

AMENDMENT #01

HEALTH CARE AUTHORITY

REQUEST FOR PROPOSALS (RFP)

**Professional Services for
Medicaid Financial and Actuarial Support**



**HEALTH CARE
AUTHORITY**

RFP# 27-630-8000-0009

RFP Release Date: September 11, 2026

Proposal Due Date: October 12, 2026

ELECTRONIC-ONLY PROPOSAL SUBMISSION

This Amendment No. 01 serves to:

- **Modify the following sections on the specified pages of the RFP**
- **Provide answers to Offeror clarification questions**

The following sections on the specified pages of the RFP have been amended as follows:

CHANGE ON PAGE 10-11

Section I. INTRODUCTION has been amended to read as follows:

C. SCOPE OF PROCURMENT

The State of New Mexico Health Care Authority (HCA), Medical Assistance Division (MAD), is seeking one or more Contractor(s) to provide Actuarial and Rate Setting Services and Medicaid Financial Consulting Services as described in Section IV of this RFP.

HCA seeks qualified Offerors with the experience and expertise necessary to perform the requirements under the stated Scope of Work. This procurement may result in a single award, multiple awards, or no award.

Offerors must meet the following conditions to be eligible for contract award:

1. The Offeror may not be a New Mexico Medicaid provider nor a Managed Care Organization (MCO).
2. The Offeror must provide sufficient assurances to the State that award of a contract will not create a conflict of interest between the Contractor and HCA, any New Mexico Medicaid MCO, or any MCO subcontractor.
3. The Offeror agrees not to enter into any contractual or employment relationship with any MCO participating in the New Mexico Medicaid managed care program.
4. The successful Offeror may not enter into consultant services agreements with potential New Mexico Medicaid managed care Offerors related to any New Mexico Medicaid managed care procurements.
5. The Offeror may not currently be a subcontractor to a company performing Medicaid services for HCA.
6. The Offeror may not be contracting with any tribal, state, or local government entity that is a Medicaid provider or contractor.

For purposes of Conditions 1–6, “Offeror” includes the legal entity submitting the proposal as well as any parent companies, subsidiaries, affiliates, and commonly controlled divisions or business

units. All conflict-of-interest requirements apply to the Offeror's broader corporate structure to ensure that no direct or indirect relationships with New Mexico Medicaid MCOs or their subcontractors create an actual or perceived conflict of interest.

The term of the resulting contract(s) will be up to four years, beginning on or before January 1, 2027, and may include optional extensions as set forth in the final contract(s). HCA provides a high-level overview of the services sought below, with further detail in Section I.B (Background Information) and Section IV.A (Detailed Scope of Work).

Additional Details on Professional Independence and Coordination

- All actuarial certifications must reflect independent professional judgment.
- Actuarial work must remain compliant with Actuarial Standards of Practice (ASOPs) and 42 CFR §438, regardless of any policy recommendations.

If separate Contractors are awarded:

- Contractors shall coordinate as directed by HCA.
- HCA retains final decision-making authority.
- Neither Contractor shall exercise supervisory authority over the other.

This procurement will result in a contractual agreement between two parties; the procurement may ONLY be used by those two parties exclusively.

CHANGE ON PAGE 33

Section III. RESPONSE FORMAT AND ORGANIZATION has been amended to read as follows:

B.1. Proposal Content and Organization

Direct reference to pre-prepared or promotional material may be used if referenced and clearly marked. Promotional material must be minimal. The proposal must be organized and indexed in the following format and must contain, at a minimum, all listed items in the sequence indicated.

Technical Proposal

DO NOT INCLUDE ANY COST INFORMATION IN THE TECHNICAL PROPOSAL.

1. Signed Letter of Transmittal
2. Signed Campaign Contribution Form
3. Table of Contents
4. Executive Summary
5. Response to Contract Terms and Conditions (from Section II.C.15)

6. Offeror's Additional Terms and Conditions (from Section II.C.16)
7. Response to Specifications. **Offeror responses to the Specifications noted in IV.B shall not exceed 50 pages.**
 - a. Organizational Experience
 - b. Organizational References
 - c. Mandatory Specifications
8. Financial Stability (Financial information considered confidential, as defined in Section I.F. and detailed in Section II.C.8, should be placed in the Confidential Information file, per Section III.B.2.a, as applicable)
9. Other Supporting Material, including Subcontracting Plan (if applicable)
10. Completion of other required forms (see Appendices).

CHANGE ON PAGE 35

This item has been amended to read as follows.

8. Response to Specifications

The Specifications and detailed Scope of Work may be found in Section IV of the RFP. This section contains information required in the submission of proposals. Offerors must respond with a thorough narrative to each numbered requirement, in the exact order in which the requirements appear. Each requirement must be restated in full, followed by the Offeror's response.

Responses to the Technical Specifications noted in IV.B (and referenced in Section III.B – Proposal Content and Organization, Item 1: Technical Proposal) shall not exceed 50 pages.

Supplemental information may be included in appendices, provided that all appendix content is clearly cited within the primary narrative and remains concise and proportionate to the overall submission.

Supplemental appendices may include:

- Additional team biographies (beyond key personnel discussed in IV.B)
- Subcontracting Plan
- Other supporting material

CHANGE ON PAGES 43-44

Section IV. SPECIFICATIONS has been amended to read as follows:

B.3 Mandatory Specifications

The mandatory specifications below directly correspond to the **Detailed Scope of Work: Actuarial and Financial Services in Section IV. A 1** Offerors responding must demonstrate their ability to successfully perform all actuarial duties described therein, including:

- a) **Rate Development & Certification**
Ability to develop and certify actuarially sound capitation rates compliant with 42 CFR Part 438, CMS checklist, ASOPs, and Academy qualification standards (FSA/MAAA).
- b) **Rate Setting Activities**
Ability to perform cohort construction, trend analysis, benefit/regulatory adjustments, and development of all non-benefit components.
- c) **Rate Updates**
Ability to perform rate updates and mid-year adjustments and provide revised certifications.
- d) **Risk Adjustment**
Ability to develop, validate, update, and apply Medicaid risk adjustment models and integrate risk scores into rates.
- e) **Financial Analysis & Reconciliation**
Ability to perform risk corridor analysis, underwriting gain calculations, contractual reconciliations, TPL analyses, and tax/assessment evaluations.
- f) **Section 1115 Modeling**
Ability to perform budget neutrality modeling, PMPM projections, cumulative tracking, and fiscal analysis of waiver amendments.
- g) **Medicaid Budget & Forecasting**
Ability to develop and maintain multi-year Medicaid financial forecast models; project enrollment and expenditure trends by eligibility category; prepare fiscal impact analyses for proposed legislation and program changes; and support HCA in responding to budgetary inquiries from State agencies, the Legislative Finance Committee, and other stakeholders, as needed.
- h) **Transparency & Documentation**
Ability to deliver all required datasets, formulas, models, assumptions, and version-controlled documentation to allow full replication.
- i) **Stakeholder Support**
Ability to participate in meetings (HCA, MCOs, CMS) and support CMS review.

j) **Transition**

Ability to perform full end-of-contract transition, including transfer of all models, data, methodologies, and documentation

CHANGE ON PAGE 46

Section V. EVALUATION has been amended to read as follows:

A. EVALUATION POINT SUMMARY

The following is a summary of evaluation factors with point values assigned to each. These weighted factors will be used in the evaluation of individual potential Offeror proposals by sub-category.

Table 1: Evaluation Point Summary: Business Specifications

Evaluation Factors	Points Available
TECHNICAL SPECIFICATIONS	650
Organizational Capability and Experience	150
Organizational References	75
Mandatory Specifications • Rate Development & Certification • Rate Setting Activities • Rate Updates • Risk Adjustment • Financial Analysis & Reconciliation • Section 1115 Modeling • Medicaid Budgeting & Forecasting • Transparency & Documentation • Stakeholder Support • Transition	425
COST PROPOSAL	300
ORAL PRESENTATIONS (if conducted)	50
TOTAL POINTS AVAILABLE	1,000
BUSINESS SPECIFICATIONS	Pass/Fail
Financial Stability	<i>Pass/Fail</i>
Letter of Transmittal	<i>Pass/Fail</i>
Campaign Contribution and Disclosure Form	<i>Pass/Fail</i>
Suspension and Debarment Requirement Form	<i>Pass/Fail</i>

CHANGE ON PAGE 48

Section V. EVALUATION has been amended to read as follows:

B. EVALUATION FACTORS

5. Business Specifications (Financial Stability)

- **Financial Stability (See Table 1)**

Pass/Fail only. No points assigned.

Financial stability will be evaluated using a viability ratio defined as:
Total Equity divided by Total Liabilities.

“Total Equity” refers to the equity available to support ongoing operations, as reported in the Offeror’s most recently completed fiscal-year audited financial statements or, where applicable, the Offeror’s most recent Form 10-K.

The Offeror must maintain a minimum viability ratio of not less than 1.00:1.00, measured at the fiscal year end.

- A ratio below 1.00:1.00 will receive a FAIL.
- A ratio equal to or greater than 1.00:1.00 will receive a PASS.

Offerors must clearly identify the financial-statement line items used to calculate the ratio.

APPENDIX D COST RESPONSE FORM

Appendix D Cost Response Form has been amended to clarify requirements and remove illustrative examples

Please see updated Appendix on page 7.

(Continued on following pages)

APPENDIX D

COST RESPONSE FORM

Professional Services for
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The offeror should indicate a total cost per state fiscal year for implementation of their service. Cost Proposals must be inclusive of the deliverables and activities described in Section IV.A and the Mandatory Specifications in Section IV.B.3, and should include any administrative or programmatic costs necessary to support the Offeror's proposed methodologies, approaches, and value-added activities.

Offeror should include relevant budget tables and accompanying budget narrative.

FIRM NAME:	
SIGNATURE:	DATE:

HCA answers to Offeror clarification questions:

RFP Section & Page Number	Question	Answer
RFP section I.B. – p. 10 – Fee-for-Service (FFS) Populations	The RFP seems focused on the managed care arrangements in the State. Can the State verify that there would be no requests, ad hoc or otherwise, related to fee-for-services costs or populations?	The Scope of Work is primarily focused on the State’s managed care program; however, New Mexico administers both managed care and fee-for-service Medicaid. While most actuarial activities relate to managed care, Offerors should anticipate that ad hoc or limited requests related to fee-for-service costs or populations may occur as needed to support program operations. Any such requests would fall within the Scope of Work as described in the RFP and within final budget.
Section I.C, Scope of Procurement (pp. 10–11); Section IV.A, Detailed Scope of Work (pp. 36–41)	The RFP states that this procurement may result in a single award or multiple awards. If multiple awards are made, how does HCA anticipate allocating responsibilities among contractors?	The RFP allows for the possibility of multiple awards if the State determines that doing so is in its best interest; however, all Offerors must propose on the complete Scope of Work. If multiple awards are made, HCA will clearly delineate roles, responsibilities, and deliverables among contractors to avoid redundancy and ensure effective coordination and collaboration.
RFP section I.C. – p. 10 – Scope of Procurement	In the Scope of Procurement, the RFP indicates that multiple contractors may be offered awards. Can an offeror respond to a subset of the scope? How would multiple awards impact other areas of the RFP – proposal evaluation, coordination of State contractors, transfer of duties, etc.?	Offerors must respond to the full Scope of Work. Partial or subset responses will not be considered. The RFP allows for the possibility of multiple awards if the State determines that doing so is in its best interest; however, all Offerors must propose on the complete scope. Proposal evaluation, contract management, and any transfer of responsibilities will be handled by HCA in accordance with the RFP and applicable State procurement requirements. If multiple awards are made, HCA will clearly delineate roles, responsibilities, and deliverables among contractors to avoid redundancy and ensure effective coordination and collaboration.
I. Introduction, C. Scope of Procurement, page 10	Section I.C states that the procurement may result in a single award or multiple awards, and provides that if separate Contractors are awarded, they shall coordinate as directed by HCA with neither exercising supervisory authority over the other. If HCA elects to make multiple awards, would a single Contractor be awarded	If multiple awards are deemed in the State’s best interest, HCA will determine the scopes of work and assign responsibilities accordingly. Specifics will be defined during contract development and provided to selected Contractors.

	developing and certifying the capitation rates required under 42 CFR §§ 438.4 and 438.7? We ask because the certifying actuary must be able to support the full rate development, including the risk adjustment methodology described at 42 CFR § 438.5(g) and documented under § 438.7(b)(5), in order to sign the certification consistent with applicable Actuarial Standards of Practice.	
I. Introduction, C. Scope of Procurement, page 10	Does HCA intend that capitation rate development, rate certification, rate updates and mid-year adjustments, and risk adjustment remain with a single Contractor, or would HCA consider dividing these activities among multiple Contractors?	See above.
C. Scope of Procurement, Conditions to be eligible for contract award, Page 10	Condition 2 requires assurances that award "will not create a conflict of interest between the Contractor and HCA, any New Mexico Medicaid MCO, or any MCO subcontractor," and Condition 3 prohibits "any contractual or employment relationship with any MCO participating in the New Mexico Medicaid managed care program." For purposes of Conditions 1–6, does "the Offeror" mean solely the legal entity submitting the proposal, or does it also include that entity's parent, subsidiaries, affiliates, and commonly controlled divisions or business units? For example, if an Offeror's parent company or an affiliate under common ownership holds contractual relationships with health insurers or MCOs, including entities participating in the New Mexico Medicaid managed care program, are those relationships attributed to the Offeror for purposes of Conditions 2, 3, and 5? To the extent the employees in the affiliate serving HCA had equity incentives in the parent company, would that be considered a conflict of interest given the value of the equity incentives could be influenced by contractual relationships a separate affiliate company had with Medicaid managed care organizations?	For purposes of Conditions 1–6, “the Offeror” includes the legal entity submitting the proposal as well as its parent companies, subsidiaries, affiliates, and any commonly controlled divisions or business units. This ensures that potential conflicts of interest are evaluated across the broader corporate structure, not solely within the specific proposing entity. Accordingly, contractual or employment relationships held by an Offeror’s parent or affiliated entities with New Mexico Medicaid MCOs or their subcontractors would be attributed to the Offeror for purposes of Conditions 2, 3, and 5. Similarly, equity-based compensation or incentives tied to a parent or affiliate organization that has relationships with New Mexico Medicaid MCOs may be considered a conflict of interest under these conditions. Offerors are responsible for disclosing any such relationships so the State may evaluate compliance with the conflict-of-interest requirements described in the RFP. Section I.C. has been updated in Amendment 1 accordingly.
I. Introduction, C. Scope of Procurement, page 11	The RFP states that “[t]he Offeror may not be contracting with any tribal, state, or local government entity that is a Medicaid provider or contractor.” Please clarify whether this restriction applies only to contracts involving New Mexico Medicaid or New Mexico Medicaid managed care, or whether it applies to an Offeror’s Medicaid-related contracts with government entities in any state.	This restriction applies to contracts involving New Mexico Medicaid or New Mexico Medicaid managed care. The intent is to avoid conflicts of interest with entities participating in the New Mexico Medicaid program. It does not extend to an Offeror’s Medicaid related contracts with government entities in other states. See additional clarification above.

I. Introduction, C. Scope of Procurement, pages 10–11	Can HCA confirm that, per bullets #3 and #5 on pages 10–11, an Offeror currently under contract to provide services directly to a New Mexico Medicaid Managed Care Organization (MCO) or Medicaid provider is ineligible for contract award?	Correct. See additional clarification above.
II. Conditions Governing the Procurement, B. Explanation of Events, 9. Oral Presentations, page 21	Are there specific proposed staff that must attend the Oral Presentation, such as any of the key actuarial and financial personnel described under IV.B.1.b of the RFP?	Oral presentations have not yet been determined to be necessary by the Evaluation Committee. At this time, there is no required list of personnel who must attend. If the Committee decides to conduct oral presentations, additional guidance, including any expectations regarding participation from key actuarial or financial staff, will be provided during the evaluation period.
RFP section III B.1 Proposal Content + Organization III B.8 Response to Specifications (pages 33 & page 35)	Responses to the Specifications shall not exceed 50 pages. Can you clarify what specifications are assumed here (mandatory only? Business?)	The 50-page limit applies only to responses to the Technical Specifications listed in Section IV.B. This includes the Offeror’s narrative responses to: • Organizational Capability and Experience • Organizational References • Mandatory Specifications The following RFP sections have been amended accordingly Section III B (PROPOSAL CONTENT AND ORGANIZATION) item 1. Technical Proposal has been amended for clarity: Technical Proposal <u>DO NOT INCLUDE ANY COST INFORMATION IN THE TECHNICAL PROPOSAL.</u> 11. Signed Letter of Transmittal 12. Signed Campaign Contribution Form 13. Table of Contents 14. Executive Summary 15. Response to Contract Terms and Conditions (from Section II.C.15) 16. Offeror’s Additional Terms and Conditions (from Section II.C.16) 17. Response to Specifications

		<u>Offeror responses to the Technical Specifications noted in IV.B shall not exceed 50 pages.</u> Technical Specifications (IV.B) include: • Organizational Capability and Experience • Organizational References • Mandatory Specifications 18. Financial Stability (Financial information considered confidential, as defined in Section I.F. and detailed in Section II.C.8, should be placed in the Confidential Information file, per Section III.B.2.a, as applicable) 19. Other Supporting Material, including Subcontracting Plan (if applicable) 20. Completion of other required forms (see Appendices). Section III B.8. Response to Specifications The Specifications and detailed Scope of Work may be found in Section IV of the RFP. This section contains information required in the submission of proposals. Offerors must respond with a thorough narrative to each numbered requirement, in the exact order in which the requirements appear. Each requirement must be restated in full, followed by the Offeror's response. Responses to the Technical Specifications noted in IV.B (and referenced in Section III.B – Proposal Content and Organization, Item 1: Technical Proposal) shall not exceed 50 pages. Supplemental information may be included in appendices, provided that all appendix content is clearly cited within the primary narrative and remains concise and proportionate to the overall submission. Supplemental appendices may include: • Additional team biographies (beyond key personnel discussed in IV.B) • Subcontracting Plan • Other supporting material
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III.8. Response to Specifications, page 35	Can HCA confirm or clarify if the 50-page maximum for the response to the mandatory specifications includes section 7A (i.e. 7A+7C)?	See above.
III.8. Response to Specifications, page 35	Can HCA confirm or clarify if the 50-page maximum for the response to mandatory specifications includes resumes?	See above. Key personnel and associated experience should be described under organizational experience as indicated in the RFP. Additional team biographies and resumes for broader roster can be included an appendix.
RFP section IV.A.1.2 – p. 37 – Capitation Rate Development	How many rate cells, program cohorts, and capitation rates are currently developed and certified under the Turquoise Care program?	Currently, there are 43 distinct rate cells called rate cohorts, including separate physical health, behavioral health, and long-term supports and services (LTSS) cohorts. For these rate cells, 27 distinct capitation rates are developed and certified.
IV.A. Detailed Scope of Work, page 36	Can HCA provide the historical annual hours for the past 3 years from the incumbent? Can the annual hours be provided by the mandatory specifications identified in the scope? How does the scope identified in this RFP vary, if at all, from the scope of the incumbent over the past 3 years?	Offerors should rely on the requirements outlined in the RFP, their own proposed methodologies and approaches, and experience from similar engagements to estimate the costs, hours and labor mix specific to their unique proposal.
RFP section IV.A.1.2 – p. 37 – Capitation Rate Development	Can a copy of the most recent capitation rate filing be provided to the Offerors?	Deliverables, materials and associated reports will be provided to the selected Offeror as part of new contract onboarding and strategic planning.
RFP section IV.A.1.2 – p. 37 – Capitation Rate Development	Do any capitation rate or Medicaid coverage benefits or parameters vary by Managed Care Organization?	In general, Medicaid coverage benefits do not vary between MCOs. Capitation rates are risk adjusted to be MCO specific. Any changes in current parameters would be discussed in collaboration between HCA and selected Actuarial contractor.
RFP section IV.A.1.2 – p. 37 – Capitation Rate Development	What is the timing of the following events in a given rate year? • Determining the state directed payment amounts • Producing the draft capitation rate report • Producing the final capitation rates • Submitting the rate certification • Applying the risk adjustment to the capitation rates • Determining if a mid-year capitation rate adjustment is warranted • Performing the risk corridor evaluation • Final settlement of all plan year payment streams	While each rate year is different, the following is a reasonable approximation of timing: • Determining the state directed payment amounts – July through September. Based on new Legislative enactments; state directed payment amounts may be needed during March-June. • Producing the draft capitation rate report – September through October • Producing the final capitation rates – November through December • Submitting the rate certification – December and for mid-year rate certifications June. • Applying the risk adjustment to the capitation rates – November through December

		• Determining if a mid-year capitation rate adjustment is warranted – March through April for July, June through July for October • Performing the risk corridor evaluation – after the end of the contract year • Final settlement of all plan year payment streams – within two years of the end of the contract year
RFP section IV.A.1.2 – p. 37 – Rate Updates & Mid-Year Adjustments	How many mid-year rate updates or rate certifications have been required during the last three years.	HCA has implemented mid-year rate updates effective July 1 during each of the last three years.
RFP section IV.A.1.2 – p. 37 – Rate Updates & Mid-Year Adjustments	If a mid-year rate update was performed in any of the last three years, can a copy of the most recent update filing be provided to the Offerors?	Deliverables, materials and associated reports will be provided to the selected Offeror as part of new contract onboarding and strategic planning.
IV. Specifications, A. Detailed Scope of Work, A 1.1 Purpose and A 1.2 Summary of Required Activities, pages 36–37 and 40	Can HCA confirm that the directed payment support referenced in Sections IV.A.1.1 (p. 36), IV.A.1.2 (p. 37), and the Annual Capitation Rate Certification Package deliverable (p. 40) is limited to incorporating directed payment impacts into capitation rate development and certification, and does not include preprint preparation, comparisons of payment levels to Medicare or other benchmarks, or reconciliations of separate payment term directed payments?	The directed payment support includes assisting HCA on preprint preparation & review, providing Medicare Comparison and or Average Commercial Rate Comparison (ACR), uniform \$ and or % increase, and reconciliations as needed. Under H.R. 1 proposed bill, directed payments will need to be reconciled to ensure accuracy from what is reported in rate certification to what was spent. CMS has two SDP proposed rules that may require additional support with directed payments.
IV. Specifications, B. Technical Specifications, 3. Mandatory Specifications, pages 37–40 and 43–44	Can HCA confirm the mapping between the lettered Mandatory Specifications and the Detailed Scope of Work headings they are intended to correspond to? The lettered items in Section IV.B.3 (pages 43–44) do not use the same headings as the corresponding activities in the Detailed Scope of Work, Section IV.A.1 (pages 37–40), and in some cases appear to split or combine SOW headers differently than they are organized in Section IV.A. Can HCA confirm whether the following mapping is correct: (a) Rate Development & Certification and (b) Rate Setting Activities correspond to the SOW’s “Capitation Rate Development” and “Rate Certification”; (c) Rate Updates corresponds to “Rate Updates & Mid-Year Adjustments”; (e) Financial Analysis & Reconciliation corresponds to “Financial Analysis, Reconciliations & Risk Mitigation”; (f) Section 1115 Modeling corresponds to “Section 1115 Financial Modeling”; and (g) Transparency & Documentation and (h) Stakeholder Support correspond to “Collaboration & Transparency”?	The Mandatory Specifications are the controlling requirements for proposal evaluation. They are derived from, and correspond substantively to, the Detailed Scope of Work, but they are not intended to mirror Section IV.A.1 headings on a one-to-one basis. As stated in Section IV.B.3, <i>Offerors must demonstrate their ability to perform all duties described in the Detailed Scope of Work, including the items listed in IV.B.3.</i> The “including” language reflects that the Mandatory Specifications intentionally summarize and restructure the SOW for clarity of required capabilities. Because the Mandatory Specifications serve as the operative criteria, Offerors are not required to organize their responses according to the SOW headers or any specific mapping between the sections. Your proposed mapping is generally consistent with the intent behind IV.B.3, but HCA is not prescribing a particular crosswalk.

		Offerors may structure their proposals in whatever manner best demonstrates the ability to perform all elements of the Detailed Scope of Work as reflected in the Mandatory Specifications. HCA will evaluate proposals based on how clearly they meet the Mandatory Specifications, regardless of the organizational format used.
RFP section IV.A.1.2 – p. 38 – Risk Adjustment	What risk adjustment scoring model is currently used by the State? Does the State anticipate material revisions or model redesign during the contract term?	HCA uses the Chronic Illness and Disability Payment System plus Pharmacy (CDPS+Rx) model developed by the University of California, San Diego (UCSD), with New Mexico specific cost weights. HCA does not anticipate significant changes to its approach at this time, but changes and updates to the risk adjustment scoring model and methodology are in scope of this RFP.
RFP section IV.A.1.2 – p. 38 – Risk Adjustment	What is the timing of the following events in a given rate year? • Establishing the risk adjustment model • Calculating risk scores for the rate year • Applying risk scores across population cohorts • Determining the final risk adjustment rates	November through December for rates effective January.
A1.2. Risk Adjustment, page 38	Can HCA provide the most recent risk adjustment methodology letter?	Deliverables, materials and associated reports will be provided to the selected Offeror as part of new contract onboarding and strategic planning.
Section IV Risk Adjustment Page 38	Which risk adjustment model is currently being used?	HCA uses the Chronic Illness and Disability Payment System plus Pharmacy (CDPS+Rx) model developed by the University of California, San Diego (UCSD), with New Mexico specific cost weights.
Section IV Risk Adjustment Page 38	Are the weights used in the risk adjustment model NM specific weights or are they national weights?	The weights used are New Mexico specific.
A1.3. Table 1 – Risk Adjustment, page 41	Can HCA clarify or provide a most recent "Plan-level comparative MLR" deliverable for the risk adjustment scope? Specifically regarding "MLR" - can the state provide more guidance into what MLR related materials are required for deliverables (i.e., is this MLR monitoring, MLR reporting, MLR reviews, etc.)?	Deliverables related to Medical Loss Ratio (MLR) refer to both MLR financial reporting submitted by the MCOs and actuarial analysis of MCO experience on an MLR basis.
RFP section IV.A.1.2 – p. 38 – Financial Analysis, Reconciliations & Risk Mitigation	Can the State provide historical frequencies for contractual reconciliations, including risk corridors, high-cost risk pool analyses, TPL reviews, retroactive eligibility reconciliations, Medical Care	Contractual reconciliations occur on an annual basis.

	Credit reconciliations, community benefit reconciliations, and incentive program reconciliations?	
RFP section IV.A.1.2 – p. 38 – Risk Corridors	What risk corridor adjustments are currently in place?	Please refer to the current Turquoise Care contract to review all risk mitigation mechanisms currently in place. Link: Turquoise Care MCO Contracts – New Mexico Health Care Authority
RFP section IV.A.1.2 – p. 38 – Risk Corridors	What are the risk corridor measurements and parameters?	Please refer to the current Turquoise Care contract to review all risk mitigation mechanisms currently in place, including risk corridor parameters. Link: Turquoise Care MCO Contracts – New Mexico Health Care Authority
RFP section IV.A.1.2 – p. 38 – Risk Corridors	How frequently are the risk corridor parameters re-considered?	Risk mitigation parameters are reconsidered on an ongoing, annual basis.
RFP section IV.A.1.2 – p. 38 – Risk Corridors	When in the plan year are the risk corridor calculations performed?	Risk corridor calculations are performed after the end of the contract year.
RFP section IV.A.1.2 – p. 39 – Value-Based Purchasing & Payment Reform	Are any value-based arrangements currently in place? If so, can copies of the contracts be made available prior to the RFP response? Otherwise, can some details behind these arrangements be provided (how many are in place for how many providers, etc.)?	HCA operates a number of State Directed Payment (SDP) value-based initiatives as part of its managed care program. All approved SDP preprints are publicly available/ Link: State Directed Payments Medicaid . In addition, HCA has VBP Financial reporting required quarterly and annually by the TC MCOs. There are 3 Levels of VBP reporting. This VBP Fin report is created, reviewed, and updated by actuarial partners. Please refer to the current Turquoise Care contract to review VBP MCO requirements. Attachment 10 of the TC contracts provides the SDPs for HCA.
RFP section IV.A.1.2 – p. 39 – Section 1115 Financial Modeling	Does the State anticipate any changes or adjustments to the waiver programs prior to the current extension through December 31, 2029?	HCA does not anticipate changes at this time, but any changes and their impacts to capitation rates are in scope of this RFP.
RFP section IV.A.1.2 – p. 39 – Section 1115 Financial Modeling	Are there currently planned Section 1115 waiver amendments, demonstrations, or renewal activities that the State anticipates will require contractor support during the term of the contract?	Most waiver programs are already implemented but renewals and amendments are anticipated during the period of performance of this contract. These activities will be lead by HCA’s Medicaid Policy and Program Support Contractor. The selected Actuarial Contractor will collaborate with the Policy team and HCA to assist with associated calculations.

RFP section IV.A.1.2 – p. 39 – Section 1115 Financial Modeling	Can the most recent budget neutrality report be provided?	Historical budget neutrality reporting for New Mexico’s Section 1115 demonstration are posted on the State’s website https://www.hca.nm.gov/wp-content/uploads/Attachment-B-29.pdf However, HCA is not able to provide additional CMS budget neutrality reports or underlying documentation as part of this procurement. Detailed information will be provided to the selected Contractor as part of onboarding.
RFP section IV.A.1.2 – p. 39 – Medicaid Budget & Forecasting	Approximately how many legislative fiscal analyses and budget forecasting requests does the State typically require each year?	This is highly variable and dependent on a multitude of factors coming out of legislative sessions and committee meetings. HCA expects contractor <i>support, contribution and counsel</i> in this activity area dependent on budget availability and nuance of request, but the selected contractor would <i>not necessarily have to lead</i> all analysis.
IV. Specifications, B. Technical Specifications, 3. Mandatory Specifications, pages 39 and 43–44	Is “Medicaid Budget & Forecasting” a required capability Offerors must address in the Technical Proposal, and if so, under which Mandatory Specification letter should that response be organized? Section IV.B.3 (pages 43–44) states that the Mandatory Specifications “directly correspond to the Detailed Scope of Work” in Section IV.A.1 (pages 37–40). However, “Medicaid Budget & Forecasting” is a distinct SOW activity area with its own deliverables listed in Table 1 (page 41) but has no corresponding letter among the Mandatory Specifications (a) through (i).	Medicaid Budget & Forecasting is a required activity in the Technical Specifications and scope of work. The Mandatory Specifications and associated Evaluation Criteria have been updated in Amendment 1 and address this discrepancy.
RFP section IV.A.1.2 – p. 40 – Collaboration & Transparency	Please clarify the anticipated frequency of meetings with State staff, MCOs, CMS, legislative stakeholders, and other external parties, as well as any anticipated onsite attendance requirements.	The Medicaid Financial and Actuarial Support Contractor is a key partner to the Medical Assistance Division, and Offerors should expect a regular cadence of meetings with division staff, bureaus, and subject matter experts. Given the breadth of the Scope of Work, Offerors should assume weekly stand-up or strategy meetings, along with additional weekly meetings and informal work sessions associated with activity-specific workgroups. The selected Contractor is not expected to lead external meetings without HCA present. Engagements with MCOs, CMS, legislative stakeholders, and other external entities will occur on an as-needed

		basis, rather than on a regular recurring schedule, and will be coordinated and led by HCA. There are no ongoing onsite attendance requirements. However, the selected Contractor should be amenable to periodic in-person planning meetings, generally anticipated on a semi-annual or annual basis, as needed. Historically these have included mid-year and annual rate-setting meetings with MCOs. Cost proposals should include any necessary travel expenses.
RFP section IV.A.1.2 – p. 40 – Collaboration & Transparency	Who typically attends these meetings from the State and the State’s Contractors?	Attendance at Collaboration & Transparency meetings is highly variable and depends on the purpose and context of each. HCA operates in a collaborative, hands-on manner, and meeting participation reflects that approach. Participants generally include Medical Assistance Division executive and senior leadership, Bureau Chiefs, subject matter experts, and day-to-day implementation staff. Depending on the topic, meetings may also involve cabinet-level appointees, leadership from other state agencies, or other internal stakeholders as needed.
Section IV.A.1.2, Data & Model Transparency / Transition Requirements (pp. 40–41)	Please confirm which existing models, workpapers, methodologies, specifications, data layouts, documentation, and other tools maintained by the current contractor will be provided to the successful Offeror at contract initiation. Please indicate whether these materials will be provided in native, editable format and whether they include current capitation-rate models, risk-adjustment models, reconciliation models, forecasting tools, and Section 1115 budget-neutrality models.	Deliverables, materials and associated reports will be provided to the selected Offeror as part of new contract onboarding and strategic planning.
A1.2. Collaboration & Transparency, page 40	Should offerors assume in-person attendance for stakeholder meetings, MCO meetings, legislative briefings, and CMS discussions?	There are no ongoing onsite attendance requirements, and Offerors may assume that most meetings will be conducted virtually. In-person meetings have occurred historically around annual rate setting with MCOs. The Medicaid Financial and Actuarial Support Contractor will participate in a regular cadence of meetings with HCA staff, bureaus, and subject matter experts, including weekly stand-up or

		strategy meetings and additional workgroup sessions associated with specific activities; these meetings can generally be assumed to be virtual. However, the selected Contractor should be amenable to periodic in-person planning meetings, generally anticipated on a semi-annual or annual basis, as needed. In-person attendance for stakeholder meetings, MCO meetings, legislative briefings, or CMS discussions is not routinely required and would only occur if specifically requested by HCA.
RFP section IV.A.1.3 – p. 41 – Transition	Can the State verify that all current incumbent work products (models, data, methodologies, assumptions, and documentation) will be provided to the new Consultant? Is the State aware of any proprietary models or intellectual property that will not be transferred to the new Consultant?	HCA will ensure that all work products developed under the current contract that are the property of the State are made available to the selected Offeror as part of transition activities. Offerors should assume that all State-owned deliverables, data, models, and methodologies necessary to perform the Scope of Work will be provided.
RFP section IV.A.1.3 – p. 41 – Transition	Given that this RFP will be awarded with less than 6 months lead time before the start date, how will the State ensure that the transition plan and knowledge transfer sessions are appropriately performed by the incumbent?	HCA will ensure a complete and orderly transition. The incumbent contractor will be required to participate in all transition and knowledge-transfer activities as directed by the State. HCA will coordinate these tasks to ensure the selected Offeror receives the information and documentation needed to begin work by the contract start date.
RFP section IV.A.1.3 – p. 41 – Other Deliverables	What is the frequency of ad hoc requests from the State? What are some examples of recent ad hoc requests	The frequency and nature of ad hoc requests varies based on operational needs and emerging priorities. Ad hoc tasks are generally associated with time-sensitive analyses, policy changes, data inquiries, or support for leadership decision-making. Recent examples include short-turnaround financial analyses, rate-related data checks, legislative or executive briefing support, and CMS information requests. Offerors should anticipate that ad hoc requests occur periodically and should be able to accommodate reasonable, time-sensitive needs as they arise.
Section IV.A.1.2–1.3, Required Activities and Deliverables (pp. 37–41)	For purposes of developing staffing and cost assumptions, please provide the expected frequency of activities related to: 1) risk adjustment calculations and model recalibration, 2) Section 1115 budget neutrality analyses, and 3) provider payments/VBP support.	See above.

IV. Specifications, B. Technical Specifications, 1. Organizational Capability and Experience, page 42	Must the two project successes and two challenges required under Section IV.B.1(d) come from four distinct engagements, or may an Offeror draw a success and a challenge from each of only two engagements?	Offerors may use their judgement when determining the most impactful way to demonstrate organizational capability and experience.
IV. Specifications, B. Technical Specifications, 3. Mandatory Specifications, a) Rate Development & Certification, page 43	Section IV.B.3(a) (p. 43) requires the actuarial certification to be signed by an FSA who is an MAAA member. However, 42 CFR §§ 438.4 and 438.7 and ASOP 49, which are the governing standards for Medicaid capitation rate certification, require only MAAA membership, not the FSA credential specifically. Can HCA confirm that an ASA who is an MAAA member may sign the certification, consistent with these federal and actuarial standards?	Confirmed, an ASA who is an MAAA member may sign the certification.
RFP Section IV.D – p. 93 – Cost Proposal	Does the State prefer that pricing be submitted as a fixed annual fee, time-and-materials pricing, deliverable-based pricing, or a hybrid approach?	Offerors shall prepare Cost and Pricing proposals that provide the State with transparency and clarity around the budget proposed, including labor rates by category and other narrative assumptions. For a large, complex engagement like the scope here, we do not anticipate a fixed fee budget is appropriate or in the best interest of the State.
RFP Section IV.D – p. 93 – Cost Proposal	Should offerors assume that all ad hoc work is included within the proposed annual cost, or may ad hoc work be separately priced using proposed labor rates?	Offerors should assume that ad hoc work is included within the total proposed cost and can outline any assumptions necessary when proposing costs, considering factors such as the nature of the work, Medicaid actuarial and financial programs and previous organizational experience providing support on such programs.
RFP Section IV.D – p. 93 – Cost Proposal	The Cost Proposal section states that costs should include activities related to "Random Moment Surveys, Administrative Claiming, and Direct Medical Service Cost Reporting and Settlement." These services do not appear elsewhere within the Scope of Work for Medicaid Financial and Actuarial Support. Please confirm whether this language was included in error or whether these services are intended to be included within the scope of this procurement.	The language in Section IV.D referencing Random Moment Surveys, Administrative Claiming, and Direct Medical Service Cost Reporting and Settlement is intended to identify examples of administrative cost activities and does not establish these activities as specific deliverables under the Scope of Work for this procurement. Cost Proposals should be based on the deliverables and activities outlined in Section IV.A and the Mandatory Specifications in Section IV.B.3, and should include any additional administrative or programmatic costs necessary to support the Offeror's proposed methodologies, approaches, and value-added activities Appendix D has been updated in Amendment 1.

IV. Specifications, D. Cost Proposal and Appendix D – Cost Response Form, pages 36–41, 45, and 93	Section IV.D (p. 45) and Appendix D (p. 93) require Offerors to include costs for Random Moment Surveys, Administrative Claiming, and Direct Medical Service Cost Reporting and Settlement. However, these activities are not identified in the Detailed Scope of Work (Section IV.A.1, pp. 36–41). Please clarify whether they are within scope and must be addressed in the Technical Proposal, or whether these references were included in error and should be disregarded.	See above.
Section IV.D, Cost Proposal (p. 45); Appendix D, Cost Response Form (p. 93)	Section IV.D and Appendix D reference Random Moment Surveys, Administrative Claiming, and Direct Medical Service Cost Reporting and Settlement. These activities do not appear in the actuarial and financial Scope of Work in Section IV.A. Please confirm whether these services are included in this RFP. If they are not included, please confirm that Offerors should exclude them from the Cost Proposal and clarify the intended cost-proposal structure for the services described in Section IV.A.	See above.
Appendix D – Cost Response Form	The form states that the cost should be inclusive of completing all of the specification related “Random Moment Survey, Administrative Claiming & Direct Medical Service Cost Reporting & Settlement”. Is this a typo? If not, then where is this discussed in the RFP?	See above.
Section IV.D, Cost Proposal (p. 45); Appendix D, Cost Response Form (p. 93)	To facilitate accurate staffing and pricing assumptions, please provide the incumbent contractor's actual annual hours for actuarial related work for each of the past two contract years, segmented by: ▪ Capitation rate development (including activities, rate development, rate updates, and Risk Adjustment) ▪ State directed payment support ▪ Financial Analysis & Reconciliation ▪ Section 1115 Modeling ▪ Stakeholder support ▪ Ad hoc requests and special studies Additionally, please provide the approximate percentage of hours performed by labor class (e.g., senior staff (Partners, directors, credentialed actuaries, analysts, and other labor categories)).	Offerors should rely on the requirements set forth in the RFP, their own proposed methodologies and approaches, labor categories and rates, and experience from similar engagements to develop appropriate staffing plans and cost proposals. Cost Proposals must be based on the deliverables and activities described in Section IV.A and the Mandatory Specifications in Section IV.B.3, and should include any administrative or programmatic costs necessary to support the Offeror’s proposed methodologies, approaches, and value-added activities. HCA will evaluate proposals based on the Offeror’s ability to meet the Scope of Work and provide best value to the State.
IV.D. Cost Proposal, page 45	Can HCA provide details on how cost estimates should be completed by vendors - fixed annual amounts, hourly rates, or a combination of both? Should the annual cost estimates differentiate between the mandatory specifications and ad-hoc related services?	Offerors shall prepare Cost and Pricing proposals that provide the State with transparency and clarity around the budget proposed, including labor rates by category and other narrative assumptions. For a large, complex engagement like the scope here, we do not

		anticipate a fixed fee budget is appropriate or in the best interest of the State. Cost Proposals must be based on the deliverables and activities described in Section IV.A and the Mandatory Specifications in Section IV.B.3, and should include any administrative or programmatic costs necessary to support the Offeror's proposed methodologies, approaches, and value-added activities. Offerors should assume that ad hoc work is included within the total proposed cost and can outline any assumptions necessary when proposing costs, considering factors such as the nature of the work, Medicaid actuarial and financial programs and previous organizational experience providing support on such programs.
Appendix D - Cost Response Form, page 93	Can HCA provide additional clarification around the Cost Proposal Appendix D? Specifically, Appendix D references Random Moment Surveys, Admin Claiming, and Direct Medical Service Cost Reporting that do not appear to relate to this SOW. Can HCA provide additional context related to the requested relevant budget tables in the Appendix D?	See above. Appendix D has been updated in Amendment 1.
V. Evaluation, B. Evaluation Factors, 5. Business Specifications (Financial Stability), page 48	The RFP states that financial stability will be evaluated using a pass/fail viability ratio calculated as "Total Unrestricted Net Assets divided by Total Liabilities," with a minimum required ratio of 1.00:1.00. The RFP also requires submission of audited financial statements and, where applicable, the most current Form 10-K. Please clarify how a for-profit Offeror should calculate "Total Unrestricted Net Assets," as this terminology is generally associated with nonprofit financial statements and may not appear as a separately reported line item in a for-profit entity's audited financial statements or Form 10-K. Specifically, should a for-profit Offeror use shareholders' equity, total equity, or another specified financial-statement measure as the numerator? Please also confirm which fiscal-year financial statements should be used and whether the State will provide a prescribed calculation or reconciliation format.	For-profit Offerors should use total equity (shareholders' equity) as the numerator when calculating the viability ratio described in Section I.C. The term "Total Unrestricted Net Assets" is used in nonprofit reporting and is intended here to represent equity available to support operations. Total equity, as reported in the Offeror's audited financial statements or Form 10-K, is the appropriate measure. Offerors should use financial statements from their most recently completed fiscal year. HCA is not prescribing a specific reconciliation format; however, Offerors must clearly identify the financial-statement line items used. This viability ratio is intended to provide a consistent measure of financial stability across both nonprofit and for-profit entities.

		RFP section V.B.5 has been updated in Amendment 1 accordingly.
Appendix D - Cost Response Form, page 93	Can HCA provide additional clarification around the Cost Proposal Appendix D? Specifically, Appendix D references Random Moment Surveys, Admin Claiming, and Direct Medical Service Cost Reporting that do not appear to relate to this SOW. Can HCA provide additional context related to the requested relevant budget tables in the Appendix D?	The language referencing Random Moment Surveys, Administrative Claiming, and Direct Medical Service Cost Reporting and Settlement is intended to identify examples of administrative cost activities and does not establish these activities as specific deliverables under the Scope of Work for this procurement. Cost Proposals should be based on the deliverables and activities outlined in Section IV.A and the Mandatory Specifications in Section IV.B.3, and should include any additional administrative or programmatic costs necessary to support the Offeror's proposed methodologies, approaches, and value-added activities. Appendix D has been updated in Amendment 1.
N/A	Can you provide us with the most recent actuarial certification submitted to CMS?	Deliverables, materials and associated reports will be provided to the selected Offeror as part of new contract onboarding and strategic planning.
N/A – Incumbent Information	Can the State provide any details around the current incumbent – identity, hours logged by month, hourly rates, number of team members assigned by job category, etc.?	The current incumbent is Mercer (Marsh). Offerors should rely on the requirements outlined in the RFP, their own proposed methodologies and approaches, and experience from similar engagements to estimate the costs for their proposals.
N/A	How many hours in the past year was billed for this contract?	N/A. Offerors should rely on the requirements outlined in the RFP, their own proposed methodologies and approaches, and experience from similar engagements to estimate the hours and associated costs for their proposals.
Financial	Is there any bond required for this project ?	No.
Staffing	Do we need to provide actual or sample resume of these Lead Actuary, Senior Actuarial Staff, Financial Analysts, and Project Manager staff with proposal?	HCA requests the actual resumes of the expert personnel named and proposed.
N/A	During the conference, HCA indicated that Offerors must propose against the full Scope of Work in Section IV.A, may not submit proposals limited to individual scopes of services, and must submit a single price for the entire Scope of Work. Would HCA please confirm these responses in writing?	Confirmed.

(End)