Health Notes

Program Evaluation Unit
Legislative Finance Committee
Date: June 5, 2018

# Centennial Care 2.0
# Medicaid MCO Procurement

## AT A GLANCE

The Human Services Department has procured new Medicaid managed care contracts, worth over $4 billion per year for the next four years, to provide health care for nearly 670 thousand New Mexicans currently receiving their Medicaid services through managed care. Centennial Care 2.0, the state's updated Medicaid waiver, will carry the program through at least 2022, and the new MCOs HSD has selected and the contracts it negotiates will be inherited by a new administration next year.

Four and a half months after HSD issued its Centennial Care 2.0 (CC 2.0) request for proposals (RFP), contracts with three MCOs were awarded in mid-January, 2018, to two 'legacy' MCOs, Blue Cross Blue Shield and Presbyterian, and one MCO new to the state, Western Sky Community Care. The CC 2.0 contracts include nine months for unpaid readiness review activities before 'go-live' on January 1, 2019.


This Health Note reviews the department's procurement process for the CC 2.0 MCOs. Scoring methodology is one key difference between the initial 2012 procurement cycle and the CC 2.0 procurement, with notably lower overall scores this year for five out of six MCOs that also participated in 2012. The cost proposal structure for this procurement cycle generated some relatively low cost bids that could have positive implications for the program's finances; however, the appropriateness of the rate ranges was also a central issue for the protests lodged by four of the MCOs that were not awarded contracts, and now for the court appeals filed by two MCOs.

Key issues to watch over the coming year include the transition of over 300 thousand Molina and United Healthcare members to new MCOs. Such a major transition is likely to be particularly challenging for the more vulnerable behavioral health and long-term services populations, and may be complicated by the end of one administration and the possible arrival of a new leadership team at HSD. Looming over the transition are the uncertainties surrounding the final outcome of the MCO protests. Shortly after HSD issued its administrative denials, Molina and UnitedHealthcare both filed appeals with the district court; AmeriHealth and WellCare may yet decide to follow suit. The potential delays and complications from the appeals may be an important factor in how effectively HSD is able to focus on preparing for CC 2.0, and could pose challenges for smooth member – and provider – transitions. The protests have already cost the department time and money to respond to, and the legal cases will have additional financial implications for the program going forward.

**Health Notes** are briefs intended to improve understanding of healthcare finance, policy, and performance in New Mexico.

New Mexico Legislative Finance Committee

## Background

In 2014, the New Mexico Medicaid program underwent considerable consolidation and expansion. The state's multiple waiver populations were combined into the new comprehensive Centennial Care waiver, where all recipients have integrated access to the full array of Medicaid services, including physical health, behavioral health, and community-based long term care services. In addition, the state embarked on Medicaid expansion, adding an entirely new population of recipients to the program.

As part of the transformation, HSD went through a formal procurement process and reduced the number of Medicaid managed care organizations (MCOs) from seven – Amerigroup, Blue Cross Blue Shield, Evercare/UnitedHealthcare (United), Lovelace, Molina Healthcare, OptumHealth, and Presbyterian to four – Blue Cross Blue Shield, Molina, Presbyterian and United. Before the Centennial Care procurement in 2012, HSD determined that its MCO contracts are not subject to the New Mexico Procurement Code, under the hospital and health care exemption, but the department has nonetheless indicated that it will follow the procurement process established by statute. The Centennial Care waiver was approved by the Centers for Medicare and Medicaid Services (CMS) for a five year demonstration period, from 2014 through 2018.

In early 2012, before the first Centennial Care procurement, HSD determined that its MCO contracts are not subject to the New Mexico Procurement Code, under the hospital and health care exemption. The department states that it nonetheless follows the procurement process established by statute.

As the end of the initial five year period approached, HSD developed the waiver renewal, called Centennial Care 2.0 (CC 2.0). CC 2.0 retains the basic structure of the original program, including eligibility and benefits, but adds what the department refers to as targeted improvements and modifications to build on key initiatives begun during the first five years, including expanded value-based purchasing and payment reform, health homes, and patient-centered medical homes. CC 2.0 continues HSD's efforts to refocus care coordination towards high-needs individuals and the challenges faced by individuals transitioning from one setting of care to another (e.g. from a hospital back into the community, or release from incarceration). Features that are new to CC 2.0 include a home visiting pilot project in collaboration with the New Mexico Children, Youth and Families Department (CYFD), a supportive housing benefit for individuals with serious mental illness, enhanced enrollment and care coordination efforts for the justice-involved population, and limited copayments and premiums for some populations. CC 2.0 also includes a request to waive current federal limitations on short-term inpatient behavioral health treatment options. Under the new waiver MCOs are encouraged to increase their use of community health workers, community health representatives and peer workers to assist with care coordination activities and outreach. Lastly, CC 2.0 includes several adjustments aimed at ensuring sustainability for the community benefits portions of the program, such as placing limits on some goods and services and trimming administrative costs by eliminating annual nursing facility level of care (NF LOC) evaluations for individuals with essentially unchanging conditions.

HSD began planning and design meetings for CC 2.0 in October, 2016, and worked with the Medicaid Advisory Committee (MAC) and a subcommittee dedicated to the CC 2.0 process from October, 2016, through April, 2017. The department also discussed plans for the waiver renewal with tribal partners during this time. HSD published the Centennial Care 2.0 concept paper in May, 2017, and held a series of public meetings around the state to collect input and feedback. The first draft of

the waiver renewal application was published in September, 2017; after additional public meetings and tribal consultation, the application was finalized and submitted to CMS on December 6, 2017. The federal public comment period ended January 30, 2018, and the waiver proposal is now under CMS review. The review process typically involves many months of discussion and negotiation between the state and CMS as program changes and details are finalized.

## Procurement of CC 2.0 Managed Care Organizations

Eight MCOs bid for CC 2.0 contracts: current Centennial Care MCOs Blue Cross Blue Shield, Molina, Presbyterian, and United, as well as Amerigroup, AmeriHealth Caritas, WellCare of New Mexico, and Western Sky Community Care.

At the same time the waiver renewal was taking shape, HSD was developing the request for proposal (RFP) to select MCOs for the redesigned program. The RFP was released on September 1, 2017, with proposals due by November 3, 2017 – a month before the CC 2.0 waiver renewal was submitted to CMS (the full procurement schedule can be found in Appendix A).

The RFP set out the schedule for the procurement process and provided detailed direction about the content, submission, and evaluation of proposals. Content was divided into four categories. Mandatory requirements included basic information about each company and its preparedness to engage in procurement. Three professional references were required, to be submitted directly to HSD. Cost proposals, explored in more depth later in this brief, included each MCO's best per member per month cost proposals for each Medicaid cohort within a range provided by HSD. Lastly, the technical proposal contained 94 separate questions for MCOs to respond to, ranging from organizational experience and qualifications to questions and scenarios related to specific elements of the CC 2.0 program. A glance at the scoring systems for 2012 and 2018 (Table 1) shows the relative weight given to each sub-section.

**Table 1: Proposal Scoring Systems**

| *RFP Section* | *2012* | *2018* |
|---|---|---|
| Experience & Qualifications | 75 | 130 |
| Provider Network | 150 | 70 |
| Benefits & Services | 125 | 160 |
| Care Coordination | 275 | 280 |
| Info Systems & Claims Management | 200 | 220 |
| Long-term Services and Supports | *n/a* | 160 |
| Patient centered programs | 150 | *n/a* |
| Native Americans | 75 | 50 |
| Member & Provider Services | 100 | 80 |
| Quality Improvement & Management | 100 | 60 |
| Reporting & Program Integrity | 175* | 50 |
| Financial Management | 100 | 50 |
| Readiness | 100 | *n/a* |
| Value-Based Purchasing | *n/a* | 80 |
| **Technical proposal** | **1,625** | **1,390** |
| **Cost proposal** | **400** | **400** |
| **References** | **n/a** | **300** |
| **Oral presentations (not held either cycle)** | **(100)** | **(400)** |
| **TOTAL possible points** | **2,025** | **2,090** |

*2012 separated reporting requirements (100) and program integrity (175)

Source: HSD

In 2012, all proposals had to earn at least 75 percent of the possible points for each section of the technical proposal to remain in consideration.

The 75 percent requirement was not in place this year; if it had been, none of the eight prospective MCOs would have survived the RFP process.

Eight MCOs bid for CC 2.0 contracts: current Centennial Care MCOs Blue Cross Blue Shield (BCBS), Molina, Presbyterian, and United, as well as Amerigroup, AmeriHealth Caritas (AmeriHealth), WellCare of New Mexico, and Western Sky Community Care. (Amerigroup, BCBS, Molina, Presbyterian, United and Western Sky were also among the bidders in 2012. Only AmeriHealth and WellCare were entirely new to the state this year.)

Evaluation and scoring of proposals was completed by late December. Scoring methodology and outcomes are key differences between the original Centennial Care procurement in 2012 and the CC 2.0 procurement this year. HSD has had five years' experience running the Centennial Care program and the RFP reflected the department's new ideas and priorities about what to request from potential CC 2.0 bidders in terms of how they would address program challenges. However, some of the changes to the scoring process appear unconnected to the substance of the program.

The total points available were roughly the same each cycle, 2,025 in 2012 and 2,090 in 2018. As might be expected, the questions and the point values assigned to them were somewhat different in 2018. However, there was also a change in the weight given to major sections of the proposals: in 2012 almost all the weight was given to the technical section of the proposals, while in 2018 the technical score was worth relatively less as new points were added for references. (Table 2.)

**Table 2: Overall MCO Scores by RFP Component**

| Section | Amerigroup | AmeriHealth | BCBS | Molina | Presbyterian | UHC | WellCare | Western Sky | Total points possible |
|---|---|---|---|---|---|---|---|---|---|
| Technical | 880 | 830 | 944 | 942 | 1,146 | 932 | 954 | 1,022 | 1,390 |
| References | 138 | 285 | 285 | 288 | 288 | 165 | 167 | 284 | 300 |
| Cost | 320 | 400 | 315 | 120 | 337 | 400 | 152 | 254 | 400 |
| Total points | 1,338 | 1,515 | 1,544 | 1,350 | 1,771 | 1,497 | 1,273 | 1,560 | 2,090 |
| Percent score | 64% | 72% | 74% | 65% | 85% | 72% | 61% | 75% | |
| Rank | 7 | 4 | 3 | 6 | 1 | 5 | 8 | 2 | |
| Outcome | Not selected | Protest | Awarded | Protest | Awarded | Protest | Protest | Awarded | |

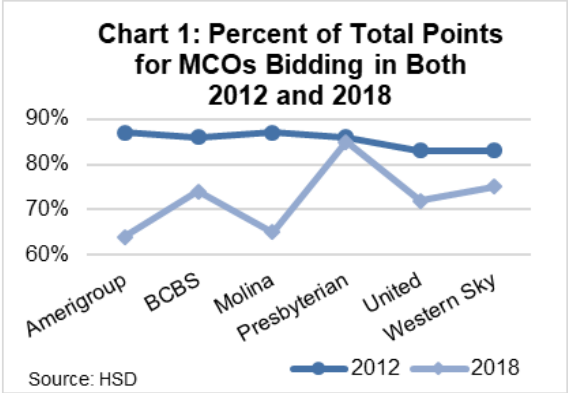
Source: HSD

**BCBS Proposal Strengths and Weaknesses Identified by HSD's Evaluation Teams:**

Strengths:
Innovative on-line portal for health literacy education;
Strong competency in performance improvement projects;
Desirable claims payment accuracy process.

Weaknesses:
Volume of sanctions in other states;
Several responses did not meet expectations for an MCO operating in the state since 2014;
Did not demonstrate systems capability for reporting requirements or fraud, waste and abuse detection and prevention programs.

At first glance, this shift in the relative weight of the technical section might appear to make it easier for a bidder to get a higher score. The 300 points for references should have been a relatively easy goal for any bidder, all major national health care corporations (or subsidiaries) active in Medicaid around the country, and indeed five MCOs earned 284 points or better for their reference letters. The remaining three, however, earned 167 points or below for this section of their proposals.




More significantly, in 2012 all proposals had to earn at least 75 percent of the possible points for each section of the technical portion of the proposal in order to remain in consideration. All of the seven MCOs that bid in

the original procurement cleared that hurdle, and each earned an overall 82 percent or higher. The 75 percent requirement was not in place this year; if it had been, none of the eight prospective MCOs would have survived the process. Chart 1 shows, five of the six MCOs that bid in both procurement cycles received considerably lower scores this year. The winning MCOs received 85 percent, 75 percent and 74 percent, respectively.

Contracts were awarded to two 'legacy' MCOs, BCBS and Presbyterian, and one MCO new to the program, Western Sky. The contracts were signed in mid-January, 2018. HSD included a draft CC 2.0 contract as part of the RFP process, which may have reduced the time needed for contract negotiations.

The CC 2.0 contracts include nine months for unpaid readiness review activities before 'go-live' on January 1, 2019. There may be changes before then, however, as CMS reviews and responds to the program changes found in the waiver renewal application. BCBS and Presbyterian have been Centennial Care MCOs for over four years now and although they will have to make some changes to respond effectively to new elements of CC 2.0, they may reasonably be expected to require less in the way of readiness preparations, allowing HSD staff time to work more closely with Western Sky.

## The transition to CC 2.0 will be complex.

The transition from the four current Centennial Care MCOs to the three CC 2.0 MCOs will be a complex process for recipients who are currently enrolled with Molina and United, providers and MCOs, and will occur at the same time HSD's administration may be experiencing a leadership transition of its own.

For recipients, the transition means that as the CC 2.0 go-live date of January 1, 2019, approaches, over 300 thousand New Mexicans on Medicaid will need to select and transition to a new MCO. As of the end of March, 2018, Molina had nearly 220 thousand members and United had just over 88 thousand. Open enrollment for CC 2.0 begins in October and runs through the end of November. Presbyterian and BCBS members who want to stay with their MCO can sit tight, but former Molina and United members will need to select a new MCO or they will be automatically assigned to one. Many providers in New Mexico are in-network with only one or two Medicaid MCOs, so recipients will need to do some research to find out which MCO(s) their preferred providers are associated with. Once the open enrollment period ends, recipients may switch MCOs one time within the first 90 days and, if they wish, recipients may shift again at the end of their annual recertification period.

For providers, the CC 2.0 contracts require that all MCOs enter into new provider contracts, in part to further the CC 2.0 goal of expanding value-based purchasing. So as the go-live date approaches, some providers will be responding to requests for medical records, helping patients to transition to new providers if necessary, learning the details of the CC 2.0 program, and negotiating new contracts – most likely with new emphasis on pay for performance – with MCOs.

The MCOs are operating under formal transition agreements with HSD, signed with all four of the current MCOs in September, 2017, and then with Western Sky on January 10, 2018 (several days before their contract was signed). The agreements spell out HSD's expectations for a cooperative and smooth transition, in-

Over 300 thousand New Mexicans on Medicaid will need to select and transition to a new MCO before the end of the year.

**Presbyterian Proposal Strengths and Weaknesses Identified by HSD's Evaluation Teams:**

Strengths:
Demonstrated good understanding of cultural diversity of the state;
Solid provider recruitment and retention strategies, especially for behavioral health;
Innovative and multi-faceted performance improvement projects.

Weaknesses:
Absence of innovative approaches to using technology for member engagement;
Value based purchasing plans may limit participating providers and be unreasonable for nursing facilities;
Absence of innovative strategies to build long-term services and supports (LTSS) community-based provider network.

**Western Sky Proposal Strengths and Weaknesses Identified by HSD's Evaluation Teams:**

Strengths:
Innovative strategies for addressing member needs;
Strong focus on person-centered planning;
Promising emergency diversion results in other states.

Weaknesses:
Pattern of penalties for late payments and untimely service authorizations;
Passive and undesirable approach to member engagement;
Response lacked detail in several key areas.

Cost proposals submitted by the current Centennial Care MCOs do not look anything like the actual rates these four MCOs have been paid for any of the last five years.

The proposals will be the starting point for CY19 rates. HSD will make adjustments before the rates are finalized—depending on how substantial these are, the state could still see substantial cost savings.

cluding MCO participation in a transition workgroup, exchange of member data, timely completion of key assessments, and assured continuity of care for high need members. As the only new MCO, Western Sky will receive the highest percent of auto-assigned members until it reaches at least 10 percent of total managed care enrollment as of January 1, 2019; Western Sky had the second lowest overall score on its proposal among the three CC 2.0 MCOs, and proposed the highest rates. After the 10 percent threshold has been reached, HSD will switch to giving heavier weight in auto-assignments to the MCO that proposed the lowest rates, Presbyterian.

## MCO cost proposals

The cost proposal section of the RFP provided a rate range within which MCOs were directed to provide their most competitive cost proposals for each Centennial Care rate cohort (physical health, behavioral health, long term services, and the expansion group) in three components, medical, administrative and underwriting gain. The narrative explains that cost proposals are to be "inclusive of all costs necessary to operate the program" *except* for a set of costs that HSD has excluded and which are subject to adjustment after the contracts have been awarded. Excluded costs include some items that were truly unknowable at the time the RFP was written, such as the impact of potential CMS-driven changes to the benefits or populations covered by the waiver, as well as other items the Centennial Care rates have always included, such as projections about population demographics, hepatitis C pharmacy costs, and assessments for the New Mexico Health Insurance Exchange and the New Mexico Medical Insurance Pool.

**Table 3: Cost Proposal Scores and Outcome**

| MCO | Score | Contract awarded? |
|---|---|---|
| AmeriHealth | 400 | x |
| United | 400 | x |
| **Presbyterian** | 337 | ✓ |
| Amerigroup | 320 | x |
| **BCBS** | 315 | ✓ |
| **Western Sky** | 254 | ✓ |
| WellCare | 152 | x |
| Molina | 120 | x |

Source: HSD

The cost proposals are structured to facilitate direct comparison: there is a range of rates for each Medicaid cohort, each MCO proposal falls somewhere within the range, and HSD scored the proposals based on the percentile of the range. This means AmeriHealth and United, the two MCOs that bid at the bottom of the rate range – the zero percentile – for every cohort, received 100 percent of the available 400 points. Two MCOs, Amerigroup and Molina, spread their risk by bidding a consistent percent of the range across all cohorts, in the 20$^{th}$ and 70$^{th}$ percentiles respectively, leading to scores that were 80 and 30 percent of the available points, or 320 points for Amerigroup and 120 points for Molina. The remaining five MCOs made more varied proposals and mixed bottom of the range bids with mid or even top of range bids.

Ultimately, what stands out from reviewing cost proposals is that none of the current Centennial Care MCO bids look anything like the actual rates these four MCOs have been paid for the last five years. The specific rates are not comparable because these will all be adjusted upwards when the excluded costs are included as the rates are finalized What is striking is where the proposals fall within the rate ranges set by HSD. Previous LFC recommendations to HSD have encouraged the department to set rates at the lower end or bottom of the range, and HSD has made progress in this area. But just as BCBS and United have never received payment at the bottom of the range for every cohort – a key highlight of both of their CC 2.0 cost proposals – Molina has never received payments at 70 percent of the range across all cohorts, as it proposed for CC 2.0. Presbyterian mixed top of the range bids with bottom of the range bids to get an overall bid of 15.8 percent, significantly higher than its rates for CY18. The vivid differences between the real rates for the last five years and the CC 2.0 cost proposals appear to demon-

strate that the MCOs all used their cost proposals strategically; some strategies were successful, others less so.

That said, the cost proposal portion of the response was only worth a maximum of 400 out of 2,090 points, or less than 20 percent. A high cost proposal score (for bidding lower rates) was helpful to winning bidders BCBS and Presbyterian, while a lower score (for relatively higher rates) did not prevent Western Sky from gaining a contract. (Table 3.) The bids will be the starting point for CY19 rates – the RFP forewarns bidders that their cost proposal is binding and that HSD will not accept changes to rates if the bidder later decides they are insufficient. However, no estimate of potential savings can be made at this time because HSD will adjust rates for a number of factors prior to finalization. But if HSD holds the MCOs to their bids the state could see substantial cost savings.

Four of the five MCOs not awarded contracts filed formal protests with HSD:

- AmeriHealth
- Molina
- United
- WellCare

## MCO protests and HSD responses

HSD announced the three CC 2.0 contract winners on January 19, 2018, and less than two weeks later, on January 31, 2018, Molina filed a complaint in the First Judicial District Court. Molina's initial argument, which was expanded in later filings and in its formal protest to HSD, raised three primary allegations: HSD used criteria to evaluate proposals that were not included in the RFP; the payment rates included in the RFP were not actuarially sound, which resulted in bidders (other than Molina) being rewarded for proposing unsustainable rates; and Mercer, HSD's actuary who developed the RFP bid range and played a large role in guiding the procurement process, had a financial conflict of interest with one of the winning MCOs.

Now that HSD has denied the protests, two MCOs have filed legal appeals with the First District Court:

- Molina
- United

Molina requested the court issue a temporary restraining order so that HSD could not proceed any further with the contract award process until the bid protest process could be completed. No formal order has been entered in the case yet, but at a hearing on February 26, 2018, the district judge agreed with HSD that Molina had not yet exhausted its administrative remedies and dismissed the case from the bench.

On February 5, 2018, four of the five MCOs not awarded contracts filed formal protests with HSD: AmeriHealth, Molina, UnitedHealthcare, and WellCare of New Mexico. Over the following weeks all four also filed at least one supplement to their protest as more of the documents they requested from HSD were made available. The MCO protests contain selections from the reportedly tens of thousands of pages of internal HSD documents the MCOs successfully obtained from the department through the IPRA process. On May 17, 2018, HSD issued its formal denials of the protests, in the form of recommendations from the cabinet secretary and final decisions from the HSD chief procurement officer. The letters are accompanied by more detailed discussion briefs for each protest prepared by HSD's Office of General Counsel, as well as relevant exhibits. (The protests and HSD's denials are all public documents, posted on HSD's website.)

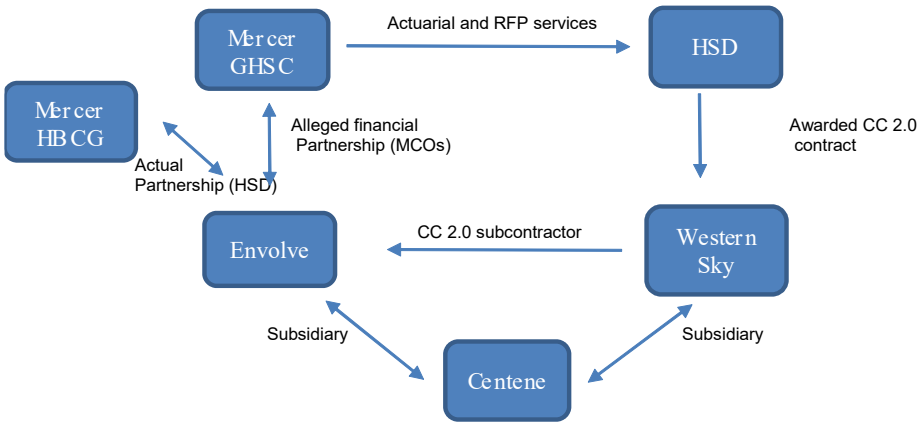
Major common themes among the protests are summarized below, along with a brief recap of HSD's reasoning for denial.

- Allegedly incurable conflict of interest between Mercer and winning MCO Western Sky and its parent company Centene. HSD's contracted actuary, Mercer, was tasked with helping to prepare the RFP, including creating the

rate ranges bidders were directed to use to develop their cost proposals. Mercer also developed an evaluation guide for HSD staff and subject matter experts to use as they scored the proposals, facilitated consensus scoring sessions, and, based on emails released to the MCOs, appears to have had a significant role in guiding and advising on daily decisions throughout the procurement process. The protests raise two conflict of interest concerns. Mercer has a financial relationship with Envolve, a specialty health services company. Envolve is a subsidiary of Centene Corporation, as is Western Sky; the Western Sky proposal indicates it will be working with at least four Envolve companies for CC 2.0, for disease management and nurse advice line services, as well as management of dental benefits, pharmacy benefits, and vision benefits. The losing MCOs allege Mercer therefore had a significant financial interest in Western Sky's success as a bidder, which tainted all elements of the procurement process. (Figure 1.)

One major common theme among the protests is the allegation that there is an incurable conflict of interest between HSD's long-time contracted actuary, Mercer, winning MCO Western Sky, its parent company Centene, and another Centene subsidiary, Envolve.

**Figure 1: Sources of Alleged Conflict of Interest**




HSD determination: there is no conflict of interest between Mercer and Western Sky and Centene, nor is there a conflict of interest between Mercer and BCBS.

HSD determination: HSD responded that HSD subject matter experts and management, not Mercer staff, made all relevant decisions and evaluations throughout the procurement process, which was both transparent and proper. Further, while none of the MCOs provided direct evidence for this allegation, HSD has letters and affidavits from Mercer, Western Sky and Envolve that the department says demonstrate two points: first, HSD's actuary, Mercer's Government Human Services Consulting group, is distinct from Mercer's Health and Benefits Consulting Business unit, which has the contract with Envolve, and neither unit was aware of the other's activities. Second, the business relationship between Mercer and Envolve is essentially a screening and recommendation contract and Mercer does not receive any payment from Envolve.

- The second alleged potential conflict of interest revolves around a request from Mercer to HSD to allow it to contract with the parent company of one of the bidding MCOs; HSD reports that it refused this request, but the protesting MCOs claim there is no solid evidence that HSD took any action or that Mercer did not proceed anyway.

  HSD determination: HSD responded that Mercer properly informed the department that BCBS's parent company had asked it to consult on assessing

mental health parity for its commercial products. HSD says it requested Mercer not take on that work, and Mercer agreed and declined the contract.

- Rate structures included in the RFP were not actuarially sound; as noted above, the RFP as well as HSD responses to bidder questions make clear the department planned to make numerous adjustments after the contracts were awarded. The MCO protests allege the use of actuarially unsound rates violates federal Medicaid regulations and resulted in the winning MCOs being improperly rewarded for submitting unsustainably low cost proposals.

  Another key protest theme: the RFP instructed responding MCOs to propose rates within a rate structure that was not actuarially sound, allegedly in violation of federal Medicaid regulations.

  HSD determination: HSD responded that the RFP was clear that the minimum and maximum rates in the ranges provided in the RFP data book were not actuarially sound because some costs could not be known at the time of the procurement and were not included. The department states the process by which the rate ranges were developed was transparent and spelled out in the data book, and all bidders had multiple opportunities to ask questions, get clarification, or raise objections to the rate ranges prior to submitting their bids; none raised any questions about actuarial soundness.

- Allegedly uneven scoring of MCO responses to RFP questions. The MCOs allege that the procurement evaluation guide developed by Mercer for HSD's use includes instructions to base scores on criteria that were not included in the RFP or the individual questions, while emails released in response to MCO IPRA requests indicate HSD purposefully did not 'give away' too much about what it was looking for when it wrote the questions themselves.

  HSD determination: The RFP clearly stated the rate ranges for proposals were not actuarially sound and fully explained the adjustments that will be made before final rates are set.

  HSD determination: HSD responded that all evaluation and scoring criteria were properly disclosed in the RFP, and it was permissible to give guidance to the HSD scoring teams for the purpose of "avoiding arbitrary and capricious results." The department's position is that the procurement code does not require an agency to specify the response it expects from a bidder.

- HSD's decision not to hold oral presentations even though evaluation committee notes indicated the need for clarification of some MCO responses. HSD has not provided any detailed reasoning for this decision, which allegedly limited the ability of the losing MCOs to respond and possibly increase their scores.

  HSD's determination: HSD responded that the RFP stated oral arguments would be at HSD's discretion; no oral presentations were held for the 2012 procurement, either. The department's position is that notes made by scoring teams did not obligate HSD to hold oral presentations, and affidavits from members of HSD's executive evaluation committee affirm that the consensus of the group was that oral presentations were not necessary.

- Other allegations repeated across protests include differences in the extent of assistance HSD provided to some bidders, erroneous scoring of reference letters, and HSD's unexplained decision to award only three contracts.

  HSD determination: HSD responded that the RFP clearly stated it was the bidder's responsibility to submit the required references, and the department bore no responsibility to obtain references for any bidder. In the instances

where HSD did communicate with MCO references, the department asserts the communication was a "fair and reasonable effort" to clarify a reference that had been sent, not to solicit one that had not been received. As with oral presentations, the RFP was clear that HSD would select between three and five MCOs, at its discretion.

Protest allegation: HSD did not handle references objectively, proving assistance to some bidders and not to others.

The allegations raised by the four MCOs regarding unsound cost proposals and conflict of interest are not similar to any issues raised in protests to the 2012 procurement. Some of the other allegations are comparable to issues raised in 2012; complaints about uneven scoring and unanticipated criteria were dismissed without further litigation or cost to the department.

HSD determination: bidders, not HSD, were responsible for ensuring their references were received by HSD. Failure to meet this requirement led to a reduced score.

Procurement code regulations, 1.4.1 NMAC, establish the right to protest within 15 days of a decision and specify that all other parties to the procurement – meaning all of the other bidding MCOs – are by definition parties to the protest process. Past these requirements, the regulations allow substantial discretion for how each agency handles protests: discovery is permitted, hearings are optional, and resolution is to be prompt. The protesting MCO may accept the final decision, make a motion for reconsideration, or proceed directly to judicial review. The process HSD followed began with receipt of the protests, after which the winning MCOs were permitted to submit briefs with their own responses to the protests. HSD's general counsel then reviewed the cases and prepared detailed discussion documents for each protest, including proposed findings of fact and recommendations. The HSD secretary reviewed the full files, and in each case adopted the proposed findings of fact and recommendations and then forwarded his recommendation to deny each protest in its entirety to HSD chief procurement officer, who in turn made the final decision to deny. As of this date, Molina and United have responded to the denials of their protests by filing formal appeals with the First District Court.

Medicaid procurements are high value, high risk activities. Other states with major Medicaid procurements in 2016 and 2017 also saw substantial protest activity, and some are still in litigation.

Medicaid procurements are high value, high risk activities. They involve high value for the bidding MCOs – the CC 2.0 contracts are worth a total of over $4 billion per year for each of the four years of the new contracts. Because of their high value, the procurements carry a high risk of bid protests and other legal action for the department. Other states with major Medicaid procurements in 2016 and 2017, including Illinois, Mississippi, Nebraska, Pennsylvania and the District of Columbia, also saw substantial protest activity. In some cases, resolution of the protests led to re-scoring of proposals, which in turn led to further legal action by the MCOs that lost points the second time around.

In New Mexico, the protests that arose out of the 2012 procurement cycle were settled with relative ease. However, review of the current protests and HSD's responses indicates there may be the potential for a more complex resolution this time around. When Lovelace lost its Medicaid contract in 2012, it transferred its 84,000 members to Centennial Care MCO Molina in a $53.5 million deal. Now that HSD has denied the current protests, Molina and United may try to make a similar type of deal with one of the CC 2.0 MCOs, although the sheer size of Molina's membership and operations in the state may make that difficult.

## Conclusion

Transitioning to the CC 2.0 waiver and MCOs is a complex undertaking for HSD, MCOs, providers and many Medicaid recipients. HSD's position is that the department successfully handled an even more complex transition to Centennial Care back in 2014 and is well-prepared to make this transition. The department's confidence is encouraging, but the challenges described in this brief are real.

Key issues and processes to watch over the next year include transition of 300 thousand Molina and United members to new MCOs, particularly the more vulnerable behavioral health and long-term services populations, as well as how Western Sky develops its provider network and services around the state.

The readiness period for CC 2.0 contractors is underway. As noted above, for BCBS and Presbyterian readiness should consist of updating their existing programs to conform to the new elements of CC 2.0, something they have presumably been preparing for since HSD first introduced the new waiver concept. Readiness preparations for Western Sky should be more extensive as it has no current business in the state at all and will be developing its program from the ground up. (Another Centene subsidiary, Centurion, currently holds a contract to provide health care services to the New Mexico Department of Corrections.) The first round of deliverables – including documentation of a wide array of policies and procedures – was due to HSD by the end of March, and the department plans to conduct two day on-site reviews with BCBS and Presbyterian in July and a week-long on-site review with Western Sky in late July or August.

Final MCO payment rates will not be in place until the end of the year, so the implications of the low bids from BCBS and Presbyterian won't be known until then.

Key issues and processes to watch include transition of 300 thousand Molina and United members to new MCOs, particularly the more vulnerable behavioral health and long-term services populations, as well as how Western Sky develops its provider network and rolls out services around the state. During the first year of Centennial Care many of the now-quarterly MCO reports were monitored by HSD on a weekly and even daily basis; whether HSD intends to reinstate this type of frequent monitoring as Western Sky gets off the ground is unknown. Final payment rates won't be in place until the end of the year, so the implications of the low bids from BCBS and Presbyterian won't be known until then.

The appeals filed by Molina and United and the probability of a protracted legal conflict compound the difficulty of the transition. The potential delays and complications will be an important factor in how effectively HSD is able to focus on preparing for CC 2.0

The appeals filed by Molina and United and the probability of a protracted legal conflict compound the difficulty of the transition. The potential delays and complications will be an important factor in how effectively HSD is able to focus on preparing for CC 2.0, and could pose challenges for smooth member – and provider – transitions. Lastly, the protests have already cost the department time and money to respond to, and the legal cases will have additional financial implications for the program going forward.

## Appendix A: Centennial Care 2.0 MCO Procurement Schedule

| Centennial Care 2.0 MCO Procurement Schedule | |
|---|---|
| **Event** | **Date** |
| Release RFP and procurement library | Friday, Sept. 1, 2017 |
| Deadline for offerors to submit mandatory, acknowledgement of receipt form to HSD | Monday, Sept. 18, 2017 |
| Mandatory pre-proposal conferences – morning: RFP; afternoon: actuarial | Tuesday, Sept. 19, 2017 |
| Deadline for offerors to submit formal written questions for HSD response | Friday, Sept. 29, 2017 |
| Release of HSD responses to written questions and amendment(s) to RFP | Friday, Oct. 20, 2017 |
| References due - deadline: 5:00 pm MDT | Thursday, Nov. 2, 2017 |
| Proposals due – deadline: 3:00 pm MDT | Friday, Nov. 3, 2017 |
| Evaluation and scoring of proposals | Nov. 6 – Dec. 22, 2017 |
| Notifications to offerors that do not meet mandatory requirements | Friday, Nov. 10, 2017 |
| Selection and notification of finalists | Friday, Dec. 22, 2017 |
| Oral presentations (at HSD's discretion) | Jan. 3 – Jan. 5, 2018 |
| Notice of intent to award | Monday, Jan. 8, 2018 |
| Contract negotiations | Jan. 9 – Jan. 26, 2018 |
| CMS contract approval period | Jan. 27 – Feb. 27, 2018 |
| Signature process (contractors and State) | Feb. 28 – March 14, 2018 |
| Contract award date | March 15, 2018 |
| Protest period – 15 days from contract award | March 16 – 31, 2018 |
| Contract effective date | April 1, 2018 |
| Effective date for readiness period (no compensation) | April 1, 2018 |
| Readiness period | April 1 – Dec. 31, 2018 |
| Go-live date and start of new waiver | Jan. 1, 2019 |

**Appendix B: HSD Determination of Procurement Code Exemption**

OGC-COPY

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March 6, 2012

**DETERMINATION OF PROCUREMENT CODE EXEMPTION**

The Medicaid Managed Care program was created by the New Mexico Legislature which empowered the New Mexico Human Services Department ("HSD") to "provide for a statewide, managed care system to provide cost-efficient, preventative, primary and acute care for Medicaid recipients by July 1, 1995." See, NMSA 1978, §27-2-12.6. Since its enactment, the Department received approvals from the Centers for Medicare and Medicaid Services of certain 1915(b) waivers (permissible waivers pursuant to section 1915(b) of the Social Security Act) to provide Medicaid state plan services using managed care organizations in Salud!, CoLTS (Coordination of Long-Terms Services), and the Behavioral Health statewide entity. In providing these services, the Department has engaged seven (7) managed care organizations ("MCO"), duly licensed in the State of New Mexico, to provide a network of health care providers for which eligible Medicaid recipients can receive medically necessary services.

Although the MCO contracts were awarded pursuant to Requests for Proposals, as early as 2009 it was recognized by HSD's Medical Assistance Division, which administers the State's Medicaid program and oversees the MCO contract; HSD's Administrative Services Bureau; and HSD's Office of General Counsel that such contracts are exempt from the New Mexico Procurement Code [13-2-28 *et seq.* NMSA 1978].

Accordingly, it is determined that pursuant to Section 13-1-98.1 NMSA 1978, as amended, the foregoing procurement of health care services via the Department's contracts with managed care entities is exempt from the provisions of the New Mexico Procurement Code [13-1-28 NMSA 1978, *et seq.*] as the services involved will or likely reduce health care costs, improve quality of care or improve access to care.

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## Table 4: Centennial Care 2.0 2018 Proposal Scores

| Section # | | Maximum available points | Amerigroup | AmeriHealth | BCBS | Molina | Presbyterian | United Healthcare | WellCare | Western Sky |
|---|---|---|---|---|---|---|---|---|---|---|
| **Technical Proposal sections** | | | | | | | | | | |
| 6.1 Experience & Qualifications | | 130 | 114 | 110 | 120 | 116 | 126 | 120 | 120 | 110 |
| 6.2 Provider Network & Agreements | | 70 | 52 | 34 | 46 | 52 | 56 | 44 | 46 | 50 |
| 6.3 Benefits & Services | | 160 | 88 | 72 | 100 | 92 | 132 | 84 | 76 | 124 |
| 6.4 Care Coordination | | 280 | 168 | 164 | 180 | 172 | 224 | 204 | 204 | 196 |
| 6.5 Long-term Services and Supports | | 160 | 96 | 80 | 124 | 112 | 128 | 108 | 108 | 144 |
| 6.6 Info Systems & Claims Management | | 220 | 140 | 152 | 160 | 148 | 180 | 136 | 180 | 164 |
| 6.7 Native Americans | | 50 | 24 | 32 | 30 | 26 | 40 | 32 | 26 | 28 |
| 6.8 Member & Provider Services | | 80 | 54 | 54 | 52 | 54 | 58 | 52 | 48 | 46 |
| 6.9 Quality Improvement & Mgmt. | | 60 | 36 | 32 | 44 | 44 | 46 | 38 | 36 | 36 |
| 6.10 Reporting & Program Integrity | | 50 | 48 | 22 | 26 | 44 | 50 | 32 | 44 | 34 |
| 6.11 Financial Management | | 50 | 28 | 30 | 26 | 34 | 42 | 34 | 34 | 30 |
| 6.12 Value-Based Purchasing | | 80 | 32 | 48 | 36 | 48 | 64 | 48 | 32 | 60 |
| **Technical Proposal score** | | **1,390** | **880** | **830** | **944** | **942** | **1,146** | **932** | **954** | **1,022** |
| **References** | | | | | | | | | | |
| Reference #1 | | 100 | 82 | 100 | 100 | 92 | 92 | 73 | 0 | 100 |
| Reference #2 | | 100 | 56 | 85 | 100 | 96 | 100 | 0 | 72 | 92 |
| Reference #3 | | 100 | 0 | 100 | 85 | 100 | 96 | 92 | 95 | 92 |
| **References score** | | **300** | **138** | **285** | **285** | **288** | **288** | **165** | **167** | **284** |
| **Cost proposal** | **Program weight** | | | | | | | | | |
| Physical health | 37.09% | 400 | 320 | 400 | 400 | 120 | 326 | 400 | 116 | 196 |
| LTSS | 24.35% | 400 | 320 | 400 | 400 | 120 | 360 | 400 | 145 | 325 |
| Behavioral health | 10.62% | 400 | 320 | 400 | 400 | 120 | 155 | 400 | 170 | 223 |
| OAG | 27.95% | 400 | 320 | 400 | 94 | 120 | 400 | 400 | 200 | 280 |
| **Cost proposal score** | | **400** | **320** | **400** | **315** | **120** | **337** | **400** | **152** | **254** |
| **TOTAL SCORE** | | **2,090** | **1,338** | **1,515** | **1,544** | **1,350** | **1,771** | **1,497** | **1,273** | **1,560** |
| **Percent of total possible points** | | 100% | 64% | 72% | 74% | 65% | 85% | 72% | 61% | 75% |

Source: HSD

## Table 5: Centennial Care 2012 Proposal Scores for MCOs Also Submitting Proposals for CC 2.0

| Section # | Maximum available points | Amerigroup | BCBS | Molina | Presbyterian | United Healthcare | Western Sky |
|---|---|---|---|---|---|---|---|
| **Technical Proposal sections** | | | | | | | |
| 6.1 Experience & Qualifications | 75 | 65.81 | 64.5 | 66.25 | 61.69 | 70.63 | 66.69 |
| 6.2 Provider Network | 150 | 125.06 | 135.21 | 132.41 | 130.75 | 124.71 | 123.14 |
| 6.3 Benefits & Services | 125 | 99.63 | 114.06 | 110.13 | 114.06 | 114.06 | 100.5 |
| 6.4 Care Coordination | 275 | 220.79 | 244.2 | 247.44 | 243.98 | 249.41 | 215.98 |
| 6.5 Info Systems & Claims Management | 200 | 172.18 | 181.28 | 176.64 | 172.88 | 172.88 | 169.46 |
| 6.6 Patient-Centered Programs | 150 | 130.31 | 124.19 | 127.25 | 131.19 | 132.5 | 120.69 |
| 6.7 Native Americans | 75 | 68.88 | 69.31 | 68.0 | 68.0 | 64.06 | 62.75 |
| 6.8 Member & Provider Services | 100 | 87.31 | 88.63 | 87.75 | 89.84 | 88.19 | 85.56 |
| 6.9 Quality Assurance & Utilization Management | 100 | 83.81 | 85.56 | 86.0 | 82.5 | 82.5 | 82.5 |
| 6.10 Reporting Requirements | 100 | 82.5 | 85.56 | 87.31 | 89.94 | 80.31 | 80.75 |
| 6.11 Compliance Program | 75 | 59.25 | 68.44 | 68.44 | 68.44 | 57.94 | 57.94 |
| 6.12 Financial Management | 100 | 91.25 | 89.5 | 90.38 | 93.0 | 86.0 | 90.38 |
| 6.13 Readiness | 100 | 77.69 | 87.31 | 88.19 | 91.25 | 95.19 | 91.25 |
| **Technical Proposal score** | **1,625** | **1,364.47** | **1,437.75** | **1,436.18** | **1,437.61** | **1,418.37** | **1,347.58** |
| **Cost proposal** | | | | | | | |
| Physical health | | 330.2 | 357.32 | 350.82 | 366.35 | 347.11 | 284.64 |
| LTSS | | 238.01 | 245.21 | 204.61 | 280.12 | 308.56 | 313.43 |
| Behavioral health | | 351.09 | 376.9 | 357.21 | 352.55 | 319.52 | 344.87 |
| **Cost proposal score** | **400** | **306.43** | **326.48** | **304.21** | **333.01** | **325.06** | **314.31** |
| **TOTAL SCORE** | **2,025** | **1,670.90** | **1,764.23** | **1,740.39** | **1,770.62** | **1,743.43** | **1,661.89** |
| **Percent of total possible points** | **100%** | **82.5%** | **87.1%** | **85.9%** | **87.4%** | **86.1%** | **82.0%** |

Note: Lovelace submitted a proposal in 2012, but not in 2018.
Source: HSD