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# PROTEST OF MOLINA HEALTHCARE OF TEXAS, INC.

December 27, 2019

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December 27, 2019

**VIA HAND CARRY**

Ms. Kay Molina
Deputy Executive Commissioner of
Procurement and Contracting Services
Texas Health and Human Services Commission
4900 N. Lamar Blvd.
Austin, TX 78751-2316.

**RE: Protest of Molina Healthcare of Texas, Inc. of Noticed STAR+PLUS Awards in the Bexar, Dallas, El Paso, Harris, Jefferson, Lubbock, Nueces, Tarrant, and Travis Service Areas**

Dear Ms. Molina,

Under Texas Health and Human Services Commission (HHSC or the Commission) STAR+PLUS RFP No. HHS0002877 Section 7.2 and 1 Texas Administrative Code §§391.401 – 391.409, through undersigned counsel, Molina Healthcare of Texas, Inc. (MHT) protests its non-selection for awards in the service areas of Bexar, Dallas, El Paso, Harris, Jefferson, Lubbock, Nueces, Tarrant, and Travis. MHT further protests the selection of Aetna, Amerigroup, Superior, and United instead of MHT in these service areas. HHSC's noticed awards protested here do not: (1) achieve best value for the State, (2) protect the State's best financial interests and the health and safety of Texans, (3) best meet the needs of STAR+PLUS members, (4) promote fairness and competition for government contracts, (5) encourage and reward the continuing participation of quality contractors, or (6) comply with §2155.144 of the Texas Government Code. 1 T.A.C. §391.101(b).[1]

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[1] This protest is timely under 1 T.A.C. §391.405(a), because it is filed on HHSC's 10th business day following the posting of the noticed awards. *See* Exh. 1 (Kay Molina email). Additionally, contemporaneous with this filing, under 1 T.A.C. §391.405(d)-(e), MHT has mailed or delivered copies to all "interested parties." MHT requests a hearing or meeting with HHSC regarding the issues raised in this protest. All correspondence related to this protest should be addressed to Dennis J. Callahan at Rogers Joseph O'Donnell, P.C., 311 California Street, 10th Floor, San Francisco, CA 94104. Mr. Callahan's email address is

The non-selection of MHT in these service areas, and the selection of its competitors in lieu of MHT, reflect abuses of discretion and irrational and arbitrary awards determinations that are not supported by the record. In particular, HHSC employed a faulty evaluation process that produced unsupportable scores on the most weighty, and ultimately outcome-determinative, criterion related to HHSC assessments of liquidated damages and other sanctions in recent years. The evaluators of this criterion, Question 281, were unwilling or unprepared to make rational scoring decisions, and HHSC's procurement process failed to provide a meaningful quality control check on these scores.

To take the most egregious example, but by no means the only one, despite HHSC's assessment of over ten times the liquidated damages to Amerigroup than were assessed to MHT in the relevant period, the evaluators scored Amerigroup's proposal .93 points higher than MHT's on Question 281. Amerigroup's advantage over MHT on this question greatly surpassed its overall scoring advantage of .34 points over MHT. HHSC's completely ineffective quality assurance process failed to identify this glaring scoring error, and, as a result, Amerigroup was awarded contracts in 5 service areas over MHT, while MHT was awarded only a single service area contract. Had a proper evaluation of Question 281 been conducted, MHT would have been the top scoring offeror in all ten service areas for which it proposed to serve, and would have received awards in each of its incumbent service areas and others as well.

In another outcome-determinative scoring error, HHSC awarded United the 1.43 points available under Question 245, which concerns offerors' recent history of prohibited marketing practices. Because United had been sanctioned by HHSC for a marketing-related violation in the relevant period, under the evaluation rules United should have received only .14 points on Question 245. The 1.29 points United was wrongly awarded (1.43 - .14) vaulted United several spots up the rankings, to #2, and ahead of MHT. Had United been correctly scored, it would not have been selected for any of the six noticed awards it received in service areas in which MHT proposed to serve. MHT would have received some or all of these awards instead of United.

Further, HHSC abused its discretion, and acted unreasonably and without adequate support in the record, by giving short shrift in the awards selection process to the continuity of care objective, at least in the case of MHT. In incumbent MHT service areas, HHSC selected the new entrants of Aetna in Bexar, Dallas, and Harris, and of Amerigroup in Dallas, and did not award contracts to MHT. HHSC's noticed awards in these service areas wrongly credited very small scoring differences between the three managed care

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organizations (MCOs) at the expense of members' long-standing service coordination and associated provider relationships. In addition to violating 1 T.A.C §391.101(b), HHSC's noticed awards in these service areas violate Texas Government Code §533.002(1)(B) by not giving due regard to promoting the continuity of care of STAR+PLUS members.

More broadly, the October 22, 2019, "Action Memorandum" (Action Memo),[2] which sets forth HHSC awards decisions, is a mass of contradictions that resulted in the arbitrary and unsupported awards, and violations of the Texas Administrative and Government Codes. To name a few:

- The Action Memo rightly states that determining best value is "not always the result of a purely mathematical exercise," but then proceeds to base the awards decisions on a mathematical application of the scores, with inconsistent regard to HHSC's other stated objectives. HHSC confirmed in MHT's December 17, 2019 debriefing that the setting of awards was in fact a purely mathematical exercise.

- The Action Memo rightly states an important statutory objective of this procurement to be "supporting the delivery of services and benefits that best meet the needs of clients." Yet, the awards needlessly will dislodge over 70,000 current MHT STAR+PLUS enrollees, breaking tens of thousands of long-term, personnel relationships between MHT service coordinators (along with MHT's network of care providers and the full team of MHT staff) and the vulnerable clients they serve. Overall, the noticed awards would cause the separation of about 165,000 members from their current STAR+PLUS MCOs.

- The Action Memo notes that Texas Administrative Code requires HHSC to "encourag[e] and reward[] the continuing participation of quality contractors," but then proceeds to ignore MHT's very strong performance as a STAR+PLUS MCO, and instead installs a new STAR+PLUS entrant, Aetna, in the four largest service areas.

The award to Aetna also cannot stand because the firm submitted a materially deficient Historically Underutilized Business (HUB) Subcontracting Plan, the same problem that plagued HHSC's second attempt to resolicit the STAR+PLUS MCO contracts. The RFP required offerors to make good faith outreach efforts to HUB firms to include them in their

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[2] This Action Memo replaced a September 12, 2019, iteration that HHSC withdrew due to mistakes regarding the service areas for which certain MCOs had applied. Exh. 2 at 3.

HUB Subcontracting Plans. Aetna did not meet the good faith standard, as its HUB Subcontracting Plan had serious flaws. These included proposing to use HUB businesses whose certifications had lapsed or were soon to lapse and proposing HUB businesses to perform work in fields in which they did not operate.

The noticed awards were made from offerors' third rounds of proposals, as HHSC discovered fundamental flaws in the earlier two rounds that precluded awards. Unfortunately, the third time was not the charm, as the Commission did not recognize the significant procurement errors in this latest attempt before awards were noticed.

The Commission's new executive leadership, which was not in office during the aborted prior attempts to re-solicit the STAR+PLUS MCO contracts, and for a great majority of this procurement, should rescind the noticed awards, re-evaluate the challenged scores, and reconsider the awards set forth in the Action Memo to align with the State's objectives for the procurement. Such a reevaluation and reconsideration will result in the award to MHT of contracts in its incumbent service areas and in other service areas where it was not selected for award. Such awards will be faithful to the evaluation criteria and will appropriately honor the service coordination relationships at the core of STAR+PLUS.[3]

## FACTUAL BACKGROUND

## I. THE STAR+PLUS SOLICITATION, EVALUATIONS, AND NOTICED AWARDS

### A. The Solicitation Framework

Through the RFP, HHSC sought to recompete the STAR+PLUS MCO contracts in Texas's thirteen service areas. STAR+PLUS is a Texas Medicaid Managed Care program that delivers acute care and long-term services and supports to about 520,000 Texans who are 65 or older, blind, or disabled. Exh. 3, RFP §1.3, at 2.

HHSC's overriding mandate was to achieve best value for the State, to include, among other things, ensuring that the goods and services protect the State's best

[3] On behalf of MHT, the undersigned and other counsel submitted several requests for documents under the Texas Public Information Act (PIA). HHSC has released some, but far from all, responsive documents in response. Additionally, HHSC has referred the release of several categories of documents to the Texas Office of Attorney General. MHT reserves the right to supplement this protest as further documents become available under its PIA requests.

financial interest and the health and safety of Texans, meet the needs of clients, promote fairness and competition for public contracts, and encourage and reward the continuing participation of quality contractors. 1 T.A.C. §391.101; *see* Texas Gov't Code §2155.144 (setting forth the factors for determining best value).

The RFP's broad "mission objective" was to provide exceptional results to STAR+PLUS members through high quality and accessible medical care. Exh. 3, RFP §1.4, at 3. In delineating the "mission objectives," the RFP set forth "service coordination" as an "essential feature" of STAR+PLUS, and it requires the MCOs to provide qualified and competent service coordinators devoted to meeting the everyday needs of members. *Id.* §1.4.1, at 3. Closely related to the personal relationships at the heart of service coordination, the RFP states that established member-provider relationships should not be impacted significantly by the procurement. *Id.* §1.4.2, at 3. Next among the mission objectives, the RFP describes the MCOs' obligations to create and maintain networks of providers that can meet their clients' needs, and to deliver quality services in the most efficient and effective manner possible. *Id.* §§1.4.3, 1.4.4, at 3.

In sum, the RFP describes the STAR+PLUS model as having a personal service coordinator-member relationship at its core, with the service coordinator responsible for matching clients to a particular and customized network of medical, behavioral, emotional, and day-to-day living support providers.

### B. Evaluation Process Design and Proposal Scoring

The RFP states that the proposals will be evaluated in accordance with Texas Government Code, Title 4, Subtitle I and Title 10, Subtitle D. Exh. 3, RFP, at 158. Under HHSC's Medicaid Managed Care Program, the selection of MCOs should be designed to "improve[] the health of Texans by emphasizing prevention, promoting continuity of care, and providing a medical home for recipients." 4 Texas Gov't Code §533.002(1)(A)-(C). The Code further charges HHSC with contracting with MCOs that will "ensure[] that each recipient receives high quality, comprehensive health care services," promote "access to primary care physicians and providers," and will "reduce[] administrative and other nonfinancial barriers for recipients in obtaining health care services." *Id.* §533.002(2), (3), and (6).

The RFP set forth four evaluation factors with different point values to total 100. HHSC translated these four factors into 114 weighted criteria, each posed as a question. Factor 1, the extent to which the offerors' goods and services meet HHSC's needs, had 80 criteria, weighted .26 to 1.05, to total 48 points. Factor 2, probable vendor performance, had 23 criteria, weighted .36 to 1.42, to total 24 points. Factor 4, delivery terms, had 9 criteria

with weights from .56 to 2.24, totaling 14 points. And, uniquely concentrated, Factor 3, effect of the acquisition on agency productivity, had only 2 criteria, weighted 4.67 and 9.33, respectively, to total 14 points. *See* Exh. 4 (evaluation "Master Rollup" scoresheet).

HHSC used 33 evaluators (two of the initially assigned 35 having dropped out without being replaced) and assigned them sets of RFP responses to score on a scale of 1-10 for all proposals. After submitting their initial scores, HHSC procurement representatives held "outlier meetings" with the evaluators to discuss their scores. An "outlier" score was defined by HHSC to be a score that had a 1.25 or greater standard deviation from the other evaluators' scores on the same question. Following these meetings, the evaluators were allowed to change their scores. Exh. 2, Action Memo; Exh. 5 (Denise Burton email). HHSC procurement officials did not assess the magnitude of such scoring changes for reasonableness.

The final evaluator scores for each question were then averaged and multiplied by the weight to provide a score for the particular criterion. For example, the first criterion of Factor 1 on the "Master Rollup" spreadsheet, "Question 23," had a weight of 1.05. Aetna received scores of 8, 7, 9, and 8 from the four evaluators. The average score was 8, which, when multiplied by the weight, produced .84 points for Aetna (8 * .105). *See* Exh. 4 at 1.

For the five non-community MCOs that received awards,[4] the overall scores were as follows:

| Vendor | Overall Score |
|---|---|
| Superior | 78.71 |
| United | 78.44 |
| Amerigroup | 77.96 |
| Aetna | 77.94 |
| MHT | 77.62 |

The chart demonstrates the extreme closeness of overall scoring of the five MCOs that received awards in any of the ten service areas on which MHT bid.[5] Only 1.09 points separated the top scoring plan, Superior, from the fifth placed firm, MHT. And Aetna

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[4] MHT does not take issue with the contract awarded to El Paso First under Texas Gov't Code §533.004, and thus limits its discussion to non-community MCO plans. MHT notes that no community plan scored as highly as the leading non-community MCOs.

[5] MHT offered in Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, and Travis. Another Molina entity, Molina Healthcare of Texas Insurance Company, offered in North East, Central, and West.

and Amerigroup were scored only .32 points and .34 points higher than MHT, respectively. The closeness of the overall scoring is critical, because it enabled the scoring differentials that resulted from arbitrary and irrational scoring of Question 281 to far exceed the overall differences between MCOs. The unsupportable scoring of Question 281 ultimately determined the final score rankings of the offerors.[6]

### C. The Action Memorandum's Award Recommendations

HHSC's awards recommendations, which were approved by the Executive Commissioner and constitute the basis for the noticed awards, are set forth in the October 22, 2019, Action Memo. It synopsizes "best value" in the context of this procurement as the offeror that will best meet the procurement objectives of "service coordination, minimal impacts to continuity of care, timely and quality care through adequate networks, as well as the provision of quality services in the most efficient and effective manner possible." Exh. 2 at 4, Action Memo. The Action Memo cautions that the "best value determination is not always the result of a purely mathematical exercise." *Id.*

The Action Memo makes recommendations as to the number of MCOs in each service area and concerning a "covered lives selection cap," *i.e.,* the maximum number of enrollees each MCO could have at the start of performance. Through these recommendations, HHSC purports to keep the number of MCOs in each service area low enough so that they remain economically sustainable and to limit the overall number of enrollees in any one plan as a means to reduce the State's risk. But the Action Memo fails to outline how each of these recommendations is to be implemented.

The Action Memo then explains how HHSC determined its best value recommendations through these competing requirements. These included the federal requirement that each service area have at least two MCOs; that the "sustainable MCO" levels asserted earlier are honored; that mandatory contracts under Texas Government Code §533.004 be awarded as appropriate; that the recommendations "support the RFP's mission objectives, in particular continuity of care where possible"; and that the awards make the "fewest possible deviations" from the evaluators' scores "by progressing through the largest SA populations for STAR+PLUS to the smallest in order to implement the recommended selection caps." *Id.* at 7. Although the Action Memo states that the "results of the oral presentations supplemented the written proposals to form the basis of the recommendations"

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[6] Likewise, the closeness of the overall scores highlights the critical importance of the arbitrary and unearned 1.29 points United received on Question 245. *See supra* Section IV. These 1.29 points lifted United's ranking from a position where it would not have received any service area contracts to the #2 ranking, which garnered United several awards.

(*Id.* at 3), it is clear that HHSC gave oral scores no weight whatsoever in the award determinations.

The Action Memo makes evident that there is a direct tension between meeting the continuity of care mission objective and crediting the evaluated scores of the offerors. The Action Memo states that both considerations will determine awards when "possible." And while it is not entirely clear from the Action Memo how HHSC counted "covered lives" for the purpose of determining when an MCO had reached its cap, the Action Memo appears to indicate that HHSC only considered continuity of care in the context of applying the covered lives cap. That is, it appears that the four top scoring MCOs were allocated service area contracts, matched to their incumbent service areas as applicable, until they were "capped out." The result was that, despite disavowing that awards determinations were a "purely mathematical exercise," based on small (and, as detailed herein, fundamentally flawed) scoring differences the top two highest scoring MCOs in the protested service areas (Superior and United) each received 9 awards, the next highest scoring MCO (Amerigroup) received 5 awards, the next highest (Aetna) 4 awards, and the next highest (MHT) received a lone award.

The chart below shows the STAR+PLUS awards by service area, whether the awarded MCOs were incumbent or new, MCOs displaced from incumbency, and member populations.

STAR+PLUS RFP Awards

| | | | | | | | | | | | | | | Current Footprint | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Bexar | Dallas | El Paso | Harris | Hildago | Jefferson | Lubbock | Nueces | Tarrant | Travis | East | Central | West | Members | Current Service Areas | New Service Areas |
| Total STAR+PLUS Eligibles | 45,363 | 61,417 | 21,018 | 104,488 | 62,643 | 18,672 | 13,062 | 20,355 | 40,580 | 25,225 | 44,288 | 29,642 | 35,086 | 521,839 | 13 | |
| Centene/Superior | 28,104 | 25,913 | | | 31,583 | | 6,878 | 10,438 | | | | 15,415 | 19221 | 137,552 | 7 | 9 |
| United | | | | 54,379 | | 6,838 | | 9,917 | | 14,183 | 23,783 | 14,227 | | 123,327 | 6 | 9 |
| Amerigroup | 9,529 | | 11,343 | 38,380 | | 5,947 | 6,184 | | 29,579 | 11,042 | | | 15,865 | 127,869 | 8 | 5 |
| Aetna | | | | | | | | | | | | | | | 0 | 4 |
| Molina HC Tex (MHT) | 7,730 | 35,504 | 9,675 | 11,729 | 14,435 | 5,887 | | | | | | | | 84,960 | 6 | 1 |
| Molina HC Tex Ins Co (MTIC) | | | | | | | | | | | | | | | 0 | 1 |
| El Paso First | | | | | | | | | | | | | | | 0 | 1 |
| Cigna | | | | | 16,625 | | | | 11,001 | | 20,505 | | | 48,131 | 3 | 0 |

Incumbent MCO Maintaining
New MCO
Incumbent MCO Removed

## ARGUMENT

## II. THE LEGAL STANDARDS GOVERNING THIS PROTEST

Texas agency decisions that are subject to judicial review are governed by the State's Administrative Procedures Act (APA). *See* Tex. Gov't Code § 2001.171; *Texas Logos, L.P. v. Texas DOT*, 241 S.W.3d 105, 123 (Tex. App. 2007). HHSC's bid protest mechanism resolves, internally by the Commission, challenged agency decisions, in the form of bid protest issues, that would be adjudicated in court were that forum available. Accordingly, the APA standards should apply in this proceeding to the determination of whether a statutory or regulatory violation occurred with respect to the noticed awards.

The Texas APA standards are similar to those controlling federal agency decision making, and those of states throughout the Union. 5 U.S.C. § 701 *et seq.*; *Level 3 Commc'ns, LLC v. United States*, 129 Fed. Cl. 487, 496 (2016) (under the federal APA, courts review agency decisions to determine whether the agency violated a federal law or regulation and whether the agency's action is arbitrary, capricious, or an abuse of discretion); *Texas Dep't of Protective & Regulatory Servs. v. Mega Child Care, Inc.*, 145 S.W.3d 170, 180 (Tex. 2004) (Texas APA is based on the multi-state Model Administrative Procedure Act and Texas courts can look to the federal APA for guidance). These familiar and time-tested standards should guide HHSC's internal deliberations in this matter.

Under the Texas APA, "An agency's decision is arbitrary or results from an abuse of discretion if the agency: (1) failed to consider a factor the legislature directs it to consider; (2) considers an irrelevant factor; or (3) weighs only relevant factors that the legislature directs it to consider but still reaches a completely unreasonable result." *City of El Paso v. Pub. Util. Comm'n of Texas*, 883 S.W.2d 179, 184 (Tex. 1994). The Texas APA requires agencies to provide a sufficient and accurate basis for agency decisions, with "clear and specific" findings that have factual support. *Texas Health Facilities Comm'n v. Charter Med.-Dallas, Inc.*, 665 S.W.2d 446, 451 (Tex. 1984). "A mere conclusion or a recital of evidence is inadequate." *Id.* This bid protest review must consider whether HHSC has violated Texas law or regulation, exceeded its statutory authority, failed to demonstrate substantial evidence for its decision in light of the record for the decision, and/or acted in an arbitrary or capricious manner characterized by an abuse of discretion or clearly unwarranted exercise of discretion. *See id.* at 450.

Because there are few published bid protest decisions in Texas, MHT here relies on federal decisions that apply the APA standards to similar procurement requirements in the bid protest context. This approach is consistent with the many states that look to federal bid protest decisions for guidance. *See, e.g.*, *Rochester City Lines, Co. v. City of*

*Rochester*, 868 N.W.2d 655, 661 (Minn. 2015) (observing that because federal procurement law has the same basic objectives as the state, federal bid protests cases "are instructive" in determining whether the procurement actions of local officials in the "'best value' bidding process" were "unreasonable, arbitrary, or capricious"); *Wiseman Const. Co. v. Maynard C. Smith Const. Co.*, 236 W. Va. 351, 360 (2015); *Urban Dev. Sols., LLC v. D.C.*, 992 A.2d 1255, 1266 (D.C. 2010); *Pac. Architects Collaborative v. State of California*, 100 Cal. App. 3d 110, 125 (Ct. App. 1979) ("We are strongly persuaded by decisions relating to federal procurement bidding.").

It makes sense that HHSC similarly consider federal decisions, particularly of the Government Accountability Office (GAO), as persuasive authority to guide resolution of this protest. For more than 90 years GAO has provided an objective and impartial forum for adjudicating and resolving disputes concerning the award of federal contracts. Through thousands of published decisions, the GAO has created the largest and most robust and nuanced body of bid protest law in the United States.

## III. FUNDAMENTAL FLAWS IN THE PROCUREMENT PRECLUDE THE COMMISSION FROM PROCEEDING WITH THE NOTICED AWARDS

HHSC's scoring process suffered serious problems that improperly skewed the scores, and resulted in MHT not being awarded many service area contracts that it had duly earned. In particular, the scoring of Question 281, which alone constituted 9.33% of offerors' overall scores, was plagued by scorer errors that prevented MHT from obtaining what should have been the highest overall evaluated score. These errors should have been identified and addressed by HHSC procurement officials as part of their quality assurance process, but were not. The public record available on HHSC's own website shows that the scoring advantages MHT's competitors received on Question 281 were arbitrary, unearned, and unsupportable. Proper rescoring of Question 281 will entitle MHT to awards in all of its incumbent service areas, as well as contracts in all new service areas in which it bid.

### A. The Determinative Differences in the "Good Working Relationship" Scores Are Irrational and Unsupported by the Public Record

HHSC's evaluation of Question 281 was plagued by serious and unchecked problems associated with the willingness and preparedness of evaluators to provide supportable scores. Ultimately, the evaluators' scoring of Question 281 cannot be squared with sanctions data available in the public record, principally the liquidated damages and corrective action plans (CAP) information that HHSC posts to its "Managed Care Organization Sanctions" web page.

**1. The Design and Scoring of the "Good Working Relationship" Question 281**

According to statute, in determining best value, HHSC may take into account "the effect of [the] acquisition on agency productivity." Tex. Gov't Code §2155.144(d)(9). HHSC accorded this factor a weight of 14%, divided among two subfactors: (1) effort required by HHSC to monitor the vendor's performance, and (2) the effort required by HHSC to maintain a good working relationship with the vendor. Exh. 3, RFP, at 159 (Evaluation Subfactors 3.a. and 3.b.). Although unknown to the offerors at the time of proposal submission, HHSC assigned 9.33 points – by far the highest single point value of any evaluation criterion – to the "good working relationship" subfactor 3.b., and asked evaluators only a single question, Question 281, in making this assessment:

> To what extent do Respondent's Section 6.1.7 submissions demonstrate an unlikelihood of potential performance issues? If a Respondent has none, please provide maximum score.

Exh. 4 at 9.

RFP Section 6.1.7 responses were to be part of the offerors' business proposals. For respondents who had past performance as an MCO with HHSC (all of the awardees did), Section 6.1.7 required the self-reporting of information concerning HHSC's assessment of liquidated damages, CAPs, deficiency and cure notices, audits and performance reports. Exh. 3, RFP §6.1.7, at 219.

The procedural and substantive flaws related to the Question 281 evaluation had a devastating effect on MHT's overall score and ranking, and ultimately on the service area contracts it would receive. Without the Question 281 scoring, MHT's proposal would have been the highest ranked in the ten Service Areas for which it proposed to serve.

| | Aetna | AmeriGroup | MHT | Superior | United |
|---|---|---|---|---|---|
| Score | 77.94 | 77.96 | 77.62 | 78.71 | 78.44 |
| Score Excluding Question 281 (Good Working Relationship ) | 70.16 | 71.11 | 71.71 | 71.56 | 71.28 |
| Ranking | 4 | 3 | 5 | 1 | 2 |
| Ranking Excluding Question 281 | 5 | 4 | 1 | 2 | 3 |

Specifically, with 3 evaluators scoring Question 281 on a 1-10 scale, there were 30 increments of scores available (3 * 10). With this criterion valued at 9.33 points, each increment from each evaluator was worth .31 points to an offeror's overall score (9.33 ÷ 30). The scoring of Question 281 was as follows:

| Offeror | Evaluator Scores | Average Score | Question 281 Score (Avg. * .933) | Question 281 Advantage over MHT |
|---|---|---|---|---|
| Aetna | 7, 10, 8 | 8.33 | 7.78 | 1.87 |
| Amerigroup | 7, 10, 5 | 7.33 | 6.84 | .93 |
| MHT | 7, 7, 5 | 6.33 | 5.91 | - |
| Superior | 7, 8, 8 | 7.66 | 7.16 | 1.25 |
| United | 7, 8, 8 | 7.66 | 7.16 | 1.25 |

The overall score advantage each MCO had against MHT was less than their advantage on Question 281 alone. Superior and United gained 1.25 points on MHT on Question 281, but outscored MHT overall by only 1.09 and .82 points, respectively. And the 1.87 and .93 gains by Aetna and Amerigroup were much larger than their small .32 and .34 margins over MHT overall. These observations highlight the critical importance of HHSC's failure to ensure that the Question 281 evaluators use validated data under meaningful quality control.

As shown below, the public record demonstrates that MHT has a much better Section 6.1.7 history than Amerigroup and Superior, and essentially an equivalent Section 6.1.7 performance to Aetna and United. Despite these facts, MHT lost substantial and outcome-determinative ground to all of these firms on Question 281.

### 2. The Public Record on Liquidated Damages

Of the data provided by MCOs under RFP §6.1.7, liquidated damages are the most accurate and straightforward measure of a vendor's non-compliance with the requirements of the various HHSC programs on which it operates. Liquidated damages are a strong and quantifiable indicator of potential performance issues HHSC is likely to encounter with the reporting MCO. HHSC has described liquidated damages as a "transparent and thorough process for assessing and remediating contractor deficiencies." Exh. 6, February 2017 HHSC Contract Management Report. HHSC notes that the amounts of liquidated damages assessed is calibrated to the severity and recurrence of the deficiency, stating that the "assessment of liquidated damages is thoroughly reviewed by leadership and any mitigating circumstances are considered … [in determining] whether the liquidated damages should be maintained, reduced or waived." *Id.*

Liquidated damages are a better sanctions measure than CAPs because the vast majority of liquidated damages included corresponding CAPs, but some CAPs prove to be so minor or are remediated so quickly that they never result in liquidated damages. Thus,

liquidated damages are themselves a fair and accurate way to assess the significance of CAPs.[7] And liquidated damages are superior to audits as a measure of sanctions because the mere fact that HHSC Office of Inspector General (OIG) or other audits are open on a particular MCOs is no reason to downgrade its proposal under Question 281. The OIG audits identified in MHT's Section 6.1.7 response, for example, were not triggered by suspected or actual regulatory or contractual non-compliance on MHT's part; rather, the audits were just part of HHSC's routine oversight process.

Proposals in response to the third STAR+PLUS solicitation by HHSC were due in November 2018 (First Quarter, Fiscal Year 2019), and Section 6.1.7 required responses to include liquidated damages going back three years, to the first quarter of FY 2016. Exh. 7 (RFP Q&A 109-RFP-053). The data posted to the HHSC "MCO Sanctions" web page is current through Q3 FY 2017, meaning that there are seven quarters of relevant liquidated damages data available, Q1 FY 2016 – Q3 FY 2017. The liquidated damages amounts over this period are shown in the following chart.[8]

| | 2016 Q1 | 2016 Q2 | 2016 Q3 | 2016 Q4 | 2017 Q1 | 2017 Q2 | 2017 Q3 | Q1 FY 2016 - Q3 FY 2018 LDs |
|---|---|---|---|---|---|---|---|---|
| Aetna | $33,250 | $2,300 | $36,000 | $5,500 | $30,500 | $8,025 | $250 | $115,825 |
| Amerigroup | $302,250 | $297,500 | $147,200 | $2,260,000 | $3,017,000 | $3,529,700 | $7,488,250 | $17,041,900 |
| Molina | $1,250 | $900 | | $200 | $5,200 | $38,040 | $1,471,050 | $1,516,640 |
| Superior | $30,550 | $564,390 | $18,200 | $100 | $30,550 | $564,390 | $5,863,400 | $7,071,580 |
| United | $155,250 | $201,000 | $77,500 | $60,100 | $424,200 | $160,878 | $129,400 | $1,208,328 |

[7] To the extent evaluators remarked on open CAPs to determine scoring under Section 6.1.7, the observation is misplaced. Even if quickly remediated, it is HHSC's practice to keep CAPs open for at least three fiscal year quarters to ensure that the remediation sticks.

[8] The supporting data is taken from the HHSC "MCO Sanctions" web page. *See* Exh. 8 (Aetna liquidated damages); Exh. 9 (Amerigroup liquidated damages); Exh. 10 (MHT liquidated damages); Exh. 11 (Superior liquidated damages); Exh. 12 (United liquidated damages).

### 3. The Public Record Reveals That HHSC's Scoring of Question 281 is Illogical and Unsupportable

The public record of liquidated damages HHSC has assessed demonstrates that the evaluations of Question 281 were arbitrary and unsupported. The Question 281 scores are so palpably contrary to the facts that they cannot be explained away as appropriate exercises of evaluator discretion.[9]

#### a. Amerigroup's Evaluation Advantage over MHT on Question 281 is Illogical and Unsupportable

Amerigroup's overall score was .34 points higher than MHT's. This advantage was dwarfed by its .93 point advantage over MHT on Question 281. This entire advantage was due to Evaluator 9 scoring Amerigroup a "10" and scoring MHT a "7."[10] In fact, MHT's performance under RFP Section 6.1.7 is significantly better than Amerigroup's, not worse. Instead of losing .93 point to Amerigroup, MHT should have received higher scores on Question 281 than Amerigroup. This swing would have vaulted MHT above Amerigroup, and MHT would have displaced Amerigroup in Bexar, Dallas, Harris, Jefferson, and Tarrant, all of which are service areas that Amerigroup was awarded over MHT.

Question 281 tasked the evaluators to assess the following.

> To what extent do Respondent's Section 6.1.7 submissions demonstrate an unlikelihood of potential performance issues? If a Respondent has none, please provide maximum score.

With over $17 million in liquidated damages in the relevant period, Amerigroup had more than twice the amount of any other awardee (Superior at $7 million), and over eleven times the liquidated damages as MHT's $1.5 million. Yet, Evaluator 9

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[9] As explained, the public record of HHSC's assessment of liquidated damages against the noticed awardees is squarely within the data MCOs were required to submit in response to RFP Section 6.1.7. MHT has compared its proposal to the liquidated damages and CAPS information on HHSC's MCO Sanctions web page, and confirms that it matches. To the extent a noticed awardee was non-forthcoming in its Section 6.1.7 responses, it should be disqualified from this competition and reported to the HHSC Office of Inspector General.

[10] Evaluator 8 scored Amerigroup and MHT at "7" (Exh. 13, MHT's consolidation of Evaluator 8's scored onto a single scoresheet), and Evaluator 32 scored each firm a "5." Exh. 14, MHT's consolidation of Evaluator 32's scores onto a single scoresheet.

scored Amerigroup a perfect "10," the point value Question 281 directed evaluators to reserve for offerors who had no sanctions to report. Her only explanatory comment for this score is "Post outlier comment changed due to additional information." Exh. 15, Evaluator 9's final scoring spreadsheet of Amerigroup.

Moreover, a large proportion of Amerigroup's liquidated damages were in areas that are likely to impair Amerigroup's ability to maintain a "good working relationship" with HHSC, *i.e.,* the crux of Subfactor 3.b under review. *See* Exh. 3, RFP §4.1.2 (3.b), at 159. For example, of the total of nearly $14 million of liquidated damages assessed in FY 2017, over $10 million were for "encounters." *See* Exh. 9, Amerigroup liquidated damages from HHSC's MCO Sanctions web page. Encounter data is information MCOs must submit to HHSC that enables the State to set accurate capitation rates. The Medicaid system simply cannot function properly without timely, accurate, and complete encounter data reports from MCOs. It is impossible to conceive of an MCO maintaining a "good working relationship" with HHSC where the MCO is incurring such high encounter-related liquidated damages.[11]

Nor may Amerigroup's gain of .93 points over MHT be explained by CAPs, each of which must be examined on its own merit. Evaluator 9's comment on her scoring of MHT's proposal a "7" was: "September 2018 - There is an open Corrective Action Plan (CAP) with HHSC-OIG. Page 1489. Also open CAPs, one is with Starplus (page 1490)." Exh. 16, Evaluator 9's final scoring spreadsheet of MHT. But, the existence of an ongoing HHSC OIG audit does not in and of itself provide any information regarding the MCO's culpability, as many audits make no or minimal adverse findings.[12] There is no information in the record as to how HHSC trained the evaluators to assess HHSC OIG audits, and Evaluator 9 wrongly appears to take the existence of such audits as a *per se* indication of non-compliance. In any event, HHSC's posting of MCO CAPs for October 2018 also shows Amerigroup as subject to an IG Audit in all service areas for all programs. Exh. 17. It also

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[11] Likewise, about $750,000 of the liquidated damages assessed to Amerigroup in FY 2017 was related to nursing facility claims processing. *See* Exh. 9. Nursing facilities are key components of the STAR+PLUS program that historically operate on thin margins with frequent cash flow challenges. It would injure an MCO's ability to maintain a good working relationship with HHSC where nursing facilities are understandably complaining to HHSC that an MCO is not paying claims on a timely basis.

[12] As stated, the open HHSC OIG audits of MHT reflected routine oversight, and were not the result of actual or suspected contractual or regulatory non-compliance on MHT's part.

shows 4 HHSC CAPs for Amerigroup under "All Programs," and 4 more CAPs that call out the STAR+PLUS Program specifically, for a total of 8 STAR+PLUS-related CAPs. Exh. 17.

No reasonable and objective reviewer of these facts can conclude that there was any basis whatsoever for Evaluator 9 either to score Amerigroup a "10" or to score Amerigroup higher than MHT on Question 281. *See Deloitte Consulting, LLP,* B-412125.2, B-412125.3, 2016 CPD ¶119 (Apr. 15, 2016) at 16 (sustaining protest where the contemporaneous record contains no justification for the past performance ratings assigned to offerors). Nor was it reasonable or supportable for Evaluators 8 and 32 to score Amerigroup on a par with MHT on Question 281, where HHSC assessed eleven times the liquidated damages against Amerigroup than it did against MHT in the relevant period.

**b. Superior's Evaluation Advantage over MHT on Question 281 is Illogical and Unsupportable**

Superior's overall score of 78.71 was 1.09 points higher than MHT's score of 77.62. Superior's 1.25 point advantage over MHT on Question 281 alone eclipsed Superior's overall scoring advantage. The relative scoring of these two firms on this determinative question cannot withstand your Office's scrutiny. The public record shows that HHSC's assessment of liquidated damages against Superior in the relevant period of over $7 million (Exh. 11) was more than three times those the Commission assessed against MHT ($1.5 million). Exh. 10. MHT's past performance/sanctions record in the relevant period is far better than Superior's, and simply cannot be reconciled with the scoring. Had Question 281 been appropriately scored, MHT would be ahead of Superior, and entitled to awards in Bexar, Dallas, El Paso, Lubbock, Nueces, and Travis.

Superior's unmerited 1.25 point advantage over MHT primarily is attributable to Evaluator 32, who scored Superior an "8" and MHT a "5." This 3-point difference contributed .93 points to Superior's 1.25 point gain on this criterion. Evaluator 9, who scored Superior an "8" and MHT a "7," contributed the other .31 points to the 1.25 point difference. None of the comments from either evaluator supports their assessments.

Remarkably, Evaluator 32's initial evaluations scored Superior a perfect "10." His comment on his final evaluation of Superior of "8" states:

> Respondent's information provided in Section 6.1.7. demonstrates that potential performance issues will be remediated quickly. Post Outlier Meeting - Changing from 10 to 8 after discussions in outlier meeting. Reviewer was unaware of scoring guide scale and changed score to reflect reviewer's updated awareness and orginal evaluation. Exh. 18.

It is unclear how Evaluator 32 arrived at his conclusion that Superior's "potential performance issues will be remediated quickly." That is demonstrably at odds with Superior's very high liquidated damages total. After all, duration of non-compliance is a key element embedded within HHSC's liquidated damages assessments. In this regard, HHSC's "Deliverables/Liquidated Damages Matrix" includes "Measurement Period" as a factor in the assessment of liquidated damages. Exh. 19. The Matrix defines "Measurement Period" to be the "Period during which HHSC will evaluate service for purposes of tailored remedies." *Id.* And, conversely, that MHT's liquidated damages were significantly lower than Superior's is very strong, and perhaps conclusive, evidence that MHT's "performance issues" have been less significant and have been remediated quicker than Superior's. Evaluator 32's mistaken evaluation did not take account of this very relevant information.[13]

Evaluator 32's comment that purports to explain his score of MHT's Section 6.1.7 response states:

> Respondent's information provided in Section 6.1.7. demonstrates likelihood of potential performance issues by the amount of active CAPs that are currently open. Post Outlier Meeting - Changing from 7 to 5 after discussions in outlier meeting. Reviewer was unaware of scoring guide scale and changed score to reflect reviewer's updated awareness and orginal evaluation.[14] Exh. 20.

As explained above, merely counting open CAPs, as Evaluator 32 appeared to do, is a very poor measure for determining whether an MCO is apt to maintain a "good working relationship" with HHSC. As with audits of MCOs, there is no indication of the training provided to evaluators in assessing CAPs, and Evaluator 32 seemed to believe that merely counting CAPs constituted an appropriate evaluation. In any event, Superior and MHT both had 10 HHSC CAPs at the time of proposal submission. Exh. 17. Thus, even under Evaluator 32's mistaken reliance on CAP counts, he had no basis to score MHT a full 3 points lower, or .93 overall evaluation points lower, than Superior.

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[13] As with the assessment of Question 281 for Amerigroup, Superior's proposal response to RFP Section 6.1.7 should be compared to the public record of liquidated damages on HHSC's MCO Sanctions web page to determine if Superior's proposal is forthcoming in this regard. Exh. 11.

[14] Evaluator 32 misspelled "original" as "orginal" in the comments to his Question 281 evaluation of MHT, Superior, and other offerors. This shows that many of his comments were merely copy-and-pastes.

For her part, Evaluator 9 merely repeated the identical, uninformative comment she had made with respect to her other Question 281 evaluations: "Post outlier comment changed due to additional information." Exh. 21. If this evaluator had any basis for evaluating Superior's proposal higher than MHT's she did not state it.

Beyond the record of liquidated damages and CAPs, Superior's ability to meet the needs of Medicaid recipients in Texas has been called into serious question in recent years. What is more, rather than acknowledge its shortcomings and undertake remedial measures, Superior's attitude has been one of callous disregard to its performance failures. Here, an offeror's demonstrable ability to continuously provide high quality medical care to members without overly taxing HHSC's administrative capacity was key to the Factor 3 evaluations. *See* Exh. 3, RFP §4.1.2, at 159. In the circumstances, the awards to Superior cannot be supported as presenting the best value to the State.

Two cases described in an award winning investigative series by the *Dallas Morning News*, "Pain & Profit: Your tax money may not help poor, sick Texans get well, but it definitely helps health care companies get rich," illustrate the point. *See* Exh. 22 (excerpts of news story). Superior denied the doctor's recommendation that an infant, D'Ashon Morris, receive 24-hour care due to his tendency to pull out his breathing tube. Superior avoided the $500/day cost, but the gamble did not pay off. While unattended, D'ashon pulled out his breathing tube, suffocated, and suffered brain damage that left him in a permanent vegetative state. And Superior denied STAR+PLUS member Heather Powell, who is a quadriplegic, basic services and accommodations, such as a hydraulic lift to access or wheelchair and a tool to control the lights remotely, and reduced her daily care giver support from 12 hours to 7. *Id.*

These failures are illustrated in HHSC's record of Superior's liquidated damages assessments. The great majority of the approximately $6.4 million in liquidated damages assessed Superior for FY 2017 concerned the failure to "to provide administrative service to cover member." *See* Exh. 11. Superior's repeated failures in the most basic function of an MCO is diametrically opposed to the conclusion that HHSC will not have to expend considerable effort to maintain a good working relationship with Superior.

It is unconscionable that, given the well-founded outcry Superior recently has faced over its practices, HHSC would facilitate Superior's ability to further strengthen its STAR+PLUS MCO position. Yet, under HHSC's evaluations, Superior (1) did not lose a single one of its seven incumbent service area contracts; (2) added two service areas to the STAR+PLUS contracts it holds; and (3) very likely will increase its number of STAR+PLUS enrollees from about 135,000 to over 150,000. Coming on the heels of revelations of

Superior's repeated choosing of profits at the expense of adequate medical care, these stark facts are a slap in the face to STAR+PLUS members.

**c. United's Evaluation Advantage over MHT on Question 281 is Illogical and Unsupportable**

Evaluator 9 scored United's Section 6.1.7 response as an "8" to MHT's "7" (contributing .31 to United's overall scoring advantage against MHT), and Evaluator 32 scoring United as an "8" to MHT's "5" (providing United a .93 gain). United's overall score of 78.44 was .82 point higher than MHT's 77.62, which is less than its unwarranted 1.25 point gain over MHT on Question 281.

As shown in the chart above, the liquidated damages assessed to the two firms in the relevant period was very close – $1.2 million for United and $1.5 million for MHT. The two actual evaluators of Question 281 failed to provide any substantive explanation for their scores. *See* Exh. 5 (Denise Burton email letter requiring evaluators to provide comments for all scores).

Because the outcome-determinative scoring of United's Section 6.1.7 response is not adequately documented, this protest must be sustained. *Computer Sciences Corp.; HP Enterprise Servs., LLC,* B-408694.7 *et seq.,* 2014 CPD ¶331 (Nov. 3, 2014), at 10 (sustaining protest where the challenged past performance evaluation was unreasonable and undocumented, and where it was not based on the relevant information).

**d. Aetna's Evaluation Advantage over MHT on Question 281 is Illogical and Unsupportable**

Both Evaluator 9 and Evaluator 32 scored Aetna 3 points higher on Question 281. Evaluator 9 scored Aetna a "10" (Exh. 23) and MHT a "7" (Exh. 16), and Evaluator 32 scored Aetna an "8" (Exh. 29) and MHT a "5." Exh. 20. This cumulative 6-point difference resulted in Aetna scoring 1.87 points higher on this criterion alone, which was about 6 times Aetna's .32 point advantage over MHT in the overall scoring. The huge, outcome-determinative gain for Aetna is unsupported by the record.

First, the scoring instructions did not allow Aetna to be scored a "10" by Evaluator 9. Those instructions state that "10s" are reserved for those offerors whose Section 6.1.7 submissions report no CAPs, liquidated damages, etc. *See, e.g.,* Exh. 4 at 9 (Question 281) ("If Respondent has none, please provide maximum score."). Here, Aetna had 5 open CAPs at the time of submission (Exh. 17), and about $39K in liquidated damages in the relevant period (Exh. 8), so Evaluator 9's score is directly contrary to the scoring rules. *Brican Inc.*, B-402602, 2010 CPD ¶ 141 at 3-4 (June 17, 2010) (sustaining protest where agency

disparately applied evaluation scheme with respect to the same requirements, resulting in one proposal receiving an improper advantage); *The Clay Group, LLC*, B-406647, 2012 CPD ¶ 214 at 7 (July 30, 2012) (sustaining protest where scoring in a particular category was not applied consistently across proposals).

Additionally, Aetna's relatively low publicly reported liquidated damages amount is largely the product of its minor presence in HHSC's Medicaid programs. In fiscal years 2016 and 2017, Aetna performed only about $550 million of MCO work for HHSC, and in only the Bexar and Tarrant service areas. In the same period, MHT performed about $4.5 billion of such work, an 8-fold increase over Aetna, and in many service areas.[15] And, MHT's HHSC MCO business has been primarily in the STAR+PLUS program, while approximately 80% of Aetna's HHSC MCO business has been in the STAR program ($435 million of $550 million). Because liquidated damages are much more prevalent in programs that cover vulnerable populations, like STAR+PLUS, than in programs that cover healthier members, like STAR, Aetna's low liquidated damages are not a fair comparison to those MCOs who primarily service vulnerable groups.

It was irrational for HHSC to oust a high-performing and experienced STAR+PLUS partner like MHT from the Bexar, Dallas, and Harris service areas, in favor of new entrant Aetna based on Aetna's inflated Question 281 scores. In particular, Aetna's 7.78 score (vs. MHT's 5.91) on this criterion was more a reflection of its paucity of work in Texas than it was indicative of its ability not to incur liquidated damages for programmatic non-compliance.

Despite Aetna's current absence from and lack of experience in STAR+PLUS, HHSC selected it for awards in the four largest service areas: Bexar (about 45,000 STAR+PLUS eligibles), Dallas (61,000), Harris (105,000), and Hidalgo (65,000). Combined, these awards install Aetna as an MCO option in service areas that cover over half of the 520,000 STAR+PLUS eligibles. This huge leap, from a complete absence in STAR+PLUS to potentially the largest MCO contractor in the Program, cannot be supported as a best value proposition to the State. Moreover, it presents an undue undertaking of risk for HHSC, potentially straining the Agency's resources and impacting its productivity, while

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[15] Recall that Evaluator 9 scored MHT a "7" due to MHT's open CAPs (Exh. 16), of which there were 10 at the time. *See* Exh. 17. Yet, Evaluator 9 scored Aetna a "10" when its CAPs (5) were half as many as MHT's, but MHT had eight times the work on which to incur CAPs. *See* Exh. 17. This arbitrary and inconsistent scoring cannot withstand your Office's scrutiny. *See Iap World Servs., Inc.; Emcor Gov't Servs.*, B-407917.2, 2013 CPD ¶ 171 at 8 (July 10, 2013) (sustaining protest where agency disparately evaluated proposals and did not apply evaluation scheme equally).

also posing significant risk of deficient performance during the Transition Phase. In this regard, Aetna will need to build out a contractually compliant provider network, including nursing facilities, in addition to standing up a compliant Medicare Medicaid Program (MMP) contract, to serve STAR+PLUS members in these service areas.

### B. HHSC's Management of the "Good Working Relationship" Evaluation Process Was Gravely Flawed

The unsupported and arbitrary scoring of Question 281 was rooted in evaluation process failures. The individual evaluators were unwilling or unprepared to provide logical, reasoned scoring assessments for Question 281, and HHSC's administration of the evaluation process failed to provide a meaningful quality control check of the scoring. In all, HHSC's implementation of the evaluation simply was not up to the task of making the reasoned and supported assessments of the proposals necessary to identify the best value STAR+PLUS MCOs for the State.

#### 1. Contrary to the HHSC's Evaluation Rules, Only Two Evaluators Assessed the "Good Working Relationship" Criterion

Among HHSC's ground rules controlling the evaluation process was one that required a minimum of three evaluators to score each question. Exh. 25 ("Master Rollup" "Evaluation Tool Key" page).[16] While some evaluation questions were scored by four evaluators, HHSC assigned the minimum of three evaluators to the "good working relationship" Question 281: Evaluator 8, AF; Evaluator 9, MF, and Evaluator 32, JT.[17] In fact, however, Evaluator AF effectively did not participate in the scoring of Question 281, or any other question to which he was assigned. HHSC procurement officials did not notice or did not care about Evaluator 8's abandonment of his role of identifying the best STAR+PLUS MCO partners for the State. As a result, HHSC had, in effect, only two evaluators who scored this most crucial factor, not the minimum of three as set forth in HHSC's evaluation rules.

Evaluator 8 scored every one of the fifteen proposals exactly the same on every question, including Question 281. AF scored every offeror a "7" on this criterion, without discriminating between offerors at all. On the other 12 questions assigned to AF, he

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[16] When Evaluator 11, who was assigned to four questions, dropped out, HHSC did not replace her, because, as stated in a comment box: "No Question assigned dropped below the 3 Evaluator Minimum." Exh. 25.

[17] To avoid unnecessarily personalizing its challenges to evaluators' conduct and scores, this protest uses only the numbers assigned and the initials of evaluators.

scored every proposal an "8." Exh. 13 (MHT's consolidation of Evaluator 8's scores onto a single scoresheet). In sum, even though he lodged 195 separate scores (13 questions * 15 proposals), AF made no effort whatsoever to identify the best value firms for the State. His non-participation caused a violation of HHSC's ground rules by reducing to two the number of evaluators participating in the assessment of Question 281, *i.e.,* below the State's minimum of three evaluators. And, indeed, every one of the 13 questions AF scored were "3-evaluator" questions, meaning that the evaluation of all 13 of those questions violated HHSC's evaluation ground rules.[18] This violation of HHSC's evaluation ground rules requires that this protest be sustained. *See Savvee Consulting, Inc.,* B-408416, B-408416, 2013 CPD ¶231, at 7 (Sept. 18, 2013) (protest will be sustained where the agency's documentation does not adequately support the findings on which award determinations are made).

### 2. HHSC Procurement Officials Exerted No Meaningful Control Over the Evaluation Process

The situation with Evaluator 8 was not unique, as other evaluators failed to meaningfully differentiate between proposals on other criteria. Evaluator 1 was responsible for assessing 15 questions. Of her 225 scores (15 proposals * 15 questions), she awarded 224 "9s" and one "8." Exh. 26 (MHT's consolidation of Evaluator 1's scores onto a single scoresheet). And, Evaluator 10 was responsible for assessing 3 questions. Of his 45 scores (15 proposals * 3 questions), he awarded 43 "8s," a 95.5% "8" rate. Exh. 27 (MHT's consolidation of Evaluator 10's scores onto a single scoresheet).

While the effective non-participation of multiple evaluators was jarring, equally concerning are the many instances where two evaluators issued diametrically opposite scores on the same MCO response. Evaluator 2 awarded AmeriHealth Caritas a "1" on Question 49 whereas Evaluator 16 awarded it a "10" on this question. Exh. 28. Evaluator 2 also awarded both AmeriHealth and Community Health Choice a "1" on Question 50 while Evaluator 16 awarded both a "10." Exh. 29.

And, as to MHT, Evaluator 7 awarded it a "10" on Question 33 whereas Evaluator 15 issued a score of a "1" on the same question. Exh. 30. Where the evaluation scoring guide instructed evaluators to award a "1" where the "response does not address

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[18] Evaluator 8's abandonment of his duties had an outsized impact, because the questions he left with only two evaluators were heavily weighted. In addition to the 9.33 points under Question 281, AF was assigned six questions with the relatively high weight of 1.43 points (Questions 270, 272, 276, 288, 314, and 358). In total, AF was assigned to questions worth 22.97 points on the 100-point scale.

requirements" and "is completely unacceptable" but informs evaluators to issue a "10" where the response "far exceeds all aspects" of the requirement (Exh. 31, Evaluation Scoring Guide), it is simply unfathomable that such widely divergent evaluations could stand had procurement officials performed appropriate oversight.

What is more, such widely varying scoring proved systemic as there are, in sum, 38 instances where the lowest awarded score and highest awarded score for a single question to a given MCO varied by at least five points.[19] Such huge disparities cannot be attributed to reasoned differences of opinion regarding the relative merits of proposals. This troubling lack of process control went completely unchecked by HHSC. The repeated, obvious nonfeasance of multiple evaluators and the stark differences in some evaluators' assessment of the same material casts the validity and credibility of all of the evaluations in serious doubt. For example, a procurement manager could not have viewed an evaluator's having made dozens or hundreds of identical scores, with no discrimination between bidders, and reasonably concluded that the behavior was acceptable so long as each question had the minimum of three evaluators. Nor could they have reached the conclusion that everything was okay when viewing the wildly divergent scores issued to some MCOs for the same question.

Further, these observations cause one to doubt the usefulness and substance, if any, of the outlier meetings. What possible benefit could the analyst conducting the outlier meetings with Evaluator 8 and the other effectively non-participating evaluators have brought to the procurement process where the analyst did not either cause AF to register meaningful scores, or recommend to HHSC that Evaluator 8 be replaced?[20]

In this regard, an "analyst" conducted the outlier meetings with the evaluators. *See* Exh. 5 (Denise Burton email). However, in light of multiple scoring abnormalities that

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[19] Similarly exhibiting a lack of process control, in proposal sections where MHT and its affiliated entity submitted identical responses, in 25 instances the same evaluator scored the identical responses differently, with the differences as large as a 3-point spread. A procurement of this size called for process controls that were at least sufficient to catch such inconsistencies.

[20] The Action Memo states that outliers were identified by using a standard deviation of 1.25. From the Action Memo and MHT's debriefing it appears that HHSC's quality control process would not have identified evaluators' effective non-participation in discriminating between offerors if the evaluators' scores were not deemed to be "outliers." This large, unreasonable quality control "blind spot" is another critical process failure that should cause the noticed awards to be rescinded.

existed even after the outlier meetings, it appears that those meetings were yet another example of HHSC's failure to effectively design and oversee the evaluation process. The supposed quality control check to be provided by the outlier meetings were illusory. In any event, something surely was broken in HHSC's process if neither the analyst conducting the meeting nor anyone else administering the procurement raised a red flag about this disconcerting conduct.

Additionally, a member of the HHSC Procurement & Contract Services Complex Services Team supposedly performed "quality assurance checks" of the scoring sheets. *Id.* The unchecked abandonment of their duties by multiple evaluators and extreme differences across evaluators scoring the same question for the same MCO demonstrates that, despite assigning personnel to perform quality assurance checks, the Complex Services Team in fact performed no meaningful quality assurance.

In sum, here multiple evaluators failed to make any attempt to identify the State's best partners, and others submitted scores that were so divergent from those of other evaluators as to indicate serious problems. Yet, the procurement's managers uncritically rubber stamped the scores. In light of these observations, there can be no founded confidence that the State will receive "best value" from the awards, and those awards cannot stand. *ENSCO, Inc.; PAE National Security Solutions, LLC,* B-414844, 2017 CPD ¶357 (Oct. 2, 2017), at 3 (protest sustained where the "evaluation is not supported by the contemporaneous record").

**C. The Evaluators' Scoring of the "Good Working Relationship" Criterion Was Irrational and Inconsistent**

The record shows that all three evaluators were unprepared, unable, or unwilling to provide rational scoring for Question 281, by far the most weighty at 9.33 points, and therefore could not deliver the consistent and reliable evaluations promised in the RFP.

**1. The First Evaluator's Failure to Attempt to Identify the Best MCOs for the STAR+PLUS Program Produced Inconsistent Evaluations**

Evaluator 8's (AF) conduct requires HHSC to take corrective action for an additional reason beyond his nonfeasance having reduced the number of evaluators below the minimum of 3. By scoring every response to Question 281 a "7," AF inconsistently evaluated the proposals, contrary to the RFP's assurance that proposals would be "consistently evaluated and scored in accordance" with the stated criteria. Exh. 3, RFP §4.1.2, at 158. *See Grunley Constr. Co.,* B-407900, 2013 CPD ¶182, at 4 (Apr. 3, 2013) (bid

protests are reviewed to ensure evaluation "was reasonable and consistent with the stated evaluation criteria").

It is impossible to reasonably conclude that fifteen different proposals from firms of varying strengths, weaknesses, and experience were consistently evaluated where an evaluator finds all proposals of identical merit. In particular, as relevant to Question 281, in the context of the work they performed, each firm's history of liquidated damages, CAPs, and cure notices, paints a unique picture for each offeror concerning the likelihood of future performance issues.

AF's conduct may have been excusable had the record indicated that he considered each proposal on its merits, and had reasonably explained why he reached the conclusions he did. The record here, however, shows that he completely abdicated his responsibility as an evaluator. First, AF scored all proposals the same on every question. Exh. 13. AF did not, in the course of months of evaluation time, attempt to calibrate his scores according to the merits of each proposal. Second, it would be charitable to characterize Evaluator 8's comments on his scores as "perfunctory." The comments he used to explain his scoring of each MCO under Question 281 were nearly identical, and the explanatory comment on nearly every one of the other 180 scores (all "8s") he registered on the other 12 questions he was assigned merely repeats: "Respondent satisfies requirement." Evaluator 8 did not take seriously his important role in identifying HHSC's best value STAR+PLUS partners.

Evaluator 8's nonfeasance exacted tremendous damage on the credibility of the award decisions. The 13 questions he was assigned totaled 21.97 points, and all of these questions had only two additional evaluators assigned. Thus, well over 7 available points of each offerors' overall score (21.97 ÷ 3) were solely in AF's hands. Recall just how closely bunched were the scores, with, for example, Aetna and Amerigroup scoring only 32/100th of a point and 34/100th of a point ahead of MHT, respectively. And, only 1.09 points separated MHT's proposal from Superior's top-ranked proposal. If AF or a replacement actually participated in the evaluations, there is a substantial likelihood that MHT's rank among the top proposals would have been different. *See Engineering Management & Integration, Inc.,* B-400356.4, B-400356.5, 2009 CPD ¶114, at 7 (May 21, 2009) (protest sustained where protester showed that "there [was] a reasonable possibility that the evaluation error resulted in competitive prejudice, … [and] but for the errors [the protester] would have had a substantial chance of receiving an award"). Evaluator 8's conduct materially prejudiced MHT, and requires the noticed contract awards to be rescinded.

**2. The Second Evaluator of the "Good Working Relationship" Criterion Fundamentally Misunderstood Her Responsibility**

Each offeror was required to submit a "Programmatic Proposal" (RFP Section V, at p. 161) and a separate "Business Proposal" RFP (Section VI, at p. 205). As shown on the scoring sheets, where each question corresponds to either Section 5 of the RFP (the Programmatic Proposal) or Section 6 (the Business Proposal), the portions that evaluators were to review in scoring every question appeared in one of the proposal sections, but not both. The underlying data on which Question 281 was to be scored, the response to RFP §6.1.7, was contained in each offeror's Business Proposal.

The second evaluator of Question 281, Evaluator 9, MF, was assigned to score 13 questions in all. MF was so poorly prepared for her task that for all 13 questions she separately scored both each offeror's Programmatic Proposal and Business Proposal, for each question.[21] Nor did she attach explanatory comments to the great majority of her scores, which was also part of her duties. *See* Exh. 5 (Denise Burton email). The Complex Services Team notified MF of her misunderstanding regarding which proposals to score, and reminded her that she had to explain her scores on the scoring sheets. *Id.*

Neither MF's initial scores nor her final post-outlier meeting scores make sense, nor are they supported by the record. MF initially scored Aetna's Business Proposal a "10" and its Programmatic Proposal a "3," and did not provide any comments. It is not known how she could give Aetna's Programmatic Proposal any points, when that response did not even include the Section 6.1.7 expressly referenced in the evaluation question. Her final score for Aetna was a "10." Her comments on that score are internally inconsistent, nonsensical, and opaque. She stated: "Response addresses requirement, but response describe does not allow HHSC to fulfill mission. Post outlier comment changed due to additional information." Exh. 23.

The first part of the comment repeats the description of a score of "3" from the Evaluation Scoring Guide, and does not correspond to a "10." And, the opaque term

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[21] Further calling into question the reasonableness of the controls on this procurement, a member of the Procurement & Consulting Services Team who was administering the evaluations told MF that her questions "primarily … address the Respondent's Programmatic Proposal (Section 5 of the RFP)," and therefore the procurement team did "not need a separate scoring tool titled "Business Proposal." Exh. 5 (Denise Burton email). In fact, 12 of the 13 questions assigned to MF, including Question 281, pertained to offerors' Business Proposals, and not their Programmatic Proposals.

"additional information" does not convey a basis for assigning Aetna the top possible score. What "additional information"?

Evaluator 9's scoring of Amerigroup is even more baffling. Initially, she scored Amerigroup's Business Proposal a "4," without comment, and its Programmatic Proposal a "1," with the comment that "Section 6.1.7 does not exist." Her final evaluation of Amerigroup was a perfect score of "10," with the comment: "Section 6.1.7 does not exist. Post outlier comment changed due to additional information." Exh. 15. What "additional information" caused MF to change her Amerigroup score so radically? Her initial evaluation of the relevant Amerigroup proposal was a "4." She increased this score by an astounding 6 points, which were worth 1.86 points to Amerigroup's overall score (.31 * 6).[22] As shown, there is no basis in fact for the perfect score she awarded Amerigroup.

And so it went with MF's Question 281 scoring of the other proposals. United's initial scores of "2" and "1" became a final score of "8," and Superior's initial scores of "8" and "1" became a final score of "8." None of the initial scores included comments. This evaluator's identical comment for each final score was, "Response does not address requirement. Response is completely unacceptable. Post outlier comment changed due to additional information." Exhs. 21, 32. When initial scores of "2" and "1" become a final score of "8," it is unreasonable to attribute the enormous change merely to "additional information." *See The Boeing Company,* B-31344 *et seq.*, 2008 CDP ¶114 (June 18, 2008), at 20 (protest sustained where the record failed "to contain adequate documentation showing the basis for the evaluation").

As for MHT's scores, MF initially scored them "4" and "1," and gave MHT a final score of "7." In addition to her opaque "due to additional information" mantra, MF added: "September 2018 – There is an open Corrective Action Plan (CAP) with HHSC-OIG, Page 1489. Also open CAPs, one is with Starplus (page 1490)." This comment is no basis for scoring MHT a "7," while scoring Aetna (10), Amerigroup (10), Superior (8) and United (8) all higher, sometimes three points higher and with award-determining effect. All significant MCOs operating in Texas have open CAPs; that is a normal part of HHSC's compliance system. Indeed, at the time proposals were submitted, Aetna had 5 open HHSC CAPs, Amerigroup had 10, MHT 10, Superior 9 and United 4. Exh. 17. A rational assessment of CAPs, liquidated damages, and other sanctions, must take account of the

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[22] Every single increment of each evaluator on Question 281 counted as .31 points on the overall score, as the 9.33 available points were divided by 30 available evaluator points (3 evaluators scoring on a 1-10 scale).

meaning and severity of the actions or penalties. Neither MF nor any other evaluator undertook such an analysis.

MF's highly suspect scoring on Question 281 was prejudicial to MHT. For example, even though Amerigroup had a far worse sanctions history with HHSC than MHT, MF scored Amerigroup a "10" and MHT a "7" on Question 281. Amerigroup's 3-point advantage from MF's scores equated to an overall .93 point advantage (.31 * 3) from her, which far exceeded Amerigroup's overall .34 point advantage. Based on these illogical and unsupportable scores, in the firms' head-to-head competition, HHSC awarded Amerigroup five service area contracts and MHT only one.

### 3. The Third Evaluator Was Unaware of the Evaluation Scoring Guide that Was to Control his Assessments

The third evaluator of Question 281, Evaluator 32, JT, submitted the following final scores: Aetna 8, Amerigroup 5, MHT 5, Superior 8, and United 8. Incredibly, this evaluator's comments on each offeror included: "Reviewer was unaware of scoring guide scale and changed score to reflect reviewer's updated awareness and original evaluation." Exh. 18, 20, 24, 33, and 34. This admission meant that Evaluator 32 applied his own idiosyncratic scoring scale to Question 281, and to all of the other criteria he scored.[23]

It appears that JT reduced by two his initial scores regarding Question 281,[24] but this across-the-board reduction does not remove the taint of his initial untethered assignment of scores. To have taken appropriate remedial action, Evaluator 32 would have re-scored all proposals anew according to the Evaluation Scoring Guide before participating in the outlier meeting.

MHT was prejudiced by JT's scoring error. For example, he scored the proposals of Aetna, Superior and United to be "8," while he assessed MHT as only a "5." This 3-point swing equated to a .93 difference on the bottom line scores. This amount was greater than the margin of difference between the scoring of its proposal and that of Aetna

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[23] HHSC procurement officials told MHT during its debrief that the Agency conducted evaluator training that included the scoring guide. It is unclear if Evaluator 32 did not attend the training or did not understand or remember it. Either way, he was not prepared for his assigned task.

[24] JT did not have the relevant portion of Superior's proposal at the time of his initial scoring, and so initially scored Superior a "1."

and United, and would have brought MHT within .16 points of the top ranked MCO, Superior.

### D. The Prejudicial Errors in the Question 281 Scoring Requires the Noticed Service Area Awards to Be Rescinded

MHT offered to perform as a STAR+PLUS MCO in ten service areas: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, and Travis. MHT received only one contract (Hidalgo), while in these service areas Amerigroup received five contracts and Superior received seven contracts, for example. Despite a public record that required Amerigroup and Superior to be scored lower than MHT on Question 281, these two firms actually scored higher on this outcome-determinative question. And, Amerigroup's and Superior's advantage on Question 281 was larger than their overall scoring margin over MHT.[25] In these circumstances, HHSC must take corrective action that, at a minimum, includes rescinding all noticed awards and rescoring the proposals.

## IV. HHSC ERRED IN AWARDING MAXIMUM POINTS TO UNITED UNDER QUESTION 245, NEGATING THE NOTICED AWARDS TO UNITED

United wrongly received 1.43 points related to evaluation Question 245. Instead, as did three other offerors, United should have received .14 points under this criterion. This 1.29 point loss (1.43 - .14) should have dropped United's score down to 77.15 points (78.44 – 1.29). This places United below MHT (77.62 points) and AmeriHealth Caritas (77.32 points, and no awards), and completely out of the running for any STAR+PLUS service area contracts. *See* Exh. 4 at 10, Master Rollup.

Question 245, pertaining to offerors' history of prohibited marketing practices, was a 1.43 point criterion under Factor 2.a., Past Performance. Exh. 4 at 9. Question 245 states:

| Has the Respondent ever been sanctioned or placed under corrective action for prohibited Marketing practices related to managed care products by CMS, Texas, or another state? If the answer is no, award maximum points. If the answer is yes, award no points. | 5.1.6.9 - Marketing Activities and Prohibited Practices |
|---|---|

[25] As shown, the public record reveals that correct scoring of Question 281 would have resulted in MHT being the top-ranked MCO overall, eclipsing Aetna and United as well.

The referenced RFP Section 5.1.6.9, "Marketing Activities and Prohibited Practices," required MCO responses to identify instances within the past three years where the "Respondent has been sanctioned or placed under corrective action for prohibited Marketing practices related to managed care products by CMS, Texas, or another state." Exh. 3, RFP §5.1.6.9, at 181.

Question 245 required a binary assessment from the evaluators. Respondents could receive scores of either a "1" or a "10," and nothing in between.[26] If the MCO had been sanctioned within three years for marketing-related practices, the evaluators were required to assign the lowest score of "1," which would mean the MCO would receive .14 points on the question (.143 * 1).[27] If instead the MCO had no marketing violations, the evaluators were required to assign "maximum points" of "10," meaning that the offeror would receive the 1.43 points available under the question. According to the Master Rollup score sheet, on Question 245 WellCare, Magellan, and Humana each received .14 points, and the other 12 offerors, including United, each received 1.43 points. Exh. 4 at 9.

In fact, however, HHSC assessed liquidated damages against United for a marketing-related violation that occurred in the first quarter of fiscal year 2017. Exh. 12 (United liquidated damages). The entry, which appears on HHSC's "MCO Sanctions" web page, occurred on the STAR+PLUS program in the Harris service area, and states as follows:

> Prohibited marketing practices. United used unapproved letter that was mailed to member.

Exh. 12.[28]

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[26] For example, Evaluator 35 noted that the Evaluation Tool dropdown option did not allow a score of "0," so she assigned a score of "1" to Magellan. Exh. 35.

[27] This rule was applied to other offerors for single violations, and should have been applied to United in this manner as well. *See* Exh. 36 (Evaluator 32 scoring Question 245 a "1" for Magellan, noting "Respondent has had one marketing sanction within the past three years in Florida (5.1.6.9 Page 1)"); Exh. 37 (Evaluator 29 scoring Question 245 a "1" for Humana, noting "The Respondent has been sanctioned once in the state of Kentucky.").

[28] MHT has reviewed archived versions of the HHSC MCO Sanctions web page, and notes that this entry appeared on this web page at least as early as September 4, 2018. Thus, this marketing-related sanction was known to United at the time of proposal submission, and was required to be included in United's proposal.

Under the rules of the procurement, because of this sanction for "prohibited marketing practices" in the relevant period, all of the evaluators were required to assign a score of "1" to United on Question 245, and United should have received .14 points on this criterion.

MHT was materially prejudiced by HHSC's erroneous scoring of United on Question 245. United was the #2 ranked MCO overall, and United received noticed awards in six service areas in which MHT proposed to serve (Harris, Jefferson, Lubbock, Nueces, Tarrant, and Travis). MHT did not receive awards in any of these service areas. MHT would have received awards in at least some of these service areas had United[29] been properly scored on Question 245.

## V. HHSC ABUSED ITS DISCRETION BY FAILING TO AWARD MHT CONTRACTS IN THE BEXAR, DALLAS, AND HARRIS SERVICE AREAS

Even if one were to take HHSC's illogical and unsupported scoring of Questions 281 and 245 at face value, and consider the overall scores valid, HHSC erred by not awarding contracts to MHT in its incumbent service areas of Bexar, Dallas, and Harris. In these service areas HHSC abused its discretion by premising the awards on inconsequential scoring differences between offerors at the expense of tangible benefits inherent in established relationships between service coordinators and their clients. By not awarding new contracts to MHT in these service areas, HHSC unnecessarily and unwisely severed continuity of care benefits to tens of thousands of STAR+PLUS members.

HHSC's decision making process set forth in the Action Memo establishes an inherent tension between supporting "continuity of care where possible" while making "the fewest possible deviations from the initial Scoring Matrix." Exh. 2 at 7. HHSC's attempt to serve these competing concerns failed. Despite MHT's proven, long-standing history of exceptional performance on the STAR+PLUS program, HHSC neglected to recognize the benefit to members of preserving service coordination and continuity of care relationships with high-performing MCOs. Instead of promoting and continuing MHT's established relationships with its STAR+PLUS clients, in Bexar, Dallas, and Harris HHSC's noticed

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[29] It is unclear just how many more awards MHT would receive. But with United appropriately scored below AmeriHealth Caritas, which did not receive any awards, United's 9 service area awards (6 in the service areas protested here) would be re-awarded to other MCOs. MHT would then be fourth ranked in the scoring in the protested service areas, a position from which Amerigroup received 5 awards.

awards will sever nearly 55,000 current MHT enrollees from their service coordinators and the network of providers those service coordinators manage.

The State's award decisions may be questioned where there is a clear showing of unreasonableness, abuse of discretion, or a violation of procurement statutes or regulations. *Metis Corp.*, B-181387, 75-1 CPD ¶ 44 (Jan. 24, 1975). Where, as here, the record fails to support the Agency's conclusions, the Agency's determination constitutes an abuse of discretion. *Roland R. Leaton*, B-261168, 1995 U.S. Comp. Gen. LEXIS 478 (July 18, 1995). Service coordination and continuity of care were guiding principles in this procurement and were to be significant factors in HHSC's evaluation. HHSC's failure to validate these objectives with respect to MHT, when it did so for other vendors, reflects disparate treatment and an abuse of discretion that cannot withstand your Office's scrutiny. *See Cubic Applications, Inc.*, B-411305, B-411305.2, 2015 CPD ¶215 at 7 (July 9, 2015) (awarding agency must treat all offerors equally and evenhandedly, and avoid disparate treatment of offers).

**A. Maintaining Service Coordination and Continuity of Care Were Determinative Factors in Some HHSC Awards**

The State's key objectives in implementing managed care programs include maintaining service coordination relationships and promoting continuity of care for the program's members. Tex. Gov. Code § 533.002. The RFP, at Section 1.4.1, "Service Coordination," states: "The integration of Acute Care services and LTSS is an essential feature of STAR+PLUS." Exh. 3 at 3. The October 22, 2019 Action Memo confirms the "service coordination" objective, which, among other things, promotes the statutory goals of "best meet[ing] the needs of clients" and ensuring that the procurement "effectively support[s] the mission, operations, and program." Exh. 2 (citing 1 T.A.C. §391.101(b)).

The Action Memo provided an incumbency advantage to all noticed incumbent MCO awardees except MHT. It did so only by adjusting service area contract awards within the context of the covered lives cap after the mathematical rankings were made. Several times HHSC ignored its covered lives cap to award incumbents. This occurred in Harris with United and in Bexar, Dallas, and Hidalgo with Superior. *See, e.g.,* Exh. 2, Action Memo, at 7-8 ("Superior exceeds the covered lives cap of 33%; but in order to preserve continuity of care, Superior is not removed from the SA they are currently serving"). Similarly, HHSC recommended bypassing a higher-ranked, non-incumbent MCO for award, because the award would not further the continuity of care objective. This happened with Superior in Harris, East, and Tarrant, with United in Bexar, Dallas, and Hidalgo. *See id.* at 7-9.

As these examples demonstrate, in its award determinations HHSC credited select incumbents' current service to promote continuity of care. HHSC valued continuity of care in some instances, but not others. Under certain circumstances HHSC intended to avoid a mechanical selection of offerors, instead favoring a more holistic evaluation methodology that considered continuity of care through the maintenance of ongoing member-service coordinator relationships. But, HHSC had no consistent theory guiding when it would apply continuity of care principles. Despite its good intentions to honor maintaining service coordination and continuity of care, in ousting MHT from Bexar, Dallas, and Harris without good reason, HHSC abused its discretion by failing to apply continuity of care evenhandedly across all MCOs.

**B. HHSC Erred in Failing to Properly Recognize the Continuity of Care Benefits to Members with Respect to MHT's Proposal**

Scoring errors aside, the scoring of proposals among the top five non-community plan offerors in the service areas for which MHT submitted offers were closely bunched, with only 1.09 point separating the highest scored plan (Superior) and MHT. And, the scores of Aetna and Amerigroup are only 32/100ths of a point and 34/100ths of a point higher than MHT's, respectively. Such inconsequential differences in scoring between Aetna, Amerigroup, and MHT pale into insignificance when compared to the critically important benefits inuring to STAR+PLUS members from maintaining continuity of care. HHSC abused its discretion by irrationally denying MHT's members the benefits of continuity of care in Bexar, Dallas, and Harris.

In stark terms, HHSC was faced with the following choice with respect to these three service areas: Should it make awards to MCOs that scored 32/100th of a point (Aetna) and 34/100th of a point (Amerigroup) higher than MHT, where doing so will sever continuity of care for approximately 55,000 MHT STAR+PLUS members, or should continuity of care for these members take precedence over minor scoring differences?

HHSC abused its discretion by choosing to follow the tiny scoring differences at the expense of maintaining continuity of care for MHT's members.

**1. MHT's Long-Standing Service Coordination Relationships Warranted Considerable Weight in HHSC's Continuity of Care Analysis**

MHT has a well-established history of providing exceptional care through its implementation of a member-centered service coordination model. MHT prioritizes hiring and retaining highly-skilled and experienced service coordinators, and it maintains a low service coordinator-to-member ratio that promotes optimal client outcomes. Over time and

regular contact with members, MHT's service coordinators become acutely aware of their clients' particular needs, and are the lead advocators ensuring that those needs are met.

Under the noticed awards, based on tiny scoring differences HHSC unnecessarily will be dissolving about 55,000 MHT service coordinator-member relationships in Bexar, Dallas, and Harris, some of which extend back over a decade. In Bexar and Harris, MHT has served as an MCO since 2006, and currently provides care to approximately 19,500 STAR+PLUS members. And MHT has provided its services in Dallas since 2011, where it currently serves about 35,500 STAR+PLUS clients.

MHT strives to maintain these relationships, and has achieved this goal through its high retention rate among its community-based service coordinators and its nursing facility service coordinators.

**a. MHT Retains and Empowers Community-based Service Coordinators**

Over 23,000 MHT STAR+PLUS members have had the same community service coordinator for at least one year and up to three years; another 2,100 have had the same service coordinator for over 3 years and up to five years; and nearly 900 have maintained a service coordinator relationship for over five years. The service coordinator-member relationship is one-on-one, and involves all medical, physical, emotional, and social determinants of health.[30] In addition to severing the service coordinator relationships, bringing in a new MCO may mean that STAR+PLUS members will have unfamiliar primary care, specialty, behavioral health, and long term services and supports providers.

The longevity of these relationships is a two-way street. In addition to signaling that MHT has strong service coordinator retention, it also means that MHT's STAR+PLUS enrollees have chosen to remain with MHT year after year, strongly suggesting that they are pleased with MHT's level of service. MHT's STAR+PLUS enrollees have significant enrollment stability, averaging 2.44 years of enrollment. Nearly two-thirds (64.3%) have been MHT STAR+PLUS enrollees for at least two years.

The positive impacts of such continuity on STAR+PLUS community members who have intellectual or developmental disabilities, behavior health diagnoses, or other LTSS needs are evident. MHT also directly employs behavioral health case managers to

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[30] MHT's staff in the service coordination, Care Management, and Utilization Management departments averages over four years with MHT, with 62.3% having at least three years with MHT and 29.5% having worked at MHT for at least five years.

support service coordinators, rather than outsourcing this service. The stability of relationships within the STAR+PLUS population with behavioral health issues is critical, as the behavioral health specialists learn over time the behaviors that are within the usual limits of a particular client, as opposed to those behaviors that alert the specialist that targeted intervention is needed. Additionally, MHT employs “community connectors” to further support service coordinators. The community connectors are embedded in specific service areas and local communities to provide an additional enduring connection to members. Community connectors assist members in accessing services that are not covered by Medicaid, such as food pantries, assistance with utilities, and housing/rent subsidies.

HHSC has advanced no logical rationale for sacrificing the continuity of care benefits to MHT’s STAR+PLUS members at the altar of very small scoring differences. No such rationale exists for HHSC’s actions. MHT’s strong performance history, standing alone, warranted HHSC making heightened efforts to preserve the established care relationships of STAR+PLUS members with their MHT providers. HHSC’s disregard for maintaining service coordination and continuity of care with respect to MHT’s current clients will have significant adverse consequences for many of the most vulnerable Texans.

**b. MHT Retains and Empowers Its Nursing Facility Service Coordinators**

MHT also has reviewed its ability to maintain relationships between nursing facility service coordinators and their clients. Over 70% of MHT’s STAR+PLUS clients in nursing facilities have had the same service coordinator for at least a year, and nearly 20% of them have had the same service coordinator for at least three years. This continuity is invaluable, as many of the residential clients with whom these services coordinators work suffer memory loss, paranoia, and other challenges that manifest at higher rates in the elderly. MHT’s nursing facility service coordinators are registered nurses who attend their assigned nursing facilities at least 3-4 times per month, and often 2-3 times per week, depending on individual client needs.

Not only does a familiar face provide comfort to members and foster openness regarding their needs, but service coordinators who have worked long term with nursing facility residents are better positioned to notice physical and behavioral changes over time that may be addressed by the clients’ providers. Moreover, MHT’s service coordinators manage a “village of providers” for their clients. Replacement MCOs will have different provider networks for many services.

MHT recognizes the value of services coordinators’ in-depth knowledge of their clients’ individual needs that is earned over time through the personal relationships they

cultivate with clients. MHT empowers its service coordinators to be proactive about their members' care. For example, MHT has implemented its "Skill-in-Place" program under which it entrusts service coordinators serving nursing facility members to independently authorize various services that would otherwise require additional administrative approval.[31] This program is a concrete representation of the advantages and benefits of the close service coordinator-to-member relationship. MHT's approach eliminates unnecessary administrative burdens on members and, most importantly, expedites care to them.

**2. In Light of its Strong Proposal and Performance History, Proper Consideration of the Continuity of Care Benefits to STAR+PLUS Members Entitles MHT To Awards in the Bexar, Dallas, and Harris Service Areas**

It cannot be denied that MHT's submitted a very strong proposal across-the-board that was as good if not better than that of the other MCO awardees. If not for the glaring evaluation errors on Question 281, discussed *supra* Section III, MHT would have garnered awards in all of the service areas it bid, including its current service areas. For present purposes, however, it is enough to note that, even accepting the Question 281 scores, continuity of care considerations entitled MHT to contracts in its incumbent service areas of Bexar, Dallas, and Harris.

**a. MHT's Offer Was Broadly Competitive With and at Least as Meritorious as Aetna's and Amerigroup's**

Of the two MCOs whose noticed awards would result in replacing MHT in Bexar, Dallas, and Harris, in the overall scoring MHT scored only .32 points below Aetna and .34 points below Amerigroup. The extreme closeness of these scores is further highlighted by comparing their scores both broadly and on key aspects of their respective proposals. At the broadest level, MHT compared its head-to-head scores to those of these two other firms on all 114 scored questions. MHT scored as high or higher on a great majority of the questions.

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[31] Skill-in-Place is an initiative of MHT's separate unit/leadership team that is dedicated solely to Texas nursing facilities. MHT's operational structure also shows its commitment to its STAR+PLUS nursing facility members.

| | MHT v Aetna | MHT v AmeriGroup |
|---|---|---|
| % of questions MHT scored above the competitor | 42% | 33% |
| % of questions MHT tied with the competitor | 27% | 30% |
| % of questions MHT scored below the competitor | 31% | 37% |

Further, in the two areas that HHSC valued most – whether the goods and services meet the needs of members (48%) and probable vendor performance, including past performance (24%) – MHT scored very well against the competition. MHT scored 37.18 points on the "meets the needs" factor, outscoring Aetna by .42 (36.76) and tying Amerigroup (37.18 each). And on the "probable vendor performance, including past performance" factor, MHT's score of 19.64 was .18 better than Aetna (19.46), and virtually the same as Amerigroup (19.65, or .01 lower).[32]

HHSC considered the continuity of care provided by incumbents as a determinative factor in distinguishing between many of the offerors. But, HHSC abused its discretion, and made disparate awards determinations, by ignoring its commitment to continuity of care when it came to MHT's members.

**b. HHSC Improperly Ignored the Continuity of Care Objective by Not Awarding MHT Contracts in Bexar, Dallas, and Harris**

HHSC's selections of Aetna for award in Bexar, Dallas, and Harris; of Amerigroup for award in Dallas; and the non-selection of MHT for award in these service areas, represent abuses of discretion, and improper disregard for the continuity of care objective.

Notably, in each of these service areas, HHSC elected to forego awarding a contract to a higher ranked MCO. In each case, HHSC relied in part on the ground that "the

[32] It is ironic and wildly inconsistent that MHT outscored Aetna and virtually tied Amerigroup on the "probable vendor performance, including past performance" factor, while these firms were scored 1.87 and .93 point higher than MHT, respectively, on the "good working relationship" Question 281, which measured past performance sanctions assessed by HHSC against MCOs. *See infra* Section III.A.3.

continuity of care objective [would not be] furthered" by following the score-based rankings. *See* Exh. 2 at 7-10. The tables below display the rankings of the top five MCOs in each of these service areas, identifies incumbents, reports the noticed awards (*), and shows the number STAR+PLUS members whose continuity of care would be broken. These tables demonstrate HHSC's disregard for promoting continuity of care, at least with respect to MHT, by not retaining MHT where possible in the noticed awards.

**Dallas Service Area**

| Dallas Service Area (3 Awards) | | | | |
|---|---|---|---|---|
| **Vendor** | **Overall Score** | **Rank** | **Incumbent** | **Displaced STAR+PLUS Members** |
| Superior* | 78.71 | 1 | Yes | |
| United | 78.44 | 2 | No | |
| Amerigroup* | 77.96 | 3 | No | |
| Aetna* | 77.94 | 4 | No | |
| MHT | 77.62 | 5 | Yes | 35,500 |

Dallas presents perhaps the most egregious example of disregard for maintaining continuity of care when it comes to MHT's clients. Aetna and Amerigroup were selected as new entrants, despite their inconsequential overall score advantages of .32 points and .34 points over MHT. Aetna, who has never served as a STAR+PLUS MCO, scored less than one-third of a point more than MHT.[33] This was sufficient, in HHSC's illogical view, to justify cutting continuity of care for over 35,500 MHT members in the Dallas service area.[34]

Moreover, the RFP allowed HHSC to consider costs in its awards determinations. For example, the "Quality" mission objective states that HHSC seeks "cost-effective service delivery, and careful stewardship of public resources with approval from HHSC." Exh. 3, RFP §1.4.4, at 3-4. While MCO compensation is based on capitated rates,

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[33] Aetna's oral presentation was rated as "good," while MHT's was scored as "excellent." Exh. 38. HHSC seems to have disregarded oral scores entirely in selecting awards.

[34] Indeed, the data shows that STAR+PLUS members in Dallas are choosing MHT. Of the two incumbent MCOs (MHT and Superior), MHT enjoys a 58% market share. And that market share is driven by members' actively choosing MHT, and is not merely the result of members defaulting into MHT's plan.

the State likely will incur additional costs for on-boarding a new MCO in a service area. These costs may include additional enrollment broker costs for adding and changing plan codes, increased costs of implementing eligibility systems for new MCOs, setting up electronic visit verification systems, and costs related to enhanced readiness reviews and systems for claims processing. HHSC could have considered these costs in weighing whether to make awards to new entrants in a service area – such as Aetna and Amerigroup in Bexar, Dallas, and Harris – but did not.

Nor can award to Amerigroup, a new STAR+PLUS MCO in Dallas, be rationalized for this service area. In support of the award, the Action Memo relies exclusively on Amerigroup's "strong technical score" of 77.96. Exh. 2 at 8. Amerigroup's score is a mere 0.34 of a point higher than MHT's 77.62 score. Exh. 4 at 10. Moreover, whereas MHT was one of only two non-community MCOs who scored the highest rating of "excellent" on its oral presentation, Amerigroup was the only non-community plan to receive the lowest rating of "fair" on its oral presentation. Exh. 38 (oral presentations consensus rankings). In the Action Memo HHSC noted that "Amerigroup's weaker oral presentation score" did not dissuade the Agency from awarding to Amerigroup, despite the RFP's statement that oral presentation scores "will supplement the written information and become an official part of the proposal to be considered during final selection… ." Exh. 3, RFP § 4.3, at 160.

The Action Memo asserts that selection was not to be the result of a "purely mathematical exercise." Exh. 2 at 4. This assertion is shown to be false in the awards themselves, which repeatedly elevate the importance of minor scoring differences over maintaining continuity of care. And, in MHT's debriefing, HHSC admitted the emptiness of the Action Memo's statement. When asked by an MHT representative whether determining awards "was a purely mathematical exercise," an HHSC official responded, "It was a mathematical exercise, yes."

Across ten service areas on which MHT proposed to serve, although only 1.09 points separated the highest scoring MCO (Superior) from the fifth highest scoring MCO (MHT), the number of service area awards were dictated by the scores. Superior received 7 awards in these service areas, United 6, Amerigroup 5, Aetna 4, and MHT 1.

HHSC's mechanical evaluation and awards selection procedure violates the core public procurement principle that the best value analysis must weigh all relevant material information in reaching reasoned awards decisions that are supported by the record. *CSRA, LLC*, B-417635, 2019 CPD ¶ 341 at 15-17 (Sept. 11, 2019). By instead slavishly adhering to a decision tree that considered the continuity of care objective only in the context of allocating service area contracts within the covered lives cap, HHSC abdicated its

responsibility to determine best value in the Bexar, Dallas, and Harris service areas. *See Amyx, Inc.*, B-410623, 2015 CPD ¶ 45 at 11 (Jan. 16, 2015) ("[I]t is well-established that ratings, be they numerical, adjectival, or color, are merely guides for intelligent decision making in the procurement process"); *Castro & Company, LLC*, B-412398, 2016 CPD ¶ 52 at 10 (Jan. 29, 2016) (sustaining a protest for lack of reasoned rational where the awardee was selected because of its high score and the record was silent as to any comparison of the qualitative differences between the offerors).

Here, the technical scores were extremely close. Among non-community MCOs, MHT's highest oral score was superior to Amerigroup's uniquely low oral score, and Amerigroup was new to the service area. In these circumstances it was illogical, and an abuse of discretion, for HHSC to break continuity of care for 35,500 MHT STAR+PLUS members in the Dallas service area by awarding to Amerigroup, and not awarding a contract to MHT.

**Bexar and Harris Service Areas**

| Bexar Service Area (3 Contracts) | | | | |
|---|---|---|---|---|
| **Vendor** | **Overall Score** | **Rank** | **Incumbent** | **Displaced STAR+PLUS Members** |
| Superior* | 78.71 | 1 | Yes | |
| United | 78.44 | 2 | No | |
| Amerigroup* | 77.96 | 3 | Yes | |
| Aetna* | 77.94 | 4 | No | |
| MHT | 77.62 | 5 | Yes | 7,700 |

| Harris Service Area (3 Contracts) | | | | |
|---|---|---|---|---|
| **Vendor** | **Overall Score** | **Rank** | **Incumbent** | **Displaced STAR+PLUS Members** |
| Superior | 78.71 | 1 | No | |
| United* | 78.44 | 2 | Yes | |
| Amerigroup* | 77.96 | 3 | Yes | |
| Aetna* | 77.94 | 4 | No | |
| MHT | 77.62 | 5 | Yes | 11,700 |

HHSC's abuse of discretion in Bexar and Harris is similar. In both service areas, HHSC awarded contracts to new a STAR+PLUS entrant, Aetna, but not incumbent MHT, based on Aetna's .32 point technical score advantage. As with the Action Memo's discussion of the Dallas service area, HHSC never mentions MHT in its discussion of awards in Bexar and Harris. The nearly 20,000 MHT STAR+PLUS members whose service coordinator and provider network continuity is severed by this decision, and MHT, are entitled to a reasoned explanation why HHSC determined to dissolve so many service coordinator relationships over such small scoring differences. *See JW Associates, Inc.,* B-275209, 97-1 CPD ¶57 at 6 (Jan. 30, 1997) (protest sustained where the award decision was not adequately documented sufficient to enable the reviewer or the offerors to assess the reasonableness of the decision).

**Protest of Molina Healthcare of Texas, Inc.**

**c. HHSC's Utilization of Continuity of Care Was Not Equal Across All MCOs**

HHSC's inconsistent honoring of the continuity of care objective is especially evident in light of HHSC's overlooking of much wider scoring gaps in favor of maintaining continuity of care for other MCOs. In Harris, for example, Superior's .75 point advantage over Amerigroup was bypassed, and award made to Amerigroup, in order to maintain continuity of care. *See* Exh. 2 at 8. Yet, HHSC refused to weigh continuity of care the mere 33/100ths of technical point needed to award MHT over Aetna in Bexar, Dallas, and Harris. In other words, in 3 service areas HHSC elevated a .32 point scoring difference over the continuity of care objective to choose Aetna over MHT, while it ignored a scoring difference that was more than three times larger (.75) in order to preserve continuity of care for Amerigroup. The same goes for Amerigroup, a new plan in Dallas, that scored only .34 points higher than incumbent MHT, but received an award in Dallas while MHT did not.

In Harris, then, Amerigroup's STAR+PLUS members will be able to preserve their existing service coordinator and provider relationships, benefitting from a .75 point "continuity of care boost," while MHT's STAR+PLUS members in the same service area are denied the much smaller .35 "continuity of care boost" that would have allowed them the choice to keep their existing MCO. MHT's STAR+PLUS members whose service coordinator and associated relationships will be severed deserve better from HHSC than to be told "that's the luck of the draw." This disparate treatment, which violates the fundamental principle of public contracts law that all offerors be treated evenhandedly, cannot withstand your Office's scrutiny. *See Cubic Applications, Inc.*, B-411305, B-411305.2, July 9, 2015, 2015 CPD ¶ 218; *Rockwell Elec. Commerce Corp.*, B-286201., Dec. 14, 2000, 2001 CPD ¶ 65 at 5.

**3. HHSC Need Not Sacrifice Quality Service in Order to Maintain Continuity of Care**

Several good reasons urge that HHSC need not fear "incumbent entitlement" by appropriately weighing the continuity of care objective in its awards decisions. These reasons counsel in favor of rescinding the noticed awards and requiring new awards to be noticed.

*First,* in the relevant service areas, incumbents submitted 4 of the 5 top rated proposals, with Aetna barely slipping in front of MHT. There is no indication that incumbents have taken the renewal of their contracts for granted. Rather, all indications are that, Cigna aside, incumbents submitted very strong proposals that reflected their continued diligence in offering very competitive service.

*Second,* awarding MHT in its incumbent service areas will not prevent replacing low performers with new MCOs. Cigna's proposal, which was scored at 73.76 points, was ranked 13th overall, and Cigna was not selected for any awards. Cigna is an incumbent in Hidalgo, Tarrant, and North East, and its over 48,000 STAR+PLUS members will be assigned to or will choose new MCOs.

*Third,* restoring MHT's incumbent service areas will allow the continuity of care objective to be appropriately calibrated. Cigna's proposal was scored 3.86 points lower than MHT's plan. This is a 11-to-12-fold difference from the minor distinctions between MHT's score, on the one hand, and Aetna's and Amerigroup's scores, on the other, that HHSC weighted so highly. MHT is not arguing that the continuity of care objective should be asked to support more than it can reasonably bear. Indeed, as discussed, in its noticed awards HHSC has provided much greater "continuity of care boosts" than required to maintain continuity of care for MHT's STAR+PLUS clients.

*Fourth,* awarding service areas to MHT on the basis set forth here will still allow Aetna to become a new STAR+PLUS MCO. Aetna can maintain its award in Hidalgo, replacing Cigna, to gain experience on the program.

*Fifth,* the public record shows that HHSC is fully capable of policing MCO apathy or negligence, principally through the assessment of liquidated damages. In the most recent round of such assessments, from Quarter 3 of FY 2017, HHSC assessed over $17 million in liquidated damages against MCOs.

*Last,* there is no legal impediment to providing an incumbent advantage in the circumstances of this procurement. In this regard, the RFP provides ample notice to offerors that service coordination is an essential feature of STAR+PLUS, and that it and continuity of care would be important evaluation criteria. An electronic search of the RFP for "service coordinat" returns over 200 hits. And, there is ample decisional precedent for agencies to favor incumbents in appropriate circumstances. *See, e.g.s, Emax Financial & Real Estate Advisory Services, LLC,* B-408260, 2013 CPD ¶180 at 2002 CPD ¶30 at 8 (July 25, 2013) (noting that "incumbent contractors with good performance records can offer real advantages to the government"); *Main Building Maintenance, Inc.,* B-260945.4, 95-2 CPD ¶214 at 8 (Sept. 29, 1995) (noting the "government's well-established practice of recognizing in appropriate circumstances, the value of continued performance by an incumbent").

In sum, over insignificant scoring differences, the noticed awards improperly and unnecessarily eradicate the longstanding relationships MHT service coordinators and associated professionals have forged with the individuals they have long served in several service areas. Such a disruption to the lives of some of Texas's most vulnerable individuals

is unwarranted and unjust in light of the critical HHSC objective of preserving continuity of care. To properly validate the continuity of care objective, the awards to new STAR+PLUS entrant Aetna in Bexar and Harris should be rescinded, as should one of the awards to either Aetna or non-incumbent Amerigroup in Dallas. In their place, in all three of these service areas HHSC should make award to MHT.

## VI. AETNA SHOULD BE DISQUALIFIED FOR FAILING TO SUBMIT A GOOD FAITH HUB SUBCONTRACTING PLAN

The RFP required offerors to submit a HUB Subcontracting Plan, to be evaluated on a "go/no go" basis. Exh. 3, RFP §6.1.5, at 217. Aetna chose to attempt to meet its HUB requirements through a good faith effort to explore and reach out to certified HUB firms for subcontracting opportunities. Aetna was required to reach out to at least three HUB certified firms in each of the subcontracting areas Aetna used. Yet, the record indicates that, contrary to the tenets of good faith, Aetna treated its outreach as a mere check-the-box exercise. In several instances, rather than reach out to HUB certified firms with expertise in the chosen subcontracting areas, Aetna proposed subcontracting to firms that either do not perform in the area for which Aetna proposed to use them, or whose HUB certification had lapsed. What is more, the HHSC evaluators of Aetna's HSP noted these deficiencies, but, contrary to the procurement's rules, nonetheless approved Aetna's HSP.

### A. The HUB Subcontracting Plan Ground Rules

Texas agencies must make good faith efforts to meet state goals for contracting with businesses owned by economically disadvantaged persons under the "Historically Underutilized Business" ("HUB") program. Texas Gov't Code §2161 *et seq.* The RFP warns that "**if HHSC determines that the [HUB Subcontracting Plan] was not developed in good faith, it will reject the proposal for failing to comply with material RFP specifications.**" Exh. 3, RFP § 6.1.5; Exh. 39, RFP Exh. G § 1 (emphasis in original).

### B. Aetna Should Have Been Eliminated From The Competition Due To Submitting Materially Deficient HUB Subcontracting Plan

HHSC's evaluation form for Aetna indicates that Aetna did not complete its HUB Subcontracting Plan in good faith. HHSC's evaluators recognized that Aetna proposed to use HUB firms that had either lost their certification or whose certification would soon expire, and thus could not operate as certified HUB subcontractors. Aetna also put forward HUB firms for categories of work that the companies did not appear able to provide.

**1. Aetna's HUB Subcontracting Plan Was Materially Deficient**

Aetna's HUB Subcontracting Plan indicated intent to subcontract to HUB vendors in the following portions of work: (1) Translation services; (2) Marketing and promotion; (3) Transportation; (4) Claims payment and communication; (5) Printing; (6) Dental benefits manager; (7) Fulfillment services; (8) Vision services manager; and (9) Reinsurance services.

Aetna's HUB Plan contained material deficiencies in five of the nine areas identified for potential subcontracting. Exh. 40. Aetna proposed subcontractors with expired or soon-to-expire HUB certifications in its categories 2, 4, and 6, and proposed subcontractors that did not appear to perform the work they were identified for in categories 3 and 6. These errors demonstrate a lack of good faith by Aetna to identify and engage HUB subcontractors able to contribute, and should have resulted in the disqualification of Aetna.

Aetna also demonstrated a lack of good faith by listing firms in categories 3 and 6 that did not appear to actually perform work in the identified subcontracting area. Aetna's failures to locate and reach out to HUB businesses with an active record of providing the services for which Aetna identified them demonstrates a failure to complete its HUB Plan in good faith, and should have resulted in HHSC disqualifying Aetna.

**C. MHT Was Prejudiced By HHSC's Unfounded Approval of Aetna's HUB Plan**

HHSC's failure to disqualify Aetna prejudiced MHT. Aetna received awards, and MHT did not, in Bexar, Dallas, and Harris. According to the scoring matrix, MHT was next in line for award in these service areas, and would have received these awards had Aetna been properly eliminated from the competition.

## VII. CONCLUSION

For the reasons set forth above, HHSC's award decisions violated the Texas Administrative and Government Codes, and were arbitrary, unreasonable, not supported by the record, and reflected abuses of discretion. MHT's protest should be sustained, and the following remedies imposed.

1. The errors in the scoring of Question 281 prevented MHT from being the top-ranked MCO overall. The noticed awards in Bexar, Dallas, El Paso, Harris, Jefferson, Lubbock, Nueces, Tarrant, and Travis should be rescinded. Question 281 should be rescored in accordance with the procurement's rules, and new award determinations should be made in these service areas. To the extent your Office determines that scoring

errors were made on other questions, the noticed awards should be rescinded, and the offerors' entire proposals should be re-evaluated. Alternatively, if your Office determines that a fair assessment of Respondents cannot be conducted on the proposals that were submitted in November 2018, your Office should rescind the noticed awards, amend the solicitation, and receive and evaluate new proposals.

2. United was erroneously scored to have earned 1.43 points on Question 245, when in fact United should have been scored at .14 points on this question. With the proper adjustment made, United's score drops below that of a Respondent (AmeriHealth) that did not receive any service area contracts. The noticed award should be rescinded, and new awards determinations made in light of the required adjustment to United's score.

3. In the event that MHT's protests related to the scoring of Questions 281 and 245 are not sustained, in order to validate the service coordination and continuity of care objectives, the noticed awards to Aetna in Bexar, Dallas, and Harris, and to Amerigroup in Dallas, should be rescinded, and MHT should be awarded contracts in these service areas. Alternatively, HHSC may validate the service coordination and continuity of care objectives by exercising the Commission's discretion to make additional contract awards to MHT in its incumbent service areas of Bexar, Dallas, El Paso, Harris, and Jefferson.

4. Aetna failed to complete its HUB Subcontracting Plan in good faith. For this reason, HHSC should have eliminated Aetna from the competition, but did not. HHSC should rescind the noticed awards to Aetna, and make new awards decisions according to the rules of the procurement.

Respectfully Submitted,

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