Ohio | Department of Job and Family Services

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

August 20, 2012

Suzanne K. Richards
Vorys, Sater, Seymour and Pease LLP
52 East Gay Street
PO Box 1008
Columbus, Ohio 43216-1008

RE: Protest of Applicant Scoring, Anthem
RFA# JFSR1213-07-8038
Ohio Integrated Care Delivery System (ICDS)

Dear Ms. Richards:

On July 18, 2012, ODJFS received a timely protest from you of applicant scoring for the above cited RFA on behalf of Community Insurance Company d/b/a Anthem Blue Cross and Blue Shield (Anthem), pursuant to Section III.F of the RFA[1]. Please take this letter as a response to the issues raised in your protest. For ease of reference, we address the claims raised in the order presented in the letter of protest.

Summary of Claims

Anthem contends a review of its scores, as calculated by ODJFS, reveals multiple incidents of what it believes to be either improper disqualifications or inappropriate scoring of components of the Anthem application. Further, Anthem believes those decisions made by ODJFS may materially impact the final award, and therefore requests ODJFS rescore Anthem's application. Specifically, the protest relates to the following components:

1. Anthem's Medicare Healthcare Effectiveness Data and Information Set (HEDIS) results in Appendix C, Section I.a.

2. Anthem's response to quality Improvement initiative number 1 in Appendix C, Section 2.

[1] ODJFS extended the deadline to submit a protest to July 18th 2012 from the original date of July 13, 2012 to all responding applicants.

3. Anthem's response to quality Improvement initiative number 3 in Appendix C, Section 2.

4. Anthem's response to quality Improvement initiative number 4 in Appendix C, Section 2.

5. Anthem's response to Appendix D, Part A, question 8(a) on Care Management.

6. Anthem's response to Appendix E, Section E-1.

7. Anthem's response to Appendix E, Section E-2.

8. Anthem's response to Appendix F, Section 2, multiple issues.

Appendix C Section 1.

The RFA provides instructions for completing Section I., a. of Appendix C, including for the submission of Medicare HEDIS scores. As stated in Anthem's protest, those instructions state that "An Applicant must report Medicare Advantage HMO/PPO results from the State referenced in Appendix B with the largest number of Medicare Advantage HMO/PPO member months **for CY 2010 for which there are HEDIS/CAHPS results that meet the requirements set forth in (1) and (2) above.**" (emphasis added)

Anthem's original submission presented information for the state of California for CY 2011, prompting ODJFS to send a letter to Anthem requesting clarification, to be provided by June 6, 2012. Anthem complied with that deadline; however, in its reply, Anthem identified the fact that it had erred in its original reading of the RFA and as a result had supplied the 2011 California data. In its reply to the ODJFS clarification request, Anthem acknowledged that it should have provided its 2010 scores for its Ohio Medicare line of business because Ohio was the state that had the largest number of Medicare member months for CY 2010.

Contending that ODJFS is compelled to consider the information submitted by Anthem following the issuance of the clarification letter; that Anthem's original submission of the wrong state's data constitutes a minor error that could be waived as "not unreasonably obscuring the meaning of the content"; and implying that the clarification amounts to the state's adoption of supplemental evaluation criteria, Anthem requests that ODJFS rescore its Appendix C, Section I, a. and award up to 6800 points.

The ODJFS clarification letter of June 4, 2012 did not instruct Anthem to submit data for the correct state; it asked whether such results existed for 2010 for any Ohio Medicare population, and if so, whether those results had undergone a HEDIS compliance audit. ODJFS requested the clarification because it was possible that the Ohio 2010 results existed but the audit had not yet been done, and if that were true, the Anthem

submission of the California results would have been appropriate according to the RFA instructions and would have been accepted for scoring purposes.

ODJFS did indeed consider Anthem's response to the questions it had asked in the clarification letter. That Anthem chose to submit at that time the correct information it should have submitted in its original application, in addition to providing answers to the two clarification questions posed by ODJFS, does not compel ODJFS to accept, consider, and award points to that un-requested additional information. Additionally, the original RFA states (in Section III., C., Submissions) that materials provided separately from applicants' submissions, or after the deadline for submission, will not be accepted. Further, ODJFS does not agree that Anthem's original submission using the incorrect state's data could be considered a minor error that it could waive. No additional scoring criteria were adopted; Anthem's original submission, and its response to the clarification were used to score the Anthem application using the criteria as presented in the RFA.

Finally, Anthem alleges that ODJFS handled the response received from another applicant, Aetna, to a request for clarification of its HEDIS scores differently from its handling of Anthem's. Aetna was asked the same two questions, but unlike Anthem, Aetna replied that the HEDIS results of its largest CY 2010 Medicare state had not yet undergone the appropriate HEDIS Compliance Audit. With that response from Aetna, ODJFS determined that the data originally submitted by Aetna was appropriate for acceptance and scoring.

For the reasons presented above, ODJFS finds that there is no merit to this component number 1. of Anthem's protest, and no additional points will be added.

Quality Improvement Initiative 1 in Appendix C, Section 2.

The RFA asks applicants to provide essays for up to three structured quality improvement initiatives, selected from four optional topics provided in Appendix C. Anthem selected the first optional topic for one of its essays:

1. Preventing unnecessary long term institutionalization by re-directing Medicaid individuals to community settings and using community-based long term care services and supports.

The RFA, Appendix C., Section II provided complete directions (general instructions and specifics for components a. through e.) for each essay. Anthem's essay presented information on a quality improvement initiative implemented by its California CareMore project, identifying the initiative as one for its Medicare Advantage line of business.

In its protest, Anthem states that, "Because Anthem's application indicates that the Care More project falls under Anthem's Medicare Advantage Plan line of business, ODJFS apparently concluded that the population served was not a Medicaid population.

However, by definition, a D-SNP serves a Medicaid population, and therefore Anthem's submission was proper and fully responsive to the RFA request."

The Anthem essay does not state anywhere that its CareMore project is a D-SNP. The essay explains the initiative and only in its component d. does it mention a dual-eligible population or SNP, and there saying that following the success of the initiative, CareMore implemented it for its D-SNP and I-SNP populations. Anthem then provided data for these two combined SNP populations, not just for the D-SNP; it is impossible to determine from that combined data the percentage of D-SNP persons involved and whether the initiative was implemented for the D-SNP persons within the combined population no later than CY 2010, as specified in the general 'Instructions for Completing Section II.'

This optional essay topic as stated in the RFA (and provided above) specifies that if this essay option is selected by an applicant, Medicaid consumers are to be the focus of any quality improvement initiative described. In contrast with this optional topic, the third and fourth options provided in the RFA specifically state that "Medicaid and/or Medicare members" could be the focus of those essays, while the second optional topic also specifies only Medicaid individuals.

While an essay that described an initiative that focused on dually-eligible persons would have been acceptable because dually-eligible persons are in fact Medicaid consumers, the Anthem essay failed to make that connection, indicating nothing other than a Medicare Advantage population, and the CareMore project. While the protest letter defines the CareMore project as a D-SNP project, the essay did not.

Further, the Anthem protest alleges that the State handled the essay received from another applicant, CareSource, differently than it handled Anthem's. The protest points out that the CareSource essay was accepted for scoring. As quoted in Anthem's letter of protest, the CareSource essay for quality improvement topic option number 1 specifically states that its initiative was focused on the dually-eligible population, and because of that, it was accepted and scored.

For the reasons presented above, ODJFS finds that there is no merit to this component number 2. of Anthem's protest, and no additional points will be added.

Quality Improvement Initiative 3 in Appendix C, Section 2.

The second of the three structured quality improvement initiatives Anthem chose for its essays was based on the third of the four optional topics provided in the RFA:

3. Improving health outcomes or quality of life indicators for Medicaid and/or Medicare members with severe and persistent mental illness.

The Anthem essay described a project implemented by WellPoint in Indiana to improve coordination of aftercare prior to hospital discharge for persons hospitalized for behavioral health disorders. As its quality indicator, the essay identified the percentage of that population for whom an after-care coordination plan, including an aftercare appointment scheduled for not more than seven days after hospital discharge, had been established before the patients were discharged.

In its protest letter, Anthem identifies the goal it had identified in its essay as achievement of the rate of at least 90% of its members having an after-care coordination plan established before the members are discharged from their hospital stays. It also identifies the quality indicator as the percentage of the specified population of its membership who receive, "…a care coordination plan established prior to discharge that includes an aftercare appointment scheduled to occur within seven days post hospitalization." The protest also indicates that the essay's discussion of WellPoint's monthly collection of data represents the benchmark ("Anthem collected and analyzed the data monthly so that WellPoint could understand whether the intervention was affecting utilization. WellPoint had a clearly stated goal … Thus, WellPoint established a benchmark against which its monthly performance was measured…").

In its score sheet for this essay by Anthem, the reviewers determined that the plan had not discussed how the quality indicators were meaningful to monitoring the success of the intervention, and that it had failed to identify the benchmarks and goals that the quality indicators were compared to during the initiative. Anthem protests those decisions and seeks the awarding of the points available.

The Anthem essay does clearly describe the initiative's goal as achievement of the rate of at least 90% of its members having pre-discharge plans for after-care coordination, with the inclusion of a post-discharge aftercare appointment scheduled to occur within seven days as its quality indicator, as the Anthem protest letter correctly reflects. However, a review of the essay shows neither any use of the term 'benchmark,' nor the indication of any particular standard - that is, a benchmark - that supports using the quality indicator selected by WellPoint as a measure of progress toward achieving the stated goal.

ODJFS finds in the essay no clearly drawn connection between the stated quality indicator and the quality improvement initiative.

For the reasons presented above, ODJFS finds that there is no merit to this component number 3. of Anthem's protest, and no additional points will be awarded.

Quality Improvement Initiative 4 in Appendix C, Section 2.

The last of the three structured quality improvement initiatives Anthem chose for its essays was based on the fourth of the optional topics provided in the RFA:

4. Decreasing inappropriate and avoidable hospital admissions and reducing inappropriate use of high-cost acute care services for Medicaid and/or Medicare members.

In its essay, Anthem presented information on a California initiative aimed at reducing inappropriate use of emergency room care for the non-emergent condition of upper respiratory infections. In its protest letter, Anthem states that, "Ostensibly, ODJFS concluded that the project Anthem described only addressed inappropriate use of high-cost acute care services, but did not address decreasing inappropriate and avoidable hospital admissions."

On the score sheet for this Anthem essay, it is noted that it "only discussed ER use." In its protest letter, Anthem says that the reviewers' "…reaction ignores the reality of ER use" and presents information on how controlling unnecessary ER visits can result in a decrease in avoidable hospital admissions.

A review of the essay on this project as provided in the Anthem application shows that it did not discuss any linkage between ER utilization management and hospital admissions. The essay's opening statements mention the high costs of ER care that might be reduced, but it makes no mention of reducing hospital admissions.

For the reason presented above, ODJFS finds that there is no merit to this component number 4. of Anthem's protest, and no additional points will be added.

Appendix D, Part A, question 8(a) on Care Management

In this section within the RFA Appendix D., Part A., applicants are to respond with a state and line of business if a particular activity is provided. This question, worth 180 points, asks if the applicant has twelve months of experience conducting home visits with plan members to assess them in their home environments. The ODJFS review team noted on the score sheet that while Anthem's application had answered with yes, it did not identify the state and line of business, and therefore awarded no points for this item.

In its protest letter, Anthem points to the fact that in its application, for another component of this question in Appendix D (question 8d, which was asked for informational purposes and was not scored), it identified statistics on home visits for an identified line of business in a named state. Because the information was presented in another location on its Appendix D, Anthem believes the review team should have awarded its application 180 points.

A review of the Anthem proposal shows that in 8(d), the information does include a state and line of business for home visit data. However, the information was not provided as directed in 8(a), and while the two questions are both on home visit experience, there is no indication within the RFA that the two questions pertain to experience in the same

state or LOB. Question 8(d) refers to a state and LOB reported in another Appendix, 8(a) does not.

For the reason presented above, ODJFS finds that there is no merit to this component number 5. of Anthem's protest, and no additional points will be awarded.

Appendix E, Section E-1.

In its protest letter over the review team's decision to award Anthem with no points for item E-1 in Appendix E, Anthem explains that in the RFA, the instructions for this item were placed below E-2 in such a way as to make it unclear whether they actually applied to only item E-2, or to both E-1 and E-2. The instructions were related to providing an essay on the applicant's experience. Because of this confusion, ODJFS was asked for clarification during the question and answer period. The Anthem protest identifies the ODJFS answer, which was posted on the webpage for the RFA on May 11, 2011, as "The essay requirement includes both E-1 and E-2. The essay portion will validate the responses scored in E-1 and E-2." The score sheet for Anthem for item E-1 is marked by ODJFS as "no essay provided."

Anthem asks to be awarded 2002 points for E-1, because on the score sheet, that number was indicated before it was marked out and replaced with a zero. The process used by the score team for several sections of this RFA was one in which the claims made by an applicant over its experience, capacity, etc., were marked, and then sometimes crossed-out or otherwise changed after the reviewers reviewed and assessed the supporting information that applicants were to provide for responsiveness, completeness, quality, or other applicable characteristics. In the case of this score item, the review team would have determined if Anthem should actually be credited with the 2002 points through the required essay.

Anthem objects to scores awarded to some other applicants' E-1 essays for reasons related to either format or content, and asserts that it had addressed, "…many of the services identified in the E-1 chart in essay/narrative form in various places throughout its application." Also, it points to its signed attestation, as required from all applicants, which it asserts accomplishes the ODJFS purpose for requiring the essay - to validate information provided in the appendix. Based on problems Anthem identifies in other applicants' essays for E-1, the original confusion in the RFA over instructions, and with the information being provided in other parts of its application, Anthem believes it should have been awarded two thousand points.

Regardless of the strength of other applicants' two essays, the essential facts in this component of the scoring and in Anthem's protest are that first, regardless of instructions that may have been initially unclear, the Q-and-A clearly specified that applicants' responses for both E-1 and E-2 were to include essays, and secondly that Anthem's application only included an essay for E-2.

For the reason presented above, ODJFS finds that there is no merit to this component number 6. of Anthem's protest, and no additional points will be awarded.

Appendix E, Section E-2.

Anthem also objects to the ODJFS reviewer team's decision not to award 834 points for its E-2 response for the criterion of at least twelve months experience investigating individual incidents related to community long-term care plan members and providers. There were three separate scored criteria within this portion of the RFA, each of which would be scored at either 0 points or 834 points, for a possible maximum score of 2,500 points. The score team awarded Anthem no points for this item within E-2, but did award 834 points for each of the other two criteria.

In its letter of protest, Anthem says its application indicates that its CareMore staff visit facilities and homes for face-to-face visits in which abuse, neglect, or exploitation could be detected and assessed. The letter says, "The act of speaking with and observing individuals in-person in order to determine whether there has been an incident that has affected the individual's health or wellbeing is an act of investigation." If any such abuse is detected, "… the provider works closely with the ombudsman and adult protective services…" for resolution, according to the protest letter.

Anthem objects to the ODJFS decision to award no points for this issue, believing the note on the score sheet saying, "essay does not support experience in investigation," is inaccurate. Anthem contends its essay did show experience in investigating such incidents, and that it should be rescored and awarded up to 834 points in addition to the 1,668 it had earned on the other two E-2 criteria.

In the RFA Appendix E, three criteria, worth either 0 or 834 points each, are provided for scoring applicants'

- Documenting and reporting individual incidents to the State or other oversight/investigative agency
- Investigating individual incidents reported by individuals, providers and other entities and reporting outcomes to the state/oversight agency
- Prevention planning or risk management for individuals receiving long term care services in community settings

The Anthem essay was awarded 834 points for the first and third criteria, but no points for the second, with its references to both investigating and reporting. In spite of the contention made in its letter of protest that talking with and observing possible victims of abuse is an act of investigation, an investigation phase usually involves activities related to identifying cause or responsibility. Talking with individuals is an activity more closely aligned with documenting and reporting, for which the Anthem essay was credited by the review team.

In a review of the Anthem essay, one finds reference to the CareMore staff being trained to identify and report, but no discussion of CareMore's participation in any sort of investigation-related activities. The essay only mentions identifying, reporting, and referring, and gives no indication of experience in investigations of abuse. The ODJFS review team's original scoring decision is found to be based on an accurate assessment of the Anthem essay.

For the reason presented above, ODJFS finds that there is no merit to this component number 7. of Anthem's protest, and no additional points will be awarded.

Innovative Payment Methods in Appendix F., Section 2, Various Items

The protest from Anthem also objects to scores received for some of its responses to Appendix F, Section 2, in which applicants were directed to describe innovative payment methods that they would propose, using up to five different provider types selected from a list provided in the RFA as models. The directions for this portion of the RFA said that ODJFS would award points based on the strength of the applicant's vision for the State's goals, and the alignment of the proposed models with them. The points would "… be awarded based on how well each proposed innovative payment method meets expectations to promote specific goals of this project." ODJFS would use the scale of "does not meet" expectations (for 0 points), "partially meets" (for 50), "meets" (for 100), or "exceeds" expectations (for 150 points). The criteria for the evaluation included such things as keeping people in the community, increasing independence, improving care coordination, and increasing the primary care providers' accountability.

In its protest letter, Anthem explains its reasons for believing the scores awarded by the review team for its essays are inappropriate, and identifies the additional points it believes each of its five essays should be awarded. The following table tallies the essay items which Anthem believes were scored incorrectly, the scores as awarded, and Anthem's requested revised scoring:

Tally of Protested Items in Anthem Appendix F., Section 2

Provider Type Essay		ODJFS Score	Anthem's Requested Revisions of ODJFS Scoring Decisions on Specific Criteria in Essay	Anthem's Requested Add'l Points
1	HCBS	750	- 4 'Meets' (100) should be 'Exceeds' (150) - 1 'Doesn't Meet' (0) should be 'Meets' (100)	4 X 50 points 1 x 100
				+300
2	Nursing Facility / AssistLiving	600	- 2 'Meets' should be 'Exceeds' - 1 'Doesn't Meet' (0) should be 'Partially' (50) - 1 'Doesn't Meet' (0) should be 'Exceeds' (150)	2 X 50 points 1 X 50 1 X 150
				+300
3	Physicians	750	- 2 'Meets' (100) should be 'Exceeds' (150) - 2 'Doesn't Meet' (0) should be 'Exceeds' (150)	1 X 50 points 1 X 150
				+400

4	Pharmacies	550	- 1 'Partially' (50) should be 'Exceeds' (150) - 3 'Meets' (100) should be 'Exceeds' (150)	1 X 100 points 3 X 50
				+250
5	Hospitals	800	- 5 'Meets' (100) should be 'Exceeds' (150)	5 X 50 points
				+250

In the first three of these essays, Anthem objects to ODJFS awarding zero points for at least one of the ten criteria. Additionally, in all five essays, there are certain criteria that Anthem believes deserved higher than the scores of either 50 or 100 points that they were awarded. Anthem's protest over the scores of zero points, as listed in the table above, will be discussed first and a discussion of its contentions over the remaining protested items in Appendix F., Section 2 will follow.

Essay 1. For its essay on innovative payment for HCBS Case Management Providers, Anthem was awarded zero points for criterion 10, which says, "Increase the accountability and responsibility of the primary care provider to maintain the individuals' overall health" (emphasis added). In its protest letter, Anthem says:

> It is possible that ODJFS overlooked the responsibility of the community case manager team to enter the assessment and transition information into the "member's EMR [electronic medical record] in order to integrate the entire continuum of care.' *(Anthem response, Appendix F, page 19)* This fact alone makes a request for an additional 100 points appropriate.

It is notable that in the next paragraph after the quotation above, when Anthem's protest letter begins its argument for a higher score for another essay, the letter references back to the essay under discussion here, on HCBS providers, saying, " … the Area Agency on Aging and Money Follows the Person Providers will be responsible for … transition planning, *and for including it in the member's electronic medical record.*" (emphasis added) If the primary care provider is actually included in the community case manager team, or is one of the providers for Money Follows the Person projects, or is from area agencies on aging, that connection is not made clear at any point in the essay.

The term 'primary care provider' is defined in the RFA as:

> An individual physician (M.D. or D.O.), physician group practice, or an advanced practice nurse as defined in Ohio Revised Code (ORC) Section 4723.43, or advanced practice nurse group practice within an acceptable specialty. Acceptable specialty types include family/general practice and internal medicine. *(RFA, Section III., A., p. 11)*

A review of the Anthem essay shows no mention of primary care providers, and no discussion of their role or of increasing their responsibilities.

Essay 2. The Anthem Appendix F. essay for its second provider type, nursing or assisted living facilities, received scores of zero for criteria three and ten: improving the delivery of quality care and, as discussed above, increasing the accountability and responsibility of the primary care provider to maintain the individuals' overall health.

The protest by Anthem for the scores it received on those items offers general support for the innovative payment method discussed in its essay, but does not provide any specific evidence of how the essay meets those criteria. Saying that the state failed to "… take into account some important realities and the essential need to work with the nursing homes…" or noting that, "…some applicants did not even address nursing facilities as one of their target strategies", does not clarify why those scores of zero were inappropriate and must be corrected. Stating as the letter of protest does that, "The obvious clinical benefits of this strategy are expressed fully in Anthem's proposed initiative…" points this review back, properly, to the essay in question. In that essay, there is no mention of the primary care providers, or of increasing their accountability, nor is there any mention of improvements in the delivery of quality care.

Essay 3. For its innovative payment essay for physicians, Anthem received zeros for criteria one and two: keep people living in the community and increasing individuals' independence. The letter of protest says that the essay described a program in which physicians receive a bonus for participating in the initiative that will keep individuals in their communities and increase their independence.

The Anthem essay describes, "…a model to maximize the use of physician extenders to deliver the preventive and chronic care services that members may need" so that patients receive such medical attention but physicians can devote more of their time to more acute care. Physicians are encouraged to make referrals to physician extenders for comprehensive preventive care and education, and if they meet specified thresholds for referrals of members with targeted conditions, they earn bonus payments. The essay characterizes the model's features as clinical control, early intervention, and efficiency in resource allocation. The essay does not mention members' independence or their living arrangements, and it does not address any direct link between the model and increasing members' independence or maintaining them in their homes.

The Appendix F., Section 2 scores of zero in essays 1, 2, and 3, to which Anthem protests were assigned by the reviewers reasonably and consistently. The zeros in these instances were awarded because the specific criteria for which the essays were judged were not addressed by Anthem in those essays, and therefore, the scores of zero will remain unchanged.

The remaining Appendix F., Section 2 items included in the Anthem protest, and tallied in the table above are ones for which Anthem received scores of either 50 or 100 points, meaning the review team found that the essays met or at least partially met the State's expectations regarding the criteria. The Anthem protest believes those essays should have been scored higher on those criteria and awarded more points, for example, from

a score of 'meets expectations' (that is, from 100 points) to one indicating the essay 'exceeds' the State's expectations (to 150 points).

In its protest letter explaining why ODJFS should have awarded more points for some of those criteria in Appendix F., Anthem offers such statements as, "there is no better way to prevent this than Anthem's strategy," or, "this clinically-based (model)… is the best and only way to ensure success," or, "the obvious clinical benefits" and, "Anthem's initiative is the only proposal of all those submitted to offer a truly innovative financing mechanism." Anthem also discusses certain examples of other plans' applications, and of the appropriateness of the scores they earned, as evidence that the Anthem proposal deserves higher scores. Such assessments from any organization of its own work, and of that of its competitors, are understandable, but also highly subjective.

The evaluation and scoring of these essays is an inherently and unavoidably subjective process. However, there is no indication that the ODJFS review team acted carelessly, or without good judgment, were unfair, unreasonable, or inconsistent, or that they varied from the instructions and guidelines expressed in the RFA in deciding on Anthem's scores for these criteria. A review of the essays in question and of the scores that were awarded, as well as of the arguments offered by Anthem in its protest, presents no justification for awarding Anthem any additional points. Lacking any such indications, to accept Anthem's arguments for higher scores would be incorrect as it would in effect substitute Anthem's subjective and self-interested opinions for those of the State's reviewers.

For the reason presented above, ODJFS finds that there is no merit to this component of Anthem's protest regarding Appendix F., Section 2, and no additional points will be awarded.

Requested Relief

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

Conclusion

Based on review of Anthem's letter of protest and exhibits, the RFA and the scoring of Anthem's application, ODJFS finds Anthem's claims to be without merit, and therefore no rescoring based on these claims will be conducted.

Thanks you for your interest in providing services to the citizens of Ohio.

Sincerely
(Signature on File)
Jay Easterling
ODJFS/Office of Contracts and Acquisitions

Ohio | Department of Job and Family Services

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

August 20, 2012

Janet Grant
Executive Vice President, External Affairs
Corporate Compliance Officer
CareSource
230 North Main Street
Dayton, Ohio 45402

RE: Protest of Applicant Scoring
RFA# JFSR1213-07-8038
Ohio Integrated Care Delivery System (ICDS)

Dear Ms. Grant:

On July 18, 2012, ODJFS received a timely protest of applicant scoring for the above cited RFA from CareSource pursuant to Section III.F of the RFA[1]. Please take this letter as a response to the issues raised in your protest. For ease of reference, we address the claims raised in the order presented in the letter of protest.

A. CareSource (in Partnership with Humana, Inc.)

Appendix C, Section II, Initiative 3

CareSource claims it did "…discuss the benchmarks and goals that the quality indicators were compared to throughout the initiative…" as required in its essay response to Structured Quality Improvement Initiative 3: Improving health outcomes or quality of life indicators for Medicaid and/or Medicare members with severe and persistent mental illness.

In its response to Structured Quality Improvement Initiative 1, CareSource states "While the state does not set benchmarks for the program, each PIP is measured against a baseline focused on these specific quality indicators below:" and then describes the specific quality indicators (page 9 and 10). This is the only mention of the words 'benchmark' and 'baseline' throughout the 3 Structured Quality Improvement Initiative essay responses submitted by CareSource.

[1] ODJFS extended the deadline to submit a protest to July 18th 2012 from the original date of July 13, 2012 to all responding applicants.

CareSource failed to include any similar discussion in its essay response to Structured Quality Improvement Initiative 3. CareSource states the benchmarks are clearly displayed in the tables provided, however there is no label or note identifying anything in the table as such. Further, the tables submitted for Initiative 1 and 3 provide dissimilar information, leaving the determination of 'benchmark' subject to assumption or inference. **Therefore, ODJFS finds this claim to have no merit.**

Appendix C, Section II, Initiative 4

CareSource claims its discussion of emergency department (ED) usage in its essay response to Structured Quality Improvement Initiative 4: Decreasing inappropriate and avoidable hospital admissions and reducing inappropriate use of high-cost acute care services for Medicaid and/or Medicare members fits the criteria of the quality improvement initiative requested. CareSource further claims that no definition of the terms 'unavoidable or unnecessary hospital admissions' and high cost acute care services' is provided.

CareSource failed to provide any information associating the reduction of ED usage to a corresponding decrease in inappropriate and avoidable hospital admissions. The only mention of the phrase 'hospital admissions' in its essay response is in its restatement of the initiative in the heading and the certification of page and word limit. Likewise, CareSource failed to provide any information showing a reduction in ED usage reduced the high cost of acute care. The only mention of the term 'acute care' is in its restatement of the initiative in the heading and the certification of page and word limit. Any correlation to decreasing inappropriate and avoidable hospital admission and reducing inappropriate use of high-cost acute care services for Medicaid and/or Medicare members through its program to reduce ED usage is conjectural. **Therefore, ODJFS finds this claim to have no merit.**

Appendix D, Part A, Question 3.a.

CareSource claims it properly submitted its Health Risk Assessment (HRA) according the instructions in Appendix D, Part A, Question 3.a, and that its one HRA was labeled Appendix D.3.a., and was it separated by the same purple dividers used throughout its application.

CareSource's submission of its HRA in response to Appendix D, Part A, Question 3.a, lacked the necessary identification and organization in order to be scored. The instructions for this section state "If an applicant used the same tool in multiple states, only one copy must be submitted; however the tool must clearly indicate the entry to which it applies." There appears to be two submissions for this section, separated by 5 unidentified purple page dividers, and neither stating the corresponding entry for which it is associated. The purple dividers CareSource states were used to separate responses for each section were not tabbed and contained no identifying information regarding the content for which it was providing separation. Furthermore, it appears

some information for its response to Appendix D, Part A, Question 4.a is located in what CareSource contends is its submission for Appendix D, Part A, Question 3.a, but the labeling is not sufficient to determine CareSource's intent.

In Section III.D. - Application Scoring instructions of the Main RFA, ODJFS states "Applications which contain assumptions, insufficient detail, are poorly organized, have not been proofread and contain unnecessary use of self-promotional claims will be evaluated accordingly." ODJFS found CareSource's submission in response to Appendix D, Part A, Question 3.a to be poorly organized while lacking sufficient detail to describe its intent. **Therefore ODJFS finds this claim to have no merit.**

Appendix D, Part A, Question 4.a.

CareSource acknowledges it failed to identify the comprehensive assessments submitted in response to Appendix D, Part A, Question 4.a. according to the instructions. CareSource further claims ODJFS was able to identify and score its submissions, despite the required labeling being omitted, noting scores were initially provided on the score sheet, then subsequently removed.

The scoring of applicant responses in Appendix D, Part A, 4.a, was conducted using a two-step approach; indicating whether the applicant states it provided the required information, then validating that information. First, the total allowable score for the particular information required was entered in each corresponding scoring location to indicate only the applicant's acknowledgement that it provided the information. Then, these scores were adjusted accordingly based on the ability to find and/or validate the information. The fact that a score was entered, then subsequently adjusted or subtracted is only indicative of the applicant's initial indication that information was provided, and the results of the ability to score or validate that information; not that CareSource was initially correctly scored and awarded any points.

In Section III.D. Application Scoring instructions of the Main RFA, ODJFS states "Applications which contain assumptions, insufficient detail, are poorly organized, have not been proofread and contain unnecessary use of self-promotional claims will be evaluated accordingly." Due to the omission of the comprehensive assessment identification (entry numbers), ODJFS found CareSource's submission in response to Appendix D, Part A, Question 4.a to be poorly organized and lacking sufficient detail to describe its intent. **Therefore ODJFS finds this claim to have no merit.**

B. Aetna

CareSource claims Aetna 'did not represent its organizational relationships as required by the RFA' and 'utilized the experience of plans that were neither corporate family members nor partners in its RFA response.' Further, CareSource claims the experience Aetna relied upon through its subsidiary, Schaller Anderson, LLC with regard to Mercy Care Plan of Arizona and Maryland Physicians Care was improper, and all points

awarded based on this experience should be rescinded.

In Section III. A. Definitions, of the Main RFA, Corporate Family is defined as "The parent company for whom the Applicant is a subsidiary and any subsidiary of either the parent company or Applicant. All such entities must be shown on the Table of Organization that the Applicant is required to submit as part of Appendix A of the application."

In Section III. A. Definitions, of the Main RFA, Partner is defined as "An entity with which the Applicant has contractual partnership as defined under the laws of The State of Ohio."

The instructions for Appendix A includes the following attestation statement: "Applicant must submit a signed letter on the Applicant's letterhead as part of this Appendix that specifies any information included as part of the Application that documents experience or information from other entities with which the Applicant is or was in a partnership," for which Aetna provided the following: "The information being submitted is for the corporate family, and therefore this does not apply." The instructions for Appendix A were clarified in several responses in the Questions & Answers by the following: "Applicants must submit a written instrument documenting the working relationship between the parties claiming to be partners."

Aetna correctly identifies Schaller Anderson, LLC on Chart 1 and 3 of 3 of its Table of Organization as part of its corporate family. On Chart 3 of 3, Aetna provides the following note: Schaller Anderson, LLC administers Mercy Care Plan and Maryland Physicians Care pursuant to plan management services agreements." Upon review of these plan management service agreements, ODJFS finds there is no partnership between Schaller Anderson, LLC, Mercy Care Plan and/or Maryland Physicians Care and therefore no 'written instrument documenting the working relationship between the parties claiming to be partners' was required. Further,Aetna appropriately reported its experience on Appendix B, Item 3, of the RFA. **Therefore ODJFS finds this claim by CareSource to have no merit.**

C. Other Applicants

1. Appendix B, Part 1, Long Term Care Experience

CareSource states "Four applicants claimed long term care experience in Appendix B that, upon closer examination, was improper.

CareSource states Anthem claimed long term care institutional experience in its California Medicare line of business for 2010 and 2011, and that institutional long term care is not a Medicaid benefit.

Anthem used the experience of its CareMore Health Plan (CareMore) which operates

Medicare Advantage (MA) and MA Special Needs Plans (SNPs) in California. CareMore offers an Institutional SNP (I-SNP) called CareMore Touch, a health plan specifically designed for beneficiaries, including those dually eligible for Medicaid and Medicare, living in a nursing home or in a community or assisted living facility requiring the same level of care as someone in a nursing home.

ODJFS determines the services provided through Anthem's CareMore Touch health plan meets the intent of the desired experience requested in Appendix B, Part 1, and therefore finds this claim by CareSource to have no merit.

CareSource states Paramount claimed long term care institutional experience in its Ohio Medicare and Medicaid line of business for 2009, 2010 and 2011, and that institutional long term care is neither a Medicare benefit nor an Ohio Medicaid managed care benefit.

Paramount's parent company, ProMedica, owns ProMedica Lake Park, a 225-bed Nursing Facility located at its Flower Hospital (Cleveland, Ohio) which is certified for both Medicare and Medicaid patients, and provides services which meet the RFA definition of institutional long term care.

ODJFS determines the services provided through Paramount's (ProMedica) Lake Park facility meets the intent of the desired experience requested in Appendix B, Part 1, and therefore finds this claim by CareSource to have no merit.

CareSource states UnitedHealthcare claimed long term care institutional experience in its Ohio Medicaid line of business for all years reported, and that institutional long term care is not an Ohio Medicaid managed care benefit.

UnitedHealthcare, through its corporate family affiliate Evercare, provides institutional long term care in Ohio through its Institutional SNP (I-SNP) that provides these services to Medicare and Medicaid enrollees.

ODJFS determines the services provided through UnitedHealthcare's (Evercare) I-SNP meets the intent of the desired experience requested in Appendix B, Part 1, and therefore finds this claim by CareSource to have no merit.

CareSource states WellCare claimed long term care institutional experience across all of its Medicare lines of business for all years reported, and that institutional long term care is not a Medicare benefit.

WellCare operates Medicare Advantage (MA) coordinated care plans in each of the five states for which experience was reported that provide services which meet the RFA definition of institutional long term care.

ODJFS determines the services provided through WellCare's MA coordinated care plans meet the intent of the desired experience requested in Appendix B, Part 1, and therefore finds this claim by CareSource to have no merit.

2. Appendix B, Part 1, HCBS Experience

CareSource states Coventry improperly claimed HCBS experience in its Missouri and Pennsylvania Medicaid lines of business as neither states' Medicaid include LTSS.

Missouri HealthNet Managed Care health plans are required to provide personal care services which include basic personal care, advanced personal care and authorized nurse visits. These services are provided as a cost effective alternative to nursing home placement. The Pennsylvania Medicaid State Plan (In-Home and Community Services) requires personal care services coverage for individuals under age 21.

ODJFS determines the services provided through Coventry's plans in Missouri and Pennsylvania meet the intent of the desired experience requested in Appendix B, Part 1, and therefore finds this claim by CareSource to have no merit.

3.Appendix D, Part A, Long Term Services and Supports

CareSource states two applicants improperly claimed community LTSS experience in Appendix D.

CareSource states Anthem claimed LTSS and Medicaid long term care in its responses to D.1 Entry 1, (D.1 Entry 3 pertained to its Medicare line of business in Indiana, not California) D.2 Entry 1 and D.12.b through its California Medicare line of business, and that Medicare benefits do not include LTSS.

Anthem used experience of its CareMore Touch health plan, which is required to have a Model of Care (MOC) for all SNPs that meets the approval of the National Committee for Quality Assurance (NCQA). The MOC describes the care management infrastructure in place to provide for and coordinate long term services and supports for members residing in institutions or who live in the community but require the same level of care.

ODJFS determines the services provided through Anthem's CareMore Touch healthplan and its MOC meet the intent of the desired experience requested in Appendix D, Part A and therefore finds this claim by CareSource to have no merit.

CareSource states Coventry claimed community LTSS experience in D.1 Entry 3 for its Florida Medicare line of business, and that Medicare benefits do not include LTSS.

Coventry used experience of its Florida Medicare SNP (dual eligible) and its process

through Case Management which facilitates coordination of long term services and supports.

ODJFS determines the services provided through Coventry's Florida Medicare SNP meets the intent of the desired experience requested in Appendix D, Part A and therefore finds this claim by CareSource to have no merit.

4. Appendix D, Long Term Institutionalized Care

CareSource states Molina claimed care management experience for long term institutionalized care in its Ohio Medicare, Texas Medicaid and Medicare, Washington Medicare lines of business, and that long term institutional care is not a covered benefit in any of these managed care programs.

Molina used experience of its Molina Care Management Program 2011 for its Ohio Medicare line of business that describes care coordination services to its Medicare members. The Care Management staff maintains responsibility of coordination of acute medical, long term care and behavioral health services through the member's continuum of care, including for the members receiving long term institutional care. Molina's Texas Long Term Services Program (STAR+PLUS) is designed to keep the Medicaid-Medicare beneficiary in the least restrictive environment and maintained in the community, rather than in a facility, which then qualifies them for long term services and supports. Furthermore, Molina Healthcare of Texas is required by its contract with HHSC to provide comprehensive integrated care management for enrollees receiving long term institutionalized care. Washington State's Medicaid Integration Partnership (WMIP) focuses on better coordination of primary care, mental health, substance abuse and long term care for categorically needy aged, blind and disabled beneficiaries, many of whom are Medicare beneficiaries. Molina Healthcare of Washington is also required by contract with the State of Washington to provide comprehensive integrated care management for enrollees receiving long term institutional care.

ODJFS determines the services provided, as discussed above, meet the intent of the desired experience requested in Appendix D and therefore find this claim by CareSource to have no merit.

5. Appendix E-1 Nurse/Aide Contracting for Long Term Care

CareSource contends'Paramount claimed experience contracting with both nurses and aides not affiliated with an agency for both its Ohio Medicaid and Medicare lines of business for community based long term care services. Paramount's essay claimed this experience through the ProMedica home health and private duty agencies, but Paramount did not provide evidence of its direct use or management of these services in that essay.'

Question Reference # 89 on page 26 of the Questions & Answers asked 'Please confirm that Applicant may respond to Questions E-1 and E-2 of Appendix E based on experience of members of its corporate family.' In response, ODJFS states 'As part of the application, the Applicant may provide information related to other members of the corporate family or partner, as applicable, unless specifically directed not to do so by an instruction in the RFA.' Therefore, Paramount's response conforms to the RFA instructions. **ODJFS finds CareSource's claim to have no merit.**

6. Appendix E-2, Incident Reporting Experience for LTSS

CareSource contends Anthem, in its essay response to Appendix E-2, did not validate any of the three required experience types. **ODJFS, after review, stands by its original reading of the essay and finds this claim by CareSource to have no merit.**

CareSource contends Paramount, in its essay response to Appendix E-2, failed to validate LTSS experience with incident reporting, and that Paramount does not administer any LTSS programs as its lines of business include only CFC-Medicaid, Medicare, and commercial.**ODJFS, after review, stands by its original reading of the essay and finds this claim by CareSource to have no merit.**

7. Appendix C, Initiative 2

CareSource claims ODJFS incorrectly scored UnitedHealthcare's Structured Quality Improvement Initiative 2 by awarding 400 points on the summary page (page 8 of 8 of UnitedHealthcare's Appendix C scoring sheet) for Question 2.d.2 that reflected a NO answer on individual scoring page 4 of 8.

The instructions for Appendix C, Section II state that applicants will be scored for no more than three of the four Structured Quality Improvement Initiatives listed, and only the first three will be scored if more than three are submitted. UnitedHealthcare provided responses to Initiatives 2, 3, and 4.

A review of the scoring sheets for Appendix C, Section II shows three areas, corresponding with the three Initiatives that would be scored, where scores would be documented. Each of the three scoring areas is clearly marked in the left hand margin as to which Quality Initiative is being scored. So while it may appear to CareSource that UnitedHeatlthcare received 400 points for question 2.d.2, closer examination shows that UnitedHealthcare's Quality Initiative 2 was the first of their three initiatives scored and it did reflect zero points for question 2.d.2. Likewise, UnitedHealthcare's Quality Initiatives 3 and 4 both earned all allowable points as reflected by the scoring summary on page 8 of 8. **ODJFS finds this claim by CareSource to have no merit.**

Requested Relief

CareSource requests that the scoring identified in Step Three of the RFA scoring methodology be revised as set forth by its letter of protest.

Conclusion

Based on review of CareSource's letter of protest and exhibits, the RFA, the scoring of CareSource's application and correspondence from other applicants, ODJFS finds CareSource's claims without merit, and that no rescoring based on these claims will be conducted.

Thank you for your interest in providing services to the citizens of Ohio.

Sincerely

Jay Easterling
ODJFS/Office of Contracts and Acquisitions

Ohio | Department of Job and Family Services

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

August 20, 2012

Jeffrey C. Kuhn, Esq.
Chief Legal Officer
ProMedica Health System, Inc.
1801 Richards Road
Toledo, Ohio 43607

RE: Protest of Applicant Scoring, Paramount
RFA# JFSR1213-07-8038
Ohio Integrated Care Delivery System (ICDS)

Dear Mr. Kuhn:

On July 17, 2012, ODJFS received a timely protest of applicant scoring for the above cited RFA from you on behalf of Paramount Care, Inc. (Paramount) pursuant to Section III. F of the RFA[1]. Please take this letter as a response to the issues raised in your protest. For ease of reference, we address the claims raised in the order presented in the letter of protest.

Summary of Claims

Paramount contends that the scores of zero (0) points awarded for its Appendix F, Question 1, subsection D, for its third, fourth, and fifth essays on innovative payment methods were based on inappropriate decisions made by the ODJFS reviewers. Question 1, subsection D. of the RFA directs applicants to describe, in no more than 100 words, "… the results of this innovative payment method in terms of return on investment." In its protest letter, Paramount asserts that its application's essays for its Hospital Quality Incentive (third essay), its Diabetes Incentive (fourth essay), and its Orthopedic Co-management project (fifth essay) all describe results in terms of return on investment (ROI) and should have earned 200 points each, for a total of 600 additional points.

The Paramount protest letter identifies the innovative payment method each of those essays addressed as incentive-based, and says that "A favorable return is implicit in the descriptions provided." It also correctly points out that the RFA did not require a mathematical calculation of ROI.

[1] ODJFS extended the deadline to submit a protest to July 18th 2012 from the original date of July 13, 2012 to all responding applicants.

The Paramount protest also identifies examples of where it believes ODJFS had awarded points to the essays of other applicants (Anthem and Buckeye) that had not provided a specific computation of their ROI.

ODJFS' Response to Claims

The instructions in the ODJFS RFA for applicants' essays discussing innovative payment methods they have used provides some guidance on the subjects, techniques, methods about which the applicants might write, and information on some specifics that would NOT be accepted for scoring. This guidance includes, in part:

> … setting dollars aside for subsequent distribution to the best performing providers. … Other approaches involve creative use of penalties or sanctions, or paying more for particular services, tests, or assessments. … Applicable innovative payment methods might include: shared savings; comprehensive care and episode based payments; global payments; multi-payer collaborations; or bundled payments. For responses to questions in this appendix, neither fee-for-service payments, nor risk-adjusted sub-capitation, will be considered an innovative payment method.

While incentive payments were not identified as a payment method that would not be considered by ODJFS as innovative, nor was it listed as one of the options available to applicants.

In the Anthem essays pointed to in Paramount's protest, Anthem had also discussed incentive payments. In its first essay, it had also included per-member-per-month data, actual dollar changes, and per-visit (per-unit) costs, and provided data to support its claim. In its second essay, Anthem showed actual cost savings in daily hospital costs. In the Buckeye essays that Paramount points to in its protest, Buckeye presented data that serves as a clear representation of savings achieved.

In its third innovative payment essay (the first included in its protest), Paramount describes its incentive program and the percentage of retention of its incentives. In its fourth essay, Paramount provides information on the scope of its incentive project, but no indication of cost savings. In its fifth essay, Paramount offers expectations of savings but offers no supporting data.

For this Appendix F., the RFA also instructed applicants that, "For each innovative payment method described, 200 points will be awarded ***if the Applicant indicates that the initiative resulted in some positive return on investment*** (for a maximum of 1,000 points)." (Emphasis added.) The Paramount protest letter references the "implicit" favorable return in its innovative payment essays.

As already stated, while incentive payments were not mentioned by ODJFS in its instructions for this portion of the RFA, the scoring decisions were not based on that. The reviewers used their discretion fairly in deciding not to award points to the Paramount essays in question. The Paramount essays do not make clear any connection it contends exists between the incentive programs and a positive return. The reviewers were also within the bounds of fairness for accepting the Anthem and Buckeye essays as deserving of points for this subsection because those essays provided more information to show a positive return for their initiatives.

For the reasons presented above, ODJFS finds that there is no merit to this Paramount's protest, and no additional points will be added.

Requested Relief

Paramount respectfully requests that the ODJFS grant and sustain the protests asserted above, and that the Scoring Methodology be modified as specified as specified below:

> 200 additional points for Paramount's response to Appendix F-Question 1, Third Initiative Response- Hospital Quality Incentive;
>
> 200 additional points for Paramount's response to Appendix F-Question 1, Fourth Initiative Response-Diabetes Incentive;
>
> 200 additional points for Paramount's response to Appendix F-Question 1, Fifth Initiative Response-Orthopedic Co-management.

Conclusion

Based on review of Paramount's letter of protest, the RFA and the scoring of Paramount's application, ODJFS finds Paramount's claims without merit, and therefore no rescoring based on these claims will be conducted.

Thank you for your interest in providing services to the citizens of Ohio.

Sincerely

(Signature on File)

Jay Easterling
ODJFS/Office of Contracts and Acquisitions

Ohio | Department of Job and Family Services

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

August 20, 2012

Tracy L. Davidson
President
UnitedHealthcare Community Plan of Ohio
9200 Worthington Road – 3rd Floor
Westerville, Ohio 43082

RE: Protest of Applicant Scoring
RFA# JFSR1213-07-8038
Ohio Integrated Care Delivery System (ICDS)

Dear Mr. Davidson:

On July 18, 2012, ODJFS received a timely protest of applicant scoring for the above cited RFA from UnitedHealthcare Community Plan of Ohio, Inc. (UnitedHealthcare) pursuant to Section III.F of the RFA[1]. Please take this letter as a response to the issues raised in your protest. For ease of reference, we address the claims raised in the order presented in the letter of protest.

Summary of Claims

UnitedHealthcare contends a review of their scores, as calculated by ODJFS, reveals what they believe to be discrepancies with its supporting materials. Further, UnitedHealthcare feels these discrepancies may materially impact the final award, and therefore requests ODJFS review the information submitted in its letter of protest and recalculate scores accordingly. Specifically, the protest relates to Appendix C, Section 1.a., Table 2; Appendix D, Part A, Section 4.a.; and Appendix E, E-1.

Appendix C Section 1.a., Table 2

UnitedHealthcare claims the reported audited HEDIS/CAHPS Medicare Results for its experience in Arizona (H303), specifically for measurement 1 *(Pneumonia Vaccination Status for Older Adults ≥ 65 Years of Age (HEDIS CAHPS Medicare Health Plan Survey))* and measurement 24 *(Rating of Health Plan (HEDIS CAHPS Medicare Health Plan Survey))*

[1] ODJFS extended the deadline to submit a protest to July 18th 2012 from the original date of July 13, 2012 to all responding applicants.

were initially award full points but subsequently had the points subtracted for being "Not Validated." Further, United Healthcare claims the information provided in measures 1 and 24 were properly validated through information submitted and on file with ODJFS.

The scoring of applicant responses in Appendix C Section 1.a, Table 2 was conducted using a two-step approach; indicating whether the applicant states it provided the required information, then validating that information. First, the total allowable score for the particular information required was entered in each corresponding scoring location to indicate only the applicant's acknowledgement that it provided the information. Then, these scores were adjusted accordingly based on the ability to find and/or validate the information. The fact that a score was entered, then subsequently adjusted or subtracted is only indicative of applicant's initial indication that information was provided, and the results of the ability to score or validate that information, and not clerical error or oversight.

ODJFS issued clarification and revision to Appendix C., Clinical Performance, Section 1.a., 4 on 5/24/2012. Specifically, the original language was replaced to read as follows:

"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 the directly submit this information to ODJFS."

While the deadline for applicant responses to the RFA was 3:00 p.m. on 5/25/2012, applicants were given until 3:00 p.m. on 6/4/2012 to submit this additional Appendix C information. UnitedHealthcare complied with both deadlines.

The replacement language was intended to produce attestation on the accuracy of each set of Medicare HEDIS results reported for Appendix C from the applicants CMS-approved Medicare CAHPS vendor, and not to the accuracy of the data submitted to the vendor or of the vendor's data collection process. UnitedHealthcare's CMS-approved Medicare CAHPS vendor, Center of the Study of Services (CSS), attests in its letter dated 5/31/2012 only to the accuracy of the data collection process and not to the accuracy of the information provided to ODJFS per the replacement language. As a result, UnitedHealthcare's protest to the scoring of Appendix C, Section 1.a., Table 2 is found to have no merit.

Appendix D, Part A, 4.a.

UnitedHealthcare does not believe its scores in Appendix D fully credits its experience as documented in Appendix D, Part A, Section 4.a., and as supported by its submitted materials. UnitedHealthcare claims it lost points because ODJFS was unable to find

validation documentation for specific domains, and that this validation documentation was included in its RFA response and was available to ODJFS at the time it scored the application.

Appendix D, Part A, 4.a., in part, asks if the applicant has at least 12 months experience as of March 31, 2012 with conducting a comprehensive assessment for enrollees that included an evaluation of specified assessment domains. These domains included: medical and behavioral health history; social needs; nutritional needs; long term services and supports; health and welfare; and natural supports including family and community.

In its Comprehensive Health Status Assessment tool used by its Medicaid line of business in Arizona, UnitedHealthcare identifies on page 3 under the heading 8.0 Disease Management, what it contends is the validation in support of Domain i., Medical & behavioral health history. Questions 8.1 and 8.2 both ask "Are you currently being treated for any of the following conditions? (Please check all that apply)" and are followed by a number of various health conditions. Responses to these questions would presumably identify a current health condition. Similarly, question 13.0 Medicare HRA asks "What health conditions do you currently have," again followed by a number of health conditions from which to select in order to identify a "current" condition. ODJFS does not feel the assessment tool addressed, in sufficient detail, how the history of the identified condition would be determined.

In its Health Risk Assessment tool used by its Medicaid/Medicare line of business in Massachusetts, UnitedHealthcare identifies on page 3 under the heading 4.0 Visit Information, what it contends is the validation in support of Domain vi., Social Needs. The information identified addresses who the enrollee lives with and the enrollee's marital status. ODJFS does not feel the assessment tool addressed the evaluation of social needs in sufficient detail.

In its Comprehensive Health Status Assessment tool used by its Medicaid line of business in Arizona, UnitedHealthcare identifies on page 3 under the heading 7.0 Prior Services, what it contends is the validation in support of Domain vii., Nutritional needs. Question 7.1 asks whether the enrollee is receiving any of a list services which includes "Home delivered meals." ODJFS does not feel the assessment tool addressed the evaluation of nutritional needs in sufficient detail.

In its Comprehensive Health Status Assessment tool used by its Medicaid line of business in Arizona, UnitedHealthcare identifies on page 3 under the heading 7.0 Prior Services, what it contends is the validation in support of Domain viii., Long Term Services and Supports. Question 7.1 asks whether the enrollee is receiving services through an Adult Day Care Center, Adult Foster Care, and/or Skilled Nursing. In Section III.A. Definitions of the Main RFA, Long Term Services and Supports is defined as 'A broad range of health and health-related services, personal care, social and

supportive services, and individual supports. These services can be provided in institutions, and individuals home, or in a community setting.' ODJFS has determined, after further review, the information provided is responsive and accordingly awards UnitedHealthcare an additional 30 points.

In its Comprehensive Health Status Assessment tool used by its Medicaid line of business in Arizona, UnitedHealthcare identifies on page 5 under the headings 11.0 Preventive Health and 12.0 Advanced Directives, what it contends is the validation in support of Domain xv., Health and Welfare. 11.1 identifies whether the enrollee has had a flu shot; 11.2 identifies whether the enrollee has had a pneumococcal vaccine. 12.1 asks whether the enrollee has a living will, durable power of attorney, and/or advance directives; 12.2 addresses whether the enrollee is a member enrolled in a UHC-Medicare plan; and 12.3 asks whether the enrollee has undergone a Medicare HRA within the last 90 days. ODJFS does not feel the assessment tool addressed, in sufficient detail, an evaluation of an enrollee's health and welfare.

In its Comprehensive Health Status Assessment tool used by its Medicaid line of business in Arizona, UnitedHealthcare identifies on page 6 under the heading 13.0 Medicare HRA, what it contends is the validation in support of Domain xvi., Natural supports, including family and community. Question 13.11 asks 'Has it been hard for you to get the help you need.' ODJFS does not fee the assessment tool addressed the evaluation of natural supports in sufficient detail.

In Section III.D. - Application Scoring instructions of the Main RFA, ODJFS states "Applications which contain assumptions, insufficient detail, are poorly organized, have not been proofread and contain unnecessary use of self-promotional claims will be evaluated accordingly." After review of UnitedHealthcare's claim regarding Appendix D, Part A, Section 4.a, and with the exception of the 30 points to be awarded for UnitedHealthcare's response to Domain viii., Long Term Services and Supports, ODJFS finds no compelling evidence that the original scoring isn't reflective of the detail initially provided in its application, and therefore finds these claims to have no merit.

Appendix E, E-1

UnitedHealthcare feels they should be awarded full or partial credit for Appendix E, E-1. They claim the original RFA did not originally request a responsive essay for Appendix E, E-1, and that they met all the requirements to achieve a maximum score based on their understanding of the scoring methodology at that time.

ODJFS clarified the requirement of a responsive essay for E-1 in the Q & A which was posted to the RFA website on May 10, 2012. Specifically, ODJFS stated "The essay requirement includes both E1 and E2. The essay portion will validate the responses scored in E1 and E2." Further, II.B Applicant Inquires – Question & Answer Process (page 9 of the Main RFA), states " Applications for the RFA must take into account any information communicated by ODJFS in the final Question & Answer Document. **It is**

the responsibility of all potential Applicants to check this site on a regular basis for responses to questions, as well as for any amendments or other pertinent information regarding this RFA."

UnitedHealthcare freely acknowledges it did not initially provide a responsive essay to Appendix E-1 as required. Further, they acknowledge their obligation with regard to the instructions in II.B Applicant Inquiries – Question & Answer Process, but still did not submit the required responsive essay. As the responsive essay was required to validate the responses provided in the tables in E-1 and E-2, and UnitedHealthcare did not provide a responsive essay for E-1, the protest to the scoring of Appendix E, E-1 is found to have no merit.

Requested Relief

UnitedHealthcare requests that ODJFS confirm the validation of the responses discussed in their letter of protest and grant an award of an additional (1) 565.7896 points in Appendix C, Section 1.a; (2) 210 points in Appendix D, Part A Section 4.a; and (3) 2500 points in Appendix E, E-1 or an amount commensurate with UnitedHealthcare's response.

Conclusion

Based upon review of this letter of protest, the RFA and the scoring of UnitedHealthcare's application, ODJFS awards 30 points to UnitedHealthcare in response to its claim that sufficient validation was provided for Appendix D, Part 4, Section 4.a, Domain viii. Long Term Services and Supports. All other claims were found to have no merit and no additional points will be awarded.

Thank you for your interest in serving the State and the citizens of Ohio.

Sincerely,

(Signature on File)

Jay Easterling
ODJFS/Office of Contracts and Acquisitions

Ohio | Department of Job and Family Services

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

August 20, 2012

Larry L. Lanham II
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191 West Nationwide Boulevard Suite 300
Columbus, Ohio 43215

RE: Protest of Applicant Scoring, WellCare
RFA# JFSR1213-07-8038
Ohio Integrated Care Delivery System (ICDS)

Dear Mr. Lanham:

On July 18, 2012, ODJFS received from you a timely protest of applicant scoring for the above cited RFA on behalf of WellCare of Ohio, Inc., pursuant to Section III.F of the RFA[1]. Please take this letter as a response to the issues raised in your protest. For ease of reference, we address the claims raised in the order presented in the letter of protest.

Summary of Claims

WellCare contends that the ODJFS team of reviewers made several errors which resulted in a lower final score for WellCare's application than appropriate; these collectively will be referred to as Part 1 of the WellCare protest. WellCare also believes ODJFS made several errors in its scoring of other applicants, thereby negatively affecting WellCare's ranking among the field of competitors; these will be considered Part 2 of this protest.

The protest letter on behalf of WellCare requests that ODJFS correct its errors in the scoring of the WellCare application, and that ODJFS provide fair treatment to WellCare relative to errors in the scoring of its competitors' applications. For Part 1, the protest specifically relates to the following components:

1. WellCare's HEDIS and CAHPS measure results in Appendix C, Section I.a.

2. WellCare's response to Appendix C, Section II. 1.b.3.

3. WellCare's response to Appendix C, Section II. 1.d.2.

4. WellCare's response to Appendix C, Section II. 3.a.2.

[1] ODJFS extended the deadline to submit a protest to July 18th 2012 from the original date of July 13, 2012 to all responding applicants.

5. WellCare's response to Appendix C, Section II. 3.b.2.

6. WellCare's response to Appendix C, Section II. 3.b.3.

7. WellCare's response to Appendix C, Section II. 3.e.

8. WellCare's response to Appendix D, Various Items

9. WellCare's response to Appendix F-2, Initiatives 3 and 4.

Appendix C Section 1.a.

In its protest letter, WellCare discusses the data that the RFA required from applicants in response to Appendix C., Table 2., and the data WellCare presented. ODJFS had issued a clarification, or revision, to Appendix C, Section I.a., on May 24, 2012, requiring applicants to submit their:

> … 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.

As explained in the WellCare protest, the WellCare application had presented its information for Measure 1 (on pneumonia vaccinations for persons at least 65 years of age) and on Measure 24 (on ratings of the health plan). However, the May 24 revision from ODJFS added the requirement of the CAHPS vendor attestation. WellCare believes it provided that verification as required before the deadline, but the ODJFS scoring decision was to award no points for those two measures as being not validated.

The WellCare protest also asserts that ODJFS received a nearly identical attestation for the CareSource application, actually from the same CAHPS vendor (The Myers Group) and written and signed by the same representative of that vendor (Nicole Brown, Director of Quality and Compliance), but accepted that attestation as validation of CareSource's information, and awarded CareSource points.

As WellCare itself points out in its protest letter, the two letters of attestation from the Myers Group are not identical. The State's revision required applicants' CAHPS vendors to verify "… the accuracy of each set of Medicare HEDIS results reported for Appendix C." The Myers Group attestation letter for CareSource provides that verification, and therefore the reviewers were correct in awarding the corresponding points to CareSource. However, the Myers Group letter for WellCare says it attests to the accuracy of the raw data provided to CMS. The differences between verifying the accuracy of raw data provided to CMS and the accuracy of information submitted in the application could potentially be significant. The ODJFS clarification specified that the attestation was to address the accuracy of the data reported by the applicant for

Appendix C of this RFA. The WellCare information provided as a result of the ODJFS clarification of May 24, 2012 is not responsive to the instructions.

For the reason presented above, ODJFS finds that there is no merit to this component of WellCare's protest, and no additional points will be added.

Appendix C, Section II. 1.b.3.

The RFA asks applicants to provide essays for up to three structured quality improvement (QI) initiatives, selected from four optional topics provided in Appendix C. WellCare selected the first optional topic for the first of its essays:

1. Preventing unnecessary long term institutionalization by re-directing Medicaid individuals to community settings and using community-based long term care services and supports.

The ODJFS evaluation/scoring criteria for item 1.b.3. is: Did the Applicant discuss the benchmarks and goals that the quality indicators were compared to throughout the initiative?

The WellCare essay described a project implemented by its subsidiary 'Ohana Healthcare, Inc. of Hawaii to reduce the number of its members entering nursing facilities (NF) and to decrease the length of NF stays by making home- and community-based services (HCBS) available to more of its members. As its two quality indicators, the essay identified the number of its Medicaid members receiving HCBS and the number living in NF settings.

In its protest letter, WellCare identifies "the benchmark and goal" as achieving a rate of at least 10% fewer of its members in NF settings and a corresponding growth in the number of its members receiving HCBS.

The protest letter also identifies as "interesting" the fact that the score sheet showed that a checkmark by "yes" for this item had been entered and then marked out. It states that this indicates, "… that WellCare appropriately discussed benchmarks and goals." In its letter, WellCare protests the scoring decision made by the reviewers and seeks the reinstatement of the score sheet mark indicating, " 'Yes,' just as the Selection Team originally decided," and the award of the points available.

That WellCare makes an assertion about the meaning of a change on the score sheet for this item does not prove the assertion. Other potential explanations are equally plausible, if not more so. In a review process based on discussion and consensus, discussions may lead to preliminary decisions, and further reflection and discussion, or the subsequent location of other information, and may result in decisions by the reviewers to revisit and possibly revise previous decisions. It is also entirely possible that the person recording the scores simply made a mark in error and corrected it.

Further, as a review of the WellCare essay shows no use of the term 'benchmark,' nor of any other equivalent terminology, there is no support for the WellCare assertion.

The RFA's scoring criteria for this item uses the phrase 'benchmarks *AND* goals' (emphasis added), but the WellCare essay discusses only its goal for the initiative. The WellCare essay does clearly describe the initiative's goal, but it provides no indication of a benchmark against which the quality indicators were compared. This review of the WellCare essay and its ODJFS score sheet presents no evidence of error on the part of the review team when it awarded no points to WellCare for this item.

For the reasons presented above, ODJFS finds that there is no merit to this component of WellCare's protest, and no additional points will be added.

Appendix C, Section II. 1.d.2.

The next component of WellCare's protest also comes from an item of scoring for its first essay on structured quality improvement initiatives, as discussed above. The specific evaluation/scoring criteria from the RFA for this item (QI number 1, item 1., d., 2) is: Did the results for each quality indicator show improvement that was statistically significant? As stated in the WellCare protest letter concerning this item, the ODJFS review team's score sheet indicated that the WellCare essay did not show statistically significant improvement. In its protest, WellCare contends that its essay, "…provided statistically significant results…" and, referring to the score awarded as an error, asks that the score be revised and all available points be awarded.

The WellCare essay provides the following summation of its initiative's results as its answer to this scoring item:

> Through our interventions, we reduced the number of members entering a NF each month by approximately 40 percent, as calculated by comparing the final month (December 2011) to the first month (February 2009). This significantly exceeded our objective of a 10 percent shift. 'Ohana Health Plan serves over 50 percent of the managed long term care population in the program, making the results statistically significant.

The essay seems to suggest that because 'Ohana's intervention project was effective, and because 'Ohana serves such a sizeable population, the positive results achieved are important, and are therefore statistically significant. The essay does not, however, give any indication of whether a statistical test was applied to verify significance. In scientific studies, the term statistical significance refers to a formal analysis of the likelihood that observed phenomena can be tied to causal factors rather than to randomness, not that a result is important. While the initiative might have been subjected to a test of its statistical significance, as well as its achieving results that are impressive, nothing in the WellCare essay gives evidence of an analysis of statistical significance.

A review at this time of the WellCare essay and its corresponding score sheet indicates that the scoring decision made by the ODJFS reviewers for this item 1., d., 2 was based on WellCare's apparent misinterpretation of the term "statistically significant." The review team did not make a mistake in awarding WellCare zero points for this item.

For the reasons presented above, ODJFS finds that there is no merit to this component of WellCare's protest, and no additional points will be added.

Appendix C, Section II. 3.a.2.

For its second structured quality improvement (QI) initiative, WellCare selected the third optional topic:

3. Improving health outcomes or quality of life indicators for Medicaid and/or Medicare members with severe and persistent mental illness.

The ODJFS evaluation/scoring criteria for item 3.a.2. is: Did the Applicant discuss how the initiative specifically related to the organization's membership? As stated in the WellCare protest letter concerning this item, the ODJFS review team's score sheet is marked as 'No' and WellCare earned no points for this item. In its protest WellCare contends that the score awarded is in error, and asks that the score be revised and all available points be awarded.

The WellCare essay describes the study question as one of whether the implementation of intensive case management (ICM) intervention results in improved emotional health and reductions in hospital readmissions for Florida Medicaid members with severe and persistent mental illness (SPMI). The initiative was operated by Magellan, WellCare's behavioral health provider. According to the essay, one quality indicator used was member self-reported health status, as captured through a functional health assessment tool used for adult members to measure their health and wellness over time. A second indicator was the hospital readmission rate for the population. The essay indicated the success of the initiative as shown by, for example, the number of the health assessment tools completed at certain measurement points, the number of those that reported experiencing either emotional health improvement or clinically significant emotional health improvement, decreased levels of work or school absences, and a 27% reduction over a one-year period in hospital readmissions.

However, the WellCare essay does not present any demographic data on its membership to show how the initiative was relevant for it, such as for example, how many members of the WellCare organization could benefit, or how large the issue is. The essay only uses the phrases 'Medicaid members' or 'members' throughout, and while referring to members who have SPMI, and providing basic data on persons who received the services added by the initiative, no data to present the larger picture or to cohesively link WellCare's membership to the broader membership in the initiative is presented.

For the reasons presented above, ODJFS finds that there is no merit to this component of WellCare's protest, and no additional points will be added.

Appendix C, Section II. 3.b.2
And
Appendix C, Section II. 3.b.3
And
Appendix C, Section II. 3.e.

The next three components of WellCare's protest also come from scoring for its second structured quality improvement essay (QI), which is also discussed above:

3. Improving health outcomes or quality of life indicators for Medicaid and/or Medicare members with severe and persistent mental illness.

The specific evaluation/scoring criteria from the RFA for item 3., b., 2, is: Did the Applicant discuss how the quality indicators were meaningful to monitoring success of the intervention? The specific evaluation/scoring criteria from the RFA for item 3., b., 3, is: Did the Applicant discuss the benchmarks and goals that the quality indicators were compared to throughout the initiative? Item 3.e. asks, "Did the Applicant report that the results of the quality improvement initiative were independently validated?

The WellCare essay describes the study question as one of whether the implementation of intensive case management (ICM) intervention results in improved emotional health and reductions in hospital readmissions for Florida Medicaid members with severe and persistent mental illness (SPMI). The initiative was operated by Magellan, WellCare's behavioral health provider. According to the essay, one quality indicator used was member self-reported health status, as captured through a functional health assessment tool used for adult members to measure their health and wellness over time. A second indicator was the hospital readmission rate for the population. The essay indicated the success of the initiative was shown by, for example, the number of the health assessment tools completed at certain measurement points, the number of those that reported experiencing either emotional health improvement or clinically significant emotional health improvement, decreased levels of work or school absences, and a 27% reduction over a one-year period in hospital readmissions.

In its score sheet for this essay, the reviewers indicated that the plan had not discussed how the quality indicators were meaningful to monitoring the success of the intervention, and that it had failed to identify the benchmarks and goals that the quality indicators were compared to during the initiative. WellCare protests those decisions and seeks the awarding of all points available.

A careful reading of the WellCare essay shows ample discussion of the intervention, but it does not show a discussion of how both the selected quality indicators were meaningful in monitoring whether the ICM intervention was successful. The number of self-assessments completed, and even the percentage of those that over time report

improved emotional health may or may not indicate success of ICM, but there are insufficient details in the essay to determine whether the assessment tool links improvements with the use of ICM. Also, the essay itself presents no discussion of specific goals set for the implementation beyond generally improved emotional heath and fewer SPMI hospital readmissions, and no mention of any benchmarks used to support any goals.

Finally, while the review team indicated that the essay did not show that the QI was independently validated, the WellCare essay and, in more detail, the WellCare protest state that the self-assessment tool used (the SF-BH) is based on a nationally recognized and scientifically validated instrument. While that might be true, the question is not whether any tool used in the initiative was independently validated, but whether the results of the quality improvement initiative had been validated.

For the reasons presented above, ODJFS finds that there is no merit to these components of WellCare's protest, and no additional points will be added.

Appendix D., Part A, number 13, Various Items

The protest from WellCare also objects to scores received for five specific criteria in Question #13, used to score its response to Appendix D., Part A, in which applicants were directed to describe an innovative approach to care management services for dually-eligible plan members. The directions for this portion of the RFA said that ODJFS would score applications based on how well applicants' responses met the State's expectations as expressed in the appendix information and in Ohio's ICDS proposal. ODJFS would use the scale of "does not meet" expectations (for 0 points), "partially meets" (for 40), "meets" (for 70), or "exceeds" expectations (for 100 points). For three of the five items objected to in WellCare protest, three were scored at "does not meet expectations," and the remaining two at "partially meets." However, as the criteria used in this scoring section were 'weighted' the numbers of points under dispute are greater than the simple differences between these score values.

In its protest letter, WellCare explains its reasons for believing the scores awarded by the review team for its essay on five specific points are inaccurate, and identifies the minimum score it believes should have been awarded for each. The items that had been scored at zero will be discussed first.

Item 13.d. was to assess the description of an innovative care management approach for its description of how a communications plan would be established with the plan member. In an effort to show that the score of no points is an error, the protest letter says, "… the application identifies how the communication plan will be established and the medium through which enrollees will be contacted." Even the protest letter's defense of the application places the plan members in a passive role; the WellCare application does not give any indication that plan members would be engaged in developing a communication plan. The application describes a process that is driven by the plan or provider, not by the consumer.

Item 13.e. was to assess how well the innovative approach would meet Ohio's expectations for the continuous review and revision of members' care plans. The WellCare essay states that, "We analyze the entire population daily to prioritize interventions." It described how algorithms are used to keep members' risk score current and to prioritize for interventions. The score team did not find this information responsive to the criterion, and therefore marked it as not meeting expectations. A review of the WellCare response for this item shows the essay does not clearly discuss a plan for care plan revisions; the information provided seems to describe instead a system of triage and of resource allocation.

Item 13.j. seeks information on the integration of care management systems and databases. The information provided by WellCare for this item of its proposed approach is on the APS Care Connection. The essay does not discuss whether or how this system would be linked to other databases or other internal systems.

The Appendix D., question #13 scores of zero to which WellCare protests were assigned by the reviewers reasonably and consistently. The zeros in these instances were awarded because the specific criteria for which the essays were judged were not addressed, and therefore, the scores of zero will remain unchanged.

The remaining two items included in the WellCare protest are ones for which WellCare received scores of 40, meaning the review team found that the essay partially met the State's expectations regarding the criteria. The WellCare protest asserts that the essay should have been scored higher on those criteria and awarded more points, from a score of 'partially meets expectations' (that is, from 40 points) to either 'meets' or 'exceeds' the State's expectations (to 70 or 100 points). Such assessments from any organization of its own work, and of that of its competitors, are understandable, but also highly subjective.

The evaluation and scoring for this component of the RFA is an inherently and unavoidably subjective process. However, there is no indication that the ODJFS review team acted carelessly, or without good judgment, were unfair, unreasonable, or inconsistent, or that they varied from the instructions and guidelines expressed in the RFA in deciding on WellCare's scores for these criteria. A review of the essays in question and of the scores that were awarded, as well as of the arguments offered by WellCare in its protest, presents no justification for awarding WellCare any additional points. Lacking any such indications, to accept WellCare's arguments for higher scores would be incorrect as it would in effect substitute WellCare's subjective and self-interested opinions for those of the State's reviewers.

For the reason presented above, ODJFS finds that there is no merit to WellCare's protest regarding Appendix D, Question #13, and no additional points will be awarded.

Innovative Payment Methods in Appendix F., Section 2, Various Items

The protest from WellCare also objects to scores received for responses to its Appendix F, Section 2, in which applicants were directed to describe innovative payment methods that they would propose, using up to five different provider types selected from a list provided in the RFA as models. The directions for this portion of the RFA said that ODJFS would award points based on the strength of the applicant's vision for the State's goals, and the alignment of the proposed models with them. The points would "… be awarded based on how well each proposed innovative payment method meets expectations to promote specific goals of this project." ODJFS would use the scale of "does not meet" expectations (for 0 points), "partially meets" (for 50), "meets" (for 100), or "exceeds" expectations (for 150 points). The criteria for the evaluation included such things as keeping people in the community, increasing independence, improving care coordination, and increasing the primary care providers' accountability.

WellCare believes its essays on innovative payment methods regarding two provider types (Nursing Facilities and Home- and Community-Based Services Providers) were scored incorrectly for their ability to increase individuals' independence because they both included, "… structural features that would demonstrate the ability of such initiatives to increase individuals' independence." However, a review of the essays shows at best questionable alignment of the measures offered with the goal.

For the reason presented above, ODJFS finds that there is no merit to WellCare's protest regarding Appendix D, Question #13, and no additional points will be awarded.

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

WellCare contends five applicants (Buckeye, UnitedHealthcare, CareSource, Molina and Paramount) improperly claimed behavioral health experience in their Ohio lines of business. WellCare claims that "No managed care plans operating in Ohio during the time periods specified in the RFA should have received points for "Behavioral Health" experience", as partial hospitalization, an element of behavioral heath, is an excluded or limited item and not a coverage or service which is part of the beneficiary package.

Buckeye asserts that, under its contract for Ohio Medicaid, they "must ensure that members have access to all medically-necessary behavioral health services covered by the FFS program and are responsible for coordinating those services with other medical and support services, including the publicly funded community behavioral health systems … MCP must provide Medicaid-covered behavioral health services for members who are unable to timely access services or are unwilling to access services through the publicly funded community behavioral health system… ." Buckeye further contends it has routinely (with ODJFS approval) paid for alternate behavioral health services from their capitation including utilization of their Stricklin Crisis Stabilization Unit in Cleveland, a 15-bed facility short term alternative to inpatient psychiatric

hospitalization for persons experiencing a psychiatric crisis, as well as through its contract with Orca House in Cleveland.

ODJFS determines the services Buckeye provides through its Ohio Medicaid meet the intent of the desired experience requested in Appendix B, Item 4. and therefore finds this claim by WellCare to have no merit.

UnitedHealthcare used experience of its sister company, Optum Behavioral Health through which it provided access to the services listed in Appendix E of the RFA for their Medicare, Medicaid and commercial members. Specifically, UnitedHealthcare covered 36 stays for intensive outpatient therapy and provided assistance to providers in their requests for partial hospitalization of their members by connecting them with the county board or CMHC that have PHP services and then assisting members with health plan transportation benefits to go to a PHP facility.

ODJFS determines the services UnitedHealthcare provides through Optum Behavioral Health for its Medicare, Medicaid and commercial members meet the intent of the desired experience requested in Appendix B, Item 4. and therefore finds this claim by WellCare to have no merit.

CareSource asserts that, under its contract for Ohio Medicaid, they are obligated to provide the full range of services per appendix G (2)(b)(iii) of the ODJFS Provider Agreement for Managed Care Plans (MCP). Specifically, "MCPs must ensure that members have access to all medically-necessary behavioral health services covered by the FFS program and are responsible for coordinating those services with other medical and support services, including the publicly funded community behavioral health systems….MCPs must provide Medicaid-covered behavioral health services for members who are unable to timely access services or are unwilling to access services through the publicly funded community behavioral health system." CareSource covered 103 unique members for partial hospitalization and intensive outpatient in 2009, 141 in 2010 and 142 in 2011.

ODJFS determines the services provided by CareSource with regard to behavioral health meet the intent of the desired experience requested in Appendix B, Item 4 and therefore finds this claim by WellCare to have no merit.

Molina asserts that, under its contract for Ohio Medicaid, if a plan member cannot or will not access the services of the community behavioral health system, Molina provides access to medically necessary behavioral health services through independent behavioral health providers. Further, Molina states it provides transportation services and coordinates appointments for outpatient and inpatient behavioral health treatment and also partial hospitalization if requested by member or provider.

ODJFS determines the services provided by Molina with regard to behavioral health, meet the intent of the desired experience requested in Appendix B, Item 4 and therefore finds this claim by WellCare to have no merit.

Paramount asserts that, under its contract for Ohio Medicaid, they "must provide Medicaid-covered behavioral health services for members who are unable to timely access services or are unwilling to access services through the publicly funded community behavioral health system" and that by virtue of its continued participation in Ohio Medicaid, all required benefits are being provided to Medicaid members.

ODJFS determines the services provided by Paramount with regard to behavioral health, meet the intent of the desired experience requested in Appendix B, Item 4 and therefore finds this claim by WellCare to have no merit.

WellCare contends two applicants (Paramount and UnitedHealthcare) improperly claimed "LTC Institutional" experience in their Ohio lines of business. WellCare claims that "No managed care plans operating in Ohio during the time periods specified in the RFA should have received points for "LTC Institutional" experience," as "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," and that "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." WellCare states "This obligation cannot be characterized as qualifying experience with a comprehensive line of nursing facility services which meet residents' medical, personal, social and safety needs."

Paramount claimed long term care institutional experience in its Ohio Medicare and Medicaid line of business for 2009, 2010 and 2011. Paramount's parent company, ProMedica, owns ProMedica Lake Park, a 225 bed Nursing Facility located at its Flower Hospital (Cleveland, Ohio) which is certified for both Medicare and Medicaid patients, and provides services which meet the RFA definition of institutional long term care.

ODJFS determines the services provided through Paramount's (ProMedica) Lake Park facility meet the intent of the desired experience requested in Appendix B, Part 1, and therefore finds this claim by WellCare to have no merit.

UnitedHealthcare claimed long term care institutional experience in its Ohio Medicaid line of business for all years reported. UnitedHealthcare, through its corporate family affiliate Evercare, provides institutional long term care in Ohio through its Institutional SNP (I-SNP) that provides these services to Medicare and Medicaid enrollees.

ODJFS determines the services provided through UnitedHealthcare's (Evercare) I-SNP meet the intent of the desired experience requested in Appendix B, Part 1, and therefore finds this claim by WellCare to have no merit.

Requested validation of Molina's Reported Medicare Membership on Appendix B, Part II

WellCare suggests Molina incorrectly represented its Medicare membership in the following counties by region: Pickaway, Madison and Union in the Central; Butler,

Clermont and Warren in the Southwest; and Clark and Greene in the West Central, and requests validation of Molina's reported Medicare membership in each.

A review of each county, identified by CareSource, through the CMS Medicare Online Enrollment Center (www.medicare.gov) showed enrollees had the option of one Medicare plan in two counties and a choice between two Medicare plans in the other six counties. **Therefore, ODJFS finds this claim by WellCare to have no merit.**

Requested Relief

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 ODJFS make scoring appropriate reductions in relation to any points which have been erroneously awarded to other applicants by the selection team.

Conclusion

Based on review of WellCare's letter of protest and exhibits, the RFA, the scoring of WellCare's application and correspondence from other applicants, ODJFS finds WellCare's claims without merit, and therefore no rescoring based on these claims will be conducted.

Thank you for your interest in providing services to the citizens of Ohio.

Sincerely

(Signature on File)

Jay Easterling
ODJFS/Office of Contracts and Acquisitions