IN THE COMMONWEALTH COURT OF PENNSYLVANIA

Aetna Better Health of Pennsylvania Inc., Petitioner	:	
v.	:	No. 351 M.D. 2016
	:	Argued: July 6, 2016
Commonwealth of Pennsylvania, Department of Human Services, Respondent	:	

BEFORE: HONORABLE P. KEVIN BROBSON, Judge

OPINION NOT REPORTED

MEMORANDUM OPINION
BY JUDGE BROBSON **FILED: July 19, 2016**

Before the Court is Petitioner Aetna Better Health of Pennsylvania's (Aetna) emergency application for special relief in the nature of a special injunction and preliminary injunction (Application for Preliminary Injunction), in which Aetna requests this Court to stay any negotiation, execution, and/or implementation of contracts awarded pursuant to the Commonwealth of Pennsylvania, Department of Human Services'[1] (DHS) Request for Proposals

[1] The Department of Human Services (DHS), formerly known as the Department of Public Welfare (DPW), is the state agency that administers the Commonwealth's Medicaid program. *Commonwealth v. TAP Pharmaceutical Products, Inc.*, 36 A.3d 1112, 1122 (Pa. Cmwlth. 2011), *vacated on other grounds*, 94 A.3d 364 (Pa. 2013). "Medicaid is a joint state-federal funded program for medical assistance [(MA)] in which the federal government approves a state plan for the funding of medical services for the needy and then subsidizes a significant portion of the financial obligations the state agreed to assume." *Id.* DHS delivers Medicaid benefits in Pennsylvania through either (1) a "fee for service" payment program, where the provider of the care is paid by DHS on a claim-by-claim basis; or (2) a "managed care" **(Footnote continued on next page...)**

No. 06-15 (RFP 06-05), through which DHS requested proposals from managed care organizations (MCOs) for the delivery of physical health services to persons eligible for health care coverage under HealthChoices. As part of its application, Aetna further requests that any existing contracts between DHS and MCO's for the delivery of physical health services under HealthChoices, including those contracts entered into with Aetna, which were in effect prior to DHS's April 27, 2016 award pursuant to RFP 06-15, shall remain in force until further order of Court and that this matter be resolved on an expedited basis.

I. BACKGROUND

The following facts regarding HealthChoices, RFP 06-15, and DHS's evaluation and selection process pertaining to RFP 06-15 appear to be undisputed by the parties.

HealthChoices is divided into five geographic "zones" in Pennsylvania—Northeast, Southeast, Lehigh-Capital, Southwest, and Northwest. DHS contracts with MCOs to administer health benefits and services in each zone through HealthChoices to Pennsylvanians who are eligible for Medicaid.[2] Aetna is

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program, where a managed care organization (MCO), under contract with DHS, is paid on a monthly, fixed-fee basis per enrollee, and the MCO pays the provider pursuant to the terms of an agreement between the MCO and the provider. *Armstrong Cnty. Memorial Hosp. v. Dep't of Pub. Welfare of the Cmwlth. of Pa.*, 67 A.3d 160, 163 (Pa. Cmwlth. 2013). Pennsylvania's Medicaid managed-care program is known as HealthChoices.

[2] Section 443.5 of the Human Services Code, Act of June 13, 1967, P.L. 31, added by the Act of July 15, 1976, P.L. 993, 62 P.S. § 443.5, relating to prepayment for contracted medical services, authorizes DHS to enter into contracts with insurers, such as MCOs, through a competitive bidding process. Section 443.5 of the Human Services Code provides, in relevant part:

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currently contracted with DHS to provide health benefits and administrative services under HealthChoices to enrollees in all five zones in Pennsylvania and, pursuant to that contract, provides benefits to more than 200,000 enrollees.[3]

On September 16, 2015, DHS issued RFP 06-15 to commence a competitive bidding process to select MCOs to administer HealthChoices in all five zones beginning in 2017. RFP 06-15 provides that DHS will award contracts to up to five MCOs for each zone, with initial contract terms of three years. (RFP 06-15, § I-5.) In addition to meeting other qualifications, in order to qualify as a responsible offeror the MCO must make a "technical" submission that receives a total score of at least 70% of the available points allotted in the evaluation. (RFP 06-15, § III-5.) RFP 06-15 identifies the following criteria to be used in evaluating proposals: (a) technical criteria with a weight of 80% of the total points; (b) Small Diverse Business Participation (SDBP) with a weight of 20% of the total points; and (c) Domestic Workforce Utilization consisting of "bonus points" with a maximum of 3% of the total points for RFP 06-15. (RFP 06-15, § III-4.)

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> For categorically needy or medically needy persons eligible for medical assistance, prepaid capitation payments or insurance premiums for services under the medical assistance State plan may be made on behalf of eligible persons *through competitive bidding* with profit or non-profit contractors, insurers, or health maintenance organizations. Profit and non-profit insurers must be approved under applicable State laws.

(Emphasis added.)

[3] Aetna has had a contract to provide these services in two zones since 2010, and it has had a contract with DHS to provide those services in all five zones since 2013.

Aetna submitted a proposal in response to RFP 06-15 to provide services in all five zones. By letter dated April 27, 2016, DHS's Division of Procurement notified Aetna that DHS had accepted Aetna's proposal for the Northwest zone only, rejecting Aetna's proposals for the other four zones.[4] The letter provided no reason for rejecting the proposal as to the other four zones, except that Aetna's proposals in those zones "were not among those proposals determined to be most advantageous to the Commonwealth." (DHS letter, dated 4/27/16, attached to Petition for Review (PFR) as Exhibit "B.") DHS issued a press release that same day, announcing that, in addition to selecting Aetna for the Northwest zone, DHS selected three other MCOs for the Northwest zone, four MCOs for the Northeast zone, and five MCOs in each of the three remaining zones (Southeast, Lehigh-Capital, and Southwest). (DHS press release, dated 4/27/16, attached to PFR as Exhibit "C.")

By letter dated May 4, 2016, Aetna filed a bid protest and requested a stay of the procurement and a debriefing conference. DHS representatives met with Aetna representatives on May 9, 2016, for a debriefing conference. During the debriefing conference, DHS informed Aetna that Aetna's total evaluation point score ranked in the top five in the Southeast, Lehigh-Capital, and Southwest zones and in the top four in the Northeast zone. DHS, nonetheless, bumped Aetna in favor of lower ranked offerors for those zones because of what the parties refer to as the "heritage factor." Using the "heritage factor," DHS selected for contract negotiation responsible offerors who had at least 25% of the market share in each

[4] Most of the Medicaid enrollees that Aetna currently serves under HealthChoices reside in the four zones for which Aetna's proposal was rejected.

zone, regardless of where they ranked in scoring. As a result, DHS selected some offerors who did not score in the top four (Northeast zone) or top five (Southeast, Lehigh-Capital, Southwest and Northwest) in terms of evaluation criteria, bumping others that had. DHS maintained that it applied the "heritage factor" in order to avoid disruption to HealthChoices enrollees. DHS did not disclose in RFP-0615 that it would be applying this "heritage factor" in selecting MCOs for HealthChoices.

By letter post-marked May 25, 2016, and in response to Aetna's bid protest, DHS informed Aetna that the statutory bid protest procedures under the Commonwealth Procurement Code (Procurement Code), 62 Pa. C.S. §§ 101-2311, do not apply to RFP 06-15, because "it is not a procurement within the scope of [the Procurement Code]."[5] (DHS letter, post-marked 5/25/16, attached to PFR as

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[5] Section 1711.1 of the Procurement Code, 62 Pa. C.S. § 1711.1, relating to protests of solicitations or awards, provides, in part:

> (a) Right to protest.--A bidder or offeror, a prospective bidder or offeror or a prospective contractor that is aggrieved in connection with the solicitation or award of a contract, except as provided in section 521 (relating to cancellation of invitations for bids or requests for proposals), may protest to the head of the purchasing agency in writing.
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> . . . .
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> (k) Stay of procurement during pendency of protest.--In the event a protest is filed timely under this section and until the time has elapsed for the protestant to file an appeal with Commonwealth Court, the purchasing agency shall not proceed further with the solicitation or with the award of the contract unless and until the head of the purchasing agency, after consultation with the head of the using agency, makes a written determination that the protest is clearly without merit or that award of the contract without delay is necessary to protect substantial interests of the Commonwealth.
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> (l) Applicability.--This section shall be the exclusive procedure for protesting a solicitation or award of a contract by a bidder or offeror a prospective

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Exhibit "G.") DHS also declined to stay the procurement. (*Id.*) Aetna then filed a petition for review in this Court's original and appellate jurisdiction.[6] Aetna characterized its dual jurisdiction petition for review as (1) a complaint for declaratory judgment and writ of mandamus in the Court's original jurisdiction and, alternatively, (2) as an appeal in this Court's appellate jurisdiction from a final agency determination that the Procurement Code is not applicable to this procurement process and, therefore, Aetna cannot challenge DHS's final determination under the Procurement Code.

In addition to the facts set forth above, Aetna alleges in its petition for review that DHS's application of the "heritage factor" constitutes a "secret criterion, implemented contrary to Pennsylvania law, [which] favored only offerors with large market shares in each affected region." (PFR ¶ 2.) Aetna further alleges that it submitted its protest and requested a stay pursuant to the Procurement Code and that DHS's refusal to consider the protest and request for stay under the provisions of the Procurement Code also was contrary to law and contrary to DHS's own prior practices.[7] (PFR ¶ 3.) Aetna takes the position that DHS's

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> bidder or offeror, or a prospective contractor that is aggrieved in connection with the solicitation or award of a contract. The provisions of 2 Pa.C.S. (relating to administrative law and procedure) shall not apply to this section.

[6] Out of an abundance of caution, Aetna also filed an appeal with DHS's Bureau of Hearings and Appeals (BHA), seeking review of DHS's determination. (Petitioner's App. for Special Relief at 20 n.4.)

[7] Aetna specifically avers as follows:

> Since 1997, DHS has repeatedly issued requests for proposals and has entered into contracts with MCOs to administer the HealthChoices program. This is always done through a competitive bidding process. Historically, DHS

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"highly unusual course of conduct . . . constitutes a clear violation of Pennsylvania law," entitling Aetna to declaratory and injunctive relief and an immediate stay of DHS's decision as to RFP 06-15. (PFR ¶ 4.) Without such relief, Aetna alleges it will suffer irreparable harm, including denial of due process and statutory rights, disruption of services and business, and the immeasurable loss of opportunity in the marketplace. (*Id.*) Aetna alleges that DHS is proceeding to negotiate and finalize MCO contracts with the successful offerors, including those who were awarded contracts due solely to application of the illegal and arbitrary "heritage factor." (PRF ¶ 32.) Finally, Aetna alleges that, as a result of the legal improprieties in DHS's evaluation process and DHS's denial of Aetna's due process rights under the Procurement Code,

> Aetna would have to unwind extensive business operations presently serving over 180,000 enrollees, state-wide. Jobs and vendor relationships will be lost and compromised. Aetna would be denied its existing business opportunities, and foreclosed from expanding those opportunities over the next three . . . years, which it should have had the opportunity to do, if it was properly determined to be a winning offeror on the merit of its proposal.

(PFR ¶ 33.)

Aetna thereafter filed its Application for Preliminary Injunction. DHS filed an answer, in which it reiterated its position that the Procurement Code does not apply to RFP 06-15. In support of that position, DHS contends that

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> recognized that unsuccessful offerors—including Aetna in some instances—had the right to protest DHS's decision under the provisions of the Procurement Code.

(PFR ¶ 12.)

HealthChoices contract constitutes a "medical assistance provider agreement" or a grant, both of which are excluded from the Procurement Code by Section 102(e) and (f) of the Procurement Code, 62 Pa. C.S. § 102(e) and (f), respectively. DHS also avers that Aetna cannot meet the standards for special relief in the form of a preliminary injunction or stay.

This Court conduced a hearing on Aetna's Application for Preliminary Injunction on July 6, 2016. Aetna presented the testimony of Jason Rottman, Aetna's Chief Executive Officer. Mr. Rothman explained that Aetna is a Medicaid MCO engaged in the business of administering health benefits on behalf of the Commonwealth for Medicaid members assigned to it. (Notes of testimony 7/6/16 (N.T.) at 14.) Aetna does not operate anywhere other than Pennsylvania, and it has offices in the Philadelphia, Harrisburg, Blue Bell, Pittsburgh areas. (*Id.*) It employs approximately 230 employees, eighty of whom work from the main office and the rest of whom work in satellite offices or from their homes. (*Id.* at 15.) Mr. Rottman testified regarding Aetna's organizational structure and the functions of its various departments. (*Id.* at 15-19.) Aetna has been in business in Pennsylvania since 2010 and currently has contracts with DHS. (*Id.* at 19.) Mr. Rottman explained that under the current HealthChoices contracts, Pennsylvania is divided into five regions, or zones, and each zone is a separate contract. (*Id.*) Aetna is currently doing business in all five zones, so it has five contracts with DHS. With the exception of the difference in zones, he contracts are basically the same. (*Id.* at 19-20.) When asked what services Aetna provides under those contracts with DHS, Mr. Rottman explained:

> So, we are contracted with the State to administer the health benefits. So, essentially, the State determines what is a covered benefit under Medicaid. They contract with Medicaid Managed Care Organizations, and then

> assign member to us, and then we are contracted to take care of those members and administer the benefit, basically, and you know, help them navigate the system and determine what's covered, oversee to make sure that what is being provided is medically sound and meets criteria that is established.

(*Id.* at 21.)

With regard to the number of enrollees, Mr. Rottman testified that Aetna services approximately 200,000 enrollees spread throughout the state, with a bit of a concentration in the Southeast zone. (*Id.*) "About 800,000 of the 2.2 million Medicaid members on a statewide basis are in the Southeast region." (*Id.* at 22.) Aetna has more in the Southeast zone than all of the other zones, which have varying volumes of members. (*Id.*) The Northwest zone of the state—the Erie region—has the smallest Medicaid population by quite a large amount, and it is Aetna's smallest zone with just over 18,000 enrollees, representing just 9% of Aetna's overall membership. (*Id.* at 22-23.) When asked whether the population of Medicaid enrollees serviced by Aetna has grown over the years, Mr. Rottman responded:

> Absolutely. It's grown quite substantially, actually. So, in 2010, when we started in the program [Aetna] was in the Southeast and Leigh-Cap[ital z]ones, only, so we were in two zones. In around 2012, [our] parent corporation . . . purchased CoventryCares, another Managed Care Organization, and within Pennsylvania that organization had business in the other three zones. When we acquired that company and we brought that business in, then we really substantially grew. We almost doubled our membership at that point. And then beginning in January of 2015, the State embarked on the healthcare expansion program, commonly called Obama Care, [which it] implemented, and when that was done, the Medicaid enrolls have grown quite a bit since January, 2015, and Aetna has also grown quite a bit in

> the last eighteen months, acquiring, they call them, the newly eligible members.

(*Id.* at 23.)

With regard to how Aetna's contracts with DHS work in terms of funding, Mr. Rottman testified that Aetna is paid on a "per member per month" (PMPM) basis and is assigned members. (*Id.* at 24.) The Commonwealth basically pays the negotiated PMPM fee to Aetna, and in return Aetna is responsible to cover all of the covered care costs for that member. (*Id.*) The dollar amount of the PMPM is set by the Commonwealth and varies by member. (*Id.*) Aetna is also responsible for determining what is covered and ensuring that the benefit is being administered appropriately under the law and the terms of the contract with DHS. (*Id.*)

As to the timing of RFP 06-15, Mr. Rottman testified that Aetna submitted a proposal in mid-November 2015, with the expectation that new contracts would become effective in January 2017. (*Id.* at 29.) According to Mr. Rottman, DHS indicated that awards were likely to be announced at the end of January 2016, but they were not announced until the end of April 2016. (*Id.* at 30-31.) Mr. Rottman's testimony regarding what transpired following DHS's announcement of its awards is consistent with the facts set forth above. With regard to DHS's application of the "heritage factor," Mr. Rottman testified that during the debriefing conference DHS expressed some concern about member disruption, but DHS "did not specify what [it] determined disruption would be, in what form, or what [it] thought might occur." (*Id.* at 41.) DHS also did not explain when DHS conceived the "heritage factor" or when DHS decided to apply it in the bid process. (*Id.* at 41-42.) Aetna had not been given any opportunity to challenge or comment upon the application of the "heritage factor" in this context.

(*Id.* at 42.) When asked whether he could think of any way that care to Medicaid enrollees could be disrupted if an MCO with a large market share was displaced from a particular zone where there are at least five other MCOs in operation supplying the same service, Mr. Rottman responded that disruption would be "unlikely." (*Id.*) He explained:

> So, again, we don't provide care. We are the insurance company, basically. So the people who provide care are the doctors and the hospitals. And within Medicaid, we have networks like they do in commercial insurance, but one thing I will point out is that Medicaid, providers who provide Medicaid, provide Medicaid to a big extent under contract with almost all of the MCOs. There are some exceptions to that, obviously, but in general, that's the case. And so, a member would, basically, get a new I.D. card. They wouldn't even have to change doctors. The doctor they had, there would be another MCO that would have that doctor in their network. They could choose that MCO, and they'd have someone else's I.D. card, but their care would be continued under the same actual provider.

(*Id.* at 42-43.)

With regard to the availability of the remedy of a bid protest in other years, Aetna testified that, in 2012, it had bid in response a request for proposal for the same type of business in other zones, but it was not successful at that time. (*Id.* at 46.) It submitted a bid protest, which DHS allowed to proceed. (*Id.*) While not successful in the protest itself, Aetna went through the entire bid protest process without any objection by DHS (then DPW). (*Id.*)

Mr. Rottman reiterated that Aetna is not a licensed healthcare provider and "is, effectively, an insurance company that provides coverage and benefits management to Medicaid recipients as a contractor to [DHS]." (*Id.* at 47.)

As to the impact of the current situation on Aetna, Mr. Rottman testified that he understands that DHS plans to send contracts to the MCO's in

early-to-mid July 2016. (*Id.* at 50.) The situation has significantly affected employee morale, and the Aetna employees are very concerned. (*Id.* at 50-51.) Some employees have resigned due to concerns regarding job security and have obtained employment elsewhere. (*Id.* at 51.) It has affected Aetna's "ability to drive [its] business and gain membership through contact initiatives [and] through other outreach initiatives." (*Id.* at 55.) Aetna has encountered reluctance on the part of providers, community organizations, and others to partner in the area of community outreach. (*Id.*) As a result, there has been a direct impact on Aetna's ability to contract business. (*Id.*) Relationships with vendors have also been affected, as some vendors have expressed concerns that they may need to lay off employees. (*Id.* at 56.)

When asked, how it would affect Aetna's business operations if Aetna is left only with the option of operating in the Northwest zone, Mr. Rottman responded:

> [I]t would have a really dramatic effect. As I mentioned before, we would lose 91 percent of our business from a membership standpoint. And maybe more to the point, with 18,000 members, which is what we'd be left with in the Northwest, there would have to be some real considerations to whether that's a viable ongoing operation. One of the things in, sort of, the risk insurance business is you have to have a large enough pool to be actuarially sound. 18,000 members is well below what, normally, you would look to to be a stable organization. And while it might be workable, and we still have not yet finally made that decision, I think, certainly, if we were left with 18,000 members there would be quite serious consideration whether we'd be staying in the Commonwealth in this business.
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> . . . .
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> In any of those scenarios, we would have to consider layoffs, but obviously, if we shut the business down

> entirely, then we would have to consider quite a few, if not all of them.

(*Id.* at 57-58.)

Mr. Rottman further testified that DHS's decision not to award Aetna a contract in four zones

> would put [Aetna] back to square one, basically. We'd be losing 91 percent of the business, so that would be completely wiped away. And then I would add that in the Northwest, there's some very strong business dynamics there. So, for starters, there's only 160,000 Medicaid lives in the entire zone, it's by far the smallest zone, so there's very few Medicaid lives to begin with. That's compounded by the fact that there's an MCO that has a very good brand name, it has fifty-some percent of the market share. Taking that business from them is very challenging, given their brand recognition and their entrenchment in the market already. So, it would be really a challenging situation.

(*Id.* at 58-59.) Moreover, he testified that it would be very difficult for Aetna to return to the market if it was offered a chance to bid on this business again in three to five years. (*Id.* at 59.) He explained:

> So, one of the things is that, obviously, this, like any other business, is a relationship business, and that relationship is with both the providers, community organizations, et cetera. If you exit the market for a substantial period of time, three, five years, you're going to lose those business relationships and those contacts. Additionally, Medicaid tends to be a somewhat entrenched market, so if you have no market share and you're coming into the market, it's very hard to garner new membership at a substantial rate if you're effectively having to take it from other MCOs who already have those relationships. So, coming back into the market as a new entrant is very, very challenging.

(*Id.* at 59.)

On cross-examination, Mr. Rottman agreed that Aetna's response to RFP 06-15 includes an integrated care management model (ICM), which indicates a holistic, bio-psycho-social view of the member. (*Id.* at 66.) Mr. Rottman agreed that the ICM process involves "data collection, analysis, identification, assessment, individualized care panning, coordination and management, and monitoring, that helps [Aetna] ensure members['] appropriate use emergency services." (*Id.*) He further agreed that it also involves coordinating "care with behavioral health MCOs to manage members who have serious and persistent mental illness or substance abuse issues" and managing "transition of care." (*Id.*) He reiterated, however, that Aetna is a provider of managed healthcare services, like and insurer—not an actual healthcare provider. (*Id.*) Aetna recognizes that "the Medicaid population is very vulnerable" and that many of the members "have bio-psycho-social issues that impact their ability to understand discharge planning on the treatments of care." (*Id.* at 66-67.) As a result, Aetna takes "a holistic view to understand that the member[s have] issues outside of their physical health conditions, potentially, that are driving their ability to navigate and access the healthcare continuum and be an active participant in their care." (*Id.*) Aetna works with them to navigate the system and aid members in the understanding of their benefits and appropriate ways to treat them. (*Id.* at 67.) Aetna is not a licensed healthcare provider, does not provide care, and does not prescribe anything, although it has case managers working in the communities to provide face-to-face case management with members, which can be more effective than other means of case management. (*Id.* at 67-68.)

Mr. Rottman also testified on cross-examination that Aetna has a special needs unit, which assists members on a short-term basis navigate to the

right ultimate provider. (*Id.* at 69.) It also ensures that members receive essential screenings and treatments through Early Periodic Screening, Diagnostic and Treatment (EPSTD), which helps monitor the needs of those with chronic conditions. (*Id.*) Aetna works with its provider network for these types of screenings and treatments and does not provide EPSTD itself. (*Id.*) Aetna works with providers to makes sure that the treatment plan is appropriate; if Aetna believes something needs to be added, it can advocate for that service or treatment. (*Id.* at 72.)

Mr. Rottman further acknowledged on cross-examination that beginning on January 1, 2017, MCOs subject to RFP 06-15 were going to be required to provide additional services, such as targeted case management services for person with AIDS and HIV. (*Id.* at 74.) MCOs will also be required to provided additional services, such as coordination of physical health and behavioral health services, clinical quality improvement programs, special needs units, assistance to members to access health records, all of which Aetna currently provides as part of being an MCO. (*Id.* at 74-76.)

On cross-examination, Mr. Rottman also acknowledged that the copy of the Articles of Incorporation for Aetna attached to Aetna's proposal in response to RFP 06-15 provides that "[t]he corporation shall establish, maintain, and operate a Health Maintenance Organization to provide comprehensive and basic health services as well as additional services to subscribers within the geographical area of the Commonwealth of Pennsylvania." (*Id.* at 77.)

Mr. Rottman further testified on cross-examination that he was aware that Aetna also requested a hearing with DHS's Bureau of Hearings and Appeal (BHA), but that BHA has inquired of Aetna as to whether BHA has jurisdiction

over the matter. (*Id.*) Although Aetna believes that BHA is not the proper place for its protest, it appealed to BHA to protect its rights. (*Id.*)

Aetna also called Barry Bowman, who is employed by DHS, Bureau of Managed Care Operations. (*Id.* at 86.) Mr. Bowman testified that he is the project manager for RFP 06-15. (*Id.*) Mr. Bowman provided testimony, consistent with the Court's summary above, regarding RFP 06-15, DHS's evaluation of the request for proposal and awards to successful offerors, and DHS's actions in response to Aetna's protest. With regard to the application of the "heritage factor," he testified:

> There was concern that if we got a large number of bids that the possibility would exist that we could have a Heritage . . . plan . . . that had a significant membership within a zone, actually placed outside of the scoring rankings. So, at that point we discussed how acceptable it would be for us to transition a very large percentage of one of our zones to new MCOs, if they failed to score in the higher rankings to be selected. [DHS] didn't find that acceptable, because transitioning a huge number of people within a population like that involves a lot of clinical oversight, and plans with populations of that size tend to have sicker populations, they have a higher number of sicker people, or high acuity population, so it ends up being we have to monitor the transition of that care, because oftentimes a new MCO might not have those folks' doctors, they might not have that facility in contract. So, there[are] serious clinical concerns with transitioning a large percentage of the population like that.

(*Id.* at 90-91.) Mr. Bowman testified that, despite concern regarding disruption, DHS did not disclose the concern in RFP 06-15. (*Id.* at 93.) Instead, DHS used language that it would "select the most advantageous offeror," rather than select solely based on score. (*Id.*) DHS did not include any reference to the heritage factor in RFP 06-15, because it did not believe that MCOs with less than 25% of a

market share would be able to make a better proposal if they knew of the potential application of the heritage factor, and MCOs who had 25% or more of a market share may be inclined to submit a mediocre proposal and automatically be admitted into the program. (*Id.* at 93-94.)

With regard to the types of services that MCOs provide under HealthChoices, Mr. Bowman testified on cross-examination that MCOs are responsible to provide all medically-necessary services for which enrollees are eligible, including "a long list of in-plan services that are fundamentally the MCO[s'] responsibility." (*Id.* at 122.) MCOs provide clinically-oriented services and are responsible for making utilization management decision, such as whether a treatment is medically necessary, in order to determine if payment is required under the plan. (*Id.*) MCOs have medical doctors, clinical nurses, and clinically-oriented people to make those determinations. (*Id.*) MCOs must provide targeted case management for the HIV and AIDS population, are required to have a special needs unit to provide both clinical and social case management for members who identify as special needs, and are required to run quality improvement programs, which involves a lot of clinical interplay between MCOs and provider networks. (*Id.* at 122-23.)

As to DHS's conscious decision not to include bid protest language in RFP 06-15, Mr. Bowman testified on cross-examination that DHS viewed the matter as involving a "grant/provider agreement rather than a Commonwealth Procurement Code contract." (*Id.* at 134.) When asked what remedy DHS contemplated for disappointed offerors, Mr. Bowman testified that it was his understanding that they could appeal to the Commonwealth Court. (*Id.* at 152-53.) Because DHS considered the matter as involving grant agreements, DHS believed

it "had the freedom to delete elements that are required by the Procurement Code." (*Id.* at 170.)

DHS presented the testimony of Laurie Rock, who is employed by DHS, Office of Medical Assistance Programs, Bureau of Managed Care Operations, as the Bureau's Director. (*Id.* at 178.) The Bureau of Managed Care Operations is responsible to monitoring the HealthChoices agreements that DHS has with MCOs. (*Id.* at 179.) She testified that the objective of RFP 06-15 is to improve the HealthChoices program, including the coordination of physical health and behavior health services, expansion of value-based purchasing, encouragement of more use of community-based care management, and innovation. (*Id.* at 180-184.) Ms. Rock testified that if the Court were to grant a stay of the procurement, DHS would have to stop its readiness review activities and, therefore, delay the implementation of the January 1, 2017 start date for the improved HealthChoices program. (*Id.* at 185.) It would delay DHS's start of "many of the innovative ideas that have been proposed by health plans that are intended to improve the quality of care." (*Id.* at 186.) The objectives of RFP 06-15 were "intended to improve the quality of care delivered to Medicaid recipients, thereby improving health outcomes." (*Id.*)

As to DHS's concern regarding disruption if an MCO with a large number or high percentage of members were to exit the HealthChoices program, Ms. Rock testified that "there would be a lot of coordination of care issues that would need to be taken into consideration." (*Id.* at 187.) Typically, DHS

> would be concerned about . . . people who have open prior authorization from the exiting plan. So, they've told somebody we approve this service. So, we receive that information, [DHS] receives that from the exiting plan, and then [DHS] need[s] to give that information, to the plan that that member would go to. Then in addition

> to that, we would need to ensure that that was carried out. There are continuity of care, continuation of care provisions, in our agreement that open prior authorizations when people transfer. A plan has to honor those for sixty days, or such time as they have re-evaluated the patient.

(*Id.* at 187-88.) On cross-examination, Ms. Rock acknowledged that there are continuity of care provisions in place that protect members from falling out of a continuous care situation when they switch MCOs. (*Id.* at 188.) Moreover, HealthChoices enrollees freely switch from one MCO to another in the HealthChoices Program and are not discouraged from doing so. (*Id.*) In fact, they "have the freedom to choose a . . . different plan at any time." (*Id.*)

II. DISCUSSION

The merits of Aetna's claims are not before the Court. Instead, as noted above, the Court now considers whether Aetna is entitled to special relief, either in the form of a preliminary injunction or stay and/or supersedeas of DHS's awards under RFP 06-15 until resolution of this litigation. Pursuant to Pennsylvania Rule of Appellate Procedure 1532(a), this Court may order special relief, including a preliminary or special injunction, "in the interest of justice and consistent with the usages and principles of law." The standard for obtaining a preliminary injunction under Rule 1532(a) is the same as that for obtaining a preliminary injunction under the Pennsylvania Rules of Civil Procedure. *Commonwealth ex rel. Pappert v. Coy*, 860 A.2d 1201, 1204 (Pa. Cmwlth. 2004).

Aetna has the burden to prove its entitlement to preliminary injunctive relief. *Warehime v. Warehime*, 860 A.2d 41, 47 (Pa. 2004). To meet this burden, Aetna must establish each of the following "essential prerequisites":

> First, a party seeking a preliminary injunction must show that an injunction is necessary to prevent immediate and irreparable harm that cannot be adequately compensated

> by damages. Second, the party must show that greater injury would result from refusing an injunction than from granting it, and, concomitantly, that issuance of an injunction will not substantially harm other interested parties in the proceedings. Third, the party must show that a preliminary injunction will properly restore the parties to their status as it existed immediately prior to the alleged wrongful conduct. Fourth, the party seeking an injunction must show that the activity it seeks to restrain is actionable, that its right to relief is clear, and that the wrong is manifest, or, in other words, must show that it is likely to prevail on the merits. Fifth, the party must show that the injunction it seeks is reasonably suited to abate the offending activity. Sixth and finally, the party seeking an injunction must show that a preliminary injunction will not adversely affect the public interest

Summit Towne Centre, Inc. v. Shoe Show of Rocky Mount, Inc., 828 A.2d 995, 1001 (Pa. 2003) (citations omitted). A preliminary injunction may be granted to preserve the status quo when important legal questions deserving of serious consideration and resolution must be resolved and the threat of immediate and irreparable harm to the petitioning party is evident. *T.W. Phillips Gas and Oil Co. v. Peoples Natural Gas*, 492 A.2d 776, 780-81 (Pa. Cmwlth. 1985). If this Court determines that any one of the essential prerequisites is lacking, Aetna has failed to meet its burden. *Warehime*, 860 A.2d at 46.

If this Court determines that it has appellate, as opposed to original, jurisdiction, the Court may order a stay and/or supersedeas pending resolution of this matter. The Court has "broad discretion" to grant or deny a stay. *In re Penn-Delco Sch. Dist.*, 903 A.2d 600, 607 (Pa. Cmwlth. 2006). To obtain a stay or supersedeas, an applicant must establish: (1) a likelihood of success on the merits; (2) irreparable injury if a stay is denied; (3) issuance of a stay will not substantially harm other interested parties; and (4) issuance of a stay will not adversely affect

the public interest. *Pa. Pub. Utility Comm'n v. Process Gas Consumers Grp.*, 467 A.2d 805, 808-09 (Pa. 1983). "When confronted with a case in which the other three factors strongly favor interim relief, a court may exercise its discretion to grant a stay if the movant has made a substantial case on the merits." *Witmer v. Commonwealth*, 889 A.2d 638, 640 (Pa. Cmwlth. 2005).

In assessing whether Aetna has met its burden in this case, the Court has considered the evidence adduced by the parties during the hearing on July 6, 2016, as well as the parties' written pre-hearing submissions on the matter. Based upon the evidence, the Court concludes that Aetna has met its burden to prove entitlement to a preliminary injunction and/or stay. Given that the standard for reviewing a request for a stay is substantially similar to that for a preliminary injunction, the Court will address below the prerequisites for a preliminary injunction. *See Young J. Lee, Inc. v. Commonwealth, Dep't of Revenue*, 474 A.2d 266, 275 (Pa. 1983).

A. Irreparable Harm

The first factor for preliminary injunctive relief requires us to consider whether Aetna will suffer irreparable harm if this Court does not enjoin DHS from negotiating, executing, and/or implementing contracts awarded pursuant to RFP 06-15. Aetna argues that it will be irreparably harmed if DHS continues to move forward with this procurement. Aetna identifies the denial of due process rights as a basis for a determination of irreparable harm. Aetna notes that "where the offending conduct sought to be restrained through a preliminary injunction violates a statutory mandate, irreparable injury will have been established." *SEIU Healthcare Pa. v. Commonwealth*, 104 A.3d 495, 508 (Pa. 2014). Aetna contends that DHS's failure to afford Aetna its statutory right to protest and its application

of an undisclosed evaluation criterion is an ongoing violation of Pennsylvania law, which alone is sufficient to satisfy the element of irreparable harm. In addition, Aetna identifies the loss of business opportunities and business advantages, as well as enrollee confusion, as additional bases for a determination of irreparable harm. Aetna expects it will lose market share once new contracts are signed, because Medicaid enrollees serviced by Aetna will begin to transition from Aetna to competing MCOs when they learn that Aetna will no longer be offering its services. If Aetna later succeeds in obtaining relief and enrollees are told that Aetna is in fact still offering its services, severe confusion and dysfunction in the enrollee population could result. Also, Aetna's relationships with its vendors and employees are at risk of disruption. Aetna alleges that the disruption with enrollees and vendors would result in "incalculable damages," should DHS be permitted to avoid the protest procedure, and notes that "the [Pennsylvania] Supreme Court has held that 'where no certain pecuniary standard exists for the measurement of damages,' the threatened harm is irreparable." *See T.W. Phillips*, 492 A.2d at 781 (citing *Philadelphia Ball Club v. Lajoie*, 51 A. 973, 974 (Pa. 1902)).

DHS counters by observing that "speculative considerations" cannot form the basis for issuing a preliminary injunction. *Novak v. Commonwealth*, 523 A.2d 318, 320 (Pa. 1987). Instead, actual proof of irreparable harm is required, and proof of injury may not be speculative. *Reed v. Harrisburg City Council*, 927 A.2d 698, 704 (Pa. Cmwlth.), *appeal denied*, 931 A.2d 629 (Pa. 2007). DHS argues that Aetna's allegations of irreparable harm are based on speculation, and, thus, insufficient to afford Aetna preliminary injunctive relief. In addition, DHS notes that termination of DHS's current HealthChoices program

contracts with Aetna requires DHS to notify Aetna of its intent to terminate within 120 days of the termination date. As that has not yet occurred, termination is far from immediate. Moreover, the new HealthChoices program contracts will not be implemented until January 1, 2017, at the earliest. Thus, no immediate action is required.

During the hearing, the Court received credible testimony from Mr. Rottman regarding the negative impacts that the non-selection of Aetna has had and would continue to have on the ongoing business operations of Aetna. For instance, Mr. Rottman testified that as the end of 2016 draws nearer, newly eligible enrollees or enrollees contemplating changing their MCO would have a disincentive to enroll with Aetna if they believed that Aetna would not be part of the HealthChoices program in 2017, thus reducing Aetna's ability to continue to grow its membership. Furthermore, the uncertainty is affecting the willingness of other entities in the community to partner with Aetna for its outreach initiatives, thereby affecting its ability to conduct business and attract new enrollees. Some employees have resigned in anticipation of the stark reality that their jobs may be in jeopardy. Should Aetna ultimately be awarded a contract in only the Northwest zone, Aetna may find that it is not in a positon to remain in the marketplace due to the small size of that zone and its small membership in that zone. Moreover, if Aetna is required to pull out of some of the zones, it will lose the business advantages it has gained in those zones and relationships it has established, thereby making it more difficult to enter the zone in three to five years if awarded a contract during the next round of proposals. These impacts are not speculative; rather the full extent of the impacts and the dollar value of the associated losses are what are uncertain. A real danger exists that without a stay of the procurement,

DHS may proceed so far with implementation of its new HealthChoices contracts that unwinding the process may be extremely difficult to do and, by then, Aetna will already have suffered the impacts described above. For these reasons, the Court concludes that Aetna has established the requisite irreparable harm.

Even in the absence of this evidence or these findings, however, we would still find irreparable harm based on DHS's apparent refusal to follow this Court's decision in *Stanton-Negley Drug Co. v. Pennsylvania Department of Public Welfare*, 927 A.2d 671 (Pa. Cmwlth. 2007). DHS's central argument with respect to RFP 06-15 is that it is exempt from the Procurement Code under either Section 102(e) or (f) of the Procurement Code, which provides:

> (e) Application to medical assistance provider agreements and participating provider agreements.--*Nothing in this part shall apply to medical assistance provider agreements administered by [DHS]* or to participating provider agreements entered into by the Department of Health.
>
> (f) Application to grants.--*This part does not apply to grants.* For the purpose of this part, a grant is the furnishing of assistance by the Commonwealth or any person, whether financial or otherwise, to any person to support a program. The term does not include an award whose primary purpose is to procure construction for the grantor. Any contract resulting from such an award is not a grant but a procurement contract.

62 Pa. C.S. § 102(e), (f) (emphasis added). Both of these provisions existed in the Procurement Code at the time this Court decided *Stanton-Negley*.[8]

[8] Section 102(e) of the Procurement Code was amended in 2002 to address an unsettled area of the law regarding the proper forum for Medical Assistance provider reimbursement disputes. *Baptist Home v. Dep't of Pub. Welfare*, 910 A.2d 760, 762-63 (Pa. Cmwlth. 2006), *appeal denied*, 923 A.2d 41 (Pa. 2007). What is commonly referred to as "Act 142," the Act of December 3, 2002, P.L. 1147, amended the Procurement Code to give BHA exclusive **(Footnote continued on next page...)**

Stanton-Negley arose out of a request for proposal issued by the Office of Medical Assistance Programs with DHS, then DPW, seeking preferred providers for certain prescription medications referred to as "specialty drugs" to MA recipients. The petitioner, Stanton-Negley Drug Co. (Stanton), was a drug company located in Pittsburgh that, at the time, participated in the MA program. Stanton commenced suit in this Court's original jurisdiction, challenging the terms and conditions of the request for proposal. Stanton argued that the terms of the request for proposal precluded it from participating in the procurement and, ultimately, would harm its ability to continue to provide specialty drugs to MA enrollees. Stanton requested that this Court declare the procurement unlawful and enjoin its implementation.

In response, DPW filed preliminary objections, contending that this Court lacked original jurisdiction, because Stanton's exclusive remedy was to file a bid protest under the Procurement Code. *Stanton-Negley*, 927 A.2d at 673. As noted above, DPW made this legal argument notwithstanding Section 102(e) and (f) in the Procurement Code, on which DHS now relies in this matter. The Court assumes that DPW was aware of these provisions at the time it litigated *Stanton-Negley*, but determined at that time that they did not apply to the procurement of pharmacy services under the MA program. The Court sees no language in Section 102(e) or (f) that would distinguish a "provider" of pharmacy services under the MA program from a provider of managed care services (the

(continued...)

jurisdiction over provider reimbursement disputes and made clear that jurisdiction over such disputes does not lie under the procurement process or with the Board of Claims. *Id.* at 763-64.

MCO) under the MA program. Accordingly, the Court is left only to conclude that DHS has changed its position on the applicability of the Procurement Code to these types of contracts under the MA program. DHS does not attempt to distinguish this case on the facts with *Stanton-Negley*. Indeed, DHS concedes its change in position in its memorandum of law in opposition to the Application for Preliminary Injunction:

> Although the Department did consider the bid protest in *Stanton-Negley*, such consideration was improper. The General Assembly provides for a limited waiver of sovereign immunity for bid protests arising under the Procurement Code. The Department cannot simply create jurisdiction for bid protests where, as here, the procurement is outside the scope of the Procurement Code.

(DHS Mem. of Law at 24-25).

Notwithstanding that DHS has changed its preferred interpretation of Section 102 of the Procurement Code,[9] *Stanton-Negley* is binding precedent of this Court. In addition, though claiming that it should not have "considered" the bid protest in *Stanton-Negley*, DHS does not similarly acknowledge that it successfully argued before this Court that the Procurement Code applied and that, as a result, this Court dismissed Stanton's original jurisdiction action in favor of a remedy under the Procurement Code. Having successfully advocated in this Court that the

[9] The Court notes that DHS is not specially charged with the administration and enforcement of the Procurement Code. Accordingly, the Court owes no deference to DHS's current interpretation of the Procurement Code. *See Northwestern Youth Servs., Inc. v. Commonwealth, Dep't of Pub. Welfare*, 66 A.3d 301, 313 (Pa. 2013); *see also ARRIPA v. Pub. Util. Comm'n*, 792 A.2d 636, 660 (Pa. Cmwlth. 2002) (en banc) ("Normally, no deference is given when an agency interprets a statute to justify its position in litigation, as in a brief filed in court."), *appeal denied*, 815 A.2d 634, 635 (Pa. 2003).

Procurement Code applied to this type of procurement under the Procurement Code, DHS is judicially estopped from advocating a position inconsistent with its prior position in *Stanton-Negley*. *See Ligon v. Middletown Area Sch. Dist.*, 584 A.2d 376, 380 (Pa. Cmwlth. 1990).

In short, this Court is bound by *Stanton-Negley*, and DHS is judicially estopped from challenging that decision. Under *Stanton-Negley* Aetna's remedy lies under the Procurement Code. It is undisputed that DHS is refusing to accept Aetna's bid protest under the Procurement Code. "Failure to comply with a statute is sufficiently injurious to constitute irreparable harm." *Wyland v. West Shore Sch. Dist.*, 52 A.3d 572, 583 (Pa. Cmwlth. 2012).

B. Greater Injury from Refusing the Injunction

Second, the Court will consider whether greater injury would result from refusing an injunction. Aetna maintains that no harm would result to it or HealthChoices enrollees if this Court were to grant the requested injunctive relief. If, however, the procurement is not stayed pending appeal, Aetna will face a litany of serious and imminent injuries, as described above. DHS contends that a preliminary injunction will preclude DHS from implementing improvement to the HealthChoices program by January 1, 2017.

The Court is satisfied that greater injury will result from refusing the injunction than from granting it. If granted, the current MCOs in the HealthChoices program would continue to administer Medical Assistance benefits to enrollees without disruption. There is no evidence that current enrollees would suffer harm if the alleged benefits attendant to the planned improvements to the HealthChoices program are delayed pending the result of this litigation. If denied, however, DHS's implementation of the new HealthChoices program could proceed

so far as to make it extremely difficult and potentially disruptive to enrollees to unwind. Thus, Aetna has met its burden on this prerequisite as well.

C. Preserving the Status Quo

Third, the Court will consider whether granting the preliminary injunction would serve the purpose of preserving the status quo. The status quo to be maintained by a preliminary injunction is "the last actual and noncontested status which preceded the pending controversy." *Shanaman v. Yellow Cab Co. of Phila.*, 421 A.2d 664, 667 (Pa. 1980). Aetna argues that if preliminary relief is not granted, the HealthChoices contracts already in place would continue to be in effect and health care would be available to Medicaid-eligible enrollees under the same conditions that existed before DHS violated the Procurement Code and refused to award Aetna a contract to which it was plainly entitled. Thus, staying the procurement process would maintain the status quo among the parties and among the healthcare industry in the marketplace. DHS takes the position that if injunctive relief is denied, the status quo will not be disrupted because DHS has not yet acted to terminate Aetna's HealthChoices agreements in any of the zones. In addition, Medicaid enrollees will continue to receive HealthChoices services under the current contracts.

DHS's analysis fails to take into account the passage of time. Without injunctive relief, DHS would continue to negotiate contracts with selected offerors with the intention of implementing such contracts as early as January 1, 2017, so as not to result in delay of improved services to enrollees. In the interim, Aetna will experience the negative impacts described above. Moreover, it is possible that the propriety of DHS's selection decision under RFP 06-15 may not be resolved by January 1, 2017, but that DHS would nevertheless proceed with execution and

implementation of the new HealthChoices agreements, including the termination of Aetna's current agreements. The Court, therefore, concludes that Aetna has established that the requested injunctive relief will preserve the status quo.

D. Clear Right to Relief

Fourth, the Court will consider whether Aetna's right to relief is clear. "[T]he 'clear right to relief' element does not impose upon the proponent of the preliminary injunction the burden of establishing an absolute right to relief on the underlying claim." *T.W. Phillips*, 492 A.2d at 780. Moreover,

> [w]here the threat of immediate and irreparable harm to the petitioning party is evident, that the injunction does no more than restore the status quo and the greater injury would result by refusing the requested injunction than granting it, an injunction may properly be granted where substantial legal questions must be resolved to determine the rights of the respective parties.

Id. (quoting *Fischer v. Dep't of Pub. Welfare*, 439 A.2d 1172, 1174 (Pa. 1982)).

Aetna's main contention in this action is that RFP 06-15 is subject to the provisions of the Procurement Code, such that DHS is required to proceed with Aetna's protest under the provisions of the Procurement Code. Seeing as this Court has previously addressed and ruled on this very legal issue in *Stanton-Negley* and that DHS, for reasons explained above, is judicially estopped from arguing a contrary position in this litigation, the Court concludes that Aetna has satisfied this element of the preliminary injunctive inquiry.

Even in the absence of *Stanton-Negley*, the Court, upon consideration of the parties' legal arguments with respect to the proper interpretation of Section 102 of the Procurement Code, concludes that Aetna has at least presented a substantial legal question over whether MCO contracts to administer the

HealthChoices program are exempt under Section 102(e) or (f) of the Procurement Code.

E. Injunction Reasonable Suited to Abate the Offending Activity

Fifth, the Court will consider whether the injunction is reasonably suited to abate the offending activity. Aetna maintains that its requested relief is narrowly-tailored to abate the offending actively, as Aetna merely request that this Court require DHS to comply with the law. DHS, on the other hand, contends that no offending conduct has occurred, so any relief cannot be reasonably suited. Moreover, it contends that the preliminary injunction would do nothing but affect DHS's negotiations with other successful offerors and not result in Aetna's selection.

The Court disagrees with DHS's assertion that the injunction is not reasonably suited to abate the offending activity. The Court appreciates that any injunction it issues must be "reasonably suited" to abate the alleged wrong. With that noted, the Court does not wish to inflict anymore delay into this process than necessary, nor does it wish to interject unnecessarily itself into the bid protest process. The credible testimony presented, however, causes the Court concern that significant problems may attend the procurement process for RFP 06-15. A stay of the procurement pending resolution of the matter before the Court is the only mechanism to ensure that the status quo is maintained and irreparable harm does not befall Aetna while the propriety of DHS's actions is considered. Aetna, therefore, has established this prerequisite for preliminary injunctive relief.

F. No Adverse Effect on Public Interest

Finally, the Court will consider whether the injunction will have an adverse effect on the public interest. Aetna argues that it unquestionably is in the

public interest to require Commonwealth agencies to follow the law. "[W]hen the Legislature declares particular conduct to be unlawful, it is tantamount to categorizing it as injurious to the public." *SEIU*, 104 A.3d at 509. Thus, allowing DHS to violate the Procurement Code, to ignore this Court's precedent, and to negotiate contracts that were awarded pursuant to an unlawful procurement process would be seriously injurious to the public interest, which relies on transparent and fair agency action within the Commonwealth. Aetna urges the Court to grant the injunctive relief to foster public approval and trust in the agencies that regulate the MA program. DHS responds by arguing that the public interest will be harmed by delaying the planned improvements to the HealthChoices program.

Given that MCOs currently participating in the HealthChoices program will continue to administer benefits to enrollees during a stay of the procurement of RFP 06-15 and the interest in maintaining the integrity of the Commonwealth's procurement process, the Court concludes that Aetna has established that the requested relief will not adversely affect the public.

III. CONCLUSION

At this early stage in the proceedings, the Court has real concerns about the credibility of the procurement process used for RFP 06-15. It is apparent that, despite Aetna's objection to DHS's unprecedented use of a secret evaluation criterion through Aetna's bid protest and the dual jurisdiction action pending before the Court in this matter, DHS plans to move forward with the procurement. As discussed above, Aetna has met the prerequisites for a preliminary injunction or stay/supersedeas.

Accordingly, Aetna's Application for Preliminary Injunction shall be granted to the extent that it seeks to enjoin the execution and implementation of

any agreement resulting from RFP 06-15, pending further order from the Court. Should DHS elect to hear Aetna's bid protest in the meantime, DHS should use a hearing officer who is not employed by DHS and who does not have any connection to or knowledge of the solicitation, consideration, or award under RFP 06-15. In all other respects, the application will be denied.

P. KEVIN BROBSON, Judge

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

Aetna Better Health of Pennsylvania Inc., Petitioner	:	
v.	:	No. 351 M.D. 2016
Commonwealth of Pennsylvania, Department of Human Services, Respondent	:	

ORDER

AND NOW, this 19th day of July, 2016, following a hearing, Petitioner Aetna Better Health of Pennsylvania's (Aetna) emergency application for special relief in the nature of a special injunction and preliminary injunction (Application for Preliminary Injunction) is GRANTED in part and DENIED in part. Aetna's Application for Preliminary Injunctive is GRANTED to the extent that it seeks to enjoin the execution and implementation of any agreement resulting from RFP 06-15, pending further order from the Court. Should the Department of Human Services (DHS) elect to hear Aetna's bid protest in the meantime, DHS should use a hearing officer who is not employed by DHS and who does not have any connection to or knowledge of the solicitation, consideration, or award under RFP 06-15. In all other respects, the application will be DENIED. It is further ORDERED that Petitioner shall post a bond in the amount of one hundred dollars ($100).

P. KEVIN BROBSON, Judge