

## Medicaid Managed Care Procurement

*Update: June 7, 2012*

- **January 11, 2012** – The Ohio Department of Job and Family Services (ODJFS) issued a request for applications (RFA) from qualified managed care organizations (MCOs) interested in providing services to more than 1.6 million low-income, Medicaid-eligible Ohioans.

The re-procurement of Ohio's Medicaid managed care contracts is part of Ohio Medicaid's commitment to paying for performance and value, which was a hallmark of the Medicaid reforms in the Jobs Budget (HB 153). Ohio Medicaid based its evaluation of MCOs that responded to the RFA, in part, on their past performance in coordinating care and providing high-quality health outcomes for enrollees.

New contract language, based on model health plan contract language created by Catalyst for Payment Reform, will move the plans from paying for volume to paying for value. To accomplish this, MCOs will be required to develop incentives for providers that are tied to improving quality and health outcomes for enrollees. Additionally, the new contracts will increase expectations around nationally recognized performance standards MCOs must meet to receive financial incentive payments.

Ohio Medicaid will also reduce the number of managed care service regions from eight to three and combine coverage for the Aged, Blind and Disabled (ABD) and Covered Families and Children (CFC) in each region. This new design will increase individual choice and competition by offering five plan choices, up from two or three currently, and it delivers efficiencies and program improvements envisioned in the state budget, because fewer service regions reduces the administrative burden on the state and on MCOs and increases competition in the managed care marketplace.

- **March 2, 2012** – Twelve MCOs submitted letters of intent by this deadline.
- **March 19, 2012** – Eleven MCOs submitted applications by this deadline.
- **April 6, 2012** – ODJFS announced initial tentative awards to five MCOs (Aetna, CareSource, Meridian, Paramount and United) and opened the protest period through April 16 for MCOs that submitted a bid.
- **April 16, 2012** – Five MCOs filed a protest prior to the deadline (Amerigroup, Buckeye, Coventry/Carelink, Molina and Wellcare).
- **June 7, 2012** – ODJFS responds to each of the protests and announces final tentative awards to MCOs based on an ODJFS legal review of the protests (see attached summary).
- **Next Steps** – Ohio Medicaid will conduct a readiness review (June – August), Medicaid provider agreements signed (August 31), and individuals begin enrolling in the new MCOs (January 1, 2013).

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### Health Plan Award Review Summary

<b>Initial Announcement (April 6, 2012)</b>	<b>Final Announcement (June 7, 2012)</b>
<b>Tentatively Selected Health Plans</b>	<b>Tentatively Selected Health Plans</b>
Aetna Better Health	Buckeye Community Health Plan
CareSource	CareSource
Meridian Health Plan of Ohio	Molina Healthcare of Ohio
Paramount Care	Paramount Care
United Healthcare Community Plan of Ohio	United Healthcare Community Plan of Ohio
<b>Other Applicants</b>	<b>Other Applicants</b>
Amerigroup Ohio	Aetna Better Health
Anthem BlueCross/BlueShield	Amerigroup Ohio
Buckeye Community Health Plan	Anthem BlueCross/BlueShield
Carelink Health Plans	Carelink Health Plans
Molina Healthcare of Ohio	Meridian Health Plan of Ohio
WellCare of Ohio	WellCare of Ohio

*(Plans are listed within each category in alphabetical order and not by ranking)*

### **Summary of Protest Decisions by ODJFS Legal Department**

- 1) Molina, WellCare, and Amerigroup have been awarded additional points for reporting other state results for care coordination; originally they received no points for that experience.
- 2) Amerigroup was not awarded the appropriate amount of points for reporting its experience by meeting accreditation standards by the National Committee for Quality Assurance (NCQA) in Tennessee; therefore additional points were added to its score.
- 3) Carelink was not awarded the appropriate level of points for reporting other state experience regarding the clinical measures section; therefore additional points were added to its score.
- 4) When describing experience, applicants could report product lines for which they carried full risk in other states. Aetna was not able to provide evidence of full risk for its product lines in Arizona, Florida, California, Maryland and Texas (with the exception of its Texas Medicaid product line); therefore points originally awarded for this experience were retracted.
- 5) Aetna was not able to verify that it had proper Utilization Review Accreditation Commission (URAC) certification to receive experience points for California; therefore it should not have received points originally awarded under this section.
- 6) WellCare was required to report its business experience in five states, but only submitted responses for two; therefore its score was reduced.
- 7) Based upon information provided by Meridian, it did not have a Health Insuring Corporation (HIC) license or an application pending with the appropriate regulatory agency at the time the application was due; therefore its application should not have been scored.