MODRALL SPERLING

LAWYERS

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Via Hand Delivery & Email

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Re: Bid Protest by Molina Healthcare of New Mexico, Inc.
RFP # 18-630-8000-0001

Dear Secretary Earnest:

In accordance with NMAC 1.4.1.81, NMSA 1978, § 13-1-172, and Section 2.2.15 of RFP #18-630-8000-0001 ("the RFP"),[1] Molina Healthcare of New Mexico, Inc. ("Molina"),[2] respectfully submits this bid protest ("Bid Protest"), challenging the New Mexico Human Services Department's ("HSD") non-award of a contract to Molina in response to Molina's proposal to the RFP for Managed Care Organization Contractors for Centennial Care 2.0

According to HSD, the following contracts (individually "Contract" or collectively "Contracts") were awarded on or around January 18, 2018:

Blue Cross/Blue Shield: PSC 18-630-8000-0033 CC 2.0
Presbyterian Health Plan: PSC 18-630-8000-0034 CC 2.0
Western Sky Community Care, Inc.: PSC 18-630-8000-0035 CC 2.0

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[1] The RFP is attached as Exhibit A to this Bid Protest.

[2] Pursuant to Rule 7.1.6.10(B), Molina states that its address is 400 Tijeras Blvd. NW, Albuquerque, NM 87102. Molina requests that all correspondence related to this Protest be directed to the undersigned counsel for Molina at 500 Fourth Street NW, Suite 1000, Albuquerque, NM 87102 or via email to jkh@modrall.com.

See January 19, 2018 Notice of Award, attached as Exhibit B. On information and belief, those contracts are not yet effective, and lack signatures and approvals necessary for them to be enforceable. *See* Contracts, available at http://www.hsd.state.nm.us/LookingForInformation/medical-assistance-division.aspx.

Molina respectfully requests that HSD either (1) award a contract to Molina; (2) reject all bids and resolicit bids for Managed Care Organization Contractors for Centennial Care 2.0; or (3) eliminate the cost proposal component of the RFP and award a contract to Molina based on the rankings for bidders' technical proposal and referral scores only. The reasons for these requests are many: (1) HSD utilized bid evaluation criteria that were not disclosed in the RFP and thus violated the law; (2) HSD acted arbitrarily and capriciously when it scored Molina's Technical Proposal; (3) the capitation rates HSD set for the RFP were not actuarially sound and thus arbitrary and capricious; (4) HSD's practice of setting MCO's rates on numerous services at similar dollar amounts renders HSD's inclusion of a price score arbitrary and capricious; (5) HSD's scoring of the price proposals was arbitrary and capricious as the scores are grossly disproportionate to the differences between bids; (6) HSD's decision to not hold oral presentations, an additional scored component, was arbitrary and capricious; (7) HSD's decision to reduce the number of MCO's was arbitrary and capricious and will harm the citizens of New Mexico; (8) Mercer, the entity that administered the RFP and made decisions for HSD has a financial tie to Western Sky, one of the successful bidders; (9) the prices proposed by Western Sky and the other successful bidders are not sustainable and thus not in the best interests of the public; and (10) HSD's decision to eliminate Molina as an MCO in New Mexico is not in the best interest of the public.

Molina notes that it has not yet received all information necessary to fully and completely address the errors in HSD's procurement of the RFP. In an effort to ascertain the reasoning behind HSD's decision, Molina has submitted multiple Inspection of Public Records Act ("IPRA") requests seeking documents that should provide details about NMHSD's decision-making process. HSD, in response to Molina's IPRA requests, stated that it would provide responses to the majority of Molina's requests on or before January 31, 2018. HSD did not meet that deadline (with the exception of Proposals which were sent on January 26, 2018). Instead, HSD provided over fifteen-thousand pages of documents at 4:00 p.m. on Friday, February 2nd, knowing full well Molina's obligation to submit its bid protest by Monday, February 5th and the fact that the protest must be delivered, in person, by 5:00 p.m. on February 5th. Molina has had insufficient time to fully analyze the just received information to even determine whether HSD provided everything it was required to provide under IPRA, much less to assess the information and determine whether additional evidence related to this protest was included in HSD's production. Molina thus reserves its rights to supplement this protest with any additional information gleaned from documents provided by HSD in response to Molina's IPRA requests. *See* Rule 1.1.1.82(B)(4) NMAC (requiring "supporting exhibits, evidence or documents to substantiate any claim unless not available within the filing time in which case the expected available date shall be indicated"). Molina expects to have completed review and analysis of the just received information by February 17, 2018.

This protest is being filed within 15 days of Molina's receipt of notification that the Contracts had been awarded, and is thus timely. Any supplement will be submitted within 15 days of Molina's receipt of information from HSD, and thus will be timely.

BACKGROUND

A. Background of Molina's Critical Role in the Provision of Healthcare to New Mexicans

Molina is a subsidiary of Molina Healthcare, Inc. ("MHI")—a multi-state healthcare organization, which arranges for the delivery of healthcare services to nearly 4.5 million individuals and families in twelve states plus the Commonwealth of Puerto Rico, primarily through Medicaid and Medicare, as well as Exchanges, also known as Marketplaces, established by the Affordable Care Act ("ACA"). With its acquisition of Cimarron Health Plan in 2004, which had served New Mexico's families since 1997, Molina became a critical part of the care of more than 40,000 New Mexicans. *See* Declaration of Daniel Sorrells ¶ 4, attached as Exhibit C ("Sorrells Decl."). By 2005, the number of New Mexicans assisted by Molina had grown to 61,000 members. *See id.*

Molina is one of four incumbent, or current, Managed Care Organizations ("MCOs") providing managed care to New Mexicans under New Mexico's Centennial Care Medicaid program. Managed care is similar to insurance but more comprehensive, providing extensive networks of medical and behavioral health providers, managing care and services, processing claims, and similar services. Molina's contract to provide such services ends December 31, 2018, but HSD could have extended the contract (and still can) for an additional period or periods. *See* Section 7.4.2 of Molina's contract with HSD, attached as Exhibit D ("HSD reserves the right to extend this Agreement for an additional period or periods of time").

Molina was awarded the MCO Centennial Care contract in New Mexico in 2014. *See* Sorrells Decl. ¶ 5. Now, Molina provides services to nearly 260,000 New Mexicans as follows: approximately 224,000 New Mexicans through Medicaid (about 26% of all New Mexico Medicaid members and just under ten-percent of New Mexico's estimated population), approximately 5,500 New Mexicans through Medicare, and approximately 29,000 New Mexicans through the Marketplace, created by the ACA (which is about 58% of all New Mexico Marketplace members). *See* Sorrells Decl. ¶ 6. Molina has a medical and behavioral health provider network of 14,000 providers, the largest in New Mexico. *See* Sorrells Decl. ¶ 7. Consumer Reports ranked Molina's Medicaid services as the best in New Mexico from 2013 through 2016, and second best in 2017.

Molina serves more of New Mexico's most vulnerable Medicaid populations than any other MCO in the State. *See generally* Sorrells Decl. ¶¶ 8-9. Molina cares for over 22,000 New Mexicans with serious mental illnesses, over 2,300 New Mexicans in opioid treatment programs, over 103,000 New Mexicans with diagnosed chronic conditions, and over 12,500 New Mexicans who receive durable medical equipment ("DME") such as wheelchairs, oxygen supply equipment, patient lifts, and diabetic equipment. Molina serves over 5,800 New Mexicans in long term care such as nursing facilities or community based care, over 3,300 New Mexicans receiving personal care services, and 1,950 New Mexicans with disabilities on waiver services. By not selecting Molina to continue as an MCO beyond 2018, HSD will force these vulnerable populations to select new health plans. Their plans of care will also have to be restarted and, in many cases, they will be moved to new healthcare providers.

Molina also provides Medicaid managed care to over 10,000 Native Americans in New Mexico and is an MCO with the demonstrated ability to provide culturally competent services to Native populations in New Mexico and other states. *See* Sorrells Decl. ¶¶ 10-16. Molina's extensive services include: collaboration with tribal officials to provide health education and literacy to Native Americans; consultation with Native officials to provide better services to incarcerated Native Americans; grants to other providers, such as $145,000 to Pine Hill Clinic; and assisting with the installation of telemedicine

infrastructure at First Nations, whose locations are in Albuquerque, Farmington, and Gallup. Molina was the first MCO in New Mexico to provide a Traditional Healing Benefit to Native American members for traditional customs and ceremonies.

HSD's decision to end Molina's Medicaid managed care contract places at risk all of Molina's operations in New Mexico, including the Marketplace and Medicare lines of business. HSD's decision also places at risk a significant portion of the State's healthcare and behavioral health infrastructure in which Molina plays an integral role.

B. Background of the RFP Process

Rather than extend the contracts of the incumbent MCOs, and for reasons unknown to Molina, HSD issued the RFP and accelerated that process as it has proceeded. At the time that HSD issued the RFP, it was well-aware that the current administration would be changing in January 2019, and HSD thus deviated from standard practices of not making significant changes as an existing administration is winding down. HSD's procurement will saddle the new administration with changes that were not requested by the citizens of New Mexico, that are unnecessary, and that the new administration will have deal with despite having had no say in whether the procurement was even appropriate. HSD issued the RFP on or about September 1, 2017, despite the fact that HSD had an option to extend the contracts of the current Centennial Care MCOs. As required by applicable regulations, the RFP included "specifications for the services … to be provided" and "a statement of the relative weights to be given to the factors in evaluating criteria." NMAC 1.4.1.16 (emphasis added). Molina timely submitted a responsive bid on November 3, 2017. *See* Declaration of Kelly Good ¶ 3, attached as Exhibit E ("Good Decl."). Seven other companies submitted responses to the RFP (individually "Proposal" and collectively "Proposals"), including all of the incumbent MCOs. *See id.*

HSD contracted with a third-party, Mercer, to provide services related to the RFP, including drafting the RFP, training or "coaching" HSD subject matter experts on how to evaluate Proposals, and conducting "consensus scoring meetings," through which individual scores from individual evaluators were "blended" or adjusted into one consensus score. *See* Good Decl. ¶ 12.[3] Mercer also drafted the scoring summary and provided a memorandum recommending award of the Contracts, *see* Mercer December 20, 2017 Executive Committee Evaluation ("Mercer Memo"), attached as Attachment 1 to the Sorrells Decl. On January 19, 2018, about two months before the date set forth in the RFP, HSD announced the MCOs that were awarded contracts. *See* Notice of Award.

Mercer's services also included setting the "cost structure" or "cost table" for the RFP. *See* Sorrells Decl. ¶ 17. The cost table is a range of "capitation rates," from a minimum to a maximum, within which each bidder offers a price. The pricing is set at dollars per member per month ("PMPM"). The pricing varies considerably depending on the "category" of member–a member known to require behavioral health services, or living in a nursing facility, is considerably more expensive than the pricing for a healthy adult or child. *Id*..

Additionally, Mercer is the entity that has set the rate structure for the incumbent MCOs for several years. *See* Sorrells Decl. ¶ 26. In other words, for years Mercer has set the rates MCOs received, and then Mercer was allowed to set the rates upon which bidders would be scored in the RFP process. During the

[3] Contracts available at http://www.hsd.state.nm.us/LookingForInformation/medical-assistance-division.aspx.

years that Mercer has set capitation rates, Molina has challenged Mercer's rates and persuasively demonstrated (though Mercer has not agreed) that Mercer's rates are not actuarially sound,[4] and, as a result, not sustainable. *See id.* ¶¶ 29, 33-37. In the short term, these unsound rates mean losses for MCOs providing Medicaid coverage. In the long term, this means that the services promised to New Mexicans may not be provided and MCOs might leave New Mexico. *Id.* ¶¶ 33-37. Mercer appears to have an interest in ending Molina's Medicaid contract because Molina vocally and assertively challenged Mercer's rates as unsustainable and not actuarially sound. *See* Letters regarding Mercer rates, attached as Exhibit F.

HSD's procurement process did not include important stakeholders such as: the New Mexico Department of Health; the New Mexico Department of Education, which oversees School Based Health Centers and Medicaid School Based Services; the New Mexico Children, Youth and Families Department; or the Office of Superintendent of Insurance. *See* Good Decl. ¶ 11. These agencies, unlike Mercer, are all critical for the delivery of Medicaid services in New Mexico and should have had a seat at the table. Yet, HSD failed to include them and instead rubber stamped Mercer's biased and flawed recommendations.

Beginning with its decision to issue an RFP rather than exercising its option to extend the contracts of the incumbent MCOs, HSD has sought to accelerate the procurement process without a basis, or at least without an articulated basis. Examples include: the decision to announce the award of contracts in January, 2018, rather than March as set forth in the RFP; the decision to proceed with the procurement during the protests periods despite the absence of findings, reasons, basis, or support demonstrating the need to do so; and the written refusal to stay the procurement process after a written request from Molina to do so. HSD had the option to hear oral presentations from the bidders as part of the RFP process, but decided not to do so. This decision is questionable, in part because HSD selected a new MCO without a formal meeting with its principals.

HSD, via Mercer, used three separate scores to determine a bidder's total score and thus the ranking of bidders: a Technical Proposal Score (1390 possible points), a References Score (300 possible points), and a Cost Proposal Score (400 possible points). Molina was awarded a total of 1,350 points—942 on the Technical Proposal, 288 on References, and 120 on Cost Proposal. Scoring Results Summary at 12-13, attached as Exhibit G. Molina was thus ranked 6th based on the total scores even though it was tied for first on the References Score and fifth on the Technical Proposal Score.

Despite having initially indicated that it would select up to five MCOs, HSD, on the recommendation of Mercer, only awarded three contracts, two to incumbent MCOs, and one to a new MCO, Western Sky. Molina thus was not awarded a contract.

[4] According to the Actuarial Standards Board's Actuarial Standards of Practice (ASOP) on Medicaid Manage Care Capitation Rate Development and Certification, a capitation rate is "'actuarially sound' if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs." ASOP NO. 49 at Section 2.1, *available at* http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf. Under Medicaid, actuarially sound rates are rates that are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO for the time period and the population covered under the terms of the contract, and developed in accordance with applicable federal Medicaid requirements. 42 C.F.R. §438.4. In other words, a rate is only actuarially sound if it and other sources of revenue are sufficient to ensure that the care subject to the rate can actually be provided.

C. Mercer's and Western Sky's Conflict of Interest

There appears to be a serious impropriety that has infected HSD's procurement of the RFP. This impropriety stems from the connection between three companies: Mercer, Western Sky, and Envolve. Mercer is the company that HSD retained to manage all aspects of the procurement. Mercer created the RFP, trained the evaluators and came up with evaluation factors, and made critical "recommendations" that HSD adopted without analysis or explanation. Western Sky is a Centene subsidiary and was one of the three MCOs awarded a Contract through the RFP. Envolve is a specialty health services company (providing services such as pharmacy benefit delivery) that, like Western Sky, is also a Centene subsidiary. Western Sky intends to use Envolve for numerous services in connection with its Contract.

In October 2016—well before the RFP was issued—Mercer issued a press release noting that it had formed an "alliance[] with Envolve Pharmacy Solutions."[5] While Western Sky disclosed its relationship with Envolve in its Proposal, Western Sky did not disclose the relationship between Centene and Mercer in the Proposal. *See* Good Decl. ¶ 7. It is also unknown whether Mercer disclosed to HSD that its own finances are apparently interwoven with one of the bidders it chose to receive a contract. Western Sky's Proposal heavily references Envolve and details its plans utilize Envolve for many specialty services, *see id.* ¶¶ 8-9—a utilization that will likely enrich Mercer or at a minimum enrich Mercer's business partner and thus curry favor with Mercer. Mercer thus appears to have a significant conflict of interest and should not have had any involvement in the procurement process. HSD's use of a biased contractor to perform almost all aspects of the procurement requires solicitation with a fair and impartial decision maker that has no stake in the outcome of the procurement.

DISCUSSION

A. New Mexico law required HSD to only utilize evaluation criteria that were disclosed in the RFP

The New Mexico Procurement Code is unequivocal: "The invitation for bids shall set forth the evaluation criteria to be used. *No criteria may be used in bid evaluation that are not set forth in the invitation for bids*." NMSA 1978, § 13-1-105 (emphasis added). This legal standard was incorporated into HSD's own regulations, which require that bids be evaluated "based on the evaluation factors and relative weights set forth in the request for proposals." Rule 1.4.1.16 NMAC. This legal standard is also incorporated into the RFP itself: "Each proposal shall be evaluated to determine whether the requirements as specified in this RFP have been met." *See, e.g.*, RFP § 4.3.1.

The New Mexico Supreme Court has reiterated the importance of following the procurement process strictly: "[W]hen statutes and regulations define the rules of competitive bidding, these statutes and regulations will be strictly construed against the government entity that solicited the bids." *Planning & Design Solutions v. City of Santa Fe*, 1994-NMSC-112, ¶ 6, 118 N.M. 707, 885 P.2d 628. "While it is

[5] *See* Plan Sponsors Zero In on Specialty Rx Costs, Retail 90 Networks in 2017 Benefits, November 4, 2016, attached as **Exhibit N,** retrieved from https://aishealth.com/archive/ndbn110416-02; *and see* October 5, 2016 Mercer Press Release, attached as **Exhibit O**, retrieved from https://www.mercer.com/newsroom/mercer-announces-new-innovative-approach-to-help-contain-specialty-pharmacy-costs.html.

true that a [governmental agency] has 'wide discretion' to accept or reject offers, *that discretion does not include unlawful departure from its own rules and state procurement statutes*." *Id* ¶ 19 (emphasis added).

When HSD solicits bids, it thus must comply with its regulations and the New Mexico Procurement Code. Failure to comply with regulations, the Code and the RFP evaluation factors is a violation of law and is arbitrary and capricious. *Planning & Design Solutions*, 1994-NMSC-112, ¶¶ 7, 19, 22-23. HSD may not introduce new evaluation factors after the RFP is issued or during the bidding process. To evaluate a bid or offer based on evaluation factors outside of the RFP is a violation of law and arbitrary and capricious. *Planning & Design Solutions*, 1994-NMSC-112, ¶¶ 16-17, 24. By soliciting bids, HSD entered an implied contract to comply with its regulations, the Procurement Code, and its RFP. Moreover, HSD made an implied contract that bids would be evaluated and accepted based on the evaluation factors in the RFP and no other factors. *Planning & Design Solutions*, 1994-NMSC-112, ¶¶ 27, 29.

B. HSD Utilized Evaluation Criteria That Were Not Disclosed in the RFP.

Despite the fact that strict compliance with its own RFP is mandatory, HSD repeatedly departed from the criteria listed in its RFP when evaluating Molina's Proposal and relied on undisclosed criteria to deduct points from Molina, which tainted the procurement such that re-solicitation is required. The prejudice to Molina cannot be understated. This is not a situation in which a single deviation from the RFP occurred. Rather, as outlined below, HSD on numerous occasions relied on undisclosed evaluation criteria to reduce Molina's score. These undisclosed evaluation factors resulted in a decrease in Molina's overall score, and likely colored the evaluators' view of Molina such that Molina lost additional points that are not explicitly tied to the undisclosed evaluation criteria. HSD failed to abide by the Procurement Code, regulations, and factors in the RFP, and by that failure HSD has created at least an appearance of impropriety, and jeopardized the integrity of competitive bidding. *Planning & Design*, 1994-NMSC-112, ¶ 25. Further, HSD's unlawful and prejudicial conduct may deter qualified MCOs from bidding in the future, leading to fewer and lower quality choices in insurance and healthcare for New Mexicans. *Id*. ¶ 33.

HSD's utilization of undisclosed evaluation criteria is even more egregious given the role that Mercer played in the evaluation process and Mercer's conflict of interest (which results from its financial stake with one of the successful bidders). Mercer played a central role in creating the scoring criteria (including the undisclosed criteria that were improperly added by HSD) and trained the evaluators on how to assess the Proposals. *See* Exh. G, Scoring Summary p. 1 ("Mercer provided training to subject matter experts (SMEs) from HSD's Medical Assistance Division (MAD) and Behavioral Health Services Division (BHSD)…. During the training, evaluators were provided a review of the RFP process and goals, instructions for using and completing the evaluator worksheets, scoring methodology, RFP questions, and the consensus scoring process."). Given that Mercer had a financial stake in the results of the procurement, the fact that Mercer "trained" the various subject matter experts is highly questionable.

Specific questions to which HSD applied undisclosed criteria as documented in the score sheets are listed below. Molina notes that the below list may not encompass all areas where HSD used undisclosed criteria, as Molina has not yet received all information related to bid evaluations, and there is a likelihood that some undisclosed criteria were not reduced to writing such that Molina will never know what HSD considered that was outside the scope of the RFP.

HSD's reliance on undisclosed bid criteria is especially egregious given that bidders were required to limit the number of pages submitted in response to each section of the Technical Proposal. On account of

these page limitations, Molina focused its responses[6] to the information *actually asked by HSD* and did not waste space addressing questions that were unasked. Molina could have squarely addressed the issues that HSD improperly considered if HSD had disclosed the criteria prior to awarding contracts or during oral presentations, had HSD held them as permitted by the RFP.

a. Section 6.1, Question 5

This question sought "a statement of whether there is any pending or recent . . . litigation against your organization, Directed Corrective Action Plans [(CAPS)], or sanctions levied." RFP at 42. CAPs are notices from a state regulatory agency identifying actual or potential violations of the Contract. MCOs then prepare and implement a remediation plan to address the violations. Molina submitted information on its CAPs but did not submit information regarding remediation plans because the RFP question did not request information on such remediation plans. *See* RFP at p. 42. Molina tracks CAP remediation plans, and would have provided this information had it been requested. Good Decl. ¶ 24. Despite the absence of any request for information about remediation plans, the evaluators faulted Molina for not including a discussion of CAPS remediation. Score Sheet.[7] HSD thus relied on undisclosed evaluation criteria to the detriment of Molina. Moreover, while HSD stated that: "There is evidence of a repeated pattern (late reporting, inaccurate reporting, and failure to meet requirements, failure to report, reports incomplete) across the board in many states resulting in CAP and fines," Molina received almost no penalties for reporting violations in 2016 or 2017 in New Mexico. Good Decl. ¶¶ 25-26. HSD thus not only utilized an undisclosed evaluation criterion, but it also failed to consider accurate information about Molina. Instead, it appears that HSD relied on information about MHI without providing Molina an opportunity to address that information. HSD's inaccurate findings likely biased the evaluators against Molina as they reviewed and considered other components of Molina's Proposal.

b. Section 6.1, Question 8

This question sought copies of Molina's "most recent audited financial statements for each line of business operated, showing a separation between commercial and public accounts and among various contracts and various public fund sources for which your organization is responsible." RFP at p. 43. The evaluators indicated that they were "concerned about change in corporate leadership, huge losses reported for Puerto Rico and reducing workforce by 10%. There are specific risks and uncertainties noted in the response. If contracted, the State will need to discuss additional protections for NM. The team is concerned that the financial stability of the company puts the NM line of business at risk." Score Sheet for Question 8.

This comment is troubling (and evidence of the arbitrary and capricious nature of HSD's actions) for several reasons. First, the evaluators' comments make clear that HSD relied on undisclosed evaluation criteria. Question 8 did not seek information about corporate leadership or workforce reductions, nor did it seek information about the financial state of Molina's parent corporation, MHI. Molina is a New Mexico corporation, it submitted its own audited financial statement, and HSD's reliance on extrinsic information about MHI was an undisclosed criteria that Molina had no opportunity to address. Had HSD

[6] Molina notes that Blue Cross Blue Shield exceeded page limits on multiple occasions, was not penalized by HSD for doing so, and thus was able to achieve higher scores by virtue of having improperly included more information than allowed.

[7] The score sheets are not numbered. All citations to "Score Sheet" are to the page of the score sheet for Molina (or other bidders where relevant) that corresponds with the section and question at issue.

disclosed that it would be considering MHI's finances, MHI's workforce reduction, MHI's Puerto Rico operations, or the changes in leadership at MHI, Molina would have been able to explain that those issues had no bearing on the financial stability of Molina. Molina did not provide HSD with information about MHI (because such information was not responsive to the RFP). HSD's references to such information establishes that HSD improperly relied on extrinsic information that was not referenced within the RFP question and has no bearing on the viability of Molina's proposal.

Second, the comments make clear that the HSD evaluators were acting and making decisions without a complete understanding of the information. The evaluators expressly noted that they needed additional information, yet recommended that HSD decline to conduct oral presentations in which such information could have been explained. Had HSD followed up on its admitted lack of information, HSD would have learned that its criticism of Molina is unfounded. MHI's debt remained at investment grade levels throughout 2017 even in the wake of financial losses, MHI retained an investment grade Ba1 credit rating, and MHI's stock is trading at an all-time high. Any concerns regarding changes in corporate leadership are subjective and speculative at best. And, in any event, despite the changes in corporate leadership, Molina's performance in New Mexico improved in each quarter in 2017, as measured by Molina's Administrative and Medical Cost Ratios. *See* Sorrells Decl. ¶ 52. MHI's workforce reductions were prudential actions to right size the company and were designed to align the company's cost structure with the administrative allowances built into its capitation rates in each state. *Id.* ¶ 53. In sum, had Molina been asked, Molina would have fully demonstrated MHI's financial stability, that the change in corporate leadership did not impact Molina's services in New Mexico, and that MHI's workforce reduction was a necessary, and wise, business decision.

With respect to the statements regarding Puerto Rico, the reviewers clearly went outside Molina's Proposal and relied upon news and other media sources to obtain information about Molina's parent company and sister plans. Sources that are external to the offeror's response are not appropriate for consideration as HSD afforded Molina no opportunity to explain the skewed information presented by media sources or otherwise address HSD's concerns. Beyond that, the Medicaid program in Puerto Rico is substantially different than the Medicaid program in New Mexico. Losses to the Puerto Rico health plan[8] in no way effect the operation or performance of the New Mexico health plan, and the evaluator exaggerated the impact of those losses. *See* Sorrells Decl. ¶¶ 48, 54.

Third, the comment regarding "risks and uncertainties" surrounding Molina is especially concerning in light of the history of Centene, Western Sky's parent corporation, pulling out of Medicaid markets that are not profitable. While this issue is discussed in more detail below, HSD declined to award a contract to Molina in part because of inaccurate concerns about Molina's financial stability, but disregarded the fact that one of the winning MCOs has *actually* left Medicaid markets due to financial issues. While the disregard of this is perhaps unsurprising on account of the conflict of interest between Mercer and Western Sky, the failure to HSD to consider serious concerns about Western Sky while at the same time essentially fabricating concerns about Molina establishes that HSD acted arbitrarily and capriciously, abused its discretion, and failed to comply with applicable law.

c. Section 6.2, Question 13

Question 13 indicated that HSD would "assess for approval all proposed delegated/subcontracted functions" and asked bidders to "[p]rovide a list of those functions . . . your organization proposes to

[8] Molina Healthcare of Puerto Rico made a profit in Puerto Rico in Q3 2017.

delegate." RFP at p. 44. HSD criticized Molina's decision to use delegated subcontractors for certain utilization management and behavioral health functions, stating that "Generic information, lack of detail about vendors and MCO approach to oversight. Lots of vendors with minimal NM experience/presence." Score Sheet. But, all of Molina's vendors in New Mexico have been reviewed and approved by HSD for Molina's current operations to serve its New Mexico members. Good Decl. ¶¶ 27-28. That is, as an incumbent MCO, Molina has *already* been using the vendors identified in its response to Question 13, HSD has *already* approved those vendors, and those vendors have *already* been providing quality care to New Mexicans. HSD's disregard of its existing approval of Molina's designated vendors was arbitrary and capricious and an abuse of HSD's discretion.

d. Section 6.2, Question 15

Section 6.2, Question 15 asked bidders to "Describe your organizations strategies for dealing with the challenges of building a provider network for rural and frontier parts of New Mexico, including contacting with Indian Health Services, Tribally Operated Facility or Programs, and Urban Indian Clinics (I/T/Us) and critical access providers such as Federally Qualified Health Centers (FQHCs), Nursing Facilities (NFs)_ and Non-Emergency Medical Transportation (NEMT) providers, including retention and recruitment efforts for primary care and specialists in these areas." RFP at 45. The evaluators faulted Molina for not including a discussion of Native American Advisory Boards in its response to Question 15. Score Sheet. Since Question 15 did not seek any information regarding Native American Advisory Boards, HSD utilized an undisclosed evaluation criterion when it deducted points for the absence of information about such boards. Beyond that, had Molina been requested to provide that information, its response would have highlighted its work with Native American Advisory Boards. Good Decl. ¶ 23.

e. Section 6.3, Question 21

This question asked Molina to describe its "process for monitoring prescribing practices of providers, as it relates to prescription drugs." RFP at 46. HSD's evaluators were instructed to consider whether the "response address[es] cultural considerations including where members may use alternative remedies and how such remedies may interact with prescriptions." Score Sheet. HSD criticized Molina for providing only "limited details regarding cultural considerations," but Question 21 did not request information on the cultural considerations or alternative remedies that HSD instructed its evaluators to consider. Score Sheet; *and see* Good Decl. ¶ 21. HSD's deduction of points for Molina's alleged failure to address cultural considerations constituted an undisclosed evaluation criterion.

f. Section 6.3, Question 24

This question posed a hypothetical question, and then asked bidders to describe how they "will initiate and manage care, including services, supports and treatment options to achieve the best outcomes for the Member." RFP at 46. HSD instructed its evaluators to consider whether the "response describe[d] the role of the care coordinator," but Question 24 did not seek any information regarding a care coordinator. *See* Score Sheet. HSD thus relied on undisclosed criteria.

g. Section 6.3, Question 25

In Section 6.3, Question 25, HSD asked: "The New Mexico Behavioral Health Collaborative has a vision of a statewide crisis response system that meets unique community and Member needs. Describe how

your organization's crisis intervention services will be provided to Members in Urban, Rural, Frontier and Tribal areas of the State." RFP at p. 46-47. Molina's score was reduced for failing to provide information about workforce development, admission timeframes, or justice involved members; such information was not sought in Question 25. *See* Good Decl. ¶ 17; *and* Score Sheet.

h. Section 6.3, Question 27

This question asked "[d]escribe your organization's strategies and/or experience in implementing a home visiting program, such as for pregnant women and other high risk populations. Include evidence of improved outcomes." RFP at 47. HSD instructed its evaluators to consider whether the response "include[d] creative approaches for providing access to services in rural/frontier/Tribal areas (e.g. use of existing community resources." Score Sheet. HSD concluded that Molina's response was deficient because it "did not address rural or frontier areas." *Id.* Since the question did not seek information about rural or frontier areas—information that Molina could have readily provided had HSD—HSD used undisclosed bid criteria in violation of the law.

i. Section 6.3, Question 29

This question asked bidders to describe "the staffing and organizational structure of your organization's care coordination unit" and included some specific information that should be included. RFP at 47. HSD instructed its evaluators to consider , among other things, "Does the response include a comprehensive plan for training staff to work with complex populations including ways to measure the efficacy of training" and "Does the offeror plan to have staff who are bilingual" Score Sheet. HSD criticized Molina for not providing "details" regarding the use of bilingual staff and for not discussing how Molina would "evaluate[] the effectiveness of training." Score Sheet. But, neither of those factors were disclosed by HSD and HSD thus improperly relied on undisclosed evaluation criteria.

j. Section 6.4, Question 30

In Section 6.4, Question 30, HSD asked "Identify any measurable results in terms of clinical outcomes and program savings that have resulted from the Offeror's care coordination and/or service coordination initiatives." HSD reduced Molina's score for failing to provide "Details regarding integration of behavioral health lacked details." RFP at p. 48. Although behavioral health integration information was not listed in the question requirements, HSD directed its evaluators to score bids based on whether "the Offeror describe(s) any initiatives focused on behavioral health or integration strategies?" This undisclosed evaluation factor resulted in a decrease in Molina's overall score. Good Decl. ¶ 19; Score Sheet.

k. Section 6.4, Question 31

HSD asked bidders to describe their "strategies for reaching Members to engage in care coordination activities" and included a list of twelve different types of Members that were to be included. RFP at 48. HSD found Molina's response to be deficient because Molina's "use of bilingual staff lacked details" and because Molina's "efforts to engage difficult to reach members lacked innovation." Score Sheet. The RFP did not seek details about the use of bilingual staff or request innovative methods to contact hard to reach members. HSD thus used undisclosed bid criteria.

l. Section 6.4, Question 35

This question sought information regarding how bidders would "assess and evaluate effectiveness of its care coordination processes." RFP at 49. The evaluators were instructed to consider whether the response described "potential activities to implement based on results of evaluation," and Molina was faulted because its response "lacked details in how ideas are operationalized." Score Sheet. Since Question 35 did not ask for information about implementation or operationalization, HSD relied on undisclosed evaluation criteria.

m. Section 6.4, Question 37

Question 37 was based on a hypothetical scenario involving a homeless veteran with PTSD. *See* RFP at 49. Bidders were asked to describe the care coordination process that would be implemented for the hypothetical member, and 9 separate evaluation factors were disclosed. *Id.* Evaluators were told to consider whether the response indicated "effective strategies to locate and maintain contact with the member" and Molina was faulted for not providing sufficient information about how Molina would "find member." But, finding, locating, or maintaining contact were not within the nine disclosed evaluation criteria. HSD thus acted unlawfully when it considered this undisclosed criteria.

n. Section 6.4, Question 39

This question disclosed the same evaluation factors as Question 37, but used a different hypothetical member who lives in a pueblo community. HSD criticized Molina for not addressing the "frontier nature of member's home"—an evaluation factor that was not disclosed by HSD.

o. Section 6.4, Question 42

Question 42 sought information about "proposed innovations in care coordination" and asked for "examples of successful innovations implemented in New Mexico and/or other states" as well as "opportunities to increase the use of personal technology to improve member access to services and improve cost effectiveness of services." RFP at 50. The scoring criteria developed by Mercer asked the evaluators to consider, when scoring responses, "do you like it?" Score Sheet. The evaluators criticized Molina because "some innovations in response included elements that are not offeror products or did not demonstrate innovative nature." *Id.* Nothing in the RFP disclosed that a criterion of evaluation would be whether Molina's proposed innovations were its own products. Thus, HSD used an undisclosed criterion when deducting points from Molina. And, nothing in the RFP disclosed that a completely subjective standard of "do you like it?" would be used by HSD when evaluating Molina's Proposal. This subjective criteria was improper, as Molina has no way to determine what any evaluator may or may not like, and thus had no way in which to address this element of the RFP when formulating its proposal. Reviewing Proposals based upon an evaluator's personal preference is based on "information" outside the RFP process and is not permitted by the RFP. *See* Good Decl. ¶ 22.

p. Section 6.5, Question 47

Question 47 posed a hypothetical scenario involving a request for an increase in personal care service (PCS) hours for a member and asked how bidders would "address this situation with the Member, the representative and involved agencies" as well as an "explanation of your organization's processes associated with both approval and denial of this request for increased PCS hours." RFP at 52. HSD's

evaluators were instructed to evaluate whether the response addressed "the possibility of alternative solutions such as authorizing appropriate CB services (i.e., adult day health) and the ability of non-Centennial Care supports to provide assistance." Molina was criticized for not providing details about community resource options. Question 47 did not seek information about alternative solutions, and HSD thus relied on undisclosed bid criteria.

q. Section 6.5, Question 49

This question asked bidders to "describe how your organization will require the EVV vendor to update technology as it emerges to improve EVV functionality." RFP at 52. HSD instructed the evaluators to consider whether the response indicated "how the Offeror will monitor implementation of updated technology and measure effective and successful implementation." Score Sheet. Molina was faulted because its "response lacks details on how interventions will be implemented." *Id.* The question did not seek information about how interventions would be implemented or monitored and HSD thus used an undisclosed evaluation criteria.

r. Section 6.6, Question 55

Question 55 asked bidders to "describe the physical architecture and elements that will ensure that the requirements . . . for system and information security and access . . . are met." RFP at 54. Evaluators were instructed to consider whether the response "adequately address[ed] physical security" and Molina was criticized for not providing "detail regarding physical security." Question 55 did not seek details about physical security, and HSD thus used an undisclosed evaluation criteria.

s. Section 6.7, Question 62

This question sought a description of "any current or planned efforts or strategies and any barriers and proposed solutions to secure contracts with Tribal organizations for (a) non-emergency medical transportation services; (b) care coordination and/or case management services; (c) behavioral health services, including the treatment of substance abuse; and (d) Any other Medicaid-covered services provided outside of a clinic or hospital." RFP at p. 55. The evaluators stated that Molina's response was deficient in part because Molina did not provide detail about how it would "handle disputes for transportation." The evaluator's reasoning was that Molina did not "describe enough about how equipment [for telehealth] would be purchased" and that Molina only provided information about its plans to expand peer support "in one small remote area." Score Sheet. The RFP did not seek information about how Molina would handle disputes related to transportation, it did not seek information about the purchase of telehealth equipment, and it did not seek information about peer supports, much less information about plans for expansion (something that is not even a contracting strategy and thus would not be responsive to the question). HSD thus relied on an undisclosed criterion when deducting points from Molina.

t. Section 6.7, Question 65

This question in part asked Molina to describe the process it would use to "ensure that I/T/Us are reimbursed in a timely manner at one hundred percent (100%) of the rate currently established for the IHS facilities or Tribal 638 facilities by the Office of Management and Budget" as well as how Molina would "allow Native American Members to seek care from any I/T/U, whether or not the provider is a contract provider." RFP at 56. The evaluators asserted that Molina "did not address payment of claims when OMB

rate changes" and that Molina "did not adequately address how members and providers are informed about the ability to choose providers other tha[n] member handbook." The question did not seek information about OMB rate changes. To the contrary, the question was expressly limited to "the rate currently established." In addition, while the question asked how Molina would *allow* Native Americans to seek care from any I/T/U, the question sought no information about how "members and providers are informed about ability to choose"—the criteria that HSD relied on when deducting points from Molina. HSD thus used undisclosed criteria to evaluate Molina.

u. Section 6.7, Question 66

Question 66 asked bidders to "describe any current or planned efforts or strategies and any barriers and proposed solutions to secure contacts with Tribal organizations for" four types of services. RFP at 55. The evaluators were asked to consider whether the examples were "feasible for the Native American populations in New Mexico." Score Sheet. Molina was criticized because the evaluators thought that "plans to expand incarcerated outreach program does not seem feasible on tribal land. Need to explain how the Offeror will get access and data." ***Id.*** Feasibility was not a disclosed evaluation criteria, and had HSD requested information about the feasibility of the proposed solutions and the sources of data, Molina would have provided that information in its response.

v. Section 6.8, Question 72

This question sought a description of how Molina "will offer and manage separate benefit riders (buy-ins) for Members such as a dental or vision rider." HSD stated that Molina's response "lacked detail in payment and billing for rider services," but the question did not seek information regarding payment and billing. Instead, the question sought only how Molina would *offer and manage* separate benefit riders. HSD thus relied on undisclosed criteria.

w. Section 6.8, Question 74

Question 74 asked Molina to "describe your organization's proposed innovations in Member and provider services. Provide examples of successful innovations implemented in New Mexico and/or other states. Address your use or expanded use of personal technologies." Similarly to Question 42, the evaluators were asked to decide "do you like it?" when determining the responsiveness of bidders. Score Sheet. HSD stated that Molina had failed to provide information about "lessons learned"—a criterion that was not disclosed in the RFP. HSD's use of a completely subjective criterion (do you like it?) and an undisclosed criterion (inclusion of lessons learned) was improper. *See* Good Decl. ¶ 22.

x. Section 6.9, Question 75

This question asked: "Describe your organization's single case agreements and prior authorization (PA) process. Include, at a minimum: a) How PAs will be applied for Members requiring out-of-network services, or services for conditions that threaten the Member's life or health; b) How the Offeror will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration, or scope; c) Your process for Member access to emergency and nonemergency transportation; d) Your process for accessing out of state services or placements that require authorization; and e) How you will ensure and monitor for consistent application of review criteria." RFP at p. 58. Molina's response was marked as deficient because the "Response did not address exemption of ITU services from prior authorization." Score Sheet. Although the question did not request information on the prior authorization requirements

for ITU's, the evaluators were directed to score the response based on whether "the response indicate[d] an understanding that emergency services and services provided by I/T/Us do not require PA?" *Id.* The undisclosed evaluation factor resulted in a decrease in Molina's overall score. *See* Good Decl. ¶ 20.

y. Section 6.11, Question 87

This question sought information about Molina's "experience in the identification of other insurance held by its Members and other insurance that may be required to pay for services provided to Members (third-party liability) and coordination of benefits with third parties, including pay and chase methodologies." RFP at p. 60. HSD stated that Molina had not provided information about the results of its strategies, but Question 87 did not ask for information about the results of Molina's strategies. Thus, HSD relied on undisclosed criteria when deducting points from Molina.

z. Section 6.12, Question 91

Question 91 sought a description of "your organization's experience implementing VBP arrangements with providers in New Mexico or other states" and disclosed three specific evaluation criteria. RFP at 61. HSD's evaluators were instructed to consider whether "the response include[s] technical assistance that is sensitive to the needs of New Mexico providers and include[s]s methods to build provider readiness for valuebased purchasing arrangements." Score Sheet. Molina was faulted for not providing "details on how provider readiness is determined." *Id.* Provider readiness was not one of the three disclosed evaluation criteria and HSD's reliance on this undisclosed criterion was thus a violation of law.

aa. Section 6.12, Question 93

This question asked bidders to "[d]escribe how your organization evaluates the effectiveness of different VBP models, including measurement of healthcare outcomes." RFP at 61. The evaluators were instructed to consider whether the response included an "evaluation of cost, quality, and utilization of services as part of the evaluation" and Molina was criticized for not providing details about outcomes and cost evaluation. Score Sheet. Evaluation of cost and specific outcomes were not disclosed as bid criteria—Question 93 asked only for information about how Molina evaluated the *effectiveness* of models, not the cost of different models or the outcomes of different models. HSD thus used undisclosed evaluation criteria.

bb. Section 6.12, Question 94

This question stated: "New Mexico seeks to move provider payments to value-based payments per the contractual requirements outlined in Attachment 3 of the Sample Contract. . . . Describe your organization's strategy to achieve the VBP goals, including the types of VBP arrangements to be executed in each of the three levels." RFP at p. 61-62. HSD stated that Molina had "only include[d] contract year 1 and lacks detail on process and implementation." Score Sheet. The question did not seek information about multiple contract years. HSD thus relied on undisclosed criteria when it deducted points for Molina having only addressed one contract year.

C. HSD's Use of Undisclosed Bid Evaluation Criteria Requires Re-Solicitation of Bids.

The above anomalies in the evaluation process demonstrate that the procurement process as a whole was tainted and that the Contract awards were in violation of the law. HSD's evaluation of the Proposals

violated NMSA 1978, § 13-1-105 as HSD considered criteria outside the RFP itself. In other words, HSD "changed the rules in the middle of the game" by creating and applying bid criteria that were not disclosed in HSD's RFP. *Planning & Design*, 1994-NMSC-112, ¶ 17. In addition, HSD's reliance on undisclosed scoring factors is arbitrary and capricious because HSD "departed from the explicit statutory standards of the [Procurement Code and HSD regulations] and was not governed by any fixed rules." *Planning & Design*, 1994-NMSC-112, ¶ 23 (quoted authority omitted). Molina submitted its Proposal in reliance on the criteria and evaluation factors that HSD disclosed in the RFP, and HSD was prohibited from changing those factors when evaluating Proposals under New Mexico law. HSD, as evidenced by the many areas in which it and Mercer applied new and undisclosed evaluation criteria as well as irrelevant external information, "acted without an adequate determining principle." *Planning & Design*, 1994-NMSC-112, ¶ 23. "By unlawfully introducing, considering, and relying on a criterion not listed in the [RFP], [HSD] breached an informal contract that it would follow the Code and the Purchasing Manual in considering each bid." *Id.* ¶ 30. HSD's inclusion of undisclosed bid criteria *alone* justifies a reversal of HSD's Contract awards and either an award to Molina or re-solicitation of bids with full disclosure of all criteria that will be considered.

Because of the breadth of HSD's use of undisclosed bid evaluation criteria, it is difficult to determine the extent to which Molina's Technical Proposal Score would have increased but for HSD's unlawful conduct. But, under settled New Mexico law, it is not necessary for Molina to establish exactly how its score would have changed or what its score would have been had HSD not used undisclosed evaluation criteria. New Mexico does not require Molina to show that it would have been awarded a contract but for HSD's conduct. *See Planning & Design*, 1994-NMSC-112, ¶ 25 (noting that even an appearance of impropriety is consequential and "has very serious implications"). HSD's use of undisclosed criteria "defeated the object and integrity of the competitive bidding process" and has detrimentally impacted Molina as well as the citizens of New Mexico who rely on Molina as their MCO. If HSD had disclosed all of the criteria it relied on to deduct points from Molina, Molina would have submitted a different proposal. All of the areas where Molina lost points were areas where Molina readily could have provided the information at issue *had the need for that information been disclosed by HSD*. Molina was thus prejudiced by HSD's violation of law and arbitrary actions, HSD's actions impacted the entirety of the procurement process, re-solicitation of bids with full disclosure of all evaluation criteria or an award to Molina is appropriate.

D. HSD's Scoring of Molina's Technical Proposal Was Arbitrary and Capricious.

In addition to the numerous uses of undisclosed bid criteria which constitutes a violation of law, HSD also acted arbitrarily and capriciously when it evaluated Molina's Technical Proposal.[9] There are numerous instances in which HSD failed to consider information Molina provided in response to questions, engaged in disparate scoring of Molina and other bidders, deducted points for issues unrelated to the questions at issue, and otherwise failed to act with any guiding principle or with any rational and articulable basis. Because Molina believes that the undisclosed evaluation criteria listed above and the issues addressed below require either an award to Molina or re-solicitation of the RFP, Molina is not including the lengthy list of arbitrary and capricious scoring issues in the body of this protest, but is instead attaching the list as Attachment 1. Molina's inclusion of that list as an attachment is a recognition

[9] Because that proposal is in HSD's possession, Molina incorporates it by reference and will not attach as a separate exhibit hereto. The record of this bid protest includes the proposal of Molina as well as the proposals of all other bidders on the RFP, but those Proposals are not being attached hereto since they are in the possession of HSD.

that the issues addressed in Attachment 1 are not relevant if HSD reverses the Contracts on account of the other issues addressed in the body of this Protest, but is not in any way a waiver of those issues or an indication that the issues raised are not material.

Collectively, the arbitrary and capricious scoring issues identified in Attachment 1 show that (1) Molina's score would have been substantially higher if HSD had not acted arbitrarily and (2) that the procurement was so flawed that re-solicitation is required if HSD does not award a Contract to Molina.

E. HSD's Rates Were Not Actuarially Sound And Thus Should Not Have Been A Bid Criterion As The RFP Improperly Rewarded Bidders Who Accepted A Non-Viable Rate.

In addition to the services Mercer provided related to the RFP that are outlined above, Mercer's services also included setting the "cost structure" or "rate table" for the RFP. The rate table is a range of rates, from a minimum to a maximum, within which each bidder offers a price. The pricing is set at dollars PMPM. The pricing varies considerably depending on the "category" of member, as a member known to, for example, require behavioral health services, or living in a nursing facility, requires significantly more medical services than a healthy adult or child.

As an example, one category was physical health services for children whose parents receive Temporary Assistance for Needy Families (TANF) benefits who are 0 to 2 months old. *See* Sorrells Decl. ¶ 28. The rate range (rounded) was $5,004 to $5,281 PMPM. Each bidder then offered a price within that range; if accepted by HSD, the bidder would *in theory* receive that amount per member in the category, regardless of whether services were provided (this rate is termed a "capitation rate"). Lower prices offered by bidders resulted in higher scores on the cost factor.

In its proposal, Molina generally offered prices in the 70th percentile of the rate table. Thus, if the range was 0-100, Molina's offered price was about 70. Molina's pricing offer is actuarially sound and ensures that it can provide managed healthcare services to New Mexicans.

Molina is an incumbent MCO that provides healthcare services to 224,000 New Mexicans through the Medicaid program. Thus, Molina knows what it costs to provide quality healthcare to New Mexicans with Medicaid and priced its bid accordingly. By contrast, HSD admitted during the RFP process that the rate table created by Mercer and utilized for rates by bidders was not actuarially sound. In response to Question 38, submitted during the pre-bid Question & Answer process, HSD provided the following answer, which is public information:

> The min/max capitation **rates provided as part of this RFP are not the actuarially sound capitation rate range**. These are the range of rates HSD is willing to accept in response to the RFP. RFP Section 7.3, as well as the Data Book Narrative, outline elements that have been excluded from the min/max rates that will be adjusted following the contract award. (emphasis added).

See Sorrells Decl. ¶¶ 33-37. While the precise point at which the RFP rates become unsound is ultimately a determination for the certifying actuary, Molina has estimated that the RFP rates below the 50th percentile are unsound and unsustainable. *See* Declaration of Evan Swalheim, attached as Exhibit H. But, numerous bidders (and all three of the successful bidders) bid rates below this threshold and have those proposed rates that will not be approved by the certifying actuary or that, if approved, will be unsustainable.

The fact that the capitation rates set by Mercer are not actuarially sound makes the cost evaluation factor a violation of law, arbitrary and capricious, lacking in an evidentiary foundation, and fraudulent or in bad faith. Bidders were able to bid rates that HSD *knew* were unsustainable, and received a significant competitive advantage for bidding rates that simply will not allow an MCO to function in New Mexico. More importantly, the inclusion of unsound rates resulted in Proposals that, if actually implemented, will likely harm New Mexicans by forcing them to change MCOs (and likely health and behavioral healthcare providers) and will undermine the sustainability of Medicaid health coverage in New Mexico.

Given HSDs admission and Molina's own analysis, the rates bid by the successful bidders will not be deemed actuarially sound by the certifying actuary. The rates will thus have to be adjusted, and the rates *bid* will be unconnected to the rates actually paid. HSD's use of rates that it knew were unsound and would have to be adjusted was an abuse of discretion, a violation of law, and an arbitrary and capricious act. Since HSD chose to use unsound rates, rates and the bidders' scores on Cost Proposals should be eliminated from the RFP process.

F. Pricing Should Not Have Been A Factor in the Evaluation of Proposals Because the Prices Are Subject to Change, and HSD's Consideration Of Pricing Was Thus Arbitrary And Capricious.

While bidders were required to bid specific rates within the ranges that HSD has admitted were not actuarially sound, HSD's comments to questions regarding the RFP and Molina's knowledge of HSD's past practices indicate that pricing should not have been a factor in HSD's consideration of bids. HSD admitted in response to a bidder's question that rates "will be adjusted following the contract award." Thus, the rate that a bidder includes in its Proposal is, by HSD's own admission, not the rate that will actually govern the contractual relationship between HSD and a successful bidder. In its contract with Western Sky, for example, HSD makes clear that it "reserves the right to modify these Capitation Rates" and that its "decision to modify the Capitation Rates under the circumstances described above is binding on the CONTRACTOR." HSD Contract with Western Sky at 6.1.4, relevant portion attached as Exhibit I. HSD has several other contractual means to alter the rates. *See id.* at Sections 6.6. Negotiation of rates is also within the scope of the RFP. RFP at §2.2.13 ("HSD reserves the right to negotiate with successful Offerors regarding provisions that are in addition to or different from those contained in this RFP"); RFP at 28 ("HSD reserves the right to accept all or a portion of an Offeror's proposal").

On information and belief, HSD's past practices regarding rates have resulted in MCOs receiving substantially the same rate for many services such that any differences in rates between MCO's are not material. Molina is awaiting a response from HSD to IPRA requests seeking rates for the new MCOs selected during this RFP as well as historical rates for all MCOs, and will supplement this protest upon receipt of that information. If, as Molina believes, the rates actually included in the Contracts are similar, then HSD's decision to use costs and rates as a scoring factor is arbitrary and capricious as bid rates have no bearing on the actual costs to HSD. Bidders like Blue Cross Blue Shield, which received the maximum number of price score points on account of having bid the minimum (and unsound) rate across the board, should not receive a scoring benefit by virtue of their low bids if HSD, as it repeatedly reserved the right to do, adjusts the actual rates paid under the contracts. Molina bid with integrity and bid rates that it knew were sustainable and could actually be implemented in a Contract rather than unsustainable rates that will have to be adjusted either in the initial Contract or in subsequent years.

Eliminating the cost scores, which is necessary on account of the fact that the rates included in the Proposals have no bearing on actual rates paid, reorders the bidders such that Molina would have ranked third overall *even with* the numerous evaluation issues referenced above and the involvement of a biased third-party in the evaluation process. HSD's arbitrary and capricious use of a cost score thus materially impacted the order of bidders and the outcome of the RFP.

G. HSD's Scoring on Price Proposals Was Arbitrary and Capricious as the Scores Assigned Are Grossly Disproportionate to The Price Difference Between Bids.

The manner in which HSD assigned scores for bid pricing was also arbitrary and capricious. The dollar differences between the bidders' proposed prices were minimal, but the *score* differences stemming from those prices are completely disproportionate to the variation in pricing.

HSD sought price proposals in four separate categories: Physical Health, Long Term Services and Supports (LTSS), Behavioral Health, and Other Adult Group. While Molina's bid prices were consistently higher than those of the United Healthcare (the lowest bidder), the actual difference in price was minimal. *See* Cost Proposal Score Sheet. On Physical Health, Molina offered a weighted average bid price of $295.68. The lowest bidder offered a bid price of $286.25—a difference of only $9.43, or 3.29%. On LTSS, Molina bid $1,620.20. The lowest bidder bid $1,565.23—a difference of only $54.97 or 3.51%. On Behavioral Health, Molina bid $50.84. The lowest bidder bid $49.25—a difference of only $1.59 or 3.23%. And on Other Adult Group, Molina bid $409.03. The lowest bidder, United Healthcare, bid 395.92—a difference of only $13.11 or 3.31%. Molina's total bid price (a number calculated by HSD) was $477.29—only $13.79 (2.98%) less than the lowest bidder's total bid price of $463.50.

But while Molina's bid prices were just percentage points away from the lowest bidder's prices, the scoring impact was grossly disproportionate to the actual price differences. On each of the five categories (including the HSD calculated total bid price), Molina's score was *233.33%* lower than the lowest bidder's score. While Molina's bid prices were only dollars less than the lowest bidders, Molina only received 120 points on each of the price categories while the lowest bidder received 400. HSD has offered no explanation for this significant disproportionality, and HSD's significant deduction of points for minor price differences was arbitrary and capricious. There simply is no legitimate reason that Molina's pricing score would be so significantly lower than other bidders given the minimal price differences at issue.

It in fact appears that HSD's price scoring was completely unrelated to the differences between bidders' pricing, the viability of bidders' pricing (as explained above in the discussion on HSD's admission that the rates were not actuarially sound), or the benefits of different prices to the State or recipients of healthcare services. Instead, it appears that HSD simply assigned a score that was the inverse of the percentile at which a bidder bid. Molina's price bids, almost across the board, were at the 70th percentile of the permitted price range. And, Molina was awarded only 120 points of the possible 400 points for the cost proposal—30% of available points. Bidders willing to bid the unsound low end of the range were given a full 400 points, and bidders who bid at the top of the range were given no points. *See* Cost Proposal Score Sheet. HSD's decision to tie scores not to the relative merits of bidders' pricing but instead to simply the percentile in which the price fell is arbitrary and capricious. There is absolutely no rational basis for this decision which disproportionately rewarded bidders that bid rates that HSD has admitted are unsound and disproportionately penalized bidders who attempted to bid actuarially sound rates. Moreover, the price differentials between different bidders could have been readily resolved by HSD simply asking bidders at oral presentations if they would negotiate price—something that HSD expressly and repeatedly reserved the right to do. In other words, it should be the price that HSD actually

intended to include in the Contracts and bidders' willingness to accept those prices that governed price scores, not HSD's arbitrary deduction of points for bids that are not tied to what HSD would ultimately include in Contracts.

That HSD's cost scoring methodology is arbitrary and capricious is best evidenced by a comparison between Molina and Presbyterian's bid prices for LTSS. Such a comparison is provided in the table below. There were 11 categories within this tier. Molina, which bid all 11 categories with a rate in the 70th percentile, was only awarded 120 points. Presbyterian, which bid either the *highest* or the *lowest* rate in the range on all 11 categories (0 or 100th percentile), was awarded 360 points. This was because rather than look at the merits of a bidders' pricing, HSD arbitrarily assigned points based on the percentile of the bid. By bidding several rates at the bottom of the price range (a range that HSD admits is unsound and thus unsustainable), a bidder could thus ensure that several "400s" were built into the point average thus increasing the bidder's score. But for a bidder like Molina that bid prices based on (1) its knowledge of the New Mexico market (2) what rates are actuarially sound and sustainable and (3) rates intended to reflect Molina's actual expectations instead of point generating rates that would require negotiation, scores were lowered for no legitimate reason merely because the rates fell within a particular percentage range.

Program	**Min. Rate**	**Max. Rate**	**Molina Bid**	**Molina Bid Percentile**	**Molina Score**	**PHS Bid**	**PHS Bid Percentile**	**PHS Score**
Dual Eligible – NF LOC Nursing Facility (Region 1, 3, 4)	$4,993.04	$5,239.41	$5,165.5	70.0%	120	$4,993.04	0	400
Dual Eligible – NF LOC Community Benefit (Statewide)	$1,831.92	$1,917.40	$1891.76	70.0%	120	$1,831.92	0	400
Dual Eligible – NF LOC Nursing Facility (Region 2)	$6,015.61	$6,312.08	$6,223.14	70.0%	120	$6,015.61	0	400
Dual Eligible – NF LOC Nursing Facility (Region 5)	$5,657.37	$5,934.16	$5,851.12	70.0%	120	$5,934.16	100	0
Dual Eligible – Self Direction	$358.47	$374.41	$369.63	70.0%	120	$374.41	100	0
Healthy Dual	$183.21	$192.89	$189.99	70.0%	120	$192.89	100	0
Medicaid Only – NF LOC	$7,979.81	$8,355.01	$8,242.45	70.0%	120	$7,979.81	0	400

Nursing Facility (Region 1, 3, 4)								
Medicaid Only – NF LOC Community Benefit (Statewide)	$2,948.84	$3,108.50	$3,060.60	70.0%	120	$2,948.84	0	400
Medicaid Only – NF LOC Nursing Facility (Region 2)	$9,532.98	$10,012.10	$9,868.36	70.0%	120	$10,012.10	100	0
Medicaid Only – NF LOC Nursing Facility (Region 5)	$8,979.08	$9,397.40	$9,271.90	70.0%	120	$9,397.40	100	0
Medicaid Only –Self Direction	$1,799.52	$1,896.05	$1,867.09	70.0%	120	$1,896.05	100	0

If there was only one person in each of the 11 categories, the monthly payment to Molina (the total of all 11 categories) would be $52,001.54. And if there was only one person in each of the 11 categories, the monthly payment to Presbyterian (the total of all 11 categories) would be $51,576.23---only $425.31 dollars less than what Molina would receive. This minor difference in the total bid amounts has absolutely no rational relationship to the manner in which pricing was scored. Presbyterian and Molina's total bid amounts were not significantly different, but the scores each received are vastly different. By bidding very low on some areas and very high on others, Presbyterian was able to obtain a significantly better score than Molina, even though the totals between the two companies are substantially similar.

As evidenced by the gross disparity between bid differences and score differences, HSD's price scoring was arbitrary and capricious. Bidders like Molina that attempted to bid sustainable rates across the board were unduly penalized while bidders willing to bid unsustainably low rates were handsomely rewarded. HSD created a price scoring system that failed to generate pricing that will satisfy the best interests of the state, but that instead generated manipulation and gamesmanship. HSD's conduct on pricing *alone* justifies a reversal of its decisions.

H. HSD's Decision to Not Conduct Oral Presentations, an Additional Scored Component of The RFP, Was Arbitrary And Capricious.

According to the plain language of the RFP, HSD had the option to use a fourth scored component—oral presentations. *See* RFP at 17. While holding oral presentations was discretionary, HSD has failed to provide any explanation for its decision to forego oral presentations. This lack of explanation alone establishes that HSD's decision was arbitrary and capricious and an abuse of discretion. *See Phelps Dodge Tyrone, Inc. v. New Mexico Water Quality Control Com'n*, 2006-NMCA-115, ¶10 ("'An action is arbitrary or capricious if it is unreasonable, irrational, willful, and does not result from a sifting process' or 'if there is no rational connection between the facts found and the choices made.'"). Oral presentations

would have given HSD an opportunity to inquire about the financial integrity and provider/benefit issues that Centene has had in other states. *See* Sorrells Decl. ¶ 38. And, oral presentations would have allowed Molina to address the numerous undisclosed evaluation criteria, respond to extrinsic information about MHI that HSD apparently considered, address HSD's unfounded concerns about MHI's financial stability, and address issues regarding the unsound rates that HSD utilized in the RFP. HSD's procurement was well-ahead of schedule, so HSD certainly had adequate time to schedule and hold oral presentations without interfering with the anticipated March 15, 2018 contract award date. HSD's decision to not hold oral presentations, coupled with Mercer's involvement in the procurement, suggests that perhaps HSD and Mercer were concerned that the scores from oral presentations would change the bid order in a way that was unfavorable to Western Sky (and thus Centene, Envolve, and Mercer) or alternatively, favorable to Molina. Bidders could be awarded up to 400 points from the oral presentations, and a high score or a low score at oral presentations would significantly impact the order of bidders. *See* RFP at 21.

I. HSD's Decision to Reduce the Number of MCOs to Three Was Arbitrary and Capricious.

The RFP contemplated that up to five MCOs would be awarded contracts. The RFP stated that "HSD's intent is to contract with three to five MCOs unless it is in the State's best interest to do otherwise." RFP at 11. Inexplicably, HSD only awarded contracts to three MCOs—two incumbents and a third new MCO with a potentially serious conflict of interest. To date, HSD has provided no information justifying how its decision to depart from its stated intent to contract with up to five MCOs is in the State's best interest. It is difficult to imagine how reducing the number to eliminate Molina from Centennial Care is in the State's best interest, given the detrimental impact this change will have on member access to care and given Molina's service to the State and its citizens over the past 13 years. Reducing the number of MCOs from four to three will significantly constrain the options of persons who rely on MCOs, will result in *less* care, and will adversely impact the very people that HSD is responsible for protecting. But, reducing the number of MCOs is certainly in the best interests of Western Sky, Centene, Envolve, and Mercer, as Western Sky will have the ability to enroll a significantly larger number of New Mexicans if it only has two competitors in the state rather than four. Given the lack of explanation from HSD regarding its decision to reduce the number of MCOs to three, Mercer's involvement in HSD's decision, and the negative effect that the reduction will have on the State, HSD acted arbitrarily and capriciously and abused its discretion when it reduced the number of MCOs in the State.

The absence of an explanation from HSD *alone* renders HSD's decision arbitrary and capricious, as HSD was obligated to explain *how* its decision was in the best interest of the state. *See* 1.4.1.1.43(A) NMAC ("The procurement officer shall make a written determination showing the basis on which an award was found to be most advantageous to a state agency based on the factors set forth in the RFP."). It appears that rather than exercise its own discretion, HSD simply accepted wholesale the recommendations made by Mercer. By failing to explain its decision and by relying on a contractor to make decisions for it, HSD necessarily acted without a guiding principle or rational reason and its decision was thus arbitrary and capricious.

J. A Significant Financial Conflict of Interest Between Mercer And Western Sky Has Tainted The Procurement to Such An Extent That Re-Solicitation Is Required.

Western Sky, one of the three successful bidders, is a wholly-owned subsidiary of Centene. Centene has another subsidiary, Envolve, which is a specialty health services company (providing services such as pharmacy benefit delivery). *See* Western Sky Proposal at pg 1, attached as Exhibit J. Mercer has a

substantial contractual relationship with Envolve; based on information and belief, Mercer and Centene, through Envolve, have a billion or multi-billion dollar contractual business relationship.

Centene/Western Sky's Proposal makes clear that Envolve will be heavily utilized by Western Sky in New Mexico. Mercer has a vested interest in the success of Envolve, and apparently will benefit from any revenue and profit Envolve obtains from operations in New Mexico.

In its Proposal, Centene/Western Sky references Envolve often, and details its plans to utilize Envolve for many specialty services. When Centene/Western Sky referenced the use of Envolve's services, many of HSD's evaluators scored the bid particularly high. In addition, HSD evaluators made 17 comments[10] for superior elements[11] when evaluating two questions focusing on pharmacy benefits. *See* Score Summary for Western Sky Question Nos. 21 and 22. Mercer's partnership with Envolve focuses specifically on pharmacy services, and the Mercer trained evaluators' high marks for Envolve services thus directly implicates Mercer and its finances.

Because Mercer has a direct interest in the success of Envolve, and because Envolve is an integral part of Western Sky's Proposal, Mercer possibly[12] stands to gain financially from Western Sky's selection as an MCO in New Mexico and by the reduction in the number of MCO's in the State (since fewer MCOs means more enrollees for each MCO). There is nothing inherently wrong with a company benefitting from its business relationships—that is the very point of forming joint ventures, obtaining financial interests, and doing business. But, there is something inherently wrong when a company with a direct financial interest in the outcome of a procurement process is so interwoven in the process that it is, in effect, the procuring agency.

Mercer was centrally involved in developing, managing, and evaluating the RFP. Mercer created the RFP. Mercer analyzed the RFP and bidders' responses. Mercer trained the HSD employees who evaluated responses. Mercer made recommendations regarding what should be considered. Mercer made recommendations regarding the number of awards that should be given. Mercer made recommendations regarding scoring. Mercer made recommendations regarding which companies should receive awards. Mercer recommended that scoring stop once Western Sky was a top-three bidder. And, Mercer likely has substantially more involvement that will not be revealed (if ever) until HSD fully responds to Molina's IPRA requests. Not surprisingly, the only bidder in which Mercer has a financial connection was one of the three MCOs awarded a Contract and the only new MCO selected by HSD.

Mercer's conflict and its influence on the procurement process and the award results is perhaps best evidenced by Mercer's December 20, 2017 memorandum to Dan Clavio, HSD's Procurement Manager. Dec. 20, 2017 Memo, attached as Exhibit K. In that memo, Mercer recommends that HSD award contracts to the "top three highest-scoring Offerors and initiate negotiations with Presbyterian Health

[10] Other bidders received the following number of superior comments on those questions: 0 (Amerihealth), 2 (UHC) 3 (Molina and Wellcare), 9 (Amerigroup and Blue Cross Blue Shield), and 20 (Presbyterian).

[11] The score sheets include bullet-point comments in three separate sections—"Elements of the Response that Met RFP/Contract Requirements," "Superior Elements," and "Elements of the Response that are Deficient OR RFP Requirements Not addressed in Response." Molina refers to these as "superiors" or "superior marks" and "deficiencies" or "deficient marks" in this Protest.

[12] There is, at a minimum, an appearance of impropriety which requires Mercer's withdrawal from the procurement and re-solicitation of bids.

Plan, Inc., Western Sky Community Care, and Blue Cross Blue Shield of New Mexico." Without any detailed explanation, Mercer recommends that HSD only select three MCOs. And, without any explanation whatsoever, Mercer recommends "that no oral presentations will be required." *Id.* HSD accepted these recommendations without discussion or explanation.

The significance of Mercer's unexplained recommendations is that Mercer, not HSD, made the decision to forego an additional point-generating component of the procurement process at a stage when the company with which it has a financial connection was one of the top three bidders. Mercer was likely unwilling to take the risk that the oral presentations would move Western Sky from a top position to a position in which it would not be awarded a contract. Having achieved the result it wanted---selection of Western Sky---Mercer cut-off further point generation and thus ensured that Western Sky remained in the top three. HSD has provided no explanation for its decision to forego oral presentations. There was more than adequate time in HSD's proposed timeline to hold oral presentations, oral presentations would have given HSD important information about each of the bidders, and oral presentations were necessary for HSD to assess whether each bidder's proposal was in the best interests of the State. Given Mercer's connection to one of the top bidders, Mercer's decision to prevent any point shifting creates, at the very minimum, an appearance of impropriety that requires cancellation of bids and re-solicitation.

Mercer's contract with HSD for the RFP prohibits Mercer from "any interest, direct or indirect…which conflict in any manner or degree with … services provided."[13] Mercer has a clear conflict of interest, and should have played *no* role in the RFP. The conflict of interest is exacerbated because Mercer annually sets New Mexico's rates paid to MCOs for Medicaid services. Thus, Mercer will have the ability to raise the rates Centene's subsidiary will be paid, profiting Centene/Western Sky, Envolve, and Mercer itself. Because Mercer has set rates that Molina knows are not sustainable, this appears likely to occur. In other words, Mercer created the rates that allowed Western Sky to bid low, and Mercer has the ability to *increase* the rates that Western Sky is actually paid to ensure that Western Sky (and thus Envolve and Mercer) can make a profit. This impropriety has infected the procurement to such an extent that it cannot be undone.

It is not known at this time whether Mercer disclosed to HSD its substantial business relationship with Centene/Envolve/Western Sky. Mercer had a contractual obligation to disclose that business relationship. If Mercer did not disclose the business relationship, then Mercer acted in a biased manner, fraudulently or in bad faith, and in violation of law. If the business relationship was disclosed, then HSD had the right to terminate, and should have terminated, Mercer's contract related to the RFP. Mercer's contract was not terminated. If HSD knew of Mercer's relationship with Envolve, then HSD should have recognized that Mercer had a conflict of interest due to its business relationship with a Centene subsidiary. If HSD allowed Mercer to proceed with the RFP, knowing about the business relationship with Centene, then the RFP was conducted in a biased manner, fraudulently or in bad faith, and in violation of law. Either way, Mercer's conflict of interest creates, at the very least, an appearance of impropriety that requires re-solicitation of bids. *See Planning & Design*, 1994-NMSC-112, 25 ("The Code and the Procurement Manual are designed to preclude even the *appearance* of impropriety" (emphasis in original));.*Medco Behavioral Care Corp. v. Iowa Dep't of Human Servs.*, 553 NW2d 556, 568 (Iowa1996) (upholding

[13] HSD/Mercer Contract (**PSC 15-630-8000-0014) at Section 12, *available at http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Contracts/Medical%20Assistance%20Division/Actuarial%20Services/Actuarial%20%26%20Consulting%20Services%20-%20Mercer%20Contract.pdf*.**

district court's conflict of interest finding and disqualification of successful bidder finding when the parties who worked on the RFP development process had a direct or indirect, undisclosed business relationship with a subsidiary of the successful bidder); *NKF Eng'g v. United States*, 805 F.2d 372, 373-74; 376-78 (Fed. Cir. 1986) (upholding agency disqualification of bidder based on "an appearance of **impropriety**" when individual who developed portions of the RFP, including the evaluation plan and cost ranges, had an employment relationship with the bidder and noting that "whether or not the inside information [regarding costs] was actually passed" from the employee to the bidder, "the appearance of impropriety was certainly enough for the CO to make a rational decision to disqualify" the bidder); *Filtration Dev. Co., LLC v. United States*, 60 Fed. Cl. 371 (2004) (Actual organizational conflict of interest was proper basis for enjoining procurement until further analysis of the conflict of interest was performed); *Jacobs Tech. Inc. v. United States*, 100 Fed. Cl. 198 (2011) (injunction barring award of contract until further organization conflict of interest analysis was performed); *NetStar-1 Gov't Consulting, Inc. v. United States*, 101 Fed. Cl. 511 (2011), aff'd, 473 F. App'x 902 (Fed. Cir. 2012) (Potential organizational conflict of interest was not effectively mitigated, justifying preliminary injunctive relief); *Axiom Res. Mgmt., Inc. v. United States*, 78 Fed. Cl. 576 (2007) (contacting officer abused his discretion in not developing an adequate plan to mitigate organization conflict of interest).

K. The Prices Proposed by Western Sky Are Not Sustainable and, If Centene's Past Practices Hold True, Will Result in Western Sky Pressuring the State for Additional Funds Or Leaving the State.

Western Sky/Centene scored 254 points on the cost evaluation factor. Generally, it offered prices in the 40th percentile. As explained above, the prices or rates offered by Western Sky/Centene in New Mexico (and by other bidders that bid the low end of the price range or the bottom of the range) were not actuarially sound. These unsound rates will result in either Western Sky seeking additional funds from the state or Western Sky abandoning the New Mexico market. There is significant precedent for this by Centene and its subsidiaries.

Centene appears to consistently bid low in response to state requests for proposals, and then pressures a state for more money once established in the state. Centene and its subsidiaries have a history of failing to provide the services promised for the price offered. For instance, in 2013 a Centene subsidiary abruptly ceased providing managed care to Medicaid members in Kentucky when Centene began to experience adverse financial consequences from unsustainable rates. Although all of the MCOs in Kentucky at that time experienced similar losses due to the unsustainable rates, Centene was the only company to terminate its contract and leave Kentucky. This left Kentucky, its citizens, and the other MCOs to absorb the losses and solve the issue. The Commonwealth of Kentucky and its agencies estimated that Centene's exit from Kentucky cost the state upwards of $40,000,000. A settlement was eventually reached. *Kentucky Spirit Health Plan, Inc. v. Commonwealth of Kentucky*, Case # 12-CI-01373 (Franklin County Court; filed Oct. 22, 2012). We have not located an estimate of the cost to Kentucky's citizens.

It also appears that Centene fails to provide an adequate provider network as a means to lower costs. In December, 2017, another Centene subsidiary agreed to a fine of $1,500,000 imposed by the Insurance Commissioner of the State of Washington which was in part for Centene's failure to provide an adequate medical provider network to its Marketplace members. Prior to imposing the fine, the Insurance Commissioner provided Centene with a notice of suspension of its certificate of registration.

Then, on January 11, 2018, Centene and two of its subsidiaries were sued in federal court in the Eastern District of Washington. *Harvey v. Centene Corp., et al*., No. 18-cv-00012. The Complaint is a 15-state class action alleging that Centene failed to provide an adequate medical provider network for members in the following states: Arkansas, Arizona, Florida, Georgia, Illinois, Indiana, Kansas, Massachusetts, Mississippi, Missouri, New Hampshire, Nevada, Ohio, Texas, and Washington. *See Harvey*, No. 18-cv-00012, Complaint [Doc. 1], ¶ 26.

As alleged in the Washington class action, Centene denies valid claims from medical providers as a means of off-setting its low pricing, and therefore cannot sustain an adequate medical provider network. *Harvey*, No. 18-cv-00012, Complaint [Doc. 1], ¶¶ 12-21, 49-58.

Finally, another Centene subsidiary, Centurion, has been a defendant in, approximately 17 lawsuits in New Mexico for failing to provide adequate care to persons in New Mexico's prisons. *See Lawsuits claim inmates still getting poor healthcare*, Jan. 28, 2018, attached as Exhibit L. http://www.santafenewmexican.com/news/local_news/lawsuits-claim-inmates-still-getting-poor-health-care/article_a8f804d7-14a7-505e-81ab-9c47a8624b4a.html.

Based on Molina's review of documents thus far, Molina cannot confirm whether Western Sky reported these issues in the compliance history part of its Response to the RFP because that information has been redacted by HSD. These issues are substantial enough to warrant consideration for suspension or debarment. *See* NMSA 1978, § 13-1-178. Molina requests that HSD produce unredacted copies of Western Sky's compliance history so that Molina can assess the extent to which Western Sky disclosed these serious issue and whether HSD considered this significant information. Given the strong emphasis HSD put on MHI when evaluating Molina's Proposal, HSD's apparent failure to consider the serious harm Centene has caused in other states establishes that HSD acted arbitrarily and capriciously.

The fact that Mercer has a business relationship with Centene also calls into question the validity of the rates Mercer set for the RFP. Mercer is HSD's contractor for the RFP and for pricing rates for incumbent Medicaid MCOs. Centene, including through its subsidiaries, has a history of offering low prices for Medicaid contracts and other healthcare coverage, but being unable to provide the services promised. Mercer and a Centene subsidiary have a substantial business relationship and aligned business models regarding pricing. Despite that it was or should have been aware of these issues, HSD continued to contract with Mercer to manage the RFP and awarded a Contract to Western Sky, a Centene subsidiary. As the entity setting New Mexico's Medicaid pricing rates, Mercer will have the ability to raise the rates that Western Sky will be paid, profiting Centene, Envolve, and possibly Mercer itself depending on the nature of Mercer's "alliance" or partnership with Envolve.

The cost evaluation factor used in the RFP is not actuarially sound, as HSD has admitted, and is not sustainable. It was developed by Mercer and adopted by HSD despite the business relationship between Centene and Mercer, and Mercer's benefit from Envolve's proposed entry into New Mexico. Mercer had a conflict of interest in the RFP due to the bid by Centene/Western Sky. Mercer also developed a rate table and cost evaluation factors that benefitted Centene/Western Sky, and caused material harm to Molina. Likely more importantly, the cost factor has resulted in an award that will result in unsustainable pricing and impair services to New Mexicans. As such, Mercer's rate table, cost evaluation factor, and the award are not in the best interest of HSD, fraudulent and in bad faith, arbitrary and capricious, in violation of law, without substantial evidence, and outside the scope of HSD's authority.

L. HSD's Decision Is Not in the Public's Best Interest.

Unlike some procuring agencies, HSD is not obligated to award a contract to the lowest responsible bidder. Instead, HSD was only required to award contracts to bidders "whose proposals and scores are most advantageous to HSD." RFP Section 4.1. HSD is a state agency, and thus a representative of the citizens and the State of New Mexico. Thus, what is "most advantageous to HSD" equates to what is most advantageous to the citizens and the State of New Mexico. HSD's decision is not advantageous. To the contrary, HSD's decision will result in profound detriments to the citizens who rely on MCOs, to the state, and to HSD itself.

HSD intends to eliminate two incumbent MCOs: Molina and United Healthcare. HSD proposes to introduce a new MCO, Western Sky. And, HSD proposes to reduce the number of MCOs in New Mexico from four to three. Because of HSD's decision not to award a contract to Molina, Molina's members served under Molina's current contract, approximately 224,0000 New Mexicans, will be forced to seek a new MCO and health plan. Each will undergo the time, expense, and anxiety of changing plans, learning a new system, and trying to form new relationships with the MCO and new providers. Those New Mexicans will be forced to scramble for care, care which is currently and professionally provided by Molina, in a new medical provider network and a new behavioral health network. They will be forced to seek one or more new medical and behavioral health providers as a direct result of HSD's decision. Some or many may find an inadequate medical provider and behavioral health network, similar to the experience of people in Washington and, as alleged, in 14 other states. Persons who rely on Medicaid are often some of the most vulnerable, and forcing them to undergo significant changes is not in their best interests.

New Mexicans who are Medicaid members of Molina and currently in treatment will be forced by HSD to transition providers during treatment. This is difficult for any person, and is worse for members receiving behavioral health services and substance abuse services. Many of these members receiving behavioral health services had to change providers in 2013, when HSD suspended Medicaid payments to up to 15 behavioral health centers. As a result, many people went without behavioral health services at that time, and may suffer the same outcome as a result of HSD's decision with respect to Centennial Care. In New Mexico, 103,205 Molina members receive behavioral health services, and 35,036 Molina members receive substance abuse services. These members are particularly vulnerable to transitions in services and providers. The healthcare infrastructure that Molina has developed and provides to these members will be lost. That infrastructure includes detention center programs, investment in community based care, behavioral health, substance abuse programs, peer wellness centers, behavioral health telehealth equipment and supplies, paramedicine programs, and support for behavioral health providers. New Mexicans receiving behavioral health services will also likely face long wait times to receive needed treatment. New Mexico's other vulnerable populations will be particularly hard pressed to find the time, expertise, and resources to change MCOs and providers. New Mexicans receiving DME will likely face long wait times to receive needed equipment.

Moreover, as a result of HSD's decision, 10,000 Native American New Mexicans will lose an MCO with the demonstrated ability to provide culturally competent services to Native populations in New Mexico and other states. Such services were called out in the RFP as necessary in New Mexico.

Molina provides funding and services to other providers and local public agencies that will also be jeopardized by HSD's decision. For instance, Molina contracts with peer wellness centers to provide support services as an extension of its coordination and internal peer support services. Those centers

include Inside Out, Albuquerque Center for Hope and Recovery, First Nations Community Healthsource, Catron County Grass Roots, Pine Hill Health Center and Hozho Wellness. Those centers have been able to hire staff and/or expand their services and outreach as a result, and will be harmed by the elimination of Molina as an MCO in New Mexico. *See e.g.* Feb. 1, 2018 Letter from Inside Out Recovery, attached as Exhibit M. Molina has funded local public programs including the Bernalillo County Department of Substance Abuse Program ($200,000), the Dona Ana County Health and Human Services Department ($394,875), and the American Medical Response, Santa Fe Fire Department and Las Cruces Fire Department ($600,000 for paramedicine programs). Continued funding for these programs and maintaining their current staffing services is at risk due to HSD's decision.

As a result of HSD's decision, up to 1,119 New Mexicans currently employed by Molina likely will be forced to seek a new job, with new pay and benefits; and undergo the time, expense, and anxiety of trying to locate new employment, which assumes that the New Mexico market can absorb these employees, which is unlikely. Consequently, if Molina leaves New Mexico, many Molina employees may have no choice but to move outside the State.

HSD's decision is thus not in the best interests of the citizens of New Mexico, and HSD's conclusion to the contrary is arbitrary and capricious as HSD has not set forth any rational benefit that will flow from its decision.

HSD's decision to eliminate two incumbent MCOs, and add a new one, will create unnecessary administrative costs for HSD. Established business relationships, from technical to personal, will end or be changed. HSD will have to end its processes with two incumbent MCOs, Molina and UHC, as it establishes processes with the Centene subsidiary. Administrative costs will also be incurred as a result of the forced change in MCOs for at least a quarter[14] of New Mexicans with Medicaid coverage. Approximately 852,000 New Mexicans have health insurance through Medicaid. http://www.hsd.state.nm.us/uploads/FileLinks/587930e6bdd0402c9d4990a78c041734/Nov2017_MSR.pdf. Molina provides healthcare services for approximately 224,000, or about 26% of New Mexicans with Medicaid. Molina is the single largest Medicaid MCO for New Mexicans. Eliminating Molina from Centennial Care will end the economy of scale that Molina has developed. Molina has been able to provide high quality services to New Mexicans, despite unsustainable pricing rates by Mercer/HSD, due to these economies of scale. The loss of this economy of scale will place greater price pressure on Medicaid MCOs, HSD, and New Mexicans.

HSD does not seem to recognize the disruption its award will create. HSD has not recognized or addressed Molina's stability, economy of scale, or status as the largest provider of managed Medicaid healthcare services. HSD has provided no assessment or analysis regarding how the scope of Molina's services will be replaced, or whether any other MCO will be able to match Molina's provider networks, stability, and scale. HSD's decision to reduce the number of Medicaid MCOs will reduce HSD's negotiating power with the remaining MCOs. MCOs will have greater leverage to threaten to leave the state market, as a Centene subsidiary did in Kentucky. The quality of services to New Mexicans will suffer as a result. HSD's failure to articulate any rational basis for elimination of Molina, the reduction of MCOs, or its conclusion that the RFP and its results are in the best interest of the State evidences that HSD's actions were arbitrary and capricious and an abuse of HSD's discretion.

[14] HSD's elimination of United Healthcare will also have a significant impact on the State.

M. HSD Improperly Considered the Same Reference Source As Two Separate Sources When Evaluating Presbyterian's Bid.

The reference scoring sheets that HSD has provided indicate that HSD allowed Presbyterian to use the same reference twice. The reference scoring sheets indicate that Presbyterian received 96 points for reference number 3, City of ABQ Public Schools, and 100 points for reference number 2, ABQ Public Schools. While this issue would likely have been immediately recognized if HSD had not used a third-party contractor to assess the Proposals, Mercer apparently was unaware that there is only one public school district in Albuquerque—Albuquerque Public Schools. It thus appears that Presbyterian received 96 additional points on account of having used the same reference twice. Allowing a bidder to use the same reference twice is a violation of the RFP.

N. If HSD Declines to Award a Contract to Molina, Cancellation of the Three Awarded Contracts And Re-Solicitation of Bids is the Appropriate Remedy.

Rule 1.4.1.88 NMAC governs the remedies available to Molina. Pursuant to that section, "the contract may be terminated, and the business awarded the contract shall be compensated for the actual expenses reasonably incurred under the contract plus a reasonable profit or equivalent thereto prior to termination."

For the reasons stated above, moving forward with the Contracts as currently awarded is not in the best interests of HSD, and consequently not in the State's best interest. The procurement process was fatally flawed, and the interests of the public and of HSD require a *fair* and *impartial* procurement in which all evaluation factors are fully disclosed and in which no person or entity with a financial stake in the outcome of the process is permitted to participate in the decision-making or evaluation process. The very integrity of HSD's procurement process is at stake, and justice requires cancellation of all bids and re-solicitation of the RFP.

On information and belief, the Contracts between HSD and the three MCOs have not yet been approved by all stakeholders, and the effective dates are still sometime in the future. Work under the contracts does not commence until January 2019. Thus, cancellation of the contracts will have no impact on the three MCOs which likely have incurred little or no expenses in reliance on the contracts.

The New Mexico Supreme Court has instructed that cancellation and re-solicitation is appropriate when undisclosed evaluation factors are utilized, provided that the contract at issue has not been completed. *See Planning & Design*, 1994-NMSC-112, ¶ 31. Here, the contracts have not even commenced. Cancellation and re-solicitation is thus still an appropriate remedy, and HSD should remedy its errors by starting over so that all bidders have a full and fair opportunity to address the evaluation criteria and so that an impartial evaluator can determine which MCOs best meet the needs of New Mexico and HSD.

Alternatively, HSD should find that an award to Molina is in the best interests of the State and award an MCO Contract to Molina.

CONCLUSION

The defects in HSD's procurement of the RFP are legion. The impact on the State and its citizens is immense. HSD acted arbitrarily and capriciously by relying on numerous undisclosed bid criteria. HSD allowed a contractor that stands to gain from the outcome of the RFP to control nearly every aspect of the procurement. These actions have poisoned the procurement to such an extent that the only appropriate

963.**remedy is to start over. Molina's scores were materially affected by HSD's arbitrary and capricious actions, and Molina thus requests that HSD either (1) cancel all Contracts that resulted from the RFP, issue a new RFP without the involvement of Mercer, and consider the actual best interests of the State and its citizens; (2) award a Contract to Molina as such an award is in the best interests of HSD and the people of New Mexico; or (3) eliminate the cost proposal component of the scoring sheets and award a Contract to Molina.

Molina requests a hearing on these issues with a neutral decision maker.

Respectfully Submitted,

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ATTACHMENT 1: LIST OF ARBITARY AND CAPRICIOUS SCORING ISSUES

This list is based on the Score Sheet, Molina's Proposal, and where indicated, the Proposals of other bidders. All of these documents are in HSD's possession and a part of the record of this bid protest either as an attached exhibit to Molina's Bid Protest or incorporated by reference.

Question 6.1, Section 9: HSD faulted Molina for the "Use of "to the best of our knowledge" when discussing findings. The team believes the MCO should know definitively if there were findings?" Molina's use of "to our knowledge" does not reflect whether Molina knew of such findings. Instead, it reflected the uncertainty about the premium tax audit that has been an on-going and highly visible issue. Faulting Molina for using the phrase "to the best of our knowledge" is arbitrary and capricious. And, any concerns about Molina's use of that language could and should have been raised at an oral presentation.

Question 6.1, Section 13: "Generic information, lack of detail about vendors and MCO approach to oversight. Lots of vendors with minimal NM experience/presence." As discussed above, HSD has *already* approved all of Molina's vendors since Molina is an incumbent MCO, and faulting Molina for using pre-approved vendors is arbitrary and capricious.

Section 6.2, Section 14: HSD asserted that Molina was "Weak on details on addressing needs of children and adolescents." This is arbitrary and capricious because Molina's response provided detailed information about how Molina addresses needs of children and adolescents. Molina's proposal discussed Molina's "long-established statewide network of PCPs, including: pediatricians; family practice, general-practice, and certified-nurse practitioners; school-based health centers (SBHCs); Indian Health Services (IHS) providers; BH providers; specialists; and facilities to treat the various needs of New Mexico's children and adolescents." Molina also cited its 10 year-long partnership with Envision New Mexico, an extension of the University of New Mexico's Project ECHO, to address pediatric members with complex and/or chronic healthcare needs. Molina is also starting to fund All Faiths Children's Advocacy Center for their High Fidelity Wrap-around Services program, which will provide services such as intensive case management to members in the State's custody to create long-term community based natural supports for children and young people who have a history of complex behavioral health needs.

Section 6.2, Question 15: HSD faulted Molina as follows: "For LTSS only noted about VBP for NF providers. MCO only notes its existing experience – does not discuss challenges of building a network." This criticism is arbitrary and capricious because Molina did, in fact, include specific information about NFs in rural and frontier areas and was not limited to the NF VBP. Molina's answer was responsive and HSD's criticism of Molina not discussing challenges of building a network is arbitrary and capricious. In any event, Molina did provide a response regarding the strategies it has used for meeting the challenge of building a provider network, including "fostering close and collaborative working relationships, timely outreach to new providers, developing innovative programs that increase member access, and implementing VBP arrangements that support our rural and frontier providers." The response also faulted Molina for not discussing advisory boards, yet the RFP question did not ask for information on advisory boards.

Section 6.2, Question 16: HSD faulted Molina as follows: "MCO does not note what it has learned from monitoring initiatives. Does not address how results will drive future plans and strategies. More

detail on cost sharing is needed. MCO does not provide comprehensive discussion of current strategies such as data sharing." HSD's criticism of Molina is arbitrary and capricious because the RFP question did not ask for a description of what was learned, only strategies for monitoring and addressing contract issues.

Section 6.2, Question 17. HSD faulted Molina as follows: "Emphasis primarily on paraprofessionals rather
than making the pipeline bigger for clinical providers. Funding not made available to frontier, rural and
tribal areas." Contrary to HSD's statement, Molina did provide several examples of expanding services provided by licensed behavioral health practitioners. In addition, Molina provided several examples of funding to rural and frontier providers, including ITUs. HSD's disregard of Molina's responsive answers is arbitrary and capricious.

Section 6.2, Question 18: HSD criticized Molina's proposal as follows: "No mention of health homes either existing or efforts to expand to delegate care coordination." To the contrary, Molina acknowledged Centennial Care 2.0's goal of increasing care coordination at the provider level, and noted that it was entering into VBP and other arrangements in which Molina is transferring some of its care coordination activities to providers.

In addition, the evaluators asserted that Molina had not mentioned Health Homes. Health homes are not a component of behavioral health (the subject of the question), and Molina thus had no reason to address Health Homes. HSD thus deducted points from Molina for either an undisclosed evaluation criterion or due to a misunderstanding of the scope of behavioral health services.

Section 6.2, Questions 19 and 20: Molina addressed all elements of the question, including receiving superior elements for question 20, and received a score of 4 for each question. Presbyterian also received a 4 for each question, but for questions 19 and 20, Presbyterian had two deficiencies, and no superior elements. HSD thus arbitrarily assigned scores that are unconnected to its written findings.

Section 6.3, Question 21: As with other questions, HSD faulted Molina's proposal for providing limited or no information on specific items not identified in the RFP but set out as evaluation criteria in the scoring sheet. For example, the RFP question itself did not ask for cultural considerations; instead it asked Molina to ensure that medicines were appropriate to the "diagnosis, symptoms and age of child/adolescent" – those are demographical and clinical considerations – not cultural. In addition, Molina was criticized for failing to identify monitoring processes for specific drugs such as opioids, when, in fact, all of the monitoring practices Molina described would include opioids (and any other controlled substance) as a target for Molina processes.

Section 6.3, Question 22: HSD faulted Molina: "Response lacked detail on poly-pharmacy auto-denials to assess proposal." The RFP did not mention poly-pharmacy, so it was arbitrary for HSD to reduce Molina's score on this basis. This comment is especially confusing because there is no mention of poly-pharmacy in the response considerations either.

Section 6.3, Section 25: HSD commented; "Description does not expand the system – based on current approaches. For instance, there is no reference to work force development." This criticism is arbitrary because the RFP question did not reference "work force development."

Section 6.3, Question 26: HSD criticized Molina's proposal as follows: "Not clear how Offeror collaborates with providers for improved outcomes. Not clear how PCMH will conduct care coordination. Difficult to determine if PCMH model supports Integrated service delivery. Not clear that existing contract requirements are addressed such as: How community resources will be used. How HEDIS measures are used. No details regarding telemedicine approaches. Response did not address collaboration with other MCOs to reduce burden on providers." This criticism is arbitrary and capricious because the response considerations deviated from the RFP question, to which Molina responded.

Section 6.3, Question 27: HSD concluded: "Response overall was average. Response did not address rural or frontier areas. Discussion of nursing facility transitions did not appear relevant to the question. Response noted value added benefits but the examples provided are not value added benefits." To the contrary, Molina explicitly addressed rural areas, including challenges arising from providing services in rural areas and ways to address those challenges. Molina noted

> As Molina deliberated on a project to address the needs of high-risk mothers, we recognized many needed bed rest and were living in rural areas. In some situations, the nearest access to care was three hours away. This issue led us to embark on a home visiting program for pregnant mothers by expanding our contract with a company called Alere to provide medications for preterm labor.

Molina also provided many examples of benefits it considers "value added," including: Gestational Hypertension Program; Preeclampsia Program; Obstetrical Diabetes Management; Subcutaneous Insulin Infusion; Home Infusion Therapy; Continuous Ondansetron Infusion Therapy; Hydration Therapy; Continuous Metoclopramide Infusion Therapy; Lactation Consultation. HSD's failure to consider these portions of Molina's response was arbitrary and capricious.

Section 6.4, Question 29: HSD faulted Molina as follows: "Details regarding dually eligible members was lacking. Use of bilingual staff lacked details. Evaluated the effectiveness of training was not discussed. Acronyms used were not defined within the response section." This is another example of when the response considerations deviated from the RFP—the RFP question did not ask for information regarding dually eligible members and did not ask how the Offeror would utilize bilingual staff. The RFP question did ask how the Offeror will ensure diverse and culturally sensitive staff which Molina addressed in its response to this question. The RFP question did not ask to include an evaluation plan regarding the effectiveness of training for care coordination, rather it asks the Offeror how it will ensure training for complex members which Molina addressed in its response. HSD's assertion that Molina did not define all acronyms is simply wrong--all acronyms were defined except for BH, PH and IPoC, which was defined within the introduction, rather than within the question. In other words, Molina's score was reduced for failing to define a single acronym, which is arbitrary and capricious.

Section 6.4, Question 30: HSD faulted Molina as follows: "Details regarding integration of behavioral health lacked details." Nevertheless, the evaluators were tasked to consider whether "the Offeror describe[s] any initiatives focused on behavioral health or integration strategies?" The RFP question asked Molina to identify measurable results, and not behavioral health integration. As with the other examples Molina has noted, the fact that Molina did not include details regarding behavioral health integration should not have been considered a deficiency.

Also, Western Sky, whose proposal did not address behavioral health at all, scored a 4. HSD's assignment of points was thus arbitrary and capricious—not addressing a required topic at all should not result in the same point deduction as insufficient detail.

Section 6.4, Question 31: HSD faulted Molina's response to this question as follows: "Use of bilingual staff lacked details. Some areas lacked detail in actual operations. Efforts to engage difficult to reach members lacked innovation," yet the evaluators noted that Molina's "outreach innovations" were scored in the superior elements category.

Section 6.4, Question 33 and 34: HSD faulted Molina for referring to exhibits not included in question response. Although Molina did refer to exhibits not included in the question response, Molina's response was complete without the reference to the exhibits, and consequently, it was arbitrary for HSD to penalize Molina for including the exhibits.

Section 6.4, Question 36: HSD faulted Molina's response to this question as follows: "No efforts to obtain Medicaid under another category. Care coordination assignment is lacking. Response does not fully address needs of baby and mother. Response lacked details to fully evaluate the approach. Back-up plan insufficient." To the contrary, Molina's response to this question adequately addressed needs of baby with REQT D, E, F, G and H, and includes how the Operator will monitor improvements and member outcomes in addition to resolution for conflict or crisis to ensure any issues are fully resolved. HSD's criticism regarding Molina's back-up plan is arbitrary because it was not required in the RFP. Given the page constraints, there was no way Molina would have been able to mention or address all contract requirements within the narrative.

Section 6.4, Question 37: HSD faulted Molina's response as follows: "Overall response lacked details. Engagement of member was insufficient including how offeror will find member. Member outcomes in response lack understanding of challenges of homeless population and process to achieve the outcomes lacked details. Response does not demonstrate how to apply methods described in proposal." While Molina addressed all *RFP* requirements, the evaluator stated, incorrectly, that "[s]ome elements of the question were addressed." Due to the page limitations, it was not possible for Molina to mention or address all *contract* requirements within the narrative. Molina received a score of 2 on this question, even though Molina addressed each element of the question. HSD's scoring was thus arbitrary and capricious.

Section 6.4, Question 38, 39, 40: HSD faulted Molina's response failing to address elements of the RFP question, for lacking detail, and for issues with Molina's back-up plan unaddressed. Information about the back-up plan was not required by the RFP. Although it is a part of the contract, Molina could not mention or address all contract requirements within the narrative, because of the page constraints. In addition, Molina was very clearly compliant with the RFP requirements, addressing all of them. While Molina addressed all RFP requirements, the evaluators stated, incorrectly, that "[s]ome elements of the question were addressed." This was arbitrary and capricious.

Section 6.5, Question 43: HSD faulted Molina's response as follows: "Community benefit is not adequately addressed. Response indicates a lack of understanding of Medicaid eligibility. Unclear how housing need is addressed. Limited follow up to ensure BH services are provided." To the contrary, Molina, fully addressed these elements. For example, Molina answered the Medicaid eligibility item in the first paragraph of our response and Molina answered the housing item in the

diagram, "Collaborate with NF discharge planner and housing specialist to find affordable, accessible housing (e.g., MFP, reintegration housing, etc.). Molina addressed housing in Figure 5.1. HSD's disregard of that figure was arbitrary and capricious and HSD had no rational basis to ignore plainly responsive information.

Section 6.5, Question 45: HSD faulted Molina's response as follows: "Response lacks detail on types of reports used. Response lacks detail on fraud and abuse process and responsible staff. Use of EVV for self-direction lacks details to fully evaluate the approach. Response indicates a lack of understanding of use of EVV with self-direction." Penalizing Molina for alleged lack of detail on reporting is arbitrary because the RFP question asks how information from the system will be used, and is not specific to reports. This is another instance where the response considerations also do not align with the criticism of Molina's response because the response considerations also make no mention of reports.

Section 6.5, Question 47: The evaluators noted that Western Sky provided incorrect information, yet Western Sky still scored a 4. HSD's decision to give a bidder with incorrect information almost full points is inexplicable, and shows the arbitrary nature of HSD's scoring.

Section 6.6, Question 51: Molina received superior marks, but was only given four points. Presbyterian received superior marks, but was given 5 points. HSD's application of points was thus inconsistent and arbitrary.

Section 6.6, Question 52: Molina received a 4, which was the same score given to WellCare. But, Wellcare received a 4 in spite of having been marked deficient for not including a project plan. Inclusion of a project plan was a disclosed evaluation factor, and although WellCare was found deficient for not including one, the evaluators indicated that "all elements of the question were addressed"—a plainly incorrect conclusion. The scoring was thus inconsistent amongst bidders.

Section 6.6, Question 53: Molina was only awarded 3 points, and the evaluators commented "General lack of detail in the response." This was incorrect. Molina addressed each of the topics listed in the question, and described in detail who it worked with HSD on CM processes. Presbyterian, like Molina, was found to have one deficiency mark, but somehow received a 4 instead of a 3.

Section 6.6, Question 54: Molina's response was given two superior marks, but Molina was only awarded 4 points. Blue Cross, also with two superior marks, was given a 5. And Presbyterian, which received two deficiency marks, was given the same score as Molina (4). This disparate scoring establishes that HSD acted arbitrarily and capriciously as its scores were not rationally connected to its findings.

Section 6.6, Question 55: Molina was awarded only three points, and the evaluators commented that Molina's response to the question had a "lack of detail regarding physical security." Score Sheet. This was incorrect. Molina's responses addressed physical security multiple times: first in response to Question 54 ("Our Albuquerque-based Data Center and Network Operations Center provides 24/7 support for all systems and network infrastructure; industry standard safeguards include physical security measures such as card access systems, locked storage to secure equipment, 24/7 surveillance, and enforcement of policies and procedures for Data Center visitors (e.g., full time escort)") and then

again in response to Question 55 ("Our System and Information Security Matrix restricts systems access on a 'least privilege' basis. The matrix restricts user access to specific system functions and information based on an individual user profile. Users are granted the appropriate level of security access options appropriate to their function within the company."). This fully addresses the question and requirements found in Sample Contract, and meets and exceeds all standards and is fully HIPAA Compliant. HSD appears to have failed to consider Molina's actual response.

Section 6.6, Question 56: HSD stated that Molina's response did not sufficiently address SSNRI, ICD-10 and COBA. To the contrary, Molina stated in its response that it already fully complies with SSNRI, ICD-10, and COBA by supporting SSNRI, ICD-10, and COBA now and continuing to do so in the future. Molina currently supports SSNRI, ICD-10, and COBA by processes that monitor for new emerging standards. Molina also noted that it had been compliant since 2014, and that it monitors for emerging standards. HSD thus disregarded Molina's response.

In addition, United Health Care was given three deficiency marks but scored higher, and Wellcare received a deficiency mark for HIPAA transactions but somehow was given 4 points. HSD's scoring of Molina and other bidders was arbitrary and capricious.

Question 6.6, Question 57: Molina was awarded 3 points and the evaluators commented that Molina's response had a "lack of detail regarding HIE, EHR and PHR." But, Molina's response addressed all aspects of the question (and was given superior marks). Molina's response explained that

> An essential foundation for improving healthcare quality and reducing the cost of care, HIEs can support risk-based contracts through effective, patient-centric views of care, including tools and reporting to assist in achieving and measuring improved outcomes. Recognizing the value of PHRs and EHRs to the care and service of our members, we actively work with contracted providers that are utilizing EHRs to promote interoperability with our systems, New Mexico's HIE, and EDIE. We continually educate providers about the benefits of EHRs as the platform to improve communication between the members and providers.
>
> New Mexico Health Information Collaborative (NMHIC). We support NMHIC's desire to grow to include all hospitals in New Mexico and the surrounding areas as well as a majority of provider practices, including behavioral health (BH), long-term care, home care, social services, first responders, and criminal justice. We continue to work and partner with NMHIC and providers to define critical quality measures required, including new meaningful use quality measures and the Merit-based Incentive Payment System (MIPS). We also support HSD in its efforts to apply for HITECH 90/10 federal matching money that could provide the necessary capital to expand and further enhance the State's HIE, with the ultimate goal of connecting all medical providers and health systems statewide. Molina also is leading an effort with NMHIC and the state of Colorado to integrate and share data with the Colorado Regional Health Information Organization (CORHIO).
>
> PreManage EDIE. In recognition of an HIE's important role as a central coordinating entity for high value data services that connect various provider and healthcare stakeholders, we have leveraged a best practice from our sister health plan in Washington State by leading an initiative to launch an EDIE in New Mexico. To support this initiative, we have partnered with Collective Medical Technology (CMT), which works with more than 1,400 ACOs, health plans, hospitals,

clinics, and other ambulatory settings in 13 states. CMT serves most of the largest national U.S. health plans and many of the most sophisticated health systems in the country. PreManage EDIE is an ED-based collaborative care management tool leveraged by hospitals that reduces the avoidable risks of complex high-cost and high-needs patients who may frequent multiple points of care.

PreManage EDIE has produced significant quantified results; for example, our sister plan in Washington is a key partner in the ER is for Emergencies program in Washington State, which achieved the following outcomes that we also plan to target in New Mexico:
•9.9 percent decline in ED visits for the Medicaid population
• 27 percent reduction in rate of Opioid related overdoses
• 24 percent decrease in rate of visits resulting in a scheduled drug prescription
• 14 percent decrease in rate of ED visits with a low acuity diagnosis across the Medicaid population
PreManage Community connects risk-bearing healthcare stakeholders, including Managed Care Organizations (MCOs), ACOs, FQHCs, and RHCs. The solution not only provides real-time visibility into the comings and goings of a member, group or patient panel, but more importantly, it facilitates encounter-based risk stratification of the member population—down to the patient level and at the point of care; subsequently, it enables care collaboration across differential organizations united through their shared relationships with the patient.

Molina leads a collaborative effort with NMHIC and EDIE to avoid duplication of services, eliminate redundant connections to common clients/stakeholders, and add speed to value. To support a more robust and collaborative health information exchange, we diligently pursue this partnership and integration opportunity, which would have more significant and positive impact on the health of all New Mexicans."

Molina thus provided the detail that the evaluators assert was lacking.

Section 6.6, Question 58: Molina received 4 points, and the evaluators asserted that Molina did "not address reconciliations of paid claims and encounters." While Molina did not use the term "reconciliations" (it was not part of the question), Molina expressly addressed the topic by noting that it performs daily audits using a claims tool that assesses billed and approved amounts. Molina also noted that its audits include verification of payment accuracy. Molina thus provided the information that HSD's evaluators claims was lacking.

Section 6.6, Question 59: While Molina was found to have addressed all elements of the question and received three superior marks, it was not scored consistently with other similarly performing bidders. Molina was only awarded 4 points while Presbyterian was awarded 5.

Section 6.6, Question 60: Molina was only given 2 points for its response to this question, despite the evaluators having concluded that "nearly all elements of the question were addressed." It is unclear why HSD scored Molina so low, as Molina's response provided detailed information regarding how Molina responds to data requests:

Molina is experienced in responding to regular and ad hoc data requests from the State, including but not limited to claims reports, telemedicine reports (e.g., costs of telemedicine services), care

coordination levels by membership and cohort, ED data, pharmacy data (e.g., drug usage), and nursing facility level of care data. We always prioritize data requests from the state contractors and auditors over internal operational reporting.

We use several reporting systems to generate these reports, including QNXT, mClinical, Molina Operational Data Store (ODS), and the Enterprise Reporting Repository (ERR). From an operational perspective, we have dedicated teams, such as our analytics team and care coordination team, which work in concert to address State data requests.

From a drug rebate program perspective, we receive reports from the State's vendor related to pre-audits, audits, and disputes and review the requests for recoupments and re-submissions. We continually monitor and invest in QNXT to ensure all claims requirements are met before the claim is paid. In the case of claims being eligible on the CMS rebate file and subsequent retro terminations, we recoup payments made on those claims. We contact the provider to explain the issue regarding terminated National Drug Codes (NDCs) and the intent to recoup payment on those claims. In cases where certain claim elements are incorrect (e.g., when the provider bills the correct units but incorrect volume), claims are re-processed.

As described, we initiate steps to address/resolve Drug Rebate program disputes, and we continue to enhance tracking mechanisms to comply with the requirement for a two-week response for pre-audits and audits and a three week response for disputes."

Section 6.6, Question 61: Molina was awarded 4 points for its response to this question, and received 3 superior marks. But Presbyterian received the same score despite having received a deficiency mark and Wellcare was awarded 5 points despite only having received 2 superior marks. The scoring was thus inconsistent.

Section 6.7, Question 62: Molina was only awarded two points for its response to this question, but HSD failed to appropriately consider Molina's response. For example, while HSD faulted Molina for "Plan to expand peer support but only in one small remote area," HSD apparently construed Navajo to mean a location, not a language, as Molina's response discussed two Native American staff who specialize in Native American cultural approaches to recovery and who provide services to all of Molina's Native American members. While Molina mentioned that the services can be delivered in Navajo, that was a reference to the *language* that Molina's staff members speak, not a "small remote area." It appears that HSD's evaluators might have construed the response as referencing Navajo, NM—a small area in McKinley County. And while HSD faulted Molina for not providing "enough detail," HSD apparently ignored that Molina set out in detail Molina's telehealth expansion via grants and mentioned specific providers that had received grants and how the money was used.

Section 6.7, Question 63: Molina was only awarded 3 points for its response to this question. The evaluators faulted Molina for only identifying one staff member for claims and billing rather than the two required by contract. But, claims and billing had no relationship to this question and it appears that HSD either included an evaluation criteria that was not disclosed or incorrectly included a comment for another question (or another bidder) in this section. Molina should not have been penalized for that error. The evaluators also claimed that Molina's cultural sensitivity plan was too general and did not address hiring and providing Native American care coordinators, address interpreter services, address assessments or identification of language preferences for member, and did not address provider training. But, Molina's response did address these issues. HSD

acknowledged that Molina received an NCQA award in 2016 for Multicultural Health Care Distinction. But, HSD did not consider the meaning of that award (despite Molina having explained the significance). Molina noted that "The award certifies that our plan is culturally and linguistically sensitive and provides outstanding services in the following: collection of race/ethnicity and language data" [which refutes the comment that Molina does "not address assessments or identification of language preferences for members"]; "provision of language assistance" [which addresses HSD's concern about interpreter services]; "cultural responsiveness; quality improvement of culturally and linguistically appropriate services; and reduction of healthcare disparities. The distinction demonstrates our commitment to improving access to culturally and linguistically appropriate services and materials. Further, our NAA department includes members with valuable language skills, and we assign care coordinators and other staff with those language abilities as needed."

Molina also highlighted the rare expertise that its Native American Affairs staff possess in reading, writing and speaking two of the most populated languages in NM, as well as the work that the Tribal Liaisons and ITU Liaison perform to ensure providers and members are connected for continuity of care. It is referenced that Molina's ITU Liaison works with staff to receive a list of members and the Native American staff conduct regular provider training for both I/T/U and non-I/T/U staff.

Section 6.7, Question 64: Molina was only awarded 3 points for its response to this question, and the evaluators commented that Molina "did not include a rich enough group of radio stations to reach Native Americans," that "Coverage of outreach through tribal outlets was very general and not innovative," and that Molina had not indicated whether its Native American care coordinators were sufficient or whether caseloads were appropriate. With respect to the tribal outlets issue, it appears that the evaluators faulted Molina based on the evaluators' misunderstanding of tribal issues.
Molina cited Native American publications and tribal radio that are specific to the Native American community. HSD's evaluators apparently did not understand that the Navajo Times and the Gallup Independent are shared and distributed nationally and in Native American communities—these are thus far reaching publications that reach a large number of Native Americans, not just locals.

In addition, the question was to highlight "how we communicate effectively with Native American Members in Rural, Frontier, and Tribal areas…through translation, local media and outreach…" In order to be culturally sensitive to communities, Molina cited its ability to work directly with tribal administration to establish protocols and to obtain blessings from Pueblo communities in working with all of their tribal programs. Molina focuses on bringing that information back to its staff to ensure that requested protocol is followed. There are many facets of doing tribal outreach and each community is not the same. Thus, HSD's assertion that Molina's response was too general reflects a misunderstanding of tribal issues—Molina's general strategy is to identify and address the needs of each specific community.

As to the last issue HSD's evaluators found, HSD never requested information about caseload or hiring. HSD thus relied on an undisclosed evaluation criteria.

Section 6.8, Question 69: Molina was awarded 4 points for its response to this question. The evaluators commented that Molina's "expansion of provider access through contracting adjoining counties is not a desirable strategy for expanding access" but acknowledge that Molina had provided additional strategies. Given that HSD acknowledged that Molina used other strategies, HSD's criticism of Molina and apparent deduction of points for *also* including a strategy HSD dislikes was arbitrary and capricious. HSD also faulted Molina for not providing the "nature of contact" for call

center staff to contact providers (which is done within two days). But, the method of contact has no bearing on what actually matters which is the quick resolution of claims. Deduction of points for this was unwarranted.

Section 6.8, Question 71: Molina was only awarded 3 points for its response to this question, and the evaluators criticized Molina because the evaluators found it "difficult to navigate the steps in the response" and because Molina indicated that it "'Worked' with providers to waive missed appointment fee rather than taking more direct approach." With respect to the first issue, Molina provided a step-by-step graphic to support the text, and it is thus unclear how the evaluators found it difficult to navigate. With respect to the second issue, Molina cannot conceive of a more direct approach than communicating directly with a provider. Molina should not have lost points for these issues and HSD's deduction of points was arbitrary and capricious.

Section 6.8, Question 74: Molina was awarded 4 points. The evaluators asserted that Molina did not provide details on lessons learned and that innovations were focused on members and not providers. The question did not seek information about lessons learned (an undisclosed evaluation criteria) and provider innovations had been fully addressed in response to previous questions. It was thus arbitrary and capricious for HSD to deduct points for these purported deficiencies.

Section 6.9, Question 79: Molina was awarded 3 points. The evaluators asserted that the "role of NQIC was unclear." But, Molina described what the NQIC does and how the NQIC interacts with the local QI team. Molina went on to describe the NQIC in detail:

> 1)The National Quality Improvement Committee (NQIC) reviews the need for CPGs 2) The NQIC reviews the top health issues for our members, determines the need for adoption of CPGs, and researches current clinical evidence and evidence-based recommendations and guidelines published by national organizations. 3) If not, the NQIC involves board-certified practitioners from appropriate specialties in the development or adoption of its own clinical practice guidelines 4) All approved CPGs approved and adopted by NQIC are then shared with local Clinical Quality Improvement Committees for approval and adoption and distribution to appropriate network providers 5) CPGs voted on and adopted by the NQIC are monitored and updated on a quarterly basis.

HSD's criticism was thus unfounded.

Section 6.11, Question 86: Molina was only awarded 4 points, even though the evaluators noted that Molina addressed all elements of the question and received superior marks. No explanation was provided by HSD for the deduction of a point, which renders HSD's decision arbitrary and capricious.

Section 6.11, Question 87: Molina was only awarded two points, despite the evaluators having concluded that most elements of the question were addressed. But, Presbyterian received 3 points even though the evaluators found that Presbyterian had not provided enough detail for a full evaluation of the response. HSD's assignment of points thus was arbitrary and capricious as it was unconnected to the evaluators actual findings.

Section 6.11, Question 88: Molina was only awarded 4 points, even though the evaluators noted that Molina addressed all elements of the question and received superior marks. No explanation was provided by HSD for the deduction of a point, which renders HSD's decision arbitrary and capricious.

Section 6.11, Question 89: Molina was awarded only 3 points, and was faulted for not providing last calendar year's report on the average number of days to pay providers." But, Molina indicated on page 260 of its proposal that the 2016 report was attached as Exhibit 17.6. HSD's disregard of this report was arbitrary and capricious.

6.11, Question 90: Molina was only awarded 4 points, even though the evaluators noted that Molina addressed all elements of the question and received superior marks. No explanation was provided by HSD for the deduction of a point, which renders HSD's decision arbitrary and capricious.

Section 6.12, Question 91: Molina received 4 points and was faulted for not providing details on how provider readiness is determined. But, readiness is not a disclosed element of this question. And, in response to Question 94, Molina provided specific details about provider readiness, noting that

> "We apply a comprehensive assessment to determine provider readiness to participate in our VBP programs. This allows us and our providers to evaluate core capabilities and systems that are critical for providers to succeed under VBP contracts. It includes consideration of a provider's organizational size and the number of empaneled Molina members, as well as the provider's level of sophistication in managing clinical, financial, operational performance, data integration and data integrity, and levels of risk. Upon completion of the assessment, we begin collaboration and negotiation with each provider on VBP model design, readiness, and implementation."

Molina thus addressed readiness in its Proposal and should not have been faulted for not including readiness in response to Question 91 (especially given that readiness was an undisclosed criterion for Question 91). In addition, Western Sky, which like Molina had one deficiency, receive a full 5 points. This disparate treatment is arbitrary and capricious**.**

Section 6.12, Question 92: While HSD found that Molina addressed all elements of the question and that Molina had no deficiencies, HSD inexplicably only gave Molina 4 points. This unexplained deduction of a point was arbitrary and capricious.

Section 6.12, Question 94: Molina was only awarded 2 points for its response to this question. HSD faulted Molina for not addressing hospital as part of its strategy, which was an arbitrary and capricious finding given that Molina's response expressly stated that "[g]oing forward, we have a number of strategies in place to expand our network of VBP contracted providers. In 2017, we have focused on engaging larger provider groups such as . . . hospitals . . . ."