HEALTH CARE AUTHORITY

REQUEST FOR PROPOSALS (RFP)

New Mexico Health Care Authority
State Health Benefits
Dental Benefits RFP

HEALTH CARE
AUTHORITY

RFP# 26-630-0900-0006
Addendum #1
Addendum Date : 0722/2025

RFP Release Date: 07/21/2025

Proposal Due Date: 08/18/2025

ELECTRONIC-ONLY PROPOSAL SUBMISSION

Alert: Please note the Acknowledgement of Receipt Form and the NDA need to be submitted to the procurement manager, by 07/25/2025 @ 3:00PM MST/MDT. **Procurement Manager:** Sally Jameson, Telephone: 505.795.1880 Email: Sally.Jameson@hca.nm.gov. Upon receipt of Acknowledgement of Receipt Form and the NDA, vendors will receive a link to data.

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I. INTRODUCTION

A. ADDENDUM INFORMATION

Date: 07/22/2025
RFP Number: 26-630-0900-0006
RFP Title: New Mexico Health Care Authority State Health Benefits Dental Benefits RFP
Addendum: #1

ACKNOWLEDGE ADDENDUM WITH SUBMITTED PROPOSAL:
Addenda not signed and returned may consider the RFP non-responsive and may be rejected. See form APPENDIX A.

B. PURPOSE OF THIS ADDENDUM REQUEST FOR PROPOSALS

The purpose of this Addendum #1 to the Request for Proposal (RFP) is to solicit sealed proposals for fully-insured quotes to evaluate along with the self-funded proposals. All the following will be the same as for the self-funded offer:

- CONDITIONS GOVERNING THE PROCUREMENT
- RESPONS FORMAT AND ORGANIZATION
- SPECIFICATIONS
- EVALUATION
- APPENDICES A, B, C, E, F

Will be the same as the self-funded offer. There is an additional Appendix D cost proposal addendum submission for the fully-insured quote. There is no change in the evaluation scoring points criteria.

C. QUESTIONAIRE

The questionnaire has not changed. If your response on the other questions is different from the fully insured and self-funded, please note the difference in your response.

D. APPENDIX D – COST PROPOSAL ADDENDUM

The Addendum to the cost proposal requests fully-insured rates, some underwriting assumptions, performance guarantees amount at risk will be based upon insured premium rather than a percentage of ASO fees. This procurement will result in a Statewide Price Agreement that may be utilized by all State of New Mexico agencies, commissions, institutions, political subdivisions and local bodies allowed by law.

APPENDIX A

ACKNOWLEDGEMENT OF RECEIPT FORM

ADDENDUM 1

APPENDIX A

REQUEST FOR PROPOSAL

HCA SHB Dental RFP
RFP 26-630-0900-0006
ADDENDUM 1

ACKNOWLEDGEMENT OF RECEIPT FORM

This optional Acknowledgement of Receipt Form establishes a distribution list to be used for the distribution of written responses to questions, and/or any amendments to the RFP. Failure to return the Acknowledgement of Receipt Form does not prohibit potential Offerors from submitting a response to this RFP. However, by not returning the Acknowledgement of Receipt Form, the potential Offeror's representative shall not be included on the distribution list and will be solely responsible for obtaining responses to written questions and any amendments to the RFP will be through **Bonfire electronic procurement system.**

The information below will be used for all correspondence related to the Request for Proposal. Only one contact per Offeror is permitted.

ORGANIZATION: _____

CONTACT NAME: _____

TITLE: _____ PHONE NO.: _____

E-MAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

Submit Acknowledgement of Receipt Form to:
To: Sally Jameson Office of the Secretary New Mexico Health Care Authority
E-mail: Sally.Jameson@hca.nm.gov
Subject Line: HCA SHB Dental RFP 26-630-0900-0006 ADDENDUM 1

APPENDIX D

COST RESPONSE FORM

The offeror should indicate a total cost per state fiscal year for the implementation of their service. The cost should be inclusive of completing all of the specifications related to Random Moment Surveys, Administrative Claiming & Direct Medical Service Cost Reporting & Settlement. The offeror will be evaluated based on the total cost of implementation of the program. Your response should use Appendix D Cost Proposal Dental Addendum 1 attachment. Complete each part of each tab.

FIRM NAME:	
SIGNATURE:	DATE: