

Request for Proposals Issued By

The New Mexico Human Services Department



For the provision of

Third Party Assessor/Utilization Review
(TPA/UR)

RFP # 23-630-8000-0002

Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348
Dr. David Scrase, Cabinet Secretary

ISSUE DATE: July 8, 2022

I. INTRODUCTION	1
A. PURPOSE OF THIS REQUEST FOR PROPOSALS	1
B. SUMMARY STATEMENT OF WORK	2
C. BACKGROUND INFORMATION	3
D. SUMMARY SCOPE OF WORK.....	6
E. SCOPE OF PROCUREMENT.....	6
F. OFFEROR QUALIFICATIONS/CONFLICT OF INTEREST	7
G. PROCUREMENT MANAGER	7
H. PROPOSAL SUBMISSION.....	8
I. DEFINITIONS OF TERMINOLOGY	8
J. MMISR APPROACH.....	22
K. CONTRACTOR ROLE.....	23
L. TPA UM/UR PROCUREMENT LIBRARY	26
II. CONDITIONS GOVERNING THE PROCUREMENT	32
A. SEQUENCE OF EVENTS.....	32
B. EXPLANATION OF EVENTS.....	33
C. GENERAL REQUIREMENTS.....	37
III. RESPONSE FORMAT AND ORGANIZATION	48
A. NUMBER OF RESPONSES.....	48
B. NUMBER OF COPIES	48
C. PROPOSAL FORMAT	49
IV. SPECIFICATIONS	52
A. TECHNICAL SPECIFICATIONS.....	52
B. COST PROPOSAL.....	76
V. EVALUATION	77
A. EVALUATION OF PROPOSALS	77
B. EVALUATION POINT SUMMARY	77
C. EVALUATION FACTORS	78
D. EVALUATION PROCESS.....	80

APPENDIX A – Acknowledgement of Receipt Form.....	82
APPENDIX B – Letter of Transmittal Form	83
APPENDIX C – Reference Questionnaire Form	84
APPENDIX D – Campaign Contribution Disclosure Form	88
APPENDIX E – New Mexico Employees Health Coverage Form	90
APPENDIX F – SUSPENSION AND DEBARMENT REQUIREMENT	91
APPENDIX G - HIPAA BUSINESS ASSOCIATE AGREEMENT	93
APPENDIX H – DRAFT CONTRACT	103
APPENDIX I – COST PROPOSAL FORM	184

I. INTRODUCTION

A. PURPOSE OF THIS REQUEST FOR PROPOSALS

The State of New Mexico (NM) Human Services Department (HSD) through its Medical Assistance Division (MAD), is requesting proposals for a Quality Improvement Organization (QIO) or QIO-like entity to assist HSD in meeting the requirements of 42 CFR Part 456-Utilization Control. Specifically, the HSD is seeking an organization to serve as the Third Party Assessor (TPA) to conduct the following utilization review (UR) and assessment functions for services and/or programs provided in the fee-for-service environment and exchange data with the MMISR:

1. Prior authorization and medical necessity reviews for Medicaid services, both physical and behavioral health;
2. Prior authorization, medical necessity reviews, and medically frail exemptions for the Alternative Benefit Plan;
3. Medical eligibility/level of care (LOC) determinations for recipients receiving long-term care services in an Intermediate Care for Individuals with Intellectual Disabilities (ICF/IID) facility;
4. Medical eligibility/LOC determinations for recipients in the Program of All-Inclusive Care for the Elderly (PACE);
5. Medical eligibility/LOC determinations and Individual Service Plan (ISP)/Service and Support Plan (SSP) reviews and budget reviews for recipients meeting ICF/IID LOC and receiving services through a Home and Community-Based Services (HCBS) Waiver;
6. Medical necessity reviews for Emergency Medical Services for Non-Citizens (EMSNC);
7. Prior authorization reviews for Developmental Disability (DD) HCBS Waiver professional and ancillary services;
8. Prior authorization reviews for Mi Via (MV) HCBS Waiver professional and ancillary services;
9. Prior authorization reviews for Supports Waiver (SW) HCBS Waiver professional and ancillary services;
10. Prior authorization reviews for Medical Fragile (MF) HCBS Waiver professional and ancillary services;

11. System entry of retroactive fee-for-service nursing facility prior authorizations;
12. Medical necessity reviews for other designated services or programs identified by HSD as exempt from HSD's Section 1115 (a) demonstration Waiver ("Centennial Care") and,
13. Clinical validation reviews of Diagnosis-Related Group (DRG) used in the billing for hospitalizations.

The purpose of this Request for Proposals (RFP) is to solicit proposals of Offerors that have the capacity, experience and expertise to perform the requirements described within this RFP. Specifically, the Department is seeking an organization to provide Third Party Assessment (TPA) for certain home health, long-term care, Home and Community-Based Services, as well as Utilization Management (UM) functions for certain Fee-for-Service (FFS) programs.

While it is HSD's intent to implement all of the review programs listed in this RFP, HSD may, at its discretion, modify or delay certain review functions due to the implementation of New Mexico health care reform initiatives. HSD reserves the right to gradually implement review types or to implement all or only some of the reviews.

B. SUMMARY STATEMENT OF WORK

This section summarizes the work that will be required of the Contractors; however, it is not an exhaustive list of services expected.

The selected Contractors will provide services to: (1) perform work under the contract resulting from this RFP; (2) work with the Centers for Medicare and Medicaid Services (CMS) approved Independent Verification and Validation (IV&V) Contractor, and the HHS2020 Enterprise Project Management Office (EPMO), as well as the state staff dedicated to the project; (3) perform planning and leadership related to configuration of the proposed services; (4) work with the MMISR System Integrator (SI) Contractor and other BPO Contractors to ensure integration with the MMISR Solution; and (5) support attainment of CMS Certification for the MMISR Solution as a whole.

The State seeks a Contractor that understands the CMS Medicaid Information Technology Architecture (MITA) and who can help the State achieve its goal of MITA Maturity Level 4. By pursuing MITA Maturity Level 4, the State expects to achieve automation to the fullest extent, including the use of business rules to automate decision making; compliance with established industry standards; and improvements in timeliness, accuracy and customer satisfaction. Pursuant to §10-16-13 NMSA 1978 Prohibited Bidding: No state agency shall accept any bid (proposal) from a person who directly or indirectly participated in the preparation of specifications on which the competitive bidding was held.

C. BACKGROUND INFORMATION

This section provides background on the HSD and MAD programs that may be helpful to the Offeror in preparing a proposal. The information is provided as an overview and is not intended to be a complete and exhaustive description.

HSD Resources and Locations

HSD has more than 1,800 authorized employees and contracts with community-based providers throughout the state. There are more than thirty-four (34) HSD/ISD field office locations statewide. HSD's central offices are located in three (3) Santa Fe building complexes: Plaza La Prensa (Behavioral Health Services Division (BHSD), Fair Hearings (FH), MAD); 1474 Rodeo Road (Administrative Services Department (ASD), Office of Inspector General (OIG), Office of the Secretary (OOS), Income Support Division (ISD), Child Support Enforcement Division (CSED), and Office of General Counsel (OGC)); 1301 Siler Rd (Information Technology Division (ITD)).

Organization of HSD

HSD is a cabinet-level agency in the executive branch of the New Mexico state government, headed by a Cabinet Secretary appointed by the Governor and confirmed by the New Mexico Senate. HSD consists of the Office of the Secretary and six (6) divisions. *Only those divisions or bureaus within each division that are related to this RFP are described herein.*

Office of the Secretary. The Office of the Secretary consists of the Secretary of Human Services, two Deputy Secretaries, the Office of General Counsel, the Office of Human Resources, and the Office of Inspector General.

The Secretary provides cabinet-level direction for HSD and serves as a point of appeal when contractual disputes arise. The Office of General Counsel provides legal support to all of HSD's divisions, bureaus and programs. The Office of Inspector General investigates and pursues cases of fraud and abuse, and also administers the fair hearing process. The Office of Human Resources serves personnel needs of department employees, handles job recruitments, hiring, reorganizations and career counseling, as well as employee insurance and benefits, handles matters related to department personnel policies, provides coaching to the Agency's supervisors and managers, works with labor relations and delivers and coordinates training programs and staff development.

Administrative Services Division (ASD). ASD provides general administrative support for HSD and all its programs, including Medicaid.

Income Support Division (ISD). ISD is the primary source for eligibility determination for all

HSD programs, including Medicaid. The division's field staff of nearly a thousand (1,000) employees, supervisors and county directors is administered through four (4) district operations offices. Field staff are responsible for interviewing recipients, determining eligibility, and issuing benefits for the Supplemental Nutrition Assistance Program (SNAP), cash assistance, Medicaid, and other assistance programs.

Medical Assistance Division (MAD). The Medical Assistance Division manages and administers the federal Medicaid program and authorized waivers including the Centennial Care program. Medicaid is authorized under Title XIX of the Social Security Act. Federal contribution levels differ by program and vary based on relative ranking of the state in per capita income.

Program Overview

Medicaid Eligibility. New Mexico's Medicaid Program covers more than forty (40) eligibility categories. The major groups of individuals eligible for Medicaid are: individuals in households receiving cash assistance: aged, blind, and or disabled individuals receiving cash assistance (Supplemental Security Income [SSI]); certain aged, blind, and or disabled individuals requiring nursing home care; children under the jurisdiction of the state; pregnant women in households with incomes below 185% of the Federal Poverty Level (FPL); children up to age nineteen (19) in households with incomes below 235% of FPL; and adults under the Alternative Benefit Plan. The remainder of the categories are related to special circumstances and/or type of service needed.

As of SFY 2021, more than 840,000 individuals in New Mexico had Medicaid eligibility for at least part of the year.

Covered Services. Medicaid program regulations allow reimbursement for a broad array of healthcare services and providers. Mandated services include, but are not limited to: general acute inpatient hospital care; outpatient hospital services; physician services provided in a variety of settings; nurse midwives; nursing facility services for certain individuals; home health care; rural health clinic services including services in Federally Qualified Health Centers; laboratory and radiology; nurse practitioner services; and medically necessary Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services. Optional services provided in New Mexico include, but are not limited to: HCBW services; prescription drugs; eyeglasses and hearing aids; organ transplants; dental services; physical, occupational and speech therapies; rehabilitative services; ICF/IID; case management; hospice; transportation services; durable medical equipment and supplies; prosthetic devices; and adult personal care option.

Administration of the Medicaid Program. HSD/MAD works collaboratively with other state agencies in managing the Medicaid program. Specifically, it works with the Department of Health's (DOH) Developmental Disabilities and Supports Division (DDSD) to administer various HCBS waiver programs and with the Children, Youth, and Families Department (CYFD) in the administration of certain services for children.

A program to monitor and control utilization and detect fraud and abuse is operated by HSD's Office of Inspector General, and the New Mexico Attorney General Medicaid Fraud and Elder Abuse Division.

Assistance of other State Contractors. HSD/MAD works collaboratively with contractors, vendors, and consultants, to provide certain services for the division. These other contractors include, but are not limited to: New Mexico Medicaid managed care organizations (MCOs); MMISR contractors; a fiscal intermediary contractor; a financial management agent for the Mi Via and Supports Waiver programs; and various nationwide consultants familiar with Medicaid and other federally funded programs. At times, the successful Offeror will be required to work with these and other, appropriate contractors, vendors, or consultants.

Exempt Services and Programs Bureau (ESPB). The ESPB manages the following programs: HCBS waivers for individuals with Developmental Disabilities (DD) and Medically Fragile (MF) conditions; ICF/IID facilities; Medicaid school-based services; state-funded Brain Injury services; Family, Infant, Toddler contract; Program of All-inclusive Care for the Elderly (PACE); Supports Waiver; and the Mi Via Self-Directed Waiver. As the oversight agency for these HCBS waivers, HSD/ESPB works closely with the DOH DDS, the operating agency for the DD and MF waiver programs, for both the traditional, Mi Via, and Supports Waiver models. HCBS waivers are authorized by the CMS under section 1915(c) of the Social Security Act (SSA). These programs permit a state to furnish an array of home and community-based services that assist Medicaid recipients to live in the community and avoid institutionalization. Waiver services complement and/or supplement the services that are available to recipients through the Medicaid State plan and other federal, state or local public programs as well as support provided by families and communities.

This Bureau also manages the TPA contract. The current TPA contract with Comagine Health to perform TPA and utilization review functions ends on June 30, 2023.

The four (4) Medicaid HCBS waiver programs that fall under the scope of this procurement serve: the DD Waiver, MF Waiver, the Mi Via Self-Directed Waiver, and the Supports Waiver.

The Developmental Disabilities (DD) Waiver program also known in New Mexico as the "Traditional DD Waiver" is designed to provide Services and Supports that assist eligible children and adults with Intellectual and Developmental Disabilities (IDD) to participate as active members of their communities. The program serves as an alternative to institutional care.

The Medically Fragile Waiver (MFW) program is intended for individuals who have been determined to have both a medically fragile condition and a developmental disability to live in their homes.

The Mi Via Self-Directed waiver program is available to any person who is already a participant in or allocated a slot in one of the existing HCBS waivers. Mi Via is designed to assist

participants in directing their home and community-based services, supports and goods within an approved plan and budget. Eligible participants have the option to direct and purchase services, supports and goods related to their disabilities, using the essential elements of person-centered planning, individual budgeting, participant protections, and quality assurance and quality improvement.

New Mexico's new Supports Waiver (SW) is a Home and Community Based Services (HCBS) waiver that is an option for individuals who are on the Developmental Disabilities (DD) Waiver Wait List. Supports Waiver services are intended to complement unpaid supports that are provided to individuals by family and others.

Centennial Care/Managed Care Organizations. HSD received approval from the federal Centers for Medicare and Medicaid Services for a single Section 1115(a) demonstration waiver of the SSA to implement Centennial Care effective January 1, 2014. Under Centennial Care, the full array of current Medicaid services, including acute, behavioral health, certain home and community-based and long term institutional care (with the exception of PACE), and programs requiring a nursing facility level of care, will be delivered through a managed care system with contracted health plans. HCBS in Centennial Care are called Community Benefits will also include a self-direction component. HSD is beginning the procurement process for the renewal of the New Mexico Medicaid Managed Care contracts to be effective January 1, 2024. The TPA activities being procured through this RFP will be managed separately from the Managed Care health plans. The TPA, however, is expected to work collaboratively with the Managed Care health plans for recipient program transition and coordination of services.

D. SUMMARY SCOPE OF WORK

HSD requests proposals to improve third-party assessment and utilization review services through innovative and proven business and technical solutions for performing assessment and UR activities, meeting program requirements, and conducting administrative and system functions. HSD seeks an Offeror with the capacity, clinical experience and expertise in HCBS traditional and self-direction models serving developmental disabilities and medically fragile populations; medical eligibility LOC determinations for long-term/institutional care; and medical necessity/prior authorization reviews for physical and behavioral health.

The successful Contractor is expected to commit to working with HSD to make adjustments or changes according to new requirements that may arise as a result of Centennial Care and other Medicaid healthcare reform initiatives.

E. SCOPE OF PROCUREMENT

The scope of the procurement shall encompass the requirements set forth in the professional services contract (Appendix H of this RFP). This procurement will result in a single source

award. The initial term of the contract is expected to be two (2) year, with optional additional six (6) years, renewed annually (13-1-150). In no case shall the contracts, including the renewals thereof, exceed a total of eight (8) years in duration.

F. OFFEROR QUALIFICATIONS/CONFLICT OF INTEREST

This RFP is open to any Offeror capable of performing the work described in Section IV, Specifications, Technical Specifications, subject to the following stipulations:

- An Offeror shall be a Quality Improvement Organization (QIO) or a QIO-like entity approved by the CMS to perform medical and utilization review functions pursuant to section 1152 of the Social Security Act and 42 Code of Federal Regulations Part 475.
- Pursuant to the Governmental Conduct Act, NMSA 1978, 10-16-1 et. seq., an Offeror shall have no direct or indirect interest that conflicts with the performance of services covered under this RFP;
- Pursuant to NMSA 1978, § 13-19-191, § 30-24-2, and § 30-41-1 through § 30-41-3, an Offeror shall not provide or offer bribes, gratuities, or kickbacks to applicable State personnel;
- An Offeror shall ensure that it will comply with the New Mexico Governmental Conduct Act, NMSA 1978, 10-16-1 et seq.;
- An Offeror shall ensure that no elected or appointed officer or other employee of the State of New Mexico shall benefit financially or materially from the successful award of the contract to the Offeror and that no such individual shall be permitted to any share or part of the contract or to any benefit that may arise therefrom;
- An Offeror shall complete any and all required disclosure forms, including but not limited to campaign disclosure forms and other attestations; and
- The burden is on the Offeror to present sufficient assurance to HSD that awarding the Contract to the Offeror shall not create a conflict of interest.

G. PROCUREMENT MANAGER

The Department has designated a Procurement Manager who is responsible for the conduct of this procurement and whose name, address, telephone number and email address are listed below.

La Risa Rodges, Procurement Manager
New Mexico Human Services Department

Medical Assistance Division
Phone: (505) 795-3713
Email: LaRisa.Rodges@state.nm.us

1. **Any inquiries or requests** regarding this procurement should be submitted, in writing, to the Procurement Manager. Offerors may contact **ONLY** the Procurement Manager regarding this procurement. Other state employees or Evaluation Committee members do not have the authority to respond on behalf of the HSD.
2. **Protests of the solicitation or award must be submitted in writing to the Protest Manager identified in Section II.B.13.** As a Protest Manager has been named in this Request for Proposals, pursuant to §13-1-172, NMSA 1978 and 1.4.1.82 NMAC, **ONLY** protests delivered directly to the Protest Manager in writing and in a timely fashion will be considered to have been submitted properly and in accordance with statute, rule and this Request for Proposals. Protests submitted or delivered to the Procurement Manager will **NOT** be considered properly submitted.

H. PROPOSAL SUBMISSION

Submissions of all proposals must be accomplished via the Human Services Department's electronic procurement portal, Bonfire. Refer to Section III.B.1 for instructions.

I. DEFINITIONS OF TERMINOLOGY

This section contains definitions of terms used throughout this procurement document, including appropriate abbreviations.

1. **“ABP”** means the Alternative Benefit Plan that covers specific benefits and services similar to commercial insurance plans. ABP preventive services and treatment services are created through the Patient Protection and Affordable Care Act (ACA).
2. **“Abstract”** means the State long-term care assessment form submitted to the TPA to determine if a recipient meets the medical criteria, or level of care, to be in a nursing home or ICF/IID.
3. **“ADL”** means the activities of daily living. Activities of daily living are activities that reflect the client's ability to perform self-care tasks essential for sustaining health and safety such as dressing, grooming/bathing, eating, meal acquisition/preparation, transfer, mobility, toileting, and bowel/bladder control and management, and taking daily, essential prescription medication.

4. **“Adverse Determination”** means a determination that the Medicaid health care services furnished or proposed to be furnished to a recipient are not medically necessary or are not appropriate.
5. **“Agency”** means the Human Services Department.
6. **“Approval”** means a utilization review authorization based on the recipient meeting the clinical or state-approved criteria for the requested Medicaid service(s) or level of care.
7. **“ASPEN”** means New Mexico’s Automated System Program and Eligibility Network.
8. **“Award”** means the final execution of the contract document.
9. **“BMS”** means Benefit Management Services.
10. **“Business Days”** means days the State of New Mexico is open for business (i.e., Monday through Friday except for State Personnel Board approved State and Federal holidays).
11. **“Business Hours”** means 7:30 AM through 5:30 PM Mountain Daylight Time (MDT), Monday through Friday.
12. **“Business Transformation Council (BTC)”** means a dedicated organization established to drive and coordinate the implementation of required changes to ensure a successful transformation.
13. **“CA”** means a Medicaid-enrolled consultant agency that hires individual consultants to assist Mi Via waiver participants to plan and purchase services and supports within a State-approved budget.
14. **“CAP”** means a corrective action plan developed by the TPA.
15. **“Case”** means a household that Medicaid/MAD treats as a unit for purposes of eligibility determination; for example, a parent and child; a legal guardian and child; or a set of siblings.
16. **“Centennial Care”** means HSD’s Section 1115 (a) demonstration Waiver effective January 1, 2014 that provides Medicaid services, including acute, behavioral health, certain home and community-based and long term

institutional care (with the exception of the Development Disabilities and Medically Fragile waivers and other exempt programs that are specified in the waiver application) through a managed care system.

17. **“COE”** means the category of eligibility that is assigned to recipients based on the program under which they have been qualified for Medicaid eligibility. The COE can determine the level of Medicaid benefits for which the client is eligible.
18. **“Claim”** means a bill for services, a line item of service, or all services for one member within a bill.
19. **“Close of Business”** means 5:30 PM MDT.
20. **“CMS”** means the Federal Center for Medicare and Medicaid Services, an agency of the US Department of Health and Human Services.
21. **“Community-Based Care”** means a system of care that seeks to provide services to the greatest extent possible in or near the member’s home community.
22. **“Complaint”** means an expression of dissatisfaction expressed by a complainant, verbally or in writing.
23. **“Concurrent Review”** means a process of updating clinical information from a service provider regarding a recipient who is already receiving a covered service, to evaluate whether the service continues to be medically necessary. Continued stay or continued service reviews are concurrent reviews for medical necessity.
24. **“Contract”** means any agreement for the procurement of items of services, construction, or tangible personal property.
25. **“Contract Manager”** means the individual selected by HSD to monitor and manage all aspects of the contract resulting from this RFP.
26. **“Contractor”** means the TPA Contractor for the MMISR Solution who has been contracted as a result of this procurement.
27. **“Critical Incident”** means a reportable incident that may include, but is not

limited to, abuse, neglect or exploitation; death; environmental hazards; law enforcement intervention; or emergency services, and which encompasses the full range of physical health, Medicaid state plan, and home and community-based services.

28. **“Days”** means business days, unless otherwise specified.
29. **“Delegation”** means a formal process that gives an entity the authority to perform certain functions on an entity’s behalf while retaining full accountability for the delegated functions.
30. **“Deliverable”** means any measurable, tangible, verifiable outcome, result, or item that must be produced to complete a project or part of a project.
31. **“Denial”** means the TPA decision to not authorize requested services or goods.
32. **“Department”** means one of the principal divisions of the State government, headed by a secretary who is a member of the governor’s cabinet. HSD is the department that contracts for this project.
33. **“Desirable”** means the terms "may", "can", "should", "preferably", or "prefers" to identify a discretionary item or factor.
34. **“Determination”** means the written documentation of a decision of a procurement officer, including findings of fact required to support a decision. A determination becomes part of the procurement file to which it pertains.
35. **“Developmental Disabilities Waiver (Category 096)”** means the Medicaid HCBS Waiver program designed to furnish services to applicants/recipients who meet the definition of a developmental disability or specific related condition as determined by the DOH and the Disability Determination Contractor (DDC) in accordance with the approved DD waiver criteria. The individual must also require the level of care provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), and meet all other applicable financial and non-financial eligibility requirements.
36. **“Disabled”** means an individual under 65, unable to engage in any substantial gainful activity because of a medically determinable physical, developmental or mental impairment which has lasted or expected to last for a continuous period of at least twelve (12) months and meets allowable resource standards.

37. **“DOH”** means the Department of Health, the State Agency responsible for operating both the traditional and self-directed program models for the Medicaid Section 1915 (c) Home and Community-Based Services (HCBS) Waiver programs for individuals with developmental disabilities or are medically fragile that meet the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) level of care.
38. **“Due Process”** means the performance of recipient or provider requested contestation of a denial, termination, suspension, modification or reduction of service through a provider reconsideration of a review decision or a recipient fair hearing.
39. **“Emergency”** means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.
40. **“Emergency Medical Services for Non-Citizens (Category 085)”** means coverage for emergency services for certain non-citizens who are undocumented or who do not meet qualifying immigration criteria but who meet all eligibility criteria for certain Medicaid categories or SSI.
41. **“Enterprise”** means the full spectrum of NM HHS systems and agencies (departments/divisions) engaged in this Project. At the present time the Enterprise applies to ALTSD, CYFD, DOH and HSD.
42. **“Enterprise Service Bus (ESB)”** means an enterprise service bus that implements a communication system between mutually interacting software applications in a service-oriented architecture (SOA).
43. **“Evaluation Committee”** means a body appointed by HSD management to perform the evaluation of Offeror proposals.
44. **“Evaluation Committee Report”** means a report prepared by the Procurement Manager and the Evaluation Committee for submission to the

HSD Secretary for contract award that contains all written determinations resulting from the conduct of a procurement requiring the evaluation of competitive sealed proposals.

45. **“Experimental, investigational, or unproven medical practice”** means any procedure, medication product, or service that is not proven to be medically efficacious for a given procedure; or that is performed for or in support of purposes of research, experimentation, or testing of new processes or products and are not covered Medicaid services.
46. **“Fee-For-Service (FFS)”** means the traditional Medicaid payment method whereby payment is made by HSD to a service provider after services are rendered and billed.
47. **“Finalist”** means an Offeror who meets all mandatory specifications of this RFP and whose score on evaluation factors is sufficiently high to merit further consideration by the Evaluation Committee.
48. **“Financial Management Agent (FMA)”** means the Financial Management Agent that makes payment to employees for services rendered to the Mi Via or Support Waiver participant. The FMA processes employee timesheets or invoices, and bills Medicaid for services and goods approved on the Service and Support Plan. The current contractor is Palco.
49. **“Financial Services”** means the Enterprise solution for claims processing and related financial transactions.
50. **“Fiscal Agent”** means the entity responsible for administering claims for the New Mexico Medicaid program. The current contractor is Conduent. The Fiscal Agent contracts the FMA as well as provider for the fee for service self-direction FMA online management system. The current contractor is Palco for both the FMA and provider for the self-direction FMA online management system.
51. **“Framework”** means the fundamental structure to support the development of the HHS2020 Solution. The Framework acts as the architectural support for the modules, services and applications, ESB, Web services, service layers, commonly shared Core Services, etc.
52. **“Fraud”** means an intentional deception or misrepresentation made by an

entity or person with the knowledge that the deception could result in some unauthorized benefit to himself or to some other previously described entity or person. It includes any act that constitutes fraud under applicable federal or state law.

53. **“Health Plan”** means a health maintenance organization (HMO), managed care organization (MCO), prepaid inpatient health plan (PIHP), or third party payer or their agents.
54. **“Hearing or Fair Hearing”** means an administrative hearing process that provides for an impartial review of HSD actions that adversely affect recipients and providers.
55. **“HHS”** means Health and Human Services and includes all State agencies delivering HHS-related services: DOH, HSD, ALTSD, and CYFD.
56. **“HIPAA”** means the Health Insurance Portability and Accountability Act of 1996.
57. **“Home and Community-Based Services (HCBS) Waiver”** means one or more of the State’s Medicaid home and community-based waiver programs approved by CMS under the authority of section 1915 (c) of the Social Security Act. HSD, with the DOH, has authority to develop and implement these programs for Medicaid applicants/recipients who meet both financial and medical criteria for an institutional level of care.
58. **“HSD”** means the sole executive department in New Mexico responsible for the administration of Title XIX (Medicaid).
59. **“IBA”** means the annual Individual Budgetary Allotment amount, available to each Mi Via and Supports Waiver participant that can be used to purchase flexible combinations of services, supports and goods as approved in the service and support plan (SSP).
60. **“Individualized Service Plan (ISP)”** means a treatment plan for a recipient that includes the recipient's needs, functional level, intermediate and long range goals, statement for achieving the goals, and specifies responsibilities for the care needs. The plan determines the services allocated to an individual within program allowances.

61. **“Institutional Care Medicaid (Categories 081, 083, and 084)”** means coverage for services furnished to individuals who require institutional care in an acute care hospital (ACH), nursing facility and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), swing bed or certified in-state inpatient rehabilitation center. A level of care determination by the TPA is required (except for ACH) and the individual must meet all other applicable financial and non-financial eligibility requirements.
62. **“Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)”** means facilities that are licensed and certified by the DOH to provide room and board, continuous active treatment and other services for eligible Medicaid recipients with a primary diagnosis of intellectual disability.
63. **“IP”** means integrated platform.
64. **“ISD”** means the Human Services Department Income Support Division.
65. **“IT”** means information technology.
66. **“Letter of Allocation”** means written notice from the State Agency to the applicant to proceed with the HCBS waiver application process.
67. **“Letter of Direction (LOD)”** means a letter issued to the contractor by HSD/MAD giving specific direction concerning specific reviews, changes in the mix of review types, services to be reviewed, and other directions related to the scope of work.
68. **“Level of Care (LOC)”** means the level of care, or medical eligibility, needed by an individual that is provided in a nursing facility or ICF/IID.
69. **“Long-Term Services”** means a continuum of services and supports, ranging from in-home and community-based services for the elderly and individuals with disabilities who need help in maintaining their independence to institutional services for those who require an institutional care level of support.
70. **“LTC Span”** means the long-term care authorization span that is maintained in the Medicaid Management Information System (MMIS).
71. **“Mandatory”** means a required item or factor (as opposed to “desirable”).

The terms "must", "shall", "will" and "required" identify a required item or factor. Failure to meet a mandatory item or factor will result in rejection of an Offeror's proposal.

72. **“Medicaid”** means the medical assistance program authorized under Title XIX of the Social Security Act or its successors, furnished to New Mexico residents who meet specific eligibility requirements.
73. **“Medically Fragile (MF) Waiver (Category 095)”** means the HCBS waiver program for individuals diagnosed with a developmental disability, developmental delay or who are at risk for a developmental delay and diagnosed with a medically fragile condition before reaching 22 years old and who require an ICF/IID LOC and meet other defined criteria.
74. **“Medical necessity requirements”** means that the New Mexico Medicaid program reimburses providers for furnishing covered services to Medicaid recipients only when the services are medically necessary. Medical necessity is required for the specific service, level of care, and service setting, if relevant to the service.
75. **“Medically necessary services”** means clinical and rehabilitative physical or behavioral health services that are essential to prevent, diagnose or treat medical conditions or are essential to enable the individual to attain, maintain or regain functional capacity; are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the individual; are provided within professionally accepted standards of practice and national guidelines; and are required to meet the physical and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payer. A determination that a health care service is medically necessary does not mean that the health care service is a covered benefit or an amendment, modification or expansion of a covered benefit.
76. **“MITA”** means the Medicaid Information Technology Architecture initiative sponsored by the CMS and governed by the MITA Governance Board intended to foster integrated business and information technology (IT) transformation across the Medicaid enterprise to improve the administration of the Medicaid program.
77. **“MITA SS-A”** means the MITA State Self-Assessment in which the state

looks at its current capabilities (both business and technical) and develops a list of new or combined target capabilities.

78. **“Mi Via”** means the HCBS waiver providing self-directed home and community-based services to eligible waiver recipients who are developmentally disabled or medically fragile, where eligible participants have the option to access Medicaid funds, using the essential elements of person-centered planning, individualized budgeting, participant protections, and quality assurance and quality improvement.
79. **“MMIS”** means the New Mexico Medicaid Management Information System that helps manage the State’s Medicaid program and Medicaid business functions.
80. **“MMISR”** means the MMIS Replacement system and Project.
81. **“Motion to Dismiss”** means request to dismiss (close) the fair hearing case.
82. **“MDT”** means Mountain Daylight Time.
83. **“NM”** means New Mexico.
84. **“Nursing Facility”** means a Medicaid facility licensed and certified by DOH in accordance with 42 CFR 483 to provide inpatient room, board and nursing services to recipients who require these services on a continuous basis but who do not require hospital services or direct daily services from a physician.
85. **“Off Shore”** means any country outside of the United States.
86. **“Offeror”** means any person, corporation, or partnership that chooses to submit a proposal.
87. **“Omnicaid”** means the current New Mexico's Medicaid Management Information System. Omnicaid maintains provider and client eligibility information; processes and adjudicates claims; and issues remittance advices (RA) and payments.
88. **“Performance Improvement Plan (PIP)”** means a plan developed by the TPA to correct contract performance problems identified by HSD; a PIP precedes a CAP.

89. **“Person-centered planning”** means a process in which each consumer or participant is actively engaged, to the extent that the participant desires, in identifying their needs, goals and preferences, and in developing strategies to address those needs, goals and preferences.
90. **“Plan of Care (POC)”** means a written document including all medically necessary services to be provided for a specific recipient.
91. **“Prepayment Reviews”** means a utilization review conducted after services have been furnished and claims for payment have been filed by providers. If a service is either not a covered Medicaid benefit or not medically necessary, payment for that service will be denied.
92. **“Price Agreement”** means a definite or indefinite quantity contract that requires the Contractor to furnish items of tangible personal property, services or construction to a State agency or a local public body that issues a purchase order, if the purchase order is within the quantity limitations of the contract, if any.
93. **“Prior Authorization (PA) Review”** means the approved number of service units that a provider is authorized to furnish to a recipient and the date(s) the service(s) must be provided.
94. **“Procurement Manager”** means any person or designee authorized by a State agency or local public body to enter into or administer contracts and to make written determinations with respect thereto.
95. **“Procuring Agency”** means the New Mexico Human Services Department.
96. **“Program for All-Inclusive Care for the Elderly (PACE) program services”** means the New Mexico program that provides acute, long-term care, personal care and social services to a frail population that meets nursing facility clinical criteria.
97. **“Provider”** means an individual, institution, facility, agency, physician, health care practitioner, non-medical individual or agency, or other entity that is licensed or otherwise authorized to provide any of the Covered Services in the State for HHS2020 Enterprise Agencies. Providers include individuals and vendors providing services to Members.

98. **“Quality Improvement Organization (QIO) or QIO-like Entity”** means an organization approved by CMS as meeting the requirements in 1152 of the Social Security Act and 42 CFR Part 475.
99. **“QM/QI”** means quality management and quality improvement.
100. **“Recipient”** means an individual who has applied for and been determined eligible for Title XIX (Medicaid). A “recipient” may also be referred to as a “member”, “customer”, “consumer”, “participant”, or “client”.
101. **“Reconsideration”** means a request submitted by a provider who is dissatisfied with the medical necessity or level of care decision by the TPA.
102. **“Redacted”** means a version/copy of the Offeror’s proposal with the information considered proprietary or confidential (as defined by §§57-3A-1 to 57-3A-7, NMSA 1978 and NMAC 1.4.1.45 and summarized herein and outlined in Section II.C.8 of this RFP) blacked-out BUT NOT omitted or removed.
103. **“Reduction of care”** means a utilization reviewer has authorized the type of service requested by the provider, but in lesser amount or units of service than were originally requested.
104. **“Request for Administrative Action”** means an administrative action is required in the FMA system.
105. **“Request for Information (RFI)”** means the process to obtain additional or missing information needed to make a review decision from a provider or recipient, as appropriate.
106. **“Request for Proposals (RFP)”** means all documents, including those attached or incorporated by reference, used for soliciting proposals.
107. **“Responsible Offeror”** means an Offeror who submits a responsive proposal and that has furnished, when required, information and data to prove that its financial resources, production or service facilities, personnel, service reputation and experience are adequate to make satisfactory delivery of the services or items of tangible personal property described in the proposal.
108. **“Responsive Offer”** means an offer that conforms in all material respects to

the requirements set forth in the RFP. Material respects of an RFP include, but are not limited to price, quality, quantity or delivery requirements.

109. **“Retrospective review”** means reviews conducted after a claim has been processed and payment is made.
110. **“Self-Direction”** means Mi Via participants choose which services, supports and goods they need; when, where and how those services and supports will be provided; who they want to provide them; and who they want to assist them with planning and managing their services and supports.
111. **“Service and Support Plan (SSP)”** means a plan that identifies the services, supports and goods identified by the participant to meet their functional, medical or social needs and advances the desired outcomes.
112. **“Solicitations”** means an Invitation to Bid (ITB) and a Request for Proposal (RFP).
113. **“Solution”** means any combination of design, software, services, tools, systems, processes, knowledge, experience, resources, expertise or other assets that the State, the MMIS and the respective modular contractors use or provide to meet the business needs of the Project.
114. **“SPD”** means State Purchasing Division of the New Mexico State General Services Department.
115. **“Staff”** means any individual who is a full-time, part-time, or independently contracted employee with an Offeror’s company.
116. **“Stakeholders”** means internal and external individuals, agencies, organizations, departments that are integral to the Enterprise by having an interest in or a need being met by the HHS2020 Enterprise MMISR Project for the health and human service programs they manage. Stakeholders include at a minimum, State Departments, Providers, Members, and Advocacy Groups.
117. **“State (the State)”** means the State of New Mexico.
118. **“State Agency”** means any department, commission, council, board, committee, institution, legislative body, agency, government corporation,

educational institution or official of the executive, legislative or judicial branch of the government of this state. “State agency” includes the Purchasing Division of the General Services Department and the State Purchasing Agent but does not include local public bodies.

119. **“State Plan”** means a statewide plan for Medicaid services submitted for approval to CMS under Title XIX of the federal Social Security Act.
120. **“State Purchasing Agent”** means the Director of the Purchasing Division of the New Mexico General Services Department.
121. **“Subcontract”** means a written agreement between a contractor and a third party, or between a subcontractor and another subcontractor, to provide services.
122. **“Subcontractor”** means a third party who contracts with a contractor or a subcontractor for the provision of services.
123. **“Summary of Evidence (SOE)”** means the packet completed by the contractor for a client’s Fair Hearing proceedings that contains documentation of all related review information, medical records, forms, and policies that were reviewed in making an adverse determination.
124. **“System Integrator” (SI)** means an enterprise that specializes in implementing, planning, coordinating, scheduling, testing, improving and sometimes maintaining a computing operation. For the purpose of the MMISR the SI will implement the underlying infrastructure and enable to “touchpoints” between the modules.
125. **“Termination”** means the utilization review decision made during a concurrent review that yields a denial based on the current service being no longer medically necessary.
126. **“Third Party Assessor (TPA)”** means the TPA or MAD’s designee that is responsible for performing the activities outlined within this RFP.
127. **“Unredacted”** means a version/copy of the proposal containing all complete information; including any that the Offeror would otherwise consider confidential, such copy for use only for the purposes of evaluation.

128. **“Urgent Condition”** means acute signs and symptoms that, by reasonable medical judgment, represent a condition of sufficient severity such that the absence of medical attention within 24 hours could reasonably be expected to result in an emergency condition.
129. **“Utilization Review (UR)”** means a system for reviewing the appropriate and efficient allocation of health care services or level of care given or proposed to be given to a recipient.

J. MMISR APPROACH

The MMISR Project is part of NM HSD’s Health and Human Services (HHS) 2020. HHS 2020 is an Enterprise vision for transforming the way HHS services and programs are delivered to New Mexico citizens. HHS 2020 is not limited to technology; it encompasses a re-evaluation of processes and organization structures used to manage and deliver program services, efforts to work across organizational boundaries to more effectively manage and deliver all HHS services in the State and transition from current operating models to outcomes-based focus for our work.

The Medicaid Management Information System Replacement (MMISR) is the approach to replacing the current Medicaid Management Information system, Omnicaid, to implement an interconnected modular system with multiple Contractors. Some of the systems currently in use by other state agencies (like CYFD, ALTSD, and DOH) will be incorporated into the new modular system through the process of establishing system requirements and selecting Contractors through a Request for Proposal or Quote or Information. Some modules have already been procured and Contractors are beginning to provide services, while other modules are in various stages of procurement.

The MMISR Project consists of multiple modules across the Enterprise, starting with Medicaid first. Additional State partners will be added over time.

The module's scope and status at a high level include:

System Integrator (SI) – The infrastructure that supports the rest of the modules. Contracted and onboard working with the State on the MMISR.

Data Services (DS) – Dashboards, Reporting, Analytics and Business Intelligence. Contracted and onboard working with the State on the MMISR.

Consolidated Customer Service Center (CCSC) – Call Center, IVR, Chat, Bots, etc. Contracted and onboard providing services to the State on their current MMIS and will transition to support the new MMISR.

Quality Assurance (QA) – Program Integrity, Fraud and Abuse Detection system (FADS) recoveries, Third Party Liability (TPL) recoveries, Recovery Audit Contractor (RAC), etc. Contracted and onboard providing services to the State on their current MMIS and will transition to provide services for the MMISR.

Unified Portal (UP) – One online stop for services, mobile friendly, etc. Contract executed and work is beginning initially on the External Portal. An Internal worker portal will follow.

Financial Services (FS) – Claims adjudication, financial payment services and Pharmacy Benefit Management (PBM). In contract negotiations.

Benefit Management Services (BMS) – Provider Enrollment and Management. In contract negotiations.

Care/Case Management – Includes a fully functioning Care and Case Management system. Active procurement.

K. CONTRACTOR ROLE

The TPA/UR business services must support the State in achieving the vision of reducing costs, positioning for the future, meeting CMS Certification requirements and advancing in quality and efficiency.

TPA is the State's process for review of a request for medical treatment or referral for treatment. The TPA processes are intended to improve and advance the efficiency, economy, effectiveness and quality of healthcare services provided to enrolled New Mexico Medicaid Members. Authorization and referral requests typically include medical treatments using the standard processes of prior authorizations, reviewing and approving treatment plans prepared by a care management team in a care management setting, and authorizing referrals to another provider at the request of a physician for out-of-state services, and some emergency services (e.g., inpatient stay, emergency room, emergency surgery).

The State has identified three fundamental benchmarks for success of the TPA component. The first is to ensure the Members receive the services they need when they need them with the intention that the Member will experience improved health outcomes. The second is that the State wishes to improve the overall Stakeholder (e.g., Provider, Member, Case Manager, Authorized Representative) experience in the TPA process, which must include a reduction in wait times for authorization determination; and the third is that the State seeks process improvements and an efficient prior authorization tracking process for providers. With these benchmarks realized, the additional goals of reducing overall program costs can occur.

The Offeror must describe their approach to improving health outcomes including, but not limited to:

- Assure appropriate treatment specific to the Member's needs and situation;
- Minimize time for the determination of authorizations, plans of care, treatment plans and referrals, and automating such processes where possible;
- Provide State defined Business Rule driven real-time decisions;
- Provide their own EDI capability to the HHS2020 Enterprise to provide for acceptance and transmission of all electronic HIPAA transactions (e.g., 278);
- Provide an expedited appeal and Fair Hearing process supported by qualified Medical Directors or consultants who have direct experience working with the condition for which the denial has occurred;
- Provide the State with expert analysis and evaluation of mined TPA data;
- Make recommendations for strategic improvements to TPA processes to assure current trends in care are being implemented and that the appropriate services are being provided at the right time;
- Understand and be prepared to navigate the administrative processes for a Member changing between benefit plans and/or transitioning benefit plans;
- Assess TPA program effectiveness and work with the Benefit Plan Management Contractor on recommended changes;
- Improve communication to and from providers, Members, case and care managers and authorized representatives, and doing so in a culturally appropriate manner; and
- Implement workflows for monitoring all automatic and escalated authorization determinations.

The State is seeking comprehensive real-time TPA business services that are flexible and configurable so that established business rules may be modified as necessary including automatic triggering of correspondence. Standard processes will be defined to establish and modify business rules (e.g., Behavioral Health authorization by age), that identify when a review is required and under what criteria an authorization determination can be made automatically, or when the request needs to be escalated for State review. In the event the authorization being requested does not require prior review, the TPA system must immediately notify the provider upon submission and not conduct a review. The Contractor must assure the configurable edits (e.g., medical, dental, prescription, program specific) which will be applied during payment processing also will be used for authorization evaluation. The Contractor must provide, for State approval, all the Contractor's proposed criteria for authorization evaluation. The State may provide additional criteria to be used for determinations. The Contractor's services must be driven by NMAC, CFR, age requirements/limitations and InterQual or equivalent criteria. The criteria for edits must be updated by the Contractor based upon State defined timelines.

The TPA services and processes must include the ability to receive, evaluate and authorize treatment requests and referrals prior to services being rendered or paid. In such matters, time is of the essence. During design the State will define the data fields on the screen layout so that the terminology used for TPA services aligns with the State's terminology.

There will be occasions when an evaluation needs to be performed retrospectively or expedited and the TPA Contractor must be capable of and flexible enough to perform evaluations in such a

manner. An example of retrospective review includes claims for services to Emergency Medical Services for Non-Citizens (EMNC) for services that claims resolution cannot approve or deny.

Since the purpose of a medical review is to confirm that the plan provides coverage for medical services and appropriate services are being provided at the right time, the TPA Contractor must provide for a Medical Director or consultants with direct Member experience, an outside review or second opinion, of any authorization which is to be denied and must be prepared to represent the State in the event of an appeal or hearing.

The TPA services must be able to evaluate and navigate changing program criteria or transitions in program eligibility (e.g., Mi Via Waiver, DD Waiver, Supports Waiver, Medically Fragile Waiver, Centennial Care Community Benefit to a HCBS waiver, or other specialized programs of ALTSD, CYFD, DOH or HSD), perform needs assessments and establish and monitor budget for approved plans of care. The Contractor must perform program-specific budget determinations for multiple State programs (e.g., Traditional Waivers, Mi Via Waiver) which require a budget, needs assessment and plan of care.

The Contractor must evaluate the effectiveness of approved authorizations and make recommendations to the State for areas that could lead to improved health outcomes, promote program cost effectiveness, and eliminate unnecessary or unproductive reviews.

The State requires the HHS 2020 modules to be integrated, standardized and perform repeatable processes across the Enterprise, and integration with C/CMS for those Members with a Plan of Care (POC). By allowing cross-monitoring of data from multiple modules, the State can be more effective in the TPA process.

The TPA services must integrate data (e.g., Health Risk Assessment [HRA], Comprehensive Needs Assessment [CNA], Comprehensive Care Plans [CCP], Care Coordination/Case Management notes, ALTSD exception, ISP, SSP, IHA/Vineland) from external Care/Case Management systems and make such data available to all pertinent components within the MMISR modules.

The Contractor must provide all data via the IP that is needed for the Enterprise (e.g., authorization data for the FS module to appropriately process all claims, data needed by DS for reporting) to operate appropriately and as designed. The TPA system must be able to interface through the SI ESB. The Contractor must exchange data with the MMISR in the format required by the State and correct any errors when data is unable to be exchanged due to format and/or layout.

In order to assure the State's goals are met, the Contractor must supply technical resources to provide updates when needed using the State's approved terminology. The TPA is expected to make recommendations to the BMS Contractor for training, educational messaging and participation in TPA specific training.

The system shall integrate with the SI Solution, which will be comprised of a highly reliable, loosely coupled, secure SOA-compliant integration platform. The Contractor shall adhere to all standards established by the MMISR Project and approved by the State related to integration, interoperability, security and transmission of data. The Contractor shall exchange data using the ESB and shall acknowledge the data belongs to the State.

The contract resulting from this RFP also will require the Contractor integrate with the MMISR in order to support MMISR functions such as reporting, certification, claims processing. In order to support the MMISR, and their integration points, the Contractor will need to analyze the Business Transformation Council (BTC) Journeys. The BTC Journeys document the business need and HSD End-to End vision. The Contractor must use the BTC Journeys to influence their solution through the entire System Design Life Cycle (SDLC), analyze the BTC Journeys and incorporate those related to TPA/UR into their system and/or process.

HSD is seeking an Offeror who can demonstrate added value and experience delivering the services required to meet RFP requirements while integrating with the MMISR standards and processes. Offerors are encouraged to review the MMISR information presented in the Procurement Library <https://webapp.hsd.state.nm.us/Procurement/>

The TPA/UR proposals shall demonstrate the Offeror's ability and experience to:

- Apply lessons learned from other large efforts;
- Consider and understand the risks associated with integration with the MMISR approach and how to mitigate the risks;
- Integrate with the SI platform, processes and standards (e.g., data format and layout, Application Programming Interface (API) use);
- Deliver a solution and related services that are efficient, easily maintained, extendable, and easy to operate and update throughout its life;
- Deliver a solution and related services that are in the best interest of the State, and that actively assist the State in improving MITA Maturity Levels; and
- Exercise competence and experiential strength in applying well-defined methodologies and processes to manage and deliver the Project successfully

L. TPA UM/UR PROCUREMENT LIBRARY

A procurement library has been established. Offerors are encouraged to review the material contained in the Procurement Library by selecting the link provided in the electronic version of this document through your own internet connection.

Electronic version of RFP, Questions and Answers, RFP Amendments, etc
<https://www.hsd.state.nm.us/lookingforinformation/open-rfps/>
[New Mexico Human Services Department \(bonfirehub.com\)](https://www.bonfirehub.com/)

No one at the Agency other than the Procurement Manager will answer any questions about any

materials in the Procurement Library. Offerors are encouraged to use the Department website for additional information. The library includes electronic documents and web links.

All statistical data provided by HSD in regard to the RFP represents the best and most accurate information available to HSD at the time this RFP was prepared. It is the Offeror's responsibility to take into consideration normal volume increases during the contract period.

The Procurement Library contains the information listed below:

HSD:

1. Medical Assistance Division Program Policy Manual:
<https://www.hsd.state.nm.us/providers/rules-nm-administrative-code/>
 - Prior Authorization and Utilization Review
 - Developmental Disabilities HCBS Waiver
 - Mi Via HCBS Waiver
 - Medically Fragile HCBS Waiver
 - ICF-IID
 - EMSNC
 - PACE
 - Reconsiderations of Utilization Reviews
 - Recipient Hearings
 - Behavioral Health
 - ABP
 - DME, Vision, and Hearing
 - EPSDT
 - Dental Services
 - Hospital Services
 - Home Health Services
2. Alternative Benefit Plan (ABP):
<https://www.hsd.state.nm.us/lookingforinformation/intermediate-care-facility-ifc-iid/>
3. NM Home and Community-Based Services Waivers:
<https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html>
 - a. Developmental Disability Waiver
<https://www.hsd.state.nm.us/lookingforinformation/developmentally-disabled/>
<https://www.nmhealth.org/about/ddsd/pgsv/ddw/>
 - b. Medically Fragile Waiver
<https://www.hsd.state.nm.us/lookingforinformation/medically-fragile/>
<https://www.nmhealth.org/about/ddsd/pgsv/mfw/>

- c. Mi Via Waiver
<https://www.hsd.state.nm.us/lookingforinformation/mi-via/>
<https://www.nmhealth.org/about/ddsd/pgsv/sdw/>
- d. Supports Waiver
<https://www.nmhealth.org/about/ddsd/pgsv/csw/>
- 4. ICF/IID Admission Criteria:
<https://www.nmhealth.org/about/ddsd/pgsv/sdw/>
- 5. Client Eligibility:
<https://www.hsd.state.nm.us/lookingforinformation/income-eligibility-federal-poverty-level-guidelines/>
- 6. Client Privacy and Confidentiality:
<https://www.hsd.state.nm.us/lookingforinformation/recipient-privacy-and-confidentiality/>
- 7. Medicaid Eligibility Enrollment Reports:
<https://www.hsd.state.nm.us/medicaid-eligibility-reports/>
- 8. HSD Proposed Registers:
<https://www.hsd.state.nm.us/lookingforinformation/registers/>
- 9. Utilization Review Contract-Comagine Health Third Party Assessor (TPA) 2019 Contract & Amendments – Available on website:
<https://www.hsd.state.nm.us/lookingforinformation/medical-assistance-division/>
- 10. Letters of Direction Comagine Health /TPA – Available in electronic copy upon request
- 11. List of Income Support Division Offices:
https://www.hsd.state.nm.us/lookingforassistance/field_offices_1/

Forms:

- 12. MAD 379, Program of All-Inclusive Care for the Elderly (PACE) Long Term Care Medical Assessment:
<https://nmmedicaid.portal.conduent.com/static/PDFs/MAD%20379.pdf>
- 13. MAD 378, ICF/IID and Developmental Disabilities Home & Community Based Services Waiver Long Term Care Assessment Abstract:
<https://nmmedicaid.portal.conduent.com/static/PDFs/MAD%20378.pdf>
- 14. DOH 378, Medically Fragile Long Term Care Assessment Abstract:
 (Form available in hard copy)

State:

15. The RFP is posted on the NM HSD website:
<https://www.hsd.state.nm.us/lookingforinformation/open-rfps/>
16. NM Procurement regulations and RFP instructions:
<http://www.generalservices.state.nm.us/statepurchasing/resourcesandinformation.aspx>
17. NM 2015 MITA 3.0 State Self-Assessment, on the NM HSD procurement library website:
<https://webapp.hsd.state.nm.us/Procurement/>
18. New Mexico Record Retention and Disposition Schedule for Medical Records:
[1.21.2 NMAC](#)
19. New Mexico Description of Public Records:
[1.13.3 NMAC](#)
20. Lewis et al. v. NM Dept of Health et al. [PDF #24a, b, c]
Available in hard copy.

Federal:

21. Code of Federal Regulations, Title 42- Public Health, Chapter IV- Centers for Medicare and Medicaid Services:
http://www.gpo.gov/fdsys/browse/collectionCfr.action?selectedYearFrom=2011&page.g_o=Go
22. Quality Improvement Organization (QIO):
<https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityimprovementorgs?redirect=/qualityimprovementorgs/>
23. Social Security Act – Volume I (Title XVI):
https://www.ssa.gov/OP_Home/ssact/title16b/1600.htm
24. Social Security Act – Volume I (Title IVE):
https://www.ssa.gov/OP_Home/ssact/title04/0400.htm
25. Social Security Act – Volume I (Title XIX):
https://www.ssa.gov/OP_Home/ssact/title19/1900.htm

Other documents that may be relevant to the procurement are available as follows:

26. Patient Protection and Affordable Care Act, P.L. 111-148 :
<https://www.govinfo.gov/app/details/PLAW-111publ148>
27. Centennial Care – Available on Website: – Available on website:

<https://www.hsd.state.nm.us/lookingforassistance/centennial-care-overview/>

Program-related Documents in the MMISR Procurement Library:

28. The MMISR Procurement Library
<https://webapp.hsd.state.nm.us/Procurement/> contains reference documents related to this procurement, including but not limited to:
- [1 - HHS 2020 Roles and Responsibilities](#)
 - [2 - HHS 2020 Background Information NM HHS and Medicaid](#)
 - [3 - HHS 2020 Work Flows](#)
 - [4 - HHS 2020 Stakeholder Relationship Diagrams](#)
 - [5 - HHS 2020 User Views](#)
 - [6 - HHS 2020 Data Flows](#)
 - [7 - HHS 2020 Acronyms](#)
 - [8 - HHS 2020 Terms and Definitions](#)
 - [9 - HHS 2020 MMIS Activity Data](#)
 - [10 - HHS 2020 CMS Seven Conditions and Standards](#)
 - [11 - HHS 2020 Overview of the NM Medicaid Program](#)
 - [12 - HHS 2020 Legacy MMIS Interfaces](#)
 - [13 - HHS 2020 Data Needs for Reporting](#)
 - [14 - HHS 2020 Security Privacy and Standards](#)
 - [15 - HHS 2020 Omnicaid Turnover Plan](#)
 - [16 - HHS 2020 Legacy Enterprise Partner Interfaces](#)
 - [17 - HHS 2020 Process Views](#)
 - [18 - HHS 2020 MITA Business Area to Module Update 3-31-20](#) (no longer applicable - CMS and NM are using Outcomes Based Certification)
 - [19 - HHS 2020 ORGANIZATIONAL CHART](#)
 - [20 - HHS 2020 VISION AND ARCHITECTURE](#)
 - [21 - HHS 2020 Security Operational Guidelines](#)

Below is a list of documents that Offerors are encouraged to review in addition to the list of items in the Procurement Libraries. Offerors can access the documents by selecting the link provided in the electronic version of this document through their own internet connections:

29. 42 CFR Part 433 (c):
<https://www.ecfr.gov/cgi-bin/text-idx?SID=f100ecfeaa4b4f7032c97c20d7746886&node=sp42.4.433.c&rgn=div6>
30. 45 CFR Part 95 (f):
<https://www.ecfr.gov/cgi-bin/text-idx?SID=735a4beac7b39103a5c80483d3ffa209&node=sp45.1.95.f&rgn=div6>
31. State Medicaid Manual Part 11:

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>

32. CMS Seven Conditions and Standards: <https://www.medicaid.gov/medicaid/data-and-systems/mita/mita-30/index.html>
33. Privacy and Security Standards –NIST Special Publications: <http://csrc.nist.gov/publications/PubsSPs.html>
34. CMS MITA: <https://www.medicaid.gov/medicaid/data-and-systems/mita/index.html>
35. HIPAA and ACA Administrative Simplification Overview: <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html>
36. Electronic Visit Verification (EVV) 21st Century Cures Act: <https://www.hsd.state.nm.us/electronic-verification-visits-evv/>

Offerors are encouraged to review the materials contained in the online Procurement Library, or when necessary, to contact the Procurement Manager and schedule an appointment to view hard copy materials. Offerors are welcome to take notes in the Procurement Library, however all materials are available for review only and may not be copied or removed from the library. Other copies will not be made available.

II. CONDITIONS GOVERNING THE PROCUREMENT

This section of the RFP presents the schedule, description and conditions governing the procurement.

A. SEQUENCE OF EVENTS

The Procurement Manager will make every effort to adhere to the following schedule:

Table 1-Sequence of Events

No.	Action	Responsibility	Date
1	Issue RFP	Agency	July 8, 2022
2	Acknowledgement of Receipt Form	Potential Offerors	July 15, 2022
3	Pre-Proposal Conference	HSD/ASD	July 15, 2022
4	Deadline to Submit Written Questions	Potential Offerors	July 15, 2022
5	Response to Written Questions	HSD	July 19, 2022
6	Submission of Proposals <ul style="list-style-type: none"> • <i>Electronic submissions only</i> 	Offerors	August 4, 2022
7	Proposal Evaluation	Evaluation Committee	August 8, 2022- August 19, 2022*
8	Selection of Finalists	Evaluation Committee	August 22, 2022- August 23, 2022*
9	Best and Final Offers <ul style="list-style-type: none"> • <i>Electronic submissions only</i> 	Offerors	August 26, 2022*
10	Oral Presentations (At HSD's Discretion) <ul style="list-style-type: none"> • Mandatory for all RFP Committee Members to attend. • Oral Presentations will be virtual 	Offerors	September 7, 2022- September 8, 2022*
11	Finalize Contract	HSD/Offeror	October 3, 2022*

12	Contract Award <ul style="list-style-type: none"> • Send award letter • Send Non-Selection letters 	HSD/ASD	Upon signature by SPD/CRB
13	Protest Deadline	Offerors	15 calendar days from Contract Award date*
14	Begin Transition Management Plan	HSD/Current TPA/Selected Offeror	October 17, 2022
15	Effective Date of Contract	HSD/ASD	July 1, 2023

***Dates indicated are estimates and maybe subject to change without amending the RFP.**

B. EXPLANATION OF EVENTS

The following paragraphs describe the activities listed in the sequence of events shown in above in Section II, Table 1, Sequence of Events.

1. Issue RFP

This RFP is being issued by State of New Mexico Human Services Department.

2. Acknowledgement of Receipt Form

Potential Offerors must submit the "Acknowledgement of Receipt of Request for Proposals Form" that accompanies this document (APPENDIX A) to have their organization placed on the procurement distribution list. The form must be returned to the Bonfire system and emailed to the Procurement Manager. An authorized representative of the organization must sign and date the form, which the Potential Offeror then returned by 4:00 pm MDT as stated in Section VII, Table 1-Sequence of Events.

The procurement distribution list will be used to distribute amendments to the RFP, in accordance with 1.4.1.19 New Mexico Administrative Code (NMAC) and to distribute written responses to questions. 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 from the Procurement Library (Section VI.) responses to written questions and any amendments to the RFP.

3. Pre-proposal Conference

A pre-proposal conference will be held to give Offerors an opportunity to ask questions and clarify issues concerning this RFP. It will be scheduled for July 15, 2022 at 10:00 am MDT via Microsoft Teams. Below is the Microsoft Teams link:

Microsoft Teams meeting

Join on your computer or mobile app

[Click here to join the meeting](#)

Or call in (audio only)

+1 575-323-9486,,512167960# United States, Las Cruces

Phone Conference ID: 512 167 960#

[Find a local number](#) | [Reset PIN](#)

[Learn More](#) | [Meeting options](#)

Attendance by Potential Offers at the pre-proposal conference is optional. Potential Offeror(s) are encouraged to submit written questions to the Procurement Manager in advance of the conference. The identity of the organization submitting question(s) will not be revealed.

Additional written questions may be submitted at the conference. All written questions will be addressed in writing on the date listed in the SEQUENCE OF EVENTS. The State will keep a public log of the names of potential Offeror(s) who attended the pre-proposal conference.

4. Deadline to Submit Written Questions

Potential Offerors may submit written questions or comments by July 15, 2022 to the Procurement Manager related to the intent or clarity of this RFP until 5:00 PM MDT, as indicated in Section VII, Table 1- Sequence of Events. *All written questions and comments must be addressed to the Procurement Manager as declared in the Introduction, Section G. Questions shall be clearly labeled and shall cite the Section(s) in the RFP, or other document which form the basis of the question.*

5. Response to Written Questions

As indicated in the SEQUENCE OF EVENTS, the Procuring Agency will distribute written responses to written questions to all Potential Offerors whose organization name appears on the procurement distribution list. Questions which can be answered through review of information in the Procurement Library will not be included in the responses. The Procuring Agency will send an e-mail copy of questions and responses to all Offerors who provide Acknowledgement of Receipt Forms (Appendix A) before the deadline.

An electronic version of the questions and answers will be posted to:

<https://www.hsd.state.nm.us/lookingforinformation/open-rfps/>
[New Mexico Human Services Department \(bonfirehub.com\)](https://www.bonfirehub.com/)

6. Submission of Proposals

ALL OFFEROR PROPOSALS MUST BE RECEIVED FOR REVIEW AND EVALUATION BY THE PROCUREMENT MANAGER OR DESIGNEE NO LATER THAN 3:00 PM MDT ON THE DATE INDICATED IN SECTION VII. PROPOSALS RECEIVED AFTER THIS DEADLINE WILL NOT BE ACCEPTED.

The date and time of receipt will be recorded on each proposal. If an Offeror decides to use a third-party delivery entity to submit its proposal, it is still the responsibility of the Offeror to ensure that the delivery is made on time. An Offeror should consider all factors regarding the delivery by the third-party entity and ensure that the delivery is made prior to the stated deadline. Proposals will be time-stamped in the system when the Offeror clicks “OK” after “Review and Submit.” Such electronic submissions will be considered sealed in accordance with statute.

Proposals must be submitted electronically through Human Services Procurement Portal. Refer to Section III.B.1 for instructions. Proposals submitted by facsimile, or other electronic means other than through the Human Services electronic procurement portal, will not be accepted.

The Procuring Agency will keep a public log of the names of all Offeror organizations that submitted proposals. Pursuant to Section § 13-1-116 New Mexico Statutes Annotated (NMSA) Code 1978, the contents of proposals will not be disclosed to competing Potential Offerors during the negotiation process. The negotiation process is deemed to be in effect until the contract pursuant to this RFP is awarded. In this context “awarded” means the final required State agency signature on the contract(s) resulting from the procurement has been obtained.

7. Proposal Evaluation

State-selected Evaluation Committees will evaluate proposals. The evaluation process will take place as indicated in the SEQUENCE OF EVENTS, depending upon the number of proposals received. During this time, the Procurement Manager may initiate discussions for the purpose of clarifying aspects of the proposals with Offerors that submit responsive or potentially responsive proposals. However, proposals may be accepted and evaluated without such discussion. Offerors SHALL NOT initiate discussions, under the risk of violating procurement rules and of being disqualified.

8. Selection of Finalists

The Procurement Manager will notify the Finalist Offerors selected by the Evaluation Committees in accordance with the schedule in Section VII, or as soon as possible. Only finalists will be invited to participate in the subsequent steps of the procurement.

9. Best and Final Offers

Finalist Offerors may be asked to submit revisions to their proposals for the purpose

of obtaining best-and-final offers in accordance with the schedule in Section VII, NO LATER THAN 3:00 PM MDT. Best and final offers may also be clarified and/or amended at finalist Offerors' oral presentations and demonstrations.

10. Oral Presentations

Finalist Offerors will be required to make an oral presentation in accordance with the schedule in Section VII. Offerors may be required to make their presentation through electronic means (Go To Meeting, Zoom, Teams, etc). Scheduling of oral presentations and the time limitations of the presentations will be at the discretion of the Evaluation Committees. Finalist Offerors will be limited to a presentation of two (2) hours.

Finalists will be required to present their proposals and their key staff to the Evaluation Committee. An agenda will be provided by the Department. The proposal presentations may not add new or additional information and must be based on the submitted proposals.

Finalists are expected to present their approaches to the work required as indicated in this RFP. Finalists are encouraged to demonstrate their understanding of the Department's requirements, their ability to meet those requirements, and their experience related to similar engagements. Finalists are also requested to articulate their proposed services as discussed in their proposals.

11. Finalize Contractual Agreements

The contractual agreement resulting from this RFP will be finalized with the most advantageous Offeror, taking into consideration the evaluation factors set forth in this RFP, in accordance with the schedule in Section VII, or as soon as possible thereafter.

This date is subject to change at the discretion of HSD. The most advantageous proposal may or may not have received the most points. If, in the event that mutually agreeable terms cannot be reached with the apparent most advantageous Offeror in the time specified, the State reserves the right to finalize contractual agreements with the next most advantageous Offeror(s) without undertaking a new procurement process or to cancel the award.

12. Contract Award

The Contract for the Third Party Assessor (TPA) will be finalized based on the most advantageous offers to the Department as stated in the Finalize Contractual Agreements section.

Offerors are advised that the Department may require Offeror to execute separate

HIPAA Business Associate Agreements with final contract awards.

Upon receipt of the signed contractual agreement, the Agency procurement office will award in accordance with the schedule in Section VII, or as soon as possible thereafter. This date is subject to change at the discretion of the relevant Agency procurement office. The award is subject to appropriate Department and State approval.

13. Protest Deadline

Any protest by an Offeror must be timely and in conformance with NMSA 1978 §13-1-172 and applicable procurement regulations. The fifteen (15) calendar-day protest period shall begin on the day following the contract award and shall end at 5:00 pm MDT on the fifteenth (15th) calendar day after the contract award. Protests must be written and must include the name and address of the protestor and the RFP number. Protests also must include a statement of the grounds for protest, including appropriate supporting exhibits and must specify the ruling requested. The protest must be delivered to the HSD Protest Manager:

Gary O. Chavez, CPO
Office of General Counsel
1474 Rodeo Rd.
Santa Fe, New Mexico 87505
Mailing Address: P.O. Box 2348
Santa Fe, New Mexico 87504-2348

PROTESTS RECEIVED AFTER THE DEADLINE WILL NOT BE ACCEPTED.

The State reserves the right to implement the terms of the Contract with the successful Offeror during the pendency of the protest.

C. GENERAL REQUIREMENTS

This procurement will be conducted in accordance with the Procurement Code, NMSA 1978 § 13-1-28 through 13-1-99 and the Procurement Regulations, 1.4.1 NMAC.

1. Acceptance of Conditions Governing the Procurement

In the letter of transmittal, Potential Offerors must indicate their acceptance of the Conditions Governing the Procurement section of this RFP. Submission of a proposal constitutes acceptance of the Evaluation Factors contained in Section VII of this RFP.

2. Incurring Cost

The Potential Offeror shall solely bear any cost they incur in preparing, transmitting and/or presenting any proposal or material submitted in response to this RFP. The Offeror also shall solely bear any cost the Offeror incurs for set up and demonstration of any proposed equipment and/or system.

3. Prime Contractor Responsibility

Any contract that may result from the RFP shall specify that the prime contractor is solely responsible for fulfillment of all requirements of the contractual agreement with HSD. HSD will make contract payments only to the prime contractor.

4. Subcontractors/Consent

Use of subcontractors must be clearly explained in the proposal, and major subcontractors must be identified by name. The prime contractor shall be wholly responsible for the entire performance whether or not subcontractors are used. Additionally, the Contractor must receive written approval from the agency awarding any resultant contract before any subcontractor is used during the term of each agreement. The State retains the option to request replacement of any subcontractor at its discretion.

5. Amended Proposals

An Offeror may submit an amended proposal before the deadline for receipt of proposals. An amended proposal must be a complete replacement for a previously submitted proposal and must be clearly identified as such in the transmittal letter. HSD personnel will not merge, collate, or assemble proposal materials. Amended proposals will not be accepted after the submission deadline.

6. Offeror's Rights to Withdraw Proposal

Offerors will be permitted to withdraw their proposals at any time prior to the deadline for receipt of proposals. The Offeror must submit a written withdrawal request signed by the Offeror's duly authorized representative and addressed to the Procurement Manager.

The approval or denial of withdrawal requests received after the deadline for receipt of the proposals is governed by the applicable procurement regulations (NMAC 1.4.1.5 and 1.4.1.36).

7. Proposal Offer Firm

Responses to this RFP, including proposal prices for services, will be considered firm for one hundred twenty (120) calendar days after the due date for receipt of proposals, or ninety (90) calendar days after the due date for the receipt of a best-and-final offer if the Offeror is invited or required to submit such an offer.

8. Disclosure of Proposal Contents

Proposals will be kept confidential until negotiations and awards are completed by the Agency. At that time, all proposals and documents pertaining to the proposals will be open to the public, except for material that is clearly marked proprietary or confidential. The Procurement Manager will not disclose or make public any pages of a proposal on which the potential Offeror has stamped or imprinted "proprietary" or "confidential" subject to the following requirements:

- a. Proprietary or confidential data shall be readily separable from the proposal to facilitate eventual public inspection of the non-confidential portion of the proposal.
- b. Confidential data is restricted to:
 - i. Confidential financial information concerning the Offeror's organization;
 - ii. Data that qualifies as a trade secret in accordance with the Uniform Trade Secrets Act (UTSA), Sections 57-3A-1 to 57- 3A-7 NMSA 1978.

PLEASE NOTE: Offerors **shall not designate** the price of products offered or the cost of services proposed as proprietary or confidential information.

If a request is received for disclosure of data for which an Offeror has made a written request for confidentiality, State Purchasing Division (SPD) or the Agency shall examine the Offeror's request and make a written determination that specifies which portions of the proposal may be disclosed. Unless the Offeror takes legal action to prevent the disclosure, the proposal will be so disclosed. The proposal shall be open to public inspection subject to any continuing prohibition on the disclosure of confidential data.

9. No Obligation

This RFP in no manner obligates the State of New Mexico or any of its Agencies to use any Offeror's services until a valid written contract is awarded and approved by appropriate authorities.

10. Termination

This RFP may be canceled by the State at any time and any and all proposals may be rejected in whole or in part when the Agency determines such action to be in the best interest of the State of New Mexico.

11. Sufficient Appropriation

Any contract awarded as a result of this RFP may be terminated if sufficient appropriations or authorizations do not exist. Such terminations will be affected by sending written notice to the Contractor. The Agency's decision as to whether sufficient appropriations and authorizations are available will be accepted by the Contractor as final.

12. Legal Review

The Agency requires that all Offerors agree to be bound by the General Requirements contained in this RFP. Offerors must promptly submit any concerns in writing to the attention of the Procurement Manager.

13. Governing Law

This RFP and any agreement with an Offeror that may result from this procurement shall be governed by the laws of the State of New Mexico.

14. Basis for Proposal

Only information supplied in writing by the Agency through the Procurement Manager or in this RFP should be used as the basis for preparation of Offeror proposals.

15. Contract Terms and Conditions

The Contract between the Agency and a Contractor will follow the format specified by the Agency and will contain the terms and conditions set forth in Appendix H, "Draft Contract" However, the Agency reserves the right to negotiate with the successful Offeror provisions in addition to those contained in this RFP. The contents of this RFP, as revised and/or supplemented, and the successful Offeror's proposal will be incorporated into and become part of the contract.

The Agency discourages exceptions from the contract terms and conditions as set forth in the RFP Draft Contract. Such exceptions may cause a proposal to be rejected as nonresponsive when, in the sole judgment of the Agency (and its evaluation team), the proposal appears to be conditioned on the exception, or correction of what is deemed to be a deficiency, or an unacceptable exception is proposed which would

require a substantial proposal rewrite to correct.

Should an Offeror object to any of HSD's terms and conditions, as contained in this Section or in Appendix H, the Offeror must propose specific alternative language. The Agency may or may not accept the alternative language. General references to the Offeror's terms and conditions or attempts at complete substitutions are not acceptable to the Agency and will result in disqualification of the Offeror's proposal.

Offerors must briefly describe the purpose and impact, if any, of each proposed change, followed by the specific proposed alternate wording. Offerors must submit with the proposal a complete set of any additional terms and conditions that they expect to have included in a contract negotiated with the Agency.

If an Offeror fails to propose any alternate terms and conditions during the procurement process (the RFP process prior to selection as successful Offeror), no proposed alternate terms and conditions will be considered later during the negotiation process. Failure to propose alternate terms and conditions during the procurement process (the RFP process prior to selection as successful Offeror) is an **explicit agreement** by the Offeror that the contractual terms and conditions contained herein are **accepted** by the Offeror.

16. Offeror Terms and Conditions

Offerors must submit with the proposal a complete set of any additional terms and conditions that they expect to have included in a contract negotiated with HSD.

17. Contract Deviations

Any additional terms and conditions that may be the subject of negotiation will be discussed only between the Agency and the Offeror selected and shall not be deemed an opportunity to amend the Offeror's proposal.

18. Offeror Qualifications

The Evaluation Committee may make such investigations as necessary to determine the ability of the potential Offeror to adhere to the requirements specified within this RFP. The Evaluation Committee will reject the proposal of any Potential Offeror who is not a Responsible Offeror or who fails to submit a responsive offer as defined in Sections 13-1-83 and 13-1-85 NMSA 1978.

19. Right to Waive Minor Irregularities

The Evaluation Committee reserves the right to waive minor irregularities. The Evaluation Committee also reserves the right to waive mandatory requirements in instances where all responsive proposals failed to meet the same mandatory

requirements and the failure to do so does not otherwise materially affect the procurement. This right is at the sole discretions of the Evaluation Committee.

20. Change in Contractor Representatives

The Agency reserves the right to require a change in Contractor representatives if the assigned representative is not, in the opinion of the Agency, adequately meeting the needs of the Agency.

21. Notice of Penalties

The Procurement Code, Sections 13-1-28 through 13-1-199 NMSA 1978, imposes civil, misdemeanor and felony criminal penalties for its violation. In addition, the New Mexico criminal statutes impose felony penalties for bribes, gratuities, and kickbacks.

22. Agency Rights

The Agency, in agreement with the Evaluation Committee, reserves the right to accept all or a portion of a potential Offeror's proposal.

23. Right to Publish

Throughout the duration of this procurement process and contract term(s), Offerors, and Contractors must secure from the agency written approval prior to the release of any information that pertains to the potential work or activities covered by this procurement and/or agency contracts derived from this procurement. Failure to adhere to this requirement may result in disqualification of the Offeror's proposal or removal from the contract.

24. Ownership of Proposals

All documents submitted in response to the RFP shall become property of the State of New Mexico.

25. Confidentiality

Any confidential information provided to, or developed by, the Contractor in the performance of the contract resulting from this RFP shall be kept confidential and shall not be made available to any individual or organization by the Contractor without the prior written approval of the Agency.

The Contractor agrees to protect the confidentiality of all confidential information and not to publish or disclose such information to any third party without the procuring Agency's written permission.

26. Electronic Mail Address Required

A large part of the communication regarding this procurement will be conducted by electronic mail (e-mail). Any Offeror must have a valid e-mail address to receive this correspondence. (See also Response to Written Questions).

27. Use of Electronic Versions of this RFP

This RFP is being made available by electronic means. In the event of conflict between a version of the RFP in the Offeror's possession and the version maintained by the Agency, the Offeror acknowledges that the version maintained by the Agency shall govern. Please refer to the version found on the HSD website is at:

<https://www.hsd.state.nm.us/lookingforinformation/open-rfps/>
<https://newmexicohsd.bonfirehub.com/portal/?tab=openOpportunities>

28. Lobbying

No federally appropriated funds can be paid at any time by or on behalf of the Contractor or any other person, for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, or the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or modification of any federal contract, grant, loan or cooperative agreement. If any funds other than federally appropriated funds have been paid or will be paid to any person influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

29. New Mexico Employees Health Coverage

- a. If the Offeror has, or grows to, six (6) or more employees who work, or who are expected to work, an average of at least twenty (20) hours per week over a six month period during the term of the contract, Offeror must agree to have in place and agree to maintain for the term of the contract, health insurance for those employees if the expected annual value in the aggregate of any and all contracts between Contractor and the State exceeds two hundred fifty thousand dollars (\$250,000) dollars.
- b. Offeror must agree to maintain a record of the number of employees who (a) have accepted health insurance; (b) decline health insurance due to other health insurance coverage already in place; or (c) decline health insurance for other reasons. These records are subject to review and audit by a representative of the State.

- c. Offeror must agree to advise all employees of the availability of State publicly financed health care coverage programs by, at a minimum, providing each employee with the following web site link to additional information:
<https://www.bewellnm.com/>
- d. For Indefinite Delivery, Indefinite Quantity (IDIQ) contracts (price agreements without specific limitations on quantity and allowing an indeterminate number of orders to be placed against it); these requirements shall apply the first day of the second month after the Offeror reports combined revenue (from State and, if applicable, from local public bodies if from a State price agreement) of two hundred fifty thousand dollars (\$250,000).

30. Campaign Contribution Disclosure Form

Offeror must complete, sign and return the Campaign Contribution Disclosure Form, APPENDIX D, as a part of its proposal. This requirement applies regardless whether a covered contribution was made or not made for the positions of Governor and/or Lieutenant Governor or other identified official. **Failure to complete and return the signed unaltered form will result in disqualification.**

31. Pay Equity Reporting Requirements

If the Offeror has ten (10) or more employees OR has eight (8) or more employees in the same job classification, Offeror must complete and submit the required reporting form (PE10-249) if awarded a contract. Out-of-state Contractors who have no facilities and no employees working in New Mexico are exempt if the contract is directly with the out-of-state Contractor and is fulfilled directly by the out-of-state Contractor and is not passed through a local Contractor.

For contracts that extend beyond one (1) calendar year or are extended beyond one (1) calendar year, Offeror must also agree to complete and submit the required form annually within thirty (30) calendar days of the annual bid or proposal submittal anniversary date and, if more than one hundred eighty (180) calendar days has elapsed since submittal of the last report, at contract completion.

Should Offeror not meet the size requirement for reporting at contract award, but subsequently grow such that they meet or exceed the size requirement for reporting, Offeror must agree to provide the required report within ninety (90) calendar days of meeting or exceeding the size requirement.

Offeror must also agree to levy these reporting requirements on any subcontractor(s) performing more than ten percent (10%) of the dollar value of this contract if said subcontractor(s) meets, or grows to meet, the stated employee size thresholds during the contract term. Offeror must further agree that, should one or more subcontractor not

meet the size requirement for reporting at contract award but subsequently grow such that they meet or exceed the size requirement for reporting, Offeror will submit the required report for each such subcontractor within ninety (90) calendar days of that subcontractor meeting or exceeding the size requirement.

32. Disclosure Regarding Responsibility

RFP proposal should include all disclosures.

- A. Any prospective Contractor and any of its Principals who enter into a contract greater than sixty thousand dollars (\$60,000.00) with any State agency or local public body for professional services, tangible personal property, services or construction agrees to disclose whether the Contractor, or any principal of the Contractor's company:
 1. Is presently debarred, suspended, proposed for debarment, or declared ineligible for award of contract by any Federal entity, State agency or local public body;
 2. Has within a three (3) year period preceding this offer, been convicted in a criminal matter or had a civil judgment rendered against them for:
 - a. the commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) contract or subcontract;
 - b. violation of Federal or State antitrust statutes related to the submission of offers; or
 - c. the commission in any Federal or State jurisdiction of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, violation of Federal criminal tax law, or receiving stolen property;
 3. Is presently indicted for, or otherwise criminally or civilly charged by any (Federal, State or local) government entity with the commission of any of the offenses enumerated in paragraph A of this disclosure;
 4. Has been notified, preceding this offer, of any delinquent Federal or State taxes in an amount that exceeds three thousand dollars (\$3,000) of which the liability remains unsatisfied. Taxes are considered delinquent if the following criteria apply:

- a. The tax liability is finally determined. The liability is finally determined if it has been assessed. A liability is not finally determined if there is a pending administrative or judicial challenge. In the case of a judicial challenge of the liability, the liability is not finally determined until all judicial appeal rights have been exhausted.
 - b. The taxpayer is delinquent in making payment. A taxpayer is delinquent if the taxpayer has failed to pay the tax liability when full payment was due and required. A taxpayer is not delinquent in cases where enforced collection action is precluded.
 - c. Have within a three (3) year period preceding this offer had one or more contracts terminated for default by any Federal or State agency or local public body.
- B. Principal, for the purpose of this disclosure, means an officer, director, owner, partner, or person having primary management or supervisory responsibilities within a business entity or related entities.
- C. The Contractor shall provide immediate written notice to the State Purchasing Agent or other party to this Agreement if, at any time during the term of this Agreement, the Contractor learns that the Contractor's disclosure was at any time erroneous or became erroneous by reason of changed circumstances.
- D. A disclosure that any of the items in this requirement exist will not necessarily result in termination of this Agreement. However, the disclosure will be considered in the determination of the Contractor's responsibility and ability to perform under this Agreement. Failure of the Contractor to furnish a disclosure or to provide additional information as requested will be grounds for immediate termination of this Agreement pursuant to the conditions set forth in Paragraph 7 of this Agreement.
- E. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render, in good faith, the disclosure required by this document. The knowledge and information of a Contractor is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
- F. The disclosure requirement provided is a material representation of fact upon which reliance was placed when making an award and is a continuing material representation of the facts during the term of this Agreement. If

during the performance of the contract the Contractor is indicted for, or otherwise criminally or civilly charged by any government entity (Federal, State or local) with commission of, any offenses named in this document, the Contractor must provide immediate written notice to the State Purchasing Agent or other party to this Agreement. If it is later determined that the Contractor knowingly rendered an erroneous disclosure, in addition to other remedies available to the Government, the State Purchasing Agent or Central Purchasing Officer may terminate the involved contract for cause. Still further the State Purchasing Agent or Central Purchasing Officer may suspend or debar the Contractor from eligibility for future solicitations until the matter is resolved to the satisfaction of the State Purchasing Agent or Central Purchasing Officer.

33. No Resources Provided by NM HSD to the TPA Contractor

NM HSD will not provide the selected Contractors with supplies, clerical support, computers, hardware, workspace and/or other resources related to fulfilling the Contract that result from this procurement. State acknowledges its cost responsibility for future Contractor and State staff supplies. The State will provide the Contractor access to its MMIS and to other MMISR Contractors as needed.

34. Equal Employment Opportunity

HSD is committed to equal employment opportunity (EEO) and to compliance with Federal antidiscrimination laws. We also comply with New Mexico law, which prohibits discrimination or harassment against employees or applicants for employment based on race, age forty (40) and over, color, religion, national origin, ancestry, sex (including pregnancy, childbirth and related medical conditions), sexual orientation, gender identity, spousal affiliation, National Guard membership, status as a smoker or nonsmoker, genetic information, HIV status, physical or mental handicap, or serious medical condition.

HSD will not tolerate discrimination or harassment. The Contractor will be required to submit a statement confirming compliance with EEO rules as part of its contract.

35. Conflict of Interest; Governmental Conduct

The Offeror warrants that it presently has no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance or services required under the Agreement. The Offeror certifies requirements of the Governmental Conduct Act, Sections 10-16-1 through 10-16-18, NMSA 1978, regarding contracting with a public officer or state employee or former state employee have been followed.

36. New Mexico Preferences

New Mexico Preferences shall not apply because the expenditures for this RFP includes federal funds.

III. RESPONSE FORMAT AND ORGANIZATION

Failure to conform to format and organization may lead to disqualification of any submitted proposal.

A. NUMBER OF RESPONSES

Offeror shall submit only one (1) proposal. Alternative proposals will not be accepted.

B. NUMBER OF COPIES

The Offeror shall deliver:

1. **ELECTRONIC SUBMISSION ONLY Responses (Human Services Procurement Portal, Bonfire Interactive, can be accessed at [New Mexico Human Services Department \(bonfirehub.com\)](https://www.newmexico.gov/human-services))**
2. All vendors must register with the Procurement Portal to log in and submit requested information.

Proposals must be submitted in the manner outlined below. Technical and Cost portions of Offerors proposal **must** be submitted in separate uploads as indicated below in this section, and **must** be prominently identified as “Technical Proposal,” or “Cost Proposal,” on the front page of each upload.

- a. **Technical Proposals** – One (1) ELECTRONIC upload must be organized in accordance with **Section III, RESPONSE FORMAT AND ORGANIZATION, C.** All information for the Technical Proposal **must be combined into a single file/document for uploading.**

EXCEPTION: *Single electronic files that exceed 50mb may be submitted as*

multiple uploads, which must be the least number of uploads necessary to fall under the 50mb limit. The Technical Proposals **SHALL NOT** contain any cost information.

- i. **Confidential Information:** If Offeror’s proposal contains confidential information, as defined in detailed in Section VII.4.y, Offeror **must** submit **two (2) separate ELECTRONIC technical files:**
 - One (1) ELECTRONIC version of the requisite proposals identified in Section III.B.1.a above as **unredacted** (def Section I.I.#125) versions for evaluation purposes; and
 - One (1) redacted (def Section I.I.#100) ELECTRONIC for the public file, in order to facilitate eventual public inspection of the non-confidential version of Offeror’s proposal. Redacted versions must be clearly marked as “REDACTED” or “CONFIDENTIAL” on the first page of the electronic file;
- b. **Cost Proposals** – One (1) ELECTRONIC upload of the proposal containing **ONLY** the Cost Proposal. All information for the cost proposal **must be combined into a single file/document for uploading.** For technical support issues go to Support@GoBonfire.com or visit their help desk forum at <https://bonfirehub.zendesk.com/hc>

The ELECTRONIC proposal submission must be fully uploaded in Human Services e-Procurement Portal by the submission deadline in Section II.B.6.

Any proposal that does not adhere to the requirements of this Section and **Section III.C.1** may be deemed non-responsive and rejected on that basis.

C. PROPOSAL FORMAT

This section describes the required format, content and organization for all proposals. Please note, in the below Proposal Content and Organization, Offerors are expected to provide all numbered items (1-100) listed under the Technical Proposal. All discussion of proposed costs, rates or expenses must occur on the appropriate Cost Response Forms (i.e., APPENDIX I). Proposals must be no more than three hundred (300) pages in length excluding the title page, table of contents, tabs, pricing, resumes, the mandatory State required forms, detailed work plan, detailed implementation schedule and examples of documents. The Offeror is expected to include in the 300-page limit, a summary work plan with milestones and a summary implementation schedule.

1. Proposal Content and Organization

The proposal must be organized and indexed in the following format and must contain, at a minimum, all listed items in the sequence indicated. All proposals should be prepared simply and economically, providing a straightforward concise description of the Offeror's ability to meet the requirements of this RFP.

Within each section of their proposal, Offerors shall address the items in the order in which they appear in this RFP. All forms provided in the RFP must be thoroughly completed and included in the appropriate section of the proposal. All discussion of proposed costs, rates, or expenses must occur only in the Cost Proposal.

Any proposal that does not adhere to these requirements may be deemed non-responsive and rejected on that basis.

Technical Proposal

Page Numbers

The pages in each proposal must be numbered sequentially and include the proposal type (e.g. Mandatory Response – pg. 1).

Each proposal must adhere to the following specifications:

Mandatory Requirements – this submission shall be indexed in the following format and must contain, at a minimum, all listed items in the sequence indicated:

- a. Signed Letter of Transmittal
- b. Table of Contents
- c. Proposal Summary
- d. Response to Contract Terms and Conditions
- e. Offerors Additional Terms and Conditions
- f. Signed Campaign Contribution Form
- g. Signed New Mexico Employees Health Coverage
- h. Signed Certification Regarding Debarment, Suspension, Proposed Debarment, and Other Responsibility Matters
- i. Signed HIPPA Business Associates Agreement
- j. Response to Specifications (**Except Cost Information which shall be included ONLY in the cost proposal**)
 1. Implementation
 2. Administration and Operations
 3. Quality Assurance
 4. Program Integrity
 5. Management Information Systems
 6. Reporting

7. Due Process
8. Recipient and Provider Services
9. Program Services/Utilization Reviews
10. Medical Eligibility/Level of Care
11. HCBS Waivers ISP/SSP and Budgets
12. Exhibits for Technical Requirements- (Optional)

Cost Proposal

- a. Completed Cost Response Form (Appendix I)

2. Letter of Transmittal

The mandatory requirements binder must include a signed Letter of Transmittal. (See Appendix B of this RFP.) Offeror's proposal must be accompanied by the Letter of Transmittal Form located in Appendix B which must be completed and signed by an individual person authorized to obligate the company.

3. Table of Contents

The table of contents must contain a list of all sections of the proposal and the corresponding page numbers.

4. Proposal Summary

The proposal summary must be five (5) pages or less. It shall provide the Evaluation Committee with an overview of the technical and business features of the proposal. The material will not be used in the evaluation process but may be used in public notifications regarding the selection of a successful Offeror.

5. Response To Contract Terms And Conditions

The offeror shall explicitly indicate acceptance of the General Requirements (Section II.C) and the Contract Terms and Conditions (Appendix H). As provided in Section II, should the offeror object to any of the Agency's terms and conditions, as contained in Appendix H, the offeror must propose specific alternate language. The offeror must provide a brief discussion of the purpose and impact, if any, of each proposed change followed by the specific proposed alternate wording.

6. Offeror's Additional Terms and Conditions

Offerors must submit with the proposal a complete set in writing of any additional terms and conditions they request to have included in a contract negotiated with the Department.

7. Campaign Contribution Disclosure

The Offeror must complete the Campaign Disclosure form (See Appendix D of this RFP.) The Offeror must complete an unaltered Campaign Contribution Disclosure Form and submit a signed copy with the Offeror's proposal. This must be accomplished whether or not an applicable contribution has been made.

8. New Mexico Employees Health Coverage

The Offeror must agree with the terms and submit a signed New Mexico Employees Health Coverage Form with the submittal of their proposal. (See Appendix E of this RFP.)

9. Certification Regarding Debarment, Suspension, Proposed Debarment, And Other Responsibility Matters

The Offeror must complete the Certification Regarding Debarment, Suspension, Proposed Debarment, and Other Responsibility Matters form to certify compliance with federal regulations relating to suspension and debarment. (See Appendix F of this RFP.)

10. HIPPA Business Associates Agreement

(See Appendix G of this RFP.)

IV. SPECIFICATIONS

The Offeror must be in good standing with the State of New Mexico. Failure to respond to Technical Requirements will result in the disqualification of the proposal as non-responsive.

The Offeror is required to respond in narrative form to each of the numbered technical specifications below. While the proposal should be as concise as possible, it must include specifics that address each of the requirements, outcomes, activities and timelines detailed in this RFP section. The narratives along with required attachments will be evaluated and awarded points accordingly.

A. TECHNICAL SPECIFICATIONS

1. Implementation

General Expectations: The Offeror shall work closely with HSD to develop an HSD-approved comprehensive work plan prior to the actual beginning of contract operations to ensure a smooth transition from the incumbent Contractor to the successful Offeror. It is anticipated that implementation may begin as early as the contract award date, but no later than 6 months prior to the contract start date.

Mandatory Requirements:

1. The Offeror shall create and submit a comprehensive work plan that must include a narrative that provides an overview of the approach that will result in an orderly transition of responsibilities and files, to include: all work in progress from the incumbent Contractor (outstanding reviews, hearings, etc.); any assumptions or constraints

identified by the Offeror; and recommendations to handle potential or actual problems.

- The work plan must identify key tasks and transition issues to be completed and/or addressed before contract operations, with estimated timeframes, milestones, responsible parties and deliverables.
2. The Offeror must also provide a Work Plan timetable for integration with the MMISR. The Offeror must identify the assumptions underlying your Work Plan timetable and for the items below from your proposal:
- Approach for operations and maintenance;
 - Approach for integrating with the HHS 2020 EPMO tasks;
 - Approach for integrating with the HHS 2020 System Integrator tasks;
 - Approach for data exchange and compliance with standards of the HHS 2020 tasks;
 - Approach for providing HHS 2020 integration support; and
 - Approach for business service configuration
3. The Offeror shall describe how it will work with HSD and the incumbent Contractor to establish an approved secure file transfer of all data including, at a minimum, electronic copies of recipient and provider files and records. The Offeror shall also describe how it will work with HSD and any TPA/UR successors to transfer secure file transfers of all data including, at a minimum, electronic copies of recipient and provider files and records at the termination of any contract.

2. Administration and Operations

General Expectations: The Offeror shall perform all work associated with this contract in the United States, with an established office in New Mexico, preferably in Albuquerque or Santa Fe, and shall ensure a business operation capable of meeting all requirements detailed in this RFP. This includes a sufficient number of qualified administrative and professional staff to carry out the requirements detailed in this RFP in a timely, efficient, high quality, and cost-effective manner. The State of New Mexico prefers that the Behavioral Health, Home and Community-Based Service Waivers, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID), and the Program of All-Inclusive Care for the Elderly (PACE) portions of this contract be performed in the state of New Mexico (to be

determined during negotiations). The IT Team must be obligated as a one hundred percent (100%) designation to the state of New Mexico. The Offeror shall explicitly state whether a subcontractor(s) will be used and provide the name(s) of the subcontractor(s) in the response.

Mandatory Requirements:

4. Provide the organizational chart of the entire agency. Identify and include an explanation of the functions of key staff, lines of reporting, and operating units pertaining to the execution of the scope of work detailed in this RFP.
5. Include names, job titles, job descriptions and qualifications of all key staff, including a TPA contract manager, who will be responsible for completing work related to the service components outlined in this RFP. If any such positions are not currently filled or individuals are not committed to these positions, the Offeror must provide the qualifications of the position.
6. Include copies of resumes and appropriate professional licenses and/or certifications and training for all staff listed in Requirement #5 above.
7. Describe how the Offeror will maintain a level of work performance consistent with high professional standards in the industry, assuring that all employees assigned to perform work described in this RFP will be capable, efficient and no less qualified than other employees of the contractor performing the same or similar work.
8. For the staff that will be working with the Developmental Disabilities, Medically Fragile, Mi Via, and Supports Waivers reviews, describe how the Offeror will ensure that staff (including professional and paraprofessional positions) have the minimum preferred qualification of at least one (1) year of experience directly working in the field with individuals with intellectual disability or with other disability populations.
9. Describe how the Offeror will ensure that they have an IT and reporting team that is dedicated exclusively to NM to ensure that the IT and reporting teams are familiar with NM program requirements and HSD/MAD requests.
10. The Offeror must provide three (3) business client references with at least one for a state Medicaid program or similar government or public sector project within the last five (5) years that has received similar services to those proposed for this contract. If the Offeror proposes to use subcontractors for significant portions of the scope of work, the

Offeror shall provide an additional three (3) external references for each subcontractor, if applicable. The business references must submit the Questionnaire directly to the designee identified in Appendix C. The business references must not return the completed Questionnaire to the Offeror. It is the Offeror's responsibility to ensure the completed forms are submitted on or before the date indicated in Section II, Table 1-Sequence of Events, for inclusion in the evaluation process.

11. Organizational References that are not received or are not complete, may adversely affect the vendor's score in the evaluation process. Offerors are encouraged to specifically request that their Organizational References provide detailed comments. The Evaluation Committee may contact any or all business references for validation of information submitted. If this step is taken, the Procurement Manager and the Evaluation Committee must all be together on a conference call with the submitted reference so that the Procurement Manager and all members of the Evaluation Committee receive the same information. Additionally, the Agency reserves the right to consider any and all information available to it (outside of the Business Reference information required herein), in its evaluation of Offeror responsibility per Section II, C.18.
12. Each reference must include the name of the company, name of the contact person, telephone number, email address, the period of service and description of the services provided.
13. Provide documentation of the Offeror's current designation as a QIO or QIO-like entity and describe activities to maintain this designation during the term of this contract. If the Offeror is not a QIO or a QIO-like entity, the Offeror must be in active pursuit in obtaining such status. The Offeror will be required to furnish such documentation to indicate its active pursuit by no later than the effective date of the contract.
14. For any of the Offeror's contracts, has the other contracting party notified the Offeror that it has found the Offeror to be in breach of the contract? (The Offeror shall provide the required information for all public sector contracts (including, but not limited to, Medicaid, Medicare, and public employees) as well as any non-public sector contracts that cover more than 50,000 lives.)
If yes:
 - a. Provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Offeror's control.

- b. Was a corrective action plan (CAP) or its equivalent imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed.
 - c. Was a sanction imposed? If so, please describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage).
 - d. Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation?
15. If the Offeror is a New Mexico Medicaid MCO, describe how the Offeror will operationalize a business model for a separate entity including, but not limited to, operations and staffing, IT systems, and network firewalls.
 16. Describe the Offeror's process for submitting monthly invoices to HSD electronically. HSD has the right to audit billing and payments and to adjust invoices or portions thereof.
 17. Describe the Offeror's capacity to produce, within one (1) business day of the request, all documentation for any specific review conducted within one (1) year of the request.
 18. Describe how the Offeror will ensure full responsibility for public records retention and disposition in accordance with state (NMAC 1.21.2) and federal rules for medical records.
 19. Describe how the Offeror will coordinate services and TPA/UR information for clients transitioning between FFS and managed care with other Medicaid contractors, such as the New Mexico Medicaid MCOs. Provide sample agreements or documents that the Offeror might use to meet the goal of coordination.
 20. Demonstrate evidence of the Offeror's expertise and experience regarding the provision of services for individuals with intellectual disabilities that receive services from the programs identified within this RFP, including experience working directly with recipients, their families/authorized representatives, and other supports such as case managers, consultants, or service coordinators.
 21. Describe how the Offeror will coordinate with HSD, DOH and stakeholder groups on the successful implementation of the scope of work described in this RFP and related program changes.
 22. Describe how the Offeror will approach attending and actively participating in Mi Via meetings, waiver meetings, Behavioral Health

workgroups, and other meetings and ad hoc conference calls as requested by HSD/MAD, and to provide input on issues as requested.

23. Describe how the Offeror will coordinate as necessary with DOH and other Medicaid program contractors, including the New Mexico Medicaid MCOs, to ensure participant and provider questions are appropriately directed.
24. Offeror shall describe how its proposed services meet regularly with and prepare and provide copies of meeting agenda and minutes to, Third Party Assessors, authorization operations, Medical Review Staff, Fiscal Agent(s), the State and other relevant Enterprise Stakeholders to report status and resolve technical and operational issues.
25. Describe the Offeror's approach and internal oversight process to develop and maintain Standard Operating Procedures, Policies and Procedures, or its equivalent, to cover the scope of work outlined in this RFP at least annually. The procedures shall specify all steps in each process, including required documents, review process, timeframes, applicable criteria, quality assurance, and exactly how the review decision is communicated to the requesting provider, recipient, fiscal agent, Mi Via, case manager/consultant/community support coordinator, and/or HSD/ISD (ASPEN), as applicable; and, how the review decision is entered into appropriate systems. Each updated version of policies and procedures, standard operating procedures, or its equivalent, must be tracked and identified as an updated version.

3. Quality Assurance

General Expectations: The Offeror is expected to function as a partner to HSD/MAD to achieve compliance including availability to attend meetings, providing input, and problem-solving on the quality of contract-related issues. All of the Offeror's activities described in this RFP must be based on a model of Continuous Quality Improvement (CQI) through which the Offeror can identify any quality problems quickly and remedy them in a prompt, effective manner, which reflects an understanding of the needs of the customers who are served by the system and identifies and defines measures of success. Audits are a means of evaluating quality and identifying opportunities for quality improvement and/or interventions by the Offeror. HSD/MAD holds the Offeror accountable for achieving these standards and demonstrating their ability to meet HSD/MAD's quality standards.

Mandatory Requirements:

26. Describe how the Offeror will comply with HSD's quality standards in areas of staffing, procedures, review criteria, regulatory standards, and internal quality management and auditing.
27. Include evidence of other quality indicators of providing high quality services for the target or similar population.
28. Describe the Offeror's internal compliance program with regard to the scope of work detailed in this RFP to demonstrate the Offeror's capacity to develop and execute a Quality Management/Quality Improvement (QM/QI) program and/or Continuous Quality Improvement program.
29. Describe how the Offeror will meet the HSD requirements to submit an annual QM/QI report that is based on quarterly internal Inter-Rater Reliability reviews, or a similar performance-measurement tool involving a comparison of responses of reviewers by review type and program criteria and standards.
30. Describe the Offeror's grievance procedures for the TPA line of business and how customers will be notified of these procedures. Include written procedures, if available.
31. Describe how the Offeror will monitor grievances by recipients and providers for evidence of trends. Describe mechanisms for communicating the results of quality evaluations with providers, recipients and HSD/MAD.
32. Describe how the Offeror will incorporate relevant grievance data and information into the QM/QI program plan to improve the Offeror's operational performance.
33. Describe the Offeror's internal compliance program with regard to federally-required desk and on-site HSD audits of TPA/UR performance and quality assurances.
34. Describe how the Offeror will proactively address feedback received by HSD to monitor and ensure completion of key issues and tasks identified.
35. Describe the Offeror's procedure to achieve compliance in the event that a deficiency has been identified and noncompliance results in a Corrective Action Plan and/or sanction.
36. Offeror shall describe how its proposed services provide sufficient

policies and procedures that explain and ensure consistency of decisions through inter-rater reliability in approving or denying approvals, authorizations, and treatment plans.

4. Program Integrity

General Expectations: HSD/MAD is dedicated to preventing, detecting and addressing fraudulent and/or abusive billing practices in the Medicaid program. The Medicaid Integrity Program requires collaboration between the State and Offeror to review activities of providers, perform audits, identify overpayment and educate providers and members about false claims.

Mandatory Requirements:

37. Describe the Offeror's internal program to prevent, detect, investigate and report suspicious activity or potential fraud or abuse. Include applicable policies and procedures, standard operating procedures or its equivalent.
38. Describe how the Offeror will ensure compliance with all Federal and State laws, rules, regulations and executive orders of the Governor of the State of New Mexico that pertain to equal opportunity. Pursuant to all such laws, rules, regulations, and executive orders, the Offeror must ensure HSD that no New Mexico citizen shall be denied the benefit of any activity performed under a contract awarded based on this RFP or be otherwise subjected to discrimination on the grounds of race, color, national origin, gender, sexual orientation, age, disability or religion.
39. Describe how the Offeror will ensure compliance with the Americans with Disabilities Act (ADA) within its own operations and by its subcontractors and providers.
40. Describe how the Offeror will ensure compliance with all applicable New Mexico Regulations, including HSD and Medicaid standards, rules, regulations and policies.

5. Management Information Systems

General Expectations: The Offeror is responsible for maintaining a Management Information System (MIS) that is sufficient to meet the system requirements outlined in this RFP. The Offeror must be able to produce, read and exchange electronic files from HSD/MAD's personal computer (PC) application software for word processing, electronic spreadsheets, and database management and submit information electronically using

HSD/MAD's FTP site. The Offeror is responsible for receiving, testing and reporting the accuracy of all data transfers between the Offeror and HSD/MAD. This includes interfacing and/or direct transmission with the MMIS/Omnicaid, Palco, ASPEN, and MMISR systems according to guidelines that will be provided by HSD regarding entry of utilization reviews, ISP/SSPs and budgets, and level of care. The Offeror must demonstrate that it has or will have system capabilities (including but not limited to: data management systems, hardware and software capabilities, qualified and trained personnel and technical support, and data reporting requirements) to collect, maintain, and manage all data elements and to perform all required processes. The Offeror is further responsible for ensuring that its subcontractors have sufficient systems capability to meet HSD/MAD's system requirements.

The Offeror is also expected to integrate with the MMISR website/Unified Portal for dispersing and receiving information to/from providers and clients.

Mandatory Requirements:

41. Describe how the Offeror will use New Mexico program terminology in its system and describe the process to add new programs using HSD approved terminology.
42. Describe the Offeror's detailed process for submitting, receiving, testing and reporting the accuracy of all data transfers between the Offeror and HSD (MMIS/Omnicaid, MMISR Unified Portal, SI, BMS and ASPEN).
43. Demonstrate the Offeror's MIS including its tracking, reporting and interface capabilities. Also describe how the Offeror will regularly audit their systems and interfaces to ensure that fields are being transferred correctly and in a timely fashion.
44. Describe the hardware, software, and information resources that will be used by the Offeror to meet all of the system requirements outlined in this RFP. Describe how the hardware and software will be HIPPA compliant and explain the capacity of on-site band-width for adequate transmission speed for delivery and/or receipt of documents. In the description of resources, include a description of key IT staff, their qualifications, and their responsibilities and how they interface with other divisions within your organization and with subcontractors.
45. Describe the Offeror's available technical support resources that will ensure that the effects of major system malfunctions will be

minimized. Include in the response any aspects related to delivery of service in light of system disaster or malfunction recovery situations, online security, and system maintenance periods.

46. Describe the Offeror's detailed process to capture, store, and report all pertinent information related to requests for level of care determinations including, but not limited to: date of request, requesting party, communication to recipient, date assessment/reassessment performed, due date of next reassessment, transmission of determination to requesting party, re-assessment due dates, and identification of overdue re-assessments.
47. Describe the Offeror's capability to allow HSD and DOH read-only access to the Offeror's utilization review system for the ability to check the status of a review or request.
48. Describe the Offeror's capability to communicate with HSD and DOH via the Internet using a secure internal transfer site for both email and files transfers.
49. Describe the Offeror's staff initial and ongoing training plan for data entry requirements for MMIS/Omnicaid and Palco systems.
50. Describe the hardware, software or other resources that will be used by the Offeror to ensure accuracy of entries and reconcile records (including level of care, care plans and budgets) with MMIS/Omnicaid and Palco systems.
51. Describe the Offeror's plan for collaboration with the providers and the Medicaid Fiscal Agent in ensuring the use of accurate NPI numbers, and where not available, Medicaid Provider numbers.
52. Describe the Offeror's capacity to receive, maintain and retain or store secure electronic and hard copy records including clinical and financial data for a total of ten (10) years unless transfer is specifically directed by HSD.
53. Describe the Offeror's MIS change control process for changes in the type of data collected, e.g., adding new required fields.
54. Describe how the Offeror will provide technical assistance to providers to ensure that accurate and valid data is collected and reported.
55. Describe the Offeror's plan to control and limit access to HSD's MMIS/Omnicaid system for TPA/UR business operations only.

56. Describe how the Offeror will receive data from HSD on an ongoing basis and program the Offeror's MIS to immediately inform submitting Providers when a prior authorization is and is not required.
57. Describe how the Contractor will upload all relevant MAD forms and letters into their system, allow for electronic data collection and population of the Providers responses onto the MAD form. The form should also be stored in the Contractor's system for potential audits.
58. Offeror shall describe how it will include "smart" authorization support, such as the capability to search the claims history, to determine if previous steps in therapy have occurred prior to approving or denying the request.
59. Description of any technology or automation the Offeror will use to reduce administrative burden and simplify access to review information for its own staff as well as HSD/MAD and DOH staff, Medicaid providers, and recipients. Include how the Offeror will use methods to reduce administrative costs, eliminate lost or damaged attachments, and accelerate the prior authorization process.
60. Description of how the Offeror will integrate with MMISR website for providers, case managers, consultants, community support coordinators, and/or recipients, as applicable, to access forms and instructions.
61. How the Offeror will make criteria sets for use in review activities readily available to providers.

6. Reporting

General Expectations: The Offeror shall be responsible for providing reports as required by HSD/MAD in the agreed-upon format. The Offeror is also responsible for exchanging data (e.g., reporting data, claims processing required data) with the MMISR in the State defined format. Every report shall be accompanied by an explanation of the reported data elements and an analysis signed off by the responsible Offeror staff member. The reports shall be reviewed for timeliness, accuracy and completeness prior to submission to HSD/MAD. All reports must be submitted via a secured website identified by HSD/MAD. HSD/MAD shall provide a format that must be used.

OUTPUT	DOCUMENT STANDARDS
---------------	---------------------------

Word Processing	Microsoft Word 2016, or newer version
Spreadsheets	Microsoft Excel 2016, or newer version
Graphics	Microsoft Power Point or Visio 2016, or newer version
Schedule	Microsoft Project 2016, or newer version

Mandatory Requirements:

- 62. Describe the Offeror’s data analytic capabilities for reporting, analysis, and evaluation including:
 - a. Capability to produce system-generated reports for, at a minimum, due process (fair hearings, agency conferences and reconsiderations), level of care determinations, prior authorizations, budgets, ISP/SSPs, RFA/RFI, and recipient and provider services;
 - b. How the Offeror handles requests for ad hoc reports;
 - c. Staffing levels, skills and team structure available for data collection, reporting, analysis, and application of problem solving and process improvements; and,
 - d. Processes to be implemented to ensure accuracy and timeliness of reports.

- 63. Describe the Offeror’s capacity to produce required Routine Recurring Reports and Ad Hoc Reports.

- 64. Describe how the Offeror will allow the primary reviewer access to the entire utilization review history of a recipient in order to monitor LOC determinations, ISP/SSP and budgets, detect medically unnecessary duplications of service and/or significant disruptions in the continuity of care.

7. Due Process

General Expectations: The Offeror shall be responsible for carrying out Medicaid’s due process requirements for recipients and providers. This includes preparing and sending notice of adverse action decisions and due process rights, including continuation of benefits to recipients; processing provider reconsideration reviews; collaborating with HSD and/or DOH on agency review conferences; preparing and submitting complete summaries of evidence fifteen (15) calendar days prior to the hearing; processing continuation of benefits requests; and designating staff, which may include the UR reviewer, medical director, and/or attorney (required if recipient presents with counsel), to testify in fair hearing proceedings.

Mandatory Requirements:

65. Describe in detail and provide examples of the Offeror's process for generating recipient and provider notification letters. Include specifically how the free-text and relevant policy sections will be completed without manually manipulating other areas of the correspondence letter. Include the qualifications of the individuals who will perform this duty. In addition, the Offeror must address how quality assurance of the due process letters system will be monitored, by whom, and with what frequency.
66. Describe how the Offeror will provide clear and specific explanations of the reason(s) for any adverse action and denote the specific criteria and regulation as the bases for any adverse determination.
67. Describe the resources, including staffing, and processes the Offeror will dedicate to carry out activities related to due process and administrative hearings.
68. Describe how the Offeror will schedule and conduct a video Agency Review Conference to include all concerned parties such as the Consultant, Community Support Coordinator, HSD and DOH Program Managers and claimant. Also describe how the Offeror will identify and provide translation services, if requested by claimant.
69. Describe how the Offeror will ensure that the representatives attending the fair hearing will have the appropriate credentials, training and experience with administrative hearings to address the issues involved. Offeror must describe how it will ensure that qualified Medical Directors have direct experience working with the condition for which the denial has occurred.
70. Describe how the Offeror will ensure that representatives are available to participate in hearings that are scheduled in Mountain Time.
71. Describe how the Offeror will ensure that all representatives attending the fair hearing will have reviewed all submitted documentation and policy prior to the hearing.
72. Describe how the Offeror will ensure that denial decisions for reviews are made by a physician and describe the role that the Medical Director will play in this process.

8. Recipient and Provider Services

General Expectations: The Offeror shall perform customer services functions to include, but not limited to: receiving, responding to and resolving requests from providers and recipients for information concerning utilization review policies and procedures, the status of reviews, budgets, and LOC determinations, and provide technical assistance and provider trainings. These activities and any others must be performed in a professional, courteous, and timely manner.

Mandatory Requirements:

73. Describe how the Offeror will accommodate and enable providers to submit using multiple access points, including, but not limited to, telephonic, fax, mailed, and electronic submissions and inquires.
74. Describe how the Offeror will maintain adequate customer service resources, particularly when demand for a service and the service issued may vary greatly from time to time due to changes in the review criteria, policy, and/or procedures and other Medicaid program or regulation changes. Include the Offeror's proposed staffing numbers and describe the customer service function.
75. Describe the Offeror's step-by-step customer service processes and procedures and how the Offeror will monitor the process and quality of service.
76. Provide any customer service quality or performance indicators from the Offeror's previous or current government contracts. Include wait times, response times, abandonment rates, and other indicators, as appropriate.
77. Provide examples and methods of how the Offeror has worked proactively with providers, recipients, and other stakeholders including, but not limited to training providers, website announcements and updates, webinars, participation with in-person training at professional associations, etc.
78. Describe how the Offeror will accommodate non-English speaking, hearing and/or visually-impaired recipients at no additional cost to HSD/MAD.
79. Describe the Offeror's approach to ensure effective communication with the specific disability populations, with whom it will interact, and how it will implement appropriate staff training.

80. Describe how the Offeror will implement a call monitoring system to support quality assurance monitoring and training. The system shall support call recording. Describe how the Offeror will provide HSD with full access to call recordings for review of escalated calls.
81. Offeror shall describe how its proposed experts are able to understand and are prepared to navigate the administrative processes for a Member changing between benefit plans and/or transitioning benefit plan.
82. Offeror shall describe how it will maintain sufficient qualified business personnel so that ninety-five percent (95%) of all telephone authorizations are answered in person within one hundred twenty (120) seconds and be available from 7:30 a.m. to 5:30 p.m. local time, Monday through Friday (excluding holidays).

9. Program Services/Utilization Reviews

General Expectations: The Offeror shall ensure its utilization review staff are appropriately trained, credentialed and licensed to assess the medical and behavioral health needs and, specific to HCBS waiver programs, associated social needs, of all recipients that will receive services under this RFP.

Reviews will include, but are not limited to:

- Alternative Benefit Plan
- Behavioral Health
- Comprehensive Review of Practice
- Contact Lenses
- Dental Services
- Durable Medical Equipment, Prosthetics and Orthotics, and Nutrition Services
- Early and Periodic Screening and Diagnostics Personal Care Services
- Emergency Medical Services for Non-Citizens
- General Hospital Inpatient (In-State)
- Hearing Services
- Home and Community-Based Service Waivers
- Home Health Services
- Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Nursing Facility
- Out of State Services
- Private Duty Nursing Services

- Program of All-Inclusive Care for the Elderly
- Rehabilitation Services (In/Outpatient)
- Second Opinion Reviews
- Transplant Services

The staff must possess adequate current knowledge of the requirements of the Scope of Work in relation to the HSD/MAD Program Policy Manual and applicable State and Federal regulations; State-approved review criteria and standards; and, HSD/MAD-approved detailed review procedures.

The Offeror shall develop written detailed internal policies and procedures for all review types described in this RFP. Due to HSD/MAD-directed program policy changes and other changes in the external environment, the Offeror should anticipate frequent changes in procedures. However, the Offeror shall make every attempt to reduce the administrative burden on providers and recipients in all aspects of the review type.

Mandatory Requirements:

83. Describe the Offeror's utilization review system. The narrative shall include at a minimum:
 - a. How the Offeror will notify providers that certain procedure codes do not require a prior authorization or procedure codes are not a covered service prior to submission of a prior authorization request.
 - b. How the Offeror will ensure that recipients' medical needs are not delayed due to the utilization review/prior authorization process.
 - c. How the Offeror will perform emergency reviews within twenty-four (24) hours.
 - d. How the Offeror will perform routine reviews within the contractual seven (7) business days requirement for all review types.
 - e. How the Offeror will notify recipients and providers of review decisions.
 - f. How the Offeror will track review requests and determinations from date of receipt to the date of the decision notice, including pended decision, and report these timelines.

- g. Offeror shall describe how its system maintains a detailed and viewable audit trail of all submissions and subsequent updates to authorization records. For each authorization record a notation with a description and reason for the change is required.
- h. Offeror shall describe how its system provides the ability to make retroactive entry of authorization requests and maintain the history of such requests.
- i. Offeror shall describe how its system auto-assigns system-generated unique, non-duplicated authorization numbers for tracking throughout the life of the authorization.
- j. Offeror shall describe how its system generates a response to the submitter, in the applicable format all authorizations and their unique control numbers within one (1) business day.
- k. Offeror shall describe how its system will identify, search, and resolve authorizations with potentially conflicting or duplicative data.
- l. Offeror shall describe how its system will provide information that reveals potential defects in level of care and quality of service.
- m. Offeror shall describe how its system will implement and maintain the capability to incorporate evidence-based criteria tools that contain standardized medical criteria and other criteria as defined by the Enterprise to support authorization processing. The Offeror should also describe how it will store the criteria used for each individual review as part of the individual case file.
- n. Offeror shall describe how its system will maintain a history of authorizations in an easy to find format.
- o. Offeror shall describe how its system will display different data elements based upon specific authorization type.
- p. Offeror shall describe how its system will allow its staff to update PA language when business rules are updated (e.g., changing denial reasons).

- q. Offeror shall describe how its system will provide its staff electronic access to case-related clinical protocols (defined business rules) for review and assessment.
- r. Offeror shall describe how its system will implement and maintain the capability to override or force any authorization-specified fields that are auto populated, prompt its reviewers for verification before concluding the override and maintain the source of the override information.
- s. Offeror shall describe how its system will support the application of authorization and provider restrictions (e.g., If the provider is not the correct provider type or is not an enrolled NM Medicaid Provider).
- t. Offeror shall describe how its system will provide program-based screening criteria that support the differing data requirements of various types of authorizations.
- u. Offeror shall describe how its system will implement workflows for monitoring all automatic and escalated authorization determinations.
- v. Offeror shall describe how its system will automatically approve, request additional information or deny authorizations, including partial approval and escalation to a higher-level, using State defined rules-based decision processes and generate notification to the provider of the decision.
- w. Offeror shall describe how its proposed services manage PA to Enterprise limits (e.g., procedure codes/covered and non-covered services) and allow authorized Users to override limits, while supporting pre-payment UR functionality.
- x. Offeror shall describe how its system will provide a configurable rules-based engine with the flexibility, extensibility, and capacity to support diverse and complex health care and non-medical programs, including the ability to configure alerts, notification triggers and pre-adjudication business rules.

- y. Offeror shall describe how its proposed system will conduct mass adjustments of PAs (e.g., extension of established prior authorizations).
- z. Offeror shall describe how its proposed system will accommodate at a minimum the following processing requirement:
- Beginning and ending effective dates of the authorization;
 - Service type;
 - Category and Subcategory code as defined by the State;
 - Standard Dental Claims;
 - Approved unit and dollar amount modification by authorized Users;
 - Identification of authorizations that have been appealed, and determination;
 - ID of authorizing person;
 - Date of authorization request and date of request for additional information;
 - Denial reason code;
 - Date of authorization determination;
 - Date authorization notice sent;
 - Contractor patient account number;
 - DME serial number;
 - Comments/internal notes area and
 - Indicator for new authorization
- aa. Offeror shall describe how its proposed system will edit authorization requests against previously adjudicated requests (including denials) and duplicate requests in process.
- bb. Offeror shall describe how its proposed system will suspend prior authorization requests containing errors and identify the errors at the specific fields.
- cc. Offeror shall describe how its proposed system will provide an Electronic Data Interchange (EDI) capability to the HHS 2020 Enterprise for acceptance and transmission of HIPAA 278 transaction sets pertinent to UM/UR and any relevant business function requested by the State.

- dd. Offeror shall describe how its proposed system will provide the ability to assign authorizations at the agency or program level and manage capacity.
- ee. Offeror shall describe how its system will identify authorization requests for which an administrative review request has been submitted, indicating the outcome of such reviews, and identifying authorizations for which an appeal has been filed.
- ff. Offeror shall describe how its system will allow a provider to request expedited review while allowing the Enterprise to review and assign the priority.
- gg. Offeror shall describe how its system will automatically link authorizations and related documentation, based on State-defined criteria.
- hh. Offeror shall describe how its system will, at a minimum:
- Manage images, attachments, and workflow;
 - Accept and match attachments (e.g., electronic images, receipts, pdf, paper copies of supporting documentation, video, audio record, *.txt, *.xls, Word, *.jpg, *.gif,) to the original authorization requests;
 - Identify the presence of an attachment when viewing authorization header or detail information;
 - Allow Users to view or navigate to imaged attachments from within an authorization; and
 - Route authorizations to specific work queues.
- ii. Offeror shall describe how its system will alert the User, based upon Enterprise defined rules, when an action occurs on an authorization.
- jj. Offeror shall describe how its proposed services integrate with the Enterprise Service Bus (ESB) to include interfaces to providers' electronic health records (EHR) and include as data or attachments.
- kk. Offeror shall describe how its proposed services integrate the MMIS edits and Financial Services edits to assure the list of

claim edits that result in the need for a service authorization are utilized when determining the authorization.

- ll. Offeror shall describe how its system will integrate with the Shared Services to produce notices to Members, contractors, case managers and Providers regarding authorizations in the State defined format and language(s).
 - mm. Offeror shall describe how its system will define appeal types, data structures, and content necessary to accept and process incoming HIPAA 278 transactions and respond with outgoing HIPAA 278 transactions. Each authorization must support multiple servicing providers and provider types providing multiple services and service types and/or modifiers on different service dates, with varying service delivery patterns, as defined in the HIPAA 278 Implementation Guide.
 - nn. Offeror shall describe how its system will provide detailed authorization data to the Enterprise. Including but not limited to data that meets Enterprise and federal policy requirements within the Enterprise-defined schedules.
 - oo. Offeror shall describe how its system will facilitate the UR case review process (e.g., overrides, hearings) and lock a review to other users allowing only the primary User to complete a review.
 - pp. The Offeror shall describe how its system will obtain and use Enterprise industry standard information from external agencies (e.g., Enterprise Stakeholders, intrastate, interstate, Federal) for authorizing referrals and authorizing treatment.
 - qq. Describe the Offeror's method of pending a review request and obtaining and tracking additional or missing information needed to make a review decision from a Medicaid provider and/or recipient, when applicable, that does not prolong the recipient's receipt of medical care/services. This is also referred to as a Request for Information (RFI).
84. Demonstrate evidence of the Offeror's expertise and experience regarding behavioral health services, including experience working directly with recipients, their families/authorized representative, and providers.

85. How the Offeror will internally evaluate/audit at least monthly the consistency of UR/UM reviewers, including any delegated UR/UM reviewers, in applying criteria in decision-making.
86. Offeror shall describe how it will provide manual reviews and determinations on all authorization requests that cannot be processed using the automated authorization system, except for those that must be referred to the State. Activities include, at a minimum:
 - Receive and review medical authorization requests using registered nurses;
 - Make final determinations on selected medical authorization requests as designated by the State, including both approvals and denials, using registered nurses and/or Medical Affairs team; and
 - Enter authorization requests into the Authorization System online.
87. Describe the Offeror's process to review and determine when a procedure is considered experimental and what medical criteria will be applied.
88. Describe the Offeror's understanding of models of care and resources available for DD and MF populations to include both institutional and home and community-based traditional and self-direction models.
89. Describe how the Offeror will provide the ability to authorize treatment for Emergency Medical Services for Non-Citizens (EMNC).
90. Describe the Offeror's prior authorization process for behavioral health services.
91. Describe the Offeror's process for Alternative Benefit Plan medically frail exemptions and prior authorizations.

10. Medical Eligibility / Level of Care:

General Expectations: The Offeror shall provide, at a minimum, an initial LOC determination and an annual LOC determination for each waiver, including recipient and provider notification and complete required fields in various systems for DD, MF and Mi Via, Supports Waiver, PACE and ICF/IID.

System entries must comply with mandated timeframes and accuracy. In

addition, the Offeror shall conduct in-home assessments for DDW, MF, and Mi Via individuals requesting HCBS waiver services.

Mandatory Requirements:

92. Describe the Offeror's resources and processes for conducting **initial** level of care reviews. This narrative shall include at a minimum:
 - a. The Offeror's approach to identify the recipient's eligibility/ineligibility based on the level of care criteria and factors for nursing facility LOC and ICF/IID LOC.
 - b. How the Offeror will ensure consistent application of the appropriate criteria for reviewing medical and social support needs, and in addition, alternative support purchases of goods and services that are a key component of the Mi Via and Supports Waiver programs.
 - c. How the Offeror will ensure accuracy and turn-around-times for determinations and reviews, including routine and expedited/emergency determinations and reviews.
 - d. How the Offeror will collaborate with providers, recipients, DDW Case Managers, Mi Via Consultants, Supports Waiver Community Support Coordinators, and/or the DOH DDS Intake and Eligibility Bureau to ensure complete, accurate, and timely completion of LOC determinations and redeterminations.
 - e. The Offeror's capability to collect, maintain and manage all data elements required for LOC.

93. Describe the Offeror's Level of Care **redetermination/recertification** process and include what steps will be taken to ensure that there are no gaps in approval dates of coverage.
 - a. The Offeror's approach to identify the recipient's eligibility/ineligibility based on the level of care criteria and factors for nursing facility LOC and ICF/IID LOC.
 - b. How the Offeror will ensure consistent application of the appropriate criteria for reviewing medical and social support needs, and in addition, alternative support purchases of goods and services that are a key component of the Mi Via and Supports Waiver programs.
 - c. How the Offeror will ensure accuracy and turn-around-times for determinations and reviews, including routine and expedited/emergency determinations and reviews.
 - d. How the Offeror will collaborate with providers, recipients, DDW Case Managers, Medically Fragile Nurse Case Managers, Mi Via Consultants, Supports Waiver

Community Support Coordinators, and/or the DOH DDSD Intake and Eligibility Bureau to ensure complete, accurate, and timely completion of LOC determinations and redeterminations.

- e. The Offeror's capability to collect, maintain and manage all data elements required for LOC.
 - f. How the Offeror will prevent the expiration of LOCs requiring redetermination.
94. Describe the Offeror's understanding of, and vision for, self-direction, experience with self-direction models, and working in collaboration with program participants to help them comply with LOC requirements.
95. Describe the Offeror's in-home assessment process for recipients on the DDW and Mi Via waivers.

11. HCBS Waivers ISP/SSP and Budgets

General Expectations: The Offeror shall conduct a clinical review and render a decision for approximately six thousand (6,000) to eight thousand (8,000) service plans (i.e. ISP or SSP) and budget revision requests for medical necessity, program compliance, and fiscal accountability for the DD, MF, Mi Via and Supports waiver populations and compete the authorization into the appropriate systems. It is notable that the state is currently eliminating the fourteen (14) year waitlist and is aggressively releasing allocations on a quarterly basis. The Offeror should consider that the functions currently being performed by the Outside Reviewer will be transitioned fully to the TPA's responsibility. System entries must comply with mandated timeframes and accuracy. The Offeror shall collaborate as necessary with the waiver case managers, Mi Via consultants, Supports Waiver Community Supports Coordinators.

Mandatory Requirements:

96. Describe how the Offeror will apply State criteria for HCBW services that follow individualized, person-centered plans of care.
97. Describe how the Offeror will apply criteria for social support purchases of goods and services that are key components of the Mi Via and Supports Waiver programs.
98. Describe how the Offeror will ensure that reviewers have the requisite experience and training in identifying the needs of individuals in the

waiver populations described in this RFP.

99. Describe the Offeror's understanding of, and vision for, self-direction, experience with self-direction models, and of working in collaboration with program participants to help them comply with SSP/ISP and budget requirements.
100. Describe the Offeror's plan to perform prior authorization reviews for DD waiver therapies (occupational, physical and speech), adult nursing, and behavioral support consultation utilizing the state's review criteria.

B. COST PROPOSAL

The Offeror shall submit the completed Cost Proposal Form (Appendix H).

All services, activities, and requirements under sections IV, Specifications, 1, Implementation and IV, Specifications, 2, Administration and Operations, are considered non-reimbursable. These services, activities and requirements are to be considered part of the Offeror's cost of doing business under this contract.

HSD will reimburse the Contractor a flat rate according to the utilization review/assessment service performed under section IV, Specifications, A, Technical Specifications, 9, Program Services/Utilization Reviews.

Cost per review type should be inclusive of any adverse actions, to include preparation and representation for fair hearings including legal counsel, when applicable.

Cost proposal should include the reimbursement rate for the following:

- Prior Authorization Review
- EMSNC Review
- Behavioral Health Review
- Level of Care Mi Via
- Level of Care All Others
- ISP/SSP and Budgets-Initial and Annuals
- ISP/SSP and Budgets-Revisions

V. EVALUATION

A. EVALUATION OF PROPOSALS

HSD will conduct a comprehensive, fair, and impartial evaluation of proposals received in response to this RFP. All proposals will be reviewed for compliance with the mandatory, technical and cost proposal requirements as stated within the RFP. Proposals deemed non-responsive, missing key elements or received after the deadline will be eliminated from further consideration and a letter will be generated to the Offeror stating the reason for elimination. The Director of HSD/MAD will appoint an Evaluation Committee, which shall evaluate each responsive proposal on the basis of its technical merit. HSD reserves the right to use technical advisors who are employees of other State agencies and who have experience in specific areas of this RFP in this process.

B. EVALUATION POINT SUMMARY

The following is a summary of Section V, Evaluation, that identifies points available for each factor. These weighed factors will be used in the evaluation of Offeror proposals. Only finalist Offerors will receive points for an oral presentation.

No.	Evaluation Factor	Points Available
1.	Implementation	25
2.	Administration and Operations	125
3.	Quality Assurance	100
4.	Program Integrity	50
5.	Management Information Systems	150
6.	Reporting	50
7.	Due Process	100
8.	Recipient and Provider Services	100
9.	Program Services/Utilization Reviews	100
10.	Medical Eligibility/Level of Care	100
11.	HCBS Waivers ISP/SSP and Budgets	100
12.	Cost Proposal	100
13.	Oral Presentation	100
	Total Points Available	1,200

C. EVALUATION FACTORS

Points will be awarded on the basis of the following evaluation factors:

1. Implementation

The Offeror must be a CMS-approved QIO or QIO-like entity. The Offeror shall be evaluated on its QIO or QIO-like entity status, experience, expertise and performance in managing complex utilization reviews (including ISP/SSP and budget approvals) and level of care assessment processes for the provision of Medicaid services and programs identified within this RFP. The Offeror's ability to undertake and implement all service facets identified in this RFP shall be evaluated. The Offeror will also be evaluated on the details encompassed within the work plan proposal to ensure a smooth transition.

2. Administration and Operation

The Offeror shall be evaluated on its business operation model to meet the requirements detailed in this RFP, including services performed by subcontractors. The Offeror shall be evaluated on its location, staffing levels, professional qualifications and ability to perform and manage complex reviews, to work cooperatively and in partnership with HSD/MAD and, where appropriate, DOH, and other Medicaid contractors to be responsive to recipients, providers and stakeholders identified in this RFP. The Offeror shall be evaluated on its entire utilization review operational structure and ability to provide oversight of a subcontractor to ensure compliance with all contract requirements to process level of care assessments, ISP/SSPs, budgets, and medical necessity reviews for the services and programs identified in this RFP. The Offeror shall be evaluated on the 100% dedicated IT Team for the state of New Mexico and the Offeror's ability to automate processing methods utilizing clear, consistent and standardized procedures shall be evaluated, focusing on professional, timely, efficient, high quality, cost-effective operations.

The Offeror shall be evaluated on its customer service approach and capabilities, to include recording all calls received by customer service staff. The Offeror shall be evaluated on its working knowledge of the New Mexico Medicaid regulatory requirements for due process rights and the existence of a due process system for recipients and providers identified in this RFP.

3. Quality Assurance

The Offeror shall be evaluated on its ability to complete reviews accurately and timely and communicate recipient review information with various contractors serving the same population such as, but not limited to, the Fiscal Management Agent and the New Mexico Medicaid MCOs. The Offeror shall be evaluated on its approaches and practices to monitor, trend, evaluate, remediate, and report performance to HSD. The Offeror shall be evaluated on its plan to attend and participate in meetings, with the Offeror's subject matter experts, provide input, and

problem solve on the quality of contract-related issues.

The Offeror's commitment to continuous quality improvement (CQI) in all areas of services will be evaluated.

4. Program Integrity

The Offeror will be evaluated on its plan to prevent, detecting and address fraudulent and/or abusive billing practices in the Medicaid program. The Offeror will be evaluated on how it will collaborate with the State to review provider activities, perform internal audits, identify overpayment and educate providers and members.

5. Management Information Systems

The Offeror and its subcontractors shall be evaluated on the sufficiency of its management information systems capability to meet HSD/MAD's system requirements outlined in this RFP and interface with the MMIS/ Omnicaid system, ASPEN, the FMA, MMISR modules, and any other systems successors.

The Offeror will be evaluated on ensuring that its system is configured to use New Mexico program terminology and how its system will collect, maintain, and manage all data elements to perform all required processes. The Offeror will also be evaluated on the efficacy to locate historical submissions.

6. Reporting

The Offeror shall be evaluated on its overall reporting system and capabilities. The Offeror shall be evaluated on tracking/reporting all reviews identified in this RFP.

7. Due Process

The Offeror shall be evaluated on its due process to include preparing and sending notice of adverse action decisions and due process rights. The Offer will also be evaluated on the Agency Review and Fair Hearing proposed process. The Offeror will also be evaluated on the process for including legal counsel, as appropriate.

8. Recipient and Provider Services

The Offeror shall be evaluated on its customer services functions described in this RFP.

9. Program Services/Utilization Reviews

The Offeror shall be evaluated on ensuring that utilization review staff are appropriately trained, credentialed and licensed to assess the medical, social and behavioral health needs of all recipients that will receive services under this RFP. The Offeror will also be evaluated on its proposed process to ensure that staff possess an adequate knowledge of the Program Policy and State and Federal regulations, State-approved review criteria and standards and HSD approved detailed review procedures.

10. Medical Eligibility/Level of Care

The Offeror shall be evaluated on its proposed process to conduct Level of Care reviews, tracking of Level of Cares, and ensure that the Level of Care determination is successfully interfaced to the appropriate systems. Evaluations will also be focused on the efficiency of In-Home Assessment process.

11. HCBS Waivers ISP/SSP and Budgets

The Offeror shall be evaluated on its proposed process to conduct clinical reviews for the Home and Community Support Waivers and complete the authorization into the appropriate systems accurately within the contractual turnaround time.

12. Cost

The offeror will be evaluated based on the total cost of implementation of the program for the one (1) year contract period.

$$\text{Offeror's Points} = \frac{\text{Lowest Equivalent Total Cost}}{\text{Offeror's Total Cost}} \times \text{Maximum Points Allowed}$$

13. Oral Presentation

Points for the oral presentation will be awarded based upon an evaluation of the presentation, the demonstration of the project and the quality of the system offered. Points will be awarded on effective communication, technical knowledge, experience with similar contracts and the quality of the responses to questions posed by the RFP Evaluation Committee. Finalists will be the Offerors with the highest scores based on evaluations of responses. The number of Finalists will be determined at the discretion of the Evaluation Committees. If selected as a finalist, the Offeror may be required to present an overview of its proposal to the Evaluation Committees to give the Evaluation Committees the opportunity to interview proposed Key Personnel, to ask questions, to seek clarifications on the Offeror's proposal and to better assess Offeror's ability to fulfill the requirements outlined in the Statement of Work(s).

D. EVALUATION PROCESS

The evaluation process will follow the steps listed below:

1. All Offeror proposals shall be reviewed for compliance with all mandatory requirements stated within this RFP. Proposals deemed non-responsive will be eliminated from further consideration.
2. The Procurement Manager may contact an Offeror for clarification of the response as specified in Section II.B.7.
3. The Evaluation Committee may use other sources to perform the evaluation as

specified in Section II. C. 18.

4. Responsive proposals will be evaluated on the factors in Section IV, which have been assigned a point value in Section V. The responsible Offerors with the highest scores will be selected as finalist Offerors based upon the proposals submitted. Finalist Offerors that are asked or choose to submit revised proposals for the purpose of obtaining best and final offers will have their points recalculated accordingly. If oral presentations are scheduled with Finalist Offerors, points awarded from the oral presentations will be added to the previously assigned points to attain final scores.
5. The responsible Offeror whose proposal is most advantageous and innovative to HSD, taking into consideration the evaluation factors in Section IX, C. will be recommended for contract award. Please note, however, that a serious deficiency in the response to any one factor may be grounds for rejection regardless of overall score.

APPENDIX A – Acknowledgement of Receipt Form

In acknowledgement of receipt of this Request for Proposals, the undersigned agrees that s/he has received a complete copy, beginning with the title page and table of contents, and ending with APPENDIX I.

The acknowledgement of receipt should be signed and returned to the Procurement Manager no later than 4:00 pm MDT on July 15, 2022 (see contact information at end of form). Only potential Offerors who elect to return this form completed with the indicated intention of submitting a proposal will receive copies of all Offeror written questions and of the written responses to those questions, as well as RFP amendments if any are issued.

FIRM: _____

REPRESENTED BY: _____

TITLE: _____ PHONE NO.: _____

E-MAIL: _____ FAX NO.: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SIGNATURE: _____ DATE: _____

This name and address will be used for all correspondence related to the Request for Proposal. Firm does/does not (circle one) intend to respond to this Request for Proposal.

La Risa Rodges, Procurement Manager
New Mexico Human Services Department
Medical Assistance Division
1 Plaza La Prensa Santa Fe, NM 87507
Phone: (505) 795-3713
Email: LaRisa.Rodges@state.nm.us

APPENDIX B – Letter of Transmittal Form

**ITEMS #1 to #4 EACH MUST BE COMPLETED IN FULL (pursuant to Section II.C.30).
FAILURE TO RESPOND TO ALL FOUR (4) ITEMS WILL RESULT IN THE
DISQUALIFICATION OF OFFEROR'S PROPOSAL! DO NOT LEAVE ANY ITEM
BLANK! (N/A, None, does not apply, etc. are acceptable responses.)**

RFP#: 23-630-8000-0002

1. Identify the following information for the submitting organization:

Offeror Name	
Mailing Address	
Telephone	
FED ID#	
NM CRS#	

2. Identify the individual(s) authorized by the organization to (A) contractually obligate, (B) negotiate, and/or (C) clarify/respond to queries on behalf of this Offeror:

	A Contractually Obligate	B Negotiate*	C Clarify/Respond to Queries*
Name			
Title			
E-mail			
Telephone			

* If the individual identified in Column A also performs the functions identified in Columns B & C, then no response is required for those Columns. If separate individuals perform the functions in Columns B and/or C, they must be identified.

3. Use of subcontractors (Select one):

- No subcontractors will be used in the performance of any resultant contract, OR
 The following subcontractors will be used in the performance of any resultant contract:

 (Attach extra sheets, as needed)

4. Describe any relationship with any entity (such as a State Agency, reseller, etc. that is not a subcontractor listed in #3 above), if any, which will be used in the performance of any resultant contract. (N/A, None, does not apply, etc. are acceptable responses to this item.)

 (Attach extra sheets, as needed)

By signing the form below, the Authorized Signatory attests to the accuracy and veracity of the information provided on this form, and explicitly acknowledges the following:

- On behalf of the submitting-organization identified in item #1, above, I accept the Conditions Governing the Procurement, as required in Section II.C.1. of this RFP;
- I concur that submission of our proposal constitutes acceptance of the Evaluation Factors contained in Section V of this RFP; and
- I acknowledge receipt of any and all amendments to this RFP, if any.

_____, 20_____
 Authorized Signature and Date (Must be signed by the individual identified in item #2. A, above.)

APPENDIX C – Reference Questionnaire Form

The State of New Mexico requires Offerors to submit three (3) business references. The purpose of these references is to document Offeror's experience relevant to the Statement of Work in an effort to establish Offeror's responsibility.

Offeror is required to send the following reference form to each business reference listed. The business reference, in turn, is requested to submit the Reference Questionnaire directly to:

La Risa Rodges, Procurement Manager

RFP # 22-630-8000-0005

Medical Assistance Division

1 Plaza La Prensa

Santa Fe NM 87507

Phone: (505) 795-3713

Email: LaRisa.Rodges@state.nm.us

For inclusion in the evaluation process, completed Reference Questionnaires must be received by the Procurement Manager not later than the RFP submission deadline. The form and information provided will become a part of the submitted proposal. Letters or other forms of reference, other than the Reference Questionnaire, will not be accepted. The business references provided may be contacted for validation of content provided therein.

RFP # 23-630-8000-0002 REFERENCE QUESTIONNAIRE FOR:

<Offeror Name>

This form is being submitted to your organization for completion as a business reference for the company listed above. This form is to be returned to the State of New Mexico Human Services Department via e-mail:

La Risa Rodges, Procurement Manager
RFP # 22-630-8000-0005
Medical Assistance Division
1 Plaza La Prensa
Santa Fe NM 87507
Phone: (505) 795-3713
Email: LaRisa.Rodges@state.nm.us

The form must be received by the Procurement Manager no later than 3:00 PM MDT on August 4, 2022 and must not be returned to the company requesting the reference.

For questions or concerns regarding this form, please contact the State of New Mexico Procurement Manager listed above. When contacting us, please be sure to include the RFP number listed at the top of this page.

Organization Providing Reference:	
Contact Name and Title/Position	
Contact Telephone Number	
Contact E-mail Address	

QUESTIONS:

1. In what capacity have you worked with this company in the past? Describe the work this company or companies did for you.

COMMENTS:

2. How would you rate this company or company's knowledge and expertise?
_____ (3 = Excellent; 2 = Satisfactory; 1 = Unsatisfactory; 0 Unacceptable)

COMMENTS:

3. How would you rate relative to changes in project scope and/or timelines? Rate the company or company's commitment to schedule and their flexibility
_____ (3 = Excellent; 2 = Satisfactory; 1 = Unsatisfactory; 0 Unacceptable)

COMMENTS:

4. What level of satisfaction did you have with the deliverables produced by the company or companies?
_____ (3 = Excellent; 2 = Satisfactory; 1 = Unsatisfactory; 0 Unacceptable)

COMMENTS:

5. How would you rate the dynamics/interaction between the company or companies and your staff?
_____ (3 = Excellent; 2 = Satisfactory; 1 = Unsatisfactory; 0 Unacceptable)

COMMENTS:

6. Who were the company's or companies' principal representatives involved in your project and how would you rate them individually? Please comment on the skills, knowledge, behaviors or other factors on which you based the rating for each.

(3 = Excellent; 2 = Satisfactory; 1 = Unsatisfactory; 0 Unacceptable)

Name: _____ Rating: _____

Name: _____ Rating: _____

Name: _____ Rating: _____

Name: _____ Rating: _____

COMMENTS:

7. How satisfied are you with the services delivered or the products developed by the Company or companies?

_____ (3 = Excellent; 2 = Satisfactory; 1 = Unsatisfactory; 0 Unacceptable)

COMMENTS:

8. With which aspect(s) of this company or companies' services are you most satisfied?

COMMENTS:

9. With which aspect(s) of this company or companies' services were you least satisfied?

COMMENTS:

10. Would you recommend this company or companies services to your organization again? Do you recommend this company to the State of New Mexico?

COMMENTS:

APPENDIX D – Campaign Contribution Disclosure Form

Pursuant to NMSA 1978, § 13-1-191.1 (2006), any person seeking to enter into a contract with any state agency or local public body for professional services, a design and build project delivery system, or the design and installation of measures the primary purpose of which is to conserve natural resources must file this form with that state agency or local public body. This form must be filed even if the contract qualifies as a small purchase or a sole source contract. The prospective contractor must disclose whether they, a family member or a representative of the prospective contractor has made a campaign contribution to an applicable public official of the state or a local public body during the two years prior to the date on which the contractor submits a proposal or, in the case of a sole source or small purchase contract, the two years prior to the date the contractor signs the contract, if the aggregate total of contributions given by the prospective contractor, a family member or a representative of the prospective contractor to the public official exceeds two hundred and fifty dollars (\$250) over the two-year period.

Furthermore, the state agency or local public body shall void an executed contract or cancel a solicitation or proposed award for a proposed contract if: 1) a prospective contractor, a family member of the prospective contractor, or a representative of the prospective contractor gives a campaign contribution or other thing of value to an applicable public official or the applicable public official's employees during the pendency of the procurement process or 2) a prospective contractor fails to submit a fully completed disclosure statement pursuant to the law.

THIS FORM MUST BE FILED BY ANY PROSPECTIVE CONTRACTOR WHETHER OR NOT THEY, THEIR FAMILY MEMBER, OR THEIR REPRESENTATIVE HAS MADE ANY CONTRIBUTIONS SUBJECT TO DISCLOSURE.

The following definitions apply:

“Applicable public official” means a person elected to an office or a person appointed to complete a term of an elected office, who has the authority to award or influence the award of the contract for which the prospective contractor is submitting a competitive sealed proposal or who has the authority to negotiate a sole source or small purchase contract that may be awarded without submission of a sealed competitive proposal.

“Campaign Contribution” means a gift, subscription, loan, advance or deposit of money or other thing of value, including the estimated value of an in-kind contribution, that is made to or received by an applicable public official or any person authorized to raise, collect or expend contributions on that official's behalf for the purpose of electing the official to either statewide or local office. “Campaign Contribution” includes the payment of a debt incurred in an election campaign, but does not include the value of services provided without compensation or unreimbursed travel or other personal expenses of individuals who volunteer a portion or all of their time on behalf of a candidate or political committee, nor does it include the administrative or solicitation expenses of a political committee that are paid by an organization that sponsors the committee.

“Family member” means spouse, father, mother, child, father-in-law, mother-in-law, daughter-in-law or son-in-law.

“Pendency of the procurement process” means the time period commencing with the public notice of the request for proposals and ending with the award of the contract or the cancellation of the request for proposals. “Person” means any corporation, partnership, individual, joint venture, association or any other private legal entity.

“Prospective contractor” means a person who is subject to the competitive sealed proposal process set forth in the Procurement Code or is not required to submit a competitive sealed proposal because that person qualifies for a sole source or a small purchase contract.

“Representative of a prospective contractor” means an officer or director of a corporation, a member or manager of a limited liability corporation, a partner of a partnership or a trustee of a trust of the prospective contractor.

DISCLOSURE OF CONTRIBUTIONS:

Name(s) of Applicable Public Official(s) if any: _____
 (Completed by State Agency or Local Public Body)

Item	Description
Contribution Made By	
Relation to Prospective Contractor	
Name of Applicable Public Official	
Date Contribution(s) Made	
Amount(s) of Contribution(s)	
Nature of Contribution(s)	
Purpose of Contribution(s)	

(Attach extra pages if necessary)

Signature

Date

Title (position)

-OR-

NO CONTRIBUTIONS IN THE AGGREGATE TOTAL OVER TWO HUNDRED FIFTY DOLLARS (\$250) WERE MADE to an applicable public official by me, a family member or representative.

Signature

Date

Title (position)

APPENDIX E – New Mexico Employees Health Coverage Form

For all contracts solicited and awarded on or after January 1, 2008: If the Offeror has, or grows to, six (6) or more employees who work, or who are expected to work, an average of at least 20 hours per week over a six (6) month period during the term of the contract, Offeror agrees to have in place, and agree to maintain for the term of the contract, health insurance for those employees and to offer that health insurance to those employees no later than July 1, 2010, if the expected annual value in the aggregate of any and all contracts between Contractor and the State exceed \$250,000 dollars.

Offeror agrees to maintain a record of the number of employees who have (a) accepted health insurance; (b) declined health insurance due to other health insurance coverage already in place; or (c) declined health insurance for other reasons. These records are subject to review and audit by a representative of the State.

Offeror agrees to advise all employees of the availability of State publicly financed health care coverage programs by providing each employee with, as a minimum, the following web site link to additional information <https://www.bewellnm.com/>

For Indefinite Quantity, Indefinite Delivery contracts (price agreements without specific limitations on quantity and providing for an indeterminate number of orders to be placed), these requirements shall apply the first day of the second month after the Offeror reports combined revenue (from state and, if applicable, from local public bodies if from a state price agreement) of \$250,000.

Signature of Offeror: _____

Date _____

APPENDIX F – SUSPENSION AND DEBARMENT REQUIREMENT

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, PROPOSED DEBARMENT AND OTHER RESPONSIBILITY MATTERS

The entering of a contract between HSD and the successful Offeror pursuant to this RFP is a “covered transaction,” as defined by 45 C.F.R. Part 76. HSD’s contract with the successor Offeror shall contain a provision relating to debarment, suspension, and responsibility. All Offerors must provide as a part of their proposals a certification to HSD in the form provided below. Failure of an Offeror to furnish a certification or provide such additional information as requested by the Procurement Manager for this RFP will render the Offeror non-responsible. Furthermore, the Offeror shall provide immediate written notice to the Procurement Manager for this RFP if, at any time prior to contract award, the Offeror learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

Although HSD may review the veracity of the certification through the use of the federal Excluded Parties Listing System or by other means, the certification provided by the Offeror in paragraph A., below, is a material representation of fact upon which HSD will rely when making a contract award. If it is later determined that the Offeror knowingly rendered an erroneous certification, in addition to other remedies available to HSD, HSD may terminate the contract resulting from this request for proposals for default.

The certification provided by the Offeror in paragraph A., below, will be considered in connection with a determination of the Offeror's responsibility. A certification that any of the items in paragraph A., below, exists may result in rejection of the Offeror’s proposal for non-responsibility and the withholding of an award under this RFP. If the Offeror’s certification indicates that any of the items in paragraph A., below, exists, the Offeror shall provide with its proposal a full written explanation of the specific basis for, and circumstances connected to, the item; the Offeror’s failure to provide such explanation will result in rejection of the Offeror’s proposal. If the Offeror’s certification indicates that that any of the items in paragraph A., below, exists, HSD, in its sole discretion, may request, that the U.S. Department of Health and Human Services grant an exception under 45 C.F.R. §§ 76.120 and 76.305 if HSD believes that the procurement schedule so permits and an exception is applicable and warranted under the circumstances. In no event will HSD award a contract to an Offeror if the requested exception is not granted for the Offeror.

By signing and submitting a proposal in response to this RFP, the Offeror certifies, to the best of its knowledge and belief, that:

A. The Offeror and/or any of its Principals (check applicable blocks):

Status	Yes	No
Are presently debarred, suspended, proposed for debarment, or declared ineligible for the award of contracts by any Federal department or agency.		
Have, within a three-year period preceding the date of the Offeror's proposal, been convicted of or had a civil judgment rendered against them for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, state, or local) contract or subcontract; violation of federal or state antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property.		
Are presently indicted for, or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with, commission of any of the offenses enumerated in paragraph A. (2) of this certification.		
Have, within a three-year period preceding the date of Offeror's proposal, had one or more public agreements or transactions (federal, state or local) terminated for cause or default.		
Have been excluded from participation from Medicare, Medicaid or other federal health care programs pursuant to Title XI of the Social Security Act, 42 U.S.C. § 1320a-7.		

- B. "Principal," for the purposes of this certification, shall have the meaning set forth in 45 C.F.R. § 76.995 and shall include an officer, director; owner, partner, principal investigator, or other person having management or supervisory responsibilities related to a covered transaction. "Principal" also includes a consultant or other person, whether or not employed by the participant or paid with federal funds, who: is in a position to handle federal funds; is in a position to influence or control the use of those funds; or occupies a technical or professional position capable of substantially influencing the development or outcome of an activity required to perform the covered transaction.
- C. For the purposes of this certification, the terms used in the certification, such as covered transaction, debarred, excluded, exclusion, ineligible, ineligibility, participant, and person have the meanings set forth in the definitions and coverage rules of 45 C.F.R. Part 76.
- D. Nothing contained in the foregoing certification shall be construed to require establishment of a system of records in order to render, in good faith, the certification required by paragraph A. of this provision. The knowledge and information of an Offeror is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

OFFEROR:	
SIGNATURE/TITLE:	DATE:

APPENDIX G – HIPAA BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (“BAA”) is entered into between the New Mexico Human Services Department (“Department”) and [REDACTED], hereinafter referred to as “Business Associate”, in order to comply with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) as amended by Health Information Technology for Economic and Clinical Health Act of 2009 (the “HITECH Act”), including the Standards of the Privacy of Individually Identifiable Health Information and the Security Standards at 45 CFR Parts 160 and 164.

BUSINESS ASSOCIATE, by this PSC [REDACTED] has agreed to provide services to, or on behalf of the HSD which may involve the disclosure by the Department to the Business Associate (referred to in PSC [REDACTED] as “Contractor”) of Protected Health Information. This Business Associate Agreement is intended to supplement the obligations of the Department and the Contractor as set forth in PSC [REDACTED], and is hereby incorporated therein.

THE PARTIES acknowledge HIPAA, as amended by the HITECH Act, requires that Department and Business Associate enter into a written agreement that provides for the safeguarding and protection of all Protected Health Information which Department may disclose to the Business Associate, or which may be created or received by the Business Associate on behalf of the Department.

1. Definition of Terms

- a. Breach. “Breach” has the meaning assigned to the term breach under 42 U.S.C. § 17921(1) [HITECH Act § 13400 (1)] and 45 CFR § 164.402.
- b. Business Associate. "Business Associate", herein being the same entity as the Contractor in PSC [REDACTED], shall have the same meaning as defined under the HIPAA standards as defined below, including without limitation Contractor acting in the capacity of a Business Associate as defined in 45 CFR § 160.103.
- c. Department. "Department" shall mean in this agreement the State of New Mexico Human Services Department.
- d. Individual. "Individual" shall have the same meaning as in 45 CFR §160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR §164.502 (g).
- e. HIPAA Standards. “HIPAA Standards” shall mean the legal requirements as set forth in the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act of 2009, and the regulations and policy guidance, as each may be amended over time, including without limitation:
 - i. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually

Identifiable Health Information in 45 CFR Part 160 and Part 164, Subparts A and E.

- ii. Breach Notification Rule. “Breach Notification” shall mean the Notification in the case of Breach of Unsecured Protected Health Information, 45 CFR Part 164, Subparts A and D
- iii. Security Rule. “Security Rule” shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Parts 160 and 164, Subparts A and C, including the following:
 - f. Security Standards. “Security Standards” hereinafter shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR §164.306.
 - g. Administrative Safeguards. “Administrative Safeguards” shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR §164.308.
 - h. Physical Safeguards. “Physical Safeguards” shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR §164.310.
 - i. Technical Safeguards. “Technical Safeguards” shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR §164.312.
 - j. Policies and Procedures and Documentation Requirements. “Policies and Procedures and Documentation Requirements” shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR §164.316.
 - k. Protected Health Information. "Protected Health Information" or “PHI” shall have the same meaning as in 45 CFR §160.103, limited to the information created, maintained, transmitted or received by Business Associate, its agents or subcontractors from or on behalf of Department.
 - l. Required By Law. "Required By Law" shall have the same meaning as in 45 CFR §164.103.
 - m. Secretary. "Secretary" shall mean the Secretary of the U. S. Department of Health and Human Services, or his or her designee.
 - n. Covered Entity. "Covered Entity" shall have the meaning as the term “covered entity” defined at 45 CFR §160.103, and in reference to the party to this BAA, shall mean the State of New Mexico Human Services Department.

Terms used, but not otherwise defined, in this BAA shall have the same meaning as those terms in the HIPAA Standards. All terms used and all statutory and regulatory references shall be as currently in effect or as subsequently amended.

2. Obligations and Activities of Business Associate

- a. General Rule of PHI Use and Disclosure. The Business Associate may use or disclose PHI it creates for, receives from or on behalf of, the Department to perform functions, activities or services for, or on behalf of, the Department in accordance with the specifications set forth in this BAA and in this PSC [REDACTED]; provided that such use or disclosure would not violate the HIPAA Standards if done by the Department; or as Required By Law.
- i. Any disclosures made by the Business Associate of PHI must be made in accordance with HIPAA Standards and other applicable laws.
 - ii. Notwithstanding any other provision herein to the contrary, the Business Associate shall limit uses and disclosures of PHI to the “minimum necessary,” as set forth in the HIPAA Standards.
 - iii. The Business Associate agrees to use or disclose only a “limited data set” of PHI as defined in the HIPAA Standards while conducting the authorized activities herein and as delineated in PSC [REDACTED], except where a “limited data set” is not practicable in order to accomplish those activities.
 - iv. Except as otherwise limited by this BAA or PSC [REDACTED], Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
 - v. Except as otherwise limited by this BAA or PSC [REDACTED], Business Associate may disclose PHI for the proper management and administration of the Business Associate provided that the disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
 - vi. Business Associate may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 CFR § 164.502(j).
 - vii. Business Associate may use PHI to provide Data Aggregation services to the Department as permitted by the HIPAA Standards.
- b. Safeguards. The Business Associate agrees to implement and use appropriate Security, Administrative, Physical and Technical Safeguards, and comply where applicable with subpart C of 45 C.F.R. Part 164, to prevent use or disclosure of PHI other than as required by law or as provided for by this BAA or PSC [REDACTED]. Business Associate shall identify in writing upon request from the Department all of those Safeguards that it uses to prevent impermissible uses or disclosures of PHI.
- c. Restricted Uses and Disclosures. The Business Associate shall not use or further disclose PHI other than as permitted or required by this BAA or PSC [REDACTED], the HIPAA Standards, or otherwise as permitted or required by law. The Business Associate shall not disclose

- h. PHI Disclosures Recordkeeping. Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for the Department to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with the HIPAA Standards and 45 CFR § 164.528. Business Associate shall provide such information to the Department or as directed by the Department to an Individual, to permit the Department to respond to an accounting request. Business Associate shall provide such information in the time and manner reasonably designated by the Department. Within three (3) business days, Business Associate shall forward to the Department for handling any accounting request that Business Associate directly receives from an individual.
- i. PHI Disclosures Accounting. Business Associate agrees to provide to the Department or an Individual, within seven (7) days of receipt of a request, information collected in accordance with Section 2 (h) of this Agreement, to permit the Department to respond to a request for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
- j. Security Rule Provisions. As required by 42 U.S.C. § 17931 (a) [HITECH Act Section 13401(a)] , the following sections as they are made applicable to business associates under the HIPAA Standards, shall also apply to the Business Associate: 1) Administrative Safeguards; 2) Physical Safeguards; 3) Technical Safeguards; 4) Policies and Procedures and Documentation Requirements; and 5) Security Standards. Additionally, the Business Associate shall either implement or properly document the reasons for non-implementation of all safeguards in the above cited sections that are designated as “addressable” as such are made applicable to Business Associates pursuant to the HIPAA Standards.
- k. Civil and Criminal Penalties. Business Associate agrees that it will comply with the HIPAA Standards as applicable to Business Associates, and acknowledges that it may be subject to civil and criminal penalties for its failure to do so.
- l. Performance of Covered Entity's Obligations. To the extent the Business Associate is to carry out the Department 's obligations under the HIPAA Standards, Business Associate shall comply with the requirements of the HIPAA Standards that apply to the Department in the performance of such obligations.
- m. Subcontractors. The Business Associate shall ensure that any subcontractors that create, receive, maintain or transmit PHI on behalf of Business Associate, agree in writing to the same restrictions and conditions that apply to the Business Associate with respect to PHI, with 45 C.F.R. § 164.502(e)(1)(ii), and shall make such information available to the Department upon request. Upon the Business Associate’s contracting with an agent for the sharing of PHI, the Business Associate shall provide the Department written notice of any such executed agreement. Upon the Business Associate’s contracting with a subcontractor for the sharing of PHI, the Business Associate shall provide the Department written notice of any such executed agreement.

3. Business Associate Obligations for Notification, Risk Assessment, and Mitigation

During the term of this BAA or PSC [REDACTED], the Business Associate shall be required to perform the following pursuant to the Breach Notification Rule regarding Breach Notification, Risk Assessment and Mitigation:

Notification

- a. Business Associate agrees to report to the Department Contract Manager or HIPAA Privacy and Security Officer any use or disclosure of PHI not provided for by this BAA or PSC [REDACTED], and HIPAA Standards, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410, as soon as it (or any employee or agent) becomes aware of the Breach, and in no case later than three (3) business days after it (or any employee or agent) becomes aware of the Breach, except when a government official determines that a notification would impede a criminal investigation or cause damage to national security.
- b. Business Associate shall provide the Department with the names of the individuals whose unsecured PHI has been, or is reasonably believed to have been, the subject of the Breach and any other available information that is required to be given to the affected individuals, as set forth in 45 CFR §164.404(c), and, if requested by the Department, provide information necessary for the Department to investigate promptly the impermissible use or disclosure. Business Associate shall continue to provide to the Department information concerning the Breach as it becomes available to it, and shall also provide such assistance and further information as is reasonably requested by the Department.

Risk Assessment

- c. When Business Associate determines whether an impermissible acquisition, use or disclosure of PHI by an employee or agent poses a low probability of the PHI being compromised, it shall document its assessment of risk in accordance with 45 C.F.R. § 164.402 (in definition of “Breach”, ¶ 2) based on at least the following factors: (i) the nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the protected health information or to whom the disclosure was made; (iii) whether the protected health information was actually acquired or viewed; and (iv) the extent to which the risk to the protected health information has been mitigated. Such assessment shall include: 1) the name of the person(s) making the assessment, 2) a brief summary of the facts, and 3) a brief statement of the reasons documenting the determination of risk of the PHI being compromised. When requested by the Department, Business Associate shall make its risk assessments available to the Department.
- d. If the Department determines that an impermissible acquisition, access, use or disclosure of PHI, for which one of Business Associate’s employees or agents was responsible, constitutes a Breach, and if requested by the Department, Business Associate shall provide

notice to the individuals whose PHI was the subject of the Breach. When requested to provide notice, Business Associate shall consult with the Department about the timeliness, content and method of notice, and shall receive the Department's approval concerning these elements. The cost of notice and related remedies shall be borne by Business Associate. The notice to affected individuals shall be provided as soon as reasonably possible and in no case later than 60 calendar days after Business Associate reported the Breach to the Department.

Mitigation

- e. In addition to the above duties in this section, Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI, by Business Associate in violation of the requirements of this Agreement or the HIPAA Standards. Business Associate shall draft and carry out a plan of corrective action to address any incident of impermissible use or disclosure of PHI. If requested by the Department, Business Associate shall make its mitigation and corrective action plans available to the Department.
- f. The notice to affected individuals shall be written in plain language and shall include, to the extent possible, 1) a brief description of the Breach, 2) a description of the types of Unsecured PHI that were involved in the Breach, 3) any steps individuals can take to protect themselves from potential harm resulting from the Breach, 4) a brief description of what the Business Associate and the Department are doing to investigate the Breach, to mitigate harm to individuals and to protect against further Breaches, and 5) contact procedures for individuals to ask questions or obtain additional information, as set forth in 45 CFR §164.404(c).

Notification to Clients

- g. Business Associates shall notify individuals of Breaches as specified in 45 CFR §164.404(d) (methods of individual notice). In addition, when a Breach involves more than 500 residents of a State or jurisdiction, Business Associate shall, if requested by the Department, notify prominent media outlets serving such location(s), following the requirements set forth in 45 CFR §164.406.

4. Obligations of the Department to Inform Business Associate of Privacy Practices and Restrictions

- a. The Department shall notify Business Associate of any limitation(s) in the Department's Notice of Privacy Practices, implemented in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

- b. The Department shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.
- c. The Department shall notify Business Associate of any restriction in the use or disclosure of PHI that the Department has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.
- d. The Department shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by the Department.

5. Term and Termination

- a. Term. This BAA terminates concurrently with PSC [REDACTED], except that obligations of Business Associate under this BAA related to final disposition of PHI in this Section 5 shall survive until resolved as set forth immediately below.
- b. Disposition of PHI upon Termination. Upon termination of this PSC [REDACTED] and BAA for any reason, Business Associate shall return or destroy all PHI in its possession, and shall retain no copies of the PHI. In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to the Department notification of the conditions that make return or destruction of PHI not feasible. Upon consideration and mutual agreement of the Parties that return or destruction of the PHI is infeasible, Business Associate shall agree, and require that its agents, affiliates, subsidiaries and subcontractors agree, to the extension of all protections, limitations and restrictions required of Business Associate hereunder.
- c. If Business Associate breaches any material term of this BAA, the Department may either:
 - i. provide an opportunity for Business Associate to cure the Breach and the Department may terminate this PSC [REDACTED] and BAA without liability or penalty in accordance with Article 4, Termination, of PSC [REDACTED], if Business Associate does not cure the breach within the time specified by the Department; or,
 - ii. immediately terminate this PSC [REDACTED] without liability or penalty if the Department determines that cure is not reasonably possible; or,
 - iii. if neither termination nor cure are feasible, the Department shall report the breach to the Secretary.

The Department has the right to seek to cure any breach by Business Associate and this right, regardless of whether the Department cures such breach, does not lessen any right or remedy available to the Department at law, in equity, or under this BAA or PSC [REDACTED], nor does it lessen Business Associate's responsibility for such breach or its duty to cure such breach.

6. Penalties and Training

Business Associate understands and acknowledges that violations of this BAA or PSC [REDACTED] may result in notification by the Department to law enforcement officials and regulatory, accreditation, and licensure organizations. If requested by the Department, Business Associate shall participate in training regarding use, confidentiality, and security of PHI.

7. Miscellaneous

- a. Interpretation. Any ambiguity in this BAA, or any inconsistency between the provisions of this BAA or PSC [REDACTED], shall be resolved to permit the Department to comply with the HIPAA Standards.
- b. Business Associate's Compliance with HIPAA. The Department makes no warranty or representation that compliance by Business Associate with this BAA or the HIPAA Standards will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.
- c. Change in Law. In the event there are subsequent changes or clarifications of statutes, regulations or rules relating to this BAA or PSC [REDACTED], the Department shall notify Business Associate of any actions it reasonably deems necessary to comply with such changes, and Business Associate shall promptly take such actions. In the event there is a change in federal or state laws, rules or regulations, or in the interpretation of any such laws, rules, regulations or general instructions, which may render any of the material terms of this BAA unlawful or unenforceable, or which materially affects any financial arrangement contained in this BAA, the parties shall attempt amendment of this BAA to accommodate such changes or interpretations. If the parties are unable to agree, or if amendment is not possible, the parties may terminate the BAA and PSC [REDACTED] pursuant to its termination provisions.
- d. No Third Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Department, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
- e. Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and any agents, affiliates, subsidiaries, subcontractors or workforce members assisting Business Associate in the fulfillment of its obligations under this BAA and PSC

██████ available to the Department, at no cost to the Department, to testify as witnesses or otherwise in the event that litigation or an administrative proceeding is commenced against the Department or its employees based upon claimed violation of the HIPAA standards or other laws relating to security and privacy, where such claimed violation is alleged to arise from Business Associate's performance under this BAA or PSC ██████, except where Business Associate or its agents, affiliates, subsidiaries, subcontractors or employees are named adverse parties.

- f. Additional Obligations. Department and Business Associate agree that to the extent not incorporated or referenced in any Business Associate Agreement between them, other requirements applicable to either or both that are required by the HIPAA Standards, those requirements are incorporated herein by reference.

APPENDIX H – DRAFT CONTRACT

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
PROFESSIONAL SERVICES CONTRACT

THIS AGREEMENT is made and entered into by and between the State of New Mexico **Human Services Department**, hereinafter referred to as the “HSD,” and (CONTRACTOR), hereinafter referred to as the “Contractor”.

Recitals.

1. All services provided pursuant to this Agreement are subject to the New Mexico Procurement Code and 1.4.1 NMAC, unless specifically provided otherwise herein; and
2. The HSD’s Chief Procurement Officer (CPO) has made a determination that this PSC is exempt from the provisions of the New Mexico Procurement Code [13-1-28 NMSA 1978, *et seq.*] as the services involved will likely reduce health care costs, improve quality of care, or improve access to care.

IT IS THEREFORE AGREED BETWEEN THE PARTIES:

1. Scope of Work.

The Contractor shall perform all services detailed in Exhibit A, Scope of Work, attached hereto, and referenced herein.

2. Compensation.

A. The HSD shall pay to the Contractor in full payment for services satisfactorily performed pursuant to Exhibit A, Scope of Work, compensation not to exceed XX dollars (\$0.00) including gross receipts tax if applicable. 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 New Mexico gross receipts tax, if applicable, levied on the amounts payable under this PSC shall be paid by the Contractor. The parties do not intend for the Contractor to continue to provide services without compensation when the total compensation amount is reached. The Contractor is responsible for notifying the HSD 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 total compensation amount without this Agreement being amended in writing prior to those services in excess of the total compensation amount being provided.

The HSD shall pay to the Contractor in full payment for services satisfactorily performed compensation not to exceed XX dollars (\$0.00) including gross receipts tax, if applicable, for FY23.

The HSD shall pay to the Contractor in full payment for services satisfactorily performed compensation not to exceed XX dollars (\$0.00) including gross receipts tax, if applicable, for FY24.

B. Payment for FY23 and FY24 is subject to availability of funds pursuant to Paragraph 5 (Appropriations), set forth below and to approval by the DFA. All invoices **MUST BE** received by the HSD no later than ten (10) days after the termination of the Fiscal Year in which the services were delivered. **Invoices received after such date WILL NOT BE PAID.**

C. Contractor must submit a complete fixed price invoice to HSD no later than fifteen (15) business days following the acceptance of a completed reimbursable service. If the HSD finds that the services are not acceptable, within thirty days after the date of receipt of written notice from the Contractor that payment is requested, it shall provide the Contractor a letter of exception explaining the defect or objection to the services, and outlining steps the Contractor may take to provide remedial action. Upon certification by the HSD that the services have been received and accepted, payment shall be tendered to the Contractor within thirty days after the date of acceptance. If payment is made by mail, the payment shall be deemed tendered on the date it is postmarked. However, the agency shall not incur late charges, interest, or penalties for failure to make payment within the time specified herein.

3. Term.

THIS AGREEMENT SHALL NOT BECOME EFFECTIVE UNTIL APPROVED BY THE HSD and shall terminate June 30, XXXX, unless terminated pursuant to paragraph 4 (Termination), or paragraph 5 (Appropriations). In accordance with Section 13-1-150 NMSA 1978, no contract term for a professional services contract, including extensions and renewals, shall exceed eight years, except as set forth in Section 13-1-150 NMSA 1978.

4. Termination.

A. Grounds. The HSD may terminate this Agreement for convenience or cause. The Contractor may only terminate this Agreement based upon the HSD's uncured, material breach of this Agreement. Upon thirty (30) days' notice to the Contractor or for cause provided that the Contractor shall have twenty days in which to cure the cause

following HSD's written notice of termination identifying the cause and statement of what is required to cure the cause although this in no way affects HSD's right to terminate for convenience.

B. Notice; HSD Opportunity to Cure.

1. Except as otherwise provided in Paragraph (4)(B)(3), the HSD shall give Contractor written notice of termination at least thirty (30) days prior to the intended date of termination.

2. Contractor shall give HSD written notice of termination at least thirty (30) days prior to the intended date of termination, which notice shall (i) identify all the HSD's material breaches of this Agreement upon which the termination is based and (ii) state what the HSD must do to cure such material breaches. Contractor's notice of termination shall only be effective (iii) if the HSD does not cure all material breaches within the thirty (30) day notice period or (iv) in the case of material breaches that cannot be cured within thirty (30) days, the HSD does not, within the thirty (30) day notice period, notify the Contractor of its intent to cure and begin with due diligence to cure the material breach.

3. Notwithstanding the foregoing, this Agreement may be terminated immediately upon written notice to the Contractor (i) if the Contractor becomes unable to perform the services contracted for, as determined by the HSD; (ii) if, during the term of this Agreement, the Contractor is suspended or debarred by the State Purchasing Agent; or (iii) the Agreement is terminated pursuant to Paragraph 5, "Appropriations", of this Agreement.

C. Liability. Except as otherwise expressly allowed or provided under this Agreement, the HSD's sole liability upon termination shall be to pay for acceptable work performed prior to the Contractor's receipt or issuance of a notice of termination; provided, however, that a notice of termination shall not nullify or otherwise affect either party's liability for pre-termination defaults under or breaches of this Agreement. The Contractor shall submit an invoice for such work within thirty (30) days of receiving or sending the notice of termination. *THIS PROVISION IS NOT EXCLUSIVE AND DOES NOT WAIVE THE AGENCY'S OTHER LEGAL RIGHTS AND REMEDIES CAUSED BY THE CONTRACTOR'S DEFAULT/BREACH OF THIS AGREEMENT.*

D. Termination Management. Immediately upon receipt by either the HSD or the Contractor of notice of termination of this Agreement, the Contractor shall: 1) not incur any further obligations for salaries, services or any other expenditure of funds under this Agreement without written approval of the HSD; 2) comply with all directives issued by the HSD in the notice of termination as to the performance of work under this Agreement;

and 3) take such action as the HSD shall direct for the protection, preservation, retention or transfer of all property titled to the HSD and records generated under this Agreement. Any non-expendable personal property or equipment provided to or purchased by the Contractor with contract funds shall become property of the HSD upon termination and shall be submitted to the agency as soon as practicable.

5. Appropriations.

The terms of this Agreement are contingent upon sufficient appropriations and authorization being made by the Legislature of New Mexico for the performance of this Agreement. If sufficient appropriations and authorization are not made by the Legislature, this Agreement shall terminate immediately upon written notice being given by the HSD to the Contractor. The HSD's decision as to whether sufficient appropriations are available shall be accepted by the Contractor and shall be final. If the HSD proposes an amendment to the Agreement to unilaterally reduce funding, the Contractor shall have the option to terminate the Agreement or to agree to the reduced funding, within thirty (30) days of receipt of the proposed amendment.

6. Status of Contractor.

The Contractor and its agents and employees are independent contractors performing professional services for the HSD and are not employees of the State of New Mexico. The Contractor and its agents and employees shall not accrue leave, retirement, insurance, bonding, use of state vehicles, or any other benefits afforded to employees of the State of New Mexico as a result of this Agreement. The Contractor acknowledges that all sums received hereunder are reportable by the Contractor for tax purposes, including without limitation, self-employment and business income tax. The Contractor agrees not to purport to bind the State of New Mexico unless the Contractor has express written authority to do so, and then only within the strict limits of that authority.

7. Assignment.

The Contractor shall not assign or transfer any interest in this Agreement or assign any claims for money due or to become due under this Agreement without the prior written approval of the HSD.

8. Subcontracting.

The Contractor shall not subcontract any portion of the services to be performed under this Agreement without the prior written approval of the HSD. No such subcontract shall relieve the primary Contractor from its obligations and liabilities under this Agreement, nor shall any subcontract obligate direct payment from the Procuring Agency.

9. Release.

Final payment of the amounts due under this Agreement shall operate as a release of the HSD, its officers and employees, and the State of New Mexico from all liabilities, claims and obligations whatsoever arising from or under this Agreement.

10. Confidentiality.

Any confidential information provided to 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 Contractor without the prior written approval of the HSD.

11. Product of Service - Copyright.

All materials developed or acquired by the Contractor under this Agreement shall become the property of the State of New Mexico and shall be delivered to the HSD no later than the termination date of this Agreement. Nothing developed or produced, in whole or in part, by the Contractor under this Agreement shall be the subject of an application for copyright or other claim of ownership by or on behalf of the Contractor.

12. Intellectual Property.

The Contractor hereby acknowledges and grants to the HSD and the State of New Mexico, a revocable, non-transferable, non-exclusive, royalty free license to use the Contractor's logo, trademarks and other service marks (the "OPC Marks") for purposes of this Agreement in order that the HSD may promote the services and the Contractor's role in providing the Services, in a form as approved by the Contractor. The HSD does not have any other right, title, license or interest, express or implied, in and to any object code, software, hardware, OPC Marks, service mark, trade name, trade dress, formula, OPC System, Know-How, telephone number, telephone line, domain name, URL, copyrighted image, text, script (including, without limitation, IVR or the Contractor's Website scripts) or other intellectual property right of Contractor (collectively "OPC Intellectual Property"). All such OPC Intellectual Property, and all rights and title therein (other than rights expressly granted in this Agreement) are owned exclusively by the Contractor. The HSD's license to use any OPC Marks shall terminate upon the earlier of (a) the effective date of termination or expiration of this Agreement, or (b) immediately, in the event of any breach of this section of the Agreement by Agency. The HSD shall not utilize the OPC Intellectual Property in any manner that would diminish its value or harm the reputation of the Contractor. The HSD agrees that any use of the OPC Marks will conform to reasonable standards of acceptable use specified by the Contractor.

13. Conflict of Interest; Governmental Conduct Act.

A. The Contractor represents and warrants that it presently has no interest and, during the term of this Agreement, shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance or services required under the Agreement.

B. The Contractor further represents and warrants that it has complied with, and, during the term of this Agreement, will continue to comply with, and that this Agreement complies with all applicable provisions of the Governmental Conduct Act, Chapter 10, and Article 16 NMSA 1978. Without in anyway limiting the generality of the foregoing, the Contractor specifically represents and warrants that:

1. in accordance with Section 10-16-4.3 NMSA 1978, the Contractor does not employ, has not employed, and will not employ during the term of this Agreement any HSD employee while such employee was or is employed by the HSD and participating directly or indirectly in the HSD's contracting process;

2. this Agreement complies with Section 10-16-7(A) NMSA 1978 because (i) the Contractor is not a public officer or employee of the State; (ii) the Contractor is not a member of the family of a public officer or employee of the State; (iii) the Contractor is not a business in which a public officer or employee or the family of a public officer or employee has a substantial interest; or (iv) if the Contractor is a public officer or employee of the State, a member of the family of a public officer or employee of the State, or a business in which a public officer or employee of the State or the family of a public officer or employee of the State has a substantial interest, public notice was given as required by Section 10-16-7(A) NMSA 1978 and this Agreement was awarded pursuant to a competitive process;

3. in accordance with Section 10-16-8(A) NMSA 1978, (i) the Contractor is not, and has not been represented by, a person who has been a public officer or employee of the State within the preceding year and whose official act directly resulted in this Agreement and (ii) the Contractor is not, and has not been assisted in any way regarding this transaction by, a former public officer or employee of the State whose official act, while in State employment, directly resulted in the HSD's making this Agreement;

4. this Agreement complies with Section 10-16-9(A) NMSA 1978 because (i) the Contractor is not a legislator; (ii) the Contractor is not a member of a legislator's family; (iii) the Contractor is not a business in which a legislator or a legislator's family has a substantial interest; or (iv) if the Contractor is a legislator, a member of a legislator's family, or a business in which a legislator or a legislator's family has a substantial interest, disclosure has been made as required by Section 10-16-9(A) NMSA 1978, this Agreement is not a sole source or small purchase contract, and this Agreement was awarded in accordance with the provisions of the Procurement Code;

5. in accordance with Section 10-16-13 NMSA 1978, the Contractor has not directly participated in the preparation of specifications, qualifications or evaluation criteria for this Agreement or any procurement related to this Agreement; and

6. in accordance with Section 10-16-3 and Section 10-16-13.3 NMSA 1978, the Contractor has not contributed, and during the term of this Agreement shall not contribute, anything of value to a public officer or employee of the HSD.

C. Contractor's representations and warranties in Paragraphs A and B of this Article 12 are material representations of fact upon which the HSD relied when this Agreement was entered into by the parties. Contractor shall provide immediate written notice to the HSD if, at any time during the term of this Agreement, Contractor learns that Contractor's representations and warranties in Paragraphs A and B of this Article 12 were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances. If it is later determined that Contractor's representations and warranties in Paragraphs A and B of this Article 12 were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances, in addition to other remedies available to the HSD and notwithstanding anything in the Agreement to the contrary, the HSD may immediately terminate the Agreement.

D. All terms defined in the Governmental Conduct Act have the same meaning in this Article 12(B).

14. Amendment.

A. This Agreement shall not be altered, changed or amended except by instrument in writing executed by the parties hereto and all other required signatories.

B. If the HSD proposes an amendment to the Agreement to unilaterally reduce funding due to budget or other considerations, the Contractor shall, within thirty (30) days of receipt of the proposed Amendment, have the option to terminate the Agreement, pursuant to the termination provisions as set forth in Article 4 herein, or to agree to the reduced funding.

15. Merger.

This Agreement incorporates all the Agreements, covenants and understandings between the parties hereto concerning the subject matter hereof, and all such covenants, Agreements and understandings have been merged into this written Agreement. No prior Agreement or understanding, oral or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Agreement.

16. Penalties for Violation of Law.

The Procurement Code, Sections 13-1-28 through 13-1-199, NMSA 1978, imposes civil and criminal penalties for its violation. In addition, the New Mexico criminal statutes impose felony penalties for illegal bribes, gratuities and kickbacks.

17. Equal Opportunity Compliance.

The Contractor agrees to abide by all federal and state laws and rules and regulations, and executive orders of the Governor of the State of New Mexico, pertaining to equal employment opportunity. In accordance with all such laws of the State of New Mexico, the Contractor assures that no person in the United States shall, on the grounds of race, religion, color, national origin, ancestry, sex, age, physical or mental handicap, or serious medical condition, spousal affiliation, sexual orientation or gender identity, be excluded from employment with or participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity performed under this Agreement. If Contractor is found not to be in compliance with these requirements during the life of this Agreement, Contractor agrees to take appropriate steps to correct these deficiencies.

18. Rights to Property.

All equipment and other property provided or reimbursed to the CONTRACTOR by HSD is the property of HSD and shall be turned over to HSD at the time of termination or expiration of this Agreement, unless otherwise agreed to in writing. In addition, in regard to the performance of experimental, developmental or research done by the CONTRACTOR, HSD shall determine the rights of the Federal Government and the parties to this Agreement in any resulting investigation.

19. Erroneous Issuance Of Payment Or Benefits.

In the event of an error, which causes payment(s) to the CONTRACTOR to be issued by HSD, the CONTRACTOR shall reimburse HSD within thirty (30) days of written notice of such error for the full amount of the payment. Interest shall accrue at the statutory rate on any amounts not paid and determined to be due after the thirtieth (30th) day following the notice.

20. Excusable Delays.

A. The CONTRACTOR shall be excused from performance hereunder for any period that it is prevented from performing any services hereunder in whole or in part as a result of a war, civil disturbance, epidemic, court order, or other cause beyond its reasonable control, and such nonperformance shall not be a default hereunder or ground for termination of the Agreement.

B. The CONTRACTOR shall be excused from performance hereunder during any period for which the State of New Mexico has failed to enact a budget or appropriate monies to fund the managed care program, provided that the CONTRACTOR notifies HSD, in writing, of its intent to suspend performance and HSD is unable to resolve the budget or appropriation deficiencies within forty-five (45) calendar days.

C. In addition, the CONTRACTOR shall be excused from performance hereunder for insufficient payment by HSD, provided that the CONTRACTOR notifies HSD in writing of its intent to suspend performance and HSD is unable to remedy the monetary shortfall within forty-five (45) calendar days.

21. Publicity.

The CONTRACTOR shall not use HSD's name or refer to the External Quality Review Project directly or indirectly in any advertisement, news release, professional trade or business presentation without prior written approval from HSD. Nothing in this Article shall prevent the CONTRACTOR from using HSD as a reference. _

22. Applicable Law.

The laws of the State of New Mexico shall govern this Agreement, without giving effect to its choice of law provisions. Venue shall be proper only in a New Mexico court of competent jurisdiction in accordance with Section 38-3-1 (G) NMSA 1978. By execution of this Agreement, Contractor acknowledges and agrees to the jurisdiction of the courts of the State of New Mexico over any and all lawsuits arising under or out of any term of this Agreement.

23. Workers Compensation.

The Contractor agrees to comply with state laws and rules applicable to workers compensation benefits for its employees. If the Contractor fails to comply with the Workers Compensation Act and applicable rules when required to do so, this Agreement may be terminated by the HSD.

24. Records and Financial Audit.

A. The Contractor shall maintain detailed records that indicate the nature and price of Services rendered during this Agreement's term and effect and retain them for a period of five (5) years from the date of final payment under this Agreement.

B. Contract for an independent audit in accordance with 2 CFR 200 at the Contractor's expense, as applicable or upon HSD request, submit its most recent 2 CFR

200 audit. The Contractor shall ensure that the auditor is licensed to perform audits in the State of New Mexico and shall be selected by a competitive bid process. The Contractor shall enter into a written contract with the auditor specifying the scope of the audit, the auditor's responsibility, the date by which the audit is to be completed and the fee to be paid to the auditor for this service. Single audits shall comply with procedures specified by the HSD. The audit of the contract shall cover compliance with Federal Regulations and all financial transactions hereunder for the entire term of the Agreement in accordance with procedures promulgated by 2 CFR 200 or by Federal program officials for the conduct and report of such audits. An official copy of the independent auditor's report shall be available to the HSD and any other authorized entity as required by law within (fifteen) 15 days of receipt of the final audit report. The Contractor may request an extension to the deadline for submission of the audit report in writing to the HSD for good cause and the HSD reserves the right to approve or reject any such request. The HSD retains the right to contract for an independent financial and functional audit for funds and operations under this Agreement if it determines that such an audit is warranted or desired.

C. Upon completion of the audit under the applicable federal and state statutes and regulations, the Contractor shall notify the HSD when the audit is available for review and provide online access to the HSD, or the Contractor shall provide the HSD with four (4) originals of the audit report. The HSD will retain two (2) and one (1) will be sent to the HSD/Office of the Inspector General and one (1) to the HSD/Administrative Services Division/Compliance Bureau.

D. Within thirty (30) days thereafter or as otherwise determined by the HSD in writing, the Contractor shall provide the HSD with a response indicating the status of each of the exceptions or findings in the said audit report. If either the exceptions or findings in the audit are not resolved within thirty (30) days, the HSD has the right to reduce funding, terminate this Agreement, and/or recommend decertification in compliance with state and/or federal regulations governing such action.

E. This audit shall contain the Schedule of Expenditures of Federal Awards for each program to facilitate ease of reconciliation by the HSD. This audit shall also include a review of the schedule of depreciation for all property or equipment with a purchase price of \$5,000 or more pursuant to 2 CFR 200, specifically subpart F, and appendices where appropriate.

F. This audit shall include a report on compliance with requirements applicable to each major program and internal control over compliance in accordance with 2 CFR 200, specifically subpart F and appendices.

25. Indemnification.

The Contractor shall defend, indemnify and hold harmless the HSD and the State of New Mexico from all actions, proceeding, claims, demands, costs, damages, attorneys' fees and all other liabilities and expenses of any kind from any source which may arise out of the performance of this Agreement, caused by the negligent act or failure to act of the Contractor, its officers, employees, servants, subcontractors or agents, or if caused by the actions of any client of the Contractor resulting in injury or damage to persons or property during the time when the Contractor or any officer, agent, employee, servant or subcontractor thereof has or is performing services pursuant to this Agreement. In the event that any action, suit or proceeding related to the services performed by the Contractor or any officer, agent, employee, servant or subcontractor under this Agreement is brought against the Contractor, the Contractor shall, as soon as practicable but no later than two (2) days after it receives notice thereof, notify the legal counsel of the HSD and the Risk Management Division of the New Mexico General Services Department by certified mail.

26. New Mexico Employees Health Coverage.

A. If Contractor has, or grows to, six (6) or more employees who work, or who are expected to work, an average of at least 20 hours per week over a six (6) month period during the term of the contract, Contractor certifies, by signing this agreement, to have in place, and agree to maintain for the term of the contract, health insurance for those employees and offer that health insurance to those employees if the expected annual value in the aggregate of any and all contracts between Contractor and the State exceed \$250,000 dollars.

B. Contractor agrees to maintain a record of the number of employees who have (a) accepted health insurance; (b) declined health insurance due to other health insurance coverage already in place; or (c) declined health insurance for other reasons. These records are subject to review and audit by a representative of the state.

C. Contractor agrees to advise all employees of the availability of State publicly financed health care coverage programs by providing each employee with, as a minimum, the following web site link to additional information:
<http://insurenemexico.state.nm.us/>.

27. Insurance.

A. The CONTRACTOR shall procure and maintain in full force and effect during the term of this Agreement insurance as is required pursuant to Article 22.3. Policies of insurance shall be written by companies authorized to write such insurance in New Mexico.

B. The CONTRACTOR shall furnish HSD/MAD copies of certificates of required insurance in a form satisfactory to HSD/MAD (or copies of insurance policies if

HSD/MAD calls for them) within fifteen (15) calendar days after signing this Agreement. HSD/MAD shall immediately be notified if the insurance is canceled, materially changed or not renewed.

C. The CONTRACTOR shall procure and maintain during the life of this Agreement a comprehensive general liability and automobile insurance policy and liability limits in amounts not less than Five Hundred Thousand Dollars (\$500,000) combined single limit of liability for bodily injury, including death, and property damage in any one occurrence. Said policies of insurance must include coverage for all operations performed for HSD by the CONTRACTOR, coverage for the use of all owned, non-owned, hired automobiles, vehicles, and other equipment both on and off work and contractual liability coverage shall specifically insure to hold harmless provisions of the Agreement. HSD shall be named an additional insured.

D. HSD shall not be liable to claim or subrogation by the CONTRACTOR's insurance carriers and all such insurance shall be deemed for the protection of the HSD as well as the CONTRACTOR.

28. Invalid Term or Condition.

If any term or condition of this Agreement shall be held invalid or unenforceable, the remainder of this Agreement shall not be affected and shall be valid and enforceable.

29. Enforcement of Agreement.

A party's failure to require strict performance of any provision of this Agreement shall not waive or diminish that party's right thereafter to demand strict compliance with that or any other provision. No waiver by a party of any of its rights under this Agreement shall be effective unless express and in writing, and no effective waiver by a party of any of its rights shall be effective to waive any other rights.

30. Notices.

Any notice required to be given to either party by this Agreement shall be in writing and shall be delivered in person, by courier service or by U.S. mail, either first class or certified, return receipt requested, postage prepaid, as follows:

To the HSD:

Human Services Department

To the Contractor:

31. Authority.

If Contractor is other than a natural person, the individual(s) signing this Agreement on behalf of Contractor represents and warrants that he or she has the power and authority to bind Contractor, and that no further action, resolution, or approval from Contractor is necessary to enter into a binding contract.

32. Debarment and Suspension.

A. Consistent with all applicable federal and/or state laws and regulations, as applicable, and as a separate and independent requirement of this PSC the Contractor certifies by signing this PSC, that it and its principals, to the best of its knowledge and belief: (1) are not debarred, suspended, proposed for debarment, or declared ineligible for the award of contracts by any Federal department or agency; (2) have not, within a three-year period preceding the effective date of this PSC, been convicted of or had a civil judgment rendered against them for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, state, or local) contract or subcontract; violation of Federal or state antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property; (3) have not been indicted for, or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with, commission of any of the offenses enumerated above in this Paragraph A; (4) have not, within a three-year period preceding the effective date of this PSC, had one or more public agreements or transactions (Federal, State or local) terminated for cause or default; and (5) have not been excluded from participation from Medicare, Medicaid or other federal health care programs pursuant to Title XI of the Social Security Act, 42 U.S.C. § 1320a-7.

B. The Contractor's certification in Paragraph A, above, is a material representation of fact upon which the HSD relied when this PSC was entered into by the parties. The Contractor's certification in Paragraph A, above, shall be a continuing term or condition of this PSC. As such at all times during the performance of this PSC, the Contractor must be capable of making the certification required in Paragraph A, above, as if on the date of making such new certification the Contractor was then executing this PSC for the first time. Accordingly, the following requirements shall be read so as to apply to the original certification of the Contractor in Paragraph A, above, or to any new certification the Contractor is required to be capable of making as stated in the preceding sentence:

1. The Contractor shall provide immediate written notice to the HSD's Program Manager if, at any time during the term of this PSC, the Contractor learns that its certification in Paragraph A, above, was erroneous on the effective date of this PSC or has become erroneous by reason of new or changed circumstances.

2. If it is later determined that the Contractor's certification in Paragraph A, above, was erroneous on the effective date of this PSC or has become erroneous by reason of new or changed circumstances, in addition to other remedies available to the HSD, the HSD may terminate the PSC.

C. As required by statute, regulation or requirement of this PSC, and as contained in Paragraph A, above, the Contractor shall require each proposed first-tier subcontractor whose subcontract will equal or exceed \$25,000, to disclose to the Contractor, in writing, whether as of the time of award of the subcontract, the subcontractor, or its principals, is or is not debarred, suspended, or proposed for debarment by any Federal department or agency. The Contractor shall make such disclosures available to the HSD when it requests subcontractor approval from the HSD. If the subcontractor, or its principals, is debarred, suspended, or proposed for debarment by any Federal, state or local department or agency, the HSD may refuse to approve the use of the subcontractor.

33. Certification and Disclosure Regarding Payments to Influence Certain Federal Transactions.

A. The applicable definitions and exceptions to prohibited conduct and disclosures contained in 31 U.S.C. § 1352 and 45 C.F.R. Part 93, as applicable, are hereby incorporated by reference in subparagraph (B) of this certification.

B. The Contractor, by executing this PSC, certifies to the best of its knowledge and belief that:

1. No Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress on his or her behalf in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement; and

2. If any funds other than Federal appropriated funds (including profit or fee received under a covered Federal transaction) have been paid, or will be paid, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress on his or her behalf in connection with this solicitation, the offeror shall complete and submit, with its offer, OMB standard form LLL, Disclosure of Lobbying Activities, to the Contracting Officer.

C. The Contractor shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

D. This certification is a material representation of fact upon which reliance is placed when this PSC is made and entered into. Submission of this certification is a prerequisite for making and entering into this PSC imposed under 31 U.S.C. § 1352. It shall be a material obligation of the Contractor to keep this certification current as to any and all individuals or activities of anyone associated with the Contractor during the pendency of this PSC. Any person who makes an expenditure prohibited under this provision or who fails to file or amend the disclosure form to be filed or amended by this provision, shall be subject to: (1) a civil penalty of not less than \$10,000 and not more than \$100,000 for such failure; and/or (2) at the discretion of the HSD, termination of the PSC.

34. Non-Discrimination.

A. The Contractor agrees to comply fully with Title VI of the Civil Rights Act of 1964, as amended; the Rehabilitation Act of 1973, Public Law 93-112, as amended; and the Americans With Disabilities Act of 1990, Public Law 101-336; in that there shall be no discrimination against any employee who is employed in the performance of this PSC, or against any applicant for such employment, because of age, color, national origin, ancestry, race, religion, creed, disability, sex, or marital status.

B. This provision shall include, but not be limited to, the following: employment, promotion, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training including apprenticeship.

C. The Contractor agrees that no qualified handicapped person shall, on the basis of handicap, be excluded from participation or be denied the benefits of, or otherwise be subjected to discrimination under any program or activity of the Contractor. The Contractor further agrees to insert similar provisions in all subcontracts for services allowed under this PSC under any program or activity.

D. The Contractor agrees to provide meaningful access to services for individuals with Limited English Proficiency (LEP) in accordance with Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency."

35. Drug Free Workplace.

A. *Definitions.* As used in this paragraph—

“Controlled substance” means a controlled substance in schedules I through V of section 202 of the Controlled Substances Act, 21 U.S.C 812, and as further defined in regulation at 21 CFR 1308.11 - 1308.15.

“Conviction” means a finding of guilt (including a plea of *nolo contendere*) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes.

“Criminal drug statute” means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, possession, or use of any controlled substance.

“Drug-free workplace” means the site(s) for the performance of work done by the Contractor in connection with a specific contract where employees of the Contractor are prohibited from engaging in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance.

“Employee” means an employee of a contractor directly engaged in the performance of work under a Government contract. “Directly engaged” is defined to include all direct cost employees and any other contractor employee who has other than a minimal impact or involvement in contract performance.

“Individual” means an offeror/contractor that has no more than one employee including the offeror/contractor.

B. The Contractor, if other than an individual, shall:

1. Publish a statement notifying its employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the Contractor’s workplace and specifying the actions that will be taken against employees for violations of such prohibition;

2. Establish an ongoing drug-free awareness program to inform such employees about:

(i) The dangers of drug abuse in the workplace;

(ii) The Contractor’s policy of maintaining a drug-free workplace;

(iii) Any available drug counseling, rehabilitation, and employee assistance programs; and

(iv) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

3. Provide all employees engaged in performance of the PSC with a copy of the statement required by subparagraph B(1);

4. Notify such employees in writing in the statement required by subparagraph (B)(1) of this clause that, as a condition of continued employment on this PSC, the employee will:

(i) Abide by the terms of the statement; and

(ii) Notify the employer in writing of the employee’s conviction under a criminal drug statute for a violation occurring in the workplace no later than five (5) days after such conviction;

5. Notify the HSD Program Manager in writing within ten (10) days after receiving notice under (B)(4)(ii) of this paragraph, from an employee or otherwise receiving actual notice of such conviction. The notice shall include the position title of the

employee;

6. Within thirty (30) days after receiving notice under B(4)(ii) of this paragraph of a conviction, take one of the following actions with respect to any employee who is convicted of a drug abuse violation occurring in the workplace:

(i) Taking appropriate personnel action against such employee, up to and including termination; or

(ii) Require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

7. Make a good faith effort to maintain a drug-free workplace through implementation of B(1) through B(6) of this paragraph.

C. The Contractor, if an individual, agrees by entering into this PSC not to engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance while performing this contract.

D. In addition to other remedies available to the HSD, the Contractor's failure to comply with the requirements of subparagraph B or C of this paragraph will render the Contractor in default of this PSC and subject the Contractor to suspension of payments under the PSC and/or termination of the PSC in accordance with paragraph 4, above.

36. Findings and Sanctions

A. The Contractor agrees to be subject to the findings and sanctions assessed as a result of the HSD audits, federal audits, and disallowances of the services provided pursuant to this PSC and the administration thereof. Notwithstanding, the Contractor shall be entitled to pursue any appeal rights the Contractor has under New Mexico law or this Agreement.

B. The Contractor will make repayment of any funds expended by the HSD, subject to which an auditor with the jurisdiction and authority finds were expended, or to which appropriate federal funding agencies take exception and so request reimbursement through a disallowance or deferral based upon the acts or omissions of the Contractor that violate applicable federal statutes and/or regulations, subject to sufficient appropriations of the New Mexico Legislature.

C. If the HSD becomes aware of circumstances that might jeopardize continued federal funding, the situation shall be reviewed and reconciled by a mutually agreed upon panel of Contractor and the HSD officials. If reconciliation is not possible, both parties shall present their view to the Director of the Administrative Services Division who shall determine whether continued payment shall be made.

37. Performance.

In performance of this contract, the Contractor agrees to comply with and assume responsibility for compliance by its employees and its subcontractors and/or Business Associates (BA) with the following requirements:

A. All work will be performed under the supervision of the Contractor or the Contractor's responsible employees.

B. Contractor agrees that any Personally Identifiable Information (PII) made available shall be used only for the purpose of carrying out the provisions of this contract. Information contained in such material shall be treated as confidential and will not be divulged or made known in any manner to any person or entity except as may be necessary in the performance of this contract. Inspection by or disclosure to any person or entity other than an officer or employee of the Contractor is prohibited.

C. All PII will be accounted for upon receipt and properly stored before, during, and after processing. In addition, all related output will be given the same level of protection as required for the source material.

D. The Contractor certifies that the data processed during the performance of this contract will be completely purged from all data storage components of his or her computer facility, including printers, copiers, scanners and all magnetic and flash memory components of all systems and portable media, and no output will be retained by the Contractor at the time the work is completed. If immediate purging of all data storage components is not possible, the contractor certifies that any PII data remaining in any storage component will be safeguarded to prevent unauthorized disclosures.

E. Any spoilage or any intermediate hard copy printout that may result during the processing of PII will be given to the HSD or his or her designee. When this is not possible, the Contractor will be responsible for the destruction of the spoilage or any intermediate hard copy printouts, and will provide the agency or his or her designee with a statement containing the date of destruction, description of material destroyed, and the method used.

F. All computer systems, office equipment, and portable media receiving, processing, storing, or transmitting Protected Health Information (PHI), or PII must meet the requirements defined in HIPAA Security Rule, 45 CFR 160. To meet functional and assurance requirements, the security features of the environment must provide for the managerial, operational, and technical controls.

G. The Contractor will provide signed acknowledgments for its staff and its subcontractors and/or BA staff, to provide certification that information security awareness and training was completed. These signed certifications will be provided to the agency contract manager upon contract start and annually thereafter.

H. All incidents affecting the compliance, operation, or security of the information and systematic functionality must be reported to the HSD and remedied at the Contractor's expense. In addition to the self-certification and evaluation requirements, the Contractor shall notify the HSD of any instances of security breach issues or non-compliance promptly upon their discovery, but no later than a period of 24 hours. Notification shall include a description of the security/non-compliance issue and corrective action planned and/or taken.

I. The Contractor must provide the HSD with any necessary safeguards to protect further issues caused by security breaches or non-compliance discoveries. The corrective action plan approved by HSD must contain a long term solution to possible future privacy or security threat of information. In addition to the corrective action, the Contractor must provide daily updates as to the progress of all corrective measures until the issue is resolved.

J. The HSD will have the right to terminate the contract if the Contractor or its subcontractors or BAs fail to provide the safeguards described above, consistent with the termination clause herein.

38. Criminal/Civil Sanctions

A. It is incumbent upon Contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C.552a. Specifically, 5 U.S.C. 552a(i)(1), which is made applicable to contractors by 5 U.S.C. 552a(m)(1), provides that any officer or employee of a contractor, who by virtue of his/her employment or official position, has possession of or access to HSD records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is so prohibited, willfully discloses the material in any manner to any person not entitled to receive it, shall be guilty of a misdemeanor and fined not more than \$5,000.

B. Contractor agrees that granting access to PII must be preceded by certifying that each individual understands the HSD's applicable security policy and procedures for safeguarding PII.

39. Inspection

The HSD shall have the right to send its officers and/or employees into the offices and plants of the contractor for inspection of the facilities and operations provided for the performance of any work related PHI and/or PII under this contract. On the basis of such inspection, specific measures may be required in cases where the contractor is found to be noncompliant with contract safeguards.

40. Contractor's Responsibility for Compliance With Laws and Regulations

A. The Contractor is responsible for compliance with applicable laws, regulations, and administrative rules that govern the Contractor's performance of the Scope of Work of this Agreement and Exhibit A, including but not limited to, applicable State and Federal tax laws, State and Federal employment laws, State and Federal regulatory requirements and licensing provisions. This includes, but not limited to, 42 CFR Parts 438 and 455; 45 CFR Parts 160 and 164; and NMAC regulation series 8.308.

B. The Contractor is responsible for causing each of its employees, agents or subcontractors who provide services under this Agreement to be properly licensed, certified, and/or have proper permits to perform any activity related to the Scope of Work of this Agreement in Exhibit A.

C. If the Contractor's performance of its obligations under the terms of this agreement makes it a business associate of the HSD as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated thereunder, the Contractor agrees to the terms of the HSD HIPAA Business Associate Agreement (BAA), attached hereto as Exhibit B.

41. Contractor's Responsibility for Compliance With Laws and Regulations Relating to Information Security.

A. The Contractor and all its employees, subcontractors, consultants, or agents performing the Services under this Agreement must comply with the following insofar as they apply to Contractor's processing or storage of Procuring Agency's data:

1. The Federal Information Security Management Act of 2002 (FISMA);
2. The Health Insurance Portability and Accountability Act of 1996 (HIPAA);
3. The Health Information Technology for Economic and Clinical Health Act (HITECH Act);
4. IRS Publication 1075 – Tax Information Security Guidelines for Federal, State and Local Agencies to include any Service Level Agreement requirements;

5. Electronic Information Exchange Security Requirements, Guidelines, And Procedures For State and Local Agencies Exchanging Electronic Information With The Social Security Administration; and

6. NMAC 1.12.20, *et seq.* “INFORMATION SECURITY OPERATION MANAGEMENT”.

42. Entire Agreement.

This Agreement incorporates all the agreements, covenants, and understandings between the parties hereto concerning the subject matter hereof, and all such covenants, agreements and understandings have been merged into this written Agreement. No prior agreement or understanding, verbal or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Agreement.

The remainder of this page intentionally left blank.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date of signature by the Human Services Department.

By: _____ Date: _____
HSD Cabinet Secretary

By: _____ Date: _____
HSD Office of General Counsel

By: _____ Date: _____
HSD Chief Financial Officer

By: _____ Date: _____
Contractor

The records of the Taxation and Revenue Department reflect that the Contractor is registered with the Taxation and Revenue Department of the State of New Mexico to pay gross receipts and compensating taxes.

BTIN ID Number:

By: _____ Date: _____
Taxation and Revenue Department

Exhibit A
Scope of Work

1. OVERHEAD SERVICES ARE NOT SEPARATELY REIMBURSABLE

1.1 PROGRAM ADMINISTRATION

I. Organizational Structure

A. This Professional Services Contract (PSC) establishes the Third-Party Assessor/Fee-For-Service Utilization Review (TPA/FFS UR) contract.

B. The Contractor shall ensure a fully staffed, professionally qualified organization that is capable of managing a complex UR program to meet the requirements as described in this Agreement. The Contractor, and its subcontractors, must be able to meet any and all administrative requirements related to appropriate state licensure, solvency, information systems and reporting, and compliance with all applicable federal and state laws and regulations.

C. The Contractor shall employ Medical Directors who are physicians currently licensed to practice medicine in the State of New Mexico and who will perform at least the following functions:

1. Develop and/or apply medical necessity review criteria;
2. Provide professional supervision of medical necessity review determinations;
3. Provide oversight of the quality of professional physician consultants;
4. Direct primary participation in specified reviews;
5. Consult with HSD staff, HSD Medical Director and/or HSD Contract Manager, as appropriate;
6. Consult with the Medical Directors of other State agencies involved in Medicaid services and program management; and
7. Participate in fair hearings when directed by HSD.

D. The Contractor shall employ and/or contract with physician consultants. A physician consultant is defined as a person with the same or equivalent professional degree as the professional provider that provided the justification for the medical necessity and/or the appropriateness of the setting, care, diagnosis, and coding. When the peer provider is a physician, the physician consultant may be the Contractor's Medical Director or any physician consultant, specialist or generalist, designated by the Contractor's Medical Director.

1. For Behavioral Health UR determinations, the reviewing physician must be a board eligible or certified psychiatrist **in New Mexico** with five years of experience and the clinical expertise to understand the treatments. The psychiatrist shall assist the Medical Director with the development of behavioral health criteria and utilization management (UM) functions as applicable.

E. The Contractor must employ a qualified individual to serve as the TPA/FFS UR Contract Manager for New Mexico operations. The TPA/FFS UR Contract Manager must be dedicated to oversee this Agreement, work in partnership with the HSD Contract Manager, and be authorized and empowered to represent the Contractor on all matters pertaining to the Contractor's program and specifically this Agreement. The TPA/FFS UR Contract Manager must act as a liaison with the State and other state agencies, and has responsibilities that include but are not limited to the following:

1. Ensuring the Contractor's compliance with the terms of this Agreement, including securing and coordinating resources necessary for such compliance;
2. Overseeing all activities by the Contractor and all subcontractors;
3. Receiving and responding to all inquiries and requests by the State in time frames and formats reasonably acceptable by the State;
4. Meeting with the HSD Contract Manager, representatives of HSD/MAD and other State Agencies on a periodic or as-needed basis and resolving issues that arise;
5. Making best efforts to promptly resolve any issues related to this Agreement identified by the State, or the Contractor; and,
6. Working cooperatively with other State of New Mexico contracting

partners, including but not limited to the Fiscal Management Agent, Conduent; Centennial Care Managed Care Organizations; and other contractors as, from time-to-time, identified by the State.

F. The Contractor shall inform HSD of any changes in the Contractor's key personnel within 30 days of hire. The term Key Personnel as used herein refers to the Contractor's TPA/FFS UR Contract Manager, supervisors and/or managers. Replacement of any Contractor key personnel shall be with personnel with comparable ability, experience, and qualifications. The resumes of any replacement shall be submitted to the HSD Contract Manager for approval.

G. HSD reserves the right to require the Contractor to make changes in key personnel assignments if the key personnel is/are not, in HSD's sole discretion, meeting the needs and expectations of HSD or the needs of the recipients in implementing and enforcing the terms of this Agreement. Specific reasons shall be detailed by the HSD Contract Manager.

H. The Contractor shall establish at least one office in either Santa Fe or Albuquerque, New Mexico to facilitate a close working relationship with HSD and other State agencies, the Fiscal Agent, providers, and Medicaid recipients.

1. At a minimum, the TPA/FFS Director and Contract Manager, key operational supervisory staff, primary reviewers, medical director, and clerical personnel shall reside in New Mexico;
2. The Contractor shall perform all reviews described in this Agreement and the customer service function at the New Mexico location(s).

II. General Issues

A. The Contractor shall perform utilization review (UR) and assessment functions for Medicaid services provided in the fee-for-service environment, including Medicaid Alternative Benefit Plan (ABP) services as defined in section 2.1 of this Agreement. These will consist of medical necessity reviews, Prior Authorizations (PA), medical eligibility/Level of Care (LOC) determinations, and Individual Service Plan (ISP)/Service and Support Plan (SSP) and budget reviews, and ABP exemptions. The principal goals of these functions are high quality, timely, cost-effective UR and assessment activities with emphasis on the most appropriate use of covered services and responsiveness to providers and recipients.

B. The Contractor shall perform and process reviews in the least obtrusive manner consistent with HSD's utilization management needs and the state of current technology.

C. The Contractor shall make use of available industry technologies to increase efficiencies and reduce errors in UM processes and activities. Such technologies may include electronic and web-based submissions, auto adjudications, and other such technology to allow for easier communication with providers.

D. The Contractor shall be flexible and committed to work in partnership with HSD on the successful implementation of all components of this Agreement. HSD intends to direct a flexible and responsive UR effort by periodically adjusting the focus of reviews toward areas of greatest benefit to providers and recipients and in the best interest of HSD.

In this regard, HSD reserves the right to make certain adjustments regarding reviews including but not limited to:

1. Change services from one Category of Review to another;
2. Change the timing of reviews (i.e. from prior authorization to post-payment);
3. Establish new categories of review or modify categories of review or drop existing ones;
4. Changes or additions to the Scope of Work and/or volume of reviews that may result from Centennial Care and other Medicaid health care reform initiatives including Medicaid Expansion; and
5. The Contractor will be given a mutually agreed-upon time to implement such changes.

E. The Contractor shall coordinate as necessary and/or per HSD direction with the New Mexico Department of Health (DOH), other HSD contractors, and stakeholders on the delivery of services to recipients and providers.

F. The Contractor shall coordinate as necessary with the Centennial Care Managed Care Organizations (MCOs) to ensure that recipient and provider questions regarding authorizations are appropriately directed to the HSD-contractor that is responsible for the service authorization.

G. The Contractor shall conduct UR activities that meet the highest quality standards, are efficient, timely, cost-effective, and ensure that services provided to Medicaid recipients are medically necessary and appropriate in amount, scope, and duration. The Contractor shall ensure that recipients' health care needs are not delayed due to the UR and/or assessment process.

H. Unless otherwise stated whereby the Contractor shall apply state defined criteria and standards, the Contractor shall base its UR decisions on HSD-approved nationally recognized and accepted criteria from professional organizations that integrate individual clinical expertise with the best available peer reviewed scientific literature, consistent with state and federal Medicaid policy, rules and regulations, and that are applied in a fair, impartial and consistent manner to serve the best interests of Medicaid recipients, incorporating individualized risks, benefits and preferences.

I. The Contractor shall apply UR criteria that consider the goals and values of the individual recipient insofar as practical, and on the basis of health information provided by the following persons:

1. The recipient (as appropriate to his or her age and communicative abilities);
2. The recipient's family/guardian or legal representative;
3. The recipient's primary care physician; and
4. Other providers, programs, multidisciplinary teams, educational institutions, or agencies that have evaluated the recipient.

J. The Contractor shall submit evidence that it has reviewed the quality, effectiveness and utility of the approved criteria at contractor specified intervals, approved by HSD, and that the criteria have been updated, as necessary.

K. The Contractor shall determine medical necessity in a manner that is no more restrictive than that used by HSD as indicated in state statutes and regulations. A covered service or item/good is medically necessary if it meets the criteria identified in the NMAC 8.302.1.7 at the following link:

<https://www.hsd.state.nm.us/providers/rules-nm-administrative-code/>

L. Medical necessity must be determined on an individual basis and must consider the functional capacity of the person and those capacities that are appropriate for persons of the same age or developmental level, available research findings, health care practice guidelines, and standards issued by professionally recognized organizations or

government agencies. The criteria for determination of medical appropriateness shall be clearly documented.

M. Medically necessary services must be delivered in a setting (e.g., an individual's home, school, child care center, workplace, treatment facility, inpatient setting, or community-based agency) that is appropriate to the specific health needs of the individual.

N. The Contractor shall be responsive to recipients and providers in all review activities. The Contractor must, at a minimum, do the following:

1. Maximize the use of technology and automated processing methods to receive and respond to UR and assessment requests by US mail, telephonic, fax, or other secure electronic means;
2. Apply consistent and standardized procedures across all business functions covered by the Agreement;
3. Make medical necessity criteria sets for use in review activities readily available to providers upon request;
4. Use the Request for Information (RFI) process to obtain additional or missing information needed to make a review decision from a provider or recipient, as appropriate, without adversely prolonging the recipient's receipt of medical care and/or Medicaid services. The Contractor shall clearly explain and specify what information is lacking and/or needed to complete the review request and make a valid review decision;
5. For re-certifications/re-determinations, ensure that there are no gaps in approval dates of coverage;
6. Provide clear and concise explanations of the reason(s) and regulatory citation(s) for any denial, reduction, modification and/or termination of care and fair hearing rights;
7. Proactively educate and train providers on UR processes and procedures; and
8. Track UR requests from date of receipt to date of completion, including details on pending reviews.

O. The Contractor shall perform and maintain the following Methods of Reviews and Determinations:

1. **Telephonic Review:** This method of review is conducted by telephone, possibly with the aid of electronic processing equipment. The provider will call the Contractor and transmit information needed to render a review decision. At a minimum, this review involves provider identifying information, recipient identifying information, diagnosis, recipient status, and any specific information required by the criteria being used for the specific Medicaid service being reviewed. The review decision is also rendered by telephonic or electronic communication. The request must be recorded and stored.
2. **Medical Record Abstract Review:** This method of review is conducted by paper or an electronic means and may be a prior authorization review, LOC determination, retroactive review, or other type of review. The Contractor shall review documents specific to the type of review and the Medicaid service being reviewed. The package of documents to be reviewed may include, but are not limited to the following: a specified state-approved form and specific parts or abstracts of medical records, such as a history and physical examination report, functional assessment, care plan, service plan, discharge summary, and/or additional supporting documentation. The review decision is also rendered by paper communication and/or electronic communication.
3. **Medical Record Review:** This method of review is the same as a Record Abstract Review except that the entire medical record or equivalent record is reviewed. This review is always retrospective and may include a prior authorization review performed retroactively, post-payment review, or other type of review.
4. **Service Plan/Budget Review:** This method of review is electronic. This review is required for home and community-based waiver service plans and budgets for compliance with waiver requirements and covered benefits. The review decision is also by electronic and/or paper communication.

P. The Contractor shall be able to perform at least the following Categories of Reviews described in HSD/MAD Program Policy 8.302.5 NMAC, or its successor:

1. **Prior Authorization:** This Category of Review is performed on cases prior

to the care being rendered or services provided in order to determine medical necessity for the specific service, LOC, and service setting, if relevant to the request.

2. **Retroactive Prior Authorization:** This Category of Review may be approved for review if performed as part of the process of determining Medicaid eligibility for certain categories, such as institutional care Medicaid or home and community-based services waiver (HCBSW) programs or the service is furnished before the determination of Medicaid eligibility or in cases of medical emergency.
3. **Concurrent:** This Category of Review is performed on cases for continued stay, continued service, or LOC reviews for medical necessity, such as acute/non-acute recipients who are hospitalized, residing in a long-term care setting, or receiving home and community-based waiver services. In behavioral health cases, examples include concurrent reviews performed for individuals in out-of-home placements or receiving continued community based services. These reviews include a determination of appropriate admissions and length of stay, annual plan/budget review, or redetermination of LOC.
4. **Prepayment:** This Category of Review is performed after services have been furnished and claims for payment have been filed by providers, such as Emergency Medical Services for Non-Citizens (EMSNC). If a service is not a covered Medicaid benefit, is not deemed medically necessary, or does not meet the benefit definition, HSD will deny payment for that service.
5. **Retrospective:** This Category of Review is performed on assigned cases after equipment is delivered, or care has been rendered and/or after discharge from a healthcare setting and after the claim has been processed and payment has been made. This type of review also involves reconsideration of a denial.
6. **ABP Exemption:** This Category of Review is performed on cases to evaluate and authorize an exemption from the ABP.

Q. The Contractor will be issued Letters of Direction (LODs) to communicate, update and clarify information concerning types of reviews, changes of review types, services to be reviewed, guidance on reviews and other activities and services covered in the Scope of Work (SOW). These adjustments may result in significant changes to

procedures or volumes of reviews. The CONTRACTOR must be receptive to these changes and continue to meet HSD's expected performance level as set forth in this PSC.

1. The Contractor shall have a maximum time of thirty (30) business days from date of receipt to implement a LOD from HSD, unless otherwise directed by HSD. This time frame may be decreased or extended based on mutual agreement between HSD and the Contractor.
2. Only work that is specified as separately reimbursable in a LOD will be reimbursed by HSD.

III. Administrative Functions

A. Prior to actual date of review operations, the Contractor shall develop and submit to HSD its written detailed TPA/FFS UR Policies and Standard Operating Procedures, workflows, and checklists developed for provider use for all functions described in this Agreement, including but not limited to: reviews by program or review type, fair hearings, RFI, reporting, grievances, quality assurance, reconsiderations, and fraud and abuse. The Procedures must be consistent with the policies in the HSD/MAD Program Policy Manual, or its successor, and updated annually thereafter to ensure that documents are maintained and up to date.

B. The Contractor shall have HSD-approved written policies and procedures for transitioning recipient authorizations and related medical documents, including electronically stored information, to and from the Centennial Care MCOs.

C. Due to HSD-directed policy changes and other changes in the external environment, the Contractor should anticipate frequent changes in procedures.

D. The Contractor shall provide to HSD for review and approval, written Policies and Standard Operating Procedures, quick start guides, workflows, and checklists developed for provider use as they are created and updated.

E. The Contractor may initiate a change at any time, but changes to Procedures as outlined in this Agreement must be submitted to the HSD for review and approval prior to implementation. HSD retains the right to request copies of the Contractor's TPA/FFS UR Policies and Standard Operating Procedures to review and make unilateral changes.

F. The Contractor shall respond to HSD-requested changes by forwarding revised detailed Policies and Standard Operating Procedures for review to HSD within fifteen (15) business days from the date of the written request, or as stipulated in the HSD

request.

G. The Contractor shall ensure:

1. The current version of the policy and/or procedure in effect is followed;
2. Each procedure is assigned a number and dated with the effective date, or revision date, of the procedure;
3. Internal oversight processes to ensure policies and procedures are kept accurate and up-to-date, and otherwise maintained; and
4. Periodic assessment of the quality, effectiveness and utility of the HSD-approved procedures for potential modification.

H. The Contractor shall ensure all procedures for processing reviews by program or review type:

1. Specify each step in each review process including, but not limited to, exactly how the review is received, tracked, assigned and processed; what criteria is applied; what forms and other documentation are required; how the decision is communicated to the requesting provider, HSD fiscal agent, state agency, state program, consultant, case manager, MCO, and/or other relevant entities; how the decision is communicated to the recipient; required turn-around-time; required data entry; and steps for quality assurance;
2. Are consistent with the policies in the HSD/MAD Program Rules, HCBS waivers Service Standards and other utilization review guidance that HSD has made available to the Contractor and providers. The guidance may be in the form of a combination of several documents and a series of meetings and/or discussions; and,
3. Ensure the detailed Policies and Standard Operating Procedures follow a standardized format across all review types.

IV. Meetings

A. The Contractor shall function as a partner with HSD. Examples of this partnership includes attending, facilitating and actively participating in meetings with HSD

and DOH staff and offering input on a variety of TPA/FFS UR topics to HSD staff and stakeholders, as well as communicating with stakeholders to resolve issues. Some meetings will be regularly scheduled on a monthly, bi-monthly or quarterly basis.

B. The Contractor shall attend regularly scheduled contract management and compliance meetings in a mutually agreed upon location. At a minimum, the Contractor's TPA/FFS UR Contract Manager will attend these meetings.

C. The Contractor shall, upon HSD request, participate in ad hoc meetings at the Contractor's location or in Santa Fe with HSD and associated state agencies, the fiscal agent, providers and MCOs, and other stakeholders involved with TPA/FFS UR activities.

D. The Contractor shall, upon HSD request, facilitate or otherwise lead work groups or meetings with HSD, associated state agencies, the fiscal agent, providers, consultants, and other stakeholders involved with TPA/FFS UR activities.

V. Hearings

A. The Contractor shall provide testimony for HSD administrative hearings and/or court proceedings concerning protests of actions taken as a result of CONTRACTOR TPA/FFS UR decisions. The Contractor shall be prepared to testify either by telephone or in person.

B. The Contractor's legal counsel shall be required to represent the Contractor at any administrative hearing only if the recipient is represented by his or her legal counsel. The Contractor's legal counsel is expected to coordinate closely with its TPA/FFS UR Contract Manager, Fair Hearing Unit, the HSD Contract Manger, and HSD Office of General Counsel, when required, regarding the case. Administrative hearings are not covered as Separately Reimbursable Services.

C. The Contractor is required to prepare documentation, to include, but not limited to Summary of Evidence (SOE), SOE Addendums, and Motions to Dismiss. SOE's must be submitted to the Fair Hearing Unit fifteen (15) calendar days prior to the hearing to allow the Fair Hearing Unit to prepare the final SOE and mail the hearing documents to all interested parties. All SOE's need to clearly illustrate the review timeline and actions that lead to the denial. The document must be organized and clearly labeled.

D. It is the Contractor's responsibility to schedule and facilitate an Agency Review Conference (ARC) for all Fair Hearing requests. An ARC allows an opportunity to clarify issues, discuss the reason behind the requests and denials, and examine additional

information related to the fair hearing requests. The ARC must be conducted via video conference and include all concerned parties, such as the Consultant, Community Support Coordinator, HSD and DOH Program Mangers and claimant.

Within two (2) business days following the ARC, the TPA will send written notification to all concerned parties with the result of the ARC.

VI. Regulatory Standards

A. The Contractor shall conduct reviews/assessments according to federal and state regulations and HSD-approved UR criteria while following HSD-approved detailed standard operating procedures. The pertinent State Medicaid regulations are consolidated as the State of New Mexico Medical Assistance Division Program Rules, commonly referred to as the “Program Policy”. Federal requirements for a statewide utilization control program for Medicaid services are found at 42 CFR, Part 456.

B. The Contractor shall be a designated QIO (Quality Improvement Organization) as described in 42 CFR Parts 475 and 476. The Contractor shall provide documentation of this designation prior to the actual date of review operations and continue to maintain this designation during the term of this PSC.

C. The Contractor shall identify to HSD the level of professionals for all review activities. The number and types of staff performing the reviews must be identified.

D. For behavioral health, reviewers shall be Masters level clinicians with a minimum of five years’ experience in mental health and/or substance abuse.

E. The Contractor shall maintain oversight policies and procedures of all functions that ensure standards of performance are met and all state and federal regulations are followed.

F. The Contractor shall require a physician, or a dentist for dental services, to render the final decision for all reviews that result in a denial or reduction of services to a recipient based on medical necessity, the definition of an emergency, the appropriateness of diagnosis, or the appropriateness of procedure code.

G. The Contractor shall require physician consultants to render the final decision for validating breaches of professional quality or practice standards.

H. The Contractor shall ensure that the physician consultant documents his/her

review decision and that the Contractor can identify the physician consultant from that documentation.

I. The Contractor shall ensure the physician consultant documents the clinical rationale for all physician consultant determined denials and for the authorization decisions made by the physician consultant in cases when one or more of the approved criteria are not met.

J. The Contractor shall protect (by first and last name initials) the anonymity of all reviewers, including the physician consultant, with certain conditions and exceptions. The identity of all reviewers must be known to the Contractor for every review and must be made known to HSD upon request.

K. The Contractor shall release, as required by HSD or a court of competent jurisdiction, the identity of the reviewer and/or physician consultant in cases of protested review decisions that proceed through due process to an administrative Fair Hearing and/or judicial proceeding. In these cases, actual testimony from the reviewer and/or physician consultant may also be required.

L. The Contractor shall operate a two or more level review process whereby a professional who is not a peer of the requesting provider performs the initial review. In this case, the first level nurse reviewer must have sufficient education, credentials and experience to properly interpret the clinical review information and the criteria upon which authorization/denial is based. In this instance, the first level reviewer can only approve, not deny or technically deny, the request. All denial and technical denial decisions must be made by a physician, or a dentist for dental services, who is responsible for justifying the medical necessity.

VII. Review Timelines

A. The Contractor shall make review decisions in a timely manner to accommodate the clinical urgency of the recipient's situation and minimize disruption in the provision and continuity of health care services.

B. Auto-Adjudication must be used to make a near-real-time determination to approve, deny or pend a request for prior authorizations where possible.

C. The Contractor's turn-around-time (TAT) for a review decision is measured from the date the Contractor receives all materials necessary to conduct a review to the date the review process is completed in its entirety (eg. MMIS entry) and

notice of the review decision is available via the Contractor’s provider portal and correspondence is mailed.

D. For requests that are not auto-adjudicated to approve or deny, the Contractor shall assign the review request to a reviewer (or assessor for the in-home) within two (2) business days from the date of receipt, or as appropriate to meet the required TAT. The number of days to assign the review is included within the TAT calculation. The Contractor shall maintain and update a tracking system so that Portal Users can track their request in the authorization process.

E. HSD shall allow TAT exceptions for events that are beyond the Contractor’s control. These exceptions may include, but are not limited to: state-directed initiatives requiring mass revisions to authorizations; reviews pended due to a Request for Information (RFI); facility closures with associated mass transfers; the State’s information system(s) is/are down; and HSD-approved special projects.

F. The Contractor shall consider the TAT as a maximum time limit and therefore strive to complete reviews in a shorter timeframe if possible while maintaining the integrity of the review outcome. The Contractor shall complete reviews within the following maximum timeframes (business days):

Type of Review	TAT
Prior approval requests allowed by HSD to be submitted via telephone request	2 business days
Prior approval requests submitted in writing	7 business days – Routine 1 business day - Expedited
ISP/budget and SSP/budget requests	7 business days – Routine 1 business day - Expedited
EMNC requests submitted in writing	7 business days – Routine 1 business day - Expedited
Reconsideration of TPA/FFS UR Decision	7 business days
LOC Without in-home assessment	7 business days - Routine 1 business day – Expedited

LOC With in-home assessment In-home assessment	7 business days – Routine 1 business day – Expedited 30 days (including IHA and review determination)
Acute General Hospital Inpatient Retrospective Post-Payment review	45 business days of receipt of review request from HSD

Behavioral Health Inpatient/Acute Reviews				
Review Type	TAT from Receipt of Request to Decision	TAT from Decision to Notification	Notification Method	Who Must Be Notified?
Initial	72 hours	Within the same 72 hours that decision was made	Verbal, electronic or written	Facility
Concurrent	1 business day	1 business day	Verbal, electronic or written	Facility

Behavioral Health Residential Treatment Centers/Treatment Foster Care/Group Home/Substance Use Disorders				
Review Type	TAT from Receipt of Request to Decision	TAT from Decision to Notification	Notification Method	Who Must Be Notified?
Initial	5 business days	1 business day	Verbal, electronic or written	Facility
Concurrent	5 business days	1 business day	Verbal, electronic or written	Facility

Note on Children, Youth and Families Department Juvenile Justice System recipients in detention: For recipients in detention, and for whom an RTC authorization request has been submitted, determination TAT is one (1) business day. In some cases, additional information may be requested or a peer review to the requesting provider conducted.

“Expedited” is applied to those services, supplies, and/or equipment of which would reasonably be expected to result in a deterioration of the recipient’s health or a delay in appropriate transition to alternative placement (including discharge to home or community setting).

G. The Contractor shall issue a RFI to notify the provider when a review request is incomplete or lacking necessary documentation that is needed to complete the review and render an appropriate review decision. The Contractor shall begin the RFI process by notifying the provider (and/or recipient as applicable to the review type) within two (2) days of assignment to a reviewer. The provider shall be notified at least three (3) times to request the additional information. The Contractor shall send a written RFI to the provider (and/or recipient) instructing the provider/recipient to respond to the RFI with all necessary documentation within 7 calendar days of issuance of the written RFIs. The RFI shall also inform the provider/recipient that failure to return the RFI with all necessary documentation within 21 calendar days may result in a technical denial of the review request.

H. The Contractor shall determine, track, and report the timeliness of every review and assessment, including incomplete reviews and RFIs, and implement the infrastructure, systems, and procedural measures necessary to insure the integrity of this tracking system to the satisfaction of HSD.

VIII. Recipient and Provider Notices

A. The Contractor shall use HSD-approved letter templates to notify recipients, providers, state program managers, case managers, consultants or community support coordinators, as applicable to the program type, within two (2) days of the review decision, or as otherwise defined in this Agreement. Time taken for notification is included within the TAT calculation for review decisions.

B. The Contractor shall have a process to track all letter templates and revisions. This includes receiving, storing and maintaining letter templates that can be produced and provided to the HSD upon request.

C. In addition to the recipient letter, the Contractor shall notify the provider of the review decision by returning a completed copy of the HSD-approved review request form initially submitted by the provider. For example, review request forms include, but are not limited to (as applicable to the review and/or program type): New Mexico Uniform Prior Authorization Form, MAD 378, MAD 379, DOH 378; MAD 046, DDW budget worksheet for Individual Service Plans; and, MAD 331 for inpatient rehabilitation. Detailed forms and information shall be provided by HSD.

D. For the Home and Community-Based Services (HCBS) waivers, the Contractor shall provide notification to the eligible recipient, consultant, case manager or community support coordinator, as applicable to the waiver program, of the annual LOC at least 90 days before the LOC expires. If there is no response from the eligible recipient, the Contractor shall also send a final reminder notice to the eligible recipient 45 calendar days before the LOC expires.

IX. Performance Tracking - Reports

A. The Contractor shall comply with all reporting requirements established by HSD.

B. The Contractor shall adhere to HSD defined standards and templates for all reports and reporting requirements. HSD shall provide the Contractor with all appropriate reporting templates, formats, instructions, submission timetables, and technical assistance as required. HSD may, at its discretion, change the content, format or frequency of reports.

C. The Contractor shall submit reports timely and in proper format. The submission of late, inaccurate or otherwise incomplete reports constitutes failure to report.

D. Unless otherwise defined by HSD, each report must include an analysis and attestation, which shall include at a minimum: certification, as to the accuracy, completeness and truthfulness of the data in the report; identification of any changes compared to previous reporting periods as well as trending over time; an explanation of said changes; an action plan or performance improvement activities addressing any negative changes; and any other additional information pertinent to the reporting period.

E. The Contractor shall review, as part of its continuous improvement activities, timeliness and accuracy of reports submitted to HSD to identify instances and patterns of non-compliance. The Contractor shall perform an analysis identifying any patterns or issues of non-compliance and shall implement quality improvement activities to improve overall performance and compliance.

F. HSD may, at its discretion, require the Contractor to submit additional reports, both ad hoc and recurring.

G. The Contractor shall submit all reports to HSD, unless indicated otherwise in this PSC, according to the schedule below.

DELIVERABLE	DUE DATE
Weekly Report	Tuesday of the following week
Monthly Report	15 th Calendar Day of the following month
Quarterly Report	30 th Calendar Day of the following month
Semi-Annual Report	January 31 and July 31 of the Calendar year
Annual Report	90 Calendar Days after the end of the Calendar year
Ad-Hoc Report	Within 10 business days from the date of the request unless otherwise specified by HSD

H. If a report due date falls on a weekend or a State of New Mexico holiday, receipt of the report the next business day is acceptable.

I. The Contractor shall submit all reports electronically to HSD's FTP site unless directed otherwise by HSD. The email generated by the FTP upload will be used as the time stamp for the submission of the report(s).

J. The Contractor shall submit the list of reports indicated in Exhibit C.

K. HSD shall notify the Contractor in the event that a report is no longer required.

L. HSD's requirements regarding reports, report content, and frequency of submission are subject to change at any time during the term of this Agreement. The Contractor shall comply with all changes specified in writing by HSD, after HSD has discussed such changes with the Contractor. HSD shall notify the Contractor, in writing, of changes to existing required report content, format or schedule at least fourteen (14) Calendar Days prior to implementing the reporting change. When possible, HSD shall

notify the Contractor, in writing, of new reports at least forty-five (45) Calendar Days prior to implementing the new report.

X. Transition Management

A. The Contractor shall enter into a Transition Management Agreement with the prospective contractor, no later than 120 days prior to the last date of this Agreement to outline the requirements for the transition of information and services to the Contractor. The Contractor shall work with the prospective contractor to transition data such as, but not limited to, report requirements and interface configurations, client/provider documents, standard operating procedures, state approved letter templates and other pertinent documents identified by the Contractor or HSD to ensure a smooth transition of the services set forth in the scope of work.

B. The Contractor shall enter into a Transition Management Agreement with HSD 180 days prior to the end of this agreement to outline requirements for the transition of information and services to the prospective contractor.

C. The Contractor shall enter into a Business Associates Agreement with the prospective contractor for the exchange of data to include at a minimum, IT security protections for protected health information.

D. The Contractor shall attend meetings with HSD and the prospective contractor to ensure a smooth and non-disruptive transition of services.

E. The Contractor must have system capacity and interface capability in addition to the capability to upload Level of Care (LOC) daily to the Automated System Program and Eligibility Network (ASPEN) system.

1.2 SERVICES

I. Customer Service

A. The Contractor shall have customer services staff to receive, respond to, or refer requests from providers and recipients for information concerning the TPA utilization review policy, status of particular reviews, complaints, appeals and due process, and other customer-related inquiries. These activities and any others will be performed in a friendly, courteous, timely manner.

B. The Contractor shall have the customer service function to accommodate

both telephonic and electronic inquires and responses. The amount of demand for this service and the service issues may vary greatly from time to time due to changes in the review criteria, policy, and/or procedures and other Medicaid program changes. The Contractor shall anticipate and meet customer service demands to the satisfaction of HSD.

C. The Contractor shall establish a TPA/FFS UR website, approved by HSD, for information needed by providers and/or recipients that explains the scope of contracted services and review types, and provides contact information, provider forms, required TPA/FFS UR documents, provider trainings, and other information relevant to the scope of work. The Contractor shall monitor the website and update information as needed or determined by HSD. Website modifications requested by HSD shall be completed within 48 hours of the request.

E. The Contractor shall maintain a sufficient number of dedicated toll-free telephonic and fax lines for the use of providers and other callers during normal business hours. If the number of telephonic lines become insufficient to provide effective telephonic review access and customer service, the Contractor will install and maintain additional lines as needed or as directed by HSD. Telephonic response time standards shall be proposed by the Contractor.

F. The Contractor shall implement a call monitoring system to support quality assurance monitoring and training. The system shall also support a hundred percent (100%) call recording. The Contractor shall provide HSD with full access to call recordings for review of escalated calls.

G. The Contractor shall provide certain TPA/FFS UR forms related to utilization review either electronically or hard copy upon request. HSD will send the Contractor all required forms related to this PSC. The required forms shall also be accessible on the Contractor's TPA/FFS UR website.

H. The Contractor shall implement and submit to HSD the step-by-step customer service process and procedures. The Contractor shall monitor the process and quality of service, and report to HSD on a monthly basis, the number of calls received by review type by provider or recipient, the average speeds of answer and abandonment rates.

I. The Contractor shall maintain an average speed of answer of 30 seconds or less for telephone inquiries.

J. The Contractor shall provide guidance to providers to assist in submission of complete review packets, minimizing disruption to the review process.

K. The Contractor shall have the ability to trace and report the status of submitted review requests from receipt date and review start to finish. The Contractor shall provide the status of any review that has been date stamped “received” to a valid requester within one (1) business day. The Contractor shall ensure that the TPA/FFS UR review database is completely supported and consistent with the review documentation required.

L. The Contractor shall work proactively with providers, appropriate state agency staff, MCOs, case managers, consultants, community support coordinators and other stakeholders.

M. The Contractor shall ensure a sufficient number of trained TPA/FFS UR staff in order to maintain proposed standard response time in the event of a sudden increase in customer service requests.

N. The Contractor shall be equipped to handle calls and provide translation services for callers with Limited English Proficiency as well as calls from recipients who are Hearing Impaired.

O. The Contractor shall have access to bilingual staff based on the threshold of a prevalent non-English language. The prevalent language includes all languages spoken by approximately five percent (5%) or more of the population.

P. The Contractor shall have a method in place by which providers or recipients can deliver paper review packets directly to the New Mexico location.

II. Provider Relations, Education, and Training

A. The Contractor shall work proactively with providers and stakeholders to ensure a clear understanding of the UR, LOC, and assessment process. The Contractor shall be available to interact with HSD staff, providers and stakeholders as necessary for presentations and trainings.

B. The Contractor shall, upon request, mail/fax/email to providers all pertinent forms. The cost of this service will be borne by the Contractor.

C. The Contractor shall arrange and bear the cost of the shipping, transporting, or transmitting of any materials required unless otherwise specified by this Agreement.

D. The Contractor shall train providers regarding TPA/FFS UR, LOC, and assessment policy, procedures, and criteria as needed. The need for such training will be

determined by the Contractor's experience working with providers, upon the request of a provider or provider group or association, or as determined by HSD.

E. The trainings may be delivered through electronic means, using Internet technology or other alternatives as agreed upon by HSD and the Contractor. HSD and the Contractor will work in conjunction to identify the need for training sessions and schedules.

F. The Contractor shall provide HSD copies of all training and other material prior to dissemination to providers for HSD approval.

G. The Contractor shall identify providers who routinely have reviews returned and proactively initiate direct provider contact, training and education to help in reducing problematic review packets.

III. (3) Criteria Development, Revision, and Use

A. Unless otherwise directed by HSD, the Contractor shall apply criteria approved by HSD to all reviews based on medical necessity. Request for any service that does not have established criteria will be reviewed by a physician/dental consultant of the same or similar credentialing/specialty to treat the condition in question. The physician/dental consultant may approve or deny as "not a medically necessary service."

B. The Contractor shall share non-proprietary medical necessity criteria with the providers. The criteria set must be academically defensible; based on national standards of practice when such are available; acceptable to the Contractor's medical director, physician/dental consultants, and relevant local providers; and must meet utilization needs as determined by HSD.

C. Unless the documentation clearly indicates that a denial is an appropriate review decision, the Contractor will defer authorization/denial action until the appropriate information is received.

D. The Contractor shall, whenever possible, establish criteria for the Medicaid definition of "medically necessary services" that is evidence-based and consistent with existing criteria sets under the Centennial Care.

E. The Contractor shall ensure that each page of the written criteria is dated with the effective date of HSD authorization.

F. The Contractor shall offer consultation and advice to HSD on initiatives

outside of the scope of work presented in this Agreement, the cost of which will be negotiated between the parties.

G. The Contractor shall utilize quality criteria that are medically defensible when challenged by medical professionals in a court of law.

H. The Contractor shall be proactive in making recommendations to HSD regarding outdated criteria or cost savings approaches to better utilize contract funds, including, but not limited to, reducing procedure/treatment modalities requiring prior authorization if cost effective.

IV. Special Access and Research

A. The Contractor shall allow special access to recipient records by recipients themselves, providers, advocates, legal counsel, HSD, DOH, and/or the Attorney General's office. Only relevant HSD employees, the Attorney General's office and recipients themselves are allowed to access information without an explicit release of information form, signed by the recipient or legal guardian. Anyone presenting an authorized release of information form to the Contractor must have a picture identification verifying their identity and, if applicable, documentation verifying they are with the organization identified on the release form.

B. The Contractor shall be expected to provide authorized requestors with access to the requested forms or files at a private location onsite for the form/file review within five (5) business days of receipt of request.

C. The Contractor shall be prepared to make one copy of the file or requested documents upon request. The Contractor is encouraged to provide the copies at the time of visit, but if circumstances (such as the volume of the paper in the file) make this impossible, the copies must be made available to the requestor within three (3) business days from the day of the request.

D. The Contractor shall be expected to comply with requests made by HSD or the Attorney General's office for reports or specific information on recipients for research on suspected fraud cases. The request for these services will be routed through the HSD TPA/FFS UR Contract Manager, who will forward the request to the Contractor. The Contractor will propose a timeframe for project completion and provide the requestor with necessary information within that timeframe.

V. Future Services at Negotiated Rate

A. The Contractor shall negotiate with HSD for the specific work requirements and the reimbursement for future services not specified in this PSC. These requested services may be in response to Congressional, Legislative or HSD actions.

B. The Contractor shall perform services as necessary not otherwise specified in this Agreement, including special projects, as directed by specific Letters of Direction from HSD which may include negotiated reimbursement to the Contractor where applicable.

1.3 PROVIDER AND RECIPIENT RIGHTS AND PROTECTIONS

The Contractor shall be responsible for carrying out activities related to due process and administrative hearings. This includes preparing and sending notice of adverse action decisions and due process rights, including continuation of benefits, to recipients, processing provider reconsideration reviews; collaborating with HSD and/or DOH on agency conferences, preparing and submitting complete summaries of evidence; processing continuation of benefits requests; and designating staff to participate in fair hearing proceedings.

I. Due Process – Denials and Reconsiderations

A. Clinical Denial: A clinical denial occurs when the TPA/FFS UR request does not meet evidence-based principals for medical necessity criteria, LOC criteria, and/or Medicaid Program policy.

B. Technical Denial: A technical/administrative denial is defined as a TPA/FFS UR request that is denied for non-clinical reasons. Technical/Administrative denials may result, but are not limited to, when the provider or recipient fails to respond to a Contractor-initiated RFI with the appropriate information in a timely manner, fails to renew the recipient’s annual LOC, or is non-compliant with an in-home assessment.

1. If the information needed to complete the RFI is not provided to the Contractor within 21 calendar days of issuance of the request, the Contractor may notify the provider or recipient of a technical/administrative denial (8.350.2 NMAC, Reconsideration of Utilization Review Decisions).

C. Reconsideration: A provider or recipient, as applicable to the program type,

who is dissatisfied with a medical necessity or LOC decision made by the Contractor may request reconsideration. The Contractor shall perform a reconsideration review in accordance with 8.350.2 NMAC, Reconsideration of Utilization Review Decisions, including performing and furnishing the reconsideration decision within 7 business days.

II. Due Process – Required Notification

A. The Contractor shall prepare and send communication of review decisions that include a denial (includes both clinical and technical/administrative denials), termination, suspension, modification or reduction of services (includes initial and reconsideration decisions) to both the provider and recipient in accordance with requirements in 42 CFR 431.210, Fair Hearings for Applicants and Recipients and NMAC 8.352.2 Administrative Hearings, Claimant Hearings, unless otherwise directed by HSD.

1. For Level of Care reviews that result in a denial, the Contractor must ensure a successful interface with the ASPEN system to inform the Income Support Division (ISD) of the denial.

B. The Contractor shall use HSD-approved letter templates. The notification must include specific policy references directly related to the decision, reason(s) for the denial specific to the individual recipient's case and specific reference to recipient due process rights.

1. In cases of service categories such as, but not limited to: Durable Medical Equipment (DME) and Service and Support Plan (SSP)/budget, the specific item or service for which the denial has taken place must be mentioned in the body of the letter. For example, in DME, "diapers", "nutritional supplements" or "hearing aids" must be specified. Simply citing a denial for "Durable Medical Equipment" in the letter is not sufficient. For example, Living Supports for Mi Via must specify "Homemaker", "Home Health Aide Services", "Assisted Living", etc.

C. The Contractor shall have a quality assurance system in place to ensure the accuracy, quality and consistency of recipient and provider letters. Letters should be formatted appropriately and margins should be set so that language does not interrupt with current business and/or program logos.

III. Due Process – Fair Hearings

A. The Contractor will receive an "Acknowledgement of Hearing Request" from the Fair Hearings Bureau or the MAD Fair Hearing Unit (FHU). The Contractor shall

initiate an Agency Review Conference (ARC) with the claimant and appropriate staff, which may include, but is not limited to MAD program managers and Department of Health (DOH) program staff. The Contractor shall also process a Continuation of Benefits (COB) if an individual requests that the benefit that is the subject of an adverse action continue while his or her HSD administrative hearing proceeds. A request for a continuation of the benefit shall be afforded to any claimant who requests the continuation within 10 calendar days of the mailing of the notice of action by MAD or the Contractor. The continuation of a benefit is only available to an individual that is currently receiving the appealed benefit and will be the same as the individual's current allocation, budget or LOC. The Contractor must provide information in its notice of action of an individual's rights and limitations to continue a benefit during his or her HSD administrative hearing process and of the responsibility to repay MAD for the continued benefit if the HSD administrative hearing final decision is against the individual, as cited in NMAC 8.352.2.12

B. COB notification timelines are defined and determined by Specific waiver/program/service regulations.

C. Within two (2) business days following the ARC, the Contractor shall send written notification to HSD of its decision or recommendation via secure email. HSD will reply with the approval or denial of the Contractor's decision or recommendation. Once HSD's provides a response, the Contractor shall issue written notification to the claimant with the final outcome of the ARC.

D. In instances where a denial is overturned after an ARC is conducted, the Contractor is responsible to submitting a Motion to Dismiss to the Fair Hearings Bureau within two (2) business days after the overturned decision.

E. If the issue is not resolved after the ARC has been conducted, the Contractor shall prepare and deliver a Summary of Evidence (SOE) to the HSD or DOH, as determined by program that is the subject of the hearing, at least fifteen (15) business days, when possible, prior to the fair hearing in order to comply with and adhere to NMAC 8.352.2.14. The SOE shall give detailed, clinically or technically defensible reasons for the action taken based on the documentation provided for the review. All documentation used in making the review decision must be submitted as part of the SOE, and shall, at a minimum as cited in NMAC 8.352.2.14, contain:

1. the claimant's name, and as applicable, his or her authorized representative's or legal counsel's telephone number and address, and the status of any previous or concurrent appeal through the Contractor;
2. the adverse action against the claimant;
3. the documentation supporting the Contractor basis for the intended

or taken adverse action; and

4. any applicable federal or state statutes, regulations, rules or any combination of these; however, a failure by the Contractor to submit an applicable statute, regulation or rule shall not constitute per se grounds for the Administrative Law Judge to find that MAD, or the Contractor failed to meet its burden of proof.

F. The Contractor shall :

1. provide upon request to the claimant or his or her authorized representative, any document in its possession concerning its adverse action against the claimant that is not already in its SOE; and

2. provide the claimant or the claimant's authorized representative the requested documents; such documents will be provided by MAD, or Contractor to the claimant or the claimant's authorized representative in a timely manner and without charge.

G. The Contractor shall be represented by a qualified physician, nurse reviewer, dental consultant, or behavioral health clinician that has detailed knowledge of the case to offer testimony at the fair hearing via telephone; in rare circumstances, the individual may be required to provide the testimony in person. The individual must be qualified and disposed to give both prepared and spontaneous statements and answer questions related to the medical and policy justification for medical necessity determinations made by the Contractor. HSD permits physician/dental consultant anonymity at administrative and judicial hearings to the extent permissible by law. Although not all requests for fair hearings require a formal hearing, the majority do.

H. The Contractor must provide legal counsel for cases in which the recipient has legal counsel.

I. The Contractor shall have the following information available for persons authorized by HSD to have access: Date that Contractor received the SOE request form, name and qualifications of the Contractor's representative scheduled to attend the hearing, and notice of the date that the SOE was mailed.

1.4 DATA SUPPORT SYSTEMS AND MANAGEMENT

I. General Information

The Contractor shall implement and maintain their web-based care management system

for this Agreement. This Management Information System (MIS) must be sufficient to meet system requirements and allow for future configurations, additions, and/or modifications that may be required for the State of NM Medicaid program. The system must also be configured to use New Mexico program terminology and abbreviations.

A. The Contractor must have effective operational interfaces for the transmission or exchange of HSD-defined TPA/FFS UR data to HSD, or its designee. The Contractor shall have the capacity to interface with the HSD Medicaid Management Information System (MMIS), the Automated System Program and Eligibility Network (ASPEN) system, and their successors. The Medicaid Fiscal Agent maintains the MMIS/Omnicaid and Palco systems. The ASPEN system is maintained by HSD.

1. The Contractor shall use the 114 ASPEN error report to ensure the electronic exchange is operational and shall correct any errors that occur during the exchange timely.

B. HSD-defined TPA/FFS UR data includes but is not limited to, at a minimum and according to review and file type: the recipient's name; recipient Medicaid number (in some cases two numbers); ASPEN MCI (Master Client Index); date of birth; Medicaid provider number; service type and dates of services; procedure codes and/or descriptor, if applicable; units of service; unique authorization or authorization control number; level of care, if applicable; and, service plan and budgets, if applicable. The exact data requirements vary with the specific service and review type.

C. The Contractor shall transmit to HSD the following TPA/FFS UR data by method of transmission on a daily basis:

Transmission Method	Review/Program Type
Submit Electronic File to HSD MMIS	FFS prior authorizations, LTC Spans for ICF-IID, Nursing Facilities, and some BH LTC spans
Exchange Electronic Interface File to HSD/ASPEN	Waiver LOC, PACE LOC, ICF-IID, Nursing Facilities
Direct data entry into MMIS/Omnicaid system, Palco	Support Waiver Agency Based budgets, Developmental Disabilities Waiver budgets, ABA, EMSNC, some BH reviews. Mi Via, MVMF and SW PD

1. The Contractor shall submit to HSD daily electronic interface files containing prior authorization data.
2. HSD shall provide VDI tokens to the Contractor to access the web-based VDI server and user IDs and passwords for designated Contractor staff involved in the daily direct entry of prior authorization data into the MMIS/Omnicaid system for all required reviews.
3. The Contractor shall access the Palco system for daily direct entry of Mi Via and Supports Waiver (Participant-Directed) plans and budget authorizations.

D. The VDI server access requires that the Contractor use Personal Computers which meet minimum specifications of Pentium 3 with 256mg RAM and 200 mg free disc space and provide internet access with minimum DSL or T1 lines (modem access will not provide acceptable access).

E. The Contractor shall assign specific TPA/FFS UR staff to have access to MMIS/Omnicaid system via a VDI token for direct data entry. The Contractor shall ensure that the MMIS/Omnicaid system is only accessed and used for TPA/FFS UR business operations.

F. The Contractor shall ensure that TPA/FFS UR staff who have access to the MMIS/Omnicaid and Palco systems have received training on the MMIS/Omnicaid and Palco systems and the prior authorization system inquiry and update capabilities and LOC prior to performing data entry procedures. HSD, or its designee, may provide periodic training but is not responsible for training new staff as they are hired. The Contractor shall have an MMIS/Omnicaid and Palco training plan for new and current staff.

G. The Contractor shall be able to receive, store, and use a daily MMIS/Omnicaid system file from HSD containing recipient demographic and eligibility data. The Contractor shall be able to set daily reminders to trigger when eligibility has been updated for a recipient in the Contractor's system after processing the daily MMIS/Omnicaid system file from HSD.

H. The Contractor shall be able to receive, store, and use a daily MMIS/Omnicaid system file from HSD containing provider demographic and enrollment data.

- I. The Contractor shall collect, maintain, and store or access review

documentation for a total of ten (10) years unless transfer is specifically directed by HSD or by the terms of the Contract. The documentation maintained must be sufficient to allow an uninvolved reader to be able to understand and reconstruct all aspects of any review.

J. The Contractor shall be capable of producing, within one (1) business day of the request, all documentation for any specific review conducted by the Contractor.

K. The Contractor shall be capable of producing and reading electronic files from HSD's personal computer (PC) application software for word processing, electronic spreadsheet, and data base management.

L. The Contractor shall cooperate with HSD, providers and the Medicaid Fiscal Agent in performing reconciliations of changes in Medicaid Provider numbers, sometimes requiring batch and individual changes in the prior authorization historical databases of both the Contractor and MMIS/Omnicaid system.

M. The Contractor shall have a one hundred percent (100%) dedicated IT and technical support team available to assist with major system malfunctions and HSD system requests.

N. The Contractor shall allow HSD read-only access to the Contractor's utilization review system for the ability to view recipient and provider records, documentation and activity or status of a review, and shall allow DOH read-only access to the Contractor's utilization review system for the ability to view recipient and provider records, documentation and activity or status of a review for Medicaid programs.

O. The Contractor must accept and store, as specified by HSD, for reference the historical databases from the current TPA/UR contractor.

P. The Contractor must upload all relevant MAD forms and letters into their system. The Contractor should allow Providers to electronically complete MAD forms. Once the form is completed, the Contractor's system must populate the Providers responses onto the MAD form and store the submission in the Contractor's system for potential audits.

Q. The Contractor's system must immediately notify Providers if an authorization is not required.

II. Contractor's Responsibility for Compliance with Laws and Regulations Relating to Information Security

A. The Contractor, and all its subcontractors, consultants, or agents performing the Services under this Agreement must comply with the following:

1. The Federal Information Security Management Act of 2002 (FISMA);
2. The Health Insurance Portability and Accountability Act of 1996 (HIPAA);
3. The Health Information Technology for Economic and Clinical Health Act (HITECH Act);
4. Publication 1075 – Tax Information Security Guidelines for Federal, State and Local Agencies;
5. Social Security Administration (SSA) Office of Systems Security Operations Management Guidelines;
6. Affordable Care Act of 2013
7. NMAC 1.12.20, et seq.

B. The Contractor (including subcontractors) shall be HIPAA compliant in transmissions and coding procedures.

C. The Contractor (including subcontractors) shall utilize only HIPAA-compliant data systems and comply with all aspects of HIPAA security, confidentiality and transactions requirements.

III. Business Continuity and Disaster Recovery (BC-DR) Plan

A. Regardless of the architecture of its systems, the Contractor shall develop and be continually ready to invoke a BC-DR plan that has been reviewed and approved in writing by HSD by *(start date of contract)*.

B. At a minimum the Contractor's BC-DR plan shall address the following scenarios:

1. The central computer installation and resident software are destroyed or damaged;
2. System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage;
3. System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system; and

4. System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the system, i.e., causes unscheduled system unavailability.

C. The Contractor's BC-DR plan shall specify projected recovery times and data loss for mission-critical systems in the event of a declared disaster.

D. The Contractor shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures and provide the results of this testing to HSD.

1.5 QUALITY STANDARDS AND MANAGEMENT

A. The Contractor shall demonstrate its ability to meet HSD's quality standards in areas of staffing, procedures, criteria, regulatory standards, review management, and internal quality management of fraud, abuse prevention and detection.

B. The Contractor shall ensure its TPA/FFS UR staff possesses sufficient and relevant current knowledge of the requirements of this Scope of Work; the Medical Assistance Division Program Rules and the applicable Federal regulations; HSD-approved review criteria; and HSD-approved detailed review procedures.

C. The Contractor shall maintain a level of work performance consistent with high professional standards in the industry. All employees assigned to perform work relating to this PSC will be capable, efficient and no less qualified than other employees of the Contractor performing the same or similar work.

D. The Contractor shall cooperate with HSD when a decision is made to audit the Contractor's work and performance or is otherwise required for the purpose of assessing program performance measures and reporting assurances to the federal Centers for Medicare and Medicaid Services (CMS). The Contractor shall cooperate fully with HSD to prepare complete documentation, participate in audits, provide a workspace and workstation for use by the HSD auditor and otherwise allow HSD to access to its utilization management system to view recipient and provider records and documentation.

At a minimum, the Contractor's compliance will be evaluated in the following areas:

1. New Mexico Medical Assistance Division Program Rule was followed for each review;
2. HSD-approved review criteria and tools were properly applied to each review;
3. HSD-approved Standard Operating Procedures were followed; and
4. HSD-approved Turn-Around-Times were followed.

HSD will inform the Contractor in the event that additional performance measures are required.

I. Corrective Action Plans

A. If HSD determines that the Contractor is not in compliance with one or more requirements in this Agreement, HSD may issue a notice of deficiency, identifying the deficiency or deficiencies and follow-up recommendations and/or requirements (either in the form of a Corrective Action Plan (CAP) or an HSD Directed Corrective Action Plan (DCAP). A notice from HSD of noncompliance directing a CAP or DCAP will also serve as a notice for sanctions in the event HSD determines that monetary sanctions are also necessary.

B. The Contractor shall be required to provide CAP(s) to HSD within fourteen (14) Calendar Days of receipt of a noncompliance notice from HSD. CAP(s) are subject to review and approval by HSD.

C. If HSD imposes a DCAP on the Contractor, the Contractor will have fourteen (14) Calendar Days to respond to HSD.

D. If the Contractor does not effectively implement the CAP or DCAP within the timeframe specified in the CAP or DCAP, HSD may impose additional remedies or sanctions.

E. If HSD staff is required to spend more than 10 hours or more per week monitoring a CAP(s) or DCAP(s), HSD will provide notice to the Contractor that the Contractor must contract with a third party either designated by HSD or approved by HSD to oversee the Contractor's compliance with the CAP(s) or DCAP(s).

II. Intermediate Sanctions

A. Monetary penalties of up five percent (5%) of the Contractor's payment for each month in which the penalty is assessed or a recoupment of a review rate(s), depending on the severity of infraction.

B. The DEPARTMENT, in its sole discretion may reallocate monies withheld as a sanction. The Contractor shall have neither claim upon nor opportunity to recoup monies withheld as a sanction per this section.

C. The DEPARTMENT will remove its sanction upon determining that the Contractor has met its performance obligations during a subsequent month. The payment process will then resume.

III. Internal Quality Management Program

A. The Contractor shall establish and maintain an internal quality management program following the basic principles of Total Quality Management (TQM) and Continuous Quality Improvement (CQI) that are presently used throughout most industries. This program will be applied to all aspects of the Contractor's performance under this contract. The Contractor shall share TQM and CQI results with HSD.

B. The Contractor shall have a quality improvement/quality management program description, work plan and program evaluation that is updated each contract year and provided to HSD for review and approval in a manner to be specified.

C. The Contractor's internal quality management program will include procedures for conducting quarterly internal audits by each HCBS waiver type on a representative random sample of level of care reviews, level of care determinations, service plans and budgets to validate consistent and accurate application of criteria, and that utilization review functions are performed according to established timeframes. Results will be reported to HSD/MAD.

D. The Contractor shall conduct regular monitoring of inter-rater reliability of individuals performing UM activities and shall ensure that a remediation process is established and utilized for individuals not meeting at least 90 percent of agreement on sample cases.

E. The Contractor's quality management program shall include data

entry accuracy.

IV. Internal Fraud and Abuse Prevention and Detection

A. The Contractor shall establish and maintain an internal fraud and abuse, prevention and detection, preliminary investigation and reporting program.

B. The Contractor shall report any indication of suspicious activity to HSD immediately.

C. The Contractor shall promptly conduct a preliminary investigation and report the results of the investigation to HSD. A preliminary investigation entails the Contractor doing internal research to gather documentation that either substantiates or disproves the suspected activity. If, after this preliminary investigation, the activity still appears suspicious, the relevant documentation and information will be sent to HSD for a formal investigation.

D. The Contractor shall not conduct a formal investigation, but the full cooperation of the Contractor during the investigation will be required.

E. The Contractor shall fully cooperate with the New Mexico Attorney General's office (NMAG) Medicaid Fraud and Elder Abuse Division (MFEAD) and other investigatory agencies.

F. The Contractor shall have policies and procedures to address prevention, detection, preliminary investigation and reporting of potential and actual Medicaid fraud and abuse, including written policies for all Contractor's employees, agents or contractors that provide services to this Agreement. Such policies and procedures still comport with the requirements of the New Mexico Medicaid False Claims Act, NMSA 1978 §§ 22-14-1 et seq. and the Federal False Claims Act, 31 U.S.C. §§ 3729 et seq.

G. The Contractor shall have a system in place to monitor service utilization for fraud and abuse. The Contractor shall not retaliate against any employee, agent or contractor who makes a good faith complaint, whether it is an internal or external complaint, about potential Medicaid fraud and abuse.

2. SEPARATELY REIMBURSABLE SERVICES

2.1 ALTERNATIVE BENEFIT PLAN

A. The Contractor shall determine a recipient's exemption from the New Mexico Medicaid Expansion Alternative Benefit Plan (ABP) based on criteria and procedures established by HSD.

B. The following individuals are exempt from mandatory participation in an ABP and may choose to receive full Medicaid State Plan benefits:

1. Individuals who qualify for medical assistance on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individuals are eligible for Supplemental Security Income benefits;
2. Individuals who are terminally ill and are receiving benefits for hospice care;
3. Individuals who are medically frail or who have special medical needs. The following individuals are considered to be medically frail:
 - a) Individuals with disabling mental disorders, including adults with serious mental illness;
 - b) Individuals with chronic substance use disorders;
 - c) Individuals with serious and complex medical conditions;
 - d) Individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living; and
 - e) Individuals with a disability determination based on Social Security criteria.

C. The Contractor shall perform utilization reviews of HSD-specified ABP Services according to the applicable Method and Categories of Reviews currently in place for Medicaid services (see sections 1.1(2) M and 1.1(2) N of this PSC).

2.2 BEHAVIORAL HEALTH

A. The Contractor shall conduct utilization reviews by individuals who meet the MAD professional qualifications and have direct knowledge and experience in HSD specified Behavioral Health Services. Specifically, prior authorization is required for the following Behavioral Health Services:

1. Inpatient Psychiatric Care in a Free-Standing Psychiatric Hospital or Psychiatric Units of Acute Care Hospitals

2. Accredited Residential Treatment Center (ARTC) Services
3. Non-Accredited Residential Treatment Center (RTC) Services and Group Homes
4. Treatment Foster Care (TFC)
5. Treatment Foster Care II (TFCII)
6. Applied Behavior Analysis (ABA)-Stage 3

The NMAC rules for these services are 8.311.2, Hospital Services; 8.321.2, Specialized Behavioral Health Services; or their respective successors.

- a. A provider initiates a review with an HSD designated Behavioral Health prior authorization form along with required supporting documents.
- b. The Contractor shall determine if a requested service meets the criteria outlined in the HSD Behavioral Health Level of Care Guidelines. The Contractor shall provide targeted technical assistance to an ABA provider to complete RFI(s) for an ABA prior authorization request.
- c. The Contractor shall receive approval from HSD prior to issuing an ABA prior authorization denial.
- d. For any ABA reviews that result in a Fair Hearing, the Contractor shall provide testimony for HSD administrative hearings and/or court proceedings concerning protests of actions taken as a result of CONTRACTOR ABA UR decisions. The Contractor shall be prepared to testify either by telephone or in person.
 - i. The Contractor's legal counsel shall be required to represent the Contractor at any administrative hearing only if the recipient is represented by his or her legal counsel. The Contractor's legal counsel is expected to coordinate closely with its TPA UR Contract Manager and Appeals Manager and with the HSD Contract Manger, and HSD Office of General Counsel when required, regarding the case.

2.3 COMPREHENSIVE REVIEW OF PRACTICE

- A. In the event that quality concerns arise with a contracted behavioral

health provider's services, the Contractor may be asked to perform an audit. Each review is different, and the amount of effort and mix of professionals required (physician, nurse, clerk, etc.) may vary. Reviews may be conducted statewide. A Letter of Direction will specifically direct each requested review. After receiving the Letter of Direction, but prior to each review, the Contractor will provide HSD with an anticipated number of hours for completing the review and the parties will negotiate reimbursement for the Contractor.

B. The Contractor shall be capable of performing extensive and intensive reviews of records of specific providers.

2.4 CONTACT LENSES

A. The Contractor shall perform prior approval reviews for requests for contact lenses by Record Abstract Review.

B. The policy for these services is in 8.310.2 NMAC, 8.324.5, or its successors. The provider initiates the review with an HSD designated prior authorization form and other supporting documents. The focus for the review is a determination of medical necessity.

2.5 DENTAL SERVICES

A. The Contractor shall perform utilization review of HSD specified Dental Service by Record Abstract Review. The policies for these services are in 8.310.07 NMAC, Dental Services and 8.310.7UR, Dental Services Utilization Review Instructions. A New Mexico licensed dentist initiates the review with an ADA claim form, along with required supporting documentation and other material. Each request usually contains more than one type of service. Each request "package" constitutes a single review.

B. The dental consultant may be a general dentist for all reviews except those for orthodontics and oral maxillofacial surgery that require a specialist in those areas.

C. The focus for the review is a determination of the medical/dental necessity of the requested services and the amounts. The Contractor shall ensure that a dental consultant(s) determines if a requested service meets criteria. Services requiring prior authorization include diagnostic, preventive, restorative, endodontic, periodontics, removable prosthodontics, maxillofacial prosthetic, oral surgery, and orthodontic services, and for all reviews requiring interpretation

radiographs, diagnostic casts, diagnostic models, or study models.

2.6 DURABLE MEDICAL EQUIPMENT (DME), PROSTHETICS AND ORTHOTICS, AND NUTRITION SERVICES

A. The Contractor shall perform prior approval for requests for DME including oxygen and oxygen delivery equipment, and specified nutritional supplements and supplies by Record Abstract Review.

B. The policy for these services is in 8.324.5 NMAC, Durable Medical Equipment and Supplies, 8.324.8 NMAC, Prosthetics and Orthotics, and 8.324.9, Nutrition Services. A vendor, discharge planner, case manager, or other provider initiates the review with HSD designated prior authorization form and other supporting documents. The health care provider acting within his/her scope of practice must order the requested services and document the medical necessity of such services. Each request “package” constitutes a single review, regardless of the number of type of services requested. The focus for the review is a determination of the medical necessity of the requested services and the amounts, and in some cases whether purchase or rental is indicated.

C. The Contractor shall determine if a requested service meets criteria. If it does not, that service will be denied. Since a physician or other practitioner is responsible for justifying the medical necessity, any needed clarification should be directed to the practitioner.

D. The Contractor shall reduce the amount of a requested service (reduction of care) if that amount exceeds the documented needs.

E. The Contractor shall complete the MAD 303 Form and communicate the review decision to the requestor in accordance with policies and procedures approved by HSD.

2.7 EPSDT PERSONAL CARE SERVICES

A. The Contractor shall review all prior approval requests for all fee-for-service recipients for EPSDT Medicaid Personal Care Services. EPSDT Personal Care Services provide a range of services to eligible consumers under the age of 21 who are unable to perform some/all activities of daily living (ADLs) or independent activities of daily living (IADLs) because of disability or functional limitation(s). The policy for these services is 8.323.2, NMAC.

B. The focus for the review is a determination of the medical necessity of the requested services in accordance with the coverage criteria at 8.323.2.13, NMAC.

C. An eligible New Mexico Medicaid provider initiates the prior approval review by providing to the Contractor the documentation outlined in the MAD Program Policy Manual, Sections 8.323.2.16 and 8.323.2.18, or its successors.

2.8 EMERGENCY MEDICAL SERVICES FOR NON-CITIZENS (EMSNC)

A. The Contractor shall perform reviews for Emergency Medical Services for Non-Citizens by medical record review for services other than labor and delivery.

B. Medicaid covers strictly defined emergency services for eligible non-citizens. Eligibility is determined by ISD for each episode of illness/injury and is valid only for the specified health care services involved in that episode. The Medicaid policy for these services is covered in 8.325.10 NMAC.

The provider initiates the review by sending the Fiscal Agent the following documents:

1. HSD Notification of Authorization of Application for Emergency Services for Non-Citizens (MAD 310 or MAD 778 Form or HSD/ISD approval notice of emergency services);
2. The provider billing form(s) (UB-04 and/or CMS-1500, or its successor);
3. Itemized expense sheet (inpatient services only); and
4. The complete emergency room or inpatient stays medical record pertinent to the service for which the provider seeks reimbursement.
 - a) The Contractor shall run a report through MMIS/Omnicaid system on a daily basis to obtain all incoming provider and facility EMSNC review requests.
 - b) The Contractor shall determine the services for which the provider or facility is seeking reimbursement were medically necessary and provided to treat only an emergency condition as defined.

- c) The Contractor shall review the submission and forward the authorization to the Fiscal Agent for payment.
- d) Any submission that does not meet these criteria will be denied.
- e) Several providers may seek reimbursement for the same episode. The review of the inpatient stay or the outpatient stay associated with an emergency room visit is considered one review, and all other submissions associated with the inpatient stay or emergency room visit are included in that review. Documentation submitted by one provider may serve for the review of several providers involved in the same episode of illness/injury as long as it is sufficient.
- f) The Contractor shall notify the provider using the HSD-approved letter template.

2.9 GENERAL HOSPITAL INPATIENT (IN-STATE)

(1) Retrospective Pre-Payment and Post-Payment Reviews

A. As specifically directed by HSD, the Contractor shall perform retrospective pre-payment and post-payment reviews of Acute General Hospital Inpatient services by Medical Record Review. The policy for these services is in 8.311.2 NMAC, Hospital Services. These reviews are initiated by a report from HSD. The report contains the sample of acute general hospital inpatient paid hospitalizations selected using HSD-determined sampling criteria. This report contains such information as the hospital provider, recipient, and dates of services, which allows the Contractor to identify the specific recipient medical records to be reviewed.

(2) Acute General Hospital Transfers

A. The Contractor shall perform prior authorization reviews of all transfers (discharge and admission) from one Acute General Hospital to another Acute General Hospital. These reviews will be performed by telephonic/electronic review and are initiated by the transferring facility that must justify the transfer.

B. The Contractor shall approve those transfers that are medically necessary and deny those which are not. The medical necessity criteria will be the same as those used for the Retrospective Post-Payment Reviews of Acute General Hospitals plus validation of the non-availability of necessary service(s) at the transferring facility and availability of the service (s) at the transferred facility. Transfers to a hospital with lesser capability may

only be authorized in the following unique circumstances:

1. For purposes of maternal bonding when a recipient in a Level III Neonatal Unit could be managed at a lower level unit in or near the community where the mother resides, and when this community is a considerable distance away from the Level III unit;
2. In the best interest of the public health when the Level III Neonatal Units are at capacity, another bed is required, and a recipient in a Level III Neonatal Unit could be managed at a lower level unit, in or out of the area; or
3. If an Indian Health Service (IHS) recipient at a tertiary care facility who is still in need of acute inpatient care but who could be managed at an IHS hospital near the home community.

C. The Contractor shall perform prior authorization reviews retroactively (after-the fact) for cases of a transfer (discharge and admission) from one Acute General Hospital to another Acute General Hospital provided the circumstances for the provider not obtaining prior authorization before-the-fact are in accordance with 8.302.5 NMAC, Prior Authorization and Utilization Review. These retroactive prior authorizations will be performed by a review of the pertinent medical record from the transferring hospital and are initiated by the transferring facility that must justify the transfer.

2.10 HEARING AID SERVICES

- A. The Contractor shall perform prior authorization reviews for hearing aid dispensing, purchase, rental and replacement and for repairs exceeding one hundred dollars (\$100).
- B. The policy for these services is in 8.324.6 NMAC. A vendor initiates the review with an HSD designated prior authorization form and other supporting documents. Documentation that the attending physician ordered or prescribed the requested equipment or supply that is specifically designated as a purchase or rental and justification of the medical necessity is required. Each request usually contains more than one type of service. Each request “package” constitutes a single review. The focus for the review is a determination of the medical necessity of the requested services and the amounts.

2.11 HOME AND COMMUNITY-BASED SERVICE WAIVERS

- A. Medicaid Home and Community-Based Services (HCBS) are provided under separate 1915 (c) waivers through the federal Centers for Medicare and Medicaid Services (CMS) to allow state Medicaid agencies to cover home and community-based services for individuals that require long-term support and services in order to enable recipients to reside in the community rather than in institutions.
- B. The Contractor shall work in partnership with HSD and DOH on the New Mexico HCBS waiver programs: Development Disabilities, Medically Fragile, Mi Via Self-Direction, and the Supports Waiver.
- C. The waivers specify that certain medical/clinical criteria must be met. One criterion requires the recipient to meet LOC criteria for a particular health care facility type. The chart below shows each waiver program for which the Contractor will have responsibilities, the corresponding section of HSD Program Manual, LOC criteria that are followed, and management entities.

Home and Community-Based Service Waivers

Waiver	Program Manual Section	Level of Care	Administering Entity (Oversight by HSD)
Developmental Disabilities (DD)	8.314.5 NMAC	ICF-IID	DOH
Medically Fragile (MF)	8.314.3 NMAC	ICF-IID	DOH
Mi Via Waiver	8.314.6 NMAC	ICF-IID	DOH
Supports Waiver	8.314.7 NMAC	ICF-IID	DOH

- D. The Contractor shall ensure that each LOC evaluation follows the required standard operating procedure utilizing the correct instruments and tools that are specified in the waiver.
- E. In cases of LOC requests pertaining to HCBS waiver allocants whose Medicaid eligibility has not yet been decisioned by ISD, the Contractor shall determine the LOC and send the LOC data to the ISD office via the ASPEN interface, or by fax if the interface is unavailable or if the Contractor is otherwise directed by HSD. The Contractor is to assign a temporary alternative ID number and later merge the member profile with the assigned Medicaid ID when the ID determines that the participant has

received an approval of eligibility.

- F. The Contractor may need to re-evaluate the LOC more often than annually if there is an indication that the eligible recipient's health condition or LOC has changed, however, LOC evaluations are only billed once annually per client.
- G. The Contractor shall establish procedures to track and monitor new waiver allocations or waiver changes. The Department of Health (DOH) communicates waiver allocations and waiver changes via a completed Primary Freedom of Choice (PFOC) or Waiver Change Form (WCF).
- H. The Contractor shall perform prior authorizations of Individual Service Plan (ISP)/Service and Support Plan (SSP) and budgets. The Contractor may need to review and authorize service plan and budgets more often than annually if there is an indication that the eligible recipient's waiver services supports and needs have changed.
- I. The Contractor shall perform the following services for the Developmental Disabilities (DD) Waiver according to the DD waiver program rule NMAC 8.314.5.17, Developmental Disabilities Home and Community-Based Services Waiver:
 - a) DD LOC Reviews – Initial and Continuing/Annual
 - a. DD waiver case manager will submit a completed ICF-IID and DD HCBS Long Term Care Assessment Abstract (MAD 378) and required supporting documentation to the Contractor. The LOC review is done initially to determine medical necessity, annually thereafter, and whenever a LOC change is requested. The reviewer will assess for medical necessity by comparing medical/clinical material contained in the history and physical and assessment information and other supporting documentation of the LOC criteria for the DD Waiver.
 - b) DD LOC Increase Requests – (Does not apply to discharge LOC increases)
 - a. Requests for increases in LOC must originate from the DDS Regional Office (RO), and must have a Regional Office Review of LOC Increase Form attached and completed. The LOC packet contains the same assessment information required as part of the LOC determination. The Contractor reviews the LOC packet, as well as the RO recommendation, and attached documentation of change of condition/ health status which

meets criteria for the LOC change.

c) DD ISP/Budget Reviews – Initial, Annual, Initial Residential and Revision, and Professional Services:

- a. A case manager initiates the ISP/budget request using the MAD 046 form or DDW budget worksheet, as applicable, and supporting documentation. The MAD 046 or budget worksheet specifies the request for services and is submitted to the Contractor.
- b. Other than annual reviews, the instances in which the case manager's ISPs need to be reviewed for medical necessity are: 1) the case manager has requested residential services for the first time or after a break in residential services or 2) there is a request for professional services. Additionally, Outlier Services must be accompanied by a DDS RO Approval Form, and a MAD 046 or budget worksheet, with Outlier Services indicated as well as staff signature.
- c. The Contractor will conduct independent clinical reviews of individual service plans, associated budgets and revisions to service plans.
- d. The Contractor will enter the approved services from the MAD 046 or budget worksheet into the MMIS/Omnicaid system and assign a prior authorization number. The Contractor will document authorization, denial, pending or modification of the request on the MAD 046 form or budget worksheet, as applicable, along with the certification period. The approved services, including any changes due to reconsiderations or revisions, are then entered into the MMIS/Omnicaid system .
- e. The Contactor will send the MMIS/Omnicaid system-entered budgets with the prior authorization number to the case manager.
- f. The Contractor will also send the initial and annual budgets to the member. Revised budgets do not need to be mailed to the members.

J. The Contractor shall perform the following services for the Medically Fragile (MF) Waiver according to the Medically Fragile program rule, NMAC 8.314.3.16, Medically Fragile Home and Community-Based Services Waiver Services:

1. MF Waiver Level of Care (LOC) Reviews – Initial and Continuing/Annual
 - a. MF waiver case manager will initiate the LOC review process by

submitting a completed Medically Fragile Long-Term Care Assessment Abstract (DOH 378 or its successors) and required supporting documentation. The Contractor will review the packet to determine medical eligibility for ICF-IID and Medical Fragility LOC for individuals who are newly allocated to the waiver, and at least annually thereafter.

2. MF LOC Re-Admission Reviews

- a. The Contractor will complete LOC re-admission reviews for MF waiver recipients who have been admitted to a hospital for three or more midnights. Specific components for LOC re-admission reviews are described in the Contractor's standard operating procedures.

3. MF Waiver Individual Service Plans (ISP) and Budget Reviews – Initial and Continuing

- a. The Contractor will conduct utilization reviews of initial, annual and revised ISPs and MAD 046s to ensure that waiver requirements are met. The Contractor will assure the ISP budget does not exceed the capped dollar amount and only waiver services are included on the MAD 046. Specific components of the ISP and MAD 046 utilization review are described in the standard operating procedures.
- b. The approved services, including any changes due to reconsiderations or revisions, are then entered directly into the MMIS/Omnicaid system

K. The Contractor shall perform the following services for the Mi Via Waiver according to the Mi Via program rule, NMAC 8.314.6, Mi Via Home and Community-Based Services Waiver:

1. The Contractor shall conduct LOC determinations, initial and continual/annual, utilizing ICF-IID LOC criteria.
2. The Mi Via participant will initiate the LOC review by submitting a completed ICF/IID and Home & Community Based Services Waiver Long Term Care Assessment Abstract form and required supporting documentation.
3. Upon receipt of the completed Abstract form, the Contractor shall conduct

an in-home assessment with the Mi Via participant. The in-home assessment is conducted in the eligible recipient's home or at a location that is approved in advance by the State.

4. The Contractor shall coordinate, as indicated, with each individual Mi Via participant, his or her consultant and the Financial Management Agency (FMA) Contractor concerning the participant's Service and Support Plan (SSP) and budget, developed by the participant with the assistance of his/her consultant. This includes communication on RFIs, reconsiderations and Requests for Administrative Action (RFA) administered through the FMA online system.
 5. The Contractor shall conduct a review of each medically eligible individual participant's SSP and budget utilizing: (1) documentation from the participant's medical eligibility LOC determination and review; (2) the State's SSP authorization review criteria; and (3) Medicaid Mi Via rule, NMAC 8.314.6, Mi Via Home and Community-Based Services Waiver.
 6. The Contractor shall enter the SSP and budget authorization (denied, pending or modification) into the FMA online system.
 7. The Contractor shall complete the appropriate Long Term Care (LTC) span in the appropriate system once the determination has been made on the Mi Via budget.
- L. The Contractor shall perform the following services for the Supports Waiver (SW) according to the Supports Waiver program rule 8.314.7 NMAC:

The Supports Waiver allows for provision of services in two models: 1) agency based service delivery model; 2) participant-directed service delivery model. Participants have a choice of which service delivery model best supports them in their community and aligns with their personal goals, health and safety needs.

1. LOC Reviews – Initial and Continuing/Annual

- a. The Contractor shall conduct LOC determinations, initial and continual/annual, utilizing ICF-IID LOC criteria.
 - i. For SW participants receiving services through the agency based service delivery model, the Community Support Coordinator (CSC) will submit a completed ICF-IID Long Term Care

Assessment Abstract (MAD 378) and required supporting documentation to the Contractor.

- ii. Participants under the participant-directed service delivery model will submit the completed MAD 378 and required supporting documentation directly to the Contractor via the Contractor's provider portal.
- b. The LOC review is done initially to determine medical necessity, annually thereafter, and whenever a LOC change is requested. The reviewer will assess for medical necessity by comparing medical/clinical material contained in the history and physical and assessment information and other supporting documentation of the LOC criteria for the DD Waiver.

2. SW ISP/Budget Reviews – Initial, Annual, and Revision:

- a. For participants under the agency-based service delivery model, a CCSC initiates the ISP/budget request using the SW budget worksheet, and as applicable, supporting documentation. The budget worksheet specifies the request for services and is submitted to the Contractor.
 - i. The Contractor shall conduct a review of each medically eligible individual participant's ISP and budget utilizing: (1) documentation from the participant's medical eligibility LOC determination and review; (2) the State's ISP authorization review criteria; and (3) Medicaid SW rule, 8.314.7 NMAC.
 - ii. The Contractor will enter the approved services from the SW budget worksheet into the appropriate system and assign a prior authorization number. The Contractor will document the authorization, denial, pending or modification of the request on the budget worksheet, as applicable, along with the certification period. The approved services, including any changes due to reconsiderations or revisions, are to be entered into the appropriate system.
 - iii. The Contractor shall complete the Long-Term Care (LTC) span in the appropriate system once the budget has been approved.
 - iv. The Contractor will provide the approved budget and the prior authorization number to the CSC.
- b. For participants under the participant-directed service delivery model, the Contractor shall coordinate, as indicated, with each individual participant, his or her CSC and the Financial Management Agency (FMA) Contractor concerning the participant's Individualized Service

Plan (ISP) and budget, developed by the participant with the assistance of his/her CSC. This includes communication on RFIs, reconsiderations and Requests for Administrative Action (administered through the FMA online system).

- i. The Contractor shall conduct a review of each medically eligible individual participant's ISP and budget utilizing: (1) documentation from the participant's medical eligibility LOC determination and review; (2) the State's ISP authorization review criteria; and (3) Medicaid SW rule, 8.314.7 NMAC.
- ii. The Contractor shall enter the ISP and budget authorization (denied, pending or modification) into the FMA online system.
- iii. The Contractor shall complete the Long-Term Care (LTC) span in the appropriate system once the budget has been approved.

2.12 HOME HEALTH SERVICES

A. The Contractor shall perform prior authorization reviews for all Home Health Services by Record Abstract Review. The policy for these services is in MAD-768. The requests are initiated by the home health service provider using a MAD 305 Form and supporting documentation. Each request usually contains a "package" of several types of covered services. Each "package" constitutes a single review. The focus of the review is a determination of the medical necessity for skilled nursing and/or ancillary services, the amounts requested, and the adequacy of services requested given the complete clinical, social and functional history.

B. The Contractor shall be sensitive to cases of possible neglect and/or abuse based on the information provided by the provider. The Contractor shall refer such cases to the Aging and Long-Term Services Department Adult Protective Services unless the provider indicates that such a referral has already been made.

C. The Contractor shall report to HSD all abuse and neglect referrals made by the Contractor or noted to have been made by the provider.

2.13 INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

A. The Contractor shall determine ICF-IID LOC according to Medicaid ICF-IID provider policy (8.313.2 NMAC, Long Term Care Services – Intermediate Care Facilities) and process (8.350.3 NMAC, Abstract Submission for Level of Care Determinations). The Contractor shall review initial and continued stay LOC

requests using the HSD ICF-IID admission criteria. The Contractor shall close the review for discharges.

B. The Contractor shall perform LOC review by Record Abstract Review of all admissions and continued stay requests for ICF-IID residents. The provider submits a MAD 378 Form and required supporting documentation.

C. The Contractor shall review the request against the ICF-IID criteria for the three (3) levels of care and approve for a specific number of days, or deny the requested LOC.

D. In cases of LOC requests pertaining to ICF-IID recipients whose Medicaid eligibility has not yet been decisioned by ISD, the Contractor shall determine the LOC and send the LOC data to the ISD office via the ASPEN interface, or by fax if the interface is unavailable or if the Contractor is directed by HSD. The Contractor is to assign a temporary alternative ID number and later merge the member profile with the assigned Medicaid ID when the ID determines that the participant has received approval of eligibility.

E. The Contractor shall perform re-admission reviews by telephonic/electronic review in cases in which a recipient who is an ICF-IID resident with an approved LOC is admitted to an Acute General Hospital and re-admission to the ICF-IID is planned. LOC for specified days can be approved as the result of a Telephonic/electronic Review under certain circumstances. See 8.313.2 NMAC.

2.14 NURSING FACILITY

A. The Contractor shall perform NF LOC reviews for Medicaid recipients exempt from Centennial Care enrollment and are seeking hospice care in a nursing facility.

B. The Contractor shall perform NF LOC reviews for Medicaid recipients exempt from Centennial Care enrollment who are receiving short term (30 days or less) rehabilitation or skilled nursing services in a nursing facility.

2.15 OUT-OF-STATE (OOS) SERVICES

A. The Contractor shall perform prior authorization reviews of requests for non-emergency OOS Services by Out-of-State Review. Every review decision

must be determined or approved by the Contractor's medical director who must consult with pertinent specialists when necessary to render a professionally defensible decision.

B. Reviews for OOS transplants usually include three (3) separate reviews:

- a. A review of the on-site recipient evaluation as conducted by an out of state provider.
- b. Documentation related to the transplant procedure.
- c. Follow-up evaluations conducted by out of state provider(s).

C. The policy for these services is in 8.302.4, Out-Of-State and Border Area Providers. The requested services must be otherwise covered benefits of the Medicaid Program; cannot be considered experimental, investigational or unproven as a technology for the underlying condition; and must not be available in New Mexico.

D. Typically, a New Mexico physician initiates these reviews by letter and justifies the medical necessity. A written, telephonic or electronic communication may also initiate the review process depending on the emergent nature of the situation.

E. Due to the costs and/or financial risk associated with these services, the Contractor must confirm that Medicaid recipient eligibility has been established and is on file with the Fiscal Agent.

F. Commonly, requests for OOS are for organ transplant services. For OOS organ transplant reviews, the Contractor will also follow section 2.7 Transplant Services (In-State).

G. For reviews that are approved, the Contractor shall give an HSD-designated provider all information that will allow for the coordination and/or arrangement of transportation and/or other required support.

H. The Contractor shall approve out-of-state services that are medically necessary, do not involve experimental technology, are not available in New Mexico, and are to be rendered by a professionally qualified provider(s).

I. The Contractor shall deny requests that do not fit aforementioned

criteria.

J. The Contractor shall maintain a detailed file of all pertinent correspondence, memos of telephonic/electronic conversations, and documentation for each review.

K. The Contractor shall notify in writing both the requesting provider and the involved out of state provider(s) for cases that have been approved. This notification must include the Medicaid Fiscal Agent's contact information to obtain general instructions on how to become a New Mexico Medicaid provider (able to bill) and obtain billing instructions.

2.16 PRIVATE DUTY NURSING SERVICES

A. The Contractor shall perform PA reviews for all requests for Private Duty Nursing Services by Record Abstract Review. The policy for these services is in 8.323.4 NMAC, EPSDT Private Duty Nursing Services. These services are covered only for children under the age of 21 years. A case manager initiates the review with a letter, a history and physical examination report, a treatment plan, Early Periodic Screening and Diagnostic Treatment (EPSDT) Service Plan (a budget/authorization sheet), and other required documents. Each request usually contains a package of several services. Each "package" constitutes a single review.

B. The Contractor shall focus the review on the appropriateness of the treatment plan and the medical necessity of the requested services and service amounts. HSD will provide the medical necessity criteria.

C. If the Contractor determines that the documentation does not substantiate the medical necessity for the service, the request will be denied. The Contractor will reduce the amount of service requested (partial denial) if that amount exceeds the documented needs.

D. The Contractor shall complete the EPSDT Service Plan to document and communicate the review decision to the provider in accordance with policies and procedures approved by HSD.

2.17 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

A. The Contractor shall determine NF LOC for potential PACE members not in Medicaid Managed Care. The Contractor shall review initial and

annual/continued stay LOC requests for PACE using the Medicaid Nursing Facility (NF) criteria and instructions. The Contractor shall approve or deny the requested NF LOC.

B. The Contractor shall ensure that its PACE reviewers meet the following minimum criteria for education and experience:

1. Active Nursing license in New Mexico or compact license (RN or LPN) with a minimum of one (1) year of relevant experience.
2. Medical Social Worker with a minimum of 1 year of relevant experience.
3. Physical, Occupational, or Rehab Therapists with a minimum of one (1) year of relevant experience.

C. The Contractor shall perform PACE LOC reviews by Record Abstract Review of all enrollment requests. The provider submits a MAD 379 Form, History and Physical, physician order, and required supporting documentation.

D. The Contractor shall attend the initial NF LOC criteria and instructions training held by HSD. The Contractor shall develop internal reviewer trainings and evaluation using HSD approved materials. The Contractor shall submit an initial training material, evaluation and calendar of training events to HSD for approval. After final approval is given, HSD will attend the initial Contractor internal trainings. The Contractor shall ensure that all reviewers have, at a minimum, initial and annual training.

E. In cases of LOC requests pertaining to recipients whose PACE Medicaid eligibility has not yet been decided by ISD, the Contractor shall determine the LOC, and send the LOC data to the ISD office via the ASPEN interface, or by fax if the interface is unavailable or if the Contractor is otherwise directed by HSD. The Contractor is to assign a temporary alternative ID number and later merge the member profile with the assigned Medicaid ID when the ID determines that the participant has received approval of eligibility.

F. For new PACE eligible members transferring from a Medicaid Managed Care MCO, an existing NF LOC determination and functional assessment performed by the MCO can be used for NF LOC for PACE certification and TPA/FFS UR data entry.

2.18 REHABILITATION SERVICES (INPATIENT)

A. The Contractor shall perform prior authorization reviews of inpatient rehabilitation hospital admissions.

B. The Contractor shall perform record Abstract Review for continuing stays. The Contractor shall determine medical necessity, appropriateness of setting and length of stay for Medicaid recipients being admitted to inpatient rehabilitation centers with a primary emphasis on PT, OT, and/ or ST.

2.19 REHABILITATION SERVICES (OUTPATIENT)

A. The Contractor shall perform prior authorization review for Speech Therapy (ST) for evaluation and treatment for recipients 21 years of age and older. Recipients under 21 years of age do not require authorization for ST evaluation.

B. Physical Therapy (PT) and Occupational Therapy (OT) do not require prior authorization for evaluation. PT and OT do require prior authorization for therapy services. The Contractor shall perform authorization review on Record Abstract Review, including the HSD designated prior authorization form and supporting information submitted by the provider to justify specific requested amounts of service by procedure code consistent with clinical needs.

C. The Contractor shall focus on medical necessity and appropriateness of setting.

D. An eligible recipient less than 21 years of age who is eligible for a home and community based waiver program receives medically necessary rehabilitation services through the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) rehabilitation services. The Contractor shall approve a twelve (12) month prior authorization period for outpatient rehabilitation therapies when the medical conditions are expected to be of long-term duration and will require ongoing rehabilitative therapy. Maintenance therapy may be approved.

2.20 SECOND OPINION REVIEWS

The Contractor shall, at the request of HSD, perform second opinion reviews on non-fee-for-service recipients for non-fee-for-service programs with clinical criteria that may differ from that generally used in the fee-for-service reviews. The parties will negotiate reimbursement for the Contractor.

2.21 TRANSPLANT SERVICES (IN-STATE)

A. The Contractor shall perform prior authorization by record abstract review of requests for in-state organ transplant services.

B. Medicaid covers all organ transplants that are not considered experimental, investigational or unproven as a technology or for the underlying condition according to the criteria specified in 3.301.3 NMAC, General Non-covered Services.

Corneal and kidney transplants currently do not require prior authorization. Presently, the following transplants are considered covered and require prior authorization: heart, lung, heart-lung, liver, and bone marrow/stem cell transplant/replacement (rescue). The practitioner, who must justify the medical necessity, initiates these reviews.

C. The reviews described here apply to transplants to be performed within the state. Frequently, requests for these transplants involve out-of-state services. Out-of-state transplant cases will be reviewed in accordance with this section and the “Out-of-State” review section. The focus of review will be medical necessity and qualification of the provider.

D. The Contractor shall approve those transplants that are medically necessary and deny those that are not.

E. The Contractor shall develop criteria for any transplant not listed above when such a transplant is no longer considered experimental, investigational or unproven and forward them to HSD for review and authorization.

EXHIBIT B

Compensation

Utilization Review and Assessment Services	Description	Rate
Prior Authorization Review	<p>Prior authorization for the following Developmental Disabilities waiver services: adult nursing, therapies, and behavioral support consultation.</p> <p>Prior authorization for service or programs that are exempt from managed care, including physical health and Alternative Benefit Plan and Alternative Benefit Plan Medically Fragile exemption.</p>	\$ Per Review
EMSNC Review	Retrospective medical necessity review for Emergency Medical Services for Non-Citizens.	\$ Per Review
Behavioral Health Review	<p>Prior authorization for initial, concurrent and retro reviews.</p> <p>Accredited Residential Treatment Centers (ARTC), Group Homes (GH), Treatment Foster Care (TFC)</p>	\$ Annual Per Recipient
	Prior authorization for inpatient psychiatric care.	\$ Per Review
	Prior authorization for Applied Behavioral Analysis (includes any potential Fair Hearings).	\$ Per Review
	Prior authorization for Substance Use Disorder (SUD)-Inpatient Psychiatric Care and Residential Treatment reviews.	\$ Per Review
	Prior authorization for Substance Use Disorder (SUD)-Partial Hospitalization	\$ Per Review
Level of Care Mi Via /Developmental	Initial and annual ICF/IID level of care determination <u>plus</u> the in-home assessment for Mi Via and Developmental Disability	\$ Annual Per Recipient

Disability Waivers	waiver adults and children requiring ICF/IID level of care.	
Level of Care All Others	<p>Initial and annual ICF/IID level of care determinations for adults and children in the Medically Fragile, and Supports Waiver home and community-based waiver programs.</p> <p>Initial and annual ICF/IID level of care for recipients receiving long-term care services in an ICF/IID facility.</p> <p>Nursing facility level of care determinations for recipients in the Program of All-Inclusive Care for the Elderly.</p>	\$ Annual Per Recipient
ISP/SSP and Budgets-Initial and Annuals	<p>Review and approval of Initial and Annual Individual Service Plans and budgets for Developmental Disabilities Waiver (DDW) and Medically Fragile Waiver (MFW).</p> <p>Review and approval of Service and Support Plans and budgets for Mi Via (MV) and Supports Waiver (SW) Participants.</p>	\$ Per Review
ISP/SSP and Budgets-Revisions	<p>Review and approval of Individual Service Plans and budget revisions for DDW and MFW.</p> <p>Review and approval of Service and Support Plans and budget revisions for Mi Via and Supports Waiver Participants</p>	\$ Per Review

***Note: Fair Hearings are not separately reimbursable services**

EXHIBIT C

REPORTS

NUMBER	TITLE	DESCRIPTION
A1	Pay Equity Reporting Requirements	Annual completion of the PE10-249 for Contractor that has ten (10) or more employees OR has eight (8) or more employees in the same job classification.
A2	Internal Quality Management	Annual report that captures the description of program, description of processes, description of procedures, and shares TQM & CQI Results.
A3	Business Continuity and Disaster Recovery (BC-DR) Plan	Annual report that captures the BC-DR plan and addresses scenarios specified in the contract.
Q1	Fair Hearings Report	Quarterly report that captures detailed provider and participant reconsiderations, and fair hearings as received by TPA. Includes aggregate summary.
Q2	Grievance/Customer Service Calls	Quarterly report that captures customer service calls and includes data regarding the types of calls received and the resolution.
Q3	Critical Incident Reporting	Quarterly report that provides description of adverse event with client and provider details.
M1	Mi Via Master List	Monthly detailed participant list of all current and past (active and inactive) participants and their most recent budget and LOC for Mi Via (MFW and DDW).
M2	Activity and TAT Report - Long Term Care	Monthly report that captures client detail and summary for monthly Level of Care Reviews by Service Type and Status with TAT tracking.
M3	Activity and TAT Report - Mi Via	Monthly TAT Reports Assessments, Level of Care Reviews, and Budget Reviews for Mi Via (MFW and DDW). Report includes client level detail for all activity and aggregate summary.
M4	Activity and TAT Report - Waiver	Monthly TAT Assessments, Level-of-Care Reviews, Budget Reviews for Traditional MFW and DDW. Report includes client level detail for all activity and aggregate summary. Report should also collect the types of services requested.

M5	Activity and TAT Report – ABP-BH-FFS-	Monthly client detail and summary to review activity (approvals and denials for ABP, BH and FFS Prior Authorizations) by Service Type and Status with TAT tracking.
M6	DD waiver Late Log	Monthly client detail from filter of TAT Report M4 of Late DD LOC or ISP submissions.
M7	Request for Information	Monthly report that captures request for information by Program Type with Client detail and Provider information; Date RFI Requested and Information received by TPA.
M8	LOC and Budget Audit Report	Monthly report that captures all LOC and budget reviews completed in the specified month by Program Type. Report includes client level detail, final decision and aggregate summary.
M9	Pending Medicaid	Monthly report that captures clients whose COE is pending.
M10	Supports Waivers LOC and Budgets	Monthly TAT Reports Assessments, Level of Care Reviews, and Budget Reviews for the Supports Waiver. Report includes client level detail for all activity and aggregate summary.
W1	Activity and TAT Report-ICF-IID	Monthly report that captures client detail and summary for monthly ICF-IID Level of Care Reviews and Status with TAT tracking.
W2	Activity and TAT Jackson Class Report	Weekly TAT Assessments for Budget Reviews for DDW Jackson Class Members. Report includes client level detail for all activity and aggregate summary.

APPENDIX I – COST PROPOSAL FORM

New Mexico Human Services Department

Cost Proposal Form Medicaid Third Party Assessor			
Name of Offeror:			
<i>Utilization Review and Assessment Services</i>	<i>Description</i>	<i>Rate Type</i>	<i>Proposed Rate</i>
Prior Authorization Reviews	Prior authorizations for the following Developmental Disabilities waiver services: adult nursing, therapies, and behavioral support consultation.	Per Review	
	Prior authorizations for services or programs that are exempt from managed care, including physical health and Alternative Benefit Plan and Alternative Benefit Plan Medically Fragile exemption.		
EMSNC Reviews	Retrospective medical necessity reviews for Emergency Medical Services for Non-Citizens.	Per Review	
Behavioral Health reviews	Prior authorizations for initial, concurrent and retro reviews. Accredited Residential Treatment Centers (ARTC), Group Homes (GH), Treatment Foster Care (TFC)	Annual Per Recipient	
	Prior authorizations for inpatient psychiatric care	Per Review	
	Prior authorization for Applied Behavioral Analysis (includes any potential Fair Hearings)	Per Review	
	Prior authorization for Substance Use Disorder (SUD)-Inpatient Psychiatric Care and Residential Treatment reviews	Per Review	

	Partial Hospitalization for Substance Use Disorder (SUD) reviews	Per Review	
Level of Care – Mi Via/ Developmental Disability Waivers	Initial and annual level of care determinations <u>plus</u> the in-home assessment for Mi Via and Developmental Disability waiver adults and children requiring ICF/IID level of care.	Annual Per Recipient	
Level of Care – All others	Initial and annual ICF/IID level of care determinations for adults and children in the Medically Fragile and Supports Waiver home and community-based waiver programs. Initial and annual level of care for recipients receiving long-term care services in an ICF/IID facility. Level of care determinations for recipients in the Program of All-Inclusive Care for the Elderly.	Annual Per Recipient	
ISP/SSP and Budgets-Initial and Annals	Review and approval of Initial and Annual Individual Service Plans (ISP) and budgets for Developmental Disabilities Waiver (DDW), Medically Fragile (MFW) recipients and Supports Waiver participants. Review and approval of Service and Support Plans (SSP) and budgets for Mi Via participants.	Per Review	
ISP/SSP and Budgets-Revisions	Review and approval of revised ISPs and budgets for DDW, MFW recipients and Supports Waiver participants. Review and approval of revised SSPs and budgets for Mi Via participants.	Per Review	

***Note: Fair Hearings are NOT separately reimbursable services**