ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that on February 5, 2018 at 4:05 p.m., the original of UnitedHealthcare of New Mexico’s Protest of Contract Award Under RFP # 18-630-8000-001 was hand-delivered to me on behalf of the Cabinet Secretary of the New Mexico Human Services Department, along with two copies for service on Mr. Daniel Clavio, Procurement Manager, and Christopher Collins, General Counsel.

[Signature]
Name

[Signature]
Title
February 5, 2018

HAND-DELIVERED

Brent Earnest  
Cabinet Secretary  
New Mexico Human Services Department  
Pollon Plaza  
2009 South Pacheco Street  
Santa Fe NM  87505

Re: Protest of Contract Award Under RFP # 18-630-8000-0001 for Centennial Care 2.0

Dear Secretary Earnest:

This firm represents UnitedHealthcare of New Mexico, Inc. (“UHC”). In conformance with NMSA 1978, § 13-1-172 and applicable regulations, UHC protests the decision to exclude UHC from among those awarded a contract pursuant to the captioned RFP.

UHC did not make the decision to file this protest lightly. UHC has provided managed care through New Mexico’s Medicaid program for several years and very much appreciates its relationship with New Mexico and the New Mexico Human Services Department (“HSD”). After careful consideration, however, UHC has concluded that there were two fundamental errors made in the procurement process that led to HSD’s failure to award a contract to UHC for Centennial Care 2.0:

First, HSD failed to follow up with UHC’s listed contact at the Rhode Island Executive Office of Health and Human Services to inquire why no Reference had been received, and that failure was outcome determinative. Had HSD inquired—as HSD did with other Offerors’ missing or incomplete References—UHC’s missing Reference would have been supplied, and, by itself, that Reference would have vaulted UHC from fifth place in the rankings to second or third place.

Second, the RFP scoring system was not precise enough to appropriately differentiate among the second through the fifth-ranked Offerors, and there is little detriment to the State—and potentially great advantages to Medicaid members—to awarding contracts to at least four Offerors. Under the RFP, HSD had authority to award up to five Centennial Care 2.0 contracts. Particularly given the imprecision of the RFP scoring system, coupled with the slim point margins between the second, third, fourth, and fifth-ranked Offerors, HSD needed—but failed to gather—substantial evidence to justify a decision to award contracts to only three MCOs, and thus reduce the number of Medicaid providers in New Mexico from four to three, despite generally rising Medicaid rolls over the past few years. (See HSD “New Mexico Medicaid Managed Care Program Quality Strategy,” September 2017 Update, at 5, attached as Exhibit 1.)

We discuss these points in detail below. However, UHC is not asking that any of the three Centennial Care 2.0 contracts already announced be displaced (though further processing of the
contracts should best be stayed pending this protest). Rather, this protest can and should be resolved by simply (1) allowing consideration of UHC’s Reference from Rhode Island, which we understand has now been submitted, and (2) in light of that Reference, awarding a fourth Centennial Care 2.0 contract to UHC. The RFP expressly allows HSD to award up to five Centennial Care 2.0 contracts, and UHC simply desires and deserves to continue providing Medicaid services to New Mexico.¹

PROTESTOR AND AUTHORIZED REPRESENTATIVE

Protestor:

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SOLICITATION NUMBER AND TITLE

RFP # 18-630-8000-0001; Centennial Care 2.0

¹ We are submitting this protest letter now to meet the deadline set by HSD. However, we have made several IPRA requests for which all documents may not have been fully produced, or we may not have had the time to fully assess such documents due to the timing of their production. (See, e.g. UHC’s IPRA request letters and 2/2/18 letter from HSD to Mr. Mensack re IPRA requests, attached as Exhibit 2.) We therefore reserve the right to supplement this protest letter should additional pertinent documents come to light.
DETAILED STATEMENT OF THE FACTUAL AND LEGAL BASIS FOR PROTEST

A. Factual Basis and Background.

UHC is a wholly owned subsidiary of UnitedHealth Group, which has more than 34 years of Medicaid experience and services more than 6.5 million Medicaid managed care beneficiaries across 26 states. (10/30/17 Letter of Transmittal, attached as Exhibit 3.) UHC has been providing managed Medicaid services to New Mexicans since 2008. Indeed, UHC is the longest-standing and most successful provider in the State of long-term services and supports (“LTSS”) and “dual-eligible” services for people receiving both Medicare and Medicaid. UHC serves 13,000 individuals receiving LTSS services all over the State, including in remote areas on Indian reservations and in rural communities. UHC also serves nearly 18,000 dual-eligibles in its Medicare Advantage dual eligible special needs plan or DSNP, with overlapping membership of over 8,000 dual-eligibles served in both programs UHC offers.

On September 1, 2017, the New Mexico HSD issued a Request for Proposals ("RFP") soliciting “competitive, sealed proposals from managed care organizations (MCOs) to provide services to Members of the New Mexico Medicaid managed care program,” with the services to begin in January 2019. (RFP at 6.) New Mexico refers to this new program as “Centennial Care 2.0.” According to the RFP, the “purpose of this competitive RFP is to select Offerors that have the experience and expertise to perform the requirements described within.” (RFP at 10.)

Four companies—including UHC—currently administer New Mexico’s managed Medicaid program to about 700,000 people in the state who are insured through Medicaid. (RFP at 6.) On average, this means each MCO has about 175,000 Medicaid beneficiaries. This figure is closely in line with the national average of 189,000 enrollees per MCO. (Menges Decl., attached as Exhibit 4, at ¶¶ 7, 9.) The RFP states that it is “HSD’s intent to contract with three to five MCOs unless it is in the State’s best interest to do otherwise.” (RFP at 11.)

A proper response to the RFP required submission of (1) “Mandatory Requirements,” (2) three “References,” (3) a “Technical Proposal” and Exhibits, and (4) a “Cost Proposal.” (RFP at 30.) The RFP specified that the proposal had to be received by November 3, 2017. (RFP at 19-20.)

Eight organizations submitted proposals by the November 3, 2017 deadline, and all eight were deemed qualified for review, evaluation and scoring. (12/22/17 letter from Mr. Clavio to Secretary Earnest, attached as Exhibit 5.)

The “Mandatory Requirements” included, among other items, a “List of References” that would identify the three Reference entities, including the contact name and phone number for each. The Offerors were also instructed to send directly to the contact for each Reference a copy of the Reference form the entity needed to fill out, with instructions to send the completed Reference form directly to HSD, so that it was received by November 2, 2017—or one day prior to the due date for the proposals themselves. That earlier deadline for receiving the References gave HSD a day to follow up as to any missing or incomplete References.
These requirements underscore how the RFP was structured to allow HSD to follow up directly with the named Reference sources concerning any issues with the References. It is hard to think of any other reason why the Offerors would be required to give HSD the name, phone number and email address of the contact person for each Reference. As regards UHC’s Rhode Island reference, we included the following in Section 5.9 of the Mandatory Requirements (a copy of which is attached as Exhibit 6):

Name: Patrick M. Tigue – Medicaid Program Director
Email address: Patrick.Tigue@ohhs.ri.gov
Phone number: (401) 462-1965

UHC timely submitted its application, including a List of References in Section 5.9 of the Mandatory Proposal. UHC also sent copies of the HSD Reference form directly to the contact person at each of its three References. There is no dispute that UHC delivered all required elements of the proposal directly to HSC, including all Mandatory Requirements, the Cost Proposal, and the Technical Proposal.

While HSD timely received the completed Reference form from two of UHC’s listed References, HSD received nothing from UHC’s third Reference, the Rhode Island Executive Office of Health and Human Services. This was surprising, since in a confirming email to UHC dated October 20, 2017, Rhode Island’s Medicaid Director had readily agreed to provide the Reference, saying he was “happy to do it.” (Email attached as Exhibit 7.)

Rhode Island’s missing Reference was also surprising because UHC had been providing Medicaid and other health services continuously in Rhode Island since 1994—more than 20 years. In any event, HSD apparently made no effort to contact Rhode Island’s Medicaid Director, Mr. Tigue, about the missing Reference, nor did HSD at any point in the process contact UHC’s designated contact for this procurement—Charles Milligan—to notify him that the Reference had not been supplied so that Mr. Milligan could immediately follow up with Rhode Island about the matter. (Milligan Decl., ¶¶ 5-7, attached as Exhibit 8.) HSD’s failure to attempt any communication with Mr. Tigue about the missing Reference has been confirmed by UHC’s IPRA request for such communications, with none having been produced.

As was later learned, Mr. Tigue delegated the task of completing the Reference to the person charged with oversight of UHC’s contracts (a role comparable to HSD’s Contracts Bureau Chief). (Id. ¶ 8) However, the Reference inadvertently did not get submitted—but Mr. Tigue did not know this. Nevertheless, as set forth in the attached 2/1/18 letter from Mr. Tigue marked as Exhibit 9, it was Mr. Tigue’s “full intention” to timely submit the Reference by the November 2, 2017 deadline as requested. Mr. Tigue also believed that it had been submitted on time, never hearing otherwise from HSD.

When UHC reviewed the materials supplied after the contracts had been announced and learned the Reference had in fact not been received, we advised Mr. Tigue, who addressed the matter and sent the Reference directly to Mr. Clavio, the RFP Procurement Manager. Id. However,
HSD declined to review and score the Reference. (2/1-2/18 email exchange, attached as Exhibit 10.)

Although HSD failed to alert both UHC and Mr. Tigue that Rhode Island’s Reference for UHC had not been received, HSD treated Offerors WellCare of New Mexico, Amerigroup Community Care of NM, and Western Sky Community Care, very differently: by affirmatively reaching out to make sure their References were timely submitted and complete. And HSD also helped Molina Health Care get three References in a different way—by accepting a Reference from an improper Reference source, one of Molina’s paid providers.

**WellCare**

When the Procurement Manager, Mr. Clavio, received a letter from one of WellCare’s Reference contacts (Mr. Bick from the New York Department of Health) which contained only a letter of recommendation and a blank Reference form, Mr. Clavio emailed the contact the next day, stating: “Please submit a completed Reference form as provided, as they will be scored from that form and not from a letter.” (10/23-24/17 email exchange, attached as Exhibit 11.) And when Mr. Clavio still hadn’t received the completed Reference form several days later, he sent a second email to the contact, dated 10/30/17, again warning that a “reference letter in support of this Offeror will not be accepted in lieu of the form; our Reference Form (Appendix F) must be submitted.” He went on to say, “If you are not able to submit that form as a reference, you should notify Wellcare immediately, as the deadline is November 2.” (10/30/17 email, attached as Exhibit 12.)

**Amerigroup**

When Mr. Clavio received a Reference from Louisiana for Amerigroup Community Care of NM, which had some missing pages, he once again promptly and proactively sent an email inquiry to the contact, asking that the missing pages be supplied. (10/24/17 email exchange attached as Exhibit 13.) Just as with Mr. Clavio’s proactive outreach on behalf of WellCare as regards the blank Reference form, his outreach on Amerigroup’s behalf was wholly proper in an effort to enable full and complete scoring of that Reference in the evaluation of Amerigroup.

**Western Sky**

Mr. Clavio also received a completed Reference from the California Department of Health Services for “HealthNet Community Solutions,” but HealthNet was not one of the eight Offerors. In fact, the Reference was submitted at the request of Offeror Western Sky, but Western Sky is not mentioned in the Reference. Mr. Clavio promptly sent an email inquiry to the contact for the Reference, seeking clarification. (Email exchange attached as Exhibit 14.) Mr. Clavio wrote: “We don’t have an Offeror named ‘Health Net Community Solutions Inc. (‘Health Net’). Perhaps the name of their parent company is different (?) At this point I don’t know what to do with this letter, and someone may come up short.” (Emphasis added.)

Mr. Clavio plainly did not want an Offeror to “come up short” in its points merely because of incomplete compliance by a third-party Reference. He also felt compelled to assist the process by actively reaching out to cure the Reference’s irregularity. This follow up regarding Western
Sky proved of crucial importance, because the California Reference added an additional 100 points to Western Sky that it might not have received absent the inquiry. (See relevant excerpts from 12/22/17 Scoring Results Summary, Attachment 2, at 1640, attached as Exhibit 15.) As seen below, that 100 points—by itself—boosted Western Sky from 1460 points—which would have put Western Sky in only fifth place among the eight Offerors, behind UHC—to 1560 points, thus putting it in second place.

Moreover, there is a substantial question as to whether HSD should have even accepted the California reference as a proper Reference for Western Sky under the RFP. Until 2016, HealthNet had been a public company operating independently in California. But as Western Sky’s California Reference contact advised Mr. Clavio in responding to his email: “Health Net Merged with Centene in 2016. (Email attached as Exhibit 16; emphasis added.) In other words, (1) HealthNet was completely independent of Western Sky until 2016; and (2) HealthNet was now owned not by Western Sky, but by Western Sky’s parent, Centene. And as far as we know, there is no evidence in the record showing, even now, that the same people managing Western Sky had any involvement in managing HealthNet. Certainly, until 2016, a completely different group of people was managing HealthNet as a separate company. In short, Western Sky got a 100 point boost in its score from a Reference touting the operations of what was until the year before a different company.

Molina HealthCare

Mr. Clavio reached out to help Molina in a different way: namely, by accepting and scoring one of Molina’s References even though it came not from a “client”—as the RFP required—but rather from one of Molina’s paid providers, Mental Health Resources, which describes itself as a “contracted Behavioral Health provider with Molina healthcare....” Mental Health Resources Reference form at 2. (Copy attached as Exhibit 17.) A client is a “person or entity that employs a professional for advice or help in that professional’s line of work” (Black’s Law Dictionary at 309 (10th ed.)) A “client” pays a professional for services, so a client’s recommendation has value to determine whether a client thinks it is getting good value from its purchase. This is presumably what HSD wanted to know: will the Offeror deliver value on the contract HSD is paying. But a recommendation from a provider—someone who is paid by the professional—has little value. In any event, the Mental Health Resources Reference did not comply with the terms of the RFP, and should have been rejected by HSD. But HSD not only accepted the reference, but scored it so as to give Molina the maximum of 100 points for the Reference.

Consensus scoring of responses to the RFP was done during the first two weeks in December, 2017. (12/22/17 letter from Mr. Clavio to Secretary Earnest, attached as Exhibit 5.) The responses were scored in three areas: Technical, References, and Cost, and the final ranking and point scores of the eight offerors were as follows:

1. Presbyterian Health Plan (“PHP”)  1,771
2. Western Sky Community Care (“WS”)  1,560
3. Blue Cross Blue Shield of New Mexico (“BCBS”)  1,544
4. AmeriHealth Caritas New Mexico (“AH”)  1,515
5. UnitedHealthcare of New Mexico ("UHC") 1,497
6. Molina Healthcare of New Mexico ("MHC") 1,350
7. Amerigroup Community Care of NM ("AG") 1,338
8. WellCare of New Mexico ("WC") 1,273

Notably, while PHP, the highest scorer, received 211 points more than the second place scorer (WS), only a 63 point spread occurred from the second to the fifth highest offeror, UHC. Given this closely bunched scoring outcome, the way in which UHC’s missing reference is handled takes on critical importance.

Indeed, had the missing Reference from Rhode Island been received and scored, it is virtually certain that UHC would have been at least the number 3 highest scorer instead of BCBS. As scored, each of an Offeror’s three References had the possibility of adding a full 100 points to its total score. Of the 21 References that were received and scored, the mean average of the scores was 90.48, and the lowest score given for any Reference was a 56. The mean average of the scores for the two received UHC References was 82.5. Given these figures, it is highly likely that, had Rhode Island’s UHC Reference been received and scored, it would have added at least 56 total points to UHC’s total, giving UHS a total score of 1,553—which would have made UHS the third-ranked Offeror.

Indeed, only 47 points currently separate UHC from BCBS, the number 3 scorer. So if Rhode Island’s now-submitted Reference for UHC is scored at 48 or higher, UHC will become the third-ranked scorer.

B. **HSD Breached Its Duty to Inquire About UHC’s Missing Reference and Failed to Treat Offerors With Missing Information Equally.**

1. The purposes underlying public procurement.

The purposes of public procurement “are to provide for the fair and equitable treatment of all persons involved in public procurement, to maximize the purchasing value of public funds and to provide safeguards for maintaining a procurement system of quality and integrity.” NMSA 1978, § 13-1-29(C). And “[o]f all the interests involved in competitive bidding, the public interest is the most important.” *Planning and Design Solutions v. City of Santa Fe*, 118 N.M. 707, 710 (1994). To protect and further the public interest, “one of the cornerstone policy goals” is to ensure “that the government attains the best contract possible and does not take advantage of obvious contractor errors.” *Griffs Landscape Maintenance LLC v. U.S.*, 46 Fed. Cl. 257, 259 (2000).

These public policy objectives imposed on HSD a duty to further the public interest by (1) ensuring that the State, through a fair and equitable process, awarded Centennial Care 2.0 contracts to the MCOs that best met the State’s needs, and by (2) ensuring that Centennial Care 2.0 contracts were awarded to the optimum number of MCOs to adequately serve the State’s burgeoning Medicaid population.
2. HSD failed to inquire about UHC’s missing Reference.

To ensure that contracts would be offered to the best MCOs, HSD had a duty to inquire about apparent mistakes or items missing from an RFP response, otherwise a highly-desirable MCO might be eliminated due to an inadvertent happenstance unrelated to the MCO’s ability to deliver quality service in New Mexico.

Here, UHC’s missing Reference was an obvious mistake, and HSD had a duty to inquire about it. Indeed, it is a general principle of procurement law that when required information is seen to be missing from a response to an RFP, and the omission likely stems from an inadvertent mistake or clerical error, the procuring agency may not simply ignore it: rather, the agency has an affirmative duty to “inquire further.” *Griffy’s Landscape Maintenance*, 46 Fed. Cl. at 258. That duty makes perfect sense given the above-noted procurement policy goals. And the specific goal of this RFP was to “select Offerors that have the [needed] experience and expertise to perform the requirements” (RFP at 10), not to exclude an otherwise-qualified Offeror just because a third-party may have dropped the ball. Of course, an “agency need only make a reasonable effort to contact a reference,” and if that effort proves unsuccessful, “it is not objectionable for the agency to proceed with the evaluation without the benefit of that reference’s report.” *Matter of Richen Management, LLC*, B-409697(Comp. Gen.), 2014 CPD P 211, 2014 WL 3384936. But HSD made no effort whatsoever to contact UHC’s missing reference.

In *Griffy’s Landscape Maintenance*, a rejected bidder in a federal RFP protested because the “Army improperly failed to award it points for a past-performance factor because of absent insurance point of contact information,” when a “simple phone call” could have produced the missing information. *Griffy*, 46 Fed. Cl. at 258. In sustaining the protest, the Court of Claims assumed the information was missing, but made “no assumptions as to why” it was missing—it didn’t matter whether the Army or the bidder (Griffy) had slipped up. *Id.*

The facts here, however, are even stronger than in *Griffy*, because it was not UHC that slipped up, but a third party—the Rhode Island Executive Office of Health and Human Services. And the RFP was certainly not intended to gauge the responsiveness of that party.

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2 *Cf. In re: Protest by Gregory Electric Company, Inc.*, SCPD 1989-17C (S.C. Procure.Rev. Panel 1991) (affirming decision that a public bidder’s failure to timely submit required references “was a minor technicality” that could be cured because it had “no effect on price, quality, quantity or delivery....”); *PHT Supply Corp. v. United States*, 71 Fed. Cl. 1, 21 (2006) (“Although the duty to raise mistakes in an offeror’s proposal is no longer set forth explicitly in the regulations governing negotiated procurements, that duty undoubtedly still exists.”); *BC Peabody Constr. Servs., Inc. v. United States*, 112 Fed. Cl. 502, 511 (2013) (“a clerical error within the meaning [of applicable federal regulations], is a matter that could have been the subject of inquiry by the contracting officer without provoking discussions” and it was abuse of discretion not “to seek clarification . . . regarding the copying mistake in [offerors’] offer that related to [subcontractor] experience.”).
Applicable law and policy, as well as the specific language of the RFP, certainly allowed HSD—in the interest of securing contracts with the best-suited Offerors—to redress apparent mistakes or omissions in the RFP responses.

To begin with, Section 1.4.1.42 of the New Mexico State Procurement Code Regulations specifically deals with both mistakes in proposals and what it calls, “technical irregularities.” Subsection 42(B)(1) states that when the procurement officer “knows or has reason to conclude before award that a mistake has been made,” the officer “should request the offeror to confirm the proposal,” and the “proposal may be corrected....” Here, HSD had reason to know that the missing Rhode Island Reference was simply a mistake, and HSD could and should have contacted the identified Rhode Island contact, Mr. Tigue, and inquired about it. Indeed, Mr. Clavio’s emails to Reference contacts confirm that, because the References are being transmitted directly to HSD, only HSD is aware of what References are missing. HSD therefore had a duty to inquire about missing References, and—for some Offerors—HSD did so. For example, in Mr. Clavio’s 10/19/17 email to California regarding Western Sky, he warned: “At this point I don’t know what to do with this letter, and someone may come up short.” (Exhibit 9.) And in Mr. Clavio’s 10/30/17 email to New York regarding WellCare, he stated: “If you are not able to submit that form as a reference, you should notify Wellcare immediately...” (Exhibit 12.)

Subsection 42(C) further states that “technical irregularities” are “matters of form rather than substance” that can be “waived or corrected without prejudice to other offerors,” which would apply “when there is no effect on price, quality or quantity.” Rhode Island’s inadvertent failure to timely submit its Reference is a matter of form not substance. Moreover, it can be corrected—even now—without prejudice to the other Offerors, because the Reference is based on UHC’s historical performance in Rhode Island, and doesn’t affect the “price, quality or quantity” of this RFP. This is particularly true when the relief we seek is simply to be added as a fourth successful Offeror, without displacing any competitor.

In addition, language from the RFP itself authorizes HSD to modify the strict application of the RFP rules when it’s in the best interest of the state to do so. Thus, the RFP allows HSD, at its “discretion,” not to reject a response even when there is a “[f]ailure to meet a mandatory item or factor....” (RFP at 16.) The RFP also expressly gives the Evaluation Committee (the “EC”) the “right to waive irregularities.” (RFP at 28.) And, though the RFP “anticipate[s]” that awards will go to the “highest-scoring Offerors,” that is “not mandatory.” (RFP at 37.) Finally, the RFP specifically permits the Procurement Manager, during the evaluation period, to “initiate discussion with Offerors...for the purpose of clarifying aspects of the previously submitted proposals.” (RFP at 20.)

3 Although, according to HSD, the RFP would not otherwise be subject to these Regulations, by its terms the RFP subjects itself to the New Mexico procurement code. (RFP at 6.)
The above-cited provisions have a common policy goal: to make sure that a desirable public bidder is not excluded based merely on a mistake that can be easily corrected without prejudicing other bidders.\(^4\)

3. HSD failed to treat Offerors with missing information equally.

In addition to its duty to inquire about missing information, HSD also had “a duty to treat all bids fairly and equitably.” *Planning and Design Solutions*, 118 N.M. at 714. Indeed, “by requesting proposals,” HSD “entered into an implied or informal contract that it would ‘fairly consider each bid in accordance with all applicable statutes.’” *Id., citing Nielsen & Co. v. Cassia and Twin Falls County Joint Class A Sch. Dist.* 151, 103 Idaho 317, 319, 647 P.2d 773, 775 (Ct.App.1982); accord *Paul Sardella Constr. Co. v. Braintree Hous. Auth.*, 3 Mass.App.Ct. 326, 329 N.E.2d 762, 767 (1975) (“Many courts have held that it is an implied condition of every invitation for bids issued by a public contracting authority that each bid submitted pursuant to the invitation will be fairly considered in accordance with all applicable statutes.”), aff’d, 371 Mass. 235, 356 N.E.2d 249 (1976); *School Bldg. Comm. v. Commercial Union Ins. Co.*, 37 Mass.App.Ct. 911, 638 N.E.2d 499, 500 (1994) (invitation to bid upon certain conditions creates implied contract limiting bid solicitor to those conditions).

But HSD plainly violated that duty by its actions to clarify or request missing information as to References for WC, AG, and WS, as described earlier, but, in contrast, to simply ignore UHC’s missing Reference. And had Mr. Clavio sent a simple email inquiry about the Rhode Island Reference to Mr. Tigue (UHC’s Rhode Island contact)—just as Mr. Clavio sent an email inquiry to Ms. Cobb (WS’s California contact)—Mr. Tigue would have made sure the Reference was sent. In fact, as noted above, when UHC recently advised Mr. Tigue of the missing Reference, he supplied it to Mr. Clavio. And with that Reference, UHC’s point score would have very likely increased so that UHC would have become the second or third highest scorer.

Furthermore, based on the procedures set out in the RFP, it was reasonable to assume that HSD had the responsibility for communicating and following up with identified Reference contacts if References forms were missing or incomplete. Thus, for example, the RFP was structured so that the Procurement Manager could interact directly with an Offeror’s Reference.

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\(^4\) HSD in fact had a mechanism in place that would have obviated the problem of UHC’s missing reference, but HSD failed to advise the Offerors of that mechanism. Although the RFP states that an Offeror “must provide three (3) specific client References” (RFP at 39), the scoring instructions—not available to the Offerors—allowed Offerors to submit more than three references. The EC was thus told to “open, review and score all references submitted” by an Offeror, and that, if “more than three (3) references are submitted for an Offeror, the top three (3) scores will be used to determine the total points awarded for references.” See sample Reference score sheet, attached as Exhibit 18.) UHC has Medicaid operations in 26 states, and had UHC known it could submit more than three References, it would have done so—thus ensuring that at least three would be timely received, and increasing the chances of having a higher overall score, since only the three highest-scoring References would count. Failure to inform the Offerors of this “safety net” for ensuring that reference points wouldn’t be lost was a material omission.
contacts. As required by the RFP, the Offerors provided Mr. Clavio with the name, phone number
and email address for each of their Reference contacts, and—as also required by the RFP—the
Offerors advised those contacts to send the completed Reference forms directly to Mr. Clavio, not
the Offerors. The obvious purpose of requiring Offerors to include the Reference contact
information in Mandatory Section 5.9 was to enable HSD to reach out to those contacts, otherwise
HSD could simply wait to see what References arrived. And in practice, as described above, Mr.
Clavio did interact directly with the Offeror’s Reference contacts, sending multiple emails to
advise them of missing or incomplete References.

Indeed, Mr. Clavio’s second email follow up to the contact for WellCare’s New York
Reference helps highlight the issue. In that email, Mr. Clavio said: “If you are not able to submit
that form as a reference, you should notify WellCare immediately, as the deadline is November 2.”
(10/30/17 email, emphasis added, attached as Exhibit 12.) The email shows HSD’s understanding
of three important points: First, the Offeror (here, WellCare) was not expected to know, as Mr.
Clavio did, what References had been received; the Offerors were in the dark about that. Second,
the Reference contact should be given the chance to communicate with the Offeror about any
difficulty in providing a Reference. And third, HSD had a duty to reach out to an Offeror’s
Reference contact about a missing Reference, and to do so before the deadline.

Though Mr. Clavio did reach out to others, he failed to fulfill that duty as regards UHC’s
Rhode Island Reference.

4. Although HSD refuses to consider UHC’s compliant Reference, HSD
accepted and scored MHC’s and WS’s non-compliant References.

The RFP required each Offeror to submit three “client References, with at least one for a
state Medicaid program or other large similar government or large private industry project within
the last five (5) years.” (RFP at 39.) UHC has been a Medicaid MCO in Rhode Island since 1994,
and so Rhode Island was a valid Reference source under the RFP. And as pointed out above, Rhode
Island’s Medicaid Program Director has now completed and submitted its UHC Reference form
directly to HSD (though HSD has declined to consider it.)

By contrast, and as noted above, one of MHC’s References came not from a “client” but
rather from one of its paid providers, Mental Health Resources, a “contracted Behavioral Health
provider with Molina healthcare....” (Mental Health Resources Reference form at 2; attached as
Exhibit 17.). The Mental Health Resources Reference did not comply with the terms of the RFP,
and should have been rejected by HSD. But HSD not only accepted the reference, but scored it so
as to add 100 points to MHC—the maximum possible.

Also, WS’s References from California was really a Reference for a different company—
HealthNet—that WS’s parent only recently bought. Yet HSD allowed WS to receive 100 points
for that questionable Reference.
C. **The RFP Scoring System Was Not Sufficiently Precise to Appropriately Differentiate Among the Second Through the Fifth-Ranked Offerors, and There Is Little Detriment to the State—and Potentially Great Advantages to Medicaid Members—to Awarding Contracts to at Least Four Offerors.**

1. The RFP scoring system was inherently imprecise.

   For several reasons, the scoring system the RFP used, as applied, had flaws that rendered it in many respects subjective and imprecise. We discuss some of those flaws here.

   a. The Evaluation Committee’s failure to follow the Technical Proposal instructions for assessing scores of “2.”

   The consensus scoresheets for the Offerors’ Technical Proposals disclose a pervasive problem with assessing scores of “2” in many instances in which—according to the specific scoring instructions—scores of only “1” were warranted.

   Although not mentioned in the RFP, HSD issued specific scoring instructions to the EC. The Technical Proposal required each Offeror to answer 94 questions. The instructions for scoring—set forth on the first page of Attachment One to the 12/22/18 Scoring Results Summary (see excerpts attached at Exhibit 15) but not known to the Offerors in advance—told the EC to award from 1 to 5 points for each of the 94 questions, and defined the factors to be considered in doling out those points. For an answer to be awarded 2 points, for example, the instructions stated:

   The response is minimally acceptable. *Most elements of the question were addressed*; however, more detail was needed to fully evaluate the approach and/or the State did not find the approach desirable. (Emphasis added.)

   By contrast, a response deserving of only 1 point was defined as follows:

   The response is poor. *Only some elements of the question were addressed* and it lacked sufficient detail to evaluate the approach and/or the State did not find the approach desirable. (Emphasis added.)

   In apparent disregard of these instructions, however, the EC many times gave an answer a “2” score, even though the scorer specifically noted that the response “did not address most of the elements of the question.” Indeed, a close examination of the scores given for each Offeror on the 81 questions included in Sections 6.2 through 6.12 of the RFP—in other words, an analysis of 648 responses to these questions (81 X 8)—revealed that in 56 instances, a “2” point score was given, even though the scorers’ notes confirmed either that the response “did not address most elements” of the question, or said that only “some elements of the question were addressed.” In either case, however—according to the written scoring methodology—each of those 56 scores should have been “1,” not “2.”
Moreover, this scoring error prejudiced UHC disproportionately, and correspondingly benefited Offeror AH—who finished in fourth place, just 18 points ahead of UHC. In fact, it appears this scoring defect by itself likely put AH ahead of UHC. That's because AH received 16 scores of 2—32 points—from such scores, which really all should have been scored a 1—and thus should have given AH only 16 points.

A few examples help underscore the issue. For each of question 15, 16 and 17 in RFP Section 6.2, for example, AH received a score of 2, even though the EC comments for each answer stated:

   The response was minimally acceptable and did not address most elements of the question.” (Emphasis added; see Exhibit 15 attached.)

And the same situation recurred in the scoring of AH’s answers to questions 21-25 in RFP Section 6.3. In each instance the EC gave a score of 2, even though EC’s written comments noted that the answer “did not address most elements of the question,” and therefore should have received a score of 1. (See Exhibit 15 attached.)

A variation on the same theme occurred with AH’s answer to question 31 in RFP Section 6.4. The EC written notes state that “some elements of the question were addressed,” a fact that should again have called for a score of 1, but the EC nevertheless gave AH 2 points.

In these instances and others, the EC failed to follow the scoring instructions given it.

In addition, there were four instances where AH received a “2” score where the score sheets were simply silent: as to the extent the elements of the question were addressed, so HSD failed to provide enough information to ascertain the accuracy of the scoring. In short, AH received 20 extra points it likely should not have received.

By contrast, UHC received only 2 unwarranted grades of “2.” So if the total scores of AH and UHC were reduced by their respective “over-scores” of 20 points (AH) and 2 points (UHC), at minimum each would have received a total score of 1,495 points—and thus been tied for fourth place among the high scorers.

   b. The EC’s reduction of points for UHC’s answers for reasons not based on the actual questions.

In many instances, the EC docked points from UHC’s answers for reasons that were not tied to the actual questions. We give only a few examples here, but see attached Exhibit 19 for additional examples of this defect:

RFP Section 6.2, question 17 posed the following question (in its entirety):

Describe your organization’s experience with enhancing the behavioral healthcare workforce within a state, and efforts or plans to do so in New Mexico.
UHC fully answered the question, but the EC inexplicably reduced UHC’s score because UHC’s answer “does not address older adults”—a detail the question never even asked about. Indeed, nothing in the question sought information regarding specific population types. (See Exhibit 15 attached.)

RFP Section 6.6, question 51, asked the offerors to submit details regarding the organization’s existing or planned systems to meet certain functional areas. UHC was scored lower “because the response did not include external data sources for TPL” and because “[p]harmacy encounter submissions were not in line with HSD required processes.” (See Exhibit 15 attached.) However, the RFP question did not list either of those topics as specific items to be addressed in the answer.

In addition, RFP Section 6.7, question 62, asked the Offerors to describe strategies, barriers and proposed solutions to securing certain contracts with Tribal organizations. The EC score sheet inaccurately states that UHC “[d]id not address barriers to contracting with tribal providers.” (See Exhibit 15 attached.) But in fact UHC did expressly address the barriers. On page 169 of UHC’s Technical Proposal, excerpt attached as Exhibit 20, UHC stated the following:

Barriers to completing agreements with all Tribes and Tribal clinics include the limited time and staff the Tribes and/or Tribal clinics have to review and consider, the multi-level approval process some have, as well as the concern that an agreement would become a greater administrative burden.

Thus, this was not a deficiency at all.

Finally, in RFP Section 6.9, question 75, HSD asked Offerors to describe their “single case agreements and prior authorization (PA) process.” The EC score sheet states that UHC’s response was deficient because it “did not address exemption of ITU services from prior authorization.” (See Exhibit 15 attached.) But in fact the question did not ask for such information. The EC was nonetheless told to score the response based on whether “the response indicate[d] an understanding that emergency services and services provided by I/T/Us do not require PA.” It was improper to grade UHC’s response based on this undisclosed evaluation factor.

c. The highly-subjective nature of the questions coupled with the “blunt” scoring approach.

In addition to the above scoring flaws, the highly subjective nature of the questions, coupled with what might be termed a “blunt” scoring approach—applying only two scoring weights across the 94 technical questions and rounding all scoring of questions on a 0-5 scale with no scores in between used (such as 3.5 instead of 3, for example)—forced considerable imprecision upon the scoring process. (Minges Decl., ¶ 20, attached as Exhibit 4.) For example, our expert’s analysis shows that two-thirds of all the 94 technical questions were scored at 3 or 4, thus lumping
the scores of many of the Offerors close together. This is reflected in the final scores, which came out extremely close for the health plans rated second through fifth. \textit{(Id.)}

Indeed, the scoring difference from the second highest scorer (WS) to UHC as the fifth highest scorer was only 63 points, or a 4.0\% difference. That contrasts with a full 211 point or 11.9\% difference between the highest and second highest scorers (PHP and WS), and a 147 point or 9.8\% difference between the fifth and sixth highest scorers (UHC and MHC). \textit{(Id. at ¶ 21.)}

d. Oddly and arbitrarily requiring points for a \textit{bad} Reference, and even for unanswered questions in a Reference form, but giving no points for a missing Reference.

We discussed above various issues relating to the References. But one of the strangest Reference issues is that the scoring system required the EC to give an Offeror 1 point, even though the Reference said the Offeror attribute being scored was \textit{“unsatisfactory.”} Each of questions 2 through five on the Reference form asked the Reference to rate the Offeror as to three different areas (for a total of 12 areas), and to fill in either a “5” for \textit{“excellent,”} a “3” for \textit{“satisfactory,”} or a “1” for \textit{“unsatisfactory”} for each area. The EC then scored this part of the Reference form by just totaling up the numbers the Reference gave for the 12 areas.

Assuming the Reference rated the Offeror as \textit{“unsatisfactory”} in all 12 areas, the Offeror would nevertheless—perversely—still earn 12 points. On the other hand, an Offeror whose Reference contact failed to even turn in the form would get zero points.

Question 6 on the Reference form then asked the Reference to state the Offeror’s strengths, while question 7 asked what the Offeror’s weaknesses were. Although the form did not disclose how these two questions would be scored, the EC scoring instructions for question 6 were to give 5 points if any strengths were in fact identified in the answer, but also to allow 1 point even if the Reference left the question blank! In addition, the EC was to give an additional 5 points if the identified strengths \textit{“match[ed] those identified/needed in New Mexico.”} And once again, if question 6 was simply left blank, the Offeror would receive a second score of \textit{“1”} for the question. In short, if a Reference left question 6 blank, the Offeror got 2 points.

The scoring for question 7 was similarly arbitrary. If the Reference identified weaknesses with the Offeror’s operations, no matter how serious, the Offeror received 5 extra points. And if those weaknesses were, in the judgment of the EC, \textit{“easily overcome through oversight or contract language,”} the Offeror was to receive 5 more points. But if question 7 dealing with weaknesses were left entirely blank—the Offeror still got 2 points.

Based on the above, assume a Reference left question 1 on the Reference form blank, then rated the Offeror as \textit{“unsatisfactory”} in each of the 12 attributes inquired about in questions 2 through 5, left question 6 about \textit{“strengths”} blank, but in response to question 7 identified numerous weaknesses of the Offeror which could not be easily overcome, then left questions 8 and 9 blank. Despite leaving 4 of the 9 questions blank, rating the Offeror as \textit{“unsatisfactory”} in every respect, and identifying numerous weaknesses of the Offeror, \textit{the Offeror would still receive}
20 points for the Reference (12 + 2 + 6). By contrast, a qualified Offeror such as UHC whose Reference contact inadvertently failed to turn in the Reference form at all, would receive—and did in fact receive—zero points.

The above is not just hypothetical, because at least two Reference forms left questions 6 or 7 blank, but pursuant to the scoring instructions, nevertheless received points for the omissions. (See Louisiana Dep’t of Health Reference for Amerigroup leaving answer to question 6 blank, along with the EC scoring sheet for the Reference at p. 1535 of the Scoring Results Summary, showing 2 points awarded for that question (Exhibit 21 attached); see also Maryland Dep’t of Health and Mental Hygiene Reference for Amerigroup, leaving answer to question 7 blank, along with the EC scoring sheet for the Reference at p. 1545 of the Scoring Results Summary, showing 2 points awarded for that question. (Id.))

e. The inherent subjectivity of the scoring system is shown when another group scores the same responses using the system.

When UHC’s expert conducted an independent scoring of seven of the RFP questions using three reviewers with strong coordinated care and procurement experience, their results came out significantly differently than did the EC for the same questions. (Menges Decl. at ¶ 22-24, attached as Exhibit 4.)

These reviewers (the “Menges Reviewers”) did not know what scores HSD had awarded for any given applicant and question. The Menges Reviewers individually scored a question to one decimal point (e.g., 3.6) for each applicant, then held a group discussion. (Id. ¶ 22). Once hearing one another’s viewpoints, reviewers were welcome to adjust their score as they deemed appropriate or to keep their original score intact. The Reviewers then moved on to the next question. The Reviewers all took into consideration the scoring instructions shared with the HSD review team. They followed, to the best of their ability, the instructions to score each applicant as objectively and fairly as possible based entirely on the quality of the response to a given question. The process consumed approximately two full days. (Id.)

Across the seven questions, the Menges Reviewers scoring results had many significant variations from the scores produced by the HSD team. (Id. ¶ 23.) In terms of overall rankings, the Menges Reviewers ranked WellCare 1st and Presbyterian 4th. HSD essentially had the opposite findings, ranking Presbyterian 1st and WellCare 5th. (Id.) On average, the Menges Reviewers awarded a difference of 6.2 points per MCO than did the HSD team across just these seven questions.

A few specific examples of the Menges Reviewers scores demonstrate the significant variations from the EC’s scores:

- On Question #20, the Menges Reviewers rated Molina last with a 2.18 score; HSD rated Molina second with a 4.0 score. The Menges Reviewers rated United first with a 4.57 score, whereas HSD rated United 5th with a 3.0 score. HSD rated AmeriGroup first with a 5.0 score; the Menges Reviewers rated AmeriGroup 4th with a 3.57 score. (Id. ¶ 24.)
On Question #53, HSD rated BCBS tied for 1st; the Menges Reviewers rated BCBS 5th. *(Id.)*

On Question #71, HSD rated six of the 8 plans a 3.0. By contrast, the Menges Reviewers found considerable variation among these six plans, as their scores within these MCOs ranged from 2.40 to 4.20. *(Id.)*

On Question #93, HSD rated AmeriHealth 1st and United 4th; the Menges Reviewers rated AmeriHealth 4th and United 1st. *(Id.)*

The rounding of scores to the nearest whole number was a structural flaw preventing HSD from accurately differentiating the applicants within (and across) questions. However, there were many situations—beyond the rounding issues—in the seven questions the Menges Reviewers assessed where the HSD scoring did not differentiate between applicants in a manner that the Menges Reviewers found sufficient/deserved in their own review. *(Id. ¶ 25.)* Additionally, there were many situations in which the Menges Reviewers scores suggest that HSD significantly over-differentiated between applicants.

The Menges Reviewers also emphasized that some of the questions they reviewed were asked in a broad manner that gave the plans wide latitude to respond in very different ways. *(Id. ¶ 26.)* In these situations, the Menges Reviewers found it difficult to assign appropriate differentiating scores across the eight applicants (and they did not see how any reviewer would be able to do so).

That analysis also suggests that HSD’s scoring may have been significantly inaccurate (not just imprecise) in several instances. *(Id. ¶¶ 27-29.)* Within the questions reviewed by the Menges Reviewers, there were seven situations in which none of the three Menges Reviewers awarded a score within one full point (on the 0-5 scale, before weightings were applied) of the consensus HSD score awarded for that applicant and question. There were another 16 situations in which none of the Menges Reviewers awarded a score within a half point of the consensus HSD score. *(Id. ¶ 29.)*

These challenges are all exacerbated by the fact that HSD’s ultimate scoring was so tightly packed between the 2nd and 5th-ranked Offerors. UHC’s expert thus concluded that the RFP’s scoring approach did not yield the precision necessary for HSD to draw an accurate and appropriate distinction among these four MCOs regarding which of these entities constitute a better partner for HSD. *(Id. ¶¶ 31-32.)*

We offer the assessment of the Menges Reviewers not to argue that their assessment was better than, or should be substituted for, that of the EC, but rather to demonstrate that the scoring system used was subject to inherent limitations that compromised HSD’s effort to determine the three “best” Offerors. Deciding to award at least four contracts, as HSD is authorized to do, will help remedy the adverse effects of those inherent limitations.
2. The HSD decision to award only three MCO contracts was arbitrary and capricious.

Particularly in light of the flawed and imprecise scoring system which resulted in bunching the 2nd to 5th-ranked Offerors very closely based on their scores, HSD’s decision to only contract with three MCOs for Centennial 2.0—and thus reduce by one the number of MCOs currently servicing Medicaid patients in New Mexico—was not supported by any “substantial evidence,” and hence was arbitrary and capricious.

HSD stated in the RFP that it would award between three and five contracts, and HSD was obligated to exercise its discretion in making that choice based on what would be in the “best interests of the State.” (RFP at 11.) In doing so, HSD was required to make a reasoned decision establishing a rational connection between the facts found and the choice made to either reduce MCOs down to three from the current four, or instead to keep the current number of four MCOs or increase that to five. But the available records lack any evidence whatsoever showing that the decision to award only three contracts was rationally related to the available factual data.

New Mexico’s Supreme Court has said that “an agency’s action is arbitrary and capricious if it provides no rational connection between the facts found and the choices made, or entirely omits consideration of relevant factors or important aspects of the problem at hand.” Albuquerque CAB Company, Inc. v. New Mexico Public Regulation Commission, 404 P.3d 1 (N.M. 2017) (internal quotation marks and citation omitted). Moreover, an agency “abuses its discretion when its decision is not in accord with legal procedure or supported by its findings, or when the evidence does not support its findings.” Id. (internal quotation marks and citation omitted). In addition, the “substantial evidence” needed to justify an agency decision “means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion....” Id. (internal quotation marks and citation omitted). Finally, a reviewing authority will “independently review the entire record of the administrative hearing to determine whether the [agency]’s decision was arbitrary and capricious, not supported by substantial evidence, or otherwise not in accordance with law.” New Mexico Corr. Dep’t v. Am. Fed’n of State, Cty., & Mun. Employees, Council 18, AFL-CIO, 2018-NMCA-007, ¶ 9.

HSD’s decision to choose three instead of four or five MCOs was based on three unsupported conclusions set forth in the 12/20/17 letter to Procurement Manager Daniel Clavio from Jessica Osborne of Mercer. (Mercer is the independent company that guided the Executive EC in the scoring process). That letter offers three purported grounds to justify limiting MCO awards to only three contracts:

1) Limiting MCOs to only three will “further HSD’s efforts to create administrative simplicity for providers and state oversight staff while maintaining adequate choice for Members”;

2) Limiting MCOs to only three will “provide stability in the NM Medicaid program through the retention of two incumbent MCOs while providing a new MCO option for Members”; and
3) “A reduction in the number of MCOs has the potential to create economies of scale and encourage lower administrative costs.”

(Copy of letter attached as Exhibit 22.)

But Mercer’s letter offered no facts—none—to buttress these conclusions. Certainly, no facts are set forth in the 12/20/17 letter and we have found none in the administrative materials related to the RFP.

New Mexico’s Centennial Medicaid program has for several years been managed by four MCOs, and there is thus a several-year baseline of data on program effectiveness, including administrative efficiency and Medicaid access and coverage provided by the four MCOs. This baseline performance is captured in annual and quarterly reports for Centennial Care’s 1115 Waiver Demonstration. And the 1115 Waiver Demonstration reports incorporate recommendations from HSD’s Administrative Burden Reduction Workgroup (“ABRW”), which meets monthly to address ways to reduce administrative burdens, increase high-quality healthcare delivery, and propose appropriate program modifications.

But a review of the annual and quarterly 1115 Waiver Demonstration reports, as well as HSD’s own New Mexico Medicaid Managed Care Program Quality Strategy Report of September 2017, does not disclose any suggestion to reduce the number of MCOs to help achieve greater administrative efficiency. (See report, attached as Exhibit 1.) In other words, if HSD really felt there were an arguable administrative benefit to reducing the number of MCOs, that fact would have found its way into either HSD’s 1115 Waiver Demonstration reports, in recommendations from the ABRW, or in HSD’s own Quality Strategy Reports. But none of those sources recommend—or even discuss—reducing the number of MCOs to “create administrative simplicity,” or to “create economies of scale and encourage lower administrative costs.”

The absence of reference to any supporting facts or analysis for any of the three asserted grounds for reducing the number of MCOs suggests there was no evidence, let alone substantial evidence, to support the reduction. Additionally, there is no evidence that Mercer or anyone else consulted with ABRW prior to making its recommendation. This material deficiency in factual support to explain a reduction from the current four MCOs to only three is, by itself, evidence that the decision lacked substantial evidence.
Moreover, the apparently off-the-cuff conclusion that reduction from four to three MCOs could help create “administrative simplicity” is starkly inconsistent with HSD’s detailed discussion of how to improve administrative simplicity found in New Mexico’s 12/6/17 Federal Application for Section 1115 Demonstration Waiver (“1115 Application”). Section 2.5 of the 1115 Application is titled, “Administrative Simplification through Refinements to Eligibility Proposals.” It begins by asserting: “One of the core principles of the Centennial Care program is to improve administrative effectiveness and simplicity.” And although HSD offers six quite specific proposals for creating greater “administration simplification” in this 1115 Application, none of them include a reduction in MCO’s from four to three. (See excerpts at Exhibit 23.)

In short, none of the asserted reasons for limiting the number of MCO contracts to three (a reduction of MCOs from the current Centennial Care program) appears to be based on any substantial evidence. This lack of substantial evidence renders the decision arbitrary and capricious.

In addition to the lack of substantial evidence, HSD’s decision was also arbitrary and capricious because HSD failed to consider other relevant factors, such as the fact that growth in enrollment and reduction in costs is directly related to adequacy and access created by having more than three MCOs. Currently, the national average of enrollees per CMO across the nation is 189,000. (Menges Decl. at ¶ 7, attached as Exhibit 4.) New Mexico is only slightly below that average with an average of 175,000 enrollees among four MCOs. Id. If there is a reduction in MCOs, then the remaining MCOs will carry a substantially larger than average enrollment burden, as well as an increased administrative burden in handling the additional members.

There is no evidence in the record that HSD evaluated or considered what impact a reduction from four MCOs to three would have on Medicaid enrollment, access, and adequacy of service. In fact, there is considerable and substantive evidence nationwide that states with more than four Medicaid MCOs have more overall enrollees. (Id. ¶ 9.) Conversely, states with fewer than four MCOs have fewer overall enrollees than New Mexico. Id. With four or more MCOs, New Mexico is also well-protected from a loss of competition, choice and access, as well as a reduction in enrollment. Id. At minimum, HSD should have evaluated—but did not—available data and reports to determine what, if any, effect a reduction in MCOs would have.

Nor did HSD’s decision to reduce the number of MCOs from four to three take account of the RFP scoring flaws or the narrow scoring margin between the 2nd, 3rd, 4th, and 5th-ranked Offerors. Allowing at least one or possibly even two more MCOs, as HSD is authorized to do, would help temper the imprecise and arbitrary scoring.

5 “Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.” Medicaid.gov Website.
D. The Conflict of Interest

In addition to the above issues, the integrity and fairness of the procurement process, as well as the final award, may have been compromised by an undisclosed conflict of interest, or an appearance of a conflict, concerning the relationship between Mercer and Envolve Pharmacy Solutions (Envolve), a proposed subcontractor for Western Sky.\(^6\) Based on information that surfaced after the announcement of the award, we understand that Mercer has a significant business alliance with Envolve that warrants further inquiry into whether it could have affected the fairness of the procurement process.

As noted earlier, protecting the public interest is the most important goal of the Procurement Code. *Planning & Design Solutions v. City of Santa Fe*, 118 N.M. 707, 710, 885 P.2d 628, 631 (1994).\(^7\) The RFP required the disclosure of relationships between the Offeror and the State, including any relationships between the Offeror and any other entity doing business with the State. The purpose was to permit HSD to perform its duty to analyze those relationships for any potential or actual conflicts of interest to make sure that the integrity of the competitive bidding system is maintained.\(^8\)

Under Appendix J of the RFP, Western Sky was required to disclose all relationships with entities, organizations, and subcontractors/contractors proposed to perform work for the state or already performing work for the state. But Western Sky did not disclose the business relationship between its proposed Pharmacy Benefits Manager (“PBM”), Envolve, and Mercer. This raises serious concerns about a conflict or potential conflict of interest tainting the integrity and fairness of HSD’s RFP process.

In Western Sky’s bid, it references Envolve as a major subcontractor serving as its PBM and details its plans to utilize Envolve for many specialty services. What Western Sky did not disclose is that Envolve has a major business alliance with Mercer. Mercer, of course, is an entity that was already performing critically relevant work for the State – namely, it was hired as a

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\(^6\) The available record does not indicate any disclosure either by Western Sky or Mercer concerning this issue.

\(^7\) Although not directly applicable, Reg. 1.4.8.16, which applies to competitive sealed proposals for construction, requires that any agency may use independent consultants to support selection teams “provided appropriate precautions are taken to avoid potential conflicts of interest.” To avoid the appearance of a conflict of interest, similar precautions should be followed by any agency in a procurement process.

\(^8\) See *Netstar-1 Gov’t Consulting, Inc. v. United States*, 101 Fed. Cl. 511, 522 (2011) (“The relevant FAR provisions and the case law construing them expect more – they do not permit agency officials to sit passively by, waiting to be alerted to the potential existence of [a conflict of interest] by contractors bidding on a solicitation, when the agency’s own records (not to mention its daily operations) readily disclose the existence of potential problems.”).
consultant by HSD to assist in the preparation of the RFP, train the EC on how to evaluate proposals, and assist in the proposal evaluation process. In other words, Western Sky failed to disclose a significant business relationship between a contractor proposed to work for the State and a contractor already performing work for the State. Further inquiry is needed to determine if the failure to disclose this relationship should be treated as a failure to respond to a mandatory portion of the RFP and disqualify Western Sky.

The post-award disclosure of the economic relationship of Mercer and Envolve creates the appearance of a conflict of interest that may or may not rise to the level of an actual conflict of interest. The mere appearance of an undisclosed conflict of interest can be enough to justify overturning an award. See NKF Eng’g, Inc. v. United States, 805 F.2d 372, 373 (Fed. Cir. 1986) (disqualifying bidder for potential conflict of interest and concluding: “this appearance of and potential for an unfair competitive advantage so tainted the procurement process that the integrity of the process had been damaged.”)

Here, Western Sky’s failure to disclose the connection between Mercer and Envolve raises the appearance of an undisclosed apparent conflict of interest, i.e., the mutually beneficial economic alliance between Envolve and Mercer. At minimum, a hearing and further review concerning the non-disclosure of the alliance between Mercer and Envolve is warranted, as well as an examination into whether there is any actual conflict of interest that could have affected the integrity of the procurement process.

E. **Summary Conclusion.**

In sum, on the facts here, HSD’s failure to offer UHC a Centennial Care 2.0 contract was arbitrary and capricious because, among other things:

- HSD failed in its duty to follow up with Rhode Island about the missing Reference for UHC, even though HSD did so for other Offerors, and that Reference very likely would have made UHC at least the third highest scorer;

- When Rhode Island recently learned about the missing Reference, and then submitted it directly to HSD, HSD refused to review it or score it, even though doing so would not unfairly prejudice the three chosen MCOs (since UHC is not asking to displace them), HSD itself, or the integrity of the RFP;

- HSD accepted and scored at full 100-point value a reference for Western Sky that was really a reference for another company, HealthNet, which was only recently bought by Western Sky’s parent company, and but for that 100 points—all other things being equal—Western Sky would have been the fifth-ranked Offeror and UHC would have been the fourth-ranked Offeror;

- By wrongly giving AmeriHealth 20 scores of “2” that should have been “1s,” AmeriHealth received 20 points it should not have received, while using the same measure, UHC
received only 2 “extra” points it should not have, and that net gain of 18 points by UHC vis a vis AmeriHealth, by itself, would have put the two Offerors in a tie for fourth place;

- Because the EC in many instances reduced UHC’s Technical Proposal scores based on criteria not found in the questions, UHC’s total points were arbitrarily and improperly reduced;

- HSD has no substantial evidence to support a reduction from four to three MCOs in New Mexico

F. The Relief Requested.

For all the reasons set forth above, UHC respectfully asks the Secretary to direct HSD to consider and score Rhode Island’s Reference for UHC, and to offer a Centennial 2.0 contract to UHC. UHC also requests a hearing on its protest. In order to develop a complete record, we also request that HSD make Mr. Clavic, and a representative of Mercer knowledgeable regarding the issues raised in this protest, available for testimony at the hearing.

Finally, UHC asks for a stay of the procurement process. Under NMSA 1978, § 13-1-173 and NMAC 7.1.6.11, during the pendency of a protest the procurement process “shall not proceed further.” The statutory automatic stay can be overridden where HSD makes a determination that proceeding with the procurement is necessary to protect the “substantial interests” of the department. Although the January 19, 2018 notice of award letter (attached as Exhibit 24) recites, in conclusory fashion, that it is necessary to proceed forward with the procurement, it offers no justification whatsoever for setting aside the statutory presumption that a stay will be implemented until protests are resolved. Failing to provide a rational explanation and “substantial evidence” to support agency action, is, by definition, arbitrary and capricious. See Albuquerque CAB Company, Inc. v. New Mexico Public Regulation Commission, 404 P.3d, 1 (N.M. 2017). In the present circumstances, there is no reason not to stay further action on the procurement in order to allow for resolution of UHC’s protest. Under the RFP, the Centennial Care 2.0 contracts are not scheduled to go-live until January 1, 2019. Although HSD has accelerated its announcement of contract awards from the March 15, 2018 date outlined in the RFP, April 1, 2018 remains the contract effective date and the commencement of the readiness period. As a result, there is no prejudice to HSD or the prospective contract awardees from a stay while the protest is considered. On the other hand, HSD’s public announcement that it is proceeding forward with this procurement is causing immediate, and likely irreparable, harm to UHC and its employees and providers. (See, e.g. “Frequently Asked Questions for Centennial Care 2.0,” attached as Exhibit 25.) Moreover, the failure to honor the presumptive statutory stay is causing unnecessary confusion and angst among the vulnerable Medicaid populations served by UHC in New Mexico. As a result, HSD should reconsider and issue a stay.
UHC reserves the right to supplement this protest upon receipt and review of all pertinent documents that are the subject of its outstanding IPRA requests, including those that bear on the issue of whether a conflict of interest, or appearance of a conflict, involving the Western Sky/Envolve/Mercer relationships tainted the process.

Very truly yours,

GALLAGHER & KENNEDY, P.A.

By: Dalva L. Moellenberg

DLM/cjc
Enclosures
cc: Mr. Daniel Clavio
     Mr. Christopher Collins

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19. Additional Examples of Scoring Errors

20. Excerpts from UHC Technical Proposal

21. Amerigroup References and Corresponding Scoring Sheets

22. December 20, 2017 Letter from Jessica Osborne of Mercer to Daniel Clavio

23. New Mexico’s 12/6/17 Federal Application for Section 1115 Demonstration Waiver

24. Notice of Award Letter dated January 19, 2018

25. Press Release “New Mexico HSD Announces Managed Care Organizations for Centennial Care 2.0” and “Frequently Asked Questions for Centennial Care 2.0”
NEW MEXICO
MEDICAID
MANAGED CARE PROGRAM

QUALITY STRATEGY

September 2017 Update
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Section I: Introduction:

CMS requirement CFR §438.340(a)

General rule. Each State contracting with a MCO must draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCO.

Program History

CMS requirement CFR §438.340

Include a brief history of the state’s Medicaid (and CHIP, if applicable) managed care programs. Prior to 1997, New Mexico Medicaid members received their care through a Fee-For-Service (FFS) model. The New Mexico Legislature mandated that the Human Services Department, Medical Assistance Division (HSD/MAD) implement a managed care program. A proposal was submitted under section 1915(b) of the Social Security Act to provide comprehensive medical and social services to the State’s Medicaid population.

On July 1, 1997, New Mexico implemented the Salud! program, a managed care program for physical health services. The program was designed to improve quality of care and access to care while making cost-effective use of state and federal funds. During that period, approximately 65% of Medicaid eligible members were participants in Salud!.

In addition, the Medicaid safety net programs for children, including the Children’s Health Insurance Program (CHIP) were combined into one program known as New Mexikids.

In 1999, HSD/MAD implemented the Personal Care Option (PCO) as a state plan service to meet the needs of Medicaid members in need of long-term services and who met a Nursing Facility Level of Care (NF LOC). PCO was developed to allow members to receive care in their home rather than being placed in a Nursing Facility.

In August 2002, A Health Insurance Flexibility and Accountability (HIFA) waiver was approved by the Centers for Medicare & Medicaid Services (CMS). The waiver program utilized unspent CHIP funds to provide basic health benefits for New Mexicans with incomes up to 200 percent of the federal poverty level through an employer based buy-in insurance plan.

In 2004, the Interagency Behavioral Health Purchasing Collaborative (The Collaborative) was established as a pioneering effort in the behavioral health system transformation. The Collaborative had the authority to contract for behavioral health services and make decisions regarding the administration, direction and management of state-funded behavioral healthcare services in New Mexico. Optum Health, was selected as the Statewide Entity charged with the oversight of behavioral healthcare services for Medicaid recipients in Salud!.
On March 18, 2005, Governor Bill Richardson signed the State Coverage Insurance Program (SCI) into law. SCI was an innovative insurance product, combining features of Medicaid and a basic commercial health plan. Support from the federal government provided the flexibility to offer coverage to the adults most in need throughout the state.

In 2008, the Coordination of Long-Term Services (CoLTS) program was implemented as the state’s first managed long-term care program for Medicaid members who met a NF LOC. This 1915 (b) (e) concurrent program covered members residing in nursing facilities, participants of the Disabled & Elderly (D&E) waiver, Personal Care Option (PCO) members, dual eligible members and members with a qualified brain injury (BI). The program was an interagency collaboration between HSD/MAD and the New Mexico Aging and Long-Term Services Department (ALTSD). All acute, preventative and long-term care services were provided through contracted MCOs. The primary goal of the program was to mitigate the array of problems resulting from the fragmentation of services provided to Medicare and Medicaid dual eligibles.

Centennial Care
In 2013, of the two million citizens in the state of New Mexico, approximately 520,000 people received their healthcare through the Medicaid program. The Medicaid program operated 12 separate waivers as well as a FFS program. Seventy percent of the Medicaid enrollees were in a managed care setting. Seven different health plans administered the various delivery systems. Services were provided under an umbrella of programs for eligible individuals in more than 40 eligibility categories.

In 2014, New Mexico embarked on a new path to deliver integrated care to the Medicaid population through a Section 1115 Demonstration Waiver known as Centennial Care. The 1115 Demonstration Waiver consolidated all previous federal waivers, with the exception of the Medically Fragile Waiver (MFW), the Developmentally Disabled Waiver, and the Mi Via ICF/IID Waiver. Similarly, the MCO contracts were reduced from seven to four.

The Section 1115 Demonstration Waiver, Centennial Care, was approved by CMS for a 5 year period, beginning in January 2014 through December 2018. Centennial Care modernizes the Medicaid program by improving the efficiency and effectiveness of healthcare delivery; integrating physical health, behavioral health and long-term services and supports (LTSS); advancing person-centered models of care; and slowing the rate of growth in program costs. Guiding principles for Centennial Care include:

- Developing a comprehensive service delivery system;
- Increasing personal responsibility;
- Encouraging active engagement of members in their health care;
• Emphasizing payment reforms to incentivize quality versus quantity of services; and
• Maximizing opportunities to achieve administrative simplification.

Today, four MCOs administer the full array of services in an integrated model of care. The care coordination infrastructure is an integral focus of Centennial Care and promotes a person-centered approach to care with more than 900 care coordinators ensuring members receive services in the right place when they need them. Centennial Care increased access to LTSS for people who previously needed a waiver allocation to receive such services by allowing any Medicaid member who meets a NF LOC to access home and community based services (HCBS). As a result, New Mexico experienced an increase of 11.4% individuals receiving HCBS between 2014 and 2016.

Also in 2014, New Mexico became an expansion state under the Affordable Care Act. The total enrollment in the Medicaid program has grown 8.5% per year since 2014 while the per capita costs have decreased by 1.5% between 2014 and 2016. Centennial Care demonstrated improved utilization of health care services and cost-effectiveness despite significant enrollment growth.

In 2016, New Mexico launched two Health Homes sites targeting individuals with serious mental illness or severe emotional disturbance. The Medicaid program continues to see an increase in members participating in a patient centered medical home (PCMH) with over 300,000 members to date.

In November 2017, HSD/MAD will submit the Centennial Care 1115 Waiver renewal. In the renewal application, New Mexico has identified opportunities for continued progress in transforming its Medicaid program into an integrated, person-centered, value-based delivery system through the implementation of Centennial Care 2.0; therefore, building on the many successes and accomplishments achieved since implementation of the program.

**Quality Management Structure**

**Include an overview of the quality management structure that is in place at the state level.**

The Quality Bureau (QB) within HSD/MAD currently consists of 14 positions plus a bureau chief. The QB is structured with three units: Care Coordination Unit (CCU); Performance Measure Unit (PMU); and the Critical Incident Unit (CIU). The CCU conducts oversight and monitoring activities related to MCO care coordination requirements. The PMU conducts oversight of MCO quality performance and improvement initiatives and manages both the External Quality Review Organization and the 1115 Demonstration evaluation activities. The CIU conducts oversight of the reporting of critical incidents by MCOs and provider monitoring to ensure the health and welfare of members for 14 categories of eligibility (COE). All units operate in accordance within applicable state and federal regulations as well as MCO contract and policy requirements.

The QB is responsible for directing the Division’s Quality Program and coordinating existing quality improvement and future health reform initiatives with contracted MCOs. The bureau
oversees all aspects of performance measurement for Centennial Care including quality improvement projects, performance measures and performance evaluation and reporting. The State retains ultimate authority and accountability for ensuring the quality initiatives of Centennial Care are accomplished, although several internal and external collaborations/partnerships are utilized to address specific initiatives and/or issues. Administrative authority for the Quality Strategy lies within the HSD/MAD Director’s Office and is delegated to the QB for development, revision, evaluation, and reporting.

Section II: State Standards:

Quality and Appropriateness of Care Standards

*CMS requirement CFR §438.340(b)*

Summarize the procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO contracts, and to individuals with special health care needs.

Quality Management and Quality Improvement Standards:

MCOs are required to comply with state and federal standards for quality management and quality improvement (QM/QI) and shall adhere to the following:

- Establish a QM/QI program based on a model of continuous quality improvement using clinically sound, nationally developed and accepted criteria;
- Recognize the opportunities for improvement are continual;
- Ensure the QM/QI process is data driven, requiring continual measurement of clinical and non-clinical processes driven by such measurements;
- Require re-measurement of effectiveness and continuing development and implementation of improvements as appropriate;
- Reflect member and Contract Provider input;
- Develop a QM/QI annual program description that includes goals, objectives, structure, and policies and procedures that result in continuous quality improvement;
- Review outcome data at least quarterly for performance improvement, recommendations and interventions;
- Establish a mechanism to detect under and over utilization of services;
- Have access to, and the ability to collect, manage and report to the State data necessary to support the QM/QI activities;
- Establish a committee to oversee and implement all policies and procedures;
- Ensure that the ultimate responsibility for QM/QI is with the MCO and shall not be delegated to subcontractors;
• Develop an annual QM/QI work plan to be submitted at the beginning of each year and include, at a minimum, immediate objectives for each year and long-term objectives for the entire term of the contract;

• Implement Performance Improvement Projects (PIPs) identified internally by the MCO and as directed by HSD;

• Design sound quality studies, apply statistical analysis to data and derive meaning from the statistical analysis; and

• Submit an annual QM/QI written evaluation to HSD that includes, but is not limited to:
  o A description of ongoing and completed QM/QI activities;
  o Inclusion of measures that are trended to assess performance;
  o Findings that incorporate prior year information and contain an analysis of any demonstrable improvements in the quality of clinical care and service;
  o Development of future work plans based on the incorporation of previous year findings of overall effectiveness of QM/QI program;
  o Demonstration that active processes are implemented that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions and regularly monitoring each intervention’s effectiveness;
  o Demonstration that the results of QM/QI projects and reviews are incorporated in the QM/QI program;
  o Incorporation of annual HEDIS results in the following year’s plan as applicable to HSD specific programs;
  o Communication with appropriate Contract Providers about the results of QM/QI activities and opportunities for provider to review and use this information to improve their performance, including technical assistance, corrective action plans, and follow-up activities as necessary; and
  o Upon request, present about Behavioral Health aspects of the MCOs’ annual QM/QI work plan during a quarterly meeting of the Collaborative.

Utilization Management Standards:

HSD/MAD requires that the MCOs establish and implement a utilization management (UM) system that follows the National Committee for Quality Assurance (NCQA) UM standards and
promotes quality of care, adherence to standards of care, and efficient use of resources, member choice, and the identification of service gaps within the service system. The MCO UM system must:

- Ensure members receive services based on their current conditions and effectiveness of previous treatment;
- Ensure services are based on the history of the problem/illness, its context and desired outcomes;
- Assist members and/or their representatives in choosing among providers and available treatments and services;
- Emphasize relapse and crisis prevention, not just crisis intervention;
- Detect over and underutilization of services to assess quality and appropriateness of care furnished to members with special health care needs; and
- Accept the uniform prior authorization form for prescriptions drug benefits and respond to prior authorization request within three (3) business days.

**MCO Accreditation Standards:**

The MCO shall be either (i) National Committee for Quality Assurance (NCQA) accredited in the State of New Mexico or (ii) accredited in another state where the MCO provided Medicaid services and achieved New Mexico NCQA accreditation by 1/01/16.

Failure to meet the accreditation standards and/or failure to attain or maintain accreditation is considered a breach of the MCO contract with the State. Violation, breach or noncompliance with the accreditation standards may be subject to termination for cause as detailed in the contract.

**CMS requirement CFR §438.340(b)(9)**

Describe the mechanisms implemented by the State to identify persons who need long-term services and supports or persons with special health care needs. (This must include the state's definition of special health care needs.)

**Care Coordination Standards:**

A comprehensive care coordination model fosters the goal of ensuring that Medicaid recipients receive the right care, at the right time, and in the right place. MCOs establish levels of care coordination for members based on an assessment to determine the level of support that is most appropriate to meet their needs. In the event a member’s needs should change, MCOs are required to reassess the individual and, as appropriate, make the corresponding changes in their care coordination level of support.

HSD/MAD requires the MCOs to conduct a standardized health risk assessment (HRA) on each member to determine if he or she requires a comprehensive needs assessment (CNA) and/or a higher level of care coordination. The CNA identifies members requiring level 2 or level 3 care coordination and is followed by the development of a Comprehensive Care Plan (CCP), which establishes the necessary services based on needs identified in the CNA. Members assigned to
Care coordination level 2 or level 3 are assigned to a care coordinator who is responsible for coordinating their total care. MCOs are required to routinely monitor claims and utilization data for all members (including members who are not assigned to care coordination levels 2 or 3) to identify changes in health status and high-risk members in need of a higher level of care coordination.

Additional components of care coordination includes:

- Assessing each member’s physical, behavioral, functional and psychosocial needs;
- Identifying the specific medical, behavioral, LTSS and other social support services (e.g., housing, transportation or income assistance) necessary to meet the member’s needs;
- Assessing members for LTSS. This applies to members of all ages who have functional limitations and/or chronic illnesses. The primary purpose is to support the ability of the beneficiary to receive services in the setting of their choice, which may include the individual’s home, a provider-owned or controlled residential setting, a nursing facility, or institutional setting;
- Identifying members with special health care needs. The state defines members with special health care needs as those who have or are at increased risk for a disease, defect or medical condition that may hinder the achievement of normal physical growth and development and who also require health and related services of a type or amount beyond that required by individuals generally;
- Ensuring timely access and provision of services needed to help each member maintain or improve his or her physical and/or behavioral health status or functional abilities while maximizing independence; and
- Facilitating access to other social support services and assistance needed in order to promote each member’s health, safety, and welfare.

Access and Network Adequacy Standards

CMS requirement CFR §438.340(b)(1)

Define the network adequacy and availability of service standards for MCOs required by §438.68 and §438.206. Include examples of evidence-based clinical practice guidelines the State requires in accordance with §438.236.

New Mexico must ensure the delivery of all covered benefits to all Medicaid beneficiaries. Services must be delivered in a culturally competent manner and require that the MCO coordinate health care services and maintain a provider network sufficient to provide timely access to covered services for all of its members.

The MCO must have written policies and procedures that align with the Network Adequacy Standards detailed in the MCO contract and the Centennial Care policy manual. The policies and procedures must describe how access to services will be available including prior authorization and referral requirements for medical and surgical services; emergency room services; behavioral health services; and long-term care services.
The MCO must establish a mechanism to monitor adherence with Network Adequacy Standards and shall submit a Network Adequacy Report as directed by HSD/MAD to ensure compliance with the following:

- **Access Standards**
  - Member caseload of any PCP should not exceed two-thousand (2,000)
  - Members have adequate access to specialty providers

- **Distance Requirements for PCPs** (including internal medicine, general practice, and family practice types), and pharmacies
  - Ninety percent (90%) of Urban members shall travel no farther than thirty (30) miles
  - Ninety percent (90%) of Rural members shall travel no farther than forty-five (45) miles
  - Ninety percent (90%) of Frontier members shall travel no farther than sixty (60) miles

- **Distance Requirements for Behavioral Health Providers** practitioners and Specialty
  - Ninety Percent (90%) of Urban members shall travel no farther than thirty (30) miles
  - Ninety Percent (90%) of Rural members shall travel no farther than sixty (60) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by the State
  - Ninety Percent (90%) of Frontier members shall travel no farther than ninety (90) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by the State

- **Timeliness requirements**
  - No more than thirty (30) Calendar Days, for routine, asymptomatic, member-initiated, outpatient appointments for primary medical care
  - No more than sixty (60) Calendar Days, for routine, asymptomatic member-initiated dental appointments.
  - No more than fourteen (14) calendar Days for routine, symptomatic member-initiated, outpatient appointments for non-urgent primary medical, behavioral health and dental care
  - Within twenty four (24) hours for Primary medical, behavioral health and dental care outpatient appointments for urgent conditions
  - Consistent with clinical urgency but no more than twenty-one (21) calendar days for specialty outpatient referral and consultation appointments, excluding behavioral health
  - Consistent with clinical urgency but no more than fourteen (14) calendar days for routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments
  - Consistent with the severity of the clinical need, walk-in rather than an appointment, for outpatient diagnostic laboratory, diagnostic imaging and other testing
- Consistent with clinical urgency, but no longer than forty-eight (48) hours for urgent outpatient diagnostic laboratory, diagnostic imaging and other testing
- No longer than forty (40) minutes for the in-person prescription fill time (ready for pickup). A prescription called in by a practitioner shall be filled within ninety (90) minutes
- Consistent with clinical needs for scheduled follow-up outpatient visits with practitioners
- Within two (2) hours for face-to-face Behavioral Health crisis services

**Provider Standards:**
The MCO must have the appropriate licenses in the State to do risk-based contracting through a managed care network of health care providers. The MCO is required by the state to employ a full-time staff person responsible for provider services and provider relations, including all network management issues, provider payment issues and provider education.

The MCO must develop written policies and procedures that meet NCQA standards and State and federal regulations for credentialing and re-credentialing of contracted providers. The document should include but not be limited to: defining the scope of providers covered; the criteria and the primary source verification of information used to meet the criteria; the process used to make decisions that shall not be discriminatory; and the extent of delegated credentialing and re-credentialing arrangements.

MCO network providers are obligated to abide by all federal, state and local laws, rules and regulations, including but not limited to those laws, regulation, and rules applicable to providers of services under Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act and other health care programs administered by the State.

All health care providers rendering services to Medicaid beneficiaries must render covered services to eligible recipients in the same scope, quality, and manner as provided to the general public; comply with all federal and state civil rights laws; and not discriminate on the basis of race, color, national origin, sex, gender, age, ethnicity, religion, sexual orientation, sexual preference, health status, disability, political belief or source of payment.

Evidenced-Based Clinical Practice Guideline (CPGs) from the MCOs include examples from their QM/QI plan such as Asthma, Diabetes, ADHD (Attention Deficit Hyperactive Disorder)/ADD (Attention Deficit Disorder), Depression, and Obesity. CPGs are updated every two years and analyzed for relevant member population and practitioner/specialists and disseminated to providers. Typically, measurements (i.e. Healthcare Effectiveness Data and Information Set [HEDIS]) are established and evaluated through MCO Quality Committees, NCQA, and HSD/MAD.

*CMS requirement CFR §438.340(b)(6)*
Detail the State’s plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. States must identify this demographic information for each Medicaid enrollee and provide it to the MCO at the time of enrollment.

**Health Disparities**

In New Mexico many factors contribute to health disparities, including access to health care, behavioral choices, genetic predisposition, geographic location, poverty, environmental and occupational conditions, language barriers and social and cultural factors.

HSD/MAD enlists a variety of methodologies and resources, including enrollment files delivered daily to the MCOs, to identify, evaluate, reduce and overcome any barriers that limit access to appropriate care for the State’s Medicaid beneficiaries. Resources include, but are not limited to:

- Stratified data tracking and monitoring of targeted populations, illness or chronic conditions to identify at risk Medicaid beneficiaries;
- State directed interventions and oversight and monitoring of MCO directed interventions developed to address specific health care needs unique to Medicaid beneficiaries;
- Requiring that the MCOs maintain an adequate provider network that adheres to the State’s provider participation standards;
- Establishment of a Care Coordination infrastructure to assess member needs;
- Member rewards program to encourage member engagement with preventive services and follow up care by incentivizing beneficiaries to pursue healthy behaviors;
- Peer support program to provide formalized support and practical assistance to people who have or are receiving services to help regain control over their lives in their own unique recovery process; and
- Requiring the MCO to develop a Cultural Competence and Sensitivity Plan to ensure that covered services provided to members are culturally competent and include provisions for monitoring and evaluating disparities in membership, especially as related to Native Americans.

**Transition of Care Standards:**

*CMS requirement CFR §438.340(b)(5)*

Must include a description of the State’s transition of care policy.

The State is committed to providing the necessary supports to assist Medicaid beneficiaries and requires the MCOs to establish policies and procedures that adhere to the standards defined by the State in the Managed Care Policy Manual and MCO contract.

The MCOs shall facilitate and ensure a timely and seamless transition for all Medicaid members transitioning to new services or service providers without any disruptions in services. The MCOs must identify and facilitate coordination of care for all members during various transitions including, but not limited to:
- From an institutional facility into the community;
- For members turning twenty-one (21) years of age;
- From higher levels of care to lower levels of care. (e.g. acute inpatient, residential treatment centers social detoxification programs, treatment foster care, etc.);
- For members changing MCOs (e.g. while hospitalized, during major organ and tissue transplantation, or while receiving outpatient treatment for significant medical conditions); and
- For members with special conditions, circumstances, treatment needs or ongoing needs such as (e.g. pregnancy, chronic illness, significant behavioral health conditions, chemotherapy, dialysis or durable medical equipment).

**Monitoring and Compliance Standards:**

*CMS requirement CFR §438.340(b)(2)*

Detail the State’s goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO.

New Mexico’s Quality Strategy utilizes a Continuous Quality Improvement (CQI) model to achieve goals and objectives outlined for the Centennial Care program.

Centennial Care is driven by the following goals:

1. Assuring that Medicaid recipients in the program receive the right amount of care, delivered at the right time, in the right setting;
2. Ensuring that expenditures for care and services being provided are measured in terms of quality and not solely by quantity;
3. Slowing the growth of rate of costs, or “bending the cost curve” over time without cutting benefits or services, changing eligibility, or reducing provider rates; and
4. Streamlining and modernizing the Medicaid program in the State.

Centennial Care objectives include:

1. Develop a quality framework consistent with, and pertinent to all Medicaid programs;
2. Continue use of nationally recognized protocols, standards of care and benchmarks;
3. Continue use of a system of rewards for physicians, in collaboration with MCOs, based on clinical best practices and outcomes;
4. Develop collaborative strategies and initiatives with state agencies and other external partners;
5. Build upon prevention efforts and health maintenance/management to improve health status through targeted medical management;
6. Assure the effective medical management of at risk and vulnerable populations; and
7. Build capacity in rural, frontier and underserved areas.

HSD/MAD, through the QM/QM standards, requires the MCOs to apply the CQI model and identify opportunities for measurable improvement in the health status of the population served by the MCOs. The State conducts an annual review of each MCO’s QM/QI program that includes a Work Plan and Evaluation by an integrated team from the QB, the Behavioral Health Services Division (BHSD) and the Centennial Care Contracts Bureau.
HSD/MAD monitors provider access and network adequacy in a variety of ways and through various reports submitted by the MCOs. The following outlines the various methods utilized to monitor MCO provider access and network adequacy:

- Provider Satisfaction Survey
- Member Satisfaction Survey
- Secret Shopper Survey
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) results
- External Quality Review Organization (EQRO) Reviews
- MCO Call Center Reports
- Grievance & Appeals Reports
- PCP Report
- Geo Access Report
- Network Adequacy Report
- Ad Hoc Reports
- Primary Care Physician to member ratio report

In addition, the State evaluates achievement through analysis of the quality and appropriateness of care and services delivered to members by the MCOs based on member needs and the level of contract compliance of MCOs by comprehensively monitoring MCO activities on an on-going basis. The State requires monthly, quarterly, and annual reports, including Ad Hoc reports reflective of all MCO service delivery activities. Various reports evaluate structure, process, and outcome measures.

Sanctions

CMS requirement CFR §438.340(b)(7)

Detail the appropriate use of the intermediate sanctions for MCOs.

HSD/MAD has established sanctions for the failure to meet certain contract requirements by the MCO, affiliate, parent or subcontractor, and if a party fails to comply with the contract, HSD/MAD may impose sanctions.

HSD/MAD has the option to apply Corrective Action Plans (CAPs) if HSD /MAD determines that the MCO is not in compliance with one or more requirements. HSD/MAD may issue a notice of deficiency, identifying the deficiency(ies) and follow-up recommendations/requirements (either in the form of a CAP or an HSD/MAD Directed Corrective Action Plan (DCAP). A notice from HSD/MAD of noncompliance that directs a CAP or DCAP may also serve as a notice of sanction in the event HSD/MAD determines that sanctions are also necessary.

HSD/MAD may impose any or all of the non-monetary sanctions and monetary penalties to the
extent authorized by federal and state law. Non-monetary intermediate sanctions may include:

- Suspension of auto-assignment of members in a MCO;
- Suspension of enrollment in the MCO;
- Notification to members of their right to terminate enrollment with the MCO without cause;
- Disenrollment of members by HSD;
- Suspension of payment for members enrolled after the effective date of the sanction and until CMS or HSD is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;
- Rescission of Marketing consent and suspension of the MCO’s marketing efforts;
- Appointment of temporary management on any portion thereof for a MCO and the MCO shall pay for any costs associated with the imposition of temporary management; and
- Additional sanctions permitted under federal or state statute or regulations that address areas of noncompliance.

The State has established monetary penalties that may include:

- Actual damages incurred by HSD and/or members resulting from the MCO’s non-performance of obligations;
- Monetary penalties in an amount equal to the costs of obtaining alternative health benefits to a member in the event of the MCO's noncompliance in providing Covered Services. The monetary penalties shall include the difference in the capitated rates that would have been paid to the MCO and the rates paid to the replacement health plan. HSD may withhold payment to the MCO for damages until such damages are paid in full;
- Civil monetary penalties;
- Monetary penalties up to five percent (5%) of the MCO's Medicaid capitation payment for each month in which the penalty is assessed;
- HSD reserves the right to assess a general monetary penalty of five hundred dollars ($500) per occurrence with any notice of deficiency; and
- Other monetary penalties for failure to perform specific responsibilities or requirements.

<table>
<thead>
<tr>
<th>PROGRAM ISSUES</th>
<th>PENALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to comply with Claims processing as described in Section 4.19 of the contract</td>
<td>2% of the monthly capitation payment per month, for each month that the HSD determines that the MCO is not in compliance with the requirements of Section 4.19 of the contract</td>
</tr>
<tr>
<td>Failure to comply with Encounter submission as described in Section 4.19 of the contract</td>
<td>Monetary penalties up to two percent (2%) of the MCO’s Medicaid capitation payment for each quarter in which the penalty is assessed. HSD will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction.</td>
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<tr>
<td>Failure to comply with the timeframes for a Comprehensive Needs Assessment for care coordination level 2 and level 3</td>
<td>$1,000 per member where the MCO fails to comply with the timeframes for that member.</td>
</tr>
<tr>
<td>Failure to complete or comply with CAPs/DCAPs</td>
<td>.12% of the monthly capitation payment per Calendar Day for each day the CAP/DCAP is not completed or complied with as required.</td>
</tr>
<tr>
<td>Failure to obtain approval of member Materials as required by Section 4.14.1 of the contract</td>
<td>$5,000 per day for each Calendar Day that HSD determines the MCO has provided member Material that has not been approved by HSD. The $5,000 per day damage amounts will double every ten (10) Calendar Days.</td>
</tr>
<tr>
<td>Failure to comply with the timeframe for responding to Grievances and Appeals required in Section 4.16 of the contract</td>
<td>$1,000 per occurrence where the MCO fails to comply with the timeframes.</td>
</tr>
<tr>
<td>For every report that meets the definition for “Failure to Report” in accordance with Section 4.21 of the contract</td>
<td>$5,000 per report, per occurrence  With the exception of the cure period: $1,000 per report, per Calendar Day. The $1,000 per day damage amounts will double every ten (10) Calendar days.</td>
</tr>
<tr>
<td>Failure to submit timely Summary of Evidence in accordance with Section 4.16 of the contract</td>
<td>$1,000 per occurrence.</td>
</tr>
<tr>
<td>Failure to have legal counsel appear in accordance with Section 4.16 of the contract</td>
<td>$10,000 per occurrence.</td>
</tr>
<tr>
<td>Failure to meet targets for the performance measures described in Section 4.12.8 of the contract</td>
<td>A monetary penalty based on 2% of the total capitation paid to the MCO for the contract/agreement year, divided by the number of performance measures specified in the contract/agreement year.</td>
</tr>
</tbody>
</table>
HSD can modify and assess any monetary penalty if the MCO engages in a pattern of behavior that constitutes a violation of this contract/agreement or, involves a significant risk of harm to members or to the integrity of Centennial Care. This may include, but is not limited to the following: Reporting metrics not met; failure to complete care coordination activities by the timeframes specified; failure to report on required data elements in report submissions; for a report that has been rejected by and resubmitted by the MCO up to three times and the report still meets the definition of for “Failure to Report” in accordance with Section 4.21 of the contract; etc.

Monetary penalties up to five percent (5.0%) of the MCO’s Medicaid capitation payment for each month in which the penalty is assessed. HSD will determine the specific percentage of the capitation penalty based on the severity of the infraction, taking into consideration factors reasonably related to the nature and severity of the infraction.

Below is a total by year of HSD imposed monetary penalties:

- 2014: $3,212,744.66
- 2015: $3,271,585.54
- 2016: $0

Section III: Development, Evaluation and Revision of the Quality Strategy:

(This section should describe how the state initially developed the quality strategy, subsequently reviews the quality strategy for effectiveness, and the timeline/process for revision of the quality strategy.)

Development

CMS requirement CFR §438.340(c)

(This section should describe how the state initially developed the quality strategy, subsequently reviews the quality strategy for effectiveness, and the timeline/process for revision of the quality strategy.)

CMS requirement CFR §438.340(c)(1)

Include a description of how the state made (or plans to make) the Quality Strategy available for public comment.

CMS requirement CFR §438.340(c)(1)(i)

Include a description of the formal process used to develop the quality strategy. This must include a description of how the state obtained the input from the Medical Advisory Committee, beneficiaries and other stakeholders in the development of the quality strategy.

CMS requirement CFR §438.340(c)(1)(ii)
Include a description of how the state obtained the input of the Native American Advisory Committee in accordance with the State’s Tribal consultation policy.

HSD/MAD retains the ultimate authority, management, direction and oversight of the Quality Strategy and has organized a Quality Strategy work group within the QB that is responsible for the development, evaluation, and revision of the Quality Strategy.

The work group’s focus was to develop the Quality Strategy in alignment with the goals and objectives identified by HSD/MAD to provide the right amount of care, delivered at the right time, and in the right setting to all Medicaid beneficiaries. HSD/MAD believes that by driving improvements in quality, many of the goals of Centennial Care are accomplished.

New Mexico’s Quality Strategy is a coordinated, comprehensive, and pro-active approach to drive quality through targeted initiatives, comprehensive monitoring, and ongoing assessment of outcome-based performance improvement. The Quality Strategy was designed to ensure that services provided to the States Medicaid beneficiaries meet or exceed the established standards for access to care, clinical quality of care and quality of services to achieve the delivery of high-quality and high value healthcare.

The key traits of high-quality, high value healthcare include:

- Effectiveness that concentrates on the appropriateness of care (care that is indicated, given the clinical condition of the member);
- Efficient and coordinated care over time that addresses the underlying variation in resource utilization, overuse, misuse, and duplication in the system and the associated costs. The system should be safe for all members, in all processes, in all programs, at all times;
- Member-Centered to encompass respect for members’ values, preferences, and expressed needs; coordination and integration of care; information, communication and involvement of family and friends;
- Timeliness to address access issues with the underlying principle that care be provided in a timely manner;
- Equality of appropriate care that is based on an individual’s needs, not on personal characteristics that are unrelated to the member’s condition or to the reason for seeking care, such as gender, race, geographical location, disability, or insurance status; and
- Prevention and early detection to provide treatment early in the causal chain of disease, with resulting slower disease progression and to reduce the need for long-term care.

HSD/MAD developed the Quality Strategy with input from the Medicaid Advisory Committee (MAC), a diverse and comprehensive group of stakeholders and providers, including Native American Advisory Boards (NAAB) and the Native American Technical Advisory Committee (NATAC). The MAC serves as an advisory body to the Secretary of the Human Services
Department and the Medical Assistance Division Director on policy development and program administration for the Medicaid services provided to New Mexicans. The MAC encourages participation of health professionals, consumers and consumer groups, advocates, and public health entities concerned or involved with the NM Medicaid program. Additionally, quality review committees representing the various populations meet periodically to discuss quality of care issues and performance measure outcomes with the intention of improving health outcomes and safety.

HSD/MAD solicited input and recommendations regarding content and direction of the Quality Strategy from a variety of sources including:

- Medicaid beneficiaries
- The public
- Stakeholders
- Managed Care Organizations
- EQRO
- Behavioral Health Collaborative

The Quality Strategy was published on the New Mexico Human Services Department website for approximately 5 weeks prior to finalizing the document to allow all interested parties to provide feedback and public comment. The comments and feedback provided were considered and/or incorporated into the Quality Strategy as deemed applicable to the goals and objectives established by HSD/MAD.

**Evaluation**

**CMS requirement CFR §438.340(c)(2)**
Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).

**CMS requirement CFR §438.340(c)(2)(i)**
Review must include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years. HSD/MAD will continue to utilize a CQI model to evaluate and assess the effectiveness of the Quality Strategy. HSD/MAD will review the Quality Strategy annually to ensure alignment with reported outcomes from EQR technical reporting, MCO audited HEDIS reports, CAHPS survey, 1115 waiver evaluation design plan and CMS Special Terms and Conditions (STCs), reported findings from HSD internal audits and State required MCO reports, including QM/QI programs. The outcomes will be utilized to gauge effectiveness of the Quality Strategy and to determine if any necessary changes or updates to the Quality Strategy are warranted.

**CMS requirement CFR §438.340(c)(2)(iii)**
Updates to the quality strategy must take into consideration the recommendations for improving the quality of health care service furnished by the MCO including how the State can target goals.
and objectives in the quality strategy to better support improvement in the quality timeliness and access to health care services furnished to Medicaid beneficiaries. Include a timeline for modifying or updating the Quality Strategy. (If this is based on an assessment of “significant changes”)

**CMS requirement CFR §438.340(c)(3)(ii)**
Submit to CMS a copy of the revised quality strategy whenever significant changes are made to the document, or whenever significant changes occur within the State’s Medicaid Program.

**CMS requirement CFR §438.340(c)(2)(ii)**
The State must make the results of the review available on the Website.

HSD/MAD received approval for the Quality Strategy from CMS in May 2014. The Quality Strategy was reassessed in September 2017 and revised to address the program outcomes through calendar year 2016. New Mexico will continue to assess quality outcomes to determine the need for modifications to the Quality Strategy. Upon approval of the 1115 Demonstration Waiver renewal in 2018, HSD/MAD will revise the Quality Strategy to include additional goals, objectives, and outcome measures.

All aspects of the Quality Strategy will be assessed for effectiveness to determine areas of needed improvement. The review will include an evaluation of improvements implemented from the previous year’s assessment and address any significant changes made to the Quality Strategy as a result of the assessment. The State defines significant change as changes that materially affect the actual quality of information collected or analyzed. Minor changes in timeframes, reporting dates, or format are not considered significant changes. With Centennial Care 2.0 the performance measures will focus on areas that show improved member outcome with the right care at the right time and the right place as well as the integration of physical, behavioral, and long-term services and supports. The State will submit a final draft of the Quality Strategy to (CMS) for comment and feedback.

Any updates to the Quality Strategy based on “significant changes” shall be developed, reviewed, and submitted to CMS for review and feedback and will be posted on the HSD website once approved.

**Section IV: Assessment**

**CMS requirement CFR §438.340(b)(8)**
Describe how the State will assess the performance and quality outcomes achieved by each MCO.

**Quality Metrics**

**CMS requirement CFR §438.340(b)(3)**
The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO with which the State contracts, including but not limited to, the performance measures reported. The State must identify which quality measures and performance outcomes the State will publish at least annually on the Web site required. The performance improvement projects to be implemented. Include a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO.
HSD/MAD defined specific Performance Measures (PMs) and targets, Performance Improvement Projects (PIPs), quality metrics for Tracking Measures (TMs), and performance targets to ensure access, quality, or timeliness of care for all Medicaid beneficiaries. The QB monitors, analyzes, trends and provides feedback and technical assistance to the MCOs to improve access, quality, and timeliness of care to all Medicaid beneficiaries.

HSD/MAD’s QB and the contracted MCOs have formed a Quality Workgroup which meets quarterly to discuss quality outcomes and performance. The group was established to promote a collaboration of those responsible for ensuring quality of care and improved outcomes. The Workgroup provides an arena for discussion on gaps in care, interventions, barriers, and best practices. QB is also able to provide feedback on performance, direction and technical assistance in a group setting which encourages the collaborative effort. The group focuses on the key quality metrics defined by the State to assess performance and encourage positive outcomes.

HSD/MAD selects PMs and PIPS utilizing data that identifies the strengths and opportunities for improvement specific to the Medicaid population. PMs, PIPS and performance targets are reasonable and based on industry standards and consistent with CMS EQR Protocols. An annual review of PMs and PIPS is conducted by the EQRO and the final technical report with findings and recommendations are posted on the HSD website.

**Performance Measures (PMs)**

PMs and performance targets are based on HEDIS technical specification for the current reporting year. The MCO is required to follow relevant and current NCQA HEDIS standards for reporting. HSD/MAD requires the MCOs to meet the established performance targets. HSD/MAD considered calendar year 2014 and calendar year 2015 to be noncompetitive baseline years for PM thresholds and for setting PM targets.

The performance targets listed in the MCO contracts requires: 1) a two (2) percentage point improvement above the MCO’s NCQA audited HEDIS rates; or 2) achievement of the Health and Human Services (HHS) Regional Average as determined by NCQA Quality Compass, or the State’s determined target.

Failure to meet the established performance targets will result in monetary penalties as detailed in the MCO Medicaid contract.

HSD/MAD directed the MCOs to focus on eight (8) clinical initiatives to drive improved quality outcomes. The table below reflects the aggregate percentage by calendar year of the annual HEDIS results reported to HSD by the four (4) contracted MCOs.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PM#1 Annual Dental Visits</td>
<td>57.50%</td>
<td>61.50%</td>
<td>63.75%</td>
</tr>
<tr>
<td>PM#2</td>
<td>Use of Appropriate Medication for People with Asthma</td>
<td>51.75%</td>
<td>55.75%</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>PM#3</td>
<td>Controlling High Blood Pressure</td>
<td>52.75%</td>
<td>53.5%</td>
</tr>
<tr>
<td>PM#4</td>
<td>Comprehensive Diabetes Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HbA1C testing</td>
<td>85%</td>
<td>84.25%</td>
</tr>
<tr>
<td></td>
<td>HbA1C &gt;9%</td>
<td>47.5%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Retinal Eye Exam</td>
<td>56%</td>
<td>53%</td>
</tr>
<tr>
<td></td>
<td>Nephropathy Screening</td>
<td>80.75%</td>
<td>87.5%</td>
</tr>
<tr>
<td>PM#5</td>
<td>Prenatal/Postpartum Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prenatal visits within first trimester or within 42 days of enrollment</td>
<td>73%</td>
<td>70.5%</td>
</tr>
<tr>
<td></td>
<td>Postpartum visit on or before 21 &amp; 56 days after delivery</td>
<td>55%</td>
<td>50.75%</td>
</tr>
<tr>
<td>PM#6</td>
<td>Frequency of on-going prenatal care</td>
<td>52%</td>
<td>44.75%</td>
</tr>
<tr>
<td>PM#7</td>
<td>Antidepressant Medication Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute Phase 84 days</td>
<td>52%</td>
<td>53.75%</td>
</tr>
<tr>
<td></td>
<td>Continuous Phase 180 days</td>
<td>43.5%</td>
<td>38.25%</td>
</tr>
<tr>
<td>PM#8</td>
<td>Follow up after hospitalization for Mental illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 days</td>
<td>65.75%</td>
<td>62%</td>
</tr>
<tr>
<td></td>
<td>30 days</td>
<td>44.74%</td>
<td>39.25%</td>
</tr>
</tbody>
</table>

**Performance Improvement Projects (PIPs)**

HSD/MAD directed the MCOs to implement PIPs designed to meet the unique needs of its members. The PIPs were developed to ensure sustainable improvements and interventions with a focus on quality improvement. The 2014 Centennial Care Managed Care Contract directed the MCOs to implement PIPs in the following areas: one (1) on Long-Term Care Services, one (1) on services to children, one (1) on Behavioral Health, and one (1) on women’s health.

In January 2013, New Mexico was awarded the Adult Medicaid Quality Grant (AMQG) by CMS. The grant was designed to support the development of staff capacity to collect, report, and analyze data for adults enrolled in Medicaid. HSD/MAD developed Quality Improvement Projects (QIPs) in accordance with the Initial Adult Core Set Technical Specification and selected Diabetes: Prevention and Enhanced Disease Management, and Behavioral Health: Screening and Management for Clinical Depression. The AMQG ended in December of 2015, and in an effort to promote sustainability of the projects associated with the AMQG, the MCO contract was amended in 2015 directing the MCOs to incorporate the ongoing QIPs as PIPs.
The MCO contract continues to direct the MCOs to, at a minimum, implement the following PIPs:

- One (1) on Long-Term Care
- One (1) on Services to Children
- One (1) on Diabetes Prevention and Management
- One (1) on Screening and Management for Clinical Depression

**Tracking Measures**

HSD/MAD directed the MCOs to report on tracking measures (TM)s that focus on a specific target populations. TMs are areas for the MCOs to evaluate and make improvements, if necessary. The MCOs are required to submit quarterly reports to HSD/MAD using the QB developed reporting template which applies HEDIS, CMS Adult Core Set, or HSD defined technical specifications. The report is analyzed by the QB to identify performance trends, best practices, gaps and interventions reported by the MCOs.

Currently, these measures do not have associated sanctions. Feedback is shared and discussed with the MCOs during the quarterly quality workgroup meetings. Below is a timeline, description and measure of the TMs implemented:

<table>
<thead>
<tr>
<th>Date of Direction</th>
<th>Tracking Measure</th>
<th>Description of Target Population or Topic</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2014</td>
<td>Fall Risk Management</td>
<td>The Percentage of Medicaid members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 Months and who received fall risk intervention from their current practitioner.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>12%</td>
<td>8%</td>
<td>12%</td>
</tr>
<tr>
<td>August 2015</td>
<td>Diabetes, Short-Term Complications Admission Rate</td>
<td>The number of inpatient discharges with a principal diagnosis code for diabetes short-term complications for Medicaid enrollees.</td>
<td>18 to 64 years of age</td>
<td>22%</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>65 + years of age</td>
<td>88%</td>
<td>95%</td>
</tr>
<tr>
<td>Date</td>
<td>Indicator</td>
<td>Description</td>
<td>NR</td>
<td>NR</td>
<td>0.02%</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----</td>
<td>----</td>
<td>-------</td>
</tr>
<tr>
<td>August 2015</td>
<td>Screening for Clinical Depression and Follow-Up Plan</td>
<td>The percentage of Medicaid enrollees screened for clinical depression using a standardized depression screening tool and if positive a follow-up plan is documented on the date of the positive screen.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May 2016</td>
<td>Well-Child Visits in the First 15 Months of Life</td>
<td>The percentage of members who turned 15 months old during the measurement year and who had 6 or more well-child visits with a PCP during their first 15 months of life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May 2016</td>
<td>Children and Adolescents’ Access to Primary Care Practitioners (PCP)</td>
<td>The percentage of members 12 months – 19 years of age who had a visit with a PCP.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>October 2016</td>
<td>Smoking Cessation</td>
<td>The monitoring of smoking cessations products:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cost utilization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The monitoring of counseling: Products and Services (Total Units) utilization</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Child and Adult Core Set Quality Measures**

HSD/MAD reports on CMS determined Child Core Set and Adult Core Set Quality Measures through the Medicaid and CHIP Program (MACPro) systems data entry portal. The CMS defined Core Set of Quality Measures provides New Mexico with a nationally recognized set of core quality measures to track performance and identify areas needing improvement. Reporting on these performance measures will assist HSD/MAD to further enhance the quality of health care for both Children and Adults within the States Medicaid program.

**Consumer Assessment of Healthcare Providers and Systems (CAHPS)**

HSD/MAD incorporates the CAHPS 5.0H Survey required by NCQA for accreditation as part of the required MCO annual report submissions. CAHPS 5.0H allows for inclusion of state specific questions and provides information on New Mexico’s Medicaid beneficiaries and their experiences with the services provided. Below is a table with the Supplemental questions and results for 2015 and 2016.
<table>
<thead>
<tr>
<th>CAHPS Supplemental Questions</th>
<th>Year</th>
<th>BCBS</th>
<th>MHC</th>
<th>PHP</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>*CCC-Children with Chronic Conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*N/A- Not Reported</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child Care Coordination</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these doctors or other health providers? (% answering Yes)</td>
<td>2015</td>
<td>27%</td>
<td>43%</td>
<td>64%</td>
<td>71%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2016</td>
<td>28%</td>
<td>28%</td>
<td>27%</td>
<td>44%</td>
</tr>
<tr>
<td>2. In the last 6 months, who helped to coordinate your child's care?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Someone from your child's health plan</td>
<td>2015</td>
<td>4%</td>
<td>8%</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>2016</td>
<td>6%</td>
<td>6%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Someone from your child's doctor's office or clinic</td>
<td>2015</td>
<td>19%</td>
<td>22%</td>
<td>55%</td>
<td>48%</td>
</tr>
<tr>
<td></td>
<td>2016</td>
<td>22%</td>
<td>22%</td>
<td>24%</td>
<td>31%</td>
</tr>
<tr>
<td>Someone from another organization</td>
<td>2015</td>
<td>1%</td>
<td>4%</td>
<td>6%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>2016</td>
<td>3%</td>
<td>3%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>A friend or family member</td>
<td>2015</td>
<td>5%</td>
<td>6%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>2016</td>
<td>4%</td>
<td>4%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>You</td>
<td>2015</td>
<td>71%</td>
<td>60%</td>
<td>25%</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>2016</td>
<td>65%</td>
<td>65%</td>
<td>64%</td>
<td>56%</td>
</tr>
<tr>
<td>3. How satisfied are you with the help you received to coordinate your child's care in the last 6 months?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied or Very Satisfied</td>
<td>2015</td>
<td>81%</td>
<td>74%</td>
<td>86%</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td>2016</td>
<td>77%</td>
<td>77%</td>
<td>90%</td>
<td>86%</td>
</tr>
<tr>
<td><strong>Adult Care Coordination</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers? (% answering Yes)</td>
<td>2015</td>
<td>33%</td>
<td>24%</td>
<td>27%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>2016</td>
<td>38%</td>
<td>30%</td>
<td>29%</td>
<td>37%</td>
</tr>
<tr>
<td>5. In the last 6 months, who helped to coordinate your care?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Someone from your health plan</td>
<td>2015</td>
<td>9%</td>
<td>19%</td>
<td>17%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>2016</td>
<td>14%</td>
<td>12%</td>
<td>34%</td>
<td>12%</td>
</tr>
<tr>
<td>Someone from your doctor's office or clinic</td>
<td>2015</td>
<td>25%</td>
<td>48%</td>
<td>47%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>2016</td>
<td>26%</td>
<td>23%</td>
<td>48%</td>
<td>21%</td>
</tr>
<tr>
<td>Someone from another organization</td>
<td>2015</td>
<td>2%</td>
<td>3%</td>
<td>4%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>2016</td>
<td>4%</td>
<td>1%</td>
<td>1%</td>
<td>5%</td>
</tr>
<tr>
<td>A friend or family member</td>
<td>2015</td>
<td>14%</td>
<td>16%</td>
<td>13%</td>
<td>N/A</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td><strong>You</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. How satisfied are you with the help you received to coordinate your care in the last 6 months?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied or Very Satisfied</td>
<td>14%</td>
<td>11%</td>
<td>8%</td>
<td>19%</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Member Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. In the last 6 months, have you received any material from your health plan about good health and how to stay healthy? (% answering Yes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>58%</td>
<td>59%</td>
<td>62%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>73%</td>
<td>57%</td>
<td>63%</td>
<td>67%</td>
<td></td>
</tr>
<tr>
<td>8. In the last 6 months, have you received any material from your health plan about care coordination and how to contact the care coordination unit? (% answering Yes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>50%</td>
<td>48%</td>
<td>50%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>60%</td>
<td>54%</td>
<td>51%</td>
<td>59%</td>
<td></td>
</tr>
<tr>
<td><strong>Care Plan</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Did your care coordinator sit down with you and create a plan of care? (% answering Yes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>24%</td>
<td>24%</td>
<td>64%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>28%</td>
<td>25%</td>
<td>54%</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>10. Are you satisfied that your care plan talks about the help you need to stay healthy and remain in your home?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied or Very Satisfied</td>
<td>70%</td>
<td>71%</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>70%</td>
<td>83%</td>
<td>84%</td>
<td>71%</td>
<td></td>
</tr>
<tr>
<td><strong>Fall Risk</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. A fall is when your body goes to the ground without being pushed. In the last 6 months, did you talk with your doctor or other health provider about falling or problems with balance or walking? (% answering Yes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>22%</td>
<td>18%</td>
<td>22%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>23%</td>
<td>17%</td>
<td>57%</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>12. Did you Fall in the past 6 months? (% answering Yes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>19%</td>
<td>18%</td>
<td>17%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>21%</td>
<td>15%</td>
<td>52%</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>13. In the past 6 months, have you had a problem with balance or walking? (% answering Yes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>27%</td>
<td>24%</td>
<td>25%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>26%</td>
<td>20%</td>
<td>21%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>14. Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? (% answering Yes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>23%</td>
<td>23%</td>
<td>26%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>26%</td>
<td>21%</td>
<td>58%</td>
<td>38%</td>
<td></td>
</tr>
</tbody>
</table>

**External Quality Review**

*CMS requirement CFR §438.340(b)(4)*

Detail the arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO.

HSD/MAD, in accordance with 42 CFR 438.354, has retained the services of an External Quality Review Organization (EQRO), HealthInsight New Mexico, to provide External Quality Review (EQR). The EQRO will conduct all mandatory and optional EQR reviews to assess quality
outcomes and timeliness of, and access to, the services provided to Medicaid beneficiaries and covered under each MCO.

The EQRO will follow CMS protocols that set forth the parameters that must be followed in conducting the EQR for the following activities:

- Compliance Monitoring, an annual review designed to determine the MCO compliance with State and Federal Medicaid regulations and applicable elements of the contract between the MCO and State. As an extension of Compliance Monitoring, the EQRO has conducted numerous educational sessions for the MCOs regarding Transition of Care 2015 and 2016 requirements;

- Validation of PMs, an annual review designed to evaluate the accuracy of the State defined performance measures reported by the MCOs;

- Validation of PIPs, an annual review designed to verify the projects developed by the MCO were designed, conducted and reported in a methodically sound manner and address the target population defined by the State;

- Validation of Encounter Data, a review conducted every three (3) years as an independent validation to measure the consistency between submitted encounter data and corresponding health record entries;

- Independent Assessment, a review conducted every three (3) years to assess the State’s activities and efforts to monitor the MCOs’ access to services, quality of services and cost effectiveness; and

- Audit of the MCO NFLOC determinations every quarter. HSD monitors the EQRO audit of MCO NFLOC determinations and addresses trends identified.

The MCOs are required to cooperate fully with the EQRO and demonstrate compliance with New Mexico’s managed care regulations and quality standards as set forth in federal regulation and State policy.

The EQRO reports findings and recommendations to the State.

**CMS requirement CFR §438.340(b)(10)**

Describe how the state will ensure non-duplication of EQR activities.

To ensure non-duplication of EQR activities, HSD/MAD has a designated Contract Administrator authorized to represent HSD/MAD in all matters related to EQR. The Contract Administrator utilizes tracking sheets to monitor scope of work activities with relevant contractors within the division.

HSD conducts internal quality review activities such as:

- NF LOC audits by the HSD/MAD Nurse Auditor for review of service plan reduction determinations by the MCOs;
• NF LOC audits by the HSD/MAD Nurse Auditor for review of high NF LOC and low NF LOC denials on a quarterly basis to ensure the denials are appropriate and based on NF LOC criteria;

• Service Plan audits by the HSD/MAD Nurse Contractor to review service plans ensuring that the MCOs are using the correct tools and processes to create service plans. The review of service plans also ensures the MCOs are appropriately allocating time and implementing the services identified in the member’s comprehensive needs assessment, and the member’s goals are identified in the care plan;

• Care coordination audits evaluating and monitoring MCO care coordination activities. HSD/MAD monitors monthly progress reports from the MCOs outlining the MCOs’ efforts to improve care coordination practices according to HSD/MAD’s findings that required follow-up to recommendations and action steps;

• “Ride-alongs” by HSD/MAD staff were conducted with MCO care coordinators in 2015, 2016 and 2017 to observe member visits in the home setting. HSD/MAD ride-along experiences with the MCOs identified the need to continue care coordination trainings for member assessments and available services. Modifications to assessment tools and technical assistance were provided to the MCOs based on the observations. MCOs acknowledged the need for continued training and that the process was helpful to the MCO care coordinators. The ride-alongs focus on application by care coordinators of the Community Benefit Services Questionnaire (CBSQ), a tool developed collaboratively by HSD/MAD and the MCOs to educate members about available home and community based services. HSD/MAD observes the care coordinator’s use of the Community Benefit Member Agreement (CBMA), to document if the member agrees to accept or decline available services;

• Monitoring MCO continued expansion of the PCMH model by engaging PCMH providers to conduct care coordination activities for their attributed members through value based purchasing (VBP) arrangements. Centennial Care 2.0 seeks to expand of this initiative by continuing to transition care coordination functions from the MCOs to the provider level (known as a delegated model). Monitoring activities shall occur through MCO reporting to HSD and verification of VBP initiatives.

• Delivery System Improvement Performance Targets (DSIPTs) allow MCOs to be recognized for their quality improvements in specific areas. In 2014 and 2015, HSD required four target areas for DSIPTs. In 2016, HSD expanded target areas by adding emphasis on five specific areas. Below is a description of DSIPTs target areas by year:
<table>
<thead>
<tr>
<th>Delivery System Improvement Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2014</strong></td>
</tr>
<tr>
<td><strong>HIE/HIT</strong></td>
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<tr>
<td>Increase the use of electronic health</td>
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<tr>
<td>records by Contract Providers and</td>
</tr>
<tr>
<td>Increase the number of Contract</td>
</tr>
<tr>
<td>Providers who participate in the</td>
</tr>
<tr>
<td>exchange of electronic health</td>
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<tr>
<td>information.</td>
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<td></td>
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<td></td>
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<tr>
<td><strong>Telehealth</strong></td>
</tr>
<tr>
<td>A minimum of a 15% increase in</td>
</tr>
<tr>
<td>telehealth “office” visits with</td>
</tr>
<tr>
<td>specialists, including BH providers,</td>
</tr>
<tr>
<td>for members in Rural and Frontier</td>
</tr>
<tr>
<td>areas. At least 5% of the increase</td>
</tr>
<tr>
<td>must be visits with BH providers.</td>
</tr>
<tr>
<td><strong>PCMH</strong></td>
</tr>
<tr>
<td>A minimum of a 5% of members served</td>
</tr>
<tr>
<td>by PCMHs.</td>
</tr>
<tr>
<td></td>
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<td></td>
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<tr>
<td><strong>ER Diversion</strong></td>
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<tr>
<td>A minimum of a 10% reduction of</td>
</tr>
<tr>
<td>non-emergent use of the ER.</td>
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</table>

**Centennial Care Summary**

Accomplishments for Centennial Care, now in its fourth year of operation, include the following:

- Streamlined program administration by consolidating a myriad of federal waivers that segregate the care of populations. Four MCOs administer the full array of services in an integrated model of care, serving approximately 700,000 Medicaid members;

- Built a care coordination infrastructure that promotes a person-centered approach to care. More than 900 care coordinators ensure members receive services when they need them;

- Increased access to long-term services and supports (LTSS) for people who previously needed a waiver allocation to receive such services. More than 29,750 individuals are
receiving home- and community-based services (HCBS) which represents an increase of 11.4% per year between 2014 and 2016;

- Continue to be a leader in the nation in spending more of its LTSS dollars to maintain the number of members receiving services in their homes and in community settings rather than in institutional settings;

- Advanced payment reforms in partnership with the MCOs and, in 2017, requiring VBP arrangements for at least 16% of all medical payments to providers; and

- Demonstrated improved utilization of health care services and cost-effectiveness of the program despite significant enrollment growth. Total enrollment in the Medicaid program has grown 8.5% per year since 2014 while per capita costs have decreased by 1.5% between 2014 and 2016.
January 11, 2017

Ms. Julie Lovato
Public Records Custodian
P.O. Box 2348
Santa Fe, New Mexico 87504
VIA EMAIL: Julie.Lovato@state.nm.us

Re: Public Records Request Pursuant to the Inspection of Public Records Act and Litigation Hold Notice

Dear Ms. Lovato:

On behalf of the United Healthcare Community Plan of New Mexico ("United"), I am requesting production of the public records set forth below in accordance with the New Mexico Inspection of Public Records Act, NMSA 1978, Section 14-2-1 et seq. All public document requests herein relate to RFP #18-630-8000-001 ("RFP").

Pursuant to NMSA 1978, Section 14-2-9, I request that any documents responsive to this request that are available in electronic form be provided in that form.

- Each notice of award or non-award, whether temporary or final, that has been provided to an Offeror.
- Any documents supporting or relating to the evaluation or scoring of the proposals or offers submitted by vendors in response to the RFP. This request seeks any documents that show how the evaluation committee or its members evaluated the competing proposals and, in particular, scored or ranked the proposals. This would include copies of any preliminary drafts and the final evaluation committee report.
- Emails or other documents between and among evaluation committee members themselves and with any third parties, including Contractors (as defined below) and consultants, related to the RFP.
- Emails or other documents between the State and any vendor who submitted a proposal in response to the RFP.
- Any other documents in the State’s possession regarding or related to the RFP, the evaluation of proposals and the process leading to the issuance of each notice of award or non-award. This request is intended to encompass the entirety of the State’s procurement file, other than the proposals themselves.
- Any or all of the above that are in the possession of Mercer Consulting ("Mercer") and any other contractor (each a “Contractor” and, collectively with Mercer, “Contractors”) that was utilized by the State in any capacity for the RFP. (Please see State of New Mexico ex rel. Toomey v. City of Truth or Consequences, 2012-NMCA-104, 287 P.3rd 264 2012)

According to the Act, this request should be acted upon as soon as possible, but in no event later than the third business day following receipt of this letter. If access to the requested records is going to take longer, please contact me so we can discuss a reasonable date. I understand that the RFP provides that the individual proposals will be kept confidential until contracts are awarded; however, the proposals themselves and their
accompanying exhibits are expressly excluded from this request and the public records requested herein are subject to the disclosure provisions of the Act.

If you choose to deny the request, please respond in writing and state the statutory exception authorizing the withholding of all or part of the public record and the name and title or position of the person responsible for the denial.

Please be advised that United's recourse to the results of the RFP may include a protest pursuant to the New Mexico Procurement Code, NMSA 1987 Section 13-1-28 et seq. and, ultimately, litigation. Accordingly you are directed to preserve, and to direct any Contractors to preserve, all documents and information regarding the procurement process including the drafting of the RFP and any amendments, any questions submitted and answers provided, any bidder conferences materials, any proposal evaluations and scoring materials, reference checks, negotiations, communications with Offerors, and any documents related to any other steps in the procurement process, including, but not limited to the specific types of documents requested above. The duty requires the State to take affirmative steps to preserve all such information in its possession, custody or control and in the possession, custody or control of its consultants or Contractors. The obligation to preserve includes both physical and electronic documents, files and information, in all forms and formats, wherever it may reside. For electronically stored information (ESI) the duty to preserve extends to wherever that information is maintained (e.g., computer hard drives, servers, laptops, PDAs, cellphones, off-site computers and servers, extranets, voicemails, backup tapes, compact disks and other storage media). Therefore, the State should issue a “Litigation Hold” memorandum to all employees, evaluation committee members, consultants and Contractors, who may possess or have custody or control of or access to, physical evidence, paper documents and ESI. The Litigation Hold must include immediately suspending any and all document destruction programs for all paper and electronic records of the type described in this Notice. All documents must be maintained in their existing form without alteration or modification and, all ESI must be preserved in its native form and condition. The preservation obligation is ongoing and pertains to all documents created in the future related to this procurement process.

In accordance with the requirements set forth in NMSA 1978, Section 14-2-8(c), please find below my complete contact information.

Sincerely,

[Signature]

Raymond W. Mensack
Associate General Counsel
UnitedHealthcare of New Mexico, Inc.
8220 San Pedro NE
Suite 300
Albuquerque, NM 87113
(505) 449-4183
rmensack@uhc.com

cc: Charles J. Milligan, Jr.
    Brent Earnest, HSD Secretary
    Eric Wexler, Esq.
    Christopher Collins, Esq., HSD General Counsel
January 19, 2017

Ms. Julie Lovato  
Public Records Custodian  
P.O. Box 2348  
Santa Fe, New Mexico 87504  
VIA EMAIL: Julie.Lovato@state.nm.us

Re: Supplemental Public Records Request Pursuant to the Inspection of Public Records Act

Dear Ms. Lovato:

This letter is submitted as a supplement to my request for the production of the public records set forth in my correspondence of January 11, 2017, in accordance with the New Mexico Inspection of Public Records Act, NMSA 1978, Section 14-2-1 et seq. As with the original request the public documents requested herein relate to RFP #18-630-8000-001 (“RFP”).

Pursuant to NMSA 1978, Section 14-2-9, I request that any documents responsive to this request that are available in electronic form be provided in that form. Please produce any copies of the following:

- Any correspondence, phone logs, and/or notes that relate to any communications between the New Mexico Human Services Department (“HSD”), Mercer Consulting (“Mercer”), or any agent or representative of HSD or Mercer, and any of the references provided to HSD by United Healthcare, pursuant to the Section 5.9 of the RFP. Those references are, specifically, the Medicaid agencies of the States of Rhode Island, Mississippi, and Michigan.

According to the Act, this request should be acted upon as soon as possible, but in no event later than the third business day following receipt of this letter. Please note that the award of contracts has taken place, and the information requested both in this supplement and in the original request are material to United Healthcare’s ability to prepare a potential protest within the limited time period allotted by the RFP and the New Mexico Procurement Code.

If you choose to deny the request, please respond in writing and state the statutory exception authorizing the withholding of all or part of the public record and the name and title or position of the person responsible for the denial.
In accordance with the requirements set forth in NMSA 1978, Section 14-2-8(c), please find below my complete contact information.

Sincerely,

[Signature]

Raymond W. Mensack  
Associate General Counsel  
UnitedHealthcare of New Mexico, Inc.  
8220 San Pedro NE  
Suite 300  
Albuquerque, NM 87113  
(505) 449-4183  
rmensack@uhc.com

cc: Charles J. Milligan, Jr.  
Eric Wexler, Esq.
January 22, 2017

Ms. Julie Lovato
Public Records Custodian
P.O. Box 2348
Santa Fe, New Mexico 87504
VIA EMAIL: Julie.Lovato@state.nm.us

Re: Supplemental Public Records Request #2 Pursuant to the Inspection of Public Records Act

Dear Ms. Lovato:

This letter is submitted as a second supplement to my request for the production of the public records set forth in my correspondence of January 11, 2017, in accordance with the New Mexico Inspection of Public Records Act, NMSA 1978, Section 14-2-1 et seq. As with the previous requests the public document requested herein relates to RFP #18-630-8000-001 ("RFP").

Pursuant to NMSA 1978, Section 14-2-9, I request that a copy of the following document be produced:

- An email dated November 2, 2017, from Joan Pillsbury of the Office of Health and Human Services of the State of Rhode Island to the following HSD email address:

  CentennialCare.RFP@state.nm.us.

  **Please do not include in the production any documents that are attached to the email.**

According to the Act, this request should be acted upon as soon as possible, but in no event later than the third business day following receipt of this letter. **I respectfully request that this single document be given priority over all other document requests.** If you choose to deny the request, please respond in writing and state the statutory exception authorizing the withholding of all or part of the public record and the name and title or position of the person responsible for the denial.

In accordance with the requirements set forth in NMSA 1978, Section 14-2-8(c), please find below my complete contact information.

Sincerely,

Raymond W. Mensack
Associate General Counsel
UnitedHealthcare of New Mexico, Inc.
8220 San Pedro NE
Suite 300
Albuquerque, NM 87113
(505) 449-4183
rmensack@uhc.com
cc: Charles J. Milligan, Jr.
    Eric Wexler, Esq.
January 24, 2017

Ms. Julie Lovato
Public Records Custodian
P.O. Box 2348
Santa Fe, New Mexico 87504
VIA EMAIL: Julie.Lovato@state.nm.us

Re: Supplemental Public Records Request #3 Pursuant to the Inspection of Public Records Act

Dear Ms. Lovato:

This letter is submitted as a third supplement to my request for the production of the public records set forth in my correspondence of January 11, 2017, in accordance with the New Mexico Inspection of Public Records Act, NMSA 1978, Section 14-2-1 et seq. As with the previous requests the public document requested herein relates to RFP #18-630-8000-001 (“RFP”).

Pursuant to NMSA 1978, Section 14-2-9, I request that a copy of each of the eight (8) Proposals and all of their respective accompanying documents that were submitted by Offerors in the RFP be produced. As the deadline to protest the results of the RFP is February 5, 2018, I respectfully request that the documents be made available immediately. In accordance with the provisions of the Act, if any responsive documents are available in electronic form, I request that they be made available in that form. I can arrange to have any documentation picked up at your convenience.

According to the Act, this request should be acted upon as soon as possible, but in no event later than the third business day following receipt of this letter. If you choose to deny the request, please respond in writing and state the statutory exception authorizing the withholding of all or part of the public record and the name and title or position of the person responsible for the denial.

In accordance with the requirements set forth in NMSA 1978, Section 14-2-8(c), please find below my complete contact information.

Sincerely,

[Signature]

Raymond W. Mensack
Associate General Counsel
UnitedHealthcare of New Mexico, Inc.
8220 San Pedro NE
Suite 300
Albuquerque, NM 87113
(505) 449-4183
rmensack@uhc.com
cc: Charles J. Milligan, Jr.
Eric Wexler, Esq.
January 25, 2018

Ms. Julie Lovato
Public Records Custodian
P.O. Box 2348
Santa Fe, New Mexico 87504
VIA EMAIL: Julie.Lovato@state.nm.us

Re: Supplemental Public Records Request #4 Pursuant to the Inspection of Public Records Act

Dear Ms. Lovato:

This letter is submitted as a supplement to my request for the production of the public records set forth in my correspondence of January 11, 2018, in accordance with the New Mexico Inspection of Public Records Act, NMSA 1978, Section 14-2-1 et seq. As with the original request the public documents requested herein relate to RFP #18-630-8000-001 ("RFP").

Pursuant to NMSA 1978, Section 14-2-9, I request that any documents responsive to this request that are available in electronic form be provided in that form. Please produce any copies of the following:

- Any correspondence, phone logs, and/or notes that relate to any communications between the New Mexico Human Services Department ("HSD"), Mercer Consulting ("Mercer"), or any agent or representative of HSD or Mercer, and any of the references provided to HSD by any Offeror, pursuant to Section 5.9 of the RFP.
- I have previously requested, in my Supplemental Records Request dated January 19, 2018, the above documentation relating to communications with UnitedHealthcare. Accordingly, the scope of this request is limited to the remaining seven (7) Offerors.

According to the Act, this request should be acted upon as soon as possible, but in no event later than the third business day following receipt of this letter. Please note that the award of contracts has taken place, and the information requested both in this supplement and in the original request are material to UnitedHealthcare’s ability to prepare a potential protest within the limited time period allotted by the RFP and the New Mexico Procurement Code.

If you choose to deny the request, please respond in writing and state the statutory exception authorizing the withholding of all or part of the public record and the name and title or position of the person responsible for the denial.
In accordance with the requirements set forth in NMSA 1978, Section 14-2-8(c), please find below my complete contact information.

Sincerely,

[Signature]

Raymond W. Mensack
Associate General Counsel
UnitedHealthcare of New Mexico, Inc.
8220 San Pedro NE
Suite 300
Albuquerque, NM 87113
(505) 449-4183
rmensack@uhc.com

cc: Charles J. Milligan, Jr.
    Eric Wexler, Esq.
January 31, 2018

Ms. Julie Lovato  
Public Records Custodian  
P.O. Box 2348  
Santa Fe, New Mexico 87504  
VIA EMAIL: Julie.Lovato@state.nm.us

Re:  Supplemental Public Records Request #6 Pursuant to the Inspection of Public Records Act

Dear Ms. Lovato:

This letter is submitted as a supplement to my request for the production of the public records set forth in my correspondence of January 11, 2018, in accordance with the New Mexico Inspection of Public Records Act, NMSA 1978, Section 14-2-1 et seq. As with the original request the public documents requested herein relate to RFP #18-630-8000-001 (“RFP”). Pursuant to NMSA 1978, Section 14-2-9, I request that any documents responsive to this request that are available in electronic form be provided in that form.

Please provide copies of the following:

- Any documentation, including but not limited to memoranda, PowerPoint presentations, guidelines, instructional and training materials and information, notes, etc. that were created in preparation for the scoring of the Centennial Care 2.0 RFP Proposals by the Evaluation Committee, including the scoring of the Offerors’ references.

- Any and all correspondence, phone logs, internal communications, memoranda, notes and/or other documentation by or among the New Mexico Human Services Department (“HSD”), Mercer Consulting (“Mercer”), and any employee, agent, officer or representative of HSD and/or Mercer, with Conduent, Inc. (“Conduent”), or any parent, affiliate or subsidiary of Conduent, and any of their respective employees, agents, officers or representatives, that was related in any way to the Centennial Care 2.0. RFP.

- Any and all correspondence, phone logs, internal communications, etc. among or between HSD, Mercer, and Conduent, and/or any employee, agent, officer, or representative of any of the foregoing, that relates in any manner to the actual scoring of the Offerors’ Proposals, including scoring of their respective References, the development of the scoring regimen, and/or any changes to any previously established scoring regimen.

According to the Act, this request should be acted upon as soon as possible, but in no event later than the third business day following receipt of this letter. Please note that the award of contracts has taken place, and the information requested both in this supplement and in the original request are material to United Healthcare’s ability to prepare a potential protest within the limited time period allotted by the RFP and the New Mexico Procurement Code.
If you choose to deny the request, please respond in writing and state the statutory exception authorizing the withholding of all or part of the public record and the name and title or position of the person responsible for the denial.

In accordance with the requirements set forth in NMSA 1978, Section 14-2-8(c), please find below my complete contact information.

Sincerely,

[Signature]

Raymond W. Mensack  
Associate General Counsel  
UnitedHealthcare of New Mexico, Inc.  
8220 San Pedro NE  
Suite 300  
Albuquerque, NM 87113  
(505) 449-4183  
rmensack@uhc.com

cc: Charles J. Milligan, Jr.  
Eric Wexler, Esq.
February 2, 2018

Ms. Julie Lovato  
Public Records Custodian  
P.O. Box 2348  
Santa Fe, New Mexico 87504  
VIA EMAIL: Julie.Lovato@state.nm.us

Re: Supplemental Public Records Request #7 Pursuant to the Inspection of Public Records Act

Dear Ms. Lovato:

This letter is submitted as a supplement to my request for the production of the public records set forth in my correspondence of January 11, 2018, in accordance with the New Mexico Inspection of Public Records Act, NMSA 1978, Section 14-2-1 et seq. As with the original request the public documents requested herein relate to RFP #18-630-8000-001 (“RFP”). Pursuant to NMSA 1978, Section 14-2-9, I request that any documents responsive to this request that are available in electronic form be provided in that form.

Please provide copies of the following:

- Any documentation, including but not limited to memoranda, PowerPoint presentations, instructional and training materials and information, notes, research, etc., that relate to, or were relied upon by HSD, in deciding to reduce the number of Centennial Care MCOs from 4 to 3.
- Any and all correspondence, phone logs, internal communications, memoranda, notes and/or other documentation by or among the New Mexico Human Services Department (“HSD”), Mercer Consulting (“Mercer”), and any employee, agent, officer or representative of HSD and/or Mercer, regarding HSD’s decision to reduce the number of Centennial Care MCOs from 4 to 3.

According to the Act, this request should be acted upon as soon as possible, but in no event later than the third business day following receipt of this letter. Please note that the award of contracts has taken place, and the information requested both in this supplement and in the original request are material to UnitedHealthcare’s ability to prepare a potential protest within the limited time period allotted by the RFP and the New Mexico Procurement Code.

If you choose to deny the request, please respond in writing and state the statutory exception authorizing the withholding of all or part of the public record and the name and title or position of the person responsible for the denial.
In accordance with the requirements set forth in NMSA 1978, Section 14-2-8(c), please find below my complete contact information.

Sincerely,

[Signature]

Raymond W. Mensack
Associate General Counsel
UnitedHealthcare of New Mexico, Inc.
8220 San Pedro NE
Suite 300
Albuquerque, NM 87113
(505) 449-4183
rmensack@uhc.com

cc:  Charles J. Milligan, Jr.
     Eric Wexler, Esq.
February 2, 2018

Raymond Mensack
Associate General Counsel
United Healthcare of New Mexico, Inc.

Via email to: rmensack@uhc.com
Original will not follow

Re: New Mexico Inspection of Public Records Act Request

Dear Mr. Mensack:

This letter is in response to requests you have submitted to the Human Services Department (the Department) from January 16, 2018 through January 31, 2018 under the Inspection of Public Records Act.

The Department continues to process the multiple requests it has received from you within the last two weeks, however, collectively these requests are deemed to be excessively broad and burdensome and pursuant to §14-2-10, NMSA 1978 the Department requires additional time in which to respond.

The Department is currently reviewing the potentially responsive documents to determine whether each record is a public document subject to disclosure under the Inspection of Public Records Act, or whether it falls under an exception from disclosure, in part or in whole. I intend to respond on or before February 19, 2018.

Additionally, on January 26, 2018 you were provided with a copy of each offeror’s proposal which excluded information identified as “confidential and proprietary” by each offeror. Please be advised that the Department has yet to make a determination regarding this information. I will provide you with the Department’s determination as soon as it becomes available.

Sincerely,

Julie Lovato
Public Records Custodian
julie.lovato@state.nm.us
505-476-6866
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
5. Use of Sub-Contractors (Select one)

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

___ X 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. ___ X 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.

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

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

Authorized Signature and Date (Must be signed by the person identified in item #2, above.)

[Signature]

10/30, 2017
DECLARATION OF JOEL JOHN MENGES

I, Joel John Menges, declare as follows:

1. I am the Chief Executive Officer of the Menges Group. I have served in that capacity since The Menges Group was founded in April of 2013.

2. The Menges Group is a health care consulting firm. The vast majority of the company's consulting engagements involve Medicaid coordinated care programs, with much of this work involving procurements.

3. During the past year, our firm has assisted clients with Medicaid procurement projects in Delaware, the District of Columbia, Florida, New Hampshire, Kentucky, Mississippi, Oklahoma, Pennsylvania, Texas, and Virginia.

4. I have worked in the Medicaid coordinated care arena throughout the past 30 years, providing assistance to hundreds of clients including dozens of state Medicaid agencies, Medicaid health plans, and several national and state-level associations. I have served as project director for most of these engagements.

5. I have prepared the analyses below, providing context for an appropriate number of Medicaid Managed Care Organization (MCO) contract awards for New Mexico's Centennial 2.0 program using data obtained from the Centers for Medicare and Medicaid Services website, from the Kaiser Family Foundation website, and from several state agency's websites concerning Medicare and Medicaid services data.
Number of Managed Care Organizations

6. New Mexico’s RFP provided latitude for the Human Services Department (HSD) to select – at its discretion – 3, 4, or 5 Centennial Care 2.0 MCOs.

7. New Mexico currently contracts with four MCOs, who have an average Medicaid enrollment of approximately 175,000 beneficiaries. This is a robust average enrollment level, closely in line with the national average of 189,000 enrollees. There is no need to reduce the number of Medicaid MCOs in Centennial 2.0 to provide strong economies of scale to the MCOs.

8. Currently, thirty-nine (39) states use the capitated MCO model. On average, these states contract with 7.1 Medicaid MCOs. The distribution of these states (other than New Mexico, which currently has four Medicaid MCO contractors) by number of Medicaid MCOs is shown in Exhibit A (below), also taking into account the number of overall enrollees in the state Medicaid MCO program.

9. This state distribution suggests that New Mexico’s program is in appropriate balance with four Medicaid MCO contractors. Overwhelmingly, states with more than four Medicaid MCOs also have more overall enrollees than does New Mexico. Conversely, nearly all states with fewer than four MCOs also have fewer overall enrollees than New Mexico.
Exhibit A. Distribution of States by Number of MCOs and Enrollment Size

<table>
<thead>
<tr>
<th></th>
<th>Number of Medicaid MCOs</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-3 (fewer than New Mexico)</td>
<td>4 (same as New Mexico)</td>
<td>5+ (more than New Mexico)</td>
</tr>
<tr>
<td>Number of States with More Medicaid MCO Enrollees than New Mexico</td>
<td>1</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Number of States with Fewer Medicaid MCO Enrollees than New Mexico</td>
<td>12</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>4</td>
<td>21</td>
</tr>
</tbody>
</table>

10. As seen in Exhibit A (above), with four or more contractors, New Mexico is better protected from dropping down to just two Medicaid MCOs than would be the case with only three MCOs. A scenario in which there were only two MCOs would create many unwelcome challenges for HSD. For example, among the states with just two MCOs, several are actively seeking to add a third MCO contractor to protect the state from an existing threat of an unraveling of their respective overall coordinated care programs (and from giving the two plans excess negotiation leverage over the state agency). These states include Delaware, Iowa, Mississippi, and New Hampshire.

11. To the extent New Mexico contracts with three MCOs in an era where considerable industry consolidation and health plan market exits are occurring, New Mexico is taking considerable risk of finding itself with just two MCO contractors during the upcoming contract term and, thus, creating a risk
of excess negotiation leverage for the remaining MCOs over HSD. Even the specter of HSD having only two contractors creates considerable leverage for each MCO in a three-plan situation.

12. Contracting with at least four Medicaid MCOs provides greater beneficiary choice and competition than does contracting with three MCOs. While there is certainly a point where beneficiaries face too large and confusing an array of choices (e.g., 27 Medicare Advantage plans currently serve New Mexico’s senior population), four or five MCOs is not overloading the market with choice.

13. As reflected through HSD’s current Centennial Care 2.0 RFP, the current procurement has spurred a wide array of differentiating initiatives and commitments through the competitive proposals. The diminishment of choice and competition in moving down to three Medicaid MCOs is a significant concern.

14. A wider field of health plan options will also be valuable if a Medicaid buy-in is implemented in New Mexico, particularly through the participation of organizations like United HealthCare which can provide coverage, provider network, and care coordination continuity for persons and families as their health insurance dynamics change over time.

15. The differences between having three or five Medicaid MCOs is of little administrative simplification value to New Mexico’s provider community because roughly two-thirds of New Mexico’s overall population has other
health insurance. As a result, New Mexico’s providers will continue to be interacting with dozens of Medicare and commercial health plans regardless of how many Medicaid plans serve the state.

16. The lone advantage of moving to three Medicaid MCOs is the HSD administrative savings of overseeing one less health plan. We estimate this savings to be approximately 1-2 staff full time equivalents. Such small administrative savings are far outweighed by the competition and choice advantages of contracting with at least four MCOs.

17. Contracting with at least four MCOs seems particularly warranted given the challenges this procurement has experienced in discerning the most qualified MCOs to serve the Centennial 2.0 program. These procurement dynamics are summarized below.

Scoring Challenges in Identifying Best Health Plans

18. United Healthcare’s ranking dropped considerably by virtue of United Healthcare receiving 0 out of a possible 100 points for a reference that a state employee in Rhode Island failed to send. If this reference earned the lowest score of any submitted reference form, which was 56 points (or any score above 47 points), United Healthcare would have finished 3rd. If the Rhode Island reference earned the average reference score of 86 points (or any score above 63 points), United Healthcare would have been ranked 2nd.
19. Given all the effort New Mexico and the MCO applicants have expended, it makes little sense for the determination of awardees to be this significantly affected by a Rhode Island state employee’s inadvertent inaction.

20. Additionally, the highly subjective nature of the questions, coupled with the blunt scoring approach (e.g. applying only two scoring weights across the 94 technical questions and rounding all scoring of questions on a 0-5 scale (with two-thirds of all technical questions being scored at 3 or 4)), forced considerable imprecision upon the scoring process that obscured significant differences in the merits of each proposal.

21. The scoring imprecision is reflected by the end-result of the process. Ultimately, the scoring came out extremely close in the “crux area” regarding the health plans rated 2nd through 5th. The scoring difference from 2nd to 5th was only 4.0%, versus an 11.9% difference between 1st and 2nd and a 9.8% difference between 5th and 6th.

**Independent Scoring Assessment**

22. The Menges Group conducted an independent scoring of seven of the RFP questions using three reviewers (Menges reviewers) with strong coordinated care and procurement experience. The Menges reviewers did not know what scores HSD had awarded for any given applicant and question. The Menges reviewers individually scored a question to one decimal point (e.g., 3.6) for each applicant, then held a group discussion. Once hearing one another’s
viewpoints, the Menges reviewers were welcome to adjust their score as they
demed appropriate or to keep their original score intact. The team then
moved on to the next question. The Menges reviewers all took into
consideration the scoring instructions shared with the HSD review team. To
the best of their ability, the Menges reviewers followed my instructions to
score each applicant as objectively and fairly as possible based entirely on the
quality of the response to a given RFP question. The process consumed
approximately two full days.

23. Across the seven questions, our team’s scoring results had many significant
variations from the scores produced by the HSD team. In terms of overall
rankings, our team ranked WellCare 1st and Presbyterian 4th. HSD essentially
had the opposite findings, ranking Presbyterian 1st and WellCare 5th. On
average, our team awarded a difference of 6.2 points per MCO as compared to
HSD team’s scores across just these seven questions.

24. Our review team’s scores often varied significantly from the HSD team’s
scores. A few specific examples are listed below:

- On Question #20, our team rated Molina last with a 2.18 score;
  whereas, HSD rated Molina second with a 4.0 score. Our team rated
  United 1st with a 4.57 score; whereas HSD rated United 5th with a 3.0
  score. HSD rated AmeriGroup 1st with a 5.0 score; whereas our team
  rated AmeriGroup 4th with a 3.57 score.
- On Question #53, HSD rated BCBS tied for 1st; whereas our team rated BCBS 5th.

- On Question #71, HSD rated six of the 8 plans a 3.0; whereas our team viewed there to be considerable variation among these six plans – with scores for the these MCOs ranging between 2.40 to 4.20.

- On Question #93, HSD rated AmeriHealth 1st and United 4th; whereas our team rated AmeriHealth 4th and United 1st.

25. The rounding of scores to the nearest whole number was a structural flaw preventing HSD from accurately differentiating the applicants within (and across) questions. However, there were many situations -- beyond the rounding issues -- in the seven questions we assessed where the HSD scoring did not differentiate between applicants in a manner that our scoring team found sufficient/deserved in their own review. Additionally, there were many situations in which our team’s scores suggest that HSD significantly over-differentiated between applicants.

26. Our team also emphasized that some of the questions they reviewed were asked in a broad manner that gave the plans wide latitude to respond in very materially different ways. In these situations, the Menges reviewers found it difficult to assign appropriate differentiating scores across the eight applicants (and they did not see how any reviewer would be able to do so).

27. These scoring challenges are all exacerbated by the fact that HSD’s ultimate scoring was so closely bunched between the #2 and #5 rated health plans. The
Menges Group did not find that the scoring approach occurred with the precision necessary for HSD to draw an accurate and appropriate distinction among these four MCOs regarding which of these entities constitute a better partner for HSD.

28. The rounding approach alone created significant distortions while providing no offsetting advantages. Had our team's score been rounded to the nearest whole number (instead of occurring at the first decimal point), the rounding would have swung the scoring differential between two of the applicants by 9.5 points across just the seven questions we reviewed. The blunt rounding awards the exact same score across a wide range of actual detailed scores (e.g., everything from 2.50 to 3.49 became a "3"), which under-differentiated the applicants. The rounding also over-differentiated applicants – e.g. awarding a "3" for a plan at 3.4 and a "4" for a plan at 3.6 – with these differentials then being multiplied by a weighting factor of 2 or 4 (depending on the question) and thus much further distorting the modest true difference between these health plans. Our team indicated that while there was subjectivity around where to place a health plan's score at the first decimal point, they felt much better able to differentiate the plans fairly at that more precise level than had they been required to always arrive at a rounded whole number score.

29. The analyses clearly suggest that HSD's scoring may have been significantly inaccurate (not just imprecise) in several instances. Within the questions reviewed by the Menges reviewers, there were 7 situations in which all three
Menges reviewers awarded a score one full point (on the 0-5 scale, before weightings were applied) or more away from the consensus HSD score awarded for that applicant and question. In another 16 situations, all three of the Menges reviewers awarded a score half a point or more away from the consensus HSD score.

30. I point out these issues not to suggest that our review team’s judgement was superior to HSD’s team, but rather to demonstrate the inherent difficulties the questions and scoring model forced upon any review team. The scoring allowed HSD to make a reasonable general determination as to which technical proposals were most advantageous, but the scoring structure worked against (rather than in favor of) fostering precise differentiation.

Summary

31. Taking all of these concerns collectively, I and The Menges Group feel it is in HSD’s best interests to include United Healthcare as an additional awardee. Doing so exercises HSD’s latitude to create a strong competitive field of Centennial Care 2.0 health plans and addresses the scoring concerns that have been identified.

32. I propose and support this suggested remedy regardless of whether the United Healthcare reference from Rhode Island is scored. The Menges Group expects that United Healthcare would move into second place in the overall rankings if this reference is scored. While inclusion of the Rhode Island reference would

6442690v1/28076-0003
significantly alter MCO ranking within the 2nd and 5th spots, it will not change the fact that the scoring is closely bunched among all four of these health plans. For the many reasons articulated in this Declaration, I and The Menges Group feel it is in New Mexico’s best interest to contract with United HealthCare.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on this 5TH day of February, 2018.

Signature:  

Printed Name:  Joel J. Menges
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
Scoring

Evaluation and scoring was conducted as outlined in the RFP:

<table>
<thead>
<tr>
<th>Section</th>
<th>Points Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical Proposal - 12 sections, 94</td>
<td>1,390</td>
</tr>
<tr>
<td>questions/responses</td>
<td></td>
</tr>
<tr>
<td>References – 3 per Offeror</td>
<td>300</td>
</tr>
<tr>
<td>Cost Proposal</td>
<td>400</td>
</tr>
<tr>
<td>Total</td>
<td>2,090</td>
</tr>
</tbody>
</table>

The Technical Proposals were evaluated and scored on the quality of responses as determined by the SMEs during consensus scoring.

Offerors were required to provide three professional references using the form provided in the RFP (Appendix F). The reference forms were submitted directly to HSD by the referencing organization, independent of the Offerors. References were evaluated and scored on the quality of responses as determined by the SMEs during consensus scoring.

Cost Proposals were assigned points on a formula basis as outlined in the RFP, based on rates proposed within the ranges provided by HSD.

The results of the proposal evaluation and scoring process are summarized in the Scoring Results Summary (attached). General notes on the submissions of every Offeror are included in that Summary report. Additionally, extensive detailed notes on all aspects of scoring -- including consensus comments on every response -- can be found in the full Scoring Summary Report with attachments (not attached here, but available as needed).

The Scoring Results Summary was presented to the Committee for their review and consideration on December 18, 2017. Notes on the meeting of that Committee are attached.

Recommendation

The Committee thoroughly reviewed the scoring results and accepted them without reservations. Based on their review and evaluation of the scoring results, the Executive Evaluation Committee unanimously recommends awarding contracts for Medicaid managed care services under Centennial Care 2.0 to three (3) Offerors:

- Presbyterian Health Plan Inc., with the highest total score of 1,771 points.
- Western Sky Community Care, with the second-highest total score of 1,560 points.
- Blue Cross Blue Shield of New Mexico, with the third-highest total score of 1,544 points.

All scoring factors were considered, with these three (3) recommended Offerors scoring very high in each of the three scoring sections (Technical, References, and Cost).
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
5.9 List of References

The Offeror must submit a list of the References. The Offeror must provide three (3) specific client References, with at least one for a state Medicaid program or other large similar government or large private industry project within the last five (5) years. Each Reference noted on the list must include the contact name and phone number, a brief description of the services provided, and the period of service. Offerors may NOT request References from the New Mexico Medicaid agency, nor list the NM Medicaid agency as a Reference.

References for the Offeror shall be submitted to the Procurement Manager directly by the reference source using the Reference Form in RFP Appendix F. The submission deadline for References is on the date stated in Section 2.1 Procurement Schedule (Nov. 2, 2017).

Offerors are responsible for:

• Making a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix F, and adding the following customized information to the form:
  • Offeror's name;
  • Reference organization's name; and
  • Reference contact's name, title, telephone number, and email address.
  • Sending the form to each Reference contact.
  • Giving the contact a deadline that allows for HSD to receive the reference form prior to the deadline for receiving proposals (Nov. 2, 2017; see Section 2.1).

UnitedHealthcare of New Mexico, Inc. has complied with this request. We have requested the following organizations supply the provided form:

<table>
<thead>
<tr>
<th>Mississippi</th>
<th>Division of Medicaid (DOM)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>1. Name of Contracting Entity</th>
<th>Division of Medicaid (DOM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This state-funded program provides statewide health care coverage throughout Mississippi for the most vulnerable ABD and TANF members of the Medicaid population. Introducing managed care to the state, it features full Medicaid benefits and enhanced benefits beyond Medicaid FFS. These enhancements support a medical home model that connects members with a PCP and case managers to ensure members receive the best and most appropriate level care, as and when needed. State-funded program for ABD and TANF beneficiaries.</td>
<td></td>
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<table>
<thead>
<tr>
<th>2. Brief Description of Scope of Work of Relevant Experience</th>
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<tbody>
<tr>
<td>Origination: 2011 Current Contract: July 1, 2014 – June 30, 2017; plus one potential additional year</td>
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</table>

<table>
<thead>
<tr>
<th>3. Duration of Contract</th>
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</thead>
<tbody>
<tr>
<td>Name: Dr. David Dzielak</td>
</tr>
<tr>
<td>Email Address: <a href="mailto:david.dzielak@ms.gov">david.dzielak@ms.gov</a></td>
</tr>
<tr>
<td>Phone Number: (601) 359-9562</td>
</tr>
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</table>

MCO Contractors for Centennial Care 2.0 | State of New Mexico Human Services Department
RFP #18-630-8000-0001 | Mandatory – Page 173
### Rhode Island

<table>
<thead>
<tr>
<th>1. Name of Contracting Entity</th>
<th>Executive Office of Health and Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Brief Description of Scope of Work of Relevant Experience</td>
<td>This is a state-funded program that provides health care coverage throughout Rhode Island for CHIP, CSHCN and TANF beneficiaries. It covers comprehensive member care for all Rhode Island Medicaid populations; medical and behavioral health, and pharmacy services are offered. Rite Care Medicaid child members born after May 2000 are offered dental services, which is a separate contract. State-funded program for CHIP, CSHCN and TANF beneficiaries. Available in all counties.</td>
</tr>
<tr>
<td>4. Contact Name, Email Address and Phone Number</td>
<td>Name: Patrick M. Tigue – Medicaid Program Director Email Address: <a href="mailto:Patrick.Tigue@ohhs.ri.gov">Patrick.Tigue@ohhs.ri.gov</a> Phone Number: (401) 462-1965</td>
</tr>
</tbody>
</table>

### Michigan

<table>
<thead>
<tr>
<th>1. Name of Contracting Entity</th>
<th>Michigan Department of Health and Human Services – Medical Services Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Brief Description of Scope of Work of Relevant Experience</td>
<td>This state-funded program provides comprehensive health care coverage throughout Michigan for ABD, CHIP Children’s Special Health Care Services (CSHCS), expansion and TANF beneficiaries. Services are those covered by Medicaid and other expanded services, emergency and urgent care, home health, hospice, inpatient hospital care, outpatient health care, podiatry, skilled nursing facilities, chiropractic services, outpatient health care, supplies — DME, prosthetic devices, diagnostics, diabetes — self-monitoring and training, and preventive care (e.g., screenings and blood tests). Medical appointment transportation is provided for an unlimited number of trips. Members receive an enhanced vision benefit. State-funded program for ABD, CHIP CSHCS, Expansion and TANF beneficiaries. Available in 65 counties.</td>
</tr>
<tr>
<td>4. Contact Name, Email Address and Phone Number</td>
<td>Name: Kathleen Stiffler – Director of Medicaid Email Address: <a href="mailto:stifflerk@mi.gov">stifflerk@mi.gov</a> Phone Number: (517) 241-8055</td>
</tr>
</tbody>
</table>
From: Cooper, Patrice E  
Sent: Friday, October 20, 2017 6:54 PM  
To: Tigue, Patrick (OHHS)  
Subject: RE: Reference

Patrick,

Thanks very much! The New Mexico reference form is attached.

Much appreciation,

Patrice

Patrice E. Cooper, CEO  
UnitedHealthcare Community Plan, Rhode Island | 475 Kilvert Street, Warwick, RI 02886  
a: 401.732.7439 | m: 617.877.2952 | pcooper@uhc.com

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- Integrity  - Compassion  - Relationships  - Innovation  - Performance

Please consider the environment before printing

---

From: Tigue, Patrick (OHHS) [mailto:Patrick.Tigue@ohhs.ri.gov]  
Sent: Friday, October 20, 2017 3:47 PM  
To: Cooper, Patrice E  
Subject: RE: [EXTERNAL] : Reference

Hi Patrice,

Happy to do it. Thanks.

Best,

Patrick

Patrick M. Tigue  
Medicaid Program Director  
State of Rhode Island Executive Office of Health and Human Services  
Hazard Building  
74 West Road  
Cranston, RI 02920  
(401) 462-1965  
Patrick.Tigue@ohhs.ri.gov

---

From: Cooper, Patrice E [mailto:pcooper@uhc.com]  
Sent: Friday, October 20, 2017 2:52 PM
To: Tigue, Patrick (OHHS) <Patrick.Tigue@ohhs.ri.gov>
Subject: [EXTERNAL]: Reference

HI Patrick,

Hope you are well. I know you are out of the office - hopefully on vacation. I wanted to ask if you would be willing to provide UnitedHealthcare with a reference. UnitedHealthcare is submitting our response to the New Mexico Medicaid RFP and as part of the process they have asked us to include references from other states. The request is short and is confidential - you would return the request directly to the State of New Mexico Human Services Department. The reference is time sensitive and needs to be submitted by 5PM November 2nd. Please let me know if you would be willing to complete the reference and I will email it to you.

Thank you,
Patrice

Patrice E. Cooper, CEO
UnitedHealthcare Community Plan, Rhode Island | 475 Kilvert Street, Warwick, RI 02886
o: 401.732.7439 | m: 617.877.2952 | pcooper@uhc.com

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DECLARATION OF CHARLES MILLIGAN, JR.

I, Charles Milligan, Jr., declare as follows:

1. I am the Chief Executive Officer of UnitedHealthcare Community Plan of New Mexico, Inc. (UHC). I have served in that capacity since April of 2015.

2. I am proud of the managed healthcare services UHC has provided to New Mexico’s Medicaid program and on behalf of UHC wish to express my appreciation for the relationship between UHC and the New Mexico Human Services Department (HSD). However, after careful consideration of HSD’s decision concerning the Centennial Care 2.0 procurement, UHC has concluded that there were fundamental errors with the procurement process. Had these errors not occurred, UHC should have been awarded a contract for Centennial Care 2.0.

3. On behalf of UHC, I have reviewed the bid protest letter to which this Declaration is attached and I approve and affirm the substance and content of the bid protest letter.

4. One of the references provided by UHC in response to Section 5.9 of UHC’s Mandatory Proposal was Patrick M. Tigue, the Medicaid Program Director at the Rhode Island Executive Office of Health and Human Services. Mr. Tigue’s contact information was provided because UHC has been providing Medicaid and other health services continuously in Rhode Island since 1994,
which makes Rhode Island an excellent reference point for the quality of UHC services.

5. When Mr. Tigue was contacted about providing a reference for UHC’s Centennial Care 2.0 proposal, Mr. Tigue enthusiastically agreed to provide a reference for UHC via email. See Exhibit 7 to the Bid Protest Letter.

6. I was surprised to learn to after HSD made its award decision that the Rhode Island reference had not been received because I am the listed contact person for UHC’s Centennial Care 2.0 proposal and no one from HSD ever contacted me prior to the deadline to inform me that one of our listed references had yet to return a completed reference form to HSD. Had HSD contacted me about the missing reference prior to the deadline, I would have immediately contacted Rhode Island and reminded them to submit a reference.

7. It was my understanding and expectation that the purpose of having a designated contact was so that HSD could reach out to UHC to inform us of clerical errors and omissions that could be easily remedied before the RFP deadline. In fact, Mr. Daniel Clavio, the procurement officer, sent several emails to me along the way regarding the status of the procurement. See Exhibit A, attached hereto.

8. I have subsequently learned that Mr. Tigue believed the reference had been submitted to HSD on time, as he had delegated the task of completing and sending the reference to the person charged with oversight of UHC’s Rhode Island Medicaid managed care contracts (a role comparable to HSD’s
Contracts Bureau Chief). However, I understand that despite being provided Mr. Tigue's contact information, HSD made no effort to contact Mr. Tigue to inquire about the missing reference, or inform him that one was not received.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on this 5th day of February, 2018.

Signature: [Signature]

Printed Name: Charles Milligan, Jr.
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@ohhs.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
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@ohhs.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
From: RFP, CentennialCare, HSD <CentennialCare.RFP@state.nm.us>
Date: Friday, Feb 02, 2018, 2:39 PM
To: Milligan Jr, Charles J <charles.milligan@uhc.com>
Cc: Collins, Christopher, HSD <Christopher.Collins@state.nm.us>, Chavez, Gary, HSD <GaryO.Chavez@state.nm.us>
Subject: RE: RFP #18-630-8000-0001

Mr. Milligan - Thank you for your note. At this time, HSD declines your specific request. The proper place to address your concern is in any protest you may file with the agency.

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

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: Milligan Jr, Charles J [mailto:charles.milligan@uhc.com]
Sent: Thursday, February 01, 2018 6:14 PM
To: RFP, CentennialCare, HSD
Subject: RFP #18-630-8000-0001

Daniel:

It is my understanding that you will be receiving a letter very soon from the Rhode Island Executive Office of Health and Human Services (RIEOHHS) Medicaid Program Director Patrick Tigue, together with the reference that UHC previously notified you in Section 5.9 of our Technical Proposal that would be submitted in support of UHCNM’s responsive Proposal to RFP #18-630-8000-001. I am aware that this letter was sent, but I want to make it clear that United and our employees and agents have not seen the contents of that reference.

I am respectfully requesting that you give careful consideration to Mr. Tigue’s explanation regarding the Rhode Island Medicaid agency’s failure to submit the reference on or before November 2, 2017, as well as his explanation regarding the fact this only recently came to light, and score the reference. This request is not submitted in lieu of a protest to the
results of the RFP, but rather as a request that the Evaluation Committee exercise its discretion under Section 2.3.18 to waive irregularities in the procurement.

Thank you-

Chuck

Chuck Milligan, CEO

Chuck Milligan | UHC Community Plan of NM | 505 440 4146 | charles.milligan@uhc.com
Cell: 443.474.5282

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From: RFP, CentennialCare, HSD
To: "Tierno, Matthew J (HEALTH)"
Subject: RE: Wellcare of NY Recommendation Letter-RFP#18-630-8000-0001
Date: Tuesday, October 24, 2017 4:47:00 PM
Importance: High

Please submit a completed Reference Form as provided, as they will be scored from that form and not from a letter.

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

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: Tierno, Matthew J (HEALTH) [mailto:Matthew.Tierno@health.ny.gov]
Sent: Monday, October 23, 2017 9:31 AM
To: RFP, CentennialCare, HSD
Cc: Bick, Jonathan P (HEALTH); Bentley, Susan R (HEALTH); Schips, Maureen (HEALTH)
Subject: Wellcare of NY Recommendation Letter-RFP#18-630-8000-0001

Good Morning Mr. Clavio,

On behalf of the New York State Department of Health, please see the attached recommendation letter submitted on behalf of Wellcare of New York, Inc.

This correspondence is being sent only in an electronic format. If you require a hard copy, please respond accordingly and one will be mailed to your attention.

Please let me know if you have any additional questions.

Thanks,

Matt

Matthew J. Tierno, MPH
Health Program Administrator III

New York State Department of Health
Bureau of Managed Care Certification and Surveillance
Division of Health Plan Contracting and Oversight
Corning Tower
OCP-Room # 1609
Albany, NY 12237
518-474-5515
matthew.tierno@health.ny.gov
A reference letter in support of this Offeror will not be accepted in lieu of the form; our Reference Form (Appendix F) must be submitted. If you are not able to submit that form as a reference, you should notify Wellcare immediately, as the deadline is November 2.

Thank you.

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

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/

Good Morning Mr. Clavio,

On behalf of the New York State Department of Health, please see the attached recommendation letter submitted on behalf of Wellcare of New York, Inc.

This correspondence is being sent only in an electronic format. If you require a hard copy, please respond accordingly and one will be mailed to your attention.

Please let me know if you have any additional questions.

Thanks,

Matt
Matthew J. Tierno, MPH
Health Program Administrator III

New York State Department of Health
Bureau of Managed Care Certification and Surveillance
Division of Health Plan Contracting and Oversight
Corning Tower
OCP-Room # 1609
Albany, NY 12237
518-474-5515
matthew.tierno@health.ny.gov
Received in full. Thank you.

--------------------------------

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: Jen Steele [mailto:Jen.Steele@LA.GOV]
Sent: Friday, October 27, 2017 8:22 AM
To: RFP, CentennialCare, HSD
Subject: RE: Reference form

Several pages are missing. Try again.

--------------------------------

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: Jen Steele [mailto:Jen.Steele@LA.GOV]
Sent: Tuesday, October 24, 2017 3:29 PM
To: RFP, CentennialCare, HSD
Cc: MCOCommunications
Subject: Reference form

To Whom It May Concern,

Please find attached Louisiana’s reference for Anthem relative to New Mexico’s Centennial Care 2.0 RFP. Should you have questions, my contact information is below.

Jen Steele, MPA
Medicaid Director
Louisiana Department of Health
jsteele@la.gov | (337) 354-5750
Dear Mr. Clavio:
I’m checking on this. We will respond by the 11/2/17 deadline. Thank you.

Regards,
Mary

Mary F. Cobb, Contract Manager
Central Operations Unit
Managed Care Operations Division
1501 Capitol Avenue, MS 4409
P.O. Box 997413, Sacramento, CA 95899-7413

From: RFP, CentennialCare, HSD [mailto:CentennialCare.RFP@state.nm.us]
Sent: Thursday, October 19, 2017 1:19 PM
To: Cobb, Mary (MCOD)@DHCS <Mary.Cobb@dhcs.ca.gov>
Subject: RE: RFP # 18-630-8000-0001 Appendix F

We don’t have an Offeror named “Health Net Community Solutions Inc. (Health Net)”. Perhaps the name of their parent company is different (?). At this point I don’t know what to do with this letter, and someone may come up short. Please let me know, and revise accordingly.

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

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/
To: RFP, CentennialCare, HSD
Cc: Conde, Stephanie (MCOD); Retke, Michelle (MCOD)@DHCS; Portela, Javier (MCOD)@DHCS
Subject: RFP # 18-630-8000-0001 Appendix F

Dear Mr. Clavio:

RE: RFP # 18-630-8000-0001

Please find attached the Appendix F Reference Form completed by the State of California, Department of Health Care Services as a reference for Health Net Community Solutions, Inc. (Health Net).

Sincerely,

Mary F. Cobb, Contract Manager
Central Operations Unit
Managed Care Operations Division
1501 Capitol Avenue, MS 4409
P.O. Box 997413, Sacramento, CA 95899-7413
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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11. Attachment 1 – Technical Proposal Consensus Score Sheets

12. Attachment 2 – References Consensus Score Sheets

13. Attachment 3 – Cost Proposal Score Sheet
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>AH</th>
<th>BCBS</th>
<th>MHC</th>
<th>PHP</th>
<th>LHC</th>
<th>WC</th>
<th>NS</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Experience &amp; Qualifications</td>
<td>114</td>
<td>110</td>
<td>120</td>
<td>116</td>
<td>126</td>
<td>120</td>
<td>120</td>
<td>110</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>
</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>84</td>
<td>76</td>
<td>124</td>
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<tr>
<td>6.4 Care Coordination</td>
<td>168</td>
<td>164</td>
<td>180</td>
<td>172</td>
<td>224</td>
<td>204</td>
<td>204</td>
<td>196</td>
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<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>
</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>
</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>
</tr>
<tr>
<td>6.8 Member &amp; Provider Services</td>
<td>54</td>
<td>54</td>
<td>52</td>
<td>54</td>
<td>58</td>
<td>52</td>
<td>48</td>
<td>46</td>
</tr>
<tr>
<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>
</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>
</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>
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<td>6.12 Value Based Purchasing</td>
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<td>48</td>
<td>64</td>
<td>48</td>
<td>32</td>
<td>60</td>
</tr>
<tr>
<td>Total</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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## Scoring Methodology

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>The response is excellent. All elements of the question were addressed, the approach is highly desirable to the State, and the response included sufficient detail.</td>
<td>100%</td>
</tr>
<tr>
<td>4</td>
<td>The response is good. All elements of the question were addressed, and the approach is desirable to the State; however, the response was lacking detail.</td>
<td>80%</td>
</tr>
<tr>
<td>3</td>
<td>The response is acceptable. Nearly all of the elements of the question were addressed, and the approach is acceptable to the State; however, some additional detail was needed to fully evaluate the approach.</td>
<td>60%</td>
</tr>
<tr>
<td>2</td>
<td>The response is minimally acceptable. Most elements of the question were addressed; however more detail was needed to fully evaluate the approach and/or the State did not find the approach desirable.</td>
<td>40%</td>
</tr>
<tr>
<td>1</td>
<td>The response is poor. Only some elements of the question were addressed and it lacked sufficient detail to evaluate the approach and/or the State did not find the approach desirable.</td>
<td>20%</td>
</tr>
<tr>
<td>0</td>
<td>The response is unacceptable. It fails to meet the requirements or has major deficiencies OR no response was provided.</td>
<td>0%</td>
</tr>
</tbody>
</table>
The State will open, review and score all references submitted to support each proposal. If more than three (3) references are submitted for an Offeror, the top three (3) scores will be used to determine the total points awarded for references.

<table>
<thead>
<tr>
<th>Offeror Name</th>
<th>Western Sky California Dept. HealthCare Services</th>
<th>Committee Name</th>
<th>Executive Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation Area</td>
<td>References</td>
<td>RFP Section(s)</td>
<td>2.1, 3.3.2, 4.3.4, Appendix F</td>
</tr>
<tr>
<td>Reference Number</td>
<td>1</td>
<td>Contract Section(s)</td>
<td>N/A</td>
</tr>
<tr>
<td>Maximum # of Pages for Section</td>
<td>NA</td>
<td>Exhibits Allowed?</td>
<td>NA</td>
</tr>
<tr>
<td>Reference Total Score (0-100)</td>
<td>100</td>
<td>Proposal Page(s) Reviewed</td>
<td>NA</td>
</tr>
</tbody>
</table>

1. Not Scored

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 ______

   b. Expertise in managing health care programs ______

   c. Operational capacity ______

   **Scale**

   | Use reference scores. Total available – 15 points
   | Score

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. ______
b. Responsiveness to the Contracting entity. ____

c. Developing adequate Provider Networks. ____

<table>
<thead>
<tr>
<th>Scale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use reference scores. Total available – 15 points</td>
<td></td>
</tr>
</tbody>
</table>

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. ____

b. Emphasizing quality and positive outcomes over quantity. ____

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

<table>
<thead>
<tr>
<th>Scale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use reference scores. Total available – 15 points</td>
<td></td>
</tr>
</tbody>
</table>

5. How would you rate the dynamics/interaction between:  
(5 = Excellent; 3 = Satisfactory; 1 = Unsatisfactory; 0 = Unacceptable)

a. The Contractor and your staff. _____

b. The Contractor and insured Members / Beneficiaries. _____

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

<table>
<thead>
<tr>
<th>Scale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use reference scores. Total available – 15 points</td>
<td></td>
</tr>
</tbody>
</table>
6. What are the Contractor's strengths, and which aspect(s) of this Contractor's services are you most satisfied?

<table>
<thead>
<tr>
<th>Scale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total available (Parts A and B) – 10 points</td>
<td></td>
</tr>
<tr>
<td><strong>Part A</strong>&lt;br&gt;Are strengths noted in the response?&lt;br&gt;“yes/info provided” = 5 points&lt;br&gt;“blank/no response” = 1 point</td>
<td></td>
</tr>
<tr>
<td><strong>Part B</strong>&lt;br&gt;Do the strengths noted match those desired/needed in New Mexico?&lt;br&gt;“yes” = 5 points&lt;br&gt;“no/blank/no response” = 1 point</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Scale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total available (Parts A and B) – 10 points</td>
<td></td>
</tr>
<tr>
<td><strong>Part A</strong>&lt;br&gt;Are weaknesses noted in the response?&lt;br&gt;“yes/info provided” = 5 points&lt;br&gt;“blank/no response” = 1 point</td>
<td></td>
</tr>
<tr>
<td><strong>Part B</strong>&lt;br&gt;Are the weaknesses easily overcome through oversight or contract language?&lt;br&gt;“yes” = 5 points&lt;br&gt;“no/blank/no response” = 1 point</td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;yes&quot; = 20 points</td>
<td></td>
</tr>
<tr>
<td>&quot;no&quot; = 0 point</td>
<td></td>
</tr>
<tr>
<td>Total available – 20 points</td>
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</table>

9. Not scored
Mercer will enter score and comments for follow-up upon contracting.

Score Table:

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>Follow-up</th>
</tr>
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<td>2b</td>
<td>5</td>
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<td>2c</td>
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<td></td>
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<tr>
<td>3a</td>
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<td></td>
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<td>3b</td>
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<td>3c</td>
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<tr>
<td>Total</td>
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</table>
## Centennial Care RFP
### Consensus Score Sheet

<table>
<thead>
<tr>
<th>Evaluation Area</th>
<th>Provider Network/Provider Agreements</th>
<th>RFP Section(s)</th>
<th>6.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question Number</td>
<td>15</td>
<td>Contract Section(s)</td>
<td>4.8; 4.9</td>
</tr>
<tr>
<td>Maximum # of Pages for Section</td>
<td>20</td>
<td>Exhibits Allowed?</td>
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</tr>
<tr>
<td>Question Score (0 - 5)</td>
<td>2</td>
<td>Proposal Page(s) Reviewed</td>
<td>26-30</td>
</tr>
</tbody>
</table>

### RFP Question

Describe your organization's strategies for dealing with the challenges of building a provider network for rural and frontier parts of New Mexico, including contracting with Indian Health Services, Tribally Operated Facility or Programs, and Urban Indian Clinics (I/T/Us) and critical access providers such as Federally Qualified Health Centers (FQHCs), Nursing Facilities (NFs) and Non-Emergency Medical Transportation (NEMT) providers, including retention and recruitment efforts for primary care and specialists in these areas.

### Response Consideration(s)

- a) Does the response address all relevant sections of the contract?
- b) Does the response fully address all aspects of the question?
- c) Does the response demonstrate previous experience in contracting with I/T/Us and critical access providers?
- d) Does the response indicate how the Offeror will use training and technology to retain I/T/Us and critical access providers?
- e) Does the response demonstrate an understanding of challenges that the Offeror is likely to encounter in recruiting and retaining I/T/Us and critical access providers and provide reasonable ways to overcome such challenges?
- f) Does the response adequately demonstrate knowledge about the special payment considerations with regard to I/T/Us, FQHCs, and RHCs?
- g) Does the response indicate whether the Offeror will utilize the Native American Advisory Board for assistance/guidance in recruiting and retaining efforts?
- h) Does the Offeror ensure discrimination will not occur against providers that serve high-risk populations or specialize in conditions that require costly treatment?
- i) Does the Offeror’s response demonstrate innovative approaches to providing access to transportation services in rural and frontier areas?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
<th>Superior Elements</th>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The response was minimally acceptable and did not address most elements of the question.</td>
<td></td>
<td>• Very general and non-specific response. MCO discussed the problem but provided no solutions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Exceptionally poor response regarding NEMT. No discussion of the challenges in NM and how this relates to poor member outcomes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Some but not all provider associations referenced for partnering. For example, the BH Association was not discussed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Only named one FQHC.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• MCO did not address the Native American Advisory Board.</td>
</tr>
<tr>
<td>Offeror Name</td>
<td>AmeriHealth</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------------------</td>
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<tr>
<td>Evaluation Area</td>
<td>Provider Network/Provider</td>
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<td>Agreements</td>
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<td>Question Score (0–5)</td>
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<tr>
<td></td>
<td>Exhibits Allowed?</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>Proposal Page(s) Reviewed</td>
<td>30-33</td>
</tr>
</tbody>
</table>

**RFP Question**

Describe your organizations’ strategies for monitoring and addressing contract provider issues including monitoring:

a) Compliance with access standards and improving access as needed;

b) Provider network adequacy including developing services and providers where they are needed;

c) Provider compliance with cost-sharing requirements; and

d) Provider compliance with HSD Rules and the New Mexico Administrative Code (NMAC).

**Response Consideration(s)**

a) Does the response address all relevant sections of the contract?

b) Does the response fully address all aspects of the question?

c) Does the response describe a methodology to review network adequacy on an ongoing basis?

d) Does the response demonstrate an understanding of the access (ratio, distance and appointment standards) requirements in Centennial Care?

e) Does the response describe how the Offeror will monitor contract providers regularly to determine compliance and take corrective action if necessary?

f) Does the response describe the approach the Offeror will take to educate PCPs about special populations and associated service needs?

g) Does the response describe how the Offeror will ensure primary care provider responsibilities are met?

h) Does the response ensure procedures governing the process of member PCP selection and request for change(s)?

i) Does the response ensure HCBS provider compliance with 42 CFR 441.301(c)(4)?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>The response was minimally acceptable and did not address most elements of the question.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Superior Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very general and vague response – no details.</td>
</tr>
<tr>
<td>Lack of understanding about how the program operates.</td>
</tr>
<tr>
<td>Referenced LODs but did not seem to understand the use of supplements.</td>
</tr>
<tr>
<td>MCO does not seem to understand the purpose of ECHO Hub.</td>
</tr>
<tr>
<td>No detail about auditing and monitoring providers to ensure ongoing compliance with all applicable requirements.</td>
</tr>
<tr>
<td>MCO does not appear to understand the current cost sharing requirements.</td>
</tr>
</tbody>
</table>
## Centennial Care RFP
### Consensus Score Sheet

<table>
<thead>
<tr>
<th>Offeror Name</th>
<th>AmeriHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation Area</td>
<td>Provider Network/Provider Agreements</td>
</tr>
<tr>
<td>RFP Section(s)</td>
<td>6.2</td>
</tr>
<tr>
<td>Question Number</td>
<td>17</td>
</tr>
<tr>
<td>Contract Section(s)</td>
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<td>Exhibits Allowed?</td>
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<tr>
<td>Question Score (0 - 3)</td>
<td>2</td>
</tr>
<tr>
<td>Projected Page(s) Reviewed</td>
<td>33-36</td>
</tr>
</tbody>
</table>

### RFP Question
Describe your organization's experience with enhancing the behavioral healthcare workforce within a state, and efforts or plans to do so in New Mexico.

### Response Consideration(s)

- a) Does the response address all relevant sections of the contract?
- b) Does the response fully address all aspects of the question?
- c) Does the response describe the Offeror's experience in New Mexico or other States?
- d) Does the Offeror identify specific geographic regions or certain behavioral health provider types that would be a focal point when developing the network?
- e) Does the Offeror describe challenges that will be present when enhancing the behavioral health workforce within the State?
- f) Does the response include exploring opportunities to collaborate with other health plans?
- g) Does the Offeror's response seem appropriate to address the challenges in the New Mexico system of care?
- h) Does the Offeror provide innovative approaches to addressing behavioral healthcare workforce issues?
### Centennial Care RFP
#### Consensus Score Sheet

<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
<th>Superior Elements</th>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The response was minimally acceptable and did not address most elements of the question.</td>
<td></td>
<td>• Missed the mark on the question; lacks demonstrated understanding of the current system or problems in NM around BH workforce issues.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No follow through on ideas or concepts.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Poor on description of BH expansion.</td>
</tr>
</tbody>
</table>
**Centennial Care RFP**

**Consensus Score Sheet**

<table>
<thead>
<tr>
<th>Offeror Name</th>
<th>AmeriHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation Area</td>
<td>Benefits &amp; Services</td>
</tr>
<tr>
<td>Question Number</td>
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<td>RFP Section(s)</td>
<td>6.3</td>
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<td>Contract Section(s)</td>
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<td>Question Score (0-5)</td>
<td>2</td>
</tr>
<tr>
<td>Proposal Page(s) Reviewed</td>
<td>41-45</td>
</tr>
</tbody>
</table>

**RFP Question**

Describe your organization’s process for monitoring prescribing practices of providers, as it relates to prescription drugs. At a minimum, the response should include how the Offeror will:

a) Identify providers who prescribe contra-indicated drugs, and how the Offeror will address this practice;

b) Ensure that prescribers participate in the New Mexico Prescription Monitoring Program;

c) Ensure that medications provided to children/adolescents are appropriate to the diagnosis, symptoms, and age of the child/adolescent;

d) Manage over and underutilization of pharmaceuticals; and

e) Monitor drug utilization for members.

**Response Consideration(s)**

a) Does the response address all relevant sections of the contract?
b) Does the response fully address all aspects of the question?
c) Does the response address cultural considerations including where members may use alternative remedies and how such remedies may interact with prescriptions?
d) Does the response include references to how the care coordination team will be utilized in monitoring prescription use and prescribing practices?
e) Does the response include details on how the Offeror will train providers regarding prescribing practices and identification of drug seeking behavior?
f) Does the response indicate how the Offeror will use data sources to systematically identify contra-indicated drug prescriptions or drug seeking behavior?
g) Does the response indicate the ways the Offeror will determine when medications are inappropriately prescribed to children/adolescents and the measures the Offeror will take to influence the prescribing practices?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
<th>Superior Elements</th>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The response was minimally acceptable and did not address most elements of the question.</td>
<td></td>
<td>- Response very disorganized, limited details provided on approaches as well as targeted populations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Response very weak on PMP, focused on provider education on PMP.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Referenced care gap reports but no examples provided and no indication of populations targeted.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Approaches for children prescribing patterns limited to asthma and ADHD but limited to these conditions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Response did not address care coordination.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Response did not address how providers with problematic prescribing practices were identified.</td>
</tr>
</tbody>
</table>
## Centennial Care RFP
### Consensus Score Sheet

<table>
<thead>
<tr>
<th>Offeror Name</th>
<th>AmeriHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation Area</td>
<td>Benefits &amp; Services</td>
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<td>Proposal Page(s) Reviewed</td>
<td>43-45</td>
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</tbody>
</table>

### RFP Question
Describe the role of your organization’s pharmacy benefit manager (PBM) in the utilization management for specialty medications (rheumatologic, immunologic, oncologic, etc.) and opioids.

### Response Consideration(s)

a) Does the response address all relevant sections of the contract?
b) Does the response fully address all aspects of the question?
c) Does the response present a strategy to adequately manage specialty medications and prevent inappropriate utilization of opioids?
d) Does the response present a strong oversight role on the part of the Offeror regarding the performance of the PBM?
e) Does the response demonstrate timely collection and use of data to drive decision making?
### Elements of the Response that Met RFP/Contract Requirements
- The response was minimally acceptable and did not address most elements of the question.

### Superior Elements
- Referenced project ECHO.

### Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response
- Lacking details on specifics of approach in order to evaluate effectiveness for New Mexico, for example:
  - No mention of how companies are managed.
  - No mention of prospective review strategies.
  - No mention of DUR board.
  - No reference to data collection.
  - No reference to how oversight of PBM will occur.
- Specialty drug program – referenced but no details on what it entails and how it will be implemented.
- Care coordinators are used as advocates which did not appear not consistent with Centennial Care.
Centennial Care RFP  
Consensus Score Sheet

<table>
<thead>
<tr>
<th>Offeror Name</th>
<th>AmeriHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation Area</td>
<td>Benefits &amp; Services</td>
</tr>
<tr>
<td>Question Number</td>
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<tr>
<td>Contract Section(s)</td>
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<td>Proposal Page(s)</td>
<td>45-49</td>
</tr>
<tr>
<td>RFP Question</td>
<td>2</td>
</tr>
</tbody>
</table>

RFP Question

Describe how your organization will provide and monitor transportation services provided to Members in Rural, Frontier, and Tribal areas of the State. At a minimum, the response should include how the Offeror will:

a) Ensure appropriate mode of transportation for a Member.

b) Ensure that your Non-emergency Medical Transportation (NEMT) quality assurance program adequately monitors and identifies issues and addresses identified issues in a timely manner.

c) Address pick-up and delivery deficiencies identified by Members.

d) Address member grievances/complaints regarding transportation issues.

e) Ensure that transportation providers provide internet and smart phone based systems for requesting and accessing transportation needs.

Response Consideration(s)

a) Does the response address all relevant sections of the contract?
b) Does the response fully address all aspects of the question?
c) Does the response include how the Offeror will use community resources and demonstrate an understanding of how transportation services are currently provided and utilized in New Mexico?
d) Does the response demonstrate an understanding of the unique geographic challenges in New Mexico and provide creative examples for how to overcome such challenges (e.g., utilizing telemedicine, having specialty providers travel to certain areas of the state, encouraging efficient and lower-cost transport alternatives that are available in urban areas)?
e) Does the response demonstrate an understanding of the unique needs of specialized populations regarding transportation (e.g., mobility limitations, communications barriers or need for an attendant)?
f) Does the response indicate whether and how the Offeror will utilize the care coordination team in determining a member's transportation needs?
g) Does the response provide clear, concise and convincing explanations of how the Offeror will monitor applicable driving standards and quality assurance?
h) Does the Offeror describe how it will: 1) monitor and track member issues and complaints, in a timely manner; 2) resolve identified issues and convey results to members; 3) use identified issues/complaints to make program improvements, both systemically and at the member level?
i) Does the Offeror describe how technology solutions will be used for Members to request and engage with transportation providers?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The response was minimally acceptable and did not address most elements of the question.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Superior Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Met with Navajo Nation to determine tribal member concerns.</td>
</tr>
<tr>
<td>• Noted vehicle inspections as part of the program.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• App is limited to drivers at this time and no commitment to developing app for use by members.</td>
</tr>
<tr>
<td>• Member profiles are not captured in the system.</td>
</tr>
<tr>
<td>• Offeror allows vendor to address complaints and grievances.</td>
</tr>
<tr>
<td>• Member must submit a formal grievance before the issue will be addressed.</td>
</tr>
<tr>
<td>• Collaborates with AAAs as a general approach but this is only relevant for the LTSS population.</td>
</tr>
<tr>
<td>• No commitment to addressing the need of members who have no shows. Reimburses providers for no shows but not a comparable approach for members.</td>
</tr>
<tr>
<td>Offeror Name</td>
</tr>
<tr>
<td>--------------------</td>
</tr>
<tr>
<td>Evaluation Area</td>
</tr>
<tr>
<td>RFP Section(s)</td>
</tr>
<tr>
<td>Question Number</td>
</tr>
<tr>
<td>Contract Section(s)</td>
</tr>
<tr>
<td>Maximum # of Pages for Section</td>
</tr>
<tr>
<td>Exhibits Allowed?</td>
</tr>
<tr>
<td>Proposal Page(s) Reviewed</td>
</tr>
</tbody>
</table>

**RFP Question**

A 72 year old female has been diagnosed with Chronic Obstructive Pulmonary Disease (COPD) and Hemiparesis to her right side. The Member was discharged from a local hospital and admitted to an inpatient facility for rehabilitation following a Cerebral Vascular Accident (CVA). The Member has completed her therapy and is ready to be discharged. Before her CVA the member was very self-reliant. She was able to drive and live alone in a two story, three bedroom home. Upon discharge the member will remain on continuous oxygen due to her COPD and will also use a walker to stabilize mobility. She is unable to drive due to her right sided hemiparesis.

Describe how your organization will initiate and manage care, including services, supports and treatment options to achieve the best outcomes for the Member.

**Response Consideration(s)**

a) Does the response address all relevant sections of the contract?

b) Does the response fully address all aspects of the question?

c) Does the response describe the role of the care coordinator, consistent with expectations under Centennial Care?

d) Does the response provide a person-centered approach to assessing need and service delivery where the member is asked and defines objectives, goals and outcomes?

e) Does the description address assessing the comprehensive needs of the Member, including but not limited to transportation assistance, home health, nursing services, medical equipment, environmental modifications and using the assessment results to develop the develop a care plan?

f) Does the response provide details regarding how the Member will be educated about the process, steps in the process, timeframes and available options?

g) Does the response indicate how it will assist the Member in all transitions of care, follow-up and monitoring following transitions to ensure successful outcomes?

h) Does the response address the measures that will be put in place to ensure adequate availability of and access to services and supports after the Member transitions home such as home health services, nursing services and transportation assistance?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The response was minimally acceptable and did not address most elements of the question.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Superior Elements</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Evaluation Team found the response very confusing in terms of the description of roles that were not clearly defined.</td>
</tr>
<tr>
<td>• Approach lacks necessary details such as:</td>
</tr>
<tr>
<td>o No reference to educating member on program and care coordination.</td>
</tr>
<tr>
<td>o Not clear how the Offeror is identifying goals.</td>
</tr>
<tr>
<td>o The description is not member centric, does not address individuals of the member’s choice such as family or friends.</td>
</tr>
<tr>
<td>o LOC assignment inappropriate.</td>
</tr>
<tr>
<td>o Behavioral health assessment not provided.</td>
</tr>
<tr>
<td>• Discharge planning team limited to Offeror staff.</td>
</tr>
<tr>
<td>• Approach relies heavily on neighbors to provide transportation instead of utilizing covered services.</td>
</tr>
</tbody>
</table>
**Centennial Care RFP**  
**Consensus Score Sheet**

<table>
<thead>
<tr>
<th>Offeror Name</th>
<th>AmeriHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation Area</td>
<td>Benefits &amp; Services</td>
</tr>
<tr>
<td>Question Number</td>
<td>25</td>
</tr>
<tr>
<td>RFP Section(s)</td>
<td>6.3</td>
</tr>
<tr>
<td>Contract Section(s)</td>
<td>4.4.10.3;4.5.4.3;4.8.10.3.1</td>
</tr>
<tr>
<td>Maximum # of Pages for Section</td>
<td>25</td>
</tr>
<tr>
<td>Exhibits Allowed?</td>
<td>N</td>
</tr>
<tr>
<td>Question Score: (0 – 5)</td>
<td>2</td>
</tr>
<tr>
<td>Proposal Page(s) Reviewed</td>
<td>53-55</td>
</tr>
</tbody>
</table>

**RFP Question**
The New Mexico Behavioral Health Collaborative has a vision of a statewide crisis response system that meets unique community and Member needs. Describe how your organization's crisis intervention services will be provided to Members in Urban, Rural, Frontier and Tribal areas of the State.

**Response Consideration(s)**

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Does the response address all relevant sections of the contract?</td>
</tr>
<tr>
<td>b</td>
<td>Does the response fully address all aspects of the question?</td>
</tr>
<tr>
<td>c</td>
<td>Does the response indicate creative and effective ways to utilize community resources in establishing a statewide crisis response system?</td>
</tr>
<tr>
<td>d</td>
<td>Does the response provide clear and concise examples of how crisis intervention services will be utilized to avoid hospitalization or incarceration?</td>
</tr>
<tr>
<td>e</td>
<td>Does the response identify effective early intervention and treatment strategies to prevent crisis situations?</td>
</tr>
<tr>
<td>f</td>
<td>Does the response indicate how it will use community health workers, care coordinators, tribal providers, and others in crisis prevention/crisis diversion activities?</td>
</tr>
<tr>
<td>Elements of the Response that Met RFP/Contract Requirements</td>
<td>Superior Elements</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>• The response was minimally acceptable and did not address most elements of the question.</td>
<td>• Will provide training to state law enforcement on crisis interventions and supports.</td>
</tr>
<tr>
<td>• Offeror noted that they will employ CHWs for crisis intervention.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Offeror Name</td>
<td>AmeriHealth</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Evaluation Area</td>
<td>Care Coordination, Transitions, Assessments and Care Plans</td>
</tr>
<tr>
<td>Question Number</td>
<td>31</td>
</tr>
<tr>
<td>Maximum # of Pages for Section</td>
<td>45</td>
</tr>
<tr>
<td>Question Score (0 - 5)</td>
<td>2</td>
</tr>
</tbody>
</table>

**RFP Question**

Describe strategies for reaching Members to engage in care coordination activities. Please address specifically members who are or have:

a) Homeless and/or transient;
b) Significant behavioral health issues (mental health and/or substance abuse);
c) Significant cognitive deficiencies and/or Individuals with Developmental Disabilities (IDD);
d) Living in Rural, Frontier, and Tribal areas;
e) In out-of-home placements (foster care, nursing home);
f) Not English speakers;
g) Difficult to contact;
h) Justice involved;
i) Native American;
j) Members residing in Nursing Facilities;
k) Members who have high Emergency Department utilization; and
l) Members who are resistant to participation in care coordination.

**Response Consideration(s)**

a) Does the response address all relevant sections of the contract?
b) Does the response fully address all aspects of the question and identified member populations?
c) Does the response take into account the specific geographical and cultural aspects of New Mexico?
d) Does the response demonstrate an understanding of and alignment with the State’s priorities including strength based (identifying member’s self-determination and strengths), member-centric care planning?
e) Does the response demonstrate knowledge of and plans to utilize and collaborate with local programs and providers currently serving affected members?
f) Does the response indicate plans to provide resources with specialized skills to working with members with cognitive and behavioral health needs?
g) Does the response demonstrate an approach to working in Tribal areas that is inclusive of Tribal resources?
h) Does the response include a variety of methods to engage hard to find or hard to engage members that extend beyond telephonic outreach?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Some elements of the question were addressed.</td>
</tr>
<tr>
<td>• Engaged the right partners and had good coverage for DD population.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Superior Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Indicated they will build at least one community wellness center in NM.</td>
</tr>
<tr>
<td>• Will not request/use a family member to translate.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To vague – not enough detail in the response. It is not clear “how” the MCO will achieve many of the elements of their response</td>
</tr>
<tr>
<td>• Did not mention a Native American care coordinator.</td>
</tr>
<tr>
<td>• No collaboration with tribes mentioned</td>
</tr>
<tr>
<td>• Not specific about languages prevalent in NM.</td>
</tr>
<tr>
<td>Offeror Name</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>Evaluation Area</td>
</tr>
<tr>
<td>Question Number</td>
</tr>
<tr>
<td>RFP Section(s)</td>
</tr>
<tr>
<td>Contract Section(s)</td>
</tr>
<tr>
<td>Maximum # of Pages for Section</td>
</tr>
<tr>
<td>Question Score (0 – 5)</td>
</tr>
<tr>
<td>Exhibits Allowed?</td>
</tr>
<tr>
<td>Proposal Page(s) Reviewed</td>
</tr>
</tbody>
</table>

**RFP Question**

Describe your organization's experience with enhancing the behavioral healthcare workforce within a state, and efforts or plans to do so in New Mexico.

**Response Consideration(s)**

a) Does the response address all relevant sections of the contract?
b) Does the response fully address all aspects of the question?
c) Does the response describe the Offeror's experience in New Mexico or other States?
d) Does the Offeror identify specific geographic regions or certain behavioral health provider types that would be a focal point when developing the network?
e) Does the Offeror describe challenges that will be present when enhancing the behavioral health workforce within the State?
f) Does the response include exploring opportunities to collaborate with other health plans?
g) Does the Offeror's response seem appropriate to address the challenges in the New Mexico system of care?
h) Does the Offeror provide innovative approaches to addressing behavioral healthcare workforce issues?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
<th>Superior Elements</th>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Nearly all elements of the question were addressed.</td>
<td>• Good experience in other states, for example KS and Utah.</td>
<td>• MCO does not address older adults.</td>
</tr>
<tr>
<td></td>
<td>• Medicare providers in network are seamlessly enrolled as a Medicaid provider.</td>
<td>• Taking credit for existing programs.</td>
</tr>
<tr>
<td></td>
<td>• Offered online CEUs to clinician.</td>
<td>• Discusses good experiences in other states but does not always note how they will bring this experience to NM.</td>
</tr>
</tbody>
</table>
## Centennial Care RFP
### Consensus Score Sheet

<table>
<thead>
<tr>
<th>Offor: Name</th>
<th>United Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation Area</td>
<td>Information Systems and Claims Management</td>
</tr>
<tr>
<td>Question Number</td>
<td>51</td>
</tr>
<tr>
<td>RFP Section(s)</td>
<td>6.6</td>
</tr>
<tr>
<td>Contract Section(s)</td>
<td>4.19, 4.20</td>
</tr>
<tr>
<td>Maximum # of Pages for Section</td>
<td>35</td>
</tr>
<tr>
<td>Exhibits Allowed?</td>
<td>Y</td>
</tr>
<tr>
<td>Question Score (0 - 5)</td>
<td>3</td>
</tr>
<tr>
<td>Proposal Page(s) Reviewed</td>
<td>133-147, Exhibits 535-586</td>
</tr>
</tbody>
</table>

### RFP Question

Submit detailed flowcharts, narrative descriptions, and operation manuals of your organization's existing or planned systems to meet the requirements in the Sample Contract (Appendix O of this RFP) and in the Centennial Care Systems Manual, addressing – at a minimum – the functional areas listed below. Your narrative response shall describe the extent to which these systems are: (i) currently implemented as opposed to planned; and (ii) integrated (or planned to be integrated) with other systems, internal and external. Describe your organization's experience in implementing and operating in New Mexico, other states, and/or other organizations. **(Flowcharts and Operations Manuals are to be included in the Exhibits Binder and will not be counted in the Section 6.6 page count. Narrative responses for this question are to be included in the Technical Proposal Binder and are subject to page count restrictions.)**

- a) Eligibility, enrollment, and disenrollment management and data exchange;
- b) Provider network management, certification, enrollment, notification and confirmation file exchange;
- c) Member and provider information access;
- d) Report generation and transmission;
- e) Care coordination system;
- f) Level and setting of care assessments, determination, tracking, and communicating;
- g) Claims processing, edits, corrections, and adjustments due to retroactive eligibility changes or other reasons;
- h) Claims adjudication, payment, and coordination of benefits for claims with third party liability and Medicare;
- i) Systems modules to track and administer different Medicaid benefit packages, copays, and premiums;
- j) Encounter submissions, correction, voiding, and resubmission;
- k) Financial management and accounting activities; and
- l) Provider technical assistance for I/TUs, Rural Health Clinics, FQHCs, NFs as well as other specialty providers.

### Response Consideration(s)

- a) Does the response address all relevant sections of the contract and Centennial Care Systems Manual, including all the functional areas (a through l) identified in the question?  
- b) To what extent are the systems described already in place vs. planned?  
- c) To what extent are the systems described already integrated with other systems vs. planned? If planned, were processes and timeframes for integration addressed in the response?  
- d) To what extent do the systems allow for flexibility as requirements change?  
- e) Do the systems described address the management of enrollments that are contingent on further action (i.e., NF LOC determination)?  
- f) Does the response address staffing requirements for each area and if so, how much of the staff's time would be dedicated to New Mexico?  
- g) Do systems allow for subcontractors' access to the Offeror's systems for any delegated functions (i.e., care coordination)?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
<th>Superior Elements</th>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nearly all elements of the question were addressed.</td>
<td></td>
<td>Response did not include external data sources for TPL.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmacy encounter submissions were not in line with HSD required processes.</td>
</tr>
<tr>
<td>Offeror Name</td>
<td>United Healthcare</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Evaluation Area</td>
<td>Native Americans</td>
<td></td>
</tr>
<tr>
<td>Question Number</td>
<td>62</td>
<td></td>
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<tr>
<td>RFP Section(s)</td>
<td>6.7</td>
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</tr>
<tr>
<td>Contract Section(s)</td>
<td>4.8.11</td>
<td></td>
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<td></td>
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<tr>
<td>Exhibits Allowed?</td>
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<td></td>
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<tr>
<td>Question Score (0 - 5)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Proposal Page(s) Reviewed</td>
<td>168-171</td>
<td></td>
</tr>
</tbody>
</table>

**RFP Question**

Describe any current or planned efforts or strategies and any barriers and proposed solutions to secure contracts with Tribal organizations for:

a) Non-emergency medical transportation services;
b) Care coordination and/or case management services;
c) Behavioral health services, including the treatment of substance abuse; and
d) Any other Medicaid-covered services provided outside of a clinic or hospital.

**Response Consideration(s)**

a) Does the response address all relevant sections of the contract?
b) Does the response fully address all aspects of the question?
c) Does the response indicate any prior experience in contracting or having "Agreements" with Tribal organizations?
d) Does the response demonstrate that the Offeror will make "best efforts" to complete the contracting process in a timely fashion?
e) Does the Offeror recognize the specific challenges that may arise in contracting with Tribal organizations? Does the Offeror suggest specific strategies to overcome them?
f) Does the response indicate that the Offeror is prepared to pay for services delivered to Native Americans at IHS and tribal 638 facilities even in the absence of a signed contract agreement?
g) Does the response include plans for providing any necessary training to Tribal organizations to ensure the organizations are adequately prepared to meet the terms of the contract?
h) Does the response show an awareness of and sensitivity to the distances that Native Americans need to travel to receive medical care in rural and frontier areas of the State of New Mexico?
i) How will they negotiate a fair reimbursement rate for medical transportation, care coordination, BH services, CHR reimbursement, and other services if the two parties are not in agreement?
j) How will they handle disputes that may come up between the provider and member for these services?
k) How will they provide technical assistance to Tribes and IHS when requested?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
<th>Superior Elements</th>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Addressed some elements of the question.</td>
<td>• Indicate they will use Peer support workers and will compensate for their time.</td>
<td>• Did not address barriers to contracting with tribal providers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Did not specify a contracting strategy for transportation providers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Generally lacked enough detail to fully evaluate ideas.</td>
</tr>
</tbody>
</table>
## Centennial Care RFP
### Consensus Score Sheet

<table>
<thead>
<tr>
<th>Offeror Name</th>
<th>United Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation Area</td>
<td>Quality Assurance and Quality Management</td>
</tr>
<tr>
<td>RFP Section(s)</td>
<td>6.9</td>
</tr>
<tr>
<td>Question Number</td>
<td>75</td>
</tr>
<tr>
<td>Contract Section(s)</td>
<td>4.4.16.1.8 – 4.4.16.1.9; 4.8.7.1; 4.9.25; 4.10.2.2; 4.11.3; 4.12.10.16</td>
</tr>
<tr>
<td>Maximum # of Pages for Section</td>
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</tr>
<tr>
<td>Exhibits Allowed?</td>
<td>N</td>
</tr>
<tr>
<td>Question Score (0 – 5)</td>
<td>3</td>
</tr>
<tr>
<td>Proposal Page(s) Reviewed</td>
<td>208-214</td>
</tr>
</tbody>
</table>

### RFP Question

Describe your organization's single case agreements and prior authorization (PA) process. Include, at a minimum:

a) How PAs will be applied for Members requiring out-of-network services, or services for conditions that threaten the Member's life or health;
b) How the Offeror will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration, or scope;
c) Your process for Member access to emergency and nonemergency transportation;
d) Your process for accessing out of state services or placements that require authorization; and
e) How you will ensure and monitor for consistent application of review criteria.

### Response Consideration(s)

a) Does the response address all relevant sections of the contract?
b) Does the response fully address all aspects of the question?
c) Does the Offeror provide a comprehensive description of its PA process?
d) Does the description address qualifications of staff making PA determinations?
e) Does the description address single case agreements?
f) Does the response indicate an understanding that emergency services and services provided by I/T/Us do not require PA?
g) Does the description allow for an extended PA process timeframe for services to address chronic conditions?
h) Does the process ensure for continuity of care, particularly for members with special health care needs?
i) Does the Offeror describe activities that will ensure the consistent application of review criteria including internal monitoring and auditing to ensure consistency across staff?
j) Are PA determinations based on evidenced-based clinical criteria?
k) Does the description address the ability of providers to access, via a website, electronic PA requests and approvals?
l) Does the Offeror describe how it will educate members and providers about the PA process?
m) Does the Offeror describe how members and/or providers can appeal denials of requests for PA?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
<th>Superior Elements</th>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Process flow map for prior authorization process was clear.</td>
<td></td>
<td>• Response did not address exemption of ITU services from prior authorization.</td>
</tr>
<tr>
<td>• Timeframe for execution of single case agreements in exigent circumstances.</td>
<td></td>
<td>• Responses did not address NEMT for Members with special needs.</td>
</tr>
<tr>
<td>• Please describe process for reviewing instances of reduction in hours or services to verify there is no arbitrary reduction in PCS.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Dear Mr. Clavio:
Do you have an Offeror named Centene? I would imagine it’s because Centene (the parent company) is responding to the RFP and not Health Net.

Health Net Merged with Centene in 2016. Ca Health and Wellness Plan also contracts with DHCS and is also owned by Centene.
If that’s the case then DHCS can revise the Appendix F form accordingly. Please advise.
Thank You!
Mary
Mary F. Cobb, Contract Manager
Central Operations Unit
Managed Care Operations Division
1501 Capitol Avenue, MS 4409
P.O. Box 997413, Sacramento, CA  95899-7413

Dear Mr. Clavio:
I’m checking on this. We will respond by the 11/2/17 deadline. Thank you.
Regards,
Mary

Mary F. Cobb, Contract Manager
Central Operations Unit
Managed Care Operations Division
1501 Capitol Avenue, MS 4409
P.O. Box 997413, Sacramento, CA  95899-7413
We don’t have an Offeror named “Health Net Community Solutions Inc. (Health Net)”. Perhaps the name of their parent company is different (?). At this point I don’t know what to do with this letter, and someone may come up short. Please let me know, and revise accordingly.

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

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: Cobb, Mary (MCOD)@DHCS [mailto:Mary.Cobb@dhcs.ca.gov]
Sent: Thursday, October 19, 2017 1:56 PM
To: RFP, CentennialCare, HSD
Cc: Conde, Stephanie (MCOD); Retke, Michelle (MCOD)@DHCS; Portela, Javier (MCOD)@DHCS
Subject: RFP # 18-630-8000-0001 Appendix F

Dear Mr. Clavio:

RE: RFP # 18-630-8000-0001

Please find attached the Appendix F Reference Form completed by the State of California, Department of Health Care Services as a reference for Health Net Community Solutions, Inc. (Health Net).

Sincerely,

Mary F. Cobb, Contract Manager
Central Operations Unit
Managed Care Operations Division
1501 Capitol Avenue, MS 4409
P.O. Box 997413, Sacramento, CA 95899-7413
9 List of References

REQUIREMENT: RFP Section 5.9

Molina Healthcare of New Mexico, Inc. has provided each of our three references with a customized Appendix F form and instructed them to submit their completed forms directly to HSD's procurement manager by the November 2 deadline. Our three references and all required information are as follows:

Table 9-1. Reference 1: Johnny Shults, Washington State Health Care Authority

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name</td>
<td>Johnny Shults, Section Supervisor, Managed Care, Medicaid Program Operations and Integrity, Washington State Health Care Authority (HCA)</td>
</tr>
<tr>
<td>10/19</td>
<td>(360) 725-0480 <a href="mailto:Johnny.Shults@hca.wa.gov">Johnny.Shults@hca.wa.gov</a></td>
</tr>
<tr>
<td>Phone Number and Email</td>
<td></td>
</tr>
<tr>
<td>Brief Description of the Services Provided</td>
<td>Molina Healthcare of Washington (MHW) currently provides services for the Apple Health Medicaid Contract, which is a prepaid, comprehensive system of healthcare delivery, including preventive, primary, specialty, and ancillary health services for Apple Health Adult, Apple Health Family, Apple Health Blind/Disabled, and CHIP members. The scope of work/services performed includes network access and availability functions; utilization management; quality of care functions; member services; grievances and appeals; benefits administration; and oversight and monitoring. MHW also provides services for the Fully Integrated Managed Care Contract (FIMC) and the Behavioral Health Wraparound Contract, which cover the same services as Apple Health as well as a comprehensive behavioral health (mental health and substance use disorder) benefit, funded by Medicaid dollars and general-fund state dollars</td>
</tr>
<tr>
<td>Period of Service</td>
<td>2000 – present</td>
</tr>
</tbody>
</table>
Table 9-2. Reference 2: Jamie Michael, Doña Ana County Health and Human Services

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name</td>
<td>Jamie Michael, Department Director, Doña Ana County Health and Human Services</td>
</tr>
<tr>
<td>Phone Number and Email</td>
<td>(575) 525-5969. <a href="mailto:JamieM@donaanacounty.org">JamieM@donaanacounty.org</a></td>
</tr>
<tr>
<td>Brief Description of the Services Provided</td>
<td>The Doña Ana County Health and Human Services has partnered with Molina and the Dona Ana Institute of Wellness to develop and implement data-driven processes for prioritizing health conditions in the county. The county has facilitated Molina’s involvement in the Institute; together, we are planning interventions for these prioritized health issues.</td>
</tr>
<tr>
<td>Period of Service</td>
<td>9/24/2013 – present</td>
</tr>
</tbody>
</table>

Table 9-3. Reference 3: Christopher Tokarski, Mental Health Resources, Inc.

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name</td>
<td>Christopher S. Tokarski, LPCC, Executive Director, Mental Health Resources, Inc.</td>
</tr>
<tr>
<td>Phone Number and Email</td>
<td>(575) 769-2345 x131 <a href="mailto:CTokarski@mhrnewmexico.com">CTokarski@mhrnewmexico.com</a></td>
</tr>
<tr>
<td>Brief Description of the Services Provided</td>
<td>Mental Health Resources is a Community Mental Health Center and behavioral health Core Service Agency in eastern New Mexico. The center provides behavioral health services to children, adolescents, and adults. Services include residential treatment center services, behavior management services, intensive outpatient programs, psychosocial rehabilitation, comprehensive community support services, multisystem therapy, and professional outpatient services including medication management. The center is also a New Mexico CareLink Health Home provider for Curry County and provides Health Home-like services to Molina members in Roosevelt, De Baca, and Quay counties.</td>
</tr>
<tr>
<td>Period of Service</td>
<td>9/1/13 – present</td>
</tr>
</tbody>
</table>
Appendix F

Reference Form (amended/revised)

RFP # 18-630-8000-0001

For:

Molina Healthcare 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.
Company providing reference: Mental Health Resources, Inc.

Contact name and title/position: Christopher S. Tokarski, LPCC, Executive Director

Contact telephone number: (575) 769-2345 x131; (575) 760-0659 (cell)

Contact e-mail address: ctokarski@mhrnewmexcio.com

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)
   MHR has been a contracted Behavioral Health provider with Molina Healthcare providing out-patient community mental health services to 5 counties in Eastern New Mexico since January 1, 2014.

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 5
   b. Expertise in managing health care programs 5
   c. Operational capacity 5

Comments:
I have appreciated the strong partnership we have been able to develop with Molina Healthcare over the past 4 years.

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. 5
   b. Responsiveness to the Contracting entity. 5
   c. Developing adequate Provider Networks. 5

Comments:
I have found Molina Healthcare to be very flexible, responsive, and committed in providing services to their Medicaid population.
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. ____5____

b. Emphasizing quality and positive outcomes over quantity. ____5____

c. Meeting the needs of the Contracting entity and terms of the contract. ____5____

Comments:
I believe that Molina Healthcare has a strong commitment to its members and quality of care.

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

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

a. The Contractor and your staff. ____5____

b. The Contractor and insured Members / Beneficiaries. ____5____

c. The Contractor and Providers, Hospitals, healthcare community. ____5____

Comments:
Molina Healthcare staff has been extremely easy to work with and I believe has developed a strong partnership with our organization.

6. What are the Contractor's strengths, and which aspect(s) of this Contractor's services are you most satisfied?

Strengths for this Contractor is their commitment to care, their availability their ability to respond to questions and concerns in a timely manner, and their professionalism. I have been most satisfied to the Contractor's continued commitment to care in their members.

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

I do not have any identified weaknesses or issues that I am dissatisfied with in this Contractor.
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.
I would strongly recommend this Contractor's services to our organization again and I do not have any reservation in working with this Contractor.

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: Maya Stefanovic, MPH, PMP Rating: 5
Position / Role: Sr. Manager Medical Affairs

Name: Steve DeSaulnier Rating: 5
Position / Role: Director of Health Plan Operations - Behavioral Health

Name: Susan DeZavala, R.N. Rating: 5
Position / Role: Director, Value Based Reimbursement

Name: Carolyn Griego Rating: 5
Position / Role: Behavioral Health Contract Manager Govt. Contracts

Comments:
The staff of Molina Healthcare has been excellent to work with in New Mexico.
The State will open, review and score all references submitted to support each proposal. If more than three (3) references are submitted for an Offeror, the top three (3) scores will be used to determine the total points awarded for references.

<table>
<thead>
<tr>
<th>Offeror Name</th>
<th>United Healthcare Michigan DHHS</th>
<th>Committee Name</th>
<th>Executive Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation Area</td>
<td>References</td>
<td>RFP Section(s)</td>
<td>2.1, 3.3.2, 4.3.4, Appendix F</td>
</tr>
<tr>
<td>Reference Number</td>
<td>3</td>
<td>Contract Section(s)</td>
<td>N/A</td>
</tr>
<tr>
<td>Maximum # of Pages for Section</td>
<td>NA</td>
<td>Exhibits Allowed?</td>
<td>NA</td>
</tr>
<tr>
<td>Reference Total Score (0-100)</td>
<td>92</td>
<td>Proposal Page(s) Reviewed</td>
<td>NA</td>
</tr>
</tbody>
</table>

1. Not Scored

2. How would you rate this firm in the following areas?
\(5 = \text{Excellent}; \ 3 = \text{Satisfactory}; \ 1 = \text{Unsatisfactory}; \ 0 = \text{Unacceptable}\)

a. Capability to manage complex health insurance programs ______

b. Expertise in managing health care programs ______

c. Operational capacity ______

<table>
<thead>
<tr>
<th>Scale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use reference scores. Total available – 15 points</td>
<td></td>
</tr>
</tbody>
</table>

3. How would you rate the following attributes of the Contractor?
\(5 = \text{Excellent}; \ 3 = \text{Satisfactory}; \ 1 = \text{Unsatisfactory}; \ 0 = \text{Unacceptable}\)

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

c. Developing adequate Provider Networks. ______

<table>
<thead>
<tr>
<th>Scale</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>Use reference scores. Total available – 15 points</td>
<td></td>
</tr>
</tbody>
</table>

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. ______

b. Emphasizing quality and positive outcomes over quantity. ______

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

<table>
<thead>
<tr>
<th>Scale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use reference scores. Total available – 15 points</td>
<td></td>
</tr>
</tbody>
</table>

5. How would you rate the dynamics/interaction between:
(5 = Excellent; 3= Satisfactory; 1 = Unsatisfactory; 0 = Unacceptable)

a. The Contractor and your staff. ______

b. The Contractor and insured Members / Beneficiaries. ______

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

<table>
<thead>
<tr>
<th>Scale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use reference scores. Total available – 15 points</td>
<td></td>
</tr>
</tbody>
</table>
6. What are the Contractor’s strengths, and which aspect(s) of this Contractor’s services are you most satisfied?

<table>
<thead>
<tr>
<th>Scale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total available (Parts A and B) – 10 points</td>
<td></td>
</tr>
<tr>
<td><strong>Part A</strong></td>
<td></td>
</tr>
<tr>
<td>Are strengths noted in the response?</td>
<td></td>
</tr>
<tr>
<td>“yes/info provided” = 5 points</td>
<td></td>
</tr>
<tr>
<td>“blank/no response” = 1 point</td>
<td></td>
</tr>
<tr>
<td><strong>Part B</strong></td>
<td></td>
</tr>
<tr>
<td>Do the strengths noted match those desired/needed in New Mexico?</td>
<td></td>
</tr>
<tr>
<td>“yes” = 5 points</td>
<td></td>
</tr>
<tr>
<td>“no/blank/no response” = 1 point</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Scale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
<tr>
<td><strong>Part A</strong></td>
<td></td>
</tr>
<tr>
<td>Are weaknesses noted in the response?</td>
<td></td>
</tr>
<tr>
<td>“yes/info provided” = 5 points</td>
<td></td>
</tr>
<tr>
<td>“blank/no response” = 1 point</td>
<td></td>
</tr>
<tr>
<td><strong>Part B</strong></td>
<td></td>
</tr>
<tr>
<td>Are the weaknesses easily overcome through oversight or contract language?</td>
<td></td>
</tr>
<tr>
<td>“yes” = 5 points</td>
<td></td>
</tr>
<tr>
<td>“no/blank/no response” = 1 point</td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;yes&quot; = 20 points</td>
<td></td>
</tr>
<tr>
<td>&quot;no&quot; = 0 point</td>
<td></td>
</tr>
<tr>
<td>Total available – 20 points</td>
<td></td>
</tr>
</tbody>
</table>

9. Not scored
Mercer will enter score and comments for follow-up upon contracting.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>Follow-up</th>
</tr>
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<td>2b</td>
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<tr>
<td>2c</td>
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<tr>
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<td>3b</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>3c</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>4a</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>4b</td>
<td>5</td>
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<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>92</td>
<td></td>
</tr>
</tbody>
</table>
ADDITIONAL EXAMPLES OF SCORING ERRORS

UHC was repeatedly scored down to a 4, despite the fact that the scoring committee did not note any deficiencies and UHC fully answered the question.

- In Section 6.4, Question 31, UHC’s score was reduced to a 4, but there were no deficiencies listed on the scoring sheet and the response answered all elements of the question. Indeed, HSD listed 4 superior elements of UHC’s response.
- In Section 6.6, Question 52, UHC’s score was reduced to a 4, but there were no deficiencies listed on the scoring sheet and the response answered all elements of the question. Indeed, HSD listed 3 superior elements of UHC’s response.
- In Section 6.6, Question 57, UHC’s score was reduced to a 4, but there were no deficiencies listed on the scoring sheet and the response answered all elements of the question. Indeed, HSD listed 3 superior elements of UHC’s response.
- In Section 6.6, Question 61, UHC’s score was reduced to a 4, but there were no deficiencies listed on the scoring sheet and the response answered all elements of the question. Indeed, HSD listed 2 superior elements of UHC’s response.
- In Section 6.8, Question 67, UHC’s score was reduced to a 4, but there were no deficiencies listed on the scoring sheet. Indeed, HSD listed 6 superior elements of UHC’s response.
- On Section 6.8, Question 71, UHC’s score was reduced to a 4, but there were no deficiencies listed on the scoring sheet. Indeed, HSD listed 4 superior elements of UHC’s response.
- On Section 6.10, Question 81, UHC’s score was reduced to a 4, but there were no deficiencies listed on the scoring sheet. Indeed, HSD listed 3 superior elements of UHC’s response.
- In Section 6.10, Question 83, UHC’s score was reduced to a 4, but there were no deficiencies listed on the scoring sheet and UHC addressed all elements of the question.
- In Section 6.11, Question 86, UHC’s score was reduced to a 4, but there were no deficiencies listed on the scoring sheet. Indeed, HSD noted 1 superior element.
- In Section 6.11, Question 88, UHC’s score was reduced to a 4, but there were no deficiencies listed on the scoring sheet. Indeed, HSD noted 1 superior element.
- In Section 6.11, Question 89, UHC’s score was reduced to a 4, but there were no deficiencies listed on the scoring sheet. Indeed, HSD noted 2 superior elements.

On several questions, UHC received only a score of 3 because the scoring committee noted that nearly all of the elements of the question were addressed. However, the noted deficiencies related only to a lack of detail, which under the scoring rubric should have received a 4.

- For Section 6.2, Question 15, UHC received a score of 3. While the score sheet states that UHC answered “nearly all of the elements of the question,” the deficiencies column does not identify any elements that were not addressed. The only deficiency was a lack of detail regarding recruitment, which is more properly a 4 score, not a 3.
- For Section 6.10, Question 84, UHC’s score was reduced to a 3 for not addressing all elements of the question or providing sufficient detail. However, no additional feedback or deficient elements were identified on the scoring sheet.
For Section 6.8, Question 70, UHC received only a score of 3. The score sheet says that UHC addressed "nearly all elements" of the question, but the score sheet did not identify any element that was not addressed.

HSD repeatedly gave UHC lower scores on questions for UHC's failure to address elements that were not part of the question.

- In Section 6.2, Question 14, HSD asked the offerors to "Describe how your organization will ensure a sufficient network that allows for timely access to a continuum of behavioral health, physical health, and long-term care providers to deliver the full array of Covered Services as outlined in of the Sample Contract (Appendix O in this RFP)." UHC was scored lower because its response was weak as to "linguistic and cultural references"; however, this information was outside the scope of Question 14.

- Section 6.4, Question 29 asked the offerors to "[d]escribe the staffing and organization structure of the Offeror's care coordination unit." The response considerations included information for elements that were not part of the question, including sufficient levels of supervision and ways to measure the efficacy of training. Furthermore, UHC's score was reduced for an alleged failure to provide details on timing of implementation, which is not a part of Question 29.

- Section 6.5, Question 45 reads as follows: "Describe how information received from the EVV system will be used by your organization to monitor for fraud and abuse and ensure appropriate service delivery?" HSD scored UHC lower for not providing details about how the system will be used for reporting. However, reporting was not identified as an element of the question. Thus, UHC's score was reduced based on an undisclosed evaluation factor.

- Section 6.12, Question 94 asked the Offerors to describe their strategy to achieve value-based payment (VBP) goals. Despite providing a complete explanation for how UHC would achieve the VBP goals, the scoring summary noted that the "Review team is concerned at Offerors ability to meet all VBP contractual requirements, including implementation of VBP Level 3 models." This concern is based on the reviewers' personal beliefs, not UHC's written response, and therefore was based on criteria outside the procurement process.

There were also instances where the scoring committee inaccurately reduced UHC's score even though the proposal answered the elements the committee identified as incomplete.

- Section 6.10, Question 85 read: "Describe your organization's proposed innovations for reporting data in the Program Integrity area. Provide examples of successful innovations implemented in New Mexico and/or other states." UHC received a 2. The score sheet states that UHC did not address proposed innovations and program integrity data, which is inaccurate. UHC identified its online State reporting portal as a reporting innovation it would implement with Centennial Care 2.0. [UHC Technical Proposal at 241-242] UHC also provided program integrity pilots in New Mexico.

- Section 6.3, Question 27 read: "Describe your organization's strategies and/or experience in implementing a home visiting program, such as for pregnant women and
other high risk populations. Include evidence of improved outcomes." Several alleged deficiencies were noted in the score sheet; however, none of these deficiencies are accurate. Contrary to the comments in the score sheet, the Offeror did not quote the question in any portion of its response. [UHC Technical Proposal at 57-58] And UHC’s proposal could not be read to imply opposition — indeed, the proposal states that UHC is “committed to support HSD’s responsible and thoughtful intention of piloting home visiting in Medicaid as part of Centennial Care 2.0.” Moreover, UHC’s response outlined a proposed collaboration between it and the MCOs, DOH and CYFD to provide support to coordination of services and data sharing, education and training regarding billable services and obtaining reimbursement and how to submit billable services for reimbursement to meet Medicaid compliance, which shows that UHC did intend to provide technical assistance.

A copy of all scoring results mentioned herein and the relevant portions of UHC’s Technical Proposal are attached hereto as Exhibit A.
Exhibit A
# Centennial Care RFP
## Consensus Score Sheet

<table>
<thead>
<tr>
<th>Offeror Name</th>
<th>United Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evaluation Area</strong></td>
<td>Care Coordination, Transitions, Assessments and Care Plans</td>
</tr>
<tr>
<td><strong>RFP Section(s)</strong></td>
<td>6.4</td>
</tr>
<tr>
<td><strong>Question Number</strong></td>
<td>31</td>
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<tr>
<td><strong>Contract Section(s)</strong></td>
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<tr>
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<tr>
<td><strong>Question Score (0-5)</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>Proposal Page(s) Reviewed</strong></td>
<td>69-75</td>
</tr>
</tbody>
</table>

### RFP Question

Describe strategies for reaching Members to engage in care coordination activities. Please address specifically members who are or have:

- a) Homeless and/or transient;
- b) Significant behavioral health issues (mental health and/or substance abuse);
- c) Significant cognitive deficiencies and/or Individuals with Developmental Disabilities (IDD);
- d) Living in Rural, Frontier, and Tribal areas;
- e) In out-of-home placements (foster care, nursing home);
- f) Not English speakers;
- g) Difficult to contact;
- h) Justice involved;
- i) Native American;
- j) Members residing in Nursing Facilities;
- k) Members who have high Emergency Department utilization; and
- l) Members who are resistant to participation in care coordination.

### Response Consideration(s)

- a) Does the response address all relevant sections of the contract?
- b) Does the response fully address all aspects of the question and identified member populations?
- c) Does the response take into account the specific geographical and cultural aspects of New Mexico?
- d) Does the response demonstrate an understanding of and alignment with the State's priorities including strength based (Identifying member's self-determination and strengths), member-centric care planning?
- e) Does the response demonstrate knowledge of and plans to utilize and collaborate with local programs and providers currently serving affected members?
- f) Does the response indicate plans to provide resources with specialized skills to working with members with cognitive and behavioral health needs?
- g) Does the response demonstrate an approach to working in Tribal areas that is inclusive of Tribal resources?
- h) Does the response include a variety of methods to engage hard to find or hard to engage members that extend beyond telephonic outreach?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All elements of the question were addressed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Superior Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Delegation to providers will include alerts and partnerships with community providers.</td>
</tr>
<tr>
<td>• 130 Care Coordinators with BH expertise and use of peer supports is desired.</td>
</tr>
<tr>
<td>• Collaboration with tribes.</td>
</tr>
<tr>
<td>• Live-immediate access to translation services and LOA with tribes for translation services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
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</thead>
</table>
Centennial Care RFP
Consensus Score Sheet

<table>
<thead>
<tr>
<th>Offeror Name</th>
<th>United Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation Area</td>
<td>Information Systems and Claims Management</td>
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<tr>
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<td>52</td>
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<tr>
<td>Proposal Page(s) Reviewed</td>
<td>147-150</td>
</tr>
</tbody>
</table>

RFP Question

Provide a description, timeline, project plan, and list of potential risks and strategies for mitigating them, regarding how your organization will implement all new information systems and all changes to any existing systems in support of the resulting Contract and changes necessitated by HSD’s MMIS Replacement. Include a draft Gantt chart schedule and work plan detail for the transition phase. (Gantt chart and work plan detail are to be placed in the Exhibits Binder and will not be counted in the Section 6 page count. Narrative responses for this question are to be included in the Technical Proposal Binder and are subject to page count restrictions.)

At a minimum, your response shall include:

a) Capability and capacity assessment to determine if the following are required to meet Contract requirements: new or upgraded systems, enhanced systems functionality, and/or additional systems capacity;
b) Implementation and configuration of systems (e.g., business rules, valid values for critical data, data exchanges/interfaces) to accommodate Contract requirements;
c) System setup for intake, processing, and acceptance of one-time data feeds from the State and other sources (e.g., initial set of Members, claims/service utilization history for the initial set of Members, active/open service authorizations for the initial set of Members); and
d) Internal and joint (managed care plan and State) testing of one-time and ongoing exchanges of eligibility/enrollment, provider network, claims, Level of Care assessments, LTC Settings of Care, Care Coordination, and other data.

Response Consideration(s)

a) Does the response address all relevant sections of the contract?
b) Does the response fully address all aspects of the question?
c) Does the implementation plan seem feasible in the allotted time span?
d) Does the work plan indicate an understanding of the scope of the contract?
e) Does the work plan allow for testing and corrections?
f) Does the work plan account for planned system changes described in question 51?
g) If the Offeror has contracts with multiple states, does the response address how work related to the Centennial Care contract will be prioritized?
h) Does the response address how the Offeror will meet staffing needs during any required systems changes?
i) Does the response address the handling of high risk providers (those that are very dependent on cash flow from the MCO) to ensure seamless payments regardless of system changes?
# Centennial Care RFP
## Consensus Score Sheet

<table>
<thead>
<tr>
<th>Offeror Name</th>
<th>United Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evaluation Area</strong></td>
<td>Reporting &amp; Program Integrity</td>
</tr>
<tr>
<td><strong>Question Number</strong></td>
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</table>

### RFP Question

Describe your organization's fraud and abuse detection/prevention program activities for employees, caregivers and providers, including reporting and follow-up, continuous monitoring of compliance, identification of issues, and ongoing training.

### Response Consideration(s)

1. a) Does the response address all relevant sections of the contract?
2. b) Does the response fully address all aspects of the question?
3. c) Does the response describe sufficient staff to develop and maintain a compliance program and that has experience in detecting fraud and responding to identified issues? (must include compliance program, written policies/procedures, designation of compliance officer, a compliance committee, and a reporting schedule)
4. d) Does the response include an understanding of the provider training challenges that the Offeror may face due to unique geographic characteristics of the State and does the Offeror include effective and creative ways to overcome such challenges?
5. e) Does the response describe the Offeror’s experience in detecting and preventing fraud and abuse?
6. f) Does the response provide specific, concrete examples that demonstrate fraud and abuse detection/prevention?
7. g) What plans for site visits and audits of high risk providers (DME, behavioral health, home health, etc.) are described in the response?
8. h) Does the Offeror’s response indicate an understanding of the procedures to be taken when fraud is suspected including a process for developing service and client transition plans when actions are taken against providers under fraud investigation?
9. i) Does the offeror’s response extend to subcontractors, preferred vendors and sole source providers?
10. j) Does the response require compliance with the New Mexico False claims act, New Mexico Fraud against Taxpayers act and the federal false claims act?
11. k) Does the response describe efforts the Offeror will take to detect, recoup and prevent overpayments made to contract providers?
12. l) Does the response include mechanisms to suspend payments to providers that have a credible allegation of fraud, per 42 CFR 455.23?
13. m) Does the response require source verifications for any data, documentation or information specified in 42 CFR 438.604?
14. n) Does the response reflect use of encounter data requirements for FWA?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nearly all of the elements of the question were addressed. Some additional detail needed to fully evaluate the approach.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Superior Elements</th>
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</table>

<table>
<thead>
<tr>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
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</table>
Centennial Care RFP
Consensus Score Sheet

Offeror: United Healthcare
Evaluation Area: Member & Provider Services
Question Number: 70
RFP Section(s): 6.8
Contract Section(s): 4.22

Maximum # of Pages for Section: 20
Exhibits Allowed?: N
Proposal Page(s) Reviewed: 197-199

RFP Question
Describe how your organization will:

a) Educate Members about the benefits of participating in a Member incentive program and the methods the Offeror will use for this outreach and evaluation for effectiveness of methods;
b) Measure outcomes for those who participate;
c) Incentivize members to participate in health and wellness programs; and
d) Implement technology innovations that allow Members to participate in such programs using Internet and smart phone applications.

Response Consideration(s)

a) Does the response address all relevant sections of the contract?
b) Does the response fully address all aspects of the question?
c) Does the response demonstrate an understanding of the benefits to the Member in participating including the ability to pay premiums with points?
d) Does the response indicate specific efforts to inform and encourage Members to participate?
e) Does the response include plans to revise outreach approaches that are not successful?
f) Does the response include information about experience and/or success implementing this requirement in New Mexico or other States?
g) Does the response address how technology will be used to help Members interface with the Member incentive program in an effective manner?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
<th>Superior Elements</th>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Addressed nearly all elements of the question.</td>
<td>• Addressed review of member incentive data from Finity against internal claims data and using data to drive system improvements.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Kiosks on tribal lands and strategies to close gaps in care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Member outreach strategies overall, w/ inclusion of providers in outreach strategies, is desirable.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Wellness days with rewards received at events.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Online linkages between Centennial Rewards and internal rewards programs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Response lacked detail on strategies for non-Native American populations.</td>
<td></td>
</tr>
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</table>
# Centennial Care RFP
## Consensus Score Sheet

<table>
<thead>
<tr>
<th>Evaluation Area</th>
<th>RFP Section(s)</th>
<th>Question Number</th>
<th>Contract Section(s)</th>
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<tr>
<td>Provider Network/Provider Agreements</td>
<td>6.2</td>
<td>14</td>
<td>4.8; Attachment 2</td>
<td>20</td>
<td>N</td>
<td>19-24</td>
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</table>

**RFP Question:**
Describe how your organization will ensure a sufficient network that allows for timely access to a continuum of behavioral health, physical health, and long-term care providers to deliver the full array of Covered Services as outlined in of the Sample Contract (Appendix O in this RFP). The response shall also include how your organization will build a sufficient provider network that specifically addresses the needs of the following populations:

- Individuals with mental health and/or substance abuse issues;
- Children and adolescents;
- Persons with a comorbid physical, mental health and substance use conditions;
- Native Americans;
- Linguistic and cultural minorities; and
- Persons who need Long Term Services & Supports (LTSS) including Home and Community Based Services (HCBS).

**Response Consideration(s):**

- Does the response address all relevant sections of the contract?
- Does the response fully address all aspects of the question?
- Does the response adequately address the unique New Mexico challenges of providing access to services in rural, frontier, and Tribal areas?
- Does the response adequately address how the Offeror will contract with FQHCs, RHs, I/T/Us, CSAs, and other publicly supported providers?
- Does the response adequately demonstrate an understanding of the provider screening and background checks required by state and federal statutes and regulations, such as the managed care final rule?
- Does the response demonstrate an understanding of the services where building and maintaining a provider network may be challenging and ways to overcome such potential challenges?
- Does the response demonstrate an understanding of the covered services provided in Centennial Care listed in Attachment 2 of the contract?
- Does the response indicate that the Offeror has begun discussions with providers in New Mexico?
- Does the Offeror ensure members will have access to a 24/7 pharmacy in each geographic region where one is available?
- Does the Offeror indicate they will make good faith efforts to contract with State teaching hospitals?
- Does the Offeror indicate how they will utilize telemedicine, Project ECHO, and/or other innovative strategies to address gaps in services?
- Does the Offeror describe ways in which they will expand services in rural, frontier, and underserved urban areas?
- Does the Offeror describe specific strategies for attaining and maintaining adequate provider networks?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Nearly all elements of the question were addressed.</td>
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<table>
<thead>
<tr>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Weak on linguistic and cultural references.</td>
</tr>
<tr>
<td>• Inconsistent numbers regarding the number of psychiatrists in the network.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Superior Elements</th>
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</thead>
<tbody>
<tr>
<td>• Express access providers – faster appointment times.</td>
</tr>
<tr>
<td>Offeror Name</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>Evaluation Area</td>
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<td>Question Number</td>
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<tr>
<td>Maximum # of Pages for Section</td>
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<tr>
<td>Question Score (0 - 5)</td>
</tr>
</tbody>
</table>

**RFP Question**

Describe the staffing and organizational structure of the Offeror’s care coordination unit. At a minimum, the Offeror shall include in the narrative response:

- a) The title, function, and responsibilities of managers within the care coordination unit;
- b) How the Offeror will ensure a diverse and culturally sensitive staff;
- c) How the Offeror ensures training on care coordination for complex members, such as Individuals with Developmental Disabilities (IDD), Brain Injury (BI), Serious Mental Illness (SMI), Severe Emotional Disturbance (SED), Dementia and Dually-Eligible Members;
- d) How the Offeror will employ and utilize care coordinators, with both behavioral health and physical health expertise, who can assess Members with varied needs including housing, employment, food and access to available community resources;
- e) How the Offeror will make use of existing resources at the local level; and
- f) How the Offeror will implement internet and smart phone based care coordination and disease-specific care pathways.

**Response Considerations**

- a) Does the response fully address all aspects of the question?
- b) Does the response take into account the specific geographic and cultural aspects of New Mexico and provide options for use of local resources?
- c) Does the response demonstrate an understanding of and alignment with the State’s desire to utilize local, community-based staff including CSWs?
- d) Does the response demonstrate a sufficient number of care coordinators and staff to adequately address the needs of members?
- e) Does the response address levels of supervision that you believe are sufficient to ensure the quality of care coordinators work?
- f) Does the response include a comprehensive plan for training staff to work with complex populations including ways to measure the efficacy of training?
- g) Does the Offeror describe the specific activities it will undertake to ensure a diverse and culturally sensitive staff?
- h) Does the Offeror plan to have staff who are bilingual?
- i) Does the structure support use of care coordinators experienced in physical and behavioral health needs such that service delivery is fully-coordinated and seamless to the member?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
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<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most elements of the question were addressed.</td>
<td>Leveraging training instructors from community is positive.</td>
<td>Response lacked detail in use of local resources.</td>
</tr>
<tr>
<td></td>
<td>Diverse and culturally sensitive staff.</td>
<td>BH-PH integration lacked sufficient details to fully assess.</td>
</tr>
<tr>
<td></td>
<td>Diabetes management program is promising.</td>
<td>Elements under development did not include details on timing of implementation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Training table was not clear regarding required elements.</td>
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<tr>
<td>Offeror Name</td>
<td>United Healthcare</td>
<td></td>
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<tr>
<td>------------------</td>
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<td>Proposal Page(s) Reviewed</td>
<td>116-118</td>
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</table>

**RFP Question**

Describe how information received from the EVV system will be used by your organization to monitor for fraud and abuse and ensure appropriate service delivery?

**Response Consideration(s)**

a) Does the response address all relevant sections of the contract?
b) Does the response fully address all aspects of the question?
c) Does the response address the data that will be collected and shared?
d) Does the response provide sufficient information regarding how monitoring will occur, who will conduct the monitoring and what it will entail?
e) Does the Offeror indicate how the information will be used to improve the delivery of personal care (Agency-Based and Self-Directed) and respite services both at the individual and state level?
f) Does the Offeror's response demonstrate experience with EVV systems?
g) Does the Offeror's response demonstrate knowledge of the federal EVV requirements as set forth in the Cures Act?
<table>
<thead>
<tr>
<th>Elements of the Response</th>
<th>Superior Elements</th>
<th>Elements of the Response</th>
</tr>
</thead>
</table>
| that Met RFP/Contract Requirements | • Dedicated staff for monitoring EVV is desired.  
• Q-Card use with care giver is promising practice. |
| • All elements of the question were addressed but the response lacked detail. | | • Staff responsible for and interventions for monitoring lacks details.  
• How system will be used for reporting lacks details. |
Centennial Care RFP
Consensus Score Sheet

<table>
<thead>
<tr>
<th>Offeror Name</th>
<th>UHC</th>
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<tbody>
<tr>
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<td>Value-Based Purchasing</td>
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<tr>
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<td>94</td>
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<td>RFP Section(s)</td>
<td>6.12; Attachment O</td>
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<td>Contract Section(s)</td>
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<td>269-276</td>
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</tbody>
</table>

RFP Question
New Mexico seeks to move provider payments to value-based payments per the contractual requirements outlined in Attachment 3 of the Sample Contract (Appendix O of the RFP). Describe your organization's strategy to achieve the VBP goals, including the types of VBP arrangements to be executed in each of the three levels.

Response Consideration(s)

a) Does the response address all relevant sections of the contract?
b) Does the response fully address all aspects of the question?
c) Does the response demonstrate a strong understanding of VBP payment models and commitment to building and expanding value-based arrangements?
d) Does the response demonstrate experience with risk-based VBP arrangements, including bundled payments/episodes of care, shared savings, partial and full-risk models?
e) Does the response include details regarding how the annual VBP Strategy will be developed and how the VBP program will be evaluated each year?
f) Does the response include the steps the Offeror will take to ensure each of the 3 Levels goals/targets are met for each of the four contract year targets?
g) Is the Offeror's approach reasonable for New Mexico providers and demonstrate an understanding of the unique needs of providers throughout the State, especially small or rural/frontier providers?
h) Does the response address how the Offeror will establish and lead the LTC/Nursing Facility workgroup to build a LTC/Nursing Facility full-risk model?
i) Does the response include details on how the Offeror will address value based payment arrangements with all types of providers, and in particular, behavioral health, long term care and nursing facilities?
j) Does the response include details on the types of interventions hospitals will be expected to implement to decrease readmission rates?
k) Does the response include how the Offeror will identify avoidable readmissions and establish hospital baseline rates?
l) Is the Offeror's planned approach reasonable and achievable?
m) Does the response include anticipated barriers and how the Offeror will work to overcome them?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
<th>Superior Elements</th>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Alignment with D-SNP is promising.</td>
<td>- Response insufficiently addresses Level 3 activities.</td>
</tr>
<tr>
<td></td>
<td>- VBP tied to transitions of care.</td>
<td>- Response includes barriers without proposed solutions.</td>
</tr>
<tr>
<td></td>
<td>- Aligning VBP measures to provider EHRs is desirable.</td>
<td>- Response does not address all contractual years.</td>
</tr>
</tbody>
</table>
# Centennial Care RFP
## Consensus Score Sheet

<table>
<thead>
<tr>
<th>Offeror Name</th>
<th>United Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evaluation Area</strong></td>
<td>Reporting &amp; Program Integrity</td>
</tr>
<tr>
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<tr>
<td>Proposal Page(s) Reviewed!</td>
<td>241-242</td>
</tr>
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</table>

## RFP Question
Describe your organization's proposed innovations for reporting data in the Program integrity area. Provide examples of successful innovations implemented in New Mexico and/or other states.

## Response Consideration(s)

a) Does the response address all relevant sections of the contract?
b) Does the response fully address all aspects of the question?
c) Do proposed innovations include a plan for effective reporting and implementation?
d) Do proposed innovations demonstrate successful recoupments?
e) Do the proposed innovations demonstrate measurable results associated with successful innovations?
f) Do proposed innovations make data more readily to support real-time reporting?
g) Do proposed innovations demonstrate increased reporting accuracy?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Most elements of the question were addressed. More detail needed to fully evaluate the approach.</td>
</tr>
<tr>
<td>Elements of the Response that are Deficient OR RFP Requirements not Addressed in Response</td>
</tr>
<tr>
<td>• No proposed innovations were addressed.</td>
</tr>
<tr>
<td>• Did not address reporting program integrity data.</td>
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<tr>
<td>Superior Elements</td>
</tr>
</tbody>
</table>

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### Centennial Care RFP

Consensus Score Sheet
### Centennial Care RFP
#### Consensus Score Sheet

<table>
<thead>
<tr>
<th>Offeror Name</th>
<th>United Healthcare</th>
</tr>
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<tbody>
<tr>
<td>Evaluation Area</td>
<td>Benefits &amp; Services</td>
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<td>Proposal Page(s) Reviewed</td>
<td>57-60</td>
</tr>
</tbody>
</table>

#### RFP Question
Describe your organization's strategies and/or experience in implementing a home visiting program, such as for pregnant women and other high risk populations. Include evidence of improved outcomes.

#### Response Consideration(s)
- a) Does the response address all relevant sections of the contract?
- b) Does the response fully address all aspects of the question?
- c) Does the response indicate innovative approaches relevant for the Centennial Care population?
- d) Does the response indicate an understanding of New Mexico's statewide home visiting network, the services that are available, and offer strategies to build upon this network of providers and services?
- e) Does the response indicate how the Offeror has defined and demonstrated measurable outcome improvements for persons participating in a home visiting program?
- f) Does the response include creative approaches for providing access to services in rural/frontier/Tribal areas (e.g., use of existing community resources)?
- g) Does the response indicate how the Offeror tracks and monitors successful outcomes?
<table>
<thead>
<tr>
<th>Elements of the Response that Met RFP/Contract Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The response is poor.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Superior Elements</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Elements of the Response that are Deficient OR RFP Requirements Not Addressed in Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Offeror quoted the question as a response.</td>
</tr>
<tr>
<td>• Response implies opposition to the approach. No substantial details on proposal for home visiting.</td>
</tr>
<tr>
<td>• Not intending to provide technical assistance</td>
</tr>
<tr>
<td>• Response was not specific to Centennial Care.</td>
</tr>
</tbody>
</table>
We monitor PCMHs to assess efficiency, cost targets and their quality of care and service with measures such as patient outcomes in immunization rates, management of diabetes and cardiovascular disease, and improved patient satisfaction through a dashboard that is shared with the practices. We review member-level data about their high-risk patients during Joint Operating Committee (JOC) meetings. As a recent example, the quality team and our CTCs along with Dr. Leonardi met with La Clinica de Familia, Ben Archer Health Clinics, Hidalgo Medical Services, DaVita Medical Group, and Presbyterian Healthcare Services in JOC meetings to review practice-specific data. Key JOC discussion elements include access to care performance and performance tracking. The scorecard/dashboard data is shared with providers to review/reinforce the established clinical transformation processes and monitor member health outcomes. These include improving access to care, improving high-risk patient care, reducing non-emergency ER visits, reducing avoidable readmissions, improving quality and coding accuracy, and improving growth and satisfaction. We also review HEDIS gaps in care data and assist provider staff with member outreach for Clinic Days. These elements of member engagement, provider engagement, and clinical transformation with population-health data analytics tools subsequently become components for VBP and PCMH accreditation.

Using the strategies mentioned above, we are confident we will increase PCMH capacity and the number of members receiving care through a PCMH, in support of the State’s vision.

27. Describe your organization’s strategies and/or experience in implementing a home visiting program...

In the 2017 Legislative Session, the Legislature passed SB 175, which would have required Medicaid to “establish an infant, toddler, and family home visiting program.” The Bill included a number of requirements to support a child’s development to age 3. The Legislature’s fiscal impact report noted that approximately 4,000 children currently are served by a home visiting program in New Mexico, at a cost of about $4,000 per child. This impact report further noted that HSD estimated that as many as 79,000 children might qualify for the home visiting benefit if it was added to the Medicaid program as an entitlement. Governor Martinez vetoed SB 175, because the costs (potentially $316 million/year) and benefits were not adequately known, and adding a new entitlement would create risks in a period of limited general fund revenues.

With that context in mind, we are committed to support HSD’s responsible and thoughtful intention of piloting home visiting within Medicaid, as part of Centennial Care 2.0, to have a basis to evaluate whether to eventually add home visiting to the entitlement benefit on a
statewide basis. In our response, we outline our strategies and experience to implement and help the State evaluate this Medicaid-based pilot.

Our maternal and child health program coordinator, Tena Ross, will lead the home visiting program strategy and implementation. Her prior work led to a Quality Improvement Project between the University of New Mexico (UNM) and Presbyterian related to neonatal opioid withdrawal syndrome in infants and avoiding unnecessary NICU admissions by keeping an infant in a community hospital with mom. From that work emerged an active home visiting program that connects a mother and baby to a home visiting program before they leave the hospital, ensuring home visits occur immediately after discharge. Ms. Ross is actively involved in the Statewide Advisory Council for Expectant and Parenting Teens, in the Bernalillo County Home Visiting Workgroup, and the J Paul Taylor Taskforce, which actively engages the community to improve outcomes using home visiting programs.

Our experience implementing home visiting includes a model in Bernalillo County in which our members have access and a referral to a Nurse Family Partnership (NFP) home visiting program. Nationally, UnitedHealthcare has partnered and referred members to NFP in many communities where NFP sites exist.

**STRATEGIES FOR IMPLEMENTING A HOME VISITING PILOT PROGRAM**

Because New Mexico has an extensive home visiting network throughout the state, we will align our home visiting pilot with evidence-based or high-fidelity home visiting models, such as NFP, Families FIRST, AVANCE Parent-Child Education Program and First Born Program. SB 175 itself referenced the importance of evidence-based design. All programs have strong home visiting components and many are nationally recognized for improved health outcomes for pregnant women and their children.

Our pilot program will help the State measure the cost-effectiveness of home visiting programs, provider readiness to become a Medicaid provider, and measure the effectiveness of licensed practitioners or certified home visitors to promote health outcomes, whole person care, and community integration for high-risk pregnant women and children up to 3 years old. During the home visiting program pilot, we will leverage and promote strategies already successful in nine states that currently use Medicaid funds for home visiting services. Three of these states, South Carolina, New York and Minnesota, leverage Medicaid MCOs.

<table>
<thead>
<tr>
<th>Outcomes to be evaluated in the home visiting pilot:</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Evidence-based child health outcomes</td>
</tr>
<tr>
<td>▪ Persistency of family engagement</td>
</tr>
<tr>
<td>▪ Provider readiness to be Medicaid-credential</td>
</tr>
<tr>
<td>▪ Provider readiness to submit Medicaid claims</td>
</tr>
<tr>
<td>▪ Cost per member served</td>
</tr>
<tr>
<td>▪ Potential financial benefits and avoided costs</td>
</tr>
</tbody>
</table>

We recommend collaboration with all MCOs and the selected pilot home visiting partners. UnitedHealthcare has demonstrated our MCO collaboration with other New Mexico programs,
e.g., the SBHC program. To ensure success of the home visiting program pilots, we recommend collaborative MCO support in the following areas:

- Coordination of services and data sharing
- Education regarding billable services and documentation of billable services
- How to submit billable services for reimbursement to meet Medicaid compliance

To assure a successful pilot program, we will work collaboratively with the New Mexico Department of Health (DOH) and CYFD in HSD-selected counties, assist with workforce development, promote provider capacity to serve our members participating in the program, and to improve prenatal and postnatal outcomes in the identified counties. We also will promote our Baby Blocks reward program, a new mother’s value-added benefit, Doulas, traditional medicine, transportation and other incentives such as the full Medicaid benefits for COE 100 to engage our members and encourage participation in the chosen home visiting sites.

Many of these programs are grant funded and their ability to expand is limited by funding, therefore, we will encourage the organizations to seek Medicaid provider status with the State. Once contracted, the Medicaid-covered services that can be billed for reimbursements include an initial assessment and targeted care management services, which will support the home visiting programs financial sustainability.

The following table presents the anticipated health benefits associated with home visiting programs and how we will measure the health outcomes as part of the home visiting program. We commit to submitting home visiting outcomes, as determined by HSD, which will provide guidance on required reporting and the frequency.

<table>
<thead>
<tr>
<th>Anticipated Benefits</th>
<th>Measurement of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in substance abuse in pregnant women and new mothers</td>
<td>Percent of pregnant women reporting substance abuse</td>
</tr>
<tr>
<td>Fewer unplanned pregnancies after birth</td>
<td>Change in teen pregnancy rates</td>
</tr>
<tr>
<td>Decreased ER and hospitalizations for pregnant mothers</td>
<td>Decrease in number of ER visits during pregnancy</td>
</tr>
<tr>
<td>Reduction of NICU days</td>
<td>Decrease in average length of stay (ALOS) for NICU babies</td>
</tr>
<tr>
<td>Reduction in low birth weight, preterm births</td>
<td>Percent of babies born full term, percent of low birth weight babies</td>
</tr>
<tr>
<td>Decreased hospital utilization during infancy</td>
<td>Percent of Hospitalization utilization during infancy and early childhood up to age 3</td>
</tr>
<tr>
<td>Increased number of well-child visits</td>
<td>Number of well-child visits during the first 36 months</td>
</tr>
<tr>
<td>Decreased ER and hospital utilization for children</td>
<td>Percent of ER utilization for children birth to age 3</td>
</tr>
<tr>
<td>Increased frequency of breast feeding</td>
<td>Percent of moms breastfeeding</td>
</tr>
</tbody>
</table>
To prepare this pilot, we used the Center for American Progress Medicaid and Home Visiting Best Practices from States to review best practices and identify barriers/challenges to avoid.

28. Describe your organization’s strategies for developing and/or implementing technology for Member engagement by providing tools that offer easy access to information and ways to communicate with us. We recognize that web-based and smartphone technologies are used across all demographics. By leveraging technology to make member services accessible, we empower members to learn about their health plan, receive information on health, wellness and behavioral health topics, and easily reach out to us for assistance.

a. Utilization of smart phones, social media, and other emerging technologies and internet and smart...

Our innovative digital capabilities enable Centennial Care member engagement wherever and whenever needed. Channels implemented for member services are:

- **Health4Me** mobile application
- **Wellness Recovery Action Plan (WRAP)** mobile application
- **MyHealthLine** mobile phone program
- Mobile member incentive program access (e.g., Baby Blocks)
- Mobile application transportation requests/scheduling
- [uhcommunityplan.com](http://uhcommunityplan.com) public website
- [myuhc.com](http://myuhc.com) secure member portal
- [OptumRx.com](http://OptumRx.com) pharmacy management website (linked from [myuhc.com](http://myuhc.com))
- [Liveandworkwell.com](http://Liveandworkwell.com) behavioral health website (linked from [myuhc.com](http://myuhc.com))
- [KidsHealth](http://KidsHealth) online educational resource center (linked from [myuhc.com](http://myuhc.com))
- [CommunityCare](http://CommunityCare) web-based care management platform
- Kiosk placement throughout the state to provide internet access
- **Social media initiatives** — Facebook, YouTube

We leverage personal interactions to promote web and smartphone-based communications. With each contact (e.g., member services), we encourage email and text communication approval and request updated member contact information. We provide members with the ability to receive communications according to their preference, via U.S. mail delivery or electronic email.

b. Notifying Members of their Premiums and Copays status in real-time (or near real-time); and

We are prepared to support premium/copay member notifications through our experience with Medicaid programs in other states and we will collaborate with HSD to implement appropriate notifications as reflected in the 1115 waiver’s terms and conditions approved by CMS. In addition to mailing paper invoices, we will notify members of premium/copay statuses via:
TRAINING
We provide mandatory FWA education and training for employees upon hire and annually thereafter. Including, specialized training on compliance and FWA risks based upon the employee’s job function and responsibilities. The content includes, but is not limited to, Compliance and Ethics Program and FWA Program expectations, a review of pertinent laws and regulations, examples of potential FWA issues, and a review of the resources available for reporting suspected FWA. In addition, this training covers the Code of Conduct, False Claims Act and whistleblower protections.

Upon hire, program integrity unit investigators complete a comprehensive one-week fraud detection-training course. We review tips, case examples and complete periodic training sessions throughout the year. Depending on the investigators specialty, certifications are obtained from the International Association of Special Investigation Units, including attendance of conferences sponsored by the National Health Care Anti-Fraud Association.

Our dedicated program integrity compliance manager Jennifer Wadley, is certified in Healthcare Compliance. She collaborates with the investigations managers and the State to identify areas to strengthen program integrity statewide.

Providers and subcontractors are contractually required to maintain a comprehensive FWA program that includes FWA training of their employees or caregivers.

Every quarter a provider FWA and contract compliance training is offered. We are the only MCO to provide this number of trainings resulting in an increase in provider self-reporting.

85. Describe your organization’s proposed innovations for reporting data and in the Program Integrity...

Innovation is one of the five pillars of our culture. It is at the core of our identity. We continually adapt to change as we pursue a course of continuous, positive and practical innovation. The intent is to help people live healthier lives, and to pursue a simpler, more intelligent and cost-effective health care system for everyone. Specifically, we are committed to modernizing the efficiency and effectiveness of health care delivery; fundamentally changing the way we deliver value to our members and providers and supporting the State’s vision to improve health outcomes for New Mexicans.

STATE REPORTING PORTAL
UnitedHealthcare’s on-line State reporting portal is a key innovation that we will implement with Centennial Care 2.0. Distinct from the State’s DMZ, this reporting portal will provide access to designated State staff to our key program information: real-time performance metrics and actionable information; a customizable suite of static reports in on-demand formats, including contractual and standard reports that authorized users can download and population health data. It enables direct reporting capabilities and provides access 24 hours a day, seven days a week, except during scheduled maintenance.
SUCCESSFUL INNOVATIONS

Delivering actionable data to provider practices through Link provider dashboard is a core component of our provider support model. We make it easier for providers to succeed in our value-based agreements by identifying specific members/patients who have open gaps in care, at a gap-specific level, and how many of these individuals must be addressed in each measure to meet the provider’s quality target in the numerator. We also provide actionable data on member use of ER and avoidable services.

PROGRAM INTEGRITY

Controlled Substance Drug Diversion
This program focuses on medical professionals who prescribe controlled substances, specifically anti-anxiety medications, muscle relaxants, opioids/narcotics, sedatives and stimulants to our members in the absence of 1) a proper doctor-patient relationship or 2) a medical condition such as of cancer or a diagnosis of similar severity. It focuses on the following allegations: drug diversion, false medical claims (services up-coded, or not rendered to the member receiving the controlled substance prescriptions) and patient harm (poly-drug toxicity death). We identify leads at the provider- and member-levels to address improper billing and clinical practices.

Home- and Community-Based Services Pilot Program
Earlier this year, we piloted a program to test vulnerabilities and examine provider care service agencies billing during inpatient stays. We identified 368 claims of 58 providers with overlapping services an overpayment of $33,827. We recovered validated overpayments, educated providers and expanded the algorithm library to identify improper billing before payment.
New Mexico Tribes and Tribal clinics desire to better fulfill and support the health care needs of Native Americans who reside in and around their Tribal communities. Not all Tribes, Tribal organizations and Tribal clinics have the tools, such as adequate funding, equipment and staffing, to provide a greater level of care and service.

UnitedHealthcare identified that with additional funding and collaborative agreements, our Tribal partners can do much more for those they serve.

UnitedHealthcare established contracts with Tribes and Tribal clinics in the form of Tribal Letters of Agreement (LOAs). These LOAs provide the Tribes and Tribal clinics payment for supports and services their teams, such as their community health representatives (CHR), provide to our members.

We are proud to be the only MCO who finalized these collaborative agreements with our Tribal partners. We continue to work to finalize agreements with the majority of our Tribes and Tribal clinics. Our Tribal LOAs are with:

- Ohkay Owingeh Pueblo – Effective December 2015
- Zuni Pueblo – Effective April 2016
- Taos Pueblo – Effective August 2016
- Pine Hill Tribal 638 Clinic – Effective June 2017
- Jicarilla Apache – Effective October 2017
- Alamo Tribal 638 Clinic – Effective October 2017
- Mescalero Apache Tribe – To begin December 2017
- Jemez Pueblo – To begin January 2018
- Laguna Pueblo – To begin December 2017
- Northern Navajo I.H.S. – To begin December 2017
- Ft. Defiance I.H.S. – To begin January 1 2018
Barriers to completing agreements with all Tribes and Tribal clinics include the limited time and staff the Tribes and/or Tribal clinics have to review and consider, the multi-level approval process some have, as well as the concern that an agreement would become a greater administrative burden. Within the LOAs, the scope of work we have developed with the Tribes and Tribal clinics are:

<table>
<thead>
<tr>
<th>Service</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Translation</td>
<td>Flat Rate per Visit/Assist</td>
</tr>
<tr>
<td>Completion of health risk assessment (HRA)</td>
<td>Payment per HRA</td>
</tr>
<tr>
<td>Completion of HRA with translation</td>
<td>Flat Rate</td>
</tr>
<tr>
<td>Translation assistance during care coordinator initiated assessment(s)</td>
<td>Flat Rate</td>
</tr>
<tr>
<td>Care coordinator/member assistance</td>
<td>Flat Rate per Visit/Assist</td>
</tr>
<tr>
<td>Mileage reimbursement (transport to/from physical health, behavioral</td>
<td>Payment per mile per UnitedHealthcare Member</td>
</tr>
<tr>
<td>health, and pharmacy visits); drivers can be anyone designated by the Pueblo</td>
<td></td>
</tr>
<tr>
<td>Flat fee round trip reimbursement for non-controlled substance</td>
<td>Flat fee payment per round trip per member</td>
</tr>
<tr>
<td>prescription pick up and drop off on behalf of member</td>
<td>Flat fee payment per day per member</td>
</tr>
<tr>
<td>Flat fee assisted transport; assistance/companion at provider office</td>
<td>Flat fee per Virtual Visit per Member</td>
</tr>
<tr>
<td>Virtual doctor visits use of technology assistance</td>
<td>Flat Rate Per Visit/Assist</td>
</tr>
<tr>
<td>In-home CHR visit to complete any of the following activities: 1) basic</td>
<td>Flat rate per UnitedHealthcare Centennial Care member per year</td>
</tr>
<tr>
<td>health education for a new diagnosed condition; and 2) triage/review of</td>
<td></td>
</tr>
<tr>
<td>health status and referral for care and social service needs. *These services are not otherwise reimbursable through other Medicaid funding.</td>
<td></td>
</tr>
<tr>
<td>Wellness center participation (to include health and disease management activities)</td>
<td>Flat rate per UnitedHealthcare Centennial Care member per year</td>
</tr>
<tr>
<td>Reimbursements for member assist during overnight hospital stay. Limit two nights per trip.</td>
<td>Flat rate per night</td>
</tr>
</tbody>
</table>

Non-emergency medical transportation services:

UnitedHealthcare supports the State’s continued focus on the importance of our Tribes and Tribal organizations as collaborative partners in designing these solutions. Because Native American communities span across vast rural and frontier areas of the State, our focus must be on transportation solutions that are reliable, accessible and culturally competent. We have a fully contracted transportation network of providers throughout New Mexico, and we will continue to have a strong network with National MedTrans Network (NMN), our new transportation vendor beginning 2019. NMN will bring enhancements to better our member and Tribal transportation provider experience: These enhancements include detailed provider and member profiles that match members to the right drivers at the right time, self-service with real-time ride scheduling, status, and online applications for providers and members to use. We continue to have an aggressive approach to contract with Tribal owned transportation providers as well as other
options to provide safe and appropriate transport for members in rural, frontier and Tribal areas. We continue to enhance our transportation network with Tribal owned providers, and other vendors and resources to serve Tribal communities. Examples are:

- Tribal mass transit (including CHR and Title VI programs)
- Mass transit (Laguna Pueblo)
- Pueblo of Zuni Senior Bus
- Safe Ride, Inc.
- CARE Express (Navajo Nation) Navajo Transport Services
- Pueblo of Acoma
- Diné Transportation
- Caregiver gas reimbursements
- Vouchers for public transportation (Tribal and those that serve Tribal communities)
- Tribal letters of agreement (LOAs)

Our LOAs enhance member experience by expanding access to transportation via their Tribes and Tribal clinics. Neither the Tribe nor the Tribal clinic has to be a LogistiCare nor an NMN contracted vendor, and they can use their Tribal and/or Tribal clinic staff, such as their CHRs, and be reimbursed for transport.

b. Care coordination and/or case management services;

Our Tribal LOAs offer our Native American members an enhanced experience while supporting Tribal efforts to provide culturally competent supports. Tribal LOAs include the Tribe or Tribal clinic conducting HRAs, translation, resource and social services coordination, member assistance and supports to, from and during provider visits, technology assistance, health education, Traditional Healing and Wellness. They meet the State’s new “shared functions” model for delegation of certain care coordination functions. To solution the barriers Tribes and Tribal clinics have identified, such as the need of additional funding, equipment and staff, our strategy is to continue to foster additional Tribal LOAs as well as enhance our existent menu of services to meet the needs of the Tribe to best serve our members. The enhancement may include greater levels of care coordination and case management.

c. Behavioral health services, including the treatment of substance abuse; and

We understand the stigma that can prevent members from seeking behavioral health services for severe and persistent mental illness or substance use disorders. To overcome this barrier,
UnitedHealthcare has open access to all Indian Health Services, Tribally Operated Facility or Programs, and Urban Indian Clinics (I/T/U) behavioral health providers across the state. Our providers receive continued support from our teams who provide technical assistance, consultation, education and collaboration (e.g., providing a link to local Core Service Agencies [CSAs]), as we build a member-centered provider network for our Native American members.

We have Wellness Center Peer Support Agreements with Tribal organizations as well as organizations that serve Tribal communities. Peer support programs can fill gaps and provide supports to those living with a severe and persistent mental illness and/or substance use disorder. The Agreements compensate Tribal organizations that provide peer support services to UnitedHealthcare members, using Wellness Drop-In Centers and Certified Peer Support workers who are able to meet with members 1:1 or in a group setting. The local Tribal organizations with which we have current contracts for behavioral health/substance abuse treatment services (peer support) include:

- Healing Circle Drop-In Center – Shiprock, NM
- Inside Out Drop-In Center – Espanola, Taos and Los Alamos, NM
- Hozho Healing Center – Gallup, NM
- Catron County Grass Roots Behavioral Health Wellness Center — Reserve, NM
- New Mexico A.R.T. Drop-In Center – Albuquerque, NM
- Richard’s Drop-in Center – Las Vegas, NM
- Albuquerque Center for Hope and Recovery – Albuquerque, NM
- Albuquerque Indian Center – Albuquerque, NM

The continued need for crisis management drives our focus on enhancing our Wellness Center/Drop-In Center agreements to include crisis management.

d. Any other Medicaid-covered services provided outside of a clinic or hospital.

UnitedHealthcare contracts with Tribal organizations, and organizations that serve Tribal communities, to provide adult day services, personal care services, environmental modifications, and respite. Our continued strategy is to grow a greater contractual footprint in our Tribal communities for these services.

63. Describe the strategies and resources that your organization will use to operationalize the delivery...

The overarching clinical approach for Native American members is holistic in nature, respecting the traditions of health sovereignty, and aligning with the beliefs and customs of the Native communities served. With higher levels of poverty, homelessness, lack of insurance and limited English proficiency, Native Americans experience difficulties in accessing health care and suffer from significant health disparities. Cultural differences magnify the challenges in obtaining appropriate health services and demonstrate an increased need for a clinical model that must be
5.9 LIST OF REFERENCES

The Offeror must submit a list of the...

Amerigroup has requested that three specific clients submit a completed reference (Appendix F) directly to the State by the deadline specified in RFP Section 5.9. The specific clients submitting completed references are from Medicaid agencies in the following states, where our affiliate health plans coordinate services for members enrolled in Medicaid and other state-sponsored programs:

☑ Louisiana 10/28
☑ Tennessee - NOT RCVD
☑ Maryland 10/31
Appendix F

Reference Form

RFP # 18-630-8000-0001

For:

AMERIGROUP Community Care 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.

77
Company providing reference: Louisiana Department of Health
Contact name and title/position: Jen Steele, Medicaid Director
Contact telephone number: 225-342-3030
Contact e-mail address: jen.steele@la.gov

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)
   As both Medicaid Director and Medicaid Deputy Director for Finance (CFO)

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 4
   b. Expertise in managing health care programs 4
   c. Operational capacity 4

Comments:

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. 4
   b. Responsiveness to the Contracting entity. 5
   c. Developing adequate Provider Networks. 5

Comments:
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. 1

   Comments:

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. 4
   c. The Contractor and Providers, Hospitals, healthcare community. 4

   Comments:

6. What are the Contractor's strengths, and which aspect(s) of this Contractor's services are you most satisfied?

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

   The main issue was after we reduced rates (capitation) the MCO put in place a number of "cost-savings" efforts that clawed back provider payments on a retrospective basis (including retro-reimbursements on denied service/billing rules) that did not seem justified.
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

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: Sonya Nelson Rating: 5
Position / Role: State CEO

Name: Aaron Rating: 5
Position / Role: State CEO

Name: Brian Shipp Rating: 4
Position / Role: Regional CEO

Name: ___________________________ Rating: __________
Position / Role: ___________________________

Comments:
Appendix F

Reference Form

RFP # 18-630-8000-0001

For:

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(Name of Offeror/Contractor)

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

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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

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<table>
<thead>
<tr>
<th>Company providing reference:</th>
<th>Maryland Department of Health and Mental Hygiene</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact name and title/position</td>
<td>Jill Spéctor, Director, HealthChoice and Acute Care</td>
</tr>
<tr>
<td>Contact telephone number</td>
<td>410-767-5248</td>
</tr>
<tr>
<td>Contact e-mail address</td>
<td><a href="mailto:jill.spector@maryland.gov">jill.spector@maryland.gov</a></td>
</tr>
</tbody>
</table>

**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)
   Amerigroup has been a Managed Care Organization (MCO) with the Maryland HealthChoice Program since 1999.

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 4.5
   b. Expertise in managing health care programs 4.5
   c. Operational capacity 4.5

   **Comments:**
   Amerigroup is very good at case management and solving problems

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 4.5
   b. Responsiveness to the Contracting entity 4.5
   c. Developing adequate Provider Networks

   **Comments:** ACC submits information and reports timely.
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. 3

b. Emphasizing quality and positive outcomes over quantity. 3/4

c. Meeting the needs of the Contracting entity and terms of the contract. 4

Comments:
ACC gets satisfactory results on consumer report card

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:
ACC is very efficient at claims adjudication which can be hard for providers

6. What are the Contractor's strengths, and which aspect(s) of this Contractor's services are you most satisfied?

Quality, very efficient at monitoring systems and claims adjudication
Innovative programs with high utilizers and paying for visits after hours

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

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; 3 = Unsatisfactory; 0 = Unacceptable)

Name: Vince Ancona Rating: 5
Position / Role: President

Name: ___________________________ Rating: ______
Position / Role: ___________________________

Name: ___________________________ Rating: ______
Position / Role: ___________________________

Name: ___________________________ Rating: ______
Position / Role: ___________________________

Comments: ___________________________
The State will open, review and score all references submitted to support each proposal. If more than three (3) references are submitted for an Offeror, the top three (3) scores will be used to determine the total points awarded for references.

<table>
<thead>
<tr>
<th>Offeror Name</th>
<th>Amerigroup LA Dept. of Health</th>
<th>Committee Name</th>
<th>Executive Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation Area</td>
<td>References</td>
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<td>2.1, 3.3.2, 4.3.4, Appendix F</td>
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<tr>
<td>Reference Number</td>
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<td>Contract Section(s)</td>
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<td>Proposal Page(s) Reviewed</td>
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1. Not Scored

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 ______
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   c. Operational capacity ______

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c. Developing adequate Provider Networks. 

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a. Serving Insured Members/Beneficiaries. 

b. Emphasizing quality and positive outcomes over quantity. 

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b. The Contractor and insured Members / Beneficiaries. 

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

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Are strengths noted in the response?
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"blank/no response" = 1 point

**Part B**
Do the strengths noted match those desired/needed in New Mexico?
"yes" = 5 points
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Total available – 20 points

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Amerigroup – Louisiana Department of Health

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<td>In cases where the Reference provided a score range (ex. 4/5) the committee elected in all cases to take the first score.</td>
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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.
December 6, 2017

The Hon. Eric D. Hargan, Acting Secretary
U.S. Department of Health and Human Services
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Hargan:

I am pleased to submit to the U.S. Department of Health and Human Services the final Section 1115 Demonstration Waiver renewal application for New Mexico’s managed care program, Centennial Care.

Since launching in 2014, the State’s goals for reforming Medicaid through Centennial Care have been to:

- Assure that Medicaid beneficiaries in the program receive the right amount of care, delivered at the right time, and in the right setting;
- Ensure that the care and services being provided are measured in terms of their quality and not solely by quantity;
- Slow the growth rate of costs or “bend the cost curve” over time without reductions in benefits, eligibility or provider rates; and
- Streamline and modernize the Medicaid program in the State.

Today, New Mexico’s Medicaid managed care program features an integrated, comprehensive Medicaid delivery system in which the member’s MCO is responsible for coordinating his/her full array of services, including acute care (including pharmacy), behavioral health services, institutional services and home and-community-based services (HCBS). This waiver renewal application builds upon the program’s accomplishments and maximizes opportunities for targeted improvements and other modifications in the following key areas: care coordination, benefit and delivery system refinements, payment reform, member engagement and cost sharing responsibilities, and administrative simplification. In summary, the improvements and modifications include:

- Refining care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continuing to expand access to LTSS and maintain the progress achieved in rebalancing efforts;
The Hon. Eric Hargan  
December 6, 2017  
Page 2

- Improving the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health, and improving the continuum of care for substance use disorders;
- Expanding payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes;
- Building upon and incorporating policies that seek to enhance beneficiaries’ ability to become more active participants in their own health care, including the introduction of modest premiums for adults with higher income; and
- Further simplifying administrative complexities and implementing targeted refinements to eligibility.

Over the course of the demonstration waiver renewal, New Mexico will continue to introduce progressive quality goals focused on improving health outcomes, implement initiatives that advance program goals, and challenge its MCO partners to work cooperatively with the provider community to achieve a health care delivery system that is efficient and value-driven, while reducing health disparities across all populations.

We look forward to working with the Centers for Medicare and Medicaid Services as we develop and implement the innovative approaches to enhance the Centennial Care program and achieve the goals of the demonstration waiver.

Sincerely,

Susana Martinez  
Governor
State of New Mexico
Human Services Department

Application for Renewal of Section 1115 Demonstration Waiver Centennial Care Program: Centennial Care 2.0

to

The Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services

Brent Earnest, Cabinet Secretary
New Mexico Human Services Department

Nancy Smith-Leslie, Director
Medical Assistance Division

December 5, 2017
State of New Mexico
Application for Renewal of Centennial Care Program: Centennial Care 2.0

Medicaid members. Implementation may also require several phases during the demonstration waiver.

5. Administrative Simplification through Refinements to Eligibility Proposals

One of the core principles of the Centennial Care program is to improve administrative effectiveness and simplicity. In Medicaid, this is a difficult challenge — the program currently subsumes nearly 40 different categories of eligibility, multiple complicated eligibility determination methodologies, and multiple benefit packages for both children and adults. HSD proposes opportunities to streamline some of these administrative complexities and, at the same time, is examining innovations in program design aimed at addressing and resolving issues that will reduce Medicaid administrative costs, reduce health care expenses and help HSD maintain a financially viable and sustainable program. Proposed benefit and administrative refinements include:

- Incorporate eligibility for Family Planning into the waiver so that it covers men and women through the age 50 who do not have other insurance coverage, with certain exceptions;
- Allow one month of retroactive eligibility for most (non-SSI) Centennial Care members;
- Accelerate the transition off Medicaid and into coverage through the private or health insurance exchange for individuals who lose eligibility due to increased earnings by requesting a waiver of the Transitional Medical Assistance program;
- Cover former foster care individuals up to age 26 who aged out of foster care in another state; and
- Continue to provide access to Community Interveners for deaf and blind individuals.

Administration Simplification through Eligibility Refinements Proposal #1: Phase out the Medicaid retroactive eligibility period for most Centennial Care members

HSD proposes to reduce the three-month retroactive eligibility period for most Centennial Care members to a one month period of retroactive eligibility for the first year of the waiver then eliminate with the start of the second year (2020).

HSD received numerous public comments recommending that the Department not eliminate the three-month retroactive eligibility period. In consideration of those comments, HSD has opted to phase out the retroactive period of eligibility by reducing it to one month in 2019, then eliminating it entirely at the start of the second year of the demonstration (2020). Providing one month of retroactive eligibility for one year allows ample time for the delivery system to develop the necessary processes to secure coverage at point of service. Additionally, HSD is moving toward an environment in which Medicaid eligibility, both initial determinations and renewals, is streamlined where possible. Real-Time eligibility is scheduled to roll-out by the end of 2018, meaning that many individuals will receive an eligibility determination at the point of application. Additionally, the ACA and expansion of Medicaid to adults who were previously uninsured have dramatically changed the landscape of coverage options.

New Mexico hospitals have substantially reduced their uncompensated care needs and are able to make individuals presumptively eligible for Medicaid at the time of service. In calendar year 2016, only one percent of the Medicaid population requested retroactive coverage (10,000
State of New Mexico
Application for Renewal of Centennial Care Program: Centennial Care 2.0

Individuals). Safety Net Clinics are also able to immediately enroll individuals at point of service through the Presumptive Eligibility program and receive payment for services. These changes provide an opportunity to reduce the administratively complex reconciliation process with the MCOs for retroactive eligibility periods.

Other policies related to retroactive eligibility period:
• Expansion adults with household income above 100% of the FPL who are subject to a premium will have prospective coverage only (after remittance of premium) and will not have retrospective coverage;
• The retroactive period reduction does not include retroactive status changes processed by the Social Security Administration; and
• Native American members and nursing facility residents would be exempt from the new policy and continue to have access to coverage for a three-month retroactive period, providing eligibility requirements are met.

Administration Simplification through Eligibility Refinements Proposal #2: Implement a streamlined NF LOC approval with specific criteria for members whose condition is not expected to change
This proposed change would result in reducing annual assessments for certain members who meet a NF LOC, increasing administrative simplification and possibly achieve cost savings. Under this approach MCOs would still be required to complete an annual CNA and develop an annual CCP. Individuals must meet all financial eligibility criteria to qualify for ongoing coverage. This policy change is particularly relevant for members with certain conditions such as dementia, quadriplegia, etc.

Administration Simplification through Eligibility Refinements Proposal #3: Waive the Transitional Medical Assistance (TMA) requirements for Parents/Caretakers since most are transitioned to the adult expansion category of eligibility when their earnings increase above the income threshold for the Parent/Caretaker category
HSD is requesting to waive the Transitional Medical Assistance program requirements for individuals in the Parent/Caretaker category that require up to an additional 12 months of Medicaid when these individuals have increased earnings that result in loss of eligibility for the Parent/Caretaker category. With the availability of other no-cost or low-cost coverage options, TMA is no longer necessary to maintain health coverage.

As an expansion state, New Mexico has an option available to individuals in the Parent/Caretaker category when their earnings increase that it did not have prior to the passage of the Affordable Care Act (ACA):
• TMA is a concept that predates the ACA and was intended to provide coverage to Parent/Caretaker adults whose income increases above the eligibility standard for full coverage. Most of these individuals are transitioned to the adult expansion category, which has resulted in diminishing enrollment in TMA;
• In 2013, 26,000 individuals were enrolled in the TMA category; today, fewer than 2,000 individuals are enrolled; and
• Parent/Caretakers that have increased earnings above the income threshold for the adult expansion category (138% of the FPL) are eligible to receive subsidies to purchase coverage through the federal Marketplace.
Administration Simplification through Eligibility Refinements Proposal #4: Incorporate eligibility requirements of the Family Planning program

Currently, the Family Planning Category, under the state plan, serves as a catchall for individuals who apply for Medicaid, but do not meet the financial eligibility standards to qualify for full coverage. This has resulted in approximately 72,000 individuals enrolled in the program, including many who have other insurance coverage (such as an Exchange plan), or who are outside of the average Family Planning age standards. Based on an analysis of this population, only approximately six (6) percent use Family Planning and related services covered by the program. This is because the benefit package is limited to reproductive health care, contraceptives and related services, and most individuals find that it does not meet their overall health care needs. In addition, the program is administratively burdensome for HSD because all covered individuals must have their eligibility renewed yearly, at a rate of approximately 6,000 renewals per month.

HSD proposes to better target the program to those individuals who are using it by designing it specifically for men and women through the age of 50 who do not have other health insurance coverage, with certain exceptions, including those individuals under age 65 who have only Medicare coverage that does not include family planning. Streamlining the Family Planning program to apply to the appropriate population will preserve the program for those who need it while saving administrative dollars and resources that are being allocated to renewal processes.

Administration Simplification through Eligibility Refinements Proposal #5: Request waiver authority to cover former foster care individuals up to age 26 who are former residents of other states

Under the waiver, HSD proposes to cover former foster care individuals up to age 26 who aged out of foster care in another state. While New Mexico formerly had State Plan authority for this population, CMS recently finalized a regulation retracting states’ authority to receive federal Medicaid matching funds to cover this population without a waiver. New Mexico is required to cover this population under state law.

Administration Simplification through Eligibility Refinements Proposal #6: Continue to provide access to Community Interveners

The current 1115 Centennial Care Waiver provides for expenditure authority allowing certain individuals enrolled in Centennial Care who are deaf and blind to access the benefit of Community Interveners.

A Community Intervener is a trained professional who meets the criteria as determined by the state. The Intervener works one-on-one with deaf-blind individuals who are five years and older to provide critical connections to other people and the environment. The Intervener opens channels of communication between the individual and others, provides access to information, and facilitates the development and maintenance of self-directed independent living. Services for Community Interveners are covered and will continue to be covered by Centennial Care MCOs and the costs associated with the Community Interveners may be included in capitation payments from HSD to the Centennial Care MCOs.
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
For Immediate Release
Contact: Mary Elizabeth Robertson
Mary.robertson@state.nm.us

New Mexico HSD Announces Managed Care Organizations for Centennial Care 2.0

SANTA FE, N.M. – Three organizations were selected as New Mexico’s Centennial Care 2.0 Managed Care Organizations (MCO) to administer the Medicaid managed care program, Human Services Department (HSD) Secretary Brent Earnest announced today.

Blue Cross/Blue Shield of New Mexico, Presbyterian Health Plan and Western Sky Community Care (Centene Corp.) will begin operations for Centennial Care 2.0 on January 1, 2019.

The current Centennial Care MCOs will continue to provide coverage until Dec. 31, 2018, when their initial five-year agreement with the state will end. HSD is announcing the successful awards now to have sufficient time for a thorough readiness review period prior to the January 1, 2019 start date.

“By reforming Medicaid through Centennial Care, we’ve been able to improve health care for New Mexicans who need it the most – making it more patient-centered and connecting more patients with primary care providers like doctors and nursing professionals,” Secretary Earnest said. “Through the partners we’ve announced today, we’ll be able to continue improving care for New Mexicans by making it even more patient-centered and cost effective.”

HSD conducted a rigorous selection process for its new Medicaid managed care program MCOs. The three organizations were selected through a competitive procurement process that began in September 2017 with the release of a Request for Proposal (RFP).

The RFP required responders to outline their experience and ability to meet the requirements of the program and advance program goals. The responses addressed key administrative and program objectives such as care coordination, benefits, value based purchasing, provider and member services, and financial management. It also required bidders to submit a cost proposal that was evaluated and scored as part of the selection process.

“HSD will continue to focus on improving health outcomes, implement initiatives that advance program goals, and challenge its MCO partners to work cooperatively with the provider community to achieve a health care delivery system that is efficient and value-driven,” said Medicaid Director Nancy Smith-Leslie.

Centennial Care, the state’s Medicaid managed care program, provides long-term care, physical and behavioral health services to approximately 675,000 New Mexicans on Medicaid.
Centennial Care 2.0 builds upon the program’s accomplishments and maximizes opportunities for targeted improvements and other modifications in the following key areas: care coordination, benefit and delivery system refinements, payment reform, member engagement and cost sharing responsibilities, and administrative simplification. The improvements and modifications include:

- Refining care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continuing to expand access to long-term supports and services and maintain the progress achieved in rebalancing efforts;
- Improving the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health, and improving the continuum of care for substance use disorders;
- Expanding payment reform through value-based purchasing (VBP) arrangements to achieve improved quality and better health outcomes;
- Building upon and incorporating policies that seek to enhance beneficiaries’ ability to become more active participants in their own health care, including the introduction of modest premiums for adults with higher income; and
- Further simplifying administrative complexities and implementing targeted refinements to eligibility.

Those Medicaid members who are enrolled with Molina or United HealthCare can stay with their MCO through December 2018. During this year’s open enrollment period beginning in October, all Medicaid participants will have a chance to select Blue Cross/Blue Shield of New Mexico, Presbyterian Health Plan or Western Sky Community Care as their new MCO.

Medicaid members who wish to remain enrolled with Presbyterian Health Plan or Blue Cross/Blue Shield of New Mexico do not have to select an MCO during open enrollment. They will be automatically re-enrolled with the same MCO. If members with Molina Healthcare or United Healthcare opt not to select a new MCO, they will be automatically assigned to one.

More information on the new MCOs can be found at here.

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Frequently Asked Questions for Centennial Care 2.0

Who are the new MCOs for Centennial Care 2.0 and when do they start?
The three Centennial Care 2.0 MCOs are:
1. Blue Cross/Blue Shield of New Mexico (BCBS)
2. Presbyterian Health Plan (PHP)
3. Western Sky Community Care (WSCC)

The Centennial Care 2.0 MCOs will begin providing services on January 1, 2019. Members may remain with their current MCO through December 31, 2018.

When can Molina and United Healthcare members select a different MCO?
HSD will have an open enrollment period starting in October 2018 through the first week of December 2018 for a January 1, 2019 effective date. After January 1, 2019, members may select a different MCO during their annual recertification period.

Do I have to select a Centennial Care 2.0 MCO?
If you are a current Molina or United Healthcare member, you can select a new Centennial Care 2.0 MCO during the open enrollment period. If you do not select a MCO, you will be automatically assigned to one. PHP and BCBS members who wish to remain with the PHP or BCBS do not have to actively select a 2.0 MCO. They will be automatically re-enrolled with PHP or BCBS if they do not choose a different MCO. If a current member wants a different Centennial Care 2.0 MCO then he/she must select a different 2.0 MCO during the open enrollment period.

How Do I Choose a Centennial Care 2.0 MCO?
Beginning in October 2018, members may call 1-888-997-2583 to choose a Centennial Care 2.0 MCO. They may also make a selection online at https://www.yes.nm.us.

Where Can I Find More Information about the Centennial Care 2.0 MCOs?
Before choosing a Centennial Care 2.0 MCO, you should call or visit all of the MCOs’ websites:

**BCBS**  
Member Services: 1-866-689-1523  
Website: www.bcbsnm.com/community-centennial

**PHP**  
Member Services: 505-923-5200 (in Albuquerque) or 1-888-977-2333 (toll free)  
Website: www.phs.org

**WSCC**  
Member Services: 1-855-688-6589  
Website: http://www.WesternSkyCommunity.com

Do all of the MCOs provide the same healthcare services and benefits?
Generally, yes, the health benefits are the same. Each MCO offers unique value-added services that include but are not limited to: