**ADMINISTRATIVE REVIEW REQUEST 1:**

**Question 10 – Experience with Medicaid Populations.** This question is weighted to prefer out-of-state managed care companies and effectively makes new Oklahoma provider-led entities unable to compete if not excluded from the competitive process entirely. The requirements are as follows: “Describe your organization’s experience serving the Medicaid populations covered under SoonerSelect in Oklahoma and/or other states, if applicable… As part of your response, provide examples of innovative programs and initiatives implemented in Oklahoma and/or other states, results achieved, and data collected to document and measure those results... Include the completed Other State Medicaid Experience form. Describe your organization’s experience in the State of Oklahoma serving publicly- and privately funded populations, including examples of implemented programs and results achieved and how they will be integrated into your strategy for *serving Enrollees.. Include the completed Oklahoma Experience form.”* The owner providers that make up the EGAAS provider-led entity have been serving this population for decades and have arguably the most experience with their own Oklahoma patients as any bidder in this process. While the question of experience with the Medicaid population is relevant, the requirement that it is constrained to only the entity responding means that EGAAS (or any new provider-led entity) will not be able to respond to this question adequately. This question requires historical information a newly formed entity cannot show. This question also places an Oklahoma provider-led entity at a scoring disadvantage with established multi-state agencies not because they do not have the necessary Medicaid experience but because of how the question is written.

**RESPONSE 1:**

The requirements of these questions are intended to demonstrate the experience of a bidder organization in providing services to the Medicaid population. This requirement provides an opportunity to present examples of the bidder organization’s experiences with the Medicaid population in an in-state capacity, out of state capacity or a combination of the two capacities. This requirement should not be interpreted to mean that out of state experiences will be weighted greater than in-state experiences. Rather, the intent is to allow the bidder organization to provide a variety of experiences to highlight its experience serving Medicaid populations. To clarify as it relates to bidder organizations that may be newly formed and/or bidding as a Provider Led Entity, this question is intended to allow for the individual provider entities that comprise the bidder organization to leverage their experience in Oklahoma as well as other states that they may have experience in. Experience from the individual provider entities that comprise the bidder organization in providing services to Medicaid populations will be reviewed and scored with equal weight as those organizations with experience in Oklahoma and other states.

**ADMINISTRATIVE REVIEW REQUEST 2:**

**Questions 7 &11- References**. These questions appear to be pass/fail items; meaning they are a minimum threshold and if the entity cannot provide them they will be eliminated from the process. Both require, at a minimum, a bidder to provide references of past performance including, for example, the language that a bidder provide, “At least three (3) references related to the Bidder’s performance of a contract with a governmental entity or agency covering Medicaid Populations.” This means that any bidder must have at least three other state contracts in order to be considered for a contract with Oklahoma. This requirement itself effectively eliminates any new provider-led entity and any new company, as they cannot meet this minimum requirement. This is not in line with the legislature’s intent and unfairly restricts competition. As Medicaid providers, each provider within the provider-led entity has individual contracts with a governmental entity and can show compliance in other ways. The way this question is written, it restricts those avenues of response.

**RESPONSE 2:**

This question should be interpreted to allow for the individual provider entities that comprise the bidder organization to leverage their experiences with government entities or agencies serving Medicaid or indigent populations. For newly formed organizations and/or organizations bidding as a provider led entity, OHCA will consider these individual references as attributable to the bidder organization. Alternatively, OHCA would also consider references from major funders who have funded projects with the individual provider organizations that are now a part of the bidder organization. A major funder may include, but not be limited to, an organization that has provided funds to the individual provider organization in excess of $1,000,000.

**ADMINISTRATIVE REVIEW REQUEST 3:**

**Question 14 – Financial Information**. This too appears to be a pass/fail requirement. This question requires bidders to provide “a copy of the Bidder’s audited or reviewed financial statements (preferably audited) prepared by an independent Certified Public Accountant for each of the last three (3) years.” A newly formed entity will not have three years of financial statements (audited or unaudited). As written, this question precludes an entity from providing other forms of documentation showing financial stability, which would allow a newly formed entity to respond in such a way that meets the necessary qualification of financial health, but does not unfairly restrict competition.

**RESPONSE 3:**

This question should be interpreted, in the case of newly formed bidder organization bidding as a provider led entity, that OHCA will accept three (3) years of audited or reviewed financial statements prepared by an independent Certified Public Accountant for each of the individual provider entities that comprise the bidder organization.

**ADMINISTRATIVE REVIEW REQUEST 4:**

**Question 24 – *Mandatory, Voluntary and Excluded Populations****.* This question requires that a bidder provide the “Mandatory, Voluntary and Excluded Populations” that the entity does not have experience covering under a risk-based Medicaid managed care contract. EGAAS, a newly formed managed care entity will be required to reply “all populations” which will score lower, because it does not have a current managed Medicaid contract. Again, as written, this question relies on past performance as a managed care entity and does not allow a new provider-led entity or its aligned partners to demonstrate competency in this area. Therefore as written, it is exclusionary to a newly formed entity and limits competition.

**RESPONSE 4:**

This question shall be interpreted, in the case of a newly formed organization bidding as a provider led entity, that OHCA will consider experience of the individual provider organizations that comprise bidder organization in serving Medicaid populations. Experience should be limited to risk-based contracting, care coordination models or shared savings models focusing on improved health outcomes.

**ADMINISTRATIVE REVIEW REQUEST 5:**

**Question 42 – Enrollee Information**. This question requires a bidder to detail examples of social media engagement and strategy implemented previously by each bidder. Specifically the question requires bidders to “provide an example of an innovative approach you took to improve Enrollee health outcomes through social media, mobile applications or website, the results achieved and how you will apply this experience to the SoonerSelect Program.” A newly formed provider-led entity cannot respond to this question, as it does not have past experience as an entity. The question precludes other avenues of meeting the intent of the requirement. This unfairly disadvantages a newly formed entity, which is in direct contradiction to the legislature’s intent.

**RESPONSE 5:**

This question should be interpreted, in the case of newly formed bidder organization bidding as a provider led entity, that OHCA will accept engagement strategies from the individual provider organizations that comprise such bidder organization.

**ADMINISTRATIVE REVIEW REQUEST 6:**

Question 55 – Transition of Care. This question requires a bidder to “Describe your relevant experience and proposed approach for completing Transition of Care activities in accordance with requirements outlined in Contract Section 1.10.” As written, a newly formed entity will not be able to respond. However, as all provider owner/members of EGAAS currently provide this care as Medicaid providers, the collective experience could be demonstrated to meet the intent of the question, but is not allowed as written. As written, new provider-led entities will subsequently be unfairly disadvantaged when competing with out-of-state managed care plans.

**RESPONSE 6:**

This question should be interpreted, in the case of newly formed bidder organization bidding as a provider led entity, that OHCA will accept strategies and experience from the individual provider organizations that comprise the bidder organization.