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January 20, 2023

Delivered via U.S. certified mail and electronic mail

Mr. Matthew Sawchak (msawchak@robinsonbradshaw.com)
 Robinson, Bradshaw & Hinson, P.A.
 434 Fayetteville Street, Suite 1600
 Raleigh, North Carolina 27601

RE: Response to Blue Cross Blue Shield of North Carolina's Request for Protest Meeting on Request for Proposal #270-20220830TPAS

Dear Mr. Sawchak:

On January 12, 2023, the North Carolina State Health Plan for Teachers and State Employees ("Plan") received your letter delivered on behalf of your client Blue Cross Blue Shield of North Carolina ("BCBS") and titled "Blue Cross Blue Shield of North Carolina's Request for Protest Meeting on Request for Proposal #270-20220830TPAS" ("Protest Letter"). This response is intended to answer that request pursuant to § 15 of Attachment B of the Request for Proposal ("RFP") #270-20220830TPAS ("Third-Party Administrative Services RFP" or "TPA RFP"). The service period for this new third-party administrative services contract begins two years from now.

After carefully reviewing the reasons and requests stated in your Protest Letter, I have determined that your positions are without merit and am therefore denying your requests.

THE NORTH CAROLINA STATE HEALTH PLAN

The North Carolina Department of State Treasurer ("DST") is an agency of the State of North Carolina, led by the State Treasurer of North Carolina ("Treasurer"). The Plan, a division of DST, is a benefit program of the State of North Carolina that provides healthcare benefits to eligible North Carolina teachers, active State employees, retired teachers and State employees, and their dependents in accordance with applicable federal and state law and the Plan's regulations and policies. Established by N.C. Gen. Stat. § 135-48.20, the Board of Trustees for the Plan ("Board"), entrusted with fiduciary responsibilities, decides key matters and assists the Treasurer and the Plan. The Board is a bipartisan body that includes trustees representing key segments of the population the Plan serves, including active State employees, teachers, and retired State employees.

Due to rapidly increasing healthcare costs, funding that has not increased at the same rate, and the aging and declining health of the Plan member pool (due in part to the inability to

attract young and healthy dependents into the Plan because of high family premiums), the Plan is facing a \$4.2 billion budget gap over the next five years. This is an existential threat to the Plan.

This budget shortfall is in addition to the liability the Plan faces for future healthcare needs, which the Treasurer and the Board have been working to address for the last six years. The Treasurer and the Board have made it the Plan's explicit policy to cap or reduce the Plan's costs and implement strategic initiatives that will enable the Plan to lower dependent premiums to attract younger, healthier members to the Plan. The Plan has implemented finance-improving measures across the Plan's entire area of operations, including implementation of modest premiums for members who had been paying nothing for their coverage, improved cost savings from the 2023–2025 Pharmacy Benefit Manager contract, and significant cost savings from the 2021–2023 Medicare Advantage contract, to name a few.

Despite the Plan's ongoing efforts, healthcare costs continue to rise, and the budget shortfall persists, threatening the financial sustainability of the Plan for its current and future members, as well as the ability of the Plan to comply with N.C. Gen. Stat. § 135-48.1 *et seq.* and other applicable laws.

As a part of the high priority of reducing costs, the Treasurer and the Board have also made seeking transparency in healthcare costs a priority of the Plan. The ultimate goal for the transparency of healthcare costs is improved healthcare outcomes for Plan members at lower costs. To that end, the Plan implemented the Clear Pricing Project ("CPP"), partnering with thousands of healthcare providers to promote affordable, quality care and to increase transparency, predictability, and value for Plan members, in addition to reducing costs to the Plan.

Lastly, consistent with the Plan's authorizing statutes, the Treasurer set a priority for the Plan to update, improve, and streamline its Request for Proposals procurement process. In the past, the Plan's procurement process was overly laborious and time-consuming, producing reams of documentation without discernible improvement in the performance of the Plan's vendors.

RFP #270-20220830TPAS, the TPA RFP, was the second RFP to be revised and operated according to this modernization strategy, but the first RFP qualifying under N.C. Gen. Stat. § 135-48.34 as exempt from the requirements of Article 3 of Chapter 143. Modernization of the RFP process and the TPA RFP included these objectives:

- 1) Ensure that vendors are able and willing to work with the Plan to meet the priorities and requirements of the Plan and the RFP without qualification.

- 2) Avoid “micromanaging” every possible detail from the outset to provide the Plan flexibility and adaptability; instead, use Administrative Decision Memos and Business Requirements Documents to implement initiatives as needed.
- 3) Refine the scope of work to focus on the Plan’s key, non-negotiable items and move those items to the Minimum Requirements portion of the RFP.
- 4) Increase the overall objective analysis of RFPs by moving away, as much as reasonably possible, from subjective parsing of vendors’ own descriptions of their capabilities.
- 5) Revise the scoring methodology to ensure fair and objective scoring, efficient analysis by the Evaluation Committee, clarity for the Board, the decision-maker, and alignment with the Plan’s priorities.

To achieve these objectives in the TPA RFP, the Plan exercised its judgment to structure the RFP in the following ways: limiting vendor responses to the scope of work requirements presented in Attachments K and L to “Confirm” or “Does Not Confirm”; equally weighting each technical requirement; scoring technical requirements as either zero or one; and revising the cost analysis to reflect the importance the Plan places on the three components—six points for Network Pricing, two points for Administrative Fees, and two points for Pricing Guarantees.

In addition, the Plan structured the TPA RFP to support and clarify the Board’s decision-making role, which is established in N.C. Gen. Stat. § 135-48.33(a). The Treasurer and the Plan do not view the Board as a mere “rubber stamp,” so the Plan took steps to enable careful, thoughtful evaluation, deliberation, and full participation by the Board. One result was that, rather than being screened out by the Evaluation Committee, all three vendor proposals were presented to the Board for their review. It was *the Board* that then voted, unanimously, to award to Aetna Life Insurance Company (“Aetna”) the new third-party administrative services contract, which will begin two years from now.

The determining priorities mentioned above governed the Plan’s judgments and the structure and evaluation of the TPA RFP.

PROCESS FOR REQUEST FOR PROPOSAL #270-20220830TPAS

The modernized TPA RFP was made publicly available via the Interactive Purchasing System, the State’s online contracting portal, on August 30, 2022. By its terms, the TPA RFP mandated that “[t]he State shall conduct a comprehensive, fair, and impartial evaluation of the proposals.” The TPA RFP process consisted of two main stages: first, interested vendors submitted responses to the “Minimum Requirements Proposal” portion; after establishing their ability to meet the Plan’s minimum requirements, vendors then submitted responses to the Technical Proposal and Cost Proposal portions of the TPA RFP.



As with all of the Plan's RFPs, this was a voluntary process, and no vendor was mandated by contract or law to participate. Before any vendor submissions were made, the Plan held a conference call with interested vendors on September 1, 2022, regarding the TPA RFP structure and process. BCBS, Aetna, Cigna Insurance Company, and UMR, Inc., participated in that call. The Plan then issued Addendum #1 to the TPA RFP on September 16, 2022, responding to questions submitted by these interested vendors and making changes to several areas of the TPA RFP. Three of the interested vendors—BCBS, Aetna, and UMR, Inc.—submitted responses in the first stage of the process, the Minimum Requirements Proposal, by the deadline on September 26, 2022.

The Minimum Requirements Proposal, the components of which were defined in Section 2.7.1 of the TPA RFP, ensured each vendor could meet basic operational prerequisites to perform TPA services. The TPA Minimum Requirements Table included in TPA RFP Section 5.1 elicited key information from each vendor, such as: experience with large, self-funded clients, data security practices, financial health and stability, and demonstrated compliance with federal health information privacy law and regulations.

Vendors were also required to complete "Attachment K: Minimum Requirements Response" as the form for submitting responses to TPA RFP Sections 5.1.1 through 5.1.11. As noted above, the responses to the items listed in Attachment K were required to be either "Confirm" or "Does Not Confirm." In addition to the modernization objectives mentioned above, the purpose of requiring vendors to specifically confirm their ability to meet the wide variety of the Plan's minimum requirements was to preclude equivocation by vendors, discussed further below. As specific terms of the third-party administrative services contract, responses that were incomplete or did not comply with these requirements were subject to rejection.

In accordance with the terms of the TPA RFP, the Evaluation Committee then considered each vendor's comprehensive Minimum Requirements Proposal response with the assistance of subject matter experts in data security, finance, and federal health information privacy law. After the Evaluation Committee determined that each vendor met the Plan's minimum requirements stated in the TPA RFP, the vendors were given access to the worksheets and data files necessary to complete the second stage, responding to the Technical and Cost Proposals. Again, the vendors had the opportunity to ask questions relating to the RFP, specifically the technical and cost components. The Plan issued Addendum #2 to the TPA RFP on October 14, 2022, responding to all questions submitted by the three vendors.

The contents of the Technical and Cost Proposals were set forth in TPA RFP Section 2.7.2. Notably, the Technical Proposal consisted of 310 requirements divided into eleven main categories addressing matters ranging from member enrollment to plan design to finance and banking and more. Vendors were required to complete and submit "Attachment L: Technical Requirements Response," which again requested vendors to simply confirm their ability to meet the Plan's stated requirements. Again, the purpose of requiring clarity and

accuracy from all interested vendors was to reduce subjective interpretations on the part of Plan staff and to avoid negation or qualification of an ability to meet a Plan technical requirement through an explanatory description.

“Attachment A: Pricing” of the RFP comprised the Cost Proposal, which was scored based on three primary components: Network Pricing, Administrative Fees, and Network Pricing Guarantees. To complete the Network Pricing exercise, each vendor was given access to some actual Plan claims data and then asked to reprice the claims according to the vendor’s expected network discounts. This enabled the Plan to understand the financial value of each vendor’s network while also implicitly demonstrating the breadth of that network. The Administrative Fees component represented the cost charged to the Plan by the vendor for performance under the TPA RFP, and the Network Pricing Guarantees component was where each vendor could offer compensation back to the Plan if their network fails to deliver promised discounts (particularly due to rises in healthcare costs). The Cost Proposal itself consisted of ten total points a vendor could score: six points for its Network Pricing, two points for its Administrative Fees, and two points for its Network Pricing Guarantees. The Evaluation Committee, with assistance from its actuarial and health benefits consultant, The Segal Company (“Segal”), evaluated each vendor’s Proposal responses and scored them according to the terms of the TPA RFP.

As set out in the TPA RFP, the requirements in the Technical Proposal constituted half of each vendor’s score and those in the Cost Proposal constituted the other half. For the Technical Proposal component, vendors were ranked based on the total points earned out of the 310 available. The vendor earning the fewest points out of the total 310 received the rank of one. The vendor earning the most points out of the total 310 received the highest rank. To avoid subjectivity or favoritism, the TPA RFP specified that if two vendors earned the same number of points by meeting the requirements in the Technical Proposal, they would be equally ranked. In its response to the Technical Proposal’s requirements, BCBS failed to confirm its ability to meet seven of the Plan’s listed items, while the other vendors confirmed their ability to meet all 310. Thus, BCBS’ proposal earned the fewest points and received the rank of one.

The scoring and ranking methodology for the Cost Proposal was similar and also explained in the TPA RFP. Vendors were ranked based on the total Cost Proposal points earned out of the 10 available. The vendor earning the fewest points out of the total 10 received the rank of one, and the vendor earning the most points out of the total 10 received the highest rank. As with the Technical Proposal, multiple vendors earning the same Cost Proposal score were equally ranked. BCBS’ Cost Proposal response received eight points, which tied with another vendor for the most and so received the (highest) rank of three.

After reviewing the responses to the requirements of the Technical and Cost Proposals and combining the rankings, BCBS earned a final score of four, while the other two vendors earned scores of six and four. Thus, the Evaluation Committee presented all three vendors to the Plan’s Board for their consideration with a recommendation to award the third-party



administrative services contract to the vendor with the highest point total. During its meeting on December 14, 2022, the Board unanimously voted to award this contract to Aetna.

BCBS' CLAIM OF ARBITRARINESS LACKS MERIT

In the Protest Letter, you claim that the TPA RFP and its award to a vendor other than BCBS was “arbitrary,” “illogical,” and “capricious.” Therefore, you request that the award of the TPA RFP to Aetna should be rescinded and instead awarded to BCBS or that a new RFP process should be conducted. Your assertions are addressed in turn below.

Fundamentally, your assertion that the TPA RFP and its award were arbitrary is not supported by the facts and is, therefore, without merit.

A. Differences between the 2022 TPA RFP and prior RFPs

First, you incorrectly equate the mere existence of differences between the recently completed TPA RFP process and prior RFPs with unreasonableness and unfairness. In reality, the differences between the 2022 TPA RFP and prior RFPs were based on choices that were made logically in furtherance of the Plan’s fiduciary responsibilities and priorities.

For example, you complain that the scoring of the Cost Proposal was based on a 10-point scale instead of a 10,000-point scale. This complaint is meaningless, however, because BCBS’ bid was in no way adversely affected. How can BCBS now complain that the scoring of the Cost Proposal was incorrect or unfair if they received the highest ranking?

As another example, you complain that the 2022 TPA RFP eliminated the preference stated in prior RFPs for a vendor “with resources in North Carolina.” Protest Letter, p. 7. Again, this is meaningless. First, the Plan appropriately deemed this additional preference unnecessary, because any vendor confirming its ability to meet requirements in the Minimum Requirements and Technical Proposal portions is attesting to its “resources in North Carolina.” Second, in keeping with the Treasurer’s, the Board’s, and the Plan’s concerns about the consolidation, monopolistic behavior, and lack of transparency in the healthcare industry, such a preference was deemed inappropriate, anti-competitive, and detrimental to the proper exercise of fiduciary responsibilities.

The truth is that the Plan has been continuously refining and improving its RFP process over multiple years, the TPA RFP process conducted in 2019 improved upon prior RFPs, and the recently completed TPA RFP process continued that improvement in ways that will benefit the Plan’s members and Plan administration for years to come.

To be clear, you do not include these complaints about the differences between the 2022 TPA RFP and prior RFPs as a basis for BCBS’ protest of the award (so they will not be

evaluated as such). Apparently, these concerns are raised simply to cast doubt on the validity of the current RFP and the Plan's priorities and objectives, discussed above. Regardless, such post-award concerns by BCBS about the differences between RFP processes essentially amount to a complaint that the Plan failed to design its RFP process to favor BCBS, the incumbent.

B. Evaluation and weighting of the TPA RFP requirements

A second issue you raised reveals an incorrect belief that if a requirement of the TPA RFP, whether in the Minimum Requirements, the Technical Proposal, or the Cost Proposal, did not match BCBS' own priorities then there must not exist a fair, good faith, and reasoned decision by the Plan regarding that requirement. Specifically, you complain about the TPA RFP's scoring methodology in at least two ways: (1) that the Plan did not weight the requirements stated in the TPA RFP how BCBS thinks it should and (2) that the Plan did not permit BCBS to fully explain why it could not meet certain requirements.

1. BCBS' complaint about how the Plan weighted its requirements

Regarding the first complaint, the Plan is tasked with fairly, and in good faith, structuring and reviewing the RFP process and the TPA RFP to achieve its given objectives and priorities in service of the best interests of the Plan's members, to whom the Treasurer, the Board, and Plan staff owe a fiduciary duty. In exercising its duty, the Plan is not mandated to operate according to a particular vendor's internal mechanisms, procedures, and priorities. Instead, Plan staff carefully discerned and articulated requirements in the TPA RFP that we believe will best benefit the Plan's members.

In your Protest Letter you state that "the Plan could not make a reliable and informed decision" by choosing to equally weight the 310 items in the Technical Proposal and limiting vendors to confirming their ability to meet the requirements. Protest Letter, p. 10. In reality, these requirements, although presented slightly differently in the latest TPA RFP, are virtually unchanged from prior RFPs.

You have implied that the Plan's approach to the 2022 TPA RFP—such as what mandatory data, assurances, and requirements the Plan included or removed, how the Plan determined to score particular items, and the priority and weight that the Plan decided to place on specific requirements—was not reasonable. Actually, the Plan's decisions on structure, process, and award were logically connected to better achieving the objectives governing the Plan through this TPA RFP.

For example, the Plan decided to increase the weight for the score of the Cost Proposal to better align the scoring of the TPA RFP with the Plan's priority of reducing costs. In addition, within the Cost Proposal, Network Pricing was given the largest score because it reflects the highest cost to the Plan—in billions of dollars—while the Administrative Fee

and the Network Pricing Guarantees reflect smaller amounts of money—in hundreds of millions or millions of dollars.

2. BCBS' complaint about not being able to explain its answers

Regarding the complaint that the Plan did not provide BCBS an opportunity to explain its answers, it is true that the Plan decided to limit vendor answers to simple confirmations of ability to meet the Plan's requirements. This choice was made to align the Plan's RFP process, and specifically this TPA RFP process, with the goals of increasing objectivity in the analysis and ensuring that vendors are able and willing to work with the Plan to meet the TPA RFP requirements without qualification. The Plan's decisions on refining and restructuring its RFP process were based on a logical connection with the Plan's overarching objectives.

In addition, the effort to modernize the TPA RFP was specifically intended to eliminate explanations by bidding vendors that obscure and obstruct more than they reveal and clarify. For example, in the RFP for third-party administrative services issued in 2019, BCBS first stated "CONFIRMED in part, NOT CONFIRMED in part" to the Plan's requirement that its third-party administrator would "pay all claims, including non-network claims based on assignment of benefits." Requirement 5.2.12.2.b.i, 2019 TPA RFP. Later, in its explanation, BCBS described its limitations regarding this Plan requirement with this statement:

We do not confirm that we will pay all out-of-network claims based on assignment of benefits. In situations where we can negotiate a lower reimbursement in exchange for reimbursing the provider directly, we will do so. For all other out-of-network claims, we will reimburse the member directly. We have found that this policy is critical to our provider contracting ability and, ultimately, saves money for the Plan.

Requirement 5.2.12.2.b.iv, 2019 TPA RFP. Notwithstanding the reasons BCBS gave for how they wanted to handle claims payments, the fact is that the Plan has logical, considered reasons for its requirements, and asking vendors to clearly confirm their ability to meet such requirements is imminently reasonable. Avoiding equivocating explanations with the recently completed TPA RFP was *not* a failure to "proper[ly] exercise . . . its diligence," nor was the Plan's approach "illogical and arbitrary." Protest Letter, p. 10, 14. Instead, the Plan made a reasonable, careful effort to reduce the need for painstaking parsing in its evaluation of vendors' responses.

C. BCBS' problem with what "[t]he RFP does not explain"

The Plan first officially informed BCBS of its intent to issue the TPA RFP on June 15, 2022. The Plan then issued the TPA RFP on August 30, 2022. On September 1, 2022, BCBS participated in the Plan's call regarding the TPA RFP, where the Plan provided information



and answered vendor questions. The deadline to submit a response to the Minimum Requirements Proposal was September 26, 2022.

You complain in various places in your Protest Letter that the TPA RFP “does not explain” the scoring of the Cost Proposal and that “[t]he Plan has offered no justification” with respect to its weighting of the requirements in the Technical Proposal. Protest Letter, p. 5, 8–9.

But BCBS had ample opportunity to examine the Plan’s TPA RFP and its structure, process, and scoring prior to submitting its responses to the various Proposals. Like other vendors, BCBS was at liberty to ask questions, seek clarification, and request changes. BCBS did not raise *any* of the issues discussed in your Protest Letter during that time. By taking part in the TPA RFP, BCBS specifically and freely agreed to the TPA RFP and its structure, process, and scoring. Only now, after the Board has voted to award to Aetna the third-party administrative services contract beginning in 2025, is BCBS complaining about the TPA RFP’s structure, process, and scoring.

If BCBS had real concerns about the TPA RFP, and not fabricated ones, it had a responsibility to raise them during the process when it had multiple opportunities to do so. Raising these issues at this point is akin to Captain Renault’s faux shock in the movie *Casablanca*—you argue that you are surprised that the TPA RFP was structured and scored exactly as delineated in the TPA RFP.

D. Thoroughness and care exercised by the Plan

It is lawful, proper, and necessary for the Plan, the Treasurer, and the Board to implement a RFP to obtain more favorable terms for the Plan’s members and to align vendor relationships to better achieve the Plan’s strategic priorities.

Any implication that the Plan’s TPA RFP was not performed in good faith and in a fair manner does not align with the process as it actually occurred. The TPA RFP Evaluation Committee was commissioned to objectively review and score each proposal in accordance with the pre-developed criteria in the TPA RFP and to make a recommendation and presentation to the Board based on fair and ethical review practices. Those pre-developed criteria were created to achieve the objectives given to the Plan, already discussed above.

You assert that, in its pursuit of the Plan’s objectives, the Plan did not obtain sufficient information to make a reasonable decision, creating the false impression that the TPA RFP, its development, and its review were a cursory affair that only relied upon scant facts and a lack of knowledge, that “the Plan took a complex decision ...and tried to turn it into a checklist.” Protest Letter, p. 14. This dramatic language does not describe the Plan’s recently completed TPA RFP process.



In reality, the detailed, 209-page initial TPA RFP required vendors to provide substantial data to the Plan for review and a multitude of binding contractual assents (without qualification) to the Plan's essential requirements for its next third-party administrator. Specifically, the TPA RFP required submission of many mandatory items, such as (i) vendor network minimum requirements, (ii) an accessibility report of the vendor's proposed provider network, (iii) a summary of participants with and without access to network providers and facilities within established mileage parameters, and (iv) a list of each vendor's entire proposed provider network. Each vendor's proposed network was also tested through the claims repricing exercise of the Cost Proposal, described above. These and other items were requested, evaluated, and scored in accordance with the Plan's objectives to ensure that the Plan had the knowledge and assurances that its priorities and objectives would be met.

Finally, while we appreciate BCBS' stated concern regarding the disruptions that a change in third-party administrator may cause to the Plan's members, this is also something that the Treasurer, the Board, and the Plan have already carefully considered. Minimizing such disruptions is one reason why we are grateful for BCBS President and CEO Tunde Sotunde's repeated assurances of support and faithful work through the remainder of the current contract to State Treasurer Dale Folwell. In addition, this is why it matters so much to the Plan's members that the new third-party administrative services agreement will not begin for another two years: disruptions to members will be reduced by the Plan having adequate time for its implementation process. But the mere avoidance of disruption would mean that the Plan should never issue a new RFP for any services, and this would not be in keeping with the duties owed to the Plan's many members and other taxpayer like them.

CONCLUSION

Your Protest Letter also mentioned the two public records requests related to the TPA RFP submitted by BCBS on December 15 and 20, 2022. As BCBS is already aware, the deadline for all vendors to submit redacted versions of their materials just passed last week, on Monday, January 9, 2023. Thus, despite the apparent length of time since BCBS' public records requests, there have only been *seven* business days since the vendor submission deadline passed.

In addition, the Plan would not normally release procurement-related materials until after that procurement's "silent period" is lifted, which the Plan was forced to extend to cover responses to vendors' protest letters, including BCBS' own. Plan staff are still compiling the materials submitted by participating vendors, materials amounting to thousands of pages per vendor, even with the Plan's improved RFP process. Then, Plan staff must review and confirm the redactions to avoid sharing vendors' trade secret and confidential information. BCBS is already fully aware that fulfillment of these regular post-procurement public record requests usually takes multiple weeks, sometimes longer.



In this response to your Protest Letter, I have avoided an in-depth discussion of the implications of your statements about Aetna, that it was “motivated . . . to superficially ‘confirm’ its ability to meet each requirement *regardless* of its current capabilities or any limits on [its] ability to satisfy the requirement in the future.” Protest Letter, p. 10 (emphasis in original). If Aetna was untruthful when it confirmed its ability to meet all the Plan’s requirements, then the Plan will discover this during the next two years of implementation and during the term of the third-party administrative services contract. The Plan will then have contractual remedies to obtain and fiduciary responsibilities to uphold.

Regardless, a neutral examination of the facts shows that the Plan’s recently completed TPA RFP and its structure, process, scoring, and award were conducted carefully, professionally, in good faith, in a fair and reasonable manner, and in the best interest of the Plan’s members consistent with the Plan’s fiduciary responsibilities. Following its objectives, the Plan carefully considered the critical facts and arrived at decisions regarding RFP structure, process, scoring, and award that were logically connected with those objectives.

Your claim that the TPA RFP was arbitrary is without merit, and a meeting to further discuss BCBS’ protest of the award would serve no purpose. I understand BCBS’ disappointment at the award of the TPA RFP to Aetna and that this is not the outcome they desired; however, I am constrained to consider the facts and law as they exist.

I nonetheless desire to thank BCBS for their participation in the TPA RFP process—each bidder increases competition, which moves the Plan closer to achieving its overall goals of reducing the Plan’s costs, improving the Plan’s solvency, and lowering dependent premiums, all to maintain the Plan’s sustainability for this and the next generation of those who teach, protect, or otherwise serve. I have appreciated this opportunity to engage in a factual, thoughtful, and transparent review of the Plan’s contracting process for the third-party administrative services contract going into effect two years from now, and I welcome BCBS’ future bids on RFPs.

Sincerely,



Sam Watts
Interim Executive Administrator
North Carolina State Health Plan

STATE OF NORTH CAROLINA

COUNTY OF WAKE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS

19 DHR 01959, 19 DHR 02032, 19 DHR 02194

Optima Family Care of North Carolina,
Inc.,

Petitioner,

v.

North Carolina Department of Health
and Human Services, Mandy Cohen,
M.D., MPH, in her official capacity as
Secretary of the Department, and Dave
Richard in his official capacity as
Deputy Secretary of the Department for
NC Medicaid,

Respondent,

and

WellCare of North Carolina, Inc., Blue
Cross And Blue Shield of North
Carolina, AmeriHealth Caritas of North
Carolina, Inc., UnitedHealthCare of
North Carolina, Inc., Carolina Complete
Health, Inc., and North Carolina
Provider owned Plans, Inc. d/b/a My
Health by Health Providers,

Respondent-Intervenors.

North Carolina Provider Owned Plans,
Inc. d/b/a My Health By Health
Providers,

Petitioner,

v.

North Carolina Department of Health
and Human Services,

Respondent,

and

UnitedHealthCare of North Carolina,
Inc., Blue Cross And Blue Shield of
North Carolina, WellCare of North
Carolina, Inc., AmeriHealth Caritas of
North Carolina, Inc., Carolina Complete

Health, Inc., and Optima Family Care
of North Carolina, Inc.,
Respondent-Intervenors.

Aetna Better Health of North Carolina,
Inc., d/b/a Aetna Better Health of
North Carolina,
Petitioner,

v.

State Of North Carolina Department of
Health and Human Services – Division
of Health Benefits,
Respondent,

and

WellCare of North Carolina, Inc., Blue
Cross And Blue Shield of North
Carolina, AmeriHealth Caritas of North
Carolina, Inc., UnitedHealthCare of
North Carolina, Inc., Carolina Complete
Health, Inc., and North Carolina
Provider Owned Plans, Inc. d/b/a My
Health By Health Providers,
Respondent-Intervenors.

FINAL DECISION
GRANTING JUDGMENT AS A MATTER OF LAW
FOR RESPONDENT NORTH CAROLINA DEPARTMENT OF HEALTH AND
HUMAN SERVICES

These consolidated cases arise from the State’s transformation of its Medicaid delivery system from a fee-for-service model to a Medicaid managed care model operated by Prepaid Health Plans (“PHPs”) under capitated contracts as directed by the General Assembly in Session Law 2015-245, as amended (the “Transformation Act”). The Transformation Act directed the Respondent, the North Carolina Department of Health and Human Services (the “Department”), to award PHP contracts through a competitive procurement process. After issuing a request for proposals, receiving eight proposals, and evaluating those proposals, the Department

awarded four statewide PHP contracts and two regional PHP contracts to five of the eight offerors. The three unsuccessful offerors filed bid protests. When those protests were denied, these contested cases ensued.

Pursuant to N.C. Gen. Stat. § 1A-1, Rule 56, the Department filed a motion for summary judgment as to all claims of all Petitioners in these consolidated Contested Cases (the “Motion”). This Tribunal has considered all matters of record including the Motion, dispositive motions and briefs submitted by all parties, exhibits, affidavits filed in support of and in opposition to all dispositive motions, and the arguments of counsel presented at the hearing on the Motion and other dispositive motions then pending. Having considered all filings and evidence of record, this Tribunal concludes that there is no genuine issue as to any material fact and that the Department is entitled to judgment as a matter of law on all of Petitioners’ claims. Accordingly, pursuant to N.C. Gen. Stat. §§ 150B-34(e) and 1A-1, Rule 56, the Department’s Motion is GRANTED.

I.

PROCEDURAL HISTORY

1. Optima Family Care of North Carolina, Inc. (“Optima”) filed its Petition for Contested Case Hearing on 5 April 2019 in Case No. 19DHR01959, and thereafter filed an Amended Petition on 22 April 2019. North Carolina Provider Owned Plans, Inc. d/b/a My Health by Health Providers (“My Health”) filed its Verified Petition for Contested Case Hearing on 9 April 2019 in Case No. 19DHR02032. Aetna Better Health of North Carolina, Inc. d/b/a Aetna Better Health of North Carolina (“Aetna”)

filed its Petition for a Contested Case Hearing on 16 April 2019 in Case No. 19DHR02194. Optima, My Health, and Aetna are referred to herein collectively as the “Petitioners.” A fourth Petition for Contested Case Hearing was filed by Carolina Complete Health, Inc. (“CCH”), which was partly successful in its bid, but CCH later voluntarily dismissed its petition.¹

2. The successful offerors, UnitedHealthcare of North Carolina, Inc. (“UHCNC”), Blue Cross and Blue Shield of North Carolina (“BCBSNC”), WellCare of North Carolina, Inc. (“WellCare”), AmeriHealth Caritas of North Carolina, Inc. (“ACNC”), and CCH, intervened in the Contested Cases.

3. Each of the Petitioners moved for a stay, temporary restraining order, and/or preliminary injunctive relief to halt implementation of Medicaid managed care in North Carolina pending a final decision in their respective Contested Case. The parties submitted extensive briefing and affidavits on these motions and presented argument over three days of hearings. On 26 June 2019, all motions for stay and preliminary injunctive relief were denied; no Petitioner showed a likelihood of success on the merits of their claims.²

4. The four contested cases were consolidated for hearing by Order of the Chief Administrative Law Judge entered 26 July 2019.

¹ CCH voluntarily dismissed its petition on 10 October 2019, after the Department awarded CCH one additional regional contract. With that additional contract, CCH was awarded a total of three regional contracts.

² My Health also moved for a temporary restraining order, which relief was denied by the Tribunal’s order of 15 April 2019.

5. Discovery was conducted, including weeks of depositions in August, September, and October 2019, and production by the Department of over 230,000 pages of documents.

6. On 19 September 2019, Aetna moved for leave to amend its Petition to add two new claims to its Contested Case.

7. In or around November 2019, the Department suspended implementation of Medicaid managed care when the North Carolina General Assembly adjourned without providing required spending and program authority for the transition to managed care. The Department notified the Tribunal of this suspension by filed letter of 21 November 2019.

8. The parties submitted dispositive motions, responses, and replies between 8 November 2019 and 6 December 2019. In total, the parties filed eight dispositive motions and supporting memoranda, twelve responses, and nine replies, along with extensive affidavits, exhibits, and thousands of pages of deposition transcripts. Many of the issues in the briefing of these motions overlapped. The Department's Motion subsumed all claims presented by all Petitioners, including those raised by Aetna in its motion for leave to amend its Petition.³

³ In addition to the Department's Motion, the dispositive motions filed and disposed of by this Final Decision are: Aetna's Motion for Summary Judgment; My Health's Motion for Partial Summary Judgment; ACNC's Motion for Partial Summary Judgment; ACNC's Rule 12(b)(6) Motion to Dismiss Aetna's Claims that seek rescoring and a contract award; BCBSNC's Motion for Summary Judgment; UHCNC's Motion for Partial Summary Judgment; and WellCare's Motion for Partial Summary Judgment.

9. Considering that most of the parties, including two of the Petitioners, filed dispositive motions that took the position that issues could be decided summarily, and that the Department had suspended implementation of Medicaid managed care due to the General Assembly’s failure to pass implementation funding, the contested case hearing previously scheduled to begin 6 January 2020 was continued.

10. On 20 and 21 January 2020, the Tribunal heard two full days of argument on the dispositive motions.

11. By March 2020, the global COVID-19 pandemic began impacting the ordinary operation of courts and proceedings at the Office of Administrative Hearings (“OAH”). On 19 March 2020, the Chief Justice of the North Carolina Supreme Court issued the first of multiple orders suspending deadlines and extending limitations periods, and addressing other matters affecting the disposition of cases. Likewise, on 27 May 2020, Chief Administrative Law Judge Julian Mann issued an order that, effective 19 March 2020, suspended filing deadlines for petitions for contested cases before OAH.⁴

12. Three volumes of transcripts from the January 2020 hearings on the dispositive motions were filed on 6 April 2020.

13. By letter dated 8 July 2020, the Department gave notice to the Tribunal that the Department was resuming its efforts to transition to Medicaid managed care

⁴ The impacts of the COVID-19 pandemic continue through the date of this Final Decision.

in light of Session Law 2020-88, which was signed into law by Governor Cooper on 2 July 2020. This legislation provides funds for implementation of Medicaid managed care to move forward and requires capitated contracts to begin by 1 July 2021.

14. On 25 August 2020, the parties were informed of rulings on several pending motions including that Aetna's Motion for Leave to Amend⁵ would be granted and the Department's Motion would be granted. This Final Decision is now entered disposing of all issues in these Contested Cases.

II.

FACTUAL BACKGROUND

15. Consistent with N.C. Gen. Stat. § 150B-34(e) and N.C. R. Civ. P. 56, the Tribunal does not make findings of fact when ruling on a motion for summary judgment. The factual background stated in this section and in portions of this Final Decision is taken from the evidence on which there is no genuine issue of material fact, and is intended solely to provide context for this Final Decision.

A. The Transformation Act

16. The General Assembly enacted the Transformation Act in September 2015 and it has been amended several times including most recently in July 2020.⁶

⁵ Aetna sought leave to file its Amended Petition before dispositive motions were filed and heard. Upon consideration of Aetna's Motion for Leave to File its Amended Petition, that motion is granted. Although Aetna did not file the Amended Petition until 26 August 2020, the parties addressed the allegations in the Amended Petition in briefing and arguing their positions in connection with the dispositive motions, and this Final Decision adjudicates the issues raised therein.

⁶ N.C. Sess. Law 2015-245 was amended by N.C. Sess. Law 2016-121; N.C. Sess. Law 2017-57, § 11.H.17(a); N.C. Sess. Law 2017-186, Part IV; N.C. Sess. Law 2018-5, §

North Carolina’s Medicaid managed care program is expected to serve over 1.6 million lives and involve approximately \$6 billion in funds on an annual basis. The transformation is intended to “provide budget predictability for the taxpayers of this State while ensuring quality of care to those in need.” N.C. Sess. Law 2015-245, § 1.

17. The Department is the “single state agency” charged with administering North Carolina’s Medicaid program. *See* 42 U.S.C. § 1396a(a)(5); N.C. Gen. Stat. § 108A-54(a). The Transformation Act gives the Department “full authority to manage the State’s Medicaid and NC Health Choice programs” and requires it to “be responsible for planning and implementing the Medicaid transformation required by the act.” N.C. Sess. Law 2015-245, § 4(1).

18. The Department’s transformation activities and functions included defining “six regions comprised of whole contiguous counties that reasonably distribute covered populations across the State to ensure effective delivery of health care and achievement of the goals of Medicaid transformation.” *Id.* § 5(2).

19. The Transformation Act required the Department to develop a competitive procurement process and to enter into capitated PHP contracts with standardized contract terms as a result of a request for proposals and the submission of competitive bids. *Id.* § 5(6).

11.H.10(c); N.C. Sess. Law 2018-49, §§ 4-6; N.C. Sess. Law 2018-48; and N.C. Sess. Law 2020-88, Part VII.

20. A PHP is “an entity, which may be a commercial plan or provider-led entity that operates or will operate a capitated contract for the delivery of services....” N.C. Sess. Law 2015-245, § 4(2), as amended by N.C. Sess. Law 2018-48.

21. A commercial plan (“CP”) is “a person, entity, or organization, profit or nonprofit, that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles and holds a PHP license issued by the Department of Insurance.” *Id.* §4(2)a, as amended by N.C. Sess. Law 2018-48.

22. To qualify as a provider-led entity (“PLE”), an offeror not only had to meet the same requirements as a CP, but also had to meet the following governance criteria:

1. A majority of the entity’s ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more capitated contracts described in subdivision (3) of this section or Medicaid and NC Health Choice providers.
2. A majority of the entity’s governing body is composed of individuals who (i) are licensed in the State as physicians, physician assistants, nurse practitioners, or psychologists and (ii) have experience treating beneficiaries of the North Carolina Medicaid program.
3. Holds a PHP license issued by the Department of Insurance.

Id. § 4(2)b, as amended by N.C. Sess. Law 2018-48.

23. The Transformation Act required the Department to award four statewide PHP contracts and gave the Department the discretion to award “up to 12” regional PHP contracts. *Id.* § 4(6), as amended by N.C. Sess. Law 2018-48.

B. The RFP

24. On 9 August 2018, the Department issued RFP #30-190029-DHB (the “RFP”) to solicit offers for PHPs as required by the Transformation Act.

25. The RFP and associated procurement process were the result of several years of work by multiple divisions within the Department and other state agencies spanning two gubernatorial administrations.

26. Before issuing the RFP, the Department sought input from legislators, the United States Centers for Medicare & Medicaid Services (“CMS”), other states, industry experts, and stakeholders regarding the design and implementation of Medicaid managed care in North Carolina.

27. In developing the RFP, the Department used not only its own employees with relevant experience, but also outside experts including several consulting firms.

28. The RFP, including all addenda, is approximately 1,000 pages long and is divided into nine sections, including Section VIII which sets forth 65 Evaluation Questions, Seven Use Case Scenarios, and various tables and information to be completed by an offeror.

29. Under the RFP, CPs were permitted to submit bid proposals for award of a statewide contract.

30. Under the RFP, PLEs were permitted to submit bid proposals for award of a statewide contract, one or more regional contracts, or both.

31. The RFP notified potential offerors that the Department would be establishing an Evaluation Committee to review proposals and make award recommendations.

C. The Proposals

32. The Department received proposals from eight offerors. Three of the offerors qualified as PLEs (My Health, CCH, and Optima).

33. Aetna, ACNC, BCBSNC, UHCNC, and WellCare—none which sought qualification as a PLE—submitted proposals for statewide contracts. CCH submitted a proposal for either a statewide contract or regional contracts in all six regions. Optima submitted a proposal for regional contracts only in Regions 4, 5, and 6.

34. Evaluation Question (“EQ”) 1 stated: “The Offeror shall indicate if it is submitting a proposal as a Statewide or Regional contract. ***Check all that apply.***” In response to EQ 1, My Health checked the statewide contract option “XX” and did not check the regional contract option. Additionally, EQ 2 stated in pertinent part:

If the Offeror is submitting a Regional proposal (as indicated in Question #1 above), the Offeror shall indicate the Region(s) . . . it is proposing to provide Medicaid Managed Care services and coverage. (If the Offeror is submitting a Statewide proposal, it is presumed that the Offeror is proposing to provide Medicaid Managed Care services and coverage in Regions 1-6 in their entirety and the Offeror shall not be required to make any indication).

My Health made no indication of any region for which it was submitting a proposal in response to EQ 2.

D. Evaluation of Proposals

35. The Department established an Evaluation Committee tasked with evaluating and scoring the proposals and making an award recommendation. The Evaluation Committee included seven scoring members with various backgrounds and experience including in Medicaid, complex government programs, and managed care. The Evaluation Committee also included non-scoring members, such as the contract leads and the COO of NC Medicaid, who combined had decades of procurement and proposal evaluation experience.

36. Subject matter experts (“SMEs”) were made available to the scoring Evaluation Committee members and included physicians and other health care providers as well as individuals with experience in state budgeting, claims payment, technology, and other areas of relevance. The scoring members of the Evaluation Committee consulted with approximately two dozen SMEs over the course of the procurement process.

37. The RFP stated that the scoring of proposals would be based on the following criteria:

- Offeror Qualifications/Experience (20% weight)
- Scope of Services (70% weight)
- Use Cases (5% weight)
- Client References (5% weight)
- Bonus Points: Marketplace Participation (2.5% weight)

The Scope of Services subsection was further broken down into eight additional subsections with individual weights ranging from 5% to 25% of the total evaluation.

38. The Department developed a scoring rubric, allocated available points to all evaluation questions and information required as forecasted in the RFP, and developed a scoring guide for use by the scoring members of the Evaluation Committee. The scoring guide provided the Evaluation Committee members with detailed guidance to consider in evaluating the proposals. Most of the evaluation questions were evaluated using a “5 Level Rating Scale” where scoring members were directed to apply one of the following ratings to the requested components of the evaluation question: “Substantially Exceeds,” “Exceeds,” “Meets,” “Partially Meets,” or “Does Not Meet.” For questions that were to be scored using a scale other than the 5 Level Rating Scale, specific instructions were provided to the scoring Evaluation Committee members for assigning ratings.

39. The scoring members of the Evaluation Committee attended a kickoff meeting on 17 October 2018, and at that meeting and during the early stages of the evaluation process, the Evaluation Committee received instructions, guidance, and definitions of what each rating meant in order to provide an objective and consistent framework for evaluation.

40. Certain ground rules were established for the Evaluation Committee from the outset, including the consensus method of scoring, review of one section at a time for each response, and the requirement of having a minimum of five scoring members present to score or rate responses.

41. All scoring members of the Evaluation Committee and the SMEs completed confidentiality and conflict of interest statements prior to beginning work.

Further, each Evaluation Committee meeting or session began with the assessment of whether there were any conflicts to disclose for any member of the Evaluation Committee.

42. The Evaluation Committee met 46 times from October 2018 to January 2019.

43. The Evaluation Committee rated the proposals using the consensus method of scoring pursuant to which the scoring members agreed upon a particular rating for each offeror's response to each evaluation question. If the consensus score was a rating other than "Meets," the Evaluation Committee collectively drafted the reasoning and exact wording to explain the consensus score either below or above "Meets." All scores given by the Evaluation Committee were the product of consensus scoring by the scoring members of the Evaluation Committee.

44. The scoring members of the Evaluation Committee did not know the scores or rankings of the offerors until the Evaluation Committee completed its scoring and the preliminary scores were revealed to it in mid-January 2019, subject to a quality assurance review process.

45. The quality assurance review process was led by the Department's Medicaid contracting section to correct errors and to ensure that consistent and reasonable standards had been applied to all proposals. Scoring was corrected or adjusted in accordance with the findings during the quality assurance review process and with the consensus of the Evaluation Committee.

46. As part of the quality assurance review process, a consensus determination was made by the scoring members of the Evaluation Committee that the reference BCBSNC submitted for its key Core Medicaid Functions contractor, Amerigroup Partnership Plan, LLC (“Amerigroup”), from BlueChoice Health Plan of South Carolina, Inc. (“BlueChoice SC”), which initially was not scored, should have been scored. This was one of several adjustments and error corrections that were made during the quality assurance review process.

47. Following the completion of the quality assurance review process, the scores were finalized and the offerors were given final rankings. WellCare received the highest score followed by UHCNC, BCBSNC, ACNC, Aetna, My Health, CCH, and Optima. WellCare received a score of 736.19304 which was 71.824% of the total available points. ACNC, the fourth ranked offeror for a statewide contract, received a score of 706.66204 which was 68.943% of the total available points. Aetna received a score of 704.60144. My Health ranked in sixth place overall and in sixth place of the statewide offerors, with a score of 629.71280. Optima was the lowest scoring offeror, with a total score of 573.48539 points.

E. Contract Awards

48. The Evaluation Committee recommended the award of statewide contracts to the four highest ranked offerors: WellCare, UHCNC, BCBSNC, and ACNC. The Evaluation Committee did not recommend award of any regional contracts based on the scoring and ranking of the offerors that submitted proposals for regional contracts.

49. The Department's Deputy Secretary of North Carolina Medicaid, Dave Richard, agreed with the Evaluation Committee's recommendation regarding the four statewide contract awards and also recommended awarding two regional contracts to CCH. Department Secretary Mandy Cohen accepted Mr. Richard's recommendation.

50. On 4 February 2019, the Department awarded statewide PHP contracts to WellCare, UHCNC, BCBSNC, and ACNC, and regional PHP contracts in Regions 3 and 5 to CCH.

51. Aetna, My Health, and Optima each requested a bid protest meeting pursuant to 1 N.C. Admin. Code 05B .1519(c)(1) and the terms of the RFP. Bid protest meetings were held before Principal Deputy Secretary Susan Perry-Manning who issued decisions denying My Health's protest on 5 April 2019, and denying Aetna's and Optima's protests on 12 April 2019. These Contested Cases followed.

III.

STANDARD OF REVIEW

52. "An administrative law judge may grant . . . summary judgment, pursuant to a motion made in accordance with G.S. 1A-1, Rule 56, that disposes of all issues in the contested case." N.C. Gen. Stat. § 150B-34(e). Pursuant to N.C. R. Civ. P. 56, summary judgment should be granted "forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that any party is entitled to judgment as a matter of law."

53. “Summary judgment is not a ‘disfavored procedural shortcut,’ rather it is an important procedure ‘designed to secure the just, speedy and inexpensive determination of every action.’” *Town of Leland v. N.C. Dep’t of Env’tl Quality*, 17 EHR 03759, 2017 WL 7052568 (N.C.O.A.H. Dec. 21, 2017) (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 327 (1986); *Estate of Williams v. Pasquotank Cty. Parks & Rec. Dep’t*, 366 N.C. 195, 198, 732 S.E.2d 137, 140 (2012)).

54. A fact is material if “it would constitute or would irrevocably establish any material element of a claim or defense.” *Bernick v. Jurden*, 306 N.C. 435, 440, 293 S.E.2d 405, 409 (1982). A purported issue as to a material fact is deemed “genuine” only if it “may be maintained by substantial evidence.” *Id.* “Substantial evidence is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion, and means more than a scintilla or a permissible inference.” *DeWitt v. Eveready Battery Co., Inc.*, 355 N.C. 672, 681, 565 S.E.2d 140, 146 (2002) (internal citations and quotations omitted); *see also Nasco Equip. Co. v. Mason*, 291 N.C. 145, 152, 229 S.E.2d 278, 283 (1976) (a party cannot prevail against a motion for summary judgment through reliance on conclusory allegations unsupported by facts, citing Rule 56(e)).

55. A respondent may meet its summary judgment burden by: (1) proving that an essential element of the petitioner’s claim is nonexistent; (2) showing that the petitioner cannot produce evidence to support an essential element of the petitioner’s claim; or (3) showing that the petitioner cannot overcome an affirmative defense which bars the claim. *Rich v. Shaw*, 98 N.C. App. 489, 490, 391 S.E.2d 220, 221-22

(1990). “Once the moving party meets its burden, then the non-moving party must produce a forecast of evidence demonstrating that the plaintiff will be able to make out at least a prima facie case at trial.” *Purvis v. Moses H. Cone Mem. Hosp. Serv. Corp.*, 175 N.C. App. 474, 477, 624 S.E.2d 380, 383 (2006). Here, the Department has met its summary judgment burden, and the Petitioners have not produced a forecast of evidence demonstrating that they will be able to make out a prima facie case at trial on any of their claims.

56. When challenging agency action, a petitioner must establish that the agency has “substantially prejudiced the petitioner’s rights” and that the agency: (1) exceeded its authority or jurisdiction; (2) acted erroneously; (3) failed to use proper procedure; (4) acted arbitrarily or capriciously; or (5) failed to act as required by law or rule. N.C. Gen. Stat. § 150B-23(a). In reviewing such challenges, due regard is to be given “to the demonstrated knowledge and expertise of the agency with respect to facts and inferences within the specialized knowledge of the agency.” N.C. Gen. Stat. § 150B-34(a).

57. Petitioners in these contested cases challenge the Department’s award of PHP contracts pursuant to an RFP. As an initial matter, this Tribunal notes that the Department is the single state Medicaid agency in North Carolina, has decades of experience administering Medicaid, has operated using a managed care model for certain services, and includes employees with specialized knowledge of Medicaid and other experience relevant to the Department’s procurement process. Additionally, the Transformation Act gives the Department “full authority to manage the State’s

Medicaid and NC Health Choice programs” and requires the Department to be responsible for planning and implementing Medicaid transformation. N.C. Sess. Law 2015-245, § 4(1).

58. RFPs, as explained by one court, are used by a public authority for a variety of reasons, including when the qualifications and quality of service are considered the primary factors instead of price. *Emerald Corr. Mgmt. v. Bay Cty. Bd. of Cty. Comm’rs*, 955 So. 2d 647, 651 (Fla. Dist. Ct. App. 2007). Contract awards pursuant an RFP are generally based “on the results of an extensive evaluation which includes criteria, qualifications, experience, methodology, management, approach and responsiveness to the RFP.” *Id.* An RFP therefore, by its very nature, requires some exercise of discretion by the public authority.

59. It is generally recognized that a reviewing body “does not have authority to override decisions within agency discretion when that discretion is exercised in good faith and in accordance with law.” *Lewis v. N.C. Dep’t of Human Res.*, 92 N.C. App. 737, 740, 375 S.E.2d 712, 714 (1989). In determining whether the Department has acted arbitrarily or capriciously, this Tribunal “should not “replace the [agency]'s judgment as between two reasonably conflicting views, even though the court could justifiably have reached a different result.” *Town of Leland*, 17 EHR 03759, 2017 WL 7052568 (quoting *Thompson v. Wake Cty. Bd. Of Educ.*, 292 N.C. 406, 410, 233 S.E.2d 538, 541 (1977)); see, e.g., *Burton v. City of Reidsville*, 243 N.C. 405, 407-08, 90 S.E.2d 700, 703 (1956) (“If the officer acted within the law and in good faith in the exercise

of his best judgment, the court must decline to interfere even though it is convinced the official chose the wrong course of action.”).

60. When a petitioner claims that the agency’s decision was arbitrary or capricious, it “bears a heavy burden.” *Town of Leland*, 17 EHR 03759, 2017 WL 7052568. One it cannot meet by simply disagreeing with the agency position. Rather, a petitioner “must present facts that [the agency’s] decision was ‘whimsical’ or made in ‘bad faith.’” *Id.* Indeed, agency decisions may only be reversed as arbitrary or capricious when they are “patently in bad faith” or “whimsical” in the sense they “indicate a lack of fair and careful consideration” or “fail to indicate any course of reasoning and the exercise of judgment.” *Adams v. N.C. State Bd. of Registration for Prof’l Engineers & Land Surveyors*, 129 N.C. App. 292, 297, 501 S.E.2d 660, 663 (1998) (internal citations and quotations omitted); *see also Lewis*, 92 N.C. App. at 740, 375 S.E.2d at 714.

61. In ruling on the Department’s Motion, the Tribunal must presume that the Department “acted in good faith,” and it is the Petitioners’ burden to “prove otherwise.” *Pamlico-Tar River Found. v. N.C. Dep’t of Env’t and Nat. Res., Div. of Water Res.*, 13 EHR 17938, 2015 WL 3813960 (N.C.O.A.H. 2015). “Indeed, ‘[i]t is well settled that absent evidence to the contrary, it will always be presumed that public officials will discharge their duties in good faith and exercise their powers in accord with the spirit and purpose of the law.’” *Town of Leland*, 17 EHR 03759, 2017 WL 7052568 (quoting *Strickland v. Hedrick*, 194 N.C. App. 1, 10, 669 S.E.2d 61, 68 (2008)). This presumption due to the Department “places a heavy burden on the party

challenging the validity of public officials' actions to overcome [them] by competent and substantial evidence" at summary judgment. *Owens v. N.C. Dep't of Env't Qual.*, 15 EHR 07012, 2016 WL 7032833, (N.C.O.A.H. Oct. 4, 2016).

62. Together, the presumptions and due regard due to the Department in this context means that the Department's discretion under the Transformation Act to draft the RFP, evaluate the proposals received in response to the RFP through a competitive public contracting process, and award contracts for Medicaid managed care is broad, but it is not unbridled.

63. The Department has shown that its procurement process was thorough, detailed, and thoughtful and, with respect to discretionary decisions within the Department's purview, the law presumes that the Department discharged its duties in good faith and exercised its power in accord with the spirit and purpose of the law. Although Petitioners disagree with certain of the Department's positions and decisions, Petitioners have not adduced evidence showing that the Department acted in bad faith or in a manner that was whimsical or otherwise in violation of N.C. Gen. Stat. § 150B-23(a). Thus, the Department is entitled to judgment as a matter of law on all of Petitioners' claims.

IV.

THE DEPARTMENT IS ENTITLED TO JUDGMENT AS A MATTER OF LAW ON AETNA'S CLAIMS

64. Based on the undisputed evidence of record and giving appropriate due regard to the Department decisions and the presumption that the Department acted

in good faith, there is no genuine issue of material fact for trial and the Department is entitled to summary judgment on all of Aetna's claims.

65. Aetna received a final score that ranked it fifth of all offerors and fifth of the offerors submitting proposals for statewide contracts. Because the Transformation Act only authorizes the Department to award four statewide contracts, Aetna was not awarded a contract.

A. The Department is entitled to judgment as a matter of law on Aetna's scoring claims.

66. In its Amended Petition, Aetna claims that it received too few points on some of its EQ responses (EQs 5, 46, 48, and 56) and that ACNC received too many points on some of its responses (EQs 50, 62, 5, and 9).⁷

67. As noted above, in determining whether the Department has acted arbitrarily or capriciously, this Tribunal may not substitute its judgment for the Department's judgment, even if the Tribunal believes the Department acted incorrectly. The scoring decisions at issue in the present case are plainly exercises of agency discretion, thus this Tribunal is not at liberty to set them aside based on mere disagreement.

68. Instead, Aetna must show that the Department's decisions were patently in bad faith, whimsical, or otherwise indicate a lack of fair consideration,

⁷ Aetna failed to present any evidence or any argument with respect to EQs 46 and 56. Because the record evidence, when viewed in the light most favorable to Aetna, on those EQs is sufficient to warrant summary judgment in the Department's favor, summary judgment is granted for the Department on EQs 46 and 56.

any course of reasoning, or the exercise of judgment. *See Adams*, 129 N.C. App. at 297, 501 S.E.2d at 663. Aetna has not made such showing.

i. The Department is entitled to judgment as a matter of law on Aetna's claims that it received too few points.

EQ 5

69. EQ 5 sought specified information from offerors regarding entities that “will perform Core Medicaid Operations Functions.” Aetna identified some of the same subcontractors as other offerors but received lower ratings than other offerors received for the same subcontractors. Aetna asserts that it should have received the same score as other offerors for the same named subcontractors.

70. The RFP provided for each offeror's response to be evaluated on its own merits.

71. EQ 5 required offerors not only to identify its Core Medicaid Operations Functions contractors, but also required offerors to “provide information” about the entities, including the roles they would play. EQ 5 asked offerors to be “fully transparent in describing the experience, both positive and negative, related to the entity's role(s) or responsibilities.”

72. The record evidence, when viewed in Aetna's favor, establishes that: the Department followed the RFP's requirements; the Department was mindful of the quantity and quality of the information provided by each offeror and the way each offeror described its relationships with its subcontractors; and the Department's evaluation and scoring decisions with respect to the way *Aetna* described *its* use of subcontractors and the way other offerors described their use of their identified

subcontractors were reasonable, not “whimsical.” Aetna was held to its information and descriptions and scored based on what it wrote—an outcome that is fair and not arbitrary or capricious.

EQ 48

73. EQ 48 required offerors to provide information regarding their “Engagement with Community and County Organization[s]” that had been conducted in preparation to provide services in North Carolina’s Medicaid system. Aetna contends that it should receive more points for its EQ 48 response than WellCare received for its EQ 48 response because Aetna claims its response was superior to that of WellCare.

74. The record evidence shows that EQ 48 had four subcomponents and required Offerors to provide a draft “Local Community Collaboration Strategy.” The Evaluation Committee looked at the responses for each component individually and then collectively to determine the score for the entire question for each offeror. Aetna’s written collaboration strategy was written and styled as a “marketing plan,” and the Evaluation Committee reasonably viewed it and Aetna’s response to the other components of EQ 48 as lacking in details or a long term plan to achieve articulated goals and objectives for engaging communities.

75. The record evidence establishes, when viewed in Aetna’s favor, that the Department’s evaluation and scoring of EQ 48 was reasonable, not “whimsical.”

ii. The Department is entitled to judgment as a matter of law on Aetna’s claims that ACNC received too many points.

EQ 50

76. EQ 50 required the offeror to “confirm its adherence and describe its approach to meeting the Department’s expectations and requirements outlined in Section V.G.1. Service Lines.” The crux of Aetna’s EQ 50 argument is that ACNC purportedly did not commit to staff Emergency Member Service lines in North Carolina and thus should have received a score of “Does Not Meet.”

77. The RFP requires the service lines for non-emergency member issues to be open from 7 AM until 6 PM and be staffed in North Carolina and requires the service line for emergency member issues to be always open and be staffed in North Carolina. In its proposal, ACNC committed to sufficiently staff service lines with dedicated local staff to meet or exceed all contractual requirements. Notwithstanding ACNC’s written commitment to adhere to the RFP’s specific local staffing requirements for phone lines, Aetna argues that ACNC’s statement in its EQ 50 response that its “specialized after-hours team in Philadelphia, PA, will ensure members can speak to a live representative no matter what time they call” means that ACNC did not commit to staff Emergency Member Service Lines in North Carolina as required.

78. The record evidence establishes the Evaluation Committee acted reasonably in determining that ACNC had committed to the required North Carolina staffing. The record evidence shows that the Evaluation Committee members reviewed ACNC’s EQ 50 response in its entirety, determined that ACNC had committed to comply with the RFPs requirements, and, in fact, had committed to exceed the RFP’s requirements by committing to provide members access to a live

representative, 24 hours a day, seven days a week, rather than requiring them to leave a message on an after-hours answering machine.

79. The record evidence fails to support a conclusion that the Department's rating for EQ 50 was "whimsical" in the sense that it "indicate[d] a lack of fair and careful consideration" or "fail[ed] to indicate any course of reasoning and the exercise of judgment." *Lewis*, 92 N.C. App. at 740, 375 S.E.2d at 714. Rather, the record evidence supports only a conclusion that the Department acted thoughtfully and rationally in scoring ACNC's response to EQ 50.

EQs 62, 5, and 9

80. Aetna contends that ACNC should lose points because it identified two entities in its response to EQ 62 (*i.e.*, Optum and Change Healthcare Coding Advisor ("CHCA")) that were purportedly going to provide "Core Medicaid Operations Functions" but were not identified on a required list (part of EQ 62) as providing such functions. Aetna also claims that ACNC should lose points because it did not disclose Optum and CHCA in response to EQs 5 and 9, which required the disclosure of information about entities providing "Core Medicaid Operations Functions."

81. Aetna's contention related to EQs 62, 5, and 9 has two parts. First, Aetna asserts that although "fraud waste and abuse prevention" is *not* identified in the RFP as a core Medicaid operation, it is part and parcel of "processing and paying claims" (which *is* identified in the RFP as a core Medicaid operation). And second, entities performing fraud, waste, and abuse prevention functions were required to be

treated the same as entities performing the contractually defined “Core Medicaid Operations Functions” of processing and paying claims.

82. EQ 62 required each offeror to describe its approach to meeting the Department’s expectations and requirements outlined in Section V.J.3. Fraud, Waste and Abuse Prevention. EQ 62 also required each offeror to list the entities it had identified in EQ 5 “that are performing Core Medicaid Functions.”

83. Based on the narrative portion of ACNC’s response to EQ 62, Optum performs retrospective data mining and recovery operations that necessarily must be performed after claims have been processed and paid. ACNC states in its EQ 62 narrative response that it will only utilize CHCA after ACNC has one year of North Carolina claims data. That tends to establish that CHCA cannot be engaged in the “Core Medicaid Operations Functions” of claims processing and payment because claims will have been processed and paid for a year before CHCA begins its review process.

84. According to the record evidence, the Evaluation Committee did not penalize ACNC for failing to identify Optum or CHCA in response to EQs 5 and 9 because the Evaluation Committee concluded that they do not perform any of the “Core Medicaid Operations Functions, as defined in the Contract.” And, because Optum and CHCA were not required to be disclosed in response to EQs 5 and 9, ACNC was not required to list them as entities providing core Medicaid operations functions relating to its EQ 62 response. The record evidence supports the determination that the Department did not act whimsically in its decisions relating

to ACNC's responses to EQs 62, 5 and 9, so summary judgment for the Department is warranted.

85. As with almost any request for proposals, reasonable people could reach different conclusions on how any particular response should have been scored had they been sitting as a member of the Evaluation Committee. Aetna's disagreement with how certain evaluation questions were scored, however, does not warrant setting aside the Department's decision.

86. In summary, the Department has shown that the Evaluation Committee evaluated offerors' responses in a manner that was reasonable and consistent with the RFP criteria and used a consensus scoring method that accounted for potential differences among committee members. It was within the Department's discretion to award the scores that it did. Aetna has not produced evidence showing that the Department's scoring of the questions at issue was done in bad faith or whimsically, or that the Department otherwise acted in a manner that was arbitrary or capricious. Thus, Aetna's claims based on alleged scoring errors fail as a matter of law.

iii. The Department is entitled to judgment as a matter of law on Aetna's claim that WellCare should have been disqualified.

87. Aetna's claim that the Department should have disqualified WellCare also fails as a matter of law. Aetna alleges that the Department should have disqualified WellCare because it disclosed a settlement agreement and related Corporate Integrity Agreement ("CIA") regarding *qui tam* litigation in the portions of its proposal relating to litigation and financial condition instead of in response to EQ 10 relating to "sanctions imposed against the Offeror." The undisputed evidence

shows that the settlement agreement and CIA were disclosed by WellCare in its proposal, and the Evaluation Committee was aware of this information.

88. Moreover, even if this information should have been disclosed in response to EQ 10 instead of elsewhere in the proposal, at worst WellCare would have received a score of “Does Not Meet” or zero points for EQ 10 reducing WellCare’s overall score by 10 points. Under this scenario, the four highest ranked statewide offerors would not have changed and would have included WellCare, but not Aetna. Aetna has not, and cannot, show that it was substantially prejudiced by the Department’s decision.

iv. The Department is entitled to judgment as a matter of law on Aetna’s claim that UHCNC should not have received points for its response to EQ 11.

89. Aetna further claims that UHCNC should not have received bonus points for its response to EQ 11 because UHCNC was ineligible and its affiliate proposal was an after-the-fact justification. That claim, too, fails as a matter of law because (1) there is no genuine issue of material fact regarding whether the RFP allows affiliates to participate on the federally facilitated marketplace (“FFM”) on behalf of an offeror, (2) UHCNC is permitted to participate on the FFM through an affiliate with a license domiciled in North Carolina notwithstanding UHCNC’s prior withdrawal from the FFM, and (3) UHCNC’s response to EQ 11, committing to participate in the FFM in certain metropolitan areas of North Carolina, was accurate.

90. Further, Aetna waived its opportunity to protest whether the Department properly awarded UHCNC bonus points for EQ 11 because it failed to

present this claim in its original protest, and in its original Petition, when the undisputed facts demonstrate that Aetna knew UHCNC had previously withdrawn from the FFM but had earned points for its EQ 11 response.

91. Additionally, Aetna cannot show that it was prejudiced by the Department's decision to award points to UHCNC for its response to EQ 11 because if UHCNC had not received *any* such points, the four highest scoring statewide offerors would not have changed. Thus, Aetna cannot establish that it was substantially prejudiced by the award of these points to UHCNC.

B. The Department is entitled to judgment as a matter of law on Aetna's claims regarding the scoring of BCBSNC's reference.

92. In its Amended Petition, Aetna alleges that the scoring of the BCBSNC reference given by BlueChoice of SC for Amerigroup was improper. The Department is entitled to judgment as a matter of law as to this claim.

93. The Department appropriately scored the BCBSNC reference from BlueChoice of SC. Each offeror was asked for four client references "for which it has provided services of similar size and scope to that requested herein." Offerors were permitted to give references for subcontractors or other partners. The Department's instructions state: "The Offeror should indicate in the Offeror Name field the actual organization that held the contract with the submitted client reference (e.g., the Offeror, one of the Offeror's subcontractors, joint venture partner) and state the relationship to the Offeror if applicable."

94. As part of its RFP response, BCBSNC submitted a reference from BlueChoice of SC on behalf of BCBSNC's proposed subcontractor Amerigroup.

95. The Evaluation Committee's Meeting Notes and Timeline track the Evaluation Committee's consideration of the BlueChoice of SC reference for BCBSNC. The undisputed evidence shows that in December 2018, during the scoring of many of the various offerors' client references, the scoring members of the Evaluation Committee agreed "to not score the reference[] as the BCBS reference was deemed not a 'client reference.'" Consequently, the reference from BlueChoice of SC was not scored in December 2018.

96. By January 14, 2019, the Evaluation Committee had begun "several quality assurance reviews to ensure consistency and accuracy of the score." On January 15, 2019, the Evaluation Committee's Meeting Notes and Timeline note: "As part of the quality assurance process, Mona Moon inquired about the status of outstanding references."⁸ Also on January 15, 2019, contract lead Kimberley Kilpatrick brought attention to the fact that the BCBSNC reference from BlueChoice of SC had been returned but not scored in December. Ms. Moon testified that "[i]f we're not scoring something we received, I want to understand why and make sure that that's a – an appropriate action, that we're not overlooking something that the committee should be scoring." Thus, as part of the "end to end" quality assurance review process, the scoring members of the Evaluation Committee met on 22 January 2019, and reviewed and considered the overall review of offeror client references. At that meeting and "following discussion by the Committee it was determined that the

⁸ Ms. Moon is the COO of NC Medicaid and directed the "end to end" quality assurance review process in January 2019 that examined the technical and substantive facets of the scoring and evaluation process.

reference for Amerigroup Partnership Plan, LLC from BlueChoice Health Plan of South Carolina should be scored for BCBS.”

97. There is no genuine issue of material fact that the scoring members of the Evaluation Committee properly scored the BlueChoice of SC reference. The reference is for a subcontractor of BCBSNC. It is also from an entity (BlueChoice of SC) that is independent from BCBSNC. All record evidence indicates that these are independent entities, and there is nothing in the reference forms completed by either BCBSNC or BlueChoice of SC that creates a material dispute of fact on this point. Undisputed publicly available records presented to the Tribunal indicate that BCBSNC and BlueChoice of SC are independently owned and operated entities. BCBSNC is a North Carolina nonprofit corporation. BlueChoice of SC, an affiliate of mutual insurance company BlueCross and BlueShield of South Carolina, a South Carolina corporation that shares no ownership or governance with BCBSNC, would not benefit from providing a favorable reference on behalf of Amerigroup. Amerigroup is owned by Anthem, Inc., a publicly traded for profit entity. Amerigroup has contracts with other independent Blue Cross entities, but it is independently owned and operated, and there is no overlapping ownership or control among any of it, BCBSNC, or BlueChoice of SC. Aetna has presented no evidence to the contrary.

98. All of the record evidence points to the reasonableness of the Evaluation Committee’s decision to score the BCBSNC reference, a conclusion reinforced by the Evaluation Committee’s consistent treatment of Aetna’s own reference. Aetna provided a reference from Mercy Care (Southwest Catholic Health Network

Corporation d/b/a Mercy Care). In response to EQ 7, Aetna affirmed the following interrelationships among Mercy Care and other Aetna entities, including a key subcontractor of Aetna's, Aetna Medicaid Administrators, LLC:

Mercy Care is not owned by Aetna, Inc., but it *is managed by Aetna Medicaid Administrators LLC* (Aetna Medicaid Administrators), the same Aetna affiliate that will provide the majority of management services for Aetna Better Health of North Carolina. Aetna Medicaid Administrators provides plan management services to Mercy Care under a Plan Management Services Agreement (PMSA). Mercy Care, and not Aetna Medicaid Administrators, holds the Acute Care Contract directly with) [sic] Arizona's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS). This reference is from Mercy Care's Board Chair for the work Aetna Medicaid Administrators performs as the plan administrator, and not from AHCCCS.

Although Aetna alleges that the relationship between Aetna and Mercy Care is somehow different from the relationship between BlueChoice of SC and Amerigroup, it has not presented any material facts for this Tribunal's consideration in support of its position to this end. Applying the same, consistent standard to both BCBSNC's reference and Aetna's reference leads to the same result: BCBSNC has more points than Aetna, and Aetna remains the fifth place statewide offeror.

99. The undisputed evidence shows that the Department acted within its discretion and consistent with law. It did not act arbitrarily or capriciously when it scored the BCBSNC reference. The decision was made in conjunction with a reasonable quality assurance review process, it was the consensus decision of the scoring members of the Evaluation Committee, and it was consistent with the terms of the RFP and the treatment of Aetna's own reference. The Department is entitled to judgment as a matter of law as to this claim.

C. The Department is entitled to judgment as a matter of law on Aetna's claims regarding alleged conflicts of interest.

100. Aetna alleges in its Amended Petition that the entire subject procurement was fatally flawed due to alleged conflicts of interest. Aetna has failed to adduce evidence sufficient to establish a genuine issue of material fact to preclude judgment as a matter of law for the Department on this claim.

101. The standards of conduct for public officials and employees who undertake public contracting has been codified at N.C. Gen. Stat. § 14-234, and it is described in case law as “North Carolina’s conflict of interest law” applying to civil lawsuits. *Gibbs v. Mayo*, 162 N.C. App. 549, 555-56, 591 S.E.2d 905, 910 (2004).

102. Under North Carolina law, a conflict with regard to public contracting exists where employees or spouses derive a direct benefit from the contract. A direct benefit is defined as when the person owns more than ten percent of the entity awarded the contract, derives income or commission directly from a contract, or acquires property under the contract. N.C. Gen. Stat. § 14-234(a1)(4).

103. Applying this statute to this procurement, Aetna has presented no evidence that any Evaluation Committee member or his or her spouse would derive a direct benefit from the award of a PHP contract, owns more than ten percent of the entity awarded the contract, derives income or commission directly from the contract, or acquired property under the contract. Amanda Van Vleet, the target of Aetna’s assertions and a scoring member of the Evaluation Committee, was not married, has no ownership interest in BCBSNC (which is a nonprofit), and there is no evidence of a direct financial benefit to her or her boyfriend. Accordingly, under this statutory

standard, there is no genuine issue of material fact that a legal conflict of interest existed with regard to the Evaluation Committee for the subject procurement, and the Department is entitled to judgment as a matter of law.

104. Aetna points to certain policies as support for its position that certain Evaluation Committee members had an impermissible conflict of interest. But at most, the policies that applied to this procurement, and even those that Aetna cites that do not apply, required Evaluation Committee members to disclose information about potential conflict issues so that the Department could evaluate whether it would be appropriate for that person to serve on the Evaluation Committee. The undisputed evidence is that adequate disclosure was made by Evaluation Committee members and that the Department, after reasonable inquiry, came to the reasonable conclusion that it would be appropriate for the Evaluation Committee members to serve. *See, e.g., Corporate Express Office Prods., Inc. v. N.C. Division of Purchase and Contract*, 0D DOA 0112, 2006 WL 2190500 (May 17, 2006) (finding that an “appearance of impropriety could have been avoided by full disclosure” by the agency and a consultant with a client relationship with offerors). As applied here, matters that give rise to an appearance of impropriety (but do not rise to the level of a legal conflict of interest under N.C. Gen. Stat. § 14-234) can be resolved by full disclosure.

105. As to Ms. Van Vleet, the evidence is clear that she made disclosure of her relationship with a BCBSNC employee before accepting her job and her role on the Evaluation Committee. The Department inquired about the position Ms. Van Vleet’s boyfriend held, whether he had any role with BCBSNC’s potential offer under

the then-pending RFP or BCBSNC's potential Medicaid business, and whether Ms. Van Vleet believed she could be fair and objective in the review and evaluation of the proposals received. Ms. Van Vleet responded that her boyfriend was not involved with BCBSNC's Medicaid business or potential business and instead focused on BCBSNC's commercial lines. She also affirmed that she could be—and would be—fair and objective in her review and evaluation of the proposals received. Upon consideration by Department leadership, Ms. Van Vleet was then confirmed as a scoring member of the Evaluation Committee. Taking the facts in the light most favorable to Aetna, Ms. Van Vleet made adequate disclosures, the Department adequately and reasonably evaluated those disclosures, and the Department adequately and reasonably decided that Ms. Van Vleet could serve on the Evaluation Committee. Aetna has not demonstrated that there is a genuine issue of material fact as to these issues, and the Department is entitled to judgment as a matter of law.

106. In addition, Aetna has presented no evidence that Ms. Van Vleet did not serve in a fair and impartial manner. With respect to the issue of scoring the BCBSNC reference, there is no evidence that Ms. Van Vleet raised or led the discussion regarding the reference or showed any favoritism whatsoever to BCBSNC in this procurement. Further, under the consensus scoring method, all seven scoring members of the Evaluation Committee agreed that the BCBSNC reference should be scored.

107. Aetna's arguments regarding conflict issues as to other Evaluation Committee members and Department employees also fail as a matter of law. Aetna

claims that the Department had problematic “institutional” and “individual” ties to BCBSNC involving at least Secretary Cohen, COO Moon, Deputy Director of Standard Plans Sarah Gregosky, and Evaluation Committee scoring member Sheila Platts. The facts of these “ties” are as follows. First, Secretary Cohen previously worked at CMS with former BCBSNC CEO Patrick Conway, and they have remained in touch professionally since that time. Second, Medicaid COO Mona Moon previously worked at the State Health Plan from 2008 until 2017. During Ms. Moon’s tenure there, BCBSNC held a contract with the State Health Plan as third party administrator, and Ms. Moon actively participated in the administration of that contract on behalf of the State. Third, Deputy Director of Standard Plans Sarah Gregosky worked for BCBSNC from September 2015 until October 2016. She did not work in Medicaid for BCBSNC and maintained no ongoing financial connection with BCBSNC after leaving employment there. Fourth, Sheila Platts worked for Blue Cross Blue Shield of South Carolina from 2005 until 2007 prior to coming to work at the Department. As explained above, Blue Cross Blue Shield of South Carolina is a different entity than BCBSNC. In May 2019, Ms. Platts applied for and accepted a job with BCBSNC, which she began in July 2019. This job does not involve Medicaid. The undisputed evidence is that Ms. Platts saw a public advertisement for this position approximately four months after she completed her service on the Evaluation Committee.

108. None of these unremarkable facts of these four individuals’ employment histories or professional ties gives rise to any conflict of interest or appearance of

impropriety that could justify setting aside the Department's procurement. The Department exercised reasonable discretion in choosing the Evaluation Committee, and there is no evidence that any member of the Evaluation Committee acted in an unfair or impartial manner. Speculation and conjecture are insufficient to overcome the presumption that the Department acted in good faith and in accordance with law, and no evidence has been presented that would prove otherwise. Considering the presumption that the Department acted in good faith as well as the undisputed record evidence, and in the absence of any competent evidence supporting Aetna's conflict of interest claims, the claims fail as a matter of law and the Department is entitled to summary judgment on such claims.

V.

**THE DEPARTMENT IS ENTITLED TO JUDGMENT
AS A MATTER OF LAW ON MY HEALTH'S CLAIMS**

109. Considering the provisions of the relevant portions of the Transformation Act, the RFP, and My Health's proposal, the Department's discretionary authority, and the undisputed evidence of record, there is no genuine issue of material fact for trial, and the Department is entitled to judgment as a matter of law on My Health's claims.

110. The Department awarded statewide contracts to the four highest ranked offerors based on scores awarded during the evaluation of the proposals. My Health received the lowest score among the statewide offerors and was ranked last for a statewide contract—in sixth place. My Health's proposal received a total score of 629.71280, which was 76.94924 points lower than the ACNC, the fourth ranked

offeror. My Health's score was substantially below the scores of the four awardees of statewide contracts, and it was not awarded a contract.

A. The Department is entitled to judgment as a matter of law on My Health's claims that it should have been considered for the award of regional contracts.

111. In its bid protest, My Health challenged the Department's decision not to award it six regional contracts. My Health claims that the Department erred when it determined that My Health submitted a proposal only for a statewide contract and by not considering My Health for award of regional contracts. My Health's position is not supported and fails as a matter of law.

112. The undisputed evidence shows that My Health submitted a proposal only for a statewide contract. The RFP instructed offerors that "PLEs are eligible to submit offers for Statewide and/or Regional Contracts." EQ 1 asked offerors to identify whether they intended to submit a proposal for a statewide contract or a regional contract. For PLEs like My Health, an offeror could select both, and indeed, the RFP instructed offerors when asking this question to "Check all that apply." In its response to EQ 1, My Health checked only the box for statewide contracts and did not check the box for regional contracts.

113. Likewise, My Health's response to EQ 2 indicated it was not applying for regional contracts. With this question, offerors were instructed to select the regions in which they wished to be considered. My Health made no selection of any regions. My Health argues that, in addition to not checking the "regional" box in EQ 1, it did not check any regions in response to EQ 2 because of the parenthetical sentence in the middle of EQ 2: "(If the Offeror is submitting a Statewide proposal, it is presumed

that the Offeror is proposing to provide Medicaid Managed Care services and coverage in Regions 1-6 in their entirety and the Offeror shall not be required to make any indication.)” Yet in doing so, My Health ignores the first sentence of EQ 2: “**If the Offeror is submitting a Regional proposal (as indicated in Question #1 above), the Offeror shall indicate the Region(s) . . . it is proposing to provide Medicaid Managed Care services and coverage.**” (emphases added).

114. Other aspects of My Health’s proposal confirmed its statewide only bid, including its cover letter stating that it was seeking a contract for a “***Statewide Prepaid Health Plan qualifying as a Provider-Led Entity***” (bolding and italics in original). My Health further stated “[n]ot applicable” in response to other RFP inquiries on requirements for regional contracts only and in the overall structure and content of its proposal as reviewed by the Evaluation Committee.

115. The Evaluation Committee reasonably and correctly concluded that My Health was not seeking, and therefore should not be considered for, an award of any regional contract. My Health’s claim that it should have been considered for awards of regional contracts fails as a matter of law based on the clear and unambiguous provisions of the RFP and My Health’s proposal.

B. The Department is entitled to judgment as a matter of law on My Health’s claims that the Department failed to comply with the Transformation Act.

116. Similarly, My Health’s claims attacking the Department’s evaluation of offers for regional contracts fail as a matter of law. Having submitted a bid for only a statewide contract, My Health lacks standing to argue that the Transformation Act required a separate RFP for regional contracts and that the Act required at least one

regional contract to be awarded in each region. For the same reasons, My Health has not been substantially prejudiced by any of the Department's decisions and actions regarding the award of regional contracts.

117. Even if My Health had standing or had been substantially prejudiced, its claims would fail as a matter of law. The Transformation Act does not require, as My Health urges, the Department to award a contract to a PLE in every region or to issue a separate RFP just for PHP offerors who are PLEs.

118. When interpreting the Transformation Act, as with any statute, “the first principle of statutory interpretation is to ascertain the intent of the legislature and to carry out such intention to the fullest extent.” *Parkdale Am., LLC v. Hinton*, 200 N.C. App. 275, 278, 684 S.E.2d 458, 461 (2009). The words the General Assembly chooses are the primary consideration in ascertaining legislative intent. *Id.* If the statute is clear and unambiguous, the Tribunal applies the plain meaning of the language chosen. *Id.* It is “presume[d] that the legislature carefully chose each word used” in the statute. *N.C. Dep’t of Correction v. N.C. Med. Bd.*, 363 N.C. 189, 201, 675 S.E.2d 641, 649 (2009). Here the statutory language is clear and controlling on its face. *See also Wilkie v. City of Boiling Spring Lakes*, 370 N.C. 540, 547, 809 S.E.2d 853, 858 (2018) (“It is well-settled that ‘[w]here the language of a statute is clear and unambiguous, there is no room for judicial construction and the courts must construe the statute using its plain meaning.’”).⁹

⁹ My Health submitted for the Tribunal's consideration the affidavits of two individual legislators containing information regarding the interpretation of the Transformation Act. However, affidavits of legislators are “not competent evidence

119. The Transformation Act required the Department to award four statewide contracts and directed the Department to award “[u]p to 12” regional contracts. N.C. Sess. Law 2015-245, § 4(6)(a), (b) as amended by N.C. Sess. Law 2018-48. In final form, the key provision of Section 4(6) provides in pertinent part as follows:

Number and nature of capitated PHP contracts – *The number and nature of the contracts required under subdivision (3) of this section shall be as follows:*

a. *Four contracts* between the Division of Health Benefits and PHPs *to provide coverage* to Medicaid and NC Health Choice recipients *statewide* (statewide contracts).

b. *Up to 12 contracts* between the Division of Health Benefits and PLEs *for coverage of regions* specified by the Division of Health Benefits pursuant to subdivision (2) of Section (5) of this act (regional contracts). *Regional contracts shall be in addition to the four statewide contracts required* under sub-subdivision a. of this subdivision. *Each regional contract shall provide coverage throughout the entire region for the Medicaid and NC Health Choice services* required by subdivision (4) of this section. A PLE may bid for more than one regional contract, provided that the regions are contiguous.

upon which the court can make its determination as to the meaning of the statutory provision.” *State ex rel. N.C. Milk Comm’n v. Nat’l Food Stores, Inc.*, 270 N.C. 323, 332-33, 154 S.E.2d 548, 555 (1967); *see also D&W, Inc. v. City of Charlotte*, 268 N.C. 577, 581, 151 S.E.2d 241, 244, supplemented, 268 N.C. 720, 152 S.E.2d 199 (1966) (“The meaning of a statute and the intention of the legislature which passed it, cannot be shown by the testimony of a member of the legislature; it must be drawn from the construction of the act itself.”) (internal citations omitted); *Elec. Supply Co. of Durham v. Swain Elec. Co.*, 328 N.C. 651, 657, 403 S.E.2d 291, 295 (1991) (“Indeed, we have declared affidavits of members of the legislature who adopted statutes in question not to be competent evidence of the purpose and intended construction of the legislation.”). Accordingly, the Tribunal declines to consider the affidavits offered by My Health.

N.C. Sess. Law 2018-48 (emphases added). Section 5(2) of the Transformation Act also requires the Department to “[d]efine six regions comprised of whole contiguous counties that reasonably distribute covered populations across the State to ensure effective delivery of health care and achievement of the goals of Medicaid transformation ... Every county in the State must be assigned to a region.” N.C. Sess. Law 2015-245 § 5(2).

120. Here, the plain language of the Transformation Act mandated the award of four statewide contracts but used permissive language to authorize the Department to award “[u]p to 12” regional contracts.” N.C. Sess. Law 2015-245 § 4(6)(a), (b) as amended by N.C. Sess. Law 2018-48. The Department is thus vested with the discretion to award anywhere from zero to 12 regional contracts.¹⁰ It awarded two regional contracts, thus acting within its statutory discretion and in compliance with the Transformation Act.

121. My Health urges the Tribunal to adopt a reading of the Transformation Act that is contrary to its plain meaning. My Health argues that the Transformation Act imposes a floor of six regional contracts—at least one for each region—because of the use of the language “coverage of regions.” However, this language does not set a floor on the number of contracts, but instead distinguishes between the nature of the

¹⁰ Other courts have interpreted the plain meaning of the phrase “up to” as one that sets a range. *See, e.g., Kipp v. Kipp*, 844 So.2d 691, 693 (Fla. Dist. Ct. App. 2003) (“The plain meaning of the phrase ‘up to’ leads us to the inescapable conclusion that the phrase set a cap but not the amount[.]”); *Arness v. Franks*, 138 F.2d 213, 216 (C.C.P.A. 1943) (interpreting the phrase “up to 30%” to mean “anything from zero to 30%”).

contracts authorized in sections 4(6)(a) and 4(6)(b). Section 4(6)(a) requires four contracts to provide coverage statewide. N.C. Sess. Law 2018-48. Those statewide contracts must cover all 100 counties in the state. Section 4(6)(b) authorizes up to 12 contracts for coverage of regions. The “up to 12” regional contracts must provide coverage for all of the counties that comprise the given region. *Id.* § 4(6)(b) (“Each regional contract shall provide coverage throughout the entire region for the Medicaid and NC Health Choice services ...”). The General Assembly could have mandated that the Department award a minimum or certain number of regional contracts (like it did for the four statewide contracts) *or* award at least one regional contract for each of the six regions of the state. It did neither. My Health’s argument is without merit.

122. My Health’s claims that the Department also violated state and federal law on the grounds that not awarding a PLE in each region is inconsistent with the Department’s statements in its original and amended Section 1115 waiver application to CMS are further misplaced and unavailing. My Health does not have standing to invoke the waiver application terms and the waiver application is not part of the RFP.

123. Moreover, substantively, in the CMS waiver application, the Department did not guarantee to CMS that it would, in fact, award one or more contracts to a PLE in each region. Instead, the Department reported to CMS in its amended waiver application, submitted before it received responses to the RFP, that it “supports having a choice of models in each region.”

124. Even if My Health had standing to raise the issue, My Health has failed to raise a genuine issue of material fact that the Department has breached its commitments to CMS.

125. Also, the Transformation Act makes clear that the terms of any RFP issued by the Department apply to PHPs, regardless of whether the particular PHP is a PLE or not. All PHPs must perform the same complex functions in operating a Medicaid managed care organization for the contract term. The Department acted consistent with law, within its discretion, pursuant to proper procedure, and not arbitrarily when it crafted a single RFP that asked identical questions of all offerors. Notably, before the RFP issued, the Department consistently and publicly stated its intention to issue a single RFP for the procurement and sought feedback from potential offerors on its plans. My Health did not object to issuance of a single RFP until it became a disappointed bidder.

C. The Department is entitled to judgment as a matter of law on My Health's claims regarding the design of the RFP and the evaluation process.

126. My Health broadly alleges that the composition of the RFP does not reflect the Transformation Act and that the RFP that the Department developed under its discretionary authority was systemically biased towards CPs and against PLEs. My Health is incorrect and has not developed evidence to support its claims.

127. The Transformation Act vests the Department with the authority for “planning and implementing” Medicaid transformation, and the Department was responsible for issuing the RFP upon consultation with the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the RFP’s terms and

conditions. N.C. Sess. Law 2015-245 § 4(1), (3), § 5(7) (as amended by N.C. Sess. Law 2016-121). The evidence is clear that the Department engaged in a thorough, multi-year process in drafting the RFP and other relevant documents to this procurement, including extensive communications with various stakeholders.

128. The evidence is clear and undisputed that Medicaid managed care is complex and requires sophisticated technical, financial, and operational capabilities that are the same regardless of the corporate governance makeup of the PHP. All PHPs had to perform the same tasks and produce the same deliverables. The Department identified over 500 applicable federal program and technical requirements, 1,800 features, 5,300 tasks, and 161 processes required to implement managed care. Consequently, the evaluation criteria used to evaluate RFP responses were designed to determine whether the offeror was qualified to run the complex and risky business of a managed care program. Based on these important and complex considerations, the Department, in an exercise of proper discretion, developed a comprehensive RFP that addressed the statutory, regulatory, licensing, contractual, policy, and programmatic requirements for North Carolina's Medicaid managed care program.

129. Because all PHPs must perform the same complex functions, it was an appropriate exercise of the Department's discretion to craft an RFP that asked identical questions of all offerors. All offerors, including PLEs, had the same opportunity to demonstrate their strengths, innovation, and value, as well as ability to meet contract requirements, through their responses to the RFP. Neither the RFP

design nor the procurement process prevented them from doing so. My Health has developed no genuine issue of material fact to the contrary.

130. Additionally, My Health's attack on the RFP evaluation process pursuant to N.C. Gen. Stat. § 150B-23(a) fails as a matter of law. My Health did not proffer sufficient evidence to create a genuine issue of material fact regarding its claim that the scoring members of the Evaluation Committee and non-scoring SMEs were not qualified or that their performance of their duties and the process used exceeded the Department's discretion, or was arbitrary or capricious, or contrary to law.¹¹

131. My Health makes many of the same arguments as Aetna including complaining about points awarded by the Evaluation Committee for certain EQs and alleged conflicts of interests. My Health has not presented any evidence that results in a different outcome as to these claims as presented by My Health instead of Aetna.

¹¹ My Health's Petition did not raise any specific issues about purported conflicts of interest, though it raised the arguments in opposition to the Department's Motion. Thus, it is questionable if such arguments are properly before the Tribunal in its contested case. *See, e.g., R.R. Friction Products Corp. v. N. Carolina Dep't of Revenue*, No. 18 CVS 3868, 2019 WL 856295 (N.C. Super. Feb. 21, 2019), *aff'd sub nom. R.R. Friction Products Corp. v. Dep't of Revenue*, 374 N.C. 208, 839 S.E.2d 314 (2020)(upholding Administrative Law Judge's ruling that a petitioner's alternative claim was not before the OAH when the petitioner raised it for the first time in a brief in support of its motion for summary judgment at the OAH and the petitioner never moved to amend the petition or its prehearing statement). Even if properly before the Tribunal, My Health's arguments on this subject mirror Aetna's arguments and fail for the same reasons as discussed above.

Thus, for the same reasons these claims fail as a matter of law with respect to Aetna, they also fail as a matter of law with respect to My Health.¹²

132. My Health claims that the RFP was systemically biased because certain of the 65 evaluation questions (EQs 7, 45, and 46) were crafted and evaluated in such a way as not to allow PLEs to demonstrate their unique abilities and to allow non-PLEs to get large scores on questions where PLEs simply could not achieve as high of a score. As discussed above, all offerors had the same opportunity to demonstrate their strengths, innovation, and value, as well as ability to meet contract requirements, through their responses to the RFP. Both the development of the RFP and the scoring decisions are exercises of agency discretion, and the Tribunal cannot set aside such decisions based on mere disagreement.

133. EQ 7, part of the “Offeror Qualifications/Experience” section of the RFP, asked the offerors to provide a “list of prior Medicaid Managed Care contracts” for the offeror and any of its subcontractors performing Core Medicaid Operations Functions as well as certain Healthcare Effectiveness Data and Information Set (“HEDIS”) quality metrics. My Health complains that PLEs like My Health were unfairly penalized because a PLE is unlikely to have as many contracts where it was performing Core Medicaid Operations Functions or appropriate HEDIS measures as non-PLEs were likely to have. My Health received 25 out of 40 points for this question

¹² My Health also complains about the treatment of client references and the failure to disqualify WellCare on the same general grounds as Aetna. For the reasons explained above, My Health’s claims fail as a matter of law.

because it only had one such contract for the prior performance of Core Medicaid Operations Functions to report.

134. My Health further claims that EQ 45 related to “Quality” and “Value” was biased against PLEs and in favor of non-PLEs. Similar to its complaints about EQ 7, because EQ 45 seeks information about the federally required quality assessment and performance improvement (“QAPI”) program described in 42 CFR § 438.330 and certain, specific HEDIS measures, My Health claims that PLEs may not have such QAPI or HEDIS data to the extent that a non-PLE would and are therefore disadvantaged in the scoring of responses to EQ 45. My Health received a “partially meets” for this question because the Evaluation Committee found that the response was incomplete because the QAPIs and race and ethnicity stratifications were not included and My Health did not demonstrate the experience to implement a Quality Management and Improvement approach to meet the Department’s expectations.

135. My Health similarly claims that EQ 46, which sought information, among other things, regarding the offeror’s experience with value-based payment arrangements it had used in other locations, was biased against PLEs and in favor of non-PLEs. My Health received a “meets” for its response to this question in part because its answer lacked the detail present in the responses of other offerors. My Health’s only experience with value-based payments as reflected in its response was through the subcontractor of its choice, Presbyterian Network, Inc.

136. My Health’s complaints about the structure and scoring of EQs 7, 45, and 46 lack merit. It was well within the Department’s discretion to ask and score

questions regarding the prior experience of the entities seeking to perform the complex and risky requirements of Medicaid managed care. The Department was well within its discretionary authority to ask questions about prior experience and score those responses consistently among offerors. My Health has offered no evidence to the contrary, and its claims thus fail as a matter of law.

D. The Department is entitled to judgment as a matter of law on My Health's claims regarding the Department's award decisions and protest process.

137. My Health's complaint that the decision by Deputy Secretary Richard to recommend an additional award of two regional contracts to CCH was outside of the stated evaluation process lacks merit. As discussed above, My Health lacks standing to complain about regional contract awards. In addition, as disclosed in the RFP, the Evaluation Committee was empowered to review each proposal and make award recommendations. It did so. The Department retained the discretion when considering that recommendation. The Department's discretionary decision to award two regional contracts did not violate N.C. Gen. Stat. § 150B-23(a).

138. My Health's challenge to the bid protest process at the agency level also fails as a matter of law. My Health did not proffer competent evidence sufficient to create a genuine issue of material fact for trial in support of its claim that the Department's bid protest process was arbitrary, capricious, unlawful, improper, outside its authority, or otherwise erroneous.

139. Separately, even if My Health's claims were not subject to summary adjudication on their merits, to the extent that My Health asks this Tribunal to order that it be awarded a statewide contract, it would not be entitled to that relief. My

Health waived any claim that it should be awarded a statewide contract by failing to raise it within 30 days of the contract award. Specifically, pursuant to the terms of the RFP, protest letters were due within 30 days of the contract award and were required to “contain specific grounds and reasons for the protest, how the protesting party was harmed by the award made and any documentation providing support for the protesting party’s claims.” The RFP also provided that the North Carolina Administrative Code would govern the handling of the protests. The NCAC specifies that an “offeror’s [protest] letter shall contain specific reasons and any supporting documentation for why it has a concern with the award.” 01 NCAC 05B .1519(c)(1). My Health timely submitted a protest letter but failed to request the statewide contract relief it now seeks; it only asked the Department to award it six regional contracts in its bid protest letter. The matter pending before this Tribunal is the Department’s decision to deny the requested bid protest relief of six regional contract awards. Having failed to raise the issue of a statewide award in its protest at the agency level, My Health cannot now ask the Tribunal to award relief in its Contested Case that it waived before the Department.

VI.

THE DEPARTMENT IS ENTITLED TO JUDGMENT AS A MATTER OF LAW ON OPTIMA’S CLAIMS

140. Optima has failed to show that there is a genuine issue of material fact that precludes summary judgment against it on its claims that it should have been awarded a contract.

141. Optima was the lowest overall scoring offeror by a substantial margin. Optima scored the lowest, or tied for the lowest score, in seven out of eleven areas scored under Scope of Services: (i) Administration and Management; (ii) Program Operations; (iii) Members; (iv) Quality and Value; (v) Stakeholder Engagement; (vi) Claims and Encounter Management; and (vii) Compliance. In addition, Optima had the lowest score for the Use Case Scenarios.

A. The Department is entitled to judgment as a matter of law on Optima's claims that the Department improperly rejected its proposal.

142. Optima's claim that the Department's award decision should be disturbed because it applied an undisclosed "threshold" to meet overall expectations fails for lack of sufficient evidence to support it. Optima did not produce any evidence—much less evidence sufficient to create a genuine issue of material fact for trial—that it was not awarded a contract because of a "threshold." Instead, the evidence consistently shows that Optima was not awarded a contract because its proposal was found substantially inferior to those of the other seven offerors, and the Evaluation Committee had concerns whether Optima could successfully handle the complex requirements under the contracts being procured.

143. The evidence in the record is undisputed that the Evaluation Committee did not recommend Optima for an award because its proposal was found substantially inferior to the other seven, and they had concerns that Optima would be able to successfully handle the complex requirements under the procurement. The evidence in the record is further undisputed that the Evaluation Committee fully evaluated

Optima's proposal and that at no time did they establish a minimum "threshold" for considering it for an award.

144. Deputy Secretary Richard and Secretary Cohen were equally clear in their testimony that Mr. Richard did not recommend an award to Optima and the Secretary did not award a contract to Optima because it had such a low score. This undisputed testimony is dispositive of this issue, and the several comments in various documents about a "threshold" do not create an issue of material fact for trial.

B. The Department is entitled to judgment as a matter of law on Optima's scoring challenges.

145. Optima's claim that the Department made errors when scoring its proposal also fails as a matter of law. Optima has failed to demonstrate a genuine issue of material fact that could support a finding that any of the Department's scoring decisions were arbitrary, capricious, or whimsical, or that Optima was substantially prejudiced by those decisions. To be able to show substantial prejudice, Optima would have had to proffer evidence that could support a finding that it should have been awarded at least 55 more points. It did not do so. Accordingly, its score remains in last place, and it has not demonstrated an abuse of discretion or that it suffered "substantial prejudice" as a result of any claimed error.

146. Optima raises specific challenges to the Evaluation Committee's scoring of its responses to EQs 5, 7, 10, 11, and a client reference. After review of all of the evidence presented with regard to the subject EQs, Optima's responses, and the Evaluation Committee's scores and reasoning, the Tribunal concludes that the scoring decisions at issue are plainly exercises of agency discretion. Optima has

presented no evidence of material fact to support a showing that these discretionary scoring decisions were whimsical, arbitrary or capricious, or in violation of N.C. Gen. Stat. § 150B-23(a).¹³

147. Optima alleges that EQ 7 gave a clear advantage to non-PLEs over PLEs, was not scored on a “meets expectations” basis, and either should not have been scored or, alternatively, offerors with *any* prior Medicaid contracts should have received full points. Optima’s arguments on PLE bias mirror those of My Health discussed above and fail for the reasons discussed there. The mechanics of scoring EQ 7 are within the discretion of the agency to develop, and the agency did so. The evidence is clear that all of the offerors’ proposals were scored using the same scale and methodology and that, although the rating scale was edited by consensus prior to scoring EQ 7 for any offeror, such an edit did not conflict with or alter the information provided to offerors in the RFP, and the scoring criteria and weights identified in the RFP were not changed by the modification made for the way EQ 7 was rated. Consequently, offerors were not prejudiced or otherwise harmed by the change.

148. Optima alleges that it should not have received a “Does Not Meet” expectations rating for its response to EQ 10. EQ 10 asked offerors to “disclose all sanctions imposed against the Offeror” as well as all entities identified as performing

¹³ Optima failed to present any evidence or any argument with respect to EQ 5. Because the record evidence, when viewed in the light most favorable to Optima, on EQ 5 is sufficient to warrant summary judgment in the Department’s favor, summary judgment is granted for the Department on EQ 5.

Core Medicaid Operations Functions. For most of its subcontractors, Optima affirmed that no sanctions had been imposed or stated that the question was not applicable. For its subcontractor OptumRx, however, Optima stated that “OptumRx is involved in the types of legal actions that arise in the normal course of business. Based on current information, including consultation with our attorneys, OptumRx is confident that any liability that may ultimately arise from these actions would not materially affected its consolidated financial position, operational status, cash flow, or business prospects.” In giving Optima a “does not meet” expectations rating, the Evaluation Committee found that the disclosure was not thorough due to the limited information provided for Optum Rx. As Optima provided no further information about the alluded-to sanctions, the Evaluation Committee’s assessment and score is reasonable and not whimsical, arbitrary, or capricious.

149. Optima further argues that it should receive additional points for its response to EQ 11. In pertinent part, EQ 11 sought an optional commitment from offerors to participate in the FFM in North Carolina and, if the offeror chose to make that commitment, EQ 11 asked it to “outlin[e] current [FFM] participation in North Carolina and other states and *expected FFM footprint in North Carolina in 2021*” (emphasis added). In response to EQ 11, Optima committed to participate in the FFM in North Carolina in 2021 but did not describe its “footprint” for doing so, instead providing general statements of participation. Consequently, Optima did not receive any of the points associated with the requested “footprint.” Optima argues that the Evaluation Committee should have sought a clarification, but because the

Department is not required to seek a clarification and allowing an offeror to change its response is not appropriate for a clarification, Optima has failed to present evidence to create a genuine issue of material fact on this issue. The Department's discretionary decision on scoring EQ 11 was reasonable and was not whimsical, arbitrary, or capricious.

150. Optima argues that the Department should have scored a client reference for Optima received from Huntsville Hospital Health System ("Huntsville"). The response received from Huntsville stated that the Alabama Medicaid managed care program that Optima was set to participate in with Huntsville never "went live." Based on the information contained in the reference, the Evaluation Committee determined that services of similar size and scope to what the RFP requested were never actually provided to Huntsville and that the reference could not be accepted. Optima has failed to present evidence to create a genuine issue of material fact on this issue. The Department's discretionary decision not to score this reference was reasonable and was not whimsical or arbitrary and capricious.

C. The Department is entitled to judgment as a matter of law on Optima's claims that the Department failed to comply with the Transformation Act.

151. Likewise, Optima's claim that the Department's evaluation of regional PLE offerors disregarded the intent of the General Assembly, relied on improper procedure, exceeded the Department's authority, and was arbitrary, capricious, and erroneous fails as a matter of law. Optima chiefly asserts that the Department was biased against PLEs and that the Department did not have authority for its initial

award of two regional contracts to CCH. Optima, however, has failed to support its position with either evidence or law, and its claim fails.

152. With respect to the number of contracts awarded, consistent with the adjudication of My Health’s claims, the Transformation Act unambiguously grants the Department the discretion to award “[u]p to 12” regional contracts; the Department is not required to award any regional contracts or to award a contract to any PLE. Having initially awarded two regional contracts, the Department acted well within its statutory discretion and in compliance with the law.

153. With respect to Optima’s claim that the Department was biased against PLEs in its design and conduct of the procurement, Optima, like My Health, failed to proffer evidence that the Department acted contrary to law, arbitrarily or capriciously, or in any way outside the broad discretion specifically conferred on the Department by the Transformation Act. The Transformation Act conferred on the Department “full authority to manage the State’s Medicaid and NC Health Choice programs” and required it to “be responsible for planning and implementing the Medicaid transformation required by this act.” N.C. Sess. Law 2015-245 § 4(1). The undisputed evidence showed that the Department engaged in a lengthy and thorough procurement design process and a diligent and reasonable evaluation process. All offerors had the same opportunity to demonstrate their strengths, innovation, and value, and their ability to meet contract requirements, through their responses to the RFP. Neither the RFP design nor the procurement process prevented Optima or any other PLE from submitting a proposal that could have received a score that could

have resulted in a contract award. Optima's claims fail for the same reasons as My Health's claims, as discussed above.¹⁴

D. The Department is entitled to judgment as a matter of law on Optima's claims regarding CCH's status as a PLE.

154. Optima also lacks factual and legal support for its assertion that the award of regional contracts to CCH was improper. Optima failed to proffer evidence sufficient to dispute that CCH's ownership satisfies the statutory requirements for PLEs.

155. Based upon this Tribunal's review of the evidentiary record, the Tribunal finds the Department correctly determined that: (1) CCH's ownership satisfies the statutory requirements for PLEs; (2) "financial dependence" or independence is not a statutory requirement for being a PLE; and (3) CCH's delegation of certain financial matters to its Financial Matters Committee did not mean that committee had "control" over the company. Accordingly, Optima's claim that CCH does not satisfy the requirements of a PLE lacks merit and is hereby denied.

156. At summary judgment, Optima argued the Department did not "analyze [all] the information before it" regarding CCH's governance structure. Yet the record makes clear that both during the evaluation process and during Optima's bid protest,

¹⁴ Although not set out in Optima's Amended Petition, Optima has made arguments at summary judgment regarding the BCBSNC reference from BlueChoice of SC and the conflicts of interest arguments similar to those raised by Aetna. As discussed above, no genuine issue of material fact exists with regard to these claims and they fail as a matter of law.

the Department performed a thorough, reasonable, and sufficient analysis of CCH and its corporate structure to determine that CCH qualified as a PLE.

157. Optima itself admits that the Department vetted this issue after Optima raised it in its bid protest. As Optima's Amended Petition makes clear that it is challenging the Department's Protest Decision, Optima's admission that the Department considered CCH's qualification as a PLE during the bid protest is fatal to its argument here.

158. Further, Optima's desire to have N.C. Gen. Stat. § 55-8-01 broadly construed such that CCH's "governing body" is measured by committee membership (rather than by its Board of Directors) lacks any precedential support. Optima cites to no case that holds subcommittee make-up would be dispositive of Session Law 2016-121's (or any other statute's) governance control test. Optima also does not and cannot point to any Department statement, material, or guidance that reaches or compels such a conclusion. When appropriately read and interpreted in conjunction with standards of good corporate governance, Session Law 2016-121 requires provider-*led* entities such as CCH to have a governing body, *i.e.* its Board of Directors, the majority of which is composed by North Carolina Medicaid providers, not that every corporate decision made by a committee be made by one that is provider-led.

159. Perhaps most fatal to Optima's argument on this subject is N.C. Gen. Stat. § 55-8-25(f), which Optima failed to raise with or for the Tribunal and which holds *directors* responsible for compliance with their statutory requirements despite any delegation of authority to a committee. Accordingly, it is clear to the Tribunal

that neither the Financial Matters Committee nor the Medical Affairs Committee is or could be the “governing body” referred to in Session Law 2016-121. Instead, it is CCH’s Board of Directors, a majority of which is comprised by providers as required by statute.

160. For all these reasons, the Tribunal concludes that CCH satisfies the requirements of a PLE and that the Department did not err in coming to that conclusion.

VII.

CONCLUSION

161. The pleadings, depositions, answers to interrogatories, and admission on file, together with the affidavits, show that there is no genuine issue as to any material fact and that the Department is entitled to judgment as a matter of law. The Motion is therefore GRANTED disposing of all issues in these Contested Cases and entering judgment in favor of the Department. To the extent that contract awardees ACNC, BCBSNC, UHCNC, and WellCare raised additional issues in their motions to dismiss or for summary judgment as to Petitioners’ claims, this Tribunal need not address them because the determinations made herein are dispositive of all of Petitioners’ claims. The dispositive motions filed by Aetna and My Health are also correspondingly denied.

NOTICE OF APPEAL

This is a Final Decision issued under the authority of N.C. Gen. Stat. § 150B-34.

Under the provisions of North Carolina General Statute § 150B-45, any party wishing to appeal the final decision of the Administrative Law Judge must file a Petition for Judicial Review in the Superior Court of the county where the person aggrieved by the administrative decision resides, or in the case of a person residing outside the State, the county where the contested case which resulted in the final decision was filed. **The appealing party must file the petition within 30 days after being served with a written copy of the Administrative Law Judge's Final Decision.** In conformity with the Office of Administrative Hearings' rule, 26 N.C. Admin. Code 03.0102, and the Rules of Civil Procedure, N.C. General Statute 1A-1, Article 2, **this Final Decision was served on the parties as indicated by the Certificate of Service attached to this Final Decision.** N.C. Gen. Stat. § 150B-46 describes the contents of the Petition and requires service of the Petition on all parties. Under N.C. Gen. Stat. § 150B-47, the Office of Administrative Hearings is required to file the official record in the contested case with the Clerk of Superior Court within 30 days of receipt of the Petition for Judicial Review. Consequently, a copy of the Petition for Judicial Review must be sent to the Office of Administrative Hearings at the time the appeal is initiated in order to ensure the timely filing of the record.

SO ORDERED, this the 9th day of September, 2020.



Tenisha S Jacobs
Administrative Law Judge

CERTIFICATE OF SERVICE

The undersigned certifies that, on the date shown below, the Office of Administrative Hearings sent the foregoing document to the persons named below at the addresses shown below, by electronic service as defined in 26 NCAC 03 .0501(4), or by placing a copy thereof, enclosed in a wrapper addressed to the person to be served, into the custody of the North Carolina Mail Service Center who subsequently will place the foregoing document into an official depository of the United States Postal Service:

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This the 9th day of September, 2020.



Daniel Chunko
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January 12, 2023

Hand-Delivered

Mr. Sam Watts
Acting Executive Administrator
North Carolina State Health Plan for Teachers and State Employees
3200 Atlantic Avenue
Raleigh, North Carolina 27604

**Re: Blue Cross Blue Shield of North Carolina's
Request for Protest Meeting on Request for Proposal
#270-20220830TPAS**

Dear Mr. Watts:

Blue Cross Blue Shield of North Carolina (Blue Cross NC) requests a protest meeting on, and reconsideration of, the North Carolina State Health Plan for Teachers and State Employees' (the Plan's) decision to award the 2025-2027 contract for third-party administrative services to Aetna.

Blue Cross NC makes this request under section 15 of Attachment B of RFP #270-20220830TPAS. The Plan's contract for third-party administrative services was awarded no earlier than December 14, 2022. This request for a protest meeting is submitted within 30 calendar days of December 14 and is therefore timely.

This request is based on the limited information now available to Blue Cross NC. To seek transparency on the Plan's decision-making process, Blue Cross NC has submitted two requests under North Carolina's Public Records Act, N.C. Gen. Stat. § 132-6, for documents related to the 2022 RFP. Those requests were submitted on December 15 and December 20, 2022. To date, Blue Cross NC has not received any records or any timeline for their production. Blue Cross NC therefore reserves all rights, remedies, and arguments related to the Plan's award.

An executive summary and the substance of the protest follow below.

EXECUTIVE SUMMARY

- The Plan's 2022 RFP relied on arbitrary criteria and a distorted scoring system.
- The scoring system assigned no points to the strength, depth, and breadth of each bidder's provider network. Those networks play a pivotal role in North Carolinians' access to high-quality health care.
- The RFP also did not analyze the disruption that a change in network would cause to Plan members, such as the need to change providers, the need to adjust to different approaches to reviewing claims, and the need to request new prior authorizations for certain treatments. This lack of analysis contradicted the RFP's stated objective of selecting a vendor with a broad network with the least disruption.
- The Plan's scoring of cost proposals used vague standards—standards that appear to have been dispositive.
- The RFP scored technical proposals based only on answers to 310 yes-or-no questions. Even though the subjects of the 310 questions varied significantly in impact to Plan members, all 310 answers received the exact same weight.
- The Plan refused to allow *any* narrative explanation of any vendor's technical capabilities. Thus, the Plan lacks information on Aetna's detailed capabilities on those requirements.
- The scoring system in the 2022 RFP differs dramatically from the Plan's 2019 RFP. For example, the 2019 RFP scored cost proposals on a 10,000-point scale; the 2022 RFP scored cost proposals on a 10-point scale.
- The change in the scoring system in the 2022 RFP had a pivotal impact. Had Blue Cross NC been awarded just one more point for its cost proposal, it would have won the bid.
- Blue Cross NC confirmed 303 of the RFP's 310 technical requirements. At a post-award meeting, the Plan told Blue Cross NC that it lost the bid because of the seven non-confirmed requirements. If the Plan had allowed Blue Cross NC to explain why it did not confirm those requirements, the Plan would have seen that those explanations enhanced the strength and credibility of Blue Cross NC's proposal. The Plan instead penalized Blue Cross NC for the careful nature of its responses. The RFP's ban on explanations also limited the Plan's ability to evaluate other vendors' confirmed responses.

BACKGROUND

1. The 2022 RFP

The Plan provides health care coverage to hundreds of thousands of teachers, state employees, retirees, and their dependents.

Blue Cross NC is a fully taxed, not-for-profit North Carolina insurance company with a mission to support health care in North Carolina. It has major operation centers in Durham and Winston-Salem, and it employs nearly 5,000 North Carolinians.

On August 30, 2022, the Plan issued the 2022 RFP, seeking a vendor to manage its health plan by assembling a network of providers, negotiating discounts with those providers, processing claims, and administering other services. A copy of the 2022 RFP is attached to this letter as Exhibit 1. The RFP set a deadline of September 26, 2022, for vendors to submit responses to certain minimum requirements.

Three vendors met those minimum requirements and were allowed to move on to the next phase of the RFP: Blue Cross NC, Aetna, and United Healthcare. Each of these vendors then submitted a proposal on November 7, 2022, responding to questions on costs and technical requirements. Blue Cross NC's response to these technical requirements is attached as Exhibit 2.

The 2022 RFP process evaluated each vendor's proposal on two main criteria: (1) a cost proposal and (2) responses to 310 technical questions. The RFP stated that each vendor's final score would be divided equally between these two elements. *See* 2022 RFP § 3.4(a).

Cost proposals were scored on a 10-point scale, with three different cost categories evaluated: network pricing (with six available points), administrative fees (with two available points), and a network-pricing guarantee (with two available points):

- The network-pricing element involved the “repricing” of a set of claims data that the Plan provided to each vendor. Each vendor was asked to state what the total cost of the identified claims would be based on the vendor’s negotiated prices. According to the RFP, the proposal that reflected the lowest network pricing would receive a full six points for this category, as would any proposal within 0.5% of the lowest-priced vendor. Other vendors would receive fewer points depending on how close their proposal was to the lowest-priced vendor.
- The administrative-fees element evaluated the administrative fees that each vendor proposed to charge the Plan for its third-party administrative services. The lowest-cost proposal would receive the full two points available for this category. The remaining proposals would receive zero or one point.
- The network-pricing-guarantee element evaluated, in theory, the refunds that each vendor was willing to offer the Plan if the vendor failed to deliver on its stated ability to negotiate prices with providers. The 2022 RFP stated that the Plan would decide the “value” of each vendor’s network-pricing guarantee “based on the combination of the competitiveness of the guaranteed targets and the amount placed at risk.” The proposal that offered network-pricing guarantees “with the greatest value” would receive the full two points available for this category. All other proposals would receive “one (1) or zero (0) points based on the value of their proposed pricing guarantees in comparison to the highest ranked proposal and the other proposals.” 2022 RFP § 3.4(c)(3)(c).

During a post-award meeting on December 16, 2022, Plan officials told Blue Cross NC that its cost proposal tied for first place with Aetna, and that its administrative-fee proposal offered lower costs than Aetna’s proposal. Blue Cross NC received the full six points available for network pricing. The officials also said that Blue Cross NC received the full two points for administrative fees. Blue Cross NC received a total cost score of eight points, so it apparently received zero points for its network-pricing guarantee. Plan officials also told Blue Cross NC that Aetna also received a cost score of eight and that United received a cost score of seven.

On the technical requirements, the 2022 RFP process allocated one point to each of 310 technical questions or sub-questions. *See* 2022 RFP § 3.4(b). If a vendor

confirmed a technical requirement, that vendor received one point; if not, that vendor received zero points. For scoring purposes, the RFP weighted each of the 310 technical requirements the same. In the December 16 meeting, the Plan told Blue Cross NC that it received a technical-proposal score of 303 out of 310 possible points, and that Aetna and United each received 310 points.

2. Differences between the 2022 RFP and 2019 RFP

The 2022 RFP departed in many ways from the RFP that the Plan used in 2019.

a. Scoring of Cost Proposals

As noted above, the 2022 RFP evaluated each vendor's cost proposal on a 10-point scale.

The 2019 RFP, in contrast, scored each vendor's cost proposal on a 10,000-point scale. *See* 2019 RFP § 3.4(c)(i).

By compressing the cost-scoring scale by a factor of 1,000, the 2022 RFP's scoring process eliminated almost all distinctions between cost proposals. The RFP's scoring results confirm this point. The scoring yielded almost no difference in cost scores among vendors. Two of the three vendors received a cost score of 8 out of 10, while the third received a cost score of 7.

The 2022 RFP also used a different form of cost scoring from the 2019 RFP. The 2019 RFP said that the Plan would award the maximum number of points to the vendor with the "lowest total cost[,] with others receiving points proportionately." 2019 RFP § 3.4(c). In contrast, the 2022 RFP stated that the maximum number of points would be awarded to the vendor "offering the most competitive cost proposal, with others receiving points proportionately." 2022 RFP § 3.4(c). The 2022 RFP did not explain how the committee evaluating each vendor's proposal would decide which proposal was "most competitive."

b. Weight Given to Cost and Technical Scores

The 2022 RFP also changed the relative weight given to each vendor's scores for the cost and technical elements.

The 2019 RFP provided that the cost score would account for 40% of each vendor's final overall score, with the technical proposal accounting for the remaining 60%. *See* 2019 RFP § 3.4(a). The 2022 RFP changed this approach and weighted vendors' cost and technical proposals equally. *See* 2022 RFP § 3.4(a).

Combined with the change to the method for scoring cost proposals described above, the 2022 RFP *increased* the importance of cost scores, while *decreasing* the ability to measure differences in each vendor's cost proposal.

c. Permitted Responses to Technical Questions

As noted above, the 2022 RFP restricted each vendor's ability to respond to the Plan's 310 technical questions. Vendors were allowed to give only a binary yes-or-no response to each question. The Plan did not allow vendors to add any explanation or other information.

The 2019 RFP, in contrast, allowed vendors to offer narrative responses to similar technical questions. (The 2019 RFP is attached as Exhibit 3.) Blue Cross NC provided narrative responses for nearly all of the technical questions in the 2019 RFP. These narrative responses allowed Blue Cross NC to describe the basis for its responses and to state whether there would be any impact to the Plan or its members as a result. As discussed below, the inability to do so here prevented Blue Cross NC from providing helpful context and explanation for its responses. If Blue Cross NC could not confirm any element of a proposed requirement—even an immaterial element—it was forced to answer “no” without further explanation.

d. Scoring of Technical Proposals

The 2022 RFP also changed the scoring method for each vendor's responses to technical questions.

The 2019 RFP stated that each vendor's responses to the Plan's technical questions would be scored on a 10,000-point scale, just as the cost proposals were. *See* 2019 RFP § 3.4(b). The 2022 RFP, in contrast, used a 310-point scale, with one

point being awarded for the response to each of the 310 yes-or-no technical questions in the RFP. See 2022 RFP § 3.4(b). This change dramatically increased the importance of a vendor's response to each yes-or-no question.

e. Eliminated Preference for a North Carolina Vendor

The 2019 RFP stated a preference for vendors "with resources in North Carolina." 2019 RFP § 5.2.2.1. The 2022 RFP eliminated this preference.

BASIS FOR PROTEST

As shown below, the award of this contract to Aetna was an arbitrary and capricious decision. That award is not in the best interests of the Plan or its members.

1. Failure to Score Each Vendor's Network

For members, network strength is critical to whether the Plan meets the members' health needs. Plan members stretch across North Carolina, from Murphy to Manteo. Those members, regardless of their geographic location, deserve high-quality health care that is actually available to them. That availability requires a deep provider network.

The RFP's stated scoring process failed to consider these critical issues. Instead, the Plan treated Blue Cross NC's and Aetna's networks as equivalent as long as both vendors met certain minimum thresholds. Those networks, however, are not equivalent at all. Based on a preliminary review of publicly available data, Blue Cross NC has 38% more provider locations in North Carolina than does Aetna. In the vast majority of North Carolina's 100 counties, Blue Cross NC also has more provider locations than Aetna has.

The scoring system further failed to consider whether choosing a given vendor, with its network, would cause disruption to the Plan's members. Disruption can come in many forms, including forcing members to change providers because their Blue Cross NC provider is not in Aetna's network. The 2022 RFP itself noted the importance of minimizing disruption: it stated that the Plan was seeking a vendor that provided "a broad provider network with the least

disruption.” 2022 RFP, att. A, § 1.1. The RFP undermined this goal by assigning no points to it.

2. Scoring of Cost Proposals

The RFP’s scoring system for cost proposals was arbitrary.

The RFP does not explain, for example, why the administrative-fee and network-pricing-guarantee categories each received two points, even though administrative fees reflect *actual* costs to the Plan and its members, while pricing guarantees are rebates that will be paid only if a vendor does not meet its pricing commitments. Had the administrative fee received more weight than the network-pricing guarantee, Blue Cross NC would have received the highest overall score, because it was apparently the only vendor that received all available points for administrative fees.

The RFP also used vague and undefined standards for scoring network-pricing guarantees. The RFP states that the “proposal that offers the network pricing guarantee with the greatest value will be ranked the highest” and will receive two points. 2022 RFP § 3.4(c)(3)(b). It does not say, however, how the Plan would decide which guarantee provides “the greatest value,” or what that term even means.

The RFP is equally vague on how many points would be awarded to the vendors that were not ranked highest on network-pricing guarantees. The RFP says that the vendor that does not provide the “greatest value” through its network-pricing guarantee “may receive one (1) or zero (0) points based on the value of their proposed pricing guarantees in comparison to the highest ranked proposal and the other proposals.” 2022 RFP § 3.4(c)(3)(c). It does not explain how the Plan would decide whether to award zero points or one point.

Based on this vague scoring, the Plan apparently awarded Blue Cross NC zero points for its network-pricing guarantee. That unexplained decision was pivotal. Had the Plan awarded Blue Cross NC even one point here, Blue Cross NC would have received the highest overall score.

Indeed, if Blue Cross NC had received only one point on the network-pricing guarantee, Blue Cross NC would have won by a margin *three times higher* than Aetna’s winning margin. Under those circumstances, Blue Cross NC would have

won nine of the ten available points on its cost proposal. That is equivalent to 279 of the 310 available technical points. Blue Cross NC's total score thus would have been 582 (279 plus 303). Aetna's total score would have been 558 (248—80 percent of the available cost proposal points—plus 310).

In the post-award meeting with Blue Cross NC, the Plan's representatives said that Blue Cross NC did not rank the highest on the guarantee because of the amount of its administrative fee that Blue Cross NC agreed to put at risk if the guarantee failed.

In view of the context here, however, the Plan had no reason to put dispositive weight on these guarantees. Under the 2019 contract with the Plan, Blue Cross NC consistently met its contracted discounts.

3. Scoring of Technical Proposals

The Plan's method for scoring technical proposals was equally arbitrary. The Plan evaluated each vendor's technical proposal based only on yes-or-no responses to 310 technical requirements. The Plan awarded one point for each requirement that was confirmed and zero points for each requirement that was not.

This scoring presumes that each of the 310 technical requirements deserves equal weight. The Plan has offered no justification for this equal weighting.

Some of the 310 technical requirements are central to the proper functioning of the Plan's third-party administrator. For example, vendors were asked to confirm that they have experience with, and will support the implementation of, care models designed to reduce costs for Plan members. *See* Requirements 5.2.3.2(b)(xii) and (xiii). Vendors were also asked to confirm their ability to provide services to members who have an urgent medical need while outside the United States. *See* Requirement 5.2.3.2(b)(ii).

Other requirements are less central—for example, the vendor's ability to display the name of a member's employer in the vendor's online portal (Requirement 5.2.7.2(b)(xiv)) and confirmation that the vendor would provide and moderate online chat groups (Requirement 5.2.7.2(b)(xxi)).

Despite the difference in these and other technical requirements, the Plan gave every one of them the same scoring weight. That equal weight was arbitrary.

In addition, because the Plan demanded that vendors give yes-or-no answers to the 310 technical requirements, the Plan did not consider whether any vendor—including the winning vendor, Aetna—had conditions or limits on its ability to meet the requirements. Instead, the yes-or-no scoring motivated each vendor to superficially “confirm” its ability to meet each requirement *regardless* of its current capabilities or any limits on the vendor’s ability to satisfy the requirement in the future.

The binary form of the questions also penalized Blue Cross NC for its attention to detail. Because Blue Cross NC knew the history and context of the Plan’s stated requirements, it truthfully noted the seven requirements that it could not confirm without additional discussion. It received zero points for those responses. The Plan’s refusal to consider any explanation for these responses led to a decision that was uninformed and arbitrary.

Because all the Plan relied on here was a small number of technical requirements with no allowance for an explanation, the Plan could not adequately complete its due diligence review of Blue Cross NC’s proposal. The binary response format also precluded the Plan from properly assessing the remaining vendors on the same technical requirements that they had marked “confirmed.”

In sum, the Plan could not make a reliable and informed decision about the technical capabilities of any vendor by treating each of 310 technical requirements as equally important, then refusing to accept any explanation on a vendor’s detailed capabilities. The Plan nonetheless made its decision on that basis. At the post-award meeting with Blue Cross NC, Plan representatives admitted that because Blue Cross NC and Aetna had the same cost scores, the Plan awarded the bid to Aetna based on the difference in the vendors’ technical scores. Seven superficial yes-or-no answers, out of 310 technical questions, decided the entire RFP.

Choosing the vendor of a multi-billion-dollar contract that affects hundreds of thousands of North Carolinians based on seven yes-or-no responses—and refusing to accept any explanation about those responses—is illogical and arbitrary.

4. **Failure to Allow Explanations on Technical Questions**

The Plan's decision to award Blue Cross NC zero points for each "not confirmed" response assumes that those responses reflect a deficiency. But the opposite is true.

Had the RFP allowed Blue Cross NC to submit narrative explanations with its answers, those explanations would have shown the legitimate reasons why Blue Cross NC did not confirm seven technical requirements.

If Blue Cross NC had been allowed to do so, it would have offered the following information on the seven technical requirements at issue:

- a. Requirement 5.2.3.2(b)(iii): "Vendor will apply the same utilization management and payment rules to providers located in North Carolina and throughout the United States."

Blue Cross NC did not confirm this sweeping condition for good reason. On rare occasions, key out-of-state providers (for example, the Mayo Clinic) might provide care to members without first getting prior authorization for that care. Under the terms of contracts between Blue entities and these out-of-state providers, the provider is not charged a penalty for providing this care. Because of these contracts, Blue Cross NC could not accurately state that the exact same utilization-management and payment rules would apply to every single provider across the country.

Requiring mechanical sameness across all providers would not be in the best interest of the Plan or its members. Rigid enforcement of a prior-authorization requirement could prevent Plan members from receiving necessary medical care. And it would not produce any cost savings or other benefits for the Plan, for several reasons:

- First, the waiver of these penalties is rare. In over 99% of cases, these out-of-state providers get prior authorization.
- Second, in virtually all cases, the provider *would have* received prior authorization had it sought it. Thus, mechanically enforcing a requirement of prior authorization would deny treatment to Plan members over a mere "touch foul."

- Third, this lack of absolute sameness across the country is a necessary result of having out-of-state providers in the Blue network—a network that provides significant benefits to Plan members.
- Fourth, Blue Cross NC believes that the out-of-state providers at issue demand similar penalty waivers from all third-party administrators, including Aetna and United. It is therefore unlikely that these vendors can comply with the absolute-sameness requirement stated in the RFP.
 - b. Requirement 5.2.7.2(b)(xxiv): “Vendor’s member portal will accept and display Member-specific information from the other systems and Vendor’s health team, including . . . Electronic medical and health records, Disease Management Nurse notes, Case Management notes, [and] Health Coach notes”

These requirements—four of the seven technical questions not confirmed by Blue Cross NC—are not technically feasible or not in the best interest of the Plan’s members.

Blue Cross NC’s member portal does not allow it to display electronic medical records (EMRs) from a provider. Providers have different and widely varying EMR systems, so displaying EMRs on a member’s portal would require a universal platform that is compatible with each provider’s system. Blue Cross NC is not aware of any third-party administrator that can offer this feature. It believes that the other vendors who confirmed this requirement did not appreciate its full implications.

In addition, the three categories of notes discussed in this technical requirement are notes made for the third-party administrator’s own internal use, not notes meant for members’ review. At times, the notes contain candid comments on whether a patient is following a provider’s recommended course of treatment.

The Plan has not once raised the question of access to these internal notes during Blue Cross NC’s long history as the Plan’s third-party administrator. Even so, because of the scoring method that the Plan used to evaluate proposals here, this issue was given near-dispositive weight.

- c. Requirement 5.2.8.2(b)(v): “Upon request, Vendor will pay all claims, including non-network claims, based on assignment of benefits.”

Blue Cross NC does not allow assignment of benefits to providers for out-of-network claims. This policy exists for the benefit of the Plan and its members. If an out-of-network provider can count on receiving payment directly from Blue Cross NC, that provider will have little incentive to join the Blue Cross NC network. The lack of such an incentive would undermine Blue Cross NC’s ability to negotiate discounts for Plan members. Thus, treating assignment of benefits for out-of-network providers as a preferred feature of a vendor is a serious mistake.

By itself, moreover, assignment of benefits would have little benefit to Plan members. If this requirement is meant to streamline billing for out-of-network services and therefore reduce the burden on Plan members, it will not be enough to meet that objective. Any streamlining of billing would occur only when the out-of-network payment made by Blue Cross NC under an assignment of benefits is accepted as payment in full.

If, in contrast, the requirement of assignment of benefits is motivated by a concern that a large benefits payout to a member might not get paid to a provider, Blue Cross NC has already implemented safeguards to prevent this from occurring.

- d. Requirement 5.2.6.2(b)(xvi): “Vendor will use the unique Member ID number provided by the [Plan’s eligibility and enrollment] vendor as the primary Member ID for claims processing, customer services and other operational purposes; therefore, the unique Member ID number provided by the [eligibility and enrollment] vendor will be the sole Member ID on the ID Card.”

Blue Cross NC had good reasons for not confirming this requirement as well. This requirement is technically infeasible and would cause needless headaches for Plan members.

As the Plan knows, each of its vendors—including its eligibility vendor and its pharmacy-benefits vendor—has its own form of member ID. Each vendor’s form of ID is designed to be compatible with that vendor’s systems. Blue Cross NC, for example, has a sixteen-character form of ID that includes a particular prefix. When

a Plan member visits a provider, that provider is familiar with and expects to see a sixteen-character form of ID and is prepared to use that form of ID in its billing systems.

Because of providers' expectations, enforcing a "single ID number" requirement would be counterproductive for the Plan's members. It would cause confusion and disruption with providers.

As the above discussion shows, Blue Cross NC had good reason for not confirming these seven out of 310 technical requirements in its proposal. If the Plan had allowed Blue Cross NC to explain these points, it would have done so. Then, the Plan—in the proper exercise of its diligence—would have been able to assess confirmed responses from other vendors on the same point.

In any event, if the Plan had scored the technical proposal less mechanistically, the outcome of this RFP would have been different.

CONCLUSION AND REQUEST FOR RELIEF

The Plan has described the criteria and scoring of the 2022 RFP as a modernization effort, but there was nothing modern about this RFP process.

Instead, the Plan took a complex decision—selecting the third-party administrator for a health plan that covers hundreds of thousands of North Carolinians—and tried to turn it into a checklist. That approach ignored critical issues that will affect the welfare of the State and the welfare of the Plan's members.

The Plan's third-party administration is not a back-office function. Instead, the third-party administrator has responsibilities that play a central role in defining member benefits. The administrator must also deliver a provider network with the strength, depth, and reach to offer high-quality, accessible health care to Plan members.

The Plan gave short shrift to these factors when it chose its next third-party administrator. That choice was arbitrary and capricious.

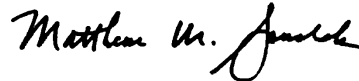
Mr. Sam Watts
January 12, 2023
Page 15

In light of the problems noted above, Blue Cross NC respectfully requests that the Plan (a) declare Blue Cross NC the winning vendor and award Blue Cross NC the contract, or (b) in the alternative, vacate its award to Aetna and conduct a new and more sound RFP process.

We look forward to meeting with the Plan to discuss these issues further.

Sincerely,

ROBINSON, BRADSHAW & HINSON, P.A.



Matthew W. Sawchak

MWS/wp
Attachments: Exhibits 1-3

Index of Exhibits to Blue Cross Blue Shield of North Carolina's
Request for Protest Meeting on Request for Proposal #270-20220830TPAS

Tab	Description
1	The North Carolina State Health Plan Request for Proposal #270-20220830TPAS
2	Blue Cross Blue Shield of North Carolina's Technical Requirements Response for Proposal #270-20220830TPAS
3	The North Carolina State Health Plan Request for Proposal #270-20191001TPAS