51%	3.25
Universal Health Care (H5429)	n=82	24%	60%	3.25

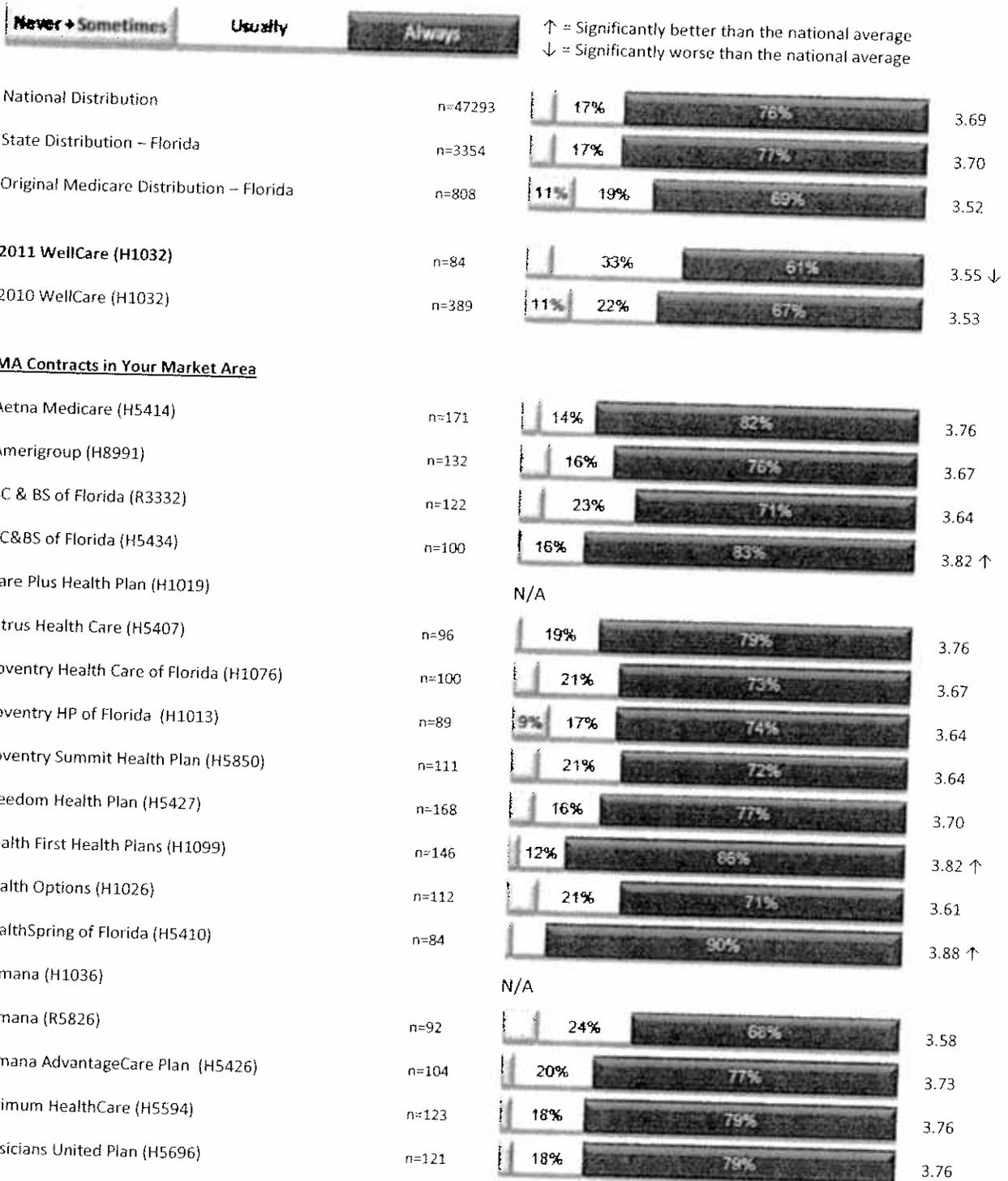
Other MA Contracts in Florida

AvMed Inc. (H1016)	n=121	19%	70%	3.58 ↑
Capital Health Plan (H5938)	n=114	15%	83%	3.82 ↑
Florida Health Care Plan (H1035)	n=84	15%	62%	3.46
Healthsun Health Plans (H5431)		N/A		
JMH Health Plan (H4155)		N/A		
Medica Healthcare Plans (H5420)	n=92	21%	66%	3.55 ↑
SecureHorizons by Unitedhlthcare (H9011)	n=126	28%	43%	3.07 ↓

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.

Health Plan Customer Service: Courtesy and Respect

Question 34: In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?



WellCare (H1032)

MA Contracts in Your Market Area

Preferred Care Partners (H1045)	n=121		3.79 ↑
Quality Health Plans (H5402)	n=141		3.70
SecureHorizons by Unitedhlthcare (H1080)		N/A	
SecureHorizons by Unitedhlthcare (H5532)		N/A	
SecureHorizons by Unitedhlthcare (R5287)	n=94		3.61
Universal Health Care (H5404)	n=96		3.79
Universal Health Care (H5429)		N/A	

Other MA Contracts in Florida

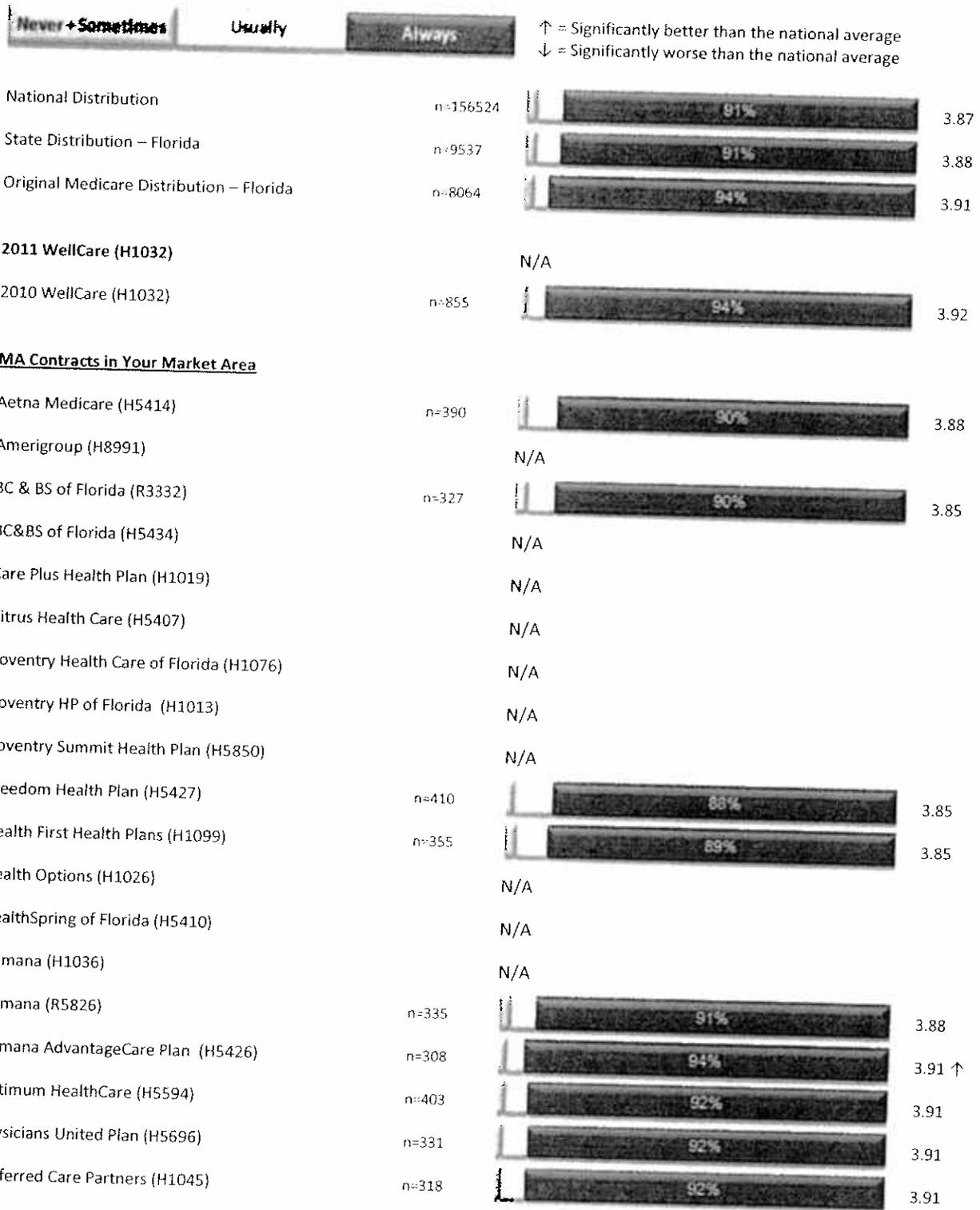
AvMed Inc. (H1016)	n=121		3.79 ↑
Capital Health Plan (H5938)	n=116		3.94 ↑
Florida Health Care Plan (H1035)	n=85		3.76
Healthsun Health Plans (H5431)		N/A	
JMH Health Plan (H4155)		N/A	
Medica Healthcare Plans (H5420)	n=92		3.76
SecureHorizons by Unitedhlthcare (H9011)	n=126		3.61

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.

WellCare (H1032)

Health Plan Customer Service: Forms Were Easy to Fill Out

Question 36: In the last 6 months, how often were the forms from your health plan easy to fill out?



MA-PD CAHPS Results

WellCare of Ohio

WellCare (H1032)

MA Contracts in Your Market Area

Quality Health Plans (H5402)	n=389		3.94 ↑
SecureHorizons by Unitedhlthcare (H1080)	n=312		3.91 ↑
SecureHorizons by Unitedhlthcare (H5532)	n=329		3.94 ↑
SecureHorizons by Unitedhlthcare (R5287)	n=358		3.88
Universal Health Care (H5404)	n=314		3.91
Universal Health Care (H5429)		N/A	

Other MA Contracts in Florida

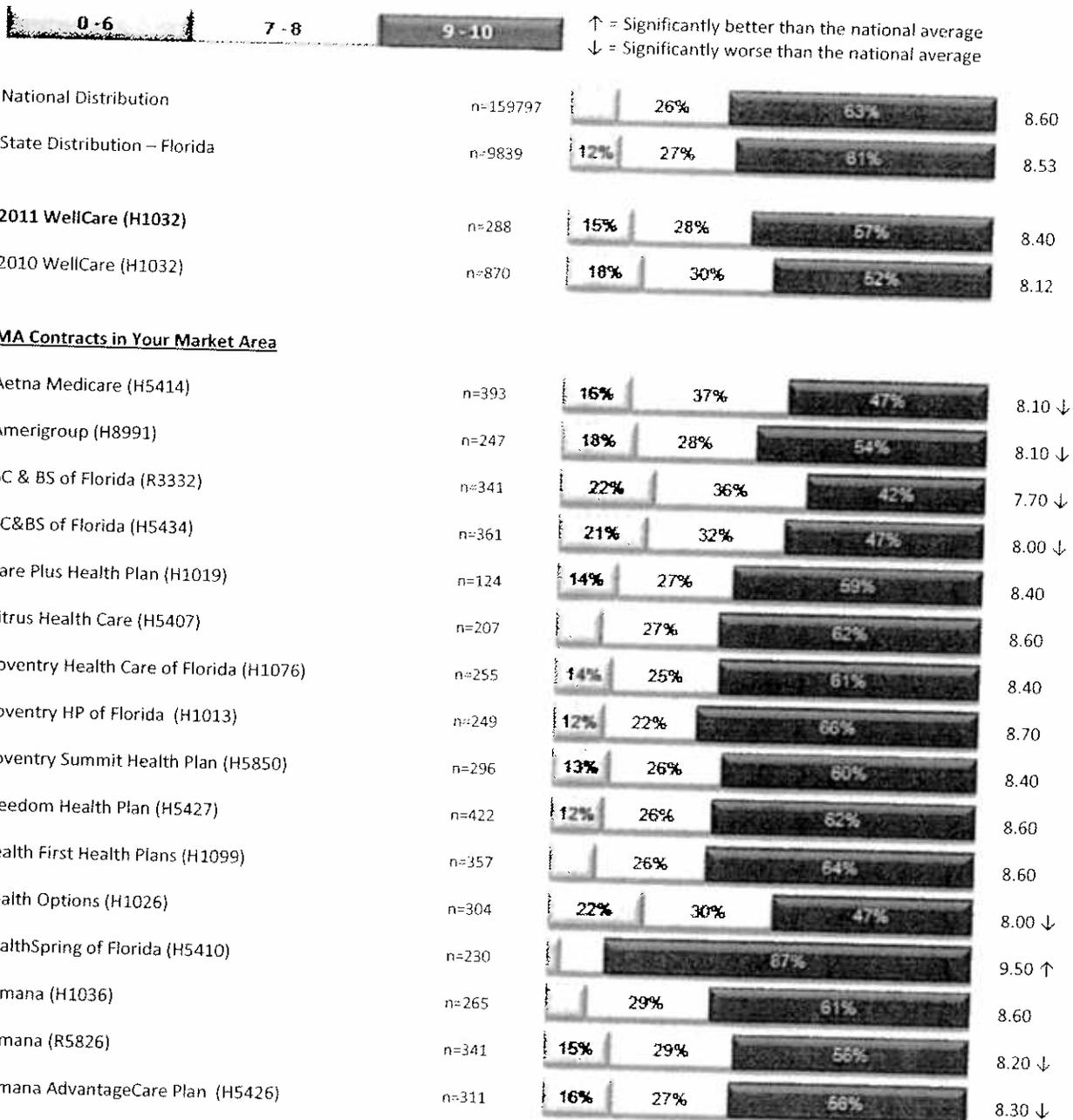
AvMed Inc. (H1016)	n=333		3.88
Capital Health Plan (H5938)	n=426		3.88
Florida Health Care Plan (H1035)		N/A	
Healthsun Health Plans (H5431)		N/A	
JMH Health Plan (H4155)		N/A	
Medica Healthcare Plans (H5420)	n=244		3.97 ↑
SecureHorizons by Unitedhlthcare (H9011)	n=285		3.91

Note: If the response to Q35 was "No", respondents were instructed to skip Q36. The response was re-coded as "Always" for Q36 for those who appropriately skipped the item. 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.

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.



WellCare (H1032)

MA Contracts in Your Market Area

Optimum HealthCare (H5594)	n=414	9%	26%	64%	8.70
Physicians United Plan (H5696)	n=332		29%	60%	8.50
Preferred Care Partners (H1045)	n=320		25%	69%	8.90 ↑
Quality Health Plans (H5402)	n=399	16%	28%	56%	8.30 ↓
SecureHorizons by Unitedhlthcare (H1080)	n=330		31%	58%	8.50
SecureHorizons by Unitedhlthcare (H5532)	n=332	9%	28%	63%	8.60
SecureHorizons by Unitedhlthcare (R5287)	n=356	16%	32%	52%	8.20 ↓
Universal Health Care (H5404)	n=325	12%	30%	58%	8.40
Universal Health Care (H5429)	n=217	21%	36%	43%	7.80 ↓

Other MA Contracts in Florida

AvMed inc. (H1016)	n=348		22%	72%	9.00 ↑
Capital Health Plan (H5938)	n=441			67%	9.40 ↑
Florida Health Care Plan (H1035)	n=378		28%	64%	8.80 ↑
Healthsun Health Plans (H5431)	n=160		17%	73%	8.80
JMH Health Plan (H4155)	n=191	16%	18%	66%	8.50
Medica Healthcare Plans (H5420)	n=251	16%		80%	9.20 ↑
SecureHorizons by Unitedhlthcare (H9011)	n=289	17%	31%	53%	8.20 ↓

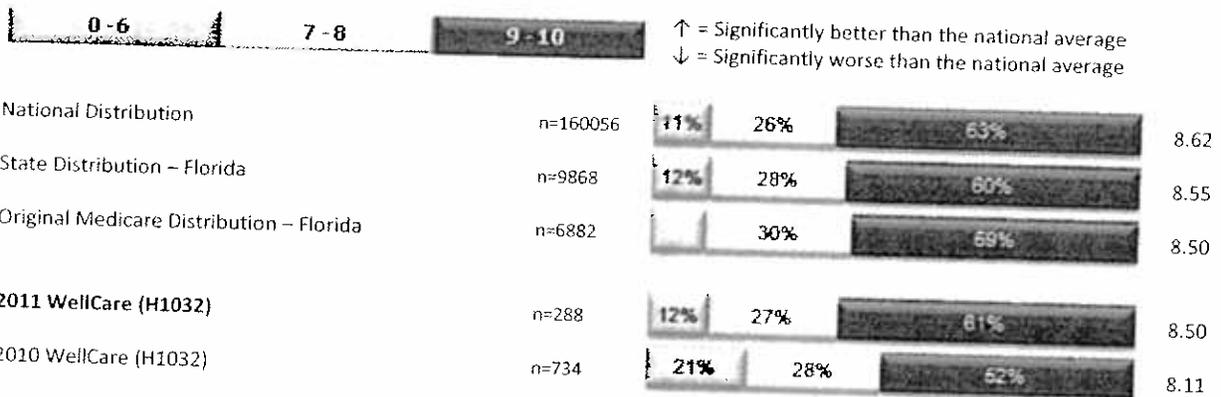
Note: Percentages may not add to 100 due to rounding. For information on how we defined your market area, calculated significance for the up and down arrows, and adjusted for case-mix, see Part 3 of this report.

Overall Rating of Care Received

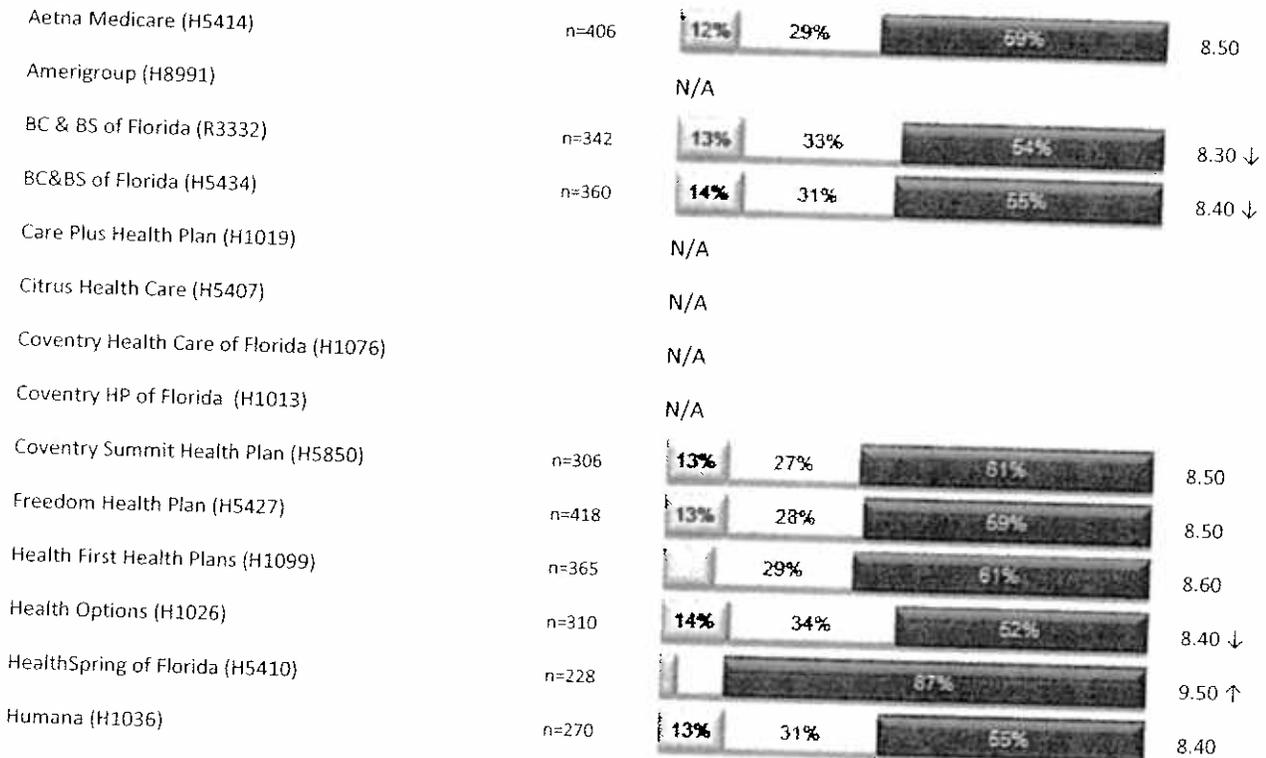
Question 12: Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

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.

[Scored only for those who visited a doctor or clinic in the last 6 months.]



MA Contracts in Your Market Area



WellCare (H1032)

MA Contracts in Your Market Area

Humana (R5826)	n=346	13%	29%	59%	8.50
Humana AdvantageCare Plan (H5426)	n=318	13%	27%	59%	8.50
Optimum HealthCare (H5594)	n=398	13%	27%	59%	8.50
Physicians United Plan (H5696)	n=331	15%	31%	54%	8.30 ↓
Preferred Care Partners (H1045)	n=315	12%	25%	64%	8.70
Quality Health Plans (H5402)	n=402	12%	29%	59%	8.50
SecureHorizons by UnitedHlthcare (H1080)	n=329	13%	23%	64%	8.60
SecureHorizons by UnitedHlthcare (H5532)	n=331	9%	27%	64%	8.70
SecureHorizons by UnitedHlthcare (R5287)	n=358	11%	31%	58%	8.50
Universal Health Care (H5404)	n=325	12%	29%	69%	8.50
Universal Health Care (H5429)	n=216	14%	40%	46%	8.20 ↓

Other MA Contracts in Florida

AvMed Inc. (H1016)	n=334	12%	27%	61%	8.60
Capital Health Plan (H5938)	n=450		22%	70%	8.90 ↑
Florida Health Care Plan (H1035)	n=381		28%	62%	8.60
Healthsun Health Plans (H5431)		N/A			
JMH Health Plan (H4155)		N/A			
Medica Healthcare Plans (H5420)	n=251		25%	64%	8.70
SecureHorizons by UnitedHlthcare (H9011)	n=292	15%	25%	60%	8.40 ↓

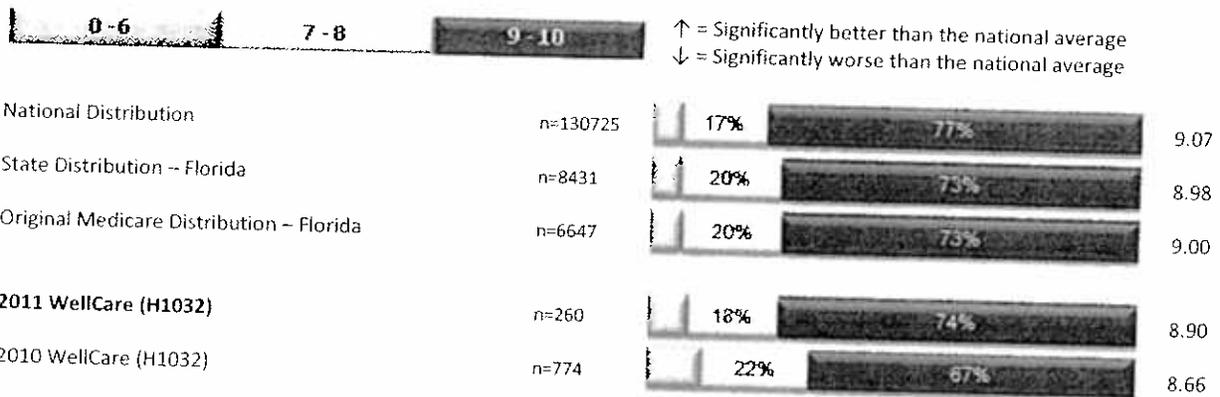
Note: Percentages may not add to 100 due to rounding. For information on how we defined your market area, calculated significance for the up and down arrows, and adjusted for case-mix, see Part 3 of this report.

Overall Rating of Personal Doctor

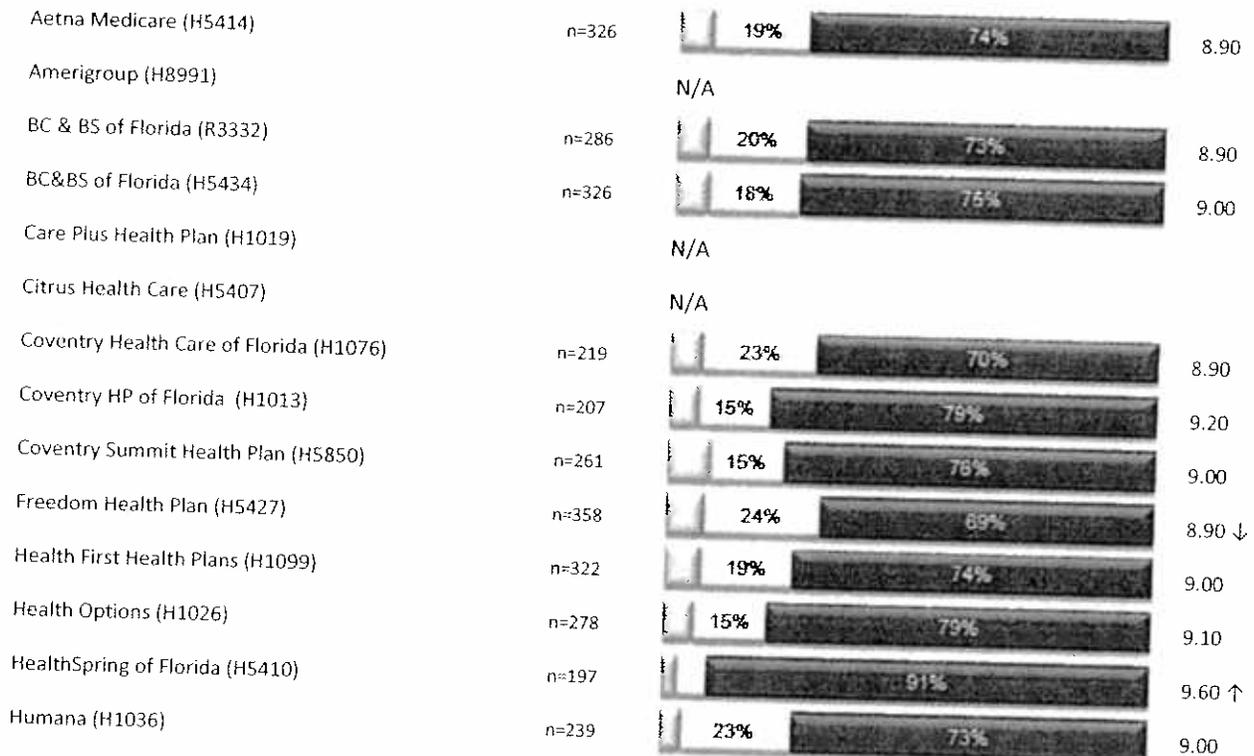
Question 21 : Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

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.

[Scored only for those who have a personal doctor.]



MA Contracts in Your Market Area



WellCare (H1032)

MA Contracts in Your Market Area

Humana (R5826)	n=282	18%	76%	9.00	
Humana AdvantageCare Plan (H5426)	n=281	19%	75%	9.00	
Optimum HealthCare (H5594)	n=352	20%	70%	8.80 ↓	
Physicians United Plan (H5696)	n=299	13%	21%	66%	8.60 ↓
Preferred Care Partners (H1045)	n=273	21%	71%	9.00	
Quality Health Plans (H5402)	n=336	23%	71%	9.00	
SecureHorizons by Unitedhlthcare (H1080)	n=280	21%	73%	9.10	
SecureHorizons by Unitedhlthcare (H5532)	n=291	20%	77%	9.10	
SecureHorizons by Unitedhlthcare (R5287)	n=315	22%	72%	8.90	
Universal Health Care (H5404)	n=278	17%	74%	9.00	
Universal Health Care (H5429)	n=172	28%	66%	8.90	

Other MA Contracts in Florida

AvMed Inc. (H1016)	n=279	19%	74%	9.00
Capital Health Plan (H5938)	n=366	16%	79%	9.10
Florida Health Care Plan (H1035)	n=312	21%	73%	9.00
Healthsun Health Plans (H5431)		N/A		
JMH Health Plan (H4155)		N/A		
Medica Healthcare Plans (H5420)	n=218	14%	79%	9.10
SecureHorizons by Unitedhlthcare (H9011)	n=240	17%	76%	9.10

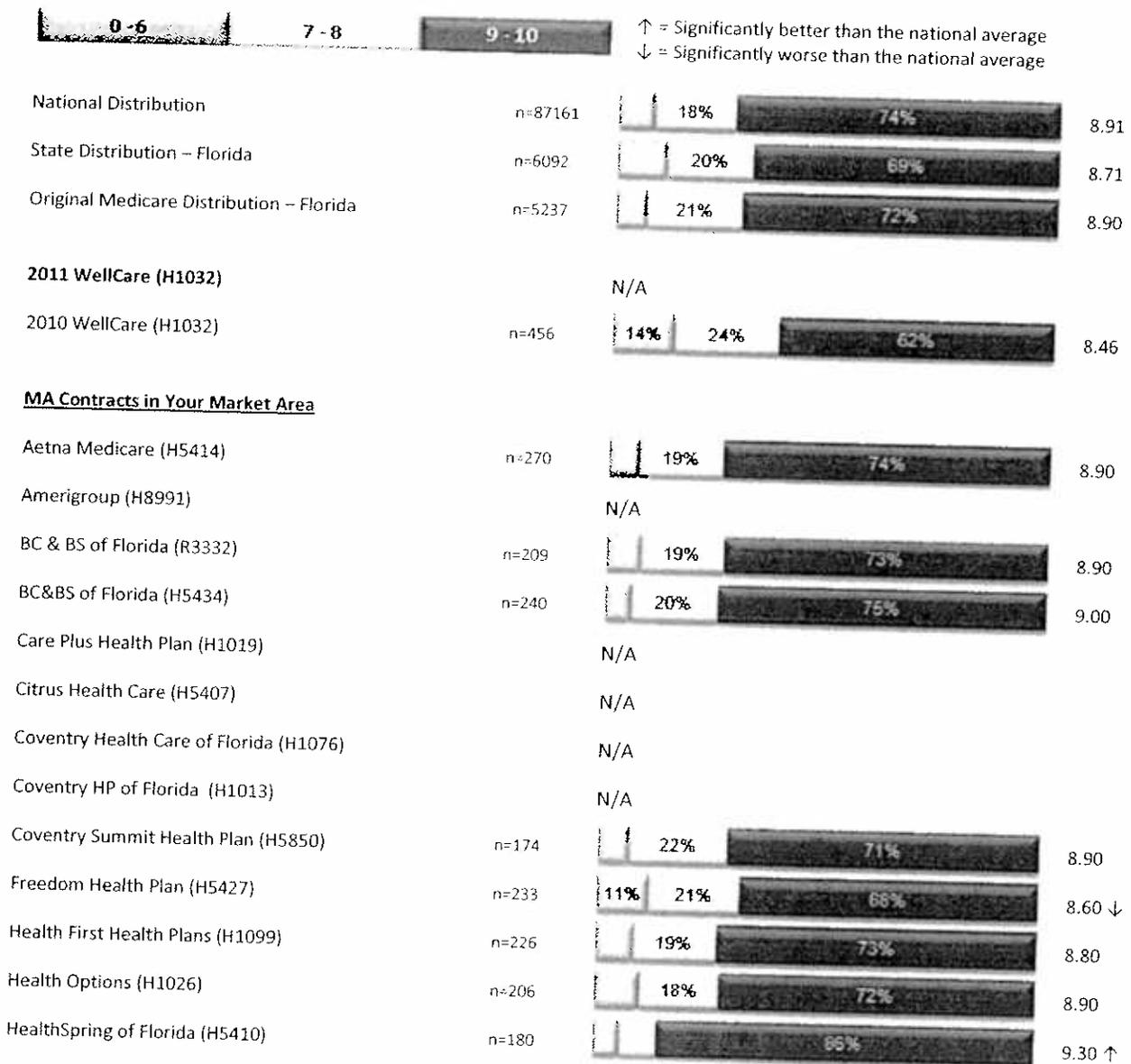
Note: Percentages may not add to 100 due to rounding. For information on how we defined your market area, calculated significance for the up and down arrows, and adjusted for case-mix, see Part 3 of this report.

Overall Rating of Specialist

Question 28: We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

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.

[Scored only for those who saw a specialist in the last 6 months.]



WellCare (H1032)

MA Contracts in Your Market Area

Humana (H1036)		N/A		
Humana (R5826)	n=207	18%	72%	8.80
Humana AdvantageCare Plan (H5426)				N/A
Optimum HealthCare (H5594)	n=214	20%	70%	8.70
Physicians United Plan (H5696)	n=189	23%	66%	8.70 ↓
Preferred Care Partners (H1045)	n=206	19%	73%	8.80
Quality Health Plans (H5402)	n=223	20%	73%	8.90
SecureHorizons by UnitedHlthcare (H1080)	n=187	23%	69%	8.80
SecureHorizons by UnitedHlthcare (H5532)	n=197	20%	73%	9.00
SecureHorizons by UnitedHlthcare (R5287)	n=230	24%	66%	8.70 ↓
Universal Health Care (H5404)	n=184	21%	71%	8.90
Universal Health Care (H5429)				N/A

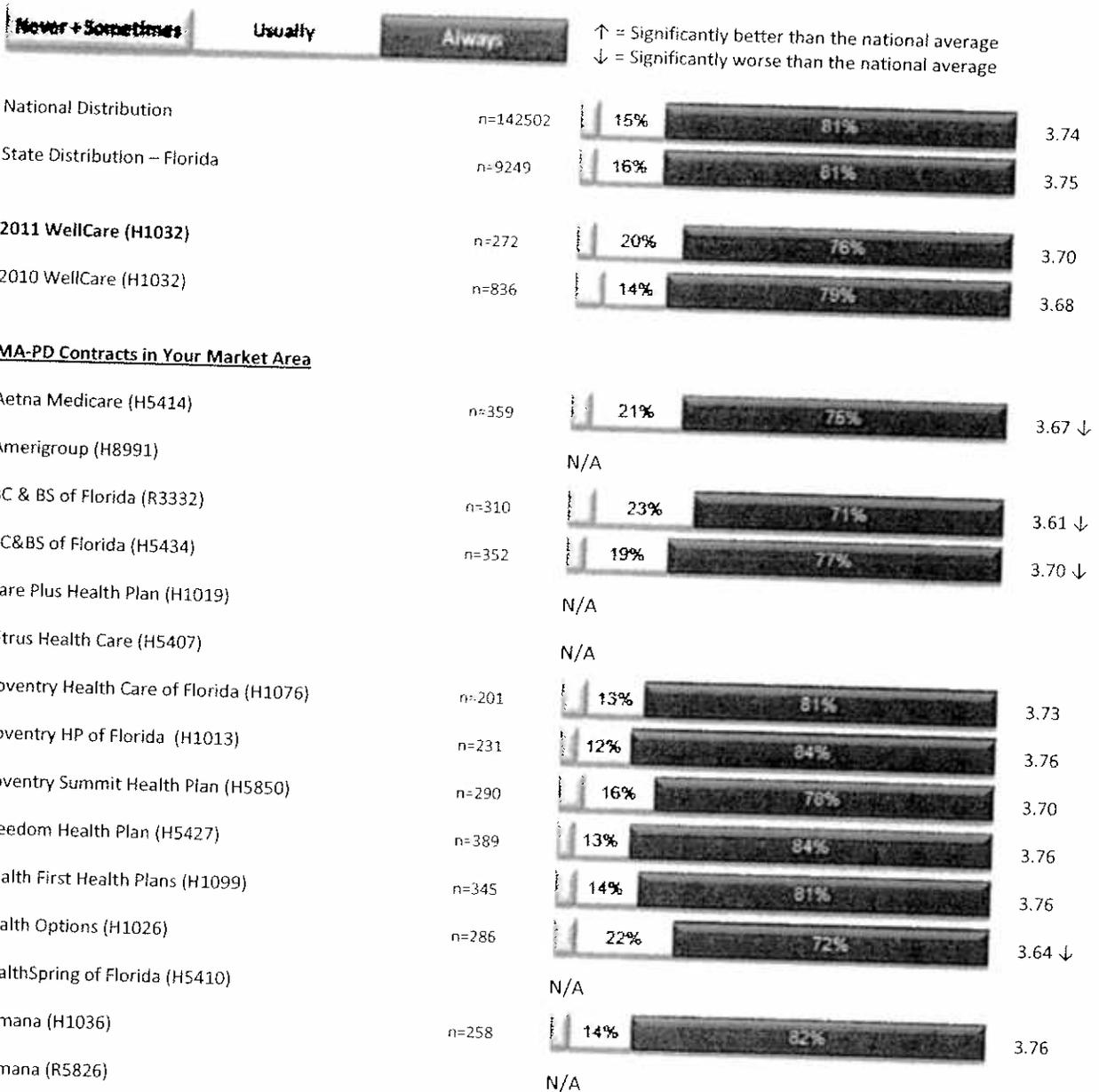
Other MA Contracts in Florida

AvMed Inc. (H1016)	n=256	17%	76%	9.00
Capital Health Plan (H5938)	n=280	18%	74%	9.00
Florida Health Care Plan (H1035)	n=245	25%	65%	8.60 ↓
Healthsun Health Plans (H5431)				N/A
JMH Health Plan (H4155)				N/A
Medica Healthcare Plans (H5420)	n=171	16%	77%	9.00
SecureHorizons by UnitedHlthcare (H9011)	n=198	22%	74%	9.10

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.

Getting Needed Prescription Drugs Composite

This table shows how your contract and other MA-PD contracts in your area performed on "Getting Needed Prescription Drugs," a composite of survey questions 55, 57, and 59. For each contract, the table shows: the number of members who answered at least one of these questions, 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-PD 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. All statistics are adjusted for case-mix. Results for the individual questions included in this composite are on the following pages. Questions 57 and 59 were combined for inclusion in the composite; both the combined and individual results are presented. There are no benchmarks for Original Medicare for this composite and its component items.



WellCare (H1032)

MA-PD Contracts in Your Market Area

Humana AdvantageCare Plan (H5426)	n=298	16%	79%	3.73
Optimum HealthCare (H5594)	n=369	13%	84%	3.79 ↑
Physicians United Plan (H5696)	n=317	15%	80%	3.73
Preferred Care Partners (H1045)	n=304	13%	84%	3.79
Quality Health Plans (H5402)	n=380	17%	81%	3.73
SecureHorizons by UnitedHlthcare (H1080)	n=309	14%	83%	3.79 ↑
SecureHorizons by UnitedHlthcare (H5532)	n=320	16%	80%	3.73
SecureHorizons by UnitedHlthcare (R5287)	n=338	18%	79%	3.73
Universal Health Care (H5404)	n=309	16%	80%	3.73
Universal Health Care (H5429)	n=192	21%	73%	3.64 ↓

Other MA-PD Contracts in Florida

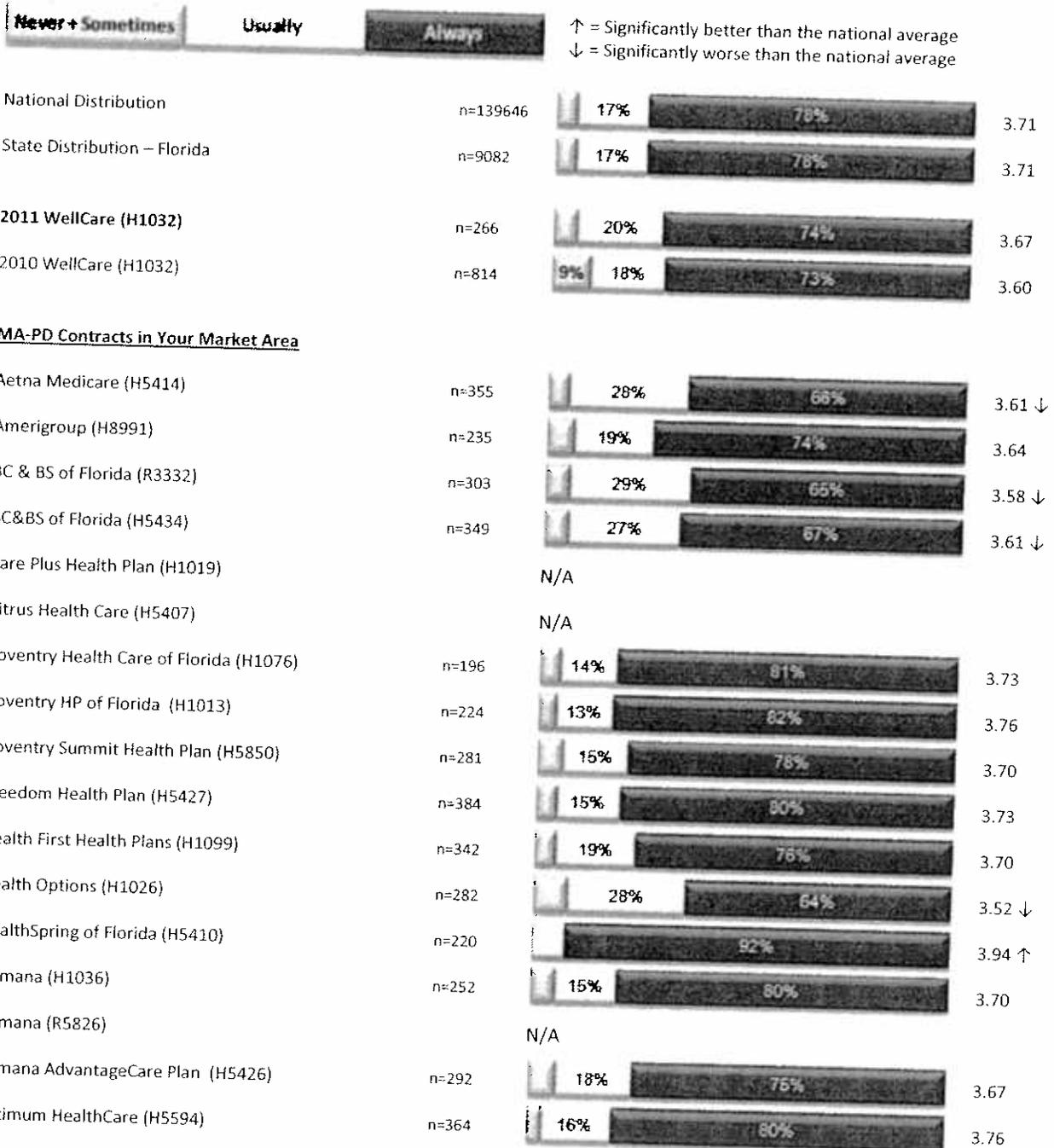
AvMed Inc. (H1016)	n=326	15%	83%	3.79
Capital Health Plan (H5938)	n=416		92%	3.91 ↑
Florida Health Care Plan (H1035)	n=358		90%	3.85 ↑
Healthsun Health Plans (H5431)		N/A		
JMH Health Plan (H4155)		N/A		
Medica Healthcare Plans (H5420)	n=233	12%	85%	3.82 ↑
SecureHorizons by UnitedHlthcare (H9011)	n=275	18%	78%	3.70

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.

Getting Needed Prescription Drugs: Ease of Getting Prescribed Medicines

Question 55: In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?

[Scored only for those who used their health plan in the last 6 months to get medicines their doctors prescribed.]



WellCare (H1032)

MA-PD Contracts in Your Market Area

Physicians United Plan (H5696)	n=314	19%	77%	3.73
Preferred Care Partners (H1045)	n=300	14%	82%	3.76
Quality Health Plans (H5402)	n=374	19%	76%	3.67
SecureHorizons by Unitedhlthcare (H1080)	n=301	19%	79%	3.76
SecureHorizons by Unitedhlthcare (H5532)	n=313	20%	75%	3.67
SecureHorizons by Unitedhlthcare (R5287)	n=331	21%	75%	3.67
Universal Health Care (H5404)	n=299	21%	73%	3.64
Universal Health Care (H5429)	n=183	29%	65%	3.58 ↓

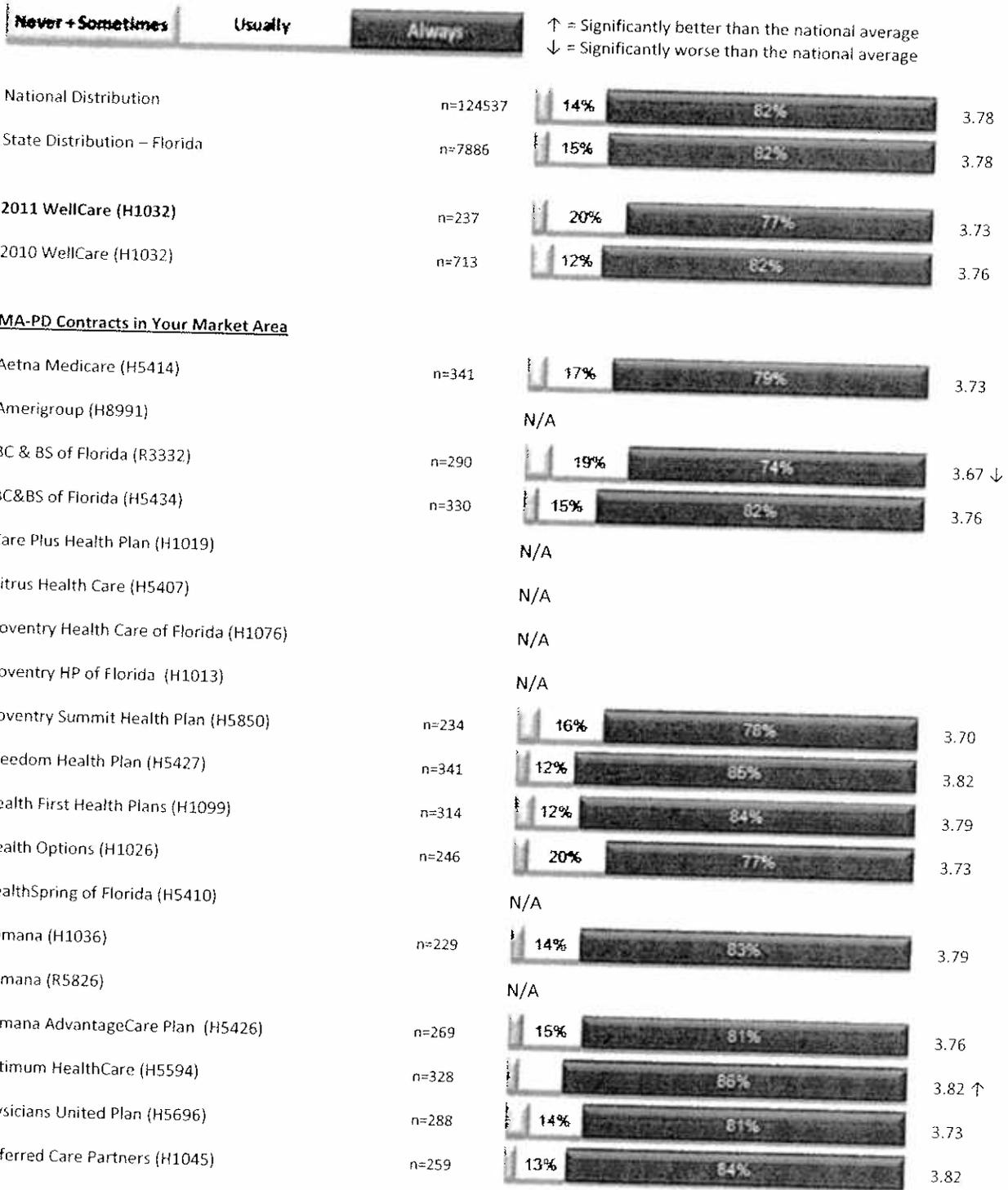
Other MA-PD Contracts in Florida

AvMed Inc. (H1016)	n=319	18%	79%	3.73
Capital Health Plan (H5938)	n=409		91%	3.91 ↑
Florida Health Care Plan (H1035)	n=354		88%	3.82 ↑
Healthsun Health Plans (H5431)		N/A		
JMH Health Plan (H4155)		N/A		
Medica Healthcare Plans (H5420)	n=232	12%	84%	3.79 ↑
SecureHorizons by Unitedhlthcare (H9011)	n=272	19%	76%	3.70

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.

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

[Scored only for those who used their health plan in the last 6 months to get medicines their doctors prescribed.]



WellCare (H1032)

MA-PD Contracts in Your Market Area

Quality Health Plans (H5402)	n=345	15%	83%	3.79
SecureHorizons by Unitedhlthcare (H1080)	n=279	12%	86%	3.82 ↑
SecureHorizons by Unitedhlthcare (H5532)	n=290	14%	82%	3.76
SecureHorizons by Unitedhlthcare (R5287)	n=313	16%	81%	3.76
Universal Health Care (H5404)	n=276	14%	83%	3.79
Universal Health Care (H5429)		N/A		

Other MA-PD Contracts in Florida

AvMed Inc. (H1016)	n=288	13%	85%	3.82 ↑
Capital Health Plan (H5938)	n=387		93%	3.91 ↑
Florida Health Care Plan (H1035)	n=223		81%	3.88 ↑
Healthsun Health Plans (H5431)		N/A		
JMH Health Plan (H4155)		N/A		
Medica Healthcare Plans (H5420)	n=199	12%	88%	3.85 ↑
SecureHorizons by Unitedhlthcare (H9011)	n=253	17%	79%	3.73

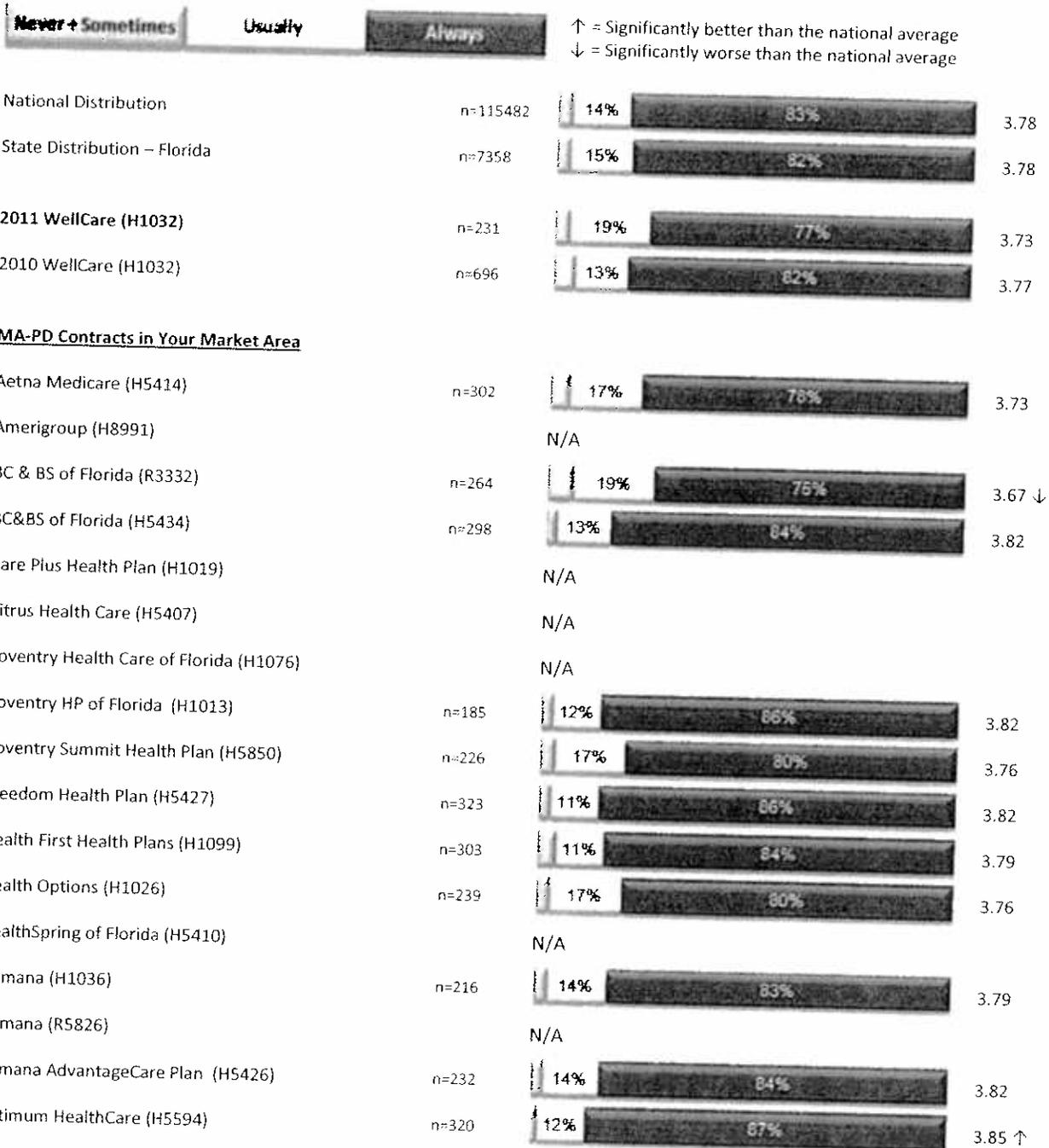
Note: Percentages may not add to 100 due to rounding. For information on how we defined your market area, calculated significance for the up and down arrows, and adjusted for case-mix, see Part 3 of this report.

WellCare (H1032)

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

Question 57: In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?

[Scored only for those who used their health plan in the last 6 months to get medicines their doctors prescribed.]



WellCare (H1032)

MA-PD Contracts in Your Market Area

Physicians United Plan (H5696)	n=276	14%	81%	3.73
Preferred Care Partners (H1045)	n=249	12%	85%	3.82
Quality Health Plans (H5402)	n=312	16%	84%	3.82
SecureHorizons by Unitedhlthcare (H1080)	n=266	12%	86%	3.85 ↑
SecureHorizons by Unitedhlthcare (H5532)	n=278	14%	82%	3.79
SecureHorizons by Unitedhlthcare (R5287)	n=294	16%	80%	3.76
Universal Health Care (H5404)	n=254	13%	84%	3.79
Universal Health Care (H5429)		N/A		

Other MA-PD Contracts in Florida

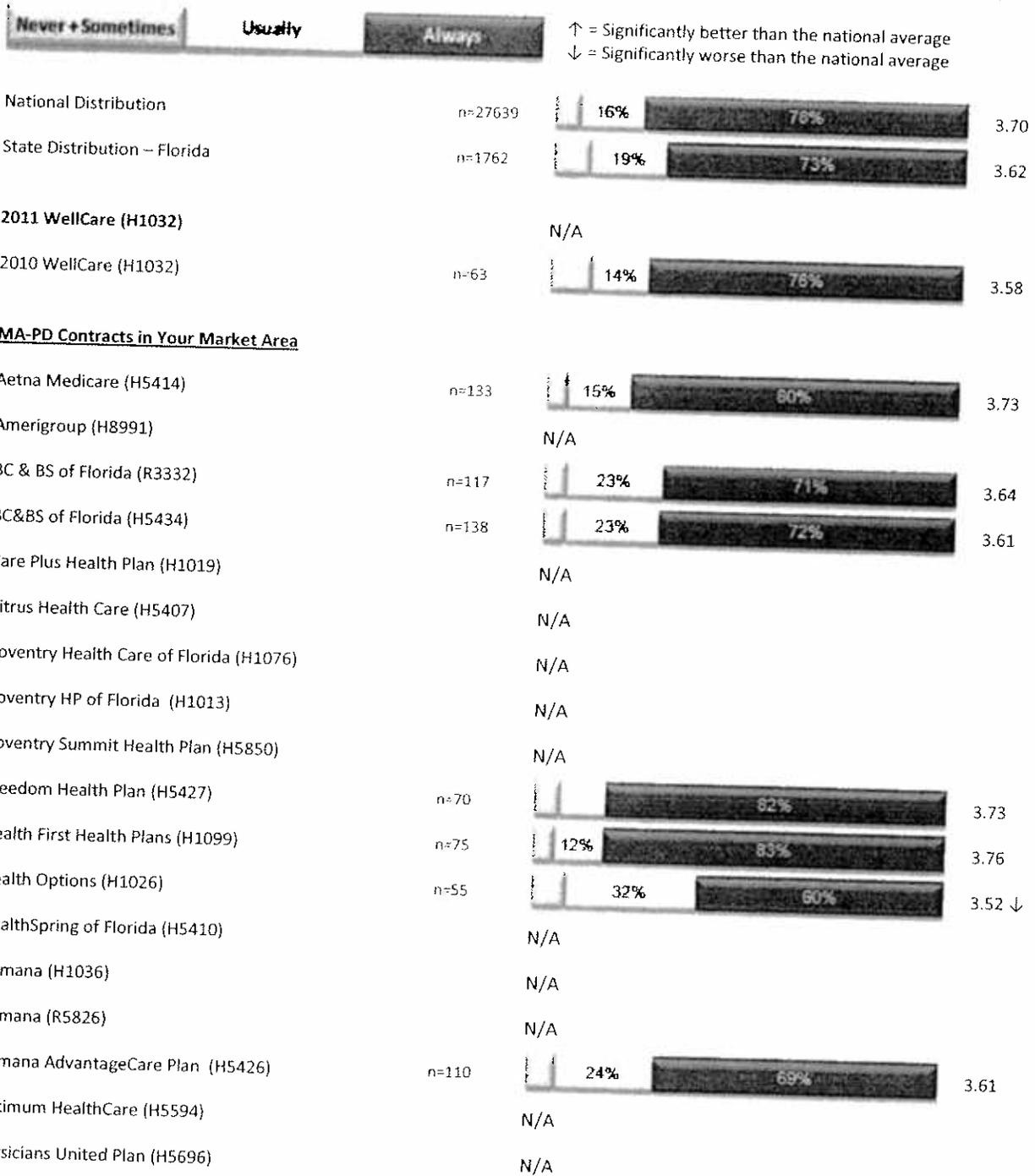
AvMed Inc. (H1016)	n=287	13%	85%	3.85 ↑
Capital Health Plan (H5938)	n=380		93%	3.91 ↑
Florida Health Care Plan (H1035)		N/A		
Healthsun Health Plans (H5431)		N/A		
JMH Health Plan (H4155)		N/A		
Medica Healthcare Plans (H5420)	n=197	12%	87%	3.85 ↑
SecureHorizons by Unitedhlthcare (H9011)	n=245	17%	80%	3.76

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.

Getting Needed Prescription Drugs: Ease of Filling Prescriptions by Mail

Question 59: In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?

[Scored only for those who used their health plan in the last 6 months to get medicines their doctors prescribed.]



WellCare (H1032)

MA-PD Contracts in Your Market Area

Preferred Care Partners (H1045)	n=49		3.79
Quality Health Plans (H5402)	n=91		3.70
SecureHorizons by Unitedhlthcare (H1080)		N/A	
SecureHorizons by Unitedhlthcare (H5532)		N/A	
SecureHorizons by Unitedhlthcare (R5287)	n=70		3.64
Universal Health Care (H5404)	n=74		3.76
Universal Health Care (H5429)		N/A	

Other MA-PD Contracts in Florida

AvMed Inc. (H1016)		N/A	
Capital Health Plan (H5938)		N/A	
Florida Health Care Plan (H1035)	n=145		3.91 ↑
Healthsun Health Plans (H5431)		N/A	
JMH Health Plan (H4155)		N/A	
Medica Healthcare Plans (H5420)		N/A	
SecureHorizons by Unitedhlthcare (H9011)		N/A	

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.

Getting Information From the Plan About Prescription Drug Coverage and Cost Composite

This table shows how your contract and other MA-PD contracts in your area performed on “Getting Information From the Plan About Prescription Drug Coverage and Cost,” a composite of survey questions 45, 46, 48, and 50. For each contract, the table shows: the number of members who answered at least one of these questions, 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-PD 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. All statistics are adjusted for case-mix. Results for the individual questions included in this composite are on the following pages. There are no benchmarks for Original Medicare for this composite and its component items.

		Never + Sometimes	Usually	Always		
					↑ = Significantly better than the national average	
					↓ = Significantly worse than the national average	
National Distribution	n=38788	16%	20%	64%		3.41
State Distribution – Florida	n=2822	16%	22%	62%		3.40
2011 WellCare (H1032)	n=73	16% ↑	35%	50%		3.28
2010 WellCare (H1032)	n=262	21%	21%	58%		3.31
MA-PD Contracts in Your Market Area						
Aetna Medicare (H5414)	n=123	13%	25%	62%		3.46
Amerigroup (H8991)	n=94	22%	20%	58%		3.31
BC & BS of Florida (R3332)	n=152	13%	31%	55%		3.40
BC&BS of Florida (H5434)	n=147	17%	29%	60%		3.46
Care Plus Health Plan (H1019)		N/A				
Citrus Health Care (H5407)	n=85	21%	19%	60%		3.31
Coventry Health Care of Florida (H1076)		N/A				
Coventry HP of Florida (H1013)		N/A				
Coventry Summit Health Plan (H5850)	n=80	23%		69%		3.37
Freedom Health Plan (H5427)	n=107	12%	13%	75%		3.58 ↑
Health First Health Plans (H1099)	n=111	12%		84%		3.79 ↑
Health Options (H1026)	n=102	20%	26%	55%		3.31
HealthSpring of Florida (H5410)	n=53			87%		3.82 ↑
Humana (H1036)		N/A				

WellCare (H1032)

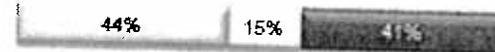
MA-PD Contracts in Your Market Area

Humana (R5826)

N/A

Humana AdvantageCare Plan (H5426)

n=152



2.68 ↓

Optimum HealthCare (H5594)

n=99



3.49

Physicians United Plan (H5696)

n=80



3.55

Preferred Care Partners (H1045)

n=82



3.64 ↑

Quality Health Plans (H5402)

n=110



3.58 ↑

SecureHorizons by UnitedHlthcare (H1080)

n=76



3.55

SecureHorizons by UnitedHlthcare (H5532)

n=76



3.49

SecureHorizons by UnitedHlthcare (R5287)

n=107



3.46

Universal Health Care (H5404)

n=95



3.55 ↑

Universal Health Care (H5429)

n=68



3.55

Other MA-PD Contracts in Florida

AvMed Inc. (H1016)

n=90



3.46

Capital Health Plan (H5938)

n=89



3.70 ↑

Florida Health Care Plan (H1035)

n=95



3.58

Healthsun Health Plans (H5431)

n=51



3.61

JMH Health Plan (H4155)

n=66



3.31

Medica Healthcare Plans (H5420)

n=50



3.67 ↑

SecureHorizons by UnitedHlthcare (H9011)

n=77

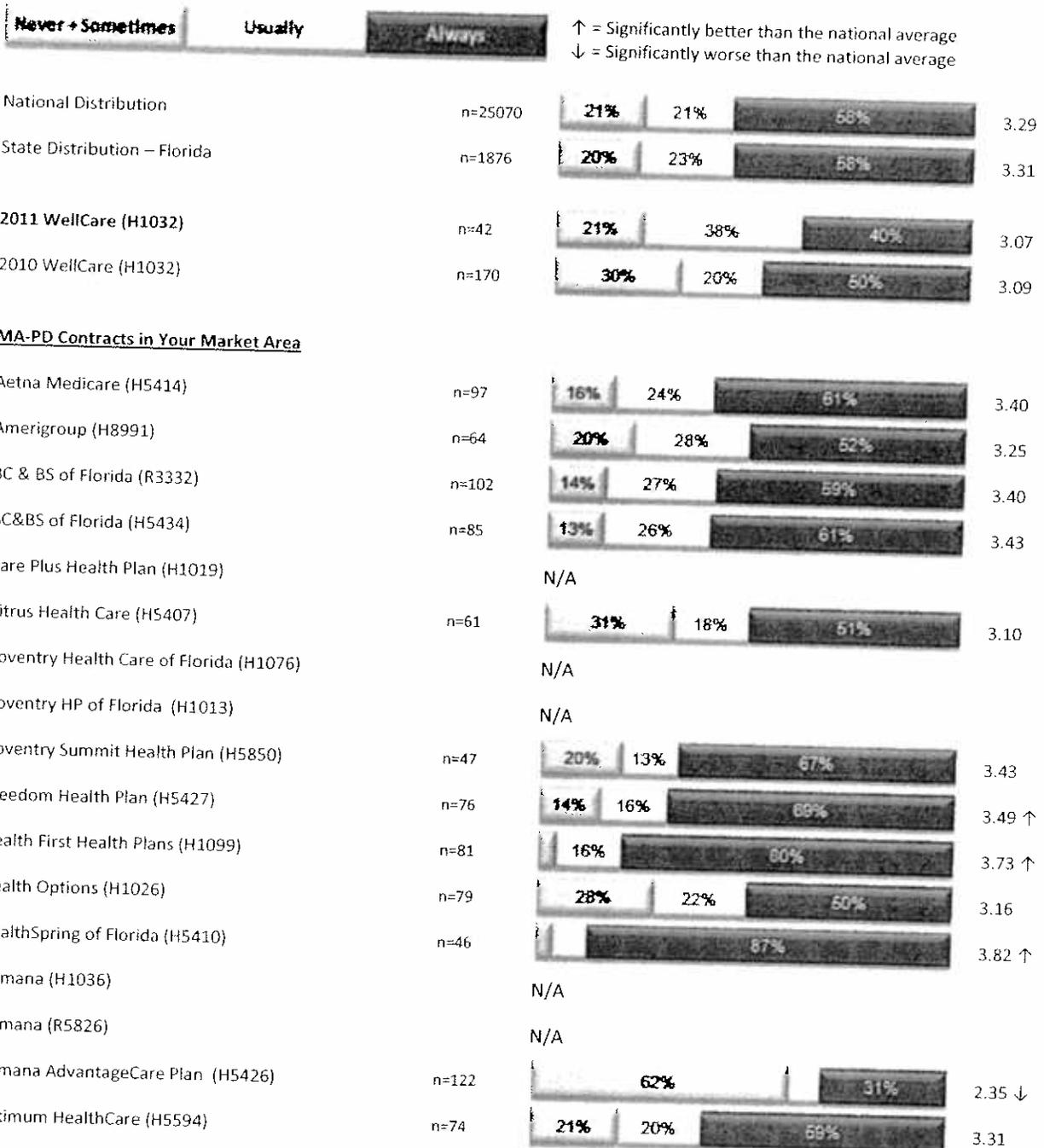


3.49

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.

Getting Information From the Plan About Prescription Drug Coverage and Cost: Customer Service Give Information About Prescription Drugs

Question 45: In the last 6 months, how often did your prescription drug plan's customer service give you the information or help you needed about prescription drugs?



WellCare (H1032)

MA-PD Contracts in Your Market Area

Physicians United Plan (H5696)	n=50	12%	37%	51%	3.37
Preferred Care Partners (H1045)	n=61	22%	71%		3.64 ↑
Quality Health Plans (H5402)	n=71	11%	25%	64%	3.52 ↑
SecureHorizons by Unitedhlthcare (H1080)	n=41	28%	62%		3.52
SecureHorizons by Unitedhlthcare (H5532)	n=40	18%	20%	63%	3.37
SecureHorizons by Unitedhlthcare (R5287)	n=56	17%	32%	51%	3.28
Universal Health Care (H5404)	n=61	14%	24%	62%	3.46
Universal Health Care (H5429)	n=51	12%	13%	75%	3.55 ↑

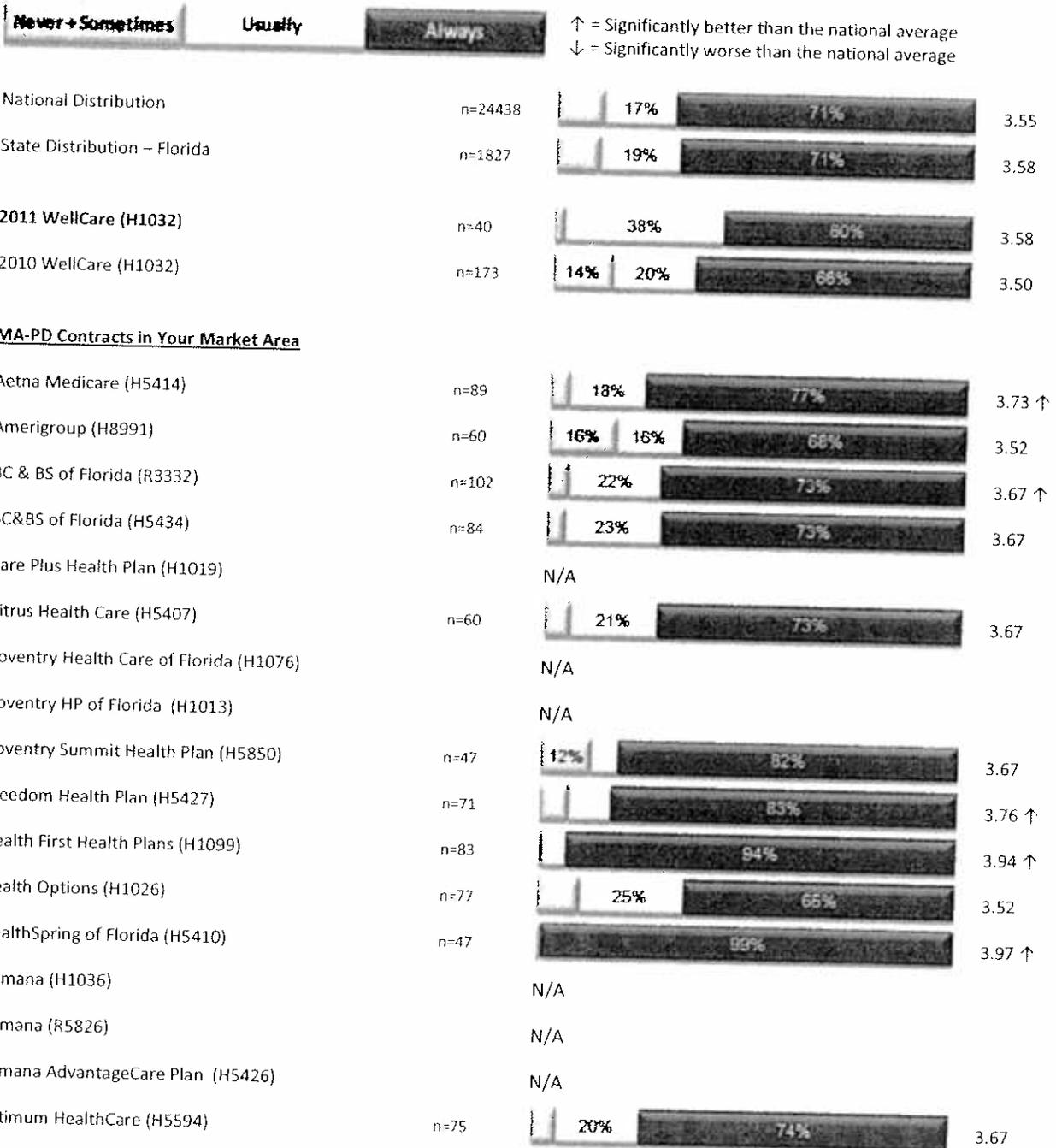
Other MA-PD Contracts in Florida

AvMed Inc. (H1016)	n=63	21%	13%	66%	3.40
Capital Health Plan (H5938)	n=57	17%	77%		3.70 ↑
Florida Health Care Plan (H1035)	n=56	13%	20%	67%	3.49
Healthsun Health Plans (H5431)	n=36	13%	13%	74%	3.61 ↑
JMH Health Plan (H4155)	n=43	32%	20%	48%	3.04
Medica Healthcare Plans (H5420)	n=31	19%	71%		3.58
SecureHorizons by Unitedhlthcare (H9011)	n=43	16%	23%	61%	3.34

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.

Getting Information From the Plan About Prescription Drug Coverage and Cost: Customer Service Treat You With Courtesy and Respect

Question 46: In the last 6 months, how often did your prescription drug plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs?



WellCare (H1032)

MA-PD Contracts in Your Market Area

Physicians United Plan (H5696)	n=51	21%	72%	3.64
Preferred Care Partners (H1045)	n=58	12%	86%	3.85 ↑
Quality Health Plans (H5402)	n=68	19%	76%	3.67
SecureHorizons by UnitedHlthcare (H1080)	n=37	12%	82%	3.73
SecureHorizons by UnitedHlthcare (H5532)	n=43	14%	77%	3.61
SecureHorizons by UnitedHlthcare (R5287)	n=57	16%	76%	3.64
Universal Health Care (H5404)	n=59	15%	76%	3.64
Universal Health Care (H5429)	n=48	13%	78%	3.70

Other MA-PD Contracts in Florida

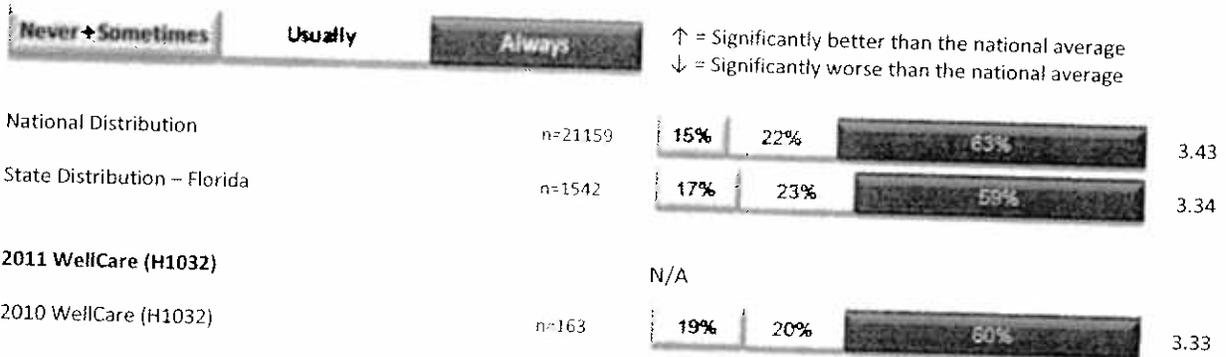
AvMed Inc. (H1016)	n=58	13%	79%	3.67
Capital Health Plan (H5938)	n=55		91%	3.91 ↑
Florida Health Care Plan (H1035)	n=55	15%	79%	3.70
Healthsun Health Plans (H5431)				N/A
JMH Health Plan (H4155)				N/A
Medica Healthcare Plans (H5420)	n=30		94%	3.94 ↑
SecureHorizons by UnitedHlthcare (H9011)	n=42	23%	71%	3.64

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.

WellCare (H1032)

Getting Information From the Plan About Prescription Drug Coverage and Cost: Which Medicines Covered

Question 48: In the last 6 months, how often did your prescription drug plan's customer service give you all the information you needed about which prescription medicines were covered?



MA-PD Contracts in Your Market Area

Aetna Medicare (H5414)		N/A	
Amerigroup (H8991)		N/A	
BC & BS of Florida (R3332)		N/A	
BC&BS of Florida (H5434)		N/A	
Care Plus Health Plan (H1019)		N/A	
Citrus Health Care (H5407)		N/A	
Coventry Health Care of Florida (H1076)		N/A	
Coventry HP of Florida (H1013)		N/A	
Coventry Summit Health Plan (H5850)		N/A	
Freedom Health Plan (H5427)		N/A	
Health First Health Plans (H1099)	n=59	14% 82%	3.76 ↑
Health Options (H1026)		N/A	
HealthSpring of Florida (H5410)		N/A	
Humana (H1036)		N/A	
Humana (R5826)		N/A	
Humana AdvantageCare Plan (H5426)		N/A	
Optimum HealthCare (H5594)		N/A	
Physicians United Plan (H5696)		N/A	

MA-PD CAHPS Results

WellCare of Ohio

WellCare (H1032)

MA-PD Contracts in Your Market Area

Preferred Care Partners (H1045)	N/A		
Quality Health Plans (H5402)	n=70		3.61 ↑
SecureHorizons by Unitedhlthcare (H1080)	N/A		
SecureHorizons by Unitedhlthcare (H5532)	N/A		
SecureHorizons by Unitedhlthcare (R5287)	N/A		
Universal Health Care (H5404)	N/A		
Universal Health Care (H5429)	N/A		

Other MA-PD Contracts in Florida

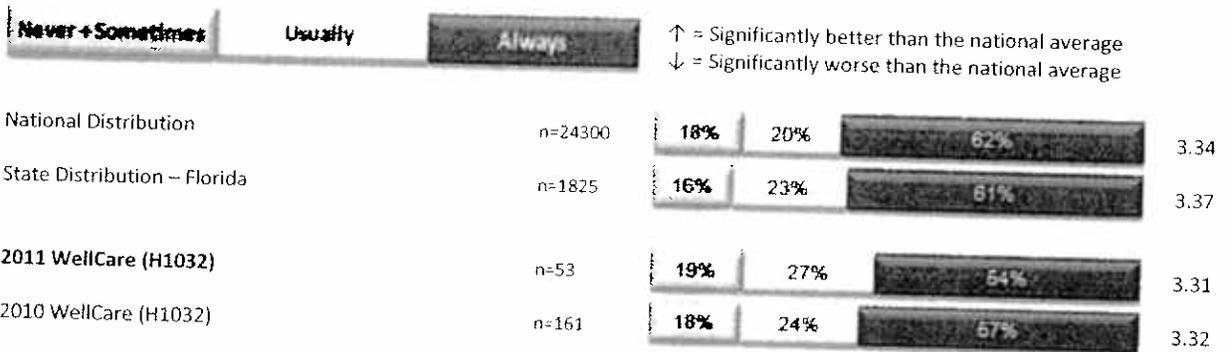
AvMed Inc. (H1016)	N/A
Capital Health Plan (H5938)	N/A
Florida Health Care Plan (H1035)	N/A
Healthsun Health Plans (H5431)	N/A
JMH Health Plan (H4155)	N/A
Medica Healthcare Plans (H5420)	N/A
SecureHorizons by Unitedhlthcare (H9011)	N/A

Note: Percentages may not add to 100 due to rounding Beneficiaries. 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.

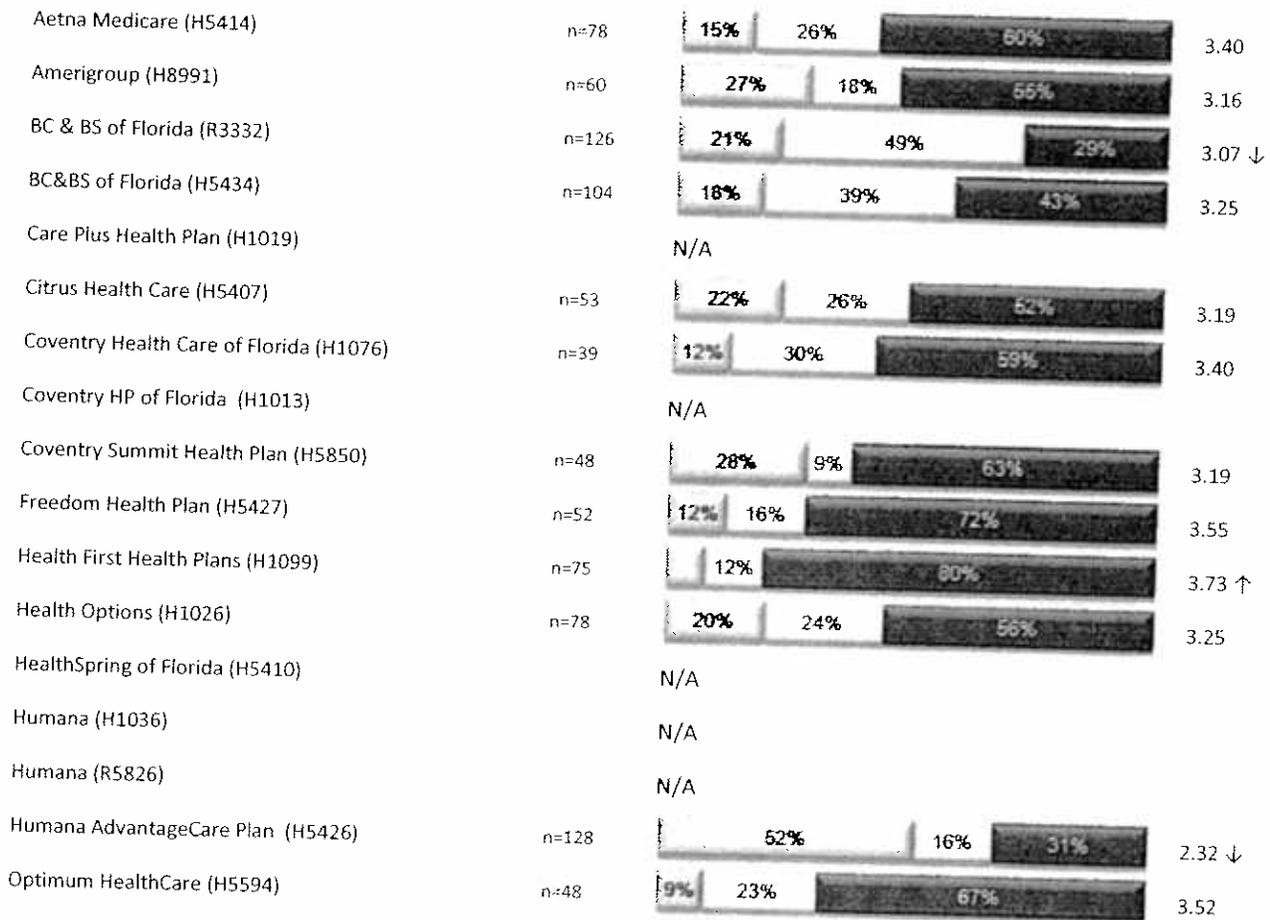
Getting Information From the Plan About Prescription Drug Coverage and Cost: Out-of-Pocket Costs

Question 50: In the last 6 months, how often did your prescription drug plan's customer service give you all the information you needed about how much you would have to pay for your prescription medicine?

[Scored only for those who tried to get information from their health plan in the last 6 months about how much they would have to pay for their prescription medicines.]



MA-PD Contracts in Your Market Area



WellCare (H1032)

MA-PD Contracts in Your Market Area

Physicians United Plan (H5696)	n=53	21%	71%	3.61 ↑
Preferred Care Partners (H1045)	n=38	16%	64%	3.37
Quality Health Plans (H5402)	n=71	20%	71%	3.55 ↑
SecureHorizons by UnitedHlthcare (H1080)	n=49	13%	66%	3.52
SecureHorizons by UnitedHlthcare (H5532)	n=55	12%	67%	3.52
SecureHorizons by UnitedHlthcare (R5287)	n=79	14%	63%	3.43
Universal Health Care (H5404)	n=63	12%	68%	3.52
Universal Health Care (H5429)	n=43	12%	72%	3.49

Other MA-PD Contracts in Florida

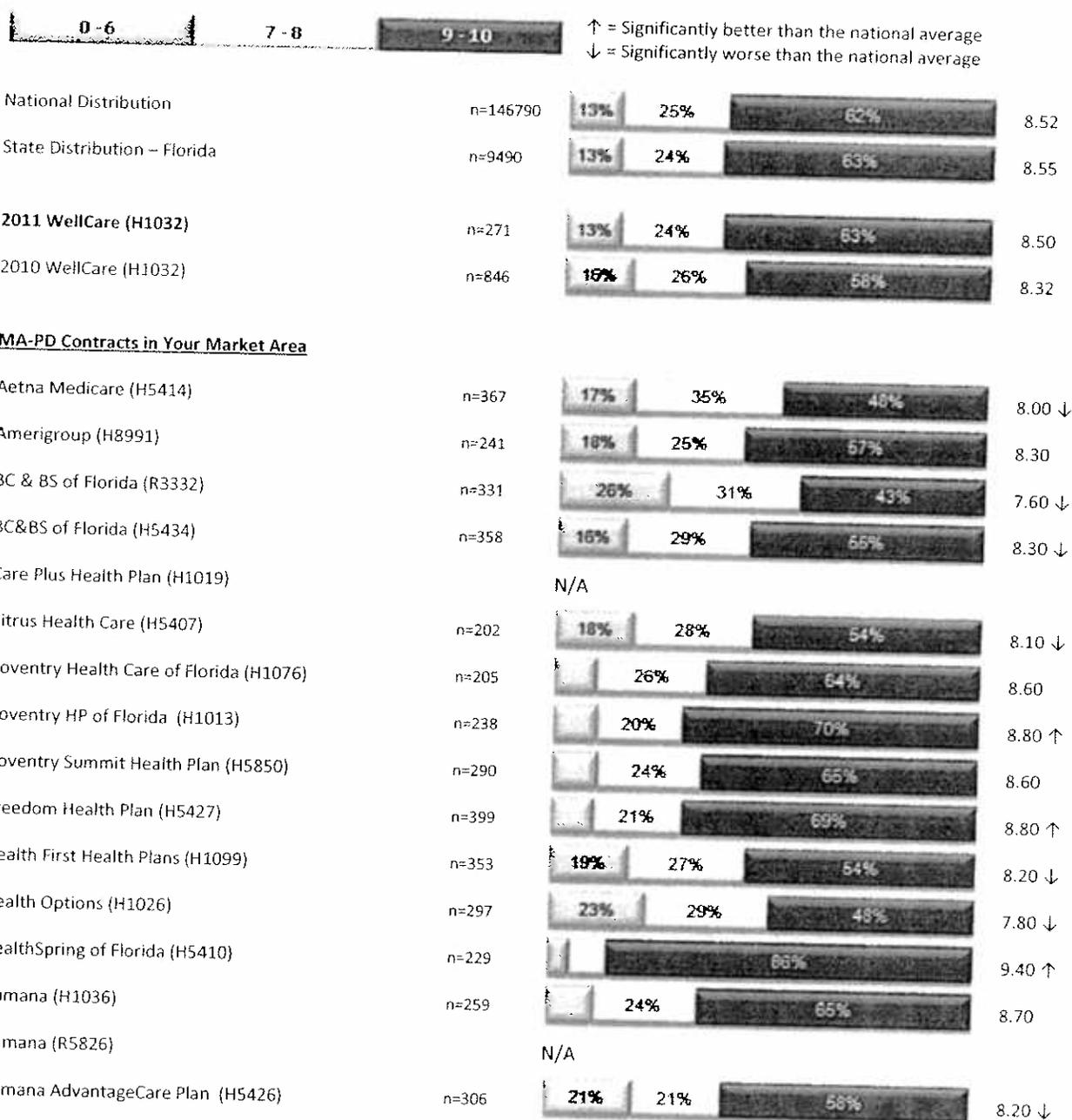
AvMed inc. (H1016)	n=53	29%	68%	3.25
Capital Health Plan (H5938)	n=49	23%	68%	3.58 ↑
Florida Health Care Plan (H1035)	n=73	16%	77%	3.70 ↑
Healthsun Health Plans (H5431)		N/A		
JMH Health Plan (H4155)	n=44	29%	63%	3.52
Medica Healthcare Plans (H5420)	n=39	16%	74%	3.55
SecureHorizons by UnitedHlthcare (H9011)	n=50	14%	69%	3.52

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.

Overall Rating of Prescription Drug Coverage

Question 60: Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug 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-PD 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. There are no benchmarks for Original Medicare for this item.



WellCare (H1032)

MA-PD Contracts in Your Market Area

Optimum HealthCare (H5594)	n=399		8.90 ↑
Physicians United Plan (H5696)	n=326		8.50
Preferred Care Partners (H1045)	n=310		9.00 ↑
Quality Health Plans (H5402)	n=392		8.70
SecureHorizons by Unitedhlthcare (H1080)	n=320		8.30 ↓
SecureHorizons by Unitedhlthcare (H5532)	n=334		8.30 ↓
SecureHorizons by Unitedhlthcare (R5287)	n=350		8.20 ↓
Universal Health Care (H5404)	n=316		8.30 ↓
Universal Health Care (H5429)	n=190		7.60 ↓

Other MA-PD Contracts in Florida

AvMed inc. (H1016)	n=336		8.80 ↑
Capital Health Plan (H5938)	n=437		9.10 ↑
Florida Health Care Plan (H1035)	n=371		8.80 ↑
Healthsun Health Plans (H5431)	n=169		8.90 ↑
JMH Health Plan (H4155)	n=192		8.60
Medica Healthcare Plans (H5420)	n=237		9.20 ↑
SecureHorizons by Unitedhlthcare (H9011)	n=280		8.50

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.

Willingness to Recommend Plan for Drug Coverage

Question 61: Would you recommend your prescription drug plan for coverage of prescription drugs to other people like yourself?

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-PD 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. There are no benchmarks for Original Medicare for this item.

			Definitely or Somewhat No	Somewhat Yes	Definitely Yes			
National Distribution	n=146038		31%		62%	3.50		
State Distribution – Florida	n=9452		29%		64%	3.52		
2011 WellCare (H1032)	n=270		32%		69%	3.46		
2010 WellCare (H1032)	n=843		9%	32%	65%	3.46		
MA-PD Contracts in Your Market Area								
Aetna Medicare (H5414)	n=366		46%		44%	3.31	↓	
Amerigroup (H8991)	n=241	15%	32%		53%	3.31	↓	
BC & BS of Florida (R3332)	n=331	17%	46%		37%	3.13	↓	
BC&BS of Florida (H5434)	n=349		37%		63%	3.37	↓	
Care Plus Health Plan (H1019)		N/A						
Citrus Health Care (H5407)	n=198	14%	32%		54%	3.34	↓	
Coventry Health Care of Florida (H1076)	n=203	13%	27%		61%	3.40		
Coventry HP of Florida (H1013)	n=237		25%		66%	3.52		
Coventry Summit Health Plan (H5850)	n=286	9%	26%		65%	3.49		
Freedom Health Plan (H5427)	n=395		21%		72%	3.61	↑	
Health First Health Plans (H1099)	n=352		36%		67%	3.49		
Health Options (H1026)	n=299	16%	36%		48%	3.25	↓	
HealthSpring of Florida (H5410)	n=228	13%			84%	3.79	↑	
Humana (H1036)	n=256		25%		68%	3.61	↑	
Humana (R5826)		N/A						
Humana AdvantageCare Plan (H5426)	n=309		32%		59%	3.49		

↑ = Significantly better than the national average
↓ = Significantly worse than the national average

WellCare (H1032)

MA-PD Contracts in Your Market Area

Optimum HealthCare (H5594)	n=400	24%	71%	3.64 ↑	
Physicians United Plan (H5696)	n=326	30%	63%	3.52	
Preferred Care Partners (H1045)	n=310	20%	76%	3.67 ↑	
Quality Health Plans (H5402)	n=386	28%	66%	3.55	
SecureHorizons by UnitedHealthcare (H1080)	n=318	36%	67%	3.46	
SecureHorizons by UnitedHealthcare (H5532)	n=334	38%	54%	3.43	
SecureHorizons by UnitedHealthcare (R5287)	n=351	40%	53%	3.43 ↓	
Universal Health Care (H5404)	n=315	34%	69%	3.49	
Universal Health Care (H5429)	n=190	13%	40%	47%	3.28 ↓

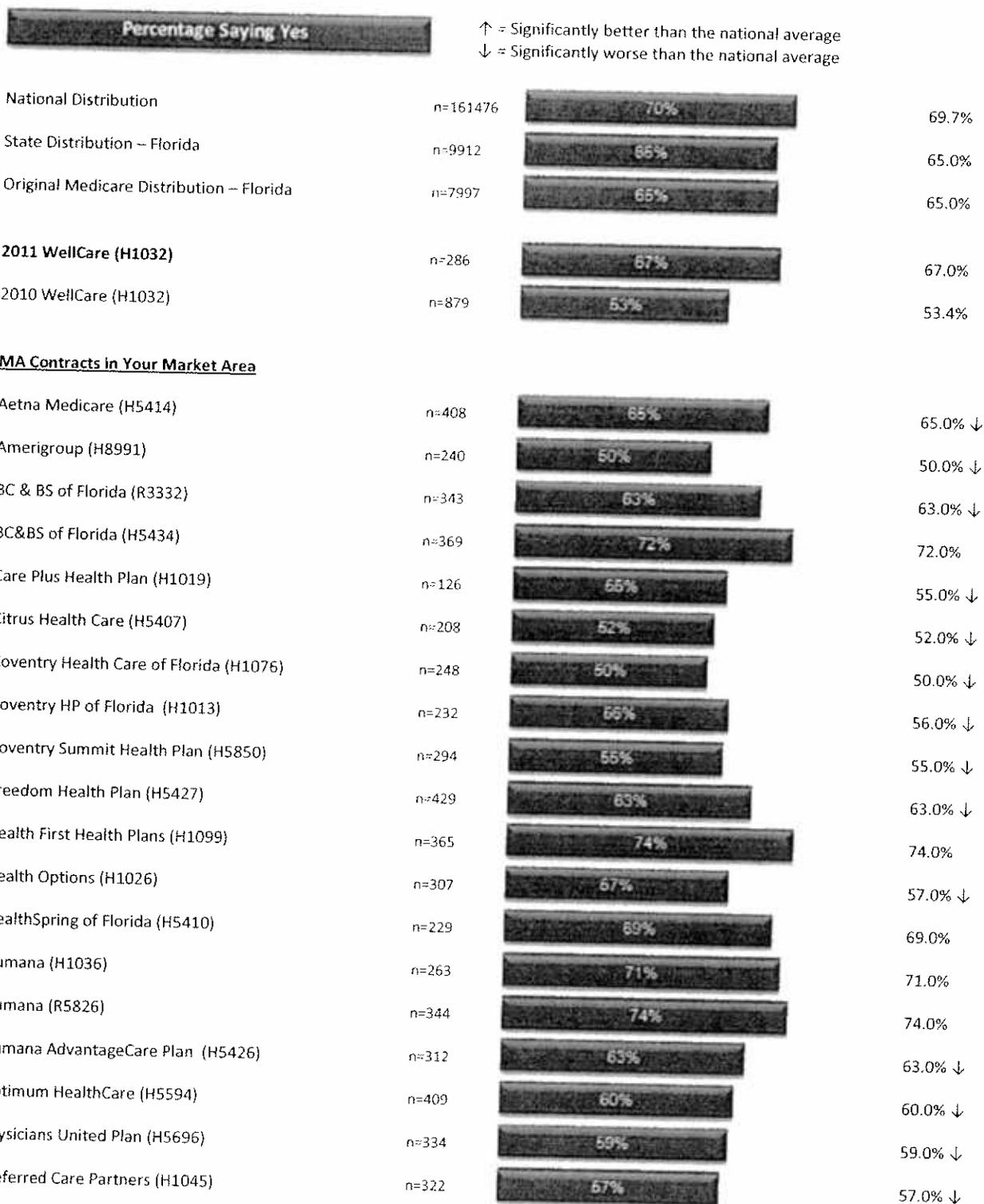
Other MA-PD Contracts in Florida

AvMed Inc. (H1016)	n=338	27%	67%	3.58
Capital Health Plan (H5938)	n=436	16%	80%	3.76 ↑
Florida Health Care Plan (H1035)	n=371	23%	71%	3.61 ↑
Healthsun Health Plans (H5431)	n=166	26%	60%	3.61
JMH Health Plan (H4155)	n=191	33%	58%	3.43
Medica Healthcare Plans (H5420)	n=233	16%	78%	3.70 ↑
SecureHorizons by UnitedHealthcare (H9011)	n=282	33%	69%	3.46

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.

Medicare-Specific and HEDIS Measures: Influenza Vaccination

Question 70: Have you had a flu shot since September 1, 2010?



WellCare (H1032)

MA Contracts in Your Market Area

Quality Health Plans (H5402)	n=412	64%	64.0% ↓
SecureHorizons by Unitedhlthcare (H1080)	n=332	59%	59.0% ↓
SecureHorizons by Unitedhlthcare (H5532)	n=342	63%	63.0% ↓
SecureHorizons by Unitedhlthcare (R5287)	n=372	66%	66.0%
Universal Health Care (H5404)	n=319	58%	58.0% ↓
Universal Health Care (H5429)	n=234	63%	63.0% ↓

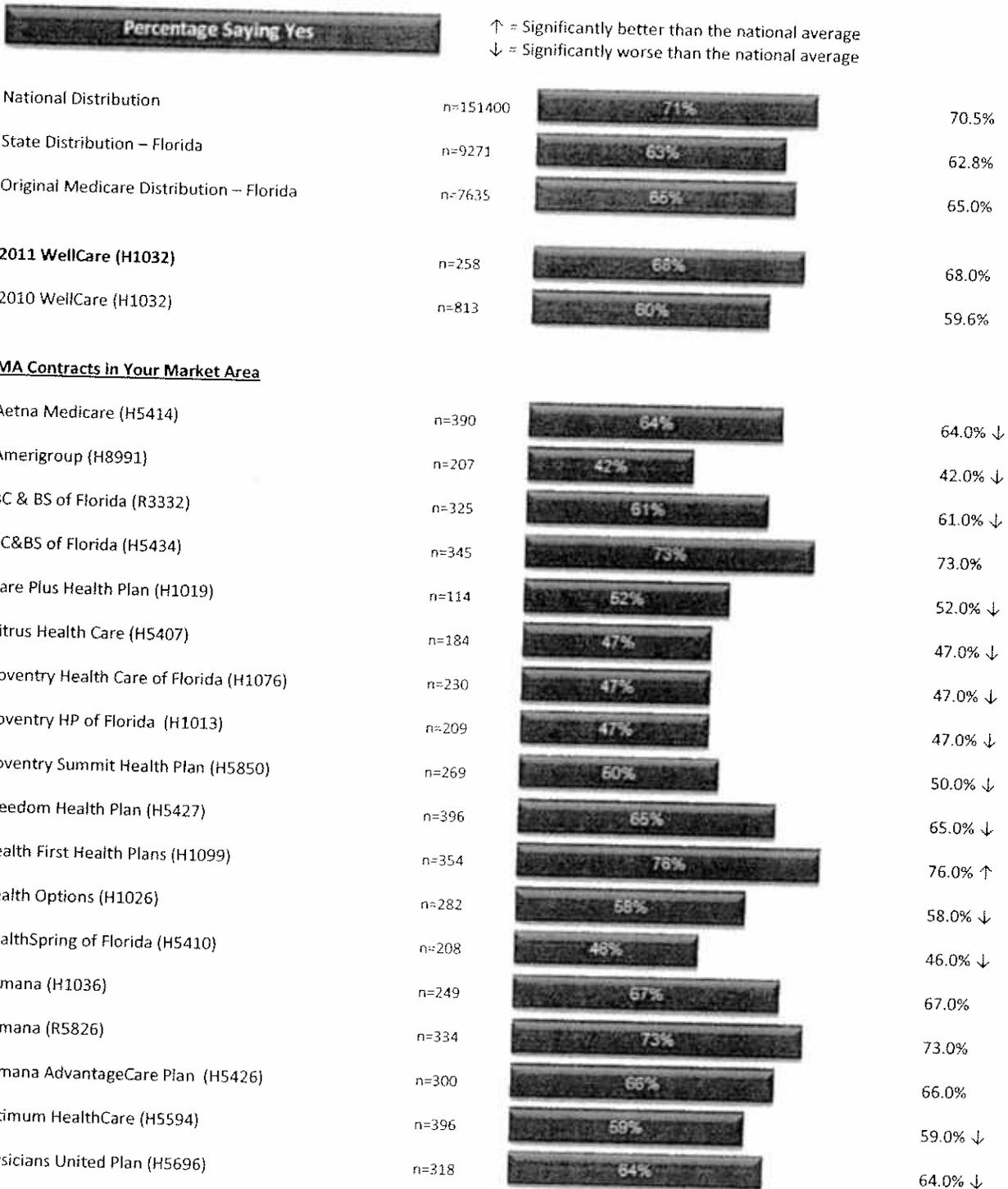
Other MA Contracts in Florida

AvMed Inc. (H1016)	n=346	63%	63.0% ↓
Capital Health Plan (H5938)	n=448	80%	80.0% ↑
Florida Health Care Plan (H1035)	n=377	71%	71.0%
Healthsun Health Plans (H5431)	n=170	55%	55.0% ↓
JMH Health Plan (H4155)	n=190	47%	47.0% ↓
Medica Healthcare Plans (H5420)	n=245	50%	50.0% ↓
SecureHorizons by Unitedhlthcare (H9011)	n=292	47%	47.0% ↓

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 arrows, see Part 3 of this report. Note that this item is not adjusted for case-mix.

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.



WellCare (H1032)

MA Contracts in Your Market Area

Contract Name	n	Percentage	Change
Preferred Care Partners (H1045)	297	56%	56.0% ↓
Quality Health Plans (H5402)	386	59%	59.0% ↓
SecureHorizons by Unitedhlthcare (H1080)	323	68%	68.0%
SecureHorizons by Unitedhlthcare (H5532)	327	68%	68.0%
SecureHorizons by Unitedhlthcare (R5287)	350	63%	63.0% ↓
Universal Health Care (H5404)	299	65%	65.0%
Universal Health Care (H5429)	214	72%	72.0%

Other MA Contracts in Florida

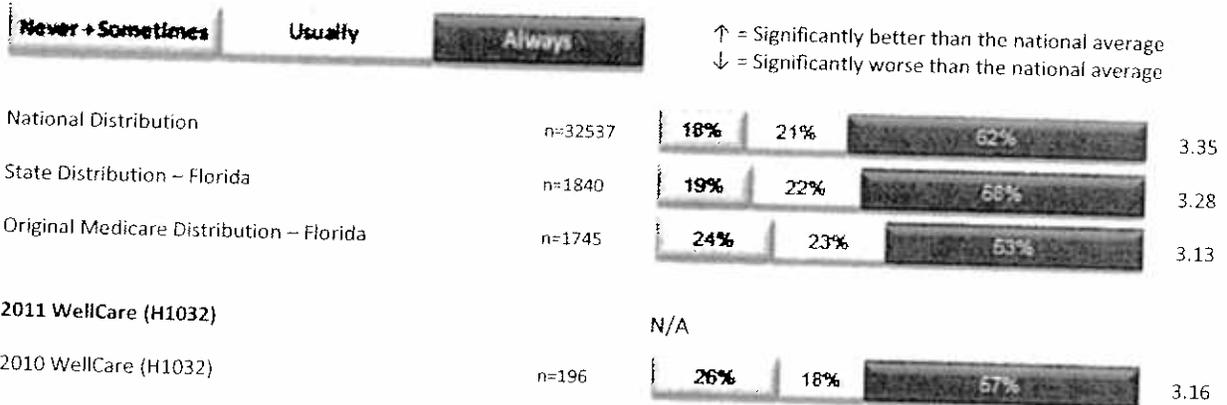
Contract Name	n	Percentage	Change
AvMed Inc. (H1016)	329	66%	66.0%
Capital Health Plan (H5938)	432	82%	82.0% ↑
Florida Health Care Plan (H1035)	365	82%	82.0% ↑
Healthsun Health Plans (H5431)	148	42%	42.0% ↓
JMH Health Plan (H4155)	164	45%	45.0% ↓
Medica Healthcare Plans (H5420)	230	49%	49.0% ↓
SecureHorizons by Unitedhlthcare (H9011)	266	44%	44.0% ↓

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.

WellCare (H1032)

Medicare Specific and HEDIS Measures: Getting Medical Equipment

Question 14: In the last 6 months, how often was it easy to get the medical equipment you needed through your health plan?



MA Contracts in Your Market Area

Aetna Medicare (H5414)	N/A
Amerigroup (H8991)	N/A
BC & BS of Florida (R3332)	N/A
BC&BS of Florida (H5434)	N/A
Care Plus Health Plan (H1019)	N/A
Citrus Health Care (H5407)	N/A
Coventry Health Care of Florida (H1076)	N/A
Coventry HP of Florida (H1013)	N/A
Coventry Summit Health Plan (H5850)	N/A
Freedom Health Plan (H5427)	N/A
Health First Health Plans (H1099)	N/A
Health Options (H1026)	N/A
HealthSpring of Florida (H5410)	N/A
Humana (H1036)	N/A
Humana (R5826)	N/A
Humana AdvantageCare Plan (H5426)	N/A
Optimum HealthCare (H5594)	N/A

MA-PD CAHPS Results

WellCare of Ohio

WellCare (H1032)

MA Contracts in Your Market Area

Physicians United Plan (H5696)

N/A

Preferred Care Partners (H1045)

N/A

Quality Health Plans (H5402)

n=80



3.34

SecureHorizons by UnitedHlthcare (H1080)

N/A

SecureHorizons by UnitedHlthcare (H5532)

N/A

SecureHorizons by UnitedHlthcare (R5287)

N/A

Universal Health Care (H5404)

N/A

Universal Health Care (H5429)

N/A

Other MA Contracts in Florida

AvMed Inc. (H1016)

N/A

Capital Health Plan (H5938)

n=100



3.49

Florida Health Care Plan (H1035)

N/A

Healthsun Health Plans (H5431)

N/A

JMH Health Plan (H4155)

N/A

Medica Healthcare Plans (H5420)

N/A

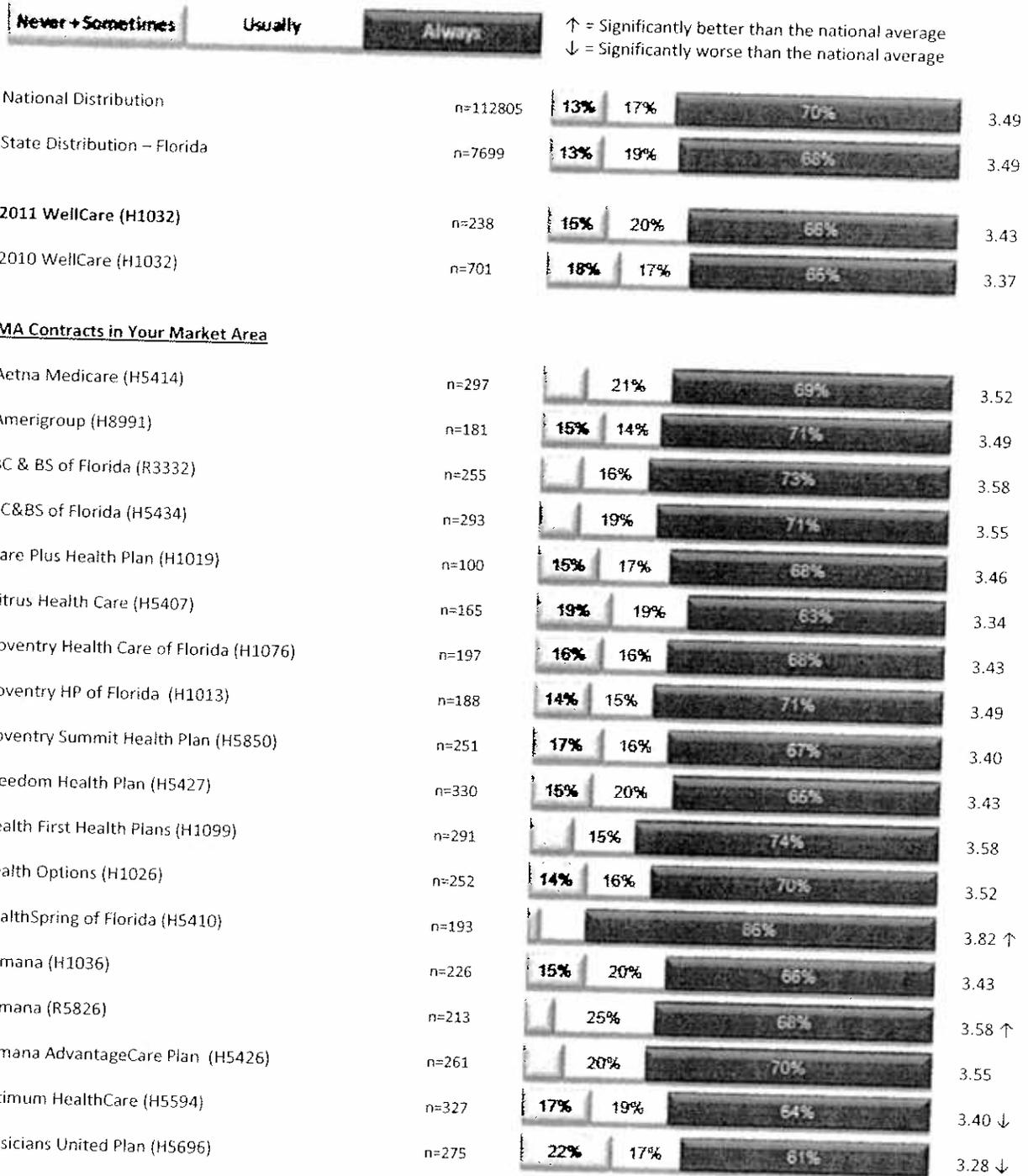
SecureHorizons by UnitedHlthcare (H9011)

N/A

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.

Medicare Specific and HEDIS Measures: Follow-up with Test Results

Question 23: In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your doctor's office follow up to give you those results?



WellCare (H1032)

MA Contracts in Your Market Area

Preferred Care Partners (H1045)	n=256	15%	17%	69%	3.46
Quality Health Plans (H5402)	n=305	16%	17%	68%	3.43
SecureHorizons by Unitedhlthcare (H1080)	n=256	13%		76%	3.58
SecureHorizons by Unitedhlthcare (H5532)	n=267	9%	18%	73%	3.58
SecureHorizons by Unitedhlthcare (R5287)	n=287	9%	20%	70%	3.55
Universal Health Care (H5404)	n=250	9%	19%	72%	3.58
Universal Health Care (H5429)	n=153	14%	20%	68%	3.43

Other MA Contracts in Florida

AvMed Inc. (H1016)	n=251	14%	24%	63%	3.43
Capital Health Plan (H5938)	n=327		15%	74%	3.61 ↑
Florida Health Care Plan (H1035)	n=285		17%	76%	3.64 ↑
Healthsun Health Plans (H5431)	n=128	12%	12%	76%	3.58
JMH Health Plan (H4155)	n=147	14%	16%	69%	3.49
Medica Healthcare Plans (H5420)	n=198		20%	69%	3.52
SecureHorizons by Unitedhlthcare (H9011)	n=216	15%	17%	68%	3.43

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.

WellCare (H1032)

Single Item: After Hour Calls

Question 9: In the last 6 months, did you phone a doctor's office or clinic with a medical question after regular office hours?

Single Item: After Hour Calls	N	Percentage Yes
National Distribution	159593	9.5%
State Distribution Florida	9730	10.7%
2011 WellCare (H1032)	286	10.5%

MA Contracts in Your Market Area	N	Percentage Yes
Aetna Medicare (H5414)	409	7.3%
Amerigroup (H8991)	235	19.6%
BC & BS of Florida (R3332)	330	8.5%
BC&BS of Florida (H5434)	349	8.9%
Care Plus Health Plan (H1019)	128	13.3%
Citrus Health Care (H5407)	209	17.2%
Coventry Health Care of Florida (H1076)	244	11.1%
Coventry HP of Florida (H1013)	240	12.9%
Coventry Summit Health Plan (H5850)	307	11.7%
Freedom Health Plan (H5427)	417	8.6%
Health First Health Plans (H1099)	356	9.0%
Health Options (H1026)	306	12.4%
HealthSpring of Florida (H5410)	221	20.4%
Humana (H1036)	260	13.8%
Humana (R5826)	349	7.7%
Humana AdvantageCare Plan (H5426)	317	7.3%
Optimum HealthCare (H5594)	394	10.2%
Physicians United Plan (H5696)	330	7.3%
Preferred Care Partners (H1045)	323	8.7%
Quality Health Plans (H5402)	384	9.9%
SecureHorizons by UnitedHlthcare (H1080)	323	10.8%
SecureHorizons by UnitedHlthcare (H5532)	332	9.3%
SecureHorizons by UnitedHlthcare (R5287)	349	11.2%
Universal Health Care (H5404)	326	8.0%
Universal Health Care (H5429)	223	6.3%

Other MA Contracts in Florida	N	Percentage Yes
AvMed inc. (H1016)	334	10.2%
Capital Health Plan (H5938)	439	10.7%
Florida Health Care Plan (H1035)	376	8.2%
Healthsun Health Plans (H5431)	163	22.7%
JMH Health Plan (H4155)	188	11.7%
Medica Healthcare Plans (H5420)	247	14.2%
SecureHorizons by UnitedHlthcare (H9011)	284	10.9%

WellCare (H1032)

Note: The results for these items are not case-mix adjusted, and statistical tests against the national average were not performed. Percentages may not add to 100 due to rounding. For information on how we defined your market area, see Part 3 of this report.

Single Item: Answer as Soon as Needed

Question 10: In the last 6 months, when you phoned a doctor's office or clinic after regular office hours, how often did you get an answer to your medical question as soon as you needed?

[Scored only for those who phoned a doctor's office or clinic with a medical question after regular office hours.]

Single Item: Answer as Soon as Needed	N	Percentage		
		Never + Sometimes	Usually	Always
National Distribution	14571	27.9%	26.5%	45.6%
State Distribution Florida	993	27.8%	24.1%	48.1%
2011 WellCare (H1032)	28	25.0%	25.0%	50.0%

MA Contracts in Your Market Area	N	Percentage		
		Never + Sometimes	Usually	Always
Aetna Medicare (H5414)	29	34.5%	31.0%	34.5%
Amerigroup (H8991)	45	35.6%	11.1%	53.3%
BC & BS of Florida (R3332)	27	25.9%	37.0%	37.0%
BC&BS of Florida (H5434)	30	26.7%	26.7%	46.7%
Care Plus Health Plan (H1019)	17	29.4%	17.6%	52.9%
Citrus Health Care (H5407)	36	41.7%	25.0%	33.3%
Coventry Health Care of Florida (H1076)	26	30.8%	19.2%	50.0%
Coventry HP of Florida (H1013)	29	37.9%	17.2%	44.8%
Coventry Summit Health Plan (H5850)	36	27.8%	25.0%	47.2%
Freedom Health Plan (H5427)	33	27.3%	30.3%	42.4%
Health First Health Plans (H1099)	30	40.0%	20.0%	40.0%
Health Options (H1026)	37	27.0%	24.3%	48.6%
HealthSpring of Florida (H5410)	44	6.8%	6.8%	86.4%
Humana (H1036)	34	17.6%	20.6%	61.8%
Humana (R5826)	27	18.5%	18.5%	63.0%
Humana AdvantageCare Plan (H5426)	20	40.0%	35.0%	25.0%
Optimum HealthCare (H5594)	37	29.7%	24.3%	45.9%
Physicians United Plan (H5696)	24	41.7%	29.2%	29.2%
Preferred Care Partners (H1045)	27	11.1%	25.9%	63.0%
Quality Health Plans (H5402)	37	35.1%	32.4%	32.4%
SecureHorizons by UnitedHealthcare (H1080)	32	28.1%	28.1%	43.8%
SecureHorizons by UnitedHealthcare (H5532)	30	26.7%	33.3%	40.0%
SecureHorizons by UnitedHealthcare (R5287)	37	27.0%	27.0%	45.9%
Universal Health Care (H5404)	24	16.7%	20.8%	62.5%
Universal Health Care (H5429)	14	28.6%	28.6%	42.9%

Other MA Contracts in Florida	N	Percentage		
		Never + Sometimes	Usually	Always
AvMed Inc. (H1016)	31	38.7%	16.1%	45.2%

WellCare (H1032)

Other MA Contracts in Florida	N	Percentage		
		Never + Sometimes	Usually	Always
Capital Health Plan (H5938)	44	13.6%	38.6%	47.7%
Florida Health Care Plan (H1035)	28	28.6%	25.0%	46.4%
Healthsun Health Plans (H5431)	36	22.2%	13.9%	63.9%
JMH Health Plan (H4155)	21	42.9%	9.5%	47.6%
Medica Healthcare Plans (H5420)	35	31.4%	22.9%	45.7%
SecureHorizons by UnitedHealthcare (H9011)	30	20.0%	26.7%	53.3%

Note: The results for these items are not case-mix adjusted, and statistical tests against the national average were not performed. Percentages may not add to 100 due to rounding. For information on how we defined your market area, see Part 3 of this report.

Single Item: Timing of Callback

Question 11: In the last 6 months, when you phoned a doctor's office or clinic after regular office hours, how long did it take for someone to call you back?

Q11a. Less than 1 hour, 1 to 3 hours, More than 3 hours but less than 6 hours, More than 6 hours.

[Scored only for those who phoned a doctor's office or clinic with a medical question after regular office hours.]

Single Item: Timing of Callback	N	Percentage			
		<1 Hr	1-3 Hrs	>3 Hrs but <6 Hrs	>6 Hrs
National Distribution	13942	35.4%	23.8%	9.6%	11.3%
State Distribution Florida	962	35.1%	25.7%	8.0%	10.8%
2011 WellCare (H1032)	26	23.1%	46.2%	11.5%	3.8%

MA Contracts in Your Market Area	N	Percentage			
		<1 Hr	1-3 Hrs	>3 Hrs but <6 Hrs	>6 Hrs
Aetna Medicare (H5414)	27	25.9%	18.5%	3.7%	22.2%
Amerigroup (H8991)	45	42.2%	11.1%	6.7%	6.7%
BC & BS of Florida (R3332)	28	35.7%	28.6%	7.1%	7.1%
BC&BS of Florida (H5434)	28	28.6%	28.6%	14.3%	10.7%
Care Plus Health Plan (H1019)	16	31.3%	37.5%	6.3%	0.0%
Citrus Health Care (H5407)	30	33.3%	30.0%	3.3%	20.0%
Coventry Health Care of Florida (H1076)	26	26.9%	11.5%	15.4%	23.1%
Coventry HP of Florida (H1013)	30	33.3%	16.7%	10.0%	20.0%
Coventry Summit Health Plan (H5850)	32	37.5%	15.6%	6.3%	12.5%
Freedom Health Plan (H5427)	34	14.7%	41.2%	17.6%	8.8%
Health First Health Plans (H1099)	29	37.9%	31.0%	3.4%	13.8%
Health Options (H1026)	37	32.4%	18.9%	8.1%	18.9%
HealthSpring of Florida (H5410)	43	48.8%	37.2%	2.3%	0.0%
Humana (H1036)	34	41.2%	32.4%	8.8%	5.9%
Humana (R5826)	24	41.7%	16.7%	12.5%	8.3%
Humana AdvantageCare Plan (H5426)	21	38.1%	9.5%	4.8%	14.3%
Optimum HealthCare (H5594)	37	45.9%	16.2%	16.2%	5.4%
Physicians United Plan (H5696)	24	33.3%	12.5%	20.8%	12.5%
Preferred Care Partners (H1045)	28	39.3%	21.4%	10.7%	10.7%
Quality Health Plans (H5402)	35	20.0%	22.9%	14.3%	17.1%
SecureHorizons by UnitedHealthcare (H1080)	30	33.3%	36.7%	3.3%	20.0%
SecureHorizons by UnitedHealthcare (H5532)	30	30.0%	30.0%	10.0%	6.7%
SecureHorizons by UnitedHealthcare (R5287)	35	31.4%	25.7%	8.6%	5.7%
Universal Health Care (H5404)	24	37.5%	29.2%	4.2%	12.5%
Universal Health Care (H5429)	14	42.9%	21.4%	0.0%	14.3%

WellCare (H1032)

Other MA Contracts in Florida	N	Percentage			
		<1 Hr	1-3 Hrs	>3 Hrs but <6 Hrs	>6 Hrs
AvMed Inc. (H1016)	30	26.7%	23.3%	6.7%	13.3%
Capital Health Plan (H5938)	43	30.2%	34.9%	4.7%	16.3%
Florida Health Care Plan (H1035)	25	40.0%	24.0%	4.0%	8.0%
Healthsun Health Plans (H5431)	32	78.1%	9.4%	3.1%	0.0%
JMH Health Plan (H4155)	20	35.0%	15.0%	5.0%	10.0%
Medica Healthcare Plans (H5420)	34	23.5%	47.1%	2.9%	8.8%
SecureHorizons by UnitedHealthcare (H9011)	30	33.3%	26.7%	10.0%	6.7%

Note: The results for these items are not case-mix adjusted, and statistical tests against the national average were not performed. The percentages in this table do not add to 100% because it does not include all of the response categories. The remaining response categories may be found in the table for Q11b. For information on how we defined your market area, see Part 3 of this report.

Single Item: Timing of Callback (continued)

Question 11: In the last 6 months, when you phoned a doctor's office or clinic after regular office hours, how long did it take for someone to call you back?

Q11b. I did not ask for a return call, I did not get a return call, or I was told to go to the Emergency Room.

[Scored only for those who phoned a doctor's office or clinic with a medical question after regular office hours.]

Single Item: Timing of Callback (continued)	N	Percentage		
		Did not ask for a return call	Did not get a return call	Told to go to the Emergency Room
National Distribution	13942	9.0%	6.1%	4.9%
State Distribution Florida	962	9.3%	7.5%	3.6%
2011 WellCare (H1032)	26	7.7%	3.8%	3.8%

MA Contracts in Your Market Area	N	Percentage		
		Did not ask for a return call	Did not get a return call	Told to go to the Emergency Room
Aetna Medicare (H5414)	27	7.4%	18.5%	3.7%
Amerigroup (H8991)	45	6.7%	15.6%	11.1%
BC & BS of Florida (R3332)	28	3.6%	10.7%	7.1%
BC&BS of Florida (H5434)	28	3.6%	14.3%	0.0%
Care Plus Health Plan (H1019)	16	12.5%	6.3%	6.3%
Citrus Health Care (H5407)	30	10.0%	3.3%	0.0%
Coventry Health Care of Florida (H1076)	26	7.7%	11.5%	3.8%
Coventry HP of Florida (H1013)	30	10.0%	10.0%	0.0%
Coventry Summit Health Plan (H5850)	32	25.0%	3.1%	0.0%
Freedom Health Plan (H5427)	34	0.0%	8.8%	8.8%
Health First Health Plans (H1099)	29	3.4%	3.4%	6.9%
Health Options (H1026)	37	13.5%	8.1%	0.0%
HealthSpring of Florida (H5410)	43	7.0%	0.0%	4.7%
Humana (H1036)	34	2.9%	2.9%	5.9%
Humana (R5826)	24	4.2%	8.3%	8.3%
Humana AdvantageCare Plan (H5426)	21	23.8%	4.8%	4.8%
Optimum HealthCare (H5594)	37	5.4%	10.8%	0.0%
Physicians United Plan (H5696)	24	4.2%	16.7%	0.0%
Preferred Care Partners (H1045)	28	3.6%	14.3%	0.0%
Quality Health Plans (H5402)	35	11.4%	14.3%	0.0%
SecureHorizons by UnitedHealthcare (H1080)	30	3.3%	3.3%	0.0%
SecureHorizons by UnitedHealthcare (H5532)	30	20.0%	3.3%	0.0%
SecureHorizons by UnitedHealthcare (R5287)	35	11.4%	11.4%	5.7%
Universal Health Care (H5404)	24	8.3%	8.3%	0.0%
Universal Health Care (H5429)	14	14.3%	7.1%	0.0%

WellCare (H1032)

Other MA Contracts in Florida	N	Percentage		
		Did not ask for a return call	Did not get a return call	Told to go to the Emergency Room
AvMed Inc. (H1016)	30	3.3%	13.3%	13.3%
Capital Health Plan (H5938)	43	7.0%	0.0%	7.0%
Florida Health Care Plan (H1035)	25	20.0%	4.0%	0.0%
Healthsun Health Plans (H5431)	32	6.3%	0.0%	3.1%
JMH Health Plan (H4155)	20	25.0%	5.0%	5.0%
Medica Healthcare Plans (H5420)	34	11.8%	2.9%	2.9%
SecureHorizons by UnitedHealthcare (H9011)	30	20.0%	3.3%	0.0%

Note: The results for these items are not case-mix adjusted, and statistical tests against the national average were not performed. The percentages in this table do not add to 100% because it does not include all of the response categories. The remaining response categories may be found in the table for Q11a. For information on how we defined your market area, see Part 3 of this report.

Frequency Tables¹

Q1. Our records show that in 2010 your health services were covered by the plan named on the back page. Is that right?

	<i>Frequency</i>	<i>Percent</i>	
Yes	308	99%	
No	4	1%	
Total	312	100%	
Missing	487		

Q3. In the last 6 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?

	<i>Frequency</i>	<i>Percent</i>	
Yes	110	38%	
No	179	62%	
Total	289	100%	
Missing	510		

Q4. In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?

	<i>Frequency</i>	<i>Percent</i>	
Never	0	0%	
Sometimes	10	9%	
Usually	31	28%	
Always	69	63%	
Total	110	100%	
Missing	689		

Q5. In the last 6 months, not counting the times you needed care right away, did you make any appointments for your health care at a doctor's office or clinic?

	<i>Frequency</i>	<i>Percent</i>	
Yes	238	83%	
No	48	17%	
Total	286	100%	
Missing	513		

¹ Note: The frequencies shown in this section are not case-mix adjusted and therefore may not be consistent with means displayed in previous report sections. In addition, percentages may not add to 100% due to rounding. Questions not pertaining to prescription drugs (Q's 1-43 and 62-82) were asked of all MA plan members, regardless of whether they have prescription drug benefits. Questions about prescription drug benefits (Q's 44-61) were asked only of those members enrolled in the prescription drug portion of the plan.

Frequency Tables (continued)

Q6. In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?

	<i>Frequency</i>	<i>Percent</i>
Never	9	4%
Sometimes	27	12%
Usually	64	27%
Always	134	57%
Total	234	100%
Missing	565	

Q7. In the last 6 months, not counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?

	<i>Frequency</i>	<i>Percent</i>
None	44	16%
1	47	17%
2	75	27%
3	43	16%
4	28	10%
5 to 9	38	14%
10 or more	2	1%
Total	277	100%
Missing	522	

Q8. Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

	<i>Frequency</i>	<i>Percent</i>
Never	52	22%
Sometimes	65	27%
Usually	77	32%
Always	47	20%
Total	241	100%
Missing	558	

Frequency Tables (continued)

Q9. In the last 6 months, did you phone a doctor's office or clinic with a medical question after regular office hours?

	<i>Frequency</i>	<i>Percent</i>
Yes	30	10%
No	256	90%
Total	286	100%
Missing	513	



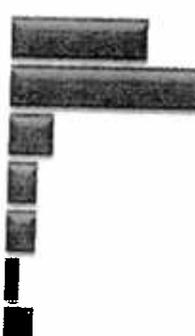
Q10. In the last 6 months, when you phoned a doctor's office or clinic after regular office hours, how often did you get an answer to your medical question as soon as you needed?

	<i>Frequency</i>	<i>Percent</i>
Never	4	12%
Sometimes	5	15%
Usually	9	27%
Always	15	45%
Total	33	100%
Missing	766	



Q11. In the last 6 months, when you phoned a doctor's office or clinic after regular office hours, how long did it take for someone to call you back?

	<i>Frequency</i>	<i>Percent</i>
Less than 1 hour	9	28%
1 to 3 hours	13	41%
More than 3 hours but less than 6 hours	3	9%
More than 6 hours	2	6%
I did not ask for a return call	2	6%
I did not get a return call	1	3%
I was told to go to the Emergency Room	2	6%
Total	32	100%
Missing	767	



Frequency Tables (continued)

Q12. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

	<i>Frequency</i>	<i>Percent</i>
0: Worst health care possible	1	0%
1	1	0%
2	1	0%
3	3	1%
4	3	1%
5	13	5%
6	14	5%
7	29	10%
8	45	16%
9	56	19%
10: Best health care possible	122	42%
Total	288	100%
Missing	511	

Q13. In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, a wheelchair, oxygen equipment, or diabetic supplies and equipment?

	<i>Frequency</i>	<i>Percent</i>
Yes	63	22%
No	226	78%
Total	289	100%
Missing	510	

Q14. In the last 6 months, how often was it easy to get the medical equipment you needed through your health plan?

	<i>Frequency</i>	<i>Percent</i>
Never	8	13%
Sometimes	7	11%
Usually	21	34%
Always	26	42%
Total	62	100%
Missing	737	

Frequency Tables (continued)

Q15. Do you have a personal doctor?

	<i>Frequency</i>	<i>Percent</i>
Yes	277	95%
No	14	5%
Total	291	100%
Missing	508	

Q16. In the last 6 months, how many times did you visit your personal doctor to get care for yourself?

	<i>Frequency</i>	<i>Percent</i>
None	10	4%
1	70	26%
2	96	35%
3	58	21%
4	17	6%
5 to 9	19	7%
10 or more	1	0%
Total	271	100%
Missing	528	

Q17. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

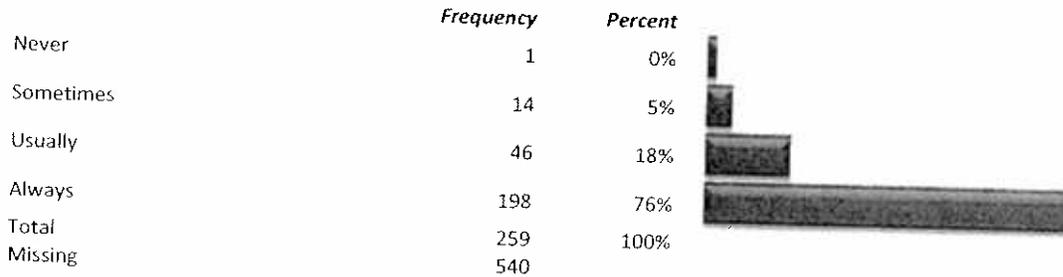
	<i>Frequency</i>	<i>Percent</i>
Never	4	2%
Sometimes	15	6%
Usually	66	25%
Always	177	68%
Total	262	100%
Missing	537	

Q18. In the last 6 months, how often did your personal doctor listen carefully to you?

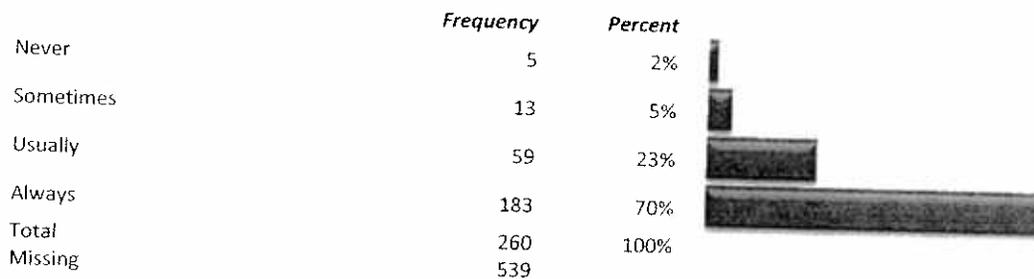
	<i>Frequency</i>	<i>Percent</i>
Never	1	0%
Sometimes	15	6%
Usually	56	22%
Always	188	72%
Total	260	100%
Missing	539	

Frequency Tables (continued)

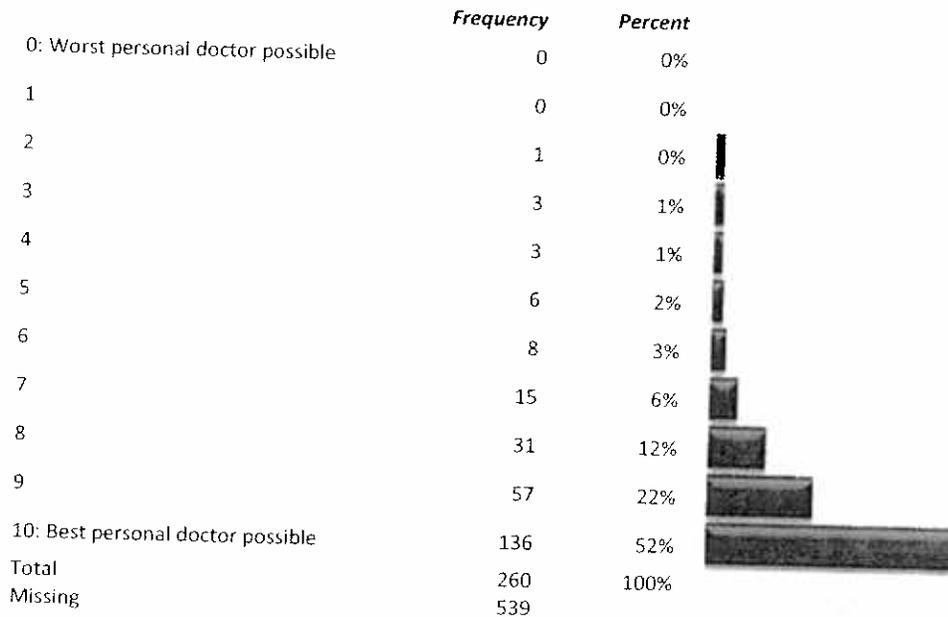
Q19. In the last 6 months, how often did your personal doctor show respect for what you had to say?



Q20. In the last 6 months, how often did your personal doctor spend enough time with you?



Q21. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?



Frequency Tables (continued)

Q22. In the last 6 months, did your personal doctor order a blood test, x-ray or other test for you?

	<i>Frequency</i>	<i>Percent</i>	
Yes	242	94%	
No	16	6%	
Total	258	100%	
Missing	541		

Q23. In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your doctor's office follow up to give you those results?

	<i>Frequency</i>	<i>Percent</i>	
Never	21	9%	
Sometimes	13	5%	
Usually	46	19%	
Always	158	66%	
Total	238	100%	
Missing	561		

Q24. How satisfied are you with the help you received to coordinate your care in the last 6 months?

	<i>Frequency</i>	<i>Percent</i>	
Very dissatisfied	13	5%	
Somewhat dissatisfied	10	3%	
Neither dissatisfied nor satisfied	12	4%	
Somewhat satisfied	57	20%	
Very satisfied	194	68%	
Total	286	100%	
Missing	513		

Q25. In the last 6 months, did you try to make any appointments to see a specialist?

	<i>Frequency</i>	<i>Percent</i>	
Yes	164	58%	
No	118	42%	
Total	282	100%	
Missing	517		

Frequency Tables (continued)

Q26 In the last 6 months, how often was it easy to get appointments with specialists?

	<i>Frequency</i>	<i>Percent</i>
Never	3	2%
Sometimes	12	7%
Usually	44	27%
Always	106	64%
Total	165	100%
Missing	634	

Q27. How many specialists have you seen in the last 6 months?

	<i>Frequency</i>	<i>Percent</i>
None	1	1%
1 specialist	82	51%
2	51	31%
3	14	9%
4	8	5%
5 or more specialists	6	4%
Total	162	100%
Missing	637	

Frequency Tables (continued)

Q28. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

	<i>Frequency</i>	<i>Percent</i>	
0: Worst specialist possible	0	0%	
1	1	1%	
2	3	2%	
3	0	0%	
4	3	2%	
5	6	4%	
6	6	4%	
7	11	7%	
8	19	12%	
9	31	19%	
10: Best specialist possible	80	50%	
Total	160	100%	
Missing	639		

Q29. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

	<i>Frequency</i>	<i>Percent</i>	
Never	5	3%	
Sometimes	18	12%	
Usually	54	35%	
Always	79	51%	
Total	156	100%	
Missing	643		

Q30. In the last 6 months, did you try to get any kind of care, tests or treatment through your health plan?

	<i>Frequency</i>	<i>Percent</i>	
Yes	175	63%	
No	103	37%	
Total	278	100%	
Missing	521		

Frequency Tables (continued)

Q31. In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?

	<i>Frequency</i>	<i>Percent</i>
Never	4	2%
Sometimes	12	7%
Usually	51	29%
Always	110	62%
Total	177	100%
Missing	622	

Q32. In the last 6 months, did you try to get information or help from your health plan's customer service?

	<i>Frequency</i>	<i>Percent</i>
Yes	80	29%
No	196	71%
Total	276	100%
Missing	523	

Q33. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?

	<i>Frequency</i>	<i>Percent</i>
Never	4	5%
Sometimes	15	18%
Usually	27	33%
Always	37	45%
Total	83	100%
Missing	716	

Q34. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?

	<i>Frequency</i>	<i>Percent</i>
Never	0	0%
Sometimes	5	6%
Usually	27	32%
Always	52	62%
Total	84	100%
Missing	715	

Frequency Tables (continued)

Q35. In the last 6 months, did your health plan give you any forms to fill out?

	<i>Frequency</i>	<i>Percent</i>
Yes	56	21%
No	212	79%
Total	268	100%
Missing	531	

Q36. In the last 6 months, how often were the forms from your health plan easy to fill out?

	<i>Frequency</i>	<i>Percent</i>
Never	4	7%
Sometimes	6	10%
Usually	18	31%
Always	30	52%
Total	58	100%
Missing	741	

Q37. 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?

	<i>Frequency</i>	<i>Percent</i>
0: Worst health plan possible	0	0%
1	1	0%
2	0	0%
3	4	1%
4	3	1%
5	20	7%
6	16	6%
7	23	8%
8	53	18%
9	57	20%
10: Best health plan possible	111	39%
Total	288	100%
Missing	511	

Frequency Tables (continued)

Q38. In the last 6 months, was there a time when you believed you needed care or services that your health plan decided not to give you?

	<i>Frequency</i>	<i>Percent</i>	
Yes	33	12%	
No	251	88%	
Total	284	100%	
Missing	515		

Q39. In the last 6 months, have you ever asked anyone at your health plan to reconsider a decision not to provide or pay for health care or services?

	<i>Frequency</i>	<i>Percent</i>	
Yes	13	43%	
No	17	57%	
Total	30	100%	
Missing	769		

Q40. When you spoke to your health plan about the decision not to provide care or services, did they...

	<i>Frequency</i>	<i>Percent</i>	
Tell you that you can file an appeal	6	40%	
Offer to send you forms that you need to file an appeal	2	13%	
Suggest how to resolve your complaint	4	27%	
Listen to your complaint but did not help resolve it	2	13%	
Discourage you from taking action	0	0%	
Do none of these things	3	20%	
Total	15	N/A	
Missing	784		

Q41. In the last 6 months, have you called or written your health plan with a complaint or problem?

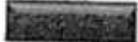
	<i>Frequency</i>	<i>Percent</i>	
Yes	29	10%	
No	254	90%	
Total	283	100%	
Missing	516		

Frequency Tables (continued)

Q42. How long did it take for your health plan to settle your complaint?

	<i>Frequency</i>	<i>Percent</i>	
Same day	10	36%	
1 week	3	11%	
2 weeks	3	11%	
3 weeks	2	7%	
4 or more weeks	3	11%	
I am still waiting for it to be settled	7	25%	
Total	28	100%	
Missing	771		

Q43. Was your complaint or problem settled to your satisfaction?

	<i>Frequency</i>	<i>Percent</i>	
Yes	17	57%	
No	5	17%	
I am still waiting for it to be settled	8	27%	
Total	30	100%	
Missing	769		

Q44. In the last 6 months, did you try to get information or help about prescriptions from your prescription drug plan's customer service?

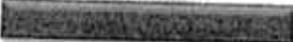
	<i>Frequency</i>	<i>Percent</i>	
Yes	46	17%	
No	227	83%	
Total	273	100%	
Missing	526		

Q45. In the last 6 months, how often did your prescription drug plan's customer service give you the information or help you needed about prescription drugs?

	<i>Frequency</i>	<i>Percent</i>	
Never	5	12%	
Sometimes	4	10%	
Usually	16	38%	
Always	17	40%	
Total	42	100%	
Missing	757		

Frequency Tables (continued)

Q46. In the last 6 months, how often did your prescription drug plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs?

	<i>Frequency</i>	<i>Percent</i>	
Never	0	0%	
Sometimes	1	3%	
Usually	15	38%	
Always	24	60%	
Total	40	100%	
Missing	759		

Q47. In the last 6 months, did you try to get information from your prescription drug plan about which prescription medicines were covered?

	<i>Frequency</i>	<i>Percent</i>	
Yes	47	17%	
No	227	83%	
Total	274	100%	
Missing	525		

Q48. In the last 6 months, how often did your prescription drug plan's customer service give you all the information you needed about which prescription medicines were covered?

	<i>Frequency</i>	<i>Percent</i>	
Never	2	5%	
Sometimes	5	12%	
Usually	16	38%	
Always	19	45%	
Total	42	100%	
Missing	757		

Q49. In the last 6 months, did you try to get information from your prescription drug plan about how much you would have to pay for your prescription medicines?

	<i>Frequency</i>	<i>Percent</i>	
Yes	55	20%	
No	218	80%	
Total	273	100%	
Missing	526		

Frequency Tables (continued)

Q50. In the last 6 months, how often did your prescription drug plan's customer service give you all the information you needed about how much you would have to pay for your prescription medicine?

	<i>Frequency</i>	<i>Percent</i>
Never	3	6%
Sometimes	7	13%
Usually	14	26%
Always	29	55%
Total	53	100%
Missing	746	

Q51. In the last 6 months, how many different prescription medicines did you fill or have refilled?

	<i>Frequency</i>	<i>Percent</i>
None	14	5%
1 to 2 medicines	55	20%
3 to 5 medicines	102	37%
6 or more medicines	108	39%
Total	279	100%
Missing	520	

Q52. In the last 6 months, did a doctor prescribe a medicine for you that your prescription drug plan did not cover?

	<i>Frequency</i>	<i>Percent</i>
Yes	70	26%
No	201	74%
Total	271	100%
Missing	528	

Q53. When this happened, did you contact your prescription drug plan to ask them to cover the medicine your doctor prescribed?

	<i>Frequency</i>	<i>Percent</i>
Yes	15	22%
No	52	78%
Total	67	100%
Missing	732	

Frequency Tables (continued)

Q54. When you contacted your prescription drug plan about the decision not to cover a prescription medicine did they...

	<i>Frequency</i>	<i>Percent</i>
Tell you that you can file an appeal	2	12%
Offer to send you forms that you need to file an appeal	1	6%
Suggest how to resolve your complaint	5	29%
Listen to your complaint but did not help resolve it	6	35%
Discourage you from taking action	0	0%
Do none of the above	3	18%
All my prescribed medicines were covered	2	12%
Total	17	N/A
Missing	782	

Q55. In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?

	<i>Frequency</i>	<i>Percent</i>
Never	6	2%
Sometimes	9	3%
Usually	52	20%
Always	199	75%
Total	266	100%
Missing	533	

Q56. In the last 6 months, did you ever use your prescription drug plan to fill a prescription at your local pharmacy?

	<i>Frequency</i>	<i>Percent</i>
Yes	235	86%
No	38	14%
Total	273	100%
Missing	526	

Frequency Tables (continued)

Q57. In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?

	<i>Frequency</i>	<i>Percent</i>
Never	2	1%
Sometimes	6	3%
Usually	42	18%
Always	181	78%
Total	231	100%
Missing	568	

Q58. In the last 6 months, did you ever use your prescription drug plan to fill a prescription by mail?

	<i>Frequency</i>	<i>Percent</i>
Yes	29	11%
No	241	89%
Total	270	100%
Missing	529	

Q59. In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?

	<i>Frequency</i>	<i>Percent</i>
Never	0	0%
Sometimes	2	7%
Usually	7	25%
Always	19	68%
Total	28	100%
Missing	771	

Frequency Tables (continued)

Q60. Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?

	<i>Frequency</i>	<i>Percent</i>
0: Worst prescription drug plan possible	2	1%
1	0	0%
2	3	1%
3	2	1%
4	6	2%
5	13	5%
6	8	3%
7	19	7%
8	43	16%
9	55	20%
10: Best prescription drug plan possible	120	44%
Total	271	100%
Missing	528	

Q61. Would you recommend your prescription drug plan for coverage of prescription drugs to other people like yourself?

	<i>Frequency</i>	<i>Percent</i>
Definitely yes	163	60%
Somewhat yes	84	31%
Somewhat no	13	5%
Definitely no	10	4%
Total	270	100%
Missing	529	

Q62. In general, how would you rate your overall health?

	<i>Frequency</i>	<i>Percent</i>
Excellent	22	8%
Very good	79	28%
Good	119	42%
Fair	48	17%
Poor	16	6%
Total	284	100%
Missing	515	

Frequency Tables (continued)

Q63. In general, how would you rate your overall mental health?

	<i>Frequency</i>	<i>Percent</i>	
Excellent	88	31%	
Very good	98	35%	
Good	65	23%	
Fair	26	9%	
Poor	6	2%	
Total	283	100%	
Missing	516		

Q64. In the past 12 months, have you seen a doctor or other health provider 3 or more times for the same condition or problem?

	<i>Frequency</i>	<i>Percent</i>	
Yes	137	48%	
No	147	52%	
Total	284	100%	
Missing	515		

Q65. Is this a condition or problem that has lasted for at least 3 months?

	<i>Frequency</i>	<i>Percent</i>	
Yes	119	89%	
No	14	11%	
Total	133	100%	
Missing	666		

Q66. Do you now need or take medicine prescribed by a doctor?

	<i>Frequency</i>	<i>Percent</i>	
Yes	260	92%	
No	22	8%	
Total	282	100%	
Missing	517		

Frequency Tables (continued)

Q67. Is this to treat a condition that has lasted for at least 3 months?

	<i>Frequency</i>	<i>Percent</i>	
Yes	234	94%	
No	16	6%	
Total	250	100%	
Missing	549		

Q68. In the last 6 months, did you delay or not fill a prescription because you felt you could not afford it?

	<i>Frequency</i>	<i>Percent</i>	
Yes	53	19%	
No	226	81%	
Total	279	100%	
Missing	520		

Q69. Has a doctor ever told you that you had any of the following conditions?

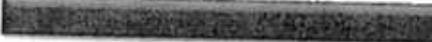
Q69a. A heart attack?

	<i>Frequency</i>	<i>Percent</i>	
Yes	28	14%	
No	169	86%	
Total	197	100%	
Missing	602		

Q69b. Angina or coronary heart disease?

	<i>Frequency</i>	<i>Percent</i>	
Yes	47	24%	
No	147	76%	
Total	194	100%	
Missing	605		

Q69c. A stroke?

	<i>Frequency</i>	<i>Percent</i>	
Yes	19	10%	
No	175	90%	
Total	194	100%	
Missing	605		

Frequency Tables (continued)

Q69d. Cancer, other than skin cancer?

	<i>Frequency</i>	<i>Percent</i>	
Yes	32	16%	
No	163	84%	
Total	195	100%	
Missing	604		

Q69e. Emphysema, asthma or COPD (chronic obstructive pulmonary disease)?

	<i>Frequency</i>	<i>Percent</i>	
Yes	42	22%	
No	149	78%	
Total	191	100%	
Missing	608		

Q69f. Any kind of diabetes or high blood sugar?

	<i>Frequency</i>	<i>Percent</i>	
Yes	114	58%	
No	81	42%	
Total	195	100%	
Missing	604		

Q70. Have you had a flu shot since September 1, 2010?

	<i>Frequency</i>	<i>Percent</i>	
Yes	191	67%	
No	95	33%	
Total	286	100%	
Missing	513		

Q71. Have you ever had a pneumonia shot?

	<i>Frequency</i>	<i>Percent</i>	
Yes	176	68%	
No	82	32%	
Total	258	100%	
Missing	541		

Frequency Tables (continued)

Q72. Do you now smoke cigarettes or use tobacco every day, some days, or not at all?

	<i>Frequency</i>	<i>Percent</i>	
Every day	26	9%	
Some days	14	5%	
Not at all	235	85%	
Total	275	100%	
Missing	524		

Q73. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider?

	<i>Frequency</i>	<i>Percent</i>	
Never	2	5%	
Sometimes	10	24%	
Usually	14	34%	
Always	15	37%	
Total	41	100%	
Missing	758		

Q74. What is your age?

	<i>Frequency</i>	<i>Percent</i>	
18 to 24	0	0%	
25 to 34	0	0%	
35 to 44	0	0%	
45 to 54	7	2%	
55 to 64	19	7%	
65 to 69	55	19%	
70 to 74	69	24%	
75 to 79	65	23%	
80 to 84	37	13%	
85 or older	32	11%	
Total	284	100%	
Missing	515		

Q75. Are you male or female?

	<i>Frequency</i>	<i>Percent</i>	
Male	109	39%	
Female	171	61%	
Total	280	100%	
Missing	519		

Frequency Tables (continued)

Q76. What is the highest grade or level of school that you have completed?

	<i>Frequency</i>	<i>Percent</i>
8th grade or less	31	11%
Some high school, but did not graduate	41	15%
High school graduate or GED	97	34%
Some college or 2-year degree	82	29%
4-year college graduate	18	6%
More than 4-year college degree	13	5%
Total	282	100%
Missing	517	



Q77. Are you of Hispanic or Latino origin or descent?

	<i>Frequency</i>	<i>Percent</i>
Yes, Hispanic or Latino	43	16%
No, not Hispanic or Latino	228	84%
Total	271	100%
Missing	528	



Q78. What is your race?

	<i>Frequency</i>	<i>Percent</i>
White	240	86%
Black or African American	31	11%
Asian	2	1%
Native Hawaiian or other Pacific Islander	0	0%
American Indian or Alaska Native	7	3%
Total	278	N/A
Missing	521	



Q79. Did someone help you complete this survey?

	<i>Frequency</i>	<i>Percent</i>
Yes	34	13%
No	220	87%
Total	254	100%
Missing	545	



Frequency Tables (continued)

Q80. How did that person help you?

	<i>Frequency</i>	<i>Percent</i>
Read the questions to me	18	53%
Wrote down the answers I gave	12	35%
Answered the questions for me	7	21%
Translated the questions into my language	5	15%
Helped in some other way	2	6%
Total	34	N/A
Missing	765	

Q81 Do you live alone?

	<i>Frequency</i>	<i>Percent</i>
Yes, I live alone	83	29%
No, I live with others	201	71%
Total	284	100%
Missing	515	

Part 3: Background and Methodology

Background

In 1998, CMS launched a nationwide effort to collect information from Medicare beneficiaries enrolled in managed care now referred to as Medicare Advantage (MA) about their experiences with, and evaluations of, their health plans. This effort has three primary goals:

- Provide Medicare beneficiaries and the general public with information to help them make more informed choices among health plans.
- Help MA plans identify problems and improve the quality of care and services by providing them with information about their performance relative to that of other health plan contracts in their state and region, as well as nationally; and
- Enhance CMS' ability to monitor the quality of care and performance of MA contracts.

In the fall of 2000, CMS began to conduct a separate annual survey of beneficiaries enrolled in the original Medicare Fee-For-Service program, and in 2007, began to collect information from Medicare beneficiaries about their experiences with the new Medicare Prescription Drug Benefit (Part D) in either an MA Prescription Drug plan or a Standalone Prescription Drug plan. The questions added to the Medicare CAHPS Survey at that time focus on beneficiaries' experiences with getting needed information about their prescription drug plan (PDP) and with getting the prescription drugs they need. The responses to these questions, as well as some overall ratings of PDPs, are included in this report.

Methodology

CMS collects information about Medicare beneficiaries' experiences with and ratings of MA plans via the annual CAHPS survey of currently enrolled beneficiaries. Beneficiaries at least 18 years of age and currently enrolled in an MA or Standalone PD plan for six months or longer are eligible for participation. Although beneficiaries provide ratings of their "plans," the unit of analysis is not a health and/or prescription drug plan but rather a health and/or prescription drug plan contract. This report refers both to plans and to contracts. In the context of this report, the terms both refer to health and/or prescription drug contracts.

The Medicare CAHPS Survey, which has been conducted annually with a sample of Medicare beneficiaries since 1998, is part of a group of surveys developed by a consortium of researchers from American Institutes for Research, Harvard Medical School, the RAND Corporation, and RTI International under a cooperative agreement between CMS and the Agency for Healthcare Research and Quality (AHRQ), a component of the U.S. Public Health Service.

The Survey Instruments

The 2011 Medicare CAHPS survey includes five versions: Medicare Advantage (MA), Medicare Advantage Prescription Drug plan (MA-PD), Medicare Advantage for PPO Enrollees (MA-PPO), Medicare Fee-for-Service, and Standalone Medicare Prescription Drug Plan (PDP). Although all five versions have a nearly identical set of core questions, each version also includes additional questions and response categories related to the enrollees' experiences in their own particular contract type.

The MA-PD Survey contains 82 questions, organized into the following sections: Your Health Plan (10 questions), Your Healthcare in the Last 6 Months (12 questions), Your Personal Doctor (10 questions), Getting Healthcare from Specialists (5 questions), Your Medicare Rights (6 questions), Your Prescription Drug Plan (18 questions, asked only of those with PD benefits), and About You (21 questions). A copy of the MA-PD CAHPS Survey instrument is included on the CD along with this report.

Many of the items in the CAHPS survey are preceded by screener questions, so that only those beneficiaries for whom the item is relevant (i.e., those with relevant needs or experiences) are asked to answer those questions.

For scoring and reporting purposes, we combined some questions into the following six composite measures: Getting Needed Care, Getting Care Quickly, Doctors Who Communicate Well, Health Plan Customer Service, Getting Needed Prescription Drugs, and Getting Information From the Plan About Prescription Drug Coverage and Cost. Table 1 displays

these composites and the survey items they comprise, as well as items that are reported individually but that are not part of composites.

Table 1. MA-PD CAHPS Survey Composites, Overall Ratings and Single-Item Measures

Composite Measures	Survey Items Included in the Composite
Getting Needed Care	<p>In the last 6 months, how often was it easy to get appointments with specialists?</p> <p>In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?</p>
Getting Care Quickly	<p>In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?</p> <p>In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?</p> <p>Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?</p>
Doctors Who Communicate Well	<p>In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?</p> <p>In the last 6 months, how often did your personal doctor listen carefully to you?</p> <p>In the last 6 months, how often did your personal doctor show respect for what you had to say?</p> <p>In the last 6 months, how often did your personal doctor spend enough time with you?</p>
Health Plan Customer Service	<p>In the last 6 months, how often did your health plan's customer service give you the information or help you needed?</p> <p>In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?</p> <p>In the last 6 months, how often were the forms for your health plan easy to fill out?</p>
Getting Needed Prescription Drugs	<p>In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?</p> <p>In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?</p> <p>In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?</p>

Table 1. MA-PD CAHPS Survey Composites, Overall Ratings and Single-Item Measures (continued)

Composite Measures	Survey Items Included in the Composite
Getting Information From the Plan About Prescription Drug Coverage and Cost	<p>In the last 6 months, how often did your prescription drug plan's customer service give you the information or help you needed about prescription drugs?</p> <p>In the last 6 months, how often did your prescription drug plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs?</p> <p>In the last 6 months, how often did your prescription drug plan's customer service give you all the information you needed about which prescription medicines were covered?</p> <p>In the last 6 months, how often did your prescription drug plan's customer service give you all the information you needed about how much you would have to pay for your prescription medicine?</p>

Overall Ratings	Survey Item
Overall Rating of Health Plan	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?
Overall Rating of Care Received	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?
Overall Rating of Personal Doctor	Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?
Overall Rating of Specialist	We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?
Overall Rating of Drug Coverage	Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?

Table 1. MA-PD CAHPS Survey Composites, Overall Ratings and Single-Item Measures (continued)

Other Single Item Measures	Survey Item
Willingness to Recommend Plan for Drug Coverage	Would you recommend your prescription drug plan for coverage of prescription drugs to other people like yourself?
Influenza Vaccination	Have you had a flu shot since September 1, 2010?
Pneumonia Shot	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 the flu shot. It is also called the pneumococcal vaccine.
Getting Medical Equipment	In the last 6 months, how often was it easy to get the medical equipment you needed through your health plan?
Follow-up with Test Results	In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your doctor's office follow up to give you those results?
After Hours Call	In the last 6 months, did you phone a doctor's office or clinic with a medical question after regular office hours?
Callback as Soon as Needed	In the last 6 months, when you phoned a doctor's office or clinic after regular office hours, how often did you get an answer to your medical question as soon as you needed?
Timing of Callback	In the last 6 months, when you phoned a doctor's office or clinic after regular office hours, how long did it take for someone to call you back?

Data Collection

Unlike previous rounds of data collection in which the data were collected by a single survey vendor, the 2011 survey was conducted by CMS-approved "qualified" vendors. Each participating Medicare Advantage health plan contracted with one of the CMS-approved vendors to conduct the 2011 survey. A total of seven vendors conducted the MA CAHPS surveys in accordance with CMS' data collection specifications and guidelines using a random sample of enrollees selected by CMS.

Sample Selection and Eligibility Criteria

CMS selected samples for the Medicare CAHPS Survey from 447 MA contracts, each identified by its name and four-digit contract or "H" or "R" number. From each contract, 800 eligible enrollees were drawn by simple random sampling, except in a few contracts where PD enrollees were oversampled as described below. For contracts with very few eligible enrollees, all were selected.

To be included in the random sample for the MA CAHPS Survey, MA contracts were required to have been in effect on or before January 1, 2010. Beneficiaries had to have been continuously enrolled in the plan for at least six months to be eligible for the survey. Institutionalized beneficiaries were not eligible for selection and, if identified during data collection, were excluded from the analysis. Beneficiaries also had to be 18 years old or older at the time of the sample draw.

In MA plans with some but not all beneficiaries enrolled for the prescription drug (PD) benefit, samples were drawn from both PD enrollees and non-enrollees, and each group was mailed the appropriate questionnaire form. In a few contracts with low rates of PD enrollment the sampling rate was slightly increased for PD enrollees and reduced for non-PD enrollees. Data from both groups were combined to obtain estimates for non-PD survey items. Some sample members were excluded from the survey protocol either prior to or during fielding of the survey due to being under 18 years of age, deceased, or identified as being in the sample for another Medicare CAHPS survey version (i.e., sample members can only be in the survey for one type of contract).

Survey Implementation

The 2011 Medicare CAHPS survey was conducted between March 1 and June 10, 2011, and asked about beneficiaries' experiences with care received in the previous six months. The data collection protocol included mailing of pre-notification

letters, up to two mailings of paper surveys, and telephone surveys with those sample members who did not respond to the mail survey. The mail and telephone surveys were available in both English- and Spanish-language versions.

Table 2. Implementation Timeline, 2011 Medicare CAHPS Survey

Task	Dates
Pre-notification letters sent to sample members	March 1 – March 14, 2011
Surveys mailed to sample members	March 8 – March 21, 2011
Wave 2 surveys mailed to non-respondents	March 29 – April 11, 2011
Follow-up calls made to non-respondents	April 15 – June 10, 2011

Sample Disposition

The sample disposition and response rates for the Medicare CAHPS Survey are presented in Table 3. Of the 729,839 beneficiaries in the original sample of the Medicare CAHPS Survey, 21,052 (2.9%) beneficiaries were classified as ineligible because they were under the age of 18, institutionalized, deceased, mentally or physically incapable, or had a language barrier that prevented them from completing the survey. Those who were excluded from the survey prior to fielding because they were under 18 years of age, deceased, or identified as being eligible for another Medicare survey version were also considered ineligible. The adjusted response rate, after accounting for both ineligible sample members and non-respondents who were excluded from the telephone follow-up, is 47.3 percent (335,150 survey completes divided by 729,839 beneficiaries in the original sample minus 21,052 beneficiaries deemed ineligible).

Table 3. Sample Disposition, 2011 Medicare CAHPS Survey

Disposition	Sample Member Count	Percentage of Sample
Completed survey	335,150	45.92%
Partially completed survey	5,077	0.70%
Ineligible	21,052	2.89%
Institutionalized	1,111	0.15%
Deceased	2,888	0.40%
Did not speak English or Spanish	5,442	0.75%
Mentally or physically unable to respond	10,629	1.46%
Otherwise excluded from survey ²	982	0.13%
Non-respondents	368,560	50.50%
Total sample	729,839	100.00%

² Please see sample exclusion criteria in text on previous page.

Data Analysis

Data from the Medicare CAHPS Survey were weighted to reflect the number of enrollees in each health plan or Standalone PD contract and also to combine PD enrollees and non-enrollees in proportion to their enrollment in MA contracts with partial PD enrollment. Researchers at the Harvard Medical School analyzed the data to produce summary statistics for public reporting. The sections below describe the major analysis steps.

Use of Composite Measures

When a survey covers many topics, a report that simply lists the answers to every question can be overwhelming to readers. To keep survey reports shorter without sacrificing important information, answers to questions about the same topic are combined to form composites. In most cases the items in a composite are given equal weight in calculating the composite score. The exception is the measure on ease of getting needed prescription drugs, which combines means on items for getting drugs from a pharmacy and by mail order, weighted in proportion to the number of respondents using each of those sources in *your* contract.

Case-Mix Adjustment

Certain respondent characteristics, such as age, education, socioeconomic status, and health status, are not under the control of the health plan but are related to the plan member's experiences and survey responses. To ensure that comparisons between contracts reflect differences in performance rather than differences in case-mix, it is necessary to adjust for such respondent characteristics when comparing contracts' Medicare CAHPS results.

Consistent with other research,^{3, 4, 5, 6} self-reported global health status, self-reported mental health status, age, and education accounted for a substantial amount of variation among contracts on the CAHPS global ratings. In general, individuals reporting better physical and mental health, those who are older, and those with less education gave higher ratings. The case-mix model used for this report includes these four self-reported characteristics, together with two variables indicating whether another person helped the respondent complete the questionnaire and whether the individual providing help answered the questions for the intended respondent, one variable indicating the Medicaid dual eligibility status, and one variable indicating whether the respondent was eligible for the low-income subsidy. These last two variables represent socio-economic status, since the survey does not collect information about income or assets. Although proxy reporting contributed only very weakly to differences in contract means, these variables were retained in the case-mix models in order to allay concerns about potential biases. Table 4 shows the variables used in the case-mix adjustment.

Table 4. Case-Mix Adjustment Variables, 2011 Medicare CAHPS Survey

Case-Mix Variable	Survey Questions	Variable Coding
Health Status	In general, how would you rate your overall health?	1) Excellent 2) Very good 3) Good 4) Fair 5) Poor
Mental Health Status	In general, how would you rate your overall mental health?	1) Excellent 2) Very good 3) Good 4) Fair 5) Poor

³ Cleary PD, McNeil BJ. Patient Satisfaction as an Indicator of Quality Care. *Inquiry*. Spring 1988; 25:25-36.

⁴ Zaslavsky AM, Zaboriski LB, Ding L, Shaul JA, Cioffi MJ, Cleary PD. Adjusting Performance Measures to Ensure Equitable Plan Comparisons. *Health Care Financing Review*, 2001; 22(3):109-126.

⁵ Hargraves JL, Wilson IB, Zaslavsky A, James C, Walker JD, Rogers G, Cleary PD. Adjusting for patient characteristics when analyzing reports from patients about hospital care. *Med Care*; 2001; 39(6):635-641.

⁶ Epstein AM, Hall JA, Foggett J, Son LH, Conant L. Using Proxies to Evaluate Quality of Life: Can They Provide Valid Information About Patients' Health Status and Satisfaction with Medical Care. *Medical Care* 1989; 27(3): S91-8.

Table 4. Case-Mix Adjustment Variables, 2011 Medicare CAHPS Survey (continued)

Case-Mix Variable	Survey Questions	Variable Coding
Age	What is your age?	1) 64 or younger 2) 65 to 69 3) 70 to 74 4) 75 to 79 5) 80 to 84 6) 85 or older
Education	What is the highest grade or level of school that you have completed?	1) 8th grade or less 2) Some high school, but did not graduate 3) High school graduate or GED 4) Some college or 2-year degree 5) 4-year college graduate 6) More than 4-year college degree
Received Help Responding	Did someone help you complete this survey?	1) Yes 0) No
Proxy Answered Questions for Respondent	How did that person help you? Check all that apply	1) Answered the questions for me 0) Read the questions to me; Wrote down the answers I gave; Translated the questions into my language; Helped me in some other way; no help.
Medicaid Dual Eligibility Flag	A flag in the data set assigns a 1 if a person is eligible for both Medicaid and Medicare or a 0 if only eligible for Medicare.	
Low-Income Subsidy Flag	A flag in the data set assigns a 1 if a person is eligible for the low-income subsidy or a 0 if ineligible.	

To adjust for case-mix, linear regression models were developed in which the dependent variable was the response on a particular survey item and the independent variables were case-mix adjustors. First, the analysts identified important predictor variables by fitting models that controlled for differences in contract performance. In these models, the predictive power of the identified variables was tested both individually and in combination. Next, the analysts determined how much contracts differed on these variables and used this information to determine which variables would have the greatest impact on plan ratings when included in the case-mix model. Case-mix coefficients for selected models appear in Table 5 and Table 6. (Coefficients shown for composites are means across items of the composite.) The coefficients for the individual items that comprise the composite measures are available on the CD.

Prior to adjusting the data, missing data were imputed to the contract mean for individual adjustors. Each contract mean was then adjusted using the regression model by predicting the mean that would be obtained if the average of the case-mix variables for the contract was equal to the average across all contracts nationally. These means are shown in Table 7 and Table 8. Means for responses to any particular item or measure may differ slightly from those due to different screeners applied for various items. Consequently, the national mean of contract means for any rating or report is unchanged by case-mix adjustment.

Case-mix adjusted data were used to compare each contract to the national mean (see Significance Testing below). The case-mix adjusted data show how each contract would compare to other contracts if the patients cared for by each contract had the same distribution of characteristics with respect to age, education, self-reported physical and mental health status, proxy status, and Medicare dual-eligibility status.

Table 5. Case-Mix Coefficients – MA Measures

Variable	Overall Rating of Personal Doctor	Overall Rating of Health Care Received	Overall Rating of Health Plan	Overall Rating of Specialist	Get Care Quickly (Composite)
Age					
64 or under	0.0264	-0.1622	-0.2116	-0.0611	-0.0084
65 – 69	-0.0190	-0.0372	-0.0441	-0.0598	-0.0010
75 – 79	0.0527	0.0751	0.1467	-0.0700	0.0077
80 – 84	0.0765	0.1007	0.2363	0.0351	0.0091
85 and older	0.0433	0.1179	0.2489	0.0161	0.0377
Education					
Less than an 8 th grade education	-0.0194	-0.1734	-0.0966	-0.1223	-0.0445
Some high school	0.0154	-0.0552	0.0605	-0.0378	-0.0139
Some college	-0.1077	-0.1451	-0.2415	-0.0660	-0.0137
College graduate	-0.1733	-0.2196	-0.2993	-0.1249	-0.0325
More than a bachelor's degree	-0.1627	-0.2861	-0.3960	-0.2648	-0.0219
General Health Rating					
Excellent	0.2267	0.4480	0.4385	0.2074	0.1274
Very good	0.0783	0.2267	0.2177	0.0844	0.0434
Fair	-0.0985	-0.2376	-0.1418	-0.1548	-0.0625
Poor	-0.1745	-0.4494	-0.1652	-0.1813	-0.0466
Mental Health Rating					
Excellent	0.3599	0.4795	0.3319	0.4322	0.0979
Very good	0.1410	0.2268	0.1689	0.1284	0.0610
Fair	-0.0534	-0.0932	-0.1509	-0.1156	-0.0197
Poor	-0.1667	-0.2303	-0.4577	-0.2935	-0.0303
Proxy					
Proxy helped	-0.0445	-0.1861	-0.1347	0.0231	-0.0309
Proxy answered	-0.0028	0.0349	-0.0440	0.0229	0.0376
Dual-Eligible					
Medicaid dual eligible	-0.1112	-0.0665	0.1732	-0.0618	-0.0129
LIS					
Low-income subsidy (LIS)	-0.0875	-0.1117	0.1066	-0.1224	-0.0525

Table 5. Case-Mix Coefficients – MA Measures (continued)

Variable	Get Needed Care (Composite)	Doctors Who Communicate Well (Composite)	Health Plan Customer Service (Composite)	Getting Medical Equipment	Follow Up with Test Results
Age					
64 or under	-0.0547	0.0471	-0.0369	-0.1308	0.0121
65 – 69	-0.0119	0.0146	0.0007	-0.0457	0.0074
75 – 79	0.0071	0.0232	-0.0020	-0.0337	0.0363
80 – 84	0.0380	0.0259	0.0590	-0.0505	0.0452
85 and older	0.0282	-0.0015	0.0387	-0.1840	-0.0369
Education					
Less than an 8 th grade education	-0.0665	-0.0095	-0.0192	-0.1109	0.0220
Some high school	-0.0391	-0.0039	0.0216	-0.0752	-0.0081
Some college	-0.0737	-0.0357	-0.0495	-0.0355	-0.0537
College graduate	-0.0597	-0.0254	-0.0550	0.0322	-0.0860
More than a bachelor's degree	-0.0899	-0.0184	-0.1041	-0.0686	-0.0630
General Health Rating					
Excellent	0.1052	0.0874	0.0358	-0.1039	0.1460
Very good	0.0578	0.0388	0.0232	0.0543	0.0661
Fair	-0.0679	-0.0421	-0.0530	-0.0512	-0.0411
Poor	-0.0670	-0.0694	-0.0857	-0.0306	-0.0727
Mental Health Rating					
Excellent	0.1422	0.1172	0.0776	0.1215	0.1205
Very good	0.0685	0.0454	0.0268	0.0492	0.0628
Fair	-0.0262	-0.0524	-0.0477	-0.1146	-0.0065
Poor	-0.0751	-0.0789	-0.1208	-0.2418	-0.0200
Dual-Eligible					
Proxy helped	-0.0459	-0.0175	-0.0831	-0.0215	-0.0153
Proxy answered	0.0231	0.0052	-0.0016	0.1487	-0.0247
Dual-Eligible					
Medicaid dual eligible	-0.0384	-0.0237	0.0306	-0.0087	-0.0292
LIS					
Low-income subsidy (LIS)	-0.0656	-0.0292	-0.0298	-0.0402	-0.0857

Table 6. Case-Mix Coefficients for MA-PD Measures

Variable	Overall Rating of Drug Coverage	Willingness to Recommend Plan for Drug Coverage	Getting Information from Plan about Prescription Drug Coverage (Composite)	Getting Needed Prescription Drugs (Composite)
Age				
64 or under	-0.2241	0.0279	0.0090	-0.0346
65 – 69	-0.0713	0.0061	0.0153	-0.0120
75 – 79	0.1759	0.0383	0.0377	0.0255
80 – 84	0.2900	0.0486	0.0450	0.0246
85 and older	0.4467	0.0743	0.0962	0.0422
Education				
Less than an 8 th grade education	-0.0354	-0.0811	-0.0634	-0.0475
Some high school	0.1134	-0.0141	-0.0707	-0.0139
Some college	-0.2464	-0.0294	-0.0414	-0.0318
College graduate	-0.3164	-0.0352	-0.0677	-0.0566
More than a bachelor's degree	-0.4609	-0.0451	-0.0987	-0.0723
General Health Rating				
Excellent	0.4132	0.1358	-0.0237	0.0149
Very good	0.2124	0.0725	0.0432	0.0315
Fair	-0.1369	-0.0663	-0.0565	-0.0334
Poor	-0.2666	-0.1197	-0.0879	-0.0494
Mental Health Rating				
Excellent	0.3187	0.1007	0.0982	0.0971
Very good	0.1922	0.0796	0.0442	0.0571
Fair	-0.1227	-0.0396	-0.0667	-0.0506
Poor	-0.5435	-0.1584	-0.0372	-0.0949
Proxy				
Proxy helped	-0.1777	0.0156	-0.0440	-0.0169
Proxy answered	-0.1344	0.0814	0.0813	0.0255
Dual-Eligible				
Medicaid dual eligible	0.5623	0.1516	0.0328	0.0134
LIS				
Low-income subsidy (LIS)	0.4817	0.1273	-0.0818	0.0009

Table 7. National Mean Values – MA Measures

Variable	Overall Rating of Personal Doctor	Overall Rating of Health Care Received	Overall Rating of Health Plan	Overall Rating of Specialist	Get Care Quickly (Composite)
Age					
64 or under	0.0975	0.0938	0.0930	0.1052	0.1115
65 – 69	0.2295	0.2328	0.2344	0.2297	0.2264
70 – 74	0.2372	0.2378	0.2385	0.2364	0.2303
75 – 79	0.2007	0.1996	0.2003	0.2012	0.1973
80 – 84	0.1371	0.1377	0.1365	0.1377	0.1370
85 and older	0.0981	0.0983	0.0974	0.0899	0.0976
Education					
Less than an 8 th grade education	0.0916	0.0927	0.0917	0.0767	0.0912
Some high school	0.1238	0.1229	0.1223	0.1065	0.1209
High school graduate	0.3493	0.3490	0.3494	0.3307	0.3411
Some college	0.2445	0.2418	0.2435	0.2586	0.2521
College graduate	0.0860	0.0880	0.0875	0.1005	0.0865
More than a bachelor's degree	0.1048	0.1056	0.1056	0.1270	0.1083
General Health Rating					
Excellent	0.0710	0.0835	0.0850	0.0632	0.0646
Very good	0.2709	0.2854	0.2857	0.2624	0.2549
Good	0.3764	0.3676	0.3674	0.3740	0.3659
Fair	0.2307	0.2161	0.2154	0.2435	0.2519
Poor	0.0511	0.0475	0.0465	0.0569	0.0628
Mental Health Rating					
Excellent	0.3065	0.3140	0.3160	0.3160	0.2955
Very good	0.3365	0.3390	0.3387	0.3346	0.3312
Good	0.2486	0.2436	0.2423	0.2428	0.2498
Fair	0.0907	0.0858	0.0856	0.0895	0.1021
Poor	0.0178	0.0176	0.0174	0.0171	0.0215
Proxy					
Proxy helped	0.1006	0.0967	0.0965	0.0996	0.1075
Proxy answered	0.0375	0.0368	0.0367	0.0374	0.0407
Dual-Eligible					
Medicaid dual eligible	0.1261	0.1228	0.1223	0.1105	0.1343
LIS					
Low-income subsidy (LIS)	0.0408	0.0398	0.0393	0.0383	0.0423

Table 7. National Mean Values – MA Measures (continued)

Variable	Get Needed Care (Composite)	Doctors Who Communicate Well (Composite)	Health Plan Customer Service (Composite)	Getting Medical Equipment	Follow Up with Test Results
Age					
64 or under	0.1051	0.0978	0.1211	0.1547	0.0975
65 – 69	0.2357	0.2289	0.2468	0.1911	0.2298
70 – 74	0.2381	0.2370	0.2326	0.2135	0.2373
75 – 79	0.1975	0.2006	0.1895	0.1884	0.2026
80 – 84	0.1342	0.1373	0.1248	0.1375	0.1371
85 and older	0.0895	0.0985	0.0853	0.1147	0.0957
Education					
Less than an 8 th grade education	0.0763	0.0917	0.0843	0.1097	0.0919
Some high school	0.1068	0.1238	0.1138	0.1328	0.1227
High school graduate	0.3296	0.3494	0.3287	0.3369	0.3477
Some college	0.2616	0.2447	0.2639	0.2541	0.2467
College graduate	0.1001	0.0857	0.0931	0.0779	0.0867
More than a bachelor's degree	0.1258	0.1046	0.1163	0.0886	0.1043
General Health Rating					
Excellent	0.0684	0.0708	0.0753	0.0264	0.0676
Very good	0.2663	0.2712	0.2613	0.1447	0.2676
Good	0.3713	0.3760	0.3654	0.3484	0.3766
Fair	0.2376	0.2311	0.2382	0.3553	0.2358
Poor	0.0564	0.0510	0.0598	0.1252	0.0524
Mental Health Rating					
Excellent	0.3163	0.3060	0.3072	0.2317	0.3034
Very good	0.3355	0.3367	0.3299	0.3102	0.3395
Good	0.2389	0.2489	0.2418	0.2845	0.2486
Fair	0.0908	0.0909	0.0997	0.1413	0.0915
Poor	0.0185	0.0175	0.0215	0.0325	0.0171
Dual-Eligible					
Proxy helped	0.0978	0.1009	0.0952	0.1429	0.1029
Proxy answered	0.0370	0.0376	0.0350	0.0561	0.0374
Dual-Eligible					
Medicaid dual eligible	0.1141	0.1266	0.1378	0.1818	0.1260
LIS					
Low-income subsidy (LIS)	0.0378	0.0409	0.0455	0.0552	0.0413

Table 8. National Mean Values – MA-PD Measures

Variable	Overall Rating of Drug Coverage	Willingness to Recommend Plan for Drug Coverage	Getting Information from Plan about Prescription Drug Coverage (Composite)	Getting Needed Prescription Drugs (Composite)
Age				
64 or under	0.1012	0.1011	0.1511	0.1055
65 – 69	0.2383	0.2386	0.2438	0.2359
70 – 74	0.2338	0.2355	0.2272	0.2342
75 – 79	0.1972	0.1957	0.1808	0.1970
80 – 84	0.1354	0.1345	0.1199	0.1347
85 and older	0.0940	0.0947	0.0772	0.0928
Education				
Less than an 8th grade education	0.0948	0.0941	0.0812	0.0910
Some high school	0.1233	0.1230	0.1110	0.1216
High school graduate	0.3455	0.3452	0.3215	0.3465
Some college	0.2464	0.2479	0.2727	0.2517
College graduate	0.0886	0.0884	0.0969	0.0887
More than a bachelor's degree	0.1013	0.1014	0.1167	0.1004
General Health Rating				
Excellent	0.0840	0.0844	0.0624	0.0751
Very good	0.2791	0.2807	0.2385	0.2770
Good	0.3702	0.3690	0.3786	0.3758
Fair	0.2175	0.2170	0.2499	0.2208
Poor	0.0492	0.0490	0.0706	0.0513
Mental Health Rating				
Excellent	0.3160	0.3169	0.2884	0.3108
Very good	0.3328	0.3340	0.3160	0.3365
Good	0.2455	0.2438	0.2560	0.2463
Fair	0.0881	0.0878	0.1159	0.0890
Poor	0.0177	0.0175	0.0238	0.0175
Proxy				
Proxy helped	0.1020	0.1022	0.0989	0.1006
Proxy answered	0.0372	0.0371	0.0322	0.0372
Dual-Eligible				
Medicaid dual eligible	0.1348	0.1346	0.1427	0.1341
LIS				
Low-income subsidy (LIS)	0.0402	0.0406	0.0463	0.0410

Significance Testing

Two-tailed t-tests were used to assess whether the case-mix adjusted mean for each contract differed significantly from the overall mean for all contracts in the nation. Contract scores that are significantly different from the national mean at the $p < 0.05$ level are marked with an up or down arrow. The absence of an arrow means that the contract's score was not significantly different from the national average. In accordance with confidentiality requirements, "N/A" is reported for any item or composite with fewer than 10 observations or if the reliability is considered very low (see below). If the minimum sample size is met but the reliability of the measure is less than 0.75 (in a 0-1 range), the mean score is given in italics. For measures on which more than 12% of all contracts with a minimum sample size of 10 had low reliability, the mean score is given in italics only for the 12% with lowest reliability. Even though italics indicate limited ability to detect smaller

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differences from the national mean, up or down arrows are shown whenever differences were sufficiently large to distinguish a contract's score from the national mean with $p < .05$.

Assessing Reliability of Scores

For each item or composite, including measures reported to consumers, criteria based on interunit reliability (IUR) were applied to classify each plan's data as acceptable or low reliability. Interunit reliability is defined by $IUR = \sigma^2 / (\sigma^2 + SE^2)$, where σ^2 = between-plan model variance, and SE = standard error of plan mean. IUR may be interpreted as the fraction of variation in plan mean scores (among those with about the same IUR) that is attributable to actual differences among plans ("signal") rather than sampling variability ("noise"). Thus IUR close to 1 indicates that sampling variability is negligible, while IUR close to 0 means that we are unable to detect any variation among plans and differences in the data are only random error. Plans with fewer than 10 responses for a measure have their scores masked. Plans for which $IUR < .75$ are considered to have low reliability. However, no more than 12% of plans (those with lowest IUR on the corresponding measure) are flagged as low reliability for a given measure, after excluding masked scores. For 2011, a new designation of "very low reliability" was introduced; plans for which $IUR < .60$ are treated the same way as scores with fewer than 10 responses in both consumer reporting and in this report.

Reliability of the estimates also is affected by a number of other factors including the fraction of the contract's respondents who are eligible to answer an item based on their experiences, the variability of responses within the contract, and the amount by which contracts differ from each other nationally on that measure. Reliability summarizes the influence of these factors on the precision of the comparisons of a contract's score to national distributions.

Within a given measure, low-reliability scores typically are those with fewer respondents, or possibly with more variability in their responses. Across measures, more low-reliability scores will be reported for measures with fewer responses (more respondents for whom the measure does not apply), less variation in scores across plans, and more variability in scores within each plan.

Defining Market Areas

Each contract's "market area" was determined by comparing its county-level enrollment with those of every other MA contract. For each pair of contracts, the analysis identified counties in which both plans had enrollment. If each plan's enrollees in the overlap counties accounted for 5 percent or more of the plan's total enrollment, the plans were considered to be in each other's market area. Private fee-for-service MA contracts, which typically have multi-state if not national enrollment, were not included in the market area analysis. (However, enrollees in Private fee-for-service contracts were included in the national and state benchmarks.)

Differences Between CAHPS and NCQA Scoring Methodology

The National Committee for Quality Assurance (NCQA) also collects CAHPS results from health plans but uses a different method for calculating MA CAHPS results for accreditation purposes. NCQA is an independent, non-profit organization that evaluates and reports on the quality of the nation's managed care organizations. Although CMS and NCQA both collect and report on CAHPS surveys, there are important differences in how the results are organized and calculated.

- Results for MA CAHPS have been case-mix adjusted using person-level characteristics, including age, education, and self-reported physical and mental health status. NCQA does not use case-mix adjustments in reporting.
- The national averages are calculated using person-level data for MA CAHPS. NCQA results are based on contract-level data.

Survey Item Crosswalk for 2011 - 2010 MA-PD Questionnaires

Survey Section	2011 Question	2010 Question
Your Health Plan	1. Our records show that in 2010 your health services were covered by the plan named on the back page. Is that right?	1. Our records show that in 2009 your health services were covered by [plan name]. Is that right?
	2. Please write below the name of the health plan you had in 2010 and complete the rest of the survey based on the experiences you had with that plan. (Please print)	2. Please write below the name of the health plan you had in 2009 and complete the rest of the survey based on experiences you had with that plan. (Please print)
Your Health Care in the Last 6 Months	3. In the last 6 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?	3. In the last 6 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?
	4. In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?	4. In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
	5. In the last 6 months, not counting the times you needed care right away, did you make any appointments for your health care at a doctor's office or clinic?	5. In the last 6 months, not counting the times you needed care right away, did you make any appointments for your health care at a doctor's office or clinic?
	6. In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?	6. In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
	7. In the last 6 months, not counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?	7. In the last 6 months, not counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?
	8. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?	11. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
	9. In the last 6 months, did you phone a doctor's office or clinic with a medical question after regular office hours?	8. In the last 6 months, did you phone a doctor's office or clinic with a medical question after regular office hours?
	10. In the last 6 months, when you phoned a doctor's office or clinic after regular office hours, how often did you get an answer to your medical question as soon as you needed?	9. In the last 6 months, when you phoned a doctor's office or clinic after regular office hours, how often did you get an answer to your medical question as soon as you needed?
	11. In the last 6 months, when you phoned a doctor's office or clinic after regular office hours, how long did it take for someone to call you back?	10. In the last 6 months, when you phoned a doctor's office or clinic after regular office hours, how long did it take for someone to call you back?
	12. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	12. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?
	13. In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, a wheelchair, oxygen equipment, or diabetic supplies and equipment?	13. In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, a wheelchair, oxygen equipment, or diabetic supplies and equipment?
	14. In the last 6 months, how often was it easy to get the medical equipment you needed through your health plan?	14. In the last 6 months, how often was it easy to get the medical equipment you needed through your plan?

Survey Item Crosswalk for 2011 - 2010 MA-PD Questionnaires (continued)

Survey Section	2011 Question	2010 Question
Your Personal Doctor	15. Do you have a personal doctor?	15. Do you have a personal doctor?
	16. In the last 6 months, how many times did you visit your personal doctor to get care for yourself?	16. In the last 6 months, how many times did you visit your personal doctor to get care for yourself?
	17. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?	17. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
	18. In the last 6 months, how often did your personal doctor listen carefully to you?	18. In the last 6 months, how often did your personal doctor listen carefully to you?
	19. In the last 6 months, how often did your personal doctor show respect for what you had to say?	19. In the last 6 months, how often did your personal doctor show respect for what you had to say?
	20. In the last 6 months, how often did your personal doctor spend enough time with you?	20. In the last 6 months, how often did your personal doctor spend enough time with you?
	21. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?	21. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?
	22. In the last 6 months, did your personal doctor order a blood test, x-ray or other test for you?	22. In the last 6 months, did your personal doctor order a blood test, x-ray or other test for you?
	23. In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your doctor's office follow up to give you those results?	23. In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your doctor's office follow up to give you those results?
	24. How satisfied are you with the help you received to coordinate your care in the last 6 months?	30. How satisfied are you with the help you received to coordinate your care in the last 6 months?
Getting Health Care From Specialists	25. In the last 6 months, did you try to make any appointments to see a specialist?	24. In the last 6 months, did you try to make any appointments to see a specialist?
	26. In the last 6 months, how often was it easy to get appointments with specialists?	25. In the last 6 months, how often was it easy to get appointments with specialists?
	27. How many specialists have you seen in the last 6 months?	26. How many specialists have you seen in the last 6 months?
	28. We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?	27. We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?
	29. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?	28. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
	No comparable question.	29. In the last 6 months, how often did you feel that the specialists you saw had all the information they needed to provide your care?
Your Health Plan	30. In the last 6 months, did you try to get any kind of care, tests, or treatment through your health plan?	31. In the last 6 months, did you try to get any kind of care, tests, or treatment through your plan?
	31. In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?	32. In the last 6 months, how often was it easy to get the care, tests or treatment you thought you needed through your plan?

Survey Item Crosswalk for 2011 - 2010 MA-PD Questionnaires (continued)

Survey Section	2011 Question	2010 Question
	32. In the last 6 months, did you try to get information or help from your health plan's customer service?	33. In the last 6 months, did you try to get information or help from your plan's customer service?
	33. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?	34. In the last 6 months, how often did your plan's customer service give you the information or help you needed?
	34. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?	35. In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect?
	35. In the last 6 months, did your health plan give you any forms to fill out?	36. In the last 6 months, did your plan give you any forms to fill out?
	36. In the last 6 months, how often were the forms from your health plan easy to fill out?	37. In the last 6 months, how often were the forms from your plan easy to fill out?
	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?	38. 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?
	No comparable question.	39. Each fall your health plan sends you a notice that describes any changes in covered services. Since September 2009, has your plan sent you this kind of notice?
	No comparable question.	40. Has your plan ever given you a document with this kind of information?
	No comparable question.	41. Did an insurance agent or broker ever call you without your asking them to, to tell you about insurance for health care or prescription medicines?
	No comparable question.	42. Did an insurance agent or broker ever visit your home without your asking them to, to tell you about insurance for health care or prescription medicines?
	No comparable question.	43. Did an insurance agent or broker ever switch you to a different health care plan without your permission?
Your Medicare Rights	38. In the last 6 months, was there a time when you believed you needed care or services that your health plan decided not to give you?	44. Was there ever a time when you believed you needed care or services that your plan decided not to give you?
	39. In the last 6 months, have you ever asked anyone at your health plan to reconsider a decision not to provide or pay for health care or services?	45. Have you ever asked anyone at your health plan to reconsider a decision not to provide or pay for health care or services?
	40. When you spoke to your health plan about the decision not to provide care or services, did they... Please mark one or more.	46. When you spoke to your health plan about the decision not to provide care or services, did they... Please mark one or more.
	41. In the last 6 months, have you called or written your health plan with a complaint or problem?	47. In the last 6 months, have you called or written your plan with a complaint or problem?

Survey Item Crosswalk for 2011 - 2010 MA-PD Questionnaires (continued)

Survey Section	2011 Question	2010 Question
	42. How long did it take for your health plan to settle your complaint?	48. How long did it take for your plan to resolve your complaint?
	43. Was your complaint or problem settled to your satisfaction?	49. Was your complaint or problem settled to your satisfaction?
Your Prescription Drug Plan	44. In the last 6 months, did you try to get information or help about prescriptions from your prescription drug plan's customer service?	50. In the last 6 months, did you try to get information or help from your health plan's customer service about prescription drugs?
	45. In the last 6 months, how often did your prescription drug plan's customer service give you the information or help you needed about prescription drugs?	51. In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs?
	46. In the last 6 months, how often did your prescription drug plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs?	52. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs.
	47. In the last 6 months, did you try to get information from your prescription drug plan about which prescription medicines were covered?	53. In the last 6 months, did you try to get information from your health plan about which prescription medicines were covered?
	48. In the last 6 months, how often did your prescription drug plan's customer service give you all the information you needed about which prescription medicines were covered?	54. In the last 6 months, how often did your plan give you all the information you needed about which prescription medicines were covered?
	49. In the last 6 months, did you try to get information from your prescription drug plan about how much you would have to pay for your prescription medicines?	55. In the last 6 months, did you try to get information from your health plan about how much you would have to pay for your prescription medicines?
	50. In the last 6 months, how often did your prescription drug plan's customer service give you all the information you needed about how much you would have to pay for your prescription medicine?	56. In the last 6 months, how often did your plan give you all the information you needed about how much you would have to pay for your prescription medicine?
	51. In the last 6 months, how many different prescription medicines did you fill or have refilled?	57. In the last 6 months, how many different prescription medicines did you fill or have refilled?
	52. In the last 6 months, did a doctor prescribe a medicine for you that your prescription drug plan did not cover?	58. In the last 6 months, did a doctor prescribe a medicine for you that your plan did not cover?
	53. When this happened, did you contact your prescription drug plan to ask them to cover the medicine your doctor prescribed?	59. When this happened, did you contact your health plan to ask them to cover the medicine your doctor prescribed?
	54. When you contacted your prescription drug plan about the decision not to cover a prescription medicine did they...	60. When you contacted your health plan about the decision not to cover a prescription medicine did they...
	55. In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?	61. In the last 6 months, how often was it easy to use your plan to get the medicines your doctor prescribed?
	56. In the last 6 months, did you ever use your prescription drug plan to fill a prescription at your local pharmacy?	62. In the last 6 months, did you ever use your plan to fill a prescription at a local pharmacy?

Survey Item Crosswalk for 2011 - 2010 MA-PD Questionnaires (continued)

Survey Section	2011 Question	2010 Question
	57. In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?	63. In the last 6 months, how often was it easy to use your plan to fill a prescription at a local pharmacy?
	58. In the last 6 months, did you ever use your prescription drug plan to fill a prescription by mail?	64. In the last 6 months, did you ever use your plan to fill any prescriptions by mail?
	59. In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?	65. In the last 6 months, how often was it easy to use your plan to fill prescriptions by mail?
	60. Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?	66. Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your plan for coverage of prescription drugs?
	61. Would you recommend your prescription drug plan for coverage of prescription drugs to other people like yourself?	67. Would you recommend your plan for coverage of prescription drugs to other people like yourself?
	No comparable question.	68. Have you signed up for this extra help program?
	No comparable question.	69. In the last 6 months, how often were you able to use Medicare's extra help program when you refilled a prescription for a medicine you had taken before?
	No comparable question.	70. In the last 6 months, did pharmacy staff tell you that you needed to provide proof that you qualify for Medicare's extra help program?
	No comparable question.	71. In the last 6 months, have you ever gone without a prescribed medicine because the pharmacy's records did not show you were signed up for Medicare's extra help program?
About You	62. In general, how would you rate your overall health?	72. In general, how would you rate your overall health?
	63. In general, how would you rate your overall mental health?	73. In general, how would you rate your overall mental health?
	No comparable question.	74. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?
	No comparable question.	75. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?
	64. In the past 12 months, have you seen a doctor or other health provider 3 or more times for the same condition or problem?	76. In the past 12 months, have you seen a doctor or other health provider 3 or more times for the same condition or problem?
	65. Is this a condition or problem that has lasted for at least 3 months?	77. Is this a condition or problem that has lasted for at least 3 months?
	66. Do you now need to take medicine prescribed by a doctor?	78. Do you now need or take medicine prescribed by a doctor?
	67. Is this to treat a condition that has lasted for at least 3 months?	79. Is this to treat a condition that has lasted for at least 3 months?

Survey Item Crosswalk for 2011 - 2010 MA-PD Questionnaires (continued)

Survey Section	2011 Question	2010 Question
	68. In the last 6 months, did you delay or not fill a prescription because you felt you could not afford it?	80. In the last 6 months, did you ever delay or not fill a prescription because you felt that you could not afford it?
	No comparable question.	81. How confident are you that you can identify when it is necessary for you to get medical care?
	No comparable question.	82. Because of any impairment or health problem, do you need the help of other persons with your personal care needs, such as eating, dressing, or getting around the house?
	No comparable question.	83. Because of any impairment or health problem, do you need help with your routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?
	No comparable question.	84. Do you have a physical or medical condition that seriously interferes with your independence, participation in the community, or quality of life?
	69. Has a doctor ever told you that you had any of the following conditions?	85. Has a doctor ever told you that you had any of the following conditions?
	70. Have you had a flu shot since September 1, 2010?	86. Have you had a flu shot since September 1, 2009?
	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.	87. 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 the flu shot. It is also called the pneumococcal vaccine.
	72. Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	88. Do you now smoke cigarettes or use tobacco every day, some days, or not at all?
	73. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider?	89. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?
	74. What is your age?	90. What is your age?
	75. Are you male or female?	91. Are you male or female?
	76. What is the highest grade or level of school that you have completed?	92. What is the highest grade or level of school that you have completed?
	77. Are you of Hispanic or Latino origin or descent?	93. Are you of Hispanic or Latino origin or descent?
	78. What is your race? Please mark one or more.	94. What is your race? Please mark one or more.
	79. Did someone help you complete this survey?	95. Did someone help you complete this survey?
	80. How did that person help you? Please mark one or more.	96. How did that person help you? Please mark one or more.
	81. Do you live alone?	97. Do you live alone?
	No comparable question.	98. Because of a health or physical problem are you unable to do or have any difficulty doing the following activities? (Please mark one response for each activity.)
	82. The Medicare Program is trying to learn more about the health care or services provided to people with Medicare. May we contact you again about the health care services that you received?	99. The Medicare Program is trying to learn more about the health care or services provided to people with Medicare. May we contact you again about the health care services that you received?

Appendix

Appendix: Consumer Reports

The results of the Medicare CAHPS survey are published in the *Medicare & You* handbook and on the Medicare web site: <http://www.medicare.gov>. These publicly reported results help beneficiaries choose a Medicare health and/or prescription drug plan, and allow the public and research community to assess Medicare program performance. Survey measures that are reported in the *Medicare & You* handbook and on the Medicare web site are not directly comparable to the ones presented in this report. The handbook and web site provide stars to indicate contract performance rather than showing response distributions. In addition, numeric scores are transformed onto a 100-point score for ease of use by consumers.

With the exception of the vaccination items, the scores are adjusted for case-mix using the same factors described elsewhere in this report.

Your contract's results as they will appear in these consumer reports are shown on the next page. Also shown are state- or sub-state-level results for Original (Fee-for-Service) Medicare for up to two states in which your contract has significant enrollment. Note: If your contract is not renewing for 2012, information about your contract will not be available on <http://www.medicare.gov>.

Appendix: Consumer Reports (continued)

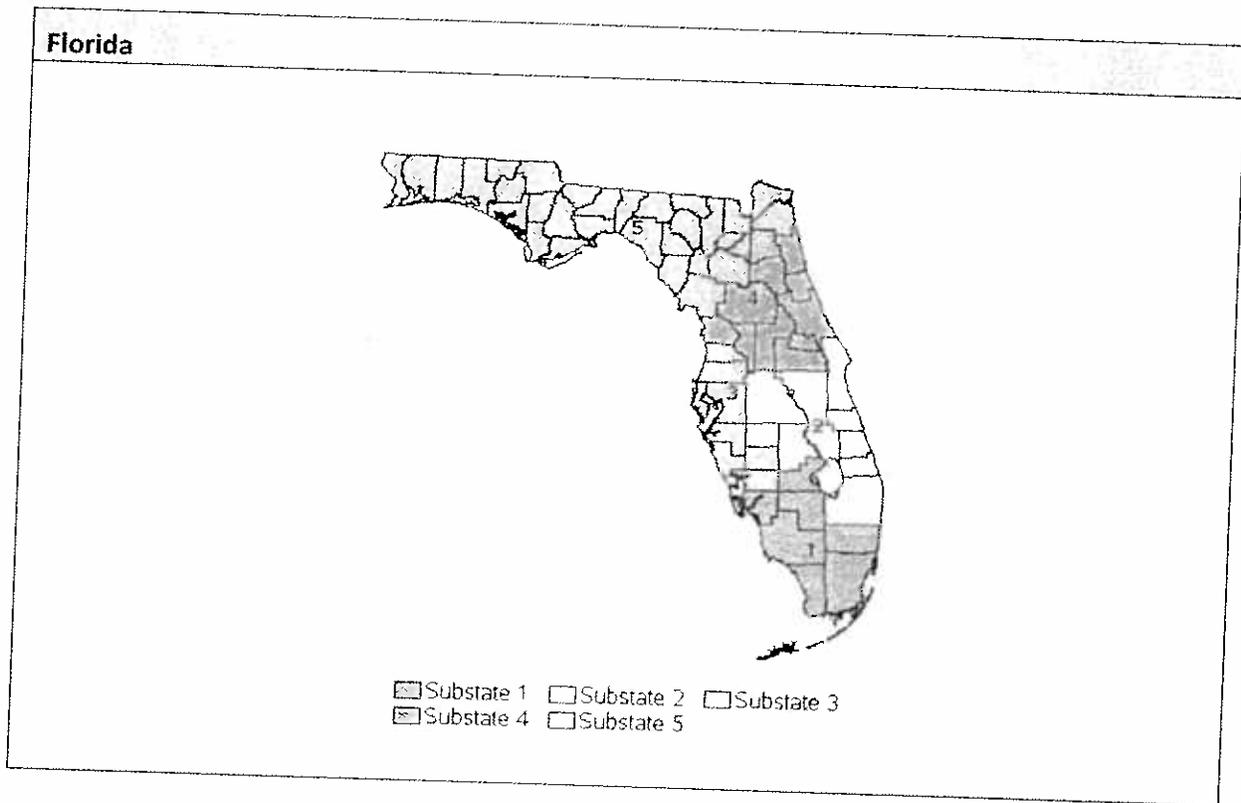


Table 9. Consumer Reports Reporting Composite or Item Scores

Reporting Composite or Item	Your Contract		FFS Substate 1		FFS Substate 2		FFS Substate 3	
	Score	Stars	Score	Stars	Score	Stars	Score	Stars
Ratings of Health Plan Responsiveness and Care								
Getting Needed Care	84	★★★	86	★★★★	87	★★★★★	88	★★★★★
Getting Care Quickly	71	★★	70	★	72	★★	74	★★
Rating of Care	85	★★★★	86	★★★★	85	★★★★	86	★★★★
Rating of Plan	84	★★★	84	★★	85	★★★★	85	★★★★
Health Plan Customer Service	84	★★	84	★★	84	★★	84	★★
Vaccines								
Flu Vaccination	67%	★★★	57%	★	69%	★★★	69%	★★★
Pneumonia Vaccination	68%	★★★	52%	★	71%	★★★★	73%	★★★★
Member Experience with Drug Plan		★★★						
Getting Needed Prescription Drugs	90	★★★						
Getting Information from the Plan About Prescription Drug Coverage and Cost	76	★★						
Overall Rating of Prescription Drug Coverage	85	★★★★						

Appendix: Consumer Reports (continued)

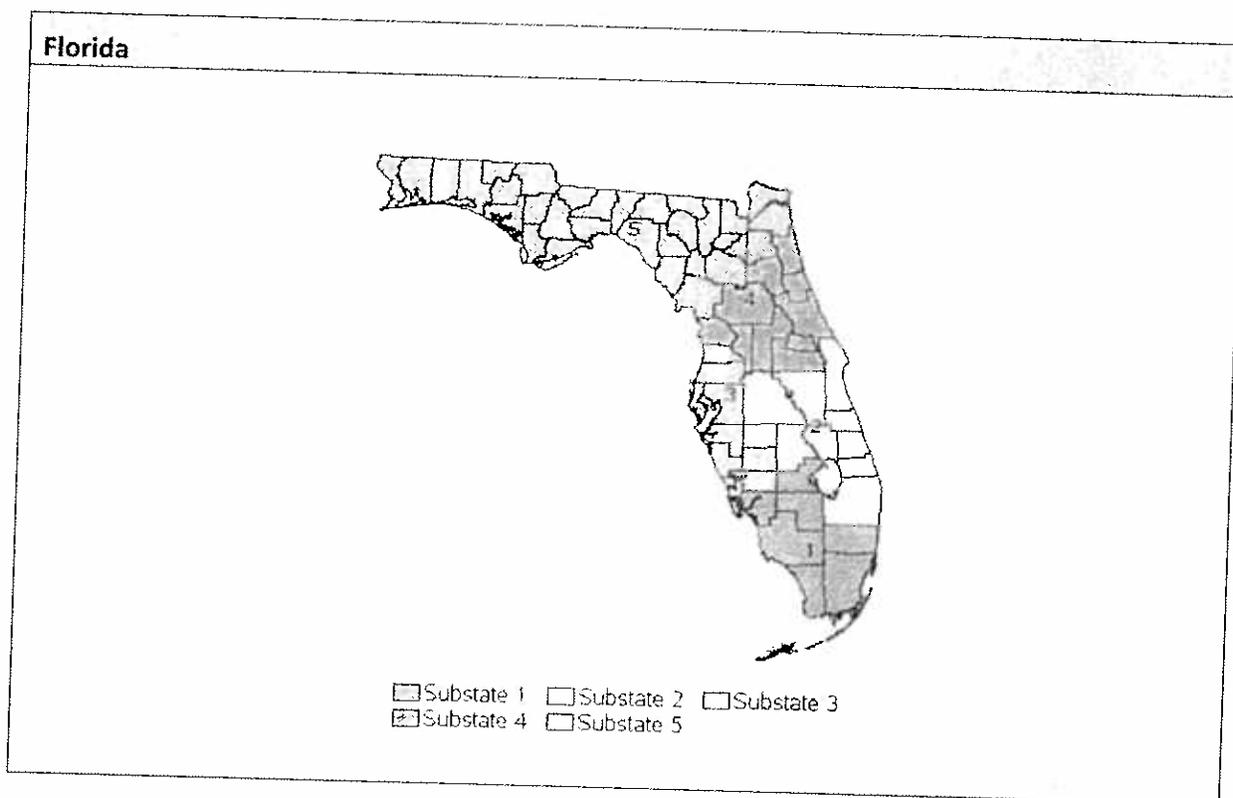


Table 9. Consumer Reports Reporting Composite or Item Scores (continued)

Reporting Composite or Item	Your Contract		FFS Substate 4		FFS Substate 5	
	Score	Stars	Score	Stars	Score	Stars
Ratings of Health Plan Responsiveness and Care		***				
Getting Needed Care	84	***	87	*****	88	*****
Getting Care Quickly	71	**	73	**	73	**
Rating of Care	85	*****	85	*****	85	*****
Rating of Plan	84	***	85	*****	85	*****
Health Plan Customer Service	84	**	85	**	89	*****
Vaccines						
Flu Vaccination	67%	***	71%	*****	69%	***
Pneumonia Vaccination	68%	***	72%	*****	71%	*****
Member Experience with Drug Plan		***				
Getting Needed Prescription Drugs	90	***				
Getting information from the Plan About Prescription Drug Coverage and Cost	76	**				
Overall Rating of Prescription Drug Coverage	85	*****				

Table 10. Fee-for-Service Substate Area Definitions

Florida	
FFS Substate Areas	FFS Substate Name(s)
1	Southern Florida
2	East Coast (Titusville to Boca Raton) and Inland
3	Tampa and the Central Gulf Coast
4	St. Augustine to Orlando and Inland
5	Jacksonville and Panhandle

EXHIBIT C

**SURVEY RESULTS FOR MA
CAHPS FOR WELLCARE OF
FLORIDA, INC. BASED ON NCQA
SCORING METHODOLOGY**



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850



Sharon Nisbet
WELL CARE OF FLORIDA, INC. H1032
8735 Henderson Road, Ren 2
Tampa FL, 33634

October 3, 2011

Dear Sharon Nisbet,

Enclosed with this letter are your health plan's results from the 2011 Medicare Advantage CAHPS Survey (MA-CAHPS). NCQA uses a variety of measures in its accreditation process. Part of your health plan's accreditation scores are derived from HEDIS measures which are part of the MA-CAHPS survey. The MA-CAHPS measures that were scored for NCQA accreditation include three composites, four ratings, the flu and pneumonia vaccination rates, as well as an item about smoking. These composite measures, ratings, and individual survey items are shown in the table below.

Composite Measures	Overall Ratings	Single items
Getting Needed Care	Overall rating of Personal Doctor	Flu Vaccination
Getting Care Quickly	Overall rating of Specialist	Pneumonia Vaccination
Doctors Who Communicate Well	Overall rating of Health Care Received	Advising Smokers to Quit
	Overall rating of Health Plan	

Generating the results using data from the 2011 MA-CAHPS survey requires several steps. This includes:

1. **Reconciling the MA-CAHPS sampling units with NCQA reporting entities.** Reconciliation is needed because there is not always a one-to-one correspondence between a given CMS sampling unit and an NCQA reporting entity. An MA-CAHPS sampling unit is defined as a sample of beneficiaries from all or part of a Medicare Advantage contract (i.e., an "H" number registered with CMS) from which survey results were calculated and reported. CMS and NCQA worked collaboratively to transform CMS sampling units into the corresponding NCQA reporting entities.

In the case of your plan or plans, the MA-CAHPS sampling unit corresponds to the NCQA reporting entity as follows:

NCQA ID includes these MA-CAHPS sampling units

6072 H1032

2. **Scoring survey responses.** The response options on the MA-CAHPS survey vary from item to item and each response is converted to a numeric value. For example, a survey response of "usually" is coded as a "2" as shown in first row of the table below. Survey items that form composite measures have response options of "never", "sometimes", "usually", and "always". Two or more survey items are grouped together to form composite measures. A mean is then derived from these groups of items after the responses have been converted to numeric values.

The second row in the table shows that the response options (0 through 10) for "Overall ratings" are collapsed into three groups (0-6, 7-8, and 9-10) and each group is assigned a specific numeric value.

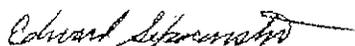
Survey response options	Response option grouping	
	MA-CAHPS Coding	NCQA Coding
Never, sometimes, usually, always	Never plus Sometimes = 1 Usually = 2 Always = 3	Never plus Sometimes = 1 Usually = 2 Always = 3
0 through 10 (rating items)	0-6 = 1 7-8 = 2 9-10 = 3	0-6 = 1 7-8 = 2 9-10 = 3

3. Changes to the Flu and Pneumonia measures. The flu and pneumonia vaccination rates are based only on those respondents who reported being 65 years of age or older. In previous versions of this report, these rates were based on all respondents.

Plans that participated in the 2011 MA-CAHPS survey will receive a separate, more detailed health plan report later this fall. It is important to note that the results in the individual health plan report will be case-mix adjusted and may not match the results shown here because NCQA does not use case-mix in its scoring methodology. In addition, CMS uses a scoring methodology different from NCQA in calculating the results shown in the health plan reports.

If you have any questions about this report, please contact Mr. Edward Sekscenski at CMS. Inquiries about NCQA accreditation scoring process can be directed to Ms. Stephanie Hoch (NCQA) at Hoch@ncqa.org.

Sincerely,



Edward S. Sekscenski, MPH
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
410-786-7167

2011 MA-CAHPS Survey Results

(based on NCQA Scoring methodology*)

Health Plan Information

NCQA ID	6072
Health Plan Name	WELL CARE OF FLORIDA, INC.
Contract Number	H1032

Survey Information

Sample Size	795
Number of Responses	299
Response Rate	37.61%

Composite Measures (Mean)

Getting Needed Care	2.5413
Getting Care Quickly	2.4776
Doctors Who Communicate Well	2.6514

Overall Ratings (Mean)

Overall rating of Personal Doctor	2.6615
Overall rating of Specialist	2.5750
Overall rating of Health Care	2.4931
Overall rating of Health Plan	2.4306

Single Item (rate)

Flu Vaccination	66.92%
Pneumonia Vaccination	69.79%
Advising Smokers to Quit Rate **	95.12%

*Please note that NCQA makes final scoring decisions for its products.
 ** "N/A" is reported if there were fewer than 30 valid respondents

EXHIBIT D

ALERT -- 5/24/2012

Clarification and Revision to Appendix C, Clinical Performance, Section 1.a., item 4., Instructions:

Replacement Language for Appendix C, 1.a., 4.

IMPORTANT: The following language replaces the current requirements specified in Appendix C, Clinical Performance, Section 1.a., 4. - **ACTION BY APPLICANTS IS REQUIRED:**

"Applicants must submit (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 for Appendix C. Applicants must obtain this information from their CAHPS vendor, and then directly submit this information to ODJFS."

This request for supporting information received by the Applicant from the CMS-approved Medicare vendor replaces the original request for the NCQA HEDIS Survey Results Report as downloaded from NCQA's IDSS for CAHPS results, given that the originally requested report is not available for Medicare CAHPS results. The requirements for reporting results for Appendix C, 1.a.4. have not changed.

Because this Alert is posted on May 24, 2012 and applications are due no later than 3:00 p.m. (local time) on Friday, May 25, 2012, Applicants may not have sufficient time to provide the information identified in this Alert within the applications, which **MUST** be received by ODJFS by the originally specified deadline. However, all other portions of the RFA, including Appendix C results and all other supporting documentation, are due as scheduled on May 25, 2012.

The data identified in this Alert, required from the Applicant's CMS-approved Medicare CAHPS vendor, must be provided to ODJFS by the Applicant directly as a separate submission. Applicants may submit the documentation required by this Alert separately, following submissions made by the May 25, 2012 deadline. The additional submission **MUST** be submitted to the same ODJFS address provided in the RFA, and **MUST** be received there no later than 3:00 p.m. (local time) Monday, June 4, 2012. These submissions must be provided in the form of one original (original signed paper version) along with 9 paper copies and 9 CD-ROMS or DVD-Rs, each containing the additional information/documentation.

There are no further opportunities for Applicant clarification over this Alert.

EXHIBIT E



5/25/2012

To Whom It May Concern:

The Myers Group is a CMS-approved Medicare CAHPS vendor that contracts with WellCare Health Plans, Inc. for purposes of collecting and providing such data and related reporting to the Centers for Medicare and Medicaid Services. This letter is an attestation verifying the accuracy of the raw data provided to CMS for contract H1032. CMS applies the Case-Mix Adjustment to the raw data.

Sincerely,

A handwritten signature in cursive script that reads "Nicole Brown".

Nicole Brown
Director of Quality and Compliance

EXHIBIT F



5/24/12

Office of Contracts & Acquisitions
Ohio Department of Job and Family Services
30 East Broad Street, 31st Floor
Columbus, Ohio 43215-3414

ATTN: RFA/ RLB Unit

To Whom it May Concern:

The Myers Group is a CMS-approved Medicare CAHPS vendor that contracts with Humana Inc. for purposes of collecting and providing such data and related reporting to the Centers for Medicare and Medicaid Services. This letter is an attestation verifying the accuracy of the enclosed results for H1036.

Sincerely,

Nicole Brown
Director of Quality and Compliance

EXHIBIT G

5101:3-26-03 Managed health care programs: covered services.

(A) Except as provided in this rule, managed care plans (MCPs) must ensure that members have access to all medically-necessary services covered by medicaid. The MCP must ensure that:

(1) Services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished;

(2) The amount, duration, or scope of a required service is not arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition;

(3) Coverage decisions are based on the practice guidelines specified in paragraph (B) of rule 5101:3-26-05.1 of the Administrative Code; and

(4) If a member is unable to obtain medically-necessary services offered by medicaid from a MCP panel provider, the MCP must adequately and timely cover the services out of panel, until the MCP is able to provide the services from a panel provider.

(B) MCPs may place appropriate limits on a service;

(1) On the basis of medical necessity; or

(2) For the purposes of utilization control, provided the services furnished can be reasonably expected to achieve their purpose as specified in paragraph (A)(1) of this rule.

(C) MCPs must cover annual physical examinations for adults.

(D) At the request of the member, MCPs must provide for a second opinion from a qualified health care professional within the panel. If such a qualified health care professional is not available within the MCP's panel, the MCP must arrange for the member to obtain a second opinion outside the panel, at no cost to the member.

(E) MCPs must assure that emergency care services as defined in rule 5101:3-26-01 of the Administrative Code are provided and covered twenty-four hours a day, seven days a week. At a minimum, such services must be provided and reimbursed in accordance with the following:

(1) MCPs may not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have resulted in the outcomes specified in paragraph (W) of rule 5101:3-26-01 of the Administrative Code.

(2) MCPs cannot limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

(3) MCPs must cover all emergency services without requiring prior authorization.

(4) MCPs must cover medicaid-covered services related to the member's emergency medical condition when the member is instructed to go to an emergency facility by a representative of the MCP including but not limited to the member's PCP or the MCP's twenty-four-hour toll-free call-in-system.

(5) MCPs cannot deny payment of emergency services based on the treating provider, hospital, or fiscal representative not notifying the member's PCP of the visit.

(6) For the purposes of this paragraph, "non-contracting provider of emergency services" means any person, institution, or entity who does not contract with the MCP but provides emergency services to an MCP member, regardless of whether or not that provider has a medicaid provider agreement with ODJFS pursuant to Title XIX of the Social Security Act. An MCP must cover emergency services as defined in paragraph (X) of rule 5101:3-26-01 of the Administrative Code when the services are delivered by a non-contracting provider of emergency services and claims for these services cannot be denied regardless of whether the services meet an emergency medical condition as defined in paragraph (W) of rule 5101:3-26-01 of the Administrative Code. Such services must be reimbursed by the MCP at the lesser of billed charges or one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate (less any payments for indirect costs of medical education and direct costs of graduate medical education that is included in the Ohio medicaid program fee-for-service reimbursement rate) in effect for the date of service. If an inpatient admission results, the MCP is required to reimburse at this rate only until the member can be transferred to a provider designated by the MCP.

(7) MCPs must adhere to the judgment of the attending provider when requesting a member's transfer to another facility or discharge. MCPs may establish arrangements with hospitals whereby the MCP may designate one of its contracting providers to assume the attending provider's responsibilities to stabilize, treat and transfer the member.

(8) A member who has had an emergency medical condition may not be held liable for payment of any subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

(F) MCPs must establish, in writing, the process and procedures for the submission of claims for services delivered by non-contracting providers, including non-contracting providers of emergency services as described in paragraph (E)(6) of this rule. Such information must be made available to non-contracting providers, including non-contracting providers of emergency services, on request. MCPs may not establish claims filing and processing procedures for non-contracting providers, including non-contracting providers of emergency services, that are more stringent than those established for their contracting providers.

(G) MCPs must assure that post-stabilization care services as defined in rule 5101:3-26-01 of the Administrative Code are provided and covered twenty-four hours a day, seven days a week.

(1) The MCP must designate a telephone line to receive provider requests for coverage of post-stabilization care services. The line must be available twenty-four hours a day. MCPs must document that the telephone number and process for obtaining authorization has been provided to each emergency facility in the service area. The MCP must maintain a record of any request for coverage of post-stabilization care services that is denied including, at a minimum, the time of the provider's request and the time that the MCP communicated the decision in writing to the provider.

(2) At a minimum, post-stabilization care services must be provided and reimbursed in accordance with the following:

(a) MCPs must cover services obtained within or outside the MCP's panel that are pre-approved in writing to the requesting provider by a plan provider or other MCP representative.

(b) MCPs must cover services obtained within or outside the MCP's panel that are not pre-approved by a plan provider or other MCP representative but are administered to maintain the member's stabilized condition within one hour of a request to the MCP for preapproval of further post-stabilization care services.

(c) MCPs must cover services obtained within or outside the MCP's panel that are not pre-approved by a plan provider or other MCP representative but are administered to maintain, improve or resolve the member's stabilized condition if:

(i) The MCP fails to respond within one hour to a provider request for authorization to provide such services.

(ii) The MCP cannot be contacted.

(iii) The MCP's representative and treating provider cannot reach an agreement concerning the member's care and a plan provider is not available for consultation. In this situation, the MCP must give the treating provider the opportunity to consult with a plan provider and the treating provider may continue with care until a plan provider is reached or one of the criteria specified in paragraph (G)(3) of this rule is met.

(3) The MCP's financial responsibility for post stabilization care services it has not pre-approved ends when:

(a) A plan provider with privileges at the treating hospital assumes responsibility for the member's care;

(b) A plan provider assumes responsibility for the member's care through transfer;

(c) A MCP representative and the treating provider reach an agreement concerning the member's care; or

(d) The member is discharged.

(H) Exclusions, limitations and clarifications.

(1) When an MCP member is placed in a nursing facility (NF), MCPs are responsible for payment for NF services as described in rule 5101:3-3-02.3 of the Administrative Code, and payment for all covered services until the last day of the month following the month of the member's NF admission, for a period not to exceed sixty-two calendar days. MCP members remaining in a NF after this period will be disenrolled in accordance with paragraph (C) of rule 5101:3-26-02.1 of the Administrative Code.

(2) MCPs are not responsible for payment of services provided to a member that has been enrolled in a home and community-based waiver program administered by ODJFS, the Ohio department of aging (ODA), or the Ohio department of developmental disabilities). MCP members enrolled in a waiver program will be disenrolled in accordance with paragraph (C)(2)(h) of rule 5101:3-26-02.1 of the Administrative Code.

- (3) MCPs are not responsible for payment of habilitation services as described in 42 U.S.C. 1396n(c)(5) (December 3, 2004).
- (4) MCP members are permitted to self-refer to mental health services offered through the Ohio department of mental health (ODMH) community mental health centers and substance abuse services offered through the Ohio department of alcohol and drug addiction services (ODADAS)-certified medicaid providers. MCPs must ensure access to medicaid-covered behavioral health services for members who are unable to timely access services or unwilling to access services through community providers.
- (5) MCP members are permitted to self-refer to Title X services provided by any qualified family planning provider (QFPP). The MCP is responsible for payment of claims for Title X services delivered by QFPPs not contracting with the MCP at the lesser of one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate or billed charges, in effect for the date of service.
- (6) MCPs must permit members to self-refer to any women's health specialist within the MCP's panel for covered care necessary to provide women's routine and preventative health care services. This is in addition to the member's designated PCP if that PCP is not a women's health specialist.
- (7) MCPs must ensure access to covered services provided by all federally qualified health centers (FQHCs) and rural health clinics (RHCs).
- (8) Where available, MCPs must ensure access to covered services provided by a certified nurse practitioner.
- (9) ODJFS may approve an MCP's members to be referred to certain MCP non-contracting hospitals, as specified in rule 5101:3-26-11 of the Administrative Code, for medicaid-covered non-emergency hospital services. When ODJFS permits such authorization, ODJFS will notify the MCP and the MCP non-contracting hospital of the terms and conditions, including the duration, of the approval and the MCP must reimburse the MCP non-contracting hospital at one hundred per cent of the current Ohio medicaid program fee-for-service reimbursement rate in effect for the date of service for all medicaid-covered non-emergency hospital services delivered by the MCP non-contracting hospital. ODJFS will base its determination of when an MCP's members can be referred to MCP non-contracting hospitals pursuant to the following:
- (a) The MCP's submission of a written request to ODJFS for the approval to refer members to a hospital that has declined to contract with the MCP. The request must document the MCP's contracting efforts and why the MCP believes it will be necessary for members to be referred to this particular hospital; and
- (b) ODJFS consultation with the MCP non-contracting hospital to determine the basis for the hospital's decision to decline to contract with the MCP, including but not limited to whether the MCP's contracting efforts were unreasonable and/or that contracting with the MCP would have adversely impacted the hospital's business.
- (10) Paragraph (H)(9) of this rule is not applicable when an MCP and an MCP non-contracting hospital have mutually agreed to that hospital providing non-emergency hospital services to an MCP's members. MCPs must ensure that such arrangements comply with paragraph (A)(9) of rule 5101:3-26-05 of the Administrative Code.

(11) MCPs are not responsible for payment of services provided through medicaid school program (MSP) providers pursuant to Chapter 5101:3-35 of the Administrative Code. MCPs must ensure access to medicaid-covered services for members who are unable to timely access services or unwilling to access services through MSP providers.

(12) MCPs must provide all early and periodic screening, diagnosis and treatment (EPSDT) services, also known as healthchek services, in accordance with the periodicity schedule identified in Chapter 5101:3-14 of the Administrative Code, to eligible individuals and assure that services are delivered and monitored as follows:

(a) Healthchek exams must include those components specified in Chapter 5101:3-14 of the Administrative Code. All components of exams must be documented and included in the medical record of each healthchek eligible member and made available for the ODJFS annual external quality review.

(b) The MCP or its contracting provider must notify members of the appropriate healthchek exam intervals as specified in Chapter 5101:3-14 of the Administrative Code.

(c) Healthchek exams are to be completed within ninety days of the initial effective date of membership for those children found to have a possible ongoing condition likely to require care management services.

(I) Out-of-country coverage

MCPs are not required to cover services provided to members outside the United States.

Effective: 10/01/2011

R.C. 119.032 review dates: 01/01/2013

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.16, 5111.162, 5111.17

Rule Amplifies: 5111.01, 5111.02, 5111.021, 5111.16, 5111.162, 5111.163, 5111.17, 5111.172, section 309.37.50 of Am. Sub. H.B. 153, 129th G.A.

Prior Effective Dates: 4/1/85, 5/2/85, 10/1/87, 2/15/89 (Emer), 5/8/89, 11/1/89 (Emer), 5/1/92, 5/1/93, 11/1/94, 7/1/96, 7/1/97 (Emer), 9/27/97, 5/14/99, 12/10/99, 7/1/00, 7/1/01, 7/1/02, 7/1/03, 1/1/06, 6/1/06, 1/1/07, 7/1/07, 1/1/08, 9/15/08, 2/1/10