



## **AETNA BETTER HEALTH® OF NEBRASKA**

March 21, 2016

**VIA HAND DELIVERY AND  
ELECTRONIC MAIL (Bo.Botelho@Nebraska.gov)**

Bo Botelho, Administrator  
Materiel Division  
Nebraska Department of Administrative Services  
P.O. Box 94847  
1526 K Street, Suite 130  
Lincoln, NE 68508

Re: Protest by Coventry Health Care of Nebraska, Inc., d/b/a Aetna Better Health of Nebraska (“Aetna Better Health”) of March 8, 2016 Notice of Intent to Award for Request for Proposal No. 5151 Z1

Dear Administrator Botelho:

This correspondence constitutes the formal, written protest on behalf of Coventry Health Care of Nebraska, Inc., d/b/a Aetna Better Health of Nebraska (“Aetna Better Health”) regarding the Department of Administrative Services’ (“DAS”) second Notice of Intent to Award, dated March 8, 2016 (“Second Award Notice”), which expressed DAS’ intent to award three contracts, in response to DAS’ Request for Proposals Number 5151 Z1 (“the RFP”), for Nebraska’s full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services to apparently successful bidders UnitedHealthcare of the Midlands, Inc. (“United”), Nebraska Total Care, Inc. (“NTC”), and WellCare of Nebraska, Inc. (“WellCare”) (collectively “Apparently Successful Bidders”). Aetna Better Health’s point of contact for this protest is:

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For the reasons set forth below, the Second Award Notice, and DAS’ decision to re-score an entire section of the proposals received in response to the RFP, is contrary to Nebraska law, is

contrary to the best interests of Nebraska's most vulnerable populations and is likely to severely impair the provision of Medicaid services in the State. Moreover, an award of a contract to apparently successful bidder WellCare is clearly not in the best interests of the State because WellCare is not a responsible bidder and its bid was non-responsive. Accordingly, Aetna Better Health requests that the Second Award Notice be reversed, that WellCare be disqualified as a non-responsive bidder and that Aetna Better Health be awarded a contract pursuant to the terms of the RFP.<sup>1</sup> Alternatively, Aetna Better Health requests only the responses that were improperly scored by Evaluator 2 in the Corporate Overview section be "corrected" because, according to DAS, only those sections contained inaccuracies.

### TIMELINESS

This Request is timely filed pursuant to the terms of the RFP, Section III.B., and the Nebraska Administrative Services, Materiel Division--State Purchasing Bureau, Standard Protest/Grievance Procedures for Vendors<sup>2</sup>, because it is filed within ten (10) business days of the posting of the Second Notice of Intent to Award. The Second Notice of Intent to Award was posted and made available to the public on March 8, 2016.

### BACKGROUND

DAS released RFP Number 5151 Z1 on October 19, 2015.<sup>3</sup> The RFP was intended to identify three "qualified contractors" to which DAS would award contracts to participate in Nebraska's full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services. Proposals submitted in response to the RFP were opened on January 5, 2016. Six bidders, AmeriHealth, Inc. (d/b/a Arbor Health Plan) ("AmeriHealth"), Aetna Better Health, Meridian Health Plan ("Meridian"), NTC, United and WellCare submitted proposals in response to the RFP.

The RFP represented that "all awards will be made in a manner deemed to be in the best interests of the State." RFP, ¶ K. The RFP provides that "[p]roposals must meet the requirements outlined in this request for proposal to be considered valid. *Proposals will be rejected* if not in compliance with these requirements." RFP at p. 1. "Proposals that do not conform to the mandatory items as indicated in the Request for Proposal *will not be considered*. Proposals shall conform to all instructions, conditions, and requirements included in the Request for Proposal." RFP § II.B. The RFP authorized DAS to "*reject*" any proposal, or "*suspend* any bidder from bidding" for "violation of the terms and conditions" of the RFP. RFP § Q (permitting rejection of non-compliant bids). "All awards will be made in a manner deemed in the *best interest* of the State." RFP § II.B.; *see also* RFP § 3.B.

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<sup>1</sup> On March 8 and 9, 2016, Aetna Better Health submitted multiple public records requests to both DAS and DHHS. While DAS has provided responses, the completeness of the DAS response remains under review. DHHS, on the other hand, has yet to provide many records responsive to Aetna Better Health's March 8 and 9 requests. As such, the issues raised in this protest are based on the information currently or publicly available to Aetna Better Health and Aetna Better Health reserves the right to supplement after DAS/DHHS produce all records responsive to Aetna Better Health's public records requests.

<sup>2</sup> Incorporated into the RFP and available at:

[http://das.nebraska.gov/materiel/purchase\\_bureau/docs/vendors/protest/ProtestGrievanceProcedureForVendors.pdf](http://das.nebraska.gov/materiel/purchase_bureau/docs/vendors/protest/ProtestGrievanceProcedureForVendors.pdf).

<sup>3</sup> All documents discussed in this Background section are available on the DAS Website for RFP 5151 Z1, at: <http://das.nebraska.gov/materiel/purchasing/5151/5151.html>.

In evaluating proposals, the RFP stated that the “State will conduct a *fair, impartial, and comprehensive evaluation* of all proposals in accordance with the criteria set forth below.” RFP § II.L. In particular, “[p]roposals will be *independently evaluated* by members of the Evaluation Committee(s). The Evaluation Committee(s) will consist of staff with the *appropriate expertise* to conduct such proposal evaluations.” RFP § II.M. (emphasis added) The RFP requires all bidders to “guarantee compliance” with the provisions in the RFP, by certifying through a responsible officer the “RFP for Contractual Services form” appended to the RFP. *See*, RFP § V.A.

One condition of the RFP required that “[p]ayment for items or services provided under this contract may not be made to any entity located outside of the United States. The term ‘United States’ means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.” RFP § P.1.e.

Bidders were also required to disclose “any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization.” RFP § V.A.2.b. The RFP further required that all bidders disclose and describe whether “the bidder or any proposed Sub-Contractor has had a contract terminated for default during the past five (5) years,” including “full details” of such termination. Based on such disclosures, DAS committed to “evaluate the facts” and “score the proposal accordingly.” *Id.* RFP § V.A.2.g.

On February 5, 2016, DAS posted its Notice of Intent to Award (“Initial Intent to Award”) and a copy of the Initial Final Evaluation Document. The DAS Initial Intent to Award stated DAS’ intent to award contracts under the RFP to United, NTC and Aetna Better Health. On February 19, 2016, DAS received written protests regarding the Initial Intent to Award on behalf of bidders AmeriHealth and WellCare.

On February 29, 2016, DAS issued a Notice of Withdrawal of Intent to Award. In the Notice of Withdrawal, DAS stated that, in response to the protests, DAS “will be performing a *limited re-evaluation* of the Corporate Overview section of all bids received.” DAS indicated such a reevaluation would “correct the scoring inconsistencies contained in the original evaluation.” To facilitate the reevaluation, DAS would “be using *new and impartial* evaluators for this purpose.”

On March 2, 2016, DAS released its written responses to the AmeriHealth and WellCare protests. In its responses, DAS stated that “some sections of the Corporate Overview were not scored properly” and that that section of the various proposals “will be re-evaluated with corrected scoring.” *See* State’s Response to WellCare and State’s Response to AmeriHealth, p. 1. In response to WellCare’s protest, DAS concluded, in a section captioned “Team 1, Evaluator 2 did not follow the Scoring Instructions” that, indeed, the Corporate Overview section was scored “as the score sheet was written.” *Id.* at 2.

On March 8, 2016, DAS Released a Final Re-Evaluation Document and its Second Intent to Award. In the Second Award Notice, after the re-evaluation of the corporate overview section, DAS stated its intent to award contracts under the RFP to UnitedHealthcare, NTC and WellCare. As a result of DAS’ re-scoring, DAS changed its evaluation of Aetna Better Health,

*reversing* its prior determination that Aetna Better Health was a successful bidder, and effectively replacing it with WellCare. Aetna Better Health—which DAS had declared a successful bidder on February 5, 2016—was no longer among the successful bidders, and was, on March 8, 2016, effectively replaced by WellCare.

### **AETNA BETTER HEALTH'S BACKGROUND AND QUALIFICATIONS FOR CONTRACT UNDER RFP 5151 Z1**

Aetna Better Health, along with its affiliate, Aetna Medicaid Administrators LLC (“Aetna Medicaid”), brings 30 years of experience managing high acuity, medically complex populations. Aetna has particular experience serving a wide variety of high-need Medicaid and CHIP-eligible populations, including ABD populations, individuals in integrated dual eligible programs, Medicaid-only dual eligible members, LTSS populations, members with Serious Mental Illness (SMI) and members with intellectual and developmental disabilities. Aetna currently serves nearly 3 million members across 17 states, including 10 LTSS/Duals programs across seven states. Recognized as a national leader in Medicaid managed care, Aetna’s success is built upon its local, community-based health plans and its bio-psycho-social integrated care management model. Aetna has demonstrated experience managing the care of the most vulnerable, using innovative approaches to achieve improved access to care, quality outcomes, and affordability.

Aetna Better Health’s expertise has served Nebraskans well for more than five years. Aetna Better Health has been the State of Nebraska’s partner from day one of the current statewide Medicaid managed care program. Aetna Better Health started work in 2010 in the 10 counties in Region 1, which includes the cities of Omaha and Lincoln, following successful proposals on both a 2009 RFP and a 2010 re-bid of the RFP for the same services. Subsequently, when the State expanded to the remaining 83 counties (Region 2) in 2012, Aetna Better Health was awarded a contract once again. Aetna Better Health was the only successful bidder on both the Region 1 and Region 2 RFPs. Aetna Better Health is the *only* MCO to have ever served all 93 Nebraska counties. Its professionals deal daily with its patients, providers, and partners within DHHS.

Today, Aetna Better Health is the largest and only statewide managed Medicaid plan in Nebraska, and submits that DAS’ decision to introduce two new MCOs—which have never served a single Nebraska Medicaid beneficiary—will significantly impact the people and families it serves. If the State moves ahead with the three entities chosen as Apparently Successful Bidders, Aetna Better Health’s 105,564 members (who make up 55% of all Nebraska physical health members covered by Medicaid managed care) all will be forced to choose a new health plan and new care manager as of January 1, 2017, and DHHS will need to start over in 83 counties as these three new MCOs and their staff learn about the State, build new provider networks, and work to replace the successful model Aetna Better Health has had in place for over 5 years.

Aetna Better Health is well recognized as a high-quality plan committed to the health and well-being of its members. Aetna Better Health is a National Committee for Quality Assurance (NCQA) accredited health plan, and is the leading Medicaid plan in the State for launching Patient Centered Medical Homes (PCMH). In Nebraska, Aetna Better Health has 42 clinic sites

and more than 280 individual providers working under our PCMH agreements, more than any other managed care organization. Individuals receive better quality care, providers collaborate more to improve a patient's health, and the State is so pleased with the program it is now part of how it does business. Aetna Better Health employs 80 caring professionals in Nebraska, all of whom are taxpayers and members of their Nebraska communities. Its professionals deal daily and effectively with patients, providers, and with their partners at DHHS.

Aetna Better Health is also a proud supporter of Nebraska's communities. Aetna Better Health's partnerships with local organizations include the Food Distribution project, Community Crops and Boy and Girl Scouts. Aetna Better Health has partnered with Nebraska providers to improve the health of the Nebraska Medicaid population since 2010 and disruption of that relationship, and the high quality of care facilitated by Aetna Better Health over the past five years, is not in the State's best interests.

### **SUMMARY OF PROTEST GROUNDS**

Aetna Better Health should be awarded a contract under the RFP because it is a highly qualified MCO contractor, having proven its abilities and character in multiple states, including Nebraska. In Nebraska, Aetna Better Health has provided managed care services for more than five years, and is the only MCO that has served all 93 Nebraska counties since the inception of Nebraska's current statewide managed care program. By continuing with Aetna Better Health, Nebraska would be assured of a continuity of quality services to its Medicaid population, with no disruption, and with no qualms about its capacity or integrity in providing these services.

Aetna Better Health protests DAS' decision to rescore portions of the bidders proposals in an arbitrary and capricious manner that effectively took away the contract DAS awarded to it in February 2016, and effectively replaced Aetna Better Health with WellCare, Inc., a Florida managed care company that is neither a responsible nor a responsive bidder, conclusions made by Iowa agency and judicial officers only weeks ago when Iowa terminated WellCare's new MCO contract.

DAS' decision to re-score the Corporate Overview section of all proposals was contrary to law, and conducted in an arbitrary and capricious manner that severely prejudiced Aetna Better Health. If DAS had re-scored the proposals to correct the errors it found, and had done so in a manner consistent with its representations to bidders and to the public, Aetna Better Health would have prevailed in the re-scoring, and Nebraskans would continue to receive the benefit of Aetna Better Health's quality MCO services. As shown below, however, DAS did not do so, but instead re-scored the proposals in a manner that was arbitrary, illogical and contrary to its representations as well as to the requirements of the RFP. DAS' Re-Scoring Decision was flawed in that DAS' rescoring was 1) inconsistent with DAS' promised corrective action, 2) DAS re-scored provisions that did not need to be corrected, 3) DAS used a new scoring methodology, 4) which methodology produced erratic, across-the-board fluctuations in scores, 5) the reevaluation was hastily conducted by untrained, unqualified evaluators, some of who were, contrary to DAS' representations, not "new," but instead had been used in the initial evaluation and were thus biased by same. Collectively, DAS' multiple errors and arbitrary decisions in re-scoring these proposals were contrary to law and to DAS' own requirements and must be reversed.

By declaring its intent to select WellCare, DAS erred by choosing a bidder which was not “responsible” under Nebraska law, and which submitted a clearly non-responsive bid. WellCare’s conduct in the Iowa MCO procurement only weeks ago, along with its failure to disclose its conduct in Iowa and in other states, demonstrates that it was not a responsible bidder with the character and integrity required by Nebraska law and by this RFP. Moreover, WellCare’s proposal was non-responsive in multiple areas, including by its violation of Nebraska’s “offshoring” prohibition, by its decision to propose improper raffles as “value added services” and in many other respects. These grave issues place Nebraska taxpayers and Medicaid beneficiaries at risk, and require that DAS reverse its intent to award a contract to WellCare.

For these and other reasons, outlined below, the Re-Scoring Decision should be reversed.

**I. THE DAS DECISION TO RE-SCORE THE CORPORATE OVERVIEW SECTION OF THE PROPOSALS AND THE PROCESS OF THAT RE-SCORING WAS ARBITRARY, CAPRICIOUS AND VIOLATED NEBRASKA LAW**

On March 2, 2016, DAS released its Notice of Withdrawal of Intent to Award. In that Notice, DAS stated it would withdraw the Initial Notice of Intent to Award because of “scoring inconsistencies contained in the original evaluation.” DAS stated that it would take corrective action, by performing “a *limited re-evaluation* of the Corporate Overview section of all bids received” using “*new and impartial evaluators* for this purpose.”<sup>4</sup> This decision responded to protests submitted on behalf of WellCare and AmeriHealth, which focused on alleged scoring errors made by “Evaluator 2” who did not score the Overview Section “as the score sheet was written.” State Response to WellCare Protest, at 2. A review of the protests, and DAS’ responses, reflects that a single evaluator, Evaluator 2 on Evaluation Team 1, apparently failed to comply with written scoring instructions that, with respect to *four questions*, limited the range of available scores, and did not complete the scores “as the score sheet was written.” DAS identified no other scoring inconsistencies.<sup>5</sup>

A fundamental principle of Nebraska law provides that State administrative agencies cannot act in an arbitrary or capricious manner. *Pierce v. Douglas County Civil Service Com’n*, 275 Neb. 722, 729, 748 N.W.2d 660, 666 (2008). Under Nebraska law:

A decision is arbitrary when it is made in disregard of the facts or circumstances and without some basis that would lead a reasonable person to the same conclusion. An action taken by an administrative agency in disregard of the facts or circumstances of the case and without some basis which would lead a reasonable and honest person to the same conclusion is arbitrary and capricious as

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<sup>4</sup> Collectively, DAS’ decision to withdraw the Initial Notice of Intent to Award and to re-score the Corporate Overview section will be described as the “Re-Score” or “Re-Scoring” Decision.

<sup>5</sup> Aetna Better Health is aware that during a prior Medicaid managed care procurement, for RFPs numbered 2832 Z1 and 3140 Z1 in 2009-2010, protests were lodged due to DAS’ alleged errors in that procurement process. Aetna Better Health has previously requested records from both DAS and DHHS regarding the errors found in the 2009-2010 procurement, but has not received full responses. As noted herein, Aetna Better Health reserves its rights to supplement this protest upon receipt of additional records from the State, including records regarding prior successful protests related to Medicaid managed care.

a matter of law. A capricious decision is one guided by fancy rather than by judgment or settled purpose; such a decision is apt to change.

*In re Proposed Amendment to Title 291, Chapter 3, of the Motor Carrier Rules and Regulations*, 264 Neb. 298, 310-11, 646 N.W.2d 650, 660 (2002). Moreover, the Nebraska Supreme Court has held that State procurement decisions may be subject to judicial review if the State acts “arbitrarily.” *Rath v. City of Sutton*, 267 Neb. 265, 286, 673 N.W.2d 869, 888 (2004).

Whether a government’s corrective action should be sustained depends on the terms of the solicitation. *Laerdal Medical Corp. v. United States*, 111 Fed.Cl. 783, 798 (Fed.Cl., 2013) (“whether the government’s corrective action should be sustained depends on interpretation of the solicitation. Interpretation of a solicitation ‘begins with the plain language of the [solicitation] . . . . When interpreting the [solicitation], the document must be considered as a whole and interpreted so as to harmonize and give reasonable meaning to all of its parts.’”) *Wildflower Intern., Ltd. v. U.S.*, 105 Fed.Cl. 362, 382-83 (Fed.Cl., 2012) (“‘procurement’ includes all stages of the process of acquiring property or services, *beginning with the process for determining a need* for property or services and ending with contract completion and closeout.”) (emphasis in original).

A “re-evaluation of proposals must adhere to the evaluation criteria set forth in the solicitation.” *Sotera Defense Solutions, Inc. v. United States*, 118 Fed.Cl. 237, 262 (Fed.Cl., 2014). “[W]hen an agency re-evaluates proposals and concurrently considers the validity of allegations of evaluation error that have been raised in a prior GAO protest, . . . the agency [must] adhere to the evaluation criteria set forth in the solicitation”); *Sotera Defense Solutions, Inc. v. United States*, 118 Fed.Cl. 237, 256 (Fed.Cl., 2014) (“in those instances where the agency’s proposed corrective action alters or fails to alter the ground rules for the competition (*i.e.*, aspects that apply to all offerors), we have considered a protester’s challenge of such to be analogous to a challenge to the terms of a solicitation, thus providing the basis for protest prior to award.”); *Glenn Def. Marine (Asia), PTE Ltd. v. United States*, 105 Fed.Cl. 541, 569 (2012) (“Agency evaluators must be allowed the discretion to review their own conclusions if they conclude a mistake has been made, or if further inquiry appears appropriate, provided the re-evaluation conforms with the solicitation, including any modifications to the solicitation and the evaluation process is conducted in a manner fair to all offerors.”); *Huntsville Times Co. Inc. v. U.S.*, 98 Fed.Cl. 100 (Fed.Cl., 2011) (sustaining protest based on “inconsistent SSP, ratings that were based on evaluation criteria different from those stated in the letter request for proposal . . . and a failure to apply the weighting scheme for evaluation criteria set forth in the LRFP”).

Moreover, corrective action must narrowly “target the identified defect.” *Sheridan Corp. v. United States*, 95 Fed.Cl. 141 (2010). Accordingly, “drastic “corrective action” in response to a protest regarding scoring errors” lacks any rational basis.” See *WHR Group, Inc. v. United States*, 115 Fed.Cl. 386, 395-98 (Fed.Cl., 2014). In considering the propriety of an agency’s corrective action, an agency’s decision must be “reasonable under the circumstances.” *Sheridan Corp. v. United States*, 95 Fed.Cl. 141, 151 (2010); *DGS Contract Serv., Inc. v. United States*, 43 Fed.Cl. 227, 238 (1999). An agency action cannot meet this bar unless it examined the relevant data and articulated a coherent and reasonable explanation for its decision. *Motor Vehicle Mfrs. Ass’n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43, 103 S.Ct.

2856, 77 L.Ed.2d 443 (1983); *Impresa Costruzioni Geom. Domenico Garufi*, 238 F.3d 1324, 1333 (Fed.Cir.2009). Indeed, “[i]t is an axiom of administrative law that an agency’s explanation of the basis for its decision must include a ‘rational connection between the facts found and the choice made.’” *Bowen v. Am. Hosp. Ass’n*, 476 U.S. 610, 626, 106 S.Ct. 2101, 90 L.Ed.2d 584 (1986) (internal citations omitted).

These standards have been applied in several decisions that delineate the limits of agency discretion within the context of a corrective action.

In *Sheridan Corp v. United States (“Sheridan II”)*, 95 Fed.Cl. 141 (2010), the plaintiff successfully challenged the decision of the United States Property and Fiscal Office of Maine, National Guard Bureau, to take “corrective action,” suspending an awarded contract and soliciting revised proposals in a procurement for construction of an aircraft maintenance hangar. The agency had taken this corrective action in response to a protest filed in the GAO by an unsuccessful offeror. That protest alleged that the agency had made an evaluation error, incorrectly excluding the protestor from the competitive range. The court sustained plaintiff’s protest on the ground that the authority to take “corrective action” does not include authority “to resolicit proposals because of a perceived evaluation error.” *Id.* at 153. The court explained that, “*corrective action must target the identified defect.*” *Id.* Because “the agency’s concern related to the evaluation of the proposals,” the corrective action, if any, “should have been targeted to that issue.” *Id.* In other words, the *Sheridan II* court determined that the agency’s decision to take corrective action did not satisfy the reasonable under the circumstances standard because conducting the solicitation anew “had no relation” to the identified defect in the procurement—an error in the evaluation of proposals. *Id.* at 154.

Similarly, in *MCII Generator & Elec., Inc. v. United States*, 2002 WL 32126244 (Fed.Cl. Mar. 18, 2002), a court set aside the decision of the United States Army (“Army”) to cancel a plaintiff’s contract award and conduct a revised solicitation due to the Army’s failure to identify a clear defect in the solicitation. There, the United States Army (“Army”) awarded the plaintiff a contract for the procurement of tactical quiet power generators. A competing offeror challenged the evaluation of proposals in the GAO, arguing that the Army’s evaluation of offers was flawed. Specifically, the protestor alleged that the Army’s evaluation the past performance factor and application of the solicitation’s pricing matrix were in error. The Army responded by announcing it would reopen competition, solicit new proposals under a revised solicitation, and conduct the procurement anew. Plaintiff protested the Army’s “corrective action.” Noting that a “corrective action” must be “*rationally related to the defect that is identified,*” *id.* at \*1, the court set aside the agency’s decision to take corrective action. The court found that the record did not show that the Army had clearly identified a defect and that the court’s “speculation” as to what the defect might be was “not enough to save the decision.” *Id.* Further, assuming that the defect was in the evaluation of proposals, the court held that soliciting new proposals was not rationally related to such defect, stating “re-evaluation is not the same thing as re-solicitation.” *Id.* at \*2.

Where, as here, a solicitation incorporates agency notices and letters, any corrective action must be reasonable and comply with their terms. *See* RFP, p xvi and p.2 (defining “Solicitation” to include the process of “posting notices . . . to prospective bidders” and incorporating by reference “any additional clauses or provisions required by the terms and

conditions . . . included as an amendment to the contract.”). In this procurement, DAS did not comply with such terms.

Because the Re-Scoring Decision was corrective action, taken to correct discrete errors of a single evaluator in a single section, DAS’ decision to re-score the entirety of these sections of all proposals was arbitrary and capricious. The Re-Score Decision was also arbitrary and capricious because DAS’ actions were inconsistent with its representation to bidders that it would only correct the scoring errors and “inconsistencies” identified in the protests. **Had DAS performed the “limited re-evaluation” it promised to perform in its Notice of Withdrawal, Aetna Better Health would have remained one of the bidders with the three highest scores and would have retained its MCO contract.** The Re-Score Decision was arbitrary and capricious because DAS changed the ground rules for the procurement after proposals were opened, and erroneously: (a) chose to re-score the entire section, even though the errors were confined to one evaluator and four questions within the single section, (b) chose to throw out *all of the prior scores* for that section, including for evaluators who had followed all scoring instructions, (c) used “new evaluators” that were not qualified or properly trained to evaluate Medicaid managed care proposals (and used some who were not actually “new”)<sup>6</sup> and (d) altered the prescribed scoring methodology for the re-scoring process in a way that would have eliminated the need for the re-scoring in the first place, to the severe prejudice of Aetna Better Health. Simply put, the DAS Re-Score Decision is unsupportable, was itself arbitrary and capricious, was undertaken in an arbitrary and capricious manner, and requires DAS to rescind the Second Notice of Intent to Award.

**A. The Re-Scoring Decision Was Not Tailored to Meet the Stated Goal of Correcting Discrete Errors in the Original Scoring Identified in the WellCare And Arbor Protests.**

The DAS Re-Scoring Decision went far beyond what it promised bidders it would do to correct the “scoring inconsistencies” identified in the WellCare and AmeriHealth protests. Its corrective actions did not “target the identified defect” as authorized and promised in its Notice of Withdrawal of Intent to Award. In fact, if DAS’ corrective action had been limited to the targeted re-scoring it promised to do, *Aetna Better Health would have remained one of the three successful bidders.*

Instead of simply correcting these “inconsistencies” in the tainted evaluator’s scores, DAS inexplicably threw out all of the initial evaluation of the entire section, including scores from evaluators who complied with the scoring instructions. DAS offered no explanation for such unnecessary and unannounced actions when the minor scoring errors of a single Evaluator formed the basis for its Re-Scoring Decision. Absent such an explanation, the DAS Re-Scoring Decision was arbitrarily made in “disregard of the facts or circumstances of the case and without some basis which would lead a reasonable and honest person to the same conclusion.”

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<sup>6</sup> Indeed, contrary to DAS’ representations, some of the “new” evaluators were actually those involved in the initial scoring, and would presumably carry the knowledge and potential biases obtained through the initial scoring and admitted errors in that process.

1. Had DAS Re-Scored Only the Scoring Inconsistencies in the Original Evaluation, Aetna Better Health Would Have Remained a Successful Bidder.

As discussed in detail below, DAS, based on the AmeriHealth and WellCare protests, identified a discrete set of scoring inaccuracies, made by Evaluator 2, in the original evaluation. Instead of correcting those scoring inaccuracies, simply by rounding up the incorrect scores to the proper scoring option (i.e., rounding 2 up to 3 or 4 up to 5), DAS arbitrarily and without notice decided to reevaluate the entire corporate overview section, using allegedly new evaluators, despite that the majority of the scores in that section were in compliance with the DAS scoring methodology. Moreover, as discussed below, DAS also decided, without notice to the bidders, without support in the RFP and without any logical reason for doing so, to *alter the scoring methodology* and to introduce non-DHHS evaluators with no background in Medicaid. Instead of irrationally attempting to reevaluate the entire section, and instead of introducing these additional blatant errors into the scoring process, DAS should have simply corrected the few scoring mistakes it had identified. Had DAS done so, Aetna Better Health, would have remained an intended awardee.

Had DAS simply corrected the inaccurate scores from Evaluator 2, giving the benefit of the doubt to the bidders who were assigned the inaccurate scores by rounding their scores *up*, Aetna Better Health still would have received a score of 1606.4. *See* Exhibit A (Aetna Better Health's Corrected Initial Scoring Spreadsheet). WellCare, one of the entities that had previously been assigned inaccurate scores, would have seen its score increase, to 1605.6. *See* Exhibit B (WellCare's Corrected Initial Scoring Spreadsheet). Those scores, by correcting the relatively few inaccuracies identified, would have been the product of the scoring method established by DAS, would have taken advantage of the greater expertise from the original evaluation teams chosen by DAS,<sup>7</sup> and would have avoided the multitude of subsequent errors discussed below. Alternatively, had DAS used the new evaluators to only correct those four questions that had been improperly scored previously, even using the new scoring methodology implemented by DAS during the re-evaluation, Aetna Better Health *still* would have remained one of the three highest bidders. Aetna Better Health would have then received a score of 99.2 on the Corporate Overview section, with WellCare receiving a new score of 90. When added to the total scores for the evaluation, Aetna Better Health would have had a total score of 1,600. WellCare's new total score would have been 1,599.4. In other words, it was *only* because DAS arbitrarily decided to go beyond the targeted corrective action it promised, and instead re-score the *entire* section, using *all* new evaluators, that WellCare moved ahead of Aetna Better Health. Any "limited" corrective actions employed by DAS would have maintained the original order of bidders. DAS' arbitrary decision to throw out accurate scores from qualified evaluators severely prejudiced Aetna Better Health (and the integrity of the procurement) and must be reversed.

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<sup>7</sup> As noted, those original evaluators were all DHHS employees.

2. The Re-Scoring Decision Was Arbitrary: It Should Have Been Limited to Correcting Only the Scores of Evaluator 2 and Only on Those Criteria in Which Evaluator 2 Incorrectly Applied Scores That Violated the Prescribed Scoring Rules.

Both the WellCare and AmeriHealth protests identified a single Evaluator, Evaluator 2 of Evaluation Team 1, as having failed to follow the scoring methodology established by DAS. *See* WellCare Protest at pp. 7-8; AmeriHealth Protest at pp. 3-4. Only four questions, worth a total of 20 points, out of the 130 points available in the totality of the Corporate Overview section, were erroneously scored. Despite the very limited nature of the issue identified in the protests—four inaccurate scores worth a maximum 20 points, for a single evaluator out of a team of five evaluators—DAS irrationally—and contrary to its announced corrective action—took the arbitrary step of throwing out *all* of the scores for each of the five evaluators who scored that section, including the correct scores of four of the five evaluators. The impact of this clearly erroneous decision far exceeds the value of the 20 points in question. Indeed, the experience criteria, which was worth a total of 80 points (four times the amount of points in dispute) was itself fully re-scored, by new and less qualified evaluators (including two with zero Medicaid experience).

Of particular concern in the re-scoring of Aetna Better Health's proposal, Mary Stahly, a DAS employee with no Medicaid experience, assigned Aetna Better Health **30** out of **80** possible points, despite Aetna Better Health's status as incumbent *in Nebraska* and its national experience of 30 years across 17 states. Ms. Stahly awarded WellCare, an entity with zero experience in Nebraska, 49 points. While Aetna Better Health acknowledges that discretion is entrusted to evaluators, this score (and disparity) demonstrates the evaluator's lack of expertise or training in Medicaid managed care and the arbitrary result created by DAS.

As discussed below, contrary to its statement in the Notice of Withdrawal, DAS did not simply engage in a "limited reevaluation." DAS offered no explanation for renegeing on this representation, or to justify why throwing out all of the scores—the vast majority of which were *correctly* done in the first place and which represented the majority of the total points available—was necessary or permissible given the very limited nature of the errors and given DAS' representations to bidders and to the public. DAS exacerbated the harm from this decision by then substituting less qualified evaluators who were selected, trained and required to complete their work on this multimillion dollar procurement in only 5 days. The decision to replace 80% of the scoring (i.e. the scores of 4 of 5 evaluators) because one Evaluator failed to follow instructions on four, low-point criteria, without any legitimate reason to invalidate those other scores, is clearly an arbitrary decision under Nebraska law.

3. Re-Scoring the Entire Corporate Overview Section Violated DAS' Own Scoring Analysis, and DAS' Representation to All Bidders, Where DAS Committed Solely to "Correct the Scoring Inconsistencies Contained in the Original Evaluation."

DAS' decision to re-score the entire Corporate Overview section, to correct inaccurate scores for only a few criteria, is inconsistent with its own representations made in response to the WellCare and AmeriHealth protests. In the DAS Notice of Withdrawal, dated February 29,

2016, DAS stated it “will be performing a limited re-evaluation of the Corporate Overview section of all bids received.” Responding to WellCare, DAS said the Section was not scored “as the score sheet was written.” In fact, however, DAS did not perform a “limited re-evaluation” of the Corporate Overview section, it performed an entire re-evaluation of that section, throwing out all scores for all of the criteria contained therein. Had DAS accurately disclosed its intention to re-score the entire section—and not simply correct its mistakes—the bidders would have challenged or otherwise protested that erroneous decision, and could have requested that DAS stay true to its promise to limit the re-scoring corrections to the errors it found. Aetna Better Health, having invested the time and resources necessary to complete the onerous bid preparation process was at least entitled to trust the State’s representations regarding the nature of any review to be undertaken. *See, e.g., King v. Alaska State Housing Author.*, 633 P.2d 256, 263 (Alaska 1981) (“We hold that in exchange for a bidder’s investment of the time and resources involved in bid preparation, a government agency must be held to an implied promise to consider bids honestly and fairly.”); *Sheridan Corp.*, 95 Fed.Cl. at 153 (“corrective action must target the identified defect”).

Further, had DAS performed the “limited re-evaluation” it suggested, then only the scores for Evaluator 2 would have been replaced, or only the scores for those criteria that were improperly scored by Evaluator 2 in the first instance. Such a remedy would have at least been proportional to the inaccuracies identified by the protestors and DAS. Such a result would not have altered the identities of the successful bidders and would not have eliminated the only MCO contractor which has served the entire state. DAS’ decision to go beyond such a “limited re-evaluation” was arbitrary and not based on the facts identified by DAS or the needs of the procurement process.

4. Replacing All Evaluators to Re-Score the Corporate Overview Section Was Arbitrary.

As noted above, only one of the team of five initial evaluators (Evaluator 2), who scored the Corporate Overview section, inaccurately scored any bids. Despite this single evaluator’s error, DAS illogically decided to invalidate the scores of four evaluators it had initially determined to be the most qualified to perform the job, despite no evidence to suggest that their scores were contrary to the requisite scoring methodology. Indeed, while all initial evaluators were DHHS employees, presumably with some knowledge of Medicaid, two of the evaluators involved in the Re-Score Decision *were DAS employees, with no experience in Medicaid issues.*<sup>8</sup> DAS offered no rational, non-arbitrary basis to justify why the four correctly evaluated scores should be withdrawn in favor of scores from new, hurriedly-selected and less qualified evaluators—simply to correct 20 points worth of apparently incorrect scores from one individual.

**B. DAS Improperly Altered the Scoring Methodology Used During the Re-Scoring of the Corporate Overview Section.**

The errors contained in DAS’ Re-Scoring Decision are significantly compounded by the fact that DAS, in its re-evaluation of the Corporate Overview sections, and without notice to bidders, *altered the scoring rules that were applied to that section.* Even more strikingly, DAS altered the scoring rules in such a way that would have obviated the need for re-scoring in the

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<sup>8</sup> *See Infra*, at § 1.E.2.

first place. DAS' decision to alter the scoring methodology, after having initially applied it, without notice or opportunity for protest on the part of the bidders, and without any rational basis for doing so, was arbitrary and necessitates that DAS withdraw the Second Notice of Intent to Award and reinstate Aetna as a successful bidder under the RFP. *See, Sotera Defense Solutions*, 118 Fed.Cl. at 262 (“A re-evaluation of proposals must adhere to the evaluation criteria set forth in the solicitation”).

1. DAS Stated It Would Undertake a “Limited” Re-Scoring to Correct Only the Scoring Inconsistencies in the Original Evaluation.

As noted above, the DAS Notice of Withdrawal of Intent to Award stated that DAS would undertake “a limited re-evaluation of the Corporate Overview section of all bids received” using “new and impartial evaluators for this purpose.” In fact, however, DAS did not simply “re-evaluate” the Corporate Overview section, it actually evaluated that section *for the first time* using a new, unjustified, unexplained scoring methodology.

Specifically, during the initial evaluation, DAS provided the evaluators scoring the Corporate Overview section with instructions that limited the possible scores available on four questions: financial statements and information (RFP § V.A.2.b); contract performance (RFP § V.A.2.g); past regulatory actions, sanctions, or deficiencies history; and criminal or civil investigation history. For contract performance, past regulatory actions, sanctions, or deficiencies history, and criminal or civil investigation history, evaluators were instructed to give a score of “0 for no response, 5 for response.” For financial statements and information, evaluators were instructed to give a score of “0 if no response, 3 if partial response, 5 if complete response.” *See* Exhibit C (Initial Score Sheet for Organization Team for Evaluator 2 for WellCare).

In the process of “re-scoring” the Corporate Overview section, however, DAS altered this scoring methodology. For each of the four categories described above, instead of limiting the appropriate scores available, now allowed the evaluators to assign a score from “0-maximum points.” *See* Exhibit D (Re-Evaluation Score Sheet for Organization Team). In other words, whereas the original evaluators were restricted in the choices available to them (variously a score of 0, 3 or 5 could be assigned), the Re-Scoring Decision evaluators were permitted a greater range of options, including the option to choose any score within the maximum range (which itself had no qualitative purpose). DAS has given no explanation for this scoring change, made with no notice to bidders or to the public.

While the decision to change the scoring methodology mid-procurement is itself arbitrary, DAS' decision is even more inexplicable because, had the change adopted by DAS been in place for the initial evaluation, *no re-evaluation would have been necessary*. In other words, DAS, after withdrawing the Initial Notice of Intent to Award, re-evaluated the proposals using the precise method it had rejected after the initial evaluation period. Thus, instead of simply correcting Evaluator 2's scores to comply with the scoring methodology initially chosen by DAS, DAS chose to throw out four other evaluator's scores and to then implement the same scoring system DAS previously believed to be flawed and that Evaluator 2 had unilaterally applied in the first instance.

At no point in the process did DAS provide *any* notice that it would be altering the scoring methodology used during the “limited re-evaluation” of the Corporate Overview section. Likewise, DAS failed to provide *any* explanation for why it would change the rules of the game after an evaluation had already been conducted. Nor did DAS explain why it would use the scoring systems it had only days previously found to be flawed. A decision without justification in the facts and circumstances of this procurement, and without notice to the affected bidders, is the definition of arbitrary action under Nebraska law.

2. DAS’ Change to the Scoring Methodology Was Arbitrary and Capricious Because It Was Not Authorized by the RFP and is Contrary to DAS’ Statements in the Notice of Withdrawal.

DAS’ random post-hoc change in the scoring methodology, without notice, with no basis in the RFP itself and contrary to DAS’s statements in the Notice of Withdrawal of Intent to Award is arbitrary and capricious. It is also patently unfair for DAS to change the evaluation criteria after the proposals have been opened and one set of scores, using a specific scoring mechanism, have been determined. DAS’ decision to alter the criteria exposes DAS and the State to claims of favoritism or bias in favor of those entities that were not previously awarded bid. *See, e.g., Margrove, Inc. v. Office of Gen. Servs.*, 27 A.D.2d 321, 323, 278 N.Y.S.2d 485, 488 *aff’d sub nom. Margrove, Inc. v. Office of Gen. Servs. of State of N.Y.*, 19 N.Y.2d 901, 227 N.E.2d 889 (1967) (“It is a fundament of fair play that there be no change in the rules during the competition . . .”); *D’Eramo v. Allegheny Cty.*, No. 1282 C.D. 2011, 2012 WL 8682067, at \*9 (Pa. Commw. Ct. Jan. 12, 2012) (affirming a preliminary injunction where the government “awarded the contract . . . using a different scoring system than in round one” and “the weight assigned to each category in the second round differed between rounds one and two”); *Progressive Dietary Consultants of New York, Inc. v. Wyoming County*, 457 N.Y.S.2d 159, 160-63, 90 A.D.2d 214, 218-19 (N.Y.A.D. 1982) (finding the government’s action was “necessarily arbitrary” where “it recomputed the bids using requirements not described in the specifications”)

**C. The Dramatic Variation in Scoring for Corporate Overview Section in All of the Proposals Demonstrates a Flawed Process.**

According to the Nebraska Supreme Court, “[a] capricious decision is one guided by fancy rather than by judgment or settled purpose; such a decision is apt to change.” *In re Proposed Amendment to Title 291*, 264 Neb. at 310-11, 646 N.W.2d at 660. The wild, unexplained alterations in scores contained in the Re-Score Decision demonstrate DAS used a flawed process, which severely prejudiced Aetna Better Health.

In the Initial Evaluation, the Corporate Overview scores for the various bidders ranged from 91.8 points to 106.2 points out of 130 possible points. After rescoring, the scores for the Corporate Overview section ranged instead from 76.4 points to 84.0 points out of 130 possible points. In other words, after DAS appointed a new evaluation team, with significantly less Medicaid experience, the scores assigned in the Corporate Overview changed by approximately *twenty percent*. Such a dramatic change in the scores assigned in this section (undertaken because one initial evaluator inaccurately scored four questions (worth a maximum of 20 points) reflects significant flaws in this procurement process and demonstrates arbitrary action. *See,*

*e.g., Recycling Solutions, Inc.*, CAB No. P-337, 42 D.C. Register 4550 (August 18, 1995) (Re-scoring was arbitrary where documentation “provides no valid, rational reason for the dramatic changes in scoring.”); *Bristol-Myers Squibb Company*, B-281681.12, 1999 WL 1448172, at \*4 (Dec. 16, 1999) (“Such a dramatic result from such a small change suggests that this mechanical scoring approach was flawed”).

1. Dramatic Scoring Variations Demonstrate the Arbitrary Nature of the Scoring and Scoring Methodology Used by DAS.

The fact that two separate evaluation teams, purportedly with “*appropriate expertise* to conduct such proposal evaluations,” RFP, at p. 5, could reach such **dramatically** different results—just 5 days later—strongly suggests that the scoring criteria established by DAS were not sufficient to ensure that the process would identify the most qualified bidders that would serve the best interests of the State. Had the evaluators from the two teams possessed similar backgrounds, training and qualifications, it is inconceivable that they could have had a *twenty percent* difference in how they evaluated the Corporate Overview section. Instead, the vast disparity in scores suggests that the training DAS provided them (if any)<sup>9</sup> or the criteria used by the evaluators, were insufficiently specific or detailed to guide the evaluators in properly assigning scores.

This difficulty is particularly true with respect to the “experience” criteria, which accounts for 80 of the available 130 points. The “Score Sheet for Organization Team” provided by DAS on its website, for the experience criteria, simply lists as the “Question or Information Evaluated”:

- Summary matrix listing the bidder’s previous projects similar to this RFP in size, scope and complexity.
- Narrative descriptions should highlight similarities between the bidder’s experience and this RFP.
- A maximum of 3 narrative project descriptions will be used by the State.
- More information is in the RFP.

See Exhibit D (Re-Evaluation Score Sheet for Organization Team). While it remains unclear whether the evaluators were provided any additional information or training to guide their scoring, the enormous variation in scoring indicates little or no training (particularly as to Medicaid) was provided to the new evaluators. Given the critical importance and magnitude of this procurement, it is incredible that such little guidance or time<sup>10</sup> would be provided evaluators, especially evaluators with no knowledge or experience with the Medicaid managed care program. This process, i.e. “one guided by fancy rather than by judgment or settled purpose,” and “subject to change” so dramatically based on the composition of the evaluation team, fails to comply with Nebraska law and cannot support a legal procurement.

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<sup>9</sup> In response to numerous public records requests, only limited evaluator training materials have been recently provided by DAS or DHHS.

<sup>10</sup> See *supra* at § I.A.2 (re-scoring completed in 5 days).

2. Such a Change Demonstrates the Arbitrary Nature of DAS' Decision to Use All New Evaluators for the Corporate Overview Section, not Simply Replacing or Re-Scoring Evaluator 2's Scores, With No Resulting Re-Scoring of any Other Sections.

Despite that the original WellCare and AmeriHealth protests identified only four improper scores on the part of a single evaluator, DAS decided it would re-score the entirety of the Corporate Overview section, using five new evaluators, and using an altered scoring methodology. As noted, no such full re-evaluation was required, however, in order to correct the errors identified in the original protests. DAS could have either substituted out Evaluator 2's scores for a new, impartial evaluator, using the same criteria originally used by the four other evaluators, or DAS could have itself corrected Evaluator 2's scores to reflect the proper scoring method. Such a decision would be supportable based on the facts available to DAS. DAS' more expansive decision, however, as reflected in the dramatic differences seen between the initial evaluation and the re-evaluation was "made in disregard of the facts or circumstances" and DAS has not offered any basis for the Re-Scoring Decision that "would lead a reasonable person to the same conclusion." As such, the DAS Re-Scoring Decision was arbitrary as a matter of Nebraska law and requires that DAS rescind the Second Notice of Intent to Award.

**D. The Short, Five Day Timing of the Re-Scoring Decision Demonstrates the Arbitrary and Capricious Nature of DAS' Re-Scoring Decision.**

The Re-Scoring Decision was announced in the DAS Notice of Withdrawal, dated February 29, 2016. The new scores, and resulting Second Notice of Intent to Award, were issued on March 8, 2016. This provided DAS with *only five (5) business days* in which to: 1) select new evaluators; 2) train those evaluators, 3) have the evaluators review all proposals; 4) perform the Re-Scoring; 5) verify those scores; and 6) reissue an award. It is not credible that DAS could have properly undertaken such a process, particularly the training and preparation of new evaluators with no Medicaid background, during that time period. DAS' haphazard and hastily-conducted Re-Score Decision was clearly arbitrary.

**E. DAS' Use of Evaluators Was Arbitrary and Capricious**

DAS' process for selecting and use of evaluators in the Re-Scoring Decision was arbitrary and capricious. Specifically, DAS erred by: 1) not selecting "new" evaluators, as promised in its official notice to bidders, 2) hurriedly choosing evaluators with no evaluation training or experience with Medicaid managed care, and 3) employing evaluators who were not independent. Through these myriad errors, the re-scoring produced scores which were wildly divergent from the initial scoring, and which were the product of arbitrary action.

1. Contrary to DAS' Stated Intent, DAS Did Not Use "New" Evaluators for the Re-Scoring of the Corporate Overview Section.

In the Notice of Withdrawal of Intent to Award, DAS stated that it would reevaluate the Corporate Overview section to "correct the scoring inconsistencies" it had identified, "using new and impartial evaluators for this purpose." Presumably, DAS committed to use "new" evaluators for a reason, so that these evaluators would not have been exposed to the initial scoring mistakes, results, or biases from the initial evaluation. Contrary to DAS' commitment, however, it *did not*

*use all new evaluators* to re-score the Corporate Overview Section. *See*, Sotera, 118 Fed.Cl. at 262 (A “re-evaluation *must* adhere to the evaluation criteria set forth in the solicitation.”) DAS’ decision to again renege on its commitment to bidders and the public is arbitrary and inconsistent with the RFP’s requirement that DAS conduct a “fair, impartial” evaluation.

The “Re-Evaluation Score Sheets” disclosed by DAS on its website reflects that five evaluators conducted the re-scoring: Cat Gekas-Steeby, Flora Coan, Jerry Broz, Kim McClintick and Mary Stahly. Three of those “new evaluators,” Cat Gekas-Steeby, Kim McClintick and Flora Coan, all conducted the initial review of the proposals in advance of the Initial Notice of Intent to Award, and *were not* “new.” Those three individuals were already familiar with the proposals, were already aware of the way that other sections of the proposals had been scored were aware of DAS’ errors and decision to re-score, and would have developed biases and pre-conceived notions of the bidders, and of DAS’ prior decisions, before being asked to undertake the re-scoring of this single section. The “new” evaluators would have known the outcome of the previous scoring, and would have known that they could, through their new scores, alter the outcome. DAS’ decision to re-score the Corporate Overview section was itself arbitrary and capricious, as noted herein, but the decision to include evaluators who were, by no definition, “new evaluators” was a further arbitrary decision—inconsistent with its promises to bidders—made by DAS during this procurement process that requires DAS to rescind the Second Notice of Intent to Award.

2. The Evaluators Used for the Re-Scoring Were Unqualified/Insufficiently Trained and the Resulting Scores Are Unreliable, Arbitrary and Capricious.

The RFP states that “[t]he Evaluation Committee(s) will consist of staff with the *appropriate expertise* to conduct such proposal evaluations.” RFP § 2.M, p. 5. The record reflects, however, that the evaluators chosen by DAS to re-score the Corporate Overview section clearly fail to meet the RFP requirement that evaluators possess “appropriate expertise.”

Unlike the evaluation teams that conducted the initial evaluation, two of the members of the team of “new evaluators” that re-scored the Corporate Overview section were not DHHS staff with any background, knowledge, training or education regarding the Medicaid program or managed care. Nothing in the record suggests these individuals were qualified to evaluate complex proposals for MCO services.

Instead, DAS used two DAS employees, Mary Stahly (Organizational Effectiveness Manager for the DAS State Personnel Division) and Jerry Broz (Administrator of the DAS State Accounting Division) (collectively “DAS Evaluators”). Neither DAS nor DHHS has provided *any* evidence that either Ms. Stahly or Mr. Broz have any knowledge or expertise in Medicaid managed care.

The DAS Evaluators lack of expertise is shown in at least two ways, based on limited information currently available. First, by selecting ONLY DHHS employees for the initial evaluation of proposals, DAS demonstrated its view that DHHS employees, not DAS employees, were qualified to evaluate these Medicaid managed care proposals. *All 25* of the initial

evaluators were DHHS employees, with at least some knowledge of DHHS and Medicaid matters.

Second, and more critically, the DAS Evaluators' scoring of proposals in the Re-Score Decision, and the resulting wide, unexplainable deviation from the initial scoring of the DHHS Evaluators, shows the DAS Evaluators lacked sufficient expertise to meaningfully review these proposals. Indeed, from the DAS Evaluators' scoring of Aetna's proposal, it appears they did not even know that Aetna has been the incumbent MCO, and has been serving Nebraskans and DHHS, since 2010. As noted above, the wide discrepancy between the initial evaluation scores and the scores after re-evaluation shows DAS did not use properly qualified or trained evaluators to evaluate complex, Medicaid managed care proposals. DAS' decision to use evaluators from DAS, instead of DHHS, with no Medicaid experience, and to provide no apparent training to such evaluators, was arbitrary under Nebraska law and invalidates the legitimacy of the re-evaluation process.

Finally, as noted above, no evidence suggests that the DAS Evaluators received *any* training as to the RFP, the needs of the program, or the type of bidder that would best serve DHHS and Nebraska's Medicaid population. Indeed, given that the Re-Score Decision came *just five (5) days* after the Notice of Withdrawal, it appears clear they had little, if any, training or knowledge of the Medicaid program's needs.

DAS' decision to use unqualified, untrained evaluators in its rushed Re-Score Decision was arbitrary and capricious.

### 3. The Evaluators Selected By DAS Were Not "Independent."

The RFP's stated purpose was to select a "*qualified contractor* to provide full-risk, capitated Medicaid managed care program for physical, behavioral health and pharmacy services". It provided that "the state will conduct a *fair, impartial, and comprehensive* evaluation of all proposals in accordance with the criteria set for the below." The RFP further stated that "proposals will be *independently* evaluated by members of the Evaluation Committee" and that the Evaluation Committee "will consist of staff with the *appropriate expertise* to conduct such proposal evaluations." RFP, at p. 5 (emphasis added throughout).

Contrary to these RFP requirements, the selected Evaluators—whose identities were not disclosed until recently—were not "independent". Rather, the State selected Evaluators who reported to one another in their employment relationships with one another and with the State. Indeed, no fewer than 7 of the 30 Evaluators involved in the scoring of the proposals here were involved in reporting relationships by which one evaluator reported to, was subordinate to, and/or whose employment was dependent in part on or rated by, other evaluators. A relationship between an employee and his or her "boss" or supervisor, is not "independent" of that boss.

Based on initial review, it appears the following Evaluators were dependent on one another in the following ways:<sup>11</sup>

- Evaluator Flora Coan reports to Evaluator Karen Gatherer
- Evaluator Cat Gekas-Steeby reports to Evaluator Rocky Thompson
- Evaluator Anne Harvey reports to Evaluator Karen Gatherer
- Evaluator Aaron Ziska reports to (Kris Azimi) who reports to Evaluator Ruth Vineyard
- Evaluator Dannie Elwood reports to Evaluator Heather Leschinsky
- Evaluator Kim McClintick reports to Evaluator Heather Leschinsky
- Evaluator Shelly Nickerson reports to Evaluator Heather Leschinsky

The lack of independent evaluators calls into question whether any internal biases or conflicts may have adversely affected the evaluation process and warrants further review upon the receipt of records responsive to Aetna Better Health's public records requests.

## **II. WELLCARE IS NOT A RESPONSIBLE BIDDER UNDER NEBRASKA LAW OR THE TERMS OF THE RFP AND ITS PROPOSAL WAS NOT RESPONSIVE TO THE RFP**

WellCare is not a responsible bidder under Nebraska law, or pursuant to the terms of the RFP, for multiple reasons. First, WellCare has been terminated as a MCO in Iowa, only weeks ago, for "character and integrity" reasons that should cause grave concern to Nebraskans. *See*, Neb. Rev. Stat. § 81-161. And, contrary to the RFP's requirement that it disclose all "details and circumstances" of its contract terminations, WellCare failed to disclose ANY of the reasons that three levels of judicial review separately determined required WellCare to be disqualified and terminated. Those reasons (intentional violations of RFP "blackout" rules and non-disclosure of major fraud litigation) were highly relevant to the responsibility determination that Nebraska law requires DAS to make. Second, WellCare failed to disclose its long-running Medicaid fraud litigation in Florida, including its \$137 million civil False Claims Act settlement, its Corporate Integrity Agreement with the United States Department of Health and Human Services, the criminal convictions of top WellCare officials, and its deferred prosecution agreement with United States and Florida Medicaid prosecutors. Finally, WellCare's proposal is plainly non-responsive. In violation of RFP terms, WellCare proposes to offshore its claims processing function to a company located off-shore in India. As set forth below, WellCare should be disqualified as a bidder in this procurement. Only by doing so, can DAS fulfill its duty to select only the "highest scoring responsible and responsive" bidders and protect Nebraskans from doing business with a non-responsible bidder not qualified to perform the proposed contracts.

### **A. WellCare Is Not a Responsible Bidder**

Nebraska law provides, in determining the responsibility of a bidder, among other things "the following elements *shall* be given consideration":

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<sup>11</sup> Reporting relationships are provided based on the DHHS Medicaid organizational chart available at: <http://dhhs.ne.gov/Org%20Charts/MLTC.pdf>

(b) The *character, integrity, reputation, judgment*, experience, and efficiency of the bidder;...

(d) The *quality of performance of previous contracts*;

(e) The *previous and existing compliance by the bidder with laws relating to the contract*; ... [and]

(k) Such other information as may be secured having a bearing on the decision to award the contract.

Neb. Rev. Stat. § 81-161 (emphasis added).

The Nebraska Supreme Court has made clear that “[r]esponsibility . . . is not merely a synonym for a bidder’s pecuniary ability . . . [R]esponsibility also pertains to a bidder’s ability and capacity to carry on the work, his equipment and facilities, his promptness, and the quality of work previously done by him, his suitability to the particular task, and such other qualities as are found necessary to consider in order to determine whether or not, if awarded the contract, he could perform it strictly in accordance with its terms” *Rath v. City of Sutton*, 267 Neb. 265, 283, 673 N.W.2d 869, 886 (2004) (citations omitted).

“In making a responsibility determination,” the agency must determine, among other things, that the contractor has “a satisfactory record of *integrity and business ethics*.” . . . *Matter of: B & B Med. Servs., Inc.*, Comp. Gen. Dec. B-407113.3 (June 24, 2013), 2013 WL 3486867, at \*3 (citing 48 C.F.R. §§ 9.103(a), (b); 9.104-1(a), (d)); see also *Interior Contractors, Inc. v. Bd. of Trustees of Newman Mem’l Cnty. Hosp.*, 185 F. Supp. 2d 1216, 1226–27 (D. Kan. 2002) (“We conclude that the word ‘responsible’ in the phrase ‘lowest responsible bidder’ was used by the Legislature in the sense in which it had long been interpreted by the courts and text-writers, and must be held to imply *skill, judgment, and integrity* necessary to the faithful performance of the contract, as well as sufficient financial resources and ability”).

In the absence of information clearly indicating that the prospective contractor is responsible, the contracting officer must make a determination of nonresponsibility. *Id.*; see also Lawrence Shire, Note, *Government Contracts – Nonresponsibility Determinations – The Federal Government Violates a Contractor’s Due Process Liberty Interest by Failing to Provide Prior Notice And an Opportunity to Rebut Charges Contained in Nonresponsibility Determinations Based on Lack of Integrity – Old Dominion Dairy Products, Inc. v. Secretary of Defense*, 631 F.2d 953 (D.C. Cir. 1980), 50 Geo. L. Rev. 90, 92 n.28 (1981–82) (quoting *Domco Chem. Corp.*, 48 Comp. Gen. 769, 771 (1969)) (Integrity means “uprightness of character, moral soundness, honesty, probity and freedom from corrupting influence or practice.”).

1. WellCare Failed to Disclose “Full Details” for its Iowa Contract Termination.

In its proposal, WellCare was required to disclose “*full details* of all termination for default,” and was required to “describe fully *all circumstances* surrounding such termination.” RFP § V.A.2.g. Contrary to the RFP’s requirements, WellCare failed to provide *any* “details” or

“circumstances” of the termination of its Iowa MCO contract. In fact, WellCare included *no information* whatsoever about *why* Iowa DHS terminated WellCare’s MCO contract.

Careful review of the details and circumstances of WellCare’s very recent Iowa MCO contract termination—which took place only weeks before WellCare submitted its proposal in Nebraska—demonstrates that WellCare is not a responsible bidder.<sup>12</sup> In brief, WellCare’s conduct—as found by three Iowa judicial officers following extensive litigation and a one-week trial before the agency—demonstrates that it lacks the character and integrity required of a “responsible bidder” under Nebraska law. Its conduct included multiple willful violations of Iowa’s blackout rules,<sup>13</sup> as well as repeated non-disclosure of its litigation history (including a non-disclosure \$137 million False Claims Act settlement involving Florida Medicaid, criminal convictions of its senior officers in Florida and a 5-year Corporate Integrity Agreement with the federal Office of the Inspector General). WellCare’s conduct resulting in the termination of its Iowa contract, as well as its failure to disclose to Nebraska the “full details” around the Iowa MCO contract termination as required by RFP Section V.A.2.g, renders WellCare a non-responsible bidder.

On October 9, 2015, WellCare entered into MCO contracts with Iowa DHS. On December 18, 2015, those contracts were terminated, after a full administrative trial in which evidence of WellCare’s myriad misconduct was found and penalized. In total, three separate Iowa decision makers separately concluded that WellCare’s misconduct required disqualification and termination.

First, after a full-week trial, Iowa Administrative Law Judge Scase concluded, on November 25, 2015 that:

“In this case, agency staff failed to disclose highly relevant [litigation] information to the evaluation committee and the Director. In doing so, they deprived these decision-makers of the opportunity to exercise discretion with regard to WellCare’s omission and past conduct. Because of this, I must conclude that the *Iowa DHS decision not to disqualify WellCare’s proposal* constituted an abuse of discretion and the notice of intent to a contract to WellCare must be reversed.

...

Director Palmer testified that in his view communication between a bidder [WellCare] and Bousselot [senior Iowa official] related to the substance of the RFP during the blackout was *inappropriate*. I agree. Although not a member of the proposal evaluation committee, Bousselot was certainly in a position to influence the content of the RFP and Director Palmer’s ultimate decision.

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<sup>12</sup> WellCare’s proposal was also not “responsive.”

<sup>13</sup> These rules, like similar ones in Nebraska, prohibit communications between bidders and state employees during the evaluation of bidders’ proposals, and are designed to prevent undue influence and fraud. Until receipt of additional public records requests, it is impossible to know if WellCare engaged in similarly improper behavior in Nebraska.

...

WellCare should have pursued their concerns through the Issuing Officer and the official question and answer process, rather than taking them to Boussetot. *This conduct violated RFP sections 2.1 and 2.2.*

Schulte's [WellCare executive] communication with Stier [Iowa Medicaid Director] on or after May 27<sup>th</sup>, when she began working as the Iowa Medicaid Director, about the terms of the RFP and the progress of the proposal evaluation process were also *clearly improper and in violation* of sections 2.1 and 2.2 of the RFP.

See Exhibit E.

Weeks later, in reviewing and upholding the Proposed Decision of ALJ Scase (above), Director Designee Phipps concluded on December 18, 2015, as follows:

I make the following additional Conclusions of Law: "In this case, the full record now before me shows that WellCare *failed to disclose* highly relevant information both in its initial response to the RFP and in its "clarifying" answer. In doing so, WellCare not only *violated the terms* of the RFP but also deprived the agency decision-makers—both the evaluation committee and Director Palmer—of the opportunity to fully exercise their discretion in determining which Bid Proposals would provide 'the greatest benefit to the Agency.' Accordingly, with the benefit of that record, I now conclude that WellCare's Bid Proposal is *disqualified* and the subsequent contract between WellCare and DHS is *terminated*."

#### Communication during the RFP "blackout" period

I make the following additional Conclusions of Law: "In this case, the full record now before me shows that WellCare not only explicitly violated sections 2.1 and 2.2 of the RFP, but *also violated the spirit of the section* which prohibits attempts to interfere with or influence the procurement process. Although the record does not show that WellCare succeeded in its efforts, *the intent was clear*. The integrity of and confidence in our public procurement process is an agency priority. I therefore conclude that *WellCare's Bid Proposal is disqualified* pursuant to RFP section 2.15.1 and the subsequent contract between WellCare and DHS is *terminated*."

See Exhibit F.

Finally, on February 12, 2016, Polk County District Court Judge Blink reviewed the above decisions of Iowa DHS and affirmed the termination of WellCare's MCO contract. He concluded that:

WellCare admits that the communications during the blackout period occurred. WellCare's communication with Ms. Stier, the director of Medicaid in Iowa, is sufficient substantial evidence to disqualify WellCare. Ms. Stier is an employee of not only DHS but of the very division to which WellCare submitted a proposal. While there may be some argument of whether Mr. Boussetot is in fact an "employee" for the purposes of the RFP, it is clear that at one point WellCare believed Mr. Boussetot to be a member of the evaluation committee and continued to have communication with him. *This shows willfulness on the part of WellCare to violate the blackout period and the RFP.* There is substantial evidence to conclude that WellCare violated the blackout period and to support disqualification.

WellCare also disputes the conclusion that it failed to disclose information required by the RFP . . . The true extent of WellCare's settlements and the actual details of the CIA were *not* disclosed to DHS *until* the contested hearing in October 2015. If DHS was unaware of the extent of WellCare's legal problems until that time, it could not have been fully informed and able to exercise discretion. . . . There is substantial evidence to conclude that WellCare *violated the RFP by failing to disclose information* and deprived the committee and Director Palmer of discretion.

*See* Exhibit G. WellCare did not challenge or appeal Judge Blink's final decision.

In this procurement, WellCare's failure to disclose the clearly relevant "circumstances" and "details" of its Iowa contract termination and disqualification caused its proposal to be non-responsive to RFP requirements. WellCare's decision to again withhold vital information about its capacity and character as an MCO deprived Nebraska decision-makers of critical information, information needed to protect the State and its vulnerable Medicaid population.

More significantly, WellCare's failure to disclose this highly relevant conduct—and the extremely serious nature of the conduct itself—shows that WellCare is not a responsible bidder. As found by three separate judicial officers in Iowa, only weeks ago, WellCare's conduct was willful and improper. Such conduct demonstrates WellCare lacks the "character" and "integrity" required under Nebraska law. *See* Neb. Rev. Stat. § 81-161(1). Despite the disclosures WellCare *did* make (which themselves were insufficient), during the re-evaluation of the proposals, WellCare was still awarded an average of 6.2 (5, 8, 6, 8 and 4 points) out of a total 10 points for the categories addressing regulatory, criminal or civil investigations histories. *See* Re-Evaluation Score Sheets-Corporate Overview. Aetna Better Health, with *no* such history of serious misconduct, was itself awarded only an average of 6.6 (8, 7, 7, 6 and 5 points) for those same categories.

WellCare's failure to meaningfully and fully disclose this conduct is only compounded by DAS' inexplicable decision to assign only 10 total points to evaluation categories addressing bidders' "past regulatory actions, sanctions or deficiencies history" and "criminal or civil investigation history." In other words, DAS, contrary to the clear intent of Neb. Rev. Stat. § 81-161(1), considered a bidder's character and integrity to be worth 10 out of a total of 2250 possible points—*less than one half of one percent* of the total points available for the RFP. The fact that any bidder, regardless of how significant its past discretions, could only lose 10 points out of the total 2250 available is contrary to Nebraska law and demonstrates the arbitrary nature of this DAS procurement.

#### **B. WellCare's Other Conduct Shows it is Not a Responsible Bidder**

WellCare is also a non-responsible bidder because it failed to disclose multiple fraud litigation matters, civil and criminal, in its Proposal, despite having a legal duty to do so based on its heavy reliance on its Medicaid "experience" in Florida. In Nebraska, a legal duty to disclose arises when "necessary to prevent his partial or ambiguous statement of the facts from being misleading." *Griffith v. Drew's LLC*, 860 N.W.2d 749, 758-59, 290 Neb. 508, 516-17 (Neb. 2015). "To reveal some information on a subject triggers the duty to reveal all known material facts." *Knights of Columbus Council 3152 v. KFS BD, Inc.*, 791 N.W.2d 317, 331-32, 280 Neb. 904, 922-23 (Neb. 2010).

"A statement that is true but partial or incomplete may be a misrepresentation, because it is misleading when it purports to tell the whole truth and does not." *Zawaideh v. Nebraska Dept. of Health and Human Services Regulation and Licensure*, 792 N.W.2d 484, 497-98, 280 Neb. 997, 1012-13 (Neb. 2011). "For instance, a statement that contains only favorable matters and omits all reference to unfavorable matters is as much a false representation as if all the facts stated were untrue." *Id.* "So when such a statement is made, there is a duty to disclose the additional information necessary to prevent it from misleading the recipient." *Id.*

"[A] partial or fragmentary statement that is materially misleading because of the party's failure to state additional or qualifying facts . . . is fraudulent." *Knights of Columbus Council 3152 v. KFS BD, Inc.*, 791 N.W.2d 317, 331-32, 280 Neb. 904, 922-23 (Neb. 2010) "Fraudulent misrepresentations may consist of half-truths calculated to deceive, and a representation literally true is fraudulent if used to create an impression substantially false." *Id.*

In Section H of its Proposal (Summary of Bidder's Corporate Experience), WellCare described its relationship with the State of Florida, stating that it has "served Florida Medicaid under successive contracts since 1994." WellCare then makes numerous representations regarding various facets of its long term relationships and contracts with Florida Medicaid.

WellCare's description of its Florida Medicaid relationship clearly "purports to tell the whole truth, and does not." *See, Zawaideh*, 792 NW 2d at 498. Nowhere does WellCare describe or disclose to Nebraska evaluators its seriously checkered past with state and federal regulators in Florida, including a \$137 million civil False Claims Act settlement with the Florida US Attorney's office, the Florida Attorney General's office, the criminal convictions of three of its officers—involving Medicaid fraud-- or the deferred prosecution agreement entered—to avoid criminal prosecution of the corporation-- into between the Florida Attorney General's

office, the Department of Justice and WellCare. *See*, Exhibits H and I (WellCare False Claims Act Settlement and Deferred Prosecution Agreement).

In 2011, WellCare Health Plans, Inc. settled with the United States Department of Justice (“DOJ”) a series of civil False Claims Act (“FCA”) cases alleging fraudulent conduct, kickbacks, and false claims submitted to the Medicare and Medicaid programs. In the settlement, WellCare agreed to pay fines and penalties of more than \$137 million, entered a deferred prosecution agreement to avoid criminal prosecution, and agreed to a 5-year Corporate Integrity Agreement with the Office of Inspector General (“OIG”) (“Settlement”). The Settlement required annual settlement payments to be made, including a final payment of \$34.375 million due on March 23, 2016. *See* Exhibit H at 7.

In the Settlement, the government alleged the following fraudulent conduct relating to the Medicaid program:

The United States contends that it has certain civil claims against WellCare arising from WellCare’s submission of false and fraudulent information in support of false claims to the Medicare and Medicaid programs from January 1, 2004 to June 24, 2010, or where a different period is noted below, during that period. These claims relate to allegations that WellCare:

1. Between June 1, 2002 and October 31, 2007, knowingly concealed its contractual obligation to pay behavioral health care services monies back to the Florida Agency for Health Care Administration (AHCA) and induced AHCA to grant inflated premium increases . . .;
3. Between October 1, 2003 and October 31, 2007, knowingly concealed its contractual and statutory obligations to pay monies back to state Medicaid programs, including the Florida Healthy Kids program and the Illinois Medicaid program . . .;
4. Falsified encounter data submitted to the state Medicaid programs;
5. Knowingly concealed and retained overpayments received from state Medicaid programs in violation of its contractual obligations to pay monies back to the state Medicaid programs[.]
6. Paid improper remuneration to physicians, Independent Practice Associations (IPAs), and other providers through manual adjustments to service funds and other means . . .;
7. Engaged in sales and marketing abuses . . .;
8. Manipulated, and falsely reported to the Centers for Medicare and Medicaid Services (CMS) and to states, the “grades of

service” or similar performance metrics of WellCare call centers and falsified appeals documentation;

9. Upcoded services, claims, and disease states by manipulating the Risk Adjusted Payment System (RAPs), which is used by CMS to calculate the per member per month (PMPM) premium paid to health plans; and
10. Operated a sham Special Investigations Unit (SIU) . . . .

See Exhibit H.

As part of the Settlement, in 2011, WellCare also agreed to a 5-year CIA with the OIG. By its terms, the CIA remains operative, requires various compliance reporting and other obligations, and imposes a number of conditions; breach of the CIA entitles OIG to impose significant penalties and to exclude WellCare from federal health programs. See Exhibit H. If WellCare breaches other provisions of the CIA, such breach may “constitute an independent basis for WellCare’s exclusion from participation in the Federal Healthcare Programs.” *Id.* at 33. The CIA remains in effect. *Id.* As a result, Nebraska Medicaid would be at risk by contracting with WellCare.

Notably, DAS’s scoring procedures did not provide any mechanism to meaningfully reflect WellCare’s demonstrated history of misconduct, such as those identified above. Not only did the scoring instructions restrict the range of choices available to the evaluators, the number of points assigned to “integrity” based factors was so insignificant as to render them meaningless and incapable of protecting Nebraska’s taxpayers from funding a contract with an entity with this dramatic civil litigation and criminal history.

### **C. WellCare’s Proposal Was Not Responsive**

WellCare’s proposal was not responsive in multiple of its provisions, including but not limited to 1) its violation of the RFP’s offshoring prohibitions, and 2) its inaccurate inclusion of items as “value-added” services that do not qualify as such services or are otherwise required by the RFP. WellCare’s cavalier approach to compliance with the RFP’s terms make its proposal not responsive and it should be rejected.

1. WellCare’s Proposal Violates the RFP’s Offshoring Prohibition.

Under Section P of the RFP (MCO Reimbursement), the State required that “Payment for items or services provided under this contract *may not be made* to any entity located outside of the United States,” and defined the term “United States” to mean “the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.” RFP § P.1.e. (emphasis added). WellCare, however, violated this essential requirement of the RFP by proposing that key subcontractor, for “claims processing services,” be *located in Janakpuri, India*. See, WellCare Proposal, at Section J. Notably, WellCare also attested to compliance with these terms, contrary to the clear violations in its proposal. See WellCare Proposal, Attestation for Section QQ, p. 24.

Outsourcing Medicaid administrative functions, such as claims processing, raises significant privacy and security concerns, according to HHS Office of the Inspector General (“OIG”). In a 2014 report from the OIG’s Deputy Inspector General, the agency concluded that if state agencies “offshore outsourcing of administrative functions that involve PHI (protected health information), it could present potential vulnerabilities. For example, Medicaid agencies or domestic contractors that send PHI offshore may have limited means of enforcing provisions of Business Associate Agreements [under HIPAA] that are intended to safeguard PHI.” Memorandum Report, Office of Inspector General, April 11, 2014, at 1. *See* Exhibit J.

The risks inherent in WellCare’s decision to off-shore certain services poses risks to Medicaid beneficiaries and the State itself. The State is legally responsible for maintaining the confidentiality of Medicaid members and ensuring that any party with whom it shares that information is similarly bound to protect it. WellCare’s unilateral decision, contrary to the terms of the RFP, to use “claims processing service” outside of the United States, and to thus share confidential information with an overseas sub-contractor, places the State at risk.

The State sensibly attempted to avoid these substantial risks by prohibiting off-showing in the RFP. By expressly proposing to offshore claims processing to an Indian subcontractor, WellCare’s proposal is non-responsive to the RFP. It clearly fails to meet this critical requirement of the RFP, and thus should be disqualified from consideration.

In addition to constituting a blatant violation of the RFP terms, WellCare’s use of off-shore sub-contractors prejudices bidders that do not use such sub-contractors. Aetna Better Health goes to great lengths to identify qualified domestic sub-contractors and goes even further in ensuring that its sub-contractors do not themselves participate in off-shoring Medicaid functions. Allowing WellCare to violate the RFP’s terms through the use of an off-shore sub-contractor gives it a distinct competitive advantage over the other bidders who “play by the rules” by devoting significant time and resources to ensuring patient privacy and compliance with State requirements.

Even more importantly, WellCare’s clear violation of the RFP’s outsourcing prohibition places Nebraska beneficiaries at risk, and threatens exposure of their private health information, as outlined by the OIG. As Nebraska prudently outlined in the RFP, such risks cannot be countenanced, and a proposal which fails to meet this important condition must be rejected.

2. WellCare’s Proposal Regarding Value-Added Items Fails to Comply with the RFP Definition of those Items.

In response to Section 23. IV.E., Covered Services and Benefits, of the RFP, WellCare listed 11 items (out of a total 26, or 46% of the total) that do not meet the RFP’s definition of “value-added service” or are prohibited under Nebraska law.

The RFP defines “value added services” as “Those services a MCO provides *in addition to a service covered under this contract* because the MCO has determined that the health status and quality of life for the member is expected to be the same or better using the value-added health service as it would be using the covered service.” In its response, WellCare listed the

following eleven items as “value-added services” despite the fact that they are otherwise “a service covered” by the terms of the RFP or are otherwise improper:

- 1) ED Diversion Program. WellCare’s “ED Diversion Program” is simply Care Management as otherwise required in the RFP. *See* WellCare Proposal, Response to Section 23. IV.E. p. 6.
- 2) Prenatal Care Management Program. WellCare’s listed “Prenatal Care Management Program,” like its “ED Diversion Program” is simply an element of Care Management as otherwise required in the RFP. *See* WellCare Proposal, Response to Section 23. IV.E. p. 10.
- 3) Community Baby Showers. WellCare’s “Community Baby Showers” proposal includes the provision of raffles for members, which are prohibited under State law and the terms of the RFP (as discussed further below). *See* WellCare Proposal, Response to Section 23. IV.E. p. 10. Because the inclusion of this provision is not permitted under Nebraska law, it cannot be considered a “value-added service” and WellCare’s score for such services, which includes this part of its proposal, was improperly inflated.
- 4) Foster Care Transition Services. WellCare’s “Foster Care Transition Services” are again simply a component of Care Management as otherwise required in the RFP. *See* WellCare Proposal, Response to Section 23. IV.E. p. 13.
- 5) Healthy Rewards Program. WellCare’s “Healthy Rewards Program” includes no details, such as a monetary amount of the award, which should have entitled it to less consideration than other bidders who gave dollar amounts for incentive cards. *See*, WellCare Proposal, Response to Section 23. IV.E. p. 14.
- 6) Health Fairs. Health fairs, such as that listed by WellCare in its Value-Added Services Proposal are required in the RFP as part of the marketing plan/outreach events. *See* WellCare Proposal, Response to Section 23. IV.E. p. 18.
- 7) WellCare Days. Events such as “WellCare Days” are again required as outreach events in the marketing plan. *See* WellCare Proposal, Response to Section 23. IV.E. p. 18.
- 8) Mini Farmers Market. Absent giveaways as part of the Farmers Market plan, WellCare’s proposed “Mini Farmers Market” is simply an outreach event which is required as part of the marketing plan. *See* WellCare Proposal, Response to Section 23. IV.E. p. 18.
- 9) Tobacco Cessation Program. WellCare lists providing nicotine replacement gum, patches and lozenges, which are all already covered per the State’s PDL. *See*, *e.g.*, <https://nebraska.fhsc.com/Downloads/NEfaxform-TobaccoCessation-201503.pdf>; <https://nebraska.fhsc.com/Downloads/NEfaxform-TobaccoCessation-201503.pdf>. *See* WellCare Proposal, Response to Section 23. IV.E. p. 17.

- 10) 24-Hour Behavioral Crisis Hotline. This is a required service per the RFP. *See* WellCare Proposal, Response to Section 23. IV.E. p. 7.
- 11) Welcome Room/Concierge. WellCare's proposal for a "Welcome Room/Concierge" lists as one of the services to be provided "application assistance." MCOs are prohibited, however, from assisting on Medicaid applications. *See* WellCare Proposal, Response to Section 23. IV.E. p. 17. Again, because this part of WellCare's proposal is improper, it cannot justify its score for these services.

Despite the inclusion of eleven items that do not qualify as permissible "Value-Added Services" under the terms of the RFP, WellCare *received the second highest score* for such services, 111.4. It simply is not possible for WellCare to have received such a score under the terms of the RFP had this section been properly evaluated and WellCare's award of a contract based, in part, on its proposal to provide already required or prohibited services, demonstrates that WellCare's proposal is non-responsive.<sup>14</sup>

Finally, the fact that WellCare received a score of 111.4, despite its inclusion of so many items that do not constitute value-added services, are impermissible under the RFP and Nebraska law, or are otherwise addressed in other parts of the RFP, strongly suggests that the individuals chosen by DAS to evaluate these sections were not qualified to have done so. Qualified, competent evaluators who understood the Nebraska Medicaid managed care system would have identified these errors on WellCare's part and would have properly scored its proposal.

### **III. THE RFP FAILED TO TAKE INTO CONSIDERATION AETNA BETTER HEALTH'S PRIOR PERFORMANCE IN NEBRASKA AND FAILURE TO AWARD A CONTRACT TO AETNA BETTER HEALTH IS NOT IN THE BEST INTERESTS OF THE STATE**

Nebraska law expressly requires that the State take into consideration, in any subsequent procurement, a bidder's prior contract performance. Aetna Better Health has been serving the people of Nebraska as an MCO since 2010. During that time, Aetna Better Health and the State have developed a mutually beneficial, highly effective relationship ensuring that Nebraska's Medicaid beneficiaries are provided high-quality care through the most cost-effective methods possible.

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<sup>14</sup> The scope of errors related to the "value-added services" sections of the proposals extends beyond the inclusion of services that fail to meet the RFP definition. Each of WellCare, United and Meridian, in response to the RFP's requirement in Section 23.IV.E. to identify "Value-Added Services," also proposed programs that, at least in part, rely on the conducting of raffles or drawings. Such activities are clearly contrary to the explicit terms of the RFP, however, and violate Nebraska law. The RFP, on page 85, lists as prohibited marketing activities the use of "raffle tickets, event attendance, or sign-in sheets to develop mailing lists of prospective members." The Nebraska Lottery/Raffle Act and Small Lottery/Raffle Act, Neb. Rev. Stat. §§ 9-401 *et seq.*, strictly restrict the use of lotteries and raffles in Nebraska to those conducted for a "lawful purpose," as defined in Neb. Rev. Stat. § 9-408. Nothing in the WellCare, United or Meridian plans for using raffles or drawings demonstrates an intent (or ability) to comply with the terms of the Nebraska Lottery/Raffle Act and Small Lottery/Raffle Act. Despite this, there does not appear to be any resulting effect on the scores received by WellCare, United or Meridian with respect to their Value-Added Services scores.

Nebraska law requires:

(1) All purchases, leases or contracts which by law are required to be based on competitive bids shall be made to the lowest responsible bidder, taking into consideration the best interests of the state. . .In determining the lowest responsible bidder, in addition to price, the following elements shall be given consideration: . . .

(d) the quality of performance of **previous contracts** . . .

Neb. Rev. Stat. § 81-161 (emphasis added). Through this RFP, the State is on the verge of replacing Aetna Better Health as a managed care contractor with no consideration of the quality of its performance for the past five plus years. Nothing in the evaluation methodology in any way considers Aetna Better Health's past performance. The reason to consider performance is obvious; it is the best indicator of future performance, either good or bad, and minimizes the risk to the State of entering into a poor contract.

Two of the three bidders awarded contracts are not now providing, nor have they ever provided, managed care services in Nebraska. They are an unknown for the State, which means the State is assuming the risk of their performance. These two new entrants, who have no experience with Nebraska's Medicaid population, providers or procedures, will have to attempt the impossible, to provide a seamless transition which does not disrupt Medicaid services.

Among the difficulties that would be created due to the transition from Aetna Better Health to the new contractors selected by DAS, particularly in those areas of the State where Aetna Better Health has been the sole presence for the last six years, would be:

- member confusion regarding the enrollment processes for a new MCO and a potentially altered provider network;
- member confusion regarding any policies and procedures that will be imposed by a new MCO, causing, among other things, additional costs due to increased emergency room visits and reducing the use of primary care physicians and preventative care;
- the risk that new MCO networks will not be fully developed and capable to meet the needs of new populations;
- disruptions to existing provider relationships resulting in billing, remittance, and coverage errors;
- risks caused by implementation of new systems and significant claims payment delays; and
- additional State and DHHS resources devoted to the transition from a familiar, capable MCO to an MCO without Nebraska experience and unfamiliar with Nebraska Medicaid policies and procedures.

These difficulties would have been easily avoided had Aetna Better Health's proposal been accurately evaluated, had Aetna Better Health's capabilities been properly considered within the context of its significant experience in Nebraska and with Nebraska Medicaid, had DAS not relied on inexperienced evaluators and had WellCare, as a not responsible bidder, been properly disqualified by DAS.

In addition, the State's evaluation methodology does not take into consideration the best interests of the state as required by law. In this case, the State is dealing with a continuation and expansion of a program that has been in existence and effective in providing services to Medicaid participants for more than five years. It is clearly in the best interest of the State to continue to administer the program through this expansion with a minimum of risk and change that can adversely affect its more than 230,000 Medicaid participants.

Replacing Aetna, the only statewide current contractor, will mean that at least one half of all Medicaid managed care participants will be forced into another plan with a different provider network. That, coupled with replacing current contractor AmeriHealth, means that 100% of all Medicaid participants and providers in 83 counties will be forced to work with three new plans. There is no conceivable analysis that could suggest the State's interests are best served by assuming the risk that the new contractors cannot establish a network or cannot pay claims in a timely manner or that a new MCO has less than satisfactory customer service affecting most of the Medicaid population in the State.

Aetna Better Health does not advocate that it should have a right to a new contract as a current contractor providing Medicaid managed care, nor is that the intent of the law. Aetna Better Health does respectfully suggest, however, that an evaluation process that does not take into account the performance of a current contractor providing these services, be that good or bad, is not in the best interest of the Medicaid beneficiaries or the State. There is nothing in the evaluation scoring methodology which allows for such an analysis and the procedure adopted by DAS through the RFP is, therefore, contrary to the letter and the spirit of Nebraska law.

### **RIGHT TO SUPPLEMENT AND STAY OF AWARDS**

DAS' Second Notice of Intent to Award was issued on March 8, 2016. On that same day, Aetna Better Health, through counsel, submitted multiple public records requests to both DAS and DHHS in an attempt to fully consider whether DAS' second evaluation of the proposals complied with the terms of the RFP and Nebraska law, or whether a protest was required. As of the date of this written protest, DAS has responded, in part, to requests directed at it. The completeness of DAS' response is currently being evaluated. DHHS, however, has yet to provide records responsive to the most important of Aetna Better Health's public records requests. Aetna Better Health has been in contact with DHHS and understands that DHHS will soon begin a rolling response to Aetna Better Health's requests. As such, Aetna Better Health expressly reserves its right to supplement this protest upon further review of relevant records.

Aetna Better Health respectfully requests that the State delay finalizing **any** contracts with the Apparently Successful Bidders until such time as Aetna Better Health's protest has been fully and finally resolved. As DAS acknowledged in its Notice of Withdrawal of Intent to Award, "each award is subject to a protest and review process" intended to "protect the process

and ensure an open and fair bidding process.” DAS correctly stated that the protest procedure “allows bidders to raise concerns with the process, and point out any flaws or omissions which may have or potentially could have adversely impacted the award.” As the wide range of issues identified in this protest demonstrates, significant questions persist regarding the integrity and fairness of this procurement. As such, any award before the protest process has had an opportunity to conclude would not be in the best interests of the State and would be inconsistent with the spirit and letter of Nebraska’s laws governing competitive bidding. Therefore, the State should voluntarily stay any further action regarding awards under the RFP.

Aetna Better Health in addition requests that DAS and DHHS stay, or suspend, any other activities to implement agreements with new MCOs, in order to avoid any unnecessary member and provider confusion or disruption of care. We submit that all communications with members and providers regarding the procurement should be suspended until resolution of this protest.

### **RELIEF REQUESTED**

Based on the foregoing, Aetna Better Health respectfully requests that DAS withdraw its Second Notice of Intent to Award contracts under the RFP. Aetna Better Health respectfully submits that it has demonstrated that it is the contractor with the greatest ability to provide high-quality services to the State, based in part on its prior five years serving the State, and that the disruptions caused by removing Aetna Better Health as a managed care organization serving Nebraska’s Medicaid population would have dramatic, and unfortunate, consequences.

Due to the apparent deficiencies in the procurement process, the improper re-scoring of the proposals and WellCare’s status as a not responsible bidder, Aetna Better Health respectfully requests that (1) WellCare be disqualified as a non-responsible bidder, (2) WellCare’s proposal be rejected as non-responsive based on its inclusion of improper and illegal terms and (3) that Aetna Better Health be again awarded a contract under the RFP. Alternatively, DAS should rescind the Second Notice of Intent to Award and correct the inaccurate scores of Evaluator 2.

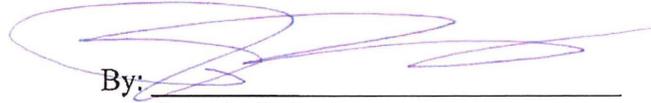
In order to facilitate DAS’ full and fair review of this Protest, Aetna Better Health is available to meet with representatives of the Materiel Division regarding issues raised in this protest. It is Aetna Better Health’s hope that reconsideration of the flaws apparent in the current process will assist DAS in maintaining the integrity of Nebraska’s competitive selection process and will result in the success of the next phase of Nebraska’s Medicaid managed care program. Please let us know if we can provide additional information to assist in your review and consideration of this Request.

Enclosures

cc: Calder Lynch, Director, Department of Health and Human Services, Division of Medicaid and Long-Term Care (via Email and Hand Delivery with Enclosures)  
Courtney Phillips, Chief Executive Officer, Nebraska Department of Health and Human Services (via Email and Hand Delivery with Enclosures)

**[Signature Page to Follow]**

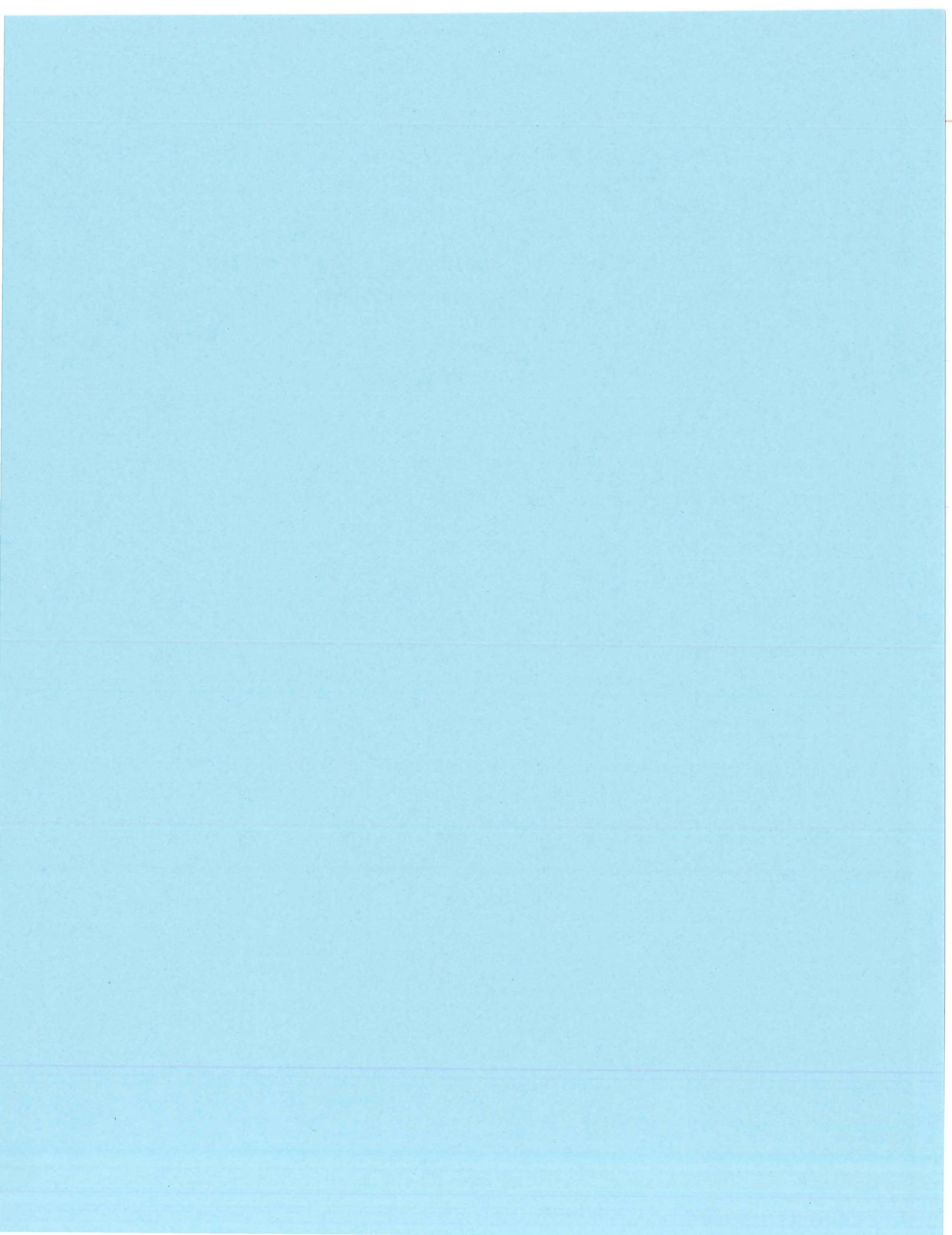
Respectfully submitted on behalf of Coventry  
Health Care of Nebraska, Inc. d/b/a Aetna Better  
Health of Nebraska,

A handwritten signature in purple ink, consisting of several overlapping loops and a long horizontal stroke extending to the right.

By: \_\_\_\_\_

Pamela Sedmak

S.V.P. and President of Aetna Medicaid



# Exhibit

# A









**Exhibit**

**B**







**Exhibit**

**C**

Score Sheet for Organization Team

T1E2

Bidder Name WellCare

Component	RFP Reference	Question or Information Evaluated	Score Possibilities	Max. Points	Score
<b>Corporate Overview (including financial information)</b>					
bidder identification and information	V.A.2.a Corporate Overview	The bidder must provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.	not scored	na	
financial statements and information	V.A.2.b Corporate Overview	<ul style="list-style-type: none"> <li>•three years of Independently audited financial statements and associated enrollment figures</li> <li>•if not publicly held, reports and statements required of a publicly-held corporation, or a description of the organization provided in such a manner that evaluators may formulate a determination about financial stability and strength; and a banking reference</li> <li>•disclosure of any and all judgments, litigation, or other real or potential reversals (More information is in the RFP.)</li> </ul>	0 if no response, 3 if partial response, 5 if complete response	5	2
change of ownership	V.A.2.c Corporate Overview	If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder must describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.	not scored	na	
office location	V.A.2.d Corporate Overview	The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified.	not scored	na	
relationships with the State	V.A.2.e Corporate Overview	The bidder shall describe any dealings with the State over the previous (number) (##) years. If the organization, its predecessor, or any party named in the bidder's proposal response has contracted with the State, the bidder shall identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.	not scored	na	
employee relations to the State	V.A.2.f Corporate Overview	•naming any party in the proposal who is or was an employee of the State (More information is in the RFP.)	not scored	na	
contract performance	V.A.2.g Corporate Overview	If the bidder or any proposed sub-contractor has had a contract terminated for default, all such instances must be described. (More information is in the RFP.)	0 for no response, 5 for response	5	4

Score Sheet for Organization Team

T1E2

Bidder Name WellCare

Component	RFP Reference	Question or Information Evaluated	Score Possibilities	Max. Points	Score
experience	V.A.2.h Corporate Overview	<ul style="list-style-type: none"> <li>•Summary matrix listing the bidder's previous projects similar to this RFP in size, scope and complexity.</li> <li>•Narrative descriptions should highlight similarities between the bidder's experience and this RFP.</li> <li>•A maximum of 3 narrative project descriptions will be used by the State.</li> </ul> (More information is in the RFP.)	0-maximum points	80	40
summary of bidders proposed approach to management of the project	V.A.2.i Corporate Overview	<ul style="list-style-type: none"> <li>•identification of specific individuals to work on the project</li> <li>•resumes for all personnel proposed</li> </ul> (More information is in the RFP.)	not scored	na	
subcontractor identification and hours	V.A.2.j Corporate Overview	If the bidder intends to Sub-Contract any part of its performance hereunder, the bidder must provide the name, address, and telephone number of the Sub-Contractor(s);	not scored	na	
risk bearing relationships	na	1. Describe proposed risk bearing partnerships/relationships, function, and oversight.	0-maximum points	15	10
past regulatory actions, sanctions, or deficiencies history	na	2. Identify and describe any regulatory action or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against the MCO's organization within the last five years. In addition, identify and describe any letter of deficiency issued, as well as any corrective actions required by any federal or state regulatory entity within the last five years that relate to Medicaid and CHIP contracts. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	0 for no response, 5 for response	5	1
criminal or civil investigation history	na	3. State whether or not the MCO is currently, or has been within the past five years, the subject of a criminal or civil investigation by a state or federal agency. If yes, provide an explanation with relevant details and the outcome. If the outcome was against the MCO, provide the corrective action plan or measures taken to prevent such future offenses. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	0 for no response, 5 for response	5	1
reinsurance arrangements	III.G.3	4. Describe risk analysis, assumptions, cost estimates, and rationale for MCO's proposed reinsurance arrangements.	0-maximum points	15	10
subtotal				130	68

Score Sheet for Organization Team

T1E2

Bidder Name WellCare

Component	RFP Reference	Question or Information Evaluated	Score Possibilities	Max. Points	Score
<b>Business Requirements (including statement of project understanding)</b>					
project understanding	V.A.3.a, Understanding of Project Requirements	The technical approach section of the Technical Proposal must consist of the following subsections: a. Understanding of the project requirements (3 pages maximum);	0-maximum points	10	8
CFR and NAC compliance	IV.C Business Requirements	10. Describe the approach the MCO will take to ensure compliance with all relevant provisions of Part 438 of Chapter 42 of the CFR, Title 471, 477, and 482 NAC.	0-maximum points	20	10
MCO licensure	IV.C Business Requirements	11. Describe how the bidder meets the Federal definition of a MCO. Include a copy of the COA from the Department of Insurance.	0-maximum points	5	3
collaboration	IV.C Business Requirements	12. Describe the MCO's proposed approach for collaboration with other entities and programs, as required in Section IV.C.6.	0-maximum points	20	13
accreditation	IV.C Business Requirements	13. Describe if any of the MCO's Medicaid MCOs are accredited by NCQA and, if not currently accredited in Nebraska, how it will attain accreditation for its Nebraska MCO. Please describe any unsuccessful accreditation attempts in other states.	0-maximum points	15	10
restrictions	IV.C Business Requirements	14. If applicable, describe any restriction of coverage for counseling or referral services the MCO is required to provide because of moral or religious obligation. Describe how the MCO will provide members with access to those services.	not scored	na	
subtotal				70	44
Subcontracting					

Score Sheet for Organization Team

T1E2

Bidder Name WellCare

Component	RFP Reference	Question or Information Evaluated	Score Possibilities	Max. Points	Score
subcontractor description		<p>provide the organization's role in this project, corporate background, size, resources and details addressing the following:</p> <ul style="list-style-type: none"> <li>• The date the company was formed, established or created.</li> <li>• Ownership structure (whether public, partnership, subsidiary, or specified other).</li> <li>• Organizational chart.</li> <li>• Total number of employees.</li> <li>• Whether the subcontractor is currently providing services for the MCO in other states and the subcontractor's location.</li> </ul>	0-maximum points	10	7
subcontractor monitoring		<p>57. For subcontracted roles included in the proposal, describe the MCO's process for monitoring and evaluating performance and compliance, including but not limited to how the MCO will:</p> <ul style="list-style-type: none"> <li>• Ensure receipt of all required data including encounter data.</li> <li>• Ensure that utilization of health care services is at an appropriate level.</li> <li>• Ensure delivery of administrative and health care services at an acceptable or higher level of care to meet all standards required by this RFP.</li> <li>• Ensure adherence to required grievance policies and procedures.</li> <li>• Ensure that subcontracts do not contain terms for reimbursement at rates that are less than the published Medicaid FFS rate in effect on the date of service unless a request has been submitted to and approved by MLTC.</li> </ul>	0-maximum points	15	6
subtotal				25	13
<b>Staffing Requirements</b>					
organizational structure	IV.D Staffing Requirements	<p>15. Describe the organization's number of employees, lines of business, and office locations. Submit an organizational chart showing the structure and lines of responsibility and authority in the company. Include the organization's parent organization, affiliates, and subsidiaries that will support this contract.</p>	0-maximum points	20	10

Score Sheet for Organization Team

T1E2

Bidder Name WellCare

Component	RFP Reference	Question or Information Evaluated	Score Possibilities	Max. Points	Score
staffing structure for contract	IV.D Staffing Requirements	16. Provide an organizational chart for this contract, including but not limited to key staff and additional required staff. Label this "Nebraska Organizational Chart."	0-maximum points	20	10
FTE's by time period	IV.D Staffing Requirements	17. In table format, indicate the proposed number of FTEs for each key staff and additional required staff for discrete time periods (no longer than 3 month intervals) from contract award through 6 months after the start date of operations and whether or not positions are located in Nebraska. Label this table "Proposed FTEs by Time Period."	0-maximum points	25	7
key staff job descriptions	IV.D Staffing Requirements	18. Provide job descriptions (including education and experience qualifications) of employees in key staff positions.	0-maximum points	5	5
organizational structure and practices support for integrated services	na	19. Describe how the MCO's administrative structure and practices will support the integration of the delivery of physical health, behavioral health, and pharmacy services.	0-maximum points	15	8
staff training, social issues, risk factors, community resources, LTSS population	IV.D.6 Staffing Requirements	20. Describe how the MCO will train staff on issues that affect its members, including: issues related to housing, education, food, physical and sexual abuse, violence, food security; behavioral health risk and protective factors; finding community resources and making referrals to these agencies and other programs; and meeting the needs of the LTSS population, including individuals with developmental disabilities and mental health concerns.	0-maximum points	15	10
DBM coordination accountability	IV.D Staffing Requirements	21. Describe how the MCO will coordinate with the MLTC Dental Benefits Manager, including processes for reciprocal referral for needed services. Include the MCO's plan to identify a dental services liaison.	0-maximum points	5	4
subtotal				105	54
<b>Program Integrity</b>					
PI program overview	IV.D Program Integrity	93. Describe the MCO's approach for meeting the Program Integrity requirements described in the RFP, including but not limited to a compliance plan for the prevention, detection, reporting, and implementation of corrective actions for suspected cases of FWA and erroneous payments. Include best practices the MCO has utilized in other states.	0-maximum points	20	13

Score Sheet for Organization Team

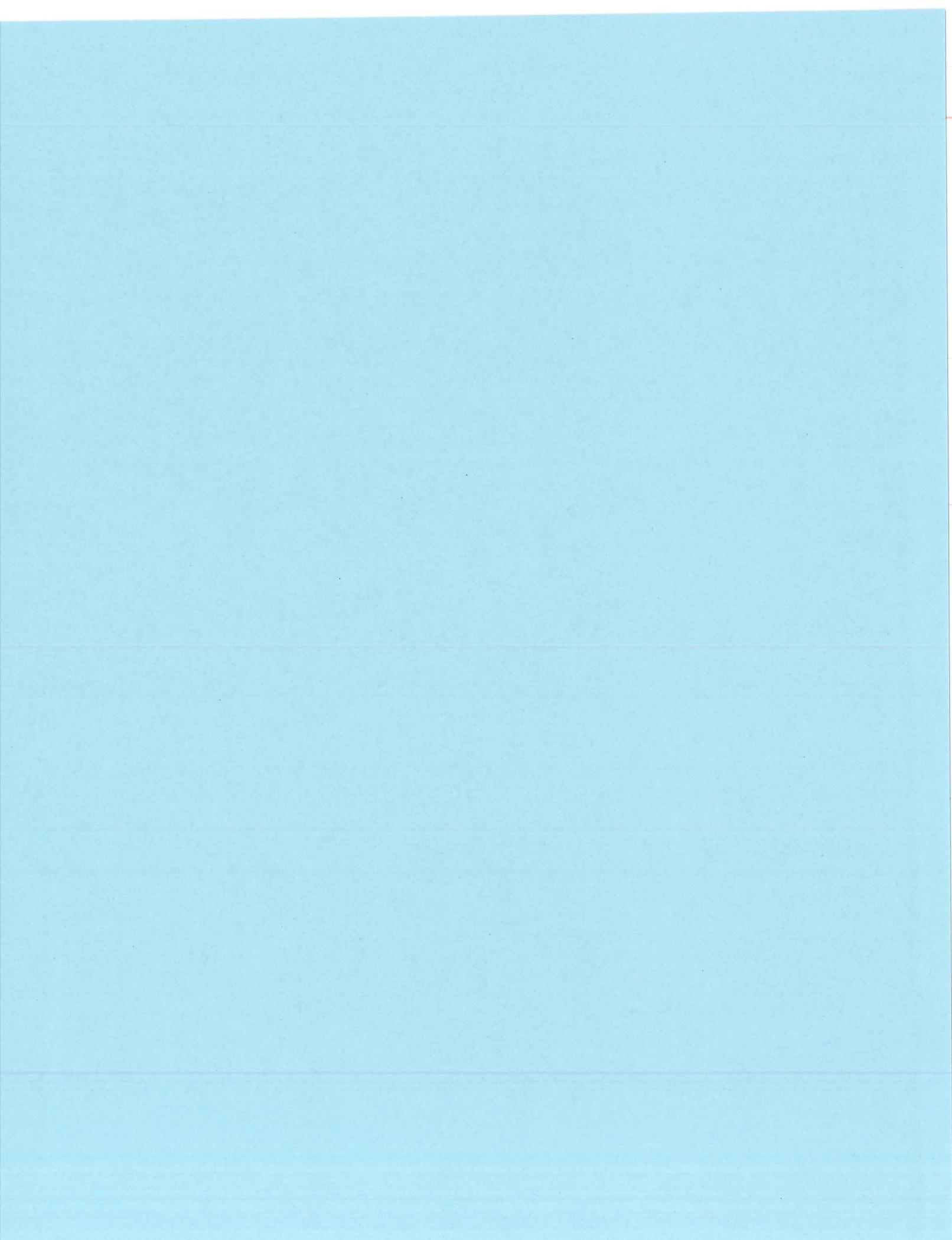
T1E2

Bidder Name WellCare

Component	RFP Reference	Question or Information Evaluated	Score Possibilities	Max. Points	Score
collaboration with other entities	IV.O Program Integrity	94. Describe how the MCO currently works with other entities that investigate and prosecute provider and member fraud, waste, and abuse.	0-maximum points	10	8
member and provider education	IV.O Program Integrity	95. Currently, how does the MCO educate members and providers to prevent fraud, waste, abuse, and erroneous payments?	0-maximum points	15	10
TPL	IV.O Program Integrity	96. Describe the MCO's method and process for capturing TPL and payment information from its claims system. Explain how the MCO will use this information.	0-maximum points	15	10
subtotal				60	41
<b>Reporting and Deliverables</b>					
dashboards		114. Provide an example of dashboards that the MCO will use to track MCO performance for MCO leadership and the QAP/ Committee.	0-maximum points	15	8
example reports		115. Provide examples of the following reports: Member Grievance System Performance Improvement Projects Care Management How will the MCO use required reports in its day to day management and operations?	0-maximum points	25	20
subtotal				40	28

Team 1 Total

430 248



**Exhibit**

**D**

Score Sheet for Organization Team

Evaluator Cat Gekas-Steeby

Component	RFP Reference	Question or Information Evaluated	Score Possibilities	Max. Points	Arbor Score	Aetna Score	Meridian Score	Nebraska Total Care Score	United Healthcare Score	WellCare Score
Corporate Overview (including financial information)										
financial statements and information	V.A.2.b Corporate Overview	*three years of independently audited financial statements and associated enrollment figures *if not publicly held, reports and statements required of a publicly-held corporation, or a description of the organization provided in such a manner that evaluators may formulate a determination about financial stability and strength; and a banking reference *disclosure of any and all judgments, litigation, or other real or potential reversals (More information is in the RFP.)	0-maximum points	5	3	3	2	3	3	3
contract performance	V.A.2.g Corporate Overview	If the bidder or any proposed sub-contractor has had a contract terminated for default, all such instances must be described. (More information is in the RFP.)	0-maximum points	5	3	3	2	3	4	4
experience	V.A.2.h Corporate Overview	*Summary matrix listing the bidder's previous projects similar to this RFP in size, scope and complexity. *Narrative descriptions should highlight similarities between the bidder's experience and this RFP. *A maximum of 3 narrative project descriptions will be used by the State. (More information is in the RFP.)	0-maximum points	80	50	60	32	64	55	60
risk bearing relationships	na	1. Describe proposed risk bearing partnerships/relationships, function, and oversight.	0-maximum points	15	9	10	7	8	10	9
past regulatory actions, sanctions, or deficiencies history	na	2. Identify and describe any regulatory action or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against the MCO's organization within the last five years. In addition, identify and describe any letter of deficiency issued, as well as any corrective actions required by any federal or state regulatory entity within the last five years that relate to Medicaid and CHIP contracts. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	0-maximum points	5	3	4	3	3	3	3
criminal or civil investigation history	na	3. State whether or not the MCO is currently, or has been within the past five years, the subject of a criminal or civil investigation by a state or federal agency. If yes, provide an explanation with relevant details and the outcome. If the outcome was against the MCO, provide the corrective action plan or measures taken to prevent such future offenses. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	0-maximum points	5	2	4	4	4	4	2
reinsurance arrangements	III.G.3	4. Describe risk analysis, assumptions, cost estimates, and rationale for MCO's proposed reinsurance arrangements.	0-maximum points	15	9	10	6	10	10	10
subtotal				130	79	94	56	95	89	91

Score Sheet for Organization Team

Evaluator Flora Coan

Component	RFP Reference	Question or Information Evaluated	Score Possibilities	Max. Points	Arbor Score	Aetna Score	Meridian Score	Nebraska Total Care Score	United Healthcare Score	WellCare Score
<b>Corporate Overview (Including financial information)</b>										
financial statements and information	V.A.2.b Corporate Overview	<ul style="list-style-type: none"> <li>•three years of independently audited financial statements and associated enrollment figures</li> <li>•if not publicly held, reports and statements required of a publicly-held corporation, or a description of the organization provided in such a manner that evaluators may formulate a determination about financial stability and strength; and a banking reference</li> <li>•disclosure of any and all judgments, litigation, or other real or potential reversals (More information is in the RFP.)</li> </ul>	0-maximum points	5	4	5	4	4	5	4
contract performance	V.A.2.g Corporate Overview	If the bidder or any proposed sub-contractor has had a contract terminated for default, all such instances must be described. (More information is in the RFP.)	0-maximum points	5	5	4	3	4	5	3
experience	V.A.2.h Corporate Overview	<ul style="list-style-type: none"> <li>•Summary matrix listing the bidder's previous projects similar to this RFP in size, scope and complexity.</li> <li>•Narrative descriptions should highlight similarities between the bidder's experience and this RFP.</li> <li>•A maximum of 3 narrative project descriptions will be used by the State. (More information is in the RFP.)</li> </ul>	0-maximum points	80	75	70	70	75	70	70
risk bearing relationships	na	1. Describe proposed risk bearing partnerships/relationships, function, and oversight.	0-maximum points	15	10	10	10	10	10	10
past regulatory actions, sanctions, or deficiencies history	na	2. Identify and describe any regulatory action or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against the MCO's organization within the last five years. In addition, identify and describe any letter of deficiency issued, as well as any corrective actions required by any federal or state regulatory entity within the last five years that relate to Medicaid and CHIP contracts. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	0-maximum points	5	2	2	2	2	3	3
criminal or civil investigation history	na	3. State whether or not the MCO is currently, or has been within the past five years, the subject of a criminal or civil investigation by a state or federal agency. If yes, provide an explanation with relevant details and the outcome. If the outcome was against the MCO, provide the corrective action plan or measures taken to prevent such future offenses. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	0-maximum points	5	5	5	5	5	5	5
reinsurance arrangements	III.G.3	4. Describe risk analysis, assumptions, cost estimates, and rationale for MCO's proposed reinsurance arrangements.	0-maximum points	15	10	10	10	10	10	10
subtotal				130	111	106	104	110	108	105

Score Sheet for Organization Team

Evaluator Jerry Broz

Component	RFP Reference	Question or Information Evaluated	Score Possibilities	Max. Points	Arbor Score	Aetna Score	Meridian Score	Nebraska Total Care Score	United Healthcare Score	WellCare Score
<b>Corporate Overview (including financial information)</b>										
financial statements and information	V.A.2.b Corporate Overview	<ul style="list-style-type: none"> <li>•three years of independently audited financial statements and associated enrollment figures</li> <li>•if not publicly held, reports and statements required of a publicly-held corporation, or a description of the organization provided in such a manner that evaluators may formulate a determination about financial stability and strength; and a banking reference</li> <li>•disclosure of any and all judgments, litigation, or other real or potential reversals (More information is in the RFP.)</li> </ul>	0-maximum points	5	3	4	2	4	4	4
contract performance	V.A.2.g Corporate Overview	If the bidder or any proposed sub-contractor has had a contract terminated for default, all such instances must be described. (More information is in the RFP.)	0-maximum points	5	3	4	3	4	4	3
experience	V.A.2.h Corporate Overview	<ul style="list-style-type: none"> <li>•Summary matrix listing the bidder's previous projects similar to this RFP in size, scope and complexity.</li> <li>•Narrative descriptions should highlight similarities between the bidder's experience and this RFP.</li> <li>•A maximum of 3 narrative project descriptions will be used by the State. (More information is in the RFP.)</li> </ul>	0-maximum points	80	55	51	58	60	50	53
risk bearing relationships	na	1. Describe proposed risk bearing partnerships/relationships, function, and oversight.	0-maximum points	15	7	9	7	6	10	6
past regulatory actions, sanctions, or deficiencies history	na	2. Identify and describe any regulatory action or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against the MCO's organization within the last five years. In addition, identify and describe any letter of deficiency issued, as well as any corrective actions required by any federal or state regulatory entity within the last five years that relate to Medicaid and CHIP contracts. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	0-maximum points	5	4	3	4	3	3	3
criminal or civil investigation history	na	3. State whether or not the MCO is currently, or has been within the past five years, the subject of a criminal or civil investigation by a state or federal agency. If yes, provide an explanation with relevant details and the outcome. If the outcome was against the MCO, provide the corrective action plan or measures taken to prevent such future offenses. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	0-maximum points	5	3	4	4	3	3	3
reinsurance arrangements	III.G.3	4. Describe risk analysis, assumptions, cost estimates, and rationale for MCO's proposed reinsurance arrangements.	0-maximum points	15	9	8	3	8	10	8
subtotal				130	84	83	81	88	84	80

Score Sheet for Organization Team

Evaluator Kim McClintick

Component	RFP Reference	Question or Information Evaluated	Score Possibilities	Max. Points	Arbor Score	Aetna Score	Meridian Score	Nebraska Total Care Score	United Healthcare Score	WellCare Score
<b>Corporate Overview (Including financial information)</b>										
financial statements and information	V.A.2.b Corporate Overview	<ul style="list-style-type: none"> <li>•three years of independently audited financial statements and associated enrollment figures</li> <li>•if not publicly held, reports and statements required of a publicly-held corporation, or a description of the organization provided in such a manner that evaluators may formulate a determination about financial stability and strength; and a banking reference</li> <li>•disclosure of any and all judgments, litigation, or other real or potential reversals (More information is in the RFP.)</li> </ul>	0-maximum points	5	3	3	3	4	4	4
contract performance	V.A.2.g Corporate Overview	If the bidder or any proposed sub-contractor has had a contract terminated for default, all such instances must be described. (More Information is in the RFP.)	0-maximum points	5	3	3	3	3	3	3
experience	V.A.2.h Corporate Overview	<ul style="list-style-type: none"> <li>•Summary matrix listing the bidder's previous projects similar to this RFP in size, scope and complexity.</li> <li>•Narrative descriptions should highlight similarities between the bidder's experience and this RFP.</li> <li>•A maximum of 3 narrative project descriptions will be used by the State. (More Information is in the RFP.)</li> </ul>	0-maximum points	80	49	32	32	49	32	32
risk bearing relationships	na	1. Describe proposed risk bearing partnerships/relationships, function, and oversight.	0-maximum points	15	8	8	10	9	9	8
past regulatory actions, sanctions, or deficiencies history	na	2. Identify and describe any regulatory action or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against the MCO's organization within the last five years. In addition, identify and describe any letter of deficiency issued, as well as any corrective actions required by any federal or state regulatory entity within the last five years that relate to Medicaid and CHIP contracts. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	0-maximum points	5	3	3	4	4	4	4
criminal or civil investigation history	na	3. State whether or not the MCO is currently, or has been within the past five years, the subject of a criminal or civil investigation by a state or federal agency. If yes, provide an explanation with relevant details and the outcome. If the outcome was against the MCO, provide the corrective action plan or measures taken to prevent such future offenses. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	0-maximum points	5	3	3	3	3	3	4
reinsurance arrangements	III.G.3	4. Describe risk analysis, assumptions, cost estimates, and rationale for MCO's proposed reinsurance arrangements.	0-maximum points	15	6	8	5	7	6	7
subtotal				130	75	60	60	79	61	62

Score Sheet for Organization Team

Evaluator Mary Stahly

Component	RFP Reference	Question or Information Evaluated	Score Possibilities	Max. Points	Arbor Score	Aetna Score	Meridian Score	Nebraska Total Care Score	United Healthcare Score	WellCare Score
<b>Corporate Overview (Including financial information)</b>										
financial statements and information	V.A.2.b Corporate Overview	*three years of independently audited financial statements and associated enrollment figures *if not publicly held, reports and statements required of a publicly-held corporation, or a description of the organization provided in such a manner that evaluators may formulate a determination about financial stability and strength; and a banking reference *disclosure of any and all judgments, litigation, or other real or potential reversals (More information is in the RFP.)	0-maximum points	5	3	3	3	3	3	3
contract performance	V.A.2.g Corporate Overview	if the bidder or any proposed sub-contractor has had a contract terminated for default, all such instances must be described. (More information is in the RFP.)	0-maximum points	5	3	3	3	2	3	3
experience	V.A.2.h Corporate Overview	*Summary matrix listing the bidder's previous projects similar to this RFP in size, scope and complexity. *Narrative descriptions should highlight similarities between the bidder's experience and this RFP. *A maximum of 3 narrative project descriptions will be used by the State. (More information is in the RFP.)	0-maximum points	80	32	30	50	16	47	49
risk bearing relationships	na	1. Describe proposed risk bearing partnerships/relationships, function, and oversight.	0-maximum points	15	9	9	9	6	9	9
past regulatory actions, sanctions, or deficiencies history	na	2. Identify and describe any regulatory action or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against the MCO's organization within the last five years. In addition, identify and describe any letter of deficiency issued, as well as any corrective actions required by any federal or state regulatory entity within the last five years that relate to Medicaid and CHIP contracts. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	0-maximum points	5	3	2	4	2	4	2
criminal or civil investigation history	na	3. State whether or not the MCO is currently, or has been within the past five years, the subject of a criminal or civil investigation by a state or federal agency. If yes, provide an explanation with relevant details and the outcome. If the outcome was against the MCO, provide the corrective action plan or measures taken to prevent such future offenses. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	0-maximum points	5	2	3	3	3	3	2
reinsurance arrangements	III.G.3	4. Describe risk analysis, assumptions, cost estimates, and rationale for MCO's proposed reinsurance arrangements.	0-maximum points	15	8	9	9	8	9	9
subtotal				130	60	59	81	40	78	77



# Exhibit

# E

Iowa Department of Inspections and Appeals  
Division of Administrative Hearings  
Wallace State Office Building – Third Floor  
Des Moines, Iowa 50319

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Iowa Total Care, Inc.,	)	Appeal No. 16001573
Meridian Health Plan of Iowa, Inc., and	)	Appeal No. 16001590
Aetna Better Health of Iowa, Inc.,	)	Appeal No. 16001623
	)	
Appellants,	)	
	)	
v.	)	
	)	
Iowa Department of Human Services,	)	
	)	
Respondent,	)	
	)	
Amerigroup Iowa, Inc., AmeriHealth	)	<b>PROPOSED DECISION</b>
Caritas, Inc., UnitedHealthcare	)	
Plan of the River Valley, Inc., and	)	
WellCare of Iowa, Inc.,	)	
	)	
Intervenors.	)	

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**Statement of the Case**

Each Appellant filed a timely Notice of Appeal contesting the Notice of Intent to Award RFP No. MED-16-009 issued by Respondent Iowa Department of Human Services on August 17, 2015. The Department transmitted the appeal to the Department of Inspections and Appeals, Division of Administrative Hearings to schedule a contested case hearing. Contested case proceedings for the appeals were consolidated by Prehearing Order issued on September 18, 2015. Motions to intervene filed by the four successful bidders, Amerigroup Iowa, Inc., AmeriHealth Caritas, Inc., UnitedHealthcare Plan of the River Valley, Inc., and WellCare of Iowa, Inc., were granted. Prehearing motions, orders, and rulings are included in the record. Protective Orders are also documented in the record.

A five-day contested case hearing was held in-person in Des Moines commencing on October 26<sup>th</sup> through October 31<sup>st</sup>. All parties participated and were represented by counsel. Live testimony was received from Charles Palmer, Elizabeth Matney, Richard Shults, Julie Lovelady, Thomas Arnold, Jean Slaybaugh, Carolyn Renée Schulte, Mikki

Stier, Jon Wetlaufer, Christopher Rants, and Lauralie Rubel. A certified transcript of the testimony is included in the record.

Written testimony from Raymond Pitera and the depositions of Susan Parker, Lorrie Tritch, Randall Clemenson, Lisa Roberts, Kathy Stone, Gerd Clabaugh, Carrie Lindgren, and Carol Steckel were also received and are included within the exhibits listed below. The following exhibits were offered and admitted into evidence: Joint Exhibits 300-490; DHS Exhibits A-K; Aetna Exhibits 5022, 5031-5033, 5077, 5119, 5132, 5137, 5139, 5142, 5247, 5149, 5160-5165, 5177, 5196, 5199, 5201, and 5204-5209; ITC Exhibits O, Q, Y, Z, QQ, and WW; Meridian Exhibits B and G (Pitera testimony); United Exhibits A-C, and E-P; and WellCare Exhibit A.<sup>1</sup>

A motion *in limine* was granted to exclude proposed expert testimony from Kelly Hannum, Ph. D., and John Pachter, Esq. (Tr. 295-310) Iowa Total Care and Aetna were granted leave to submit offers of proof for these proposed witnesses. (Tr. 1568-69) Iowa Total Care and Aetna submitted a Joint Offer of Proof for Dr. Hannum, which has been entered into the record. Aetna submitted an offer of proof for Mr. Pachter which included a supplemental expert report, dated November 4, 2015. This offer has also been entered into the record.<sup>2</sup> Objections to exhibits that were sustained and offers of proof as to some of these exhibits are detailed in the hearing transcript.

### **Issue Presented**

Whether the Department followed the correct procedures in issuing the Notice of Intent to Award.

### **Decision**

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<sup>1</sup> Aetna Exhibits 5161-5165 were offered on the last day of hearing, and received subject to a pending objection. United Exhibits A-C, and E-P were offered in rebuttal to exhibits 5161-5165, if admitted. (Tr. 1556-60, 1564-66) As detailed in footnote 17, below, the objection is overruled and all of the exhibits are admitted.

<sup>2</sup> Intervenor WellCare of Iowa, Inc. filed an objection to the inclusion of the Pachter's supplemental expert report in the offer of proof, arguing it was beyond the scope of offer discussed at the close of hearing. Aetna resisted the objection. At hearing, Aetna requested and was allowed the opportunity to submit a statement in addition to Pachter's original report. The supplemental report is one form of a statement. The offer of proof is not evidence. Rather it is an offer intended to preserve evidence that a party was not allowed to present for a reviewing tribunal. The precise form is of little consequence. The objection is overruled.

The Notice of Intent to Award is AFFIRMED as Amerigroup Iowa, Inc., AmeriHealth Caritas, Inc., and UnitedHealthcare Plan of the River Valley. The Notice of Intent to Award is REVERSED as to WellCare of Iowa, Inc.

### **Findings of Fact**

Iowa Department of Human Services (DHS) is the single state agency responsible for administering the Medicaid program in Iowa. Medicaid is a cooperative federal-state program that makes publically funded health care services available to people with inadequate financial resources, including children, elderly and disabled persons, and families with dependent children. The program is jointly funded by state and federal tax dollars. Medicaid coverage groups and the associated Iowa Health and Wellness Plan and Children's Health Insurance Program (*hawk-i*) provide health care coverage for more than 560,000 Iowans at a cost of approximately \$4.2 billion annually. (Tr. 82; Jt. Exhibit 439)

Iowa Medicaid operates largely as a fee-for-service program, although some relatively small population segments of the program, such as behavioral health, are operated through managed care contracts. Under the fee-for-service system, Medicaid directly pays doctors and other health care providers a pre-established rate for each service performed. (Tr. 84-87, 516-17; Jt. Exhibit 439) The rising cost of health care services and expansion of program eligibility and enrollment resulting from the federal Affordable Care Act have contributed to consistently rising Medicaid spending. The state's share of Medicaid costs has grown by roughly 73% over the last decade. (Tr. 507) State funding of Medicaid for the 2015 fiscal year exceeded \$1.5 billion. DHS and state policy-makers have long been striving to limit the rising cost of Medicaid.

Charles Palmer was first appointed Director of the Iowa DHS by Governor Terry Branstad in 1988. He left the agency in 1999. Palmer was again appointed to be the Iowa DHS Director when Governor Branstad resumed office in January of 2011. The state was then grappling with the question of whether to expand the Medicaid population in order to access additional federal funding available under the Affordable Care Act. Rather than expanding the traditional Medicaid program, Iowa sought and received a waiver authorizing the state to provide alternate coverage to low-income residents through the Iowa Health and Wellness Plan and Iowa Marketplace Choice Plan. Transition to these alternate expansion plans took place on January 1, 2014.

Soon thereafter the Governor and Director Palmer turned their focus to Medicaid cost containment. They had been discussing the potential of shifting the Iowa Medicaid program from the fee-for-service model to a managed care system for several years as they observed states around the country moving Medicaid service delivery to managed care. In January of 2014, the Governor decided it was time to start the transition of

Iowa Medicaid to managed care. The Governor's primary health policy advisor, Michael Boussetot, and Director Palmer were responsible for developing a plan to effectuate the change. The central concept was for the state to contract with one or more private managed care organizations to operate the various Medicaid programs and provide services to Medicaid enrollees in exchange for a fixed rate, or capitation fee, paid by the state for each enrolled member. (Tr. 92-93, 154-55) The administration's targeted start date for the switch to managed care was January 1, 2016. The administration estimated this new approach to the Medicaid program would result in \$51.3 million in cost saving to the state during the first six months. (Jt. Exhibit 439)

To execute the plan, dubbed the Iowa High Quality Health Care Initiative or "Medicaid Modernization," DHS undertook a competitive procurement process to select Managed Care Organizations (MCOs) to assume operation of the vast majority of the Iowa Medicaid program. Contracts for services with an annual value exceeding four billion dollars were at stake, making this the largest contract procurement in state history. (Tr. 145, 429) Director Palmer ultimately decided to offer contracts to four MCOs. The Appellants are among the unsuccessful bidders. They each bring multifaceted challenges to the procurement process. Determination of the merits of these challenges requires a general understanding of the procurement, as well as an in-depth study of certain aspects of the process.

**Scope of Work and RFP development:** Early in 2014, Director Palmer and Mr. Boussetot began to create the "scope of work" for the project, detailing how the Medicaid managed care plan would be structured and what services participating managed care organizations would be required to provide to individuals enrolled in Iowa Medicaid and the state. DHS enlisted Seema Verma Corporation – an outside consulting firm that previously assisted DHS with development of the Medicaid waivers needed for the Iowa Health and Wellness Plan – to assist with development of the scope of work. Director Palmer and Boussetot worked closely with Seema Verma, the corporate founder, as she and her staff prepared an initial draft of the scope of work for the procurement, meeting as often as once a week for several months to review segments of the document. No one else from DHS or the Governor's office was involved in this initial phase of the project. (Tr. 92-95, 155-56)

In August of 2014, as DHS began work on its budget proposal for the following fiscal year (FY 2016). Director Palmer shared the plan for the transition the Iowa Medicaid program to managed care to high-level DHS staff, including Deputy Director Sally Titus and Jean Slaybaugh, the Administrator of the Fiscal Management Division. Slaybaugh was assigned to serve as the "executive sponsor" of the project. (Tr. 508, 514)

Seema Verma provided the scope of work draft to DHS in October of 2014, and key DHS staff began reviewing and editing the document to ensure it was consistent with state and federal Medicaid requirements and was in a format that could serve as a basis for

providers to bid on the project. (Tr. 95-97) Acting Medicaid Director Julie Lovelady and Elizabeth Matney, the DHS Executive Director for managed care programs, were primarily responsible for finalization of the scope of work. (Tr. 518-519) A significant number of agency staff, including people from the finance area, contracting area, and Iowa Medicaid Enterprise subject matter experts were involved in the process. (Tr. 100)

The agency also consulted officials in other states where Medicaid had been shifted to managed care, seeking guidance regarding best practices and lessons learned. (Tr. 521)

The prospect of shifting Iowa Medicaid to a managed care model was not publically announced or widely known during the fall and early winter of 2014. While the scope of work was being developed, DHS staff members working on the project were instructed to keep the project confidential. (Tr. 928) The Iowa Medicaid Enterprise office building is located on Army Post Road in Des Moines. The majority of staff in that building work for contractors that perform operational functions for the program. Matney, whose regular work station was in the IME building, was moved to the Hoover Building while assigned to work on the RFP. A primary reason for the move was to ensure that IME contractors, who were potential bidders for the project, did not have access to information about the RFP. (Tr. 687-88, 1029)

The DHS Bureau of Service Contract Support began developing the Request for Proposal (RFP) documents for the procurement in December of 2014. DHS also engaged the services of Ikaso, L.L.C., a San Francisco consulting firm specializing in state government procurement support, to assist with completion of the RFP and provide technical assistance and administrative support to agency staff throughout the procurement process. (Tr. 97-99, 523-24) Ikaso director Tom Arnold led the company's work on the RFP. Arnold has been consulting on state procurement for the past 12 years and has experience with procurements involving a wide range of goods and services, including three Medicaid managed care procurements for the state of Indiana. (Tr. 335-338)

**Issuance and Revision of the RFP:** On February 16, 2015, DHS issued the RFP, which was posted to the state's official Bid Opportunities website. The RFP, formally titled "Iowa Department of Human Services – Request for Proposal – Iowa High Quality Healthcare Initiative – RFP MED-16-009," has been variously referred to throughout this proceeding by its formal title, as Medicaid Modernization, and simply as the managed care RFP. The RFP included the following general statement of purpose:

The Iowa Department of Human Services ("Agency") intends to contract for delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa (*hawk-i*) programs. The Agency intends to contract on a statewide basis with two (2) to four (4) successful bidders with a demonstrated capacity to

coordinate care and provide quality outcomes for the Medicaid and Children's Health Insurance Program (CHIP) populations. The program will enroll the majority of the Iowa Medicaid and CHIP populations and will also provide services for individuals qualifying for Iowa Department of Public Health (IDPH) funded substance abuse services. The final number of awarded contracts under this RFP will be determined at the sole discretion of the Agency.

(Jt. Exhibit 369, at p. 2)<sup>3</sup> The RFP included the anticipated procurement timeline and sections detailing the contract payment methodology; basic information about the procurement process; format and content specifications for responses; and a description of the process that would be used to evaluate proposals. The services to be provided, performance standards, and technical requirements were set out in Attachment 1 – the Scope of Work. (Jt. Exhibit 370)<sup>4</sup>

All selected contractors were to be paid the same per member per month capitation payment to cover the bulk of services under the contract. (Jt. Exhibit 369, at § 1.4.2) Because of this, cost proposals were not required and cost did not play a role in the evaluation methodology. Proposals were to be graded on a pass/fail basis for adherence to mandatory requirements and on the bidders' financial stability. Proposals passing these criteria, that were not otherwise disqualified, would then be scored solely on the basis of technical merit. (*Id.* at § 4.3) The RFP made it clear DHS would "not necessarily award a contract to the bidder with the highest point total. Rather, a contract will be awarded to the bidder that offers the greatest benefit to the Agency." (*Id.* at § 4.1)

The RFP timeline allowed prospective bidders to offer comments about the general design of the proposed program during the two weeks after the RFP was issued. (*Id.* at § 2.5) A Bidders' Conference was held in Des Moines on March 10, 2015, to provide prospective bidders with an overview of the work to be performed and give bidders an opportunity to ask verbal questions about the RFP. (*Id.* at § 2.7, Tr. 692-94) The RFP also invited prospective bidders to submit written questions or requests for clarification to DHS. Questions were to be routed through Carrie Lindgren, the designated Issuing Officer and "sole point of contact regarding the RFP." (*Id.* at §§ 2.1, 2.8) Prospective bidders were explicitly prohibited from communicating with any other employee about the RFP. (*Id.* at § 2.2)

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<sup>3</sup> The RFP was amended seven times during the course of the procurement. Jt. Exhibit 369 is the Final version of the RFP incorporating all of the amendments. Unless otherwise noted, all references to the RFP in this decision are this final version of the document.

<sup>4</sup> The Scope of Work was also amended several times while the RFP was outstanding. As with the RFP, unless otherwise noted references herein are to the final version, Jt. Exhibit 370.

Between March 11<sup>th</sup> and July 31<sup>st</sup>, DHS offered prospective bidders five rounds of written questions and answers. Questions submitted through this process were routed to appropriate DHS staff, responses were compiled and posted to the Bid Opportunities website to ensure that all bidders had access to the same information. As noted above, seven amendments to the RFP were issued between March 11<sup>th</sup> and July 31<sup>st</sup>. The amendments incorporated changes to clarify the RFP, requirements of the Scope of Work, and the procurement process; provided capitation rates and rate data; and made minor revisions to the procurement timeline. (Jt. Exhibits 313-17, 320-23, 325-27, 331-34, 335-37, 356-61, & 364-67)

The submission deadline was May 26, 2015. DHS received proposals from eleven managed care organizations. The sixth and seventh amendments to the RFP were issued after proposals were received by DHS. On July 13<sup>th</sup>, DHS issued the sixth amendment revising the capitation rates and the medical loss ratio allowed under the Scope of Work and revising the RFP timeline to include a second Bidders' Conference on July 14<sup>th</sup> and another round of written questions – limited to questions about the capitation rate and Scope of Work amendments, followed by issuance of the “finalized capitation rate data book” and rate recertification by bidders.<sup>5</sup> (Jt. Exhibits 356-59) The seventh amendment, was issued on July 31<sup>st</sup>, with the finalized capitation rate data book and a Bid Proposal Certification Addendum/Withdrawal form. (Jt. Exhibits 364-67) All bidders that desired to have their proposals considered were required to return the form by August 10<sup>th</sup>, certifying acceptance of all capitation rates established by DHS, including those published on July 31<sup>st</sup>, and accepting all terms and conditions in the amended RFP. Bidders also had the option of rejecting the changes and withdrawing their proposal. (Jt. Exhibit 367) One bidder, Gateway, chose to withdraw. The remaining ten, including the three Appellants and four Intervenors in this matter, accepted the changes.

**Evaluation of the Proposals:** *Project Evaluation Committee formed* - DHS formed the evaluation committee for the project from agency staff. The function of the evaluators was to individually review all responses to the RFP, meet as a team to score the proposals based on technical merit, solicit and consider responses to clarifying questions, attend oral presentations (if used), finalize scores and make award recommendations to the final decision maker.<sup>6</sup>

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<sup>5</sup> The capitation rate change was made at this late date because DHS discovered an error in the way data had been allocated in the initial actuarial calculation of the rates. (Tr. 603-04)

<sup>6</sup> As issued, the RFP indicated that the final decision on contract awards would be made by the Acting Administrator of Iowa Medicaid Enterprise. (Jt. Exhibit 300 at § 4.5) The first round of bidder questions included a question asking DHS to identify the acting administrator of IME. In response, DHS stated Julie Lovelady was then the acting administrator and noted that the reference in the RFP would be amended. (Jt. Exhibit 312, at Ques. 79) The first Amendment to the RFP, issued on March 26, 2015, added a definition to RFP section 1.3 – defining

Selection criteria for the committee included overall familiarity with the Iowa Medicaid program, the RFP, and the agency's goals; the ability to think broadly and comprehensively about the project; and time availability. Four individuals who had extensive knowledge of all or critical portions of the Medicaid program were selected: Jean Slaybaugh – the DHS Fiscal Management Division Administrator; Julie Lovelady – at that time the Acting Medicaid Director; Elizabeth Matney – at that time a quality oversight manager with responsibility for overseeing day-to-day operations of existing Medicaid managed care contracts; and Richard Shults – the Mental Health and Disability Services Division Administrator. Each of the evaluators was familiar with the RFP and had been involved in reviewing and finalizing the scope of work for the procurement. (Tr. 529, 531-32)

Ikaso consultants Tom Arnold and Scott Ferron facilitated two evaluator training sessions, which all four evaluators attended. Both sessions were also attended by Carrie Lindgren, the Issuing Officer for the RFP and her supervisor Jon Wetlaufer, the Chief of the DHS Service Contract Support Bureau. The first session was held on April 14<sup>th</sup>, before membership of the committee had been finalized and was attended by three additional potential evaluators. The prospective evaluators were presented with an overview of the proposed evaluation process, the scoring methodology – which was still under development, and the projected evaluation timeline. (Tr. 361-68; Jt. Exhibit 436) The second session, held on May 13<sup>th</sup>, included a similar review of the evaluation process and a more detailed discussion of the scoring methodology, including how the various sections of the RFP on which the proposals would be scored would be weighted. The evaluators were told that subject matter experts might provide input for their consideration. (Tr. 370-73, 378-79; Jt. Exhibit 437)

*Subject Matter Experts* - In addition to a pass/fail financial stability review by the Iowa Insurance Division, DHS decided to utilize subject matter experts (SMEs) to review portions of the proposals addressing information technology, pharmacy services, and Iowa Department of Public Health (DPH) funded substance abuse services (which were encompassed in the deliverables under the scope of work). The SMEs were Kathy Stone, the Director of the DPH Division of Behavioral Health; Susan Parker, the Pharmacy Director for Iowa Medicaid; and a three-person team from the DHS Division of Data Management: DHS Chief Information Officer Lorrie Tritch, Randall Clemenson, and Lisa Roberts. (Tr. 372-74; DHS Exhibits F – J) Ikaso representatives Arnold and

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“Administrator of the Iowa Medicaid Enterprise” as “the individual in the role of the Administrator of the Iowa Medicaid Enterprise, regardless of whether this individual occupies the role in an Acting or Interim capacity,” and struck the word “Acting” from RFP section 4.5. (Jt. Exhibit 314 at §§ 1.3 & 4.5) The Administrator of IME remained the designated final decision maker until the final amendment to the RFP was issued on July 31, 2015. This amendment made minor revisions to the procurement timeline and changed the designated final decision maker to the Director of the Department of Human Services. (Jt. Exhibit 365)

Ferron conducted a training session for the SMEs in early June.

The SMEs were provided with portions of the proposals relevant to their areas of expertise and were asked to create a narrative document and summary offering insights to assist the evaluation committee in its review. SMEs were told they could note strengths and weaknesses of each portion of the proposals reviewed, but they should not offer any statements that could be interpreted as suggesting a certain score. The narratives and summaries were to be factual and based on the content of the proposals. Editorial comments or statements about bidders were to be avoided. (Tr. 374; Jt. Exhibit 438) Materials were distributed to the SMEs during the second week of June. Their completed reports were to be completed and available for distribution to the evaluation committee by July 2<sup>nd</sup>.

*Scoring Methodology* - Notice of the evaluation methodology was posted to the Bid Opportunities website on May 21<sup>st</sup>. Bidders were told that the financial stability requirement would be examined by the Iowa Insurance Division, which would make a pass/fail recommendation to DHS regarding the financial stability of each bidder. Use of other SMEs was not mentioned. The scoring system was explained, including the 19 criteria that would be scored – each correlating to a section of the RFP or scope of work; the weight assigned to each criterion, and the 0 to 4 point system that would be used by the evaluation committee to assess the technical merit of the proposals. The notice described the scoring system as follows:

**Scoring Criteria & Available Points**

Points will be assigned based on the Bidders' response to RFP Sections 3.2.4, 3.2.5, 3.2.6, and 3.2.7. Bid proposals that pass the mandatory requirements and financial stability review steps will be scored against the following criteria:

Criteria	SOW Section	Points
Scope of Work Requirements: Tab 3 and Applicable Attachments in Tab 5 and Tab 6		
RFP Purpose and Background	1	1.0
General/Administrative Requirements	2	4.0
Scope and Covered Benefits	3	7.0
Long Term Services and Support	4	7.0
Billing and Collections	5	3.0
Provider Network Requirements	6	7.0
Enrollment	7	4.0
Member Services	8	7.0
Care Coordination	9	8.0
Quality Management and Improvement Services	10	8.0

Utilization Management	11	6.0
Program Integrity	12	8.0
Information Technology	13	7.0
Performance Targets and Reporting Requirements	14	6.0
Termination	15	2.0
Bidder's Background: Tab 4 and Applicable Attachments in Tab 5 and Tab 6		
Experience, Including References and Contract List	N/A	6.0
Personnel	N/A	5.0
Termination, Litigation, and Investigation	N/A	3.0
RFP Forms: Tab 6		
RFP Forms	N/A	1.0
TOTAL POINTS		100.0

### Scoring Methodology

During the evaluation process, the proposals will be scored against each of the scoring criteria on a scale ranging from 0-4. Scores will be assigned based on the sole judgement of the evaluation committee, as follows:

- 0 - Bidder has not addressed any of the requirements and/or has provided a response that is limited in scope, vague, or incomplete. Response did not provide a description of how the State's needs would be met.
- 1 - Bidder has agreed to comply with the requirements and provided some details on how the requirements would be met. Response does not clearly indicate if all the needs of the State will be met.
- 2 - Bidder has agreed to comply with the requirements and provided an adequate description of how the requirements would be met. Response indicates adequate ability to serve the needs of the State.
- 3 - Bidder has agreed to comply with the requirements and provided a good and complete description of how the requirements would be met. Response clearly demonstrates a high degree of ability to serve the needs of the State.
- 4 - Bidder has agreed to comply with the requirements and provided a clear and compelling description of how each requirement would be met, with relevant supporting materials. Bidder's proposed approach goes above and beyond the minimum requirements and indicates superior ability to serve the needs of the State.

The 0-4 score and the available points in each area will determine that area's weighted point value, with 4 receiving the full amount of available points, 3 receiving 75% of the available points, 2 receiving 50% of the

available points, 1 receiving 25% of the available points, and 0 receiving no points. For example, if a criteria has 8 available points, a score of 3 would lead to a weighted point value of 6. The weighted point values across all criteria will be summed to arrive at a total score.

Wherever possible, the evaluation committee will assign a group score. In instances where a group score is not possible, an average will be taken.

(Jt. Exhibit 340)

*Review and initial scoring of the proposals* - Three threshold requirements for consideration of proposals are listed in section 2.15.1 of the RFP:

**2.15.1 Mandatory Requirements.**

Bidders must meet these mandatory requirements or will be disqualified and not considered for award of a contract:

- The Issuing Officer must receive the Bid Proposal, and any amendments thereof, prior to or on the due date and time (See RFP Sections 2.10 and 2.11).
- The bidder is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from receiving federal funding by any federal department or agency (See RFP Additional Certifications Exhibit).
- The Bid Proposal contains a bid proposal security. Prior to disqualifying a Bid Proposal for not containing a bid proposal security, the Agency would provide notice to the bidder's email address allowing the bidder forty-eight (48) hours to submit the security to the Issuing Officer (See RFP Section 3.2.1).

(Jt. Exhibit 369, at p. 8) On May 27<sup>th</sup>, the day after the submission deadline, staff in the DHS Bureau of Service Contract Support reviewed the eleven proposals and found they all met these mandatory requirements. (Tr. 386-87; Jt. Exhibit 447-53) The proposals, scoring criteria, and note-taking templates were then distributed to the four evaluation committee members for initial review. The evaluators were instructed to independently review each proposal for strengths, weaknesses, points of clarification, and potential grounds for disqualification; but not to score the proposals until the next phase of the process when the committee would meet and assign group scores using a consensus scoring process. (Tr. 388, 704; Jt. Exhibit 437)

Although bid proposals were limited to 1000 pages, documents included behind Tab 6 (RFP forms, financial statements, staff resumes, contract lists and tables, and other referenced attachments) did not count toward the 1000 page limit. (Jt. Exhibit 369, §§ 3.1, 3.2.7; Jt. Exhibit 308) The proposals averaged about 1,700 to 1,800 pages, including

attachments. (Tr. 543) Each evaluator read through one proposal at a time and prepared notes as instructed. The time devoted to this process varied, with estimates ranging from 18 to 40 hours per proposal. (Tr. 543-44, 702-05, 861-66, 998-1001) The SME reports were distributed to the evaluators in early July. Each evaluator reviewed all the RFPS, or the relevant portions of an RFP, before reviewing the SME comments. None felt that the SME reports significantly changed their impressions of the proposals. Rather, they all agreed that the SME reports largely confirmed their initial impressions of the information technology, pharmacy, and DPH services sections of the proposals. (Tr. 546-48, 705, 865-66, 1000-01)

The evaluation committee met as a group from July 27<sup>th</sup> through July 31<sup>st</sup> to score the proposals. The Ikaso consultants were present. Tom Arnold facilitated the scoring sessions. Scott Ferron recorded the committee members' comments on four of the days. One day Ferron was absent and a DHS staff member, Julie Williams, recorded notes for the committee. Jon Wetlaufer and Carrie Lindgren from the DHS Service Contract Support Bureau were also present for a majority of the week. (Tr. 392-93) The committee worked long days, spending four to five hours scoring each proposal and putting in from 50 to 55 hours over the course of the five days. (Tr. 401, 562)

Bidder names were drawn to randomly determine the order of review of the proposals.<sup>7</sup> The committee worked through the proposals sequentially, scoring all 19 criteria or sections of one proposal before moving to the next proposal. The committee used a consensus scoring process. First, they discussed the merits of each section of the proposal in relationship to the corresponding section of the scope of work or RFP. The evaluators took turns leading the discussion by presenting the strengths and weaknesses, questions, and other comments noted during individual review. Each committee member was given a chance to respond and add comments. The designated scribe, Ferron or Williams, recorded the comments as the initial scoring notes of the committee. They attempted to make note of all comments during committee discussions and record questions raised by the evaluators for possible follow-up. The notes were projected onto a screen and evaluators were given a chance to review the notes for accuracy before a section was scored. (Tr. 393-395, 494-95, 706)

Each committee member had flip cards with the numbers 0 to 4 and a copy of the scoring methodology describing each scoring level. When the discussion and note taking was completed for each section, the evaluators were told to prepare their votes and the facilitator did a countdown from three to cue them to simultaneously hold up the score they thought appropriate for the section. If the evaluators all scored the section the same, the score was recorded on an evaluation scorecard (Jt. Exhibits 426A-432) and the committee moved to the next section. If the scores differed, the evaluators

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<sup>7</sup> The proposals were scored in the following order: 1) Aetna; 2) Iowa Total Care; 3) Meridian; 4) Gateway; 5) Molina; 6) AmeriHealth; 7) UnitedHealthcare; 8) Magellan; 9) Amerigroup; 10) WellCare; and 11) Medica. (Tr. 457)

further discussed their understanding of the proposal and the reason for their votes in an effort to reach consensus, with the understanding that if they could not agree an average of the individual scores would be recorded. More often than not, the evaluators' scores were unanimous on the first showing. In all instances, the evaluators ultimately agreed on the score awarded. (Tr. 395-98, 409-10, 557-58)

The scoring process was limited to a comparison of the various sections of each proposal to the relevant section of the RFP or scope of work. The score for each section was entered into a scoring grid as the committee worked through the process and the scores were tallied. At no point did the committee discuss the relative merits of the proposals or perform a side-by-side comparison of any section of the proposals. The evaluators finished scoring the last proposal late in the afternoon on Friday, July 31<sup>st</sup>. When they completed scoring the eleventh proposal, the initial phase of the scoring was completed. The committee did not engage in any type of comparative review of the scores. (Tr. 409-10, 461, 560-61, 747-750, 915)

*Clarifying questions* - The RFP provided that DHS could "request clarification from bidders for the purpose of resolving ambiguities or questioning information presented in the Bid Proposals" throughout the evaluation period. (Jt. Exhibit 369 at § 2.16) DHS reserved the right to "consider any changes in or clarifications to a bidder's proposal [resulting] from rounds of clarification as part of the evaluation process. (*Id.* at § 4.4.1) Questions raised by the evaluation committee members during the joint scoring process were noted by the scribe. Some were resolved by reference to the proposal and group discussion. Others were set aside for potential follow-up with the bidders. After the last scoring session adjourned, Ikaso consultants Arnold and Ferron compiled the remaining questions into lists for each bidder and sent them to the evaluators for review before relaying the questions to bidders for response by the end of the following week. Responses were received from all bidders on or before the August 7<sup>th</sup> deadline. (Tr. 399-400, 413; Jt. Exhibits 440-446)

The evaluation committee met on August 10<sup>th</sup> to review the responses to clarifying questions and finalize scoring of the proposals. Ferron, Lindgren and Wetlaufer were also present. The committee changed only one score as a result of the responses. The score given to UnitedHealthcare for the section addressing Termination, Litigation, and Investigation was reduced from 3 to 2. (Tr. 414, 568; *compare* Jt. Exhibits 432A and 432B)

*Committee report to Director Palmer* - The evaluation committee and staff met again on August 11<sup>th</sup> to finalize documents the Ikaso consultants had prepared to convey the committee's recommendation to Director Palmer. The materials included: a non-comprehensive summary the initial scoring notes compiled during the scoring sessions, titled "Select Strengths and Weaknesses of Technical Proposals;" a full copy of the initial scoring notes; the Evaluation Scorecard - a scoring grid showing the raw and weighted

score for each scored section of each proposal and the total points awarded to each proposal; and a memorandum summarizing the evaluation process and providing the committee's final ranking of the proposals. (Tr. 1009-10; Jt. Exhibits 433 - 435)

Ranking	Bidder	Final Technical Score (out of 100)
1	Amerigroup	78.00
2	United	77.25
3	WellCare	65.75
4	AmeriHealth	63.25
5	Iowa Total Care	60.25
6	Aetna	56.50
7	Magellan	51.75
8	Molina	41.25
9	Medica	40.75
10	Meridian	35.00

All committee members agreed that the ranking was based solely upon the final score awarded to each proposal. (Tr. 625-26, 753, 960-61, 1030) They did not discuss deviating from the ranking as they prepared their recommendation. (Tr. 625-26)

On August 12, 2015, the evaluation committee presented its report and recommendation to the DHS Director in a meeting attended by Director Palmer, Deputy Director Sally Titus, Iowa Medicaid Administrator Mikki Stier,<sup>8</sup> the committee members, Ikaso consultants Arnold and Ferron, and Lindgren and Wetlaufer from the DHS Service Contract Support Bureau. Arnold presented the Director with the committee's report and the supporting materials and generally explained the evaluation process. (Tr. 114, 420-21; DHS Exhibit A) The meeting lasted about two hours. Director Palmer wanted to make certain that he understood the evaluation process. They discussed the various scoring categories, how the committee determined weightings for the categories, and how the scores were derived. The Director spoke with each of the evaluators about their level of comfort with the final results and whether they thought the top scoring bidders were capable of delivering what the state wanted. In the end Palmer concluded that the evaluators were all satisfied with the scoring process. (Tr. 115-18)

**Contract award:** Director Palmer met with Ikaso consultants Arnold and Ferron for about 45 minutes the following day to discuss their impressions of the evaluation process. The consultants raised no concerns and were highly complementary of the

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<sup>8</sup> Stier was selected in April and assumed the position of Iowa Medicaid Director on May 27, 2015, replacing Acting Director Julie Lovelady.

evaluators and the process. The Director requested and received copies of the reference letters included with the bidder's proposals. (Tr. 129-30) After meeting with evaluators and consultants and reviewing the materials they provided, Director Palmer saw no reason to question the evaluation committee's ranking of the bid proposals. (Tr. 228-29)

The Director's next step was to decide how many contracts would be awarded. The RFP indicated two to four MCOs would be selected. Director Palmer thought they could possibly award as many as five contracts. On Sunday, August 16<sup>th</sup>, Director Palmer met with Deputy Director Titus, CFO Slaybaugh, IME Administrator Stier, and the Ikaso consultants to discuss the number of contracts to be awarded. They discussed the implications that contacting with three, four, or five MCOs and the effect each alternative would have on service providers, Medicaid members, administrative costs, the DHS oversight function, and the agency's ability to have the new program up and running on January 1, 2016. (Tr. 133-40, 586-89) At the end of the Sunday meeting, Director Palmer had ruled out offering five contracts, but was still trying to decide whether to offer three or four contracts. (Tr. 140-41)

The RFP called for DHS to announce the contract awards the following day – Monday August 17<sup>th</sup>. That morning Director Palmer and Jean Slaybaugh met with Michael Boussetot and Nic Pottebaum from the Governor's staff and Department of Management Director David Roederer. They further discussed the factors at play and pros and cons of selecting three versus four MCOs. (Tr. 135, 141, 590) In the end, Director Palmer concluded that contracts would be offered to the MCOs with the four highest scoring proposals. On the afternoon of August 17<sup>th</sup>, DHS issued a Notice of Intent to Award Contracts to Amerigroup Iowa, Inc., UnitedHealthcare Plan of the River Valley, Inc., WellCare of Iowa, Inc., and AmeriHealth Caritas Iowa, Inc. (Jt. Exhibit 380)

**Requests for reconsideration & appeals:** Three unsuccessful bidders – Aetna Better Health of Iowa, Inc., Iowa Total Care, Inc., and Meridian Health Plan of Iowa, Inc. – filed timely request for reconsideration of the contract award decision. Director Palmer denied each of the requests and these appeals followed. The Appellants challenge many aspects of the procurement. Some of the challenges relate directly to elements of the procurement and evaluation process discussed above. The remaining grounds for appeal concern a potential organizational conflict of interest; alleged improper communications during the RFP blackout period; alleged errors and inconsistencies in the evaluation committee's scoring of the proposals; and significant undisclosed litigation, penalties, and corrective action.

**Basis of Organizational Conflict of Interest claim:** The Appellants allege that WellCare's relationship with former state legislator and DHS contractor Renée Schulte constituted a disqualifying conflict of interest. Schulte was elected to the Iowa House of Representatives in 2008 and 2010. Schulte was one of four legislators serving on the

DHS Council and Director Palmer became acquainted with her after he returned to DHS in January of 2011. (Tr. 103) Schulte played a leading role in the passage of legislation mandating a comprehensive redesign of publically funded mental health and disability service delivery and funding systems during the 2012 legislative session. 2012 Iowa Acts (84<sup>th</sup> G.A.), ch. 1120. (Tr. 104, 1070)

Director Palmer approached Schulte shortly after she lost a bid for reelection in November of 2012, to see if she would be interested in assisting DHS with implementation of the mental health services redesign. (Tr. 192-94; *see* Aetna Exhibit 5033 for overview of redesign project) Schulte accepted. In January of 2013 Schulte Consulting, LLC, entered a contract to provide services to DHS for six months, in return for compensation of \$1,900.00 per week.<sup>9</sup> (ITC Exhibit Y) Richard Shults – the Mental Health and Disability Services Division Administrator was the DHS representative on the contract. Theresa Armstrong, a bureau chief in Shults's division, was the designated contract manager. Schulte reported to Armstrong, but also dealt directly with Shultz on occasion. (Tr. 968-69, 1081-82, 1142-43) Schulte and DHS executed four six-month extensions of the contract, the last extension for the period from January 1 to June 30, 2015, was finalized on January 2, 2015. (Tr. 1140-41; ITC Exhibit Z)

Schulte worked on a variety of tasks related to the mental health and disability services redesign, including: the development of necessary administrative rules, the implementation of peer support and family support structures and training, sub-acute care service delivery, and development of a strategic plan and assessment tool for monitoring evidence-based practices in the delivery of substance abuse and mental health services. (Tr. 196-97, 843-48, 1074-81) She was assigned exclusively to the Community Services Bureau in the Mental Health and Disability Services Division of DHS. This division is housed separately from and is not a part of Iowa Medicaid Enterprise. Schulte's work for DHS all related to the redesign project and the delivery of services to individuals not eligible for Medicaid. (Tr. 848-49, 1078-81)

Shults and Armstrong were both actively involved in drafting portions of the scope of work for the Medicaid modernization RFP. (Tr. 835-38) Schulte was not involved in development of the RFP and did not have access to the shared drive (computer file location) used to distribute documents related to the RFP. (Tr. 109, 851, 1086, 1088-89, 1128-30) Schulte was given access to cubicle space in the Hoover Building, which she used on the one or two days per week that she came to Des Moines. Most of the time, she worked from her home in Cedar Rapids. Schulte had a state email account and access to a shared drive storing documents related to her projects. (Tr. 1083, 1143)

Schulte testified that although she was aware of rumors about the privatization of

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<sup>9</sup> In June of 2012, Schulte formed a limited liability company, Schulte Consulting, LLC, with a plan to offer consulting services focused on health care services. Schulte was the sole employee of the company.

Medicaid through managed care that had been circulating since Governor Branstad returned to office, she had no confirmation that the administration was going forward with a move to managed care until she saw the Governor's proposed budget in January of 2015. (Tr. 1090-92) Schulte said that she did not see the RFP until it was released on February 16, 2015, and that she did not know that Shults and Armstrong were involved in the project. (Tr. 1102, 1232-33)

Christopher Rants was a member of the Iowa House of Representatives for 18 years. He served ten years in leadership positions, including two terms as Speaker of the House before deciding not to run for reelection in 2010. He has been self-employed doing contract work as a lobbyist, political consultant, and a consultant on government affairs and public relations since leaving the legislature. (Tr. 1383-85) Near the beginning of February 2015, Rants saw Schulte at the capitol and approached her to ask if she would be willing to assist him in placing his bid to become the government liaison – lobbyist – for WellCare. (Tr. 1093) Shortly thereafter, Rants introduced Schulte to Troy Hildreth, a Vice President of Business Development Strategy with WellCare, who was positioning the company to bid as an MCO in Iowa. They talked about Schulte's experience as a legislator, personal contacts, work for DHS, and familiarity with behavioral health issues. Hildreth asked Schulte to consider leaving her position with the state to devote her time to helping WellCare move its bid forward. (Tr. 1094, 1150-53) Schulte accepted.

On February 13, 2015, Schulte registered her company, Schulte Consulting, LLC, as supplier of services to WellCare and scheduled a meeting with Shults and Director Palmer to tell them about her decision. (Tr. 1158-59; Aetna Exhibit 5132) Schulte met with Shults and the Director on Monday, February 16<sup>th</sup>, told them she was getting involved with a company that was going to bid on the Medicaid modernization RFP, and asked to be released from the DHS contract. They mutually agreed to termination of Schulte's DHS contract effective February 20<sup>th</sup> and Schulte spent the remainder of the week organizing her work for DHS and preparing a final report to document the status of all outstanding items. (Tr. 1098-1102; ITC Exhibit Z)

Schulte immediately began working as a contractor for WellCare. She used her connections to lay groundwork for the formation of a provider network in Iowa and set up meetings between WellCare representatives and medical service providers and facilities. Broadlawns Hospital was considered a key provider and one of these meetings was with executives from Broadlawns Hospital, including Mikki Stier and the CEO. Schulte met Mikki Stier, then a Senior Vice President overseeing government relations for Broadlawns, when she was working on behavioral health issues as a legislator. Stier and Schulte had common interests and challenges. They became personal friends, and talked regularly and maintained social contact after Schulte left the legislature. (Tr. 1103-05, 1260-62)

Schulte played a primary role in drafting WellCare's proposal for the delivery of behavioral health services – the response to section 3.2.8 of the RFP. (Tr. 1100) WellCare perceived the mental health benefits required under the RFP to be “unique to Iowa.” (Tr. 1488) WellCare retained Schulte largely because her familiarity with the Iowa framework for delivery of behavioral and mental health services allowed her to tailor that portion of the WellCare proposal to directly address that section of the RFP. (Tr. 1175-76, 1488-89) Nearly all of the work Schulte did for the state under her contract with DHS directly related to the delivery of behavioral health services. She integrated references to WellCare's understanding of the Mental Health and Disability Services (MHDS) Redesign into section 3.2.8 of WellCare's proposal and assisted with preparation of another section of the proposal directly addressing the MHDS Redesign. (Tr. 1166, 1169-71; Aetna Exhibits 5139, 5142)

**Alleged improper communications:** The Appellants contend that communications between representatives of WellCare and state employees during the RFP “blackout period” violated the terms of the RFP and fatally tainted the procurement process. Several distinct lines of communication underlie this claim.

The RFP designated Issuing Officer Carrie Lindgren as the “sole point of contact regarding the RFP from the date of issuance until selection of the successful bidder.” (Jt. Exhibit 369, at § 2.1) Bidders were instructed that contact with other employees about the RFP was prohibited:

***2.2 Restriction on Communication.***

From the issue date of this RFP [2/16/15] until announcement of the successful bidder, the bidder may contact only the Issuing Officer regarding this RFP. The bidder shall not contact any other employee concerning this RFP. The Issuing Officer will respond only to questions regarding the procurement process.

(Jt. Exhibit 369) Bidders were also warned that DHS had discretion to disqualify a bid proposal for noncompliance with the specification of the RFP, including bidder-initiated unauthorized contact regarding the RFP with employees other than the Issuing Officer. (Jt. Exhibit 369, at § 2.15.2) The RFP does not define the term “employee” as used in section 2.2 and no guidance as to application of the restriction on communication was given by DHS or requested through the question and answer process. Director Palmer testified that he believed DHS employees with executive responsibility over Medicaid and staff from the governor's office with responsibilities related to the project, like Michael Boussetot, should not have had communications with bidders relating to the substance of the RFP or the specific process for decision-making on contract awards during the blackout period established by section 2.2. (Tr. 203-04)

*Schulte contact with Medicaid Director Stier* - As discussed above, Schulte and Mikki

Stier were friends. In February 2015, when Schulte began her work for WellCare, Stier was an executive at Broadlawns Hospital. Approximately 60 percent of Broadlawns business is related to Medicaid and Stier was heavily involved in monitoring the state's managed care initiative and trying to gauge how the changes in Medicaid would affect Broadlawns' business strategy. She reviewed the RFP scope of work, met with provider representatives, and attended legislative committee meetings and public meetings about the project. (Tr. 1263-65) Schulte trusted Stier's knowledge about the project and was in frequent contact with her, both as a friend and to ask questions about the RFP and lay the groundwork for a contract between Broadlawns and WellCare if WellCare had a winning bid. (Tr. 1103-06)

Stier was considering applying to become the Iowa Medicaid Director. One of Schulte's new associates at WellCare, Carol Steckel, had been Medicaid Director in two states. Schulte arranged for Steckel to meet Stier, so they could talk about the nature of the job and Steckel's experience. (Tr. 1239-40) Stier was offered the position of state Medicaid Director on April 26<sup>th</sup>. Stier shared the news with several family members and friends, including Schulte before she told her employer. Then Schulte shared the news with Steckel in an email exchange the following morning.<sup>10</sup> (Tr. 1279-80; Aetna Exhibit 5119)

Stier began working as the Administrator of Iowa Medicaid (also referred to throughout the proceeding as Medicaid Director) on May 27<sup>th</sup>, the day after the bid submission deadline. (Tr. 1252) Schulte maintained communication with Stier about the RFP. On June 3<sup>rd</sup>, Schulte forwarded a chain of emails between WellCare staff to Stier, using Stier's personal gmail account. The emails included WellCare staff's view of the timeline for demonstrating provider network adequacy and the date for transition to negotiate provider rates, with the following question: "Can you tell me if our below understanding is still correct in the most recent RFP draft?" Stier responded, inserting answers to the questions into the body of the original email and asking Schulte to call her later. Schulte did not see the response and resent the message on June 6<sup>th</sup>, asking Stier if she had replied. Stier sent a second response the following day, again answering the questions and asking Schulte to let her know when she was in town.<sup>11</sup> (Aetna Exhibit 5204, Tr. 1109-1114)

At hearing, Schulte explained that she asked Stier to respond to the questions because there had been multiple amendments to the RFP and they were trying to verify the

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<sup>10</sup> Schulte wrote: "By the way, it isn't public yet, but our friend Mikki will be the new Medicaid Director. It will be announced later this week. :)" Steckel responded: "YEAH!!! Please tell her I'm available to help in any way possible . . . and CONGRATULATIONS! This is so exciting."

<sup>11</sup> The questions in the WellCare email had both been addressed by DHS on March 26, 2015, during the first round of questions and answers about the RFP. (Tr. 1116-1120, Jt. Exhibit 312 at questions 362 & 368)

terms of the latest version at that point. (Tr. 1113) Schulte acknowledged that communication with Stier about the RFP after she began working as the director of Iowa Medicaid was improper. Schulte offered alternate explanations for the contact, saying: that she just did not think about the fact that Stier was currently the Medicaid Director (Tr. 1110); that she was unsure whether she knew Stier had started her state job; and that it was her understanding that Stier was not part of the “quiet period” because she had “recused herself” from participation in the procurement process, due to her previous contact with the MCOs that were bidding on the project while she was at Broadlawns (Tr. 1111-12).<sup>12</sup> Shortly after this email exchange during the first week of June, Schulte and Stier reached an understanding that going forward they would not discuss the RFP or scope of work. (Tr. 1112, 1121) They continued to talk occasionally during the next two months, but did not directly discuss the procurement. (Tr. 1122, 1302)

Schulte and Stier talked by telephone for 35 to 40 minutes on the evening of August 12<sup>th</sup> – the same day Stier attended the meeting at which the RFP evaluation committee presented its report and the ranking of bidders to Director Palmer. They had a wide ranging conversation about life events, challenges, and work stress. Awards for the RFP were to be announced on August 17<sup>th</sup> and Schulte was concerned about her contract with WellCare coming to an end. In response to these concerns, Stier said something to the effect of “You don’t have anything to worry about, Renée. You’re going to be okay.” (Tr. 1122-24, 1275-77, 1298-1300) Stier testified that she may have told Schulte she had a meeting with Director Palmer earlier that day, but she did not recall telling Schulte anything about the substance of the meeting. (Tr. 1278, 1301-02)

After talking to Stier, Schulte sent an email to Julie Smith, general counsel for government affairs for WellCare, in which she reported, “Mikki told me it will be Monday. She met with Palmer today.” (Aetna Exhibit 5205) Schulte also called Lauralie Rubel, the Plan President for WellCare of Iowa, to report her takeaway from the conversation with Stier was that WellCare had nothing to worry about. (Tr. 1127, 1492-93) Rubel in turn reported to Hildreth that WellCare would likely get a contract.<sup>13</sup>

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<sup>12</sup> DHS Director Palmer and Deputy Director Titus wanted Stier to focus her efforts entirely on implementation of the managed care transition and did not expect her to be involved in the procurement. (Tr. 265-66, 1267-69) Stier was not aware of any ethical or legal reason why she could not participate in the procurement. Stier testified that she did not tell anyone she was required to recuse herself from the procurement. (Tr. 1292-93)

<sup>13</sup> At 9:40 p.m. on August 12<sup>th</sup>, Rubel included the following comments in an email to WellCare VP Troy Hildreth:

Of interest, however, is some new intel. A reliable source who does not wish to be identified confirmed for our consultant Renee Schulte that Director Palmer received the final recommendations of the selection committee today and that it is not anticipated he will make an announcement before Monday. There is still a

*Contact with Boussetol* - Former state legislator and lobbyist Christopher Rants testified that he first met Michael Boussetol, the Governor's health care policy director, in January of 2015 when he contacted Boussetol to introduce himself and ask whether the governor was truly going to pursue Medicaid Modernization. (Tr. 1391) In early February, Rants was retained by WellCare to assist the organization by identifying and introducing providers, monitoring legislation related to the Medicaid Modernization initiative, and lobbying in support of the initiative on behalf of WellCare. (Tr. 1386) Over the course of the next few months, Rants estimated he spent about five percent of his time working on the Wellcare engagement. (Tr. 1388) The concept of privatizing Medicaid without direct legislative oversight was controversial and Rants was monitoring legislation related to the proposal. (Tr. 1447-50) He was also in regular contact with the governor's staff.

Rants had spoken with Boussetol in January and knew Boussetol was deeply involved with the Medicaid Modernization initiative and was the Governor's lead advocate on the proposal. Between mid-February and the end of May, Rants had several conversations with Boussetol about the state's approach to the project and concerns WellCare had about the terms of the RFP. At hearing, Rants characterized his communications with Boussetol as being exclusively about how the Medicaid Modernization proposal would impact the state budget and whether the program would be effective or ineffective after implementation. (Tr. 1432-33)

Other evidence in the record establishes that several of Rants' communications with Boussetol related directly to the content of the RFP. The following contacts between Troy Hildreth, as a representative of WellCare and Rants regarding prospective or past contacts with Boussetol relate directly to terms of the RFP, timelines imposed by the RFP, or calculation of the capitation rates that would be paid to MCOs under contracts resulting from the procurement:

- March 16, 2015: Emails between Hildreth and Rants. Hildreth instructs Rants to "pop in to visit and let me know what [Boussetol] has to say." The topic for the visit is not delineated in the email, which appears to be following up to a recently completed telephone conversation that is referenced in Rants' response. Rants responds asking if there are specific issues to raise other than "the disconnect between RFP and actuarial assumptions." Hildreth responds

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remote possibility he might do it sooner, but given that he still has final approval of the award decision, it is possible he will want some time to review the committee scoring and corresponding recommendations in detail. This same reliable source has given Renee some very promising indications that WellCare is among the awardees. Stay tuned . . .

(Aenta Exhibit 5149)

that everything else is secondary and provides a list of specific concerns about the actuarial assumptions. Later in the day, Rants reports that Boussetot was a little on guard, noting, "this is his baby after all;" and proceeds to explain information Boussetot provided to him about the underlying assumptions used in calculation of the capitation rates. (Aetna Exhibit 5210)

- March 20, 2015: Email from Hildreth to Rants regarding the proposed timeline for contracting with providers, noting the state needs to understand and appreciate the reality of the situation and how it jibes [sic] with their plan and timeline. Rants responds, "Got it. I'll sit down w MB next week." (Aetna Exhibit 5211)
- March 31, 2015: Email from Hildreth to Rants suggesting that he make Boussetot aware that the insurance requirements in the RFP "are problematic" – very high for Wellcare and prime contractor and nearly impossible for subcontractors. Rants responds asking for a thorough education and information about what level would work and notes, "Asking an official question is one thing, but in a private conversation we should be prepared to offer an alternative." (Aetna Exhibit 5212)
- April 8, 2015: Email from Rants to Hildreth, Schulte, Rubel, Steckel, and others, noting he had conversation with Boussetot that day regarding WellCare's concerns about aggregate vs. individual spending caps; conveying that Boussetot suggested WellCare submit a formal question on the issue; and indicating that Boussetot said another amendment and recalculated rates should be coming out "any day now." (Aetna Exhibit 5199)
- May 7, 2015: Email from Hildreth, telling Rants to "add to your list to discuss with MB the need for a brief extension" for submission of responses to the RFP. (Aetna Exhibit 5215)
- May 11, 2015: Email from Hildreth to Rants, indicating he was anxious to hear how Boussetot responded to the attached feedback regarding the latest data book and WellCare's projection of cost or savings to the state. (Aetna Exhibit 5214, Tr. 1415-17)

Rants said that in nearly all instances he responded to the emails by conveying WellCare's concerns to Boussetot, as Hildreth requested. (Tr. 1396-97, 1400, 1407) Rants could not recall if he actually requested an extension of the submission deadline as directed in the May 7<sup>th</sup> email. (Tr. 1473-76) There is no clear evidence that Boussetot passed the concerns on to Director Palmer or anyone else at DHS. There is also no evidence that Boussetot discouraged Rants from approaching him to discuss the RFP. To the contrary, Rants testified that Boussetot encouraged feedback about "what you

hear out there, what works and what doesn't, [and] what you've seen in other states."  
(Tr. 1404)

Questions related to the RFP concerns Rants communicated to Boussetot were also submitted to Issuing Officer Lindgren by one or more bidders through the formal question and answer process. In responses posted to the Bid Opportunities website, DHS clarified that provider payment rates during the transition prior and use of the Preferred Drug List would be factored in to capitation rates for the contracts (*Cf.* Jt. Exhibit 312, ques. 189, 197, 362, 379, 576, 635) and made it clear that Milliman (the actuarial service contractor calculating capitation rates for the state) was familiar with the requirements of the RFP (*Id.* at ques. 640). DHS also responded to an inquiry about the insurance requirements and agreed to amend the RFP to reduce the required levels of insurance. (Jt. Exhibit 318, ques. 697) A change reducing the required amount of insurance was include in the second amendment to the RFP, issued on April 22, 2015. (Jt. Exhibit 321)

The deadline for submission of bidder proposals was extended twice. When the RFP was issued, the proposal deadline was May 8, 2015. (Jt. Exhibit 300, at p. 2) The capitation rate data book was released in March. The calculations of amounts contracting MCOs would receive for servicing Medicaid members – capitation rates – were not issued until April 23<sup>rd</sup>. (Jt. Exhibits 307 & 324) On April 22<sup>nd</sup> DHS amended the RFP to add a round of questions and answers about the capitation rates and extend the proposal deadline to May 19<sup>th</sup>. (Jt. Exhibit 321) The capitation rate data book and capitation rates were amended on May 7<sup>th</sup>. (Jt. Exhibit 331) DHS received feedback from bidders seeking additional time and five days later, on May 13<sup>th</sup> DHS amended the RFP to extend the proposal deadline from May 19<sup>th</sup> to May 26<sup>th</sup>. (Jt. Exhibit 336)

*Identification of evaluators:* On March 30, 2015, Hildreth asked Schulte and Rants whether they had been able to identify who would be serving on the project evaluation committee. Schulte offered her "best guesses" as: "Jean Slaybaugh DHS CEO, Michael Boussetot, bid writers, not sure who else." Rants reported, "Rep. Miller's guess on the readers: Jean Slaybough, Little blonde girl who help[ed] write RFP (last name Lee- we'll figure out exactly who that is tomorrow),<sup>14</sup> Rick Shultz, The Division managers, Palmer, MB." (Aetna exhibit 5208)

When asked why it would be relevant to WellCare to know who the readers would be, Rants testified that all the MCOs were tailoring their proposals to highlight strengths and "it would be good to know if someone had a particular interest." (Tr. 1436-37) Hildreth had a more direct use of the information in mind. Upon receiving the list of potential evaluators from Rants, he responded with the following suggestion, referencing Tony Piagentini, who works in the WellCare business development section:

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<sup>14</sup> Most likely a reference to Elizabeth Matney.

Thanks Christopher. Can you and Tony meet to discuss how we might inform/educate and influence these folks. I'm thinking that if we can't engage them directly, that we can identify a key stakeholder who we might be able to encourage to speak with them on our behalf (e.g. someone to go to Jean Slaybough and say, "Gosh Jean, I've been really impressed with WellCare. They seem to get it, have the right style and approach for Iowa and is an organization that I think we can really work with").

(Aetna Exhibit 5208) Rants responded: "Will do." (Aetna Exhibit 5209) Rants testified that he knew this was a "dumb idea" and they could not try to influence the evaluators as Hildreth was suggesting. Instead, as an alternative strategy, they pursued letters of support and recommendations. (Tr. 1437-44)

*Iowa DPH Director's contact with prospective bidders:* The Iowa Department of Public Health (IDPH) and Medicaid often serve the same populations. The services to be delivered under the RFP included substance abuse disorder services funded by the Iowa Department of Public Health. (DHS Exhibit J – Kathy Stone Depo. at 14-16) Kathy Stone, the Director of the IDPH Division of Behavioral Health was one of the subject matter experts enlisted to review portions of the proposals to the RFP and to provide feedback to the evaluation committee. (*Id.* at 9, 19-21) Stone received the proposals in mid-June and completed her reviews in early July. She did not talk to DPH Director Gerd Clabaugh about her review of the RFP or about any of the bidders. (*Id.* at 84)

DPH Director Clabaugh wanted to ensure Iowa DHS and prospective bidders understood the public health system and the DPH funded services included in the RFP. Clabaugh met with DHS Director Palmer on March 11<sup>th</sup> to convey questions and comments from DPH staff about the RFP. (DHS Exhibit K – Clabaugh depo. at 36-38) On June 22, 2015, Clabaugh's assistance sent an email to MCOs that had submitted proposals asking for input about how IDPH could assist in connecting the MCOs to local public health agencies in Iowa. (ITC Exhibit O) Clabaugh recalled receiving responses from two or three bidders. To the best of his knowledge, no meetings with IDPH, local agencies, and MCOs were actually scheduled. (DHS Exhibit K – Clabaugh depo. at 48-50)

**Disclosure of litigation, termination, and regulatory actions:** Two sections of final version of the RFP require disclosure of prior litigation, penalties, and regulatory actions. The first, section 3.2.4.5, provides:

**3.2.5.4 Termination, Litigation, and Investigation.**

Bid Proposals must indicate whether any of the following conditions have been applicable to the bidder, or a holding company, parent company, subsidiary, or intermediary company of the bidder during the past five (5)

years that relate to services contemplated by this RFP unless otherwise noted. If any of the following conditions are applicable, then the bidder shall state the details of the occurrence. If none of these conditions is applicable to the bidder, the bidder shall so indicate.

- [List contract terminations.]
  - [List any defaults.]
  - List any damages, penalties, disincentives assessed, or payments withheld, or anything of value traded or given up by the bidder under any of its existing or past contracts as it relates to services performed that are similar to the services contemplated by this RFP. Include the estimated cost of that incident to the bidder with the details of the occurrence.
  - List and summarize any current pending or threatened litigation, administrative or regulatory proceedings, or similar matters related to the subject matter of the services sought in this RFP. Bidders may limit disclosure of these matters to a material threshold established by GAAP requirements.
  - List any irregularities that have been discovered in any of the accounts maintained by the bidder on behalf of others. Describe the circumstances of irregularities or variances and detail how the issues were resolved.
  - List any details of whether the bidder or any owners, officers, primary partners, staff providing services or any owners, officers, primary partners, or staff providing services of any subcontractor who may be involved with providing the services sought in this RFP, have ever had a founded child or dependent adult abuse report, or been convicted of a felony. Staff providing services shall include anyone having contact with members or member data.
- **Note:** Failure to disclose information about the matters in this section may result in rejection of the Bid Proposal or in termination of any subsequent contract. The subject matter in the sixth unnumbered bullet of this subsection is a continuing disclosure requirement. Any such matter commencing after submission of a Bid Proposal, and with respect to the successful bidder after the execution of a contract, shall be disclosed in a timely manner in a written statement to the Agency. For purposes of this subsection, timely means within thirty (30) days from the date of conviction, regardless of appeal rights.

(Jt. Exhibit 369, pp. 15-16 – emphasis original)

The second, RFP section 3.2.7.4.2, requires each bidder to:

1. Identify in table format all of your publicly funded managed care contracts for Medicaid, CHIP and other low income populations within the last five (5) years. . . . For each prior experience identified, provide a brief description of [details enumerated in sub-points (a) to (j)].
2. Identify and describe any debarment or suspension, regulatory action, or sanctions, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity within the last five (5) years.
3. Identify and describe any letter of deficiency issued by or corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relates to Medicare, Medicaid, CHIP, or the Substance Abuse Use Prevention and Treatment Block Grant.

(Jt. Exhibit 369, at p. 16-17)

The Appellants each challenge the manner in which DHS allowed WellCare to address an omission from its initial disclosure of requested information about prior litigation and regulatory actions. Aetna and Iowa Total Care assert that AmeriHealth and UnitedHealthcare also failed to comply with the disclosure requirements of the RFP.

*WellCare of Iowa, Inc.:* In response to the third unnumbered bullet point under section 3.2.5.4 of the RFP, WellCare acknowledged that WellCare Health Plans, Inc. and its subsidiaries from time-to-time face regulatory actions in the form of liquidated damages. In chart form WellCare purported to provide “details about damages, penalties, disincentives assessed, payments withheld or anything of value traded or given up by the Company under any of our existing or past contracts as it relates to services performed that are similar to those contemplated by this RFP, including the cost of each incident, over the past five years. Eighteen liquidated damages payments are listed on the chart. The payments, ranging in amounts from \$250 to \$460,000, related to WellCare operations in the states of Florida, Kentucky, Georgia, and Ohio. (ITC Exhibit HH)

In response to the fourth unnumbered bullet point under section 3.2.5.4, WellCare stated: “[t]here are no instances of administrative or regulatory proceedings for WellCare Health Plans or our subsidiaries during the past five years.” WellCare identified two pending litigation matters, both relating to claims disputes with providers. (ITC Exhibit HH)

In response to section 3.2.7.4.2, question 2, WellCare referred the reader to its response

to section 4.2.5.4 for “information regarding regulatory actions in the form of corrective actions and sanctions.” As to question three, WellCare again provide a chart outlining “regulatory actions required of the WellCare health plans participating in federal and state healthcare programs.” The chart list approximately three dozen required corrective actions and one monetary sanction in the amount of \$290,050. (Jt. Exhibit 489, Tab 6 at pp. 1028-1031)

Evaluator Elizabeth Matney was the Managed Care Director for Iowa Medicaid from the spring of 2014 until October of 2015. In that role she attended multiple trainings at the Medicaid Integrity Institute related to managed care programming oversight and program integrity. (Tr. 684) While reviewing WellCare’s RFP proposal, Matney remembered that WellCare had been involved in some fraud-related case sometime in the past, that had been a topic at the Medicaid Integrity Institute on a couple of occasions. (Tr. 716) Matney mentioned this recollection while the evaluation committee was scoring the WellCare proposal. Given that no fraud-related proceedings were referenced in WellCare’s responses to the RFP, the Ikaso consultants, Wetlaufer, and Lindgren set about trying to figure out how to clarify the point. (Tr. 405-06)

First, they met with DHS legal counsel from the Attorney General’s office. (Tr. 406) Wetlaufer recalled being advised to do an internet search for information. Wetlaufer did a search, trying to find a telephone number of someone that was involved with a proceeding against WellCare. He did not find a telephone number, but did locate some information about fraud proceedings. At 4:03 p.m. on July 31<sup>st</sup>, Wetlaufer forwarded links to Lindgren in an email. (Tr. 1315-17; Aetna Exhibit 5220 – Lindgren depo. at 82-86 and depo. exh. 76)

The links lead to a page with information about the federal Department of Health and Human Services Office of Inspector General (OIG) and two documents. The first document link, through the HHS OIG website, led to a Corporate Integrity Agreement between HHS OIG and WellCare Health Plans, Inc. referencing a contemporaneous Settlement Agreement and imposing enhanced corporate integrity obligations and monitoring requirements for a five-year period from the effective date of the agreement, April 26, 2011.<sup>15</sup> (ITC Exhibit Q) The second document link, through the United States Department of Justice website, led to a press release about a settlement agreement issued on April 3, 2012, by the Department of Justice, headlined: “Florida-Based

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<sup>15</sup> A Corporate Integrity Agreement (CIA) is a document that outlines the obligations an entity agrees to as part of a civil settlement. OIG negotiates CIAs with health care providers and other entities as part of the settlement of Federal health care program investigations arising under a variety of civil false claims statutes. Providers or entities agree to the obligations, and in exchange, OIG agrees not to seek their exclusion from participation in the Medicare, Medicaid or other federal health care programs. Further information about CIAs is available through the OIG website, at: <http://oig.hhs.gov/faqs/corporate-integrity-agreements-faq.asp>

Wellcare Health Plans Agrees to Pay \$137.5 Million to Resolve False Claims Act Allegations.” The press release describes alleged misconduct, lists nine states that will receive a portion of the settlement proceeds, and notes that this was the second monetary settlement reached with WellCare since criminal and civil investigations of WellCare commenced in 2006. The release does not give the date of the conduct underlying the allegations. (Aetna Exhibit 5220, Lindgren depo. exh. 78)

Lindgren tried during the following week to determine whether the Corporate Integrity Agreement was still in effect. She contacted the state of Florida and the HHS OIG, but was unable to confirm the status of the agreement. (Aetna Exhibit 5220 – Lindgren depo. at 86-87) Meanwhile, the following clarifying question was posed to WellCare:

There is public information concerning false claims actions against WellCare Health Plans Inc. Please clarify the resolution of any and all such claims within the last 5 years and identify any and all measures taken by the company to ensure compliance with federal and state health care program statutes, regulations, and directives.

(Jt. Exhibit 445) WellCare provided a lengthy response. (*Id.*) They explained: federal and state enforcement authorities initiated investigations of WellCare in 2006, after certain then-current and former employees filed qui tam or “whistleblower” lawsuits alleging misconduct and seeking damages; that all of the proceedings have concluded and related charges and claims have been dismissed; that all individuals implicated in the allegations were separated or terminated from WellCare by the end of 2008; that in November of 2009, and CMS lifted intermediate sanctions imposed against the company earlier that year. With regard to the corporate integrity agreement and settlement, WellCare stated:

As is often the case, the settlement of the underlying whistleblower claims was a more protracted process and it was finally completed in late April 2011, when WellCare also entered into a Corporate Integrity Agreement with the Office of Inspector General of the United States Department of Health and Human Services. Some of these resolutions included substantial financial payments and penalties.

WellCare did not provide copies of the Corporate Integrity Agreement or settlement agreement. WellCare did not disclose any detail about the allegations underlying the claims resolved through the settlement or the amount of payment under the settlement. WellCare did not disclose that, although related charges against the company were dismissed, at least four WellCare executives were criminally convicted of making false statements and/or health care fraud. (Tr. 1498-1502; Aetna Exhibits 5170-73)

The settlement agreement was offered into evidence at hearing. (Meridian Exhibit B)

The agreement encompasses false claims act litigation originating in the states of Florida, Connecticut, and New York. Review of the agreement reveals that the United States intervened in the proceedings and was alleging civil claims against WellCare “arising from WellCare’s submission of false and fraudulent information in support of false claims to the Medicare and Medicaid programs” during a period from January 1, 2004 to June 24, 2010. (*Id.*, at p. 2) Under the terms of the settlement, WellCare did not admit liability. WellCare did agree to pay the federal government and the participating states a fixed payment of \$137.5 million and contingent payment of an additional \$35 million in the event of a change in control of the corporation prior to full payment of the fixed payment. (*Id.*, at pp. 7-8)

WellCare’s response to the clarification question identified a second enforcement proceeding related to Medicaid capitation payments initiated in June of 2013 by the United States Attorney in New York State. Several MCOs were involved in that action, which was resolved through settlement based upon payment-by-mistake theory, rather than misconduct. WellCare’s share of the \$1.3 million settlement was \$52,000.00. Reference to this proceeding was also omitted from WellCare’s initial response to RFP sections 3.2.5.4 and 3.2.7.4.2.

WellCare’s response included an extensive review of steps taken since 2008 to “build a culture of compliance.” WellCare failed to point out that the vast majority of compliance training, engagement, and oversight steps outlined in the response are required under the terms of the Corporate Integrity Agreement, which remains in force for five years, through April of 2016. (Compare Jt. Exhibit 445 to ITC Exhibit Q)

As noted above, the evaluation committee met on August 10<sup>th</sup> to review all responses to clarifying questions and to finalize scoring of the proposals. The committee was not told that Wetlaufer and Lindgren had researched the WellCare situation. Nor were the evaluators given the Corporate Integrity Agreement or USDOJ press release, despite provisions of the RFP that allowed DHS verify the contents of a bid proposal and consider information from sources other than the bidder. (Tr. 408, 600, 1323; Jt. Exhibit 369, §§ 2.17, 2.19) The committee was given WellCare’s response to the clarifying question about past false claims proceedings. The committee briefly discussed the fact that WellCare had not disclosed those proceedings in their original proposal, but concluded that the wording of RFP section 3.2.5.4 could have been misunderstood. (Tr. 573, 598-600, 718)

Upon reviewing the response, the committee was satisfied that WellCare provided a full response and had measures in place to ensure future compliance. WellCare initially received a score of 3 on Experience (including References and Contact List) sections of the RFP (4.5 out of 6 possible points) and a score of 2 on the Termination, Litigation, and Investigation section of the RFP (1.5 out of 3 possible points). (Jt. Exhibit 431A) The committee made no adjustment to scoring of the WellCare proposal. (Tr. 573, 719-

20; Jt. Exhibit 431B)

Director Palmer was made aware of the false claims act litigation involving WellCare during his August 12<sup>th</sup> meeting with the evaluation committee. His recollection was that it was in the past; that the evaluation committee was satisfied with the information provided; that adequate corrective action had been shown; and the company was not barred from Medicaid involvement. (Tr. 131-32, 237-38) Palmer was not provided with or told about the Corporate Integrity Agreement or USDOJ press release regarding the WellCare false claims act settlement. He relied on the process used by the evaluation committee and the committee's explanation of the situation. (Tr. 132, 249)

*UnitedHealthcare Plan of the River Valley, Inc.:* In response to section 3.2.5.4 of the RFP, UnitedHealthCare identified 664 relatively minor fines and penalties, ranging from \$100 to \$186,000 imposed against its parent/holding company in the normal course of business over the past five years. No pending or threatened litigation was listed. (Jt. Exhibit 490, Attachment 3.2.5.4) In response to section 3.2.7.4.2, UnitedHealthCare submitted a table listing 1,875 separate fines, sanctions, letters of deficiency, and corrective action plans imposed against related organizations during the past five years. At least six of the fines and overpayment penalties exceeded one million dollars.<sup>16</sup> To place these matters in context, the company pointed to the fact that "UnitedHealthcare, being part of a large, international organization with over 5.1 million Medicaid, CHIP and dual-eligible members in 23 states, is subject to litigation as well as certain fines and penalties in the normal course of business." (*Id.*)

The committee asked United to respond to one clarifying question related to the termination query in RFP section 3.2.5.4: "Are there instances in the past 5 years where you, an affiliate, or parent company have failed to come to terms or other factors in the middle of a contract? What was the result?" (Jt. Exhibit 446) In response, United identified two instances where affiliates terminated contracts. The first with Oklahoma in February of 2012 was characterized as a termination by mutual agreement based on programmatic incompatibilities. The second occurred in February of 2013 when United refused to accept renegotiated rates for a contract with Wisconsin. (*Id.*)

Upon reviewing the response, the committee lowered the score given to United on the

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<sup>16</sup> The following payments are listed: \$7,927,877 paid to New Mexico Human Services Department in November of 2014 (item 1763); \$2,364,846 paid to the Maryland Department of Medicaid and Medical Assistance in October of 2011 (item 734); \$1,252,500 paid to Florida Agency for Healthcare Administration in December 2010 (item 405); \$1,410,841 paid to New Jersey Department of Medical Assistance and Health Services in October of 2010 (item 335); \$7,604,157 paid to Georgia UnitedHealthcare Services, Inc. in May of 2010 (item 149); and \$1,530,000 paid to New Mexico Behavioral Health Collaborative in February 2010 (item 7). (Jt. Exhibit 490, Attachment 3.2.5.4.2 Table – Attachment Q2 and Q3)

Termination, Litigation, and Investigation section of the RFP from 3 (2.25 out of 3 possible points) to 2 (1.5 out of 3 possible points). United's score of 3 for the Experience section of the RFP (4.5 points out of a possible 6 points) was not changed. (Jt. Exhibits 432A & 432B)

Aetna offered exhibits 5161 through 5165 – documents relating to litigation in the states of Nevada, California, and Colorado – as evidence to support its claim that United failed to disclose items within the scope of RFP section 3.2.5.4.<sup>17</sup> The Nevada matter concerned allegations that Health Plan of Nevada and Sierra Health Services, Inc. were negligent in credentialing and monitoring of privately owned in-network endoscopy center. The action, commenced by individuals following a hepatitis C outbreak at the center, was resolved through settlement in December of 2014, following a large jury verdict against the Defendants. (Aetna Exhibits 5161-63, 5174 – United Health Group 10-K, at p. 79-80; United Exhibit E) The matter is no longer pending. The Appellants make no showing that the Nevada matter involved Medicaid or CHIP managed care.

The California matter is a regulatory proceeding initiated in 2008 by the California Department of Insurance against PacifiCare Life and Insurance Company, a subsidiary of UnitedHealth Group (the parent of UnitedHealthcare of Iowa), alleging wide-spread unfair business practices. Extensive proceedings resulted in a decision by the Insurance Commissioner imposing a \$174 million fine. (Aetna Exhibit 5164) The company's action for judicial review of the agency decision remains pending. (United Exhibits A-C, Aetna

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<sup>17</sup> United objected to the admission of exhibits 5161 through 5165 on the ground that the exhibits were not the subject of any testimony and therefore there was no foundation or showing of authenticity laid as to the documents. United also challenged the relevance of these exhibits. Aetna countered that the documents were self-authenticating and were relevant to Aetna's claim that United failed to disclose information responsive to section 3.2.5.4 of the RFP. I took the objection under advisement and allowed United and Aetna to file written arguments in support of the objection and resistance. (Tr. 1556-1560)

The evidentiary standards for contested cases, as established by Code section 17A.14, are more relaxed than the rules of evidence for civil trials. Exhibits 5161 through 5165 purport to be copies of documents filed in various court proceedings. Despite the lack of testimony regarding the exhibits, they are clearly relevant to a claim raised by Appellants Aetna and Iowa Total Care in their notice of appeal. All relevant evidence, including hearsay evidence, is generally admissible and “[d]ocumentary evidence may be received in the form of copies or excerpts, if the original is not readily available.” Iowa Code § 17A.14(1)-(2); *see Clark v. Iowa Dep't. of Revenue and Finance*, 644 N.W.2d 310, 320 (Iowa 2002) (“The administrative law judge may base the decision upon evidence that would ordinarily be deemed inadmissible under the rules of evidence, as long as the evidence is not immaterial or irrelevant. [Iowa Code § 17A.14(1)]. Consequently, hearsay evidence is admissible ...”). Having reviewed the arguments of both parties, United's objection to the exhibits is overruled and the exhibits are admitted into the record. Correspondingly, UnitedHealthcare exhibits A, B, C, and E – P, which were offered only in the event the objection to exhibits 5161 – 5165 was overruled (Tr. 1564-66), are admitted into the record.

Exhibit 5174 – United Health Group 10-K, at p. 79) This action pertained only to PacifiCare’s preferred-provider organization (PPO) line of business (*Id.* at p. 1, fn. 1) and was not related to services similar to services to be provided under the Iowa RFP. PacifiCare provides no Medicaid or CHIP managed care services in California. (United Exhibit G)

The Colorado matter is a false claim action initiated by the United States Attorney against Evercare Hospice, Inc., an entity purchased by UnitedHealth Group, Inc. in 2011. The complaint, filed in November of 2014, alleges that Evercare has filed false claims for Medicare hospice benefits since 2007. (Aetna Exhibit 5165) The action remains pending. It includes no allegations related to Medicaid or CHIP managed care services.

*AmeriHealth Caritas:* In response to section 3.2.5.4 of the RFP, AmeriHealth listed liquidated damages and penalties assessed against and funds withheld against from organizations within the AmeriHealth family of companies related to Medicare and Medicaid/CHIP and behavioral health managed care programs operating in the states of Pennsylvania, Florida, Louisiana. None of the sanctions exceeded \$300,000. (Jt. Exhibit 488, Tabs 4-5 at pp 961-66). AmeriHealth provided a list of additional regulatory actions in response to section 3.2.7.4.2. (Jt. Exhibit 488, Tab 6 at pp. 1129-33)

The evaluation committee gave AmeriHealth a score of 2 (1.5 out of 3 possible points) on the Termination, Litigation, and Investigation section of the RFP and a score of 3 (4.5 out of 6 possible points) on the Experience section of the RFP. The committee did not ask any clarifying questions about these responses and AmeriHealth’s scores were not adjusted for the final scoring. (Jt. Exhibits 430A & 430B)

Iowa Total Care offered a copy of the January 2011 edition of a newsletter from the Office of the Kentucky Attorney General as evidence to support the claim that AmeriHealth failed to disclose an item within the scope of RFP section 3.2.5.4. An article in the newsletter reports that AmeriHealth Mercy agreed to pay more than \$2.0 million in damages to the Kentucky Medicaid Program for submitting false data while acting as a third-party administrator for the Passport Health Plan. (ITC Exhibit QQ)

### **Conclusions of Law**

#### **DHS contracting authority and applicable review standards -**

**DHS authority to contract with managed care organizations:** The Medicaid program is a “cooperative federal-state program through which the federal government provides financial assistance to states so that they may furnish medical care to needy

individuals.” *TLC Home Health Care, L.L.C. v. Iowa Dep’t of Human Services*, 638 N.W.2d. 708, 711 (Iowa 2002). Each participating state must designate a “single state agency” responsible for administering the Medicaid program. 42 C.F.R. § 431.10. In Iowa, is the designated single state agency.

The Director of the DHS is “responsible for the efficient and impartial administration” of Iowa Medicaid, in accordance with Iowa Code chapter 249A and applicable federal law and regulations and is vested with the authority to “make rules, establish policies, and prescribe procedures to implement” the program. Iowa Code § 249A.4 (2015). The Director is specifically empowered and directed to:

Have authority to contract with any corporation authorized to engage in this state in insuring groups or individuals for all or part of the cost of medical, hospital, or other health care or with any corporation maintaining and operating a medical, hospital, or health service prepayment plan under the provisions of chapter 514 or with any health maintenance organization authorized to operate in this state, for any or all of the benefits to which any recipients are entitled under this chapter to be provided by such corporation or health maintenance organization on a prepaid individual or group basis.

Iowa Code § 249A.4(4); Iowa DHS has been contracting with various managed care organizations to administer segments of the Iowa Medicaid program for more than 20 years. *See* 441 Iowa Admin. Code (IAC), ch. 88 (administrative rules governing the delivery of managed health care under the Medicaid program); Tr. at pp. 89-90, 680-81.

The current dispute arises in the context of expansion of the use of managed care to encompass virtually the entire Medicaid program. The details of this plan to convert the majority of Iowa Medicaid from a fee-for-service model to a managed care model were developed by Director Palmer and the governor’s staff during the first half of 2014. This “Medicaid Modernization” plan was disclosed to the legislature and the public in January of 2015 when the Governor announced his budget proposal for fiscal year 2016. The budget included Medicaid funding based upon a projected \$51 million reduction in state Medicaid costs based on use of managed care contracts during the second half of the fiscal year. Legislators and the public did not universally support the Governor’s plan to transform Iowa Medicaid into a managed care system operated by private for-profit companies.

Senate File 452, a bill establishing a “Medicaid transformation oversight commission” and specifying directives for the transition to Medicaid managed care, passed the Senate unanimously, but died in committee in the house. Despite debate regarding the wisdom of the Governor’s plan, the legislature passed no legislation to impede the process. Rather, the legislature recognized the authority of DHS to move forward with the plan

by incorporating projected savings from the plan into appropriations funding Medicaid for FY16 and authorizing DHS to “adopt emergency rules as necessary to implement the governor’s Medicaid modernization initiative beginning January 1, 2016.” 2015 Iowa Acts (86<sup>th</sup> G.A.), ch. 137, (S.F. 505) § 12, par. 24.

Applicable procurement procedures: Competitive bidding requirements for the award of government contracts are a creature of statute, designed “for the protection of the public to secure by competition among bidders, the best results at the lowest price, and to forestall fraud, favoritism, and corruption in the making of contracts.” *Medco Behavioral Care Corp. v. Iowa Dep’t of Human Servs.*, 553 N.W.2d 556, 563 (Iowa 1996) (quoting *Istari Constr., Inc. v. City of Muscatine*, 330 N.W.2d 798, 800 (Iowa 1981); *Elview Constr. Co., Inc. v. N. Scott Cmty. Sch. Dist.*, 373 N.W.2d 138, 141 (Iowa 1985)); see also *Master Builders of Iowa, Inc. v. Polk County*, 653 N.W.2d 382, 395 (Iowa 2002) (noting that the paramount purpose of the law requiring counties to use competitive contract letting procedures for public improvement project costing greater than \$50,000 “is to protect the public as taxpayers”). “The common law did not mandate that public contracts be let upon competitive bidding; rather the requirement is purely statutory and must be considered under the legal authority of the particular governmental entity in question.” *Medco*, 553 N.W.2d at 563.

Iowa law grants the state Department of Administrative Services (DAS) the authority to “adopt rules establishing competitive bidding procedures” for state executive branch agencies. Iowa Code § 8A.311. DAS has done so by enacting 11 Iowa Administrative Code Title VI, chapters 117 through 120. Chapter 117, entitled “Procurement of Goods and Services of General Use,” establishes procurement procedures used by DAS and other state executive branch agencies when purchasing goods and services of general use. 11 IAC 117.1(1). DAS is responsible for centralized procurement of most goods and services of general use. 117.4(1) 117.7(1). Other state agencies, including Iowa DHS “may procure services unique to the agency’s program or used primarily by that agency and not by other agencies. [DAS] will assist agencies with these procurements upon request. Procurement of services by an agency shall comply with the provisions of 11 [IAC] Chapters 118 [purchasing standards for service contracts] and 119 [uniform terms and conditions for service contracts].” 11 IAC 117.14(2).

DAS rules Chapter 118 requires state agencies to use “competitive selection” when acquiring “services from private entities when the estimated annual value of the service contract is equal to or greater than \$5,000 or when the estimated value of the multiyear service contract in the aggregate, ...” 11 IAC 118.5. In this context,

“*Competitive selection*” means a formal or informal process engaged in by a state agency to compare provider qualifications, terms, conditions, and prices of equal or similar services in order to meet the objective of purchasing services based on quality, performance, price, or any

combination thereof. During a competitive selection process, a state agency may weigh the relevant selection criteria in whatever fashion it believes will enable it to select the service provider that submits the best proposal. The lowest priced proposal is not necessarily the best proposal.

11 IAC 118.3 (definitions). A *formal* competitive selection process employing a request for proposal or other competitive selection process authorized by applicable law must be employed when the annual value of the service contract is equal or greater than \$50,000. 11 IAC 118.3, 118.5(2). The DAS chapter 118 rules do not further define the competitive selection process to be used by agencies for procurement of service contracts and Iowa DHS has enacted no rules or standards for competitive bidding of service contracts.

The Iowa Supreme Court applied provisions of the federal acquisition regulations and case law interpreting the regulations to resolve a conflict of interest question presented in *Medco Behavioral Care Corp. v. Iowa Dep't of Human Services*, 553 N.W.2d 556 (Iowa 1996). The parties disagree regarding the ongoing applicability of federal acquisition regulations to the Iowa DHS Medicaid procurement under review here. *Medco* involved a challenge to the procurement process used by DHS to award a contract for providing managed care to a relatively small portion of Iowa's Medicaid program. The primary issue was a conflict of interest claim, arising from the fact that the winning bidder was a co-subsidiary of the company that advised the state on implementing managed mental health care and had ongoing business relationship with the company that assisted in drafting the RFP. The court recognized that Iowa law had no established conflict of interest standard applicable to public contracting. Because Code section 249A.4 requires DHS to follow applicable federal law in administering the Medicaid program, the court turned to federal law in search of an applicable standard for testing the existence of a conflict of interest.

The *Medco* court held that the district court did not err in applying the conflict standard set forth in the federal acquisition regulations. As the court reasoned, Iowa DHS was bound to follow applicable federal regulations, including the procurement procedures applicable to the federal department of Health and Human Services (HHS), then codified within 45 C.F.R., part 74, at Appendix G. Section 10 of appendix G required all procurement transactions to avoid practices restrictive of competition, including "organizational conflicts of interest." The HHS regulation did not define the term "organizational conflict of interest." As an executive branch federal agency, HHS procurements were subject to the Federal Acquisition Regulations (FAR), which both defined and provided examples of organizational conflicts of interest. The *Medco* court found, "[b]y operation of Iowa Code § 249A.4, the FAR appears to set forth the federal regulatory guidance governing the conflict of interest question at issue here." 553 N.W.2d at 564 n.6.

Recent amendments to the HHS procurement standards provide a strong basis for the Department's contention that under current law, the regulation prohibiting practices restrictive of competition including organizational conflicts of interest (45 C.F.R. section 75.328) and the federal acquisition regulations are not directly applicable to state procurements.<sup>18</sup> Even so, given the minimal nature of state standards for competitive contract procurements, the HHS standards and interpretations of the federal acquisition regulations continue to provide useful guidance for judging the overall fairness and reasonableness of the procurement process employed by Iowa DHS in this case. Indeed, all parties to this protest proceeding refer to federal procurement decisions as support for the arguments they advance to challenge or defend the procurement procedure and contract awards at issue here.

Standard of review: The Appellants and Respondent DHS all cite the judicial review standards set forth in the Iowa Administrative Procedures Act (IAPA) as the appropriate basis upon which to determine the validity of the contract procurement at issue in this case. Under the IAPA,

The court may affirm the agency action or remand to the agency for further proceedings. The court shall reverse, modify, or grant other appropriate relief from agency action, equitable or legal and including declaratory relief, if it determines that substantial rights of the person seeking judicial relief have been prejudiced because the agency action is any of the following:

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<sup>18</sup> The federal HHS recently replaced the regulations cited in *Medco* with new uniform administrative requirements, cost principles and audit requirements for federal awards, to give effect to revised Office of Management and Budget (OMB) guidance. See 79 Fed. Reg. 75871, 75889 (Dec. 19, 2014). The newly adopted regulations, found at 45 C.F.R. Part 75, include restated and revised procurement standards applicable to states and other non-federal entities. 45 C.F.R. §§ 75.326 - 75.335. Although the regulations include general procurement standards (75.327), competition requirements (75.328), procurement procedures (75.329), and several other requirements, the bulk of the provisions are not applicable to states.

When procuring property and services under a Federal award, a state must follow the same policies and procedures it uses for procurements from its non-Federal funds. The state will comply with § 75.331 [referencing Solid Waste Disposal Act] and ensure that every purchase order or other contract includes any clauses required by § 75.335. All other non-Federal entities, including subrecipients of a state, will follow §§ 75.327 through 75.335.

d. Based upon a procedure or decision-making process prohibited by law or was taken without following the prescribed procedure or decision-making process.

e. The product of decision making undertaken by persons who were improperly constituted as a decision-making body, were motivated by an improper purpose, or were subject to disqualification.

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j. The product of a decision-making process in which the agency did not consider a relevant and important matter relating to the propriety or desirability of the action in question that a rational decision maker in similar circumstances would have considered prior to taking that action.

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n. Otherwise unreasonable, arbitrary, capricious, or an abuse of discretion.

Iowa Code § 17A.19(10). The Iowa Supreme Court has found the “substantial rights” language in the first paragraph of Iowa Code section 17A.19(10) is “analogous to a harmless error rule.” *Hill v. Fleetguard, Inc.*, 705 N.W.2d 665, 671 (Iowa 2005). An agency’s action “should not be tampered with unless the complaining party has in fact been harmed.” *Id.*, quoting *City of Des Moines*, 275 N.W.2d at 759. The Appellants bear burden of demonstrating the invalidity of the challenged agency action and that they were prejudiced as a result. *Id.*, citing Iowa Code § 17A.19(8)(a); *Titan Tire Corp. v. Employment Appeal Bd.*, 641 N.W.2d 752, 758 (Iowa 2002).

A competitive selection procurement process, as defined by DAS rule, affords an agency the discretion to “weigh the relevant selection criteria in whatever fashion it believes will enable it to select the service provider that submits the best proposal.” 11 IAC 18.3. All contractors selected under the Iowa Medicaid RFP will receive the same per member per month capitation payment to serve Medicaid enrollees. (Jt. Exhibit 369, § 1.4.2) Therefore, cost was not a factor in evaluation of the proposals. Rather, the selection criteria included pass/fail compliance with mandatory formatting and financial stability requirements; and scoring of the relative merits of each bidder’s background statement and planned approach to delivering the scope of work. The RFP stated that DHS, represented by an evaluation committee, would “conduct a comprehensive, fair and impartial evaluation” to determine which Bid Proposals provide “the greatest benefit to the Agency.” (*Id.* at § 4)

This use of the “greatest benefit” as the decisive factor in the contract award affords the agency greater discretion than a simple lowest price bid letting. “Finding the lowest possible price between bids is a simplistic and mechanical process limited to unsealing and comparing submitted bids. Determining the bid that will provide the best results requires greater discretion.” *Master Builders of Iowa, Inc. v. Polk County*, 653 N.W.2d 382, 395 (Iowa 2002). “Effective contracting demands broad discretion . . . agencies are

entrusted with a good deal of discretion in determining which bid is the most advantageous to the Government.” *Bannum v. United States*, 119 Fed.Cl. 291, 301 (2014), quoting *Lockheed Missiles & Space Co., Inc. v. Bensten*, 4 F.3d 955, 958-59 (Fed. Cir. 1993) (citations omitted).

In order to prevail, the Appellants must show that Iowa DHS failed to follow prescribed procedure or acted irrationally, abusing this broad discretion.

“An agency's action is ‘arbitrary’ or ‘capricious’ when it is taken without regard to the law or facts of the case.... Agency action is ‘unreasonable’ when it is ‘clearly against reason and evidence.’” *Soo Line R.R. v. Iowa Dep’t of Transp.*, 521 N.W.2d 685, 688–89 (Iowa 1994). An abuse of discretion occurs when the agency action “rests on grounds or reasons clearly untenable or unreasonable.” *Schoenfeld v. FDL Foods, Inc.*, 560 N.W.2d 595, 598 (Iowa 1997). We have said an “abuse of discretion is synonymous with unreasonableness, and involves lack of rationality, focusing on whether the agency has made a decision clearly against reason and evidence.” *Id.* (quoting *Stephenson v. Furnas Elec. Co.*, 522 N.W.2d 828, 831 (Iowa 1994)).

*Dico, Inc. v. Iowa Employment Appeal Bd.*, 576 N.W.2d 352, 355 (Iowa 1998); *see also Scheckel v. Jackson County*, 467 N.W.2d 286, 289-90 (Iowa 1991) and *Istari Const., Inc. v. City of Muscatine*, 330 N.W.2d 798, 800 (Iowa 1983) (both applying abuse of discretion standard in context of review of challenged contract award).

Despite this deferential review standard, a finding that an agency failed to engage in a required competitive bidding process or failed to follow the terms of the RFP when awarding a contract may present sufficient grounds to overturn the agency’s award of the contract. *Noridian Administrative Services, LLC v. Iowa Dep’t of Human Services*, CV 8960 – Ruling on Petition for Judicial Review (Polk Co. Dist. Ct. 12/7/12), citing *Bradley v. Iowa Dept. of Personnel*, 596 N.W.2d 526, 530-32 (Iowa 1999). Iowa DHS and the Intervenors contend the Appellants have not met their burden.

### **Review of the Medicaid RFP procurement process –**

The Appellants filed separate appeals identifying distinct, although somewhat overlapping, grounds for appeal. The Appellants each filed a timely amendment to or amended version of its Notice of Appeal on October 9, 2015, further aligning their claims. *See* 441 IAC 7.44(3). Except as otherwise noted, the challenges to the RFP process discussed below were raised by all Appellants.

Alleged organizational conflict of interest: Aetna asserts that WellCare’s relationship with former Iowa DHS contractor Renée Schulte constitutes an organizational conflict

of interest that was not and cannot be mitigated. This argument is rooted in the conflict of interest analysis applied in the *Medco* case and the federal acquisition regulations underlying the court's analysis. As discussed above, amendments to the HHS regulations cast doubt on whether the conflict provisions of the FAR are directly applicable in this case. For purposes of analyzing this issue, I assume that *Medco* and the analysis applied by the court in that case remain the controlling law in Iowa.

In *Medco*, the Iowa Supreme Court affirmed a district court's disqualification of a successful bidder based on finding that an organizational conflict of interest arose between the bidder and companies involved in development of the RFP. Relying on the definition of organizational conflict of interest in the FAR, the court described three categories of situations which may give rise to an organizational conflict of interest. The first and third categories are at issue under the facts of this case.

The first category consists of those instances where a firm, by virtue of its performance of a government contract, has to some degree set the "ground rules" for the government contract at issue by, for instance, writing the work statement or drafting the contract specifications. In such cases the concern is that the firm could either skew competition in favor of itself when developing the terms of the procurement, or, through its inside knowledge of the agency's requirements, gain an unfair advantage in the competitive bidding process.

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The third category involves circumstances in which a firm has access to nonpublic information as part of its performance of an earlier government contract that may provide it with a competitive advantage in the current government contract in question.

*Medco*, 553 N.W.2d at 565 (internal citations omitted).

Following federal court interpretations of the FAR, the Iowa court recognized that "hard facts" are required to establish the existence of an organizational conflict, while proof of the specific impact of the conflict once proven is not required.

On the one hand a bidder may be disqualified based on an "appearance of impropriety" where the bidder may have gained an unfair competitive advantage through an actual or potential conflict of interest in the procurement process. On the other hand mere conjecture, innuendo, or speculation of an actual or potential conflict of interest, without factual support, provide no basis for disqualification.

*Id.* (citations omitted).

No evidence was presented to establish that Schulte had any role in “setting the ground rules” for the Iowa Medicaid RFP. Her contract and work assignments were with the DHS Division of Mental Health and Disability Services (MHDS) and she worked exclusively on projects related to the mental health redesign. Schulte drafted rules for implementation of this initiative and worked on strategic planning and training related to subacute services, crisis services, peer and family support services. The redesign services that Schulte was involved with were not directly funded through Medicaid. Schulte’s work did not include development, preparation, drafting or editing of the RFP.

Schulte’s work directly related to the structure of systems for delivery of behavioral health services. This allowed her to become intimately familiar with Iowa law and DHS policies regarding the delivery of behavioral health services. Some of the same approaches to services delivery that Schulte helped shape were included in the Scope of Work for the RFP. Without question, information Schulte gained about the Iowa behavioral health delivery system was beneficial to WellCare. In large part, that is why they hired her. This alone does not prove a conflict of interest. The operative question in determining whether Schulte’s past work for Iowa DHS creates an organization conflict of interest for WellCare is whether she had access to *nonpublic* information as part of her performance of work for Iowa DHS that may have provided WellCare a competitive advantage in the Iowa Medicaid procurement.

Schulte clearly had access to a great deal of information that was of use during preparation of a response the RFP. However, no evidence was offered to prove that she had access to any nonpublic information either about the terms of the RFP or about the structure of Iowa’s mental health delivery system. Her experience with the agency gave her a working knowledge and familiarity with this system that competitors may have lacked, but the Appellants failed to show that any of this information was confidential. I am not convinced that others could not have gained the same knowledge through study of public information. I find insufficient evidence to prove that Schulte had gained access to nonpublic information through her work for Iowa DHS that could have provided an unfair advantage to WellCare. Although this type of public-private revolving door troublesome, I conclude that the record lacks hard facts proving that WellCare had an organizational conflict of interest.

Non-disclosure of prior litigation, penalties, and regulatory sanctions: As set forth in the findings of fact, three of the successful bidders omitted reference to prior litigation and/or regulatory actions from their proposals. This failure in disclosure does not necessarily provide a basis for disqualification of the bidders or establish an abuse of discretion. The critical questions are whether the undisclosed matters fell within the scope of information requested by the RFP and, if they did, whether Iowa DHS acted unreasonably and abused its discretion in deciding that the failure to disclose did not

merit disqualification of the bidders.

Section 3.2.5.4 of the RFP provides:

Bid Proposals must indicate whether any of the following conditions have been applicable to the bidder or [a related company] during the past five (5) years that relate to service contemplated by this RFP . . .

- List any damages, penalties, disincentives assessed, or payments withheld, or anything of value traded or given up by the bidder under any of its existing or past contracts as it relates to services performed that are similar to the services contemplated by the RFP . . .
- List and summarize any current pending or threatened litigation, administrative or regulatory proceedings, or similar matters related to the subject matter of the services sought in this RFP. Bidders may limit disclosure to these matters to a material threshold established by GAAP requirements.

*WellCare* – The Appellants argue that Iowa DHS mishandled WellCare’s failure to disclose the settlement payment and Corporate Integrity Agreement flowing from the false claims act litigation. They assert that disclosure of these events was clearly required; that the “clarifying question” posed to WellCare after the initial round of scoring was improper in that it was used to give WellCare an opportunity to provide previously withheld information, not to resolve an ambiguity or question about information presented in its bid proposal; and that Iowa DHS should have disqualified WellCare from the procurement, rather than accepting the company’s response to the clarifying question. WellCare and Iowa DHS argue that section 3.2.5.4 did not require the disclosure of payments made pursuant to settlements; that ambiguity in the question justified the clarifying question; and that Iowa DHS had the discretion to waive or permit cure of variances.

As an initial matter, I find the fact that the false claims act claims were resolved through settlement virtually irrelevant. The third bullet point of section 3.2.5.4 (the first quoted above), clearly required the disclosure of all types of monetary payments made or withheld under any existing or past contract regardless of the context in which the payments were made. The inquiry in no way limited the context in which payments were made. That WellCare made the \$137.5 million payment to resolve false claim litigation, to avoid potential suspension from the Medicaid program, rather than in response to an audit claim is beside the point. WellCare paid a penalty within the last five years, to resolve liability related to false claims under contracts relating to Medicaid managed care services. WellCare should have disclosed the payment in its initial response to section 3.2.5.4 of the RFP.

Further, as discussed in the findings of fact, two sections of the RFP must be considered. Although inexplicably not addressed by the parties, RFP section 3.2.7.4.2 also required disclosure of prior regulatory proceedings related to publicly-funded managed care contracts, including:

- any debarment or suspension, regulatory action, or sanctions, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity within the last five (5) years; and
- any letter of deficiency issued by or corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relates to Medicare, Medicaid, CHIP, or the Substance Abuse Use Prevention and Treatment Block Grant.

I recognize that the \$137.5 million settlement payment may not have fallen within the ambit of this section. Although it was a monetary sanction paid within the past five years, arguably the sanction was not imposed by a regulatory agency. The same is not true of the Corporate Integrity Agreement. Through this agreement, entered within the past five years, HHS required WellCare to take corrective actions to prevent a repetition of past misconduct. HHS is a regulatory agency. WellCare's obligations under the agreement run for five years and remain in effect. I conclude RFP section 3.2.7.4.2 required disclosure of the existence of the CIA.

The next question that must be resolved is whether the evaluation committee abused its discretion when it issued the clarifying question allowing WellCare to supplement its response to the RFP or when it accepted WellCare's response to the question. Two provisions in the RFP state that bidders *may* be disqualified for failing to include content required by the RFP: section 2.15.2 and the note in section 3.2.5.4. Disqualification is not required under the terms of either section. Rather, as explained in section 2.1.5.1, "the Agency reserve[d] the discretion to permit cure of variances, waiver variances, or disqualify. ... The determination of whether or not to disqualify a proposal and not consider it for award of a contract, ... or to waive or permit cure of variances in Bid Proposals, is at the sole discretion of the Agency."

It is not uncommon for agencies to reserve the right to waive minor deficiencies in RFP proposals and some courts have found that government bodies have an inherent right to waive "discretion to waive minor bid defects that do not materially undermine the bidding process." *Dunbar v. Downingtown Area Sch. Dist.*, 901 A.2d 1120, 1127 (Pa. Commw. Ct. 2006), citing *Gaeta v. Ridley School District*, 567 Pa. 500, 788 A.2d 363 (2002). I agree that Iowa DHS had the discretion to seek clarification from WellCare and to conclude that disqualification was not appropriate. However, under the facts as developed at hearing, I am compelled to find that the agency decision-makers were not afforded an opportunity to fully exercise their discretion.

Iowa DHS staff located a copy of the WellCare – HHS Corporate Integrity Agreement and the Department of Justice press release describing the settlement agreement on the afternoon of July 31<sup>st</sup>, the day of the last evaluation committee group scoring session. The record does not show whether the scoring session was completed when Wetlauffer discovered these documents and forwarded them to Lindgren at 4:03 that afternoon. The record does establish that the evaluators were not given the documents then, or at any time. Instead, with assistance the Ikaso consultants, the committee issued a clarifying question to WellCare, providing the company an opportunity to disclose and explain the basis for and resolution of the false claims act litigation in a light highly favorable to the company. The evaluation committee was given WellCare's response and decided it was satisfactory, but they did so without having seen the CIA and without any information about the settlement.

Because this information was not shared with the evaluators, they had no basis to determine the completeness or accuracy of WellCare's response. Without this information, they could not exercise reasoned judgment as to whether WellCare's failure to disclose these events in its initial response was an intentional or material omission. The same is true as to Director Palmer. Palmer accepted the decision of the evaluation committee as to the omission and WellCare's response to the clarifying question, but he was provided with no more information than the evaluation committee.

The grant of discretion carries with it the obligation to exercise that discretion. The law in Iowa is clear: "A failure to exercise discretion is an abuse of discretion." *IBP, Inc. v. Al-Gharib*, 604 N.W.2d 621, 631 (Iowa 2000), citing *Sullivan v. Chicago & N.W. Transp. Co.*, 326 N.W.2d 320, 328 (Iowa 1982). Based on how the evaluation committee assessed and scored the responses of other bidders and the manner in which the committee accepted WellCare's response to the clarifying question, I find it is quite possible that if they had been presented with all available background information, they still would have accepted WellCare's proposal. But this potential does not negate the abuse of discretion arising from the failure to exercise discretion. "A refusal or failure to exercise discretion will not be affirmed by demonstrating that the result reached could have been the same upon the exercise of the withheld discretion." *Sullivan v. Chicago & Nw. Transp. Co.*, 326 N.W.2d at 328, citing *State v. Hildebrand*, 280 N.W.2d 393, 396 (Iowa 1979) and *State v. Boston*, 233 Iowa 1249, 1257, 11 N.W.2d 407, 411 (1943).

In this case, agency staff failed to disclose highly relevant information to the evaluation committee and the Director. In doing so, they deprived these decision-makers of the opportunity to exercise discretion with regard to WellCare's omission and past conduct. Because of this, I must conclude that the Iowa DHS decision not to disqualify WellCare's proposal constituted an abuse of discretion and the notice of intent to a contract to WellCare must be reversed.

*UnitedHealthcare* – The non-disclosure issues with regard to UnitedHealthcare and AmeriHealth Caritas are narrower. The Appellants identified three lawsuits against

United, two which were resolved within the past five years and one which was still pending when the company's RFP proposal was filed. They assert that all of these actions should have been disclosed by United in response to RFP section 3.2.5.4. United's counter argument is that none of these lawsuits fell within the litigation disclosure requirement of the RFP.

Upon review of the documents submitted by the parties, I find that the Appellants failed to present convincing evidence to support their position. It does not appear that any of the cases involved contracts for the delivery of services related to Medicaid managed care or CHIP. There is no showing that these actions related to the subject matter of the RFP.

*AmeriHealth Caritas* – The only evidence offered by the Appellants to establish that AmeriHealth failed to comply with the litigation disclosure requirement is a press release from the Kentucky Attorney General announcing a Medicaid fraud settlement. The press release describes AmeriHealth not as a managed care provider, but as a third party administrator. There is no showing that these actions related to the subject matter of the RFP.

Communication during the RFP “blackout” period: Aetna and Iowa Total Care assert that bidders had sufficient prohibited contact with state officials while the Iowa Medicaid procurement was pending to require the Notice of Award to be overturned. Their arguments are based upon Christopher Rants' repeated communications with Michael Boussetot, Renée Schulte's communications with Mikki Stier and Boussetot, and the Iowa Department of Public Health Director's outreach to bidders. The specific communications underlying the Appellants' arguments are detailed in the findings of fact.

WellCare defends the communications between Rants and Boussetot as legitimate lobbying. WellCare acknowledges that Schulte should not have communicated with Stier about the RFP after Stier started serving as the Director of Iowa Medicaid, but maintain that the contact was inadvertent and non-prejudicial. DHS focuses on the evaluation process and the fact that no communication between WellCare representatives and the evaluators about the RFP was proven.

As set forth above, an alternate basis for disqualification of WellCare has been established. I proceed with consideration of this claim to address the Appellants' argument that the appearance of impropriety flowing from these communications tainted the procurement as a whole.

A threshold question that must be addressed is whether the “blackout” language in the RFP prohibits bidders from communicating with state officials and employees outside of DHS. Sections 2.1 and 2.2 of the RFP identified the Issuing Officer, Carrie Lindgren, as the “sole point of contact regarding the RFP” and directed that “the bidder shall not

contact any other employee concerning the RFP. The RFP did not include a definition of “employee,” leaving the scope of the section 2.2 restriction on communication somewhat unclear.<sup>19</sup>

Michael Boussetot was not an employee of DHS. He was an employee of the state with a direct involvement in the procurement process. Boussetot, serving in his role as the Governor’s primary health policy advisor, worked closely with Director Palmer in drafting the initial Scope of Work for the project. Director Palmer met with and sought guidance from Boussetot and other representatives of the administration, immediately before he made a decision as to how many contracts to issue. Director Palmer testified that in his view communication between a bidder and Boussetot related to the substance of the RFP during the blackout was inappropriate. (Tr. 203-04) I agree. Although not a member of the proposal evaluation committee, Boussetot was certainly in a position to influence the content of the RFP and Director Palmer’s ultimate decision.

Rants and WellCare’s lead executive on the Iowa project, Troy Hildreth, were well aware of Boussetot’s involvement and interest in the Medicare Modernization plan.<sup>20</sup> This is precisely why they conveyed the company’s concerns directly to him when possible. At hearing, Rants characterized all of his contact with Boussetot as appropriate lobbying concerning the potential for the Medicaid modernization initiative to succeed with the projected savings of state funds. While Rants undoubtedly talked to Boussetot about pending legislative initiatives and the program’s potential for success, Rants’ contacts with the Governor’s aide were clearly not limited to these topics. Rather, many topics about which he spoke to Boussetot related directly to terms of the RFP, timelines imposed by the RFP, or calculation of the capitation rates that would be paid to MCOs under contracts resulting from the procurement. WellCare should have pursued their concerns through the Issuing Officer and the official question and answer process, rather than taking them to Boussetot. This conduct violated RFP sections 2.1 and 2.2.

Schulte’s communication with Stier on or after May 27<sup>th</sup>, when she began working as the Iowa Medicaid Director, about the terms of the RFP and the progress of the proposal evaluation process were also clearly improper and in violation of sections 2.1 and 2.2 of

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<sup>19</sup> DAS provides “Service Contracting Resources” on the agency’s website, including an RFP template. (available at: <https://das.iowa.gov/procurement/agencies> – link for “RFP Template”) This model form includes the Restriction on Communication found in section 2.2 of this form provides: “Contractors may contact only the Issuing Officer. . . . Contractors may be disqualified if they contact any State employee other than the issuing Officer about the RFP . . .” The record contains no explanation why DHS used alternate language in the Iowa Medicaid RFP.

<sup>20</sup> In the spring of 2015, when Rants and Boussetot had several discussions about the RFP, Rants, Schulte, and presumed Hildreth, also thought the “MB”, Boussetot might possibly be an evaluator for the RFPs.

the RFP. Although in some ways these communications were more understandable and less offensive. Schulte and Stier were long-time friends and Shulte regularly talked with Stier about many things, including the Medicaid Modernization plan and RFP. There is no evidence that Schulte's contacts with Stier were intended to directly influence the procurement process.

Having found that WellCare representatives engaged in prohibited contact with Stier and Bousselot, the next step is to consider whether that contact necessitates reversal of the contract awards. Aetna cites a number of federal procurement decisions for the proposition that an agency's improper discussions or communications with a bidder may require reversal of a contract award based on the appearance of impropriety. The cases are unpersuasive. They generally involve procurements under which a single contract was awarded to a bidder with which the agency had improper contact. The current situation is readily distinguishable. Here multiple contracts were awarded and the evidence establishes only one bidder that engaged in improper contact with the agency.

Section 2.15.1 of the RFP lists a number of actions that *may* result in disqualification of a bid proposal, including: "Bidder initiated unauthorized contact regarding [the] RFP with employees other than the Issuing Officer." Disqualification under this section is discretionary. Nothing in the RFP explicitly authorizes Iowa DHS to abandon the procurement or reject all proposals based on a finding that one bidder violated the restriction on communication.

Competitive bidding requirements, including those such as the restriction on communication, serve the purpose of protecting the public. They are intended to secure competition, obtain the best results for the lowest price, and to "forestall fraud, favoritism, and corruption in the making of contracts." *Medco*, 553 N.W.2d at 563. Communication in violation of a procurement blackout period directly affects the fairness of a contract award if one bidder attains an unfair advantage over competitors. It is very difficult to determine the actual impact of WellCare's conduct in this case. Concerns that Rants took to Bousselot were addressed by DHS. However, since the same concerns also arose through the formal question and answer process the changes cannot be attributed solely to the improper contact.

In the end, although the improper communications by WellCare representatives present a sufficient independent basis for disqualification of the WellCare proposal, this misconduct does not sufficiently taint the entire process to necessitate reversal of the award of contracts to the remaining successful bidders.

Evaluation methodology: DAS rules 118.3 and 118.5(2) required DHS to use a formal competitive selection process to compare provider qualifications and proposals and allowed the agency to weight relevant selection criteria in whatever fashion it believed

would enable it to select the service providers that submit the best proposals. The Iowa Medicaid RFP stated that DHS intended to conduct a comprehensive, fair and impartial evaluation of the proposals received and that an evaluation committee could determine the relative merit of the proposals by scoring bidder responses to RFP sections 3.2.4, 3.2.5, 3.2.6, and 3.2.7 on a 100 point scale. The committee was then required to present a final ranking and recommendation(s) to the DHS Director. (Jt. Exhibit 369, § 4)

Subject to the limits of controlling law and the terms of an RFP, agencies are afforded a great deal of discretion in the design and execution of the evaluation methodology used select prevailing bidders. Given the breath of agency discretion regarding bid evaluation, the nature of review is necessarily constrained.

Contracting officers may properly exercise wide discretion in their evaluation of bids and in their application of procurement regulations. The court cannot substitute its judgment for that of the agency, even if reasonable minds could reach differing conclusions, and must give deference to the agency's findings and conclusions. . . . The question before the court is not whether the agency's decision was right or wrong; instead the court must determine whether that decision was the result of a considered process, rather than an arbitrary and capricious choice based on factors lacking any intrinsic rational basis or relation to the questions at issue.

*Dismas Charities, Inc. v. United States*, 61 Fed. Cl. 191, 198 (2004). Despite careful consideration of the Appellants numerous arguments the contrary, I find that the scoring and evaluation methodology used by DHS was not unfair, unreasonable, arbitrary, or capricious.

*Independence of evaluators / bias claims* – Four DHS employees with varied areas of subject matter expertise were selected to serve on the evaluation committee. Each of the evaluators had extensive experience working with the Iowa Medicaid program and played a role in drafting the RFP Scope of Work. They were very familiar with the Medicaid Modernization project and goals of the agency. DHS took steps to ensure that each evaluator was prepared and able to devote the time necessary to fully review and score the proposals.

The Appellants raise dual challenges to the composition of the evaluation committee. First, they point to the fact that Julie Lovelady, then the Acting Director of Iowa Medicaid, was the direct supervisor of Elizabeth Matney, the Managed Care Director for Iowa Medicaid. They assert that the superior-subordinate relationship of these two evaluation committee members creates a serious question as to whether Matney was able to exercise independent judgment and fully express her opinions during the group-scoring process. Appellants assert Matney may have been likely to go along with the

opinions of her supervisor and hesitant to speak her mind if she disagreed with Lovelady.

It is certainly possible to envision how a superior-subordinate relationship between evaluators might interfere with the free exchange of opinions and ideas. That said, there is no evidence in the record showing that Matney's participation in the scoring process was in any way constrained by Lovelady's presence on the committee. To the contrary, all evidence points to the fact that Lovelady and Matney had a strong collaborative working relationship in which Matney felt free to speak her mind.

The Appellants also point to the potential that one or more evaluators may have been biased by prior experience with bidders. Iowa Total Care attempted to establish that evaluator Richard Shults carried negative bias against ITC or affiliated corporations, Centene and Cenpatico, stemming from Shults' interaction with these firms years ago when he worked for the state of Kansas. ITC argues that Ikaso and/or DHS should have screened each evaluator for potential bias.

Evaluator bias based on past experience is a possibility with any procurement. Ideally, agencies would be wise to question potential evaluators about past contact with bidders when selecting and screening the evaluators. However, the question here is not whether the process could be improved, but whether the process used was fair and reasonable. Evidence in the record does not prove that Shults was biased against ITC or its affiliates; nor was it shown that any of the evaluators carried positive or negative bias into the selection process.

*Use of consensus scoring* – The Appellants contend that use of consensus scoring enhanced the potential for bias or undue influence to affect the evaluation process, because a single evaluator had the opportunity to exert outsized influence. The absence of individual scoring does remove one potential avenue for identifying bias, but I have no basis on which to conclude that consensus scoring enhances the ability of a single evaluator to exert undue influence on the scoring process. Rather, the evidence and authority presented to me supports the opposite conclusion.

The consensus scoring model “helps prevent bias, because a single member [of an evaluation committee] cannot impact the results by scoring a bidder significantly higher or lower than the committee as a whole.” *Kuder v. Department of Administrative Services*, Appeal No. 09DASV001 (Proposed Decision, Sept. 28, 2009) (quoting testimony of Iowa DAS procurement officer); *In re Xcel's Request to Issue Renewable Development Fun Cycle 4 Requests for Proposals*, 2015 WL 2341257 at \*5 (Minn. Ct. App. May 18, 2015) (noting the use of consensus “minimized the role of possible conflicts of interest”). Consensus scoring may well lead to more objective and accurate results.

Agency evaluators may meet to discuss the relative strengths and weaknesses of proposals, as was done here, in order to reach a consensus rating, which often differs from the ratings given by individual evaluators, since such discussions generally operate to correct mistakes or misperceptions that may have occurred in the initial evaluation.

*Bean Stuyvesant, L.L.C. v. United States*, 48 Fed. Cl. 303, 326 (2000), citing *Resource Applications, Inc.*, B-274943.3, Mar. 5, 1997, 97-1 CPD ¶ 137 at 5.

The Scope of Work required by the Iowa Medicaid RFP is extraordinarily large. Not surprisingly, the bidders' proposals were voluminous and complex. The consensus scoring method allowed the evaluators to talk through their individual questions and concerns regarding each section of each proposal before assigning a numerical score. The evaluators found this aided them in understanding the proposals and were confident that the use of consensus scoring resulted in a fair ranking of the proposals. I cannot fault Iowa DHS for using consensus scoring.

*Use of subject matter experts* – DHS asked subject matter experts from both inside and outside the agency to review relevant portions of the proposals addressing three topics: information technology, pharmacy services, and DPH-funded substance abuse disorder services. The SMEs were asked to provide feedback to the evaluators through narrative reports. They did not score or rank the proposals. The evaluators used the SME reports to inform and validate their observations concerning the sufficiency of the proposals to meet the RFP requirements in these areas. The RFP did not require or prohibit the use of SMEs. The RFP did allow DHS to “obtain and consider information from other sources” for use in review of proposals. (Jt. Exhibit 369 at § 2.19) Use of the SMEs did not violate the terms of the RFP.

*Zero-to-4 scoring scale* – The Appellants assert that the 0-to-4 scoring scale used by the evaluation committee was flawed, in that it was vague and imprecise and was not tailored to the nature of the services being procured. The scoring scale was recommended to DHS by the Ikaso consultants. As applied, the scoring system provided the evaluators with a means of differentiating proposals based on the degree to which a bidder addressed and agreed to comply with the requirements of the RFP and each section of the Scope of Work. The evaluators found the scoring scale clear and easy to use. Selection of this scoring tool was not an abuse of discretion.

*Documentation of basis for decision* – The Appellants allege that the evaluation committee did not maintain an adequate record to document their decision-making. The initial scoring notes maintained by the facilitators during the group scoring session document the comments the evaluators made as they discussed each section of each proposal. The Appellant's argue that there is no direct correlation between the notes and the scores. They are even more critical of the “Select Strengths and Weaknesses”

document and the lack of criteria for selecting items include in this summary of the initial scoring notes.

The evaluators reviewed each proposal at least twice; once individually and once during the group scoring sessions. During the group session, the evaluators discussed items that stood out to each of them when they individually reviewed the proposals. Both positive factors and weaknesses were discussed. These comments were contemporaneously captured in the initial scoring notes. The Appellants raise legitimate questions about the accuracy of some of the notes. Given the complexity and sheer length of the proposals, it is certainly possible that some items were overlooked or misinterpreted. The notes are sufficient to prove that the committee reviewed each proposal in detail and are adequate to document the exercise of reason and judgment in scoring the proposals.

*Sequential scoring of proposals* – The Appellants assert that the sequential scoring process used by the evaluation committee made it impossible for the committee to fairly compare the competing proposals. Each evaluator reviewed each proposal its entirety before the evaluation committee convened to score the proposals. The evaluators did not score the proposals during this individual review. When the committee met to score the proposals, they proceeded through the proposals in randomly selected order. The committee scored all 19 sections of one proposal against the requirements of the RFP and Scope of Work before moving to the next proposal. They did no side-by-side comparison or comparative analysis of competing proposals.

DHS defends this sequential scoring approach, asserting that it allowed the evaluators to keep their focus on compliance with the RFP and Scope of Work, thereby ensuring that all proposals were evaluated and scored against the “yardstick” of the Scope of Work. Evidence shows that the committee used the same approach throughout its review of the bid proposals. To the degree possible, the evaluators took care to ensure they fairly and consistently evaluated each proposal throughout the week.

The Appellants support their argument with federal case law reviewing “best-value” procurements in which price *and* other factors – such as relative technical merit – are to be considered by procurement officials in selecting the winning proposal. *E.g. One Largo Metro, LLC v. U.S.*, 109 Fed. Cl. 29 (2013); *FirstLine Transp. Sec., Inc. v. U.S.*, 100 Fed. Cl. 359, 376-80 (2011). The weight given to technical scores in best-value procurements varies, depending on the nature of the project. The process permits “tradeoffs among cost or price and non-cost factors and allows the Government to accept other than the lowest prices proposal.” 48 C.F.R. § 101-1(c). This procurement method may result in selection of a higher-priced technically superior proposal or a lower-priced technically inferior proposal. When conducting a best-value procurement, the purchasing agency must engage in a meaningful comparison of the competing proposals and weigh the relative benefits and disadvantages of the technical proposals

against the relative cost of the proposals. *FirstLine Transp.*, 100 Fed. Cl. at 380.

The RFP at issue here is not a “best-value” procurement. Under the Iowa Medicaid RFP, contracts were to be awarded to the MCOs with proposals that offered the “greatest benefit” to the agency and the state. (Jt. Exhibit 369 at § 4.1) Price was not a factor and there was no need for the agency to balance relative cost versus relative technical merit. Rather, the sole purpose of the evaluation process was to identify the proposals that would produce the greatest benefit or best outcome for the state. If the Scope of Work accurately described the services required to meet the state’s needs and the proposals were fairly and consistently scored against the requirements of the RFP and Scope of Work, the resulting scores provided a sound basis for determining which proposals would produce the greatest benefit to the state.

Certainly, the agency could have taken a different approach to scoring the proposals. Given the sheer size and complexity of the proposals, it would have been reasonable and possibly preferable to approach scoring the proposals in a different way. For instance, scoring the proposals section-by-section (completing the scoring of the same section of all proposals before moving to the next section) might have made it easier for the evaluators to assess the relative technical merit of each proposal and to ensure scoring consistency. Once again, however, it does not matter whether DHS chose the best possible method of evaluating the proposals. The operative question is whether the selection of bidders was the result of a considered process, rather than an arbitrary and capricious choice based on irrational factors. The Appellants presented insufficient evidence to prove that sequential scoring of the proposals resulted unfair or irrational scores.

*The scores:* All three Appellants dispute the scores assigned to their bid proposals and the “strengths” and “weaknesses” identified in the “Select Strengths and Weaknesses” document. In essence, they disagree with outcome of the evaluations process, each arguing that their proposal should have been scored and ranked higher. I am not totally unsympathetic to these claims. Some aspects of the scoring do appear illogical. The scores awarded for section 3.2.5.4 of the RFP, Termination, Litigation, and Investigation, provide a clear example. It is difficult to fathom why Meridian – a company that reported no substantial penalties or repayments or regulatory sanctions during the past five years received a score of 1 for this section, a lower score than all other bidders; while UnitedHealthcare Plan – a company that reported 100s of regulatory actions, six resulting in penalty payments in excess of \$1.0 million, and two contract terminations – and WellCare – a company that failed to disclose a Corporate Integrity Agreement entered four years ago to resolve a significant false claims action – both received scores of 2 for this section.

I must conclude, however, that the existence of this and other apparent inconsistencies and potential errors in the scoring, provides an insufficient basis for me reject the scores

awarded by the committee. Reviewing tribunals are consistently, and rightly, reluctant to second guess or reject the discretionary technical scoring and ranking decisions made by procurement officials. As a general rule, “the details of technical rating decisions involve discretionary determinations of contracting officials that a court will not second guess. *Dismas Charities v. United States*, 61 Fed. Cl. at 205-6, citing *CW Government Travel v. United States*, 53 Fed. Cl. 580, 590 (2002); *Textron, Inc. v. U.S.*, 74 Fed. Cl. 277, 286 (2006) (stating the court would not re-examine the, “minutiae of the procurement process”) (quoting *E.W. Bliss v. United States*, 77 F.3d 445, 449 (Fed. Cir. 1996).

Claims of erroneous scores go “to the very heart of the discretionary judgments involved in a public procurement process. An evaluator brings a certain amount of subjective personal judgment to any procurement rating process, and the extremely deferential standard of review for discretionary procurement decisions respects the exercise of that judgment.” *Law Offices of Elizabeth G. Rich v. State of Wisconsin Department of Administration*, 2007 WL 7242049 (Wis. Ct. App. Nov. 12, 2007). This is particularly where, as here, “an agency’s decisions are highly technical in nature.” *Electro-Methods, Inc. v. United States*, 7 Cl. Ct. 755, 762 (1985) (citing *Isometrics v. United States*, 5 Cl. Ct. 420, 423 (1984)).

Understandably, the United States Court of Federal Claims has declined to venture too far into the weeds of most bid protests that are factually driven. As such, the most relevant existing guidance in this case is the determination in *Fort Carson Support Servs. v. United States*, 71 Fed. Cl. 571 (2006), that the “identification of strengths and weaknesses ... does not convert the evaluators’ subjective judgment into some objective fact that may be disproved in court, nor does it result in a product that can be mechanically summed or subtracted.” *Id.* at 591.

*Akal Sec., Inc. v. United States*, 103 Fed. Cl. 310, 332 (2011).

The evidence at the hearing shows that the committee’s process was thorough and methodical. The committee discussed each section of each proposal at some length before arriving at a consensus score. Based on my review of the initial scoring notes, segments of the proposals, hearing testimony, and the arguments advanced by the parties, I simply cannot conclude that the scores awarded by the committee were blatantly unreasonable or arbitrary.

*Recommendation to the Director* – In a distinct, but closely related, argument the Appellants contend that the evaluation committee failed to provide the DHS Director with a “recommendation,” as required by the RFP. Section 4.5 of the RFP provides:

The evaluation committee shall present a final ranking and

recommendation(s) to the Director of the Department of Human Services for consideration. In making this recommendation, the committee is not bound by any scores or scoring system used to assist with initially determining the relative merits of each Bid Proposal. The Agency reserves the right to consider any changes in or clarifications to a bidder's proposal that may result from rounds of clarifications, oral presentations, and/or a Best and Final Offer (BAFO) round as part of the evaluation process. This recommendation may include, but is not limited to, the name of one or more bidders recommended for selection or a recommendation that no bidder be selected. The Director shall consider the committee's

recommendation when making the final decision, but is not bound by the recommendation.

The evaluation committee presented Director Palmer with a recommendation in the form of a memorandum summarizing the evaluation process, the scoring methodology, the final technical proposal scores, and the ranking of the bidders based on these scores, during a meeting with Director Palmer on August 12<sup>th</sup>. Director Palmer was also given a scoring grid showing the scores awarded to each section of each proposal, the Select Strengths and Weaknesses document, and the initial scoring notes. He requested and was later given reference letters and the responses giving to questionnaires DHS sent to the authors of the reference letters.

The Appellants argue that by limiting their recommendation to the ranking of bidders, the committee failed to exercised its discretion to look beyond the technical scores and abdicated its duty to make a true "recommendation" to the Director. This argument is bolstered by the fact that when asked during depositions about their report to the Director, the evaluators denied they made a "recommendation." The deposition testimony does not prove that the committee erred. It is clear from hearing testimony that as far as the evaluators and Director Palmer were concerned the technical score ranking of the bidders was the committee recommendation. The RFP afforded the committee discretion to consider factors other than the scores in ranking the proposals. After completing the scoring process, the evaluators all believed that the scores represented a fair assessment of relative merit of the proposals. Palmer discussed the evaluation and scoring process with the evaluators and agreed.

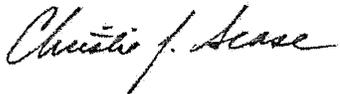
Again, presuming that the Scope of Work accurately described the services required from an MCO to meet the state's needs and that the proposals were fairly and consistently scored against the requirements of the RFP and Scope of Work – two premises supported by the record here, this was a valid conclusion. The evaluation committee's decision to limit its recommendation to the Director to the ranking of the proposals was a rational exercise of their authority under the RFP.

Due process violation arising from appeal procedure: The procedural rules governing this proceeding, found in 441 IAC chapter 7, division II, create an expedited timeline for resolution of appeals from DHS procurement decisions. The hearing must be conducted within 60 days of the date the notice of appeal is received by the agency and discovery is to be completed at least 15 days prior to hearing. 441 IAC 7.43(1); 7.44(1) and (3). Aetna asserts that the time limits established for these appeals violate its due process rights. This issue has been preserved for appeal. *See Shell Oil Co. v. Bair*, 417 N.W.2d 425, 429 (Iowa 1987).

### Order

The Notice of Intent to Award is **AFFIRMED** as Amerigroup Iowa, Inc., AmeriHealth Caritas, Inc., and UnitedHealthcare Plan of the River Valley. The Notice of Intent to Award is **REVERSED** as to WellCare of Iowa, Inc.

Issued on November 25<sup>th</sup>, 2015.



Christie J. Scase  
Administrative Law Judge

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**AmeriHealth Caritas, Inc.**

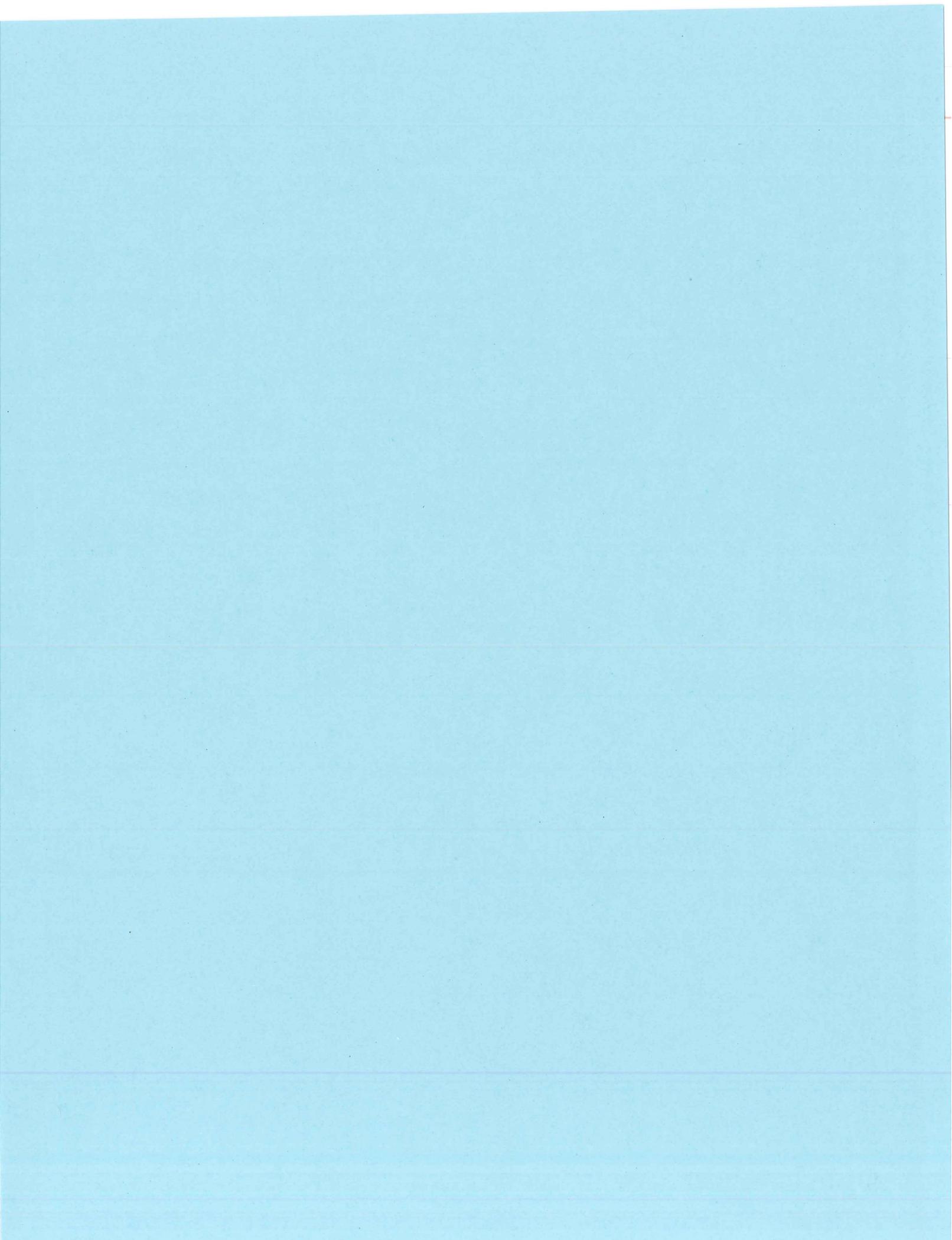
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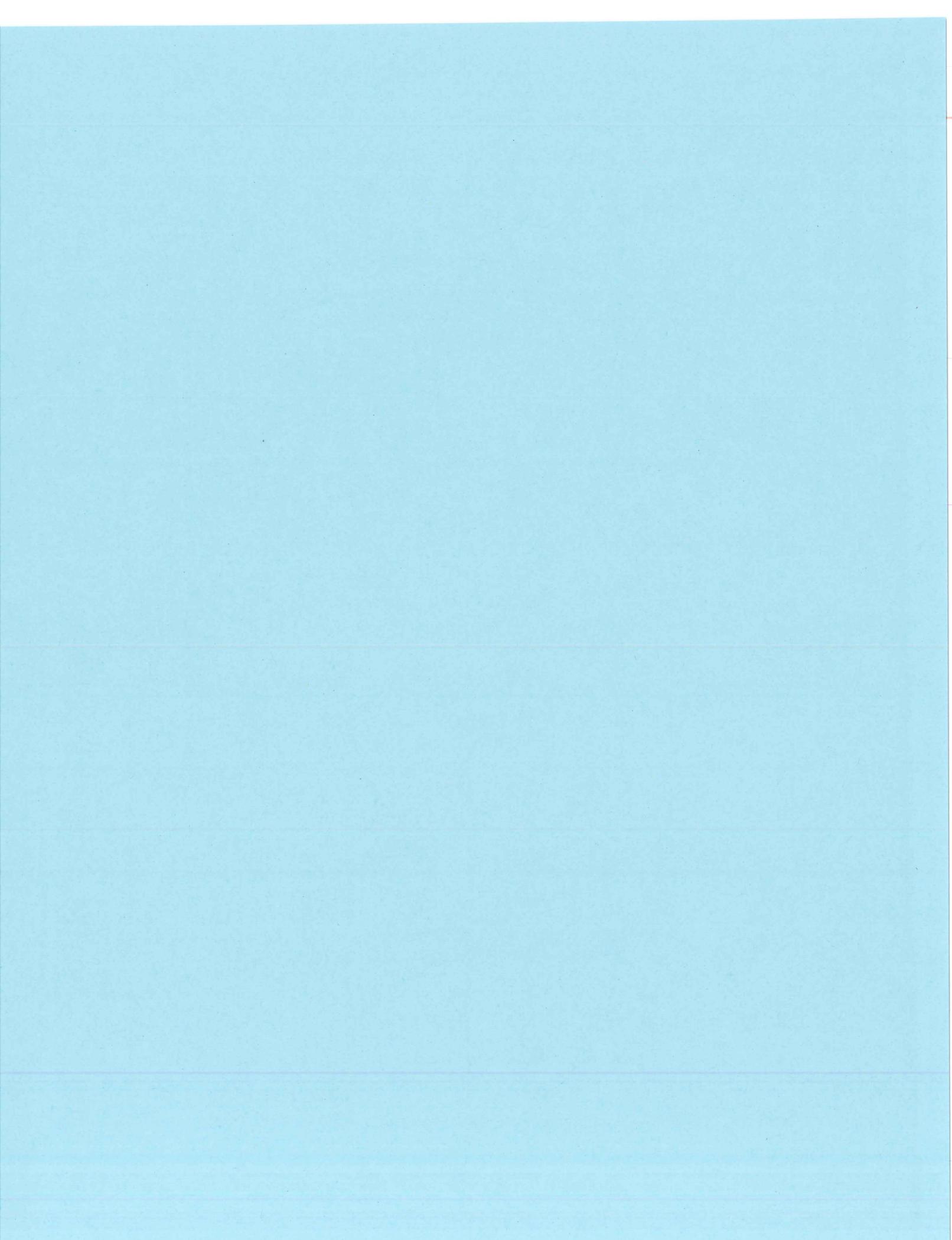
**WellCare of Iowa, Inc.**

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Attorney – Lindsay A. Vaught  
Attorney – Robert S. Highsmith, Jr.  
Attorney – Keith M. Wiener  
Attorney – A. André Hendrick



# Exhibit

# F



**IOWA DEPARTMENT OF HUMAN SERVICES  
HOOVER STATE OFFICE BUILDING – FIFTH FLOOR  
DES MOINES, IOWA 50319**

<p>Iowa Total Care, Inc. Meridian Health Plan of Iowa, Inc., and Aetna Better Health of Iowa, Inc.,</p> <p style="text-align:center">Appellants,</p> <p>v.</p> <p>Iowa Department of Human Services,</p> <p style="text-align:center">Respondent,</p> <p>Amerigroup Iowa, Inc., AmeriHealth Caritas, Inc., United Healthcare Plan of the River Valley, Inc., and WellCare of Iowa, Inc.,</p> <p style="text-align:center">Intervenors.</p>	<p>Appeal No. 16001573 Appeal No. 16001590 Appeal No. 16001623</p> <p style="text-align:center"><b>FINAL DECISION</b></p>
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Aetna Better Health (Aetna), WellCare of Iowa, Inc. (WellCare), Meridian Health Plan of Iowa, Inc. (Meridian), and the Iowa Department of Human Services (DHS) filed timely Requests for Review of the Proposed Decision issued on November 25, 2015. Review was granted on December 8, 2015.

For the reasons set forth below, the Notice of Intent to Award is AFFIRMED as to Amerigroup Iowa, Inc., AmeriHealth Caritas, Inc., and UnitedHealthcare Plan of the River Valley. The Notice of Intent to Award is REVERSED as to WellCare of Iowa, Inc. and its contract with DHS is terminated.

**STANDARD OF REVIEW**

In reviewing the Proposed Decision, the undersigned, as substitute decision maker, “stands in the shoes” of DHS Director Palmer in this matter. Pursuant to the Iowa Administrative Procedure Act, the following is the standard of review for agency review of an ALJ’s proposed decision:

On appeal from or review of the proposed decision, the agency has all the power which it would have in initially making the final decision except as it may limit the issues on notice to the parties or by rule. The agency may reverse or modify any finding of fact if a preponderance of the evidence will support a determination to reverse or modify such a finding, or may reverse or modify any conclusion of law that the agency finds to be in error.

Iowa Code § 17A.15. In addition, in my review, I give deference to findings of fact that are impacted by credibility determinations made, expressly or impliedly, by the ALJ who presided at the hearing.

### **SCOPE OF REVIEW**

In issuing this Final Decision, a careful review of the record was conducted. This included a review of the Proposed Decision; transcripts from the five day contested case hearing, including admitted exhibits<sup>1</sup>; post-hearing briefs from the parties; four Requests for Review from Meridian Health Plan of Iowa, Inc. (Meridian), Aetna Better Health of Iowa, Inc. (Aetna), WellCare of Iowa, Inc. (WellCare), and the Department of Human Services (DHS); briefs from Iowa Total Care, Inc. (Iowa Total Care), Amerigroup Iowa, Inc. (Amerigroup), AmeriHealth Caritas, Inc. (AmeriHealth), and UnitedHealthcare Plan of the River Valley, Inc. (UnitedHealthcare); and Offers of Proof of expert testimony of John S. Pachter and Dr. Kelly Hannum.<sup>2</sup>

NOTE: The following tracks the structure of the ALJ's Proposed Decision.

### **FINDINGS OF FACT**

I adopt the "Findings of Fact" set forth at pages 3 through 32 of the Proposed Decision.

### **CONCLUSIONS OF LAW**

#### **DHS contacting authority and applicable review standards**

##### DHS authority to contract with managed care organizations

I adopt the Conclusions of Law set forth under this heading at pages 32 through 34 of the Proposed Decision.

I make the following additional Conclusion of Law: "The legislature also specifically recognized DHS's authority to "transition to managed care" and enter into "managed care" contracts for the delivery of Medicaid services. 2015 Iowa Acts, ch. 137 (S.F. 505), § 115."

##### Applicable procurement procedures

I adopt the Conclusions of Law set forth in the first three paragraphs under this heading at pages 34 and 35 of the Proposed Decision.

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<sup>1</sup> On December 10, 2015, Aetna filed a Motion to Correct Proposed Decision on Exhibits Admitted into Evidence. Aetna's Motion was granted on December 11, 2015, to reflect that Exhibits 5166-5168, 5170-5173, 5174 (instead of 5274), and 5210-5215 were admitted into evidence in the contested case hearing. The Findings of Fact contained in the Proposed Decision are adopted in this Final Decision, as amended with the aforementioned exhibits.

<sup>2</sup> The ALJ excluded this testimony on procedural grounds. My review of the record as a whole included the offers of proof and that evidence has been considered in reaching my final decision.

The fourth and fifth full paragraphs under this heading at page 35 of the Proposed Decision are moved to the sub-section "Alleged organizational conflict of interest" and will be addressed therein.

I reverse the Conclusions of Law set forth in the first full paragraph on page 36.

#### Standard of Review

I reverse the Conclusions of Law set forth in the first two paragraphs under this heading at pages 36 and 37 of the Proposed Decision.

I adopt the Conclusions of Law set forth in the third and fourth paragraphs under this heading at pages 37 and 38 of the Proposed Decision.

I reverse the Conclusions of Law set forth in the fifth and sixth full paragraphs under this heading at page 38 of the Proposed Decision.

#### **Review of the Medicaid RFP procurement process**

I adopt the Conclusions of Law set forth in the first paragraph under this heading on page 38 of the Proposed Decision.

#### Alleged organizational conflict of interest

The first paragraph under this heading is deleted as superfluous.

I adopt and insert the Conclusions of Law set forth in the fourth and fifth full paragraphs under the heading "Applicable procurement procedures" on page 35 of the Proposed Decision.

I adopt and insert the Conclusions of Law set forth in the text of footnote 18 on page 36 of the Proposed Decision and move that text to the body of the decision.

I make the following additional Conclusions of Law: "I conclude therefore that the regulatory guidance relied upon by the Medco court does not govern the conflict analysis in this procurement; nonetheless, as discussed below, I conclude that even if I were to apply the Medco standard, there was no 'organizational conflict of interest' that would require nullifying the entire RFP process."

I adopt the Conclusions of Law set forth in the second, third, fourth, fifth, and sixth full paragraphs under this heading at pages 39 and 40 of the Proposed Decision.

#### Non-disclosure of prior litigation, penalties, and regulatory sanctions

I reverse the Conclusions of Law set forth in the first paragraph under this heading on pages 40 and 41 of the Proposed Decision.

I make the following additional Conclusions of Law: “As set forth in the findings of fact, three of the successful bidders omitted reference to prior litigation and/or regulatory actions in their proposals. The three questions that must be answered with regard to these undisclosed matters is whether they fell within the scope of the information requested by the RFP, whether Iowa DHS’s decision to permit WellCare to submit “clarifying” information was improper, and whether the failure to disclose the information should result in disqualification of the bidders under the terms of the RFP.”

I adopt the Conclusions of Law set forth in the second paragraph under this heading at page 41 of the Proposed Decision.

*WellCare*

I adopt the Conclusions of Law set forth in the first six paragraphs under this heading at pages 41 and 42 of the Proposed Decision.

I reverse the Conclusions of Law set forth in the seventh, eighth, ninth, and tenth paragraphs under this heading at page 43 of the Proposed Decision.

I make the following additional Conclusions of Law: “In this case, the full record now before me shows that WellCare failed to disclose highly relevant information both in its initial response to the RFP and in its “clarifying” answer. In doing so, WellCare not only violated the terms of the RFP but also deprived the agency decision-makers – both the evaluation committee and Director Palmer – of the opportunity to fully exercise their discretion in determining which Bid Proposals would provide ‘the greatest benefit to the Agency.’ Accordingly, with the benefit of that record, I now conclude that WellCare’s Bid Proposal is disqualified and the subsequent contract between WellCare and DHS is terminated.”

*UnitedHealthcare*

I adopt the Conclusions of Law set forth in the two paragraphs under this heading at pages 43 and 44 of the Proposed Decision.

*AmeriHealth Caritas*

I adopt the Conclusions of Law set forth in the paragraph under this heading on page 44 of the Proposed Decision.

Communication during the RFP “blackout” period

I adopt the Conclusions of Law set forth under this heading at pages 44 through 46 of the Proposed Decision.

I make the following additional Conclusions of Law: “In this case, the full record now before me shows that WellCare not only explicitly violated sections 2.1 and 2.2 of the RFP, but also violated the spirit of the section which prohibits attempts to interfere with or influence the

procurement process. Although the record does not show that WellCare succeeded in its efforts, the intent was clear. The integrity of and confidence in our public procurement process is an agency priority. I therefore conclude that WellCare's Bid Proposal is disqualified pursuant to RFP section 2.15.1 and the subsequent contract between WellCare and DHS is terminated."

Evaluation methodology

I adopt the Conclusions of Law set forth in the first two paragraphs under this heading on pages 46 and 47 of the Proposed Decision.

*Independence of evaluators / bias claims*

I adopt the Conclusions of Law set forth in the five paragraphs under this heading on pages 47 and 48 of the Proposed Decision.

*Use of consensus scoring*

I adopt the Conclusions of Law set forth in the four paragraphs under this heading on pages 48 and 49 of the Proposed Decision.

*Use of subject matter experts*

I adopt the Conclusions of Law set forth under this heading on page 49 of the Proposed Decision.

*Zero-to-4 scoring scale*

I adopt the Conclusions of Law set forth under this heading on page 49 of the Proposed Decision.

*Documentation of basis for decision*

I adopt the Conclusions of Law set forth under this heading on pages 49 and 50 of the Proposed Decision.

*Sequential scoring of proposals*

I adopt the Conclusions of Law set forth under this heading on pages 50 and 51 of the Proposed Decision.

*The scores*

I adopt the Conclusions of Law set forth under this heading on pages 51 and 52 of the Proposed Decision.

*Recommendation to the Director*

I adopt the Conclusions of Law set forth under this heading on pages 52 and 53 of the Proposed Decision.

Due Process violation arising from appeal procedure

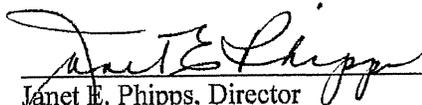
I adopt the Conclusions of Law set forth under this heading on page 54 of the Proposed Decision.

I also note that throughout this appeal process Aetna has repeatedly sought to further expedite the timeline for other parties and the decision-makers.

**FINAL ORDER**

The Notice of Intent to Award is AFFIRMED as to Amerigroup Iowa, Inc., AmeriHealth Caritas, Inc., and UnitedHealthcare Plan of the River Valley. The Notice of Intent to Award is REVERSED as to WellCare of Iowa, Inc. and its contract with DHS is hereby terminated.

Dated this 18<sup>th</sup> day of December, 2015.



Janet E. Phipps, Director  
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A copy of this Final Decision was sent to the following parties via email on December 18, 2015.

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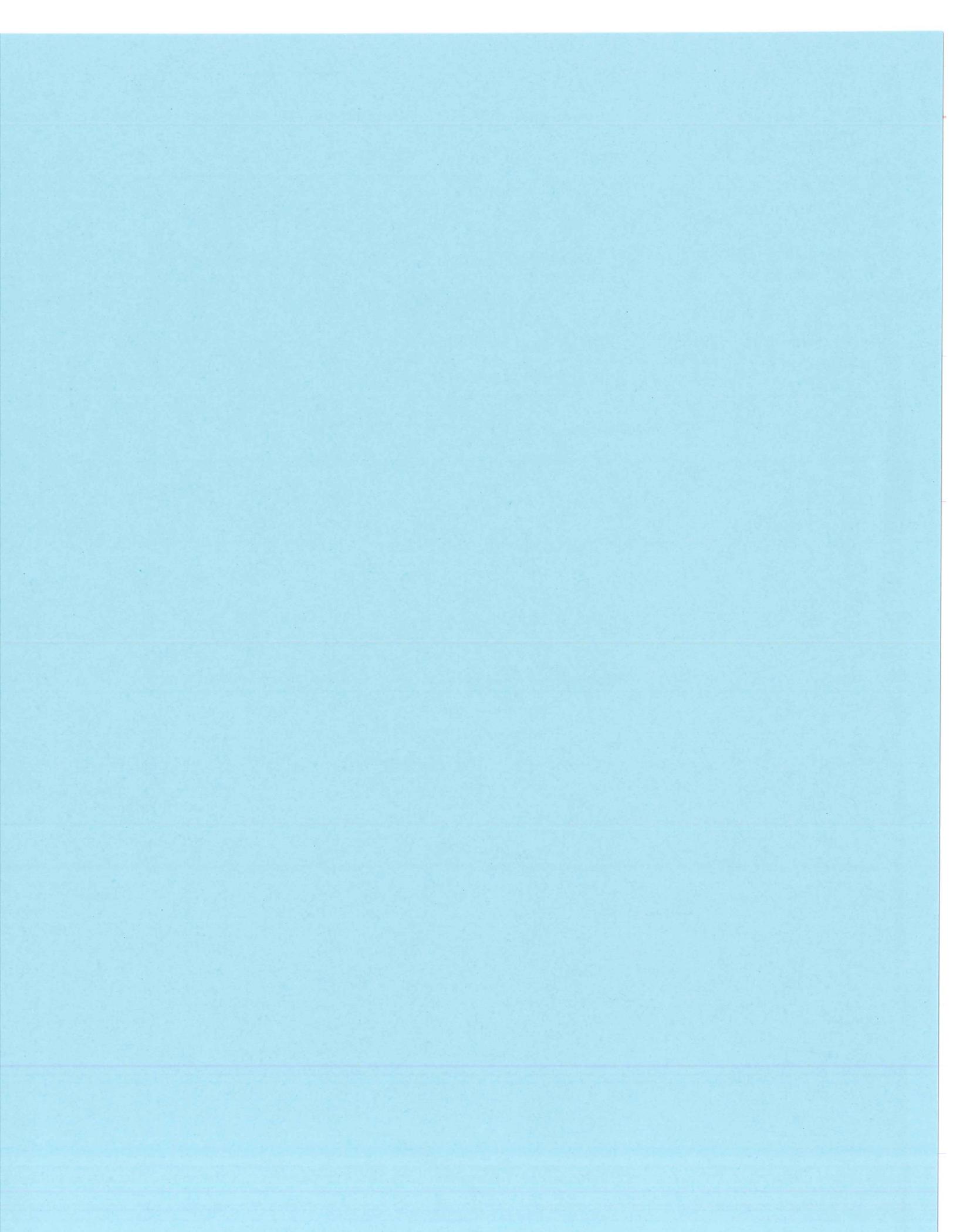
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Allwise Alton Dts Appeals  
Section 12/18/15



# Exhibit G

IN THE IOWA DISTRICT COURT FOR POLK COUNTY

<p><b>WELLCARE OF IOWA, INC., and MERIDIAN HEALTH PLAN OF IOWA, INC.,</b></p> <p><b>Petitioners,</b></p> <p><b>v.</b></p> <p><b>IOWA DEPARTMENT OF HUMAN SERVICES,</b></p> <p><b>Defendant.</b></p> <p><b>AMERIGROUP IOWA, INC., AMERIHEALTH CARITAS IOWA, INC., and UNITED HEALTHCARE PLAN OF THE RIVER VALLEY, INC.,</b></p> <p><b>Interveners</b></p>	<p><b>Case No. CVCV051022</b></p> <p><b>RULING ON PETITION FOR JUDICIAL REVIEW</b></p>
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I.

This case concerns Petitions for Judicial Review filed by Meridian Health Plan of Iowa, Inc. and WellCare of Iowa, Inc. The Iowa Department of Human Services resisted. Oral arguments were heard on February 1, 2016.

This is a judicial review of DHS's implementation of the Iowa High Quality Healthcare Initiative, also known as "Medicaid Modernization."<sup>1</sup> Meridian and WellCare seek review of the Final Decision issued by DHS on December 18, 2015. This decision followed a contested case heard by Administrative Law Judge Christie Scase and substitute decision maker Janet Phipps, Director of the Department of Administrative Services.<sup>2</sup> The Final Decision confirmed AmeriGroup Iowa, Inc., AmeriHealth Caritas Iowa, Inc. and UnitedHealthCare Plan of the River Valley, Inc. as Medicaid

<sup>1</sup> This case includes three consolidated cases: *Aetna Better Health Iowa, Inc. v. Iowa Department of Human Services*, CVCV051022; *WellCare of Iowa, Inc. v. Iowa Department of Human Services*, CVCV051039; and *Meridian Health Plan of Iowa, Inc. v. Iowa Department of Human Services*, CVCV051064. All plaintiffs sought judicial review of the same agency decision and the cases were consolidated under case number CVCV051022. Aetna Better Health Iowa, Inc. did not participate in the February 1, 2016 hearing.

<sup>2</sup> Governor Branstad appointed Director Phipps substitute decision maker after Director Palmer was called as a witness at the contested case hearing.

service providers under the Initiative and disqualified WellCare as a provider. On January 14, 2016, this court heard Motions to Stay by WellCare and Aetna Better Health of Iowa, Inc. Those motions were denied on January 22, 2016, after which Aetna Better Health of Iowa, Inc. dismissed its case.

## II.

On February 16, 2016, DHS issued Request for Proposal No. MED-16-009. The RFP sought companies to provide managed care services to Iowans qualifying for Medicaid. Companies were invited to submit proposals meeting the criteria of the RFP. After evaluating those bids, DHS was to award contracts to two to four companies. DHS received eleven bids. One bidder later withdrew its proposal. Meridian and WellCare were two of the bidders.

The RFP stated that bids would be evaluated by a committee and evaluated and scored based on their responses to specific sections of the RFP, including instructions to:

[i]dentify and describe any debarment or suspension, regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity within the last five years

and

[i]dentify and describe any letter of deficiency issued by or corrective actions requested or required by any federal or state regulatory entity within the last five years that relates to Medicare, Medicaid, CHIP, or the Substance Abuse Prevention and Treatment Block Grant.<sup>3</sup>

The bidders were required to provide information about any litigation, penalties, terminated contracts, or irregularities of accounts in the past five years.<sup>4</sup> Failure to disclose that information would subject the bidder to possible disqualification. The RFP reserved the committee's right to ask "clarification questions" of the bidders. The RFP stated that the evaluation committee would present any final ranking and recommendation to the Director of the Department of Human Services for consideration. The committee was not bound by any scores, nor was the Director bound by the committee's recommendation. The RFP noted that "when making this determination, the Agency will

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<sup>3</sup> RFP 3.2.7.4.2 (2) and (3), Joint Appendix ("JA") Tab 65.

<sup>4</sup> RFP 3.2.5.4, JA Tab 65.

not necessarily award a contract to the bidder with the highest point total. Rather, a contract will be awarded to the bidder that offers the greatest benefit to the Agency.”<sup>5</sup>

The RFP expressly reserved the right of DHS to disqualify bidders based on reasons that included, but were not limited to: “Bidder initiates contact regarding the RFP with employees other than the [designated contact person];” “Bidder fails, in the Agency’s opinion, to include the content required for the RFP;” and “Bidder fails to respond to the Agency’s request for clarifications, information, documents, or references that the Agency may make at any point in the RFP process.”<sup>6</sup> The discretion to disqualify a bidder or waive a violation was at the sole discretion of DHS.

The committee reviewed each proposal and met in July 2015 to discuss and score the bids. The proposals were scored against the Scope of Work defined by the RFP, and not against each other. The committee asked the bidders clarification questions. WellCare indicated in its bid that it had been subject to some prior regulatory action. One of the committee members recalled WellCare being the subject of an investigation related to a federal healthcare program. This prompted the committee to ask WellCare to clarify its answer and identify measures taken by the company to ensure compliance with federal and state law. WellCare responded that it had been the subject of a number of false claims lawsuits and, to resolve those claims, had entered into a five year Corporate Integrity Agreement with the federal Department of Health and Human Services and made a “substantial” settlement payment.<sup>7</sup> WellCare *did not* disclose that this settlement payment was \$137.5 million, nor did it disclose the terms of the CIA.

Communication with DHS during the bidding process was subject to a “blackout period,” during which all communication regarding bids and the Medicaid program were to be directed to, and only communicated to, the designated contact person.<sup>8</sup> During the blackout period, representatives of

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<sup>5</sup> RFP 4.1, JA Tab 65.

<sup>6</sup> RFP 2.15.2, JA Tab 65.

<sup>7</sup> JA Tab 124.

<sup>8</sup> RFP 2.15.2, JA Tab 65.

WellCare, Christopher Rants, former speaker of the Iowa House, and Renee Schulte, communicated with individuals regarding the RFP. Mr. Rants communicated with Michael Boussetot, a member of Governor's Branstad's staff and known to be one of the architects of the Initiative. Email messages between a WellCare executive and Mr. Rants indicate that WellCare was aware of the relation of Mr. Boussetot to the program, and even speculated that he may be a member of the evaluation committee.<sup>9</sup> Ms. Schulte's communication was with Mikki Stier, the newly appointed head of the Medicaid program in Iowa. Ms. Schulte's emails to Ms. Stier were in regards to the implementation of the Initiative.

On August 12, 2015, the committee met with DHS Director Charles Palmer and provided him with the scores, scoring notes, and a ranking of the bids. Director Palmer discussed the scoring process with the committee until he was comfortable with the methods used to score and the final ranking of the bids. He found no reason to change the ranked order of the proposals. On August 17, 2015, DHS issued a Notice of Intent to Award contracts to four bidders: Amerigroup Iowa; AmeriHealth Caritas Iowa, Inc.; UnitedHealthcare Plan of the River Valley, Inc.; and WellCare.

Three of the unsuccessful bidders — Aetna Better Health Iowa, Inc.; Iowa Total Care, Inc.; and Meridian — appealed the Notice of Intent to Award. ALJ Scase heard the appeals in a week-long contested case hearing in October 2015. On November 25, 2015, the ALJ issued a proposed decision that confirmed the Notice of Intent to Award as to Amerigroup Iowa, AmeriHealth Caritas, and UnitedHealthcare, but reversed the Notice as to and disqualified WellCare for failing to disclose the information required by the RFP and for engaging in improper communications during the blackout period.<sup>10</sup> On December 18, 2015, substitute decision-maker Director Phipps issued the Final Decision, adopting the findings of fact of ALJ Scase and largely affirming the conclusions of the proposed

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<sup>9</sup> JA Tab 34.

<sup>10</sup> JA Tab 10.

a provision of law in the discretion of the agency.”<sup>22</sup> “When an agency is delegated discretion in applying a provision of law to specified facts the scope of review appropriately applied by courts must be deferential over that matter in the discretion of the agency rather than in the courts.”<sup>23</sup>

The Iowa Code invests the Director of DHS with the authority to implement the Medicaid program. The director is responsible for its “effective and impartial administration,” including the authority to “make rules, establish policies and proscribe procedures” with respect to the Medicaid program.<sup>24</sup> The Director has the authority to enter into contracts for managed care services.<sup>25</sup> The Iowa Supreme Court has held that agencies have broad discretion in contracting decisions and that “discretion to determine what constitutes the best results for a public contract exists throughout the contract letting process.”<sup>26</sup> The fact that there may be different ways to approach the bidding process does not make the agency’s decisions in the competitive bidding process irrational.<sup>27</sup>

#### IV.

The parties challenge the Final Decision on different grounds and seek different remedies. Meridian challenges the outcome of the entire bidding process and seeks to have the bids rescored by DHS. WellCare challenges only its disqualification in the Final Decision and seeks have its contract with DHS restored.

#### Meridian

Meridian argues that the court should reverse the Final Decision under Iowa Code sections 17A.19(10)(d), 17A.19(10)(j), and 17A.19(10)(n). Meridian argues that reversal is appropriate because DHS took action “without following the prescribed procedure or decision-making process,” the action was “the product of a decision-making process in which the agency did not consider a relevant and important matter relating to the propriety or desirability of the action in question that a rational decision

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<sup>22</sup> *Burton v. Hilltop Care Ctr.*, 813 N.W.2d 250, 256 (Iowa 2012).

<sup>23</sup> *Meyer v. IBP, Inc.*, 710 N.W.2d 213, 219 (Iowa 2006).

<sup>24</sup> Iowa Code § 249A.4.

<sup>25</sup> Iowa Code § 249A.4(4).

<sup>26</sup> *Master Builders of Iowa, Inc. v. Polk County*, 653 N.W.2d 382, 395 (Iowa 2002).

<sup>27</sup> *See Dico*, 576 N.W.2d at 356.

maker in similar circumstances would have considered prior to taking that action,” and that the action was “unreasonable, arbitrary, capricious, or an abuse of discretion.” Meridian asks the court to reverse the Final Decision, cancel all contracts awarded under the Initiative, and require DHS to re-evaluate all bids received.

Meridian argues that the Final Decision errantly found that DHS complied with the terms of the RFP. Meridian believes that the RFP required the committee to compare the bid proposals to each other and make a recommendation to Director Palmer. Meridian claims that DHS failed to take these steps and failed to find the bidder that would provide the greatest benefit to the state. Meridian contends the committee was required to provide more than a raw score ranking to Director Palmer in the form of a recommendation, and that when the committee failed to do so, DHS failed to exercise discretion when awarding contracts.

Meridian also argues that the Final Decision should be reversed because DHS failed to follow the RFP when asking a clarification question to WellCare. Meridian states that DHS’s question to WellCare was not a “clarification question,” but an opportunity for WellCare to provide additional information that should have been included in its original bid. Meridian argues that the Final Decision erred when it concluded that the committee had the discretion to seek clarification from WellCare regarding its omissions in its initial bid. Meridian asserts WellCare was given an opportunity not provided to the other bidders which tainted the entire procurement process and requires that DHS re-evaluate all the bids.

According to Meridian, the Final Decision incorrectly found that the scoring process was adequately documented and that the scores given to Meridian’s bid were not arbitrary, capricious, and unreasonable. Meridian states that the only documentation of the process used by the committee are the committee’s scoring notes, which do not give an adequate picture of why certain bids received certain scores. Meridian argues that this lack of documentation is compounded by the “illogical” scores its proposal received in several categories.

DHS responds that the Final Decision is supported by substantial evidence as to each conclusion challenged by Meridian. DHS notes that the scope of review of this court is limited to the conclusions of the Final Decision. It is not a review of the individual actions of the committee or Director Palmer in evaluating or selecting which to bidders to offer a contract. DHS argues that it is not within the scope of this court to decide whether or not the actions of DHS complied with the RFP, whether there was adequate documentation, or that the scoring was correct – only that there was substantial evidence to support the Final Decision.

#### WellCare

WellCare seeks reversal of its disqualification as a successful bidder and cancellation of its contract to provide managed care as part of the Initiative. WellCare, originally a successful bidder, was disqualified in the Final Decision for failure to disclose documents and engaging in improper communications with DHS during the selection period. WellCare argues there is not substantial evidence to support the conclusions that led to its disqualification, and that the conclusions reached were based on an “irrational, illogical, or wholly unjustifiable application of law to fact that has clearly been vested by a provision of law in the discretion of the agency.”<sup>28</sup> WellCare also argues that the Final Decision did not make a finding that WellCare’s actions prejudiced the other bidders and should be considered harmless.

WellCare claims that the Final Decision is an improper substitution of the ALJ and Director Phipps’ judgment for that of the committee and Director Palmer. It urges the court to interfere with the exercise of an agency’s statutory and regulatory authority because the agency acted wholly outside its authority, arbitrarily and capriciously in its decision-making, rendered a decision that is clearly erroneous, or acted in violation of constitutional rights. WellCare argues that because the ALJ and Director Phipps did not make such a finding in the proposed or Final Decision, they have improperly substituted their judgment for that of the committee and Director Palmer.

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<sup>28</sup> Iowa Code § 17A.19(10)(m).

WellCare argues the Final Decision incorrectly finds that WellCare deprived the selection committee and Director Palmer of the opportunity to fully exercise their discretion by allegedly failing to disclose the existence of past adverse legal action. WellCare states that it provided information regarding the existence of a settlement and a CIA through its response to the RFP and the clarification question and that the committee was satisfied with WellCare's answer. WellCare argues that it was not required to disclose information about the settlement under RFP 3.2.5.4 because that section only required disclosure of "pending or threatened litigation."<sup>29</sup> WellCare also argues that it was not required to disclose of the CIA under RFP 3.2.7.4.2 as a sanction or regulatory action because a CIA is an alternative to a regulatory action.<sup>30</sup> WellCare states that because the committee and Director Palmer had knowledge of a settlement and the CIA and still awarded WellCare a contract, WellCare did not prevent DHS from exercising its discretion.

WellCare believes the alleged improper communications were not improper at all, but if they were, they did not prejudice any other bidders or influence the selection process. WellCare does not deny that individuals representing its company engaged in the communications of which they are accused. WellCare contends that because Mr. Rants was in communication with a member of the governor's staff and not a direct member of DHS, he was not violating the bar on communication with "employees" found in the RFP. WellCare thinks Ms. Schulte's communications only concerned information that was already public, and did not give WellCare a competitive advantage over the other bidders.

DHS notes the decision to disqualify WellCare was entirely within the discretion of Director Phipps. DHS argues that the review standards identified by WellCare regard judicial review of agency action, and that Director Phipps' Final Decision is not a judicial review of an agency action. DHS reiterates that the standard of review here is one of determining the existence of substantial evidence

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<sup>29</sup> RFP 3.2.5.4, JA Tab 65.

<sup>30</sup> RFP 3.2.7.4.2, JA Tab 65.

supporting conclusions found in the Final Decision. DHS argues that because the decision to disqualify WellCare was completely within the discretion of DHS, it was within the discretion of Director Phipps in issuing the Final Decision.

V.

Meridian

Although Meridian frames its argument as one of an agency failing to follow rules set forth in its own procurement process, the proper scope of review is limited to final agency action.<sup>31</sup> Meridian asks this court to decide whether the committee followed the rules set forth in the RFP, whether the committee asked a clarification question or invited WellCare to supplement its proposal, whether the committee adequately documented its process, and whether the committee's scoring of Meridian's proposal was proper. None of these issues are proper for a judicial review.

The court is limited to the factual findings and conclusions as made by Director Phipps in the Final Decision. When an agency has been vested with the discretion to make factual determinations, "it follows that application of the law to the facts is likewise vested by a provision of law in the discretion of the agency."<sup>32</sup> "When an agency is delegated discretion in applying a provision of law to specified facts the scope of review appropriately applied by courts must be deferential over that matter in the discretion of the agency rather than in the courts."<sup>33</sup> A court may overturn an agency action when the factual determination is not supported by substantial evidence or the application of law to those facts is an abuse of discretion.<sup>34</sup> That is not the case here.

The final agency action subject to review is the Final Decision issued December 18, 2015. DHS is clearly vested with the authority to make rules, decide procedure, and enter into contracts in the execution of Iowa's Medicaid program.<sup>35</sup> DHS, and therefore Director Phipps, as substitute decision-

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<sup>31</sup> Iowa Code § 17A.19(1).

<sup>32</sup> *Burton*, 813 N.W.2d at 256.

<sup>33</sup> *Meyer*, 710 N.W.2d at 219.

<sup>34</sup> Iowa Code § 17A.19(10).

<sup>35</sup> Iowa Code § 249A.4.

maker, had the discretion to make factual determinations and draw conclusions from those determinations. The court can only review whether the factual conclusions made in the Final Decision are supported by substantial evidence and whether the conclusions of law drawn from those facts are reasonable. The court cannot overrule the agency simply because it may have come to a different conclusion based on the same facts if supported by substantial evidence.<sup>36</sup>

There is substantial evidence to support the conclusions made in the Final Decision. DHS did not violate the rules of the RFP by relying on the scores to determine the winning bids. This is supported by the RFP itself, which, while reserving the right to use more than just the scores to determine the winning bids, did not *require* the committee to use more. The committee and Director Palmer were satisfied that the scoring method used adequately determined which bidders provided the greatest benefit to the state.

There is substantial evidence to support the conclusion that the committee adequately documented the evaluation process. The committee's scoring notes evidenced adequate documentation.

The Final Decision addressed the scoring process used and found that the process was logical. While the Final Decision questioned why Meridian received a lower score than WellCare in one category, Director Phipps deferred to the expertise of the committee. The Final Decision stated "an evaluator brings a certain amount of subjective personal judgment to any procurement rating process, and the extremely deferential standard of review for discretionary procurement decisions respects the exercise of that judgment."<sup>37</sup> There is substantial evidence to support the conclusion that scores given were not illogical.

The factual conclusions made in the Final Decision are supported by substantial evidence. The application of the law to those facts is not unreasonable or illogical and is not an abuse of discretion. The court affirms the Final Decision as to Meridian's claims.

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<sup>36</sup> *Burns*, 495, N.W.2d at 699.

<sup>37</sup> JA Tab 10, p. 52.

WellCare

WellCare's argument that the ALJ and Director Phipps improperly substituted their judgment for that of DHS is a misstatement of law. WellCare attempts to constrain DHS's ability to review its own actions by placing the limits of a judicial review. This court is limited in its ability to review agency action. An agency making a final decision, however, has all the power it would have in initially making that decision.<sup>38</sup> Director Phipps had the same authority as DHS had during the initial selection process and did not improperly substitute her judgment for that of DHS.

The Final Decision disqualified WellCare for its failure to disclose information required by the RFP and for violating the blackout period. Section 2.15.2 of the RFP specifically reserves the right of DHS to disqualify a bidder when: "bidder initiates contact regarding the RFP with employees other than the [designated contact person];" "bidder fails, in the Agency's opinion, to include the content required for the RFP;" and "bidder fails to respond to the Agency's request for clarifications, information, documents, or references that the Agency may make at any point in the RFP process."<sup>39</sup> The discretion to disqualify a bidder for any of the above reasons is within the authority of DHS and Director Phipps. The question is simply whether the conclusions made were supported by substantial evidence.

WellCare admits that the communications during the blackout period occurred. WellCare's communication with Ms. Stier, the director of Medicaid in Iowa, is sufficient substantial evidence to disqualify WellCare. Ms. Stier is an employee of not only DHS but of the very division to which WellCare submitted a proposal. While there may be some argument of whether Mr. Boussetot is in fact an "employee" for the purposes of the RFP, it is clear that at one point WellCare believed Mr. Boussetot to be a member of the evaluation committee and continued to have communication with him. This shows willfulness on the part of WellCare to violate the blackout period and the RFP. There is substantial evidence to conclude that WellCare violated the blackout period and to support

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<sup>38</sup> Iowa Code § 17A.15(3).

<sup>39</sup> RFP 2.15.2, JA Tab 65.

disqualification.

WellCare also disputes the conclusion that it failed to disclose information required by the RFP. WellCare argues that not only did it disclose the information, but it was not actually required to make the disclosures. WellCare avers that the committee was fully aware of the information in its disclosures and could not have deprived the committee and Director Palmer of the ability to exercise discretion. The true extent of WellCare's settlements and the actual details of the CIA were *not* disclosed to DHS *until* the contested hearing in October 2015. If DHS was unaware of the extent of WellCare's legal problems until that time, it could not have been fully informed and able to exercise discretion. Only after that information came out at the contested hearing was DHS, through the Final Decision, able to exercise discretion and find that WellCare failed to disclose required information. There is substantial evidence to conclude that WellCare violated the RFP by failing to disclose information and deprived the committee and Director Palmer of discretion.

The factual conclusions made in the Final Decision are supported by substantial evidence. The application of the law to those facts is not unreasonable or illogical and is not an abuse of discretion. The court affirms the Final Decision as to WellCare's claims.

V.

Both litigants have failed to persuade the court that the agency acted improperly. The factual determinations of the Final Decision are supported by substantial evidence. The conclusions drawn from those determinations were not an abuse of discretion.

The Final Decision of December 18, 2015 is affirmed. The petitions are dismissed with costs assessed to Petitioners.



State of Iowa Courts

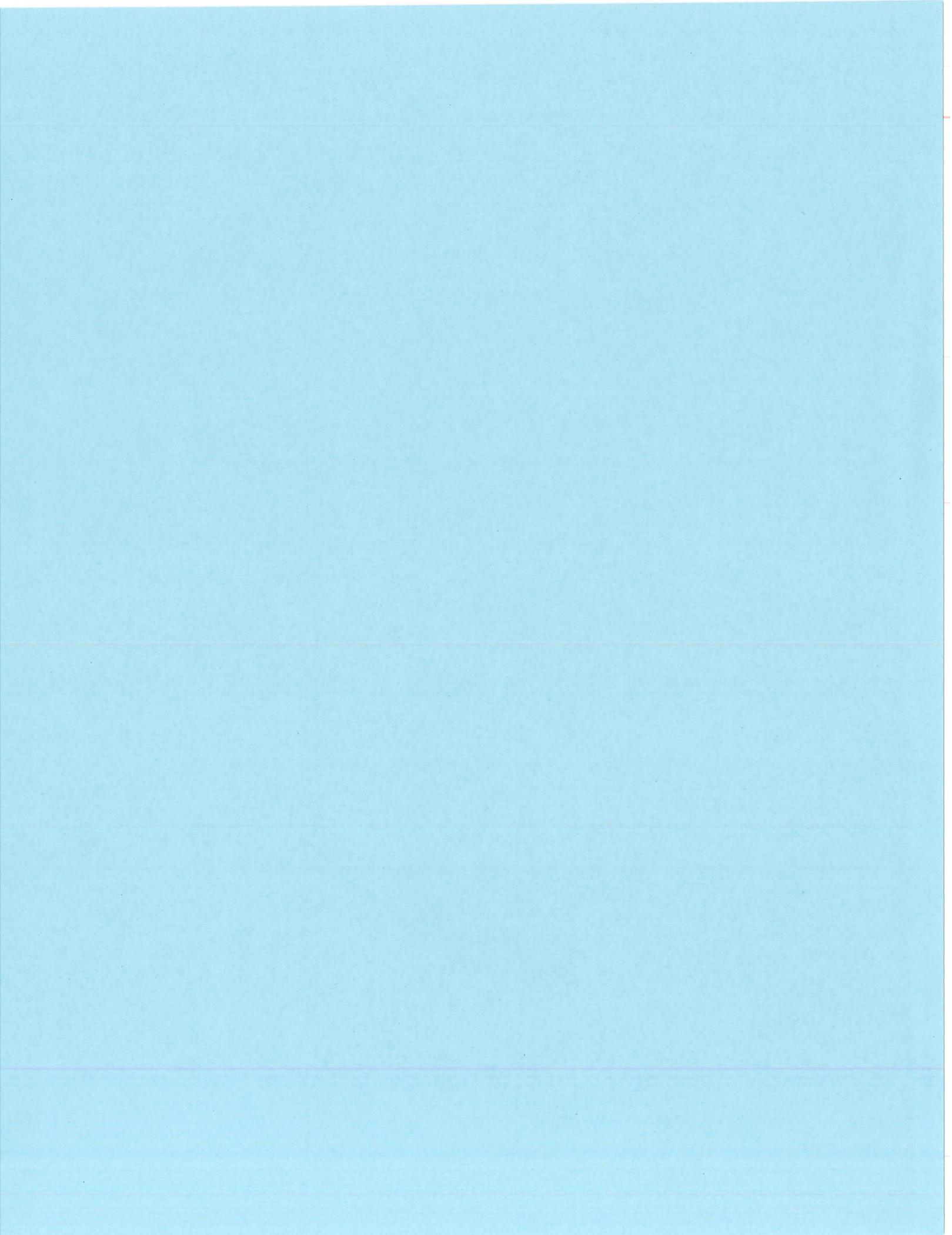
**Type:** OTHER ORDER

**Case Number** CVCV051022  
**Case Title** AETNA BETTER HEALTH V IA DEPT OF HUMAN SERVICES

So Ordered

A handwritten signature in black ink, appearing to read "RJB", written over a horizontal line.

Robert J. Blink, District Court Judge,  
Fifth Judicial District of Iowa



**Exhibit**

**H**

EX-10.20 2 settlement.htm SETTLEMENT AGREEMENT

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Exhibit 10.20

SETTLEMENT AGREEMENT

This Settlement Agreement (Agreement) is entered into among the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General of the Department of Health and Human Services (OIG-HHS)(collectively the “United States”), WellCare Health Plans, Inc., Comprehensive Health Management, Inc., Comprehensive Reinsurance, Ltd., Harmony Behavioral Health, Inc., HealthEase of Florida, Inc., WellCare Prescription Insurance, Inc., WellCare of Connecticut, Inc., WellCare of Florida, Inc., WellCare of Georgia, Inc., WellCare of New York, Inc., WellCare of Ohio, Inc., Harmony Health Plan of Illinois, Inc., and Harmony Behavioral Health IPA, Inc. (collectively “WellCare”) and Relators Sean J. Hellein, Clark J. Bolton, Eugene Gonzalez, and SF United Partners (Relators)(hereafter collectively referred to as “the Parties”), through their authorized representatives.

RECITALS

A. WellCare is a health maintenance organization (HMO) headquartered in Tampa, Florida, that services approximately 2.3 million members enrolled in Medicare and Medicaid plans across the country

B. Pursuant to the *qui tam* provisions of the False Claims Act, 31 U.S.C. § 3730(b), Relator Hellein filed *U.S. ex rel. Sean Hellein v. WellCare Health Plans, Inc., et al.*, Case No. 8:06-cv-01079-T-30TGW (M.D. Fla.) on June 7, 2006; Relator Bolton filed *U.S. ex rel. Clark Bolton v. WellCare Health Plans, Inc., et al.*, Case No. 8:07-cv-1909-T-30TGW (M.D. Fla.) on October 19, 2007; Relator SF United Partners filed *U.S. ex rel. SF United Partners v. WellCare Health Plans, Inc., et al.*, Case No. 3:07cv1688 (SRU) (D. Conn.)(UNDER SEAL), on

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November 15, 2007; and Relator Gonzalez filed *U.S. ex rel. Eugene Gonzalez v. WellCare Health Plans, Inc., et al.*, Case No. CV 08 0723 (E.D.N.Y.)(transferred to M.D. Fla. as Case No. 8:08-cv-1691-T-30-TGW), on February 21, 2008 (the "Civil Actions"). The United States intervened either in whole or in part in the Civil Actions filed by Relators Hellein, Bolton, and Gonzalez on June 24, 2010. The United States will timely intervene in the Civil Action filed by SF United Partners.

C. The United States contends that WellCare submitted or caused to be submitted claims for payment to the Medicare Program (Medicare), Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.*, and the Medicaid Program (Medicaid), Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 - 1396w-5.

D. The United States contends that it has certain civil claims against WellCare arising from WellCare's submission of false and fraudulent information in support of false claims to the Medicare and Medicaid programs from January 1, 2004 to June 24, 2010, or where a different period is noted below, during that period. These claims relate to allegations that WellCare:

1. Between June 1, 2002 and October 31, 2007, knowingly concealed its contractual obligation to pay behavioral health care services monies back to the Florida Agency for Health Care Administration (AHCA) and induced AHCA to grant inflated premium increases by (a) falsely and fraudulently inflating actual expenses incurred in providing behavioral health care services to Florida Medicaid recipients, through use of its subsidiary Harmony Behavioral Health ("HBH") and a contract providing

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- for capitated premiums to HBH at a rate of 85% regardless of actual medical costs expended, (b) using those improperly inflated expenses in calculating the relevant medical loss ratio (MLR)(the percentage of every premium dollar spent on health care), (c) submitting those improperly inflated expenses and/or improperly calculated loss ratios to AHCA, (d) coordinating its billing practices with other entities to minimize chances of detection by AHCA, and (e) retaining monies owed to AHCA;
2. Manipulated WellCare's MLR by (a) creating a wholly-owned reinsurance subsidiary that charged higher premiums to WellCare's affiliates than those paid by WellCare to independent reinsurers in order to maintain WellCare's premiums at higher levels than justified by WellCare's actual costs, (b) counting reinsurance profit as a medical expense, (c) under-reporting its profit margin and misrepresenting its costs, (d) manipulating its Incurred But Not Reported (IBNR) (an actuarial estimate of claims which have not yet been reported or paid, but are likely to be incurred within a certain time frame), and (e) manipulating and falsely reporting its behavioral health MLR;
  3. Between October 1, 2003 and October 31, 2007, knowingly concealed its contractual and statutory obligations to pay monies back to state Medicaid programs, including the Florida Healthy Kids program and the Illinois Medicaid program, by (a) including false and fraudulent expenses in its reported MLR calculations, (b) shifting and misallocating costs, including

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- prepayment of medical expenses for future years, (c) entering improper capitation and payment arrangements, (d) fraudulently increasing the per member per month cost for over-the-counter pharmacy benefits, and (e) retaining monies owed to the state Medicaid programs;
4. Falsified encounter data submitted to the state Medicaid programs;
  5. Knowingly concealed and retained overpayments received from state Medicaid programs in violation of its contractual obligations to pay monies back to the state Medicaid programs, including (a) overpayments for newborn Medicaid premiums received by WellCare from AHCA between July 1, 2005 and October 31, 2005, (b) overpayments received by WellCare due to overstated membership in the New York State Family HealthPlus program, and (c) overpayments received by WellCare as a result of data or programming errors;
  6. Paid improper remuneration to physicians, Independent Practice Associations (IPAs), and other providers through manual adjustments to service funds and other means, in order to (a) induce the physicians and IPAs to upcode or deny services to patients, (b) reward the physicians and IPAs for marketing and switching patients to WellCare in violation of regulations, (c) enable IPAs to maintain deceased members on the membership rolls and improperly billing and collecting premium payments for months after the members' deaths, (d) reward IPAs who terminate sick patients and send them to other health plans or IPAs, (e)

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- induce IPAs to make political contributions to WellCare's favored candidates, and (f) sanction or terminate providers who fail to keep claims payments below WellCare's desired threshold;
7. Engaged in sales and marketing abuses by (a) unlawfully disenrolling certain Medicaid patients and by "cherry-picking" others, (b) marketing in a manner designed to discriminate among potential enrollees on the basis of such enrollees' health status or need for health services, (c) improperly encouraging dual eligible beneficiaries to change their health plans frequently in order to generate inflated commissions;
  8. Manipulated, and falsely reported to the Centers for Medicare and Medicaid Services (CMS) and to states, the "grades of service" or similar performance metrics of WellCare call centers and falsified appeals documentation;
  9. Upcoded services, claims, and disease states by manipulating the Risk Adjusted Payment System (RAPS), which is used by CMS to calculate the per member per month (PMPM) premium paid to health plans; and
  10. Operated a sham Special Investigations Unit (SIU) that (a) failed to perform its oversight responsibilities with respect to claims submitted to Medicare and Medicaid by providers and third party administrators, and claims associated with its Medicare Part D Prescription Drug Plan, (b) used an improper methodology to compute overpayments received by providers, thereby allowing WellCare to seek excessive reimbursement

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from the providers, (c) failed to provide the proper notification of settlements with providers regarding overpayments to government agencies and to remit settlement funds to the Medicaid and Medicare programs in Florida; and (d) filing false and misleading fraud prevention plans

The conduct described above, except insofar as it may overlap with the conduct and allegations set forth in Paragraphs 6.j. and 6.k. below, is herein referred to as the "Covered Conduct."

E. Except as governed by the terms of the Deferred Prosecution Agreement dated May 5, 2009 between WellCare and the U.S. Attorney's Office for the Middle District of Florida and the Florida Attorney General's Office, this Agreement is neither an admission of liability by WellCare nor a concession by the United States that its claims are not well founded.

F. Relators claim entitlement under 31 U.S.C. § 3730(d) to a share of the proceeds of this Settlement Agreement and to Relators' reasonable expenses, attorneys' fees and costs.

To avoid the delay, uncertainty, inconvenience, and expense of protracted litigation of the above claims, and in consideration of the mutual promises and obligations of this Settlement Agreement, the Parties agree and covenant as follows:

#### TERMS AND CONDITIONS

1. The Settlement Amount in this case shall consist of a fixed component and contingent component.
  - a. Fixed Component: WellCare shall pay to the United States and States that execute separate settlement agreements with WellCare to resolve WellCare's

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potential state liability for the Covered Conduct (Participating States), a collective total of \$137.5 million (including the federal share of \$83,980,591.88 and state share of \$53,519,408.12), plus interest accruing annually at 3.125% in four installments, not exceeding 36 months from the Effective Date of this Agreement. The first installment payment due under this Agreement shall be made by electronic funds transfer pursuant to written instructions to be provided to WellCare by the United States Department of Justice. Subject to Paragraph 33 below, all subsequent installment payments shall be made pursuant to the separate written instructions to be provided to WellCare by the United States Department of Justice and the National Association of Medicaid Fraud Control Unit's Team acting on behalf of the Participating States. The first installment payment in the amount of \$34.375 million plus accrued interest shall be made within five (5) business days after the Effective Date of this Agreement as defined in Paragraph 31 (Initial Fixed Payment Date); the second installment in the amount of \$34.375 million plus accrued interest shall be made on or before the one year anniversary of the Initial Fixed Payment Date; and the third installment in the amount of \$34.375 million plus accrued interest shall be made on or before the two year anniversary of the Initial Fixed Payment Date; the fourth and final installment payment in the amount of \$34.375 million plus accrued interest shall be made on or before the third year anniversary of the Initial Fixed Payment Date. Interest shall begin to accrue as of December 22, 2010, when counsel for the United States notified counsel for WellCare in writing that the Government had received

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settlement authority from the United States Department of Justice. WellCare may accelerate payments under the fixed component provision without penalty.

b. Contingent Component: (i) In the event of a change in control (a "CIC," as defined below) prior to completing payment of the final Fixed Component of the Agreement, WellCare will pay any outstanding amount due under the Fixed Component of the Agreement with a credit for any interest not yet accrued or owing. (ii) In addition, if within 36 months of the Effective Date of the Agreement there is a CIC for an amount equal to or greater than the aggregate market capital value of WellCare common stock as existed as of the close of market trading on the New York Stock Exchange (4:00 p.m. Eastern Daylight Time) on June 24, 2010, WellCare will pay the United States and the Participating States an additional \$35 million dollars within five (5) business days of the CIC. For the purposes of this paragraph and calculation, the aggregate market capitalization value of WellCare on June 24, 2010 at the end of the trading period (4 p.m. EDT) was \$1,129,841,928.30, based on a closing price of WellCare common stock of \$26.63 on the New York Stock Exchange, multiplied by 42,427,410 issued and outstanding shares of WellCare's common stock that were issued and outstanding as of June 24, 2010. (iii) For purposes of this paragraph, a CIC shall mean (A) the date of acquisition of legal title of more than 50 percent of WellCare's then issued and outstanding common stock by a person, entity or group (as such terms are defined in Section 13(d)(3) of the Securities Exchange Act of 1934); (B) a merger, reorganization, consolidation, or similar

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transaction resulting in a business combination where WellCare shareholders before the transaction own less than 50 percent of the new entity, or a person, entity, or group own more than 50 percent of the shares of the new entity; or (C) a sale of substantially all of WellCare's assets to an unrelated third party or unrelated third parties. WellCare will provide the United States with written notice of the anticipated contingent payment at least 30 days before a CIC. After receiving written notice of the anticipated contingent payment from WellCare, the United States will promptly provide WellCare with written instructions for the transmittal of the contingent payment.

WellCare's obligation to pay Relator expenses, attorneys' fees and/or costs (if any), shall be determined at a later date and is not affected by this Agreement.

Subject to the exceptions in Paragraph 6 (concerning excluded claims) below, and conditioned upon WellCare's full payment of the Settlement Amount, the United States releases WellCare from any civil or administrative monetary claim the United States has for the Covered Conduct under the False Claims Act, 31 U.S.C. §§ 3729-3733; the Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a; the Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-3812; or the common law theories of payment by mistake, unjust enrichment, and fraud.

Subject to the exceptions in Paragraph 6 below, and conditioned upon WellCare's full payment of the Settlement Amount, Relators, for themselves and their heirs, successors, attorneys, agents and assigns, release WellCare from any civil monetary claim the Relators have on behalf of the United States for the Covered Conduct under the False Claims Act, 31 U.S.C. §§ 3729-3733.

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5. In consideration of the obligations of WellCare in this Agreement and the Corporate Integrity Agreement (CIA), entered into between OIG-HHS and WellCare, conditioned upon WellCare's full payment of the Settlement Amount, OIG-HHS agrees to release and refrain from instituting, directing, or maintaining any administrative action seeking exclusion from Medicare, Medicaid, and other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) against WellCare under 42 U.S.C. § 1320a-7a (Civil Monetary Penalties Law) or 42 U.S.C. § 1320a-7(b)(7) (permissive exclusion for fraud, kickbacks, and other prohibited activities) for the Covered Conduct, except as reserved in Paragraph 6 (concerning excluded claims), below, and as reserved in this Paragraph. OIG-HHS expressly reserves all rights to comply with any statutory obligations to exclude WellCare from Medicare, Medicaid, and other Federal health care programs under 42 U.S.C. § 1320a-7(a) (mandatory exclusion) based upon the Covered Conduct. Nothing in this Paragraph precludes OIG-HHS from taking action against entities or persons, or for conduct and practices, for which claims have been reserved in Paragraph 6, below.

6. Notwithstanding the releases given in paragraphs 3 through 5 of this Agreement, or any other term of this Agreement, the following claims of the United States are specifically reserved and are not released:

- a. Any liability arising under Title 26, U.S. Code (Internal Revenue Code);
- b. Any criminal liability;
- c. Except as explicitly stated in this Agreement, any administrative liability, including mandatory exclusion from Federal health care programs;
- d. Any liability to the United States (or its agencies) for any conduct other

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- than the Covered Conduct;
- e. Any liability based upon obligations created by this Agreement;
  - f. Any liability for express or implied warranty claims or other claims for defective or deficient products or services, including quality of goods and services;
  - g. Any liability for failure to deliver goods or services due;
  - h. Any liability for personal injury or property damage or for other consequential damages arising from the Covered Conduct;
  - i. Any liability of individuals;
  - j. Any claims or liabilities arising from the allegations against Wellcare or Wellcare-affiliated defendants in any of the *qui tam* actions listed in the letter from the U.S. Department of Justice to WellCare dated April 26, 2011; or
  - k. Claims or liabilities arising from (i) Wellcare's claims for payment to the Hawaii Medicaid program for deceased beneficiaries, or (ii) services provided to Medicaid beneficiaries for which the Hawaii Medicaid program paid twice, once under a Wellcare managed care contract, and again under a fee-for-service program.

7. Relators and their heirs, successors, attorneys, agents, and assigns do not and shall not object to this Agreement and confirm that this Agreement is fair, adequate, and reasonable under all the circumstances, pursuant to 31 U.S.C. § 3730(c)(2)(B). In connection with this Agreement and the Civil Actions, Relators and their heirs, successors, attorneys, agents, and assigns agree that neither this Agreement, any intervention by the United States in any individual

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Civil Action, nor any dismissal of any Civil Action, shall waive or otherwise affect the ability of the United States to contend that provisions in the False Claims Act, including 31 U.S.C. §§ 3730(d)(3) and 3730(e), bar Relators from sharing in the proceeds of this Agreement. Moreover, the United States and Relators and their heirs, successors, attorneys, agents, and assigns agree that they each retain all of their rights pursuant to the False Claims Act on the issue of the share percentage, if any, that Relators should receive of any proceeds of the settlement of their claim(s).

8. Relators, for themselves, and for their heirs, successors, attorneys, agents, and assigns, release WellCare, and its officers, agents, and employees, from any liability to Relators arising from the Civil Actions, or under 31 U.S.C. § 3730(d), except for expenses or attorneys' fees and costs.

9. WellCare waives and shall not assert any defenses WellCare may have to any criminal prosecution or administrative action relating to the Covered Conduct that may be based in whole or in part on a contention that, under the Double Jeopardy Clause in the Fifth Amendment of the Constitution, or under the Excessive Fines Clause in the Eighth Amendment of the Constitution, this Agreement bars a remedy sought in such criminal prosecution or administrative action. Nothing in this paragraph or any other provision of this Agreement constitutes an agreement by the United States concerning the characterization of the Settlement Amount for purposes of the Internal Revenue laws, Title 26 of the United States Code.

10. During the course of negotiations of this Agreement, up to and including the Effective Date of this Agreement, WellCare has provided numerous financial materials and disclosures (collectively "Financial Statements"). The United States has relied on the accuracy

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and completeness of those Financial Statements in reaching this Agreement. WellCare warrants that the Financial Statements were complete and materially accurate as of the date they were produced to the United States or publicly filed. The United States understands, however, that some of the Financial Statements provided by WellCare included "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended ("Forward Looking Statements"). Accordingly, to the degree that Forward Looking Statements were made in any Financial Statements, WellCare warrants only to the United States that such Forward Looking Statements were made by WellCare in good faith and without actual knowledge that such Forward Looking Statements were false or misleading. If the United States learns of any material nondisclosure or misrepresentation by WellCare on, or in connection with, the Financial Statements, and if such material nondisclosure or misrepresentation resulted in the underreporting of WellCare's total net assets by \$6,875,000 (5% of the Settlement Amount) or more, the United States may at its option pursue relief under this Paragraph as follows: (a) the United States will provide WellCare with written notice of the nature of the Material Nondisclosure or Material Misrepresentation; (b) within ten (10) calendar days of the date of the written notice, WellCare shall provide the United States, in writing, with any explanation it may have regarding the Material Nondisclosure or Material Misrepresentation referenced in the written notice; (c) if unsatisfied with WellCare's explanation, as determined in its sole and absolute discretion, the United States may file an action seeking relief under this Paragraph in which action the United States shall bear the burden of establishing by a preponderance of the evidence the Material Nondisclosure or Material Misrepresentation. If the United States files such an action and establishes, by a preponderance of the evidence, a Material

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Nondisclosure or Material Misrepresentation, then (i) the Settlement Amount shall be increased by one hundred percent (100%) of the amount of the Material Nondisclosure or Material Misrepresentation; (ii) the remaining unpaid principal portion of the Settlement Amount shall become accelerated and immediately due and payable, with interest at a simple rate of 5% from the Effective Date of this Agreement to the date of the court finding, and at the Medicare interest rate (per 42 C.F.R. part 405.378) from the date of the court finding until the date of payment; (iii) the United States may offset the remaining unpaid balance of the Settlement Amount (inclusive of interest) from any amounts due and owing to WellCare by any department, agency, or agent of the United States; and (iv) WellCare shall immediately pay the United States all reasonable costs incurred in the action seeking relief under this Paragraph, including attorneys' fees and costs.

11. In the event that the United States, pursuant to Paragraph 10 (concerning disclosure of assets), above, opts to rescind this Agreement, WellCare agrees not to plead, argue, or otherwise raise any defenses under the theories of statute of limitations, laches, estoppel, or similar theories, to any civil or administrative claims that (a) are filed by the United States within 90 calendar days of written notification to WellCare that this Agreement has been rescinded, and (b) relate to the Covered Conduct, except to the extent these defenses were available on the Effective Date of this Agreement.

12. WellCare fully and finally releases the United States, and its agencies, employees, servants, and agents from any claims (including attorney's fees, costs, and expenses of every kind and however denominated) that WellCare has asserted, could have asserted, or may assert in the future against the United States, and its agencies, employees, servants, and agents, related to the Covered Conduct and the United States' investigation and prosecution thereof.

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13. The Settlement Amount shall not be decreased as a result of the denial of claims for payment now being withheld from payment by any Medicare carrier or intermediary, or any state payer, related to the Covered Conduct; and WellCare agrees not to resubmit to any Medicare carrier or intermediary or any state payer any previously denied claims related to the Covered Conduct, and agrees not to appeal any such denials of claims.

14. WellCare further agrees to the following:

- a. Unallowable Costs Defined: All costs (as defined in the Federal Acquisition Regulation, 48 C.F.R. § 31.205-47; and in Titles XVIII and XIX of the Social Security Act, 42 U.S.C. §§ 1395-1395kkk and 1396-1396w-5; and the regulations and official program directives promulgated thereunder) incurred by or on behalf of WellCare, its present or former officers, directors, employees, shareholders, and agents in connection with:
- (i) the matters covered by this Agreement and the May 5, 2009 Deferred Prosecution Agreement between WellCare and the United States;
  - (ii) the United States' audit(s) and civil and criminal investigation(s) of the matters covered by this Agreement;
  - (iii) WellCare's investigation, defense, and corrective actions undertaken in response to the United States' audit(s) and civil and criminal investigation(s) in connection with the matters covered by this Agreement (including attorneys' fees)
  - (iv) the negotiation and performance of this Agreement and the May 5, 2009 Deferred Prosecution Agreement;

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- (v) the payments WellCare makes to the United States pursuant to this Agreement and any payments that WellCare may make to Relators, including costs and attorneys' fees; and
  - (vi) the negotiation of, and obligations undertaken pursuant to the CIA to:
    - (A) retain an independent review organization to perform annual reviews as described in Section III of the CIA; and
    - (B) prepare and submit reports to the OIG-HHS, are unallowable costs for government contracting purposes and under the Medicare Program, Medicaid Program, TRICARE Program, and Federal Employees Health Benefits Program (FEHBP) (hereinafter referred to as Unallowable Costs). However, nothing in this paragraph 14.a.(6) that may apply to the obligations undertaken pursuant to the CIA affects the status of costs that are not allowable based on any other authority applicable to WellCare
- b. Future Treatment of Unallowable Costs: Unallowable Costs shall be separately determined and accounted for in nonreimbursable cost centers by WellCare, and WellCare shall not charge such Unallowable Costs directly or indirectly to any contracts with the United States or any State Medicaid program, or seek payment for such Unallowable Costs through any cost report, cost statement, information statement, or payment request submitted by WellCare or any of its subsidiaries or affiliates to the Medicare, Medicaid, TRICARE, or

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FEHBP Programs.

c. Treatment of Unallowable Costs Previously Submitted for Payment: WellCare further agrees that within 90 days of the Effective Date of this Agreement it shall identify to applicable Medicare and TRICARE fiscal intermediaries, carriers, and/or contractors, and Medicaid and FEHBP fiscal agents, any Unallowable Costs (as defined in this Paragraph) included in payments previously sought from the United States, or any State Medicaid program, including, but not limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by WellCare or any of its subsidiaries or affiliates, and shall request, and agree, that such cost reports, cost statements, information reports, or payment requests, even if already settled, be adjusted to account for the effect of the inclusion of the unallowable costs. WellCare agrees that the United States, at a minimum, shall be entitled to recoup from WellCare any overpayment plus applicable interest and penalties as a result of the inclusion of such Unallowable Costs on previously-submitted cost reports, information reports, cost statements, or requests for payment.

Any payments due after the adjustments have been made shall be paid to the United States pursuant to the direction of the Department of Justice and/or the affected agencies. The United States reserves its rights to disagree with any calculations submitted by WellCare or any of its subsidiaries or affiliates on the effect of inclusion of Unallowable Costs (as defined in this Paragraph) on WellCare or any of its subsidiaries or affiliates' cost reports, cost statements, or

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information reports.

d. Nothing in this Agreement shall constitute a waiver of the rights of the United States to audit, examine, or re-examine WellCare's books and records to determine that no Unallowable Costs have been claimed in accordance with the provisions of this Paragraph.

15. WellCare agrees to cooperate fully and truthfully with the United States' investigation of individuals and entities not released in this Agreement. Upon reasonable notice, WellCare shall encourage, and agrees not to impair, the cooperation of its directors, officers, and employees, and shall use its best efforts to make available, and encourage, the cooperation of former directors, officers, and employees for interviews and testimony, consistent with the rights and privileges of such individuals. WellCare further agrees to furnish to the United States, upon request, complete and unredacted copies of all non-privileged documents, reports, memoranda of interviews, and records in its possession, custody, or control concerning any investigation of the Covered Conduct that it has undertaken, or that has been performed by another on its behalf. WellCare further agrees to provide prompt, complete, and truthful testimony, certifications, and/or other non-privileged information, as required by the United States, necessary to identify or establish the location, authenticity, or evidentiary foundation to admit into evidence documents in any proceeding relating to matters within the Covered Conduct.

16. This Agreement is intended to be for the benefit of the Parties only. The Parties do not release any claims against any other person or entity, except to the extent provided for in Paragraph 17 (waiver for beneficiaries paragraph), below.

17. WellCare agrees that it waives and shall not seek payment for any of the health

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care billings covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals, or third party payors based upon the claims defined as Covered Conduct.

18. WellCare warrants that it has reviewed its financial situation and that it currently is solvent within the meaning of 11 U.S.C. §§ 547(b)(3) and 548(a)(1)(B)(ii)(I), and shall remain solvent immediately following payment to the United States of the Settlement Amount. Further, the Parties warrant that, in evaluating whether to execute this Agreement, they (a) have intended that the mutual promises, covenants, and obligations set forth constitute a contemporaneous exchange for new value given to WellCare, within the meaning of 11 U.S.C. § 547(c)(1), and (b) conclude that these mutual promises, covenants, and obligations do, in fact, constitute such a contemporaneous exchange. Further, the Parties warrant that the mutual promises, covenants, and obligations set forth herein are intended to and do, in fact, represent a reasonably equivalent exchange of value that is not intended to hinder, delay, or defraud any entity to which WellCare was or became indebted to on or after the date of this transfer, within the meaning of 11 U.S.C. § 548(a)(1).

19. In the event WellCare or any other party commences, within 91 days of the Effective Date of this Agreement (defined below), or of any payment made hereunder, any case, proceeding, or other action under any law relating to bankruptcy, insolvency, reorganization or relief of debtors, (a) seeking to have any order for relief of WellCare's debts, or seeking to adjudicate WellCare as bankrupt or insolvent, or (b) seeking appointment of a receiver, trustee, custodian or other similar official for WellCare for all or any substantial part of its assets, WellCare agrees as follows:

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a. WellCare's obligations under this Agreement may not be avoided pursuant to 11 U.S.C. §§ 547 or 548, and WellCare will not argue or otherwise take the position in any such case, proceeding or action that: (i) WellCare's obligations under this Agreement may be avoided under 11 U.S.C. §§ 547 or 548; (ii) WellCare was insolvent at the time this Agreement was entered into, or became insolvent as a result of the payment made to the United States hereunder; or (iii) the mutual promises, covenants and obligations set forth in this Agreement do not constitute a contemporaneous exchange for new value given to WellCare;

b. In the event that WellCare's obligations hereunder are avoided for any reason, including, but not limited to, the exercise of a trustee's avoidance powers under the Bankruptcy Code, the United States, at its sole option, may rescind the releases in this Agreement, and bring any civil and/or administrative claim, action or proceeding against WellCare for the claims that would otherwise be covered by the releases provided in this Agreement. If the United States chooses to do so, WellCare agrees that, for purposes only of any case, action, or proceeding referenced in the first clause of this Paragraph, (i) any such claims, actions or proceedings brought by the United States (including any proceedings to exclude WellCare from participation in Medicare, Medicaid, or other Federal Health Care programs) are not subject to an "automatic stay" pursuant to 11 U.S.C. Section 362(a) as a result of the action, case or proceeding described in the first clause of this Paragraph, and that WellCare will not argue or otherwise contend that the United States' claims, actions or proceedings are subject to an automatic stay; (ii) that WellCare will not plead, argue or otherwise raise any defenses under the theories of statute of limitations, laches, estoppel or similar theories, to any such civil or administrative claims, actions or proceedings which are

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brought by the United States within 30 calendar days of written notification to WellCare that the releases herein have been rescinded pursuant to this Paragraph, except to the extent such defenses were available before the Effective Date of this Agreement; and (iii) the United States and the Participating States have valid claims against WellCare in at least the aggregate amount of the Settlement Amount and they may pursue their claims, inter alia, in the case, action or proceeding referenced in the first clause of this Paragraph, as well as in any other case, action, or proceeding; and

c. WellCare acknowledges that its agreement in this Paragraph is provided in exchange for valuable consideration provided in this Agreement.

20. In the event that WellCare fails to pay any and all of the payments (including both fixed and contingent components) owed pursuant to this Agreement within 15 calendar days of the due date, Wellcare shall be in "Default" of this Agreement. Furthermore, in the event of Default,

- a. any dismissals as to WellCare shall, at the United States' option, be null and void, and the Settlement Amount referenced in Paragraph 1 above, less any payments already made, shall become immediately due and payable and shall bear interest at the Medicare interest rate (per 42 C.F.R. part 405.378) as of the date of Default until payment of the Settlement Amount is made in full.
- b. the United States may at its option: 1) rescind its releases; 2) offset the remaining unpaid balance of the Settlement Amount from any amounts due and owing to WellCare by any department, agency, or agent of the United

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States or Participating States at the time of Default; 3) reinstitute an action or actions against WellCare in this Court; and 4) WellCare agrees not to contest any draw, offset, or collection action undertaken by the United States pursuant to this Paragraph, either administratively or in any court.

- c. WellCare agrees to pay the United States all reasonable costs of collection and enforcement of this Agreement, including attorneys' fees and expenses. In the event the United States reinstitutes an action under this Paragraph, WellCare expressly agrees not to plead, argue, or otherwise raise any defense under the theories of statute of limitations, laches, estoppel, or similar theories, to any civil or administrative claims, which: (a) are filed by the United States within 90 calendar days of written notification to WellCare that this Agreement has been made a nullity, and (b) relates to the Covered Conduct, except to the extent these defenses were available on the Effective Date of this Agreement.
- d. OIG-HHS may exclude WellCare from participating in all Federal health care programs until WellCare pays the Settlement Amount and reasonable costs as set forth above and in Paragraph 1, above. OIG-HHS will provide written notice of any such exclusion to WellCare. WellCare waives any further notice of the exclusion under 42 U.S.C. § 1320a-7(b)(7), and agrees not to contest such exclusion either administratively or in any state or federal court. Reinstatement to program participation is not automatic. If at the end of the period of exclusion WellCare wishes to apply for

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reinstatement, WellCare must submit a written request for reinstatement to OIG-HHS in accordance with the provisions of 42 C.F.R. §§ 1001.3001-.3005. WellCare will not be reinstated unless and until OIG-HHS approves such request for reinstatement.

21. Should no Relator object to this Settlement, upon receipt of the initial payment described in Paragraph 1, above, the United States and Relators shall promptly sign and file in the Civil Actions a Joint Stipulation of Dismissal of the Civil Actions pursuant to Rule 41(a)(1). The dismissal by the United States shall be with prejudice as to the claims identified as "Covered Conduct" in Paragraph D above and without prejudice as to all other claims in the Civil Actions filed against WellCare. The dismissal by Relators shall be with prejudice as to the entire Civil Action filed against WellCare by each Relator, except that Relators reserve their right (if any) to seek attorneys' fees and costs under 31 U.S.C. § 3730(d) (1). Furthermore, the Stipulations of Dismissals filed in the Civil Actions shall be subject to all of the terms of this Agreement, including the timely payment of all Fixed and Contingent Settlement Amounts. The rights and obligations of the Participating States, including the dismissal of state False Claims Act causes of action that were asserted in by Relators in the Civil Actions, will be addressed in separate state settlement agreements.

22. Each Party shall bear its own legal and other costs incurred in connection with this matter, including the preparation and performance of this Agreement.

23. Each party and signatory to this Agreement represents that it freely and voluntarily enters in to this Agreement without any degree of duress or compulsion.

24. This Agreement is governed by the laws of the United States. The exclusive

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jurisdiction and venue for any dispute relating to this Agreement is the United States District Court for the Middle District of Florida, except that jurisdiction and venue for any dispute relating exclusively to the *qui tam* complaint filed by SF United Partners shall be in the United States District Court for the District of Connecticut. For purposes of construing this Agreement, this Agreement shall be deemed to have been drafted by all Parties to this Agreement and shall not, therefore, be construed against any Party for that reason in any subsequent dispute

25. This Agreement constitutes the complete agreement between the Parties. This Agreement may not be amended except by written consent of the Parties.

26. The undersigned counsel represent and warrant that they are fully authorized to execute this Agreement on behalf of the persons and entities indicated below.

27. This Agreement may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same Agreement.

28. This Agreement is binding on WellCare's successors, transferees, heirs, and assigns.

29. This Agreement is binding on Relators' successors, transferees, heirs, and assigns.

30. All parties consent to the United States' disclosure of this Agreement, and information about this Agreement, to the public.

31. The Effective Date of this Agreement shall be as follows. If no Relator objects to, or otherwise demands a hearing regarding this settlement, the Effective Date shall be the date of signature of the last signatory to the Agreement (Effective Date of this Agreement). For the purposes of this paragraph, the signatories to the Agreement are the United States, WellCare and its counsel, and the Relators to the Civil Actions and their counsel. For the purposes of this

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agreement, a Relator will be deemed to have objected to the Agreement if the Relator fails to sign and return the Agreement to the United States on the date specified by the U.S. Department of Justice. Facsimiles of signatures shall constitute acceptable, binding signatures for purposes of this Agreement. However, should any Relator object to this settlement, or demand any hearing regarding this settlement, then the Effective Date shall be the date on upon which the Court approves this settlement, whether by oral pronouncement, written ruling, or otherwise, which settlement includes an executed stipulation of dismissal of the Civil Actions. If any Relator objects and the Court does not approve the settlement, this Agreement is null and void and the Parties mutually release each other from any obligations owed under this Agreement

32. Should any Relator object to this settlement, or demand any hearing regarding this settlement, or should the Court for any other reason hold a hearing regarding this settlement, then WellCare agrees that it will, at its own expense, support any effort of the United States and the Participating States to defend the fairness, adequacy, and reasonableness of this settlement including, as necessary, the filing of briefs, attendance at hearings, and presentation of evidence.

33. In the event that any Relator asserts an objection or otherwise demands a hearing regarding this settlement (see paragraph 31 above) and the District Court issues a ruling approving the settlement agreement and triggering the Effective Date, WellCare shall pay the first installment payment plus accrued interest (as described in paragraph 1.a.), and any other installment payments that come due during the pendency of any appeals, into escrow in an interest-bearing escrow account for which the United States Attorney's Office for the Middle District of Florida (USAO), or, at the USAO's discretion, the Clerk of the United States District Court for the Middle District of Florida or other USAO designee, shall serve as the escrow agent. The USAO or its designated escrow agent shall hold all such installment payments plus accrued

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RELATOR SEAN HELLEIN

3/23/2012  
Date

BY: /s/ Sean Hellein  
Sean Hellein  
Relator

3/23/2012  
Date

BY: /s/ Barry A. Cohen  
Barry A. Cohen  
Kevin Darken  
Cohen, Foster & Romine, P.A.  
Counsel for Relator

3/23/2012  
Date

BY: /s/ Daniel Gasti  
Daniel Gasti  
Counsel for Relator

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WELLCARE, THE UNITED STATES  
AND RELATORS**

RELATOR CLARK J. BOLTON

4/8/11

Date

/s/ Clark J. Bolton

Clark J. Bolton  
Relator

4/10/11

Date

/s/ Chris Hoyer

Chris Hoyer  
Elaine Stromgren  
James, Hoyer, Newcomer & Smiljanich,  
P.A.  
Counsel for Relator

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RELATOR SF UNITED PARTNERS

4/14/11  
Date /s/ Eric D. Fader  
For Relator SF United Partners  
Eric D. Fader

April 14, 2011  
Date /s/ Jock Ferguson  
For Relator SF United Partners  
Jock Ferguson

April 14, 2011  
Date /s/ Dina McKenna  
For Relator SF United Partners  
Dina McKenna

4/14/11  
Date /s/ Diane Schulman  
Davidow  
For Relator SF United Partners  
Diane Schulman Davidow

4/14/11  
Date /s/ Suzanne E. Durrell  
Suzanne E. Durrell  
Counsel for Relator

4/14/11  
Date /s/ Robert M. Thomas,  
Jr.  
Robert M. Thomas, Jr.  
Counsel for Relator

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AND RELATORS**

RELATOR EUGENE GONZALEZ

April 13, 2011  
Date

/s/ Eugene Gonzalez  
Eugene Gonzalez  
Relator

4/15/2011

/s/ Cliff Johnson

**AGREEMENT BETWEEN  
WELLCARE, THE UNITED STATES  
AND RELATORS**



# Exhibit

# I

FILED

UNITED STATES DISTRICT COURT  
MIDDLE DISTRICT OF FLORIDA  
TAMPA DIVISION

2009 MAY -5 AM 9:56

U.S. DISTRICT COURT  
MIDDLE DISTRICT OF FLORIDA  
TAMPA, FLORIDA

UNITED STATES OF AMERICA

v.

CASE NO. 8:09-cr- 00203-T. 27EAS

WELLCARE HEALTH PLANS, INC.

**DEFERRED PROSECUTION AGREEMENT BETWEEN THE  
UNITED STATES ATTORNEY'S OFFICE FOR THE MIDDLE DISTRICT OF FLORIDA,  
THE FLORIDA ATTORNEY GENERAL'S OFFICE, AND  
WELLCARE HEALTH PLANS, INC., AND ITS AFFILIATES AND SUBSIDIARIES**

1. Parties and Effective Date: WellCare Health Plans, Inc., and its affiliates and subsidiaries, including but not limited to, Harmony Behavioral Health, Inc., Healthsease of Florida, Inc., WellCare of Florida, Inc., Well Care HMO, Inc., Comprehensive Reinsurance, Ltd., and Comprehensive Health Management, Inc. (hereinafter, collectively identified as "WellCare"), the United States Attorney's Office for the Middle District of Florida ("USAO"), and the Florida Attorney General's Office (hereinafter, collectively identified as the "Offices"), are parties to this Deferred Prosecution Agreement ("DPA" or "Agreement"). The Effective Date of this Agreement shall be Tuesday, May 5, 2009.
2. Resolution: The Offices have agreed to permit WellCare to enter into this Agreement with the Offices in lieu of the Offices' pursuit of a criminal conviction of WellCare. In reaching this decision, the Offices have carefully weighed and considered WellCare's remedial actions to date, including its willingness to (a) undertake additional remediation as necessary; (b) accept and acknowledge responsibility for certain past conduct giving rise to this Agreement; (c) continue its cooperation with the Offices and other governmental agencies; and (d) demonstrate its good faith and commitment to full compliance with all federal and state health care laws. The Offices have also considered the potential impact upon current Florida health care program recipients,<sup>1</sup> and the possible adverse consequences to innocent WellCare employees and other WellCare stakeholders that could result from a conviction of WellCare.
3. Duration: The duration of this DPA shall be thirty-six months from the Effective Date of this Agreement. However, after a period of eighteen months, the USAO may agree to reduce the duration of this Agreement to a term of twenty-four months upon consideration of (a) WellCare's continued remedial actions; (b) WellCare's compliance with all federal and state health care laws and regulations; (c) the written Monitor's

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<sup>1</sup> Within this Agreement, the terms "recipient" and "beneficiary" are used interchangeably and are deemed to have the same meaning.

Reports described below in paragraph 14 of this Agreement; and (d) WellCare's satisfaction of all obligations under this Agreement.

4. **Charging Document:** On the Effective Date of this DPA, an Information will be publicly filed by the USAO in the United States District Court for the Middle District of Florida, Tampa Division, charging WellCare with conspiracy to commit health care fraud against the Florida Medicaid program in WellCare's reporting of expenditures under its 80/20 community behavioral health contracts, and against the Florida Healthy Kids Corporation program under certain Florida Healthy Kids Corporation contracts, in violation of 18 U.S.C. § 1349. Said Information will be filed together with a legally executed Waiver of Indictment.

5. **Statement of Facts:** WellCare agrees that a Statement of Facts, attached hereto as "Exhibit A," and this DPA will also be publicly filed by the USAO along with the Information and the Waiver of Indictment in the United States District Court for the Middle District of Florida, Tampa Division. WellCare acknowledges that it has read and understands the assertions contained within the Statement of Facts. WellCare further acknowledges that it has carefully considered all of the assertions contained within the Statement of Facts against facts gathered by the Special Committee of WellCare's Board of Directors during its own independent, internal investigation into the conduct at issue giving rise to this Agreement.

6. **Financial Component:** WellCare received approximately \$40 million in proceeds to which WellCare was not entitled as a result of its conduct under certain Florida Medicaid and Florida Healthy Kids Corporation program contracts. WellCare therefore agrees to pay to the USAO a total of \$80 million plus accrued interest, the sum of which represents \$40 million in restitution and \$40 million in civil forfeiture. The \$40 million civil forfeiture will divest WellCare of the proceeds of such conduct and will be based upon the conduct detailed in the Statement of Facts, which will be an exhibit to the civil forfeiture complaint to be filed pursuant to Title 18, United States Code, Section 981(a)(1)(C). WellCare further agrees to sign any additional documents necessary to complete the civil forfeiture, including but not limited to a consent to forfeiture. The parties further agree that the \$80 million sum will be remitted to the USAO in three installment payments as follows:

- A. WellCare shall receive a credit against the \$80 million sum of \$35,200,000, which amount was remitted by WellCare to the USAO pursuant to an agreement executed on or about August 18, 2008, by the USAO, WellCare, and other parties. By entering into this Agreement, WellCare agrees to release any and all claims to any part of the \$35,200,000 remitted to the USAO, including any interest earned thereon after August 18, 2008.

- B. Within five business days of the Effective Date of this DPA, WellCare will make a payment of \$25 million to the USAO, in accordance with wiring instructions to be provided to WellCare by the USAO.
- C. WellCare will make its best effort to pay the balance of the \$80 million, or \$19.8 million, as soon as possible. In any event, WellCare will pay the \$19.8 million to the USAO no later than December 31, 2009, in accordance with wiring instructions to be provided to WellCare by the USAO. Further, WellCare agrees to pay to the USAO interest at a rate of .40% as of the Effective Date of this Agreement until full satisfaction of the \$19.8 million.

7. Deferral Recommendation: Within five business days of the Effective Date of this DPA, the USAO will recommend to the assigned United States District Court Judge that the prosecution of WellCare on the Information be deferred for the duration of this DPA. Except as otherwise provided for under this DPA, neither the Criminal Division of the USAO nor that component of the Florida Attorney General's Medicaid Fraud Control Unit responsible for investigating and prosecuting violations of Florida criminal law (hereafter referred to as "MFCU-Criminal Component"), will prosecute WellCare for any of the matters that have been the subject of the USAO's investigation, giving rise to this Agreement.<sup>2</sup> In the event that the Court declines to defer prosecution for any reason, all charges brought under the charging document will be dismissed without prejudice and this DPA will be null and void. However, any monies paid to the USAO by WellCare prior to the date the Court declines to defer prosecution will not be returned to WellCare and WellCare will make no claim upon such monies.

8. Publication: Within five business days of the Effective Date of this DPA, WellCare will prominently post on its website the Information, this DPA, and the Statement of Facts, as referred to above in paragraphs 4 and 5 for the duration of this Agreement. WellCare agrees that it will not, through its attorneys, agents, officers, directors, trustees, employees, or any other person or vehicle, directly or indirectly, make any:

- (a) public statements,
- (b) filings, or
- (c) argument in any criminal or civil proceeding brought by the United States and/or either of the Offices,

contradicting or undermining any statement or assertion made in this Agreement or Statement of Facts.

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<sup>2</sup> The matters that have been the subject of the Offices' investigation are specifically identified in a letter between the Offices and WellCare, dated May 5, 2009.

9. Commitment to Compliance and Remedial Measures: WellCare commits itself to exemplary corporate citizenship, best practices of effective corporate governance, the highest principles of honesty and professionalism, the integrity of the operation of all federal and state health care programs including Medicare and Medicaid, the sanctity of the doctor-patient relationship, and a culture of openness, accountability, and compliance. Prior to execution of this DPA, WellCare will provide a status report to the USAO on all policies and procedures, and all remedial measures, adopted to date by WellCare. To advance and underscore WellCare's commitment, WellCare further agrees:

- A. To fully cooperate with federal and state law enforcement agencies and federal and state health care regulatory agencies in matters arising from the Offices' continuing investigation of individuals responsible for the conduct giving rise to this Agreement. However, in accordance with Department of Justice (or "DOJ") policies, the Offices will not suggest or require that WellCare waive any of WellCare's legal privileges.
- B. To continue to develop and operate an effective corporate compliance and governance program, including adequate internal controls to prevent recurrence of any of the improper and/or illegal activities at issue in the investigation giving rise to this Agreement.
- C. To implement, within 60 days of the Effective Date of this DPA, updated policies and procedures designed to ensure complete and accurate reporting of all federal and state health care program information.
- D. To evaluate and revise WellCare's internal bid procedures and processes to ensure fair and accurate submission of all data and information in responses to any government bids and/or any government requests for proposals.

10. Retention of Monitor: By the Effective Date of this DPA or later as allowed by the Offices, WellCare will retain, at its expense, an outside independent individual (the "Monitor") who will be selected by the USAO, consistent with DOJ guidelines, and after consultation with WellCare. In selecting the Monitor, the USAO will engage in a process designed to (a) select a highly qualified and respected person or entity based on suitability for the assignment and all of the circumstances; (b) avoid potential and actual conflicts of interests; and (c) otherwise instill public confidence. WellCare agrees that it will not employ or be affiliated with any selected Monitor for a period of not less than one year from the date the monitorship is terminated.

WellCare also agrees that if the Monitor resigns or is unable to serve the balance of his or her term, a successor Monitor shall be selected by the USAO, consistent with

DOJ guidelines, and after consultation with WellCare, within forty-five calendar days. WellCare agrees that all provisions in this Agreement that apply to the Monitor shall apply to any successor Monitor.

11. Duration of the Monitorship: The duration of the monitorship shall be eighteen months from the Effective Date of this DPA.

12. Notification by WellCare to Monitor: WellCare agrees to notify the Monitor and the USAO of any credible report or evidence of any wrongdoing by WellCare, its officers, employees and/or agents relating to compliance with any federal or state health care laws, regulations, and/or reporting requirements. At the request of the Monitor or the USAO, WellCare agrees to provide the Monitor and the USAO with all relevant non-privileged information concerning the allegations and report to the Monitor concerning any investigation it plans to conduct with respect to such evidence and any resulting disciplinary and/or remedial measures. Following completion by WellCare of its investigation, and in the event the Monitor reasonably concludes that the investigation was incomplete or otherwise deficient, the Monitor will identify to WellCare any deficiencies in its investigation and allow WellCare 30 days to cure.

13. Role of Monitor: The Monitor shall have access to all non-privileged WellCare documents and information the Monitor determines are reasonably necessary to assist in the execution of his or her duties. The Monitor shall have the authority to meet with any officer, employee, or agent of WellCare. The Monitor will undertake to avoid the disruption of WellCare's ordinary business operations or the imposition of unnecessary costs or expenses to WellCare.

The Monitor shall also, *inter alia*:

- A. Monitor and review WellCare's compliance with this DPA and all applicable federal and state health care laws, regulations, and programs. Within 30 days of retention, the Monitor shall meet with representatives of WellCare, the Offices, and the Securities and Exchange Commission ("SEC"), and thereafter develop a protocol to fully effectuate the Monitor's obligations herein.
- B. As requested by the Offices, fully cooperate with the Criminal and Civil Divisions of the Offices,<sup>3</sup> the United States Department of Justice Criminal and Civil Divisions, the FBI, the HHS-OIG, and the SEC, and, as requested by the USAO, provide information about WellCare's compliance with the terms of this DPA.

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<sup>3</sup> Specifically including the MFCU-Criminal Component.

- C. Provide a total of three written reports to the USAO, that is one report every six months for the duration of the monitorship, as detailed more fully below in paragraph 14.
- D. Immediately report the following types of misconduct directly to the USAO and not to WellCare: (1) any misconduct that poses a significant risk to public health or safety;<sup>4</sup> (2) any misconduct that involves senior management of WellCare; (3) any misconduct that involves obstruction of justice; (4) any misconduct that involves a violation of any federal or state criminal statute, or otherwise involves criminal activity; or (5) any misconduct that otherwise poses a significant risk of harm to any person or to any federal or state entity or program. On the other hand, in instances where the allegations of misconduct are not credible or involve actions of individuals outside the scope of WellCare's business operations, the Monitor may decide, in the exercise of his or her discretion, that the allegations need not be reported directly to the USAO.
- E. Immediately review and evaluate policies and procedures relating to the topics described below, and make written recommendations as necessary to WellCare concerning:
  - i. The efficacy of policies and procedures relating to fairly, truthfully, and accurately accounting for and reporting of all revenues and/or expenditures and/or costs incurred in providing any services to federal and state health care program beneficiaries.
  - ii. The efficacy of policies and procedures relating to true, accurate, and complete documentation of medical records pertinent to any health care services furnished by WellCare to federal and state health care program beneficiaries.
  - iii. The efficacy of policies and procedures relating to the submission of true, accurate, and complete claims for payment to all federal and state health care programs, including the Medicare, Medicaid, and Florida Healthy Kids Corporation programs.
  - iv. The efficacy of policies and procedures relating to the fair, truthful, and accurate preparation, certification, and submission of bids to all federal and state health care

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<sup>4</sup> The USAO will determine whether to also immediately report said misconduct to WellCare.

programs, including the Medicare, Medicaid, and the Florida Healthy Kids Corporation programs.

- v. The efficacy of training relating to the above topics, and on the obligation of each WellCare employee to ensure that, in dealing with all federal and state health care programs, any information provided to the health care programs is true, accurate, complete, and transparent.

WellCare shall adopt all recommendations submitted to WellCare by the Monitor, unless WellCare objects to the recommendation. In that event, WellCare and the Monitor may present the issue to the USAO for its consideration and final decision, which is non-appealable.

14. Monitor's Reports: Every six months during the term of this DPA, the Monitor will prepare in writing a Monitor's Report to the senior management of WellCare and the Board of Directors, with a copy to the USAO. The first Monitor's Report to the USAO shall be due six months after the Effective Date of this Agreement.

The Monitor's Report shall address the following: (a) WellCare's compliance with this Agreement and all applicable federal and state health care laws, regulations, and programs; (b) a summary of the Monitor's recommendations to WellCare during the reporting period concerning the topics identified in paragraph 13(E)(i-v) above, and WellCare's responses and/or performance in implementing the Monitor's recommendations; and (c) any other relevant information that the Monitor deems necessary to further the Monitor's obligations under this Agreement.

The Monitor's Report to the USAO shall not be received or reviewed by WellCare prior to submission to the USAO. The Monitor's Report will be preliminary until WellCare is given the opportunity, within ten calendar days after the submission of the Monitor's Report to the USAO, to comment to the Monitor and the USAO in writing upon such Report, and the Monitor has reviewed and provided to the USAO a response to such comments, upon which such Report shall be considered final.

WellCare agrees that the Monitor may disclose the Monitor's Report(s), as directed by the USAO, to any other federal and/or state law enforcement or regulatory agency in furtherance of an investigation of any other matters discovered by, or brought to the attention of, the USAO in connection with the USAO's continuing investigation or the implementation of this DPA. In such event, WellCare may identify any trade secret or proprietary information contained in any Monitor's Report, and request that the Monitor redact such information prior to disclosure. The Monitor shall fairly and in good faith consider WellCare's request to redact any information. However, the Monitor's decision, which is non-appealable, shall be based upon the Monitor's overarching obligations as set forth in this Agreement.

15. Additional Cooperation of WellCare: WellCare acknowledges and understands that its future cooperation is an important factor in the decision of the Offices to enter into this DPA, and WellCare agrees to continue to cooperate fully with the Offices, and with any other government agency designated by the USAO, regarding any issue about which WellCare has knowledge or information with respect to compliance with federal and state health care laws. More specifically, WellCare agrees that, during the term of this DPA, WellCare will:

- A. Consent to any order sought by the USAO permitting disclosure to the Civil Division of the United States DOJ of materials relating to compliance with federal health care laws that constitute "matters before the grand jury" within the meaning of Federal Rule of Criminal Procedure 6(e) (with protection for any trade secrets).
- B. Take reasonable steps to make available current WellCare officers and employees to provide information and/or testimony at reasonable times as requested by the Offices, with respect to matters that have been the subject of the Offices' investigation leading to this DPA. WellCare will not be required to request that these individuals forgo seeking the advice of an attorney or act contrary to that advice.
- C. Disclose all non-privileged information about which the Offices may inquire with respect to matters that have been the subject of the Offices's investigation leading to this DPA.
- D. Provide prompt, complete and truthful testimony, certifications, and/or other non-privileged information, as required by the Offices, necessary to identify or establish the location, authenticity or evidentiary foundation to admit into evidence documents in a criminal or other proceeding relating to matters that have been the subject of the Offices' investigation leading to this DPA.

16. Breach of Agreement:

- A. Should WellCare commit a health care offense in violation of federal and/or state criminal law subsequent to the effective date of this DPA, WellCare will immediately and without notice be subject to federal and/or state prosecution, and WellCare will be in material breach of the DPA.
- B. Otherwise, should the USAO determine that WellCare has knowingly and willfully breached a material provision of this DPA, the USAO will provide WellCare with written notice of the alleged breach. WellCare will have 30 days following receipt of such notice, or such longer period as the parties

may agree, to demonstrate that no breach occurred, that the breach was not material, or that the breach was not knowingly and willfully committed.

C. If the USAO, in its sole discretion, determines:

- (i) That WellCare has materially breached this DPA in the manner described above in paragraph A of this section, or
- (ii) That WellCare has knowingly and willfully breached a material provision of this DPA in the manner described above in paragraph B of this section after WellCare has had the opportunity to demonstrate that no breach occurred, that the breach was not material, or that the breach was not knowingly and willfully committed,

then the USAO may proceed with the prosecution of WellCare through the filed information or otherwise, as determined solely by the USAO. Further, the USAO may utilize the Statement of Facts, referred to above in paragraph 5, in any such prosecution. Should there be a prosecution in accordance with this Agreement, WellCare agrees that upon such prosecution: (1) WellCare, through its attorneys, agents, officers, directors, trustees, employees, or any other person or vehicle, will not refute in any way or manner, directly or indirectly, any of the assertions contained within the Statement of Facts; (2) WellCare and its counsel will stipulate that the Statement of Facts is admissible in any such prosecution as evidence against WellCare pursuant to Federal Rule of Evidence 801(d)(2)(A),(B),(C), and (D); (3) WellCare and its counsel will stipulate that the Statement of Facts is true and correct and that the Statement of Facts may be read to the jury or other fact-finder in whole or in part, as elected by the USAO, as a stipulation to which the parties have agreed; and (4) the admissibility of the Statement of Facts is not barred or prohibited in any way or manner by the Federal Rules of Evidence, specifically including Federal Rule of Evidence 410, by the Federal Rules of Criminal Procedure, specifically including Rule 11, or by any other means. Nothing in this paragraph shall be construed as an acknowledgment that this Agreement and/or the Statement of Facts are admissible or may be used in any proceeding other than a proceeding brought by the Offices following a breach as described in this paragraph 16.

D. Regardless of whether the USAO pursues criminal charges against WellCare upon any breach of the DPA, any monies paid to the USAO at any time by WellCare will not be returned to WellCare and WellCare will make no claim upon such monies.

- E. All parties agree and acknowledge that, except in the case of a material breach of this DPA, all investigations of WellCare relating to the filed Information, and to all other matters that have been investigated by the USAO prior to the date of this DPA, will not be pursued further as to WellCare by the USAO Criminal Division nor by that component of the Florida Attorney General's Medicaid Fraud Control Unit responsible for investigating and prosecuting violations of Florida criminal law,<sup>5</sup> but will continue as to any and all individuals bearing responsibility for any violations of federal and/or state health care laws. Nothing in this paragraph is to be read or construed as stating, suggesting, or implying that this DPA in any way limits the ongoing investigations being conducted by the Offices' Civil Divisions and/or components, the Civil Division of the DOJ, or any other federal or state office, agency, or department.

17. Tolling Agreement. Waivers and Limitations:

WellCare expressly waives all rights to a speedy trial pursuant to the Sixth Amendment of the United States Constitution, Title 18, United States Code, Section 3161, Federal Rule of Criminal Procedure 48(b), and any applicable Rules of The District Court of The United States For The Middle District of Florida, and pursuant to Rule 3.191, FLA. R. CRIM. P., for the period that this DPA is in effect for any prosecution of WellCare.

The parties agree that any statutes of limitations applicable to the Offices' investigation leading to this Agreement shall be tolled as of the Effective Date of this Agreement, and that WellCare hereby waives any and all rights to claim the period between the Effective Date of this Agreement and any prosecution brought by the USAO pursuant to paragraph 16 of this Agreement, as a bar to prosecution, in any claim that the statute of limitations has expired for offenses charged against WellCare related to the subject matter of the investigation giving rise to this Agreement. The subjects covered by the tolling of the applicable statutes of limitations include any and all alleged violations of any Title of the United States Code, specifically including any and all alleged violations of Title 18 involving WellCare that are within the scope of said investigation.

This waiver is knowing and voluntary and in express reliance on the advice of counsel. Any such waiver shall terminate upon final expiration of this DPA.

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<sup>5</sup> The matters that have been the subject of the Offices' investigation are specifically identified in a letter between the Offices and WellCare, dated May 5, 2009.

18. No Sale or Transfer of WellCare Prior to Full Satisfaction of the Financial Component: Prior to full satisfaction of the Financial Component of this Agreement as described in paragraph 6 above, WellCare agrees that it will not sell all or substantially all of WellCare's business operations as they exist as of the Effective Date of this Agreement to a single purchaser or group of affiliated purchasers during the term of this Agreement, or merge with a third party in a transaction in which WellCare is not the surviving entity, without the express written permission of the Offices.

19. Transferability of DPA: Absent the express written consent of the Offices to conduct itself otherwise, WellCare agrees that if, after the Effective Date of this Agreement, WellCare sells all or substantially all of WellCare's business operations as they exist as of the Effective Date of this Agreement to a single purchaser or group of affiliated purchasers during the term of this Agreement, or merges with a third party in a transaction in which WellCare is not the surviving entity, WellCare shall include in any contract for such sale or merger a provision binding the purchaser, successor, or surviving entity to the obligations contained in this Agreement.

20. Other Proceedings:

- A. WellCare specifically agrees that this DPA in no way restricts the ability of the USAO or the MFCU-Criminal Component from proceeding against any individual in any capacity.
- B. WellCare also specifically agrees that this DPA in no way limits or precludes the United States and/or either of the Offices from instituting, maintaining, or intervening in any action or other proceeding to recover any civil or administrative monetary or other remedy or penalty.

21. Dismissal of Charging Document: The Offices agree that if WellCare has complied with this DPA, within 5 days of the expiration of the DPA, the USAO will seek dismissal with prejudice of the Information filed pursuant to paragraph 4 above.

22. Expressed Limitation of the Agreement: The agreement between the parties expressed in this DPA in no way limits or waives WellCare's contractual obligations to any federal or state health care agency or program, except as expressly provided herein.

23. Entire Agreement: This DPA constitutes the full and complete agreement between WellCare and the Offices and supersedes any previous agreement between them. No additional promises, agreements, or conditions have been entered into other than those set forth in this DPA, and none will be entered into unless in writing and signed by the Offices, WellCare counsel, and a duly authorized representative of WellCare. It is understood that the Offices may permit exceptions to or excuse particular requirements set forth in this DPA at the written request of WellCare or the Monitor, but any such permission shall be in writing.

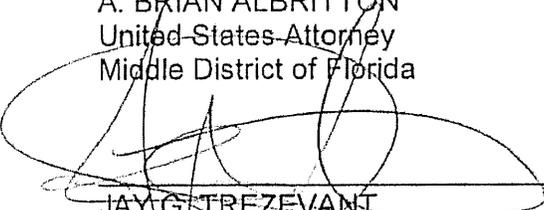
AGREED & ACCEPTED BY:

WELLCARE HEALTH PLANS, INC.

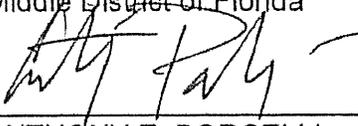
UNITED STATES OF AMERICA

A. BRIAN ALBRITTON  
United States Attorney  
Middle District of Florida

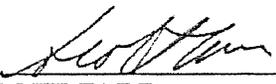
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GREGORY W. KEHOE, ESQ.  
Greenberg Traurig, P.A.  
Attorney for WellCare Health Plans, Inc.

  
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JAY G. TREZEVANT  
Assistant United States Attorney  
Middle District of Florida

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THOMAS F. O'NEIL, III  
Secretary  
WellCare Health Plans, Inc.

  
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ANTHONY E. PORCELLI  
Assistant United States Attorney  
Middle District of Florida

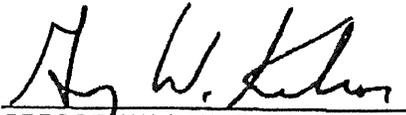
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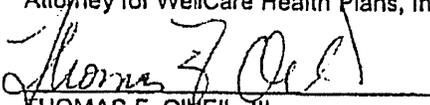
  
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SCOTT FARR  
Regional Chief  
Office of Attorney General

23. Entire Agreement: This DPA constitutes the full and complete agreement between WellCare and the Offices and supersedes any previous agreement between them. No additional promises, agreements, or conditions have been entered into other than those set forth in this DPA, and none will be entered into unless in writing and signed by the Offices, WellCare counsel, and a duly authorized representative of WellCare. It is understood that the Offices may permit exceptions to or excuse particular requirements set forth in this DPA at the written request of WellCare or the Monitor, but any such permission shall be in writing.

AGREED & ACCEPTED BY:

WELLCARE HEALTH PLANS, INC.

  
GREGORY W. KEHOE, ESQ.  
Greenberg Traurig, P.A.  
Attorney for WellCare Health Plans, Inc.

  
THOMAS F. O'NEIL III  
Secretary  
WellCare Health Plans, Inc.

UNITED STATES OF AMERICA

A. BRIAN ALBRITTON  
United States Attorney  
Middle District of Florida

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JAY G. TREZEVANT  
Assistant United States Attorney  
Middle District of Florida

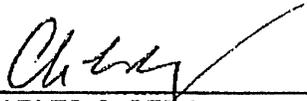
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ANTHONY E. PORCELLI  
Assistant United States Attorney  
Middle District of Florida

STATE OF FLORIDA

\_\_\_\_\_  
SCOTT FARR  
Regional Chief  
Office of Attorney General

**DIRECTOR'S CERTIFICATE**

I have read this agreement and carefully reviewed every part of it with counsel for WellCare. I understand the terms of this Deferred Prosecution Agreement and voluntarily agree, on behalf of WellCare, to each of the terms. Before signing this Deferred Prosecution Agreement, I consulted with the attorneys for WellCare. Counsel fully advised me of WellCare's rights, of possible defenses, of the Sentencing Guidelines' provisions, and of the consequences of entering into this Deferred Prosecution Agreement. No promises or inducements have been made other than those contained in this Deferred Prosecution Agreement. Furthermore, no one has threatened or forced me, or to my knowledge any person authorizing this Deferred Prosecution Agreement on behalf of WellCare, in any way to enter into this Deferred Prosecution Agreement. I am also satisfied with counsel's representation in this matter. I certify that I am a director of WellCare, and that I have been duly authorized by the Board of Directors of WellCare to execute this certificate on behalf of WellCare.



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CHARLES G. BERG  
Executive Chairman of the Board of Directors  
WellCare Health Plans, Inc.

CERTIFICATE OF COUNSEL

I am counsel for WellCare. In connection with such representation, I have examined relevant WellCare documents, and have discussed this Deferred Prosecution Agreement with the authorized representative of WellCare. Based on my review of the foregoing materials and discussions, I am of the opinion that:

1. The undersigned counsel is duly authorized to enter into this Deferred Prosecution Agreement on behalf of WellCare; and
2. This Deferred Prosecution Agreement has been duly and validly authorized, executed and delivered on behalf of WellCare, and is a valid and binding obligation of WellCare. Further, I have carefully reviewed every part of this Deferred Prosecution Agreement with the Directors of WellCare. I have fully advised these Directors of WellCare's rights, of possible defenses, of the Sentencing Guidelines' provisions, and of the consequences of entering into this Agreement. To my knowledge, WellCare's decision to enter into this Agreement is an informed and voluntary one.



GREGORY W. KEHOE, ESQ.  
Greenberg Traurig, P.A.  
Attorney for WellCare Health Plans, Inc

SECRETARY'S CERTIFICATION

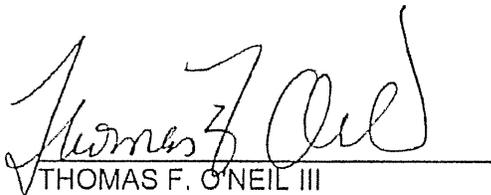
I, THOMAS F. O'NEIL III, the duly elected Secretary of WellCare, a corporation duly organized under the laws of the State of Florida, hereby certify that the following is a true and exact copy of a resolution approved by the Board of Directors of WellCare following a meeting of the Board;

WHEREAS, WellCare has been engaged in discussions with the USAO-MDFL in connection with an investigation being conducted by the USAO-MDFL;

WHEREAS, the Board of Directors of WellCare consents to resolution of these discussions on behalf of WellCare by entering into this Deferred Prosecution Agreement that the Board of Directors has reviewed with outside counsel representing WellCare;

NOW THEREFORE, BE IT RESOLVED that outside counsel representing WellCare from Greenberg Traurig, P.A. be, and they hereby are authorized to execute the Deferred Prosecution Agreement on behalf of WellCare substantially in the same form as reviewed by the Board of Directors during a meeting of the Board, and that a Director of WellCare is authorized to execute the Director's Certificate for the Deferred Prosecution Agreement.

IN WITNESS WHEREOF, I have hereunto signed my name as Secretary and affixed the Seal of said Corporation this 4<sup>th</sup> day of May, 2009.



THOMAS F. O'NEIL III  
Secretary  
WellCare Health Plans, Inc.

**CERTIFIED COPY OF RESOLUTION**

Upon motion duly made, seconded, and carried by the affirmative vote of all the Directors present, with one abstaining, the following resolutions were adopted:

WHEREAS, WellCare has been engaged in discussions with the United States Attorney's Office for the Middle District of Florida ("USAO-MDFL") in connection with an investigation being conducted by the USAO-MDFL;

WHEREAS, the Board of WellCare consents to resolution of these discussions by entering into a deferred prosecution agreement that the WellCare Board of Directors has reviewed with outside counsel representing WellCare;

NOW THEREFORE, BE IT RESOLVED that outside counsel representing WellCare from Greenberg Traurig, P.A., be, and they hereby are, authorized to execute the Deferred Prosecution Agreement on behalf of WellCare substantially in the same form as reviewed by the WellCare Board of Directors during a meeting of the Board, and that a Director of WellCare is authorized to execute the Director's Certificate for the Deferred Prosecution Agreement.

# **ATTACHMENT A**

UNITED STATES DISTRICT COURT  
MIDDLE DISTRICT OF FLORIDA  
TAMPA DIVISION

UNITED STATES OF AMERICA

v.

CASE NO. 8:09-cr-

WELLCARE HEALTH PLANS, INC.

**STATEMENT OF FACTS**

1. Beginning in or about mid-2002, and continuing through at least October 2007, within the Middle District of Florida, and elsewhere, WELLCARE HEALTH PLANS, INC. (formerly doing business as Wellcare Holdings, LLC, and also known as WCG Health Management, Inc., referred to herein as "WELLCARE"), acting through its former officers and employees, knowingly and willfully conspired, confederated and agreed with others to execute and attempt to execute a scheme and artifice to defraud two health care benefit programs: the Florida Medicaid program and the Florida Healthy Kids Corporation ("FHKC") program. Additionally, WELLCARE knowingly and willfully conspired, confederated and agreed with others to defraud the Florida Medicaid program of approximately \$33,649,553 and the FHKC program of approximately \$6,395,500 by means of materially false pretenses, representations, and promises in connection with the delivery of and payment for health care benefits, items, and services.

### **The Florida Medicaid Program**

2. The Medicaid program, as established by Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations, authorized Federal grants to States for medical assistance to low-income persons who are blind, disabled, or members of families with dependent children or qualified pregnant women or children (herein referred to as "Medicaid beneficiaries" or "Medicaid recipients"). The Centers for Medicare and Medicaid Services ("CMS"), previously known as the Health Care Finance Administration ("HCFA"), was an agency of the United States Department of Health and Human Services ("HHS"), and was the federal governmental body responsible for the administration of the Medicaid program. CMS, in turn, authorized each state to establish a state agency to oversee the Medicaid program.

3. The Florida Medicaid program was authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. Florida further established the Agency for Health Care Administration ("AHCA") as the single state agency authorized to administer the Florida Medicaid program.

4. States electing to participate in the Medicaid program had to comply with the requirements imposed by the Social Security Act and regulations of the Secretary of HHS.

5. The federal government reimbursed states for a portion of the states' Medicaid expenditures based on a formula tied to the per capita income in each state. The federal share of Medicaid expenditures (otherwise referred to as "federal financial participation" or "FFP") varied from a minimum of 50% to as much as 83% of a state's total Medicaid expenditures. The federal government's "financial participation" in the

Florida Medicaid program equaled approximately 59% of Florida's total Medicaid expenditures.

6. The Florida Medicaid program reimbursed health care practitioners, healthcare facilities, or health care plans that met the conditions of participation and eligibility requirements and that were enrolled in Medicaid for rendering Medicaid-covered services to Medicaid beneficiaries.

7. "Capitation reimbursement" was one of several ways that the Florida Medicaid program reimbursed health care providers, including health maintenance organizations ("HMOs") such as WELLCARE. "Capitation reimbursement" was a form of payment where HMOs and other providers were paid a fixed amount each month for each beneficiary or member (per capita) enrolled to receive services from that HMO or provider.

8. Florida sought to provide certain behavioral health care services to the Florida Medicaid program beneficiaries, and in 2002 enacted Florida Statute 409.912(4)(b), which provided, in pertinent part:

To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency.

Beginning in or about mid-2002, AHCA began covering certain behavioral health care services, and it provided these services through contracts with HMOs, such as

WELLCARE, which included provisions for the new services to be delivered to the Florida Medicaid program beneficiaries and reimbursed through a capitated payment arrangement.

#### **The Florida Healthy Kids Corporation Program**

9. The FHKC program contracted with licensed managed care organizations and health insurance entities to extend affordable, accessible, quality health care to the qualifying population of uninsured children in families with incomes too high to qualify for the Florida Medicaid program, but too low to afford private health insurance.

10. Title XXI of the Social Security Act and Title 42 of the Code of Federal Regulations authorized the creation of the FHKC program, and Florida created FHKC as a not-for-profit corporation pursuant to Section 624.91, Florida Statutes. FHKC was funded through a combination of state and federal funds under the State Children's Health Insurance Program as described in Title XXI of the Social Security Act.

#### **WELLCARE's "80/20" Contracts with AHCA**

11. WELLCARE, a Delaware entity, acted through its subsidiaries to provide managed health care services primarily for government-sponsored health care programs such as Medicaid and Medicare. Among other business activities, WELLCARE provided Medicaid services in a number of states, including Florida. The Medicaid program for each state paid WELLCARE for the managed care services provided to Medicaid beneficiaries residing in that state.

12. WELLCARE was one of the largest providers of managed care services in Florida, and it enrolled Medicaid patients into one of its two plans: Wellcare of Florida,

Inc. (formerly known as Well Care HMO, Inc., and doing business as StayWell Health Plan of Florida, referred to herein as "STAYWELL") and Healthease of Florida, Inc. ("HEALTHEASE"). Both STAYWELL and HEALTHEASE were wholly-owned subsidiaries of WELLCARE and legal entities created under Florida law. As noted above, AHCA was the agency charged with administering the Florida Medicaid program.

13. To govern aspects of the provision of additional Florida Medicaid program services, that is, certain behavioral health care services, to Florida Medicaid beneficiaries, Florida Statute 409.912(4)(b) was enacted, effective June 7, 2002, which read, in pertinent part:

To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency.

14. Thus, beginning in or about mid-2002, AHCA began covering the behavioral health care services, via contracts which included provisions for the new services to be delivered to Florida Medicaid beneficiaries through a capitated arrangement. WELLCARE, through its STAYWELL and HEALTHEASE plans, contracted with AHCA to provide a variety of services to Florida Medicaid beneficiaries, including community behavioral health services (also sometimes referred to as "mental health services"). The contracts between AHCA and STAYWELL and HEALTHEASE

provided that STAYWELL and HEALTHEASE were paid on a flat or "capitated" rate for each beneficiary or member enrolled in one of the two health plans. The capitated rate varied depending on age, sex, geographic location, and other factors. Per the relevant AHCA contracts' provisions relating to community behavioral health services and in accordance with Florida law, STAYWELL and HEALTHEASE were allowed to retain 20% of the related premiums received from AHCA to cover their administrative expenses and overhead. As to the remaining 80% of the premiums received from AHCA, both the contracts and Florida law required that any funds not expended by STAYWELL or HEALTHEASE or paid directly or indirectly to community behavioral health services providers solely for the provision of those services had to be returned to the state (these AHCA contracts which included such 80/20 provisions are referred to herein as "80/20 contracts").

15. The AHCA 80/20 contracts included language identical, or substantially similar, to the following:

**Community Behavioral Health Services Annual 80/20 Expenditure Report.**

1. By April 1 of each year, Health Plans shall provide a breakdown of expenditures related to the provision of community behavioral health services, using the spreadsheet template provided by the Agency (see Section XII, Reporting Requirements). In accordance with Section 409.912, F.S., eighty percent (80%) of the Capitation Rate paid to the Health Plan by the Agency shall be expended for the provision of community behavioral health services. In the event the Health Plan expends less than eighty percent (80%) of the Capitation Rate, the Health Plan shall return the difference to the Agency no later than May 1 of each year.

- a. For reporting purposes in accordance with this Section, 'community behavioral health services' are defined as those services that the Health Plan is required to provide as listed in the Community Mental Health Services Coverage and Limitations Handbook and the Mental Health Targeted Case Management Coverage and Limitations handbook.
- b. For reporting purposes in accordance with the Section 'expended' means the total amount, in dollars, paid directly or indirectly to community behavioral health services providers solely for the provision of community behavioral health services, not including administrative expenses or overhead of the plan. If the report indicates that a portion of the capitation payment is to be returned to the Agency, the Health Plan shall submit a check for that amount with the Behavioral Health Services Annual 80/20 Expenditure Report that the Health Plan provides to the Agency."

16. To facilitate the required reporting of expenditures relating to the provision of the community behavioral health care services, AHCA provided each participating health plan in Florida, including STAYWELL and HEALTHEASE, with a worksheet titled "Financial Worksheet For Behavioral Healthcare," or other similar title (such worksheet is referred to herein as "AHCA Behavioral Healthcare Worksheet"), that was organized in a manner to calculate and present to AHCA the amount of refund, if any, due AHCA under the relevant 80/20 contracts.

17. The AHCA Behavioral Healthcare Worksheet required, in part, each participating health plan, including STAYWELL and HEALTHEASE, to provide AHCA

with the plan's true and correct expenditure information relating to the plan's provision of behavioral health care services. "Behavioral health care services" was defined as those services that the plan was required to provide per the Community Mental Health Services Coverage and Limitations Handbook and the Mental Health Targeted Case Management Coverage and Limitations handbook.

**WELLCARE's FHKC Program Contracts**

18. Florida Statute 624.91(10) authorized the FHKC to:

[c]ontract with authorized insurers or any provider of health care services, meeting standards established by the [FHKC], for the provision of comprehensive insurance coverage to participants. Such standards shall include criteria under which the [FHKC] may contract with more than one provider of health care services in program sites. Health plans shall be selected through a competitive bid process. The [FHKC] shall purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care. The maximum administrative cost for a [FHKC] contract shall be 15 percent. For health care contracts, the minimum medical loss ratio for a [FHKC] contract shall be 85 percent.

19. Since in or about October 2003, WELLCARE, through its STAYWELL and HEALTHEASE plans, contracted with the FHKC to provide insurance coverage to FHKC participants.

20. In accordance with Florida Statute 624.91(10), the relevant contracts between the FHKC and the WELLCARE entities STAYWELL and HEALTHEASE included a provision that established a medical loss ratio ("MLR") of 85% which required STAYWELL and HEALTHEASE to return to the FHKC one-half of the difference between the 85% MLR and the actual loss ratio experienced by STAYWELL and HEALTHEASE in providing the covered services. For example, the contract between

FHKC and the WELLCARE entities STAYWELL and HEALTHEASE for the period beginning in October, 2005, read, in pertinent part:

In the event that the medical loss ratio for this Agreement is better than eighty-five percent (85%) in the aggregate for both [STAYWELL] and HEALTHEASE calculated in the same manner as the premium development and allocation methodology utilized in the [WELLCARE's] original rate proposal in its response to the RFP, [WELLCARE] shall share equally with [FHKC] the dollar difference between the actual loss ratio for said period and the predicted eighty-five percent (85%).

[WELLCARE] shall provide annually [FHKC] with a written copy of its findings each year during the term of this Agreement by February 1st. If any payments are due under this provision, [WELLCARE] shall forward such payment with its written notification. [WELLCARE] may be subject to audit or verification [FHKC] or its designated agents.

#### **The Conspiracy**

21. WELLCARE, through its former officers and employees, conspired to defraud the Florida Medicaid program and the FHKC program. It was part of the conspiracy that:

- (a) to fraudulently reduce WELLCARE's contractual payback obligations to AHCA under the 80/20 contracts and to the FHKC program, under its relevant contracts, and thereby correspondingly benefit WELLCARE through an increase in profits, WELLCARE, acting through its former officers and employees, would and did falsely and fraudulently inflate medical expenditure information reported to AHCA and to the FHKC program concerning WELLCARE's STAYWELL and HEALTHEASE plans through various acts and strategies including, but not limited to:

- i. falsely and fraudulently including expenses in the relevant AHCA Behavioral Healthcare Worksheets for WELLCARE plans STAYWELL and HEALTHEASE that were not expenses incurred by the plans in providing the required community behavioral health services as defined and listed in the Community Mental Health Services Coverage and Limitations Handbook and the Mental Health Targeted Case Management Coverage and Limitations handbook;
- ii. falsely and fraudulently including expenses in calculating the actual loss ratio reported by STAYWELL and HEALTHEASE to the FHKC program;
- iii. using a wholly-owned entity named Harmony Behavioral Health, Inc. (formerly known as Wellcare Behavioral Health, Inc.), to conceal and falsely and fraudulently inflate the STAYWELL and HEALTHEASE plans' true and actual expenses incurred in providing the required certain medical services to Florida Medicaid and FHKC program recipients; and
- iv. submitting false and fraudulent AHCA Behavioral Healthcare Worksheets to AHCA.

(b) to conceal WELLCARE's false and fraudulent reporting of expenditure information to AHCA, WELLCARE, through its former officers and employees, acting within the scope of their duties and authorities, would and did falsely and fraudulently provide certified Medicaid behavioral health encounter data to AHCA. Generally, "behavioral health encounter data" referred to the actual cost or expense of providing a particular behavioral health service; or in other words, "behavioral health encounter data" is the relevant data that details what specific services were performed and how much each service cost.

(c) WELLCARE's former officers and employees, acting within the scope of their duties and authorities, would and did engage in meetings and other conduct in a concerted and organized effort to conceal and cover-up the false and fraudulent nature of WELLCARE's various expenditure information and encounter data submissions to AHCA.

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By:

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# Exhibit

# J



DEPARTMENT OF HEALTH AND HUMAN SERVICES

# OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



APR 11 2014

**TO:** Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services

Leon Rodriguez  
Director  
Office for Civil Rights

**FROM:** Brian P. Ritchie  
Acting Deputy Inspector General  
for Evaluation and Inspections

**SUBJECT:** Memorandum Report: *Offshore Outsourcing of Administrative Functions by State Medicaid Agencies*, OEI-09-12-00530

This memorandum report provides information about State Medicaid agencies' requirements for outsourcing administrative functions offshore. Outsourcing occurs when Medicaid agencies enter into agreements with contractors to perform administrative functions. Outsourcing can occur inside the United States (domestic outsourcing) or outside (offshore outsourcing). In 2011, an Office of Inspector General (OIG) review found that one Medicaid agency was unaware that a contractor had sent electronic copies of Medicaid claims offshore for processing. This Medicaid agency inquired whether OIG had information regarding how States regulate offshore outsourcing. In response, we initiated the current study, obtaining information from all 56 Medicaid agencies regarding their requirements and practices for outsourcing administrative functions offshore. This memorandum report summarizes the information we collected from those States.

## SUMMARY

Only fifteen of fifty-six Medicaid agencies have some form of State-specific requirement that addresses the outsourcing of administrative functions offshore. The remaining 41 Medicaid agencies reported no offshore outsourcing requirements and do not outsource administrative functions offshore. Among the 15 Medicaid agencies with requirements, 4 Medicaid agencies prohibit the outsourcing of administrative functions offshore and 11 Medicaid agencies allow it. The 11 Medicaid agencies that allow offshore outsourcing of administrative functions each maintained Business Associate Agreements (BAAs) with contractors, which is a requirement under the Health Insurance Portability and Accountability Act (HIPAA). Among other purposes, BAAs are intended to safeguard protected health information (PHI). These 11 Medicaid agencies do not have additional State requirements that specifically address safeguarding PHI.

Seven of the eleven Medicaid agencies that allow offshore outsourcing of administrative functions reported that they outsource offshore through subcontractors, but none reported sending PHI offshore. If Medicaid agencies engage in offshore outsourcing of administrative functions that involve PHI, it could present potential vulnerabilities. For example, Medicaid agencies or domestic contractors that send PHI offshore may have limited means of enforcing provisions of BAAs that are intended to safeguard PHI. Although some countries may have privacy protections greater than those in the United States, other countries may have limited or no privacy protections.

## **BACKGROUND**

### **The Medicaid Program**

Medicaid is a joint Federal and State program that provides health care coverage to low-income and medically needy populations, such as children, senior citizens, and people with disabilities. States administer the Medicaid program subject to Federal guidelines and policies established by the Centers for Medicare & Medicaid Services (CMS).<sup>1</sup> For example, States establish—within Federal parameters—their own eligibility requirements, health care benefit packages for beneficiaries, and provider reimbursement rates. Medicaid agencies must cover acute and long-term care services that include, but are not limited to, inpatient and outpatient hospital services; laboratory and x-ray services; and nursing home facilities and home health care.<sup>2</sup> In addition, Medicaid agencies may choose to cover optional services such as prescription drugs, durable medical equipment, and personal care services.<sup>3</sup>

### **Medicaid Agencies' Administrative Functions**

Medicaid agencies perform a variety of functions, usually through the integration of information technology (IT) or data systems, to support the administration of the Medicaid program. Medicaid administrative functions include, but are not limited to:<sup>4</sup>

- enrolling eligible individuals,
- determining what benefits the Medicaid agency will cover,
- determining how much the Medicaid agency will pay for covered benefits and from whom it will purchase services (i.e., fee-for-service and managed care plans),
- having a system for processing claims from fee-for-service providers and making capitation payments to managed care plans,
- monitoring the quality of the services that the Medicaid agency purchases,
- ensuring that State and Federal health care funds are not spent improperly or fraudulently,
- collecting program information and reporting it to CMS, and
- resolving grievances from applicants, beneficiaries, providers, and health plans.

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<sup>1</sup> Social Security Act (SSA) §§ 1901–1936, 42 U.S.C. §§ 1396–1396v.

<sup>2</sup> 42 CFR § 440.210.

<sup>3</sup> 42 CFR § 440.220.

<sup>4</sup> See generally SSA § 1902(a), 42 U.S.C. § 1396a(a).

### **Outsourcing of Medicaid Administrative Functions**

Although Federal law requires that each State designate a single State agency to administer the State's Medicaid program, Medicaid agencies have the authority to delegate or outsource their administrative functions to other State agencies and/or contractors.<sup>5,6</sup> Medicaid agencies may outsource by entering into agreements with contractors to perform specific administrative functions on a periodic or routine basis. These contractors may be private companies identified as covered entities,<sup>7</sup> business associates,<sup>8,9</sup> or trading partners.<sup>10</sup>

Medicaid agencies may outsource directly, i.e., through contractors, or indirectly, i.e., through subcontractors. Direct offshore outsourcing occurs when a Medicaid agency contracts with an offshore contractor. Indirect offshore outsourcing occurs when a Medicaid agency's contractor subcontracts to an offshore contractor. In a 2006 report on 45 State Medicaid agencies, the Government Accountability Office (GAO) found that at least one Medicaid agency directly outsourced offshore and at least one Medicaid agency indirectly outsourced offshore. GAO stated that such reporting may be understated because many Federal contractors and agencies did not know whether their domestic vendors transferred personal health information to other locations or vendors.<sup>11</sup> Moreover, the GAO report did not assess States' compliance with existing HIPAA regulations.

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<sup>5</sup> SSA § 1902(a)(5), 42 U.S.C. § 1396a(a)(5).

<sup>6</sup> 42 CFR § 431.10.

<sup>7</sup> Covered entities are health plans, clearinghouses, and providers that electronically transmit PHI. Examples of PHI include a beneficiary's name, Medicaid number, billing transactions, and date of birth. PHI can be transmitted in electronic, oral, or paper formats. The HIPAA Privacy Rule provides Federal safeguards to maintain the privacy of PHI. Health plans, including Medicare and Medicaid, provide or pay for the cost of health care. Clearinghouses process and convert health information from one format to another. Health care providers include physicians and pharmacies that electronically submit PHI for financial or administrative transactions, such as beneficiary claims. 45 CFR § 150.103.

<sup>8</sup> Business associates are persons or organizations that perform certain functions involving the use or disclosure of PHI on behalf of a covered entity. Business associates are subject to the HIPAA Privacy Rule. 45 CFR § 150.103.

<sup>9</sup> Covered entities and business associates must have BAAs. Covered entities are required to have BAAs for "downstream" outsourcing—i.e., when the original outsourcing contract is followed by one or more subcontracting arrangements. In such cases, BAAs must establish the conditions under which downstream contractors may use and disclose PHI and must include the required privacy safeguards. 45 CFR §§ 150.103 and 165.504(e).

<sup>10</sup> Trading partners are entities that transmit electronic health data to covered entities, business associates, providers/suppliers, and software vendors, or that receive such data. Trading partners are subject to the HIPAA Privacy Rule.

<sup>11</sup> GAO, *Domestic and Offshore Outsourcing of Personal Information in Medicare, Medicaid, and TRICARE*, GAO-06-676, September 2006.

### **Federal Requirements for Offshore Outsourcing**

There are no Federal regulations that prohibit the offshore outsourcing of Medicaid administrative functions. CMS requires that Medicare contractors or subcontractors obtain written approval prior to performing system functions<sup>12</sup> offshore.<sup>13</sup> Although there are no similar requirements from CMS for Medicaid, CMS has issued guidance in accordance with the Affordable Care Act (ACA) stating that Medicaid agencies are permitted to provide payments to contractors operating offshore for tasks—including administrative functions—that support the administration of the Medicaid program.<sup>14, 15</sup>

### **METHODOLOGY**

We conducted an electronic survey of all 56 Medicaid agencies.<sup>16</sup> In May 2013, we asked these agencies (1) whether they had any policies, Executive Orders, State laws, or contract requirements (collectively, “requirements”) that addressed the outsourcing of administrative functions offshore<sup>17</sup> and (2) whether they directly or indirectly outsourced administrative functions offshore.

For Medicaid agencies with outsourcing requirements, we asked whether the requirements included provisions specifically addressing PHI and whether the Medicaid agencies monitor contractors’ compliance with the outsourcing requirements. We requested their requirements and BAAs, and we reviewed the requirements to identify the type or form of the requirement. For the Medicaid agencies that outsource administrative functions offshore, we asked what types of administrative functions are outsourced offshore. In June 2013, we conducted telephone interviews, as needed, with selected Medicaid agencies to clarify survey responses, and in some cases, we clarified inconsistent survey responses via email.

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

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<sup>12</sup> Medicare system functions include, but are not limited to, the transmission of electronic claims, receipt of remittance advice, or any system access to obtain beneficiary PHI and/or eligibility information.

<sup>13</sup> *Medicare Fee For Service Standard Companion Guide*, page 18. Accessed at <http://www.medicarenhic.com/edi/download/J14%20PART%20B%20Medicare%20FFS%205010A1%20Companion%20Guide.pdf> on May 25, 2012. *Appendix A, CMSR High Impact Level Data*, Section SA-9. Accessed at [http://www.cms.gov/informationsecurity/downloads/ARS\\_App\\_A-CMSR\\_HIGH.pdf](http://www.cms.gov/informationsecurity/downloads/ARS_App_A-CMSR_HIGH.pdf) on May 25, 2012.

<sup>14</sup> ACA, P.L. No. 111-148, § 6505.

<sup>15</sup> Although Medicaid agencies cannot pay for *health care benefits or services* to any entity located offshore or provided by offshore providers, payments for *administrative functions* are permitted. CMS, *State Medicaid Directors Letter #10-026*, December 2010.

<sup>16</sup> Medicaid agencies include those in the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

<sup>17</sup> We sent letters to each State Medicaid Director requesting contact information for the person or persons knowledgeable about whether the agency outsources administrative functions offshore. We then sent the survey to those contacts. In some cases, State Medicaid Directors identified themselves as the appropriate contact.

## RESULTS

### **Fifteen Medicaid agencies have requirements addressing the offshore outsourcing of administrative functions**

Only one-quarter (15 of 56) of Medicaid agencies reported having some form of requirement addressing the offshore outsourcing of Medicaid administrative functions. Of those 15 Medicaid agencies, 11 have requirements that allow such offshore outsourcing. Nine of the eleven Medicaid agencies have requirements that allow offshore outsourcing with very few restrictions, and 2 of the 11 have requirements that allow offshore outsourcing only under limited circumstances. The remaining 4 of the 15 Medicaid agencies have requirements that prohibit the offshore outsourcing of administrative functions. None of the 41 States without such requirements reported outsourcing Medicaid administrative functions offshore.

*Nine Medicaid agencies have requirements allowing offshore outsourcing with very few limitations.* Among the nine Medicaid agencies that allow offshore outsourcing with very few limitations, three agencies addressed offshore outsourcing through Executive Orders, State laws, or a Medicaid agency policy manual. The remaining six Medicaid agencies addressed offshore outsourcing through contract provisions. All nine Medicaid agencies allow indirect offshore outsourcing—i.e., they allow their direct contractors to have offshore subcontractors. Two of these Medicaid agencies also allow direct offshore outsourcing, in which the Medicaid agency contracts with offshore contractors for administrative functions. Two other Medicaid agencies allow indirect offshore outsourcing, but specifically prohibit direct offshore outsourcing. (Table 1 shows details on the nine agencies that allow offshore outsourcing with very few limitations.)

According to the requirements that these nine Medicaid agencies have in place, the agencies must approve any contractor requests to outsource administrative functions offshore. Among the nine Medicaid agencies, views and practices regarding offshore outsourcing varied—some reported that they outsource offshore on a case-by-case basis, some reported giving preference to domestic contractors, and some reported that they generally do not view the offshore outsourcing of administrative functions any differently than they view domestic outsourcing.

**Table 1: Description of Nine Medicaid Agencies' Requirements Allowing Offshore Outsourcing of Administrative Functions with Very Few Restrictions**

State Medicaid agency	Form of requirement <sup>18</sup>	Description of the requirement for <i>direct</i> offshore outsourcing	Description of the requirement for <i>indirect</i> offshore outsourcing	Does the requirement specifically address PHI?	Does the State monitor contractor compliance with the requirement?
Florida	State law <sup>19</sup>	No requirement	Allows	No	Yes
Massachusetts	Contract provisions	No requirement	Allows	No	Yes
Mississippi	Contract provisions	No requirement	Allows	No	Yes
Montana	Contract provisions	Prohibits	Allows	No	Yes
New Mexico	Contract provisions	Prohibits	Allows	No	Yes
North Dakota	Contract provisions	No requirement	Allows	No	Yes
Pennsylvania	Executive Order <sup>20</sup>	Allows	Allows	No	Yes
Rhode Island	Contract provisions	No requirement	Allows	No	Yes
Tennessee	Medicaid Policy Manual	Allows	Allows	No	Yes

The nine Medicaid agencies did not have offshore outsourcing requirements that specifically addressed the safeguarding of PHI. Instead, these nine Medicaid agencies require contractors and subcontractors to have BAAs complying with HIPAA requirements for the protection of PHI. HIPAA requires that BAAs specify the contractor's responsibilities for safeguarding PHI, the circumstances under which PHI

<sup>18</sup> In their contract provisions, Medicaid agencies may reiterate and/or expand on the requirements they have already specified elsewhere (e.g., in Executive Orders, State law, and Medicaid policy manuals).

<sup>19</sup> The Medicaid agency allows indirect offshore outsourcing for managed care organizations and prepaid health plans; however, certain statutory and/or contractual restrictions exist. For example, contract provisions may require that some administrative functions be performed in a domestic location.

<sup>20</sup> Contractors must identify during the procurement process whether they or any subcontractor will perform administrative functions offshore. During the selection of contractors, the State may give additional consideration to contractors that will perform services within the United States.

may be used and disclosed, and the requirements for reporting PHI violations or breaches. However, for all nine agencies, BAAs did not specifically address the offshore outsourcing of administrative functions involving PHI. If Medicaid agencies engage in offshore outsourcing of administrative functions that involve PHI, it could present potential vulnerabilities. For example, Medicaid agencies or domestic contractors who send PHI offshore may have limited means of enforcing provisions of BAAs that are intended to safeguard PHI. Although some countries may have privacy protections greater than those in the United States, other countries may have limited or no privacy protections to support HIPAA compliance.

All nine Medicaid agencies reported that they monitored contractors to ensure compliance with the agencies' requirements on offshore outsourcing. Although some of these Medicaid agencies reported that they directly monitor subcontractors, other Medicaid agencies reported that they rely on contractors to monitor subcontractors. Examples of monitoring activities reported by the nine Medicaid agencies included approving contractors' requests to subcontract; conducting ongoing reviews of contractors' and/or subcontractors' policies and procedures; and requiring performance reports from contractors. These activities may vary based on the scope of the contract.

*Two Medicaid agencies have requirements allowing offshore outsourcing only under limited circumstances.* Two Medicaid agencies addressed offshore outsourcing through an Executive Order or a State law. As shown in Table 2, both of these Medicaid agencies allow offshore outsourcing directly and indirectly.

**Table 2: Description of Two Medicaid Agencies' Requirements Allowing Offshore Outsourcing of Administrative Functions Only Under Limited Circumstances**

State Medicaid agency	Form of requirement <sup>21</sup>	Description of the requirement for <i>direct</i> offshore outsourcing	Description of the requirement for <i>indirect</i> offshore outsourcing	Examples of circumstances under which offshore outsourcing is allowed	Does the requirement specifically address PHI?	Does the State monitor contractor compliance with the requirement?
Missouri	Executive Order <sup>22</sup>	Allows	Allows	Contractor or subcontractor must meet one of four conditions, such as providing a unique service that is mandatory for the State to purchase	No	Yes
New Jersey	State law	Allows	Allows	The function or service cannot be provided by domestic contractor or subcontractor	No	Yes

Source: OIG analysis of State survey responses and regulations, 2013.

One Medicaid agency reported that State agencies must award contracts to domestic contractors unless certain circumstances exist—for example, the contractor or subcontractor provides a unique service that is mandatory for the State agency to purchase. The second Medicaid agency reported that all contracts awarded by the State must be performed domestically except when the contracted services cannot be provided within the United States. In such cases, the contractor and subcontractor must specify why these services cannot be performed domestically. Both Medicaid agencies reported that they must approve offshore outsourcing contracts. For more information about the two Medicaid agencies' regulations, see the Appendix.

Similar to the nine Medicaid agencies that allow offshore outsourcing with very few limitations, these two Medicaid agencies do not have requirements that specifically address PHI. However, these two Medicaid agencies include requirements to protect PHI in BAAs with all contractors and subcontractors. In both States, the Medicaid agency contractors must also have BAAs with their respective subcontractors that include similar requirements for protecting PHI.

Both Medicaid agencies reported monitoring contractors and subcontractors. For example, one of the Medicaid agencies reported that all contract requirements are monitored for compliance by the contract administrator and by the State agency responsible for oversight of State contracts.

<sup>21</sup> As noted in Footnote 18, Medicaid agencies may use contract provisions to reiterate and/or expand on requirements they have already specified elsewhere.

<sup>22</sup> Contractors must disclose the location where all services are performed.

*Four Medicaid agencies have requirements prohibiting offshore outsourcing.* Of the four Medicaid agencies with requirements prohibiting the offshore outsourcing of administrative functions, three rely on Executive Orders that prohibit such outsourcing and one relies on contract provisions that prohibit it. All four Medicaid agencies reported monitoring contractors and subcontractors to ensure compliance with the agencies’ regulations. For example, contractors and subcontractors sign attestations of compliance with the Medicaid policies, disclose the location where all work is performed, and/or provide the primary place of business for the contractor or any subcontractor.

**Seven Medicaid agencies reported currently outsourcing Medicaid administrative functions offshore**

Seven of the fifty-six Medicaid agencies reported that they currently outsource administrative functions offshore; all seven of these have requirements allowing offshore outsourcing. As shown in Table 3, all seven Medicaid agencies indirectly outsource offshore, and one of the seven also directly outsources offshore.

**Table 3: Description of the Seven Medicaid Agencies’ Practices for Outsourcing Administrative Functions Offshore**

State Medicaid agency	Form of requirement	Examples of administrative functions outsourced offshore	Type(s) of offshore outsourcing
Florida	State law	IT	Indirect
Massachusetts	Contract provisions	IT	Indirect
Mississippi	Contract provisions	No specific types or examples	Indirect
Missouri	Executive Order	No specific types or examples	Direct and indirect
Montana	Contract provisions	No specific types or examples	Indirect
North Dakota	Contract provisions	IT	Indirect
Rhode Island	Contract provisions	IT	Indirect

Source: OIG analysis of State survey responses and regulations, 2013.

Four of the seven Medicaid agencies reported that the most common type of administrative function that is outsourced offshore relates to IT. For example, a Medicaid contractor in one State reported that it outsourced the Medicaid Management Information System (MMIS) implementation projects to offshore programmers and

software developers.<sup>23</sup> In another State, a domestic contractor used offshore subcontractors to help develop and design a new claims processing system for the Medicaid agency. In this instance, the offshore subcontractor designed programming and systems testing for this new system. The remaining three Medicaid agencies did not report any common type of administrative functions that are outsourced offshore.

All seven Medicaid agencies reported that they do not outsource offshore any administrative functions involving PHI. In fact, some of these seven Medicaid agencies reported that for administrative functions involving PHI, they strongly prefer to outsource only domestically. For example, one of the seven Medicaid agencies explicitly reported denying all requests to send offshore any administrative functions involving PHI.

## CONCLUSION

This memorandum report provides information about the current Medicaid environment for outsourcing administrative functions offshore. As of June 2013, 15 of 56 Medicaid agencies had some form of State-specific requirements that addressed offshore outsourcing. The remaining 41 Medicaid agencies reported no offshore outsourcing requirements and do not outsource administrative functions offshore. Among the 15 Medicaid agencies with requirements, 4 Medicaid agencies prohibit the outsourcing of administrative functions offshore and 11 Medicaid agencies allow it. The 11 Medicaid agencies that allow offshore outsourcing of administrative functions each maintain BAAs with contractors, which is a requirement under HIPAA. Among other things, BAAs are intended to safeguard PHI. These 11 Medicaid agencies do not have additional State requirements that specifically address the safeguarding of PHI. Seven of the eleven Medicaid agencies reported outsourcing offshore through subcontractors, but none reported sending PHI offshore. If Medicaid agencies engage in offshore outsourcing of administrative functions that involve PHI, it could present potential vulnerabilities. For example, Medicaid agencies or domestic contractors who send PHI offshore may have limited means of enforcing provisions of BAAs that are intended to safeguard PHI. Although some countries may have privacy protections greater than those in the United States, other countries may have limited or no privacy protections.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-09-12-00530 in all correspondence.

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<sup>23</sup> MMIS is a claims processing and information retrieval system for Medicaid. All Medicaid agencies operate an MMIS to support program administration and maintain information, such as provider enrollment and claims processing. Medicaid agencies may use a contractor to operate their MMIS. 42 CFR pt. 433.

**APPENDIX: STATE REQUIREMENTS FOR TWO MEDICAID AGENCIES  
THAT ALLOW OFFSHORE OUTSOURCING OF ADMINISTRATIVE  
FUNCTIONS UNDER LIMITED CIRCUMSTANCES**

**State of Missouri's Executive Order**

RECEIVED & FILED

MAR 17 2004

Executive Order  
04-09

  
SECRETARY OF STATE

WHEREAS, Missouri state agencies and political subdivisions procure some goods and services, by contract, through public and private vendor corporations and businesses (collectively, "vendors"); and

WHEREAS, in a limited number of instances, vendors providing services may seek to subcontract or otherwise obtain some of these services from a location outside the United States; and

WHEREAS, such international outsourcing could aggravate unemployment and workforce dislocation of Missouri and United States residents, including industries and jobs this state has expended resources to attract; and

WHEREAS, international outsourcing potentially erodes revenues from the state of Missouri and the United States by drawing away jobs and income; and

WHEREAS, international outsourcing could provide fewer privacy protections for state residents whose personal information may, in the course of service delivery, be transmitted to locations outside the United States.

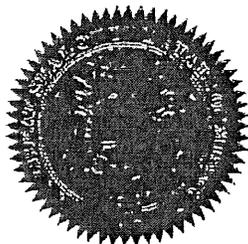
NOW, THEREFORE, I, BOB HOLDEN, GOVERNOR OF THE STATE OF MISSOURI, by virtue of the authority vested in me as governor of the State of Missouri, do hereby order as follows:

1. Each vendor submitting a bid to the State of Missouri shall be required to provide certification of the location where the contracted services are to be performed, and whether the vendor contemplates any of the work necessary to provide the contracted services being performed offshore.
2. The Office of Administration shall direct all current contractors to disclose whether any work pursuant to existing contracts is being performed offshore.
3. If during the term of the contract, the contractor or subcontractor has certified that work will be performed in the United States and proceeds to shift work outside of the United States, the contractor shall be deemed in breach of contract, unless the Office of Administration shall first have determined in writing that extraordinary circumstances require the shift of work or that a failure to shift the work would result in economic hardship to the State of Missouri.
4. No state agency shall award a contract to a vendor who contemplates performing work (or having a subcontractor perform work) pursuant to the contract at a site outside the United States, or does not provide disclosures as required above, unless one of the following conditions is met:
  - a. The vendor or its subcontractor provides a unique good or service; the particular good or service is deemed mandatory for the purposes of the purchasing agency; and no comparable domestically-provided good or service can adequately duplicate the unique features of the good or service provided by the vendor or its subcontractor; or
  - b. The vendor or its subcontractor is a foreign firm hired to market Missouri services or products to a foreign country; or
  - c. A significant and substantial economic cost factor exists that outweighs the economic impact of providing the function or professional services within the United States, such that a failure to use the vendor or subcontractor's services would result in economic hardship to the State of Missouri; or

APPENDIX (continued)

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d. The vendor or its subcontractor maintains a significant business presence in the United States and only performs a trivial portion of work under the contract outside of the United States.



ATTEST:

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 17<sup>th</sup> day of March 2004.

  
\_\_\_\_\_  
Bob Holden  
Governor

  
\_\_\_\_\_  
Matt Blunt  
Secretary of State

**APPENDIX (continued)**

**State of New Jersey's State Law**

**New Jersey Statutes Annotated 52:34-13.2: State contracts, services performed within U.S.; exceptions.**

1. a. Every State contract primarily for the performance of services shall include provisions which specify that all services performed under the contract or performed under any subcontract awarded under the contract shall be performed within the United States.

b. The provision of subsection a. of this section shall not apply whenever:

(1) the Director of the Division of Purchase and Property or the Director of the Division of Property Management and Construction, as appropriate, certifies in writing a finding that a service is required by the Executive Branch of the State and that the service cannot be provided by a contractor or subcontractor within the United States and the certification is approved by the State Treasurer;

(2) the contracting officer for the Legislature or for any office, board, bureau or commission within or created by the Legislative Branch certifies in writing a finding that a service is required by the Legislature or the office, board, bureau or commission within or created thereby and that the service cannot be provided by a contractor or subcontractor within the United States and the certification is approved by the appropriate legislative authority;

(3) the contracting officer of any independent State authority, commission, instrumentality or agency certifies in writing a finding that the service required by the independent State authority, commission, instrumentality or agency cannot be provided by a contractor or subcontractor within the United States and the certification is approved by the executive director or other equivalent authority of that authority, commission, instrumentality or agency; or

(4) any of the directors or contracting officers in paragraphs (1) through (3) of this subsection b., as may be applicable, certifies in writing a finding that inclusion in the State contract of a provision as described in subsection a. of this section with respect to the performance of a service required by their contracting entity under the State contract would violate the terms, conditions, or limitations of any grant, funding or financial assistance from the federal government or any agency thereof, and the certification is approved by the appropriate approval officer.

As used in this section, "State contract" means every contract entered into by (1) the Governor, the head of any of the principal departments in the Executive Branch of the State Government, and the head of any division, board, bureau, office, commission or other instrumentality within or created by such department. (2) the contracting officer of the Legislature of the State and any office, board, bureau or commission within or created by the Legislative Branch, and (3) the head or contracting officer of any independent State authority, commission, instrumentality or agency within or created by such an authority, who is authorized to enter into contracts that include the performance of services. A county, municipality or school district shall not be deemed an agency or instrumentality of the State for the purpose of this section. L.2005,c.92,s.1.

decision.<sup>11</sup>

### III.

When considering an application for judicial review, appropriate deference must be given to the agency.<sup>12</sup> A “fundamental tenet of administrative law” is that “administrative decisions are to be made by the agencies not the courts...court interference with any agency determination is extremely rare.”<sup>13</sup> The party challenging the agency action has the burden of demonstrating the invalidity of that action.<sup>14</sup> A reviewing court will only grant relief when an agency has exceeded its legal authority, it acts capriciously, arbitrarily or unreasonably, abuses its discretion, it does not support its factual decisions with substantial evidence, or its actions are otherwise affected by some other error of law.<sup>15</sup> A decision is “arbitrary” or “capricious” if it is made without regard to the law or underlying facts.<sup>16</sup> A decision is “unreasonable” if it is against reason and evidence, “as to which there is no room for difference of opinion among reasonable minds.”<sup>17</sup> An “abuse of discretion” is “synonymous with unreasonableness, and involves a lack of rationality, focusing on whether the agency has made a decision clearly against reason and evidence.”<sup>18</sup> Judicial review is limited to “final agency action” only.<sup>19</sup>

The court will overturn an agency decision based on factual determinations that are vested in the discretion of the agency only when that decision is not supported by substantial evidence.<sup>20</sup> “Evidence is substantial if a reasonable person would find it adequate to reach the given conclusion, even if a reviewing court might draw a contrary inference.”<sup>21</sup> When an agency has been vested with the discretion to make factual determinations, “it follows that application of the law to the facts is likewise vested by

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<sup>11</sup> JA Tab 15.

<sup>12</sup> *Marovec v. PMX Industries*, 693 N.W.2d 779, 782 (Iowa 2005); Iowa Code § 17A.19(11)(c).

<sup>13</sup> *Leonard v. Iowa State Bd. Of Educ.*, 471 N.W.2d 815, 816 (Iowa 1991).

<sup>14</sup> Iowa Code § 17A.19(8)(a).

<sup>15</sup> Iowa Code § 17A.19(10).

<sup>16</sup> *Norland v. Iowa Dep't of Job Serv.*, 412 N.W.2d 904, 912 (Iowa 1987).

<sup>17</sup> *Id.*

<sup>18</sup> *Dico, Inc. v. Iowa Employment Appeal Board*, 576 N.W.2d 352, 355 (Iowa 1998).

<sup>19</sup> Iowa Code § 17A.19(1).

<sup>20</sup> Iowa Code § 17A.19(10)(f).

<sup>21</sup> *Burns v. Board of Nursing*, 495, N.W.2d 698, 699 (Iowa 1993).