

**Joint Legislative Committee on Performance  
Evaluation and Expenditure Review (PEER)**

Report to  
the Mississippi Legislature



---

## **A Review of the Process Used by the Health Insurance Management Board in 2009 to Procure Insurance Coverage for Mississippi's Children's Health Insurance Program**

---

In early 2009, the State and School Employees Health Insurance Management Board began a process to procure insurance coverage for Mississippi's Children's Health Insurance Program (CHIP) upon expiration of the previous policy. The board received proposals from three companies for insurance coverage for the period of January 1, 2010, to December 31, 2013. The PEER Committee commenced this review of the procurement process in response to a complaint that was received shortly after the board voted in June 2009 to select UnitedHealthcare by Americhoice.

In procuring CHIP insurance coverage, the board complied with applicable state regulations by developing a formal request for proposals, by publicly issuing and advertising the request for proposals, and by receiving and opening proposals in a manner that maintained the confidential integrity of the proposals. However, PEER found that the board did not have a disciplined, equitable process of evaluating proposals and selecting a proposer. At critical points during the process, the board lacked evaluative criteria, treated some proposers differently from others, had no operationally defined standards for point values awarded to proposers, or lacked documentation. As a result, the board's process was not fully objective and transparent, thus creating the appearance that the board did not make its award decision objectively.

The board complied with state regulations by notifying all proposers of its award decision. However, the board did not conduct debriefings with proposers that were not selected to provide insurance coverage.

## **PEER: The Mississippi Legislature's Oversight Agency**

The Mississippi Legislature created the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) by statute in 1973. A joint committee, the PEER Committee is composed of seven members of the House of Representatives appointed by the Speaker and seven members of the Senate appointed by the Lieutenant Governor. Appointments are made for four-year terms, with one Senator and one Representative appointed from each of the U. S. Congressional Districts and three at-large members appointed from each house. Committee officers are elected by the membership, with officers alternating annually between the two houses. All Committee actions by statute require a majority vote of four Representatives and four Senators voting in the affirmative.

Mississippi's constitution gives the Legislature broad power to conduct examinations and investigations. PEER is authorized by law to review any public entity, including contractors supported in whole or in part by public funds, and to address any issues that may require legislative action. PEER has statutory access to all state and local records and has subpoena power to compel testimony or the production of documents.

PEER provides a variety of services to the Legislature, including program evaluations, economy and efficiency reviews, financial audits, limited scope evaluations, fiscal notes, special investigations, briefings to individual legislators, testimony, and other governmental research and assistance. The Committee identifies inefficiency or ineffectiveness or a failure to accomplish legislative objectives, and makes recommendations for redefinition, redirection, redistribution and/or restructuring of Mississippi government. As directed by and subject to the prior approval of the PEER Committee, the Committee's professional staff executes audit and evaluation projects obtaining information and developing options for consideration by the Committee. The PEER Committee releases reports to the Legislature, Governor, Lieutenant Governor, and the agency examined.

The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

PEER Committee  
Post Office Box 1204  
Jackson, MS 39215-1204

(Tel.) 601-359-1226  
(Fax) 601-359-1420  
(Website) <http://www.peer.state.ms.us>

The Mississippi Legislature

**Joint Committee on Performance Evaluation and Expenditure Review**

PEER Committee

**SENATORS**  
NOLAN METTETAL  
Chair  
SIDNEY ALBRITTON  
TERRY BROWN  
MERLE FLOWERS  
CINDY HYDE-SMITH  
GARY JACKSON  
SAMPSON JACKSON



**REPRESENTATIVES**  
HARVEY MOSS  
Vice Chair  
ALYCE CLARKE  
Secretary  
WILLIE BAILEY  
DIRK DEDEAUX  
WALTER ROBINSON  
RAY ROGERS  
GREG WARD

**TELEPHONE:**  
(601) 359-1226

**FAX:**  
(601) 359-1420

Post Office Box 1204  
Jackson, Mississippi 39215-1204

Max K. Arinder, Ph. D.  
Executive Director

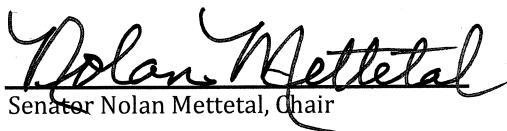
[www.peer.state.ms.us](http://www.peer.state.ms.us)

**OFFICES:**  
Woolfolk Building, Suite 301-A  
501 North West Street  
Jackson, Mississippi 39201

July 21, 2010

Honorable Haley Barbour, Governor  
Honorable Phil Bryant, Lieutenant Governor  
Honorable Billy McCoy, Speaker of the House  
Members of the Mississippi State Legislature

On July 21, 2010, the PEER Committee authorized release of the report entitled **A Review of the Process Used by the Health Insurance Management Board in 2009 to Procure Insurance Coverage for Mississippi's Children's Health Insurance Program.**

  
Senator Nolan Mettetal, Chair

**This report does not recommend increased funding or additional staff.**



## *Table of Contents*

Letter of Transmittal .....	i
List of Exhibits .....	v
Executive Summary .....	vii
Introduction .....	1
Authority .....	1
Problem Statement .....	2
Scope and Purpose .....	2
Method .....	3
Terms Used for Participants in the CHIP Procurement Process .....	3
Background .....	5
Legal Authority for Mississippi’s CHIP.....	5
CHIP Eligibility Requirements .....	6
Administration of Mississippi’s CHIP .....	7
History of Provider Selection for Mississippi’s CHIP, 1999-2009.....	8
Requirements for Procuring Health Insurance Coverage for Mississippi’s CHIP .....	10
Legal Requirements for Procuring CHIP Insurance .....	10
Personal Service Contract Review Board Requirements for Competitive Procurement .....	11
Best Practices for Competitive Procurement .....	14
Procurement Process Described in the Request for Proposals .....	15
Chapter 1: Request for Proposals, Public Notice, and Receipt of Proposals .....	18
Did the board procure CHIP insurance coverage through the use of a formal request for proposals? .....	18
Did the board notify potential proposers about the 2009 CHIP RFP?.....	19
Did the board receive and open proposals in a manner that maintained the confidential integrity of the proposals? .....	20
Chapter 2: Evaluation of Proposals and Selection of Proposer .....	22
Did the board’s request for proposals state the areas on which the evaluation committee would evaluate the proposals? .....	23
How did the board score the six areas comprising Phase Two of the evaluation process?.....	25

**Table of Contents (continued)**

Did the board solicit additional information and documentation from proposers after the proposal deadline date? ..... 31

Did the board conduct reference checks on the proposers to determine their ability to provide the services described in the RFP?..... 32

Did the board allow proposers to make presentations—i. e., conduct technical question-and-answer interviews? ..... 34

Did the board allow proposers to submit “best and final” offers during their presentations and, if so, what effect did such offers have on the proposers’ final composite scores?..... 37

Did the board conduct on-site visits with proposers?..... 39

Chapter 3: Notification and Debriefing of Proposers..... 44

    Did the board promptly notify all proposers of its award decision? ..... 44

    Did the board conduct debriefings with proposers that were not selected to provide CHIP insurance coverage to furnish the basis for its award decision?..... 45

Chapter 4: The Effect of the Board’s 2009 CHIP Insurance Procurement Process..... 49

Chapter 5: Recommendations..... 52

Agency Response ..... 55

***List of Exhibits***

1.	Components of a Competitive Sealed Proposals Procurement Process, Based on PSCRB Requirements and the ABA <i>Model Procurement Code</i> .....	17
2.	Weighted Scoring for Evaluation Areas in Phase Two of the 2009 CHIP Proposal Evaluation Process .....	24
3.	Scoring Points for Cost Analysis of CHIP Proposals .....	30
4.	Summary of Composite Scores of the Three Proposers for Mississippi's CHIP Insurance, 2009.....	50





# A Review of the Process Used by the Health Insurance Management Board in 2009 to Procure Insurance Coverage for Mississippi's Children's Health Insurance Program

## Executive Summary

### Introduction

Created in 1997 by Congress, the Children's Health Insurance Program (CHIP) is a joint federal/state program, with funds for the program being appropriated by Congress as well as by each state's legislature. The purpose of CHIP was to expand health insurance coverage to children in families whose income is modest but too great to qualify for traditional Medicaid.

Responsibility for administration of Mississippi's CHIP is divided between the Division of Medicaid and the State and School Employees Health Insurance Management Board (hereafter referred to as "the board" or HIMB), with administrative support provided by the Department of Finance and Administration's Office of Insurance.

In early 2009, the board began a process to procure insurance coverage for CHIP upon expiration of its policy. The board requested proposals for either fully insured or self-insured coverage.<sup>1</sup> The board received proposals from Blue Cross, UnitedHealthcare by AmeriChoice (hereafter referred to as United), and AmeriHealth Mercy (hereafter referred to as AmeriHealth).

Shortly after the board voted on June 24, 2009, to enter into negotiations with United for CHIP insurance coverage for the period January 1, 2010, to December 31, 2013, PEER received a complaint regarding the procurement process utilized by the board.

Specifically, the complainant alleged that:

---

<sup>1</sup> As part of the RFP, the board asked proposers to provide proposals on a *fully insured* (i. e., the purchase of an insurance product with the insurance company bearing financial risks of the plan) or *self-insured* (i. e., contracting with a third-party administrator with the state bearing financial risks of the plan) basis.

- evaluation committee members' scoring of presentations and on-site visits did not comply with regulations or the request for proposals (RFP);
- pricing considerations and methodology utilized by the board's consulting firm to analyze proposals did not comply with the RFP;
- scoring committee members allowed a proposer to submit additional information after the proposal deadline; and,
- through the use of inappropriate criteria, the scoring methodology utilized by scoring committee members favored one proposer over other proposers.

In response to the complainant's allegations, the PEER Committee conducted a comprehensive review of the process utilized by the State and School Employees Health Insurance Management Board in 2009 to procure insurance coverage for Mississippi's CHIP. The scope of PEER's review included only the process used by the board to select an insurer for Mississippi's CHIP. The scope did not include a review of the performance of UnitedHealthcare once the agreement became effective on January 1, 2010.

## Requirements for Procuring Health Insurance Coverage for Mississippi's CHIP

In procuring health insurance coverage for Mississippi's CHIP, the Office of Insurance is subject to legal requirements, requirements of the Personal Service Contract Review Board for competitive procurement, best practices for competitive procurement, and requirements of the 2009 request for proposals for CHIP insurance:

- *legal requirements for procuring CHIP insurance--* While state law establishes procedures for the procurement of commodities, personal services, and public construction, no statutory provisions govern the procurement of insurance coverage such as that provided to CHIP-eligible recipients.
- *Personal Service Contract Review Board requirements for competitive procurement--* State law created the Personal Service Contract Review Board to oversee the solicitation and selection of personal and professional services contractual personnel. PSCRB regulations specify certain requirements for requests for proposals for procuring personal or professional service contracts. PSCRB regulations allow the use of competitive sealed proposals for procuring a contract if the agency head determines that the use

of competitive sealed bidding is either not practicable or advantageous to the state.

Because the board did not know which option it would exercise for selection of a CHIP insurance provider—non-participating insured or self-insured—the board structured its procurement process based on the PSCRB’s competitive sealed proposals requirements.

- *best practices for competitive procurement*—Because the board’s intent was to select the lowest and best proposal for providing insurance coverage for Mississippi’s CHIP, it was imperative that the board adhere to accepted competitive procurement principles such as those promulgated by the PSCRB and the American Bar Association. Exhibit A, page x, defines the components of a competitive sealed proposal procurement process, based on PSCRB requirements and the American Bar Association’s *Model Procurement Code for State and Local Governments*.
- *procurement process described in the request for proposals*—DFA’s February 18, 2009, request for proposals for CHIP insurance coverage specified mandatory requirements for proposers and included evaluation criteria on which proposals would be judged. Pages 15 and 16 of the report provide detail on the requirements of the request for proposals, including the specific evaluation criteria and the components of each phase of the evaluation process.

## Conclusions

This section states the main conclusion of each of the report’s chapters and summarizes, in question-answer format, PEER’s subconclusions regarding compliance of the State and School Employees Health Insurance Management Board with applicable requirements for procuring health insurance coverage for Mississippi’s CHIP.

---

**Exhibit A: Components of a Competitive Sealed Proposals Procurement Process, Based on PSCRB Requirements and the ABA Model Procurement Code for State and Local Governments**

Component	Description
<i>Request for Proposals</i>	Procuring entity solicits proposals through a Request for Proposals (RFP)
<i>Public Notice</i>	Procuring entity provides adequate public notice of the RFP in a newspaper published in the county or municipality in which the agency is located or in electronic format
<i>Receipt of Proposals</i>	Procuring entity opens proposals so as to avoid disclosure of contents to competing offerors during the process of negotiation. Procuring entity prepares a Register of Proposals and makes the register open for public inspection after contract award. The register indicates the name of all vendors submitting proposals.
<i>Evaluation Factors</i>	The procuring entity's RFP states the relative importance of price and other evaluation factors.
<i>Discussion with Responsible Offerors and Revisions to Proposals</i>	The procuring entity may conduct discussions with responsible offerors that submit proposals determined to be reasonably eligible of being selected for award for the purpose of clarification to assure full understanding of, and responsiveness to, the solicitation requirements. The procuring entity shall treat offerors in a fair and equal manner with respect to any opportunity for discussion and revision of proposals. Such revisions may be permitted after submissions and prior to award for the purpose of obtaining best and final offers. In conducting discussions, the procuring entity shall not disclose any information derived from proposals submitted by competing offerors.
<i>Award</i>	Procuring entity shall make the award to the responsible offeror whose proposal is determined in writing to be the most advantageous to the state, taking into consideration price and the evaluation factors set forth in the RFP. The procuring entity shall use no other factors or criteria when evaluating proposals. The procuring entity shall send a written notice of award to the successful bidder. In addition, the procuring entity shall make the notice of award available to the public.
<i>Debriefing*</i>	The entity's procurement officer may provide debriefings that furnish the basis for the source selection decision and contract award.

\* PSCRB regulations do not include this component. However, it is included within the American Bar Association's recommendations for competitive sealed proposals.

SOURCE: PEER analysis of PSCRB regulations and the American Bar Association's *Model Procurement Code for State and Local Governments*.

---

## **Request for Proposals, Public Notice, and Receipt of Proposals**

**The board complied with PSCRB regulations by developing a formal request for proposals for CHIP insurance coverage, by publicly issuing and advertising the RFP, and by receiving and opening proposals in a manner that maintained the confidential integrity of the proposals.**

*Did the board procure CHIP insurance coverage through the use of a formal request for proposals?*

The board complied with PSCRB regulations by developing a formal request for proposals to solicit proposals from potential proposers.

*Did the board notify potential proposers about the 2009 CHIP RFP?*

The board complied with PSCRB regulations by publicly advertising the RFP for CHIP insurance and by notifying potential proposers about the RFP.

*Did the board receive and open proposals in a manner that maintained the confidential integrity of the proposals?*

The Office of Insurance's staff complied with applicable PSCRB regulations by documenting receipt of proposals from proposers and opening the proposals in the presence of staff.

## **Evaluation of Proposals and Selection of Proposer**

**The board did not have a disciplined, equitable process of evaluating proposals and selecting a proposer. At critical points during the process, the board:**

- **lacked evaluative criteria;**
- **treated some proposers differently from others;**
- **had no operationally defined standards for point values awarded to proposers; or,**
- **lacked documentation.**

**As a result, the board's process was not fully objective and transparent, thus creating the appearance that the board did not make its award decision objectively.**

*Did the board's request for proposals state the areas on which the evaluation committee would evaluate the proposals?*

The request for proposals included evaluation areas on which proposals would be evaluated. However, the RFP did not disclose the weighted importance of the six evaluation areas included within Phase Two.

*How did the board score the six areas comprising Phase Two of the evaluation process?*

On behalf of the board, a five-member committee scored the proposals using weighted scoring for items included

within Phase Two of the evaluation process. However, committee members did not consistently adhere to the scoring methodology.

*Did the board solicit additional information and documentation from proposers after the proposal deadline date?*

The board solicited additional information and documentation from proposers after the March 30 deadline for receiving proposals. The board's requests included one to United regarding its additional network affiliations; however, the board did not request such from the other two proposers. United's additional information ultimately resulted in a change in that proposer's score.

*Did the board conduct reference checks on the proposers to determine their ability to provide the services described in the RFP?*

The board conducted telephone reference checks on the three proposers and concluded that they could perform as required in the RFP. However, the board did not define what information about a proposer's previous performance would have eliminated that company from further consideration. Also, the board could not provide documentation that it utilized information available from the Mississippi Department of Insurance for evaluating each proposer's previous performance.

*Did the board allow proposers to make presentations—i. e., conduct technical question-and-answer interviews?*

As stated in the RFP, the board allowed the proposers to make presentations to the evaluation committee. However, the board did not establish criteria by which the evaluation committee could award points to proposers for their presentations. Also, the board awarded an additional point to United based on new information provided in that company's presentation, after the scoring had been completed during the evaluative phase of the selection process.

*Did the board allow proposers to submit "best and final" offers during their presentations and, if so, what effect did such offers have on the proposers' final composite scores?*

As allowed by the board, two proposers submitted "best and final" offers at the time of their presentations before the evaluation committee. However, the board had no uniform evaluation process for these "best and final" offers.

*Did the board conduct on-site visits with proposers?*

The scoring committee conducted on-site visits with United and Blue Cross, but excluded AmeriHealth from such visits, even though the company was considered a finalist at the conclusion of Phase Two and a sufficient

number of points were available from the site visit to change the outcome of the award. In addition, without applying any objective criteria, the scoring committee awarded one point to United and deducted four points from Blue Cross.

## Notification and Debriefing of Vendors

The board complied with PSCRB regulations by notifying all proposers of its award decision. However, the board did not conduct debriefings with proposers that were not selected to provide insurance coverage, as recommended by the *Model Procurement Code for State and Local Governments*.

*Did the board promptly notify all proposers of its award decision?*

The board complied with PSCRB regulations and provisions of the *Model Procurement Code* by promptly notifying all proposers of its award decision.

*Did the board conduct debriefings with proposers that were not selected to provide CHIP insurance coverage to furnish the basis for its award decision?*

The board did not conduct debriefings with proposers that were not selected to provide insurance, as recommended by the *Model Procurement Code*, even though after the board made its award decision one proposer requested information from the Office of Insurance as to the deficiencies of its proposal.

## The Effect of the Board's 2009 CHIP Insurance Procurement Process

PEER found that two of the four complaints about the CHIP procurement process had merit. Also, beyond concerns raised by the complainant, PEER documented weaknesses in the board's procurement process that the board should address for future procurement efforts. Despite utilizing a process that incorporated some of the components of best practices, the board's procurement process lacked discipline in some instances and was not fully objective and transparent, thus creating the appearance that the board did not make its award decision objectively.

## Recommendations

1. The Legislature should require the State and School Employees Health Insurance Management Board (or any other agency made responsible for Mississippi's CHIP) to procure competitively the insurance coverage for the program using a request for proposals, specific criteria for evaluation, and written rationale for selecting a proposer to provide coverage. MISS. CODE ANN. Section 25-15-

301 (1972) imposes a similar requirement on the board for administration of the state health plan.

2. When developing a request for proposals to procure insurance coverage for Mississippi's CHIP, the board should include the weighted values for areas on which the cost and technical merits of a company's proposal will be evaluated. Such values should allow companies to develop proposals that are more responsive to the needs of CHIP.
3. To ensure the integrity of the board's competitive procurement process for CHIP insurance coverage, the board should require the Office of Insurance's staff and its consultants to complete the development of all evaluative tools (e. g., scoring grids, cost methodology) prior to the time the board issues its RFP for such insurance coverage.
4. To document the receipt and opening of proposals, the board should require Office of Insurance staff responsible for such activity to sign their names on the "Register of Proposals."
5. To assist scoring committee members in objectively and accurately scoring a proposal, the board should ensure that recommended responses for items in the RFP questionnaire are stated in operationally defined terms consistent with the services being requested of the proposers. Also, the board should ensure that scoring committee members adhere to point values assigned to criteria for items included within the RFP questionnaire. At the conclusion of the scoring process, the board should require Office of Insurance staff to conduct an inter-rater reliability analysis to identify variances among scorers that should be discussed and evaluated further.
6. If the board chooses to continue using the competitive sealed proposal method of procurement, the board should require the Office of Insurance's staff to establish a firm date by which proposers may submit a "best and final" offer. Such offers should include revisions of cost proposals, if any, and submission of additional information or changes to the proposer's initial proposals. The board should not allow evaluation committee members or its consultants to request or accept information from proposers after the established "cut off" date for "best and final" offers.
7. With regard to reference checks, the board should require the Office of Insurance's staff to consult



with the Mississippi Department of Insurance (and document such consultation) to determine whether the department has information that would reflect on a company's ability to provide the requested services. In addition, the board should develop criteria by which reference check information will be judged and factored into the overall evaluation process.

8. The board should review the practice of having evaluation committee members score finalists' presentations and on-site visits to determine whether this practice ensures that all proposers are treated fairly and objectively. If the board chooses to continue the practice, it should:
  - develop an agenda or itinerary to guide committee members through this portion of the evaluation process;
  - require the Office of Insurance's staff to develop criteria by which finalists' presentations and on-site visits will be scored; and,
  - determine an appropriate number of points that may be awarded to finalists for presentations and on-site visits.
9. Unless the RFP explicitly states that presentations and/or on-site visits will be discretionary on the part of the board or the evaluation committee, the board should require that all proposers considered to be finalists in the evaluation process be afforded an opportunity to make a presentation and receive an on-site visit.
10. The board should require the Office of Insurance's staff to conduct debriefings with proposers that were not selected, upon request, after the board has voted to enter into negotiations with a selected proposer. Such debriefings could provide general information regarding the quality of a proposal that was not selected. At the conclusion of negotiations and after the board has signed an agreement with a company to provide CHIP insurance coverage, the Office of Insurance's staff should be authorized to conduct more comprehensive debriefings with proposers that were not selected, upon request. However, there should be no disclosure of any information derived from proposals submitted by competing proposers.
11. To ensure that the board can justify and support its selection of a particular company to provide

CHIP insurance coverage, the board should require the Office of Insurance's staff to maintain appropriate work papers to document major decisions and thought processes associated with the development of the request for proposals, development of evaluative tools, and the scoring of proposals, presentations, and on-site visits.

**For More Information or Clarification, Contact:**

PEER Committee  
P.O. Box 1204  
Jackson, MS 39215-1204  
(601) 359-1226  
<http://www.peer.state.ms.us>

Senator Nolan Mettetal, Chair  
Sardis, MS 662-487-1512

Representative Harvey Moss, Vice Chair  
Corinth, MS 662-287-4689

Representative Alyce Clarke, Secretary  
Jackson, MS 601-354-5453

# A Review of the Process Used by the Health Insurance Management Board in 2009 to Procure Insurance Coverage for Mississippi's Children's Health Insurance Program

---

## Introduction

### Authority

In accordance with MISS. CODE ANN. Section 5-3-51 et seq. (1972), the PEER Committee reviewed the process used in 2009 by the State and School Employees Health Insurance Management Board to procure health insurance coverage for Mississippi's Children's Health Insurance Program (CHIP).

### Problem Statement

Created in 1997 by Congress, the Children's Health Insurance Program is a joint federal/state program, with funds for the program being appropriated by Congress as well as by each state's legislature. The purpose of CHIP was to expand health insurance coverage to children in families whose income is modest but too great to qualify for traditional Medicaid. CHIP enrollees pay no premiums to participate in the program. Within Mississippi, the State and School Employees Health Insurance Management Board (hereafter referred to as the board) has administrative and contractual responsibilities for the program, with the Division of Medicaid providing funding for the program.

The interagency agreement between the board and the Division of Medicaid required the board to design CHIP as a fully insured single insurer program and to execute a contract to provide health care coverage and services under the program. The board initially entered into a contract with an insurer for the period January 1, 2000, to December 31, 2004. In mid-2004, the board competitively bid a second agreement, with an insurer being contracted to provide CHIP coverage for the period January 1, 2005, to December 31, 2008. The board exercised an option to extend that agreement one year to December 31, 2009.

In early 2009, the board began a process to procure insurance coverage for CHIP upon expiration of the second agreement. As recommended by PEER in its report entitled *Mississippi's Children's Health Insurance Program: A Policy Analysis* (December 10, 2008), the board requested proposals for self-insured or fully insured coverage.

In response to the request for proposals (RFP), the board received proposals from Blue Cross Blue Shield of Mississippi (hereafter referred to as Blue Cross), UnitedHealthcare by AmeriChoice (hereafter referred to as United), and AmeriHealth Mercy (hereafter referred to as AmeriHealth). Shortly after the board voted on June 24, 2009, to enter into negotiations with United for CHIP insurance coverage for the period January 1, 2010, to December 31, 2013, PEER received a complaint regarding the procurement process utilized by the board. Specifically, the complainant alleged that:

- evaluation committee members' scoring of presentations and on-site visits did not comply with regulations or the request for proposals (RFP);
- pricing considerations and methodology utilized by the board's consulting firm to analyze proposals did not comply with the RFP;
- scoring committee members allowed a proposer to submit additional information after the proposal deadline; and,
- through the use of inappropriate criteria, the scoring methodology utilized by scoring committee members favored one proposer over other proposers.

In response to the complainant's allegations, the PEER Committee conducted a comprehensive review of the process utilized by the State and School Employees Health Insurance Management Board in 2009 to procure insurance coverage for Mississippi's CHIP.

## Scope and Purpose

PEER sought to determine whether the State and School Employees Health Insurance Management Board, acting through the Department of Finance and Administration's Office of Insurance, complied with state regulations, best practices standards for procurement, and provisions of the request for proposals for Mississippi's CHIP insurance coverage. PEER addressed the following questions:

- Did the State and School Employees Health Insurance Management Board develop an RFP, notify potential proposers of the RFP, and receive

and open proposals in a manner that maintained the confidential integrity of the proposals?

- Did the board evaluate proposals from prospective insurance providers in accordance with provisions contained in the RFP and select an insurance provider based on an objective evaluation of proposals?
- Did the board notify proposers of its selection decision and explain the rationale of its decision or debrief proposers that were not selected?

The scope of PEER's review included only the process used by the board to select an insurer for Mississippi's CHIP. The scope did not include a review of the performance of UnitedHealthcare once the agreement became effective on January 1, 2010.

## Method

In conducting this review, PEER:

- reviewed relevant state laws and regulations, as well as best practices regarding competitive procurement methods; and,
- interviewed the complainant, as well as selected members and staff of the State and School Employees Health Insurance Management Board.

Also, PEER reviewed applicable documentation relative to the board's:

- development of the 2009 CHIP request for proposals;
- issuance and advertisement of the RFP;
- receipt of proposals from prospective insurance providers;
- evaluation and scoring of proposals;
- selection of a proposer to provide health insurance coverage for CHIP; and,
- debriefing of proposers that were not selected.

## Terms Used for Participants in the CHIP Procurement Process

For the remainder of this report, PEER uses the following terms to refer to participants in the CHIP procurement process:

- *Board*: This is the ten-member State and School Employees Health Insurance Management Board

created by MISS. CODE ANN. Section 25-15-303 (1972). The board has responsibility for selecting an insurer for Mississippi's CHIP.

- *Office of Insurance:* The Department of Finance and Administration's Office of Insurance provides administrative support to the Health Insurance Management Board. The State Insurance Administrator supervises the office.
- *Scoring Committee:* This committee consisted of five senior-level staff of the Office of Insurance designated to score proposals received from proposers.
- *Evaluation Committee:* This committee consisted of members of the scoring committee, plus representatives of the four-person subcommittee of the Health Insurance Management Board appointed by the board chairman on August 27, 2008, to oversee the procurement process on behalf of the board.

---

## Background

This chapter addresses the legal authority, eligibility requirements, and administration of Mississippi's CHIP.

### Legal Authority for Mississippi's CHIP

The Federal Balanced Budget Act of 1997 created Title XXI of the Social Security Act, which established CHIP. State law, in conjunction with recommendations of the state's CHIP Commission, established Mississippi's CHIP as a separate program that is implemented by a single insurer and is administered through the Mississippi State and School Employees Health Insurance Management Board.

#### Statutory Authority for Mississippi's CHIP

*Title XXI of the Federal Social Security Act established CHIP. MISS. CODE ANN. Section 41-86-1 et seq. (1972) governs Mississippi's CHIP, creating a CHIP Commission that established the operational aspects of the program.*

Congress established the State Children's Health Insurance Program through the Balanced Budget Act of 1997 and created Title XXI of the Social Security Act. The purpose of CHIP was to expand health insurance coverage to children in families whose income is modest but too great to qualify for traditional Medicaid. States are given broad guidelines and flexibility (Title 42, Chapter IV, Part 457 of the *Code of Federal Regulations*) to implement and design their own CHIPs, including eligibility, benefits, and cost sharing provisions.

Mississippi's CHIP is governed by MISS. CODE ANN. Section 41-86-1 et seq. (1972). This statute created the Children's Health Insurance Commission and empowered it to develop the State Child Health Plan, which determines the structure for CHIP. The plan had to meet the requirements set forth in Title XXI of the Social Security Act. Duties of the commission included designation of the agency to administer the program, coordination of health care benefits under the program with other sources of health care benefits, establishment of benefits and eligibility standards, and institution of quality assurance measures. The commission submitted its final report in July 1998 and was dissolved by law on August 1, 1998.

## Recommendations of Mississippi's CHIP Commission

*Following the guidelines promulgated by state law, the CHIP Commission recommended that Mississippi's Children's Health Insurance Program operate as a separate, fully insured program under the direction of the State and School Employees Health Insurance Management Board.*

The commission designated the Health Insurance Management Board (the board) to administer Mississippi's Children's Health Insurance Program. The commission directed the state to operate a fully insured separate insurance program with a single insurer, with the coverage to be benchmarked to the State and School Employees Life and Health Plan. The program was to be operated by the State and School Employees Health Insurance Management Board (HIMB), which oversees the State and School Employees Health Insurance Plan. The commission members left open the possibility that the program could become self-insured if economically feasible. State law directed the powers and duties of the commission, enrollee eligibility determination, and benefit coverages. These directives are codified in MISS. CODE ANN. §41-86-9, §41-86-15, and §41-86-17 (1972).

### CHIP Eligibility Requirements

**Eligibility for CHIP is primarily determined by age and family income.**

In accordance with state and federal laws, the HIMB has set the following eligibility requirements for Mississippi's CHIP:

- family income must not exceed 200% of the federal poverty level (FPL);
- must be a Mississippi resident;
- must not be eligible for Medicaid; and,
- must not be an inmate of a public institution or a patient in an institution for mental illnesses.

These eligibility requirements have been submitted to and approved by the Centers for Medicare and Medicaid Services (CMS). Eligibility is further determined by age and income levels (also referred to as *maintenance of effort* levels), shown in the following chart:



<b>Ages of Children Eligible for Coverage</b>	<b>Annual Family Income</b>
Birth to 12 months	185% to 200% FPL
Ages 1 - 5	133% to 200% FPL
Ages 6 - 18	100% to 200% FPL

A child is eligible for Medicaid up to the lower income limits for each age category. These levels prevent placement of Medicaid-eligible children in the CHIP program in order to receive the enhanced federal match rate for CHIP.

The federal poverty level (FPL) is updated periodically in the *Federal Register* by the U. S. Department of Health and Human Services. For Federal Fiscal Year 2010, the federal poverty level for a family of one is \$10,830 and \$14,570 for a family of two. Each additional individual in a family increases the amount by \$3,740.

Presently, there are approximately 65,000 children enrolled in Mississippi's CHIP. Most current estimates are that CHIP has reached a significant number of the state's eligible children. State law provides that the Division of Medicaid may limit enrollment in the program should funding shortfalls occur.

## **Administration of Mississippi's CHIP**

**Responsibility for administration of Mississippi's CHIP is divided between the Division of Medicaid and the State and School Employees Health Insurance Management Board, with administrative support provided by the Department of Finance and Administration's Office of Insurance.**

Acting in accordance with MISS. CODE ANN. § 41-86-11 (1972), the HIMB, acting administratively through the Department of Finance and Administration's Office of Insurance, entered into an interagency agreement with the Division of Medicaid in December 2000. The agreement authorized the board to "promulgate rules and regulations governing the operations of the insurance plan, including, but not limited to, defining the scope of coverages provided by insurance plan, seeking proposals for services or insurance, and developing and adopting strategic plans and budgets for the insurance plan." Whereas the Office of Insurance actually administers the State and School

Employees Life and Health Plan, for the state's CHIP, the office's responsibility consists chiefly of purchasing the insurance product for the program.

The interagency agreement also stated that the Division of Medicaid shall receive appropriations for CHIP and provide such funds to the board as needed for the administration of the insurance component of the program.

## History of Provider Selection for Mississippi's CHIP, 1999-2009

**Mississippi's initial CHIP insurer was Blue Cross. The board selected the insurer through a competitive process in which two companies submitted proposals.**

As noted on page 6, the CHIP Commission's recommendations gave the HIMB the authority to operate a fully insured program with a single insurer. In 1999, DFA's Office of Insurance prepared and disseminated a request for proposals to procure an insurer for Mississippi's CHIP. DFA received one response and selected Blue Cross to serve as the state's CHIP insurer from January 1, 2000, to December 31, 2004. Prior to the expiration of the initial agreement, DFA's Office of Insurance, on behalf of the HIMB, competitively bid a second agreement for CHIP by issuing a request for proposals in February 2004. Blue Cross, as well as one other company, submitted proposals in response to the RFP; however, the other company failed to meet the minimum vendor requirements.

The board retained Blue Cross as the state's CHIP insurer for the period of January 1, 2005, to December 31, 2008. The State and School Employees Health Insurance Management Board exercised an option to extend the agreement one year to December 31, 2009. (Because the board was procuring insurance coverage for CHIP, it was not required to seek approval through the Personal Service Contract Review Board for such coverage.)

**Mississippi's current CHIP insurer is UnitedHealthcare by AmeriChoice. The board selected the insurer through a competitive process in which three companies submitted proposals.**

As stated previously, Mississippi's previous five-year policy with Blue Cross to provide health insurance coverage to children covered under the Mississippi CHIP was set to expire on December 31, 2009.

In developing a request for proposals for CHIP insurance coverage, the Office of Insurance staff reviewed previously issued CHIP and non-CHIP RFPs, reviewed applicable state and federal laws and regulations, reviewed rules and regulations of the Centers for Medicare and Medicaid Services, reviewed the current CHIP insurance policy and

CHIP State Plan, consulted with Division of Medicaid staff, and conferred with the board's consultant, PricewaterhouseCoopers. The development of the 2009 RFP began on October 14, 2008, with a meeting between Office of Insurance staff and staff of the board's consultant and concluded on February 18, 2009, with the issuance of the board's request for proposals.

The term of the new health insurance agreement was to be for four years (January 1, 2010, to December 31, 2013), with an option to renew for one additional year at the Health Insurance Management Board's discretion. As part of the RFP, the board asked proposers to provide proposals on a *fully insured* (i. e., the purchase of an insurance product with the insurance company bearing financial risks of the plan) or *self-insured* (i. e., contracting with a third-party administrator with the state bearing financial risks of the plan) basis.

In response to the RFP, the board received proposals from Blue Cross Blue Shield of Mississippi, UnitedHealthcare by AmeriChoice, and AmeriHealth Mercy. After evaluating the proposals, the board voted on June 24, 2009, to enter into negotiations with United and finalized an agreement with the company in late 2009.

---

# Requirements for Procuring Health Insurance Coverage for Mississippi's CHIP

This chapter addresses legal requirements for procuring CHIP insurance, requirements of the Personal Service Contract Review Board for competitive procurement, best practices for competitive procurement, and requirements of the 2009 request for proposals for CHIP insurance.

## Legal Requirements for Procuring CHIP Insurance

**Other than the provisions of the interagency agreement between the Division of Medicaid and the board, there were no specific statutory requirements to guide the board in procuring insurance for Mississippi's CHIP.**

As stated on page 6, the Mississippi Children's Health Insurance Program Commission, established in MISS. CODE ANN. Section 41-86-9, designated the State and School Employees Health Insurance Management Board as the entity to administer Mississippi's CHIP. According to the December 2000 interagency agreement between the Division of Medicaid and the board, the agreement charged the board with designing "the program as a fully insured single insurer state program" and executing a contract or contracts to "to provide the health care coverage and services under the program, with said contract awarded to the vendor who submits the best and most cost-effective bid."

The agreement further directed the board to prepare and issue requests for proposals for health insurance coverage for CHIP-eligible children. (See page 6 for CHIP eligibility requirements.) The board was also required to define the minimum level of benefits to be provided by the contractor and to evaluate the bids based on the contractor's ability to provide all services required and meet all access, quality, and contractual standards at the lowest price.

While state law establishes procedures for the procurement of commodities, personal services, and public construction, no statutory provisions govern the procurement of insurance coverage such as that provided to CHIP-eligible recipients. Therefore, other than the provisions of the interagency agreement between the Division of Medicaid and the board, there were no specific statutory requirements to guide the board in procuring insurance for Mississippi's CHIP.

## Personal Service Contract Review Board Requirements for Competitive Procurement

Regulations of the PSCRB allow the use of competitive sealed proposals for procurement of contracts, rather than sealed bids, in certain situations. In 2009, the Office of Insurance's managers determined that procuring CHIP insurance coverage through competitive sealed bidding would not be practicable or advantageous to the state and utilized a competitive sealed proposals process to procure the coverage.

### Authority of the PSCRB

*State law created the Personal Service Contract Review Board to oversee the solicitation and selection of personal and professional services contractual personnel.*

MISS. CODE ANN. § 25-9-120 (1972) empowers the Personal Service Contract Review Board (PSCRB) to promulgate rules and regulations governing the solicitation and selection of personal and professional services contractual personnel. The section also requires the board to approve all personal and professional services contracts involving expenditures of funds in excess of \$100,000.

PSCRB regulations state that, unless otherwise authorized by law, all Mississippi contracts for professional and personal services shall be procured by competitive sealed bidding, competitive sealed proposals, small purchases, sole-source procurement, or emergency procurement.

### PSCRB Requirements for Requests for Proposals for Contracts

*PSCRB regulations specify certain requirements for requests for proposals for procuring personal or professional service contracts.*

PSCRB regulations state that an RFP for personal or professional service contracts should contain at least the following information:

- type of services required;
- description of the work involved;
- estimate of when and for how long the services will be required;
- type of contract to be used;
- date by which proposals for the performance of the services shall be submitted;

- statement that the proposals shall be in writing;
- statement that offerors may designate those portions of the proposals that contain trade secrets or other proprietary data that may remain confidential in accordance with Sections 25-61-9 and 79-23-1 of the MISSISSIPPI CODE;
- statement of the minimum information that the proposal shall contain, to include:
  - the name of the offeror, the location of the offeror's principal place of business and, if different, the place of performance of the proposed contract;
  - the age of the offeror's business and average number of employees over a previous period of time, as specified in the request for proposals;
  - the abilities, qualifications, and experience of all persons who would be assigned to provide the required services;
  - a list of other contracts under which services similar in scope, size, or discipline to the required services were performed or undertaken within a previous period of time, as specified in the request for proposals; and,
  - a plan giving as much detail as is practical explaining how the services will be performed; and,
- factors to be used in the evaluation and selection process and their relative importance.

### **Use of Competitive Sealed Proposals Versus Use of Competitive Sealed Bids**

*PSCR B regulations allow the use of competitive sealed proposals for procuring a contract if the agency head determines that the use of competitive sealed bidding is either not practicable or advantageous to the state.*

PSCR B regulations allow the use of competitive sealed proposals, rather than sealed bids, when the agency head determines that the use of competitive sealed bidding is either not practicable or advantageous to the state. PSCR B regulations state that the key element in determining advantageousness is the need for flexibility. According to the PSCR B, the competitive sealed proposals method of procurement differs from competitive sealed bidding method of procurement in the following ways. Competitive sealed proposals:

- permit discussions with competing offerors and changes in their proposals, including price, and;
- allow comparative judgmental evaluations to be made when selecting among acceptable proposals for award of the contract.

With regard to the difference between competitive sealed proposals and competitive sealed bidding, PRSCRB regulations state the following:

*Under competitive sealed proposals, alterations in the nature of a proposal and in prices may be made after proposals are opened. Such changes are not allowed, however, under competitive sealed bidding (except to the extent allowed in the first phase of a multi-step sealed bidding.) Therefore, unless it is anticipated that a contract can be awarded solely on the basis of information submitted by bidders at the time of opening, competitive sealed bidding is not practicable or advantageous.*

*Another consideration concerns the type of evaluations needed after offers are received. Where evaluation factors involve the relative abilities of offerors to perform, including the degrees of technical or professional experience or expertise, use of competitive sealed proposals is the appropriate procurement method....Further, where the types of services may require the use of comparative judgmental evaluations to evaluate them adequately, use of competitive sealed proposals is the appropriate method.*

Due to the complex and technical nature of services associated with providing coverage to CHIP-eligible recipients, the Office of Insurance's managers determined that procuring CHIP insurance coverage through competitive sealed bidding would not be practicable or advantageous to the state and utilized a competitive sealed proposals process to procure the coverage.

### **Applicability of PSCR B Regulations to Fully Insured and Self-Insured Insurance Coverage**

*Because the board did not know which option it would exercise for selection of a CHIP insurance provider--non-participating (fully) insured or self-insured--the board structured its procurement process based on the PSCR B's competitive sealed proposals requirements.*

As stated in its request for proposals (RFP), the State and School Employees Health Insurance Management Board asked proposers to provide proposals on a non-participating (fully) insured and/or self-insured basis. A non-participating insured basis equates to the purchase of health insurance coverage--i. e., an insurance product--and would not fall within the purview of the PSCRB. However, a self-insured basis would require the board to contract with a third-party administrator--i. e., a service provider--to manage the program and would fall within the purview of the PSCRB. Because at the outset of the selection process the board did not know which option it would exercise--non-participating insured or self-insured--it structured its procurement process based on the PSCRB's competitive sealed proposals requirements. Exhibit 1, page 17, describes the PSCRB's requirements for a competitive sealed proposals process.

## Best Practices for Competitive Procurement

**Because the board's intent was to select the lowest and best proposal for providing insurance coverage for Mississippi's CHIP, it was imperative that the board adhere to accepted competitive procurement principles such as those promulgated by the PSCRB and the American Bar Association.**

Because state agencies are bound by responsibility to expend resources efficiently, effectively, and fairly, in addition to procurement regulations promulgated by control agencies such as the PSCRB, they should adhere to effective contracting processes or a "best practices" model. One such model for procurement is the American Bar Association's *Model Procurement Code for State and Local Governments*.

On February 13, 1979, the House of Delegates of the American Bar Association (ABA) adopted the *Model Procurement Code for State and Local Governments*. The primary purpose of the *Code* was to help create transparent, competitive, and reliable processes by which public funds could be expended through contracts with private sector businesses. Since 1979, many states and local jurisdictions have followed, in full or in part, provisions of the *Code* to govern procurement decisions.

With regard to competitive sealed proposals, the ABA *Model Procurement Code* recommends the following components in the procurement process and that they be followed in this general order:

- developing a request for proposals;
- providing public notice;
- receiving proposals;



- developing evaluation factors;
- holding discussions with responsible offerors and allowing revisions to proposals;
- selecting a vendor for award; and,
- holding debriefings.

(See Exhibit 1, page 17, for definitions of these components.)

With exception of the debriefing component, the PSCRB's regulations for competitive sealed proposals procurement already mirror those of the ABA's *Model Procurement Code*.

Because the board's intent was to select the lowest and best proposal for providing insurance coverage to Mississippi CHIP, it was imperative that the board adhere to accepted competitive procurement principles, such as those promulgated by the PSCRB and the American Bar Association. PEER based its review of the process used by the board in 2009 to procure insurance coverage for Mississippi's CHIP on these principles (in addition to provisions of the RFP).

## Procurement Process Described in the Request for Proposals

**DFA's February 18, 2009, request for proposals for CHIP insurance specified mandatory requirements for proposers and included criteria on which proposals would be judged.**

As stated on page 9, on February 18, 2009, the Office of Insurance issued a request for proposals to procure health insurance coverage for the Mississippi CHIP for the period of January 1, 2010, through December 31, 2013.

Chapter Two of the RFP includes "Proposal Submission and Evaluation Information." Specifically, Section 2.20 described the proposal evaluation criteria and process. Section 2.5 informed potential proposers that "the information contained in your response to this RFP will be used by the Board in determining whether or not you will be selected."

The RFP stated that "a comprehensive, fair and impartial evaluation of proposals received in response to this Request for Proposals will be conducted" in three phases, as described below.

- *Phase One:* Proposals would be reviewed to determine whether they met the mandatory requirements of the RFP (e. g., complying with the proposal submission deadline, meeting minimum vendor requirements, providing answers to narrative questionnaire).

- *Phase Two:* Proposals would be judged relative to the cost and/or technical merits of each proposal in the following areas:
  - experience/qualifications;
  - components of cost (i. e., provider discounts, administrative fees, total premium);
  - member access, provider match, provider network and services;
  - medical management, pharmacy benefit management, vision, dental, nurse triage, and disease management programs;
  - member services; and,
  - organizational stability, administrative and management information systems, administrative staff and procedures, and quality assurance programs.
- *Phase Three:* Finalists would undergo reference checks and be allowed to make presentations, generally consisting of technical “question and answer” interviews, to evaluation committee members. In addition, scoring committee members would conduct on-site reviews to clarify or verify the proposer’s proposal and to develop a comprehensive assessment of the proposal.

Section 16 of the board’s RFP is a 246-item questionnaire. (The 2009 RFP questionnaire was similar in form and content to the one used by the board in its 2004 RFP.) The questionnaire was designed to elicit responses from proposers in various operational areas such as staffing, references, member access, provider network, and cost. With the exception of items designed as “information only,” each item had a weight assigned to it for scoring purposes. To assist scoring committee members in analyzing and scoring each proposer’s proposal, each of the items in the questionnaire was categorized by one of the six areas included within Phase Two of the evaluation process so that proposers could receive total scores for those areas.

---

**Exhibit 1: Components of a Competitive Sealed Proposals Procurement Process, Based on PSCRB Requirements and the ABA Model Procurement Code**

Component	Description
<i>Request for Proposals</i>	Procuring entity solicits proposals through a Request for Proposals (RFP)
<i>Public Notice</i>	Procuring entity provides adequate public notice of the RFP in a newspaper published in the county or municipality in which the agency is located or in electronic format
<i>Receipt of Proposals</i>	Procuring entity opens proposals so as to avoid disclosure of contents to competing offerors during the process of negotiation. Procuring entity prepares a Register of Proposals and makes the register open for public inspection after contract award. The register indicates the names of all vendors submitting proposals.
<i>Evaluation Factors</i>	The procuring entity's RFP states the relative importance of price and other evaluation factors.
<i>Discussion with Responsible Offerors and Revisions to Proposals</i>	The procuring entity may conduct discussions with responsible offerors that submit proposals determined to be reasonably eligible of being selected for award for the purpose of clarification to assure full understanding of, and responsiveness to, the solicitation requirements. The procuring entity shall treat offerors in a fair and equal manner with respect to any opportunity for discussion and revision of proposals. Such revisions may be permitted after submissions and prior to award for the purpose of obtaining best and final offers. In conducting discussions, the procuring entity shall not disclose any information derived from proposals submitted by competing offerors.
<i>Award</i>	Procuring entity shall make the award to the responsible offeror whose proposal is determined in writing to be the most advantageous to the state, taking into consideration price and the evaluation factors set forth in the RFP. The procuring entity shall use no other factors or criteria when evaluating proposals. The procuring entity shall send a written notice of award to the successful bidder. In addition, the procuring entity shall make the notice of award available to the public.
<i>Debriefing*</i>	The entity's procurement officer may provide debriefings that furnish the basis for the source selection decision and contract award.

\* PSCRB regulations do not include this component. However, it is included within the American Bar Association's recommendations for competitive sealed proposals.

SOURCE: PEER analysis of PSCRB regulations and the American Bar Association's *Model Procurement Code for State and Local Governments*.

---

## Chapter 1: Request for Proposals, Public Notice, and Receipt of Proposals

The board complied with PSCRB regulations by developing a formal request for proposals for CHIP insurance coverage, by publicly issuing and advertising the RFP, and by receiving and opening proposals in a manner that maintained the confidential integrity of the proposals.

To determine whether the board complied with relevant PSCRB requirements, PEER sought to answer the following questions:

- Did the board procure CHIP insurance coverage through the use of a formal request for proposals?
- Did the board notify potential proposers about the 2009 CHIP RFP?
- Did the board receive and open proposals in a manner that maintained the confidential integrity of the proposals?

### Did the board procure CHIP insurance coverage through the use of a formal request for proposals?

*The board complied with PSCRB regulations by developing a formal request for proposals to solicit proposals from potential proposers.*

As stated on page 9, on February 18, 2009, the board issued a formal request for proposals for CHIP insurance coverage for the period January 1, 2010, through December 31, 2013. PEER analyzed the board's request for proposals for CHIP insurance coverage in light of the requirements of the PSCRB for personal service contract RFPs (see page 11 of this report) and concluded that the board complied with the PSCRB's requirements in developing the 2009 RFP.

The following were major provisions of the 2009 RFP that differed from the 2004 RFP for the previous CHIP health insurance policy:

- As recommended in PEER's 2008 report (*Mississippi's Children's Health Insurance Program: A Policy Analysis*), the board requested proposals for fully insured and self-insured insurance.

- The 2009 RFP required the per member per month administrative fee to be guaranteed for five years, rather than for three years.
- The 2009 RFP required the primary contractor to have experience covering a group with at least 50,000 covered lives, rather than 25,000 lives as required by the 2004 RFP.
- In anticipation that the contractor would utilize subcontractors and in order to ensure the qualifications, experience, and capabilities of any subcontractors included in a proposer's proposal, the 2009 RFP required any subcontractor of the primary contractor to have experience covering a group with a total population of 300,000 lives (rather than 5,000 covered lives as had been specified in the 2004 RFP).
- The 2009 RFP included a scoring category for the experience and qualifications of proposers. The 2004 RFP did not score proposers based on their experience or qualifications.
- The 2009 RFP allowed proposer access networks to include only executed contracts and letters of commitment with health providers, which the Office of Insurance considered to be the most reliable indicators of provider access.
- The 2009 RFP stated that technical question and answer interviews and on-site reviews would be conducted during Phase Three of the proposal evaluation process. The 2004 RFP had stated that such interviews and reviews would be conducted at the discretion of the board.

### **Did the board notify potential proposers about the 2009 CHIP RFP?**

***The board complied with PSCRB regulations by publicly advertising the RFP for CHIP insurance and by notifying potential proposers about the RFP.***

With regard to notifying potential proposers about an RFP, PSCRB regulations require the procuring entity to mail or otherwise furnish a notice of the RFP to "a sufficient number of bidders for the purpose of securing competition." For procurements in excess of \$100,000, the regulations require the procuring entity to publicize the RFP in a newspaper published in the county or municipality in which the agency is located. In addition, the entity may publicize the RFP in:

- a newspaper of general circulation in the area pertinent to the procurement;
- industry media; or,

- a government publication designed for giving public notice.

The regulations require the advertisement for proposals to appear in a newspaper once each week for two consecutive weeks, with the second notice being published on or after the seventh calendar day after the first notice was published.

The board complied with these regulations by advertising the 2009 request for proposals in the *Clarion-Ledger*, Mississippi's largest newspaper, for three consecutive weeks—i. e., on February 18, 2009; February 25, 2009; and, March 4, 2009. In addition, the board sent e-mails and/or notification letters to thirty-five potential proposers. (DFA's Office of Insurance routinely maintains a list of potential proposers that have submitted proposals to the office in the past or that have requested to be notified of future requests for proposals. The office used this list to notify potential proposers of the CHIP RFP.) The office also posted the RFP on the Mississippi Procurement Technical Assistance Program website.

### **Did the board receive and open proposals in a manner that maintained the confidential integrity of the proposals?**

***The Office of Insurance's staff complied with applicable PSCRB regulations by documenting receipt of proposals from proposers and opening the proposals in the presence of staff.***

With regard to the receipt and registration of proposals, Personal Service Contract Review Board regulations require the following:

*Proposals shall not be opened publicly but shall be opened in the presence of two or more procuring agency officials. Proposals and modifications shall be date-stamped or time/date-stamped upon receipt and held in a secure place until the established due date. After the date established for receipt of proposals, a Register of Proposals shall be prepared which shall include for all proposals the name of each offeror, the number of modifications received, if any, and a description sufficient to identify the service offered. The Register of Proposals shall be open to public inspection only after award of the contract. Proposals and modifications shall be shown only to personnel having a legitimate interest in them.*

As stated on page 15, Office of Insurance staff notified potential proposers of the opportunity to submit a proposal for CHIP insurance coverage. The request for proposals issued by the office required proposers to submit proposals no later than 2 p. m. on March 30, 2009.

The office received proposals from the following proposers prior to the deadline established by the RFP:

- UnitedHealthcare by AmeriChoice (received on March 27, 2009, at 12:05 p. m.);
- AmeriHealth Mercy Health Plan (received on March 30, 2009, at 9:35 a. m.); and,
- Blue Cross Blue Shield of Mississippi (received on March 30, 2009, at 1 p. m.)

Upon receipt of each proposal, the Office of Insurance's staff applied a date stamp on a sheet within the proposal and wrote the actual time of receipt. At 2 p. m. on March 30, 2009, the office's staff formally opened the proposals in the presence of three staff members: the director of Benefits and Participant Services, the Director of Policy Development, and a staff officer.

Office staff prepared a Proposal Receipt Record noting the proposers that submitted proposals, the dates and times of the receipt of the proposals, and the number of proposal copies submitted. While the Proposal Receipt Record lists the names of office staff who witnessed the opening of the proposals, the individuals did not personally sign the record to verify their participation in the event and validate that the opening was handled in a fair and objective manner.

Once the office staff formally opened the proposals, the office's Director of Special Programs, who coordinated the CHIP procurement effort, took possession of and secured the proposals in preparation for the evaluation phase.

---

## Chapter 2: Evaluation of Proposals and Selection of Proposer

The board did not have a disciplined, equitable process of evaluating proposals and selecting a proposer. At critical points during the process, the board:

- lacked evaluative criteria;
- treated some proposers differently from others;
- had no operationally defined standards for point values awarded to proposers; or,
- lacked documentation.

As a result, the board's process was not fully transparent, thus creating the appearance that the board did not make its award decision objectively.

The objective of an evaluation process is to develop and apply criteria that will ensure that proposals are evaluated objectively, fairly, equally, uniformly, and that the procuring entity selects the best proposal from among those received.

Section 2.20 of the board's request for proposal stated "a comprehensive, fair and impartial evaluation of proposals received in response to the Request for Proposals will be conducted." The RFP further stated that proposals would be evaluated in three phases, described on pages 15-16.

This chapter will address the following questions:

- Did the board's request for proposals state the areas on which the evaluation committee would evaluate the proposals?
- How did the board score the six areas comprising Phase Two of the evaluation process?
- Did the board solicit additional information and documentation from proposers after the proposal deadline date?
- Did the board conduct reference checks on the proposers to determine their ability to provide the services described in the RFP?
- Did the board allow proposers to make presentations—i. e., conduct technical question-and-answer interviews?
- Did the board allow proposers to submit "best and final" offers during their presentations and, if so, what effect did such offers have on the proposers' final composite scores?



- Did the board conduct on-site visits with proposers?

### **Did the board's request for proposals state the areas on which the evaluation committee would evaluate the proposals?**

*The request for proposals included evaluation areas on which proposals would be evaluated. However, the RFP did not disclose the weighted importance of the six evaluation areas included within Phase Two.*

As described on page 15, Phase One of the evaluation process included mandatory requirements with which proposals had to comply in order to be considered further. Phase Two involved the independent scoring of the proposals for six specific areas. Phase Three involved reference checks, presentations, and on-site visits. A scoring committee consisting of five senior-level staff within the Office of Insurance, including the State Insurance Administrator, Deputy State Insurance Administrator, Director of Special Programs, Director of Benefits and Participant Services, and Director of Policy and Planning, evaluated the proposals.

At the outset of the evaluation process, the scoring committee evaluated the proposals of Blue Cross, United, and AmeriHealth to determine whether they met the mandatory requirements included within Phase One. The RFP described Phase One as a "pass/fail" evaluation. The scoring committee concluded that all three proposals met the mandatory requirements and should proceed to Phase Two of the evaluation process.

The committee evaluated the proposals using weighted evaluation factors, or areas, that were stated in the RFP. As stated on page 12, PSCRB regulations require that a request for proposals state the relative importance of evaluation factors. The American Bar Association's *Model Procurement Code* elaborates on this requirement by stating:

*A statement in the RFP of the specific weighting to be used by the jurisdiction for each factor and subfactor, while not required, is recommended so that all offerors will have sufficient guidance to prepare their proposals.*

As described on page 16, Phase Two consisted of six areas on which the scoring committee would judge each proposal. The RFP stated that the six areas were "listed in order of their relative importance." Without any additional information, it would be reasonable for an insurance

company interested in responding to the RFP to conclude that the first area listed was more important than the second area, etc. However, the board’s weighted value of the six areas did not follow such sequence, as illustrated in Exhibit 2, below.

---

**Exhibit 2: Weighted Scoring for Evaluation Areas in Phase Two of the 2009 CHIP Proposal Evaluation Process**

2009 RFP Category	2009 RFP Weighted Score
Experience/Qualifications	25%
Cost	25%
Member Access, Provider Match, Provider Network, and Provider Services	25%
Medical Management, Pharmacy Benefit Management, Vision, Dental, Nurse Triage, and Disease Management Programs	15%
Organizational Stability, Administrative and Management Information Systems, Administrative Staff and Procedures, and Quality Assurance Programs	5%
Member Services	5%

SOURCE: PEER analysis.

---

As shown in Exhibit 2, the first three evaluation areas were weighted equally at 25%, with the remaining three areas being weighted at lesser amounts. The statement in the RFP that the six areas were listed in the order of their relative importance could have led to a company’s incorrect assumption that a more fully developed response to the first evaluation area would have generated a greater point value than a fully developed response to the second area.

The American Bar Association’s *Model Procurement Code* states that a fair competition requires an understanding on the part of all proposers of the basis upon which an award will be made. In addition, the *Code* states that a “statement of the basis for award is also essential to assure that the proposals will be as responsive as possible so that the jurisdiction can obtain the optimum benefits of the competitive solicitation.”

## How did the board score the six areas comprising Phase Two of the evaluation process?

*On behalf of the board, a five-member committee scored the proposals using weighted scoring for items included within Phase Two of the evaluation process. However, committee members did not consistently adhere to the scoring methodology. Representatives of the board's consulting firm adhered to an established methodology when scoring the cost portion of each proposal.*

As described on page 16, Phase Two of the board's proposal evaluation process involved the scoring of six specific areas. In concert with the board's consulting firm, scoring committee members determined scoring weights for each of the areas. The members determined the weights based on their collective experience and expertise with the services being requested, reviews of previous RFPs used by the board to procure CHIP insurance, and reviews of previous RFPs issued by the Office of Insurance for similar services.

Subsequent to the proposal deadline on March 30, the five members of the scoring committee began reviewing and scoring each proposal. The board's consulting firm was responsible for scoring the "cost" area independent of the scoring committee (see page 28).

*The scoring criteria on the master scoring grid contained terms of measurement in the RFP questionnaire that were not operationally defined.*

Subsequent to issuance of the board's request for proposals, but prior to the March 30 deadline for receipt of proposals, Office of Insurance staff worked with the board's consulting firm to develop a master scoring grid to be used by scoring committee members to score each proposal. The development of the scoring grid was an iterative process, with several versions of the scoring grid being produced.

The final product of this effort was a master scoring grid that included for all items in the questionnaire (that were not "information only") a scoring methodology with a criterion for judging each response and a point value. Although the master scoring grid noted that the maximum point value available for any item was ten points, items on the scoring grid had point values assigned to them (usually zero or ten or specific values between zero and ten). In some cases, the criteria contained terms of measurement that the scorer was to use to determine how many points to assign.

The criteria for judging responses for at least twenty-nine items on the scoring grid contained terms that were not operationally defined, such as “complete information,” “partial information,” or “clearly defined,” leaving such definitions to the interpretation of committee members (i.e., specifically, how would an answer with “partial information” differ from one containing “complete information”?).

The following is an example of one of these RFP questions to proposers that had a criterion including a term of measurement that was not operationally defined. This is how the RFP question appeared on the scoring grid to the scoring committee:

Scoring Category	RFP Question #	RFP Question	Input Score	Maximum Score	Scoring Methodology	Question's Relative Category Weighting	Points
XI	119	Describe your proposed procedures to assist Members in receiving recommended immunization, per Section 8.11 of this RFP		10	Procedure to identify non-compliance and method to contact parents/guardians, or physician/practitioner to arrange for an appointment to receive the required immunizations, fully explained=10 pts. If no procedure and/or no method=0 points.	2%	

The scorer would complete the “Input Score” column and a computer program would compute the value for the “Points” column based on the input score multiplied by the question’s relative category weighting.

The “Scoring Methodology” for RFP question 119 recommended that scorers award ten points to proposers that “fully explained” the procedure in the “RFP Question” column and zero points if a proposer did not have that procedure or method. Because each scoring committee member’s interpretation of the term of measurement “fully explained” varied, committee members’ scores for question 119 ranged significantly for one proposer—scores of five, six, and eight—with none of the committee members awarding that item’s recommended values of ten or zero.

Scoring criteria are the standards and measures used to determine how satisfactorily a proposal has addressed the requirements identified in the RFP. For scoring criteria to be effective, they must have operational definitions for the values assigned-i. e., taking something that is subjective

and making it as objective as possible, making it measurable or quantifiable. Without operational definitions, scores may vary significantly based on each scorer's subjective judgment and interpretation of submitted information.

*When evaluating each proposal, scoring committee members did not consistently adhere to scoring criteria point values included on the score grid.*

The board's master scoring grid incorporated criterion-referenced scoring as the technique to be used by scoring committee members to evaluate proposals. In procurement decisions, such scoring allows a scorer to compare responses in a proposal with that of pre-determined standards.

As stated on page 16, the RFP questionnaire included criteria for all items that were not "information only." PEER noted that criteria for some of the items were stated in "presence/absence" terms with point values for those items typically being ten or zero--i. e., proposers whose response met the required standard were to receive the maximum point value (ten) versus proposers whose response did not meet the required standard (were to receive zero points). For other items, the RFP questionnaire contained criteria that included a range of point values for specific sub-criteria.

Rather than requiring scoring committee members to adhere to the criteria and point values included within the RFP questionnaire, the board allowed each scoring committee member to determine a point value based on that person's evaluation and interpretation of a proposer's response and any supporting documentation. PEER identified instances in which scoring committee members awarded point values that were not consistent with criteria in the scoring grid, as illustrated in the following examples.

- Item 35 required proposers to provide employee turnover rates for two years. The criteria stated that a proposer should receive ten points if the rates for both years were less than 15%, five points if the rates were between 16% and 20%, and zero points if the rates were greater than 20%. For one proposer's response to Item 35, two scoring committee members awarded zero points, while the remaining three members awarded one point each for the proposer's response. Given that the response could be quantified, the only points awarded for this item should have been either ten, five, or zero.

- Item 49 asked the number of times and the percentage of time that the proposer’s computer hardware has been “down.” The criterion stated that a proposer should receive ten points if the “down” time was less than three days in six months; five points for less than six days; two points for less than twenty-one days; and, zero points if more than twenty-one days. For one proposer’s response to Item 49, four scoring committee members awarded ten points, while the remaining member awarded an eight, a point value not included within the criterion.
- Item 180 asked whether the state would have the option to decline certain programs under a fully insured plan. The scoring grid recommended that ten points be awarded for a “yes” response and zero points for a “no” response. For one proposer’s response to item 180, none of the five scoring committee members awarded ten or zero points, but awarded points that were different and varied significantly among the members—e. g., five, seven, and nine.

The staff assert that variability among scorers is not uncommon but is expected. To deal with such variability, Office of Insurance staff conducted an analysis of individual scores to identify significant variances among the scorers. Scoring committee members met on May 11, 2009, to discuss scoring and review any member questions or variances. Based on these discussions, scoring committee members either revised their initial scores or chose to let those scores stand as entered.

Given the amount of evaluative and scoring judgment afforded to scoring committee members, it was imperative that the members’ rationale for awarding points be documented in some form. PEER found no work papers to document scoring decisions made by individual scorers or the group discussion of scores conducted on May 11. Office of Insurance staff state that individual notes by scoring committee members were neither required nor encouraged and that any paper documents created by a member during the scoring process were purged.

*In adherence to its established cost methodology, the board’s consulting firm scored each proposal’s cost component.*

As stated on page 4, the Office of Insurance designated five senior staff to function as a committee to score CHIP proposals received from Blue Cross, United, and AmeriHealth. Scoring committee members were responsible for reviewing and scoring each proposer’s responses to all items in the RFP questionnaire, except those relating to cost. As part of its general contract with

the board, the board's consulting firm, PricewaterhouseCoopers (PwC), analyzed the cost components of each company's proposal.

On March 13, 2009, prior to the board's March 30 deadline for receipt of proposals, PwC staff finalized a methodology for scoring the cost component of each proposal. PwC staff consulted with Office of Insurance staff in developing its cost methodology. The basis for the cost methodology was twenty-nine items in the RFP's questionnaire. Twenty-four of those items elicited specific cost information from proposers while five of the items were for information only.

As previously stated, proposers had the option to submit proposals for fully- or self-insured coverage. The scoring analysis and points differed for the two types of coverage due to the level of risk to be assumed by the board and the costs of administrative services that would have been covered under self-insured options that would not be required for fully insured options. Exhibit 3, page 30, details the scoring points for the cost analysis. PwC staff conducted a cost analysis for each proposal and submitted the scores to Office of Insurance staff, which they entered into the cost category on each proposer's composite score sheet.

To determine whether PwC staff complied with the scoring methodology finalized on March 13, 2009, when evaluating the three proposals, PEER obtained supporting documentation of the cost analysis from the consulting firm. While the supporting documentation contains proprietary cost information protected by court order for each proposer and cannot be reproduced in this report, PEER concluded that the board's consulting firm adhered to its established methodology when analyzing the cost component of each proposal.

---

### Exhibit 3: Scoring Points for Cost Analysis of CHIP Proposals

Proposers had the option of submitting proposals for fully insured or self-insured coverage. Scoring for the two options differed due to the level of risk assumed by the board.

<u>Points</u>	<u>Fully Insured Option</u>
55	<p>The first 55 points were based on the CY 2010 guaranteed per member per month (PMPM) cost for benefits and administrative costs.</p> <p>The proposer with the lowest projected cost received the full 55 points. Points for other proposers were determined by multiplying 55 by the ratio of the proposer with the lowest PMPM cost to the proposer's PMPM cost.</p>
40	<p>The next 40 points were based on the sum of the estimated 2011 net paid claims PMPM for each proposer and the four-year average guaranteed rates for administrative expenses for 2011 through 2014.</p> <p>The proposer with the lowest projected cost received the full 40 points. Points for other proposers were determined by multiplying 40 by the ratio of the proposer with the lowest PMPM cost to the proposer's PMPM cost.</p>
5	<p>The remaining 5 points were based on the scoring for five specific items contained in the RFP's questionnaire.</p> <p>Proposers that received the maximum score of 50 for those questions received the full 5 points. Points for other proposers were determined by multiplying 5 by the proposer's score for those items divided by 50.</p>

---

<u>Points</u>	<u>Self Insured Option</u>
95	<p>The first 95 points were based on the sum of projected 2010 net paid claims and the five-year average guaranteed administrative expense for each proposer.</p> <p>The proposer with the lowest projected cost received the full 95 points. Points for other proposers were determined by multiplying 95 by the ratio of lowest PMPM cost to the proposer's PMPM cost.</p>
5	<p>The remaining 5 points were based on the scoring for five specific items contained in the RFP's questionnaire.</p> <p>Proposers that received the maximum score of 30 for those items received the full 5 points. Points for other proposers were determined by multiplying 5 by the proposer's score for those items divided by 30.</p>

SOURCE: PEER analysis of cost methodology developed by PricewaterhouseCoopers.



**Did the board solicit additional information and documentation from proposers after the proposal deadline date?**

*The board solicited additional information and documentation from proposers after the March 30 deadline for receiving proposals. The board's requests included one to United regarding its additional network affiliations; however, the board did not request such from the other two proposers. United's additional information ultimately resulted in a change in that proposer's score.*

*On four occasions after the March 30 deadline, the board contacted all three proposers and requested clarifying information regarding their proposals.*

In a competitive sealed proposals procurement, PSCRB regulations allow procuring entities to conduct discussions with proposers. According to the regulations, one purpose of such discussions is "to promote an understanding" between the state's requirements contained in the RFP and services being offered by a proposer. Another purpose of such discussions is to determine in greater detail a proposer's qualifications to provide the services being requested. The eventual goal of discussions with proposers is to craft a contract that is most advantageous to the state, taking into consideration price and other evaluation factors listed in the RFP.

Subsequent to the March 30 deadline for proposers to submit proposals, the five-member scoring committee began evaluating the proposals received from Blue Cross, United, and AmeriHealth. As part of the evaluation process, committee members determined that they needed additional clarifying information from all three proposers. On April 6, April 7, April 29, and April 30, the Office of Insurance's Special Projects Officer corresponded with the three proposers, requesting specific clarifying information from each proposer. The letters provided brief periods in which the companies could respond to the follow-up requests. Scoring committee members utilized the additional information as they scored each proposer's proposal.

Even though the American Bar Association's *Model Procurement Code* states that "there must be a cut-off for the submission of revised proposals and final offers," the Office of Insurance's staff describe their evaluation process as a "moving target," with the office allowing proposers to submit additional information and documentation while scoring committee members are evaluating proposals. The Office of Insurance's staff state that a final-cut off for submission of such information

would probably occur after scoring committee members conducted an on-site visit at a company's location.

*During the on-site visit to United, the board's consultant requested that the company re-submit answers to questions in its proposal regarding access. The company did so and United's score for the member access area subsequently changed.*

Prior to its on-site visit by the scoring committee on June 8 and 9, United had received a score of 77.29 from the scoring committee for the "member access, provider match, provider network and services" area in Phase Two of the evaluation process. During the on-site visit with United, a representative of the board's consulting firm, PricewaterhouseCoopers, asked the company to re-submit answers to questions in its proposal regarding access. Since submitting its proposal, the company had acquired the University of Mississippi Medical Center as part of its health provider network. As requested, United resubmitted the information, the scoring committee rescored those questions in the company's proposal and the company's member access score changed from 77.29 to 77.87, an increase of .58 points.

While such a change may appear insignificant, one must consider that the composite scores of Blue Cross and United at the conclusion of Phase Two were 83.17 and 83.14, respectively. Once the scoring committee rescored United's access information and factored in the company's "best and final offer," the Phase Two scores were 83.32 for Blue Cross and 83.99 for United.

### **Did the board conduct reference checks on the proposers to determine their ability to provide the services described in the RFP?**

*The board conducted telephone reference checks on the three proposers and concluded that they could perform as required in the RFP. However, the board did not define what information about a proposer's previous performance would have eliminated that company from further consideration. Also, the board could not provide documentation that it utilized information available from the Mississippi Department of Insurance for evaluating each proposer's previous performance.*

*The board did not define what information about a proposer's previous performance (as obtained through a reference check) would eliminate that company from further consideration.*

Questions 32, 33, and 34 of the questionnaire included within the 2009 request for proposals required proposers to provide the following information for three of the proposer's current largest group clients and three of the proposer's three current largest group clients located within the State of Mississippi:

- client name and address;
- name, title, telephone number, e-mail address, and facsimile number of a key contact;
- number of covered lives and services provided to client; and,
- duration of relationship with the organization.

Each of the proposers submitted the required number of client references. While Blue Cross and United provided the names of clients within Mississippi, AmeriChoice stated that it did not presently have any clients within the state.

Section 2.20.3 of the 2009 CHIP RFP stated that client “references will be contacted and service provision verified.” To accomplish this task, the Office of Insurance’s staff utilized a reference check worksheet consisting of nineteen questions covering various operational areas. The worksheet allowed references to provide answers ranging from “very satisfied” to “very dissatisfied.” For two of the proposers, United and AmeriHealth, Office of Insurance staff contacted at least six references for each company. For Blue Cross, the staff received information from only four references, with one of those being the State Insurance Administrator. Office of Insurance staff stated that despite multiple attempts, they were unable to obtain information from two other Blue Cross references, both of which were businesses located in Mississippi. Scoring committee members did not eliminate from further consideration any of the three proposers due to information received during the reference check process.

The composite scoring sheet for the evaluation phase stated that proposers would be scored on a “pass/fail” basis for reference checks. The sheet also stated “if significant problems are discovered during a vendor’s reference verification, the vendor may be eliminated from consideration.” PEER found nothing in the RFP or the Office of Insurance’s documentation that explained what information would constitute “significant problems” and possibly eliminate a proposer from further consideration.

*Although the Mississippi Department of Insurance has access to a national database that denotes whether insurance companies have had regulatory sanctions levied against them, the Office of Insurance’s staff could not provide documentation showing whether they considered this information in evaluating each proposer’s previous performance.*

According to staff of the Office of Insurance, they contacted staff of the Mississippi Department of Insurance, specifically the director of the department’s Consumer Services Division, to obtain information

regarding the three proposers. The staff made the contacts to determine whether each proposer was licensed in Mississippi and whether there were any compliance issues associated with the proposers. Other than testimonial evidence, the Office of Insurance's staff could not provide PEER with any documentary evidence of the contacts or illustrate how such information was factored into the evaluation of each proposer's proposal.

The Mississippi Department of Insurance has access to a database maintained by the National Association of Insurance Commissioners (NAIC) that includes documentation of any regulatory sanctions against insurance companies. The Office of Insurance's staff did not provide PEER with documentation showing whether they utilized information from this database in evaluating each proposer's ability to provide the requested services.

As part of this project, PEER contacted staff of the Mississippi Department of Insurance to determine information contained in the database relative to the three proposers. At the time of PEER's fieldwork on this project, the NAIC database did not contain any regulatory sanctions for Blue Cross. The database contained one sanction for AmeriHealth. However, the database included ninety-four regulatory sanctions against United, with the oldest occurring in 1996 and the most recent due to a multi-state settlement with the company. (In 2007, United entered into a \$20 million settlement agreement with thirty-seven states over alleged claims mishandling. According to the Department of Insurance's staff, the company's claims and market conduct activity are being monitored as a result of the settlement and the company has met or exceeded the benchmark for claims accuracy and timeliness.) The Office of Insurance's staff contend that most large insurance companies in the United States would probably have sanctions levied against them at some point.

In the absence of objective information, such as actions taken by regulatory bodies after investigations and reviews, the Office of Insurance is basing its judgment of a company's ability to perform on a satisfaction survey.

**Did the board allow proposers to make presentations-i. e., conduct technical question-and-answer interviews?**

*As stated in the RFP, the board allowed the proposers to make presentations to the evaluation committee. However, the board did not establish criteria by which the evaluation committee could award points to proposers for their presentations. Also, the board awarded an additional*

***point to United based on new information provided in that company's presentation, after the scoring had been completed during the evaluative phase of the selection process.***

Section 2.20.3 of the 2009 RFP stated that those proposers selected as finalists after the Phase Two evaluation concluded would be allowed to make presentations to the evaluation committee and representatives of the board's consulting firm. (All three proposers were ultimately selected as finalists at the conclusion of Phase Two.) The RFP said that the presentations would consist of technical "question and answer" interviews to allow finalists to "showcase their service area." The RFP also said that the presentations would allow those in attendance to verify information provided in each proposal.

On May 12, 2009, the Office of Insurance's Special Projects Officer communicated in writing with all three proposers notifying them that presentations would be conducted on May 22, 2009. The letter included a two-hour allotment for each proposer's presentation and requested that each proposer's presentation cover the following areas:

- member access, provider network and services;
- medical management;
- pharmacy benefit management;
- disease management; and,
- member services.

The board's composite score sheet for the RFP evaluation process states that proposers could receive a plus or minus ten points for the presentation. To assist the evaluation committee and a representative of PricewaterhouseCoopers in evaluating the presentations, the Office of Insurance's staff compiled a "fill-in-the-blank" worksheet that included points of inquiry for each of the five areas listed above. The worksheet also included specific questions for each of the proposers. At the conclusion of the presentations, evaluation committee members awarded one point to United and no points to Blue Cross or AmeriHealth.

*The board did not require evaluation committee members or its consultants to maintain a formal record of the scoring of proposers' presentations or the work papers to support the overall summary of scores.*

Although the Office of Insurance's staff compiled a worksheet that appeared to give analytical structure to those responsible for evaluating and scoring the presentations, the board did not require the evaluation committee members or its consultants to use the worksheets to record their observations and concerns. Because the board did not require the use of the

worksheet, there is no evaluative record regarding each proposer's presentation. The only written record of each presentation is a one-sheet summary compiled by the Office of Insurance's Special Projects Officer. Because the summary report is based on group discussions, PEER found no work papers with which to determine the accuracy or completeness of the summary report.

*The board did not establish criteria by which the evaluation committee could award points to proposers for their presentations (i. e., did not correlate a specified number of points with specified performance elements).*

As stated on page 35, each proposer could receive plus or minus ten points during the presentation phase of the evaluation process. Although the board established a point value for the presentation phase, it did not establish criteria for awarding points for the presentation.

Office of Insurance staff stated that the evaluation committee used a consensus basis and "professional discretion" to score the presentations. While consensus scoring is an acceptable method for evaluators to use, such scoring can only be done in an objective manner when there is a specification or criterion against which group members measure performance or capabilities, with documentation as to how a measured item exceeds or does not meet specifications. In this case, evaluation committee members relied exclusively on their own subjective judgment regarding each proposer's presentation to determine whether each proposer should receive points.

*The board awarded an additional point to United based on new information provided in that company's "best and final offer" presentation. This point was awarded after the scoring had been completed during the evaluative phase of the selection process (i. e., Phase Two).*

As noted on page 35, the board's composite score sheet for the RFP evaluation process stated that proposers could receive a plus or minus ten points for the presentation. While all proposers were told in letters inviting them to make a presentation that they could tender a "best and final" offer, nothing in the letter indicated that their offering of or lack of offering a "best and final" offer would impact their ability to receive points for their presentation.

After scoring of the proposals in Phase Two of the evaluation process and subsequent to the best and final offers/presentations, the board awarded United an additional point. AmeriHealth did not receive any points because the company's "best and final" offer did not offer any pricing concessions or extend any guarantees. United

received one point because the company's "best and final" offer included a premium price guarantee of two additional years beyond the required one-year guarantee. (See page 38.) Blue Cross did not make a "best and final" offer, even though this was not required by the RFP (see page 38).

The evaluation committee did not treat all three proposers equitably when it awarded a point to United for its presentation. As stated on page 39, the "value" of United's "best and final" offer was computed and included within the cost score received by the company. Given that the valuation of the offer was reflected in Phase Two scoring, United apparently received a point for its presentation simply for making a "best and final" offer. Using such logic, the evaluation committee should have also awarded a point to AmeriHealth since it also made a "best and final" offer prior to its presentation. However, the committee did not award the company any points for its presentation.

**Did the board allow proposers to submit "best and final" offers during their presentations and, if so, what effect did such offers have on the proposers' final composite scores?**

*As allowed by the board, two proposers submitted "best and final" offers at the time of their presentations before the evaluation committee. However, the board had no uniform evaluation process for these "best and final" offers.*

PSCRB regulations for competitive proposals allow procuring entities to provide proposers with an opportunity to submit "best and final offers." The regulations require the procuring entity to establish a date and time for the submission of such offers. (PEER research determined that the submission of "best and final offers" is a common component in other states' procurement regulations.)

The Office of Insurance's staff state that a "best and final offer" option is frequently included during the finalist stages of RFPs handled by the office. The office's RFP does not include any discussion of a "best and final offer" because proposers are encouraged and expected to provide their best offers at the time of their original proposal submission.

As stated on page 35, the Office of Insurance's Special Projects Officer notified representatives of Blue Cross, United, and AmeriHealth of their timeslots for making presentations to the selection committee on May 22. The letters included a notification that each company could

make a “best and final offer” concerning its rates for CHIP insurance prior to the beginning of each presentation. Because Blue Cross and United were proposing a fully insured product, the letters to those companies further requested that each company note if it would “guarantee a not to exceed percentage increase from your 2010 premium for 2011 and 2012.” (The RFP required proposers to guarantee their premiums for 2010.)

Prior to each presentation, evaluation committee members received the following “best and final offers”:

- AmeriHealth submitted a “best and final offer” stating that the company had improved inpatient and outpatient rates for four hospitals in its network and had contracted with additional providers for its network.
- United submitted a “best and final offer” guaranteeing a rate increase not to exceed 4% for 2011 and a rate increase not to exceed 5% for 2012.

Blue Cross did not submit a “best and final offer.” PEER notes that this was not required by the RFP.

*Although United’s proposal was re-scored after the “best and final offer” and its composite score increased, the board did not formally re-score AmeriHealth’s “best and final offer.”*

Because United’s “best and final offer” affected the company’s price proposal, staff of PricewaterhouseCoopers recomputed the cost component of the company’s proposal. Prior to the “best and final offer,” United had received 95.9 points for its cost proposal. After the “best and final offer,” United received 98.7 points for its cost proposal, an increase of 2.8 points in the score previously awarded for the company’s cost proposal.

Evaluation committee members did not change the composite score of AmeriHealth because the company’s “best and final offer” did not offer any pricing concessions or extend any guarantees. Office of Insurance staff state that staff of the board’s consulting firm, PricewaterhouseCoopers, performed a cursory review of AmeriHealth’s “best and final offer” and concluded that the offer would not have a material impact on the company’s composite score. AmeriHealth’s cost score remained at 91.20 after submission of its “best and final offer.”



*Because United received additional points both for making a “best and final offer” prior to its presentation and for the cost proposal that it presented during that time, United received extra credit. This was an opportunity that was not described in the RFP.*

As stated on page 38, the board’s consulting firm recomputed the score awarded to United’s cost proposal as a result of its “best and final offer.” The recomputation increased the cost score by 2.8 points. In addition to receiving an improved cost score, the company also received one point from evaluation committee members for its presentation. The summary report for United’s presentation justified the one point based on the value of the premium cap and United’s willingness to offer a pricing protection.

While the “best and final offer” improved United’s cost proposal and extended a price guarantee to CHIP, the premium cap was “valued” when the board’s consulting firm recomputed the score for the company’s cost proposal. There was no need to award an additional point during the presentation phase of the evaluation process, which resulted in the company receiving extra credit for its “best and final offer.” PEER found nothing in the board’s RFP to indicate that a company could receive additional points for making a “best and final offer,” plus extra points for that same offer.

### **Did the board conduct on-site visits with proposers?**

*The scoring committee conducted on-site visits with United and Blue Cross, but excluded AmeriHealth from such visits, even though the company was considered a finalist at the conclusion of Phase Two and a sufficient number of points were available from the site visit to change the outcome of the award. In addition, without applying any objective criteria, the scoring committee awarded one point to United and deducted four points from Blue Cross.*

Section 2.20.3 of the 2009 RFP stated that those proposers selected as finalists after the Phase Two evaluation concluded would proceed to Phase Three, which included on-site visits. The RFP stated that the purpose of the visit would be to “clarify or verify the proposer’s proposal and to develop a comprehensive assessment of the proposal.” The RFP further stated that during the on-site review each proposer would be required to provide information on a proposed provider network and negotiated discount arrangements, provider contracts, and proposed pharmacy pricing information.

On June 3, 2009, the Office of Insurance’s Special Projects Officer communicated in writing with representatives of United and Blue Cross stating that staff of the Office of

Insurance and the board's consulting firm would conduct on-site visits on June 8 and 9 and June 9 and 11, respectively. The letters stated that areas of interest for the visits would include "claims processing, medical management, customer service, and provider contract reviews." The letters also asked proposers to make available for interviews and discussions the "functional leadership" from each of the key service areas included within the proposal.

The board's composite score sheet for the RFP evaluation process stated that proposers could receive a plus or minus fifteen points for the on-site visit component of the evaluation. To assist in evaluating each on-site visit, staff of the Office of Insurance compiled two sample guides for use during the visits. The guides covered areas such as security, personnel policies, claim control and payment, customer service, quality assurance and audit, medical review, 24/7 nurse line, and case management. At the conclusion of the on-site visits, scoring committee members awarded one point to the composite score of United and deducted four points from the composite score of Blue Cross.

*The scoring committee did not conduct an on-site visit with AmeriHealth, even though the company was considered a finalist at the conclusion of Phase Two of the evaluation and the RFP stated that on-site visits "will be conducted" for all finalists.*

As stated on page 19, the 2004 RFP used to select a CHIP insurer made on-site visits with proposers discretionary on the board's part. However, the 2009 RFP stated "on-site reviews **will be conducted**" [emphasis added] for all proposers deemed to be finalists at the conclusion of Phase Two. Office of Insurance staff stated that the necessity of presentations and/or on-site visits for the 2009 RFP would be at the discretion of the board dependent on the specific evaluation rankings. The staff considered the wording change from the 2004 RFP to be primarily cosmetic in nature.

Despite the explicit statement in the 2009 RFP regarding on-site visits, the board conducted on-site visits with only United and Blue Cross. The board did not conduct an on-site visit with AmeriHealth. Office of Insurance staff state that "a general consensus was reached following the presentations to limit the on-site visits to the two top scoring proposals based on the disparity between the second and third scoring proposals."

The composite scores for the three proposers at the conclusion of the Phase Two evaluation (prior to the submission of "best and final offers") were as follows:

- Blue Cross: 83.17;
- United: 83.14; and,
- AmeriHealth: 77.17.

The “disparity” cited by Office of Insurance staff amounted to six points between the highest and lowest scored proposals. To eliminate a proposer due to a six-point deficit at the end of Phase Two does not take into consideration the possibility that all proposers could have received or had deducted a maximum of fifteen points from their composite scores following on-site visits.

The decision not to conduct an on-site visit with AmeriHealth appears to be a subjective one that was not consistent with the provisions of the board’s RFP. The RFP clearly did not afford the board or Office of Insurance staff the discretion to choose not to conduct on-site visits with all finalists. Also, PEER found no work papers explaining, justifying, or supporting the board’s decision to not conduct on-site visits with all three proposers.

*The board did not require scoring committee members and its consultants to utilize a standardized worksheet to score the proposers’ on-site visits.*

Although the Office of Insurance’s staff compiled two review guides that appeared to give analytical structure to scoring committee members for scoring on-site visits, the board did not require scoring committee members to use the guides. According to Office of Insurance staff, “individual scoring was not performed on site visits. Individual notes by members of the scoring committee were neither required nor encouraged. Any paper documents created by a member that were no longer needed by that member were appropriately purged.”

The only written documentation of each on-site visit consists of site visit notes “compiled from observations of scoring committee and PwC staff,” a summary report in which scoring committee members awarded or deducted points, and a summary of findings compiled by staff of PricewaterhouseCoopers. Because the site visit notes and summary report are based on group discussions, PEER found no work papers with which to determine the accuracy or appropriateness of the scoring committee’s observations of the on-site visits. In addition, neither Office of Insurance staff nor PricewaterhouseCoopers staff provided PEER with work papers supporting the consulting firm’s findings.

*The board's lack of criteria for the on-site visits created, at the least, an appearance that the board had no objective basis for awarding or deducting points.*

As stated on page 40, each proposer could receive plus or minus fifteen points during the on-site phase of the evaluation process. Although the board established a point value for the on-site visit phase, it did not establish criteria for awarding such points. The Office of Insurance's staff acknowledged that scoring committee members were allowed "professional discretion" and there were no formal scoring criteria for evaluating on-site visits.

Other than the areas of interest listed in the June 3 letters to United and Blue Cross scheduling the on-site visits (claims processing, medical management, customer service, and provider contract reviews), the Office of Insurance's staff did not provide the companies with an agenda describing the format and structure of the on-site visits. The Office of Insurance's staff contend that "vendors proposing on projects of this magnitude and complexity are expected to anticipate the information needs of a site visit committee and be prepared to respond appropriately beyond any items detailed in a notification letter."

Subsequent to United's on-site visit, scoring committee members, by consensus, awarded the company one point for demonstrating a comprehensive member orientation and education process. Subsequent to the Blue Cross on-site visit, scoring committee members, by consensus, deducted four points from the company for the following reasons:

- failure to have key staff in attendance;
- lack of prepared materials;
- inability to respond to specific questions; and,
- the system demonstration included non-CHIP items.

According to Office of Insurance staff, these were the explanations for the four-point deductions:

- The deduction for the "failure to have key staff in attendance" occurred because the company's medical director was not in the office on the day of the on-site visit. However, Blue Cross had notified Office of Insurance staff in advance of the on-site visit that the medical director would not be available and wanted to know if his absence would be an "issue." Office of Insurance staff responded that they would "miss" the medical director but

thought “someone else can provide answers to any questions regarding MM [medical management].”

- When asked by PEER what materials had Blue Cross staff not prepared, Office of Insurance staff responded that the company had undergone on-site reviews in the past and knew what to expect and how to prepare.
- Regarding the company’s perceived inability to respond to specific questions, the Office of Insurance’s staff gave one example of program managers who could not provide an accurate answer regarding staffing of the CHIP program.
- With regard to the deduction of a point for the system demonstration including non-CHIP items, the site visit notes compiled by Office of Insurance staff and consulting staff in attendance following the on-site visit do not provide specific information concerning that event.

While one purpose of the on-site visit was to observe and evaluate current systems, processes, and staffing, the scoring committee’s deduction of points from Blue Cross is noteworthy considering that the company had served as the CHIP insurer in Mississippi since the program’s inception (2000) and Office of Insurance staff acknowledged to PEER that they had few concerns with the company’s performance during this period.

The board’s lack of criteria for the on-site visits created, at the least, an appearance that the board had no objective basis for awarding or deducting points. At the conclusion of Phase Two, a phase that involved criteria and independent scoring, the composite scores of United and Blue Cross differed by only .67 points. The final composite scores for both companies eventually differed by 6.67 points due to the scoring committee’s addition and deduction of points from the two companies that appeared to be based on subjective judgment.

---

## Chapter 3: Notification and Debriefing of Proposers

The board complied with PSCRB regulations by notifying all proposers of its award decision. However, the board did not conduct debriefings with proposers that were not selected to provide insurance coverage, as recommended by the *Model Procurement Code*.

To determine whether the board complied with relevant PSCRB requirements and *Model Procurement Code* recommendations, PEER sought to answer the following questions:

- Did the board promptly notify all proposers of its award decision?
- Did the board conduct debriefings with proposers that were not selected to provide CHIP insurance coverage to furnish the basis for its award decision?

### Did the board promptly notify all proposers of its award decision?

***The board complied with PSCRB regulations and provisions of the Model Procurement Code by promptly notifying all proposers of its award decision.***

With regard to publicizing an award decision, PSCRB regulations state that a “written notice of award shall be sent to the successful bidder.” Also, the regulations state that notice of the award shall be made available to the public. The American Bar Association’s *Model Procurement Code for State and Local Governments*, which PEER considers to be a best practices model for procurement, states that “written notice of the award of a contract to the successful offeror shall be promptly given to all offerors.”

As stated previously, the board voted on June 24, 2009, to enter into negotiations with United to serve as the insurer for CHIP. On that same date, the Office of Insurance Special Projects Officer notified the Chief Executive Officer of United that the board had selected the company to enter into negotiations to provide CHIP health insurance coverage. On June 24, the Special Projects Officer also notified representatives of Blue Cross and AmeriHealth, the other two proposers, that the board had decided to begin negotiations with United for CHIP insurance coverage.

**Did the board conduct debriefings with proposers that were not selected to provide CHIP insurance coverage to furnish the basis for its award decision?**

*The board did not conduct debriefings with proposers that were not selected to provide insurance coverage, as is recommended by the Model Procurement Code, even though after the board made its award decision one proposer requested information from the Office of Insurance as to the deficiencies of its proposal.*

**Elements of a Debriefing Recommended in the *Model Procurement Code***

*The Model Procurement Code states that a procuring entity's procurement officer should be authorized to "provide debriefings that furnish the basis for the source selection decision and contract award."*

As stated on page 15, with the exception of a requirement that procuring entities debrief proposers regarding award decisions, Personal Service Contract Review Board regulations mirror the recommendations contained in the American Bar Association's *Model Procurement Code for State and Local Governments*. With regard to debriefings of proposers, the *Model Procurement Code* states that a procuring entity's procurement officer should be authorized to "provide debriefings that furnish the basis for the source selection decision and contract award." The *Code* states that post-award debriefings may include:

- the state's evaluation of significant weaknesses or deficiencies in a proposal, if applicable;
- the overall evaluated cost or price (including unit prices) and technical rating, if applicable, of the successful offeror and the debriefed offeror;
- the overall ranking of all proposals, when any such ranking was developed during the source selection;
- a summary of the rationale for award; and,
- reasonable responses to relevant questions about whether source selection procedures contained in the RFP and applicable law were followed.

The *Code* further states that post-award briefings should not include a point-for-point comparison of proposals received in response to an RFP. In addition, debriefings should not reveal any information that is prohibited by law from being disclosed, such as trade secrets or privileged or confidential commercial information.

By providing the basis for the board's award decision in a debriefing meeting with proposers that were not selected to provide CHIP insurance coverage, Office of Insurance staff could assist those proposers in critiquing their own

proposals and identifying areas of improvement for future proposal submissions.

### **Proposer's Request for a Debriefing**

*Although after the board made its award decision, Blue Cross requested specific information as to the deficiencies of the company's proposal, the board did not formally respond.*

As stated on page 44, the Office of Insurance's Special Projects Officer notified all proposers in writing regarding the board's decision to negotiate with United to become the Mississippi CHIP insurer. On July 10, 2009, the Blue Cross Vice President for Audit and Compliance wrote the Special Projects Officer and noted that the letter had not provided any "reasons, information, detail or explanation as to why our [Blue Cross] proposal did not meet the Mississippi State and School Employees Health Insurance Management Board's ("Board") standards or specifics or as to why the selected entity's proposal, United through AmeriChoice, was more beneficial than ours."

In his letter, the Blue Cross official requested specific information as to the deficiencies of the company's proposal to the board's 2009 CHIP request for proposals. The official suggested a meeting between Blue Cross officials and the Office of Insurance's staff to discuss the requested information. The Office of Insurance's staff did not respond in writing to the July 10 letter nor did they convene a meeting with Blue Cross officials to discuss their concerns. The State Insurance Administrator (i. e., director of the Office of Insurance) stated that she contacted Blue Cross by telephone to discuss the company's July 10 letter. However, the Chief Financial Officer and Vice President for Audit and Compliance contend that neither they nor anyone else at Blue Cross had spoken with the State Insurance Administrator regarding the July 10 letter. (The Blue Cross Chief Financial Officer [CFO] and State Insurance Administrator met in December 2009 to discuss CHIP transition issues. During that meeting, the CFO and State Insurance Administrator briefly discussed the company's proposal and the scoring committee's perception that Blue Cross was unprepared for the committee's on-site visit.)

The Office of Insurance's staff state that their practice is to not discuss an award decision until an agreement has been finally negotiated and signed by the chair of the Health Insurance Management Board. (The staff also noted that AmeriHealth had filed a formal protest to the board's award decision, with a protest hearing being held on August 20, 2009.) While such practice may be reasonable, especially if negotiations with the preferred proposer might prove to be unsuccessful and the board chooses to negotiate with an alternate proposer, nothing would



preclude the Office of Insurance's staff from providing the proposers that were not selected to provide CHIP insurance coverage with summary information as to why the board selected the preferred proposer.

## **Proposer's Public Information Request**

*Blue Cross filed a public information request to obtain specifics on the deficiencies of its proposal because the Office of Insurance never debriefed the company after the board voted to negotiate with United.*

As a result of not receiving a written or verbal response to their July 10 letter, Blue Cross officials, through their attorney, filed a public information request on July 29, 2009, with the Office of Insurance requesting all documents relating to:

- reasons, details, or explanation as to why Blue Cross's proposal did not meet the standards of the Health Insurance Management Board;
- analysis or evaluation of Blue Cross's proposal;
- any perceived deficiencies in Blue Cross's proposal;
- any perceived deficiencies in the May 2009 "question and answer" interview in which Blue Cross participated in the DFA offices as part of Phase Three of the evaluation process;
- all deficiencies noted during the two site visits to Blue Cross by PwC in June 2009; and,
- methods, recommendations, choice of administrator and reasons for making the choice and all related inquiries, as provided in MISS. CODE ANN. Section 25-15-301(1) (b) (1972).

On August 18, 2009, the Office of Insurance's staff responded to the public information request by providing Blue Cross with copies of: (1) the final scoring sheet of all proposals; (2) the final cost analysis compiled by the board's consultant, with each proposer's cost information redacted; and, (3) the summary of the on-site review conducted at Blue Cross offices by staff of the Office of Insurance and the board's consultant. While the Office of Insurance's staff provided the above-referenced information, they did so only in response to a public information request.

MISS. CODE ANN. Section 25-61-1 et seq. (1972) provides public access to public records. MISS. CODE ANN. Section 25-61-5 (1972) states that public bodies must respond to a public information request no later than fourteen days after receipt of the request. While the Office of Insurance provided the requested information to Blue Cross within the fourteen-day response period required by state law, Blue Cross should not have had to resort to a public information request to obtain information about its

proposal. Requiring such actions on the part of the company are not within the spirit of debriefings contemplated in the *Model Procurement Code*.

---

## Chapter 4: The Effect of the Board’s 2009 CHIP Insurance Procurement Process

**PEER found that two of the four complaints about the CHIP procurement process had merit. Also, beyond concerns raised by the complainant, PEER documented weaknesses in the board’s procurement process that the board should address for future procurement efforts. Despite utilizing a process that incorporated some of the components of best practices, the board’s procurement process lacked discipline in some instances and was not fully transparent, thus creating the appearance that the board did not make its award decision objectively.**

As stated on page 2, shortly after the board voted on June 24, 2009, to enter negotiations with United for CHIP insurance for the period of January 1, 2010, to December 31, 2013, PEER received a complaint regarding the process used by the Health Insurance Management Board to procure such coverage. The complainant expressed concerns that the board’s process was unfair and not consistent with provisions of the request for proposals.

While state law is silent as to the method to be used by the board to procure CHIP insurance coverage, the board chose to follow procurement regulations promulgated by the Personal Service Contract Review Board (PSCRB). As noted in this report, the PSCRB regulations mirror procurement recommendations of the American Bar Association’s *Model Procurement Code for State and Local Governments*. In part, these standards—which PEER considers to be “best practices”—are designed to ensure fair and equitable treatment and to provide for public confidence in procurement procedures used by public entities.

As described in this report, the board’s process resulted in the composite scores for the three proposers shown in Exhibit 4, page 50.

After the evaluative phase of the selection process (i. e., Phase Two), which included scores generated from proposers’ “best and final” offers, United was the leading scorer, with a composite score exceeding the scores of Blue Cross and AmeriHealth by .67 and 8.61 points, respectively. During Phase Three, which included reference checks, presentations, and on-site visits, the variance in the final composite scores of United and Blue Cross, the second highest scorer, increased by 6.67 points. Thus United was the high scorer after both Phase Two and Phase Three, although PEER notes in this report that some components of Phase Three reflected the process’s subjectivity (see pages 32 through 43).

---

#### Exhibit 4: Summary of Composite Scores of the Three Proposers for Mississippi's CHIP Insurance, 2009

	Blue Cross	United	AmeriHealth
Phase Two (Before "Best and Final")	83.17	83.14	77.17
Phase Two (After "Best and Final")	83.32 <sup>a</sup>	83.99 <sup>b</sup>	75.38 <sup>c</sup>
Phase Three			
<i>Presentation</i>	0.00	1.00	0.00
<i>On-site visit</i>	(4.00)	1.00	0.00
Final Composite Score	79.32	85.99	75.38

NOTES:

<sup>a</sup>The board's consultant, PricewaterhouseCoopers, scored United's initial cost proposal, which included mandatory generic drugs. The Office of Insurance required United to re-submit its cost proposal to include non-mandatory generic drugs rather than mandatory generic drugs. The Blue Cross cost proposal included only non-mandatory generic drugs. Once PricewaterhouseCoopers scored United's second cost proposal, United's 2010 guaranteed per member per month cost proposal remained less than Blue Cross's per member per month (PMPM) cost proposal. As a result, United received the maximum points for this component of the cost analysis. Because the board's cost methodology required the proposer that submitted the second lowest PMPM proposal to receive a weighted score benchmarked from the lowest cost proposal, Blue Cross's points for this component of the cost analysis changed slightly. While the changes for United and Blue Cross are reflected in the after "best and final" portion of the score sheets, the change in Blue Cross's score is not the result of United's "best and final offer."

<sup>b</sup>United's composite score for Phase Two changed because the company submitted a "best and final offer" that offered rate guarantees for 2011 and 2012. The company's increased score also reflects an enhancement in the company's provider network.

<sup>c</sup>During fieldwork on this project, PEER determined that the Office of Insurance incorrectly used a calculation to analyze AmeriHealth's self-insured proposal that was designed to be applied to fully insured proposals only (those submitted by Blue Cross and United). Office of Insurance staff acknowledged the error and recalculated AmeriHealth's score for the "medical management, pharmacy benefit management, nurse triage and disease management programs" component, which reduced the company's composite score from 77.17 points to 75.38 points.

SOURCE: PEER analysis of records of the Office of Insurance.

---

With regard to the complainant's concerns, summarized on page 2, PEER found the following.

- The on-site visit portion of the evaluation process did not comply with RFP provisions because the scoring committee did not conduct a visit with AmeriHealth, even though the company was a finalist at the conclusion of Phase Two and made a presentation before the evaluation committee.

- The board's consulting firm, PricewaterhouseCoopers, performed its cost analysis of proposals in compliance with the cost methodology developed prior to receipt of proposals.
- As provided in PSCRB regulations for a competitive sealed proposals procurement method, the board received clarifying or additional information from proposers after the March 30 deadline for receipt of proposals. However, the board did not formally analyze and score additional information submitted by AmeriHealth, but specifically requested that United submit additional information, which the board formally analyzed and scored.
- The board's scoring methodology did not appear to favor one proposer over other proposers.

Beyond concerns raised by the complainant, PEER documented weaknesses in the board's procurement process that the board should address for future procurement efforts. Specifically:

- In some instances, the board's process lacked evaluative criteria. For example, the board had no criteria to determine whether a proposer should be considered further after receiving information from a proposer's references.
- The board did not treat all proposers in an equitable manner by scoring information from or conducting on-site visits with all proposers.
- The board did not have operationally defined standards for point values awarded to proposers, primarily points awarded during the presentation and on-site visit phases.
- The board did not take into consideration information from a state regulatory agency that appeared to reflect upon a proposer's ability to provide services to CHIP clients and health care providers.
- Other than summary notes or reports, the board's process did not have documentation that tracked the committee members' rationale and decision making. There is no obvious audit trail of the board's evaluation and selection process.

Therefore, despite utilizing a process that incorporated components of best practices in procurement, the board's process lacked discipline in some instances and was not fully transparent, thus creating the appearance that the board did not make its award decision objectively.

---

## Chapter 5: Recommendations

1. The Legislature should require the State and School Employees Health Insurance Management Board (or any other agency made responsible for Mississippi's CHIP) to procure competitively the insurance coverage for the program using a request for proposals, specific criteria for evaluation, and written rationale for selecting a proposer to provide coverage. MISS. CODE ANN. Section 25-15-301 (1972) imposes a similar requirement on the board for administration of the state health plan.
2. When developing a request for proposals to procure insurance coverage for Mississippi's CHIP, the board should include the weighted values for areas on which the cost and technical merits of a company's proposal will be evaluated. Such values should allow companies to develop proposals that are more responsive to the needs of CHIP.
3. To ensure the integrity of the board's competitive procurement process for CHIP insurance coverage, the board should require the Office of Insurance's staff and its consultants to complete the development of all evaluative tools (e. g., scoring grids, cost methodology) prior to the time the board issues its RFP for such insurance coverage.
4. To document the receipt and opening of proposals, the board should require Office of Insurance staff responsible for such activity to sign their names on the "Register of Proposals."
5. To assist scoring committee members in objectively and accurately scoring a proposal, the board should ensure that recommended responses for items in the RFP questionnaire are stated in operationally defined terms consistent with the services being requested of the proposers. Also, the board should ensure that scoring committee members adhere to point values assigned to criteria for items included within the RFP questionnaire. At the conclusion of the scoring process, the board should require Office of Insurance staff to conduct an inter-rater reliability analysis to identify variances among scorers that should be discussed and evaluated further.

6. If the board chooses to continue using the competitive sealed proposal method of procurement, the board should require the Office of Insurance's staff to establish a firm date by which proposers may submit a "best and final" offer. Such offers should include revisions of cost proposals, if any, and submission of additional information or changes to the proposer's initial proposals. The board should not allow evaluation committee members or its consultants to request or accept information from proposers after the established "cut off" date for "best and final" offers.
7. With regard to reference checks, the board should require the Office of Insurance's staff to consult with the Mississippi Department of Insurance (and document such consultation) to determine whether the department has information that would reflect on a company's ability to provide the requested services. In addition, the board should develop criteria by which reference check information will be judged and factored into the overall evaluation process.
8. The board should review the practice of having evaluation committee members score finalists' presentations and on-site visits to determine whether this practice ensures that all proposers are treated fairly and objectively. If the board chooses to continue the practice, it should:
  - develop an agenda or itinerary to guide committee members through this portion of the evaluation process;
  - require the Office of Insurance's staff to develop criteria by which finalists' presentations and on-site visits will be scored; and,
  - determine an appropriate number of points that may be awarded to finalists for presentations and on-site visits.
9. Unless the RFP explicitly states that presentations and/or on-site visits will be discretionary on the part of the board or the evaluation committee, the board should require that all proposers considered to be finalists in the evaluation process be afforded an opportunity to make a presentation and receive an on-site visit.
10. The board should require the Office of Insurance's staff to conduct debriefings with proposers that

were not selected, upon request, after the board has voted to enter into negotiations with a selected proposer. Such debriefings could provide general information regarding the quality of a proposal that was not selected. At the conclusion of negotiations and after the board has signed an agreement with a company to provide CHIP insurance coverage, the Office of Insurance's staff should be authorized to conduct more comprehensive debriefings with proposers that were not selected, upon request. However, there should be no disclosure of any information derived from proposals submitted by competing proposers.

11. To ensure that the board can justify and support its selection of a particular company to provide CHIP insurance coverage, the board should require the Office of Insurance's staff to maintain appropriate work papers to document major decisions and thought processes associated with the development of the request for proposals, development of evaluative tools, and the scoring of proposals, presentations, and on-site visits.



# Agency Response



STATE OF MISSISSIPPI  
HALEY BARBOUR, GOVERNOR

DEPARTMENT OF FINANCE AND ADMINISTRATION  
KEVIN J. UPCHURCH  
EXECUTIVE DIRECTOR



July 12, 2010

Honorable Nolan Mettetal, Chairman  
Joint Committee on Performance Evaluation and Expenditure Review  
501 North West Street  
Woolfolk Building, Suite 301-A  
Jackson, Mississippi 39201

Dear Chairman Mettetal:

We have reviewed the draft ***A Review of the Process Used by the Health Insurance Management Board in 2009 to Procure Insurance Coverage for Mississippi's Children's Health Insurance Program*** prepared by the Joint Committee for Performance Evaluation and Expenditure Review (PEER) and offer the following response from the Department of Finance and Administration.

The Department of Finance and Administration is appreciative of this PEER review and the opportunity to respond to this report. We also commend the PEER staff for their professionalism and cooperation throughout this process. While the selection of the insurer for the Children's Health Insurance Program was conducted in a fair, objective, and professional manner, we acknowledge and appreciate the recommendations noted in this report. We will carefully review these recommendations to consider how the procurement process may be improved. We recognize our responsibility to the uninsured children of Mississippi, as well as to the taxpayers, and will continue to ensure the lowest and best solution is selected for the Children's Health Insurance Program.

Again, thank you for the opportunity to review and respond to this draft report.

Sincerely,

A handwritten signature in cursive script that reads "Kevin J. Upchurch".

Kevin J. Upchurch

---

## PEER Committee Staff

Max Arinder, Executive Director  
James Barber, Deputy Director  
Ted Booth, General Counsel

### Evaluation

David Pray, Division Manager  
Linda Triplett, Division Manager  
Chad Allen  
Kim Cummins  
Brian Dickerson  
Lonnie Edgar  
Barbara Hamilton  
Matthew Holmes  
Kevin Mayes  
Angela Norwood  
Jennifer Sebren  
Charles Sledge, Jr.  
Corey Wiggins

### Editing and Records

Ava Welborn, Chief Editor/Archivist and Executive Assistant  
Tracy Bobo

### Administration

Mary McNeill, Accounting and Office Manager  
Rosana Slawson  
Gale Taylor

### Information Technology

Larry Landrum, Systems Analyst

### Corrections Audit

Louwill Davis, Corrections Auditor