To: Charles Milligan, Jr.
Chief Executive Officer
UnitedHealthcare of New Mexico, Inc.
8220 San Pedro NE
Albuquerque, NM 87113

From: Daniel Clavio
Procurement Manager
NM Human Services Department

Date: January 19, 2018

Subject: Announcement of Award - RFP # 18-630-8000-0001
For Managed Care Organization Contractors for Centennial Care 2.0

Via email: charles.milligan@uhc.com

Dear Offeror:

This letter is to advise you that on January 19, 2018 contracts were awarded to the following vendors as a result of the referenced procurement, RFP # 18-630-8000-0001 for Managed Care Organization Contractors for Centennial Care 2.0.

- HCSC Insurance Services Company, operating as Blue Cross and Blue Shield of New Mexico
- Presbyterian Health Plan, Inc.
- Western Sky Community Care, Inc. (Centene Corp.)

The following documents summarizing the RFP evaluation and scoring process are attached in this email:

- Scoring Results Summary – Executive Report, no attachments
- Evaluation Committee Report to Secretary Earnest
- Evaluation Committee Report Signatures
- Evaluation Committee Meeting Notes Memo

The Scoring Results Summary with attachments (1600+ pages) will be sent in a separate email.

The protest period shall begin on January 20, 2018 and end at 5:00 p.m. Mountain Time Zone on February 5, 2018. In the event of a protest, HSD will continue with this procurement because the award of the contract is necessary to protect the substantial interests of the Human Services Department (HSD).

Requests for additional documents related to this procurement should be directed to Julie Lovato, HSD Public Records Custodian, at Julie.Lovato@state.nm.us.

Sincerely,

Daniel Clavio
Procurement Manager

cc: Christopher Collins, General Counsel, HSD
    Gary O. Chavez, Chief Procurement Officer, HSD
AFFIDAVIT OF NANCY SMITH-LESLIE

STATE OF NEW MEXICO
COUNTY OF SANTA FE

NANCY SMITH-LESLIE states as follows:

1. My name is Nancy Smith-Leslie. I am over the age of eighteen years, and I am competent to make this statement. I have personal knowledge of each factual matter set forth in this statement and each factual matter contained herein is true and correct.

2. I am the Director of the Medical Assistance Division ("MAD") for the State of New Mexico Human Services Department. I previously served in various other capacities with MAD from 2000 to 2002 and again since 2006 to present.

3. HSD, through MAD, is responsible for administering Medicaid funds and oversees Centennial Care, the State’s Medicaid managed care program.

4. The Centennial Care program serves roughly 700,000 New Mexicans and is presently administered by four Managed Care Organizations ("MCO"): Presbyterian Health Plan ("PHP"), Blue Cross Blue Shield ("BCBS"), United Healthcare and Molina Healthcare of NM ("Molina").

5. HSD implemented Centennial Care through a Section 1115 Demonstration Waiver that was approved by the Centers for Medicare and Medicaid Services ("CMS"), a division of the U. S. Department of Health and Human Services ("HHS"), for a five year period, from January 2014 through December 2018.

6. Because the Section 1115 Waiver expires at the end of 2018, HSD is in the process of renewing the Centennial Care federal waiver, which will be effective January 1, 2019. This is what is referred to as Centennial Care 2.0.
7. HSD conducted extensive public input sessions and outreach events from October 2016 through October 2017 to obtain feedback about its plan to renew the Section 1115 Waiver. Throughout the year-long public process, and on multiple occasions, HSD presented its timeline for both the waiver renewal and the re-procurement of the MCOs, describing how the two processes were in alignment.

8. Leadership from Molina was present at many of these public sessions and did not object to HSD’s plan to align the renewal of the Waiver with the MCO procurement.

9. The New Mexico Department of Health (“DOH”) and the New Mexico Children, Youth and Families Department (“CYFD”) also participated in the public input process for the renewal of the Section 1115 Waiver and offered feedback, including provisions of new Medicaid services, such as home visiting for at-risk families.

10. Prior to Centennial Care, when HSD managed multiple MCO waiver programs, HSD procured new managed care contracts every four or five years. With the integrated Centennial Care Program in 2014, HSD procured its current contracts in alignment with the five-year Centennial Care Section 1115 Waiver and purposefully established them as five-year contracts to align with programmatic requirements and services in the 1115 Waiver.

11. The last re-procurement was in 2012, when Molina was a successful bidder. Most of 2013 was a ‘readiness review period’ to ensure MCOs were prepared to offer all services and accept enrollment for Centennial Care, beginning January 1, 2014. Similarly, most of 2018 will be used as ‘readiness review period’ in preparation for Centennial Care 2.0, beginning January 1, 2019.
12. Mercer provided consulting services during the 2012 MCO procurement, assisting with the evaluation process, and provided the exact same services for the 2017 MCO procurement. All Offerors were aware of Mercer's role in the process.

13. Given that the Section 1115 Waiver expires in December 2018, HSD sought bids from companies for provision of managed care services for Centennial Care 2.0 in a September 2017 Request for Proposal, RFP # 18-630-8000-0001 (the “RFP”).

14. In the RFP, HSD published an estimated timeline to complete the procurement process. HSD also included a disclaimer in several sections of the RFP stating that the timeline was an approximation and that HSD reserved the right to change it at any time. The estimated timeline for contract negotiations with successful offerors was shorter than anticipated, largely because the expected contract was provided with the RFP and there were few requested changes.

15. The RFP also stated that oral presentations regarding the RFP were to be conducted at HSD's discretion. No oral presentations were held regarding the RFP, as they were deemed unnecessary by the evaluation committee.

16. Molina did not object to HSD's decision not to hold oral presentations, until learning they were unsuccessful.

17. No oral presentations were held for the 2012 procurement process in which Molina was a successful offeror.

18. The RFP disclosed the criteria that HSD would consider in evaluating the bids, including each factor, the maximum points available for each factor, and each subfactor. See RFP at Section 6, p. 42. The RFP also disclosed the relative weight given to each factor, as required by NMSA 1978, §13-1-114.
19. The RFP did not require offerors to propose price offers that they deemed “actuarially sound.” The RFP requested offerors to propose rates within a minimum and maximum range, as described below. See ¶¶ 21 through 22.

20. HSD/MAD contracts with an actuary, Mercer, to make final determinations of rates that are actuarially sound. Managed care plans do not determine actuarial soundness of the rates submitted to CMS for approval.

21. The minimum and maximum rates could not be certified as “actuarially sound” because certain costs, unknown at the time of the procurement, were explicitly excluded. See RFP, Section 7.3. These exclusions were addressed in the RFP, data book narrative, mandatory pre-proposal conference presentation, pre-proposal conference discussion and written responses to offerors’ questions.

22. The RFP, data book narrative, mandatory pre-proposal conference presentation, pre-proposal conference discussion and written responses to offerors’ questions provided consistent information about the following elements of the cost proposal process:

- HSD supplied all offerors with a data book that included detailed documentation describing the methodology, data sources and adjustments used to develop the minimum and maximum rates. HSD clearly documented the rate elements that were specifically excluded from the rate ranges, such as premium taxes, which were unknown at the time of the RFP release and would be adjusted prior to finalizing the rates as actuarially sound;
- The minimum and maximum rates were developed in accordance with generally accepted actuarial principles and practices by Mercer credentialed actuaries who are members of the American Academy of Actuaries;
- The data book provided as part of the RFP identified how the minimum and maximum rates were derived, including detailed information about the various adjustments and their impacts;
- The RFP clearly stated that the range represented the amount HSD was willing to pay (prior to these identified adjustments) for each of the 26 rating cohorts and that the cost proposal amounts would be used for purposes of cost scoring and later adjusted to include the identified exclusions prior to January 1, 2019; and
Each Offeror could calculate its own cost proposal score prior to submitting its RFP response by utilizing all of the materials supplied by HSD, including the RFP, data book, pre-proposal conference materials, and HSD's responses to Offerors' questions.

23. On September 19, 2017, HSD held a pre-proposal conference, where bidders had an opportunity to ask questions and clarify issues concerning the RFP. Daniel Sorrells, President, and Tina Rigler, Vice President of Government Contracts, from Molina were present but did not raise any concerns regarding the evaluation criteria.

24. HSD was responsible for evaluating and scoring the bids. Thirty-two HSD subject matter experts from HSD's MAD and Behavioral Health Services Division served as the state's RFP evaluation team. They participated on 15 evaluation committees and were assigned based on their particular expertise. During the weeks of November 6th through December 3rd 2017, each HSD evaluator independently read assigned sections of the RFP, within their area of expertise, and scored each Offeror's response. From December 4th to 15th, 2017, the HSD evaluators participated in the consensus scoring sessions. These sessions resulted in one consensus team grade per question. This process is further described in the “Scoring Results Summary.” See Exhibit G.

25. Mercer had no decision making authority in the RFP technical evaluation process.

26. Molina's technical score was fifth out of eight offerors, having scored low in the following key areas: benefits and services, experience and qualifications, care coordination, value-based purchased, among others. Molina's responses did not showcase a thorough understanding of the care coordination program or cultural considerations for New Mexico's unique populations.

27. Molina's cost proposal was the highest (receiving the lowest score). While Molina has asserted the difference in its cost proposal from another Offerors' cost proposal is only "pennies on the dollar," an initial estimation of Molina's proposal would cost the Medicaid program $94 million more annually than another successful Offeror.
28. On January 19, 2018, HSD awarded contracts to PHP, BCBS, and Western Sky, the successful offerors. The Secretary of DOH and the Secretary of CYFD, as Executive Committee members of the Behavioral Health Purchasing Collaborative, reviewed and signed the new MCO contracts.

29. Four of five unsuccessful offerors have submitted protests, as provided for in the RFP.

30. An injunction would be harmful to the public, HSD, and the successful offerors. The Medicaid program is highly complex and requires significant investment and resources to operate.

31. A thorough readiness review period is necessary to ensure provision of basic health care services, such as paying claims to providers, enrolling New Mexicans in the health plan, and administering multiple benefit packages to ensure services are provided -- from prenatal care to nursing facility services to pharmacy.

32. The alignment of the federal 1115 waiver start date, (See ¶ 5-10, ¶ 13) with the MCOs’ contract start date is necessary so that the new MCOs are ready to implement all of the new initiatives approved by CMS. Some of the new initiatives include:

- substance use disorder care and treatment;
- home visiting services to focus on prenatal care, post-partum care and early childhood development; and
- Supportive housing for individuals with serious mental illness.

33. The existing MCO contracts and provider networks do not include these services.

34. HSD must have a sufficient “readiness period” in order to provide continuity of care and services and ensure the health and safety of Medicaid members. HSD must also ensure that the MCOs are able to meet all state and federal regulatory standards and requirements, including:
• ensuring mandatory and optional benefit administration;
• meeting capitation rate development standards;
• complying with provider network adequacy standards;
• extending enrollee rights and protections;
• meeting quality standards;
• implementing program integrity safeguards;
• adherence to system requirements for enrollment and payment standards, including the ability to pay timely and accurate claims submitted by providers for services rendered to patients; and
• ability to meet all federal financial participation requirements.

The complex compliance assessment conducted by HSD in all of these areas requires considerable planning and allocation of staff resources that cannot be over-stated.

35. A review and readiness period of less than ten months is not sufficient to provide continued levels of service established under the Centennial Care program and is not in the best interest of the state nor of its Medicaid members. HSD must ensure and certify readiness of Centennial Care 2.0 MCOs by August in preparation for open enrollment in October. The open enrollment period provides an opportunity for members to choose the MCO that best serves their needs.

36. Based on letter from Mercer [Exhibit B], it is my understanding that Mercer does not have a financial partnership with Envolve, as asserted by Molina.

37. Mercer informed HSD that it does have a financial relationship with Molina in another state's market.

38. On a separate matter, in October of 2017 and prior to HSD's evaluation of the RFP responses submitted by Offerors, Mercer informed HSD that they had received a request from the parent company of Blue Cross/Blue Shield of New Mexico to provide consulting services to assess mental health parity for its commercial products. I requested that Mercer not proceed with the consulting services to avoid even the appearance of a conflict of interest. Mercer agreed and declined the work.
FURTHER AFFIANT SAYETH NOT.

NANCY SMITH-LESLIE

The foregoing instrument was subscribed, sworn to and acknowledged before me this 15th day of February, 2018, by NANCY SMITH-LESLIE.

My Commission Expires:

March 14, 2019

Deanna Anaya
Notary Public

OFFICIAL SEAL
Deanna Anaya
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires: 3/14/2019
STATE OF NEW MEXICO  
COUNTY OF SANTA FE  
FIRST JUDICIAL DISTRICT  

MOLINA HEALTHCARE OF NEW MEXICO, INC.,  
Plaintiff,  
v.  
NEW MEXICO HUMAN SERVICES DEPARTMENT,  
and BRENT EARNEST, as Cabinet Secretary of the  
New Mexico Human Services Department.  
Defendants  

AFFIDAVIT OF JARED NASON  

STATE OF ARIZONA  
COUNTY OF MARICOPA  

Case No. D-101-CV-2018-00356  

1. My name is Jared Nason. I am over the age of eighteen years and I am competent to make  
this statement. I have personal knowledge of each factual matter set forth in this statement,  
and each factual matter contained herein is true and correct.  

2. I am a principal within Mercer Government Human Services Consulting group (Mercer  
GHSC). Mercer GHSC is located in Phoenix, AZ and is an independent unit of Mercer  
Health and Consulting LLC (Mercer). Mercer GHSC’s work focuses exclusively on  
government Medicaid consulting and our primary goal is to help states efficiently purchase  
health care. Mercer GHSC does not engage with Mercer’s many clients in sectors unrelated  
to government consulting services.
3. Mercer GHSC has a long-term consulting relationship with the New Mexico Human Service Department (HSD). I was the project leader for the Mercer GHSC team that provided HSD with consulting services in connection with Request for Proposals 18-630-8000-0001 (the RFP), in which HSD sought to contract with a number of Managed Care Organizations (MCOs) to provide managed care to New Mexicans under New Mexico’s Centennial Care Medicaid program.

4. Mercer GHSC assisted HSD by facilitating the RFP process. Mercer GHSC provided consultation on the drafting of the RFP and in answering questions from prospective offerors. My team facilitated discussions among HSD evaluation committee personnel, and only HSD subject matter experts scored the numerous technical aspects of the proposals. Mercer’s only direct role in the scoring process was to compute the scores for the cost proposals – a merely quantitative exercise.

5. Mercer GHSC provided similar services to HSD when HSD first solicited MCOs for Centennial Care 1.0 in 2012. Molina Healthcare of New Mexico, Inc. (Molina) was a winning offeror in that process and had no complaints regarding Mercer’s work on it. In fact, Molina defended Mercer GHSC’s work on the 2012 RFP against challenges from the unsuccessful offerors.

6. Molina now questions the propriety of Mercer GHSC’s participation in the RFP based on a contractual relationship between Envolve Pharmacy Solutions (“Envolve”) and Mercer, but as the Affidavit of David Dross sets out, that contract provides no compensation to either party.

7. More importantly, neither I nor any member of the Mercer GHSC group working for HSD had any knowledge prior to this lawsuit that Mercer and Envolve have a contractual
relationship in the limited area of specialty Pharmacy Benefit Managers. I polled my team after learning of the press release and lawsuit and none had even heard of Envolve. We could not have acted in support of an alleged interest based on a relationship we did not know existed.

8. Mercer GHSC provided consulting services to HSD free from bias or any real or perceived conflict of interest.

9. Further, since the filing of this lawsuit, I have also learned for the first time that Molina NM’s parent company, Molina Healthcare, Inc. (a Delaware corporation) is also a Mercer client. Beginning in 2016, Mercer professionals located in California and elsewhere began providing health consulting services to Molina, a client relationship which continues. The services do not include Medicaid – related matters. Neither I, nor any other member of my team on the NM HSD engagement was aware of this fact until after the lawsuit.

FURTHER YOUR AFFIANT SAYETH NAUGHT.

JARED NASON

The foregoing Affidavit of Jared Nason was subscribed and sworn before me on February 23, 2018.

Notary Public

My commission expires:

FRANCINE F TARNOW
NOTARY PUBLIC, ARIZONA
MARICOPA COUNTY
My Commission Expires July 31, 2020
April 18, 2013

Sidonie Squier
Cabinet Secretary
New Mexico Human Services Department
2009 S. Pacheco
Santa Fe, NM 87505

Re: RFP # 13-630-8000-0001; UnitedHealthcare’s Response to the Arguments Posed in Protest Letters

Dear Cabinet Secretary Squier:

Following the February 8, 2013 announcement from the New Mexico Human Services Department ("the Department") that it intended to enter into Contracts for the Centennial Care program with BlueCross BlueShield of New Mexico, Molina Health Care, Presbyterian Healthcare, and UnitedHealthcare Community Plan, several of the unsuccessful Offerors, including Western Sky Community Care, Lovelace Community Health Plan, and Amerigroup Community Care of New Mexico (hereinafter, "Protestors") filed protests with the Department on March 5, 2013. We have reviewed and analyzed the protests from the three unsuccessful bidders, and we believe their arguments are without merit. Specifically, we believe that the Protestors cannot satisfy their burden of establishing that the Department’s decision was anything but fair, reasonable, and in conformance with New Mexico law. Accordingly, please consider this letter as a response to protests on the Centennial Care Request for Proposal ("RFP") # 13-630-8000-0001. For the reasons set forth below, we respectfully submit that all claims contained in the protests should be dismissed.

ARGUMENT & AUTHORITIES

The Protestors essentially challenge two aspects of the RFP process: (1) the Department’s scoring methodology as applied in the RFP; and (2) the Department’s decision to discard individual scorers’ notes, while maintaining the consensus scoring tabulations. However, the Protestors’ arguments are without merit. Specifically, the Protestors cannot establish that the Department’s decision on the Contract awards should be set aside because it was somehow erroneous, unfair, not supported by substantial evidence or in violation of New Mexico statutes or regulations. In fact, the Department’s scoring methodology is a well-recognized process. It has been utilized in numerous bidding situations as a way to determine whether the bidders have a cost effective yet responsible price bid. The scoring used by the Department has been in general use in multiple states and is an accepted and proper methodology. As such, the Department’s decision should be upheld in full.
Furthermore, as to Lovelace’s arguments, the Department should find that Lovelace’s challenge to the cost scoring methodology is waived because Lovelace (1) was the successful bidder under a similar scoring process used by the Department here on a prior occasion, (2) signed a Transmittal Letter and Compliance and Acceptance Statement acknowledging that it would be bound by the terms of the scoring methodology process, and (3) failed to challenge or question the scoring methodology prior to its bid submission.

Finally, Lovelace’s submission is flawed and nonresponsive because it made significant and inappropriate population adjustments to the Physical Health sub-cohort, and it failed to make an adjustment for the nursing facility increase as instructed by the RFP and accompanying documents. These failures to adhere to the RFP’s cost proposal instructions and accompanying cost proposal templates should disqualify Lovelace’s bid. At the very least, these failures demonstrate that Lovelace’s point deductions for falling outside the accepted rate ranges were appropriate.

I. ACTS OF PUBLIC OFFICIALS ARE PRESUMED TO BE VALID

Before turning to the merits of the Protestors arguments, it should first be noted that there is a strong presumption in New Mexico that acts of government officials are presumed valid. All public officers in New Mexico take an oath to support the Constitution of the State. State ex rel Gibson v. Fernandez, 40 N.M. 288, 295, 58 P.2d 1197 (1936). Accordingly, in New Mexico, “there is a presumption that public officers have performed their duties in a regular and lawful manner.” State v. Rivera, 115 N.M. 424, 431, 853 P.2d 126 (Ct. App. 1993); see also Davis v. Westland Development Co., 81 N.M. 296, 298, 466 P.2d 862 (1970); Fulwiler v. Traders & Gen. Ins. Co., 59 N.M. 366, 374-75, 285 P.2d 140, 145-46 (1955) (finding that a public official was presumed to have complied with his duties); Herrera v. Zia Land Co., 51 N.M. 390, 391-92, 185 P.2d 975, 976 (1947) (“the law presumes that public officials perform their duties until the contrary is shown”); State ex rel. Delgado v. Romero, 17 N.M. 81, 85, 124 P. 649, 650 (1912) (presumption exists that each department of the government will do its duty). This presumption places the burden on the party challenging the agency’s decision, namely, Lovelace, Amerigroup, and Western Sky, to produce evidence to establish the contrary. State v. Rivera, 115 N.M. at 431.

II. THE SCORING APPROACH APPLIED BY THE DEPARTMENT WAS FAIR, REASONABLE AND IN CONFORMANCE WITH NEW MEXICO LAW

The Protestors cannot establish that the scoring approach taken by the Department in the RFP was unfair, unreasonable, or in violation of New Mexico law, such that the Department’s contract awards should be set aside. See McDaniel v. New Mexico Bd. of Med. Exam., 86 N.M. 447, 449, 525 P.2d 374, 376 (1974) (finding that where there is room for two or more opinions, an agency’s decision should not be set aside as long as it is exercised honestly and upon due consideration, even though it may be believed that an erroneous conclusion has been reached).
A. The RFP's Use of Rank and Range in the Proposal Process Was Logical and Reasonable

The Protestors do not have a successful challenge to the rank and range components of the Cost Proposal process because the Department followed a logical and reasonable scoring approach that promotes viable long-term business relationships and complies with State law.

New Mexico requires that procurement awards for professional services “shall be made to the responsible offeror or offerors whose proposal is most advantageous to the state agency or a local public body, taking into consideration the evaluation factors set forth in the request for proposals.” N.M.S.A 1978 § 13-1-117. In other words, under this statute, the cost element of the proposal is only one factor to be used in making an award. Other factors, including the bidder’s ability to deliver the services at the cost specified in its bid, must also be considered. Nonetheless, Lovelace argues that the Department should have valued the rank component (how a proposal ranks from a cost standpoint in relation to other proposals) more than the range component (how a proposal compares to the actuarially sound rate ranges for cohorts). Lovelace Protest, pg. 3.

As background on the rank and range components, Medicaid health plans get paid a monthly capitation rate or set amount for each enrollee. Typically, these rates vary according to the enrollee’s geographic location, eligibility category, and age/gender cohorts. Cohorts are merely groupings of like people based on demographics, statistics or market research. Furthermore, states (such as New Mexico) and the federal government require that the rates be “actuarially sound”, meaning that the rates must be approved by a qualified actuary who must determine that the capitation rates have been developed through a sound actuarial process. See 42 C.F.R. § 438.6(c)(2); 42 C.F.R. § 438.50(c)(1); Section 1903(m) of the Social Security Act. States often contract the rate derivation and actuarial certification to actuarial consulting firms (such as Mercer). In acknowledgement that there are inherent factors in setting rates for future time periods that cannot be precisely foreseen in advance, Mercer develops an actuarially sound range (rather than a single number) for each rate cohort.

In the bid process for a Medicaid MCO procurement, Mercer typically provides the same prior year baseline information it used to develop the rate ranges and then invites the applicants to make their own assumptions about cost trends and the degree to which their care coordination will be able to impact the baseline costs. These rate ranges are intentionally not disclosed. Price bid points are awarded for the rate (e.g., lower bids warrant more points), and for where each bid falls within the rate range. Bids near the low end of the rate range warrant the most points, with fewer points being awarded the higher the bid and for bidding outside the range. Mercer’s scoring methodology evaluates each rate cohort bid individually and then rolls the cohort-specific bids into an aggregate price bid score, which requires weighting of the different cohorts.

Use of rank and range scores in RFPs is a standard process that has been used in over a dozen Medicaid procurements in multiple states for many years. See Report of J. Menges, p. 2 (Ex. A). Specifically, utilization of the range score is a sensible method for determining how well an MCO can serve the Department, as well as the Medicaid population. The Department’s range score
compares the Offeror’s bid ranges to the Department’s predetermined range. The Department’s range includes the full corridor which the Department determined is actuarially sound. Report of J. Menges, p. 2. All payments to selected MCOs will occur inside the rate range in every rate cell. Report of J. Menges, p. 2. Thus, comparing the Offers to the “hidden” range is advantageous to the Department.

In addition, the range indicates how well an MCO can serve the Department because the difference in ranges has significant ramifications for the State. Report of J. Menges, p. 2. Small percentage variations in the rates translate to large dollar actual payment differences. Report of J. Menges, p. 2. Medicaid coordinated care is a tight margin business, with the difference between a financially viable contract and a non-viable contract being quite narrow. Report of J. Menges, p. 2. For these reasons, it makes sense for the MCOs to be allowed to exert control over their own price bid, but also to give the Offerors strong incentives to bid in a manner that is responsive to the needs of the Department and the State. Report of J. Menges, p. 2.

Similarly, the Department has a strong reason for discouraging irresponsibly low bids. The Department realizes no marginal benefit when an MCO bids below the bottom of the rate range in any given rate cell. Report of J. Menges, p. 2. Plans that bid below the rate range in a given cell are moved to the lowest point in the rate range for that cell. Report of J. Menges, pp. 2–3; 42 C.F.R. 438.6(c)(2); 42 C.F.R. § 438.50(c)(1); Section 1903(m) of the Social Security Act. The Department will pay the lowest amount it legally can under actuarially sound regulations—it cannot pay a bid that is too low regardless of the Offeror’s original bid. Report of J. Menges, p. 3. When a bid is outside the rate range, it needs to be brought back into the nearest end point of the rate range. Report of J. Menges, p. 3. Thus, the range score is very important because that is the amount the Department must pay.

Lovelace asserts that what the Offerors bid was irrelevant, as this price bid would be adjusted during the contract negotiations. This argument is erroneous. Contrary to Lovelace’s assertions, all price bids that were made by the selected Offerors were accepted as the contracted rate, based on the fact that these price bids fell within the range that the Department determined to be actuarially sound. Any bidder that submitted a price bid outside the Department’s range was docked points; however, it is still possible that a bidder who bid outside the range could still have been awarded a contract. In this low-bid situation, however, the price bid would have been brought up to the nearest end point on the range, such that the contracted rate fell within the Department’s actuarially sound range. Accordingly, the only situation in which an adjustment would be made to a price bid for purposes of contracting would be if the bid fell below or above the actuarially sound range.

In addition, contrary to Lovelace’s assertions, there is no significant detriment for having a low bid. The scoring “penalty” for bidding just below the low end of the range is modest in the context of the overall procurement. Report of J. Menges, p. 2. It is only when an applicant bids high (within or above the range) or bids far below the range that significant price point deductions occur. Report of J. Menges, p. 2. Lovelace exaggerates the price differences that will persist once all bid amounts that lie outside the rate ranges are brought back to the nearest boundary. The statement clearly exaggerates the State Funds impact and also presumes that the initial bid rate differentials will carry
forth throughout the five year contract, whereas pricing dynamics will likely evolve in the out-years of the contract in ways that are not strongly tied to each MCO's 2012 price bids. Report of J. Menges, p. 3.

Here, Lovelace suggests it did not properly benefit from its rank bid—the third lowest—and argues its poor performance in the range category was too heavily weighted. Lovelace Protest, pg. 2. Lovelace also asserts that the range component yielded more variation in the scoring and skewed the results. Lovelace Protest, pg. 4. However, New Mexico law requires the Department to award a Contract to the Offeror whose proposal is most advantageous to the agency. Here, it is advantageous for the Department to have a viable business relationship with its Managed Care Organizations (“MCOs”). The RFP’s bidding methodology promoted this business relationship by encouraging Offerors to provide their lowest actuarially sound bid and by providing Offerors incentives for bidding responsibly.

Accordingly, the Protestors cannot establish that the Department’s use of the rank and range scores in its Cost Proposal was arbitrary and capricious, or anything but reasonable and logical. Planning & Design v. City of Santa Fe, 118 N.M. 707, 715, 885 P.2d 628 (1994) (finding that an agency’s actions should be set aside only if they are unreasonable and without consideration and in disregard of the facts and circumstances).

B. The RFP Properly Set Forth the Weighted Factors and Scored the RFP Based on the Disclosed Factors

The Protestors cannot establish that the scoring methodology applied in the RFP was erroneous, unreasonable, or in violation of New Mexico law because the Department specifically set forth the weight to be given to the factors in evaluating the RFP and scored the RFP based on the disclosed factors. As such, the Protestors claims are without merit.

The Protestors allege that the Department violated N.M.S.A. § 13-1-114, which requires RFPs to “state the relative weight to be given to the factors in evaluating proposals.” Western Sky alleges that the Department failed to set forth the relative weight of each of the thirteen major technical factors and subfactors, or, alternatively, that the Department stated in the RFP that the factors were to be of equal importance. Furthermore, Amerigroup also argues that criteria not articulated in the RFP were used to justify findings of technical deficiencies resulting in score reductions. However, it should be noted that there was no reason for any of the Offerors to assume that each of the questions would be equally weighted. Report of J. Menges, p. 5. And, the Offerors were not misled as the Protestors suggest. Rather, the Department made the decision to provide the Offerors with significant amounts of information related to the scoring process, while at the same time withholding certain details in an effort to maintain and preserve the integrity of the scoring process. Report of J. Menges, p. 5.

Contrary to the Protestors’ assertions, in the “Point Summary” section of the RFP, all Offerors were provided with a table, which set forth the “Total Points Possible” for each of the sections contained within the Technical Proposal. RFP 4.3. For example, an Offeror could be awarded a possible 75
Secretary Sidonie Squier  
April 18, 2013  
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points under the “Experience and Qualifications” section of the RFP and 150 points under the “Provider Network/Provider Agreements” section. Id. Accordingly, from this table, the Offerors were clearly given notice that the “Provider Network/Provider Agreements” section of the RFP was given twice the weight as that of the “Experience and Qualifications” section. This table provides the total point allocations for each of the thirteen major technical factors considered under the RFP. Id.

Furthermore, the Cost Proposal Process, the Cost Scoring and Cost Proposal Instructions informed the Offerors that each of the three programs considered, namely, Salud! Physical Health (“PH”), Coordinated Long Term Care Program (“LTC”), and Behavioral Health (“BH”), would be allocated a potential of 400 points per program and would be scored following a rank and range approach. Cost Scoring and Cost Proposal Instructions 1. The Offerors were further informed that the rank and range scores would be equally weighted, each accounting for a potential 200 points out of the total 400 points allocated to each program. Id. Furthermore, Offerors were informed that each program (PH, LT, and BH) would be scored individually using the rank and range approach and the aggregate score by program would be combined using an equal weighting. Id. Accordingly, the Department clearly provided the Offerors with an up-front explanation of the relative weight to be given to the factors in the RFP in accordance with N.M.S.A. § 13-1-114.

Nothing in the New Mexico Procurement Act required the Department to disclose every aspect of the scoring process in the procurement documents. The Protestors have failed to put forth any evidence to this effect. Furthermore, it is increasingly common in Medicaid MCO procurement situations to avoid sharing all scoring details with the review team because doing so would allow the reviewers to “keep a running score” while conducting their review. Report of J. Menges, p. 5. Accordingly, it is a strength—not a flaw—in Mercer’s scoring process that the weights between questions were not disclosed to the individual reviewers. Report of J. Menges, p. 5. This process reduced the opportunity for reviewer bias and strengthened the integrity of the bid process.

Contrary to the Protestors’ assertions, the scoring methodology applied by the Department was transparent, and any attempt to claim it was unfair or arbitrary and capricious at this stage is improper. The Protestors were aware of the methodology from the very beginning of the bidding process because the RFP’s scoring approach was well-conveyed. Report of J. Menges, p. 2. For example, Mercer provided a Data Book and extensive information to bidders as to how the price bids would be scored. Report of J. Menges, p. 2. All Offerors were bidding on a level playing field. The transparency and fairness of the scoring methodology reinforces the Department’s overall reasonable approach to provide Medicaid in a way that is responsible and advantageous to the State. Accordingly, because the Department clearly provided the Protestors with an up-front explanation of the relative weight to be given to the factors in the RFP in accordance with N.M.S.A. § 13-1-114, the Protestors cannot establish that the Department’s actions should be overturned.

C. The Department’s Scoring Methodology Was Impartial

In addition, the RFP was impartial as to all Offerors. The Protestors’ related claims that the scoring was somehow biased fail because the Department put careful thought and consideration into the
scoring process applied to the RFP. Accordingly, the Protestors cannot establish that the Department’s actions were without consideration and in disregard of the facts and circumstances. *McDaniel*, 86 N.M. at 449, 525 P.2d at 376 (finding that even though a party may consider the outcome to be erroneous, an agency’s actions should not be set aside as long as they are exercised honestly and with due consideration given to the facts presented).

Our outside consultant has confirmed that there is strong evidence that each MCO was scored on the basis of the content of its response to each question—as opposed to its general reputation or other factors that might create biased scoring. Report of J. Menges, p. 5. Each of the seven MCOs had numerous questions where it fared quite well, as well as numerous questions where it fared quite poorly. Report of J. Menges, p. 5. Every applicant was singled out at least once as having a uniquely high score within a question. Report of J. Menges, p. 5. Every applicant was singled out at least once as having a uniquely low score within a question. Report of J. Menges, p. 5. Of the forty-nine instances where an applicant received a uniquely low score, the most this occurred for a single MCO was thirteen (Western Sky). Report of J. Menges, p. 5.

Amerigroup identifies approximately sixty-seven situations where it believes it deserves a higher score. Amerigroup Protest, pg. 4-37. However, the scoring process was clearly defined and reasonable; the variations in points between the bidders merely comes down to an exercise of reasonable judgment by the scorers and the Department. Amerigroup’s protest fails to mention a single instance when it may have been over-scored relative to any competitor. As a result, Amerigroup argues that it should receive at least 103.2 additional points. Furthermore, in its protest, Amerigroup argues that it should receive the same number of points as all competitors that it felt were undeservedly awarded more points during the scoring process. Most likely, this logic would also often warrant an increase in other Offerers’ scores in response to those same questions (or possibly a decrease in the other Offerers’ score rather than an Amerigroup increase). Report of J. Menges, p. 4. This dynamic, however, was never acknowledged or considered by Amerigroup.

Pursuant to Amerigroup, the only solution to any identified concern involves Amerigroup—and only Amerigroup—deserving more points. Report of J. Menges, p. 4. This type of analysis is blatantly biased. Report of J. Menges, p. 4. Although it is understandable that Amerigroup will argue what is necessary to place fourth and obtain a Contract award, these arguments do not promote fairness or impartiality. In fact, the arguments promote the opposite. The Department should not have to consider them.

Lovelace takes a similar approach to the technical proposal as Amerigroup does in its protest letter. Lovelace has identified twenty-two questions where it believes its proposal warrants a higher score, with the collective “under-scoring” being 29.14 points. Zero questions are identified where Lovelace suggests it may have received too high a score.

Overall, these challenges are nothing more than a feeble attempt to squeeze into fourth place by Amerigroup and Lovelace. The Department conducted a standard process. Report of J. Menges, p. 6. Also, outside consultants have confirmed that the Department’s process was conducted fairly and impartially. Report of J. Menges, p. 6. Each Offeror may have disagreements about the individual scores; however, this is a natural reaction, especially among unsuccessful bidders. The
protestors should not be able to question the discretion and administrative judgment of the individual scorers with the benefit of hindsight. This is improper. The Department acted in a reasonable and impartial way, its decision should not be overturned. McDaniel, 86 N.M. at 449.

IV. LOVELACE WAIVED ITS CHALLENGE TO THE DEPARTMENT’S COST SCORING METHODOLOGY

In addition, the Department should find that Lovelace waived its challenge to the Department’s scoring methodology based on its acceptance of the scoring methodology in prior bidding situations, its signature on the Transmittal Letter and Compliance and Acceptance Statement, and its failure to challenge and submit questions regarding the RFP’s scoring process prior to its submission of the bid.¹

A. Lovelace Waived Its Argument That The Scoring Methodology Was Flawed Based On Its Acceptance Of A Similar Methodology On A Prior Bidding Occasion

The scoring process utilized by the Department in the RFP is a well-recognized process; it has been utilized in many jurisdictions as a way to determine whether a bidder has a cost effective yet responsible price bid. Report of J. Menges, p. 2. Lovelace has successfully bid using a similar scoring process in New Mexico on prior occasions. This process is not foreign to Lovelace. It would be unfair and wrong for Lovelace to be able to benefit from the scoring process on one occasion and then challenge the same or similar process a few years later when the process does not produce a favorable result. Accordingly, the Department should consider Lovelace’s argument waived based on its prior acceptance of the scoring process.

B. Lovelace Should Be Estoppe From Challenging The Scoring Methodology Based On Its Signature On The Transmittal Letter And Compliance And Acceptance Statement

Furthermore, Lovelace specifically signed a Transmittal Letter and Compliance and Acceptance Statement, acknowledging acceptance of the terms contained in the RFP. Specifically, Section 5.3 of the RFP states that all proposals must include a “signed statement that explicitly indicates acceptance of the Conditions Governing the Procurement stated in Section 2 of this RFP and the Offeror’s agreement to comply with all requirements as described in this RFP, including all appendices, attachments, written clarifications, and amendments provided during the procurement process.” RFP § 5.3 (emphasis added). Furthermore, Section 2.3.1 of the RFP states: “Offerors must indicate their acceptance of the conditions governing the procurement section in the Letter of Transmittal form. Submission of a proposal constitutes acceptance of the evaluation process contained in Section 4 of this RFP.” RFP § 2.3.1 (emphasis added).

¹UnitedHealthcare hereby asserts that the waiver arguments set forth in Sections IV(B) & (C) apply equally to Western Sky and Amerigroup.
Lovelace’s Letter of Transmittal Form, included as part of its Mancatory Requirements Binder, contains a signed statement acknowledging that submission of its proposal “constitutes acceptance of the Evaluation Factors contained in Section 4 of this RFP” and also that Lovelace “accept[s] the Conditions Governing the Procurement as required in Section 2.3.1 and 5.3 of this RFP.” Lovelace’s Mandatory Requirements Binder, pg. 3. In addition, Lovelace’s Chief Executive Officer, Ben Slocum, signed the Compliance and Acceptance Statement, which acknowledges acceptance of the Conditions Governing Procurement stated in Section 2 of the RFP and agrees that Lovelace will be bound by all requirements in the RFP. Lovelace’s Mandatory Requirements Binder, pg. 11-12.

By signing these acknowledgements, the Department should find that Lovelace is estopped from making any challenge to the scoring methodology set forth in Section 4 of the RFP. Estoppel is defined as “the preclusion, by acts or conduct, from asserting a right which may have otherwise existed, to the detriment and prejudice of another, who, in reliance of such acts and conduct, has acted thereon.” Brown v. Taylor, 901 P.2d 720, 120 N.M. 302 (N.M. 1995). New Mexico courts recognize the doctrine of waiver by estoppel if the following conditions are present: (1) the party to be estopped made a misleading representation by conduct; (2) the party claiming estoppel had an honest and reasonable belief based on the conduct that the party to be estopped would not assert a certain right under the contract; and (3) the party claiming estoppel acted in reliance on the conduct to his/her detriment or prejudice. Id. at 723 – 24. A party may be estopped under this doctrine despite a lack of intent—provided that the waiver induced a material change in the relying party’s actions. J.R. Hale Contracting Co. Inc. v. United New Mexico Bank at Albuquerque, 110 N.M. 712, 717, 799 P.2d 581, 585, n. 1 (1990) (recognizing that the important question was not the party’s intent but whether a reasonable person or the estopped party should have known a waiver could have been perceived by the opposite party).

Here, by signing the Transmittal Letter and Compliance and Acceptance Statement, Lovelace directly acknowledged to the Department that it agreed to comply with the requirements described in the RFP and that it also agreed to be bound by the scoring evaluation process. RFP §§ 5.3, 2.3.1. Based on Lovelace’s signature on the forms, the Department had a reasonable and honest belief that Lovelace accepted and approved the scoring process, and it proceeded forward with the RFP as written based on these representations from Lovelace and others. Lovelace should not be able to go back on its word. It would be unfair and wrong for Lovelace to be able to challenge the scoring methodology in direct contradiction to their affirmations in the Transmittal Letter and Confirmation and Acceptance Statement, which acknowledge that Lovelace will be bound to the terms of the scoring methodology. The Department proceeded forward with the RFP in reliance on these statements; accordingly, the Department should find that Lovelace’s argument has been waived by estoppel. See J.R. Hale Contracting Co. Inc, 110 N.M. at 717.
C. Lovelace Waived Its Challenge To The Scoring Methodology Based On Its Failure to Challenge And Submit Questions Regarding The RFP’s Scoring Process

Lovelace waived its challenge to the Department’s scoring methodology based on its failure to challenge, question, or seek clarification of the scoring process or weighting of certain factors through the Q&A process and under the Compliance and Acceptance section of the proposal. Lovelace is a sophisticated MCO; it fully understood the RFP process and the purpose behind the Q&A period, such that it was well aware that any issues with the scoring process should be brought to the Department’s attention before the bids were scored. Accordingly, Lovelace’s failure to question, seek clarification, or challenge the process should result in waiver.

Section 2.2.7 of the RFP states that “[p]otential Offerors may submit written questions as to the intent or clarity of the RFP and its appendices . . . Questions shall be clearly labeled and shall cite the Section(s) in the RFP or other document that forms the basis of the question.” RFP § 2.2.7. After receiving and analyzing the questions, the Department then had an opportunity to analyze the RFP and to amend it if necessary at any time before the closing date for submitting proposals. RFP § 2.2.8. Accordingly, Lovelace could have posed questions to the Department during the Q&A process regarding why the Range scores were not being provided to the bidders, why Range scores were even being considered based on the fact that such scores would be adjusted after the bidding process was completed, and why Behavioral Health had equal weighting with Physical Health and Long-Term Care. These types of questions would have alerted the Department that there may be an alleged problem with these areas in the RFP, such that the Department could have made any necessary corrections to the alleged problem before the proposals were submitted. In fact, based on questions posed by other bidders on other topics, the Department reacted and made changes to the Contract following the Q&A process. Lovelace did not even give the Department the opportunity to correct any alleged flaws by not bringing the issues to the Department’s attention timely.

Furthermore, the Department afforded Lovelace the opportunity to challenge the terms and conditions contained within the RFP in the Compliance and Acceptance section of the proposal. Section 5.3 of the RFP states: “If the Offeror is unwilling to comply with any terms, conditions, or other requirements of this RFP, the Offeror must clearly describe any deviations from the terms, conditions, or requirements and shall include a complete explanation of alternative terms and the reasons such deviations are proposed.” RFP § 5.3. Lovelace had the opportunity in this Section of its proposal to challenge (1) the weighting of Behavioral Health, (2) the fact that Range scores were not provided to the bidders prior to submission of the proposals, (3) the relevancy of the Range calculation, or (4) any other aspect of the scoring methodology that it did not agree with.

The Department provided Lovelace with significant amounts of information related to the scoring methodology that would be applied in the RFP before the bids were due. The Department provided each of the Offerors with a Data Book and Narrative, Cost Scoring and Cost Proposal Instructions, a PowerPoint presentation highlighting the Data Book, specifics of the programs, and additional considerations for the Cost Proposal, a Cost Proposal and Scoring Weights exhibit, a CoLTS Data book exhibit, and a Cost Proposal Question Matrix. See
http://www.hsd.state.nm.us/mad/CentennialCareProcLib.html. In these documents, the Department was extremely transparent and made it abundantly clear how the scoring methodology would be applied to the bids made by the Offerors. Accordingly, Lovelace knew exactly how to properly bid on the price and should have objected initially if it thought the scoring process was wrong.

Lovelace also had the opportunity to provide the Department with proposed specific alternative language that it believed should be applied to correct the alleged “flaws” in the scoring process that are claimed in Lovelace’s protest letter. See generally, Lovelace Protest. Accordingly, Lovelace had the specific right in the Compliance and Acceptance section to challenge the RFP language, including all terms and conditions, and/or to clarify the Department’s interpretations of the RFP provisions. Lovelace knowingly did not take advantage of this right and, thus, has waived its right to now challenge the Department’s interpretation of how the proposals were scored. See Green v. U.S., 355 U.S. 184, 191 (1957) (finding that “waiver ... connotes some kind of voluntary knowling relinquishment of a right”); see also J.R. Hale Contracting Co. v. United N.M. Bank at Albuquerque, 110 N.M. 712, 716, 799 P.2d 581, 585 (1990) (finding that waiver is “the intentional relinquishment or abandonment of a known right”).

V. LOVELACE’S FAILURES TO FOLLOW THE RFP INSTRUCTIONS AND TEMPLATES SHOULD DISQUALIFY ITS BID, AND AT THE VERY LEAST DEMONSTRATE THAT ITS LOSS OF POINTS WAS APPROPRIATE

The RFP states:

Bidders will be provided with templates and instructions for use to submit their bids. No deviations from the template will be allowed. Deviations from the template will constitute noncompliance and result in the bid’s being considered nonresponsive. However, clarifying notes and explanations related to the bids will be permitted.

Bidders will be awarded points based on the criteria outlined in the cost proposal instructions. Certain details beyond the scoring information, templates, and instructions will not be entertained.

RFP § 7.4.

As already demonstrated, the Department provided adequate instructions and templates in the RFP and accompanying documents to allow all proposed bidders to submit actuarially sound bids. Lovelace, however, failed to follow those instructions and templates and substantially deviated from the guidance that the Department provided. Consequently, Lovelace’s bid should be considered nonresponsive and should be disqualified. At the very least, Lovelace’s failures to follow the RFP instructions and templates demonstrate why its rate ranges fell outside those Mercer deemed actuarially sound, thereby making Lovelace’s point deductions appropriate.

As set forth in the expert report of Ross Winkelman, attached hereto as Exhibit B, the cost proposal scoring approach documented in the RFP was very clear, and Mercer appears to have followed the documented approach. Report of R. Winkelman, p. 5. Lovelace’s cost proposal, however, fell
substantially outside the ranges provided by Mercer. *Id.* at 4. This was due primarily to Lovelace’s Range Score for the Physical Health cohort being significantly lower than the other bidders. *Id.* at 3.

Lovelace’s capitation rate bid development included components that were different from other bidders. Report of R. Winkelman, p. 4. For example, Lovelace included a significant population adjustment by Physical Health sub-cohort to “reflect the expected difference in cost between all Medicaid members in New Mexico and the expected members enrolled by LCHP.” *Id.; see also* Lovelace Cost Proposal Binder -2. A population adjustment, however, was not included as one of the specific adjustments described in the cost proposal instructions and accompanying cost proposal templates. Report of R. Winkelman, p. 4. Furthermore, the information available in the RFP and supporting documents did not give bidders reason to expect that Mercer would include MCO-specific population adjustments in the development of its rate ranges.4 *Id.* at 5. Consequently, no other bidder included population adjustments by detailed population cohort.3 By including a significant population adjustment by Physical Health sub-cohort, Lovelace deviated from the templates and instructions provided to the bidders for use in preparing their bids. See RFP § 7.4.

In addition, the Data Book specifically provided guidance to prospective bidders to make an adjustment for a nursing facility increase. Report of R. Winkelman, p. 4. Specifically, the Data Book states on page 17:

> Effective July 1, 2012, the State implemented a nursing facility program change which contractors are expected to pass through to the nursing facilities. The approximately $26 million that the plan is obligated to pay during the SYF 2013 rate period is built into the nursing facility component of the capitation rate and will be distributed to the facilities at the plans’ discretion with guidance from the state. Future capitation rates will be prospectively established to account for ongoing and future changes to this policy.

The fee increase resulted in an estimated 3% increase to state-owned nursing facilities and an 11.27% increase to private nursing facilities. Report of R. Winkelman, p. 4. Lovelace did not make an adjustment for the nursing facility fee increase. *Id.* By failing to include this adjustment, Lovelace once again deviated from the templates and instructions provided to the bidders for use in preparing their bids. See RFP § 7.4.

Because Lovelace deviated from the RFP’s instructions and templates, its bid should be considered nonresponsive and should be disqualified. At the very least, because Lovelace’s points deductions stem from its failure to follow the instructions and templates provided with the RFP, these point deductions are appropriate.

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2 Lovelace further provided no supporting information for the population adjustments in its cost proposal. Report of R. Winkelman, p. 5.

3 Only one other bidder included a population adjustment (Amerigroup) and their adjustment was uniform across the detailed cohorts within the Physical Health population cohort, indicating that they understood that detailed cohort level population adjustments were not the best approach. Report of R. Winkelman, p. 5.
VI. THE PROTESTORS CANNOT ESTABLISH THAT THE DEPARTMENT’S DECISION SHOULD BE OVERTURNED BASED ON THE DISCARDING OF THE INDIVIDUAL SCORER NOTES

The Protestors’ argument that the Department erred in discarding individual scorer’s notes is also flawed. Specifically, the Department, as detailed in the RFP, utilized “consensus” scoring, and the results and summaries of the consensus meetings were maintained and produced. As such, the Protestors cannot establish that the Department erred in discarding the individual scorers’ notes or that the decision not to award Contracts to Lovelace, Amerigroup, and Western Sky was not supported by substantial evidence.

A. The Department Had Discretion To Determine That The Individual Scorers’ Notes Were Not Appropriate For Preservation

Protestors Western Sky and Amerigroup cannot establish that the Department acted in violation of the New Mexico Inspection of Public Records Act by discarding the individual scorers’ notes, given that the Act afforded the Department the discretion to determine what was appropriate and not appropriate for preservation. The purpose behind the Public Records Act is to afford citizens the right to inspect records that form the basis of an agency’s decision. Specifically, the Act defines “public records” as:

all books, papers, maps, photographs or other documentary materials ... made or received by any agency in pursuance of law or in connection with the transaction of public business and preserved, or appropriate for preservation, by the agency or its legitimate successor as evidence of the organization, functions, policies, decisions, procedures, operations or other activities of the government or because of the informational and historical value of data contained therein.

N.M.S.A. 1978, § 14-3-2 (emphasis added). Thus, the plain language of the statute affords the Department the discretion to determine exactly what records are appropriate for preservation, such that those records preserved evidence the ultimate decision of the agency.

Here, the Department determined that the individual scorers’ notes were not “appropriate for preservation” because those documents did not form the basis of the Department’s ultimate decision. As plainly set forth in the Procurement Scoring Summary, the Department utilized a consensus scoring system to evaluate the Offerors’ proposals. The RFP questions were divided into groups and evaluators were assigned to each group. The evaluators were provided with individual scoring sheets and were instructed to review the proposals independently in preparation for a consensus meeting. The individual evaluators graded the responses to the individual proposals on a scale of 0 to 5, and recorded superior elements and deficiencies. See Centennial Care Procurement Scoring Summary.

After the individual scoring process, a consensus meeting was held from December 10, 2012 through December 14, 2012, wherein the individual evaluators all met to discuss the final scoring
determinations. A facilitator was present and acted as a scribe for the evaluation groups. "Each evaluator’s scoring for each question for each proposal was discussed by the evaluators until a consensus score was reached." Centennial Care Procurement Scoring Summary, pg. 1. The groups also agreed on superior elements and deficiencies for the Offerors, and this information was also recorded in the consensus scoring sheets. Given that the consensus of the evaluators had been recorded, the individual scoring notes were discarded.

The Department acted within its discretion afforded under the Public Records Act and determined that the individual scoring notes were not “appropriate for preservation,” given that they did not form the basis of the Department’s decision on the contract awards. Accordingly, the Protestors cannot establish that the Department erred or that its conduct was arbitrary and capricious, as the consensus documents reflecting the evaluator discussions were preserved and produced as part of an Open Records Request to the Protestors. The only evidence that was discarded and deemed not “appropriate for preservation” were those documents that did not form the basis of the Department’s ultimate decision. In addition, the Department complied with the plain language of the RFP, which provides that “[e]ach subgroup of the Evaluation Committee shall evaluate their assigned section of each qualifying proposal and document their comments, concerns, and questions using standard evaluation tools”. RFP § 4.2. The Department documented the findings of the subgroups and maintained and produced the consensus scoring sheets, which ultimately formed the basis of the decision on the contract awards.

Furthermore, the consensus scoring approach adopted by the Department for the RFP was reasonable and appropriate and anything but arbitrary and capricious. The consensus scoring process allowed the individual evaluators to discuss their findings and reach a consensual score after listening to one another. This approach is superior to a mere score derived by averaging different individuals’ scores together, which has the significant disadvantage of factoring in those evaluators who had less experience with a certain technical area or those who were less careful/thorough in their review. Report of J. Menges, p. 4. The consensual scoring process allowed the full scoring team to express and justify their views and should result in a better quality outcome.

Accordingly, because the scoring was determined based on consensus, and not based on a mere average of the individual scoring sheets, the Department acted within its discretion in determining that the individual scoring notes were not appropriate for preservation, given that the consensus documents ultimately formed the basis of the Department’s decision.

B. The Department’s Decision to Discard the Individual Scorer’s Notes Does Not Eliminate all Substantial Evidence of the Department’s Decision

Furthermore, even with the destruction of the individual scorers’ notes, the Protestors cannot establish that the final decision made by the Department was not supported by substantial evidence or “relevant evidence that a reasonable mind might accept as adequate to support a conclusion.” Gallup Westside Dev., LLC v. City of Gallup, 135 N.M. 30, 34, 84 P.3d 78, 82 (N.M. App. 2003) (citing Oil Transp. Co. v. N.M. State Corp. Comm’n, 110 N.M. 568, 571, 798 P.2d 169, 172 (1990)).
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When reviewing an agency decision, a court will independently examine the entire record and will further view the evidence in the light most favorable to the agency. *Gallup Westside Dev., LLC*, 135 N.M. at 34, 84 P.3d at 82 (emphasis added); see also *Snyder Ranches, Inc. v. Oil Conservation Comm’n*, 110 N.M. 637, 639, 798 P.2d 587, 589 (1990). A record of sufficient completeness does not translate into a complete verbatim transcript of the decision-making process. *Village of Angel Fire v. Wheeler*, 2003-NMCA-041, 133 N.M. 421, 429, 63 P.3d 524 (citing *State v. Ibarra*, 116 N.M. 486, 489, 864 P.2d 302, 305 (Ct. App. 1993)). Ultimately, “[f]or review to be meaningful, the record must only be of sufficient completeness to permit proper consideration of an appellant’s claims.” *Village of Angel Fire*, 133 N.M. at 429 (citing *State v. Herrera*, 84 N.M. 46, 47–48, 499 P.2d 364, 365–66 (Ct. App. 1972)) (meeting minutes sufficient record when tapes recordings of the meeting were destroyed).

Here, in order to be successful on its claim, the Protestors must demonstrate that the entirety of the remaining record, taken as a whole, represents “no substantial evidence in the record to support [the Department’s] decision.” *Gallup Westside Dev., LLC*, 135 N.M. at 34, 84 P.3d at 82 (emphasis added) (citing *Hart*, 1999–NMCA–043, ¶ 19). Stated another way, the Protestors must show that the entire record, in the absence of the individual scorers’ notes, is not sufficient to uphold the Department’s decision. *Id.* However, the Protestors have not presented evidence or authority for the proposition that destruction of some relevant evidence from the record eliminates the weight and value of any remaining relevant evidence in the record.

Given the fact that (1) the evaluator groups came to a consensus on the scores for each bidder, (2) the consensus sheets were the basis for the ultimate scoring determination, and (3) no individual evaluator’s scores formed the basis for the Department’s decision, the Protestors’ argument that the destruction of the individual scorers’ notes omits “substantial evidence”, when taken alone, is insufficient to overturn the Department’s awards. *See Centennial Care Procurement Scoring Summary* at 1. Indeed, Western Sky’s argument that it is entitled to the individual scorers’ notes is simply a demand for a “verbatim transcript” of the decision-making process, which it is not entitled to under New Mexico law. *Village of Angel Fire*, 63 P.3d at 429 (citing *State v. Ibarra*, 116 N.M. at 489). Accordingly, the Protestors cannot establish that the Department’s Contract awards were not supported by substantial evidence.

**CONCLUSION**

The Department complied with New Mexico law and established a fair and reasonable process to achieve a procurement that was responsible and advantageous to the Department and the State. For the reasons set forth above, we believe that the Protestors’ arguments are without merit and should be dismissed.

Very truly yours,

[Signature]

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## CC2.0 MCO RFP Evaluation Teams

### SME Sub-groups for evaluating and scoring Section 6 Technical Proposal sub-sections

<table>
<thead>
<tr>
<th>RFP Sub-sections</th>
<th>Evaluator/Scorer Teams</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6.1 Experience &amp; Qualifications</strong></td>
<td>Angela Medrano</td>
</tr>
<tr>
<td>13 Qs x 10 = 130 pts</td>
<td>Mike Nelson</td>
</tr>
<tr>
<td>12/4 &amp; 12/5 in North</td>
<td>Wayne Lindstrom</td>
</tr>
<tr>
<td><strong>6.2 Provider Networks &amp; Agreements</strong></td>
<td>Kim Carter</td>
</tr>
<tr>
<td>6 Qs x 10 = 60 pts</td>
<td>Tonya Pamatian</td>
</tr>
<tr>
<td>12/14 &amp; 12/15 in South</td>
<td>Crystal Hodges</td>
</tr>
<tr>
<td></td>
<td>Maria Kniskern</td>
</tr>
<tr>
<td></td>
<td>Karen Meador</td>
</tr>
<tr>
<td><strong>6.3 Benefits &amp; Services</strong></td>
<td>Crystal Hodges</td>
</tr>
<tr>
<td>8 Qs x 20 = 160 pts</td>
<td>Roy Burt</td>
</tr>
<tr>
<td>12/6 &amp; 12/7 in CCCB</td>
<td>Karen Meador</td>
</tr>
<tr>
<td></td>
<td>Valerie Tapia</td>
</tr>
<tr>
<td></td>
<td>Kari Armijo</td>
</tr>
<tr>
<td><strong>6.4 Care Coordination and Transitions</strong></td>
<td>Megan Pfeffer</td>
</tr>
<tr>
<td>14 Qs x 20 = 280 pts</td>
<td>Tallie Tolen</td>
</tr>
<tr>
<td>12/6 &amp; 12/7 &amp; 12/8 in North</td>
<td>Marvin Martinez</td>
</tr>
<tr>
<td><strong>6.5 Long Term Care</strong></td>
<td>Tallie Tolen</td>
</tr>
<tr>
<td>8 Qs x 20 = 160 pts</td>
<td>Angela Medrano</td>
</tr>
<tr>
<td>12/11 &amp; 12/12 in North</td>
<td>Joey Kellenaers</td>
</tr>
<tr>
<td></td>
<td>Shari Roanhorse</td>
</tr>
<tr>
<td><strong>6.6 Information Systems and Claims Management</strong></td>
<td>Linda Gonzales</td>
</tr>
<tr>
<td>11 Qs x 20 = 220 pts</td>
<td>John Padilla</td>
</tr>
<tr>
<td>12/4 &amp; 12/5 &amp; 12/6 in South</td>
<td>Joseph Tighe</td>
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<tr>
<td></td>
<td>Manny Martinez</td>
</tr>
<tr>
<td><strong>6.7 Native Americans</strong></td>
<td>Theresa Belanger</td>
</tr>
<tr>
<td>5 Qs x 10 = 50 pts</td>
<td>Kathy Slater-Huff</td>
</tr>
<tr>
<td>12/11 in CCCB</td>
<td>Valerie Tapia</td>
</tr>
<tr>
<td><strong>6.8 Member &amp; Provider Services</strong></td>
<td></td>
</tr>
<tr>
<td>8 Qs x 10 = 80 pts</td>
<td>Kathy Slater-Huff</td>
</tr>
<tr>
<td>12/12 &amp; 12/13 in CCCB</td>
<td>Tonya Pamatian</td>
</tr>
<tr>
<td></td>
<td>William Wuestenhagen</td>
</tr>
<tr>
<td></td>
<td>Wanicha Burapa</td>
</tr>
<tr>
<td></td>
<td>Cindy Romero</td>
</tr>
<tr>
<td><strong>6.9 QI and QM</strong></td>
<td>Megan Pfeffer</td>
</tr>
<tr>
<td>6 Qs x 10 = 60 pts</td>
<td>Wanicha Burapa</td>
</tr>
<tr>
<td>12/4 &amp; 12/5 in CCCB</td>
<td>William Wuestenhagen</td>
</tr>
<tr>
<td><strong>6.10 Reporting and Program Integrity</strong></td>
<td>Kim Carter</td>
</tr>
<tr>
<td>5 Qs x 10 = 50 pts</td>
<td>Victoria Herrera</td>
</tr>
<tr>
<td></td>
<td>Maria Kniskern</td>
</tr>
<tr>
<td>Date</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>12/11 &amp; 12/12</td>
<td>in South</td>
</tr>
<tr>
<td>6.11 Financial</td>
<td>Management</td>
</tr>
<tr>
<td>5 Qs x 10 = 50 pts</td>
<td></td>
</tr>
<tr>
<td>12/7 &amp; 12/8</td>
<td>in South</td>
</tr>
<tr>
<td>6.12 Value-Based Purchasing</td>
<td></td>
</tr>
<tr>
<td>4 Qs x 20 = 80 pts</td>
<td></td>
</tr>
<tr>
<td>12/13 &amp; 12/14</td>
<td>in North</td>
</tr>
<tr>
<td>References</td>
<td></td>
</tr>
<tr>
<td>3 Refs per x 100 = 300 pts</td>
<td></td>
</tr>
<tr>
<td>12/15 in North</td>
<td></td>
</tr>
<tr>
<td>Cost Proposals</td>
<td></td>
</tr>
<tr>
<td>400 pts, formula based on proposed rates Entered by Mercer, provided to Exec Team</td>
<td></td>
</tr>
<tr>
<td>12/18 in North</td>
<td></td>
</tr>
<tr>
<td>Executive Evaluation Committee</td>
<td></td>
</tr>
<tr>
<td>Review summaries of all scoring Make recommendation</td>
<td></td>
</tr>
<tr>
<td>12/18</td>
<td></td>
</tr>
</tbody>
</table>
2017 CENTENNIAL CARE 2.0
MCO RFP #18-630-8000-0001
SCORING RESULTS SUMMARY

DECEMBER 22, 2017

New Mexico Human Services Department
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INTRODUCTION

On September 1, 2017, the New Mexico Human Services Department (NM HSD) released a Request for Proposals (RFP) to procure managed care organizations (MCOs) that will bring innovative approaches to New Mexico's Medicaid/CHIP program (Centennial Care 2.0). The RFP included mandatory requirements that each bidding MCO (hereinafter "Offeror") was required to meet to qualify for the technical evaluation, references and cost proposal scoring. Eight Offerors responded to the RFP and all eight (8) passed the mandatory requirements phase.

On November 6, 2017, Mercer provided training to subject matter experts (SMEs) from HSD's Medical Assistance Division (MAD) and Behavioral Health Services Division (BHSD) who served as the State's RFP evaluation team. 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.

Following the training, during the weeks between November 6th and December 3rd, 2017, each evaluator independently read and scored each Offeror’s response to the RFP and documented their score and notes for each question in the evaluator worksheet for the applicable Offeror.

From December 4th to December 15th, 2017, the evaluators participated in consensus scoring sessions. These sessions were conducted using the individual reviewer score sheets and notes and resulted in one consensus team grade per question and supporting notes. The consensus decisions were documented by consultants from Mercer who served as independent unbiased facilitators. Prior to finalizing a consensus score, all members of the evaluation team agreed to the final score and documentation. These consensus score sheets are attached for reference (Attachment 1 - Technical Proposal Consensus Score Sheets).

Following the consensus scoring, the Executive Evaluation Committee (hereinafter "Committee") reviewed the references submitted as part of the proposal. Each reference was reviewed and scored by the Committee using a predetermined methodology (Attachment 2 - References Consensus Score Sheets).

Finally, the cost proposals were reviewed and assigned a score, again using a predetermined methodology (Attachment 3 - Cost Proposal Score Sheet).

The following chapters of this report reflect the final scores and details for each Offeror (in alphabetical order) including a high-level summary of some of the noted strengths, weaknesses and
points for discussion. The summary does not reflect all comments from the evaluation committees, 
for a complete listing of comments from each consensus session see Attachment 1 - Technical Proposal Consensus Score Sheets.
ALL PLAN RESULTS (SCORES)

The following tables represent the final scores for each Offeror. The scores reflect technical scores, reference scores and cost proposal scores.

Table 1 – Technical Proposal Consensus Scores by Section

<table>
<thead>
<tr>
<th>SECTION</th>
<th>AG</th>
<th>AS</th>
<th>AOPS</th>
<th>A110</th>
<th>B116</th>
<th>C116</th>
<th>D116</th>
<th>E101</th>
<th>F102</th>
<th>W50</th>
<th>W50</th>
<th>W50</th>
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</thead>
<tbody>
<tr>
<td>6.1 Experience &amp; Qualifications</td>
<td>114</td>
<td>110</td>
<td>120</td>
<td>116</td>
<td>120</td>
<td>120</td>
<td>120</td>
<td>120</td>
<td>110</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.2 Provider Network</td>
<td>52</td>
<td>34</td>
<td>46</td>
<td>52</td>
<td>56</td>
<td>44</td>
<td>46</td>
<td>50</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.3 Benefits and Services</td>
<td>88</td>
<td>72</td>
<td>100</td>
<td>92</td>
<td>132</td>
<td>64</td>
<td>76</td>
<td>124</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6.4 Care Coordination</td>
<td>166</td>
<td>164</td>
<td>180</td>
<td>172</td>
<td>224</td>
<td>204</td>
<td>204</td>
<td>196</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.5 Long-term Care</td>
<td>96</td>
<td>80</td>
<td>124</td>
<td>112</td>
<td>128</td>
<td>108</td>
<td>108</td>
<td>144</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.6 Info System/Claims Management</td>
<td>140</td>
<td>152</td>
<td>160</td>
<td>148</td>
<td>180</td>
<td>136</td>
<td>180</td>
<td>164</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.7 Native Americans</td>
<td>24</td>
<td>32</td>
<td>30</td>
<td>26</td>
<td>40</td>
<td>32</td>
<td>26</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.8 Member &amp; Provider Services</td>
<td>54</td>
<td>54</td>
<td>52</td>
<td>54</td>
<td>56</td>
<td>52</td>
<td>48</td>
<td>46</td>
<td></td>
<td></td>
<td></td>
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<td>6.9 QI/QM</td>
<td>36</td>
<td>32</td>
<td>44</td>
<td>44</td>
<td>46</td>
<td>38</td>
<td>36</td>
<td>36</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6.10 Reporting &amp; Program Integrity</td>
<td>48</td>
<td>22</td>
<td>26</td>
<td>44</td>
<td>50</td>
<td>32</td>
<td>44</td>
<td>34</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.11 Financial Management</td>
<td>28</td>
<td>30</td>
<td>26</td>
<td>34</td>
<td>42</td>
<td>34</td>
<td>34</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.12 Value Based Purchasing</td>
<td>32</td>
<td>48</td>
<td>36</td>
<td>48</td>
<td>64</td>
<td>48</td>
<td>32</td>
<td>60</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>880</td>
<td>839</td>
<td>944</td>
<td>942</td>
<td>1,148</td>
<td>932</td>
<td>954</td>
<td>1,022</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Reference Consensus Scores
Each MCO was required to submit three (3) references for scoring. The following table indicates the score by reference.

Table 2 – Reference Consensus Scores

<table>
<thead>
<tr>
<th>SECTION</th>
<th>A9</th>
<th>A10</th>
<th>BPBS</th>
<th>A12</th>
<th>FHP</th>
<th>VRO</th>
<th>WC</th>
<th>NS</th>
<th>VS</th>
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<tbody>
<tr>
<td>Reference 1</td>
<td>82</td>
<td>100</td>
<td>100</td>
<td>92</td>
<td>92</td>
<td>73</td>
<td>0</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Reference 2</td>
<td>56</td>
<td>85</td>
<td>100</td>
<td>96</td>
<td>100</td>
<td>0</td>
<td>72</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Reference 3</td>
<td>0</td>
<td>100</td>
<td>85</td>
<td>100</td>
<td>96</td>
<td>92</td>
<td>95</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>138</td>
<td>285</td>
<td>285</td>
<td>288</td>
<td>288</td>
<td>165</td>
<td>167</td>
<td>284</td>
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</tr>
</tbody>
</table>

Cost Proposal Scores
Each Offeror was required to submit a cost proposal by program and rate cohorts using a cost template that included minimum and maximum rates by per member per month (PMPM). The submitted cost proposal was scored in accordance with the RFP. Points were assigned by cohort based on the Offeror’s bid between the minimum and maximum PMPM rate and then aggregated based on a pre-determined and published distribution methodology.

Table 3 – Cost Proposal Scores

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>PROGRAM WEIGHT</th>
<th>PH</th>
<th>AH</th>
<th>ECRS</th>
<th>MHO</th>
<th>FHP</th>
<th>UHC</th>
<th>WC</th>
<th>NS</th>
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</thead>
<tbody>
<tr>
<td>PH</td>
<td>37.09%</td>
<td>320</td>
<td>400</td>
<td>400</td>
<td>120</td>
<td>326</td>
<td>400</td>
<td>116</td>
<td>106</td>
</tr>
<tr>
<td>LTSS</td>
<td>24.35%</td>
<td>320</td>
<td>400</td>
<td>400</td>
<td>120</td>
<td>360</td>
<td>400</td>
<td>145</td>
<td>325</td>
</tr>
<tr>
<td>BH</td>
<td>10.62%</td>
<td>320</td>
<td>400</td>
<td>400</td>
<td>120</td>
<td>155</td>
<td>400</td>
<td>170</td>
<td>223</td>
</tr>
<tr>
<td>OAG</td>
<td>27.95%</td>
<td>320</td>
<td>400</td>
<td>94</td>
<td>120</td>
<td>400</td>
<td>400</td>
<td>200</td>
<td>280</td>
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<tr>
<td>Total</td>
<td>100.0%</td>
<td>320</td>
<td>400</td>
<td>315</td>
<td>120</td>
<td>337</td>
<td>400</td>
<td>152</td>
<td>254</td>
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</table>

* Totals may differ due to rounding based on the program weight percentage.
Overall Scores
The technical, reference and cost proposal scores were aggregated and presented in Table 4 and the ranking of scores in Table 5.

Table 4 – Overall Scores by RFP Component

<table>
<thead>
<tr>
<th>SECTION</th>
<th>AG</th>
<th>AM</th>
<th>DOR</th>
<th>HCP</th>
<th>PHP</th>
<th>UHC</th>
<th>WIC</th>
<th>WS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical</td>
<td>880</td>
<td>830</td>
<td>944</td>
<td>942</td>
<td>1.146</td>
<td>932</td>
<td>954</td>
<td>1,022</td>
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<tr>
<td>References</td>
<td>136</td>
<td>285</td>
<td>285</td>
<td>288</td>
<td>288</td>
<td>165</td>
<td>167</td>
<td>284</td>
</tr>
<tr>
<td>Cost</td>
<td>320</td>
<td>400</td>
<td>315</td>
<td>120</td>
<td>337</td>
<td>400</td>
<td>152</td>
<td>254</td>
</tr>
<tr>
<td>Total</td>
<td>1,338</td>
<td>1,515</td>
<td>1,544</td>
<td>1,350</td>
<td>1,771</td>
<td>1,497</td>
<td>1,273</td>
<td>1,560</td>
</tr>
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</table>

Table 5 – Final Ranking

<table>
<thead>
<tr>
<th>OFFEROR</th>
<th>TOTAL SCORE</th>
<th>RANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup Community Care of NM, Inc. (AG)</td>
<td>1,338</td>
<td>7</td>
</tr>
<tr>
<td>AmeriHealth Caritas New Mexico, Inc. (AH)</td>
<td>1,515</td>
<td>4</td>
</tr>
<tr>
<td>Blue Cross Blue Shield of New Mexico (BCBS)</td>
<td>1,544</td>
<td>3</td>
</tr>
<tr>
<td>Molina Healthcare of New Mexico, Inc. (MHC)</td>
<td>1,350</td>
<td>6</td>
</tr>
<tr>
<td>Presbyterian Health Plan, Inc. (PHP)</td>
<td>1,771</td>
<td>1</td>
</tr>
<tr>
<td>United Healthcare of New Mexico, Inc. (UHC)</td>
<td>1,497</td>
<td>5</td>
</tr>
<tr>
<td>WellCare of New Mexico, Inc. (WC)</td>
<td>1,273</td>
<td>8</td>
</tr>
<tr>
<td>Western Sky Community Care (WS)</td>
<td>1,580</td>
<td>2</td>
</tr>
</tbody>
</table>
MEMORANDUM FOR THE NEW MEXICO HUMAN SERVICES
DEPARTMENT (HSD)

TO: Brent Earnest, HSD Secretary
FROM: Gary O. Chavez, Certified HSD Chief Procurement Officer
SUBJECT: RFP # 18-630-8000-0001

1. I am HSD’s Certified Chief Procurement Officer, in accordance with Section 13-1-38.1 NMSA.

2. Molina Healthcare has submitted a “formal request…for a post-bid protest stay of the procurement.”

3. HSD has already executed contracts with the successful offerors.

4. Some unsuccessful offerors have submitted protests pursuant to the RFP process (See ¶ 2.2.15). As Chief Procurement Officer I have reviewed the protests submitted by the unsuccessful offerors. HSD is in the process of responding to those protests.

5. On March 15, 2018 Nancy Smith-Leslie, Director of the Medical Assistance Division (“MAD”) for the State of New Mexico signed an affidavit in response to Molina’s request for a Temporary Restraining Order. Director Smith-Leslie’s affidavit contained the following language:

“31. A thorough readiness review period is necessary to ensure provision of basic health care services, such as paying claims to providers, enrolling New Mexicans in the health plan, and administering multiple benefit packages to ensure services are provided— from prenatal care to nursing facility service to pharmacy.

32. The alignment of the federal 1115 waiver start date, (See ¶¶ 5-10, ¶13) with the MCO’s contract start date is necessary so that the new MCOs are able to implement all of the new initiatives approved by CMS. Some of the new initiatives include:
   - Substance use disorder care and treatment;
   - Home visiting services to focus on prenatal care, post partum care and early childhood development; and
   - Supportive housing for individuals with serious mental illness

33. The existing MCO contracts and provider networks do not include these services.

34. HSD must have a sufficient “readiness period” in order to provide continuity of care and services and ensure the health and safety of Medicaid members. HSD must also certify that the MCOs are able to meet all state and federal regulatory standards and requirements, including:
   - Ensuring mandatory and optional benefit administration;
   - Meeting capitation rate development standards;
- Complying with provider network adequacy standards;
- Extending enrollee rights and protections;
- Meeting quality standards;
- Implementing program integrity standards;
- Adherence to system requirements for enrollment and payment standards, including the ability to pay timely and accurate claims submitted by providers for service rendered to patients; and
- Ability to meet all federal financial participation requirements.

The complex compliance assessment conducted by HSD in all of these areas requires considerable planning and allocation of staff resources that cannot be overstated.

35. A review and readiness period of less than ten months is not sufficient to provide continued levels of service established under the Centennial Care program and is not in the best interests of the state nor its Medicaid members. HSD must ensure and certify readiness of Centennial Care 2.0 MCOs by August in preparation for open enrollment in October. The open enrollment period provides an opportunity for members to choose the MCO that best serves their needs. "

6. I have discussed with Director Smith-Leslie the issues and the contents of her affidavit. I acknowledge and agree with her analysis.

7. Based upon my review of this matter, including my discussions with Director Smith-Leslie, I make the following findings:

- Preparations to implement Centennial Care 2.0 have already begun, and both HSD and Medicaid beneficiaries would be damaged if that process were brought to a halt.

- The public interest weighs strongly in favor of not interrupting the process already in place to ensure Centennial Care 2.0 commences on schedule.

8. Since contracts have already been awarded in this procurement, the applicable directive can be found in NMAC 1.4.1.83(B). For the reasons described above, I have concluded that there are no exceptional circumstances and good cause has not been shown to justify halting the procurement.

9. Molina alleges that the applicable statute is NMSA 1978 13-1-173. I disagree. HSD has already executed contracts with the successful offerors and the applicable regulation is NMAC 1.4.1.83(B).

10. To the extent that an analysis is also necessary for NMSA 1978 13-1-173 and NMAC 1.4.1.83(A), for the reasons described above, I also conclude that the award of the contract is necessary to protect the substantial interest of HSD.
GARY O. CHAVEZ
Certified HSD Chief Procurement Officer

Date: 3/15/18
DESIGNATION OF AUTHORITY

MEMORANDUM FOR the New Mexico Human Services Department (HSD)
ATTENTION: Brent Earnest, HSD Secretary

FROM: Gary O. Chavez, Certified HSD Chief Procurement Officer

SUBJECT: Designation of Authority for Protest Proceeding re # RFP # 18-630-8000-0001

1. I am HSD’s Chief Procurement Officer, which includes the role of state purchasing agent, certified pursuant to Section 13-1-95.2 NMSA, and in accordance with Section 13-1-38.1 NMSA.

2. Pursuant to 1.4.1.90 (A) NMAC, at any point during a protest proceeding, I may appoint a designee, as defined in Section 13-1-51 NMSA, to preside over the protest proceeding.

3. I have the power to appoint as my designee, any person not directly involved in the procurement, so long as that person is not the procurement officer or procurement manager. 1.4.1.90 (B) NMAC.

4. Brent Earnest, Secretary of HSD, has not been directly involved in the procurement, nor is he the procurement officer or manager.

5. I hereby appoint Brent Earnest as my designee to preside over the referenced protest proceeding.

GARY O. CHAVEZ
Dated: 3/2/18

Designation Accepted

BRENT EARNEST
Dated: 3/13/18
5.1 Letter of Transmittal

The Mandatory Requirements Binder must include a signed Letter of Transmittal (see Appendix B of this RFP).

The signed Letter of Transmittal (Appendix B) is included after this page.
Appendix B

Letter of Transmittal Form

RFP # 18-630-8000-0001

Offeror Name: UnitedHealthcare of New Mexico, Inc.

Items #1 to #7 EACH MUST BE COMPLETED IN FULL. Failure to respond to all seven items WILL RESULT IN THE DISQUALIFICATION OF THE PROPOSAL!

1. Identity (Name) and Mailing Address of the submitting organization:

   UnitedHealthcare of New Mexico, Inc.
   8220 San Pedro NE, Albuquerque, NM 87113

2. For the person authorized by the organization to contractually obligate on behalf of this Offer:

   Name Charles Milligan, Jr.
   Title Chief Executive Officer
   E-Mail Address charles.milligan@uhc.com
   Telephone Number (505) 449-4146

3. For the person authorized by the organization to negotiate on behalf of this Offer:

   Name Charles Milligan, Jr
   Title Chief Executive Officer
   E-Mail Address charles.milligan@uhc.com
   Telephone Number (505) 449-4146

4. For the person authorized by the organization to clarify/respond to queries regarding this Offer:

   Name Kevin LeClair
Title Proposal Director

E-Mail Address  kevin_leclair@uhc.com

Telephone Number  (952) 931-4231

5. Use of Sub-Contractors (Select one)

___ No sub-contractors will be used in the performance of any resultant contract OR

___ The following sub-contractors will be used in the performance of any resultant contract:

(list)

(Each proposed subcontractor must be identified and described using the Proposed Subcontractor Template, Appendix K, with references attached, and included in the Exhibits Binder.)

Preferred Vendors include United HealthCare Services, Inc. and United Behavioral Health. Major Subcontractors include OptumRx, Inc., OptumHealth Care Solutions, LLC, Dental Benefits Provider, Inc., MARCH® Vision Care Inc. (Enhanced benefit), National MedTrans Network Inc., CareCore National, LLC d/b/a eviCore healthcare, ProtoCall Services, Inc. and Conduent Inc. (Xerox). Subcontractors include: First Data Government Solutions, LP (EVV), Finity, Inc., and OptumInsight, Inc.

6. Please describe any relationship with any entity (other than Subcontractors listed in 5 above) which will be used in the performance of any resultant contract.

UnitedHealthcare is a wholly owned subsidiary of UnitedHealth Group, whose diverse array of companies cover a wide variety of programs and services related to the health and well-being industry. Nationwide, UnitedHealth Group has more than 34 years of Medicaid experience and serves more than 6.5 million Medicaid managed care beneficiaries across 26 states. We are part of the UnitedHealth Group family of companies that include three health benefits organizations serving distinct populations: Medicare & Retirement, Employer & Individual coverage and Medicaid (including Medicaid/Medicare dual eligible) through our Community & State division. In addition, UnitedHealth Group provides services through UnitedHealthcare Services, a subsidiary that provides services through a management services agreement, OptumHealth (a diversified health and wellness business serving the physical, emotional and financial needs), OptumRx (pharmacy benefit manager) and OptumInsight (a health care information, technology, services and consulting company) that support states, health plans, insurers and employers.

(Attach extra sheets, as needed, and submit with this Letter of Transmittal form, Appendix B.)

7.  ___ On behalf of the submitting organization named in item #1, above, I accept the Conditions

   Governing the Procurement as required in Section 2.3.1.

   ___ I concur that submission of our proposal constitutes acceptance of the Evaluation Factors contained in Section 4 of this RFP.

   ___ I acknowledge receipt of any and all amendments to this RFP.

   [Signature]  10/5/17, 2017

Authorized Signature and Date (Must be signed by the person identified in item #2, above.)
Hi Chris. Yes, we do have a copy of the email, which I've attached below. Please note that although we requested a copy of the email to confirm that it had been sent, we neither requested, received, nor have in our possession the attachment that was intended solely for HSD.

At our request, RI Medicaid has taken precautions to preserve the email.

Regards,

Ray

---

From: Pillsbury, Joan (OHHS)
Sent: Thursday, November 02, 2017 4:11 PM
To: CentennialCare.RFP@state.nm.us
Cc: 
Subject: RFP # 18-630-8000-0001

Daniel Clavio
New Mexico Human Services Department

See Attached Reference

Joan M. Pillsbury
Senior Operations & Product Support Manager
CONDUENT Consultant
RI Executive Office of Health & Human Services
Hazard Building #74, 1st floor
74 West Road
Cranston, RI 02920
Phone: (401) 462-3516
joan.pillsbury@ohhs.ri.gov

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prohibited. If you have received this e-mail in error, please notify the sender by replying to this message and delete this e-mail immediately.
Mr. Clavio

I am sending a letter from the Rhode Island Medicaid Director along with the Appendix F reference form that we intended to submit in November. Please contact me with any questions on this submission.

v/r
John Bonin

John J. Bonin
Medicaid Program Chief of Staff
RI EOHSS
Office: (401) 462-3035
Mobile: (401) 474-0231
john.bonin@ohhs.ri.gov

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February 1, 2018

Mr. Daniel Clavio
New Mexico Human Services Department
Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504

Dear Mr. Clavio:

It was recently brought to my attention that Reference Form RFP #18-630-8000-0001 for UnitedHealthcare of New Mexico, Inc. was not submitted to the State of New Mexico from the State of Rhode Island, Medicaid Program. It was my full intention to submit this form by the November 2nd deadline, however, this did not occur. While UnitedHealthcare made us aware the Rhode Island form was not received in their New Mexico application; my office has had no substantive conversation with United Healthcare regarding the content of the reference form, nor will we share our intended submission.

I am enclosing our reference form Appendix F – References (RI) with this letter. This will not be shared with UnitedHealthcare, Inc. Please contact my Chief of Staff, John Bonin at john.bonin@ahs.ri.gov for any questions concerning this reference form.

Sincerely,

Patrick M. Tigue

C: Charles Milligan, Jr.
CEO UnitedHealthcare of New Mexico, Inc.
(no enclosure)

Enclosure
Appendix F

Reference Form

RFP # 18-630-8000-0001

For:

UnitedHealthcare of New Mexico, Inc.
(Name of Offeror/Contractor)

*Offerors may NOT request references from the New Mexico Medicaid agency.*

This form is being submitted to your company for completion as a business reference for the company listed above, in response to a Request for Proposals to provide Medicaid managed care healthcare services for the State of New Mexico. This form is to be returned to the State of New Mexico Human Services Department via e-mail at:

Daniel Clavio  
New Mexico Human Services Department  
Medical Assistance Division  
P.O. Box 2348  
Santa Fe, NM 87504

Phone: (505)-827-1345  
E-mail: CentennialCare.RFP@state.nm.us  
Fax: (505) 827-3185

The submission deadline for References to HSD is 5:00 PM (MST) on November 2, 2017. References must not be returned to the company requesting the reference.

For questions or concerns regarding this form, please contact the State of New Mexico Procurement Manager listed above. When contacting us, be sure to include the Request for Proposal number listed at the top of this page.
**QUESTIONS:** *Please comment on each question.*

1. In what capacity have you worked with this Contractor in the past? (Describe relationship and nature of contract and work)

UnitedHealthcare of New England has participated in the Rhode Island managed Medicaid program for over 20 years. Currently they administer comprehensive healthcare benefits for approximately 95,000 Medicaid recipients. Served populations include children and adults within the following eligibility categories: TANF, pregnant women and children, CHIP, ABD, Expansion and children with special healthcare needs. Interactions have been contract oversight and monitoring of a shared risk-based agreement as well as collaboration on state healthcare initiatives.

2. How would you rate this firm in the following areas?

   *(5 = Excellent; 3 = Satisfactory; 1 = Unsatisfactory; 0 = Unacceptable)*

   a. Capability to manage complex health insurance programs 3

   b. Expertise in managing health care programs 4

   c. Operational capacity 4

   **Comments:**

   UnitedHealthcare possesses extremely qualified staff with many years of government program experience. This combined expertise lends itself to remarkable input and feedback for state healthcare initiatives. United’s national programs can provide best practices for efficient management of complex health needs and programs.

3. How would you rate the following attributes of the Contractor?

   *(5 = Excellent; 3 = Satisfactory; 1 = Unsatisfactory; 0 = Unacceptable)*

   a. Flexibility relative to changes in the project scope and timelines 3
b. Responsiveness to the Contracting entity. 4

c. Developing adequate Provider Networks. 3

Comments:

UnitedHealthcare's size and complexity can sometimes cause limitations in their flexibility to meet and address specific state requests. The national structure does lend expertise in many areas but can also be a barrier. Regarding provider networks, the national presence enhances the ability to provide adequate provider networks both locally and across the country. The local and national teams are responsive.

4. What is your overall level of satisfaction with the following areas?

(5 = Excellent; 3 = Satisfactory; 1 = Unsatisfactory; 0 = Unacceptable)

a. Serving Insured Members/Beneficiaries. 4

b. Emphasizing quality and positive outcomes over quantity. 4

c. Meeting the needs of the Contracting entity and terms of the contract. 3

Comments:

UnitedHealthcare provides many care management programs to address the needs of the population. Their focus on quality and positive outcomes is reflected in their recognition as a high quality plan. The ability to leverage resources on a national level are valuable. RI EOHHS has a strong relationship with the local UHC plan and collaborate on all aspects of the contract.

5. How would you rate the dynamics/interaction between:

(5 = Excellent; 3 = Satisfactory; 1 = Unsatisfactory; 0 = Unacceptable)

a. The Contractor and your staff. 4

b. The Contractor and insured Members / Beneficiaries. 3

c. The Contractor and Providers, Hospitals, healthcare community. 3

Comments:

UnitedHealthcare and the State of RI have a long standing positive relationship. Relationships with both members and providers are satisfactory. Limited financial resources on government funded products is often a concern of providers. Member satisfaction on a national level is good.
6. What are the Contractor’s strengths, and which aspect(s) of this Contractor’s services are you most satisfied?

UnitedHealthcare has vast experience and expertise within all aspects of the healthcare industry. Their financial strength provides the resources to be innovative. UHC is committed to providing practical solutions to improve quality, access and affordability of healthcare. UHC has a national network of providers and a wide variety of programs in all 50 states. United has core capabilities in data and technology and clinical expertise.

7. What are the Contractor’s weaknesses, and which aspect(s) of this Contractor’s services are you least satisfied?

Part of what makes UnitedHealthcare very successful can also sometimes be a barrier. While UnitedHealthcare’s size and national structure means it can leverage a wide range of expertise and operational capacity, sometimes it limits the ability to customize programs and materials for local use.
8. Would you recommend this Contractor's services to your organization again? Describe any reservations or suggestions you may have in working with this Contractor.

Yes, UnitedHealthcare is one of the high quality managed care organizations in the industry today with significant expertise in administering publicly funded programs. The local Medicaid plan is one of the Top Rated by NCQA and US News and World Report. UHC has an innovative approach to the future of healthcare.

9. Who were the Contractor's principal representatives involved in your project and how would you rate them individually? Please rate each person and comment on the skills, knowledge, behaviors or other factors on which you based the rating? List at least 3. 
(5 = Excellent; 3 = Satisfactory; 1 = Unsatisfactory; 0 = Unacceptable)

Name: Patrice Cooper __________________________ Rating: 4

Position / Role: Chief Executive Officer, UnitedHealthcare Community Plan RI

Name: Michael Floreczyk ________________________ Rating: 4

Position / Role: Chief Operating Officer, UnitedHealthcare Community Plan RI

Name: Maria Viveiros, JD, MPA, PMP ____________ Rating: 4

Position / Role: Compliance Officer, UnitedHealthcare Community Plan RI
Good afternoon Mr. Clavio.

Are you able to confirm your receipt of our three references for RFP # 18-630-8000-0001?

1. California Department of Health Care Services
2. Kansas Department of Health & Environment
3. Mississippi Division of Medicaid

Thank you in advance for your time.

Sincerely,
Monica Arter
Western Sky/Centene Proposal Development

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Mr. Clavio –

Presbyterian Health Plan (PHP) respectfully requests that you advise whether HSD has received the three (3) References for PHP. If not, I request that you let us know who has responded so that we can follow up immediately with those that have not.

I apologize for asking this again however, we need to ensure that this element of the proposal is met.

Thank you for your assistance!

Mary

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If you would like more information about Presbyterian Healthcare Services please visit our web site http://www.phs.org
From: RFP_CentennialCare_HSD
To: "Eden, Mary"
Subject: RE: PHP References
Date: Monday, October 23, 2017 8:17:00 AM

Good Morning - HSD has not received any references for PHP to date.

+-----------------------------------------------------------+

Daniel Clavio
Procurement Manager

Centennial Care 2.0 MCO RFP #18-630-8000-0001
Medical Assistance Division
NM Human Services Department

CentennialCare.RFP@state.nm.us
505-827-1345

http://www.hsdb.state.nm.us/centennial-care-2.0.aspx
http://www.hsdb.state.nm.us/

From: Eden, Mary [mailto:meden@phs.org]
Sent: Sunday, October 22, 2017 2:27 PM
To: RFP, CentennialCare, HSD
Subject: PHP References

Mr. Clavio –

Presbyterian Health Plan (PHP) respectfully requests that you advise whether HSD has received the three (3) References for PHP. If not, I request that you let us know who has responded so that we can follow up immediately with those that have not.

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If you would like more information about Presbyterian Healthcare Services please visit our web site http://www.phs.org.
Thank you for the prompt response!

Mary

Good Morning - HSD has not received any references for PHP to date.

++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++

Daniel Clavio
Procurement Manager

Centennial Care 2.0 MCO RFP #18-630-8000-0001
Medical Assistance Division
NM Human Services Department

CentennialCare.RFP@state.nm.us
505-827-1345

http://www.hsd.state.nm.us/centennial-care-2-0.aspx
http://www.hsd.state.nm.us/

Mr. Clavio –

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Two reference forms for PHP have been received to date, from the City of Albuquerque and Albuquerque Public Schools.

---------

Daniel Clavio
Procurement Manager

Centennial Care 2.0 MCO RFP #18-630-8000-0001
Medical Assistance Division
NM Human Services Department

CentennialCare.RFP@state.nm.us
505-827-1345

http://www.lsd.state.nm.us/centennial-care-2-0.aspx
http://www.lsd.state.nm.us/

---

From: Eden, Mary [mailto:meden@phs.org]
Sent: Sunday, October 29, 2017 4:35 PM
To: RFP, CentennialCare, HSD
Subject: PHP References

Mr. Clavio –

Presbyterian Health Plan (PHP) respectfully requests that you advise whether HSD has received the three (3) References for PHP. If not, I request that you let us know who has responded so that we can follow up immediately with those that have not.

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From: Eden, Mary
To: RFP_CentennialCare_HSD
Subject: RE: PHP References
Date: Monday, October 30, 2017 11:30:08 AM

Thanks much.

Mary

From: RFP, CentennialCare, HSD [mailto:CentennialCare.RFP@state.nm.us]
Sent: Monday, October 30, 2017 11:26 AM
To: Eden, Mary
Subject: RE: PHP References

Two reference forms for PHP have been received to date, from the City of Albuquerque and Albuquerque Public Schools.

+++++++++++++++++++++++++++++

Daniel Clavio
Procurement Manager

Centennial Care 2.0 MCO RFP #18-630-8000-0001
Medical Assistance Division
NM Human Services Department

CentennialCare.RFP@state.nm.us
505-827-1345

http://www.hsd.state.nm.us/centennial-care-2-0.aspx
http://www.hsd.state.nm.us/

From: Eden, Mary [mailto:moden@phs.org]
Sent: Sunday, October 29, 2017 4:35 PM
To: RFP, CentennialCare, HSD
Subject: PHP References

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If you would like more information about Presbyterian Healthcare Services please visit our web site http://www.phs.org.
Mr. Clavio –

I am sorry to have to ask again however, our third reference (NM Retiree Healthcare Authority) has assured us that he submitted the reference for PHP. Can I please impose on you to confirm this?

Thanks much!

Mary

Two reference forms for PHP have been received to date, from the City of Albuquerque and Albuquerque Public Schools.

+++++++++++++++++++++ 

Daniel Clavio
Procurement Manager

Centennial Care 2.0 MCO RFP #18-630-8000-0001
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Yes, confirmed.

+++++++++++++++++++++++++++++++++++

Daniel Clavio
Procurement Manager

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CentennialCare.RFP@state.nm.us
505-827-1345

http://www.hsd.state.nm.us/centennial-care-2-0.aspx
http://www.hsd.state.nm.us/

From: Eden, Mary [mailto:meden@phs.org]
Sent: Wednesday, November 01, 2017 8:57 AM
To: RFP, CentennialCare, HSD
Subject: RE: PHP References

Mr. Clavio –

I am sorry to have to ask again however, our third reference (NM Retiree Healthcare Authority) has assured us that he submitted the reference for PHP. Can I please impose on you to confirm this?

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Mary

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Sent: Monday, October 30, 2017 11:26 AM
To: Eden, Mary
Subject: RE: PHP References

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Daniel Clavio
Procurement Manager

Centennial Care 2.0 MCO RFP #18-630-8000-0001
Medical Assistance Division
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CentennialCare.RFP@state.nm.us
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To: RFP, CentennialCare, HSD
Subject: PHP References

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To: Brent Earnest, Secretary, NM Human Services Department
From: Daniel Clavio, Procurement Manager
on Behalf of the RFP Executive Evaluation Committee
Date: December 22, 2017
Subject: Evaluation Committee Report and Recommendation, RFP No. 18-630-8000-0001
Managed Care Organizations for Centennial Care 2.0

The Human Services Department (HSD) issued a request for proposals (RFP) on September 1, 2017 to solicit proposals from qualified Managed Care Organizations (MCOs) to provide managed care services to members of New Mexico's Medicaid program under Centennial Care 2.0.

Eight (8) qualified organizations submitted proposals by the November 3, 2017 deadline. All eight (8) submissions were deemed eligible for review, evaluation and scoring.

Process

Consensus scoring of responses to 94 questions within twelve (12) sub-sections of the Technical Proposal was done by groups of HSD subject matter experts (SMEs) over a two-week period in early December. Consensus scoring of References was done by another HSD SME group. All consensus scoring participants had been trained in the scoring process and were given adequate time for reviewing and evaluating the Offerors' response materials. The scoring sessions were facilitated by neutral professional consultants; I provided oversight as the Procurement Manager for this RFP.

Participants in the consensus scoring process were well-prepared, articulate, thoughtful, and extremely knowledgeable in their sub-section reviews. This resulted in a robust and thorough evaluation and scoring process. Consensus was achieved by every group for every question and reference submitted by each Offeror.

Subsequent to the conclusion of the consensus scoring process, Cost Proposals were opened and scored using the methodology outlined in the RFP.

Committee

The Executive Evaluation Committee ("Committee") for this RFP consisted of:
- Michael Nelson, Deputy Secretary, HSD
- Wayne Lindstrom, Director, BHSD
- Karen Meador, Deputy Director, BHSD
The Committee believes that the best interests of the State of New Mexico, HSD, our federal partner (CMS), and our Medicaid members will be served by these three (3) Offerors in the implementation and operation of Centennial Care 2.0.

Further, the Committee recommends that Oral Presentations are not needed and should not be conducted, as they are satisfied that the procurement process to this point has provided a satisfactory outcome. (Oral Presentations are noted in the RFP as "optional, at HSD’s discretion").

Thank you for your consideration of this recommendation.

Daniel Clavio, Procurement Manager

12/22/17

Date

Cc: Nancy Smith-Leslie, Director, Medical Assistance Division

Attachments:
- Notes from Executive Evaluation Committee Meeting
- Scoring Results Summary
- Signature page, Evaluation Committee
MEMO

TO: Dan Clavio, Procurement Manager
DATE: December 20, 2017
FROM: Jessica M. Osborne, Principal
SUBJECT: 2017 CENTENNIAL CARE 2.0 MCO RFP #18-630-8000-0001

Executive Evaluation Committee Recommendation

On Monday December 18, 2017 the Executive Evaluation Committee ("Committee") held a meeting to discuss the information contained in the RFP Scoring Results Summary and develop a recommendation for the Medicaid Director and Secretary of Human Services Department. The Committee reviewed all scores and rankings for each of the Offerors and discussed the needs and priorities of the State.

Based on this discussion, the Committee recommends that the New Mexico Human Services Department select the top three highest-scoring Offerors and initiate negotiations with Presbyterian Health Plan, Inc., Western Sky Community Care, and Blue Cross Blue Shield of New Mexico. The Evaluation Committee notes the following benefits of this recommendation to include:

- The three (3) highest-scoring plans overall demonstrated strong scores in the Technical Proposal.
- Contracting with three (3) MCOs furthers HSD's efforts to create administrative simplicity for providers and state oversight staff while maintaining adequate choice for Members.
- The recommendation will provide stability in the NM Medicaid program through the retention of two incumbent MCOs while providing a new MCO option for Members.
- A reduction in the number of MCOs has the potential to create economies of scale and encourages lower administrative costs.

The Evaluation Committee further recommends that no oral presentations will be required. Please accept this recommendation with the attached executive scoring summary which includes the details regarding the procurement process and results.
AFFIDAVIT OF KAREN MEADOR

STATE OF NEW MEXICO )
COUNTY OF SANTA FE ) ss.

KAREN MEADOR, on oath, and under penalty of perjury, states as follows:

1. My name is Karen Meador. I am over eighteen years of age, and I am competent to make this statement. I have personal knowledge of each factual matter set forth in this statement and each factual matter contained herein is true and correct.

2. I served as a member of the Executive Evaluation Committee for the 2017 Centennial Care 2.0 MCO RFP #18-630-8000-0001 (CC 2.0).

3. On December 18, 2017, the Committee met to review and discuss the Scoring Results Summary for the RFP and develop recommendations for the Medical Assistance Director and HSD Secretary regarding the RFP.

4. In the meeting, after discussion the Committee agreed, by consensus, to recommend that it would not be necessary to receive oral presentations from the Offerors, and that contracts be awarded to Presbyterian Health Plan, Inc., Western Sky Community Care, and Blue Cross/Blue Shield of New Mexico.

5. The foregoing recommendations were arrived at based upon the independent judgment of the Committee members, and were not directed, guided, or influenced by any third party.

FURTHER AFFIANT SAYETH NOT

[Signature]

KAREN MEADOR
The foregoing instrument was subscribed, sworn to and acknowledged before me on this 4th day of MAY, 2018 by KAREN MEADOR

NOTARY PUBLIC

My Commission Expires: 10/21/2020

OFFICIAL SEAL
PETER KIM PHIPPS
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires: 10/21/2020
AFFIDAVIT OF LINDA GONZALES

STATE OF NEW MEXICO  
COUNTY OF SANTA FE  

LINDA GONZALES, on oath, and under penalty of perjury, states as follows:

1. My name is Linda Gonzales. I am over eighteen years of age, and I am competent to make this statement. I have personal knowledge of each factual matter set forth in this statement and each factual matter contained herein is true and correct.

2. I served as a member of the Executive Evaluation Committee for the 2017 Centennial Care 2.0 MCO RFP #18-630-8000-0001 (CC 2.0).

3. On December 18, 2017, the Committee met to review and discuss the Scoring Results Summary for the RFP and develop recommendations for the Medical Assistance Director and HSD Secretary regarding the RFP.

4. In the meeting, after discussion the Committee agreed, by consensus, to recommend that it would not be necessary to receive oral presentations from the Offerors, and that contracts be awarded to Presbyterian Health Plan, Inc., Western Sky Community Care, and Blue Cross/Blue Shield of New Mexico.

5. The foregoing recommendations were arrived at based upon the independent judgment of the Committee members, and were not directed, guided, or influenced by any third party.

FURTHER AFFIANT SAYETH NOT

LINDA GONZALES

Linda Gonzales
The foregoing instrument was subscribed, sworn to and acknowledged before me on this 30th day of May, 2018 by LINDA GONZALES

NOTARY PUBLIC

My Commission Expires:

10/21/2020

OFFICIAL SEAL
PETER KIM PHIPPS
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires 10/21/2020
AFFIDAVIT OF KARI ARMijo

STATE OF NEW MEXICO )
) ss.
COUNTY OF SANTA FE )

KARI ARMijo, on oath, and under penalty of perjury, states as follows:

1. My name is Kari Armijo. I am over eighteen years of age, and I am competent to make this statement. I have personal knowledge of each factual matter set forth in this statement and each factual matter contained herein is true and correct.

2. I served as a member of the Executive Evaluation Committee for the 2017 Centennial Care 2.0 MCO RFP #18-630-8000-0001 (CC 2.0).

3. On December 18, 2017, the Committee met to review and discuss the Scoring Results Summary for the RFP and develop recommendations for the Medical Assistance Director and HSD Secretary regarding the RFP.

4. In the meeting, after discussion the Committee agreed, by consensus, to recommend that it would not be necessary to receive oral presentations from the Offerors, and that contracts be awarded to Presbyterian Health Plan, Inc., Western Sky Community Care, and Blue Cross/Blue Shield of New Mexico.

5. The foregoing recommendations were arrived at based upon the independent judgment of the Committee members, and were not directed, guided, or influenced by any third party.

FURTHER AFFIANT SAYETH NOT

[Signature]

KARI ARMijo
The foregoing instrument was subscribed, sworn to and acknowledged before me on this 8th day of May, 2018 by KARI ARMijo

NOTARY PUBLIC

My Commission Expires:

10/21/2020
AFFIDAVIT OF JASON SANCHEZ

STATE OF NEW MEXICO )
COUNTY OF SANTA FE ) ss.

JASON SANCHEZ, on oath, and under penalty of perjury, states as follows:

1. My name is Jason Sanchez. I am over eighteen years of age, and I am competent to make this statement. I have personal knowledge of each factual matter set forth in this statement and each factual matter contained herein is true and correct.

2. I served as a member of the Executive Evaluation Committee for the 2017 Centennial Care 2.0 MCO RFP #18-630-8000-0001 (CC 2.0).

3. On December 18, 2017, the Committee met to review and discuss the Scoring Results Summary for the RFP and develop recommendations for the Medical Assistance Director and HSD Secretary regarding the RFP.

4. In the meeting, after discussion the Committee agreed, by consensus, to recommend that it would not be necessary to receive oral presentations from the Offerers, and that contracts be awarded to Presbyterian Health Plan, Inc., Western Sky Community Care, and Blue Cross/Blue Shield of New Mexico.

5. The foregoing recommendations were arrived at based upon the independent judgment of the Committee members, and were not directed, guided, or influenced by any third party.

FURTHER AFFIANT SAYETH NOT

[Signature]

JASON SANCHEZ
The foregoing instrument was subscribed, sworn to and acknowledged before me on this 5th day of April, 2018 by JASON SANCHEZ

NOTARY PUBLIC

My Commission Expires:

10/21/2020

OFFICIAL SEAL
PETER KIM PHIPPS
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires 10/21/2020
AFFIDAVIT OF ANGELA MEDRANO

STATE OF NEW MEXICO  
COUNTY OF SANTA FE  

SS.

ANGELA MEDRANO, on oath, and under penalty of perjury, states as follows:

1. My name is Angela Medrano. I am over eighteen years of age, and I am competent to make this statement. I have personal knowledge of each factual matter set forth in this statement and each factual matter contained herein is true and correct.

2. I served as a member of the Executive Evaluation Committee for the 2017 Centennial Care 2.0 MCO RFP #18-630-8000-0001 (CC 2.0).

3. On December 18, 2017, the Committee met to review and discuss the Scoring Results Summary for the RFP and develop recommendations for the Medical Assistance Director and HSD Secretary regarding the RFP.

4. In the meeting, after discussion the Committee agreed, by consensus, to recommend that it would not be necessary to receive oral presentations from the Offerors, and that contracts be awarded to Presbyterian Health Plan, Inc., Western Sky Community Care, and Blue Cross/Blue Shield of New Mexico.

5. The foregoing recommendations were arrived at based upon the independent judgment of the Committee members, and were not directed, guided, or influenced by any third party.

FURTHER AFFIANT SAYETH NOT

[Signature]
ANGELA MEDRANO
The foregoing instrument was subscribed, sworn to and acknowledged before me on this 35th day of [Month], 2018 by ANGELA MEDRANO

NOTARY PUBLIC

My Commission Expires:

10/21/2020

OFFICIAL SEAL
PETER KIM PHIPPS
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires 10/21/2020
AFFIDAVIT OF MICHAEL NELSON

STATE OF NEW MEXICO    )
COUNTY OF SANTA FE  ) ss.

MICHAEL NELSON, on oath, and under penalty of perjury, states as follows:

1. My name is Michael Nelson. I am over eighteen years of age, and I am competent to
make this statement. I have personal knowledge of each factual matter set forth in this statement
and each factual matter contained herein is true and correct.

2. I served as a member of the Executive Evaluation Committee for the 2017 Centennial
Care 2.0 MCO RFP #18-630-8000-0001 (CC 2.0).

3. On December 18, 2017, the Committee met to review and discuss the Scoring Results
Summary for the RFP and develop recommendations for the Medical Assistance Director and HSD
Secretary regarding the RFP.

4. In the meeting, after discussion the Committee agreed, by consensus, to recommend
that it would not be necessary to receive oral presentations from the Offerors, and that contracts
be awarded to Presbyterian Health Plan, Inc., Western Sky Community Care, and Blue Cross/Blue
Shield of New Mexico.

5. The foregoing recommendations were arrived at based upon the independent judgment
of the Committee members, and were not directed, guided, or influenced by any third party.

FURTHER AFFIANT SAYETH NOT

MICHAEL NELSON
The foregoing instrument was subscribed, sworn to and acknowledged before me on this 30th day of May, 2018 by MICHAEL NELSON

NOTARY PUBLIC

My Commission Expires:

10/21/2020

OFFICIAL SEAL
PETER KIM PHIPPS
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires: 10/21/2020
AFFIDAVIT OF WAYNE LINDSTROM

STATE OF NEW MEXICO )
COUNTY OF SANTA FE ) ss.

WAYNE LINDSTROM, on oath, and under penalty of perjury, states as follows:

1. My name is Wayne Lindstrom. I am over eighteen years of age, and I am competent to make this statement. I have personal knowledge of each factual matter set forth in this statement and each factual matter contained herein is true and correct.

2. I served as a member of the Executive Evaluation Committee for the 2017 Centennial Care 2.0 MCO RFP #18-630-8000-0001 (CC 2.0).

3. On December 18, 2017, the Committee met to review and discuss the Scoring Results Summary for the RFP and develop recommendations for the Medical Assistance Director and HSD Secretary regarding the RFP.

4. In the meeting, after discussion the Committee agreed, by consensus, to recommend that it would not be necessary to receive oral presentations from the Offerors, and that contracts be awarded to Presbyterian Health Plan, Inc., Western Sky Community Care, and Blue Cross/Blue Shield of New Mexico.

5. The foregoing recommendations were arrived at based upon the independent judgment of the Committee members, and were not directed, guided, or influenced by any third party.

FURTHER AFFIANT SAYETH NOT

[Signature]
WAYNE LINDSTROM
The foregoing instrument was subscribed, sworn to and acknowledged before me on this 5th day of ______ MAY____, 2018 by WAYNE LINDSTROM

NOTARY PUBLIC

My Commission Expires:

10/21/2020

OFFICIAL SEAL
PETER KIM PHIPPS
NOTARY PUBLIC
STATE OF NEW MEXICO
My Commission Expires 10/21/2020
STATE OF NEW MEXICO  
COUNTY OF SANTA FE  
FIRST JUDICIAL DISTRICT

MOLINA HEALTHCARE OF NEW MEXICO, INC.,

Plaintiff,

v.  

NEW MEXICO HUMAN SERVICES DEPARTMENT, 
and BRENT EARNEST, as Cabinet Secretary of the 
New Mexico Human Services Department.

Defendants.

Case No. D-101-CV-2018-00356

**AFFIDAVIT OF DAVID DROSS**

1. My name is David Dross. I am over the age of eighteen years, and I am competent 
to make this statement. I have personal knowledge of each factual matter set forth in this 
statement. I affirm under penalty of perjury under the laws of the State of New Mexico that this 
statement is true and correct.

2. I am a partner within Mercer’s Health & Benefits Consulting Business, and Head 
of its Pharmacy Benefits Practice, located in Houston, Texas.

3. I have been made aware of a press release issued by Molina Healthcare of New 
Mexico, Inc. (Molina) on January 31, 2018 in connection with a lawsuit it filed against the New 
Mexico Human Services Department (HSD), and have been asked to respond to allegations in it 
about Mercer. These allegations concern a relationship between Envolve Pharmacy Solutions 
(“Envolve”) and Mercer Health & Benefits.

4. Mercer Health and Benefits is a business unit of Mercer that is separate from 
Mercer’s Government Human Services Consulting practice (Mercer GHSC). I have been told
that Mercer GHSC advised the State of New Mexico Human Services Department in connection with an RFP process for its Centennial Care 2.0 Medicaid program. Mercer Health and Benefits had no involvement in this work and I was unaware of it until I was shown Molina’s press release.

5. Molina claims Mercer GHSC had an undisclosed conflict of interest because Mercer Health & Benefits had a “substantial multi-billion dollar contractual relationship with Envolve” which resulted in Mercer GHSC having a “vested interest” in Envolve’s financial success. These statements are not true. One of the winning offerors in the RFP process, Western Sky, is a subsidiary of Centene, and Envolve is also a subsidiary of Centene.

6. The relationship between Mercer Health and Benefits and Envolve not only is not a “multi-billion dollar” relationship—it is not a financial relationship at all. Envolve is a pharmacy benefit manager (PBM) and has a pre-screening contract with Mercer that specifically provides for no compensation from Envolve to Mercer or vice versa. Mercer Health and Benefits is engaged by its clients to design and implement employee benefit plans, including health insurance plans. As part of our services for our clients, we screen and pre-approve PBMs for our clients to choose and incorporate into their plans. A specialty PBM provides high-cost medication services (like cancer drugs) to a relatively small universe of patients. Envolve is a specialty PBM, and the only contractual relationship Mercer has with Envolve is this screening and pre-approval contract. Mercer has a similar screening and pre-approval contract with one of Envolve’s leading competitors, Magellan Rx Management, and with many other PBMs.

7. The advantage of Mercer’s clients using one of Mercer’s pre-screened PBMs is that Mercer will have determined that the PBM has competitive pricing and enhanced service levels. Mercer’s compensation is not contingent on which pre-screened provider is selected by
the client, or whether a non-screened PBM is selected. Mercer derives no compensation from the PBM at all. Mercer’s compensation comes directly from the clients for whom it set up the benefit plans. The statements that Mercer has a “substantial multi-billion dollar relationship” with Envolve or a “vested interest” in Envolve’s financial success are totally false.

FURTHER YOUR AFFIANT SAYETH NAUGHT.

Signed and affirmed on February 23, 2018.

[Signature]

DAVID DROSS
February 14, 2018

Via E.mail & Regular Mail

Christopher P. Collins, Esq.
Deputy Cabinet Secretary & General Counsel
New Mexico Human Services Department
Pollon Plaza
Post Office Box 2348
Santa Fe, New Mexico 87504-2348

Molina Health v New Mexico HSD & Brent Earnest (Case No. D-101-CV-2018-00356)

Dear Mr. Collins:

At your request, this will address allegations made in a public press release on January 31 by Molina Healthcare of New Mexico, Inc. (Molina) in connection with a lawsuit it had filed against the New Mexico Human Services Department (HSD). This will confirm Mercer’s position that Molina’s allegations concerning Mercer lack any factual basis.

1. Molina, an incumbent vendor, was an unsuccessful offeror for one of the contracts to provide managed care services under New Mexico’s Centennial Care Medicaid program recently awarded through RFP #18-630-8000-0001 (RFP).

2. Mercer’s Government Human Services Consulting group (Mercer GHSC) has a long term consulting relationship with HSD. Those consulting services included services to HSD in connection with the RFP which is the subject of Molina’s lawsuit.

3. Molina claims the RFP process was “flawed” because of a relationship between Envelope Pharmacy Solutions (“Envelope”) and Mercer Health & Benefits which resulted in Mercer GHSC having a “vested interest” in Envelope’s financial success - based upon an alleged “substantial multi-billion dollar contractual relationship with Envelope.” Envelope and one of the winning offerors (Western Sky) share a common parent (Centene), and Envelope will be “heavily utilized” in the New Mexico fulfillment work.

4. Mercer GHSC’s RFP consulting work was not tainted by any conflict of interest. Factually, the Mercer professionals involved did not have any knowledge of any relationship between any Mercer business and Envelope. The first they heard or learned of such an assertion was when they learned of the lawsuit and read the press release. In any event, nothing that Western Sky (Envelope’s affiliate) could do as a successful offeror could result in compensation to Mercer. As discussed below, Mercer’s relationship with Envelope does not and cannot result in payment of compensation from Envelope to Mercer. Therefore, the
allegations concerning a financial relationship between Mercer and Enolve are simply incorrect.

5. Moreover, the nature of Mercer's work for HSD - specifically that Mercer had no discretion or decision-making authority - cannot support a claim that the process was tainted. Mercer's work on the RFP involved assisting HSD in designing and implementing the process. Mercer had no decision-making role in the technical evaluation. Mercer's only direct role in the "scoring process" was in compiling the scores for the cost offers - a wholly transparent and a largely computational exercise.

6. As noted, Mercer GHSC, and the professionals involved in the RFP consulting project, were unaware of any Enolve relationship. Therefore, paragraphs 7-8 of this letter are based on inquiries made of other Mercer colleagues who have been involved in developing Mercer's relationship with Enolve.

7. In October 2016, Mercer entered into a relationship with Enolve Pharmacy Solutions, Inc, a specialty pharmacy benefit manager (PBM). Mercer's health practice has relationships with a number of PBMs. The advantage of Mercer's clients using one of Mercer's "pre-screened" PBMs is that Mercer will have determined that the PBM has competitive pricing and pre-screened and enhanced service levels.

8. Generally, Mercer is agnostic whether its clients use one of the pre-screened PBMs. Indeed the PBMs whom Mercer introduces to clients compete among themselves (eg, Express Scripts vs CVS) for the clients' business. Mercer's compensation is not contingent on which pre-screened provider is selected by the client or indeed whether another PBM is selected. Mercer derives no compensation from the PBM at all. Mercer's compensation for services comes directly from the Mercer client; Mercer's contract with Enolve provides specifically that no compensation will be paid by Enolve to Mercer (nor vice versa). The statement that Mercer has a "substantial multi-billion dollar relationship" with Enolve is therefore simply incorrect.

Sincerely,

Derek MacKenzie

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1 A specialty pharmacy benefit manager provides high-cost medication services to a relatively small universe of patients. Mercer has contractual relationships with Enolve, and with one of its leading competitors - Magellan Rx Management. Compensation arrangements are largely the same in the specialty space, namely no compensation flows from the PBM to Mercer.
AFFIDAVIT OF CARMEN FONTANEZ

STATE OF Florida )
                   ) ss.
COUNTY OF Orange )

Carmen Fontanez, being first duly sworn on oath, states:

1. I am employed by Centene’s subsidiary, Envolve Pharmacy Solutions, Inc., as Executive Vice President of Sales & Account Management.

2. This affidavit is based on my personal, firsthand knowledge.

   MERCER DOES NOT HAVE A CONFLICT OF INTEREST AS A RESULT OF ANY RELATIONSHIP WITH ENVOLVE

3. Western Sky, to which HSD awarded a contract as a result of RFP 18-630-8000-0001, is a wholly-owned subsidiary of Centene Corporation. Centene has another separately held subsidiary, Envolve Pharmacy Solutions, Inc., which is a Pharmacy Benefit Management ("PBM") company also specializing in Specialty Drug Management (providing services such as pharmacy benefit delivery).

4. Envolve Pharmacy Solutions specializes in Managed Medicaid business and is the PBM serving the largest managed Medicaid population. This scale and scope brings the tools and services to manage drug trends while providing the most appropriate and affordable access to care, delivering the best outcome. Envolve Pharmacy Solutions is focused on the unique needs of this population, such as the Opioid crisis and patient engagement challenges.

5. The extent of any business relationship between Envolve and Mercer Health & Benefits LLC Mercer ("Mercer") is a single contract, a Master Service Provider Agreement ("MSPA"), entered into in October of 2016. Under the terms of the Agreement, Mercer
had the option to refer plan sponsors to Envolve Pharmacy Solutions. There are no financially beneficial terms to Mercer from this agreement.

6. The MSPA does not contain any monetary remuneration between the parties for services or property. The MSPA is a zero dollar contract.

7. Envolve and Mercer do not have a billion or multi-billion dollar contractual business relationship.

8. Mercer does not derive any financial benefit from the success of Envolve and will not benefit from any revenue Envolve obtains from Western Sky’s operations in New Mexico.

9. Mercer will not benefit from any revenue and profit Envolve or Western Sky obtains from operations in New Mexico or through other plan sponsors that would contract with Envolve in the future.

10. Mercer has no interest, direct or indirect, in Envolve’s operations, revenue, or profitability.

FURTHER AFFIANT SAYETH NOT.

\[signature\]

Carmen Fontanez

Subscribed and sworn to before me this 22nd day of February, 2018.

\[signature\]

Renee Crain

Notary Public

My commission expires:

\[signature\]

6/12/18
AFFIDAVIT OF BRENT LAYTON

STATE OF MISSOURI )
) ss.
COUNTY OF ST. LOUIS )

Brent Layton, being first duly sworn on oath, states:

1. I am employed by Centene/Western Sky Community Care ("Western Sky") as Executive Vice President, Chief Business Development Officer for Centene.

2. This affidavit is based on my personal, firsthand knowledge.

3. I have reviewed and have personal knowledge with regard to Western Sky’s proposal submitted to the New Mexico Human Services Department ("HSD") in response to RFP 18-630-8000-0001.

BACKGROUND ON CENTENNIAL CARE 2.0 PROCUREMENT

4. The New Mexico’s HSD is the state agency that administers the state’s Medicaid program. Medicaid is a joint state-federal funded program for medical assistance in which the federal government approves a state plan, including amendments and waivers, for the funding of medical services for the needy and then subsidizes a significant portion of the financial obligations the state agrees to assume. HSD delivers most Medicaid benefits in New Mexico through a managed care program, where a managed care organization ("MCO"), under contract with HSD. New Mexico’s Medicaid managed care program is known as Centennial Care.

5. The theory of managed care is relatively simple. Rather than pay providers directly every time a Medicaid beneficiary receives care (i.e., fee-for-service), the state instead contracts
with managed-care organizations ("MCOs") and pays them a flat "capitation rate" each month to provide, within certain limits, all of the care a beneficiary needs. The state pays the same amount regardless of whether the beneficiary receives healthcare services or not. So the MCO bears the risk that the costs of care may exceed the capitation payment.

6. In exchange for receiving a capitation payment, an MCO is responsible for three principal tasks: forming a contracted network of healthcare providers to care for its members; ensuring members can obtain medically necessary health care services and supports; and paying providers for their services. An MCO then directs its members to in-network providers, with whom the MCO has negotiated discounted rates.

7. On September 1, 2017, HSD issued RFP 18-630-8000-0001 requesting proposals from MCOs for the delivery of health care coverage under HSD's Centennial Care 2.0 program to provide Medicaid managed care to New Mexicans.


9. On January 18, 2018, HSD publically announced that Western Sky, Presbyterian Health Plan ("PHP"), and Blue Cross Blue Shield of New Mexico ("BCBS") were competitively selected MCOs under the RFP and were awarded contracts.


11. HSD did not award contracts to Molina Healthcare of New Mexico, Inc. ("Molina") or United Healthcare ("UHC"), both of which are incumbent MCOs in New Mexico.

CENTENNIAL CARE 2.0 PROVIDES BETTER SERVICES THAN PROVIDED UNDER CENTENNIAL CARE 1.0

12. In development of the Centennial Care 2.0 program, HSD identified key opportunities for improving the program in the following key topic areas: Care Coordination, Behavioral Health Integration, Long Term Services & Supports ("LTSS"), Payment Reform, Member
Engagement, and Administrative Simplification. Opportunities identified under Care Coordination include: Increase care coordination at the provider level, improve transitions of care including discharge from hospital/nursing facility, release from jail/prisons, returning home from foster care, and expand programs working with high needs populations such as use of peer supports, use of Tribal Community Health Representatives, pilot maternity home visit programs, and leverage federal funding for supportive housing. Under Behavioral Health Integration, opportunities for improvement were identified as expanding integration of physical and behavioral through the continued deployment of Health Homes (CareLink NM) and supporting Workforce Development by training primary care providers and psychiatric residents with a focus on areas of the State most difficult to attract and keep providers. Opportunities and benefit enhancements under LTSS include a proposed one-time start-up benefit for members transitioning to self-direction; additional caregiver respite hours (increasing the benefit from 100 to 300 hours); continuing access to Community Benefit services for nursing facility level of care and establishing cost limits on certain services (one-time start-up, non-emergency medical transportation, and specialized therapies) to ensure long-term sustainability of the program; implementing an automatic nursing facility level of care renewal for members whose conditions are not expected to change and required inclusion of nursing facilities in value based payment arrangements and use Project ECHO to provide help to nursing home staff. Under Payment Reform, HSD required an increased percentage of payments to be risk based and defined targets by level for each year of the contract and required value-based purchasing to drive program goals. Member Engagement opportunities for enhancement include: advancing the Centennial Care Rewards program by lowering participant age to
15 years old, allow rewards to be used to pay premiums/co-payments, add mobile app technology, and enhance the list of healthy behaviors rewarded through the program.

**WESTERN SKY BACKGROUND**

13. Western Sky is a wholly-owned subsidiary of Centene Corp. which is a national healthcare enterprise that provides a range of services to government-sponsored healthcare programs, focusing on under-insured and uninsured individuals.

14. Centene is the largest Medicaid MCO in the country with experience across 25 states.

15. Centene has been providing services to Medicaid beneficiaries for over three decades since 1984.

16. Centene has over 30,000 employees. Centene currently provides healthcare services to over 12 million individuals in 29 states who benefit from Medicaid, Medicare, CHIP, and other public sector healthcare programs.

17. Local presence: Western Sky will locate all management staff and staff that interface with members and providers, such as, Member and Provider Call Centers, Marketing, Care Coordination, Utilization Management, Quality Improvement, Network Contracting, Provider Relations/Engagement, Grievance and Appeals, and Compliance, in New Mexico headquarters. Western Sky will have approximately 400 employees in New Mexico depending on final membership allocation, and will have networks of medical and behavioral health providers.
MERCER DOES NOT HAVE A CONFLICT OF INTEREST AS A RESULT OF ANY RELATIONSHIP WITH ENOLVE

18. Western Sky, to which HSD awarded a contract as a result of RFP 18-630-8000-0001, is a wholly-owned subsidiary of Centene Corporation. Centene has another separately held subsidiary, Envolve Pharmacy Solutions, Inc., which is a Pharmacy Benefit Management ("PBM") company also specializing in Specialty Drug Management (providing services such as pharmacy benefit delivery).

19. Western Sky’s proposal discloses and references Envolve as a subcontractor in its proposal to HSD. Envolve, through its family of companies, including Envolve Pharmacy Solutions, Inc., provides flexible and affordable healthcare solutions to health plans and partners nationwide (collectively, “Envolve”).

20. From 2016-17, out of five government procurements in which Mercer served as a consultant, Centene, or a subsidiary, was awarded a contract zero times.

21. Prior to the award of Centennial Care 2.0, Centene and Mercer did not communicate with each other regarding RFP 18-630-8000-0001, Western Sky’s proposal or the scoring of the proposal, any other offeror’s proposal or the scoring of any proposal.

NEW MEXICO WILL BE BETTER SERVED BY WESTERN SKY

22. Western Sky is well equipped to serve some of New Mexico’s most vulnerable and traditionally underserved Medicaid populations. Developed with key NM providers and stakeholders, through multiple years on the ground meeting with partners across the state, our innovative strategies support an integrated, comprehensive, health care delivery system that offers the full array of Medicaid services, including physical health (PH), behavioral health (BH), pharmacy, and LTSS.
23. Opiate Mortality: As New Mexico routinely ranks in the top three states related to opiate mortality, and with Rio Arriba County particularly affected by heroin overdoses, Western Sky will work closely with Substance Use providers, the BH Collaborative, and national experts to address the opioid epidemic with leading edge evidence based practices. Western Sky will work with Duke City Recovery Tool Box in ABQ, NM Treatment Services in Espanola, Courageous Transformations in ABQ, ALT Recovery in Las Cruces, and others, to create a coalition to help ensure a comprehensive prevention, treatment, and recovery strategy including our “OpiEnd” Prevention Program. Provider engagement is a key strategy in our “OpiEnd” program, including provider profiling reports that highlight prescribing patterns; guidelines and appropriate prescribing practices; member and provider engagement templates; promotion of the NM Prescription Monitoring Program; and expanded access to Medication Assisted Treatment with therapy support.

24. Western Sky can provide statewide behavioral health services: Western Sky has established relationships with Presbyterian Medical Services and other core service agencies, including Mental Health Resources, La Clinica de Familia, Hidalgo Medical Services, University of New Mexico, Tri County Community Services, and BH resources such as Solace Crisis Center to support engagement. A specific strategy is supporting expansion of Treat First, leveraging the experience of PMS pilot sites and providing technical assistance to add new sites. Innovative solutions that Western Sky is bringing to New Mexico to further support access to behavioral health services includes: Community Based Mobile Engagement Teams providing crisis intervention in the community; a Tribal Warm Line, a culturally-responsive telephonic peer support program; and 7 Cups Online Peer Support program providing secure connection to trained peer listeners. Native American population will be
better served by Western Sky: Western Sky’s affiliates successfully serve Native American populations across the county. Native American Community Health Representatives (CHRs) will be central to our Integrated Care Coordination (ICC) strategy for Native American members. CHRs will serve an important role in addressing cultural barriers, conducting outreach with hard to reach members, and assisting members with linkages to social service supports for the full array of issues impacting health and wellness.

25. Western Sky’s extensive services will include providing a Traditional Healing Benefit to Native American members for traditional customs and ceremonies.

26. In responding to the RFP, Western Sky has had ongoing discussions and meetings with the various New Mexico tribes and tribal organizations, including the two Apache tribes, Navajo Nation, all 19 Pueblos, and the All Pueblo Council of Governors. Western Sky met frequently with members of the Pueblo Health Council and the Native American Advisory Council, leaders of the Navajo Health Council, Eight Northern Pueblo and First Nations as well as individual tribes. Through Western Sky’s Native American Liaison, Erik Lujan, Western Sky is working with each tribe to understand how and where they receive services and establish contracts or preferred relationships with the I/T/Us caring for them today. This will include ensuring a network of healers and other alternative treatment options. Western Sky has agreements with Acoma Pueblo, Santa Ana Pueblo, and Jemez. A pilot with Mescalero Apache Tribe is being developed to increase capacity for CHRs to educate members on prevention, disease management, and community resources. In addition, UNM has committed to opening clinics in tribal areas to help to build out tribal health systems as directed by the tribes.

PROCEEDING WITH CENTENNIAL CARE 2.0 WILL NOT DISRUPT SERVICES
27. HSD’s “Readiness Review Period” prior to the effective roll-out of Centennial Care 2.0 in January 2019 will ensure that Western Sky is prepared to offer all services and accept enrollment January 1, 2019.

28. Western Sky has had staff on the ground in New Mexico for more than two years, listening and meeting with providers, advocates, tribal leaders, and associations in urban, rural, frontier, and tribal regions. The goal is a comprehensive network to support a whole-person care model that is built on strategic partnerships that are physician-led, collaborative, and fully integrated between physical health, behavioral health, long-term services and supports, and social determinants of health.

29. Western Sky has already deployed our Transition Leadership and Business Implementation and Integration Teams comprised of expert executive, management, and technical staff who have implemented multiple managed care programs and have significant collective experience in health plan operations, network development, project management, and new health plan implementations.

30. Centene has never missed an implementation deadline for providing managed care to any state.

HSD's RATES TO BE PAID TO MCOs UNDER THE RFP WILL BE ACTUARially SOUND AND IN THE STATE'S INTERESTS

31. Western Sky’s cost proposal is based on its business model, not Molina’s. Each bidder had an opportunity to make a competitive business decision with respect to where they needed to land within the draft rate range. This is a common industry practice. Molina and WellCare recently participated in a very similar cost proposal process for the State of Illinois whereby the bidders were awarded points based on where the bidder’s cost proposals fell within a draft rate range.
32. Lower rates paid to the MCOs will benefit the agency and New Mexicans served by the Centennial Care 2.0.

33. Lower prices offered by bidders resulted in higher scores on the cost proposal.

34. Molina’s offered price was the highest of all bidders and, as a consequence, its cost proposal was scored the lowest with 120 points out of a possible 400 points.

35. Western Sky scored 254 points on the cost evaluation factor.

36. HSD’s rates to be paid to MCOs under the Contract will be certified by their actuary as actuarially sound once they are finalized as described in the procurement materials.

AWARDING ONLY THREE CONTRACTS WILL RESULT IN LOWER COSTS TO HSD, STATE, AND TAXPAYERS

37. The primary goal of all sealed bid projects is to maximize competition in order to obtain the best possible combination of quality and price.

38. Awarding three contracts rather than up to five contracts will increase economies of scale and encourage lower administrative costs for HSD.

WESTERN SKY DISCLOSED ALL INFORMATION REGARDING LITIGATION AND SANCTIONS AS REQUIRED IN RFP 18-630-8000-0001

39. Section 3.4.3.3, Section 6.1, Question 5, of the RFP requires all offerors to: “Provide a statement of whether there is any pending or recent (within the past five (5) years) litigation against your organization, Directed Corrective Action Plans, or sanctions levied.”

40. Molina, in its Complaint, states that Western Sky should be debarred or suspended because it failed to disclose litigation and sanctions. Specifically, Molina alleges that Western Sky failed to disclose two cases: (1) Kentucky Spirit Health Plan, Inc. v. Commonwealth of Kentucky, Case # 12-CI-01373 (Franklin County Court; filed Oct. 22, 2012) (“Kentucky Spirit”); and, (2) Harvey v. Centene Corp., et al., No. 18-cv-00012 (“Harvey”).
41. The Kentucky Spirit litigation was disclosed by Western Sky in its proposal to HSD. A true and correct excerpted page from Western Sky’s exhibits evidencing the disclosure to its proposal is attached hereto. See attached Exhibit 1.

42. With regard to the Kentucky Spirit litigation, Kentucky Spirit tendered notice of its intent to terminate the Contract with the Commonwealth of Kentucky effective twelve months before the expiration of the Contract’s initial term pursuant to the terms of the Contract. Kentucky Spirit filed a complaint in court seeking a declaration that the contract afforded it the right to terminate the contract. On November 3, 2016, all parties entered into a settlement agreement with respect to all lawsuits and complaints associated with the aforementioned contract termination. Under the terms of the settlement agreement, Kentucky Spirit received an immaterial cash payment from the Commonwealth’s actuarial firm and each party dismissed all claims related to the litigation with prejudice. The Commonwealth agreed that Kentucky Spirit did not act in bad faith; that it took reasonable positions in light of the applicable contractual language; and that Kentucky Spirit acted in good faith in attempting to address a difficult situation.

43. The Harvey litigation was not disclosed because the complaint was not filed until January 11, 2018, nearly ten weeks after HSD’s November 3, 2017, deadline for Western Sky and other offerors to submit proposals and supporting information. Moreover, the Harvey litigation relates to Centene’s marketplace product, Ambetter, not Medicaid.

44. With regard to sanctions imposed by the State of Washington which is referenced in the Molina’s Complaint, the sanctions related to the Ambetter product and were imposed in December 2017, after the HSD’s November 3, 2017, deadline for Western Sky and other
offerors to submit proposals and supporting information. Centene's Washington subsidiary, Coordinated Care, has addressed these issues and continues to offer all services.

45. Western Sky timely reported all litigation and sanctions information, including in Washington and Kentucky, in the compliance history part of its bid to RFP 18-630-8000-0001.

FURTHER AFFIANT SAYETH NOT.


BRENT LAYTON


Subscribed and sworn to before me this 22nd day of February 2018.


Notary Public

My commission expires:

Oct 21, 2018
Kentucky Spirit Health Plan v. the Commonwealth of Kentucky; Commonwealth of Kentucky, Franklin Circuit Court, No. 12-CI-1373). On July 5, 2013, Centene’s subsidiary, Kentucky Spirit, terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believed it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. In response, the Commonwealth alleged that Kentucky Spirit’s exit constituted a material breach of contract. The Commonwealth sought to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. The Commonwealth asserted that the Commonwealth’s expenditures due to Kentucky Spirit’s departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputed the Commonwealth's alleged damages on several grounds. Prior to terminating the contract, Kentucky Spirit filed a legal complaint in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches.

On May 26, 2015, the Commonwealth issued a demand for indemnification to its actuarial firm, for “all defense costs, and any resultant monetary awards in favor of Kentucky Spirit, arising from or related to Kentucky Spirit’s claims which are predicated upon the alleged omissions and errors in the Data Book and the certified actuarially sound rates.” The actuarial firm moved to intervene in the litigation and the Franklin Circuit Court granted that motion on September 8, 2015. Also, on August 19, 2015, the actuarial firm filed a petition seeking a declaratory judgment that it is not liable to the Commonwealth for indemnification related to the claims asserted by Kentucky Spirit against the Commonwealth. On October 5, 2015, the Commonwealth filed an answer to the actuarial firm’s petition and asserted counterclaims/cross-claims against the firm.

On November 3, 2016, all parties entered into a settlement agreement with respect to all lawsuits and complaints associated with the aforementioned contract termination. Under the terms of the settlement agreement, Kentucky Spirit received an immaterial cash payment from the Commonwealth’s actuarial firm and each party dismissed all claims related to the litigation with prejudice. In addition, the Commonwealth and Kentucky Spirit have agreed that neither party acted in bad faith; that the parties took reasonable positions in light of the applicable contractual language; and that the parties acted in good faith in attempting to address a difficult situation. Filed: 10/22/2012 (settled in November 2016)

Cheryl Greenfield and Stephanie Robinson on behalf of themselves and all others similarly situated v. Centene Corporation, Centene Management Company, LLC, and Executive Business Solutions EBS LLC (US District Court for the North District of Georgia) Plaintiffs filed a collective action which can be summarized as misclassification in non-exempt and/or non-employee status, failure to pay for all hours worked, and overtime for all hour worked