Iowa Department of Inspections and Appeals
Administrative Hearings Division
Wallace State Office Building, Third Floor
Des Moines, Iowa 50319

CareSource Iowa Co., Appellant, v. Iowa Department of Health and Human Services, Respondent, Amerigroup Iowa, Inc. and Molina Healthcare of Iowa. Interveners.	Case No. 23002109 **PROPOSED DECISION**

STATEMENT OF THE CASE

The hearing in this case was held starting on November 17, 2022. Jennifer Battle, Jeffery Lipps, and Mark Schultheis appeared on behalf of CareSource Iowa Co. ("CareSource"). Lisa Reel Schmidt, Laura Kron, and Robert Thole appeared on behalf of the Iowa Department of Health and Human Services ("HHS"). Andrew Anderson, David Yoshimura, and Benjamin Grossman appeared on behalf of Amerigroup Iowa, Inc. ("Amerigroup"). Jennifer Lindberg, James White, Thomas Kenny, and Edward Fox appeared on behalf of Molina Healthcare of Iowa, Inc. ("Molina"). Witness testimony was presented by the parties, and the administrative file (excluding the exhibits not allowed as stated on the record) was admitted into the record. The record was held open until January 4, 2023, for closing briefs, which were received.

ISSUE PRESENTED

Whether HHS followed the correct procedures in issuing the Notice of Intent to Award.

DECISION

The Notice of Intent to Award is AFFIRMED (found to be correct).

FINDINGS OF FACT

The overarching issue presented in this case is whether HHS erred in issuing the Notice of Intent to Award ("Notice") selecting Molina and Amerigroup and not CareSource as the winner of

the procurement process concerning Request for Proposal ("RFP") #MED-23-005. The RFP itself concerns managing the multibillion-dollar delivery of Medicaid and related health services for the next four to eight years in Iowa, and for the reasons discussed below, no material legal error exists in issuing the Notice.

A.

HHS is the single state agency responsible for administering the Medicaid program in Iowa. Ex. 87, at p. 3.[1] Currently, Medicaid has over of 800,000 members with an annual budget "approaching 8 billion." See, e.g., Nov. 17 Tr., at p. 94; see also Nov. 18 Tr., at p. 66.

On April 1, 2016, HHS transitioned from a fee for service model of administering Medicaid and related programs to a managed care organization ("MCO") model, where MCOs would "operate the various Medicaid programs and provides services to Medicaid enrollees in exchange for a fix rate, or capitation fee, paid by the State for each enrolled member." Ex. 1, at p. 10; Ex. 87, at p. 4. In theory, this system shares the risk of higher than expected medical costs while also promoting efficiency. As part of this transition, in 2015, HHS issued the "managed care RFP" formally known as the "Iowa Department of Human Services – Request for Proposal – Iowa High Quality Healthcare Initiative – RFP MED-16-009."[2] Ex. 87, at p. 5.

The outcome of that first MCO procurement was a notice of intent to award contracts to four bidders, namely: Amerigroup, UnitedHealthcare Plan of the River Valley, Inc. ("UnitedHealth"), WellCare of Iowa, Inc. ("WellCare"), and AmeriHealth Caritas Iowa, Inc. ("AmeriHealth"). Ex. 87, at p. 15. Three unsuccessful bidders filed an appeal of that notice of intent to award, and ultimately, HHS affirmed the notice with respect to Amerigroup, UnitedHealth, and AmeriHealth. The notice was rescinded as to WellCare because of "improper communication" between a representative and state employees during the blackout period, which is essentially the time when bidders of an RFP can only talk to a designated representative of HHS about a pending RFP. Id., at p. 46.

After the procurement process, HHS entered into contracts with all three winning bidders, each of which commenced providing services. However, in 2017, AmeriHealth announced it was withdrawing from the Iowa Medicaid market, and it ceased operations in the State thereafter. See, e.g., Ex. 91, at p. 1. This left two remaining MCOs, and in order to return to having three MCOs, HHS initiated a second MCO procurement process in 2018 that resulted in two bidders submitting proposals and Iowa Total Care being awarded a MCO contract with a start date of July 1, 2019. Nov. 17 Tr., at p. 98, 178-79. Iowa Total Care's contract expires in 2023, with an option for HHS to renew it for two years. Nov. 17 Tr., at p. 179; Nov. 18 Tr., at p. 121.

In 2019, UnitedHealth announced it was withdrawing from the program. See, e.g., at Ex. 90. Both withdrawals were prompted at least in part by the MCO essentially having a disproportionately high number of higher cost members selecting it and being unable to offset the higher costs with the capitation rates set looking at the aggregate costs of all members, including members with lower cost needs. See, e.g., Nov. 17 Tr., at pp. 96-98; Nov. 18 Tr., at p. 245. Because states like Iowa are required under federal law to have at least two MCOs if the state employs a managed care model, HHS

[1] All evidence was considered in making each finding of fact, including the demeanor of the witnesses when applicable. The references provided are meant to be a guide to the more pertinent portions of the record and not meant to be an exhaustive list of each and every portion of the record that supports the finding.

[2] On July 1, 2022, the Iowa Department of Human Services ("DHS") merged with the Iowa Department of Health, and for convenience, the Tribunal will refer to DHS as HHS. Nov. 18 Tr., at p. 6.

negotiated the contract so that United Health would leave the market the day before Iowa Total Care commenced operations. Nov. 17 Tr., at p. 205. In addition, HHS modified its current contract with Amerigroup to change the original expiration date of March 2023 to June 2023, so that the third and pending procurement process could be completed. Nov. 18 Tr., at p. 117-18; Ex. H-5.

B.

The third MCO procurement process concerns RFP #MED-23-005, and the outcome gives rise to the present case. In terms of material communication with the public, the procurement process started essentially when HHS issued a May 14, 2021 Notice of Intent to release a MCO RFP. Ex. H-43. As relevant to the parties' claims, the pertinent portions of the letter state:

> The Iowa Department of Human Services (the Agency) is providing this notice of intent to release a request for proposal (RFP) on or around December 22, 2021, to procure the most qualified Managed Care Organizations (MCOs) to deliver high-quality health care services to the citizens of Iowa.
>
> *The Agency intends to procure up to four (4) contracts with MCOs* with a demonstrated capacity to coordinate care and provide quality outcomes for the Medicaid and Children's Health Insurance Program (CHIP) populations. *The final number of awarded contracts under this competitive procurement will be determined at the sole discretion of the Agency.*

Id., at p. 1 (emphasis added). Prior to the issuance of this memorandum, there were internal discussions within HHS suggesting the procurement of "three MCOs" in order to "allow[ ] the even distribution of membership among the selected MCOs and reduce[ ] the administrative burdensome cause by the continue review/negotiation of provider agreements and rate negotiation." H-14, at p. 2. In addition, such a conclusion would result in "members [not having] to be redistribute[d] for at least 6 years." Id. Due to perhaps the passage of time or transitions in the key personnel at HHS, the Tribunal can discern no specific, aggregate intent on the part of HHS to award a specific number of awards prior the release of the Notice of Intent. See generally, Nov 17 Tr., at p. 203. After the release, though, the leadership in HHS expressed the general idea of only awarding two contracts. Id., ("Q. And as I understand it, after you talked with Director Garcia for the first time about this procurement, she made it clear to you that her view was she only wanted two plans, new plans, as well as the existing Iowa Total Care? A. Correct.").

On or about February 14, 2022, HHS commenced issuing RFP #MED-23-005. Ex. A-1, at p. 9. In its final form, the RFP contemplated a four-year base contract with any winning MCO, with HHS having the unilateral ability to extend the contract for two-additional, two-year terms. Id., at p. 7. This would provide for up to eight years of service, and as for the number of contracts that could be awarded, the RFP stated in relevant part:

> *The Agency intends to contract on a statewide basis with one (1) or more bidders* with a demonstrated capacity to coordinate care and provide quality outcomes for the Medicaid and CHIP populations. The IA Health Link program enrolls the majority of the Iowa Medicaid and CHIP populations. *The final number of awarded contracts under this RFP will be determined at the sole discretion of the Agency.*

Id. (emphasis added). The RFP did note there was a possibility no contracts would issue awarded, stating in another provision: "The Agency reserves the right to reject any or all Bid Proposals, in

whole and in part, and to cancel this RFP at any time prior to the execution of a written contract." Id., at p. 13. Further, concerning restrictions on communications between bidders and the State, the RFP provided:

> **2.2 Restriction on Bidder Communication.**
> From the issue date of this RFP until announcement of the successful Bidder, the Issuing Officer is the point of contact regarding the RFP. There may be no communication regarding this RFP with any State employee other than the Issuing Officer, except at the direction of the Issuing Officer or as otherwise noted in the RFP. This section shall not be construed as restricting communications related to the administration of any contract currently in effect between a Contractor and the Agency.

Id., at p. 11 (emphasis in the original).

Moreover, the RFP also laid out the timeline for the submission and evaluation of bids. Id. More specifically, the RFP provided for a March 9, 2022, deadline for bidders to indicate their intents to bid, deadlines in March and April of 2022, for bidders to submit questions and HHS to provide answers, and a May 11, 2022, deadline for the submission of the proposals themselves. Id., at p. 9. Select bidders would also be required to participate in oral presentations of the proposals on August 9 and 10, 2022. A.-18, at p. 1. The notice of intent award would then be issued on August 31, 2022, with transition activities beginning September 1, 2022, and with a anticipate start date of services of July 1, 2023. Id., at p. 2.

Of note, HSS waited until May 11, 2022, to publish its "evaluation methodology" on how the proposal would be scored. Ex. A-19. This was an intentional choice to incentivize the bidders to focus on the entire RFP instead of directing their resources to the areas with the greatest weight. See, e.g., Nov. 17 Tr., at 129 ("Q. And why did you decide to delay the posting of that methodology? A. We decided to align the methodology release with the RFP proposal submissions so that bidders weren't writing to the score. . . ."). The following point assignment methodology was utilized for the written portion of the proposals:

Criteria	SoW/RFP Section	Weight	Potential Maximum Points
RFP Section 3.2.3 "Information to Include Behind Tab 3: Bidder's Approach to Meeting Deliverables"			
General	A (SoW)	15	60
Enrollment and Disenrollment	B (SoW)	25	100
Beneficiary Notification	C (SoW)	30	120
Payment	D (SoW)	35	140
Providers and Provider Network	E (SoW)	30	120
Coverage (not including F.12 and F.13)	F (SoW) excluding F.12 and F.13	25	100
Long-Term Services and Supports (LTSS) (not including F.12A - F.12D)	F.12 (SoW) excluding F.12A - F.12D	20	80
Long Term Care Facilities (ICF/ID, NF, SNF, and NF/MI)	F.12A (SoW)	50	200

1915(c) and 1915(i) Home and Community-Based Services	F.12B (SoW)	50	200
Community Based Case Management	F.12C (SoW)	50	200
Consumer Choice Option	F.12D (SoW)	50	200
Mental Health and Substance Use Disorders Benefits & MH/SUD Parity	F.13 (SoW)	35	140
Quality, Care Coordination, and Utilization Management	G (SoW)	40	160
Grievances and Appeals	H (SoW)	25	100
Program Integrity	I (SoW)	30	120
General Terms and Conditions	J (SoW)	20	80
Health Information Systems and Enrollee Data	K (SoW)	40	160
Termination	M (SoW)	15	60
Reporting	N (SoW)	30	120
RFP Section 3.2.4 "Information to Include Behind Tab 4: Bidder's Experience"			
Bidder's Experience	3.2.4 (RFP)	15	60
RFP Section 3.2.5 "Information to Include Behind Tab 5: Personnel"			
Personnel	3.2.5 (RFP)	15	60
TOTAL POINTS		645	2,580

Ex A, 19, at pp. 1-2 (emphasis in the original). The following point assignment methodology governed the oral presentations:

Criteria	Weight	Potential Maximum Points
Overview of Bid Proposal	15	60
Response to Agenda Questions	45	180
Response to Additional Questions	15	60
TOTAL POINTS	75	300

Id. (emphasis in the original). Finally, the underlying scoring methodology giving rise to the points was as follows:

> **Scoring Methodology**
>
> During the evaluation process, the written technical proposal responses and oral presentations (if held) will be scored against each of the scoring criteria on a scale ranging from 0-4. Scores will be assigned based on the sole judgement of the evaluation committee, as follows:

4	Bidder has agreed to comply with the requirements and provided a clear and compelling description of how each requirement would be met, with relevant supporting materials. Bidder's proposed approach frequently goes above and beyond the minimum requirements and indicates superior ability to serve the needs of the Agency.
3	Bidder has agreed to comply with the requirements and provided a good and complete description of how the requirements would be met. Response clearly demonstrates a high degree of ability to serve the needs of the Agency.
2	Bidder has agreed to comply with the requirements and provided an adequate description of how the requirements would be met. Response indicates adequate ability to serve the needs of the Agency.

1	Bidder has agreed to comply with the requirements and provided some details on how the requirements would be met. Response does not clearly indicate if all the needs of the Agency will be met.
0	Bidder has not addressed any of the requirements or has provided a response that is limited in scope, vague, or incomplete. Response did not provide a description of how the Agency's needs would be met.

Id., at p. 3 (emphasis in the original).

C.

Faced with these RFP requirements, five bidders indicated first their respective intents to bid, with HHS acknowledging such in a March 23, 2022, notice. Ex. A-8, at p. 1. The five potential bidders were: Aetna Health of Iowa Inc. d/b/a Aetna Better Health of Iowa, Amerigroup, CareSource, Molina, and UCare Iowa d/b/a UCare ("UCare"). Id. The typical and contemplated question and answer period then ensued, and of relevance to this case, the following question was asked: "Is there a distinction between the Enrolled Member advisory committee referred to in F.12.02 and the LTSS Stakeholder Advisory Board in F.12.04. If there is no distinction, what is the preferred nomenclature?" Ex. A-12. The following answer was provided: "There is no distinction, the Enrolled Member Advisory committee is federal nomenclature located at 42 CFR 438.110. The Agency preferred nomenclature is the LTSS Advisory Board." Id. Of note, the record strongly suggests HHS's answer was incorrect and the product of the highly credible HHS subject matter expert on the issue being tasked as an evaluator and segregated off from this portion of the procurement process. See, e.g., Nov. 21, Tr., at pp. 293-94 (Tribunal pressing the expert on whether HHS's answer was correct).

Ultimately, the five companies that notified HHS of their intent to bid did submit substantive proposals. Ex. A-20. This triggered HHS to commence its evaluation process, starting with a five-person evaluation committee to score the proposals. Originally, there were six members; however, one withdrew, leaving: (1) Brandi Archibald ("Archibald"); (2) Theresa Armstrong ("Armstrong"); (3) Marcus Johnson-Miller ("Johnson-Miller"); (4) Derek McComas ("McComas"); and (5) Jennifer Steenblock ("Steenblock"). Exs. D-1; D-3; D-8; D-11; D-14. Archibald was the assistant superintendent of integrated services at Woodward Resource Center. Nov. 22, 2022, Tr., at p. 106. She previously was an executive officer in facility support as well as staff for AmeriHealth when it was providing MCO services in Iowa. Id., at pp. 106-08, 114-15, 118. Armstrong was a bureau chief of behavior health and disability services, having been at that role for 12 years, with a total of 17 years of services with HHS. Nov. 18, Tr., at p. 333. Johnson-Miller was a bureau chief of family health and served in a variety of roles with the State for twenty years. Johnson-Miller Deposition Tr., at pp. 6-7. McComas recently joined HHS as a complex needs manager in 2021 after working in community services in the private sector. Nov. 22 Tr., at p. 175, 191. Steenblock was a bureau chief of the program integrity and compliance unit for HHS, and she has been working with HHS for nearly three decades. Nov. 21 Tr., at pp. 206. Of note, none of the evaluators were either supervisors or subordinates of the other evaluators, and none reported being unduly influenced by the other committee member's expertise or experience, any of their present work with Amerigroup on RFP related matters, or the fact that Molina had a former Iowa Medicaid director as part of its organization. See, e.g., Nov. 22 Tr., at pp. 195-96; see also Nov. 21 Tr., at p. 211 ("Q. Did you consider everyone in the group's point of view equally? A. Yes. Everyone in the group had different subject matter expertise that they brought to the evaluation team.").

The review and scoring of the proposals by the evaluation committee can be broken into three phases. The first stage was *individual* review of the proposals *without* any scoring. See, e.g., Nov. 22 Tr., at p. 114 ("1 Q. Now, as you were reviewing these individual bids, one of the things that you did not have was the -- what has been referred to as the scoring rubric, the 0 to 4; is that accurate? A. Yes."). Archibald credibly testified she read through each proposal, which generally totaled over 1,300 pages, first and then reviewed them a second time, utilizing sticky notes to flag items to which she wanted to return. Id., at pp. 114-15. She also reviewed her proposals the weekend before the second phase of group scoring of the written proposals. Id., at p. 118. Armstrong reviewed the proposal by first "scan[ing] each one" and then going through each proposal taking notes. Nov. 17 Tr., at p. 341. Johnson-Miller reviewed the RFP prior to the group discussions, and he took notes. Johnson-Miller Deposition Tr., at pp. 51, 143. McComas reviewed the proposals more than once using sticky notes to highlight sections on which he wanted to have additional focus. Nov. 22 Tr., at pp. 170, 173, 191-92. Steenblock reviewed the materials taking notes, stating she needed to do so to feel prepared for the group meeting. Nov. 21 Tr., at p. 268.

The second phase of the evaluation committee's consideration of the bids was *group scoring* of the written proposals. This occurred from July 25, 2022 to July 28, 2022. Nov. 18, Tr., at p. 396. At this group meeting, the issuing officer for the procurement, who was essentially the point of contact for the bidders concerning the procurement and the facilitator of the evaluation committee's review of the bids, randomly selected the names of the bidders in order to determine evaluation order. Nov. 21, Tr., at p. 93 ("[I]t was either a bowl or a hat, but I wrote down all of the bidders that had submitted proposals, put them in and then drew them out one by one to see what the order would be."); see also Ex. W-6 (noting that five days were originally reserved). The randomly selected evaluation order was CareSource, Amerigroup, Ucare, Molina, and Aetna. Ex. W-5. The evaluation committee members were given the 0-4 scoring rubric to utilize in assessing the bids, and they were told *not* to compare the bids directly to each other. See, e.g., Nov. 21 Tr., at p 99 ("I also reminded [the committee members] not to compare proposals during the process when we were discussing them, that, if we were on CareSource, CareSource is the proposal that we are focused on and reviewing so that there was no comparisons between what was going to come or what had come.").

In terms of assigning point values, the committee went section by section in each proposal, and the evaluation committee would rotate members who spoke first on the section under review, with the other committee members providing further discussion when those individuals wanted to add something. See, e.g., Nov. 21, Tr., at p. 97. At this point, the committee members would simultaneously indicate (either through holding up numbers on camera—as the meetings were held virtually—or through chat if there were technical difficulties) their respective scores. Id. If there were disagreement between the committee members, then there would be further discussion until a consensus score was reach, with one evaluation committee member succinctly testifying:

> Q. So after you had done the review of each proposal twice, there was the consensus scoring meetings. There's been plenty of testimony about this, so I'm not going to belabor it, but there would be a discussion about a section, and then you all would hold up a little score card to indicate what your scores were for that; correct?
> A. Correct.
> Q. And then, if you held up a score that was in the minority -- say, you and two – one other had a 2 and everybody else had a 3 -- 5 you would concede to the majority, wouldn't you?
> A. I can't recall. There would be further discussion, and eventually we would come to a consensus, whether that be with a 2 or a 3, the example that you used.

Nov. 22 Tr., at p. 121. The committee would have the scores recorded by a contractor, who would also be taking notes of the conversations. Nov. 17. Tr., at p. 257 ("Now, at the same time that people were speaking, there was a screen share that everybody could see that had each of these sections listed here[. N]ext to that were columns for strengths, weaknesses and points of clarification. And as the individual team members were speaking about strengths and weaknesses and identifying any points of clarification, our team was typing notes, bullets, into that sheet so that people could see how their comments were being documented on the screen."). Of note, the committee took longer to review Caresource's proposal than the others, although much of this is due to the Caresource being first and taking longer as the committee worked on getting its process established. See, e.g., Nov. 21, Tr., at p. 171 ("Q. And I think you acknowledged that that [Caresource's proposal] went slower because it was the first time the team was working through the process? A. Yes, that's correct."). Also, a review of the chat messages from the written scoring meeting—which included some section scores when there was a technical glitch with the showing of the scores by video during the meeting—reveals that the committee spent differing amounts of time scoring different sections, taking at times only a limited number of minutes. See generally, Ex. O-11, at pp 4-5, 7-9. It also reveals that, as the committee members indicated in various portions of their testimony, the committee often viewed the strength of the various sections similarly at the outset. See, generally, Nov. 21 Tr., at pp. 120.

The third phase of the evaluation committee consideration of the bids was the *group scoring* of the bidder's oral presentations. The oral presentations occurred on August 9, 2022, and the group scoring occurred after each one. Ex. 203, at pp. 16-18. All the bidders presented in the order in which their written submissions were considered by the evaluation committee with the exception of Ucare, which was not asked to present because its bid was deemed to essentially be non-viable during the written evaluation meeting. See, e.g., Nov. 21 Tr., at p 113 ("Q. And how did they select who would be asked to do an oral presentation? A. They basically just decided that they didn't need to hear anymore from UCare after review of that proposal, so they invited everyone but UCare for oral presentations."). Each presentation generally lasted 60 minutes, with 15 minutes for answers to questions. Id., at pp. 116.

After the individual review and two group-scoring sessions, the evaluation committee met one last time near the end of August to finalize its ranking and scoring. Ex. 203, at p. 19. The product of the meeting was a memo entitled "Recommendation of the Evaluation Committee," and the relevant portions of that memo state:

Technical Proposal score summary after initial scoring meeting:

Bidder	Technical Score (out of 2,580)
Aetna	1,375
Amerigroup	1,885
CareSource	1,605
Molina	2,520
UCare	600

. . .

Oral presentation score summary:

Bidder	Oral Presentation Score (out of 300)
Aetna	150

Amerigroup	225
CareSource	225
Molina	300

. . .
Total Score Summary (Technical Proposal and oral presentations) . . . :

Bidder	Total Score (out of 2,880)
Aetna	1,525
Amerigroup	2,110
CareSource	1,830
Molina	2,820

The [evaluation committee's] final ranking of shortlisted bidders is as follows:

Ranking	Bidder
1st	Molina
2nd	Amerigroup
3rd	CareSource
4th	Aetna

After careful consideration of the Technical Proposals, oral presentations, and responses to clarifications questions the PEC developed this final ranking. The [evaluation committee's] recommendation is reflected by the above ranking of bidders, including the exclusion of the bidder who did not make the shortlist.

Ex. O-7, at pp. 2-4 (emphasis in the original). The evaluation committee also developed a "Select Strength and Weaknesses of Technical Proposals." Id., at p. 5. This document was generated by the committee with their notes and general discussion, and it was an overall "summary" of the respective proposals meant to highlight aspects of the proposals that the "decision-makers should know." See, e.g., Nov. 21, Tr. at p. 128-29. In other words, the document provided context for the committee's numerical scoring. With respect to CareSource, the strengths and weaknesses document stated:

Vendor: CareSource Iowa Co.

Strengths	Weaknesses
● Thorough response overall; strong person-centered planning process with detailed framework ● Demonstrated high engagement with community partners ● Real-time claims payment for rural providers ● Strong claims system with testing processes in place with providers ● Demonstrated innovation and experience through response	● Some sections of proposal lacked detail, particularly in important areas to IA such as community-based case management ● Some sections did not clearly address requirements outlined in RFP ● Staffing plan framework did not appear to clearly address LTSS staffing ● Did not appear to include Iowa Behavioral Health Association as a community partner

● Staffing preparedness (additional positions beyond those required by the RFP) ● Detailed description of training and retention of call center staff ● HCBS Report Card ● Unique ACL-funded program focusing on quality measures ● Thorough descriptions of value-added services, including data on member impact ● Use of analytics monitoring member outcomes and needs ● Plan for collaboration with MHDS regions to align evidence-based practices and other services	● *Did not appear to clearly distinguish between enrolled member advisory committee and the LTSS member stakeholder advisory board, both of which are required*

Ex. O-9, at p. 2 (italic emphasis added and other emphasis in the original).

D.

After the evaluation committee finalized its scoring, its recommendation was presented to Elizabeth Matney, Director of Iowa Medicaid ("Director Matney"). Director Matney first received the evaluation committee's final documents, including the recommendation and select strengths and weakness documents on August 24, 2022. Nov. 17, Tr. at p. 133. Director Matney reviewed the documents and met with the issuing officer as well as other HHS personnel on August 25, 2022, and the Director inquired as to how Molina scored so high, as such a score is "pretty unusual." Id., at pp. 133-35. The issuing officer then summarized the evaluators' various statements about the bid (as the evaluators were not at the meeting), stating in part:

> A. She -- she summarized the team – some of the team's feedback in terms of what they thought was exemplary, including extensive outreach throughout the State with very specific examples of how they've already developed relationships and partnerships with different entities and how they were going to embed that in their processes moving forward, also just really a -- an overall member-centric view to everything that they are doing. We call individuals who are in the Medicaid program members, so really focusing on them and what they need and how they need to design their program to accomplish that. The other piece that really [the issuing officer] referenced was, as they were writing their proposal and like reflecting what they plan to do in the State of Iowa, they wove in a number of the pain points that providers were reflecting they had experienced as managed care organizations had come into the State and outlined exactly how they were going to mitigate each one of those pain points.

Id., at p. 135-36. Director Matney also checked to ensure no known issues in the process existed, such as any bias or other procedural errors, and she eventually concluded the meeting. Id., at p. 137. After the meeting, on August 25, 2022, Director Matney had the consensus notes of the committee pulled for her review, looking primarily at Molina and Amerigroup. Id., at p. 138.

Also, on August 25, 2022, Director Matney had a "three minutes or less" hallway conversation with Kelly Garcia, Director of HHS ("Director Garcia"), about the procurement. Id., at pp. 138-39. Director Matney "updated [Director Garcia] on the ranking of scores and reflected on the unusual nature of Molina's very high score." Id., at p. 139; see also Nov. 18 Tr, at pp. 56-57. After the conversation, Director Matney secured additional information and put together a document entitled "Managed Care Update" for a meeting later that afternoon. Nov. 17 Tr., at p. 139; see also Ex. U-4. The memo contained a chart of the evaluation committee's score as well as including a section on "Molina's scoring," again to address the concern of its unusual score. Ex. U-4, at p. 1. In addition, the memo outlined several award options, stating in part:

U-4

OPTIONS:

	PROS	CONS
1. **Award to Molina only**	Less administrative cost long-term Fewer members to redistribute Fewer MCOs for providers to work with More economies of scale	Potential that having only two MCOs results in less negotiating power Less competition in market Lost continuity for individuals who prefer Amerigroup
2. **Award to Molina and Amerigroup**	More competition in the market leads to innovation Member continuity maintained for individuals who prefer Amerigroup Better negotiating power for state Less risk if one MCO leaves the State More member choice Less litigation risk	Additional administrative cost to State to oversee three MCOs More MCOs for providers to work with (this can be both a pro and a con) Redistribution of all members

COST OF OPTIONS:

	INITIAL COST	ONGOING COST	TOTAL	STATE SHARE
Option 1	$965,000		$965,000	$289,000
Option 2	$965,000	$689,000	$1.7M	$490,000

DISTRIBUTION OF MEMBERS BY OPTION:

	IOWA TOTAL CARE	AMERIGROUP	MOLINA	TOTAL
Current	344,289	455,107		799,396
Option 1	340,500		340,500	681,000
Option 2	227,000	227,000	227,000	681,000

Id., at pp. 1-2.

At the meeting (again where none of the evaluators were present but other members of HHS were present), Director Matney walked through her memo and reviewed other documents, with her discussion with Director Garcia mostly focusing on whether to choose one MCO or two MCOs. Nov. 17 Tr., at pp. 140-43. Director Garcia credibly stated of her analysis concerning awarding only to Molina:

> Q. So when you look at the pros and cons for the award to Molina only, what -- what really stood out to you in your decision-making?
>
> A. Well, Molina clearly had a demonstrated bid, and so that decision was clear to me, very clear, that Molina earned the right to do business in our state. The -- which really gets to the cons on -- that start there and then bleed into the next option, which is then do we award a third and, you know, what does a third look like. So loss of continuity for individuals in our network as well as the kind of competition factor were the two driving factors that I was looking at once that we were satisfied with the idea that the bidders themselves, whoever they were, had satisfied kind of filling in the vulnerabilities of the program. So that question had been answered. We were now focused on two or three. Member continuity and competition were the driving factors.

Nov. 18 Tr., at pp. 60-61. With respect to the number of bidders, Director Garcia went on to credibly opine:

> Q. And when we look at the next page with the pros and cons were an award to Molina and Amerigroup, what were some of the more significant pros and cons that stood out to you?
>
> A. So when we think about three, we incent competition, I think, in a different way. And, again, when I think about the evolution of the program, the vulnerabilities, the maturity, our ability to take what managed care was originally supposed to be in the state and delivering that to fruition, which is the space I believe we are in, three makes sense, in that two can kind of pair up. Three provides a little -- I mean, it is. It's a space of true competition. I think that will be good for the creativity of concepts like paying for performance, which really largely still, in an immature program, are not at the level that they could be. We're interested in moving the program forward in really creative ways, and so that competition matters.
>
> Q. Would it be more competition with four?
>
> A. Well, sure. But you also have to think about member makeup, and there's no -- there's risk even with a third. I mean, folks are wanting stability. I'm hearing that loud and clear, and so you're weighing both at the same time. Four was never in my mind, and it's really around the number of our -- our caseload number and the size of the program today, but certainly at its prepandemic levels and what we project to be post-pandemic levels.

Id., at pp. 62-63. Ultimately, Director Garcia chose to award two contracts, which would mean that there would be three total MCOs in the State at least initially, and as for which two bidders, Director Garcia credibly testified it came down *solely* to points, stating when pressed by the Tribunal:

> [The Tribunal]: All right. With respect to CareSource versus Amerigroup, was it simply points that ultimately, once you made the decision you wanted two, that had CareSource scored higher, it would have been the one, and Amerigroup did score higher, so it was the one? Is it as simple as that?
>
> THE WITNESS: It is as simple as that.

Id., at p. 172; see also Nov. 18 Tr., at pp 173-74 (witness confirming it was points that was the decisive factor when choosing which two bidders would be selected). As a result of Director Garcia's decision, HHS issued the Notice on August 31, 2022, selecting Molina and Amerigroup as the "apparent successful bidders." Ex. A-21, at p. 1.

E.

On September 28, 2022, CareSource filed a timely appeal of the Notice. Ex. 186A. The appeal followed an unsuccessful request for reconsideration, and in the appeal, CareSource alleged the award was arbitrary and capricious "for two reasons," namely CareSource was underscored in several areas of its bid when compared to the other bidders that either had similar or less robust answers. Id., at p. 2. In addition to this substantive claim, CareSource further alleges a procedural claim, namely that the scoring criteria was impermissibly "vague and ill-defined," the process lacking blind scoring and a process to stop "conflict of interest," and insufficient training existed to eliminate subjectivity such as favoritism. Id., at p. 2. To support its first claim of substantive mis-scoring, CareSource provided a lengthy chart on what areas of its bids were mis-scored, and it summarized the most illustrative examples as follows in its appeal request:

- In F.12.B (Home and Community Based Services), CareSource was awarded just 2 raw points out of the 4 available. Because of the weighting, however, this translated into a loss of 100 weighted points from its total score. Amerigroup scored the same as CareSource, while Molina earned a perfect 4 (which translates to 200 weighted points). The only explanation provided for downgrading CareSource appears in the consensus "Strengths and Weaknesses" summary document, in which the Evaluation Committee claimed that CareSource failed to address certain material components. But, as detailed in Appendix A, for ***every single item*** that CareSource purportedly failed to address, a review of CareSource's proposal reveals that CareSource ***did*** in fact address ***each and every one*** of the allegedly "missing" items. Thus, assigning CareSource only half of the available points was clearly arbitrary and contrary to the evidence. **This error caused a 100-point reduction to CareSource's final score.**

- In F.12.C. (Community Based Case Management), the same thing happened: CareSource earned a 2, Amerigroup a 3, and Molina a 4. Due to the weighting, however, this meant CareSource missed 50 of the available weighted points as compared to Amerigroup. A review of the proposals themselves, and the evaluator comments, reveals that there was no rational basis for CareSource to earn a 2 as compared with Amerigroup's 3. *See* Appendix A hereto. Indeed, Amerigroup was scored higher even though its response was incomplete and CareSource's response was not. For example, "Coordination with CBCMs" (Community Based Care Managers) was expressly noted as a ***weakness*** of Amerigroup's proposal, but not of CareSource's, so even the one-point raw score differential between CareSource and Amerigroup is perplexing and indefensible. Moreover, the consensus comments (which identified weaknesses for CareSource that,

again, are contradicted by specific items included in CareSource's submission) were dramatically inconsistent with the individual evaluator notes, which were uniformly positive for CareSource in this area. In fact, the "weaknesses" attributed to CareSource are so disconnected from CareSource's actual submission and the evaluator's individual observations that it appears likely that the scoring and comments were erroneously attributed to CareSource, as opposed to another bidder. **This error caused at least a 50-point reduction to CareSource's final score.**

- In F.12.D (Consumer Choice Option), CareSource again missed 2 raw points and thereby was deprived of 100 weighted points. Here, the Evaluation Committee identified as a "weakness" CareSource's purported failure to mention Integrated Health Homes—yet the facts show CareSource ***directly addressed*** this topic on page 657 of its proposal. There is no other evidence explaining or justifying the point differential between CareSource's 2 raw points (100 weighted points), Amerigroup's 3 raw points (150 weighted points), or Molina's perfect 4 raw points (200 weighted points). Thus, the Evaluation Committee plainly erred, and its underscoring of CareSource was arbitrary and without a factual basis. **This error caused a 100-point reduction to CareSource's final score.**

- In Section G (Quality, Care Coordination, and Utilization Management), CareSource again scored a 2 while Molina and Amerigroup each scored a 4. There were a number of inconsistencies here: (1) In several instances, the evaluators identified a "weakness" in CareSource's proposal because it purportedly did not address a specific item. In reality, however, CareSource did specifically address each item (as detailed in Appendix A). (2) Molina was heralded as "thorough" by the evaluators, even though its proposal contained 60 *fewer* pages of detail than CareSource's. (3) CareSource was identified as having multiple "strengths" in this area, and **no** weaknesses, while Amerigroup was found to have weaknesses—yet Amerigroup scored higher than CareSource. **These errors and inconsistencies caused an 80-point reduction to CareSource's final score.**

- Section F.12 (Long-Term Services and Supports (LTSS)) contains perhaps the most blatantly egregious error. Here, CareSource and Amerigroup were both awarded a 2, while Molina received a 4. The only documented basis for CareSource's lower score was its purported failure to clearly distinguish between the enrolled member advisory committee and the LTSS member stakeholder advisory board. In reality, however, CareSource's proposal spent two pages apiece on each of these two committees, clearly discussing them separately. **This error caused a 20-point reduction to CareSource's final score.**

- Section D (Payment) is equally as egregious in that it requires only a simple comparison of statistics. CareSource was scored a 2 compared to Molina's 4, even though the statistics Molina lists in its bid (page 124) are objectively and quantifiably inferior to CareSource's comparable statistics (pages 329-330) regarding claims payment metrics. This error caused a 70-point reduction to CareSource's final score.

Id., at pp. 8-10; see also Ex. 186B (eight page spreadsheet of claimed scoring errors). CareSource did not amend its appeal request prior to the hearing.

At the hearing and in its closing briefs, CareSource refined its arguments. CareSource first argues the entire procurement process is fatally flawed because Iowa competitive bidding law requires bids to be compared and because HHS intentionally designed its review to not compare proposals,

going so far as to instruct the evaluation committee to not compare the proposals. CareSource Closing Br, at pp. 8-13 ("The unequivocal testimony from all evaluators, facilitators, and the paid Ikaso consultant (Tom Arnold) was that the proposals were never compared to one another."). As for any claim that the comparison took place through the points, CareSource claims:

> While the Agency may now contend that it attempted to measure each proposal against a common yardstick (i.e., the RFP), this simply does not qualify as "compar[ing]" them as required by Iowa law. Indeed, the above dictionary definitions make clear that a comparison involves an examination to "look for the differences between two or more things," which requires that each item being compared must be "view[ed] in relation to" the others, something DHS admittedly chose not to do.

Id., at p. 12.

Second, CareSource claims the evaluation process was "devoid of reliability" because the process was not capable of producing a rationale result given: the various committee members lacked sufficient Medicaid experience to meaningfully consider the proposals; the members were not given enough time to review the proposals; the committee members did not have the scoring rubric when they conducted their individual review; the committee members did not all take notes and were required to rely on their "distant memories" during the group scoring, the scoring rubric was not sufficiently detailed or explained; and there is proof there was scoring of large sections in mere minutes showing insufficient deliberation. Id., at pp. 13-17. The evidence of this lack of reliability, according to CareSource, is the table of inconsistent scoring it provided. Id., at pp. 17-23 ("Thus, Mr. Van Allen's analysis amply demonstrates that, had the evaluators (or Directors Matney or Garcia) ever compared the proposals as required, it would have been clear that, in a number of categories, CareSource's proposal deserved scores comparable to those received by Molina or Amerigroup."). CareSource points specifically to the aforementioned inaccuracy concerning CareSource's bid about the LTSS Stakeholder and Member Advisory Board. Id., at p. 21-22. CareSource further claims that the lack of documentation as to why a specific score was reached, particularly with a vague rubric, also renders the scoring without sufficient foundation to justify an award. Id., at pp. 23-28 ("All of these cases are rooted in the fundamental principle—equally applicable under Iowa state law standards—that the lack of detail on the basis of the scores made it impossible for the reviewing court to review the outcome under an abuse of discretion standard."). CareSource additionally claims the procurement failed to sufficiently screen for conflicts of interest as the standard is effectively whether there is any appearance of impropriety and the evaluators had varying degrees of contact with Amerigroup, making them incurably bias or at least have the perception of bias. Id., at pp. 28-33. CareSource also claims only Steenblock "had more than a year's worth of direct experience with Medicaid manage care contracts," and as a result, the other committee members must have improperly deferred to her judgment, making the committee fail in its claimed objective of having "a range of equally knowledgeable perspectives." Id., at pp. 34-35.

Third, CareSource claims HHS "abused its discretion" in only awarding two contracts because its initial communications stated "up to four" contracts would be awarded, thereby luring CareSource, a nonprofit, to spend millions of dollars to create a viable bid. Id., at pp. 36-37. CareSource takes issue with Director Garcia stating four contracts were never really on the proverbial table, noting that such lacks a reasoned basis. Id., at pp. CareSource cites what it calls the woefully incomplete and cursory analysis of only selecting two bidders, and argues that, when "an acquisition plan stated a preference for multiple bidders, an acquiring agency act[s] improperly when negotiating with only one of the qualified bidders." Id., at p. 39. Ultimately, CareSource requests that it be awarded a contract

or have the entire Notice set aside. Id., at p. 40.

In response, HHS—at the hearing and in its closing brief—broadly asserts CareSource has failed in its burden of proof to show any material error. With respect to the procedural challenges, HHS first takes issue with CareSource's claim of a lack of required comparison, noting the governing rules permit agencies to fashion their own evaluative methods and the process employed does compare the bids in a method that has repeatedly been affirmed. HHS Closing Br, at pp. 31-34 ("There is no requirement in the plain language of the rule mandating that evaluators line up proposals side-by-side to conduct a section-by-section review."). HHS also takes issue with CareSource's "scattershot" procedural claims, noting broadly it has broad discretion in selecting the means of a procurement and none of the alleged deficiencies—such as having implicit bias training, a different scoring rubric, blind scoring, or committee members with certain MCO experience—are based in any legal requirements. Id., at pp. 36-42. Instead, such procedures are essentially policy preferences HHS is not required to have, particularly since each suggested procedures comes with its own set of costs. Id. As for bias and conflict of interest, HHS argues there is no proof of bias, particularly since the committee members had both negative and positive experiences with Amerigroup. Id., at pp. 42-45. HHS further claims the conflict-of-interest standards of Medco Behav'l Care Corp. v. Iowa Dep't of Human Svcs., 553 N.W.2d 556, 563-566 (Iowa 1996), do not apply anymore and, even if it did, none of the three organizational conflicts of interest identified in that case exist here, where Amerigroup did not write the RFP, did not evaluate any of the bids, and did not have access to non-public information. Id., at pp. 46-50. HHS also claims there is no prohibition against evaluators interacting with bidders, as the Tribunal has found before. Id., at pp. 50-53.

HHS further concludes the Tribunal does not have the authority to simply substitute its judgment for the committee and re-score the proposal despite the lack of a specific standard of review. Id., at pp. 54-57. In making this claim, HHS does engage in a detailed response to at least some of the CareSource's specific scoring challenges, stating more broadly:

> Appellant reveals the significant organizational issues in their proposal, which legitimately provided a basis for the evaluation committee to find deficiencies; gives inappropriate weight to individual comments not found in the consensus notes; conflates volume of response for substance; misreads or mischaracterizes the consensus notes; makes subjective conclusory statements about inconsistent treatment; and fails to prove that errors in consensus notes would translate to a change in scores.

Id., at pp. 61-66. Finally, HHS argues there was no error in how Director Garcia chose the number and identity of the successful bidders given: she could rely on the committee's point scoring; did not need to meet with them individually; was not required to read the entire proposals; and otherwise acted within the bounds of her discretion in making her choice. Id., at pp. 67-75.

The successful bidders mostly reiterates HHS's arguments at the hearing and in their respective closing briefs. Amerigroup, for its part, argued in particular HHS's claim that the standard of review should only be substantial compliance despite the fact HHS has never passed a rule on the governing standard of review at this stage of the process and Tribunal has previously employed a deferential standard. Amerigroup Closing Br., at pp. 4-7. Amerigroup further claims most of the specific arguments raised by CareSource were not preserved because they were not referenced in the appeal letter and because the appeal letter was not amended as allowed by rule. Id., at pp. 8-10. Amerigroup further challenges CareSource's various claims of scoring errors. Id., at pp. 22-25. Molina, for its part,

argues in particular a "weakness attributed to one single section of CareSource's proposal on the strengths and weakness document" is an insufficient basis to conclude any, let alone all, of the committee's scoring of the bids was flawed, particularly with respect to Molina's bid. Molina Closing Br, at pp. 12. Molina also claims that there was no promise by HHS to award any contracts, let alone four, given the language of the final RFP. Id., at pp. 15-17. Both interveners further reiterate the various persuasive and not binding administrative decisions that address and generally foreclose the myriad of procedural claims CareSource alleges.

In response, CareSource in its Reply brief not only reiterates its various arguments, but it also focuses on stating many of the prior HHS cases supporting the validity of the procedures in this case are not controlling. See generally, Reply Br. Further, CareSource sharpens its argument that prejudice should be presumed (although it claims it has proven prejudice) because the errors alleged are structural or so fundamental that no additional showing is needed. See generally, id.

F.

Of note, prior to the hearing, HHS and the interveners moved to strike the expert testimony of Dr. Prudence Gourguechon ("Dr. Gourguechon"). See Joint Motion to Strike. Dr. Gourguechon is a psychiatrist and psychoanalyst, with commanding credentials ranging from degrees or training from Yale, University of Michigan, and Northwestern University to being a former president of the American Psychoanalytic Association and a prolific author and speaker. Id., at Ex. A. She submitted an expert report that, at a high level, opined the following:

> Summary of opinions:
>
> The evaluation process in this case opened the door for the operation of numerous conscious and unconscious biases, including social influence bias, group think, bandwagon effect, proximity bias, and conservatism bias. Taken together, it is probable that these group psychological biases, well known in the organizational and social psychology fields, led to a biased decision in this case, especially favoring the incumbent Amerigroup.
>
> Simple and easily implemented mitigation steps can be implemented to reduce bias in a decision-making process, but no meaningful mitigation efforts were made in this case. Blinding the selection process would have significantly reduced the amount of bias operating in this decision, especially removing the tilt towards favoring the incumbent.
>
> Opinion 1:
> The composition of the group, such that some members had vastly more experience with Medicaid and leadership than others, set up a situation that would likely lead to a biased outcome due to "social influence bias."
> . . .
> Opinion 2
> The evaluation and decision-making process as designed is faulty in terms of the likelihood of leading to a fair outcome.
> . . .
> Opinion 3:
> Unconscious biases such as group think and social influence bias can be mitigated, at

least in part, by measures as listed above, but no mitigation measures were included in the evaluation group process.

Opinion 4:
Unconscious bias in favor of the incumbent was inevitable as this process was structured and could only (but easily) be eliminated if the process had been blind.

Opinion 5:
A blinded process, wherein the evaluators had no knowledge of the identity of the bidders, would have mitigated much of the bias identified above.

Id., at pp. 7-11. Sensing that at least some of her testimony would likely be admissible depending on the factual record made at the hearing and recognizing the expedited timeframe of this case and the need to have only one hearing, the Tribunal reserved ruling on the admissibility of her testimony, allowing the parties to make a full record.

At the hearing, Dr. Gourguechon acknowledged that she did not observe the scoring process and had no specific information concerning the evaluator's physiological make-up or personal history. See, e.g., Nov. 22 Tr., at pp. 233 (testifying she did not attend or listen to a recording of the scoring meetings and does not know nor has personally met any of the evaluators). Instead, her information was drawn mostly from reviewing depositions, committee documents, and LinkedIn pages. Id., at pp. 234-35; see also Motion to Strike, Ex. B, at pp. 2-3 (summarizing all the documents reviewed such as the review notes and disclosure forms). Dr. Gourguechon further acknowledged she has no ability to quantify the impact of any implicit bias she identified. Nov. 22 Tr., at p. 276 ("Q: You don't know the magnitude of any impact that the bias you speak of might have had on this process, do you? A. No."). In fact, Dr. Gourguechon admitted she had no information on whether any specific score was substantive erroneous, stating in part: "I'm not saying [the scores were] wrong. I didn't say they were wrong. I said it's probable that they're subject to bias." Nov. 22 Tr., at p 276; see also id., at p. 295 ("Q. But you have not reached an opinion as to whether bias did, in fact, affect the outcome here, have you? A. No."). Dr. Gourguechon also equivocated on the extent to which personality traits and personal history affect the impact of group decision making, stating in response to the Tribunal asking about the tension in her testimony:

[The Tribunal]: Let me rephrase it. Your testimony doesn't make sense to me because on one hand you said you don't need to talk to the individuals because their individual characteristics don't matter. On the other hand in cross you said, yeah, [a] contrarian could change the dynamic, which means that you would need to know their individual characteristics. So which is it?

THE WITNESS: Well, I think in real life you can always find an example -- you can always find an exception that might -- might make it -- these are generalizations of how groups behave, and you can say, well, what if there's a contrarian there, could it behave differently. Yeah, but what if there is an uneducated person there, could it be different. You know, these are well-established mechanisms of how groups function. And I don't think -- it would be ideal if I spent, you know, two weeks interviewing all the participants, but I don't really honestly think it's necessary.

Id., at pp. 309-10. Dr. Gourguechon finally acknowledged her limited knowledge on the feasibility of blinded Medicaid procurement. Id., at p. 312 ("[Q:] So it'd be fair to say then you can't provide any

expert insights on the feasibility on any blinded Medicaid procurement because you don't have any experience with it? [A:] That's right.").

For clarity, and as discussed below, the record indicates Dr. Gourguechon's general testimony about the existence and types of implicit biases that *can* arise in individuals when interacting in group settings is credible. Indeed, her statements about individuals often subconsciously using shortcuts to process information, which can manifest in part in utilizing certain biases, is a well-accepted concept routinely seen in both individual and group decision-making—including at the hearing in the various teams of attorneys representing the parties in this case. Her more specific claims, though, concerning the alleged bias in the evaluation committee is highly problematic.

First, from a relevancy perspective, Dr. Gourguechon acknowledges she cannot quantify the impact of any bias on the final work product of the evaluation committee and cannot opine that any specific score of the committee was in error. Given that evidence must generally be relevant to be admissible and that relevancy generally requires a showing an item makes a material fact more or less probable, a shadow exists on the usefulness of the information. This is because prejudice is generally required to be shown from any claimed irregularity, and Dr. Gourguechon seems to indicate that any impact of the bias is either non-existent or unknowable. See Iowa Code 17A.14 (noting evidence must be relevant to be admissible in contested cases); Iowa Rule of Evidence 5.401 (providing the general test of relevance). While this issue could likely be skirted by noting the limited barrier the relevancy standard poses and the reality that such biases could explain the reason for the alleged scoring errors thereby making them more likely much as motive evidence can serve to be relevant explanatory evidence in the other contexts, the deeper issue of persuasiveness in her specific testimony cannot be solved. Godfrey v. State, 962 N.W.2d 84, 119 (Iowa 2021) (Appel, J., concurring in part and dissenting in part) (noting "the standard of relevance for the admission of evidence generally is not a high bar").

Second, Dr. Gourguechon's specific expert opinions on the actual existence of bias (as opposed to the general testimony about biases being able to exist) in the evaluation committee is not credible with the record made at the hearing. On its most rudimentary level, Dr. Gourguechon moves from generally opining the "evaluation process in this case opened the door for the operation of numerous conscious and unconscious biases" to the specific conclusion that "it is probable that these group psychological biases . . . led to a biased decision in this case[.]" See Joint Motion to Strike. Dr. Gourguechon, Ex. A, at pp. 7-11. Dr. Gourguechon is effectively claiming, then, to know *both* the subconscious thought and behavior patterns of individuals with whom she knows almost nothing beyond resume information from a LinkedIn page *and* how this played out during a multi-day evaluation process she did not observe (learning only limited information from the depositions and committee documents) concerning a complex and niche subject. Such a bold statement has no compelling force. Even the most casual observer of humanity knows that people and situations are too diverse for such broad claims, at least with her level of information. Indeed, Dr. Gourguechon was forced to acknowledge on cross-examination that individuals' personality traits could have negated or modified the impact of any bias, and she was not even meaningfully asked about the impact of a host of other confounding variables, such as the specific interactive history between each of the evaluators. Dr. Gourguechon did attempt to save her testimony by stating it was only more likely than not the committee's decision was biased and not that it was certain the decision was bias—claiming essentially that cofounding variables like the presence of a contrarian were not sufficiently likely to negate her overall claims, but this is also not persuasive. To put it mildly, there are no specific scientific studies directly analogous to the situation at hand that controlled for all confounding variables to confirm her conclusions, and frankly, given her various statements and noticeable hesitations during cross, the Tribunal lacks the record to find her specific claims are anything more than guesses.

In fact, Dr. Gourguechon appears to have fallen into the classic expert witness shortcoming of not realizing the predictive limits of her knowledge, something which was also seen in her drifting testimony on blinding the procurement evaluation process. On the specific claim concerning bettering the procurement process through blinding, the record made at the hearing indicates her conclusions are meaninglessly abstract given her limited knowledge about procurements. It is akin to a lay observer simply stating a heart medication needs to be increased as it would improve the cardiac function of an ailing patient while also not considering the patient may have other needs that dictates balancing the amount of heart medication to preserve other organ functioning, like the kidneys. In this case, truly blinding the evaluation (if possible where an incumbent is a bidder) would effectively remove considering work history, and little doubt exists Amerigroup's performance history in this State is of critical relevance, particularly given that what is at stake is the well-being, if not the lives, of hundreds of thousands of Iowans. Single-minded statements about a complex, interdependent process is useless absent the most unusual circumstances not present in this case, and this cuts against viewing her testimony as anything more than a product whose substance was dictated by the funding source.

Accordingly, given the substance of her specific testimony is not materially credible or at least useful in the real world but that at least some of her general testimony about opening up the proverbial door to bias likely meets the limited relevancy (and reliability) bar, the Tribunal will admit the evidence, giving it the weight it is due. This leaves for another day—when the resolution of the issue may have some significance—determining the extent to which the traditional tests for the admissibility of expert/scientific evidence bears on the relaxed evidentiary standards of administrative proceedings.[3]

CONCLUSIONS OF LAW

A.

The Medicaid program is a "cooperative federal-state program through which the federal government provides financial assistance to states so that they may furnish medical care to needy individuals." TLC Home Health Care, L.L.C. v. Iowa Dep't of Human Services, 638 N.W.2d. 708,

[3] The Tribunal's resolution of discrediting Dr. Gourguechon specific testimony as to how the alleged biases manifested in the evaluation committee side-steps another core difficulty with her claims, namely the slippery nature of precisely what is a bias and whether all such biases are in fact inappropriate. After all, deferring to the experience and judgment of a subject matter expert may meet the technical definition of a bias (depending upon the definition of rationality) as appears to be the conclusion of Dr. Gourguechon, but even if such occurred with the evaluation committee (where a more inexperienced member in a specific subject deferred to the expertise of the subject matter expert on the committee), it is a difficult task to conclude such an action moves beyond the broad range of reasonable. See generally, Mot. to Strike Ex. B, at p. 9 (Dr. Gourguechon opining that "less experienced members are inevitably going to defer to the opinions of the 'experts' in the group" and this a form of bias); see also Nov. 22 Tr., at pp. 307-08 (Dr. Gourguechon defining bias as "psychological force that causes a decision to deviate from what would be optimally rational" and rationality in this context as "consistency with underlying values in a logical framework"). Generally, it is within the range of reasonable absent strong mitigating circumstances to rely on experts (such as an oncologist who is providing advice on cancer treatment), and thus, Dr. Gourguechon's analytical framework may not be sufficiently precise to delineate out what impermissible biases existed and played a role even if her testimony were taken as fully fact. Dr. Gourguechon appears to recognize this shortcoming and address it through sprinkling such phrases as "undue amount of influence" through her opinions, but this concept—just like trying to define with specificity and consistency which thought processes/assumptions lack sufficient rationality so as to be capable of being labeled a bias—is hopeless nebulous in the real world where the circumstance at hand are not the extreme case. After all, when does reliance on an expert go from rational to "undue," and if such a line could be drawn with clarity, how could Dr. Gourguechon possibly have enough information about the evaluation of the proposals to state where the line was likely crossed. In short, her specific testimony may have great value in academia, but not here.

711 (Iowa 2002). Each participating state must designate a "single state agency" responsible for administering the Medicaid program. 42 Code of Federal Regulation ("C.F.R.") § 431.10. In Iowa, HHS is the designated single state agency, and the Director of the HHS is "responsible for the efficient and impartial administration" of Iowa Medicaid, in accordance with Iowa Code chapter 249A and applicable federal law and regulations, and is vested with the authority to "make rules, establish policies, and prescribe procedures to implement" the program. Iowa Code § 249A.4.

When contracting for the Medicaid and related services at issue here, HHS must engage in a competitive bidding process. Competitive bidding requirements for the award of government contracts are a creature of statute, which are designed "for the protection of the public to secure by competition among bidders, the best results at the lowest price, and to forestall fraud, favoritism, and corruption in the making of contracts." Medco Behavioral Care Corp. v. Iowa Dep't of Human Servs., 553 N.W.2d 556, 563 (Iowa 1996) (internal quotation marks and citations omitted). The standards applicable to the process come from a variety of sources. One source is the enabling statute for HHS, which requires procurements to be done impartially and in accord with federal law. Id., at p. 564 (citing Iowa Code § 249A.4).

Another source governing the process comes from the Iowa Department of Administrative Services' ("DAS") rules on competitive bidding. Iowa law grants DAS the authority to "adopt rules establishing competitive bidding procedures" for state executive branch agencies. Iowa Code § 8A.311. DAS has done so by enacting 11 Iowa Administrative Code Title VI, chapters 117 through 120. Chapter 117, entitled "Procurement of Goods and Services of General Use," establishes procurement procedures used by DAS and other state executive branch agencies when purchasing goods and services of general use. 11 I.A.C. § 117.1(1). DAS is responsible for centralized procurement of most goods and services of general use. Id. §§ 117.4(1), 117.7(1). Other state agencies, including HHS, "may procure services unique to the agency's program or used primarily by that agency and not by other agencies. [DAS] will assist agencies with these procurements upon request. Procurement of services by an agency shall comply with the provisions of [chapters] 118 [purchasing standards for service contracts] and 119 [uniform terms and conditions for service contracts]." Id. § 117.14(2).

DAS rules Chapter 118 generally requires state agencies to use "competitive selection" when acquiring "services from private entities when the estimated value of the service contract is greater than $15,000." Id. § 118.5. "'Competitive selection' means a formal or informal process engaged in by a state agency to compare provider qualifications, terms, conditions, and prices of equal or similar services in order to meet the objective of purchasing services based on quality, performance, price, or any combination thereof." Id. § 118.3. A formal competitive selection process employing a request for proposal or other competitive selection process authorized by applicable law must be employed when the annual value of the service contract is equal or greater than $50,000. Id. §§ 118.3, 118.5(1). Importantly, "[d]uring a competitive selection process, a state agency may weigh the relevant selection criteria in whatever fashion it believes will enable it to select the service provider that submits the best proposal," and the "lowest priced proposal is not necessarily the best proposal." Id. § 118.3.

Given the value of the proposed contracts is at least several billion dollars, HHS was required to use the formal competitive selection process, and it did so through issuing the RFP that spelled out what was required of proposals and how such proposals would be evaluated. The RFP's requirements, while not having the force of law since it is not an administrative rule, nonetheless bind the agency's discretion in this matter. See Noridian Administrative Services, LLC v. Iowa Department of Human

Services, Ruling on Petition for Judicial Review, CV8960 (Iowa Dist. Ct. Dec. 7, 2012) (collecting cases country and holding "the RFP itself . . . provides the procedures that it was required to follow").

B.

Unlike the statutory and regulatory authority governing HHS utilizing the RFP process to procure MCO services, relatively little controlling law exists defining the standard of review for the Tribunal when passing on the propriety of a notice of intent to award following a procurement process. While all agree the Tribunal is tasked with making findings of fact and such are *de novo* given the rules on contested cases in Iowa Code chapter 17A and HHS's rules, some doubt exists as to the legal standard the Tribunal should apply. See generally, 441 I.A.C. § 7.44(5). HHS acknowledges this in its brief, stating: "There Is No Standard of Review for the Administrative Tribunal." HHS Br, at p. 16.

Until HHS decides to resolve this issue by promulgating an administrative rule or publically indexing its cases on the subject, the Tribunal will fall back on the general measure of determining the validity of government action. See generally, Iowa Code § 17A.3(2) ("No agency rule or other written statement of law or policy, or interpretation, order, decision, or opinion is valid or effective against any person or party, nor shall it be invoked by the agency for any purpose, until it has been made available for public inspection and indexed as required[.]"). It has long been held that the government in most contexts must substantially comply with any legal mandate, with substantial compliance being defined as "compliance in respect to essential matters necessary to assure the reasonable objectives of the statute." Sims v. NCI Holding Corp., 759 N.W.2d 333, 338 (Iowa 2009). Generally speaking, prejudice must be shown from the act that failed to full comply with the legal mandate in order to secure relief. Willett v. Cerro Gordo Cty. Zoning Bd. of Adjustment, 490 N.W.2d 556, 560 (Iowa 1992). In some cases, however, the government is required to strictly comply with the controlling legal mandate, in which case no further showing must be made for relief beyond showing an act that failed to comply with the law. Id. The Court of Appeals explained the difference and the test for determining which type of compliance is required when it stated:

> In addition, appellants have wisely and correctly directed to our attention that when we are called upon to determine whether strict compliance with a statute is required or whether substantial compliance is adequate, we must consider whether the duty imposed by the statute is mandatory or directory. . . . It follows that when the duty imposed by the provision is essential to effect the main purpose of the statute, the provision is mandatory and failure to perform the duty will invalidate subsequent proceedings. . . . On the other hand, when the duty imposed is not essential to the main statutory objective, the provision is directory and failure to perform the duty will not affect the validity of subsequent proceedings unless prejudice is shown.

Glawe v. Ohlendorf, 547 N.W.2d 839, 843 (Iowa Ct. App. 1996).

This outcome is generally consistent with how procurements have been considered in Iowa. Under Iowa Chapter 17A, which does not govern the standard of review within an agency but still provides a baseline standard for agency action to be lawful, prejudice must generally be shown. See Hill v. Fleetguard, Inc., 705 N.W.2d 665, 671 (Iowa 2005) (holding the statutory requirement for an individual's "substantial rights" to be prejudice before relief is granted requires the person "demonstrating both the invalidity of the agency's action and resulting prejudice"). In some contexts, though, prejudice can be presumed, such as when there is a material conflict of interest in a RFP

process. See Medco, 553 N.W.2d at 565–66 (adhering to the proposition in a Medicaid procurement case "[o]rganizational conflicts of interest call into question the integrity of the competitive procurement process, and, as with other such circumstances, no specific prejudice need be shown to warrant corrective action"). In another example, a district court presumed prejudice from the failure of HHS to convene a cost committee due to the fact the impact of such a basic structural failure could not be ascertained. Noridian, Ruling at p. 22 ("Accordingly, while the Tennessee Court of Appeals acknowledged that not every procedural defect is a basis for judicial relief, it held that failing to convene a committee as required by the RFP was an illegal and arbitrary action. The same is true here.").

The Tribunal's approach of falling back on established standards of review does not appear to fully square with any of the parties' respective positions. For its part, HHS essentially argues the only standard of review can be substantial compliance regardless of the statutory language at issue because of its prior decisions, the Medco case was based on "underlying federal law [that] has been clarified," and Noridian case found prejudice. HHS Br., at p. 25. However, without public indexing the prior administrative cases (or otherwise attempting to show the alternative path towards utilizing these cases), they do not appear binding on the Tribunal to the extent such are even fully consistent if all procurement cases and not just those cited are considered. Iowa Code § 17A.3(2). Moreover, HHS's arguments do not clarify why the Tribunal should only adopt the substantial compliance doctrine from general case law on reviewing state action and not the companion doctrine of strict compliance.

Indeed, determining which standard to use is the starting point to reviewing the propriety of action, as it effectively decides which proverbial ruler is used to measure the action. See generally, Dix v. Casey's Gen. Stores, Inc., 961 N.W.2d 671, 681 (Iowa 2021) (starting the analysis on compliance with the governing law with a discussion on whether to utilize strict or substantial compliance). HHS's position effectively means there can be no requirement so essential regardless of the specific language and structure of the governing law that failure to meet it alone is insufficient to set aside the ensuing action. Such a strong position would seemingly allow HHS to deliberately exclude certain bidders from a RFP process without just cause and then defend against any challenge, stating the excluded company cannot secure relief as it cannot prove it would have had a winning bid given how could any bidder not considered demonstrate with confidence it would have won. In a similar fashion, using informal competitive selection process instead of the formal process when required would also have no remedy, as how could a bidder ever establish prejudice. There would additionally be difficulty with dealing with bribery, where proving a specific prejudice would often be challenging, and HHS's tacit suggestion at least through use of its quotes that the Tribunal could lower the necessary showing for prejudice depending on the error recognizes the difficulty with its position when taken to its logical ends. In fact, lowering the prejudice bar for key requirements of the law that generally are not capable of showing specific prejudice would appear to be a *de facto* use of the strict compliance doctrine, which is likely why the concept has withstood the test of time through the generations.

Notwithstanding HHS's selective focus on portions of the analysis in Noridian, this was the overarching point of the case. While the decision must be read in its full entirety to reveal what the court was doing given the sheer number of difficulties, the following specific analysis is insightful on certain errors requiring reversal even though specific prejudice cannot be shown:

> Furthermore, all of the Department's claims as to why Noridian was not prejudiced are purely speculative because it did not, in fact, have the separate cost committee established to perform the required review. As the Tennessee Court of Appeals recognized in a similar scenario – "it is impossible to know what action that committee

> would have taken." . . . The Department is, however, missing the point: how could the Department find any bidder-imposed cost limitations when it didn't even establish or use the committee whose job was to locate such limitations?
> . . .
> The Department contends that Noridian's complaint fails because it has been unable to show actual prejudice. Apparently, in the Department's view, petitioner would be required to obtain an admission from Ms. Holmes that her scoring was affected by her prior experience with a bidder. In the Court's view, the situation is analogous to a jury trial where a potential juror is subject to challenge for cause. See Iowa Rule of Civil Procedure 1.915(6). In such a case, for example, where a member of the jury panel is an existing client of one of the attorneys, the juror is not questioned as to whether he or she can be fair despite the relationship. It is irrelevant whether the juror so believes in good faith. The rule recognizes that such a relationship should serve as an automatic disqualifier. The rule established in the RFP here was that no unit manager could serve on the evaluation committee. The obvious reason for the creation of the rule was the same reason that automatic disqualifiers are established for jurors. The Department's rationale that the evaluator in question believes she was unswayed by her prior experience while doing her scoring provides no comfort to petitioner or the Court.

Noridian, Ruling at pp. 22-25. On the most rudimentary level, there are certain legal requirements so fundament or structural to the process that failure to meet them can be fatal even if the impact of the error cannot be quantified, and this concept—well entrenched in law—is what the Tribunal falls back on until HHS simply resolves the issue by promulgating an administrative rule. Also, a close look at the jurisprudence giving rise to the federal case law the Supreme Court cited in Medco reveals it is still being utilized, including after the hearing in this case, even though the requirements on states has changed as described below. See generally, Michael Stapleton Assocs., Ltd v. United States, No. 22-573, 2022 WL 17347730, at *21 (Fed. Cl. Nov. 30, 2022) ("OCIs call into question the integrity of the competitive procurement process, and, as with other such circumstances, no specific prejudice need be shown to warrant corrective action.").

For its part, CareSource at least in its Reply argues that prejudice should always be presumed at least with the issues at hand in this case. However, this too is not persuasive. Whatever the bounds of strict compliance in the abstract, its use is exceedingly rare, and this case is no exception. While it is true that the Tribunal applies a purely *de novo* standard in non-procurement HHS cases where there is a similar lack of a standard of review, this does not change the outcome. Indeed, in other HHS cases such as HHS background check matters involving working in care facilities, the Tribunal steps into the proverbial shoes of the agency and decides *de novo* whether an individual's difficult past should prevent that person from working in a facility. It does not defer to HHS's initial decision under review and is not limited to considering only whether the denial was unreasonable. However, the dynamics of a procurement case are different in terms of complexity and structure to other HHS cases, which justifies applying what is in effect a deferential standard that is common across the country.

Finally, and as the parties seemingly agree, the burden of proof is on the party challenging the Notice. This is because government action carries a presumption of propriety, moving parties such as appellants typically bear the burden of proof, and there is no statute or rule that shifts the burden to HHS. See Wonder Life Co. v. Liddy, 207 N.W.2d 27, 31 (Iowa 1973) (holding, "in administrative proceedings, as well as in court proceedings, the burden of proof, apart from statute, is on the party asserting the affirmative of an issue"); see also Norland v. Iowa Dept. of Job Services, 412 N.W.2d 904, 910 (Iowa 2987).

C.

In this case, CareSource raises a variety of arguments as to why it believes the procurement at hand is fatally flawed. While acknowledging significant conceptual overlap exists, CareSource's specific challenges can be generally divided into procedural claims (i.e., how the process was structured) and substantive claims (i.e., whether the application of the scoring rubric to the bids and final decision was correct). As explained fully below, there were no procedural errors in HHS's process because no provision of law or the RFP required HHS to act in a manner different than it did and because the catchall rationality requirement for agency action is a limited standard HHS satisfied. Likewise, while certain scoring conducted by the evaluation committee does cast a shadow on the results (such as the high score of Molina that caused immediate follow up by Directors Garcia and Matney), insufficient evidence exists to establish a material error, particularly given the limited ability to pass on the accuracy of the scoring. Accordingly, CareSource cannot prevail on its claim to amend or rescind the Notice.

i.

Given the discretion afforded agencies in procurements and HHS's compliance with the RFP it issued, none of the procedural challenges CareSource raise have enough substance to rescind or otherwise amend the Notice. CareSource's foundational procedural claim is that the governing DAS rules require bids to be "compared" and the bids in this case were not compared. This, according to CareSource, is because the evaluation committee was told not to compare bids to each other but to use a common scoring rubric and because Director Garcia primarily relied on the points assigned by the evaluation committee when selecting the winners. CareSource Br. at pp. 9-10. In explaining why such a process was legally insufficient, CareSource again states: "While the Agency may now contend that it attempted to measure each proposal against a common yardstick (i.e., the RFP), this simply does not qualify as comparing them as required by Iowa law." Id., at p. 12 (internal alterations omitted). While the Tribunal understands the textual claims CareSource is making, it is not persuasive.

The overarching DAS procurement rules require agencies to "compare provider qualifications, terms, conditions, and prices of equal or similar services" with the agencies being allowed to "weigh the relevant selection criteria in whatever fashion it believes will enable it to select the service provider that submits the best proposal." 11 I.A.C. § 118.3. Whether the term "compare" requires bids to be evaluated solely against each other as CareSource maintains or whether a comparison can involve the use of a scoring rubric as HHS maintains (and did) requires an analysis of what the term compare means. Interpretation of statutes and administrative rules follows a well-established methodology. The overarching purpose behind any statutory interpretation is to effectuate the legislature's intent, and the "first step when interpreting a statute is to determine whether it is ambiguous." State v. Iowa Dist. Court for Scott Cty., 889 N.W.2d 467, 471 (Iowa 2017). "A statute is ambiguous if reasonable minds could differ or be uncertain as to the meaning of the statute." The Sherwin-Williams Co. v. Iowa Dep't of Revenue, 789 N.W.2d 417, 424 (Iowa 2010) (internal quotation marks omitted). "Ambiguity arises in two ways—either from the meaning of specific words or from the general scope and meaning of the statute when all of its provisions are examined." State v. McCullah, 787 N.W.2d 90, 94 (Iowa 2010) (internal quotation marks omitted). A term or phrase is given its "common and ordinary meaning" often from a common usage dictionary, unless the legislature chose to define it or it had "a well-settled legal meaning" at the time the legislature passed the law. Miller v. Marshall Cty., 641 N.W.2d 742, 748 (Iowa 2002).

"If no ambiguity exists, [a] statute is rationally applied as written." Andover Volunteer Fire Dep't, 787 N.W.2d at 81. This is true absent the most exceptional circumstances where confidence exists that

"the legislature did not intend the result required by literal application of the statutory terms." Brakke v. Iowa Dep't of Nat. Res., 897 N.W.2d 522, 541 (Iowa 2017). Indeed, "the task is to interpret the statute, not improve it," and statutory interpretation cannot be used a guise for redrafting a statute, even one that is at best a "half measure" on an important issue. Id. A similar approach applies when considering the meaning of administrative rules. Colwell v. Iowa Dep't of Hum. Servs., 923 N.W.2d 225, 235 (Iowa 2019) ("The rules of statutory construction and interpretation also govern the construction and interpretation of administrative rules and regulations." (internal quotation marks and citation omitted)).

Here, the common and ordinary definition of the term "compare" is "to examine the character or qualities of (as two or more ... things) esp. for the purpose of discovering resemblances or differences." NextEra Energy Res. LLC v. Iowa Utilities Bd., 815 N.W.2d 30, 41 (Iowa 2012). The governing administrative rule does not appear to contain a more specific definition, and this common and ordinary definition includes agencies applying scoring rubrics to bids as HHS did because measuring how each bid scores in each subsection and overall is a method of discovering the resemblances or differences between them. The similarity and difference is represented in the scores, and the benefits of a common scoring rubric include ensuring that any given bid *also* meets a minimum level, which is critical for HHS as it provides medical care to hundreds of thousands of Iowans. It is not enough for a MCO bidder to just be better than other bidders; the MCO must also provide a minimum level of service.

To the extent there is any ambiguity in the term as to how a comparison can be conducted, the language and structure of the overall DAS rule would resolve it in favor of allowing HHS's action in this case. This is because the remaining language of the rule allows an agency to identify and weigh "relevant selection criteria in whatever fashion" the agency deems appropriate. This broad grant of authority is meant to provide substantial flexibility in the evaluation of bids, and this cuts in favor of a broad definition of compare that would allow far more types of comparison than HHS employed. The fact Director Garcia considered the scores *and* the related materials presented to her to decide on awarding two winning bids to the top two scoring bidders only enhances the conclusion a sufficient and reasonable comparison was made. There is just no substance to this claim.

ii.

CareSource's other procedural arguments fair little better. CareSource argues the evaluation process was not capable of producing reliable results because: the evaluation committee members lacked sufficient experience; the members were not given enough time to review the materials on their own; the scoring rubric was only provided later in the process; the committee members were not trained on the rubric's use; some of the documentation reveals some lengthy sections were scored in minutes; and there was insufficient notes justifying the scores. CareSource Br, at pp. 12-17. Proof of the lack of a meaningful evaluation, according to CareSource, can be seen in the variable and insufficient time spent scoring subsections, with CareSource stating in part: "It would have been physically impossible for the five evaluators to make a meaningful comparison of the content in 134 pages against the requirements set forth in Section A of the RFP in those 19 minutes, particularly given that the observations they made regarding 'strengths and weaknesses' were not tethered to the scoring rubric." Id., at p. 15. Whatever the cursory appeal of this multi-faceted argument, two difficulties exist in the position, namely that no statute, rule, or RFP requirement mandated a different evaluation process than what occurred and the catchall rationality requirement for all agency action cannot be used to demand more under the facts of this case.

First, there is no provision of law specifically requiring HHS to evaluate the bids in a manner different than that which occurred. Taking CareSource's specific arguments in turn, no statute or rule governs the qualifications and composition of an evaluation committee, and the RFP simply states:

> **4.2 Evaluation Committee.**
> The Agency intends to conduct a comprehensive, fair, and impartial evaluation of Bid Proposals received in response to this RFP. In making this determination, the Agency will be represented by an evaluation committee.

Ex. A-1, at p. 22. Accordingly, even though the Tribunal has little doubt about the collective expertise and experience of the committee (given each member brought a wealth of experience on a variety of relevant matters and represented a diverse perspective in terms of experience within government employment and the private sector), there is no technical error in its composition.

Likewise, no statute, rule, or RFP provision specifically detailed the method or means of either the individual or group review of the proposals beyond detailing a scoring rubric to be applied to the bids by the committee and what the final work product of the evaluation committee would be. Id., at p. 23. Relevant portions of the RFP state:

> ***4.3 Proposal Scoring and Evaluation Criteria.***
> The evaluation committee will use the method described in this section to assist with initially determining the relative merits of each Bid Proposal.
> . . .
> **Scoring Guide.**
> The Scoring Guide will be posted on the date indicated in the Procurement Timetable.
> 4.5 Recommendation of the Evaluation Committee.
> . . .
> The evaluation committee shall present a final ranking and recommendation(s) to the Medicaid Director for consideration. In making this recommendation, the committee is not bound by any scores or scoring system used to assist with initially determining the relative merits of each Bid Proposal.

Id. The Fourth Amendment to the RFP flushed out what the rubric would be, again stating: "During the evaluation process, the written technical proposal responses and oral presentations (if held) will be scored against each of the scoring criteria on a scale ranging from 0-4. Scores will be assigned based on the sole judgement of the evaluation committee[.]" Ex. 19, at p. 3. As such, since the governing standards do not articulate a specific method of individual review, no error can arise from the manner in which the committee members individually reviewed the materials or the timing of each member's review. In addition, since there were no proscribed standards for the length of discussions during the group scoring or what in particular had to be discussed, no error can arise from the committee collectively choosing to take the time it did when considering the bids or seemingly not discussing in depth certain sections upon which they apparently generally agreed on the quality.

In addition, no statute or administrative rule required the evaluation committee to be trained on the scoring rubric, which seeks to quantify the qualitative and thus uses more generalized standards. Indeed, with descriptions such as a three on the scoring rubric being "[b]idder has agreed to comply with the requirements and provided a good and complete description of how the requirements would be met," it is unclear what additional training would even be useful as the standard is straightforward. Ex. A-19, at p. 3. To the extent that one evaluator had a different perspective on the differences

between the scoring categories, the collective discussion and scoring would effectually ensure that the same view on the differences between the numerical scoring categories are applied in an equal fashion across the sections of each bid and between the bids. Having a consistent scoring regime is all that is required, and the Tribunal will note that reliance on standards versus mathematical computations is the norm not the exception in the Medicaid realm because of the complexity and variability of many services to be provided. Further, without any requirement in law as to when scoring rubrics had to be released, the timing of the release of the rubric also has no salience.

The lack of comprehensive notes justifying each scoring decision of the evaluation committee is also not fatal to the procurement. In most federal procurements, a general requirement exists to have sufficient documentation from an evaluation committee to enable review of its action (including scoring) and failure to do so will result in the award being set aside. See, e.g,. Matter of: Celta Servs., Inc., B-411835 (Nov. 2, 2015)("While we will not substitute our judgment for that of the agency, we will sustain a protest where the agency's conclusions are inconsistent with the solicitation's evaluation criteria, undocumented, or not reasonably based."). However, this requirements stems from a specific administrative rule. See, e.g., Dep't of the Army-Reconsideration, B-240647 (Feb. 26, 1991) ("The Federal Acquisition Regulation (FAR) requires agencies to document their selection decisions so as to show the relative differences among proposals, their weaknesses and risks, and the basis and reasons for the selection decision. FAR § 15.612(d)(2)."). DAS has no comparable rule, and without any other provision of law or the RFP requiring notes, the lack of any documentation beyond that which the committee produced cannot create any procedural defect. In fact, CareSource seems to acknowledge that many of the procedural errors it alleges do not conflict with any specific provision of law and are instead grounded in the catchall requirement for agency action to be rational. See, e.g., Reply Br., at p. 18 ("CareSource does not contend that there is a statutorily-prescribed process for either evaluator training or the individual review. CareSource does contend, however, that these aspects of the process should have been designed and implemented in furtherance of a fair, impartial and objective procurement—but were not.").

Second, and turning to CareSource's broader rationality claim, the reasonableness requirement for agency action did not require the procedures CareSource demands and cannot be used to modify the Notice, at least under the facts of this case. At its core, all agency action must at least be rational, that is not "unreasonable, arbitrary, capricious, or an abuse of discretion." Iowa Code § 17A.19(10)(n). The test for unreasonableness is generally "an action in the face of evidence as to which there is no room for difference of opinion among reasonable minds, or action not based on substantial evidence," and the test for arbitrary and capricious is an action "taken without regard to the law or facts of the case." Arora v. Iowa Bd. of Med. Examiners, 564 N.W.2d 4, 7 (Iowa 1997). Abuse of discretion "is synonymous with unreasonableness, and involves lack of rationality[.]" Stephenson v. Furnas Elec. Co., 522 N.W.2d 828, 831 (Iowa 1994).

Caresource's claim—that it was beyond the range of reasonable to select the evaluation committee members it did, given some had limited experience with Medicaid or at least procurement and given the power differential in their positions within HHS—is not compelling. This is because the broad range of rationality allows for an agency to make the policy decision on which individuals' training and experience would be worthwhile as balanced by the other needs of the agency absent the most compelling circumstances not present here. Moreover, no implicit bias training was required as such generalized concerns—at least with respect to the types of implicit bias alleged in this case, that is, "social influence bias, group think, bandwagon effect, proximity bias, and conservatism bias"—are not sufficient to require agency in a procurement matter where the procedural protections are limited to expend resources to address such to meet the baseline rationality requirement for its action. HHS

may wish to invest in such training, but the Tribunal cannot find any authority directly requiring, as at most the doctrine appears to be in a state of flux mostly in criminal matters where the procedural protections are higher and the background circumstances at issue appear distinguishable. See, e.g., State v. Williams, 929 N.W.2d 621, 633 (Iowa 2019) (discussing the issue in terms of a requested instruction in a criminal case). Likewise, it is not beyond the vast range of reasonable to allow committee members to review the bids individually to their own satisfaction and then score them with a self-explanatory rubric in a collective fashion, taking the time the committee deemed fit. Rationality also does not require fabricating a documentation requirement.

While HHS went out of its proverbial way to ensure a balanced discussion through alternating initial speakers during the committee evaluation after randomly determining the order of evaluation, such was not required, and rationality does not require each member to speak for a certain amount of time or the committee to spend equal amounts of time scoring each section. This is particularly true since the testimony of all the evaluation committee members and demeanor (at least of the committee members that testified) revealed they were thoughtful professionals, who cared deeply about the mission of HHS and ensuring they did what was necessary to have a balanced, reasoned review of the bids. Each knew the stakes of the procurement and brought their unique wisdom and insight to the process. Whatever the precise contours of the rationality line, this case does not approach it.

Director Garcia's final decision also does not violate any procedural rationality requirement of procurements. CareSource effectively argues Director Garcia could not have rationally selected the two winners of the bids because Director Garcia's decision "appears to have been based entirely on a single, hastily-constructed, two page document," with neither her nor Director Matney ever reading "the submitted proposals or [speaking] with the evaluation committee." CareSource Br., at p. 2, 4. CareSource specifically takes issue with both Directors looking at the strengths and weakness document submitted by the committee to "allay" their concerns about Molina's high score and failing to delve "deeper into the factual basis" for the difference between Amerigroup and CareSource. Id., at p. 16. Whatever the cursory appeal of such a claim, it has no substance because it is within the range of reasonable for the final decision maker to rely on an evaluation committee's technical score of the proposals to determine which bids are superior absent extraordinary circumstances not present here. Indeed, the purpose of the evaluation committee is generally to determine the technical value of the bids, and Directory Garcia using this and deciding to award contracts to the two highest bidders in light of her judgment on the needs of the agency and overall landscape of the government is exceedingly common and well-within the bounds of reasonable. Director Garcia overseas the largest agency in Iowa, and her strongest expertise lies in management of Medicaid and related systems.

Frankly, it would be unusual (but permissible) for the final decision maker to conduct an individual, internal review of all of the bids on a project of this complexity, as what would the point of the evaluation committee be. The fact that Directors Matney and Garcia reviewed the committee's final work product, checked on the atypical Molina score, and had rough calculations on options reveals a process that falls within the vast expanses of reasonableness. The additional fact this procurement concerns billions of dollars and is likely the largest in Iowa history does not materially alter the analysis. This is particularly true since the related strengths and weaknesses document along with the scoring material provided the context for the scores, thereby further enabling a decision maker to rely on the underlying scores. If the committee needed to say something, it could have, and its silence on any material issue with the scores makes it even more reasonable to not individually meet with the members and instead rely on its scores. This claim again has no substance, and CareSource cannot use the rationality requirement to demand an entirely new procurement process.

iii.

CareSource's final procedural arguments also lack sufficient substance to set aside the Notice. CareSource argues an impermissible conflict of interest existed because the evaluators often worked with Amerigroup as part of their regular duties and because at least some had knowledge of Molina's chief executive officer, given she used to run Iowa Medicaid and has otherwise been involved in the market. CareSource argues the improper apparent and actual conflict of interest can be seen in part by some of the evaluators raising the concern on their conflict forms and HHS doing nothing. CareSource relies in part on Medco, and its arguments are again unpersuasive because, while the position it advocates is within the range of reasonable, it is not required.

In Medco, the Iowa Supreme Court held HHS's requirement to follow federal law in Medicaid matters included the duty to follow federal law concerning procurements, which in that case included rules on organizational conflicts of interest. Medco, 553 N.W.2d at 564 ("The statute thus directs DHS, in its impartial administration of the state Medicaid program, to follow federal law concerning the procurement process for the managed mental health care contract."). While the duty to follow federal law has remained since Medco, federal procurement law has changed with the governing rule now stating:

> When procuring property and services under a Federal award, a state must follow the same policies and procedures it uses for procurements from its non–Federal funds. The state will comply with § 75.331 and ensure that every purchase order or other contract includes any clauses required by § 75.335. All other non–Federal entities, including subrecipients of a state, will follow §§ 75.327 through 75.335.

45 C.F.R. § 75.326. Since HHS meets the definition of a state in this context and since sections 75.331 and 75.335 do not relate to conflicts of interest in procurements, HHS is only bound to follow the procurement procedures used for its non-federal acquisitions. See generally, 42 C.F.R. § 431.10 (federal requirement for a single state agency). What this means is that the process in this case must only comply with the general procurement requirements demanded by the Iowa Constitution, the Iowa Administrative Procedures Act's standards for agencies, HHS's governing statute, and the variety of aforementioned statutes and rules on competitive selection in this context.

As evidenced by the Supreme Court's analysis is Medco, Iowa law has no established conflict of interest standards applicable to public contracting. Medco, 553 N.W.2d at 563. A statutory duty does exist for HHS to administer the Medicaid program impartially under Iowa Code chapter 249A, and coupled this with the omnipresent duty of an agency to act rationally, little doubts exists some conflicts of interest would intrinsically be improper. As for the precise counters of what would be an intrinsic conflict of interest, it will remain unknown because the RFP effectively creates standards for such and the RFP's requirements are not unreasonable or otherwise beyond the scope of impartiality. Indeed, in allowing HHS staff to communicate on "any contract currently in effect" between a bidder and the agency, the RFP effectively authorizes incumbents to bid (which is expressly contemplated in other parts of the RFP) and agency staff working with incumbents on current contracts to still be evaluators, decision makers, or otherwise involved in the RFP process. Ex. A-1, at p. 11. HHS's position to allow such conduct and not view it as a disqualifying actual or apparent conflict of interest is common and within the bounds of propriety. Requiring a full separation from evaluators and a current vendor performing work that is also bidding to renew the contract would result in an agency being forced to choose between selecting less knowledgeable personnel for the evaluation or taking key personnel away from their duties for a significant period of time. This is a high cost and not

required at least under the facts of this case, which shows the evaluators and final decision maker did not let Amerigroup improperly influence the process. In fact, reviewing the transcripts of the hearing and recalling the demeanor of the various witnesses discussing Amerigroup, Amerigroup's current contract performance appears so unremarkable that no one considered it of significance good or bad beyond what points the MCO properly secured during the review of its bid. The general gist of each witness's claims was that Amerigroup was a competent MCO with various problems like every other major vendor. Indeed, Director Garcia simply chose the two highest scoring bids, and the fact she almost selected Molina alone due to its high score is telling of the lack of an improper influence by Amerigroup.

Even the Medco case upon which CareSource focuses would not prohibit this. At the time of Medco, the governing federal rules prohibited "organizational conflicts of interest," which generally included: (1) "by virtue of its performance of a government contract, [a contractor] has to some degree set the 'ground rules' for the government contract at issue by, for instance, writing the work statement or drafting the contract specifications"; (2) "a firm's work under one government contract might require an evaluation of its own performance under another government contract"; and (3) "a firm has access to nonpublic information as part of its performance of an earlier government contract that may provide it with a competitive advantage in the current government contract in question." Medco, 553 N.W.2d at 565. None of these situations exist in this procurement (meaning that, even if Medco still applies, the result would be the same), and none of the three categories of organizational conflicts of interest either prohibit an incumbent from bidding or agency staff from evaluating an incumbent's bid when they have to work with the bidder on an existing contract. Further, the court's decision in Noridian, which CareSource also cites, does not change this because the conflict-of-interest issue in that case arose because of an RFP requirement that is not at issue here. Noridian, at pp. 23-24. Caresource's remaining attempt to graft the exacting conflict-of-interest rules for the judiciary onto the evaluators and decision makers is also no avail in part because those rules—to the extent that they can be conceptualized into a bidder evaluation process—are generally limited to quasi-judicial agency action, such as the Tribunal hearing this matter. See, e.g., Iowa Farm Bureau Fed'n v. Env't Prot. Comm'n, 850 N.W.2d 403, 418 (Iowa 2014) ("The common thread tying contested cases together in the due process context—a fair tribunal—is only truly necessary because of the function of determining adjudicative facts.").

In short, the fact that that the evaluation committee members and other agency personnel interacted with the bidder on an existing contract does not create either an appearance of conflict or an actual conflict under the facts of this case. This does not change because some of the evaluators raise this as a concern when signing the no-conflict forms; it just shows how conscientious they were about the process. Moreover, this does not change because a key staff of another bidder previously ran Iowa Medicaid and had some professional relationships with evaluating HHS staff at some points in time. Indeed, it is unclear why this fact alone would create an inference of a material conflict of interest, and while not dispositive in anyway, it is worth noting CareSource even attempted to recruit the prior Director. Nov. 22 Tr., at p. 359 ("Q. How did you know who she was? A. She was former Medicaid director in Iowa. I actually, my very first month here, also tried to get her to come work for CareSource, knowing that she was going to be a, you know, a benefit to whoever had the opportunity to snag her."). Accordingly, no impermissible conflict of interest existed.

iv.

CareSource's substantive claims as to improper scoring by the evaluation committee and the final decision, while have some salience, are insufficient to set aside or otherwise modify the Notice

in this case. As indicated by its representative during testimony, the heart of CareSource's appeal is its claim that the evaluation committee improperly scored CareSource's bid and that HHS must either explain why the evaluation committee' scoring is correct or change its action. This desire to have a specific explanation for the scoring is more than understandable, but this is one of the few areas of government action where such a demand generally cannot be fully answered because of the judgment calls involved in evaluations of proposals and the standard of review.

Broadly speaking, and regardless of the specific legal regime in place, great hesitation exists in delving into the actual scoring of a proposal whether the review is administrative or judicial in nature. See, e.g., Dismas Charities, Inc. v. United States, 61 Fed. Cl. 191, 198 (2004) ("Generally, the details of technical rating decisions involve discretionary determinations that a court will not second guess."); Advanced Electromagnetics, Inc., B-208271, 83-1 CPD P 360, at p. 3 (Apr. 5, 1983) ("Our review of the evaluation of technical proposals is thus necessarily limited—we do not independently evaluate proposals and make our own determination as to their acceptability. Nor do we refer proposals to independent technical reviewers for evaluation."). This is because "evaluation of proposals for their technical excellence or quality is a process that often requires the special expertise of procurement officials" that reviewing officers and courts lack. Tech Sys., Inc. v. United States, 98 Fed. Cl. 228, 243 (2011). Even when such evaluation is done, it is generally restricted whether there was a reasonable basis for the score and not a de novo review of the score. See, e.g., Matter of: The Clay Grp., LLC, B-406647, 2012 CPD P 214, at p. 7 (July 30, 2012) ("Given the limited nature of the evaluation record, and the agency's failure to address the protester's challenges, we are unable to conclude that the agency's evaluation had a reasonable basis."). This is the appropriate standard in this case because all agency action must, at its core, be rational—meaning that all scores are within the range of reasonable and not beyond all review—and because the substantial compliance standard that would apply to any scoring errors does not appear to demand more.

As for whether any specific score was reasonable, the Tribunal must first note there do not appear to be any material, facial errors in the scoring. There is, for example, no missing section nonetheless given the highest score or a similar issue that is readily apparent as a matter of simple observation or logic. At most, some of the comments on the strength and weaknesses or other documents do give some pause for concern such as the critique of how CareSource handled the LTSS member stakeholder advisory board and enrolled member advisory committee. Ex. O-9, at p. 2. However, because such comments are general in nature in terms of overall impression and do not indicate any specific scoring impact, any questionable comment alone is insufficient to prove a material error in the scoring or even the final decision—as Director Garcia relied essentially on the scoring. CareSource even appears to acknowledge this disconnect between the overall comments and the specific scoring, arguing in its closing brief "no effort to ensure that the select strengths and weaknesses were linked to or consistent with the numerical scoring." CareSource Br, at pp. 26-27; see also Reply Br., at p. 30 (CareSource noting "the consensus notes are not tethered to the scoring. Witness after witness testified, unequivocally, that the consensus notes are totally disconnected from the numerical scores, and there is no way to make sense of the numerical scores through references to the consensus notes").

Further, it is unclear the extent to which many of the identified weaknesses CareSource takes issue with are erroneous or the extent to which any seemingly similar sections between the bidders were scored differently. The evaluation committee was not limited to blindly accepting the claims and proposed solutions in the bids. Instead, the evaluation committee was tasked with bringing its collective experience, wisdom, and judgment to understand the proposed solution being offered to discern its feasibility and value, which entails: making a variety of judgment calls including on the ability of a bidder to execute a promise; looking at how a specific section interlocks with the overall proposal; and even occasionally

assessing information beyond the proposal. See, e.g., A-19, at p. 1. ("The Agency reserves the right to obtain and consider information from other sources concerning a Bidder, such as the Bidder's capability and performance under other contracts, and the Bidder's authority and ability to conduct business in the State of Iowa. Such other sources may include subject matter experts."). A Tribunal reviewing the scoring must look beyond cursory claims of similarity or erroneous weaknesses to consider the deeper totality of the proposals and their respective portions. It is on the deeper level CareSource cannot carry its burden of proof to establish error or at least material error sufficient to overcome the points with Amerigroup necessary to show prejudice since points controlled the outcome.

Taking section F.12.B for example, as it is CareSource's first claim of error, CareSource effectively alleges it was improperly given 2 points instead of 4 points like Molina even though there is no explanation for the difference beyond the strengths and weaknesses document, which criticizes CareSource for items it has in its bid. Ex. 186A, at pp. 8-9 ("The only explanation provided for downgrading CareSource appears in the consensus "Strengths and Weaknesses" summary document, in which the Evaluation Committee claimed that CareSource failed to address certain material components. But, . . ., a review of CareSource's proposal reveals that CareSource ***did*** in fact address ***each and every one*** of the allegedly 'missing' items. Thus, assigning CareSource only half of the available points was clearly arbitrary and contrary to the evidence."). This claim, though, misses the mark. Apart from the aforementioned issue of attempting to use the comments to shed light on a scoring decision, comparing Molina's F.12.B section to CareSource's and considering the remainder of the proposals, it is readily apparent significant overlap exists in the responses, given many aspects of the responses effectively use similar marketing language to state the respective company will meet or exceed requirements by using training, metrics, prior experience and other generally described methods which are self-evident to any business of substance. In the aggregate, though, and frankly in a way the Tribunal finds difficult to specifically articulate, Molina's bid section does appear to be both more grounded and substantive than CareSource's section, which appears have a stronger emphasis on stylistic presentation. Couple this with the fact that the solutions are not identical in all respects, the Tribunal cannot find any basis to conclude the score was unreasonably different or even in error at all, particularly given the evaluation committee's independent assessment has more credibility than the committee CareSource had reviewing the matter. In fact, many aspects of CareSource's claims requires its proposal to be accepted at face value if not more with little scrutiny, and this is not how evaluations occur or even how the Tribunal reviews evaluations. Broadly speaking, the same overarching analysis applies to the myriad of other scoring challenges CareSource raises in that the Tribunal cannot find enough in the record to demonstrate an utter lack of rationality when a holistic review of the matter is conducted. This is fatal to CareSouce's claim because it bears the burden of proof.

Finally, Director Garcia's final decision to select two winners and rely on the evaluation committee's points was not substantively unreasonable. As an initial matter, the RFP did not require Director Garcia to select any specific number of bids, as the RFP stated it reserved the right to terminate the procurement process and it only "intend[ed] to contract on a statewide basis with one (1) or more bidders." Ex. A-1, at p. 7. The prior materials also did not promise any specific number of winning bidders, and even though it would be substantively unreasonable particularly for a sophisticated company like CareSource to read any of HHS's claims as guaranteeing a specific number of winners, it is worth noting estoppel does not lie against the government absent the most unusual circumstances not present here. See, e.g., ABC Disposal Sys., Inc. v. Dep't Of Nat. Res., 681 N.W.2d 596, 607 (Iowa 2004) ("We have consistently held equitable estoppel will not lie against a government agency except in exceptional circumstances."). As for deciding on two winning bidders based on her perception of Medicaid needs and the overall acceptance of a decision, this easily falls within the range of reasonable, and the Tribunal will not second guess such an intrinsically strategic policy decision. Such decisions are best left to the elected officials and their appointees, and this is particularly true since there is oversight and related costs to

bringing additional MCOs on board. CareSource's claim that the money at issue in this case makes such costs irrelevant is unpersuasive and not mindful of the limited resources in the Medicaid program. As for using a proverbial "back of the napkin" forecast on the costs of various MCO options and member distribution, this is also well within the range of appropriate. The procurement would have been proper even without any such sheet, and the fact this procurement is worth more than other procurements does not change the substantive requirements. This also overlooks the overall conversations about the bids Director Garcia had with her staff. Finally, as for relying on the points to identify the two winning bidders, this is also well within the range of reasonable because the calculus behind the decision was that there was nothing atypical enough in the process or bidders to justify deviating from the scores and because such a calculus is supported by the record and is at the very heart of the broad range of what is reasonable.

In short, CareSoruce's various claims are insufficient to alter the Notice, and as such, HHS's action in this case must be AFFIRMED in full. This conclusion moots out some of the procedural arguments by HHS and the interveners, and to the extent that CareSource was attempting to raise additional claims in its expansive opening statement and briefs, such are rejected.

ORDER

HHS's action in this case is AFFIRMED. HHS shall take whatever action is necessary to implement this decision.

IT IS SO ORDERED.

Dated this the 3rd day of February 2023.



Jonathan M. Gallagher
Administrative Law Judge

cc: AAC IME
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