Amendment #02
Health Care Authority

REQUEST FOR PROPOSALS (RFP)

Medical RFP
RFP # 26-630-0900-0009

HEALTH CARE
AUTHORITY

Amendment Date: 10/24/2025
RFP Release Date: 09/12/2025

Proposal Due Date: 11/10/2025

This Amendment No. 02 serves to modify the following section on the specified page of the RFP:

Change on page: ii - iii
From:

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To:

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Changes beginning on page 23 - 34

To:

IV. SPECIFICATIONS

A. DETAILED SCOPE OF WORK

C. **Network Provider Management.** Prior to contracting with a medical provider, Contractor will use reasonable diligence to ensure that medical providers qualifications established by the Contractor. During the term of this Agreement, Contractor will administer a recredentialing program designed to periodically re-examine each network provider's satisfaction of criteria and qualifications established by the Contractor.

Contractor is hereby authorized, without the consent of the Agency, to add and/or delete the names of network providers contracted. Significant additions and/or deletions ("significant" defined as +/-5%) will be communicated by Contractor to the Agency ~~as quickly as possible~~ at minimum 5 days in advance, at least monthly.

2) **Negotiated Changes.** Negotiated provider network changes involve the inclusion or exclusion of key network providers, a set of network providers, or an entire network where the Contractor is in a contracting position to accept or reject a reasonable and appropriate financial arrangement proposed by the network provider. Contractor agrees to ~~provide~~ notify the Agency a minimum of 5 days in advance,~~with reasonable notice~~ in the event negotiated provider network changes would result in significant or material access issues ("significant" defined as affecting more than 5% of members) and will work with the Agency to resolve or mitigate such access issues to the extent possible and in furtherance of the purposes of this Agreement.

H. **New Mexico's Senate Bill 42:** ~~Under SB 42, vendors administering medical benefits for public coverage must contribute to the state's coordinated care model, including ensuring each newborn has a plan of safe care, a care coordinator, and home-based follow-up aligned with state statute and rules. Suggested RFP Language could be:~~ The Contractor must adhere to the requirements of New Mexico Senate Bill 42 and related State of New Mexico rules regarding substance-exposed newborns. This includes ensuring for each enrolled newborn identified as substance-exposed:

~~I.~~

~~1) The Contractor must adhere to the requirements of New Mexico Senate Bill 42 and related State of New Mexico rules regarding substance-exposed newborns. This includes ensuring for each enrolled newborn identified as substance-exposed:~~

- assignment of a care coordinator as defined under SB 42;
- timely development and transmission of a written Plan of Safe Care, signed by the birthing facility and caregiver;
- provision of referrals, outreach, and support services through the Comprehensive Addiction and Recovery Act (CARA) ~~CARA~~ navigator program;
- seamless coordination with State agencies when families do not engage.

~~J.~~I. **Value-Based Payment and Outcome Strategies**

1. The Contractor shall, with Agency approval, implement innovative value-based payment models and care management strategies aimed at improving health outcomes and controlling total cost of care. Strategies must include metrics for evaluating success (e.g., reduced ER utilization, improved chronic condition management) and provisions for care coordination, high-risk member management, and provider accountability.

~~K.~~J. **Fiscal Year Alignment and Rate Development**

1. All plan years shall be aligned with the State of New Mexico fiscal year (July 1 – June 30).
2. Insured rate proposals must be developed using actuarial sound methodologies.
3. Contractors shall collaborate with the Agency's actuaries to ensure timely and accurate rate setting, reflecting the most up-to-date utilization and trend data.
4. Contractors must submit historical utilization and claims data to support annual forecasting, including but not limited to, tying claims to date of service.~~.~~

~~L.~~K. **Benefit Quality.** The Contractor must demonstrate a rigorous approach to benefit quality that measurably improves members' medical-health outcomes. Minimum requirements include, but are not limited to:

1. Quality metrics & performance guarantees
    1) Track and report quarterly on: Preventive and diagnostic screening rates, Net Promoter Score, and claim-accuracy rate.
2. Continuous quality-improvement (CQI) program
    1) Implement provider feedback loops and automated care-gap reminders (text, email, or app).
    2) Submit an annual CQI report that summarizes interventions, outcome trends, and next-year action plan.

~~M.~~L. **Utilization Review.** The Contractor will perform the pre-certification and utilization review services described in the contract to the extent such services are consistent with the Plan. Annually, the Contractor shall report denial rates, appeal outcomes, and the number of prior authorizations (as well as the percentage of prior authorizations approved and denied, and the average turnaround time for prior authorizations).

~~N.~~M. **Claims Processing.** The Contractor will accept from network providers, other providers, and Members claims for services provided to Members. The Contractor shall, consistent with the current claim administration procedures and practices and the claim determination accuracy standards then applicable to its own medical plan administration business:

1) receive claims for Plan benefits and requests for Plan services, and expeditiously review such claims and requests to determine what amount, if any, is due, payable and/or allowable with respect thereto in accordance with the terms and conditions of the Plan; and

2) disburse or provide, to the person entitled thereto, benefit payments or authorization for services it determines to be due in accordance with the provisions of the Plan.

The Contractor agrees the Agency's Plan of Benefits shall be administered and adjudicated in accordance with the provisions of the Summary Plan Description detailed in in the contract attached hereto and incorporated by reference. Any exceptions, as determined by either party, will be reviewed and mutually agreed upon. If no consensus is made, the Agency will retain the final decision-making authority, subject to the decision not creating a negative financial impact or network management conflict for the Contractor or the Contractor's other self-funded clients.

The Contractor shall identify and investigate suspected fraudulent activity by providers and/or Members and inform the Agency of the findings. In the event any payment is made because of fraudulent activity, The Contractor will provide reasonable assistance in pursuing recovery, but the Contractor shall not be required to initiate court proceedings to pursue recovery nor, except to the extent Contractor's obligations under Indemnification, of this Agreement, will Contractor be required to reimburse the Agency.

~~O~~.N. **Audits, Evaluations, and Data Reviews.** The Contractor shall fully cooperate with any audits, evaluations, or data reviews initiated or authorized by the Agency, including but not limited to claims integrity audits, alternative payment models, reference-based pricing validation, financial reconciliations, and performance guarantee validations. Failure to comply with the audit and data access requirements as outlined herein may result in contractual remedies, including but not limited to, withholding payment, imposition of administrative fees, or termination for cause. The Contractor shall:

1. Provide all data, documents, claims files, reports, and records reasonably requested by the Agency or its authorized third-party auditor(s), in a format and manner specified by the Agency, and within a time frame designated by the Agency.
2. Not require any separate agreement, including but not limited to a Non-Disclosure Agreement (NDA), between itself and the Agency's designated audit firm or vendor. The Agency shall be solely responsible for contractual arrangements with its auditors, including applicable confidentiality and data protection agreements. The Contractor shall accept such arrangements as sufficient.
3. Transmit all requested data using secure electronic means, including encrypted file transfer, secure portals, or other industry-standard secure transmission methods as approved by the Agency. The use of physical mail or unencrypted channels for transmission of protected health or confidential information is prohibited unless expressly authorized in writing by the Agency.
4. Provide reasonable support to facilitate the audit process, including the designation of knowledgeable staff to respond to auditor inquiries, clarification of data fields, and assistance with technical questions regarding Contractor systems and reporting.
5. Upon the Agency's request, provide read-only access or system-generated extracts necessary for the Agency or its auditors to validate the accuracy and completeness of claims processing and adjudication, provider reimbursements, and other services provided under this Agreement; and

6. Retain all claims, payment, and supporting documentation related to services rendered under this Agreement for a minimum of ~~seven~~ eight (~~7~~8) years from the date of service, or longer if required by applicable federal or state law and shall make such records available to the Agency or its designated agents upon request.

~~P.~~O. **Administrative Material.** The Contractor will prepare and distribute to network providers all materials necessary to enable network providers to participate in the Plan. As needed, changes to this material will be developed and distributed to network providers. In addition, Contractor will prepare and distribute to SHB administrative manuals for the use of Agency staff, as needed, changes to the manual will be developed and distributed to the Parties.

~~Q.~~P. **Fee Schedule.** The Contractor has developed and will continuously maintain fee schedules applicable to network and non-network providers who provide medical care services to enrolled Members of entities who contract with the Contractor. The fee schedules will be reviewed periodically by the Contractor and updated, as necessary. The Contractor may modify any fee schedule applicable to the Plan. At least annually, Contractor will make available for review by the Agency or their auditors a complete list of its current provider fee schedules. This information will be made available at Contractor's place of business. At least 90 days prior to any change in provider fee schedules that will have a material impact on claims paid under the Plan, or as soon as reasonably practicable, Contractor will provide written notice to the Agency of an anticipated change(s) in provider fee schedule(s). The Agency shall have the right to review such changes in fee schedules.

The Agency agrees that the Contractor's provider fee schedules, and the basis for establishing those fee schedules, are proprietary and agrees to include a confidentiality agreement as part of the contract. Unless required by the Inspection of Public Records Act, NMSA 1978, Sections 14-2-1 to -12 (1947, as amended through 2013) (the "IPRA") or other applicable law, the Contractor's provider fee schedules shall be kept confidential and shall not be made available to any individual or organization without prior written approval of the Contractor.

~~R.~~Q. **Member Services.** The Contractor will promptly respond to inquiries from Members regarding the Plan and the services of network and other providers. The Contractor will respond to benefit questions. All such responses will be consistent with either:

1. the prior written administrative procedures in place as of the effective date of the Plan, or
2. the Contractor's standard operating procedures for services as agreed to by the Agency.

The Contractor shall:

1. Support the development and dissemination of clear, member-friendly plan comparison materials to enable informed decision-making.
2. Ensure members have readily available cost-sharing, network access, and covered service information.

3. Provide online and mobile access to benefit summaries and network directories.

~~S.~~R. **Reports and General Data Transfer Requirements.** Until notified by HCA, Contractor will provide reports as illustrated in Exhibit B attached hereto and incorporated by reference. As requested by the Agency, the Contractor shall add or discontinue reports shown on the contract. The parties will agree upon any adjustment necessary to the current Administrative Services Only (ASO) Per Member Per Month (PMPM) fee, as illustrated in the contract attached hereto and incorporated by reference, or any other appropriate charge or credit relevant to the change in required reporting. Within 30 days following the end of each quarter, Contractor will provide quarterly electronic claim files in an Agency-prescribed format as permitted by law. Contractor will provide assistance in converting the data, including, but not limited to, file production schedule, identification and interpretation of data fields, etc., without additional charge to the Agency.

Data dashboard: ~~As vendors administering benefits on behalf of the State, you have a responsibility to ensure the state has the data infrastructure necessary to oversee performance, track outcomes, and ensure accountability. This is part of being a trusted partner to the state and its members. Selected vendors should contribute funding to support its development and maintenance as part of their administrative responsibilities.~~

~~o~~ The Contractor shall contribute a one-time implementation fee and ongoing annual support, as specified by the Agency, to fund the development and maintenance of a state-operated medical claims utilization, and outcomes dashboard. This dashboard will be used by the Agency to monitor plan performance, member outcomes, utilization trends, and cost drivers. This funding obligation shall be considered a non-negotiable component of the Contractor's administrative duties under this Agreement.

Upon the termination of this Agreement, to the extent it is feasible, the ~~Contract Administrator~~Contractor will return to the Agency all records received by the ~~Contract Administrator~~Contractor in performing its duties under this Agreement, including, but not limited to, financial records, employee records, all records relating to claims filed, processed, and paid, in a manner and format designed to enable efficient transition to a new service provider. Files related to the relationship between the parties or other documents not specifically prepared on behalf of the Plan shall remain the property of the ~~Contract Administrator~~Contractor. The Contractor shall provide, at a minimum:

- Monthly claims and utilization reporting.
- Annual cost trend analysis and utilization review.
- Member satisfaction and access metrics.
- Provider disruption reports in the event of network changes.
- Performance dashboards measuring plan design efficacy and health outcomes.

~~T.~~S. **Identification Card.** The Contractor will issue Member identification cards for use in connection with the Plan, which may include physical cards, digital cards accessible via a mobile app, and options compatible with digital wallets. The Contractor will assign an individual Member number to each identification card with the appropriate number appearing on the card.

~~U.~~T. **Eligibility Data:** The Contractor will maintain current eligibility data for all Members enrolled in the Plan. In the event there is an immediate need to provide medical care services for a new hire, the Contractor shall contact the Agency for eligibility verification. The Agency may utilize any reasonable electronic means to communicate and enroll immediately eligible Members and will enter this Member into the Agency's eligibility system as soon as possible.

~~V.~~U. **Member Benefit Booklets:** Plan materials shall be subject to review and approval by the Agency prior to distribution. The Contractor shall provide these materials a minimum of ten days in~~far enough in~~ advance to allow the Agency a reasonable opportunity to review and provide suggested and/or. necessary changes.

~~W.~~V. **Network Provider Directories:** The Contractor will make network provider directories available via the Internet through the Contractor's website and, when requested, the Agency's website either through links or through updated network provider directories provided directly to the Agency. The Contractor will be responsible for making paper copy provider directories available at the initial and all future enrollment meetings, and is encouraged to have provider directories accessible via a mobile app. The Contractor is also responsible for updating the Directories a minimum every 90 days.

~~X.~~W. **Account Management Team.** The Contractor agrees to provide the Agency with local presence, as requested. When The Contractor has knowledge of a change in the Account Manager for SHB Plans, the Contractor shall ~~provide~~ notify the Agency a minimum of ten days in advance ~~with advance notice~~ of the change and discuss with the Agency the qualifications of the person being considered as the replacement for the position. The Contractor shall also provide the Agency with advance notice, if possible, of the resignation or retirement of the Account Manager.

~~Y.~~X. **Orientation Meetings:** The Contractor will conduct Member orientation meetings (virtual and in-person) in locations identified by the Agency to familiarize members with the offered medical services. The Agency will conduct member enrollment meetings prior to the beginning of the Plan year throughout the state to provide employees the information regarding all benefits offered by the Agency, any changes to the Plan, etc. In addition, the Contractor will attend enrollment meetings as requested by the Agency.

~~Z.~~Y. **Meeting Attendance:** A condition of this Agreement requires attendance by the Contractor from time to time and as requested at Board, Committee and/or Legislative meetings, as well as informational meetings that pertain to SHB benefit matters. Contractors additionally agree to attend:

1) Semi-annual performance appraisal meetings, with quarterly feedback (in-person or online), and
2) Health & Wellness Fairs (in-person or online).

~~AA.~~Z. **Presentations:** The Contractor will be required to provide slide and/or video presentations and create comparison of benefits sheets and enrollment forms (including

online). No Contractor representative may contact Members directly or participate in meetings to market any other Contractor products.

Reporting: The Contractor will provide experience, financial, and data management reports detailing enrollment, paid claim data, and other information as illustrated in the attached Exhibit B. As requested by the Agency, the Contractor shall make presentations to the legislature, governing boards or entities regarding the status of the medical benefit program. Unless required by the Inspection of Public Records Act, NMSA 1978, Sections 14-2-1 to -12 (1947, as amended through 2013) (the "IPRA") or other applicable law, any confidential information provided by or developed by the Contractor in the performance of this Agreement shall be kept confidential and shall not be made available to any individual or organization by the Agency without the prior written approval of the Contractor. The Contractor shall report claims denial rates, types of claims denials by category, data regarding appeals outcomes, and the average time to process prior authorizations.

~~BB.~~AA. **Performance Guarantees:** The Contractor agrees to the terms and conditions of the Performance Guarantees contained in the contract attached hereto and incorporated by reference. Performance guarantee results will be determined, and penalties will be calculated and reported to the Agency as defined in the contract. Nothing in this Agreement or in the provisions in the contract shall be construed as a liquidated damages clause.

~~CC.~~BB. **Additional Services.** The Agency may request, in writing, that the Contractor provide additional Member services or services for other special projects. If the Contractor agrees to provide such services, the Agency and Contractor shall mutually agree on the duration, scope of the services or project and on a cost estimate. The Contractor shall bill the Agency only for the actual cost of the services agreed upon. "Actual cost" as used in this paragraph is the cost to the Contractor of providing the specific service or project without any additional mark-up. In the event the additional services are requested on an on-going basis rather than a single-event basis, the Agency can terminate the services or project by giving Contractor at least thirty (30) days prior written notice. The Contractor shall be able to bill for all actual costs incurred prior to the date of termination.

~~DD.~~CC. **Prescription Drug Implementation.** The Agency will award the contract for prescription drug services in early 2026. Contractor agrees, contingent upon the full cooperation from the PBM, to coordinate and perform ongoing interface services. The Agency will ensure that any agreements required for such services are signed by Pharmacy Benefit Manager (PBM) before Contractor is required to perform the interface services.

~~EE.~~DD. **Clinical Reporting:** Contractor shall be required to measure the progress of each Member related to all specific illnesses. This includes clinical results, satisfaction, functional status, as well as Healthcare Effectiveness Data and Information Set (HEDIS) scores, as appropriate. In addition, summary results and percentage enrollment for each illness should be reported to the Agency no less than Quarterly. **Reconciliation File.** The Contractor agrees to submit a reconciliation file to the Agency by the second Tuesday of every month. This file must contain all Members Contractor has enrolled in the Plan as of the date of the file.

The file must be received in the format as mutually agreed upon by the Agency and Contractor.

~~FF.~~EE. **Customer Satisfaction Survey**. Contractor agrees to conduct an annual customer satisfaction survey at its own expense (Annual CAPHS Survey). The content of the survey shall be reviewed and approved by the Agency.

~~GG.~~FF. **Performance Guarantees.** Contractor shall comply with the terms and conditions of the Performance Guarantees attached as Exhibit D and hereby incorporated into and made a part of this Agreement. Nothing in this Agreement or in the provisions of Exhibit D shall be construed as liquidated damages clause.

~~HH.~~GG. **Funding and Payment of SHB Claims (self-funded).**

1. The Agency will fund, by wire transfer, amounts sufficient to fund the weekly claims run through the Contractor's designated Claim Payments Account, Contractor shall give weekly notice to the Agency of the amounts required to be transferred to Contractor's Claim Payments Account to fund checks issued during the prior week, the Agency will appropriately fund the Claims Payments Account within ten (10) banking days after the notification from Contractor.
2. Contractor shall issue checks from Contractor's Claims Payments Account to pay benefits in the amount the Contractor determines to be proper under the particular Member's Plan.
3. In the event Contractor pays any person less than the amount to which that person is entitled under the Plan, Contractor will promptly pay the person the amount of fie underpayment and adjust the underpayment by including the additional amount in the following weeks' claims payment request. In the event Contractor overpays any person entitled to benefits under the Plan or pays benefits to any person not entitled to them, Contractor shall take all reasonable steps to recover the overpayment under Contractors standard claims procedures, except that Contractor shall not be required to initiate court proceedings to recover an overpayment. Contractor shall promptly notify the Agency if it is unsuccessful in recovering any overpayment.
4. In accordance with the Termination provision, following termination of this Agreement, the Agency shall remain solely responsible for payment of all Plan benefits due any Provider for services rendered prior to termination.
5. ~~Should the Agency fail to make a timely deposit into Claims Payments Account and in the event Contractor elects to pay for unfunded claims, interest shall be charged on unpaid amounts in accordance with the Compensation Clause.~~

~~II.~~HH. **Agency Obligations.**

1. Administrative Policies. The Agency will submit all future modifications of the SPD thereof to Contractor for approval. Within thirty (30) days of the date any modification is submitted to Contractor, Contractor will review the modifications and verify Contractor's ability to administer the benefit modification. No

modification will be binding upon Contractor or the Providers until approved in writing by Contractor.

2. Employee Contribution Funding and Pricing. The Agency will establish the initial contribution funding of medical plans based on the current claims experience adjusted for medical trend and margin. Annually based on the actual enrollment results of the Agency, new contribution funding for SHB will be actuarially determined by the Agency based on combined age, gender and claim experience factors.
3. The Agency retains responsibility and authority for eligibility determinations and benefit Plan designs. Regarding decisions made on any benefit claims, The disputes or grievances:
    1) The Contractor is responsible for making initial benefit claims decisions and for conducting internal reviews requested by the Member.
    2) The Agency is responsible for the final decisions made on appeal of any benefit claim dispute or grievance.
    3) In the event of a dispute which is presented to the SHB Director, Contractor will provide information relating to the claim, an explanation of the basis of Contractor's decisions and provide additional information as requested by the Agency regarding claim resolution.
    4) In the event of a complaint or an external review request presented to the Office of Superintendent of Insurance, the Agency and Contractor will provide the information relating to the claim, an explanation of the basis of Contractor's decisions and will provide additional information as requested by the Superintendent regarding claim resolution.
    5) Any appeal of the Superintendent's external review decision to district court. is the responsibility of the Agency. Contractor, at its option, may also pursue an appeal or participate with the Agency in such an appeal.

Compensation

A. Compensation Schedule. The Agency shall pay to the Contractor based upon fixed prices for Services, per the schedule outlined in Exhibit B, which is hereby incorporated into and made a part of Ibis Agreement, and the claims payment fees in accordance with this Agreement and the Plan.

B. Payment. The total compensation payable to Contractor under this Agreement, including administrative services fees and claims payment, shall be indicated in the contract.

This amount is a maximum and not a guarantee that the work assigned to be performed by Contractor under this Agreement shall equal the amount stated herein. The Parties do not intend for the Contractor to continue to provide the Services without compensation when the total compensation amount is reached. Contractor is responsible for notifying the Agency when the services provided under this Agreement reach the total compensation amount. In no event will the Contractor be paid for Services provided in excess of the totalcompensation without this

Agreement being amended in writing prior to those Services in excess of the total compensation amount being provided.

Payment shall be made upon Acceptance of the Services and upon the receipt and Acceptance of a detailed, certified Payment Invoice, Payment will be made to the Contractors ~~designated mailing address~~via electronic transfer of funds (ACH payments). In accordance with Section 13-1-158 NMSA 1978, payment shall be tendered to the Contractor within thirty (30) days of the date of written certification of Acceptance. Unless otherwise agreed upon between the Agency and the Contractor, within fifteen (15) days from the date the Agency receives written notice from the Contractor that payment is requested for administrative services the Agency shall issue a written certification of complete or partial acceptance or rejection of the administrative services. Unless the Agency gives notice of rejection within the specified time period, the administrative services will be deemed to have been accepted. All Payment Invoices MUST BE received by the Agency no later than fifteen (15) days after the termination of this Agreement. Payment Invoices received after such date WILL NOT BE PAID.
~~If the Agency fails to pay as required above, the Contractor may assess a late fee on the unpaid balance of more than 60 days, The periodic (monthly) late fee rate shall be 1.5% and the corresponding Annual Percentage Rate for the State will be 18%.~~.

C. Taxes. The Parties agree that gross receipts tax (GRT) is not applicable to the Services in this Agreement on the date this Agreement is executed, and if during the term of this Agreement, GRT or any new compensating tax is imposed upon Contractor by any government agency on the amount of administrative services fees and/or claims fees payable under this Agreement or the number of persons covered, the Parties agree to amend this Agreement to provide that Contractor will be compensated for the associated increase in taxes and the change will be effective as of the date defined under the applicable tax law. Notwithstanding the foregoing, payment of any other taxes for any money received under this Agreement shall be the Contractor's sole responsibility and should be reported under the Contractor's Federal and State tax identification number(s). Contractor shall pay all Federal, state and local taxes applicable to its operation and any persons employed by the Contractor.

~~JJ.~~II. The Contractor will ensure the plan and administration comply with the following requirements as applicable to SHB medical plan:

1) Claims and Appeals Procedures as required under Department of Labor regulations section 2560.503-1 to the extent Contractor has responsibility for determining claims and/or appeals.
2) Health Status Discrimination rules prohibiting discrimination based on health status under Department of Labor regulations section 2590.702.
3) Data Transmission provisions of state law and the Health Insurance Portability and Accountability Act (HIPAA) (45 CFR Parts 160 & 162) regarding the transmission