CHRISTENSEN
LAW GROUP, P.L.L.C.

February 11, 2021

**Via Electronic Mail**
Oklahoma Health Care Authority
Attn: Legal Services Division
4345 North Lincoln Blvd.
Oklahoma City, OK 73105
legalservices@okhca.org

**Re: SoonerSelect RFP Solicitation Number: 8070001240**
**Notice of Protest of Award and Request for Stay**

Ladies and Gentlemen,

We represent Aetna Better Health of Oklahoma Inc. ("Aetna") with regard to the Request for Proposals to procure contracts on a statewide basis with managed care organizations (MCOs) to deliver risk-based managed care services to SoonerCare Children, Deemed Newborns, Pregnant Women, Parent and Caretaker Relatives, and Expansion Adults (the, SoonerSelect Plan), and to other children in the SoonerSelect Specialty Children's Plan, Solicitation Number 8070001240 (the "SoonerSelect RFP"). As a fully qualified but unsuccessful bidder to the SoonerSelect RFP, Aetna hereby registers its formal protest of the award of the contract by the Oklahoma Health Care Authority ("OHCA") announced on Friday, January 29, 2021, in accordance with Section 2.9 of the RFP and the Oklahoma Administrative Code ("OAC") 317:2-1-14.

## SUMMARY OF PROTEST

Aetna is grateful for this opportunity to be heard and for your attention to and consideration of this protest which seeks to carry out Oklahoma's worthy goal of improving health outcomes for the Medicaid population and making Oklahoma a top ten state in the national health rankings. As set forth in more detail below, Aetna has demonstrated its: commitment to improving Medicaid health outcomes, ability to meet or exceed the program goals and standards, and drive to deliver innovative practices and value-based purchasing. Absent corrective action, Oklahomans will not receive the best-value available for some of the largest contracts awarded in State history because of a scoring differential of less than seven tenths of one percent, *i.e.*, 11 points out of 1700. This

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statistically insignificant difference creates significant consequences for Oklahomans and Aetna—the only qualified bidder denied a contract.

Unfortunately, because it was not awarded a contract, Aetna is in the awkward position of having to point out flaws in the bid review process that necessitates corrective action by the OHCA to include Aetna in the contract award or to void the contract award and starting over.

Pending review of this protest, Aetna respectfully requests that the execution of and/or the implementation of the contracts be stayed pending the outcome of this protest and until all avenues of appeals relative to this protest are exhausted.

## GROUNDS AND REASONS FOR PROTEST

Aetna understands and appreciates the hard work, challenge, complexity, and dedication involved in making final award decisions. In bringing this protest, Aetna aims to improve (1) Oklahoma's transition from predominately fee-for-service to managed care, and (2) the healthcare outcomes of the beneficiaries of the SoonerSelect program. With this in mind, Aetna protests its omission as the recipient of a statewide contract and the contract awards announced on January 29, 2021 for the following reasons:

(1) The OHCA Board, alone, was vested with the authority to approve the contracts and the contracts were not presented to the Board for approval.

(2) The evaluation process was fatally flawed with clear and documented deviations from the RFP criteria and instructions.

(3) Violations of both the Open Records Act and Open Meetings Act occurred in violation of state law.

The facts and information put forth in this protest confirm that the process used has **not** provided for a defendable result by the OHCA. As such, the contracts related to the SoonerSelect RFP must not be executed and, if already executed, must not be implemented until these matters are fully resolved.

Aetna reserves its right to supplement or augment this protest if or when additional records are produced by the OHCA.

### I. Only the OHCA has the authority to approve and grant these contracts.

As mentioned above, this is a massive undertaking and one of the largest expenditures in Oklahoma State history. As such, it is necessary that the process be above reproach and that the decision-making is completely in line with the legal requirements. In this proposal process, there have already been questions raised by members of the OHCA Board, as well as members of the Oklahoma healthcare community regarding the ability to complete this process in the manner that

has been used. A thorough review of the process is necessary to make certain citizenry and state are best served and protected.

The OHCA CEO was the final decisionmaker regarding the contracts. The question is whether the OHCA CEO has the legal authority to award the contracts on his own. His authority derives from statute and the regulations governing the OHCA. If there was not authority to award the contracts, the awards should be reversed and reconsidered.

**A. Statutorily, the OHCA CEO can develop a contracting process, but is not empowered to make a decision of this magnitude without board approval.**

The RFP submissions were evaluated by the OHCA's personnel and the CEO purportedly made the final decision based on the evaluations. Among the items on the agenda for the OHCA Board meeting on January 26, 2021 was a request for the board to authorize the CEO to expend up to $2,102,453,437.00 in funds, comprising some of the largest contracts in Oklahoma history to operate SoonerSelect.

Pursuant to statute, the Administrator of the OHCA acts as the chief executive officer of the agency and has the power and duty to establish a contract bidding process which "encourages competition among entities contracting with the Authority for state-purchased and state-subsidized health care."[1] Although the OHCA CEO has the legislative authority to establish a contracting process once a program is approved by the legislature, this language does not give the OHCA CEO authority to make contracting decisions. Simply put, the OHCA CEO is not empowered to enter contracts of this magnitude on his own.

**B. OHCA regulations do not allow the CEO to award these contracts without the Board's approval of the contracts.**

At the January 26, 2021 OHCA Board of Directors meeting, the Board approved the $2 billion expenditure. Yet this decision was not without controversy: members of the Board were concerned about the managed care idea, whether the Board should seek the opinion of the attorney general's office as to the Board's actual authority, and whether the Board should vote on the contracts. These disagreements were not resolved by the Board; the Board simply decided to delegate what authority it *might* have to award these contracts to the OHCA CEO.

Remarkably, the OHCA Board does <u>not</u> have the authority to delegate a decision of this magnitude. Under its own rules, the OHCA Board is limited in its ability to delegate its decision-making authority by the amount of the procurement at issue. The OHCA Board cannot delegate procurement decisions in excess of $500,000 for supply and non-professional service acquisitions, and in excess of $125,000 for professional service contracts.[2] The contracts awarded under the

[1] 63 O.S.§ 5008. B.5.a.

[2] Okla. Admin. Code 317:10-1-16 ("Any single acquisition of this kind [supply and non-professional services] over $500,000 must be approved by the Authority Board … All professional service contracts over $125,000 must be approved by the Authority Board.")

SoonerSelect RFP are clearly in excess of OHCA Board's authority to delegate. As a result, the contracts cannot be awarded without the OHCA Board's approval. The applicable provisions of the Oklahoma Administrative Code refer to the approval of contracts and amendments that exceed the permitted monetary amount. Having the Board approve the excessive expenditure but not the actual contract is not only outside the scope of the allowable delegation of authority that is authorized by Oklahoma Administrative Code, it is clearly prohibited.

These contracts are some of the largest ever in Oklahoma history. To allow the decision to award massive contracts affecting the lives of some of Oklahoma's most vulnerable citizens to be made by a single person in violation of the very agency's own regulations is wholly outside of the parameters set forth by state statutes. The Board has the responsibility of making this decision. Board involvement and approval would have resulted in the award decision being discussed and differing opinions being heard. These contracts impact the entire state, and all of its citizens, and will have long-term, significant and perhaps generational ramifications. Permitting a decision of this magnitude to be made by a single person is improper, is clear error, and is not in the best interest of the State of Oklahoma.

Only the OHCA Board has the authority to award the contracts at issue and that authority cannot be delegated. The decision and award should be rescinded until the Board can make a decision.

## II. Evaluation Process Integrity: The evaluation and scoring process was fatally flawed.

### A. Criteria should have been developed, clearly communicated to bidders and evaluators, and applied during the scoring process.

The SoonerSelect Proposals were evaluated on unknown criteria. As a result, the evaluation process did not yield awards that are defensible, objective, and able to withstand challenge. While there were broad categories to be scored, there was a lack of information guiding the evaluation team regarding how the wide-ranging score should be broken down and points assigned.

The competitive and open bidding process is intended to make certain that the State and its beneficiaries are provided with the best value and services from the most qualified vendors. In order to achieve this goal, all efforts must be made to remove all inherent and/or unintentional biases. In the past Oklahoma used a 1-5 scoring system, but that quantitative process was cast aside for the more subjective PQMI note system. The subjective scoring model and lack of rigidity inherent in the PQMI scoring model renders scores inconsistent and without defense. The evaluators were not provided with clear instruction as to how to score individual portions of the proposals. For instance, the evaluators were trained in using the P/M/Q/I methodology, in which the evaluator marks their comments as P for positive; M for minus; Q for uncertainties; and I for interesting or innovative.[3] Yet, the training materials and record are devoid of an explanation of

[3] Health Management Associates, "SoonerSelect Evaluator Training." Dec. 7-8, 2020 PowerPoint, p. 18. Attached hereto as Exhibit A.

how to convert these characterizations into the numbers necessary to score the proposals. This omission has inherently caused serious discrepancies in how individual reviewers quantified these concepts. These discrepancies remove a layer of objectivity from the scoring and make the process more subjective. Additionally, there is no indication as to whether certain questions were weighted differently than others. For example, while the number one stated goal of the program is to achieve better healthcare outcomes,[4] there is no suggestion that evaluators were trained to consider the importance of that goal when weighting their scores.

Section 2.7 of the SoonerSelect RFP provides opaque evaluation guidance: "*Following the closing of the RFP, an administrative review and evaluation process will be conducted to determine the responsiveness and quality of each Proposal. Proposals will be evaluated based upon the ability of the Bidder to satisfy the requirements of the RFP in best serving the interests of the citizens of Oklahoma. Each of the evaluation steps is described below with a brief explanation of the evaluation criteria in that step.*"

During the Question & Answer period, the OHCA provided the following answer to various questions regarding what the criteria would be: "*OHCA will evaluate each bidder fairly based on the substance and quality of their responses. Points available for evaluation areas outlined in Section 2.7.2 are weighted according to importance to the state.*"

While there were wide-ranging categories to be scored, such as Covered Benefits and Information Technology, there was a lack of information guiding how the broad score assigned to each evaluation area should be broken down by individual question or what criteria should be considered when determining what was a Plus, Minus or Innovation. Section 1.5 of the Solicitation Evaluation Guide purports to outline the review and scoring to be conducted by the evaluators, however, once again there are no criteria articulate. The relevant section is attached hereto as Exhibit B.

### B. The RFP Required Supporting Documentation That Evaluators Did Not Review

The SoonerSelect RFP allowed for, and at times, required attachments, yet evaluators were specifically, and incorrectly, advised that they did not need to consider all of the supporting documentation provided in the proposals.

> **Do NOT be overwhelmed by the sheer size of the Bidder's responses. Much of this is supporting documentation that you do NOT have to review.**

Exhibit C, Email from Lee Repasch dated December 15, 2020, addressed to the evaluators.

In the December 15, 2020 email, Mr. Repasch advises the evaluators that they are not required to review the supporting documentation, which is, generally, the information contained

[4] This objective was repeated in the Evaluation Materials, by the Governor, by the OHCA CEO, within the SoonerSelect RFP - all of which indicate that outcomes were the highest priority.

in attachments. For Aetna, the attachments included vital information that did not appear to be considered by the evaluators. Nothing in the SoonerSelect RFP indicates and OHCA ever advised bidders that the attachments would not be reviewed. It is unfair and completely inappropriate in a competitive bidding situation to demand information from the bidders, permit such information to be included in attachments and supporting documentation, and then instruct evaluators not to consider such attachments and supporting documentations when scoring proposals and deciding how to award the contract. This is entirely inconsistent with the RFP itself which encouraged MCO's to be inclusive. In addition, this conclusion is further supported by Exhibit D, the SoonerSelect Evaluator Assignment Spreadsheet, wherein the evaluators were told they need only review the narrative pages of the proposals, leaving them at a serious disadvantage of understanding the entire proposal offered by each MCO.

As discussed above, the evaluators were advised that they were not required to review the supporting documentation. It appears from several of the negative comments related to Aetna's score that the evaluators took that instruction to heart. Aetna's scores appear to have been adversely impacted by the evaluation team's failure to review Aetna's entire response. Further, the OHCA cannot refute whether any points deducted from Aetna are attributable to its disregard of Aetna's supporting documentation, particularly since evaluators were instructed not to retain their notes.

**C. The Evaluators Improperly Compared the Proposals.**

One area where the evaluators were properly trained was the need to score the proposals on their own merit without comparisons to the other bids. Yet, time and time again, the evaluators compared the proposals. These comparisons were improper and have likely resulted in skewed scoring results.

For example, Aetna received a comment under the section titled: "Corporate Information and Experience In Improving Outcomes", that it was "not as innovative as other plans". Also, under the section titled "Covered Benefits", Aetna received the comments that its response was "Middle of the road, not as robust section as others" and "Good variety on VAB but less generous relatively". For additional examples see the SoonerSelect Consensus Scoring Notes. Attached hereto as Exhibit E.

**D. Rush to review; not enough time.**

Unfortunately, given the rush to complete this process and a seeming need to keep the information within the OHCA, the evaluators were placed in an untenable position of having to evaluate detailed and often highly technical bid specifications, sometimes without being provided the requisite background information or time.

One example is the pharmacy section, where there were no comments made for any bidder. Given the importance of this covered benefit not only to the SoonerSelect program, but perhaps more importantly to the beneficiaries, it is difficult to imagine a scenario where a thorough review would not include comments on the pharmacy benefits offered by the MCOs.

## III. The OHCA violated the Open Records Act and the Open Meetings Act resulting in a breach of the RFP's Protest process and a violation of Oklahoma law.

The OHCA violated Oklahoma law and the provisions of the RFP by failing to provide Aetna and the citizens of Oklahoma the facts concerning how the evaluators scored the bids leading to the award of the contracts. Competitive bidding for state contracts, especially large bids, are required to be open and public because allocation of public money is of great concern to the citizenry.

**Open Records Act.** The intent of the ORA is to fulfill the inherent right of Oklahoma citizens to "know and be fully informed about their government" and, to that end, creates no rights of privacy and protects no release of information except as explicitly provided in the ORA. *Id.* at § 24A.2. Certain notes are confidential pursuant to the act, but only prior to action being taken. The Open Records Act provides that

> **[p]rior to taking action**, including making a recommendation or issuing a report, a public official may keep confidential his or her personal notes and personally created materials . . . as an aid to memory or research leading to the adoption of a public policy or the implementation of a public project [emphasis added].

51 O.S. § 24.A9. A public official is defined by 51 O.S. § 24.A3(4) to include "any official or employee of any public body" and therefore includes the evaluators.

Health Management Associates ("HMA"), which provided consulting services for the bidding process advised the evaluators to take copious notes and that the evaluating team members' notes and initial scoring forms would not be public records. In violation of the ORA, HMA advised the evaluating team members that their notes would be destroyed. Now that the awards have been announced, those notes are plainly subject to the ORA.

In preparing for this protest, Aetna requested amongst other documents, the notes and initial scoresheets from the evaluators. No notes or scoring sheets were provided in response to the request, which means the notes where either (1) destroyed in violation of the ORA or (2) not made. Either reason is sufficient to grant Aetna an award or to rebid the RFP as the citizens of Oklahoma are unable to confirm that best and most qualified MCO was selected.

Moreover, Section 2.9 of the RFP provides Aetna the right to protest the award of contracts under this solicitation. Explicit in Section 2.9 is the requirement that a protest "must state the **relevant** facts and the Bidder's ground for protest."

By refusing to provide Aetna with the documents and information relating to the evaluators notes and scoring the OHCA has stripped Aetna of its ability to have a full and fair review of the scoring process and award and has thereby violated Section 2.9 of the RFP.

Because these notes were not produced, there is no way to determine or evaluate how the individual reviewers initially scored the proposals, whether there were significant changes from the initial scoring to the consensus scoring that could indicate any potential bias, or whether there were other questions concerning the individual versus the consensus scores. These are some of the very reasons why the ORA includes these kinds of documents as public records.

Without these notes and scoring documents, Aetna has been harmed and is at a disadvantage in fully asserting its protest.

**Open Meetings Act.** The evaluation committee exercised *de facto* decision making authority on behalf of the OHCA and failed to comply with the Oklahoma Open Meetings Act rendering the OHCA's decision void.

The OHCA designated 11 agency employees to serve as its SoonerSelect RFP evaluation committee. The participants individually reviewed assigned sections and then met as a team to create a consensus score. The evaluation committee's rankings were then presented to the CEO, ***not*** the OHCA Board, and the CEO announced the RFP awards. As indicated in the prior sections, the OHCA Board did not review the evaluation committee's scoring or reports. This means that the evaluation committee exercised *de facto* decision-making authority on behalf of the OHCA.

The Oklahoma Supreme Court has considered the applicability of the Open Meeting Act ("OMA"), 25 O.S. § 301 et seq., to a subordinate entity of a public body, , and determined that the subordinate entity may be subject to the OMA.[5] Where the subordinate entity simply provides information and assists the public body by making recommendations, it was not exercising any actual or *de facto* decision making authority, thus was not subject to the OMA. However, the Court stated: "If the subordinate entity in the performance of its assigned duties and responsibilities exercises actual or *de facto* decision-making authority, it must comply with the open meetings law."[6]

Specifically, in the context of bid evaluations, the Oklahoma Attorney General concluded that "when a subordinate entity reviews and eliminates bids for contracts from consideration by a parent entity then the subordinate entity is exercising actual or *de facto* decision making authority and is subject to the Open Meeting law."[7] In this case, such decision making authority was exercised by the evaluators and subject to the OMA.

The evaluation committee meetings were not open to the public and notice of the meetings was not provided. The committee's recommendations should have been presented to and acted on by the OHCA Board rather than the OHCA CEO.

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[5] *Sanders v. Benton*, 1978 OK 53, 579 P.2d 815. The committee at issues in this case was formed to make a recommendation regarding locations for a treatment center.

[6] *Id.* at 820.

[7] 16 Okl. Op. Atty. Gen. 105 (1984). *See also, Int'l Ass'n of Firefighters, Local 2479 v. Thorpe*, 1981 OK 95, 632 P.2d 408, *Carl v. Bd of Regents of University of Okl.*, 1978 OK 49, 577 P.2d 1978.

## CONCLUSION

As this protest demonstrates, there is an important opportunity to identify, review, and remedy the potential flaws of the SoonerSelect RFP contract award process. Among these concerns is the fact that the OHCA Board was without legal authority to delegate its decision-making authority away; there were clear and documented instances in the evaluation process that deviated from the RFP criteria and instructions; in a manner that may have improperly and uniquely disadvantaged Aetna; and there were violations of Open Records and Open Meetings Acts.

Aetna respectfully requests that the OHCA take the appropriate corrective action by including Aetna in the contract award or voiding the contract award and issuing a re-bid. While this protest is being reviewed, to avoid further prejudice, Aetna reiterates its earlier request that the execution of and/or the implementation of the contracts be stayed until all avenues of appeals relative to this protest are exhausted.

We genuinely appreciate the opportunity to be heard and hope that this matter can be resolved in the best interest of the State and the persons most in need of the services provided under SoonerSelect.

Respectfully submitted,

**CHRISTENSEN LAW GROUP, PLLC,**

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Oklahoma City, OK 73116
(405) 232-2020

**COUNSEL FOR AETNA BETTER HEALTH, INC.**

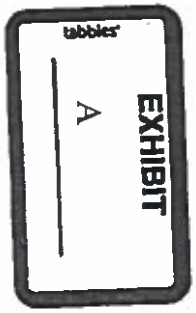
cc: procurement@okhca.org.
susan.eads@okhca.org
melody.anthony@okhca.org

Enclosures

SoonerSelect

# EVALUATOR TRAINING
# December 7th and 8th, 2020

Health Management Associates



## Evaluation Process

PMQI

**One method of individual note taking that has been successfully utilized is using the P/M/Q/I method. Using this method, evaluators mark their individual comments with one of the four letters. The letters represent:**

+ P (Positive): Indicates what the evaluator sees as a strength
+ M (Minus): Indicates what the evaluator sees as a weakness or gap
+ Q (Question): Indicates the evaluator is uncertain about the information presented
+ I (Interesting) or Innovative: Indicates the evaluator finds the information interesting (i.e., when the Bidder provides an innovative approach or solution that has data points to back its success

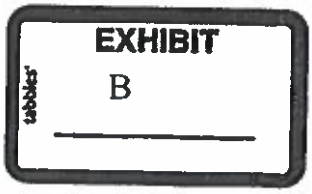
# The Oklahoma Health Care Authority

SoonerSelect

## *Proposal Evaluation Guide*

**Solicitation Number 8070001240**

**December 13, 2020**



(A) Failure to provide required information. If the solicitation specifies that suppliers submit information relating to responsibility and a bidder does not submit said information, or the State Purchasing Director determines the bidder is not responsible, the bid may be rejected.

(B) Proof of insurance. Whenever applicable to a solicitation, if a supplier is unable to provide proof of workers' compensation insurance or an alternative or exemption as authorized by state law, the supplier may be found not responsible.

(C) Past performance. If the State Purchasing Director has received complaints on a supplier, the supplier may be found not responsible.

(i) Samples. When a solicitation specifies a bidder submit samples, the State Purchasing Director shall examine the sample to determine the expected performance and service capabilities.

(1) The State Purchasing Director shall indicate the method of testing and rate the sample's performance in the evaluation document.

(2) When the State Purchasing Director issues a solicitation on behalf of a state agency, the State Purchasing Director, with input from the requisitioning agency, shall make the final determination whether a sample meets the solicitation specifications.

(j) Other factors in determination of award.

(1) Minor deficiencies. The State Purchasing Director may waive minor deficiencies or informalities in a bid if the State Purchasing Director determines the deficiencies or informalities do not prejudice the rights of other Bidders or are not a cause for bid rejection.

(2) Other types of deficiencies. If the State Purchasing Director determines there is sufficient time prior to the award of a contract and it is in the best interest of the State, the State Purchasing Director may authorize a bidder to cure the following types of deficiencies prior to the award of a contract:

(A) failure to have an authorized signature;

(B) failure to obtain a notary signature, stamp or seal;

(C) failure to sign or initial amendments to bid.

## 1.5 Review and Scoring of Written Submission Requirements

Evaluation teams comprised of state employee subject matter experts (SMEs) will review and score all bids other than those to be reviewed solely for compliance with minimum requirements or to be scored through application of an algorithm. Evaluation team activities will include the following:

- Training will be conducted with all evaluators prior to the start of the review process.
- Evaluators will be assigned specific submission requirements appropriate to their subject matter expertise.
- Proposals must be evaluated against the criteria of the RFP. Evaluators should not evaluate or compare proposals to each other except when evaluating for cost.

- Evaluators will review all items and areas to a submission requirement using an approach similar to the "PQMI" method and assign scores prior to convening as a consensus team. Scores will be assigned based on the possible points iterated in the scoring criteria. Using the PQMI method, evaluators will make observations of positive/strengths and minuses/weaknesses, questions, and innovative approaches of each scoring area based on the responsiveness to the bidder to each item within the scoring area (for discrete scoring areas) and to each scoring area (for global scoring areas). Evaluators will score areas based on total points possible.
  - P (Positive): Indicates what the evaluator sees as a strength.
  - M (Minus): Indicates what the evaluator sees as a weakness.
  - Q (Question): Indicates the evaluator is uncertain about the information presented.
  - I (Interesting): Indicates the evaluator finds the information interesting or innovative.
- Following individual scoring, the evaluation team will meet to discuss each response and reach a consensus score for each scored Area of the submission.
  - The evaluation team will arrive at a consensus as to assignment of points on each evaluation Area of each proposal during the evaluation team meetings. A facilitator will assist the team in developing consensus, but the facilitator will not exercise decision-making in the determination of the assignment of points to proposals.
- Consensus scores will be based on the total score available per evaluation area, as iterated it the RFP.
- A consultant working on behalf of OHCA will facilitate SME evaluation meetings but will not serve as an evaluator. The consultant will document consensus scores and, where applicable, the basis for the scores in the appropriate sections of the form.
- Evaluation team members and consultant will sign the completed form, attesting to the consensus score. The signed consensus form will be retained, while any draft work papers will be destroyed.

## 1.6 Review and Scoring of Oral Presentations

OHCA may invite some or all Bidders to participate in Oral Presentations. OHCA may "short-list" some Bidders as a result of their Technical Proposal scores and invite only those Bidders "short-listed" to participate in Oral Presentations.

Bidders may have little notice as to whether they will be invited or not invited to provide Oral Presentations (to occur January 18-22, 2021), so all Bidders should be prepared to provide Oral Presentations that follow the instructions for Oral Presentations that will be distributed after the Proposal submission deadline. If Bidders are invited to provide Oral Presentations,

| | |
|---|---|
| **From:** | Lee Repasch |
| **To:** | Trae Rahill |
| **Cc:** | Susan Geyer; Joe Moser |
| **Subject:** | [EXTERNAL] Here you go, the final docs, the please do not have a heart attack email |
| **Date:** | Tuesday, December 15, 2020 3:00:28 PM |
| **Attachments:** | SoonerSelect Evaluator Training - Final.pptx<br>Solicitation_ Scoring Tools_Final.docx<br>Solicitation_ Evaluation_Guide_SoonerCare_Final.docx<br>SoonerSelect Evaluator Assignment Spreadsheet_Final.xlsx |

Hey Trae, please add/subtract from this and cc me when you send out. Once we have a distribution method established we should let everyone know (documents are large so I'd recommend a SP site with them broken up and zipped as it may collapse Outlook otherwise).

Thank you,

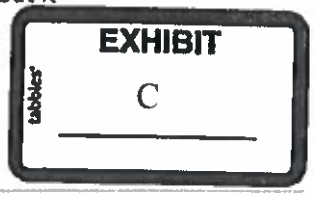
Lee

Good Afternoon, Evaluation Team,

Attached are the final documents to help you with your evaluation. Please disregard any past versions of these documents and use only the attached. This incudes:
Solicitation_Evaluation_Guide_SoonerCare_Final
Solicitiation_Scoring Tools_Final (there are some helpful individual scoring tools in this document; consensus scoring tools should be disregarded at this time)
SoonerSelect Evaluator Training_Final
SoonerSelect Evaluator Assignment Spreadsheet_Final

A few extra tips for the SoonerSelect Evaluation

- Do NOT be overwhelmed by the sheer size of the Bidder's responses. Much of this is supporting documentation you do NOT have to review. Documents can be over 5,000 pages – don't let that give you unnecessary anxiety. Remember, because there was no overall limit on pages, Bidders will include cover pages, break up Items with page breaks, etc.
- A lot of Bidders will break up space – they understand the importance of white space and of breaking up narrative to allow evaluators to get to the heart of the response.
- The page numbers on the Evaluator Assignment Spreadsheet pertain ONLY to the page limits per Items in each Area; remember, there are also associated and referenced forms, care plans, HEDIS and other data, etc. you must also review that are part of each Plan's submission package.
- It is recommended that you consider reading each Area across bids rather than reading all your assigned Areas before moving to the next Bid.
- I recommend reading the Executive Summary for each Bid first, even if you are not scoring it. This will introduce you to the Bidder.
- Take lots of notes to ensure our Consensus Scoring sessions are robust and that you are able to effectively support your score.
- Set aside time on your calendar each day to review; do not fall behind.
- Take breaks and evaluate bit by bit (Item by Item, Area by Area). This may take longer but it



can help you stay focused.

- Staring at computer screens for long stretches causes eye strain and pain. One rule I like is the 20/20 rule – Look away from the screen every 20 minutes or so and look at something 20 feet away for about 20 seconds. Don't forget to blink often.
- If you find yourself reading something over and over again, make sure it's not fatigue that's driving the rereads. It may very well be that the narrative is poorly written but before deciding that, make sure it is not your fatigue. Another trick I learned was to read aloud if things seem to not make sense, read it aloud once.
- Consult with members of your team who are evaluating the same Areas if you have questions. DO NOT consult with non Evaluation Team members or consult with evaluation team members on an Area they are not also evaluating.
- Remember to read through the training tips one last time before diving in. It is important that we not compromise the process.
- You all know yourselves better than I do, so the above is merely a recommendation. You may have a tried and true method that works for you.

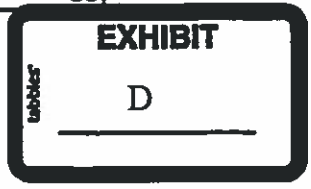
Finally, please feel free to call me at 571.214.6432 any reasonable time (which is a pretty broad time frame for this night owl/early bird combo) or email me at lrepasch@healthmanagement.com – I live in Denver, CO so I'm 1 hour behind you (the cell phone exchange is from my days in DC area...). I cannot comment on any Bidder or Bid or evaluate, but I can help clarify items and help in other ways, I hope.

HMA | Lee Repasch
Senior Consultant | Denver, CO
Direct: 720-638-6715 | Mobile: 571-214-6432
www.healthmanagement.com

SoonerSelect

| | Items | Possible Points | Max Pages | Eval 1 |
|---|---|---|---|---|
| Executive Summary | 6 | 25 | 6 | Maule |
| Staffing and Organization Structure | 17-21, 23 | 75 | 18 | Harland |
| References and Past Information | 9,10 | 50 | 0 | Harland |
| Corporate Information and Experience in Improving Outcomes | 7-8, 11-16, 22 | 100 | 23 | Harland |
| Implementation Plan | 24-29, 31 | 50 | 13 | Harland |
| Provider Network | 82-88 | 75 | 26 | Gregg |
| Covered Benefits | 27-29, 31-38 | 100 | 86 | Shipp |
| Rural Health Strategy (entire response) | Global | 75 | 0 | Maule |
| American Indian/Alaska Native Understanding and Strategy | 94-96 | 50 | 9 | Maule |
| Care Management and Population Health | 45-54, 58-59 | 150 | 60 | Beam |
| Medical Management | 39-44 | 100 | 25 | Beam |
| Quality Improvement | 62-70, 116 | 100 | 45 | Beam |
| Health Plan Enrollee Services | 71-81, 97-98 | 75 | 64 | Beam |
| Provider Services including: Claims Payment Processing, Call Center | 82-88 | 75 | 21 | Gregg |
| Program Integrity | 99 | 75 | 5 | Gregg |
| Information Technology | 100-109 | 100 | 48 | Gregg |
| Financial Standards and Third Party Liability | 110 | 75 | 3 | Harland |
| Reporting | 111 | 50 | 5 | Puebla |
| Behavioral Health Integration (entire response) | Global | 100 | 0 | Maule |
| Value-Based Payment Strategy (Item 92 specifically and globally) | 92 | 50 | 5 | Maule |
| Case Studies (Items 55, 56, 57, 60, 61) | 30, 55-57, 60-61, 73 | 75 | 53 | Beam |
| Contractor Performance/Compliance Strategy | 112-115 | 25 | 18 | Harland |
| Total | | 1650 | 533 | |

| | Sections Scoring | Pages | | E |
|---|---|---|---|---|
| Beam | | 247 | | 247 |
| Gregg | | 213 | | 100 |
| Harland | | 219 | | 75 |
| King | Specialty Children | 0 | | 0 |
| Maule | Global | 533 | | |
| Shipp | | 224 | | 86 |



| Eval 2 | Eval 3 |
|---|---|
| Puebla | Thomason |
| Herndon | Witcosky |
| Herndon | Witcosky |
| Herndon | Witcosky |
| Herndon | Witcosky |
| Harland | Herndon |
| Thomason | Witcosky |
| Puebla | Thomason |
| Puebla | Thomason |
| Gregg | Herndon |
| Harland | Herndon |
| Harland | Herndon |
| Shipp | Puebla |
| Shipp | Witcosky |
| Puebla | Herndon |
| Harland | Witcosky |
| Puebla | Witcosky |
| Herndon | Witcosky |
| Puebla | Thomason |
| Puebla | Thomason |
| Gregg | Shipp |
| Maule | Puebla |
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| F | G | |
|---|---|---|
| 0 | 247 | |
| 113 | 0 | |
| 144 | 0 | |
| 0 | 0 | |
| | | Additional scoring outside of global areas |
| 85 | 53 | |

| | | | | |
|---|---|---|---|---|
| Puebla | Global | 533 | | |
| Herndon | | 0 | | 0 |
| Shropshire | Specialty Children | 0 | | 0 |
| Thomason | Global | 533 | | |
| Witcosky | | 217 | | 0 |

*** Pages apply only to limits on specific items and do NOT include supporting documentation that**

Global Readers for SoonerSelect: Maule, Puebla, Thomason
Shropshire and King will NOT have evaluation responsibility for SoonerSelect

Global Readers for Specialty Children's: King, Shropshire
Maule, Puebla, Thomason will NOT have evaluation responsibility for SoonerSelect Specialty Childre

| | | |
|---|---|---|
| | | Additional scoring outside of global areas |
| 0 | 0 | |
| 0 | 0 | |
| | | Additional scoring outside of global areas |
| 0 | 217 | |

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**SoonerSelect Specialty Children's**

| | Items | Possible Points | Max Pages | Eval 1 |
|---|---|---|---|---|
| Technical Approach and Experience with specialty populations | 117 | 70 | 10 | King |
| Staffing | 118-122 | 30 | 21 | King |
| Covered Benefits | 123-125 | 40 | 9 | King |
| Medical Management | 126-127 | 30 | 12 | King |
| Care Management and Transitions of Care | 128-132 | 75 | 38 | King |
| Health Plan Enrollee Services | 133-134 | 35 | 5 | King |
| Provider Network | 135-138 | 30 | 15 | King |
| Case Studies | 139-141 | 30 | 20 | King |
| Quality Improvement | 142 | 20 | 3 | King |
| Inter-Agency Coordination and Data Sharing | 143-144 | 40 | 8 | King |
| **Total** | | **400** | **141** | |

| | Sections Scoring | Pages |
|---|---|---|
| Beam | 1 | 20 |
| Gregg | 1 | 24 |
| Harland | 2 | 11 |
| King | All | 141 |
| Maule | 0 | |
| Shipp | | 38 |
| Puebla | 0 | |
| Herndon | 0 | 0 |
| Shropshire | All | 141 |
| Thomason | 0 | |
| Witcosky | 0 | 36 |

Global Readers for Specialty Children's: King, Shropshire
Maule, Puebla, Thomason will NOT have evaluation responsibility for SoonerSelect Specialty C

Global Readers for SoonerSelect: Maule, Puebla, Thomason
Shropshire and King will NOT have evaluation responsibility for SoonerSelect

| Eval 2 | Eval 3 |
|---|---|
| Shropshire | Gregg |
| Shropshire | Witcosky |
| Shropshire | Gregg |
| Shropshire | Herndon |
| Shropshire | Shipp |
| Shropshire | Gregg |
| Shropshire | Witcosky |
| Shropshire | Beam |
| Shropshire | Harland |
| Shropshire | Harland |
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SoonerSelect Plan Notes

**Executive Summary**

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| Aetna | • Hit on all points, laid out intro to plan well, well rounded<br>• Positive – overall approach to OK, social programs would be beneficial, CVS connections |
| BCBS | • Good approach, strong experience working with other states that were similar to OK & presence in OK<br>• Positive – Medicare market experience with high needs population<br>• Accountability section well done but cost avoidance relatively low |
| CareSource | • Positive – people first approach (but lacked detail) and Ohio presence<br>• Negative - not a lot of how they would accomplish increased accountability |
| Humana | • Hit on all points, laid out intro to plan well, well rounded<br>• Hit on highlights that resonate with OK - Hope Centers work, emphasis on maternity care, school based services, MAT, decreasing ER and readmits, provider network<br>• Strong presence in counties brought out |
| Molina | • Good write up but accountability not well described (particularly between Telligen and Molina)<br>• Positive - recognition of state landscape, VBP |
| OK Complete | • VBP programs emphasis, experience in expansion states, jobs bringing to state<br>• Science of Hope stood out but didn't resonate as much |
| United | • Very well done intro, got good sense of plan and operations in OK<br>• Positive - work with ASO, OSU, MyCare, use of IPADs, work with rural areas, QA work |

**Rural Health Strategy**

- All plans - emphasis on tech solutions or in person services but looking for how plans bring services to people, especially in rural areas that lack WIFI, bandwidth

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| Aetna | • Very strong approach via hot pots, addresses bandwidth, working through pharmacy, community resource centers, multi-mode transportation<br>• Community touch & local care connection teams, Care in All Places initiative, emphasis on Primary Care medical home model<br>• CVS telemedicine networks + commitment to adding more |
| BCBS | • Overall, not as much detail as others on approach to rural state but positives<br>• Paramedicine innovative, work with rural health coalition & indep rural hospitals, pharmacists as provider – may require legal change but good, already contract with FQs, community based approach<br>• Work in NM (similar state) |
| CareSource | • Positive - 2-3 Satellite offices in rural areas with CHWs, bringing specialists to rural settings (mobile health, etc.), Focus on face-to-face with telemed backing<br>• SDOH examples, comprehensive PC model, experience with Appalachian population, residencies in rural areas via grants |
| Humana | • Good plan but heavily based on provider network in state & lacked how they get access to providers by rural population |

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| | • Positive - Bonus payments for hospital, Bundled payments for EOC, every touch SDOH screening with members (big impact in rural OK), ER diversion, EMT at home approach |
| Molina | • Proposed solutions are contrary to state law at present (OOS services)<br>• Positive - pharm as providers, physician grants, Hope Centers, employment education, mobile pop up clinics, approach to bring wireless to rural, housing assistance to homeless, MAT access (big issue in rural OK), financial commitment to expand health access, targeted marketing for areas of low literacy<br>• Question/Negative - OK law (OOS services and pharmacists' scope of practice) |
| OK Complete | • Services are heavily tech based and low impact strategies throughout (no high impact); mention ACO in Tulsa – Tulsa is not rural<br>• Some positive SDOH (5 trip a year for social needs) innovation |
| United | • Tech heavy but some mobile unit deployment<br>• Positive - Doctor chat, express access BH visits, expansion of provider network … (recognized lacked CHCs, FQHCs, community based providers in network), regional presence, SDOH navigator |

**AI/AN**

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|---|---|
| Aetna | • Strong write up<br>• Positive - regional based liaisons, IAN payer managers as part of teams, regional tribal health specialists, MBS training, emphasis on vets, representation in 4 quadrants, dedicated tribal staff<br>• Experience in other states but lacked some detail |
| BCBS | • Well done<br>• Positive - contract with 100% IHCPs, traditional medicine benefit, involvement in tribal organizations, relationships, partnerships, FTE tribal specialist; annual roundtable for tribal partners, Tribal education and training of employees, enrollment events in isolated areas; well laid out billing process & commitment to 100% tribal services at 100% FMAP<br>• Serve 29/38 tribal nations & special plan Native American plan (Native Blue) and own network + work in other states with large tribal presence |
| CareSource | • In the middle, not standout<br>• Positive - tribal health reps / nurse, tribal transport and create jobs, tribal rep in Quality program and nurse line, relaxation of PA requirements<br>• Trained in cultural competency/NA health (less targeted than BCBS)<br>• Will recruit AI/AN reps for call line<br>• Q/N: Telehealth push for tribal providers (have lower usage); AI/AN CM "if warranted" – what does this mean?<br>• Focused on two tribes though good experience as provider for two nations in OK<br>• Public health academy support to train community workers in tribal health |
| Humana | • Existing contracts with clinics and hospitals strong<br>• Emphasis on I/AN CMs with awareness of traditional med and cultural norms<br>• Grants to southern plains to train CHWs on tribal health<br>• Microgrants targeted to AI<br>• VAB for nontraditional medicine |

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| | • Willing to work with (OK) tribal consultation panel – didn't focus on all tribes<br>• Will evaluate IHCPs in terms of delegating functions (not robust)<br>• Heat map census of where tribal members were located but not sure how they'd link them to preferences<br>• Tribal member concierge & advisory board, enrollee advocate<br>• Lacked detail on billing and reimbursement<br>• Detail on how members would be assigned to CM<br>• Quarterly reports to CEO |
| Molina | • 94-1: tribal outreach strategy is strong<br>• P: Diabetes program, practice facilitators, food programs for tribal members, elder outreach, attention to culturally appropriate approach, Tribal HC Advisory Board – innovative, letter of intent from OK city clinic to work with AI/AN<br>• CM focus on Tribal Pops<br>• Very detailed strategy – only bid with chart on tribal initiatives and how they were operationalized and how they worked in OH<br>• Not a lot of detail on what they will do with reimbursement/payments |
| OK Complete | • Low impact strategies<br>• Value traditional healing<br>• Tribal warm line and peer support – innovative<br>• Strong attention to complexity of reimbursement<br>• Work with tribes in AZ<br>• Strategic PDSA approach in developing strategies with tribes (evolve policy)<br>• "listening" to Tribal leaders – significant |
| United | • Lack explanation/broad assertions<br>• 2 FTEs under liaison<br>• Nurse tribal coordinator<br>• Training / provider toolkit tribal specific<br>• Almost 40,000 AI/AN enrollees nationally<br>• Regional/localized provider support<br>• Lacked some detail on tribal strategy<br>• Only MCO with IHS today<br>• Strong attention to complexity of reimbursement<br>• Strong infrastructure to support AI/AN<br>• Called out waiver of credentialing for tribal partners<br>• Experience in states with tribal populations (AZ, WA) |

**Staffing and Org Structure**

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|---|---|
| Aetna | • Experienced leadership with understanding of OK<br>• Community based resource centers, All places model with rural touch (CHWs); alignment with CVS<br>• CM team – 35 or 55? (org chart and narrative don't match)<br>• Strong QM team<br>• Staffing & resources sufficient but chart doesn't match the narrative in terms of positions<br>• Current partnerships with FQs |

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| | • Community provider participants on the Board |
| BCBS | • National presence/experience<br>• Experienced staff; experience in OK<br>• Less detail; more generic feel and lack of commitment<br>• No proposed locations noted (vague/generic feel)<br>• Mobile access teams lacked detail<br>• Lack of consistent compliance statements causes unease about compliance<br>• Overall lack of detail and generic feel |
| CareSource | • Staffing was light; subcontractor heavy<br>• Key leadership not OK oriented<br>• Small board; no members are located in OK<br>• Sense that OK presence wasn't priority in leadership |
| Humana | • CEO experience in OK, strong OK presence & staffing model<br>• Mature, established plan with focus on local care<br>• Lack of detail on marketing staff training and marketing to population<br>• Emphasis on SDOH, innovative partnerships in SDOH<br>• Wellness navigators stood out<br>• Use of specific ratios for nurse CMs for different tiers<br>• Proactive hiring of staff/readiness<br>• Board composition was difficult to follow |
| Molina | • Relatively lighter proposed staff<br>• Resource navigators and concierge team, focus on SDOH strong<br>• Focus on Telligen and not Molina; focus on Telligen to exclusion of talking about Molina and how this would work<br>• Lack of innovation / stand out in offering |
| OK Complete | • Concern about hiring timeline of key staff<br>• Strong staff, experienced, resonated with OK<br>• Rural coverage, staffing strong<br>• Experience – 16 new Medicaid health plans implemented<br>• Co-location of clinical BH/Rx in high volume practices and FQs<br>• Strong CM presence<br>• Not sure sufficient staff – question |
| United | • Good approach though not clear on transitions (all key staff except CEO are interim)<br>• Care Continuum Subcommittee on Board<br>• Strong, experienced leadership proposed & staff (though not consistent with chart)<br>• POD model – innovative<br>• SDOH navigators, peer support specialists (focus on training)<br>• Strong job descriptions<br>• Recovery and Resilience Manager was unique<br>• Overall positives offset any negatives |

**References and Past Information**

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|---|---|
| Aetna | • 3 References included mid-range reviews – good KY, VA references; WV reference slightly less generous though cited as terrific partner and leading partner (reference very thoughtful)<br>• No concerning litigation |
| BCBS | • No concerning litigation but relatively more cost though good transparency on litigation<br>• 5 references, all good (not 10) – but overall fair but not glowing<br>• OK Public Employees reference with low scores in communication and ability to maintain schedule of concern |
| CareSource | • Strong references, including from OK based entities & prior Medicaid program in similar states<br>• Relatively low lawsuits; transparency on lawsuits |
| Humana | • No concerning litigation though lacked some detail on litigation (but due to confidential nature of settlement) lacking transparency on litigation<br>• 5 References are relevant and Medicaid-centric with similar sized programs though 7 on maintaining a schedule<br>• Demonstrated a robust representation for references |
| Molina | • Q - No concerning litigation but much litigation, particularly for breach of contract which was confusing (not on Molina OK, but parent company); though some concerning litigation (payment of non-payments from hospitals)<br>• 3 references with no comments from UT or IL – not standout |
| OK Complete | • No concerning litigation / transparent about litigation<br>• Strong/relevant references, cited as "innovative" |
| United | • No concerning litigation<br>• Good / relevant reference |

**Program Integrity**

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|---|---|
| Aetna | • Lack detail of "how" (indicates compliance/exceeding compliance without detail)<br>• Lack detail on suspension of incorrect payment processes (generic reference to system)<br>• Locally based PI<br>• Competent in what they are doing but weaker approach<br>• Strong IT system to support detection of outliers/ opioid misuse |
| BCBS | • Comprehensive, included sufficient detail on how<br>• FWA Hotline is not staffed by own staff<br>• Clear business processes for how they would accomplish things<br>• Supplement FWA program with SoonerSelect – specific plan<br>• Staffing clear; strong compliance department/SIU<br>• Artificial Intelligence / analytics for F/A good |
| CareSource | • Good processes<br>• Good leadership/focus<br>• Lack some detail on staffing<br>• Data analytic tool – detail on/spike reports stood out & peer comparison provider letters<br>• Detailed data analytics |

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| Humana | • Strong approach though lacks detail on staffing for OK though overall large investment in FWA (FTE and funds) (but not sure how this translates to OK)<br>• strong focus on analytics / use of software analytics/data mining<br>• telemedicine fraud detection stood out |
| Molina | • Thorough approach but nothing stood out; lacking in some OK detail & innovation<br>• Proactive / preventive approach<br>• Not a lot about data analytics / weak data analytics |
| OK Complete | • Very thorough and responsive, detailed<br>• Proactive / preventive approach, good detail / presentation<br>• State of the art systems to detect overutilization<br>• Strong data analytics tools<br>• Training employees on OK – specific PI |
| United | • Strong staffing in OK with solid training<br>• Multiple strong analytic tools<br>• CDS program for high prescribers stood out<br>• Oversight of OON providers stood out<br>• Strong procedures in place/ good statistics & savings generated<br>• Collaboration with OHCA to review data and work with OHCA<br>• Q - No discussion of hotline or whistleblower protections |

**Reporting**

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| Aetna | • Strong experience in other states, commitment to exceed requirements<br>• Not just about reporting, about improving outcomes<br>• Good dashboards & reporting software<br>• Focus on pop health and predictive analytics and risk stratification<br>• Report tracking system<br>• "Can" generate ad hoc reports and alter reporting |
| BCBS | • Lack compliance statement<br>• Didn't give as much detail on ability to change reports<br>• Good – analyze reports for trends and build into business processes<br>• Didn't talk about QI in detail<br>• Ability / number of reports they can generate<br>• Use of provider scorecards to monitor timeliness and accuracy |
| CareSource | • Lacked detail on staffing/org structure for reporting<br>• Good response – but lacked sufficient detail/ pop<br>• Wasn't as well written as the others<br>• lack sufficient detail on system generated vs. manual reporting |
| Humana | • Good detail, analytics, software<br>• Change order process was discussed but not thorough/detailed |
| Molina | • Mature system<br>• Use of dashboards<br>• Past year – addition of new reports substantial – showed flexibility but do not link volume to use<br>• Nimble generation of reports demonstrated |

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| | • Lacking detail how they used reporting to inform changing processes/improving quality |
| OK Complete | • Well-articulated approach<br>• Centelligence platform, Use of KPIs on dashboards, Good information on org structure to oversee this, Report builder for ad hoc reports<br>• Existing library of Medicaid managed care reports is robust<br>• Good detail on report categories<br>• Great approach, detail on capabilities, process for running reports, process for reviewing reports before sending |
| United | • Colorful language but not directly stating what they do<br>• "reporting system is qualified to do these reports"<br>• Report tracking<br>• Good system, strategy<br>• Not as much on dashboards, tools for leadership, etc.<br>• Report tracking system did not seem as sophisticated |

**Corporate Information and Experience in Improving Outcomes**

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|---|---|
| Aetna | • Good understanding of OK<br>• Commitment to community, whole person care & staff<br>• Not as innovative as other plans<br>• Hesitation about retrospective cap payments re cash flow<br>• Work with ACOs, partnership with Tribes, maternal health program for women with SUD (positive) and Rx CM program (positive) |
| BCBS | • OK presence strong, well established, large national presence<br>• Strong subs<br>• Decent Medicaid experience<br>• Predefined payment schedules to delay cap payments<br>• Didn't stand out |
| CareSource | • Leveraging HCA but otherwise not a lot of presence in OK<br>• Good programs in other states<br>• Lacked innovation<br>• Adjust quality withhold cash flow approach weaker than other approaches |
| Humana | • Sound, strong approach<br>• Innovative examples, programs, initiatives<br>• Demonstrated results that show how they are targeted to OK population<br>• Work with state for deferment of cap funding to help with cash flow was sound/they had experience with other states<br>• Good community orientation<br>• Established in states; good Medicaid experience<br>• Economic impact articulated well |
| Molina | • Lacked OK experience (with exception of collaboration with Telligen)<br>• Lacked innovation / taking ownership of the OK plan<br>• Cap rate percent reduction method not as strong/may be difficult to implement<br>• Limited OK partners & Economic impact |

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| | • Homeless to home housing assistance was good |
| OK Complete | • Connections to community via partnerships good but no direct experience (though much national experience)<br>• Financially strong, some innovative approaches (housing for homeless, suicide prevention)<br>• Solid P&Ps<br>• Cash flow solution may be difficult to implement<br>• Staffing solution, promotion, use of OK personnel good |
| United | • Kansas experience stands out, public and private sector experience, – good work, improved HEDIS<br>• NCQA certification in multi-cultural health care call out<br>• Innovative - Tx – Small Town Big Health initiative innovative<br>• Work with community, community reinvestment strong, charitable giving, innovative, National Medicaid presence, great financials<br>• Defer first month's cap payments (not as detailed)<br>• Cap reconciliation overpayment program strong<br>• Investment in OK substantial<br>• Cash flow solution strong/ easier to implement |

**Implementation Plan**

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|---|---|
| Aetna | • Good experience implementing<br>• Supporting workplan strong<br>• PM strong / PMBOK<br>• Implementation Steering committee, deployment command center – more innovative<br>• Care Connection team approach<br>• Risk weaker/more focused on state (not possible Aetna Risks) |
| BCBS | • Strong PM, timeline, roles and responsibilities clearly articulated<br>• Strong approach<br>• Addressing vendors for EVV, HIE stood out and wove into readiness review<br>• Well-articulated & clear plan to move forward<br>• Leadership team/internal business owners' participation in develop P&Ps<br>• Project team approach |
| CareSource | • Working with a lot of subcontracts; difficult implementation plan – how to manage this plan<br>• IT handoff sound<br>• Standard PM approach<br>• Less detailed discussion of readiness review |
| Humana | • Lacked discussion on submitting policies to OHCA for approval prior to implementation<br>• Standard approach, nothing stood out<br>• Sound PM approach & good experience<br>• Good implementation track record<br>• Gap between choosing to plan and enrollment |

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| | • Section on recruiting and training providers lacks detail, particularly on how they'd build out a network quickly lacked substance<br>• Weak discussion of readiness review |
| Molina | • Mock readiness review innovative<br>• Implementation plan good; easy to follow and interpret<br>• Recognition of provider abrasion as factor in implementation<br>• Provider recruitment plan lacked detail<br>• SQUADS approach sound<br>• PMP approach/use of industry standard |
| OK Complete | • Well written, solid approach<br>• Use of lessons learned to improve implementation<br>• P&Ps – functional area approach to develop P&Ps<br>• Strong pre-planning in market / understanding of OK<br>• Key local staff commitment to overseeing transition<br>• Good experience/ clear go forward plan with stakeholder engagement in process<br>• Examples provided stood out |
| United | • Implementation plan strong but some concerns with timeline<br>• Attention to engaging multiple stakeholders in the process<br>• Experience in OK; strong presence<br>• Depth of Medicaid experience |

**Covered Benefits**

- All can do what they are being asked to do

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| Aetna | • Middle of the road, not as robust section as others<br>• Good variety on VAB but less generous relatively<br>• SDOH – multiple examples and results, but lacking language on application to OK<br>• ILS – not as clear and low impact, no demonstrated cost savings<br>• EPSDT screening – showed improvement in results over years; school based services program – not clear on implications for larger population (not well articulated)<br>• Advance use of ACT but not acknowledgement of OK MAT network but other coordination with OK resources sound<br>• Not a lot of understanding of the current landscape in OK indicated in response (lacked detail) (particularly OK's robust telehealth situation)<br>• Reimburse for z codes is positive |
| BCBS | • Middle of the road response (akin to Aetna)<br>• NEMT – lacked discussion of seamless delivery<br>• SDOH innovation – small pilot, not sure of reach, lacked other examples<br>• ILS – good services but limited reach? Adult BH OP treatment great and provide cost savings data<br>• Offered a robust VAB, though not all were VAB (more standard, like nurse line)<br>• EPSDT screening innovative example was small sample size so not sure of impact on OK<br>• Coordination on quality measures, promotion of co-location of services, mobile response team partnership |

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| | • VAB – gift cards for healthy activities are good; like OTC meds & supplies reimbursement; weren't able to calculate costs on these items<br>• Covered benefits report – good stats on EPSDT services but small program |
| CareSource | • Light on detail to ensure seamless delivery of NEMT or handoff<br>• Like approach to SDOH but not sure if the program is in effect in other places or any data on its effectiveness<br>• ILS – low impact (not a lot of lives touched)<br>• VAB – good range of benefits, vision, Rx, and dental home - agree to bring all VABs to OK<br>• EPSDT screening rate example lacked data (sample size, low uptake)<br>• How do they ensure compliance with school based services – lacked detail<br>• IN example of special ed didn't connect with OK<br>• No proactive statements /sense of what they would do in OK; more focused on what they do in other states<br>• Good BH benefits |
| Humana | • Offer to waive all copayments stands out<br>• Working on expanding BH network<br>• VABs didn't resonate as much with OK<br>• SDOH – Unitas platform; trained all enrollee facing staff on Unitas INNOVATIVE – language unclear in commitment to offering<br>• VAB – strong incentives that resonate in OK; collaboration with other partners to provide VAB package<br>• EPSDT is sound; school based plan of care approach may be askew of OK regs<br>• Collaboration with OHCA / proactive approach to developing uniform processes across MCOs<br>• Practice innovation to help providers improve practice of med |
| Molina | • Good approach; benefits resonate; added transport benefit for non-medical<br>• SDOH –good examples working with urban league of OK city, other things to reduce ER in IP service utilization<br>• Robust VAB, like focus on traditional medicine<br>• EPSDT screening rates – rewards/incentives seen as beneficial<br>• Molina Insights with 4 quadrant model, using integrated data in real time<br>• Co-locations of services model in OH but not sure if would apply or how to OK<br>• Incentives for providers to submit SDOH codes<br>• Rx attention to not driving rural pharmacists out of business, Caremark discount card<br>• Very Strong VAB package<br>• Z code payments for performance as part of larger value strategy stood out |
| OK Complete | • Very strong / sound approach<br>• Innovative approach to SDOH and homeless housing and noted how it would apply to OK and provided data<br>• ILS & VAB – services align with OK need<br>• Data on cost savings, reduced IP, ED visit<br>• Robust online BH services<br>• EPSDT screening – example had good results but limited sample (1 practice) but increases in EPSDT promising for OK |

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| | • Understanding of current OK system/working with what exists resonated; strong approach |
| United | • No negatives, good approach<br>• SDOH – homeless housing program with demonstrated results<br>• ILS, VAB –good range of benefits offered wide range of benefits, innovative BH benefits approach to help provider succeed<br>• EPSDT dashboard example, EMR<br>• focus on smooth, easy referral process to BH<br>• Understanding of OK; had reviewed data & good understanding of OK's current crisis system and other policies and procedures, virtual visit program innovative<br>• Housing first model stood out, also Peer specialist model<br>• On My Way interactive app for young adults |

**Financial Standards and TPL**

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|---|---|
| Aetna | • Lacked detail, timeline<br>• Pay and chase back approach (rather than deny upfront) |
| BCBS | • Solid response, Hit on all points of program |
| CareSource | • Sufficient response, not clearly written, gaps in section |
| Humana | • Responsive but gaps, lacked some detail<br>• Use of data analytics to determine if member has TPL – interesting/innovative |
| Molina | • Weak, many gaps, lacked detail and clarity (not well laid out)<br>• Concerns with compliance with TPL |
| OK Complete | • Good approach with robust experience; well written, good detail, & aligned with model contract<br>• Speak to CRM use in collecting TPL information & provider training on TPL stood out |
| United | • Good approach, some questions and want of detail (services excluded from TPL; subs or cost sharing exclusion) |

**IT**

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| Aetna | • Lack of detail, but sufficient system<br>• Cybersecurity framework/alignment with best practices not iterated, not explicit; lite on the how they do this/processes, not proactive as others<br>• Process to correct a medical record discrepancy was questioned<br>• Providers not connecting with HIE approach limited and not very supportive or realistic |
| BCBS | • Sufficient system, average performance/ approach<br>• Provider portal – none but will partner with OHCA? Q<br>• Data lake – innovative; liked duplicate ID approach, good section on enrollee ability to change record<br>• Roadmap – poor readability<br>• Data storage, documentation on data solid |

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| | • Nod to processing paper claims (though not a big issue in OK)<br>• Inconsistent statement of compliance with model contract throughout proposal<br>• Not sure how they developed cybersecurity/how they aligned it<br>• Experienced in info sharing, health information exchange,<br>• Return mail processes stood out (awareness of and solution is sound)<br>• Didn't speak to MAC experience |
| CareSource | • Didn't speak to MAC experience, general experience not as in depth as other plans<br>• Duplicate ID approach was not clear<br>• Response didn't give confidence; lacked committal language –<br>• HIE confusing – use of "may" too and don't demonstrate how they're a leader<br>• Use of data masking when sending information<br>• Didn't talk about cybersecurity aligns with framework<br>• Didn't address possible CAPs (most plans didn't)<br>• BC DR less detailed in actions |
| Humana | • Good system, excellent write up that aligned with OK approach<br>• Well written, hits on all areas of RFP with sufficient detail<br>• Work with Gainwell experience<br>• Strong HIE language<br>• Practice transformation incentives to assist provider in getting up and running on HIE |
| Molina | • Lacked detail; some gaps<br>• Partnership with Telligen<br>• 103 - Statistics from at least two other states that demonstrate your ability to submit timely, accurate and complete Encounter Data – only included one state (OH)<br>• Didn't speak to MAC<br>• Zero trust policy/approach – stood out<br>• Fast processing of 834s |
| OK Complete | • Good system, subsystems/standard, trustworthy<br>• Positives/innovative include mobile websites / apps strong<br>• IT roadmap well laid out<br>• Privacy and security good<br>• Experience with other state agencies<br>• went over page limits in 1 section due to chart insertion but still remained a good response<br>• HIE section good discussion of AHC grant (understanding of current OK landscape)<br>• somewhat choppy writing but overall good |
| United | • Better response than most good detail on most<br>• Experience with EVV vendor<br>• Ability to run on generator for 3+ days<br>• Cybersecurity – didn't address comprehensively<br>• 107 - Lite on detail for cybersecurity but rest is very strong<br>• Everything else except cybersecurity was comprehensive<br>• Well written, easy to follow |

**BH Integration**

- All bids were good

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| Aetna | • Positive - use CDS telehealth spots as BH hotspots<br>• Specific modalities of education (TIC, ACE) lead out with detail, and use throughout organization, Community Care Team with BH focus (interdisciplinary team)<br>• BH integration woven throughout RFP, impact on SDOH<br>• Colocation of BH personnel within primary care approach (VBP strategy)<br>• Decrease PA process for high performing BH providers<br>• Approach to use of MI on hotline<br>• Unitas to address SDOH<br>• BH hotline staffed by live voice<br>• Less informative case study approach<br>• Good highlights – admin simplification, VABs supported BH but less robust than other plans<br>• Woven thru the proposal underpins a solid understanding of BH integration |
| BCBS | • Solid, good approach/proposal – not as stand out as others<br>• Community touch/response<br>• Use of community response teams, work with MH Assoc of OK; provider identification of SDOH as relates to MH (like approach)<br>• Suicide prevention for all employees<br>• BH services after hours specialist – key service<br>• BH Advisory Board, hotline<br>• BH screenings at PCMH + financial support for PCMH to admin SBIRT<br>• ACE training in primary care (not as robust as other plans)<br>• Co-location - different approach (not embedded)<br>• Integration with BH good (not as good as other plans)<br>• Experience with CPC+ (embedding CMs); demonstrated good results (included data) & shared savings and support from medical homes providers<br>• Community social care team program<br>• Strong job on school based services |
| CareSource | • Stand out for CS<br>• Administered expansion of BH carve in in OH<br>• Focus on incarcerated populations and work with reentry - positive<br>• 99% BH claims paid in 15 days<br>• Continuum of care model, strong emphasis on MAT<br>• Colocation with state CCHBCs<br>• Care coord. Between ED and BH providers – strong – stood out<br>• RX MTM for Rx with BH focus stood out<br>• Self-managed BH apps<br>• Partnership with NAMI, regional BH plan, listening sessions in community learning collab with community providers<br>• Job training was also positive<br>• Often nodes to lack of experience with FC population which didn't fit in this bid |
| Humana | • In the middle; Solid, compliant but not standout<br>• Good experience, emphasis on preventive screens in PC |

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| | • BH rapid access stood out<br>• BH contracting with border states to shore up access – some legal concerns with that; this should be a question at oral<br>• Relationship with the BH Assn / in partnership with them<br>• CMs, CHWs, care guides – good staffing approach<br>• Integrated model – strong network on BH spectrum<br>• Microgrants for BH strong<br>• Tele-BH program good<br>• Colocation strategy good<br>• Expand access to SUD for pregnant women<br>• Remote patient monitoring system, digital tools for people with SUD<br>• Innovative practices via technology tools to track patient monitoring, etc.<br>• BH strategy throughout – middle of road<br>• Waive of copays |
| Molina | • Meets requirements, compliant, solid approach<br>• VAB and school based sections particularly good and thorough<br>• Colocation but not talk of embedding<br>• VBP for opioid providers strong<br>• SUD navigators stood out<br>• 24/7 virtual services via app for immediate telehealth<br>• Called out that members can self-refer for BH services<br>• No caps on OP BH visits and no PAs called out – stood out |
| OK Complete | • Meet all requirements, some innovative approaches<br>• Positive – approach to drug court system, built on FQ network, Science of Hope emphasis, health equity approach<br>• Good apps for providers and members to support BH<br>• Emphasis on SDOH supports<br>• Approach – talk to integrated comprehensive assistant – don't treat BH as something separate<br>• Understand state, align their approach with state approach<br>• Emphasis on health equity<br>• ILS strong, including support for those with eating disorders, Rx pain management support<br>• Particularly strong section on privacy protections dealing with misuse – good job<br>• Use of youth village model<br>• BH PIPs |
| United | • Didn't stand out like other plans<br>• Positive - honor PAs during transition, MAT preferred intervention, PRTF diversion<br>• Didn't seem to have a comprehensive approach of other plans<br>• Stress person/integrated care, single access points stood out; recognize importance of being accessible<br>• Provider feedback via scorecards quarterly resonated<br>• Recognized tribal providers furnish BH and may be most appropriate setting for tribal members who opt in<br>• Emphasis on housing + health (PH, BH) and stress on housing first model |

**Value Based Payment Strategy**

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| Aetna | • Performance based work – 2 measures not a population they're serving<br>• Performance based implementation strategy doesn't align / doesn't follow for reviewers<br>• Good write up of quality measures relationship to TCOC reductions<br>• Good response but error<br>• Quarterly meetings to go over results with providers |
| BCBS | • Well written, aligned with model contract<br>• Demonstrated track record with implementing VBP programs<br>• Good incorporation of feedback into program<br>• CPC+ work stood out - solid example but not innovative |
| CareSource | • Demonstrated implementation of VBP in OH<br>• Good detail<br>• Emphasis on quarterly meetings with providers and interactive tools<br>• Incentive for pharmacies stood out<br>• Assessment of providers at beginning – well done – resonates with OK<br>• Non-monetary incentives, removing auth requirements for certain procedures – innovative, resonates with OK<br>• Incentives for SDOH screenings thru use of z codes stood out<br>• Reward for treating patients outside usual hours for BH stood out<br>• Inclusion of SDOH<br>• Called out OB/GYN as practice type to focus on – resonates with OK<br>• Innovative example was in OH – children's ACO – not hard data on ACO improving EPSDT – no results yet |
| Humana | • In line with other plans<br>• Focus on BH and obstetrics, SDOH<br>• OK experience in VBP thru MA plan resonated<br>• Plan for PCMH path to value notable<br>• Recognize continuum and meeting providers where they are – resonates<br>• BH providers – BH Rapid Access /payment for MAT stood out<br>• Understanding of OK environment – build on things OK knows<br>• Called out work with OB/Gyns<br>• SDOH screening; colocation of BH (FL example) highlighted<br>• community based approach |
| Molina | • Meet requirements but weakest approach & lacked detail, more high level<br>• Hospital bonus – resonated good program overall<br>• Good experience in other states<br>• Involved FQs<br>• 3M transformation suite technology – data focus to get there with VBP resonates<br>• Emphasis on transparency with providers –<br>• Movement towards bundled EOC – innovation for OK<br>• Emphasis on Medicaid and experience implementing<br>• Meet providers where they are / offer full range |
| OK Complete | • Depth of Experience with Medicaid |

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| | • uses OK's payment structure/bonuses and build on that – understanding of state landscape would resonate with providers<br>• Example from TX was positive<br>• Providers moving towards greater risk; good tools to support providers, including staff support to help providers make transition from volume to value<br>• Graphics were helpful and wow;<br>• Good results cited<br>• Interesting/innovative -aggregating smaller providers<br>• Interactive dash and customized reports (IT solution) – treat providers as individuals,<br>• Stratify quality measures by different demographic is good strategy<br>• Very specific examples with quantitative results<br>• PIP program stood out<br>• Good examples of how they use in other places and will use in OK<br>• Focus on health outcomes for members in VBP stood out<br>• Both providers and members focus |
| United | • Good approach<br>• Positive - payment structure – incentives for closing gaps in care resonate with OK need, ACO framework<br>• ACO framework good, like EOC programs & shared savings for high cost conditions<br>• Enhanced payment for CM process and Opioid misuse/SUD<br>• Visually not as appealing (no charts, text heavy) – harder to visualize<br>• less robust continuum compared to other plans but may be more realistic<br>• Lesser percent or providers in VBP<br>• Liked approach to data sharing and reporting and tailoring to specific providers<br>• Impressed with example in Houston<br>• Lighter on tools but good approach to collaboration, data sharing, quality focused; good approach |

**Health Plan Enrollee Services**

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| Aetna | • Standard approach<br>• Training isn't as detailed<br>• Key component of marketing assuring OK knows how adoption healthy lifestyles in increasing;<br>• digital campaign for COVID 19 called out (quick adaption)<br>• main marketing strategy is being in the community stood out<br>• GnA – trend of balance billing in FL used to improve practice by educating providers<br>• |
| BCBS | • In line with other plans<br>• Some highlights but gaps<br>• Positive - 60% of health education events in rural areas, |
| CareSource | • Meet basic RFP standards -<br>• Use of community partners to expand outreach to non-English community<br>• Strong training on cult comp, part on how poverty impacts health<br>• Lacked in detail |

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| | • Use of apps, monitor and analyze social media interactions with Sprout and use to tailor messages<br>• Community marketing representatives, focus on FQs, community / local events; partner with HCA to work on strategy; outlined examples of marketing materials; focused approach (more so than others) – drilled down into material – good description |
| Humana | • Impressive system that recognizes language and language barriers and puts them in correct language; wide array of languages available and 5th grade; diverse staffing<br>• Concierge for language accessibility<br>• Several national awards for inclusivity<br>• Tailor social media approach<br>• Technology focus, strong use of website/social media staff<br>• Good write up<br>• algorithm well described and teased out for PCMH |
| Molina | • 6th grade reading level<br>• Annual population needs assessment against staff<br>• Telemed has translators<br>• National award for multi- cultural organization<br>• OH, program for members with disabilities realized 92% reduction in grievances<br>• Training on call centers – soft skills was great<br>• Nothing stood out on marketing for Molina<br>• Healthy frontiers marketing strategy for rural areas<br>• Enrollee first approach |
| OK Complete | • Store communication preferences with every enrollee outreach<br>• No description of cultural competency plan<br>• Lack robust cultural competency staff training (or description of it)<br>• Stand out – disability access grants- good examples<br>• Otherwise meet all requirements<br>• Hard to contact section – lacked detail (very general)<br>• Database is regularly updated for SDOH Aunt Bertha<br>• Incentives for picking a PCMH and for going to first visit stood out |
| United | • Good section, in line with others<br>• Recruitment pipeline with local disabled stood out<br>• Conduct self-assessment for cultural and ling competency prior to start of services each year<br>• Recognized as best employer for diversity, and place to work for disability inclusion<br>• Partners in Premier Maricopa AZ Crisis Now (model for rest of country) (resonates with OK) good to have that experience<br>• Secure website – lot information on website, forms, lab results, conditions, each member had own dashboard<br>• Strong call center training<br>• Good section on incorporating GnA in QI |

**Provider Network**

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| Aetna | • Hard to delineate the timeline of their approach – not clear (telehealth); general approach difficult to follow<br>• Sufficient providers / coverage – existing shortages (using border states to fill gaps given OK's restriction on the use of OOS providers)<br>• Positives - co-locating providers, Hotspots in each quadrant of state; add additional hotspots in CVS stores<br>• Provider appointments and accessibility section well written<br>• Innovation – working to increase pediatric BH services in rural areas, telehealth initiative, assist providers who are less telehealth savvy<br>• CVS mini clinics & state health hubs for telehealth<br>• Talked about challenges and driving partnership to expand broad band access and distribution of laptops<br>• PCMH – focus on advancing BH integration via co-location<br>• AZ Practice innovation institute |
| BCBS | • Excellent approach<br>• Already have a substantial network and enrollees, presence<br>• 2953 PCMH providers already enrolled<br>• Proactive approach to building network; already meeting with providers<br>• Monitoring and compliance tools sound<br>• Overall philosophy and approach to telehealth was good - proactive in state<br>• PCMH – not as strong as others but did discuss My Health & talked about CPC experience<br>• Strong monitoring, robust data analytics<br>• Sample provider agreement attachment – great crosswalk with model contract and their agreement<br>• Also do secret shopper work for appointment availability called out – Positive<br>• Good partnerships in rural areas<br>• Strict requirements re privacy and security<br>• Credentialing – great workflow<br>• Their approach to providers stood out -non-punitive, focus on working with the provider to get onboard |
| CareSource | • Offering provider contracts to any and all providers (good and bad)<br>• Not as robust a network to start with; ask the FQs to step up (good and bad)<br>• Good process to monitor provider panels for access<br>• Telehealth – they did homework, know what OK is at but didn't address broadband issue in rural areas<br>• 30 days to process (faster) provider enrollment<br>• CMH – VBP for PCMH and PCMH transformation learning program; want PCMH practices to be NCQA recognized but over 2000 PCMH practices in OK and expectation is high; will also help offset fees to get to NCQA<br>• Project to use telehealth for non-emergent services so hospital can focus on what hospitals do in rural areas (to keep hospitals from being overwhelmed) |
| Humana | • Focus on existing network in several LOBs, expanding Rx role<br>• SDOH, looking at local community barriers<br>• Partnering with health access networks to help with PCMH development/CM role; leveraging the existing OK health access networks to grow provider network |

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| | • Secret shopper program to monitor appointment availability and timeliness<br>• Telehealth platform is sound – variety of specific population targeted offerings<br>• Practice transformation – ADT reports 7 day f/u rates had greatly improved<br>• Employing a lot of staff to recruit providers in OK<br>• understand their gaps and the state's concerns<br>• encourage PCMH for BH<br>• work with Project ECHO<br>• lots of activity in state |
| Molina | • lack OK presence; lackluster approach - will be heavy lift to build network<br>• Telligen centric, rural strategy is light<br>• Positive - $150 – to resolve gaps in care; understand providers have difficulty moving to MCO and understand rural shortage; work with Project ECHO<br>• PCMH innovation – FQs with RNs as PCPs – something OK has been doing for 20 years<br>• Monitoring is traditional<br>• More limited than others |
| OK Complete | • Nationwide success, great experience, rely on FQ and Primary Care network<br>• Strong monitoring<br>• Telehealth – technology aspect sound (distribution of iPad, work with My Health) but whole solution was limited (the way it was written up)<br>• PCMH – fairly proactive, well thought out<br>• No provider is deemed into their network – like approach<br>• Building networks and partnerships over 2 years with strong network in works<br>• Provider story – good layout<br>• Helped finance brick and mortar provider sites in rural areas, support for providers and communities<br>• Only plan to say that providers had to enroll with OHCA first – recognition of this<br>• Investing $ in express/urgent care and adding urgent care centers at PCMH site – didn't resonate as much with reviewers as rural health solution |
| United | • Great approach, well laid out, strong Area<br>• Already strong coverage/presence/network - do have other LOBs in OK, different population/network than existing network but they do have contract with OSU, CCBHCs, big systems, OK BHA allaying concerns with strength with women and children, 360 enrollee view<br>• Regional provider network teams & proactive outreach to providers to build capacity<br>• Strong BH capacity<br>• Advanced telehealth solution – dedicated telehealth specialists – stood out<br>• TX – Member Advocacy Program (MAP) – stood out<br>• Network access specialists dedicated to helping people get care<br>• Urgent care – Dr. Chat program is innovative and would help prevent ED utilization, also like Lifeline program, HCO, "Tuck-Ian" to reduce ED via PCMH<br>• PCMH – very good innovation – EMR tool Point of Care Assist to push real time health data to providers & quality incentives for PCMH<br>• Visual presentation/well written<br>• Urban enroll plan was very well laid out |

**Provider Services**

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| Aetna | • Compliant description that lacks innovation/doesn't resonate with OK<br>• Work sheet tool to help providers with readiness assessment – positive/good but not stand out<br>• Good claims tools for reports (not innovative but solid); compliance with timely payment is good; good auto adjudication of claims (85%) |
| BCBS | • Complete answer with some highlights: approach to dealing with newly transitioned population, mobile crisis response, localized staff for provider services<br>• Approach Blue Bear program - innovative<br>• Underscores that this is a big change with OK providers to MC and expansion of Medicaid and nod to need to tailor approach to this<br>• Claims – comprehensiveness of staff training on claims<br>• Not as well laid out; lacking white space; denser and a bit difficult to read |
| CareSource | • Multiple levels of intervention/engagement with providers stood out; thoughtful approach that is well written<br>• Provider services innovation example was interesting but not sure of the OK impact but like idea of concierge approach for large health systems; also, like specialty FQHC support<br>• Option to pay providers through v-card which resonates with OK where providers may not be able to do direct deposit or prefer not to |
| Humana | • Not as strong a section as others; innovative example – not as relevant to OK or Medicaid<br>• PCMH provider in FL; did improve quality but not sure how that worked with provider services (not focused on improving the provider services – not relevant for this section);<br>• 90 – didn't discuss in depth method for identifying providers who need outreach sufficiently (gap)<br>• Establish practice transformation incentive to build infrastructure – not a lot of details though<br>• Educating providers on resources available in the community; multiple layer approach to working with providers<br>• New practice orientation – within 30 days of effective date – how does this work on front end when you're loading new providers; is this realistic? |
| Molina | • Partner with Telligen, with COVID, how has this approach changed?<br>• Monitor denials to see if there are any trends – good process<br>• Timely resolution of provider complaints; multiple methods to submit compliant – this was a nice response<br>• Concern – example of innovation – gave an example of a transition to managed care from IL – provider service reps will commit to TATs for issues – this may not be reasonable. Not as easy to follow<br>• High touch provider service; Molina one stop health centers & good grasp on OK provider landscape; like You Matter to Molina Approach |
| OK Complete | • Good approach to OK<br>• Innovative example – ABA focus – doesn't hit a lot of providers<br>• Positive - multi level support reps even up through physicians; GA reduced provider complaints by 25% via their provider services model |

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| | • Duplicate claims finder call out – good call out but data seemed off |
| United | • Excellent approach, resonated with OK<br>• Innovative example – biannual expos; seemed like a way for some providers to connect; nod to virtual sessions due to COVID stood out (also works with rural providers better)<br>• Gave multiple examples – TX – Provider Hugs – visited over 2000 provider offices in 2 weeks before program went live; will use in OK – increased provider satisfaction<br>• Effective peer to peer intervention stood out; claims adjudication – good presentation; like chart on accuracy (stood out), monitoring denials to help improve provider claims positive<br>• good detail on pre-implementation approach and post implementation approach<br>• Pre and post payment auditing called out – automation of this process<br>• Has reduced denial rate consistently over the years – good stats on this |

**Care Management & Population Health**

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| Aetna | • Not as much clarity in writing as others but good response<br>• Didn't discuss transitioning between tiers; attachments were also unclear<br>• Predictive modeling and risk scores – clearer, broken out well<br>• No innovation in HRA completion<br>• Flu vaccine campaign positive<br>• Clear layout of staffing<br>• Lock-in – "supportive managed care program" not just Rx but non emergent use of ER stood out – unclear pharmacy director involvement which is critical in OK<br>• Didn't speak to detail on how data will be exchanged; how notification occurs – OK doesn't have ADT fully in place<br>• Positive - opportunity to do Medication review via CVS upon transition (available resource) |
| BCBS | • – "care plan rooted in MI" stood out<br>• Incorporate PA data in risk stratification stood out/predictive analytics<br>• Share their utilization data with patients and medical home providers (wish they'd expanded on this and provider feedback report)<br>• Strong on community partnership language<br>• Health access networks and will accept referrals from networks during transition process understanding of people in CM will need a place to go; resource and value to what current networks brought – good understanding of current landscape in OK and how to transition CM<br>• Tobacco cessation success story resonated with OK<br>• Experience in other states with HRS and excellent success rates in screenings (staff use of IPADs that are not reliant on internet access – good nod to rural lack of bandwidth)<br>• Comprehensive assessments – good use of robust tool kit<br>• Blue University stood out – training program above average & peer support specialists program working with members at hospitals to connect to care<br>• Strong lock in program – Prime Therapeutics – don't just notify member but also notify provider and why |

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| | • Paired teammate approach to CM to cover CMs who were out – good coverage strategy<br>• After hours CM live – 24/7/365 & nurse advice line (separates CM live from nurse advice line)<br>• Coordination with other programs – HOPE Centers<br>• Transitions of care command center during implementation – good approach/description |
| CareSource | • Monthly refresh of claims and Rx (seems a long period)<br>• Use JHU ACG approach & focus on homelessness<br>• CareSource kiosk in public shopping areas<br>• Include palliative care<br>• Lacked detail in oversight and monitoring plan<br>• Combine HRS and complete assessment into 1 – confusing discussion (hard to tease out assessments due to nomenclature - refer to screening tool inconsistently causing confusion throughout area<br>• Lacked detail on health assessors<br>• CareSource Life Services – people can reach out for SDOH – connection to member stood out<br>• CM have MI training, but CM training lacked specifics but liked partnership with Career Smart was positive (but not really CM training). Lacked detail on training.<br>• CM changes was weak<br>• 24 hour nurse advice line is only approach to accessing CM<br>• Weak on detail Innovative – embed CMs in high volume EDs |
| Humana | • Risk strategy is clear and on point, well written<br>• Mom's first program, NICU rounds, opioid model, addresses food insecurity, pop health approach stood out<br>• Solid, comprehensive write up<br>• 24/7 advice line and BH line<br>• Innovative – Mom's first, NICU, transplant team, pop health strategy<br>• 45 – very well done, very comprehensive, strong delineation between populations, calls out specific populations that resonate with OK (NICU) very specific<br>• Example outcomes shared resonated<br>• Use incentives for HRS completion; 6 avenues to complete it – really stood out and engagement vendor – underscores the importance of this to Humana<br>• Plan is well developed for HRS<br>• Use many opportunities to get HRS done, multiple modes to do it, multiple team approach<br>• Training is standard; cm changes – retention numbers were confusing; CM ratings seem low; do like 3 way call when transition CM; training didn't resonate with OK<br>• Difficult to understand who is doing assessment reviews<br>• Lock in program criteria /program average – didn't' call out if they'd honor lock in from other programs<br>• Can't locate a member after discharge dispatch CHW to find them called out<br>• Addressed their experience in FL –transitioned 864,575 unique transaction records – significant experience |
| Molina | • Predictive modeling, experience, risk Strat model sound |

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| | • Weaker section – questions about tool, uncertainty about Telligen role<br>• Focus on Disease management – weaker<br>• Building Brighter Days program, Healthy Plate for obesity, SDOH innovation center, altruistic approach, care analyzer system... but not sure how they will deliver statewide<br>• Telligen' s experience is limited in terms of populations Medicaid will look like (not so ABD)<br>• Lacked specifics; not as well laid out on how this will work with OK Medicaid population<br>• Many ways to complete HRS, website/mobile app, some positives; experience completing HRS and experience in different plans; understood need for standardized tool and willingness to collaborate – OK also in conversation with Telligen to standardize a tool<br>• Missed opportunity on training –<br>• Coordinate with other MCOs to discuss case and to avoid duplication of past services – proactive approach; Not a lot of detail on Telligen approach; Telligen reach is not statewide/broad; never explain how they will expand Telligen program statewide and for this population; otherwise good risk tools to predict readmits; risk navigators |
| OK Complete | • Not as well presented; poorly done section, underwhelming, didn't flow well<br>• Do they plan to reimburse pharmacists for self-care education? Not a lot of detail<br>• Poor presentation<br>• Science of Hope in Training<br>• Contract with OSU – seen as positive<br>• CM for the day – not a great approach – not setting that up for success, very brutal day, not maybe best for member – this is not workable and will not serve the members well<br>• Loose criteria for lock in<br>• 46 – enrollee incentive for HRS assessment was good; comprehensive assessment can be done virtual; CM credentials – positive<br>• Missing piece – f/u timeframe not included; lacked detail |
| United | • Good experience, good approach, well rounded, collaborative spirit with other agencies<br>• Algorithms were innovative; beyond saying at risk, says what is impactful for the CM indicators<br>• did homework, understood and aligned with OK strategy<br>• Hot spotting for detecting health disparities, Homeless approach, small town big health united initiative designed to invest in rural communities' long term<br>• HOPE, NWD, incentive for completing HRS<br>• Good success with D-SNP in OK<br>• Comprehensive assessment good; engagement of CHWs to get them completed; care planning – empowerment of member to participate stressed which resonated<br>• IDT team – includes BH, good examples, Mention IEP as part of planning for kids<br>• Bridges to Health Program<br>• Use of Pods (teams) approach – interesting model<br>• TX experience solid, 24 hour Advocate for Me Line<br>• Coordination with other programs – Mobile clinic collaboration |

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| | • RX director oversight and experience with lock-in programs – example in LA of recidivism rate once released from lock in was good<br>• National SDOH strategy<br>• Use of dashboards<br>• Transitions of care – very good<br>• Positive – f/u in phone or in person quick; make sure they have a f/u appointment; take steps to alleviate barriers to member getting f/u care<br>• retention high for CMs<br>• CM training – large national training program, use of clinical trainers |

**Medical Management**

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| Aetna | • Innovative guidelines: FL provider forums for provider input into guidelines stands out<br>• Well-articulated processes / guideline approach; use of gold standard guidelines<br>• Aetna are gold standard of guidelines<br>• VBP – incentivize clinics to stay open after hours but didn't focus as much on provider feedback in reporting<br>• All else fell in line with the others & lacked innovation<br>• Used OK data / awareness of landscape<br>• Concerns with automation of PA process |
| BCBS | • Very well put together process<br>• PA process were consistent and good<br>• Hospital utilization well done; good examples – stood out; approach to reducing stood out, good process and approach to reducing<br>• Some degree of innovation; good success in other states<br>• ED – good success in IL; well rounded, strong strategy includes CHWs, incentives, data; included telehealth provider incentives, addresses BH<br>• High users – well articulate predictive tech for high users<br>• Cover my Meds portal – used by many; good description of PA process<br>• Smart review methodology; more detail and innovation than some of the others and right there with United<br>• Innovative and money saving – NM paramedicine program – send paramedic to home; saves on ER and ambulance transportation<br>• 39 – approach to documenting stood out; well written, clear to reader |
| CareSource | • Good, solid approach but not much stands out<br>• Board structure is good; OK presence – representation of SoonerSelect on Board<br>• Push for participation<br>• Provider profiling stood out, address low performers, pay incentive for good reporting, reduce elective early deliveries – good focus<br>• Innovative - nurse advice line being able to process PA Reports<br>• High utilizers well written but didn't stand out<br>• Lacked some data<br>• Good data from OH on reduction of inappropriate ED use |
| Humana | • in OK, have shown some results with physician group here<br>• Concurrent reviews; medical management nurses onsite, personalized planning |

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| | • Have incentive program for BH providers to deliver follow up to enrollees 7 days of discharge<br>• Advisory board local strong<br>• Good DM process – driven by people and analytics (good mix)<br>• Cross train departments; use IRR<br>• Good examples on provider engagement<br>• Gold Card program stood out as did Practice transformation incentive & after hours bonus to providers to extend hours (to reduce ED overutilization)<br>• CM team for high utilizers which addresses SDOH – multidisciplinary approach<br>• Comparable to united; united more advanced and better articulated<br>• In home urgent care services stood out – EMT visit in home |
| Molina | • Average approach,<br>• Good evidence based supports and guidelines are sufficient - Covers bases but nothing stands out<br>• Regional approach – tailoring of methods by region and population<br>• Reliance on Telligen without providing detail on Telligen<br>• Flawed process to get guidelines out<br>• Not mention of Real time approvals of PAs<br>• Not strong response |
| OK Complete | • strong experience articulated<br>• Positive - Share outcome/clinical reviews with enrollees, focus on looking beyond clinical factors (home environment, SDOH)<br>• Educate providers and good detail on provider education<br>• Good PA workflow process and tools<br>• Good data on reducing avoidable admits, lowering ED usage<br>• Understand OK landscape<br>• Good evidence based DM tools<br>• Good training process<br>• High utilizers program solid<br>• Meet requirements; not above and beyond; less readable than others |
| United | • Great experience & overall excellent approach<br>• Use of evidence based guidelines, National Medicaid managed care oversees med management, additional guidelines for SUD, National sources – top of line<br>• Provider toolkits to help distribute guidelines<br>• Use of incentive models for adherence to guidelines – great approach to evidence based guidelines<br>• Strong policies and workflows, provider education on medical management<br>• Data analytics; current on trends<br>• TX – SUD example stands out<br>• Great PA processing times, good collaboration to get uniformity in guidelines<br>• Hospital utilization rates sound, good reporting and schedule; partner with OU; provider engagement; examples of TX initiatives with results<br>• In home urgent care services stood out – EMT visit in home, use of remote patient monitoring technology, Airways Asthma program<br>• Impressed with hospital utilization – have analyzed OK data |

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| | • VBA analysis for benchmarking reports; share data with hospitals; predictive modeling for readmits (good data and analytics tools)<br>• SDOH coordinators – innovative<br>• Platform notifies CMs of events (admits) – commendable<br>• Peer-to-peer discussions with providers re members who lack in care led to ED or admits - TX – decrease IP stays by 43% and ED utilization substantially<br>• Focus aligns with OK<br>• Telehealth for medical management stands out<br>• Liked website education modules<br>• High utilizers dashboard and interventions stood out; also processes to tier and notify providers |

**Quality Improvement**

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| Aetna | • QAPI is good; not standout<br>• Addressing health disparities – technical, not sure how practical in OK<br>• PIPs – standard, did not standout<br>• Strategic alignment – well done, addressed TIC; incentives for annual exams; remote patient monitoring good call; VBP – put a lot of money into; overall summary was well done; focus on teaching members to take care of themselves – meet their health goals without being prompted<br>• State coverage good<br>• Provider satisfaction good (and increased score trends in all plans they cited) |
| BCBS | • QAPI is good, in line with others<br>• Member and provider satisfaction – no stand outs but decreased provider satisfaction decreased in 2019 – went down in all states<br>• QI measures – diabetes control resonated; asthma medication; f/u after ED visits<br>• PIPs, provider profiling – good, not standout (no innovation) but nod to<br>• Maternal and infant mortality – special beginnings program interesting<br>• Strategic Alignment – partnership with EPIC; active participant in CPC and CPC+ but initiative and they were at the table (solid history of trying to participate)<br>• Lessons learned – **quality is a team sport** |
| CareSource | • QAPI good<br>• Member and provider satisfaction typical<br>• Health disparities – CS Life Services stands out – different approaches for different populations for<br>• Liked PIP focus areas resonated with OK –<br>• Strategic alignment – liked explanation of volume to value explained well – goal to make lasting difference –<br>• Overall good section |
| Humana | • QAPI very specific and well written<br>• Health disparities – good, OK knowledge, liked Humana hometown support; HOPE center, community relations stood out<br>• PIP – not sold on selection of measures but interested in approach<br>• Maternal and infant mortality – likes Mom's first program – good example in FL with good results and program in connecting moms with SUD with specialized provider |

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| | • Strategic alignment – well laid out; good data on moving needle in FL (NICU admits, low birth weights) VBP experience very good<br>• Solid, resonated with OK; use of local resources, naming staff, committee structure positive; large quality staff |
| Molina | • QAPI program –hard to follow, not well written, lacked details on "how" and supportive data<br>• Member and provider satisfaction difficult to follow; not well articulated;<br>• Good PIPs -<br>• Like PACIFY program<br>• Strategic alignment – mothers of Molina program was liked; like dedicated EPSDT coordinators; experience in CA with incentives for cancer screenings, SUD navigators<br>• Inferior presentation not enough facts – lots of words that don't add up |
| OK Complete | • QAPI<br>• CAHPS okay; provider satisfaction not great – picked and choose who they reported on so not sure of lower scores<br>• Quality measures – mention IHI model / approach<br>• HEDIS – rates are good<br>• Like health equity improvement model<br>• PIPs – 3 chosen all that aligned with OK but otherwise good = Maternal mortality<br>• Good experience in Strat alignment; moved needle in several states; good experience in VBP; like shared savings model<br>• Philosophy of deliver local resonated & strong examples - increased rates of pediatric well-child visits – good call out – recognized problem, acted, raised them |
| United | • QAPI structure good; put quality ratings for providers on website to drive improvement – nationally shown to drive improvement; have practice consultants that help lower performing providers – very good best practice/acknowledgement of poor score and efforts to improve<br>• Experience, accreditation in states strong<br>• Member, provider satisfaction – good<br>• Quality measures – well done section<br>• Disparities – NCQA multicultural distinction; did address mobile clinics with OK DoH<br>• PIPs – lots of experience; really well done<br>• Provider profiling – great example of TX; use provider feedback<br>• Programs are innovative, particularly for maternal and infant mortality and morbidity<br>• Strategic alignment – like clinical PODs; well-articulated VBP model and good model<br>• CAHPS not laid out very well and hard to read<br>• Provider scorecard –not as clear |

**Case Studies**

- **All overall good and in same range**

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| Aetna | • Sound approaches, James a bit weaker |
| BCBS | • Call out on James good – good write up<br>• aligns with OK approach |
| CareSource | • sound approaches, nothing stand out |

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| Humana | • Consistent approaches across board<br>• Tim particularly resonated |
| Molina | • Good approaches<br>• James = good write up but otherwise not stand out |
| OK Complete | • Good approaches<br>• The way they built out the stories; build in way that focused on what they could do but made them multi-pronged problems but didn't always fulfill the pieces – presentation weaker; more difficult to follow – could have been better written |
| United | • Good approaches<br>• Good visual representation; lined out well<br>• More consistently on right track than others & like use of apps/technology<br>• One of 2 plans that mentioned potential for PDN services for feeding |

**Contractor Performance**

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| Aetna | • good response no stand outs |
| BCBS | • Good response, comprehensive, termination approach stood out |
| CareSource | • Didn't address 113 and included wrong language (Item 13 response)<br>• Lacked detail |
| Humana | • A lot stood out<br>• Keep a lesson learned book, Monitor metrics and non-metrics, contractor relationship managers, lines of defense |
| Molina | • Didn't give examples on process, KPIs<br>• Bringing in new things that they will customize for OHCA, rural providers customization and generally good approach |
| OK Complete | • Not standout<br>• Good detailed list of customizations – did good job on this<br>• "will develop" written P&Ps – but not a lot of detail on how; concerns with terminations not addressed well |
| United | • Like approach, strong staff, Medicaid data warehouse with smart report<br>• Customization sections / hybrid – strong section but not in line with BCBS and Humana |

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