

**New Mexico Human Services Department**



HUMAN  
SERVICES  
DEPARTMENT  
MEDICAL ASSISTANCE DIVISION

**Request for Proposals for the Evaluation of the  
Centennial Care 1115 Demonstration Waiver**

**RFP# 14-630-8000-0006**

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## **I. INTRODUCTION**

### ***A. PURPOSE OF THIS REQUEST FOR PROPOSALS***

In July 2013, the Centers for Medicare & Medicaid Services (CMS) approved the State of New Mexico Human Services Department's (HSD's or Department's) request for Centennial Care, a new Medicaid Section 1115 demonstration waiver. Centennial Care will consolidate nine Medicaid waiver programs into a single, comprehensive managed care delivery system with four managed care organizations (MCOs). Centennial Care's mission is to educate Medicaid participants to become more savvy health care consumers, promote more integrated care, deliver proper care coordination for participants, involve participants in their own wellness, and pay providers for outcomes. The purpose of this Request for Proposals (RFP) is to select an Offeror to perform an evaluation of the Centennial Care waiver, as required by CMS. HSD is soliciting the services of an independent Contractor to evaluate the waiver against its stated program goals and hypotheses.

The procurement will result in a single source award to an Offeror that shall be wholly responsible for conducting the evaluation of Centennial Care. The Offeror must demonstrate the experience and knowledge necessary to perform the services described in the Summary Scope of Work and Section IV Specifications.

### ***B. BACKGROUND INFORMATION***

HSD is the fifth largest state agency in New Mexico, with approximately 2,000 full-time equivalent positions in fifty six (56) locations across the state. Its mission is to "reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance." HSD manages a budget of over \$5 billion in state and federal funds that offer essential needs to New Mexico's low-income populations. More than eight hundred thousand (800,000) New Mexicans are provided with medical care, food assistance, and income support through HSD's various programs, including Medicaid and the Children's Health Insurance Program (CHIP).

#### **Organization of the Agency**

HSD is a cabinet-level Agency in the Executive Branch of New Mexico State government. HSD is headed by a Cabinet Secretary appointed by the Governor and confirmed by the New Mexico State Senate. The Agency consists of the Office of the Secretary, and its programs are administered through several divisions.

The Medical Assistance Division (MAD) manages and administers New Mexico's Medicaid/CHIP Program. In 2013, Medicaid helped pay for health care coverage for more than 527,000 New Mexicans, or almost a quarter of the state's population. Of the five hundred twenty seven thousand (527,000) Medicaid enrollees, two key groups make up that number: children (approximately three hundred thirty seven thousand (337,000) or sixty four percent (64%) and elderly or disabled people (approximately sixty five thousand (65,000) or twelve percent (12%)).

The remaining beneficiaries are enrolled through various eligibility categories. The program supports more than \$3.64 billion in payments for health services each year.

### **Centennial Care**

Centennial Care covers most of New Mexico's Medicaid and CHIP beneficiaries, including:

- Parents and childless adults with low income
- Pregnant women with low income
- Individuals in the Family Planning Program
- Women in the Breast and Cervical Cancer Program
- Children with low income
- CHIP participants
- Children in foster care
- Aged, Blind, and Disabled (ABD) Supplemental Security Income (SSI) recipients
- Medically needy ABD individuals
- Working individuals with disabilities
- Nursing facility residents who are not otherwise eligible for Medicaid with income up to three hundred percent (300%) of the SSI standard
- Individuals who are not otherwise eligible for Medicaid who meet nursing facility level of care criteria and reside in the community with income up to three hundred percent (300%) of the SSI standard

Centennial Care provides a full range of physical health, behavioral health, and long-term services and supports (LTSS), including home and community-based services (HCBS) and institutional care. Participants will receive comprehensive benefits that are at least equal in amount, duration, and scope to those available in the New Mexico Medicaid State Plan. The program design consolidates existing delivery system waivers into a single, comprehensive managed care product. Centennial Care also provides some new and enhanced benefits, including care coordination, a comprehensive community benefit that includes personal care and HCBS, new behavioral health services, and a member rewards program that will provide incentives to individuals for participating in state-defined activities that promote healthy behaviors.

Centennial Care is driven by the following goals:

1. Assuring that Medicaid recipients in the program receive the right amount of care, delivered at the right time, in the right setting
2. Ensuring that expenditures for care and services are measured in terms of quality and not solely by quantity

3. Slowing the growth rate of costs, or “bending the cost curve,” over time without cutting benefits or services, changing eligibility, or reducing provider rates
4. Streamlining and modernizing the Medicaid program in the State

New Mexico further articulated the following four (4) guiding principles for the program:

1. Developing a comprehensive service delivery system that provides the full array of benefits and services offered through the State’s Medicaid program
2. Encouraging more personal responsibility so that recipients become more active participants in their own health and more efficient users of the health care system
3. Increasing the emphasis on payment reforms that pay for performance rather than for the quantity of services delivered
4. Simplifying the administration of the program where possible for providers, recipients and the State.

CMS approved the Centennial Care waiver for an initial demonstration period from January 1, 2014, through December 31, 2018. CMS requires evaluations of all Section 1115 waiver demonstrations, and HSD has submitted an Evaluation Design Plan for CMS approval.

### ***C. SUMMARY SCOPE OF WORK***

HSD is in search of an independent entity to carry out an evaluation of Centennial Care — using the CMS-approved Evaluation Design Plan as a guideline — to ensure that Centennial Care is meeting its goals. See Appendix A for the Evaluation Design Plan: Section II Evaluation Design Requirements; Section III Goal and Guiding Principles; and Section IV Evaluation Design Plan.

This section summarizes the work that will be required of the Offeror, which may change depending on CMS requirements.

#### **A. Oversight**

##### **1. Evaluation Design Requirements**

CMS requires evaluations of all Section 1115 waiver demonstrations. The first step in the evaluation process is to develop and submit an evaluation design plan for CMS approval. CMS regulations require the design plan to include the following elements (42 C.F.R. §431.424):

- Discussion of the demonstration hypotheses
- Description of the data that will be utilized and the baseline value for each measure
- Description of the methods of data collection
- Description of how the effects of the demonstration will be isolated from other changes occurring in the state

- Proposed date by which a final report on findings from activities conducted under the evaluation plan must be submitted to CMS
- Any other information pertinent to the state's research

The special terms and conditions of the Centennial Care waiver further specify that the design plan include descriptions of the following components:

- Research questions and hypotheses
- Study design
- Study population
- Outcome measures
- Data collection
- Data analysis
- Timeline
- Evaluator

HSD submits this report as its evaluation design plan for CMS approval.

## **2. Goals and Guiding Principles**

Centennial Care is driven by the following goals, which will guide the evaluation plan:

1. Ensuring that Medicaid recipients in the program receive the right amount of care, delivered at the right time, in the right setting
2. Ensuring that expenditures for care and services provided are measured in terms of quality as well as quantity
3. Slowing the growth rate of costs, or “bending the cost curve,” over time without cutting benefits or services, changing eligibility, or reducing provider rates
4. Streamlining and modernizing the Medicaid program in the State

New Mexico further articulated the following four guiding principles for the program:

1. Developing a comprehensive service delivery system that provides the full array of benefits and services offered through the State’s Medicaid program
2. Encouraging more personal responsibility so that recipients more actively participate in their own health and use the health care system more efficiently
3. Increasing the emphasis on payment reforms that pay for performance rather than for the quantity of services delivered
4. Simplifying the administration of the program for the State, providers, and recipients where possible

## B. Measures

These reports must include the measures described in the Evaluation Design Plan Section IV: Research Questions and Hypotheses. In addition, the reports must also use analytic techniques to isolate the effects of the Centennial Care demonstration from other external influences also described in the Evaluation Design Plan Section IV: Research Questions and Hypotheses. The measures are largely drawn from National standards. The Offeror will be required to demonstrate comprehensive proficiency of this section.

## C. Data Sources and Collections

HSD will provide the Contractor with data from the following sources to perform the evaluation. The Contractor will be expected to review, analyze, and organize these data. The data should be stored in a format that may be transferred to HSD as described in the Evaluation Design Plan Section IV: Data Sources and Collection.

- **The New Mexico Medicaid Management Information System (MMIS).** The MMIS contains information about enrollment, providers, and claims/encounters for health services. HSD will provide the Contractor with summarized data from the MMIS to perform the measures described in the Evaluation Design Plan. The Contractor will not be expected to process raw MMIS data.
- **Healthcare Effectiveness Data and Information Set (HEDIS).** HEDIS is a nationally recognized system for measuring and reporting health plan performance. HSD contracts with an External Quality Review Organization (EQRO) to review results from data obtained from HEDIS and HEDIS-like measures. HSD will provide the Contractor with these results.
- **Consumer Assessment of Health Plans Survey (CAHPS).** CAHPS is a national, standard survey instrument that will be administered to representative samples of the Centennial Care population to measure patient access and plan satisfaction. HSD contracts with a vendor to perform the CAHPS survey. HSD will provide the Contractor with the CAHPS survey results.
- **CMS 416 Report.** The CMS 416 is the state's annual report to CMS on Medicaid children's utilization of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. This report includes the number of children who receive health screening services, referrals for corrective treatment, and dental services. These data are used to calculate the state's screening ratio by age group. HSD will provide these reports to the Contractor.
- **MCO-Specific Reports.** HSD's contracts with the MCOs require the plans to submit extensive reports on multiple aspects of plan operations, including but not limited to, participant and health care provider activity, specialized services, care coordination, utilization management, quality, systems availability, claims management, and financial management. Many of these reports will supply information that answers research questions and provides or supplements the measures used to test research hypotheses. HSD will provide the Contractor with the MCO reports.

- **Census and Other Publicly Available Data.** The Contractor may be required to analyze Census or other publicly available survey data to evaluate certain measures and analytic techniques.
- **Other.** HSD will consider other data sources proposed by the Contractor.

## D. Reports

The Contractor shall deliver the following to HSD:

1. **Quarterly Reports for CMS.** The Contractor must report quarterly on the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The Contractor must include interim findings when available. The Contractor shall submit the first quarterly report draft to HSD for review at least one month prior to the CMS deadline. The Contractor shall submit subsequent quarterly report drafts to HSD at least two weeks prior to the CMS deadline.
2. **Annual Reports for CMS.** The Contractor must report annually on the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The Contractor must include interim findings when available. The Contractor shall submit a draft of the annual report to HSD at least one month prior to the CMS deadline.
3. **Interim Evaluation Report for CMS.** If the state submits a request for a renewal of the Centennial Care demonstration, the Contractor must develop an interim evaluation report. The Contractor's report must follow the Evaluation Design Plan and must include an executive summary, a description of the demonstration, a discussion of the study design, a discussion of findings and conclusions, and a description of policy implications. The interim evaluation report is due to CMS at the time of the renewal application. CMS determines the deadline for the renewal application, and this deadline is typically twelve (12) months prior to the waiver expiration date. The Contractor will be required to submit a detailed outline of this report at least six months prior to the CMS deadline. The Contractor shall submit the first draft of the report at least four months prior to the CMS deadline.
4. **Final Evaluation Report for CMS.** The Contractor must develop a final evaluation report that follows the Evaluation Design Plan and includes an executive summary, a description of the demonstration, a discussion of the study design, a discussion of findings and conclusions, and a description of policy implications. The final evaluation report is due to CMS on or before April 20, 2019 (or one hundred twenty (120) days following the expiration date of the demonstration). The Contractor will be required to submit a detailed outline of this report at least six months prior to the CMS deadline. The Contractor shall submit the first draft of the report at least four months prior to the CMS deadline.
5. **Analytic and Summary Data Files.** The Contractor shall provide HSD with its summary and analytic data files used to conduct the evaluation upon request. These files must be organized, clearly labeled, and accompanied by a data dictionary.

- 6. Monthly Progress Reports.** The Contractor shall provide written monthly progress reports to HSD during the contract period. These reports must describe the tasks, deliverables, and key milestones performed under the contract during the month. These must also indicate the staff members working on each activity.

This section summarizes the work that will be required of the Offeror, which may change depending on CMS requirements. HSD reserves the right to modify the Evaluation Design as needed over the course of the project period. The evaluation reports will be developed in a format agreed upon by HSD and the Contractor.

#### ***D. SCOPE OF PROCUREMENT***

This procurement will result in a base year contract (sample contract incorporated in this RFP as Appendix B) with four optional one-year extensions. The total number of contract years under this procurement will not exceed four (4) years. Contract extensions are not guaranteed. The initial contract will begin upon final execution from the Department of Finance Administration/Contracts Review Bureau. At the discretion of HSD, the contract and/or its extensions may be amended as needed in order to meet the requirements of this procurement or any future related federal or state requirements for Medicaid or other policy changes affecting the course of the evaluation. Any contract resulting from this procurement shall not be subcontracted, assigned, or otherwise transferred to another Contractor without written prior approval from HSD.

#### ***E. PROCUREMENT MANAGER***

HSD has assigned a Procurement Manager who is responsible for the conduct of this procurement whose name, address, telephone number and e-mail address are listed below:

Name: Reina Guillen, Procurement Manager  
Address: 2025 South Pacheco St., Santa Fe, New Mexico 87504  
Telephone: (505) 827-7232  
Fax: (505) 827-3126  
Email: [Reina.Guillen@state.nm.us](mailto:Reina.Guillen@state.nm.us)

All deliveries of responses via express carrier must be addressed as follows:

Name: Reina Guillen, Procurement Manager  
Reference RFP Name: Evaluation of the Centennial Care 1115 Demonstration  
Waiver RFP# 14-630-8000-0006  
Address: 2025 South Pacheco St., Santa Fe, New Mexico 87504  
Telephone: (505) 827-7232  
Fax: (505) 827-3126  
Email: [Reina.Guillen@state.nm.us](mailto:Reina.Guillen@state.nm.us)

Any inquiries or requests regarding this procurement should be submitted, in writing, to the Procurement Manager. Telephone questions will not be accepted. 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 HSD.

## ***F. DEFINITION OF TERMINOLOGY***

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

“Agency,” “Department,” or “HSD” means the New Mexico Human Services Department.

“Authorized Purchaser” means an individual authorized by a Participating Entity to place orders against this contract.

“Award” means the final execution of the contract document.

"Contract" means any agreement for the procurement of items of tangible personal property, services or construction. For this procurement, the Contract will be based on the contract standard most recently approved by HSD.

"Contractor" means an Offeror who successfully enters into a binding contract.

"Determination" means the written documentation of a decision of a procurement manager including findings of fact required to support a decision. A determination becomes part of the procurement file to which it pertains.

"Evaluation Committee" means a body appointed by HSD to perform the evaluation of Offeror proposals.

"Evaluation Committee Report" means a document prepared by the Procurement Manager and the Evaluation Committee for submission to the Secretary of HSD for contract award. It will contain written determinations resulting from the procurement.

“Finalist” means an Offeror who meets all requirements of this Request for Proposals and whose score on evaluation factors is sufficiently high to merit further consideration by the Evaluation Committee.

"Mandatory" means the terms "must", "shall", "will", "is required", or "are required", identify a mandatory item or factor. The Evaluation Committee reserves the right to waive mandatory requirements provided that all or the majority of the otherwise responsive proposals failed to meet the mandatory requirements and/or doing so does not otherwise materially affect the procurement

"Offeror" is any person, corporation, or partnership who chooses to submit a proposal.

"Price Agreement" means a definite quantity contract or indefinite quantity contract which requires the contractor to furnish items of tangible personal property, services or construction to a state agency or a local public body which issues a purchase order, if the purchase order is within the quantity limitations of the contract, if any.

"Procurement Library" means documents related to this request for proposal that may be stored on an HSD website to support this procurement.

"Procurement Manager" means the person or designee authorized by the Department to manage or administer a procurement requiring the evaluation of competitive sealed proposals.

"Project" means a temporary process undertaken to solve a well-defined goal or objective with clearly defined start and end times, a set of clearly defined tasks, and a budget. The project terminates once the project scope is achieved and project acceptance is given by the project executive sponsor.

"Request for Proposals" means all documents, including those attached or incorporated by reference, used for soliciting proposals.

"Responsible Offeror" means an Offeror who submits a responsive proposal and who has furnished, when required, information and data to prove that his 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.

"Responsive Offer" or "Responsive Proposal" means an offer or proposal which conforms in all material respects to the requirements set forth in the request for proposals. Material respects of a request for proposals include, but are not limited to price, quality, quantity or delivery requirements.

"Secretary" means the Cabinet Secretary of the New Mexico Human Services Department.

"SPD" means State Purchasing Division of the New Mexico State General Services Department.

"Staff" means any individual who is a full-time, part-time, or an independently contracted employee with the Offerors' company.

"State (the State)" means the State of New Mexico.

"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.

"State Purchasing Agent" means the director of the purchasing division of the general services department.

"Technical Proposal" means the Offeror's proposal not including the Cost Proposal.

### ***G. PROCUREMENT LIBRARY***

The Procurement Library related to this RFP can be found at: <http://www.generalservices.state.nm.us/statepurchasing/>. Offerors are encouraged to access the website for documents and materials related to this RFP periodically.

The Procurement Manager may expand these documents materials after the initial RFP release.

## II. CONDITIONS GOVERNING THE PROCUREMENT

This section of the RFP contains 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:

<u>Action</u>	<u>Responsibility</u>	<u>Date*</u>
1. Issue of RFP	HSD	4/18/14
2. Acknowledge Receipt (of RFP) Form	Potential Offerors	4/30/14
3. Pre-proposal Conference	HSD, Potential Offerors	4/30/14
4. Deadline for Submission of Written Questions	Potential Offerors	5/7/14
5. Response to Written Questions	HSD	5/14/14
6. Deadline for Submission of Proposals	Offerors	5/29/14
7. Proposal Evaluation	Evaluation Committee	5/30/14-6/11/14
8. Selection of Finalists	Evaluation Committee	6/12/14
9. Best and Final Offers from Finalists	Finalists	6/17/14
10. Oral Presentations/Demonstration by Finalists ( Conducted at HSDs discretion)	Finalist(s)	6/18-19/14
11. Negotiate/Finalize Contract	HSD and Finalist	6/20/14-6/27/14
12. Contract Award	HSD	7/1/14
13. Protest Deadline award	Offerors	15 days after contract
14. Effective Date of Contract		8/1/14

\* Dates subject to change at the discretion of the Department

## **B. EXPLANATION OF EVENTS**

The following paragraphs describe the activities listed in the sequence of events shown in Section II.

### **B. EXPLANATION OF EVENTS**

The following paragraphs describe the activities listed in the sequence of events shown above.

#### **1. Issue of RFP**

This RFP is being issued by HSD. The RFP may be obtained from the HSD website under the RFP category (<http://www.hsd.state.nm.us/LookingForInformation/open-rfps.aspx>).

#### **2. Acknowledgment of Receipt of Request for Proposals Form Due**

Potential Offerors should hand deliver or return by facsimile, registered or certified mail, or by email with the attachment in Word format, the Acknowledgment of Receipt Form that accompanies this document (Appendix C) to have their organization placed on the procurement distribution list. The form should be signed by an authorized representative of the organization, who shall be the sole contact for the Procurement Manager. The form shall be dated and returned to the Procurement Manager as stated in Section II, A. SEQUENCE OF EVENTS.

The acknowledgment form is used to develop the procurement distribution list. The distribution list shall be used for the distribution of written or e-mailed responses to questions and any RFP amendments. Failure to return this form shall constitute a presumption of receipt and rejection of the RFP and the potential Offeror's organization name shall not appear on the distribution list. Submission of an acknowledgment form does not commit an Offeror to respond to the RFP.

#### **3. Pre-Proposal Conference**

A pre-proposal conference shall be held as stated in Section II, A. SEQUENCE OF EVENTS at 2:00 P.M. Mountain Time, at the HSD MAD Ark Plaza, South Conference Room, 2025 South Pacheco in Santa Fe, New Mexico or at a location as designated by the Procurement Manager. The conference will allow verbal discussion and clarification of the RFP and the procurement in general. Potential Offerors are encouraged to submit written questions to the Procurement Manager seven (7) calendar days in advance of the conference. Questions can be either e-mailed or sent by hard copy. Any e-mail attachments must be in Word format. If questions are submitted in hard copy, the Offeror must also submit them via email in a Word document attachment. If the Offeror does not have access to word processing software meeting these requirements, questions shall be submitted on non-letterhead paper in clear twelve (12) point or larger font, to facilitate scanning. Questions shall be clearly labeled and shall cite the specific section(s) in the RFP, the contract, or other attachments to the RFP that form the basis of the question. The identity of the organization submitting the question(s) shall not be publicly revealed.

Additional written questions may be submitted at the conference. Written questions submitted up to the date of the conference may be answered at the conference. Offerors shall not rely on

verbal answers provided during the pre-proposal conference. Final written answers to all questions shall be issued by HSD as stated in Section II or at a date determined by the Procurement Manager. All potential Offerors of this RFP are invited to participate. A public log shall be kept of the names of potential Offerors that attended the pre-proposal conference. Attendance at the pre-proposal conference is not a prerequisite for submission of a proposal.

**4. Deadline to Submit Additional Written Questions**

Potential Offerors may submit additional written questions as to the intent or clarity of this RFP as stated in Section II, A. SEQUENCE OF EVENTS, by 5:00 P.M., Mountain Time. Any questions received after the due date and time will not be acknowledged by HSD. The Procurement Manager will provide a copy of all questions and answers and/or clarifications to all potential Offerors no later than as stated in Section II. HSD will be bound only to answers and/or clarifications provided in writing by the Procurement Manager.

Questions can be initially either e-mailed or sent by hard copy. Any e-mail attachments must be in Word format. If questions are submitted in hard copy, the Offeror must also submit them via email in a Word document attachment. If the Offeror does not have access to word processing software meeting these requirements, questions shall be submitted on non-letterhead paper in clear twelve (12) point or larger font, to facilitate scanning. Questions shall be clearly labeled and shall cite the specific section(s) in the RFP, the contract, or other attachments to the RFP that form the basis of the question. The identity of the organization submitting the question(s) shall not be publicly revealed.

**5. Response to Written Questions and RFP Amendments**

Written responses to written questions shall be distributed by HSD as stated in Section II, A. SEQUENCE OF EVENTS to all potential Offerors whose organization name appears on the procurement distribution list. HSD shall make every effort to meet this timeline or provide answers as close to the deadline as possible.

If HSD extends the deadline for responding to the written questions and/or, if more than one (1) set of responses to written questions is sent to potential Offerors of record, an Acknowledgment of Receipt Form shall accompany each distribution package and a deadline for its return shall be indicated in the transmittal letter. Failure to acknowledge receipt of any transmittal of Written Questions and RFP Amendments by returning the accompanying form by the deadline requested in the transmittal letter shall constitute a presumption of receipt and also withdrawal by the potential Offeror from the procurement process, and the Offeror's organization name shall be deleted from the procurement distribution list.

**6. Submission of Proposal**

ALL OFFEROR PROPOSALS MUST BE RECEIVED FOR REVIEW AND EVALUATION BY THE PROCUREMENT MANAGER OR DESIGNEE NO LATER THAN 2:00 PM MOUNTAIN STANDARD TIME/DAYLIGHTTIME ON as stated in Section II, A. SEQUENCE OF EVENTS. Proposals received after this deadline will not be accepted. The date and time of receipt will be recorded on each proposal.

Proposals must be addressed and delivered to the Procurement Manager at the address listed in Section I, Paragraph E. Proposals must be sealed and labeled on the outside of the package to clearly indicate that they are in response to the Evaluation of the Centennial Care 1115 Demonstration Waiver RFP #14-630-8000-0006. Proposals submitted by facsimile, or other electronic means, will not be accepted.

A public log will be kept of the names of all Offeror organizations that submitted proposals. Pursuant to Section 13-1-116 NMSA 1978, the contents of proposals shall not be disclosed to competing potential Offerors during the negotiation process. The negotiation process is deemed to be in effect until the contract is awarded pursuant to this Request for Proposals. Awarded in this context means the final required state agency signature on the contract(s) resulting from the procurement has been obtained.

**7. Proposal Evaluation**

The evaluation of proposals shall be performed by an Evaluation Committee appointed by HSD management. This evaluation process shall take place as stated in Section II, A. SEQUENCE OF EVENTS. During this time, the Procurement Manager may at her option, initiate discussions with Offerors who submit responsive or potentially responsive proposals for the purpose of clarifying aspects of the proposals, but proposals may be accepted and evaluated without such discussion. Discussions shall not be initiated by the Offerors.

**8. Selection of Finalists**

The Evaluation Committee shall select the finalists as stated in Section II, A. SEQUENCE OF EVENTS. The Procurement Manager shall notify the finalist Offerors in writing (electronic) by 5:00 P.M., Mountain Time, of their selection as finalists and shall transmit HSD's response to the finalist Offerors' alternative terms and conditions. Only finalists shall be invited to participate in the subsequent steps of the procurement. The Evaluation Committee shall finalize the remainder of the procurement schedule at this time.

**9. Best and Final Offers From Finalists**

Finalist Offerors may be asked to submit revisions to their proposals for the purpose of obtaining best and final offers. Best and final offers may be submitted, clarified and amended before the finalist Offeror's oral presentation but no later than 5:00 P.M. Mountain Time, as stated in Section II, A. SEQUENCE OF EVENTS.

**10. Oral Presentation Finalists**

At HSDs discretion, Finalist Offerors may be required to present their proposals, demonstrations, and designated members of the proposed staff to the Evaluation Committee at a specific time as stated in Section II, A. SEQUENCE OF EVENTS. All oral presentations shall be held at Ark Plaza, 2025 South Pacheco Street, Santa Fe, New Mexico, and shall be limited in duration to no more than two hours per finalist. The Procurement Manager may contact each finalist to schedule the time for each Offeror's presentation. Oral presentations shall be held at a specific date as stated in Section II. Offerors may not initiate contact seeking information about the finalists. Failure to comply shall result in the assessment of penalties as described in Section II, Paragraph C. 21.

#### **11. Finalize Contract**

The contract will be finalized with the most advantageous Offeror during the calendar period as stated in Section II, A. SEQUENCE OF EVENTS. In the event that mutually agreeable terms cannot be reached within the time specified, HSD reserves the right to finalize a contract with the next most advantageous Offeror without undertaking a new procurement process. The Procurement Manager shall contact the successful Offeror. Offerors may not initiate contact with any HSD or other State of New Mexico personnel.

#### **12. Contract Awards**

After review of the Evaluation Committee Report, the recommendation of HSD's management and the negotiated, signed contract, HSD shall award the contract as stated in Section II, A. SEQUENCE OF EVENTS. This date is subject to change at the discretion of HSD. The location will be determined at a later date.

HSD reserves the right to reject any or all of the offers if HSD determines that an insufficient number of the offers meet the needs of HSD. None of the evaluation factors, including the cost factor, is outcome determinative. Should HSD determine that all the offers meet HSD's needs, then the contract shall be awarded to the Offeror whose proposal is most advantageous, taking into consideration the evaluation factors set forth in the RFP. A proposal shall be considered the "most advantageous" if HSD determines the proposal shall best meet HSD's needs. The most advantageous proposal may or may not have received the most points.

The award may be subject to the successful completion of additional contract negotiations and appropriate State and Federal approvals.

HSD also reserves the right to request further clarification on information provided in proposals and to allow for correction of errors contained in proposals submitted by Offerors.

#### **13. Protest Deadline**

Any protest by an Offeror must be timely and in conformance with NMSA 1978, Section 13-1-172 and applicable procurement regulations. The fifteen (15) calendar day protest period for responsive Offerors shall begin on the day after notification of the contract award and will end as of close of business as stated in Section II, A. SEQUENCE OF EVENTS. Protests must be written and must include the name and address of the protestor and the request for proposals

number. It must also contain a statement of grounds for protest including appropriate supporting exhibits, and it must specify the ruling requested from the Secretary. The protest must be physically delivered no later than 5:00 P.M. Mountain Standard Time on the 15th day of protest period to:

Office of General Counsel  
Pollon Plaza  
2009 South Pacheco  
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.

### ***C. GENERAL REQUIREMENTS***

#### **1. Acceptance of Conditions Governing the Procurement**

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

#### **2. Incurring Cost**

Any cost incurred by the potential Offeror in preparation, transmittal, and/or presentation of any proposal or material submitted in response to this RFP shall be borne solely by the Offeror. Any cost incurred by the Offeror for set up and demonstration of the proposed equipment and/or system shall be borne solely by the Offeror.

#### **3. Prime Contractor Responsibility**

Any professional services contract or contractual agreement that may result from this RFP shall specify that the prime contractor is solely responsible for fulfillment of all requirements of the professional services contract or contractual agreement with a state agency which may derive from this RFP. The state agency hiring a vendor from the professional services contract or entering into a contractual agreement with a vendor will make payments to only the prime contractor.

#### **4. Subcontractors/Consent**

The use of subcontractors is allowed. The prime contractor shall be wholly responsible for the entire performance of the contractual agreement whether or not subcontractors are used. Additionally, the prime contractor must receive approval, in writing, from the

agency awarding any resultant contract, before any subcontractor is used during the term of this agreement.

## 5. Amended Proposals

An Offeror may submit an amended proposal before the deadline for receipt of proposals. Such amended proposals must be complete replacements for a previously submitted proposal and must be clearly identified as such in the transmittal letter. The Agency personnel will not merge, collate, or assemble proposal materials.

## 6. Offeror's Rights to Withdraw Proposal

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

The approval or denial of withdrawal requests received after the deadline for receipt of the proposals is governed by the applicable procurement regulations.

## 7. Proposal Offer Firm

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

## 8. Disclosure of Proposal Contents

- A. 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:
- B. Proprietary or confidential data shall be readily separable from the proposal in order to facilitate eventual public inspection of the non-confidential portion of the proposal.
- C. Confidential data is restricted to:
  - 1. Confidential financial information concerning the Offeror's organization.
  - 2. Data that qualifies as a trade secret in accordance with the Uniform Trade Secrets Act, Sections 57-3A-1 to 57-3A-7 NMSA 1978.
  - 3. PLEASE NOTE: The price of products offered or the cost of services proposed **shall not be designated** 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, the Agency shall examine the Offeror's request and make a written determination that specifies which portions of the proposal should 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 the use of any Offeror's services until a valid written contract is awarded and approved by appropriate authorities.

**10. Termination**

This RFP may be canceled 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 process may be terminated if sufficient appropriations or authorizations do not exist. Such terminations will be effected 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. Any Offeror concerns must be promptly submitted in writing to the attention of the Procurement Manager.

**13. Governing Law**

This RFP and any agreement with an Offeror which 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 the preparation of Offeror proposals.

**15. Contract Terms and Conditions**

The contract between an agency and a contractor will follow the format specified by the Agency and contain the terms and conditions set forth in Sample Contract (Appendix B). However, the contracting agency reserves the right to negotiate with any Offeror provisions in addition to those contained in this RFP (Sample Contract). The contents of this RFP, as revised and/or supplemented, and the successful Offeror's proposal will be incorporated into and become part of any resultant contract.

The Agency discourages exceptions to contract terms (Sample Contract) and conditions in the RFP. 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 which would require a substantial proposal rewrite to correct is proposed.

Should an Offeror object to any of the terms and conditions in RFP Sample Contract (Appendix B), strongly enough to propose alternate terms and conditions in spite of the above, 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 provide a brief discussion of the purpose and impact, if any, of each proposed change followed by the specific proposed alternate wording.

**16. Offeror's Terms and Conditions**

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

**17. Contract Deviations**

Any additional terms and conditions, which 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 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 provided that all of the otherwise 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 discretion 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(s) is (are) 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, 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 deriving 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(s) 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). Offeror must have a valid e-mail address to receive this correspondence. (See also Section II.B.7, 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: <http://www.generalservices.state.nm.us/statepurchasing/>.

**28. New Mexico Employees Health Coverage**

1. 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 must agree 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 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 two hundred fifty thousand dollars (\$250,000).
2. Offeror must agree to maintain a record of the number of employees who have (a) 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.
3. Offeror must agree 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/>.
4. For Indefinite Quantity, Indefinite Delivery contracts (price agreements without specific limitations on quantity and providing for 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 sales (from state and, if applicable, from local public bodies if from a state price agreement) of two hundred fifty thousand dollars (\$250,000).

**29. Campaign Contribution Disclosure Form**

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

**30. Pay Equity Reporting Requirements**

- A. If the Offeror has ten (10) or more employees OR eight (8) or more employees in the same job classification, Offeror must complete and submit the required reporting form (PE10-249) if they are awarded a contract.
- B. 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 180 days has elapsed since submittal of the last report, at the completion of the contract.

- C. Should Offeror not meet the size requirement for reporting at contract award but subsequently grows such that they meet or exceed the size requirement for reporting, offer must agree to provide the required report within ninety (90) calendar days of meeting or exceeding the size requirement.
- D. 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 term of the contract. Offeror must further agree that, should one or more subcontractor not meet the size requirement for reporting at contract award but subsequently grows such that they meet or exceed the size requirement for reporting, offer will submit the required report, for each such subcontractor, within ninety (90) calendar days of that subcontractor meeting or exceeding the size requirement.”

### **31. Disclosure Regarding Responsibility**

- A. Any prospective Bidder/Offeror (hereafter Offeror) and any of its Principals who seek to enter into a contract greater than twenty thousand dollars (\$20,000.00) with any state agency or local public body for professional services, tangible personal property, services or construction agree to disclose whether they, or any principal of their company:
  - 1. Are presently debarred, suspended, proposed for debarment, or declared ineligible for award of contract by any federal entity, state agency or local public body.
  - 2. Have within a three-year period preceding this offer, been convicted of or had 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 related to the submission of offers; or 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. Are presently indicted for, or otherwise criminally or civilly charged by any (federal state or local) government entity with, commission of any of the offenses enumerated in paragraph B of this disclosure.
  - 4. Have preceding this offer, been notified of any delinquent Federal or state taxes in an amount that exceeds three thousand dollars (\$3,000.00) of which the liability remains unsatisfied.
    - 1. Taxes are considered delinquent if both of 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.

5. Have within a three 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 a person having primary management or supervisory responsibilities within a business entity or related entities.
- C. The Offeror shall provide immediate written notice to the Procurement Manager or Buyer if, at any time prior to contract award, the Offeror learns that its disclosure was erroneous when submitting 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 withholding an award under this solicitation. However, the disclosure will be considered in the determination of the Offeror's responsibility. Failure of the Offeror to furnish a disclosure or provide additional information as requested will render the Offeror nonresponsive.
- 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 an Offeror is not required to exceed that which is the 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. 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 Procurement Manager or Buyer. If it is later determined that the Offeror 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 such time as the matter is resolved to the satisfaction of the State Purchasing Agent or Central Purchasing Officer.

### **32. Conflict of Interest; Governmental Conduct Act**

The Offeror warrants that it presently has no interest and 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. 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.

### **III. RESPONSE FORMAT AND ORGANIZATION**

This section describes the format and organization of the Offeror's response. Failure to conform to these specifications may result in the disqualification of the proposal.

#### ***A. NUMBER OF RESPONSES***

Offerors must submit only one proposal in response to this RFP.

#### ***B. NUMBER OF COPIES***

##### Hard Copies

Offerors must deliver one (1) original and five (5) identical hard copies of their technical proposal (binder 1), one (1) original and two (2) identical hard copies of their cost proposal (binder 2), and five (5) copies of supporting documentation (binder 3) to the location specified in Section I, Paragraph E on or before the closing date and time for receipt of proposals. Original binders must be identified as such.

##### Electronic Copies

In addition, all materials in binders 1 and 3 must be submitted on one single CD, and all materials in binder 2 must be submitted on a separate single CD. Proposals submitted on CD must be formatted in PDF, Word, and/or Excel to enable HSD to organize comparative review of documents.

#### ***C. PROPOSAL FORMAT***

All proposals must be printed using Times New Roman 12-point font on standard 8 ½ x 11 inch paper and placed within binders with tabs delineating each section. The proposal should be well organized, and each page should include a page number. The proposal must be organized and indexed in the following format and must contain, at a minimum, all listed items in the sequence indicated. Binders must be clearly labeled, and promotional content must be minimal.

##### **1. Technical Proposal Organization (Binder 1, Mandatory):**

The technical proposal (Binder 1) must include the following:

- a) Signed Letter of Transmittal (see Appendix E)
- b) Table of Contents
- c) Proposal Summary (two (2) single-sided pages maximum)
- d) Understanding and Technical Approach (ten (10) single-sided pages maximum)
- e) Qualifications and Prior Experience (ten single-sided pages maximum)
- f) Staffing and Key Personnel (five (5) single-sided pages maximum)
- g) Management Plan (one (1) single-sided page maximum)
- h) Response to Contract Terms and Conditions (see Appendix B)

- i) Signed Campaign Contribution Form (see Appendix D)
- j) Signed Employee Health Coverage Form (see Appendix F)

**2. Cost Proposal Organization (Binder 2, Mandatory):**

- a) Completed Cost Response Form (see Appendix G)

**3. Supporting Documentation (Binder 3, Optional):**

- a) Supporting Documentation (10 single-sided pages maximum)

Offerors may attach other materials that they feel improve the quality of their responses. However, these materials may not exceed 10 single-sided pages.

Within each section of the proposal, Offerors must address the items in the order in which they appear in this RFP. **All forms provided in this 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 Binder #2 on the cost response form.**

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

**4. Letter of Transmittal**

Offeror's proposal must be accompanied by the Letter of Transmittal Form located in Appendix E which must be completed and signed by an individual person authorized to obligate the company. The letter of transmittal **MUST**:

1. Identify the submitting business entity.
2. Identify the name, title, telephone, and e-mail address of the person authorized by the Offeror organization to contractually obligate the business entity providing the Offer.
3. Identify the name, title, telephone, and e-mail address of the person authorized to negotiate the contract on behalf of the organization (if different than (2) above).
4. Identify the names, titles, telephone, and e-mail addresses of persons to be contacted for clarification/questions regarding proposal content.
5. Identify sub-contractors (if any) anticipated to be utilized in the performance of any resultant contract award.
6. Describe the relationship with any other entity which will be used in the performance of this awarded contract.
7. Identify the following with a check mark and signature where required:
  - a. Explicitly indicate acceptance of the Conditions Governing the Procurement stated in Section II, Paragraph C.1;
  - b. Acceptance of Section V of this RFP; and
  - c. Acknowledge receipt of any and all amendments to this RFP.
8. Be signed by the person identified in paragraph 2 above.

## **IV. SPECIFICATIONS**

Offerors should respond in the form of a thorough narrative to each specification, unless otherwise instructed. The narratives, including required supporting materials, will be evaluated and awarded points accordingly.

### **A. TECHNICAL SPECIFICATIONS**

#### **1. Proposal Summary**

Provide a narrative summary of the proposal not to exceed two single-sided pages. The summary should identify all products and services being offered in the proposal and provide a brief description of the Offeror's organization. Do not include cost information in the summary.

#### **2. Understanding and Technical Approach**

A. Provide a detailed description of the Offeror's approach to conducting the evaluation described in the Evaluation Design Plan. Specifically, include descriptions of:

- i. The Offeror's approach to obtaining, reviewing, storing, and analyzing the data sources described in the Evaluation Design Plan Section IV: Data Sources and Collection. Describe any software that will be utilized.
- ii. The Offeror's approach to performing the measures described in the Evaluation Plan Section IV: Measures.
- iii. The Offeror's approach to isolating the effects of the demonstration from other external influences as described in the Evaluation Design Plan Section IV: Isolating the Effects of the Demonstration.
- iv. The Offeror's understanding of Medicaid 1115 waiver evaluation requirements.

B. Provide a timeline of milestones for the completion of project deliverables and the tasks necessary to accomplish each deliverable, including review of data, analysis, quarterly reports, annual reports, and the interim/final evaluation report.

This section should not exceed ten single-spaced pages. Do not include cost information in this section.

#### **3. Qualifications and Prior Experience**

A. Describe relevant experience with government and the private sector. The experience of all proposed subcontractors must also be described. The narrative must thoroughly describe how the Offeror has supplied ten (10) years expertise for similar contracts and must include the extent of their experience, expertise, and knowledge in evaluating publicly-funded health care services and programs. Experience in

evaluating Medicaid 1115 waivers is desirable. Specifically, the description must address the following:

1. Experience in performing quantitative and qualitative evaluation of large-scale public assistance programs, preferably of populations served by Centennial Care. Emphasize experience with Medicaid 1115 waivers, if applicable.
  2. Experience in analyzing Medicaid program administrative data, including enrollment, provider, cost, and service utilization data. Describe the specific data sources, analytic techniques, and analytic software used.
  3. Experience in performing the specific measures and analyses described in the Evaluation Design Plan Section IV: Measures and Section IV: Isolating the Effects of the Demonstration.
  4. Understanding of federal and state (New Mexico) Medicaid policy generally and specific understanding of policy changes related to the Medicaid Expansion and the Affordable Care Act.
- B. Describe the related health services program evaluation experience the Offeror has had in the last two years and the percentage of business revenue that derived from these activities.

This section should not exceed ten single-spaced pages. Do not include cost information in this section.

#### **4. Staffing and Key Personnel**

Briefly describe the key staff that will conduct and manage the program evaluation, including all subcontractors and consultants. Include a description of their role in the project, qualifications, and relevant experience. Biographies or curriculum vitae for all key staff must be provided. This section should not exceed five single-spaced pages. Do not include cost information in this section.

#### **5. Management Plan**

Describe how the Offeror plans to manage the evaluation. Include an explanation of how the Offeror plans to work with HSD over the contract period. This section should not exceed one single-spaced page. Do not include cost information in this section.

#### **6. Business References**

Offerors must provide a minimum of three (3) references from similar projects performed for private, state, or large local government clients within the last three years. Offerors may submit additional reference forms if they wish to provide more than the three required references. **Offerors are required to submit Appendix H, Reference Form, to the business references they list. The business references must submit the Reference Form directly to the designee described in Section I Paragraph E.** It is the Offeror's responsibility to ensure the completed forms are received on or before the proposal submission deadline for inclusion in the evaluation process. Business References that are not

received, or are not complete, may adversely affect the vendor's score in the evaluation process. The Evaluation Committee may contact any or all business references for validation of information submitted. Additionally, the Agency reserves the right to consider any and all information available to it (in addition to the Business Reference information required herein), in its evaluation of Offeror responsibility per Section II, Paragraph C.18.

Offerors shall submit the following Business Reference information as part of Offer:

- 2.1 Client name;
- 2.2 Project description;
- 2.3 Project dates (starting and ending);
- 2.4 Technical environment (i.e., Software applications, Internet capabilities, Data communications, Network, Hardware);
- 2.5 Staff assigned to reference engagement that will be designated for work per this RFP; and
- 2.6 Client project manager name, telephone number, fax number, and e-mail address.

## **7. Oral Presentation**

If selected as a finalist, Offerors **must** agree to provide the Evaluation Committee the opportunity to interview proposed staff members identified by the Evaluation Committee, at the option of the Agency. The Evaluation Committee may request a finalist to provide an oral presentation of the proposal as an opportunity for the Evaluation Committee to ask questions and seek clarifications. **A statement of concurrence must be submitted in the Offeror's proposal.**

## **8. Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance**

Offeror and all subcontractors must attest to HIPAA compliance and provide a description of data security procedures.

## ***B. BUSINESS SPECIFICATIONS***

### **1. Cost**

Offerors must complete the Cost Response Form in Appendix G. All charges listed on Appendix G must be justified and evidence of need documented in the proposal.

### **2. Financial Stability**

Offerors **must** submit copies of the most recent years independently OMB Circular A-133 type of audited financial statements and the most current 10K if publicly owned, as well as financial statements for the preceding three years, if they exist. The submission **must** include the audit opinion, the balance sheet, and statements of income, retained earnings, cash flows, and the notes to the financial statements. If independently audited financial statements do not exist, Offeror **must** state the reason and, instead, submit

sufficient information (e.g. Dun & Bradstreet report) to enable the Evaluation Committee to assess the financial stability of the Offeror.

**3. Performance Bond**

Offeror(s) must have the ability to secure a Performance Surety Bond in favor of the Agency to insure the Contractor's performance upon any subsequent contract award. Each engagement will be different but the option must be available to the Agencies to require at time of contract award. **A statement of concurrence must be submitted in the Offerors proposal.**

**4. Letter of Transmittal Form**

The Offeror's proposal **must** be accompanied by the Letter of Transmittal Form located in Appendix E. The form **must** be completed and must be signed by the person authorized to obligate the company.

**5. Campaign Contribution Disclosure Form**

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. (See Appendix D)

**6. Employee Health Coverage Form**

The Offeror must agree with the terms as indicated in Appendix F. The unaltered form must be completed, signed by the person authorized to obligate the Offeror's firm and submitted with Offeror's proposal.

**7. Pay Equity Reporting**

The Offeror **must** agree with the requirements of reporting as defined in Section II.C.30. Report is due at the time of contract award. **A statement of concurrence with this requirement must be included in Offeror's submitted proposal.**

## V. EVALUATION

### A. EVALUATION POINT SUMMARY

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

<b>Factor</b>	<b>Points Available</b>
Qualifications and Prior Experience	200
Understanding and Technical Approach	250
Staffing, Key Personnel, and Management Plan	200
Business References	50
Cost	300
Oral Presentations	Pass/Fail
HIPAA Compliance	Pass/Fail
Financial Stability	Pass/Fail
Performance Bond	Pass/Fail
Letter Of Transmittal	Pass/Fail
Campaign Contribution Disclosure Form	Pass/Fail
Employee Health Coverage Form	Pass/Fail
Pay Equity Reporting	Pass/Fail
<b>TOTAL</b>	<b>1,000 points</b>

### B. EVALUATION FACTORS

#### 1. Qualifications and Prior Experience

Points will be awarded based on the thoroughness and clarity of the response, the breadth and depth of the engagements cited, and the perceived validity of the response.

#### 2. Understanding and Technical Approach

Points will be awarded based on the Offeror's understanding of the evaluation requirements and the quality and clarity of the technical approach proposed.

#### 3. Staffing, Key Personnel, and Management Plan

Points will be awarded based on the qualifications of key staff and clarity of staff roles and management plan.

#### 4. Business References

Points will be awarded based upon an evaluation of the responses to a series of questions that will be asked of the references concerning the quality of the Offeror's services, the timeliness of services, responsiveness to problems and complaints and the level of satisfaction with the Offeror's overall performance.

**5. Cost**

The evaluation of each Offeror’s cost proposal will be conducted using the following formula:

$$\frac{\text{Lowest Responsive Offer Bid}}{\text{This Offeror’s Bid}} \times \text{Available Award Points}$$

**6. Oral Presentation**

Tally will be based on the quality, organization, and effectiveness of the information presented, as well as the professionalism of the presenters and technical knowledge of the proposed staff. If no Oral Presentations are required all Offerors will receive the same amount of total points for this evaluation factor.

**7. HIPAA Compliance**

Pass/Fail only. No points assigned.

**8. Financial Stability (See Table 1)**

Pass/Fail only. No points assigned.

**9. Performance Bond**

Pass/Fail only. No points assigned.

**10. Letter of Transmittal**

Pass/Fail only. No points assigned.

**11. Campaign Contribution Disclosure Form**

Pass/Fail only. No points assigned.

**12. Employee Health Coverage Form**

Pass/Fail only. No points assigned.

**13. Pay Equity Reporting**

Pass/Fail only. No points assigned.

***C. EVALUATION PROCESS***

1. All Offeror proposals will be reviewed for compliance with the requirements and specifications stated within the RFP. Proposals deemed non-responsive will be eliminated from further consideration.
2. The Procurement Manager may contact the Offeror for clarification of the response as specified in Section II, Paragraph B.7.
3. The Evaluation Committee may use other sources of information to perform the evaluation as specified in Section II, Paragraph C.18.

4. Responsive proposals will be evaluated on the factors in Section IV, which have been assigned a point value. The responsible Offerors with the highest scores will be selected as finalist Offerors, based upon the proposals submitted. The responsible Offerors whose proposals are most advantageous to the State taking into consideration the evaluation factors in Section IV will be recommended for award (as specified in Section II, Paragraph B.8). Please note, however, that a serious deficiency in the response to any one factor may be grounds for rejection regardless of overall score. The state reserves the right not to award a contract if there are no acceptable proposals.

**APPENDIX A**  
**CENTENNIAL CARE EVALUATION DESIGN PLAN**

**State of New Mexico  
Human Services Department**

Evaluation Design Plan  
for Centennial Care Demonstration Waiver

March 10, 2014



HUMAN  
SERVICES  
DEPARTMENT  
MEDICAL ASSISTANCE DIVISION

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## Centennial Care Demonstration Evaluation Design Plan

### I. Background on Centennial Care

In July 2013, the Centers for Medicare & Medicaid Services (CMS) approved the New Mexico Human Services Department's (HSD's) request for Centennial Care, a new Medicaid Section 1115 demonstration waiver. Centennial Care will consolidate nine waiver programs into a single, comprehensive managed care delivery system with four managed care organizations (MCOs). The mission for Centennial Care is to educate Medicaid participants to become more savvy health care consumers, promote more integrated care, deliver proper care coordination for participants, involve participants in their own wellness, and pay providers for outcomes. CMS approved this waiver for an initial demonstration period from January 1, 2014, through December 31, 2018.

#### *Populations Covered*

Centennial Care will cover most of New Mexico's Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. Table 1 describes the populations that will enroll in Centennial Care.

**Table 1. Centennial Care Populations**

New Mexico Centennial Care Waiver Demonstration Groups	Description	Federal Poverty Level (FPL)
Childless Adults	Childless adults aged 19-65 years with low income	Below Exchange subsidy eligibility level
Parents	Parents aged 19-65 years with low income	Below Exchange subsidy eligibility level
Pregnant Women	Pregnant women (includes presumptive eligibility) with low income, pregnancy-related services	Below 185% of the FPL
Individuals in the Family Planning Program	Family planning services only	Below Exchange subsidy eligibility level
Women in the Breast and Cervical Cancer Program	Breast and cervical cancer program services only	Below Exchange subsidy eligibility level
Children with Low Income	Children up to age 19 with low income	Below 138% of the FPL
Qualified Children	Children above 138% of the FPL up to age 19	Between 138%-185% of the FPL
CHIP Participants	Uninsured children above 185% of the FPL up to age 19	Between 185%-235% of the FPL
Foster Children	Former foster children up to age 26 who were on Medicaid while in foster care	N/A
Aged, Blind, and Disabled (ABD) Supplemental Security Income (SSI)	Individuals receiving SSI	Federal SSI standard

New Mexico Centennial Care Waiver Demonstration Groups	Description	Federal Poverty Level (FPL)
Recipients		
Medically Needy ABD	Individuals who are aged, blind, or disabled and spend down to below the SSI standard	Federal SSI standard
Working Individuals with Disabilities	Individuals with disabilities above the SSI standard	250% of the FPL
Nursing Facility Residents	Individuals not otherwise eligible for Medicaid who meet nursing facility level of care (LOC) criteria and reside in nursing facilities	300% of SSI standard
Community Benefit	Individuals not otherwise eligible for Medicaid who meet nursing facility LOC criteria and reside in the community (includes those electing self-directed services [Mi Via])	300% of SSI standard

The following coverage groups are excluded from the Centennial Care 1115 demonstration waiver:

- Qualified Medicare beneficiaries
- Specified low-income Medicare beneficiaries and qualified individuals
- Qualified disabled working individuals
- Non-citizens eligible only for emergency medical services
- Program for All-Inclusive Care for the Elderly (PACE) participants
- Individuals residing in intermediate care facilities for mental retardation
- Developmental disability waiver participants for home and community-based services (HCBS)
- Medically fragile waiver participants for HCBS (until July 2015)

Native Americans who meet nursing facility level of care (LOC) or who are dually eligible for Medicare and Medicaid are required to participate in Centennial Care. Other Native Americans may choose to participate in Centennial Care, or they may choose to access Medicaid benefits through the fee-for-service delivery system.

***Benefits***

Centennial Care will provide a full range of physical health, behavioral health, and long term services and supports (LTSS), including HCBS and institutional care. Participants will receive comprehensive benefits that are at least equal in amount, duration, and scope to those available in the Medicaid State Plan. The program design consolidates existing delivery system waivers into a single, comprehensive managed care product. The demonstration will include services previously offered under the following waivers:

- Salud! 1915(b) waiver: acute managed care for children and parents
- CoLTS 1915(b)(c) waivers: managed LTSS for dual eligibles and individuals with a nursing facility LOC
- Behavioral health 1915(b) waiver: managed behavioral health services through a statewide behavioral health organization
- Mi Via-nursing facility 1915(c) waiver: self-directed HCBS
- AIDS 1915(c) waiver: HCBS for people living with HIV/AIDS
- Medically fragile 1915(c) waiver (beginning July 1, 2015): HCBS for individuals who are determined to be medically fragile

Centennial Care also provides some new and/or enhanced benefits, including:

### ***Care Coordination***

Care coordination is a key Centennial Care benefit. Each MCO performs an initial health risk assessment (HRA) for all participants. The HRA determines initial placement into a care coordination level t assigned on a scale from 1 to 3. Individuals in levels 2 and 3 also receive a comprehensive needs assessment. After initial placement, the MCOs administer the HRA annually to individuals in care coordination level 1. Individuals in care coordination levels 2 and 3 are assigned to a care coordinator, who develops, implements, and monitors a care plan. Individuals in care coordination level 2 receive an annual comprehensive needs assessment to determine whether the care plan is appropriate and if a higher or lower level of care coordination is needed; individuals in level 3 receive this assessment semi-annually.

### ***Community Benefit***

Centennial Care also expands access to LTSS by creating a comprehensive community benefit that includes personal care and HCBS benefits that will be accessible without the need for a slot for beneficiaries who are otherwise Medicaid eligible and have a nursing facility level of care (LOC). Individuals who are not otherwise Medicaid eligible and meet certain criteria will also be able to access the community benefit if a slot is available.

### ***Behavioral Health***

Centennial Care adds three new behavioral health services:

- Recovery services
- Family support
- Respite for youth

### ***Member Rewards Program***

Centennial Care offers a member rewards program that provides incentives to individuals for participating in state-defined activities that promote healthy behaviors. Activities include asthma controller medication compliance, annual recommended testing for diabetes, participation in a prenatal program, schizophrenia treatment compliance, bipolar disorder treatment compliance, osteoporosis management, and annual dental visits. Individuals participating in these activities earn credits that may be used for health-related items.

## **II. Evaluation Design Requirements**

CMS requires evaluations of all Section 1115 waiver demonstrations. The first step in the evaluation process is to develop and submit an evaluation design plan for CMS approval. CMS regulations require the design plan to include the following elements (42 C.F.R. §431.424):

- Discussion of the demonstration hypotheses
- Description of the data that will be utilized and the baseline value for each measure
- Description of the methods of data collection
- Description of how the effects of the demonstration will be isolated from other changes occurring in the state
- Proposed date by which a final report on findings from activities conducted under the evaluation plan must be submitted to CMS
- Any other information pertinent to the state's research

The special terms and conditions of the Centennial Care waiver further specify that the design plan include descriptions of the following components:

- Research questions and hypotheses
- Study design
- Study population
- Outcome measures
- Data collection
- Data analysis
- Timeline
- Evaluator

HSD has submitted this report as its evaluation design plan for CMS approval.

### **III. Goals and Guiding Principles**

Centennial Care is driven by the following goals, which will guide the evaluation plan:

1. Assuring that Medicaid recipients in the program receive the right amount of care, delivered at the right time, in the right setting
2. Ensuring that expenditures for care and services being provided are measured in terms of quality and not solely by quantity
3. Slowing the growth rate of costs, or “bending the cost curve,” over time without cutting benefits or services, changing eligibility, or reducing provider rates
4. Streamlining and modernizing the Medicaid program in the State.

New Mexico further articulated the following four guiding principles for the program:

1. Developing a comprehensive service delivery system that provides the full array of benefits and services offered through the State’s Medicaid program
2. Encouraging more personal responsibility so that recipients become more active participants in their own health and more efficient users of the health care system
3. Increasing the emphasis on payment reforms that pay for performance rather than for the quantity of services delivered
4. Simplifying the administration of the program where possible for providers, recipients and the State.

### **IV. Evaluation Design Plan**

#### ***Study Design***

Because Centennial Care is multifaceted, with impacts on diverse segments of the New Mexico Medicaid population, the evaluation of Centennial Care will be an ongoing study that consists of both discrete and continuous elements. Aspects of the program have particular end goals that must be achieved early in the implementation of the program, and which will then be monitored regularly to assure that they are maintained. Other aspects of the program reflect continual performance process and outcomes measurements as part of service delivery under Centennial Care.

As specified in the Special Terms and Conditions, research to measure and evaluate program performance should be of sufficient rigor to meet standards of peer-reviewed scientific journals. The contract evaluator shall be selected on demonstrated capacity to maintain these research standards. However, each element of the program measured and evaluated may require different research methodologies, some of which HSD can anticipate, and some which will be determined after discussion with the designated evaluation contractor.

Because of the complexity of the Centennial Care program, HSD has developed the following logic model to illustrate and specify causal relationships that can be measured both quantitatively and qualitatively. This illustration explains the input resources, participant activities, program outputs, and expected measured outcomes, for which HSD and the evaluation contractor would be responsible for collecting the quantitative and qualitative data. The sections following the discussion of the logic model then detail the sources for data and their collection methods, the specific research questions and hypotheses tested in the study design, a list of individual measures collected and their application to the questions and hypotheses, and finally a discussion of the analysis of data and the analytic techniques anticipated will be necessary.

### *Logic Model*

The logic model for the Evaluation Plan (Figure 1) presents the inputs or resources available to Centennial Care, program activities, anticipated outputs, and the expected impacts of the program (short, medium, and long-term). The logic model illustrates the connections among the key inputs to Centennial Care, the activities and outputs engendered by these resources, and the expected outcomes of the activities, in relation to the goals of Centennial Care.

The key inputs include coordinated care from the MCOs; administrative oversight of Centennial Care from CMS and HSD; and the participation by enrollees, providers, and citizens. Activities include determination of the care coordination level for each participant and integrated access to high quality physical health, behavioral health, LTSS, and other Centennial Care benefits. The outputs are the products of those activities, which then lead to outcomes that effectuate the ultimate goals of Centennial Care: to improve access to care, enhance quality, control costs, and streamline and modernize the delivery system.

**Figure 1. Logic Model for Centennial Care Evaluation**

Inputs	Activities	Outputs	Outcomes -- Impact		
			Short-Term	Medium-Term	Long-Term
<p>Federal government – CMS</p> <p>State government – NM HSD</p> <p>MCOs</p> <p>Providers (including physical health, behavioral health, and LTSS)</p> <p>Enrollees</p> <p>NM citizens and advocacy groups</p>	<p>Enroll individuals in Centennial Care</p> <p>Determine care coordination level for each participant by assessing risks and health needs</p> <p>Improve access to physical health, behavioral health, and LTSS by providing care coordination and Patient-Centered Medical Homes</p> <p>Integrate care across physical health, behavioral health, and LTSS by giving MCOs full responsibility for all services</p> <p>Ensure quality of services delivered under Centennial Care to Medicaid recipients and their providers through monitoring and incentive systems</p> <p>Improve infrastructure to streamline health service delivery</p>	<p>Care coordinators have responsibility and knowledge of individual participants</p> <p>Participants have improved access even when their health needs are complex, requiring physical health, behavioral health, and LTSS services</p> <p>Providers have responsible point of contact for clients’ needs and can obtain necessary supports</p> <p>Providers receive better compensation for delivering quality services</p> <p>Citizens and advocates receive better value for Medicaid expenditures</p>	<p>Participants access to appropriate high-quality physical health, behavioral health, and LTSS</p> <p>Continuity of care for participants across the spectrum of services and the duration of their needs</p> <p>Efficient provider credentialing</p> <p>Improved claims adjudication</p> <p>Improved grievance and appeals processing</p>	<p>Appropriate utilization of outpatient, inpatient, institutional, and HCBS services</p> <p>Effective and wide-spread use of electronic health records and telemedicine</p> <p>Provider network adequacy across all domains of service (physical health, behavioral health, and LTSS)</p> <p>Satisfaction among all providers of care (physical health, behavioral health, and LTSS)</p> <p>Participant satisfaction</p>	<p>Improved overall health status for Centennial Care participants</p> <p>Decline in growth rate of Medicaid expenditures</p> <p>Health service provider payment reform</p> <p>Delivery system reform</p>

The data sources and collection methods, research hypotheses, and measures are based in part on finding ways to test the causal relationships predicted by this logic model.

### *Data Sources and Collection*

The evaluation will draw on multiple data sources depending on the research question, variable being measured, and population. The study will require both individual-level and aggregate measures of relevant utilization, expenditures, health status, and other outcomes. These data sources include:

- **The New Mexico Medicaid Management Information System (MMIS).** The MMIS contains information about enrollment, providers, and claims/encounters for health services. HSD has revised and improved its information technology systems for the collection of encounter data from the MCOs, validating the quality of the data exchanged with the MCOs, and requiring that payment to providers be included among the encounter data fields. Encounter data, in measuring each participant's interaction with the health care system, will underlie many of the measures of cost and utilization of particular services by individual participants. Detailed data on participant characteristics maintained in the MMIS will allow particular analyses to be stratified by participants' demographic and health service use characteristics. The MMIS system will be used to generate specific reports required by the evaluator. Claim/encounter lag time will depend on the type of service and service provider.
- **Healthcare Effectiveness Data and Information Set (HEDIS).** HEDIS is a nationally-recognized system for the measurement and reporting of health plan performance. HEDIS requires input of high quality encounter and enrollment data to construct comparison groups based on specific clinical criteria, as defined by diagnosis and procedure codes, and demographic characteristics such as age. Because HEDIS measures typically require the accumulation of data over at least one year to establish a baseline measurement, HEDIS reports for Centennial Care will not be available until July 2016. In the interim, HSD has contracted with an External Quality Review Organization (EQRO) to conduct HEDIS-like measures. The MCOs will provide the EQRO with administrative claims and encounter data, as well as supplemental data bases and medical record review data as allowed by HEDIS technical specifications. The EQRO will audit and validate the data provided by the MCOs and perform reports on the measures.
- **Consumer Assessment of Health Plans Survey (CAHPS).** CAHPS is a national, standard survey instrument that will be administered to representative samples of the Centennial Care population to measure patient access and plan satisfaction. The data collected from CAHPS will be used to assess measures of satisfaction with participants' personal physicians, health care experience as a whole, provider communication, and customer service.

- **HRAs.** The Centennial Care MCOs will perform HRAs on all new enrollees. Although the specific HRA instruments will not be uniform across MCOs, the MCO contracts prescribe minimum requirements for the HRA questions. The care coordination level assigned to the participant through the HRA will be reported to the MMIS, which will allow for some control and comparison of measures by levels of severity of chronic conditions.
- **CMS 416 Report.** The CMS 416 is the state's annual report to CMS on Medicaid children's utilization of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. This report includes the number of children who receive health screening services, referrals for corrective treatment, and dental services. States report both the expected number of screening services given the number of children enrolled, and the number of services delivered. These data are used to calculate the state's screening ratio by age group. This data source can be used to measure the number of children who access care.
- **MCO-Specific Reports.** HSD's contracts with the MCOs require the plans to submit extensive reports on multiple aspects of plan operations, participant and health care provider activity, specialized services, care coordination, utilization management, quality, systems availability, claims management, provider satisfaction, and financial management. Many of these reports will supply information that answers research questions and provides or supplements the measures used to test research hypotheses. Although all participating MCOs must meet reporting requirements, there will be no independent validation of the content of the reports, with the exception of the audited HEDIS, CAHPS, and financial reports. Hence, these reports will be used to supplement information from the main analytic data sources. HSD is providing the MCOs with detailed specifications and uniform templates for reporting.

## ***Research Questions and Hypotheses***

Given the previously stated goals of the demonstration, hypotheses and research questions are necessary to assess whether Centennial Care is achieving its purposes. Each of these goals is operationalized through specific measures found later in the evaluation plan.

**Goal 1.** Assure that Medicaid beneficiaries in the demonstration receive the right amount of care, delivered at the right time, in the right setting. The design of the program seeks to eliminate programmatic silos through the consolidation of several waiver programs.

**Hypothesis 1.** Centennial Care's managed care design will deliver greater access in an appropriate and timely fashion.

Research Questions:

- A. Has Centennial Care impacted access to care for all populations and services covered under the waiver, including physical health, behavioral health, and LTSS services?
- B. Is access to care timely?
- C. Are care coordination activities meeting the goals of the right amount of care, delivered at the right time, in the right setting?

**Goal 2.** Ensure that expenditures for care and services being provided are measured in terms of quality and not solely by quantity. This goal is guided by the principle that health care services improve health status most efficiently through coordinated, efficacious care. Centennial Care seeks to provide high quality services and reduce preventable adverse events.

**Hypothesis 2.** Increased care coordination will lead to improved care outcomes and a reduction in adverse events.

Research Questions:

- A. Has quality of care improved under Centennial Care?
- B. Is care integration effective?

**Goal 3.** Slow the growth rate of costs or "bend the cost curve" over time without cutting benefits or services, changing eligibility, or reducing provider rates. Measuring Centennial Care's progress toward this goal requires monitoring the impact of the expansion in Medicaid eligibility authorized under the Affordable Care Act (ACA), as well as determining whether improved care coordination results in a shift in spending towards more comprehensive services for individuals with chronic conditions and/or behavioral health needs and away from unnecessary and often costly service utilization by populations with lesser needs. Centennial Care's success in slowing cost growth by

rewarding participants who achieve certain health care goals will also need to be monitored.

**Hypothesis 3.** The rate of growth in program expenditures under Centennial Care will trend lower over the course of the waiver through lower utilization and/or substitution of less costly services

Research Questions:

- A. To what extent did service utilization and costs increase or decrease due to the implementation of the Centennial Care Program for Medicaid/CHIP beneficiaries in New Mexico?
- B. Has the member rewards program encouraged individuals to better manage their care?

**Goal 4.** Streamline and modernize the Medicaid program in the state. The consolidation of multiple waivers, benefits, and services into the Centennial Care program by itself will streamline New Mexico's Medicaid program. The hypothesis and research questions addressing this goal test whether this consolidation has substantive implications for the health care delivery system in the state, providers, enrollees, and the state administration.

**Hypothesis 4.** Streamlining through Centennial Care will result in improved health care experiences for beneficiaries, improved claims processing for providers, and efficiencies in program administration for the state.

Research Questions:

- A. Are enrollees satisfied with their providers and the services they receive?
- B. Are provider claims paid accurately and on time?
- C. Has the state successfully implemented new processes and technologies for program management, reporting, and delivery system reform?

## *Measures*

Table 2 presents the measures that will be used to determine if each program goal has been achieved. This table describes the data source, National Quality Forum (NQF) number (where applicable), stratification categories, comparison groups, and frequencies for each measure. A number of criteria were used to select the measures, including their relevance to the goals and research questions, applicability to the populations affected, and feasibility of measurement using the data sources available to HSD and the evaluator.

Most measures may be performed for various demographic groups and populations of special interest. These include age, gender, race/ethnicity, county, geographic region (including rural, urban, and frontier), Native Americans opting in/opting out of Centennial Care, individuals with LTSS needs, individuals with behavioral health needs, coverage group (e.g., Medicaid expansion), and others identified by HSD and/or the evaluator. The measures are largely drawn from CMS' *Initial Core Set of Adult Health Care Quality Measures*,<sup>1</sup> CMS' *Initial Set of Children's Health Care Quality Measures*,<sup>2</sup> the Agency for Healthcare Research and Quality (AHRQ) *Prevention Quality Indicators*,<sup>3</sup> and AHRQ *Pediatric Quality Indicators*.<sup>4</sup> Other measures are specifically designed for unique aspects of Centennial Care.

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<sup>1</sup> <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-%E2%80%93-Adult-Health-Care-Quality-Measures.html>

<sup>2</sup> <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html>

<sup>3</sup> [http://www.qualityindicators.ahrq.gov/Modules/PQI\\_TechSpec.aspx](http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx)

<sup>4</sup> [http://www.qualityindicators.ahrq.gov/Modules/PDI\\_TechSpec.aspx](http://www.qualityindicators.ahrq.gov/Modules/PDI_TechSpec.aspx)

**Table 2. Measures for Centennial Care Evaluation**

Research Questions	Measure	NQF Number	Data Source	Stratification Category	Comparison Groups	Frequency
<b>Goal 1. Assure that Medicaid beneficiaries in the program receive the right amount of care, delivered at the right time, in the right setting</b>						
A. Has Centennial Care impacted access to care for all populations and services covered under the waiver, including physical health, behavioral health, and LTSS services?	Access to preventive/ambulatory health services among Centennial Care enrollees in aggregate and within subgroups	Similar to 1332	HEDIS /NCQA	MCO; demographic characteristics* (such as age, gender, race/ethnicity, geographic region (including rural, urban, and frontier), county)	Comparison to baseline; trending over time	Annual
	Mental health services utilization		HEDIS/NCQA	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Number of telemedicine providers and telemedicine utilization		MCO telehealth report	MCO; geographic region; service type (physical health, LTSS, and behavioral health)	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually
	Number and percentage of people meeting nursing facility LOC who are in a nursing facility		MMIS and encounter data	MCO; demographic characteristics; care coordination level	Pre-Centennial Care compared to post Centennial Care; trending over time	Annual
	Number and percentage of people meeting nursing facility LOC who		MMIS and encounter data	MCO; demographic characteristics; care coordination level; self-directed	Pre-Centennial Care compared to post Centennial	Annual

Research Questions	Measure	NQF Number	Data Source	Stratification Category	Comparison Groups	Frequency
	receive HCBS			population	Care; trending over time	
	Number and percentage of people with annual dental visit	1388	HEDIS/NCQA CMS Core Quality Measure for Children	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Enrollment in Centennial Care as a percentage of state population		MMIS and Current Population Survey	Demographic characteristics	Comparison to baseline; trending over time	Annual
	Number of Native Americans opting in and opting out of Centennial Care		MMIS	Demographic characteristics	Comparison to pre-Centennial Care; trending over time; comparison of opt-in v. opt-out population	Annual
?	Number and percentage of participants who accessed a physical health, behavioral health, and LTSS service		MMIS and encounter data	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Annual
	Number and percentage of participants with behavioral health conditions who accessed any of the 3 new behavioral health		MMIS and encounter data	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Annual

<b>Research Questions</b>	<b>Measure</b>	<b>NQF Number</b>	<b>Data Source</b>	<b>Stratification Category</b>	<b>Comparison Groups</b>	<b>Frequency</b>
	services (respite, family support, and recovery)					
	Number and percentage of unduplicated participants with at least one PCP visit, in aggregate and among subgroups		MMIS and encounter data  CMS Core Quality Measure for Children	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Annual
	Number/ratio of participating providers to enrollees		MCO network adequacy, PCP, and geographic access reports	MCO; provider type (PCP, etc.)	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually
	Percentage of PCP panel slots open		MCO PCP report	MCO	Comparison to baseline; trending over time	Reported by MCOs monthly; evaluator may summarize to present annually
B. Is access to care timely?	Number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving residential treatment center (RTC)	Similar to 0576	MMIS and encounter data	MCO; demographic characteristics; participants leaving RTC placement	Comparison to baseline; trending over time	Annual

Research Questions	Measure	NQF Number	Data Source	Stratification Category	Comparison Groups	Frequency
	placement					
	Number and percentage of acute care participants with a follow-up outpatient visit 7 days and 30 days after hospitalization	Similar to 0576	MMIS and encounter data/NCQA	Demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Annual
	Number and percentage of behavioral health participants with follow-up after hospitalization for mental illness	0576	HEDIS /NCQA CMS Core Quality Measure for Adults and Children	MCO; care coordination level; demographic characteristics	Comparison to baseline; trending over time	Annual
	Childhood immunization status	0038	HEDIS /NCQA CMS Core Quality Measure for Children	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Immunizations for adolescents	1407	HEDIS /NCQA CMS Core Quality Measure for Children	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Well-child visits in first 15 months of life	1392	HEDIS/NCQA CMS Core Quality Measure for	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual

<b>Research Questions</b>	<b>Measure</b>	<b>NQF Number</b>	<b>Data Source</b>	<b>Stratification Category</b>	<b>Comparison Groups</b>	<b>Frequency</b>
			Children			
	Well-child visits in third, fourth, fifth, and sixth years of life	1516	HEDIS /NCQA CMS Core Quality Measure for Children	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Adolescent well care visits		HEDIS /NCQA CMS Core Quality Measure for Children	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Prenatal and postpartum care: timeliness of prenatal care and percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	1517	HEDIS/NCQA CMS Core Quality Measure for Adults and Children	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Frequency of ongoing prenatal care	1391	HEDIS/NCQA CMS Core Quality Measure for Children	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Breast cancer screening for women		HEDIS/NCQA CMS Core Quality Measure for Adults	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual

<b>Research Questions</b>	<b>Measure</b>	<b>NQF Number</b>	<b>Data Source</b>	<b>Stratification Category</b>	<b>Comparison Groups</b>	<b>Frequency</b>
	Cervical cancer screening for women	0032	HEDIS/NCQA  CMS Core Quality Measure for Adults	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Flu vaccinations for adults	0039	CAHPS or MMIS claims and encounter data/NCQA  CMS Core Quality Measure for Adults	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Initiation and engagement of alcohol and other drug dependence treatment	0004	HEDIS/NCQA  CMS Core Quality Measure for Adults	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Geographic access measures		MCO network adequacy and geographic access reports	MCO; geographic regions	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually
C. Are care coordination activities meeting the goals of right amount of care, delivered at the	Number and percentage of participants with health risk assessments completed within contract timeframes		MCO care coordination report	MCO; demographic characteristics; self-directed population; care coordination level; population with behavioral health needs	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually

<b>Research Questions</b>	<b>Measure</b>	<b>NQF Number</b>	<b>Data Source</b>	<b>Stratification Category</b>	<b>Comparison Groups</b>	<b>Frequency</b>
right time, in the right setting?	Number and percentage of participants who received a care coordination designation and assignment of care coordinator within contract timeframes		MCO care coordination report	MCO; care coordination level; demographic characteristics; self-directed population; population with behavioral health needs; geographic region	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually
	Number and percentage of participants in care coordination level 2 that had comprehensive needs assessments scheduled and completed within contract timeframes		MCO care coordination report	MCO; care coordination level; demographic characteristics; population with behavioral health needs	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually
	Number and percentage of participants in care coordination level 3 that had comprehensive needs assessments scheduled and completed within contract timeframes		MCO care coordination report	MCO; care coordination level; demographic characteristics; population with behavioral health needs	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually

<b>Research Questions</b>	<b>Measure</b>	<b>NQF Number</b>	<b>Data Source</b>	<b>Stratification Category</b>	<b>Comparison Groups</b>	<b>Frequency</b>
	Number and percentage of participants in care coordination level 2 who received in-person visits and telephone contact within contract timeframes		MCO care coordination report	MCO; care coordination level; demographic characteristics; self-directed population; population with behavioral health needs	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually
	Number and percentage of participants in care coordination level 3 who received in-person visits and telephone contact within contract timeframes		MCO care coordination report	MCO; care coordination level; demographic characteristics; self-directed population; population with behavioral health needs	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually
	Number and percentage of participants the MCO is unable to locate for care coordination		MCO unreachable members report	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Reported by MCOs monthly; evaluator may summarize to present annually

<b>Research Questions</b>	<b>Measure</b>	<b>NQF Number</b>	<b>Data Source</b>	<b>Stratification Category</b>	<b>Comparison Groups</b>	<b>Frequency</b>
	Number and percentage of members transitioning from HCBS to a nursing facility; number and percentage of participants in nursing facilities transitioning to community (HCBS)		MMIS and encounter data	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Annual
	Number and percentage of participants receiving HCBS whose Individualized Service Plans (ISPs) address all assessed needs from the comprehensive needs assessment (services and supports needed to live in the community)		Record review of a representative sample	MCO; care coordination level; demographic characteristics; population with LTSS needs; population with behavioral health needs	Comparison to baseline; trending over time	Annual

Research Questions	Measure	NQF Number	Data Source	Stratification Category	Comparison Groups	Frequency
	Number and percentage of participants receiving HCBS whose services were delivered in accordance with the ISP (type, scope, amount, and frequency)		MMIS and encounter data; record review of a representative sample	MCO; care coordination level; demographic characteristics; population with LTSS needs; population with behavioral health needs; self-directed population	Comparison to baseline; trending over time	Annual
	Number and percentage of participants who refuse care coordination		MCO unreachable members report	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Reported by MCOs monthly; evaluator may summarize to present annually
<b>Goal 2. Ensure that expenditures for care and services being provided are measured in terms of quality and not solely by quantity</b>						
A. Has quality of care improved under Centennial Care?	EPSDT screening ratio		CMS 416 report	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Monitoring for patients on persistent medications		HEDIS/NCQA CMS Core Quality Measure for Adults	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Neonatal mortality rate (AHRQ Pediatric Quality Indicators)		MMIS and encounter	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Annual

Research Questions	Measure	NQF Number	Data Source	Stratification Category	Comparison Groups	Frequency
	Number and percentage of births pre-term		MMIS and encounter	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Annual
	Low birth weight rate (AHRQ Prevention Quality Indicators)	0278	MMIS and encounter/AHRQ CMS Core Quality Measure for Children	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Annual
	Medication management for people with asthma	1799	HEDIS/NCQA CMS Core Quality Measure for Children	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Use of appropriate medications for people with asthma	0036	HEDIS/NCQA	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Asthma medication ratio	1800	HEDIS/NCQA	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Adult BMI assessment; weight assessment for children/adolescents	0024, 0421	HEDIS/NCQA CMS Core Quality Measure for Adults and Children	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Comprehensive diabetes care	0061, 0055, 0575, 0059,	HEDIS/NCQA CMS Core Quality Measure for Adults	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual

Research Questions	Measure	NQF Number	Data Source	Stratification Category	Comparison Groups	Frequency
		0057, 0064, 0063, 0062				
	Ambulatory care sensitive (ACS) admission rates (AHRQ Prevention Quality Indicators):diabetes short- and long-term complications, uncontrolled admission rates	0274, 0272, 0638	MMIS and encounter/AHRQ  CMS Core Quality Measure for Adults	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Annual
	ACS admission rates (AHRQ Prevention Quality Indicators): COPD or asthma in older adults; asthma in younger adults	0275, 0283	MMIS and encounter/AHRQ  CMS Core Quality Measure for Adults	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Annual
	ACS admission rates (AHRQ Prevention Quality Indicators): hypertension	Similar to 0709	MMIS and encounter/AHRQ	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Annual
	ACS admission rates (AHRQ Pediatric Quality Indicators):pediatric asthma	0283	MMIS and encounter/AHRQ	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Annual

Research Questions	Measure	NQF Number	Data Source	Stratification Category	Comparison Groups	Frequency
	Number and percentage of emergency department (ED) visits that are potentially avoidable <sup>5</sup>		MMIS and encounter	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Annual
	Smoking and tobacco use cessation	0027	HEDIS/NCQA CMS Core Quality Measure for Adults	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Number of critical incidents by reporting category (abuse, neglect, exploitation, environment hazard, emergency services, law enforcement, elopement/missing, and death)		MCO critical incidents report	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Monthly
	Drug overdose mortality rate		MMIS and encounter	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Annual
	Antidepressant medication management	0105	HEDIS/NCQA CMS Core Quality Measure for Adults	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual

<sup>5</sup> One widely used methodology for classifying ED visits is the algorithm developed by researchers at the New York University Center for Health and Public Service Research. This algorithm is available for free and may be downloaded from: <http://wagner.nyu.edu/faculty/billings/nyued-download>.

<b>Research Questions</b>	<b>Measure</b>	<b>NQF Number</b>	<b>Data Source</b>	<b>Stratification Category</b>	<b>Comparison Groups</b>	<b>Frequency</b>
	Inpatient admissions to psychiatric hospitals and RTCs		MMIS and encounter	MCO; demographic characteristics; populations of special interest	Comparison to baseline; trending over time	Annual
	Percentage of nursing facility residents who transitioned from a low nursing facility to a high nursing facility		MMIS and encounter	Demographic characteristics	Comparison to baseline; trending over time	Annual
	Percentage of members aged 65 years and older who have had a fall or problem with balance in the past 12 months who were seen by a practitioner in the last 12 months and who have received a fall risk intervention)	0035	HEDIS/NCQA	Demographic characteristics	Comparison to baseline; trending over time	Annual
	Linkage to HIV medical care: number of persons with HIV who attended a routine HIV medical care visit within 3 months of HIV diagnosis		MMIS and Encounter Data/HHS	Persons with HIV Diagnosis	Comparison to baseline; trending over time	Annual

<b>Research Questions</b>	<b>Measure</b>	<b>NQF Number</b>	<b>Data Source</b>	<b>Stratification Category</b>	<b>Comparison Groups</b>	<b>Frequency</b>
	Retention in HIV medical care: number of persons with HIV who had at least one HIV medical care visit in each 6-month-period of the 24-month measurement period	2079	MMIS and Encounter Data/HRSA	Persons with HIV Diagnosis	Comparison to baseline; trending over time	Annual
	Antiretroviral therapy (ART) among persons In HIV medical care: number of persons with HIV who are prescribed ART in the 12-month measurement period	2083	MMIS and Encounter Data/HHS	Persons with HIV Diagnosis	Comparison to baseline; trending over time	Annual
B. Is care integration effective?	Percentage of population accessing a behavioral health service that received a PCP visit in the same year		MMIS and encounter data	MCO; demographic characteristics; participants diagnosed with a behavioral health condition	Comparison to baseline; trending over time	Annual
	Percentage of population accessing an LTSS service that received a PCP visit in the same year		MMIS and encounter data	MCO; demographic characteristics; participants diagnosed with a behavioral health condition	Comparison to baseline; trending over time	Annual

<b>Research Questions</b>	<b>Measure</b>	<b>NQF Number</b>	<b>Data Source</b>	<b>Stratification Category</b>	<b>Comparison Groups</b>	<b>Frequency</b>
	Percentage of population accessing an LTSS service that also accessed a behavioral health service in the same year		MMIS and encounter data	MCO; demographic characteristics; participants diagnosed with a behavioral health condition	Comparison to baseline; trending over time	Annual
	Percentage of population with behavioral health needs with an ED visit by type of ED visit		MMIS and encounter data	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Percentage of population with LTSS needs with an ED visit by type of ED visit	Similar to 0173	MMIS and encounter data/CMS	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Percentage of population at risk for nursing facility placement who remain in the community		MCO care coordination report	MCO; demographic characteristics	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually
	Number and percentage of participants who accessed a behavioral health service that also accessed HCBS		MMIS and encounter data	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual

Research Questions	Measure	NQF Number	Data Source	Stratification Category	Comparison Groups	Frequency
	Number and percentage of participants that: a. Maintain their care coordination level/LOC b. Move to a lower care coordination level/LOC c. Move to a higher care coordination level/LOC		MCO care coordination report and LOC report	MCO; demographic characteristics	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually
	Percentage of population accessing a behavioral health service that received an outpatient, ambulatory visit in the same year		MMIS and encounter data	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	1932	HEDIS/NCQA	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Diabetes monitoring for people with diabetes and schizophrenia	1934	HEDIS/NCQA	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
<b>Goal 3. Slow the growth rate of costs or "bend the cost curve" over time without cutting benefits or services, changing eligibility, or reducing provider rates</b>						

<b>Research Questions</b>	<b>Measure</b>	<b>NQF Number</b>	<b>Data Source</b>	<b>Stratification Category</b>	<b>Comparison Groups</b>	<b>Frequency</b>
A. To what extent did service utilization and costs increase or decrease due to the implementation of the Centennial Care program for Medicaid/CHIP beneficiaries in New Mexico?	Total program expenditures		Audited MCO financial reports; encounter payment data	Total program; populations of special interest; demographic characteristics; domains of service; care coordination level; self-directed population; behavioral health population	Trending over time	Annual
	Costs per member		Audited MCO financial reports; encounter payment data	Total program; populations of special interest; demographic characteristics; domains of service; care coordination level; self-directed population	Trending over time	Annual
	Cost per user of services		Encounter payment data	Total program; populations of special interest; demographic characteristics; domains of service; care coordination level; self-directed population	Trending over time	Annual
	Utilization by category of service		MMIS and encounter	Populations of special interest; demographic	Trending over time	Annual

<b>Research Questions</b>	<b>Measure</b>	<b>NQF Number</b>	<b>Data Source</b>	<b>Stratification Category</b>	<b>Comparison Groups</b>	<b>Frequency</b>
				characteristics		
	Hospital costs		Encounter payment data; expenditures by category of services report	Populations of special interest; demographic characteristics	Trending over time	Quarterly
	Use of HCBS		Encounter payment data; MCO self-directed report	Domains of service; care coordination level	Trending over time	Quarterly
	Use of institutional care (skilled nursing facilities)		Encounter payment data; MCO facilities readmission report	Populations of special interest; demographic characteristics; care coordination level	Trending over time	Quarterly
	Use of mental health services		Encounter payment data; MCO utilization by category of services report; MCO expenditures by category of services report; MCO over/under utilization report	Populations of special interest; demographic characteristics	Trending over time	Quarterly

<b>Research Questions</b>	<b>Measure</b>	<b>NQF Number</b>	<b>Data Source</b>	<b>Stratification Category</b>	<b>Comparison Groups</b>	<b>Frequency</b>
	Use of substance abuse services		Encounter payment data; MCO utilization by category of services report; MCO expenditures by category of services report; MCO over/under utilization report	Populations of special interest; demographic characteristics	Trending over time	Quarterly
	Use of pharmacy services		Encounter payment data; MCO utilization by category of services report; MCO expenditures by category of services report; MCO over/under utilization report	Populations of special interest; demographic characteristics	Trending over time	Quarterly
	Inpatient services exceeding \$50,000 <sup>6</sup>		Encounter payment data	Total program; populations of special interest; demographic characteristics; domains of service; care coordination level. Vendor to identify high cost	Trending over time	Annual

<sup>6</sup> This threshold may be adjusted after reviewing encounter data.

Research Questions	Measure	NQF Number	Data Source	Stratification Category	Comparison Groups	Frequency
				diagnoses for monitoring		
	Use of diagnostic imaging		Encounter payment data	Total program; populations of special interest; demographic characteristics; domains of service; care coordination level	Trending over time	Annual
	ED use		Encounter payment data	Total program; populations of special interest; demographic characteristics; domains of service; care coordination level	Trending over time	Annual
	All cause readmissions	Similar to 1768	MCO facilities readmission report/NCQA  CMS Core Quality Measure for Adults	MCO; facility type; procedure code	Trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually

Research Questions	Measure	NQF Number	Data Source	Stratification Category	Comparison Groups	Frequency
	Inpatient mental health/substance use services		Encounter payment data	Total program; populations of special interest; demographic characteristics; domains of service; care coordination level	Trending over time	Annual
B. Has the member rewards program encouraged individuals to better manage their care?	<b>Members Receiving Rewards in Each Category, as a Percentage of those with Eligible Conditions:</b>					
	Asthma controller medication compliance (children)		MMIS and encounter data; MCO member rewards report	Populations of special interest; demographic characteristics	Comparison to baseline; trending over time	Annual
	Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam)		MMIS and encounter data; MCO member rewards report	Populations of special interest; demographic characteristics	Comparison to baseline; trending over time	Annual
	Prenatal program (earned when signing up for the MCO's program)		MMIS and encounter data; MCO member rewards report	Populations of special interest; demographic characteristics	Comparison to baseline; trending over time	Annual
	Treatment adherence - schizophrenia		MMIS and encounter data; MCO member rewards report	Populations of special interest; demographic characteristics	Comparison to baseline; trending over time	Annual
	Treatment adherence - bipolar		MMIS and encounter data; MCO member rewards report	Populations of special interest; demographic characteristics	Comparison to baseline; trending over time	Annual

Research Questions	Measure	NQF Number	Data Source	Stratification Category	Comparison Groups	Frequency
	Osteoporosis management in elderly women – females aged 65+ years		MMIS and encounter data; MCO member rewards report	Populations of special interest; demographic characteristics	Comparison to baseline; trending over time	Annual
	Annual dental visit – adult		MMIS and encounter data; MCO member rewards report	Populations of special interest; demographic characteristics	Comparison to baseline; trending over time	Annual
	Annual dental visit – child		MMIS and encounter data; MCO member rewards report	Populations of special interest; demographic characteristics	Comparison to baseline; trending over time	Annual
	Number of members spending credits		Fulfillment vendor report on member rewards program activities	Populations of special interest; demographic characteristics	Comparison to baseline; trending over time	Annual
<b>Goal 4. Streamline and modernize the Medicaid program in the state</b>						
A. Are enrollees satisfied with their providers and the services they receive?	Percentage of grievances with expedited resolution within 3 business days		MCO grievances and appeals report	MCO; populations of special interest	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually
	Percentage of grievances resolved within 30 days		MCO grievances and appeals report	MCO; populations of special interest	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually

<b>Research Questions</b>	<b>Measure</b>	<b>NQF Number</b>	<b>Data Source</b>	<b>Stratification Category</b>	<b>Comparison Groups</b>	<b>Frequency</b>
	Percentage of appeals upheld		MCO grievances and appeals report	MCO; populations of special interest	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually
	Percentage of appeals partially overturned		MCO grievances and appeals report	MCO; populations of special interest	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually
	Percentage of appeals overturned		MCO grievances and appeals report	MCO; populations of special interest	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually
	Number and percentage of calls answered; answered within 30 seconds; call abandonment rate		MCO call center report	MCO	Comparison to baseline; trending over time	Reported by MCOs monthly; evaluator may summarize to present annually

<b>Research Questions</b>	<b>Measure</b>	<b>NQF Number</b>	<b>Data Source</b>	<b>Stratification Category</b>	<b>Comparison Groups</b>	<b>Frequency</b>
	Number and percentage of participants in care coordination levels 2 and 3 satisfied with their care coordination		MCO grievances and appeals report	MCO; populations of special interest	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually
	Rating of personal doctor	0006	CAHPS/NCQA CMS Core Quality Measure for Adults and Children	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Rating of health care	0006	CAHPS/NCQA CMS Core Quality Measure for Adults and Children	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	How well doctors communicate composite measure	0006	CAHPS/NCQA CMS Core Quality Measure for Adults and Children	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Customer service composite measure	0006	CAHPS/NCQA CMS Core Quality Measure for Adults and Children	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual
	Rating of specialist seen most often	0006	CAHPS/NCQA CMS Core Quality Measure for Adults and Children	MCO; demographic characteristics	Comparison to baseline; trending over time	Annual

<b>Research Questions</b>	<b>Measure</b>	<b>NQF Number</b>	<b>Data Source</b>	<b>Stratification Category</b>	<b>Comparison Groups</b>	<b>Frequency</b>
B. Are provider claims paid accurately and on time?	Percentage of clean claims adjudicated in 30/90 days		MCO claims activity reports	Provider type: behavioral health, physical health, I/T/U, specialty pay provider	Comparison to baseline; trending over time	Reported by MCOs weekly; evaluator may summarize to present annually
	Percentage of claims denied		MCO claims activity reports	Provider type: behavioral health, physical health, I/T/U, specialty pay provider	Comparison to baseline; trending over time	Reported by MCOs weekly; evaluator may summarize to present annually
	Dollar accuracy rate		MCO claims payment accuracy reports	Claim type: inpatient hospital, behavioral health, nursing facility, I/T/U, crossover, HCBS, dental, FQHC/RHC	Comparison to baseline; trending over time	Reported by MCOs monthly; evaluator may summarize to present annually
	Percentage of grievances resolved on time		MCO grievances and appeals report	MCO	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually
	Percentage of provider appeals resolved on time		MCO grievances and appeals report	MCO	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may

Research Questions	Measure	NQF Number	Data Source	Stratification Category	Comparison Groups	Frequency
						summarize to present annually
	Provider satisfaction survey results		MCO provider satisfaction survey report	MCO	Comparison to baseline; trending over time	Annual
C. Has the state successfully implemented new processes and technologies for program management, reporting, and delivery system reform?	Number and percentage of providers using electronic health records/participating in the Health Information Exchange		MCO performance improvement project report	MCO	Comparison to baseline; trending over time	Annual
	Use of different care delivery models, such as number of health home participants		TBD once implemented	TBD once implemented	TBD once implemented	TBD once implemented
	Percentage of claims paid accurately		MCO claims payment accuracy reports	MCO	Comparison to baseline; trending over time	Reported by MCOs monthly; evaluator may summarize to present annually
	Use and outcomes of payment reforms, e.g., bundled rates for adult diabetes, pediatric asthma, and urban hospitals		TBD once implemented	TBD once implemented	TBD once implemented	TBD once implemented

Research Questions	Measure	NQF Number	Data Source	Stratification Category	Comparison Groups	Frequency
	Number and percentage of visits in compliance with electronic visit verification system <sup>7</sup> requirement		MCO electronic visit verification report	MCO	Comparison to baseline; trending over time	Reported by MCOs monthly; evaluator may summarize to present annually
	Adoption of electronic case management/care coordination system by MCOs		MCO care coordination report	MCO	Comparison to baseline; trending over time	Reported by MCOs quarterly; evaluator may summarize to present annually
	Amount of federal waiver reporting and oversight – number of reports and staff time		HSD staff reports	N/A	Pre-Centennial Care compared to post Centennial Care; trending over time	Annual

\*Demographic characteristics include: age, gender, race/ethnicity, county, and geographic region (including rural, urban, and frontier).

\*\*Populations of special interest include: Native Americans opting in/opting out of Centennial Care, individuals with LTSS needs, individuals with behavioral health needs, coverage group (e.g., Medicaid expansion), children in foster care, individuals with HIV/AIDS, and others identified by HSD/evaluator.

<sup>7</sup> The electronic visit verification system monitors receipt and utilization of community benefit services.

## *Data Analysis*

A major concern for planning analysis in evaluation research and scientific study design is whether the effects of an intervention can be separated from other activities and external influences that may affect the measured outcomes of that intervention. External changes that may affect Centennial Care performance include:

- Economic trends, such as changes in employment and/or inflation
- Introduction of new medical care standards or technology, e.g. a new pharmaceutical protocol for behavioral health issues
- Epidemiology of disease patterns, such as a flu epidemic
- Expected increased enrollment in the program, bringing new populations into the Centennial Care delivery system
- Simultaneous implementation of other physical health, behavioral health, and HCBS models
- Changes in case-mix (e.g., relative severity of illness) as Centennial Care consolidates services and expands care for newly-enrolled populations
- State and/or federal policy changes

Any external changes beyond the control of the Centennial Care program make isolating the effects of Centennial Care more difficult. As a preliminary stage, a qualitative environmental survey, conducted with the assistance of HSD and other state agencies, would identify policy changes and other economic and technological trends of potential impact. The evaluator would consult with interest groups in communities of concern to identify other health and social service initiatives that may affect the outcomes. This qualitative analysis would attempt to assess the counterfactual, i.e., would the changes (or absence of changes) observed in the relevant measures have occurred without the Centennial Care program? Can those changes be explained by the causes suggested in a systematic survey of alternatives? If not, then the analysis can conclude that the Centennial Care program had an impact, although the value of that impact might not yet be quantifiable at this stage.

Quantifying the impact is further complicated because Centennial Care is being implemented state-wide. This means that individuals cannot be randomly assigned to Centennial Care, with others remaining in the existing program as controls. Without random assignment, other research designs can be used, but are less able to separate and distinguish program effects from the simultaneous effects of external impacts. Multiple regression techniques can be used to isolate the effects of non-random differences in characteristics that influence outcomes from the effects of the program itself. For example, because Native Americans can choose whether to participate in Centennial Care, the effects of the Centennial Care program on the health of Native American populations in the state allow for a comparison between non-random control groups. Because those Native Americans who choose to join

the program may differ from those who choose not to join the program, observed differences between the two groups might be caused by the non-random selection into Centennial Care. The analytical model would need to examine the characteristics of Native American Centennial Care participants and determine how they differ from those Native Americans who did not join and elected to receive services through the fee-for-service program.

However, multiple regression approaches would need to acknowledge that unmeasured characteristics of the joiners and non-joiners could explain differences in outcomes. Alternatively, a sample of joiners and non-joiners could be selected based on a propensity scoring model, matching enrollees who chose to opt out with enrollees who chose to opt in on their predicted propensity to join the program. The propensity score would be based on a multivariate probit regression model, which would generate an estimated probability for each individual enrollee to either join or not join Centennial Care. Cases and controls would then be matched on their predicted probability scores, and further multivariate modeling would then test the effects of the Centennial Care interventions.

To measure program effects for populations that cannot be separated into case and control groups, an interrupted time-series analysis is suitable for those program measurements that are frequently repeated and can be measured prior to the initiation of Centennial Care in 2014. An example is financial measurements, including total program costs and costs per capita, for enrollees as a whole and for particular subgroups. The selected evaluator would obtain access to financial data from HSD and/or the MCOs related to their operational and service costs prior to implementation of Centennial Care.

Other measures, such as those affecting newly enrolled individuals and populations, can be used only to assess change from the baseline measurement year of 2014. Although Centennial Care could compare its results on instruments such as CAHPS and HEDIS to national benchmarks, Centennial Care will only be able to monitor its progress after baseline measures are established during the first year of operation. Without the opportunity to measure characteristics and status before the intervention, this is the weakest design in terms of controlling for other causal influences. However, assuming that all participants of a study group experience the same external causal influences along with enrollment in Centennial Care, the environmental scan previously described would inventory potential external causes and qualitatively assess their relative importance in affecting the measured outcomes.

## **V. Next Steps: Evaluator and Timeline**

HSD will issue a request for proposals (RFP) for an independent evaluator to conduct the evaluation described in this report. Once awarded, HSD will provide CMS with a description of the evaluator's qualifications, the contract award amount, and other pertinent information. The following outlines HSD's draft timeline, as specific dates might change, depending on CMS' approval of this design:

- Submission of evaluation design to CMS – December 9, 2013
- Final CMS approval of evaluation design – TBD
- Issue RFP and award evaluation contract – First quarter of 2014
- Evaluation updates to CMS – Quarterly and annual reports, as required in the Special Terms and Conditions
- Interim evaluation report – Submitted with waiver application renewal
- Final evaluation report- Submitted 120 days following waiver expiration

HSD requests flexibility in the proposed design plan, as unanticipated events, policy changes, and the eventual evaluation contractor may impact the evaluation design.

**APPENDIX B**  
**SAMPLE CONTRACT**

# SAMPLE 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 **NAME OF CONTRACTOR**, hereinafter referred to as the "Contractor," and is effective as of the date set forth below upon which it is executed by the Department of Finance and Administration (DFA).

IT IS AGREED BETWEEN THE PARTIES:

**1. Scope of Work.**

The Contractor shall perform all services detailed in Exhibit A, Scope of Work, attached to this Agreement.

**2. Compensation.**

A. The HSD shall pay to the Contractor in full payment for services satisfactorily performed at the rate of \_\_\_\_\_ dollars (\$\_\_\_\_\_) per hour (OR BASED UPON DELIVERABLES, MILESTONES, BUDGET, ETC.), such compensation not to exceed (AMOUNT) including gross receipts tax, if applicable, **in FYXX**. 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.

**(FOR MULTI-YEAR CONTRACTS REPEAT THE sub paragraph above for each additional year. Then delete this bolded instruction.)**

B. Payment is subject to availability of funds pursuant to the Appropriations Paragraph set forth below and to any negotiations between the parties from year to year pursuant to Paragraph 1, Scope of Work, and to approval by the DFA. All invoices **MUST BE** received by the HSD no later than fifteen (15) days after the termination of the Fiscal Year in which the services were delivered. **Invoices received after such date WILL NOT BE PAID.**

(—OR—)

**(FOR MULTI-YEAR CONTRACTS REPEAT B, below, for each additional year, replacing each XX with digits representing the year(s), then delete this bolded instruction and B, above, which is for a single year contract.)**

B. Payment in FYXX, FYXX, FYXX, and FYXX is subject to availability of funds pursuant to the Appropriations Paragraph set forth below and to any negotiations between the parties from year to year pursuant to Paragraph 1, Scope of Work, and to approval by the DFA. All invoices **MUST BE** received by the HSD no later than fifteen (15) 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 detailed statement accounting for all services performed and expenses incurred. 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 DFA. This Agreement shall terminate on **(DATE)** 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 four 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.

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. 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).

**13. 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.

**14. 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.

**15. 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.

**16. 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.

**17. 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.

**18. 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.

**19. Records and Financial Audit.**

A. The Contractor shall maintain detailed time and expenditure records that indicate the date, time, nature and cost of services rendered during the Agreement's term and effect and retain them for a period of five (5) years from the date of final payment under this Agreement. The records shall be subject to inspection by the HSD, the Department of Finance and Administration and the State Auditor. The HSD shall have the right to audit billings both before and after payment. Payment under this Agreement shall not foreclose the right of the HSD to recover excessive or illegal payments.

B. Contract for an independent OMB Circular A-133 audit at the Contractor's expense, as applicable. 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 OMB A-133 Circular or by Federal program officials for the conduct and report of such audits. On a yearly basis as specified in the solicitation, subrecipients must provide a copy of their OMB Circular A-133 type of audited financial statements to the Division or Office Program Manager. An official copy of the independent auditor's report shall be made 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 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 a schedule of financial expenditures for each program to facilitate ease of reconciliation by the HSD. This audit shall also include a schedule of depreciation for all property or equipment with a purchase price of \$5,000 or more pursuant to OMB Circulars A-21, A-87, A-110, A-122 and A-133 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 OMB Circulars A-21, A-87, A-110, A-122 and A-133 where appropriate.

**20. 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.

**21. 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/>.

**22. Employee Pay Equity Reporting.**

Contractor agrees if it has ten (10) or more New Mexico employees OR eight (8) or more employees in the same job classification, at any time during the term of this contract, to complete and submit the PE10-249 form on the annual anniversary of the initial report submittal for contracts up to one (1) year in duration. If contractor has (250) or more employees, contractor must complete and submit the PE250 form on the annual anniversary of the initial report submittal for contracts up to one (1) year in duration. For contracts that extend beyond one (1) calendar year, or are extended beyond one (1) calendar year, contractor also agrees to complete

and submit the PE10-249 or PE250 form, whichever is applicable, within thirty (30) days of the annual contract anniversary date of the initial submittal date or, if more than 180 days has elapsed since submittal of the last report, at the completion of the contract, whichever comes first. Should contractor not meet the size requirement for reporting at contract award but subsequently grows such that they meet or exceed the size requirement for reporting, contractor agrees to provide the required report within ninety (90) days of meeting or exceeding the size requirement. That submittal date shall serve as the basis for submittals required thereafter. Contractor also agrees to levy this requirement on any subcontractor(s) performing more than 10% of the dollar value of this contract if said subcontractor(s) meets, or grows to meet, the stated employee size thresholds during the term of the contract. Contractor further agrees that, should one or more subcontractor not meet the size requirement for reporting at contract award but subsequently grows such that they meet or exceed the size requirement for reporting, contractor will submit the required report, for each such subcontractor, within ninety (90) days of that subcontractor meeting or exceeding the size requirement. Subsequent report submittals, on behalf of each such subcontractor, shall be due on the annual anniversary of the initial report submittal. Contractor shall submit the required form(s) to the State Purchasing Division of the General Services Department, and other departments as may be determined, on behalf of the applicable subcontractor(s) in accordance with the schedule contained in this paragraph. Contractor acknowledges that this subcontractor requirement applies even when contractor itself does not meet the size requirement for reporting and therefore is not required to report itself.

Notwithstanding the foregoing, if this Contract was procured pursuant to a solicitation, and if Contractor has already submitted the required report accompanying their response to such solicitation, the report does not need to be re-submitted with this Agreement.

**23. 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.

**24. 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.

**25. 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:

[insert name, address and email].

To the Contractor:

[insert name, address and email].

**26. 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.

**27. Debarment and Suspension**

A. Consistent with either 7 C.F.R. Part 3017 or 45 C.F.R. Part 76, 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.

**28. 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 or Subparts B and C of 7 C.F.R. Part 3018, 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.

**29. 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."

**30. 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.

**31. 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.

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.

**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 DFA Contracts Review Bureau below.**

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.

ID Number: **00-000000-00-0**

By: \_\_\_\_\_ Date: \_\_\_\_\_  
Taxation and Revenue Department

This Agreement has been approved by the DFA Contracts Review Bureau:

By: \_\_\_\_\_ Date: \_\_\_\_\_  
DFA Contracts Review Bureau

## **Exhibit A**

### **Scope of Work**

*The scope or statement of work (SOW), referenced on page 1 in Section 1, is to be presented here as Exhibit A in the PSC.*

**APPENDIX C**  
**ACKNOWLEDGEMENT OF RECEIPT FORM**

ACKNOWLEDGEMENT OF RECEIPT FORM  
Evaluation of the Centennial Care 1115 Demonstration Waiver  
14-630-8000-0006

In acknowledgement of receipt of this Request for Proposal 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 close of business April 30, 2014. 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 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.

Name: Reina Guillen, Procurement Manager  
Address: 2025 South Pacheco St.,  
Santa Fe, New Mexico 87504  
Telephone: (505) 827-7232  
Fax: (505) 827-3126  
Email: [Reina.Guillen@state.nm.us](mailto:Reina.Guillen@state.nm.us)

**APPENDIX D**  
**CAMPAIGN CONTRIBUTION DISCLOSURE FORM**

## **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:**

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**  
**LETTER OF TRANSMITTAL FORM**

## Letter of Transmittal Form

**RFP#:** \_\_\_\_\_

**Offeror Name:** \_\_\_\_\_

Items #1 to #7 EACH MUST BE COMPLETED IN FULL Failure to respond to all seven items WILL RESULT IN THE DISQUALIFICATION OF THE PROPOSAL!

1. **Identity (Name) and Mailing Address** of the submitting organization:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. For the person authorized by the organization to contractually obligate on behalf of this Offer:

Name \_\_\_\_\_

Title \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

3. For the person authorized by the organization to negotiate on behalf of this Offer:

Name \_\_\_\_\_

Title \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

4. For the person authorized by the organization to clarify/respond to queries regarding this Offer:

Name \_\_\_\_\_

Title \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

5. Use of Sub-Contractors (Select one)

No sub-contractors will be used in the performance of any resultant contract OR

The following sub-contractors will be used in the performance of any resultant contract:

\_\_\_\_\_  
(Attach extra sheets, as needed)

6. Please describe any relationship with any entity (other than Subcontractors listed in (5) above) which will be used in the performance of any resultant contract.

\_\_\_\_\_  
(Attach extra sheets, as needed)

7.  On behalf of the submitting organization named in item #1, above, I accept the Conditions Governing the Procurement as required in Section II, Paragraph C.1.

I concur that submission of our proposal constitutes acceptance of the Evaluation Factors contained in Section V of this RFP.

I acknowledge receipt of any and all amendments to this RFP.

\_\_\_\_\_, 2012  
Authorized Signature and Date (Must be signed by the person identified in item #2, above.)

**APPENDIX F**  
**NEW MEXICO EMPLOYEES HEALTH COVERAGE FORM**

## NEW MEXICO EMPLOYEES HEALTH COVERAGE FORM

1. 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 must agree 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 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.
2. Offeror must agree to maintain a record of the number of employees who have (a) 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.
3. Offeror must agree 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://insurenwemexico.state.nm.us/>.
4. For Indefinite Quantity, Indefinite Delivery contracts (price agreements without specific limitations on quantity and providing for 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 sales (from state and, if applicable, from local public bodies if from a state price agreement) of \$250,000.

Signature of Offeror: \_\_\_\_\_ Date \_\_\_\_\_

**APPENDIX G  
COST RESPONSE FORM**

**COST RESPONSE FORM**

**Sample Below**

**(Buyers note: Ensure statutory requirements of NMSA 13-1-150 regarding Multi Term Contracts limits are complied with when establishing Pricing/Term periods or extension pricing)**

<b>Description</b>	<b>Type</b>	<b>Quantity</b>	<b>Cost per Item</b>

Example Format: Base Period: (xx/xx/xxxx thru xx/xx/xxxx) Price: \$  
**(includes all labor, materials, equipment, transportation, fees and taxes to provide the Services described in Section I, paragraph C, (as amended by any current RFP amendments for the period specified above)**

**Option Year 1: (xx/xx/xxxx thru xx/xx/xxxx) Price:\$\_\_\_\_\_**

(includes all labor, materials, equipment, transportation, configuration, installation, training, taxes and profit to provide the Services described in Section I, paragraph C, (as amended by any current RFP amendments for the period specified above)

**Option Year 2: (xx/xx/xxxx thru xx/xx/xxxx) Price:\$\_\_\_\_\_**

(includes all labor, materials, equipment, transportation, configuration, installation, training, taxes and profit to provide the Services described in Section I, paragraph C, (as amended by any current RFP amendments for the period specified above)

**Option Year 3: (xx/xx/xxxx thru xx/xx/xxxx) Price:\$\_\_\_\_\_**

(includes all labor, materials, equipment, transportation, configuration, installation, training, taxes and profit to provide the Services described in Section I, paragraph C, (as amended by any current RFP amendments for the period specified above)

Option Year 4: (xx/xx/xxxx thru xx/xx/xxxx) Price:\$\_\_\_\_\_

(includes all labor, materials, equipment, transportation, fees and taxes to provide the Services described in Section I, paragraph C, (as amended by any current RFP amendments for the period specified above)

**APPENDIX H**  
**REFERENCE QUESTIONNAIRE**

## REFERENCE QUESTIONNAIRE

The State of New Mexico, as a part of the RFP process, requires Offerors to submit a minimum of three (3) business references as required within this document. The purpose of these references is to document Offeror's experience relevant to the scope 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 Form directly to:

Name: Reina Guillen, Procurement Manager  
Address: 2025 South Pacheco St.,  
Santa Fe, New Mexico 87504  
Telephone: (505) 827-7232  
Fax: (505) 827-3126  
Email: [Reina.Guillen@state.nm.us](mailto:Reina.Guillen@state.nm.us)

by the RFP submission deadline for inclusion in the evaluation process. The form and information provided will become a part of the submitted proposal. Business references provided may be contacted for validation of content provided therein.

### RFP # 14-630-8000-0006 REFERENCE QUESTIONNAIRE FOR:

---

(Name of Offeror)

This form is being submitted to your company for completion as a business reference for the company listed above. This form is to be returned to the State of New Mexico,

Name: Reina Guillen, Procurement Manager  
Address: 2025 South Pacheco St.,  
Santa Fe, New Mexico 87504  
Telephone: (505) 827-7232  
Fax: (505) 827-3126  
Email: [Reina.Guillen@state.nm.us](mailto:Reina.Guillen@state.nm.us)

no later than **<Insert date>**, 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 Request for Proposal number listed at the top of this page.

**CONFIDENTIAL INFORMATION WHEN COMPLETED**

<b>Company providing reference:</b>	
<b>Contact name and title/position</b>	
<b>Contact telephone number</b>	
<b>Contact e-mail address</b>	

QUESTIONS:

1. In what capacity have you worked with this vendor in the past?

COMMENTS:

2. How would you rate this firm's knowledge and expertise?

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

COMMENTS:

3. How would you rate the vendor's flexibility relative to changes in the project scope and timelines?

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

COMMENTS:

4. What is your level of satisfaction with hard-copy materials produced by the vendor?

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

COMMENTS:

5. How would you rate the dynamics/interaction between the vendor and your staff?

\_\_\_\_\_ (3 = Excellent; 2 = Satisfactory; 1 = Unsatisfactory; 0 = Unacceptable)  
COMMENTS:

6. Who were the vendor's principal representatives involved in your project and how would you rate them individually? Would you comment on the skills, knowledge, behaviors or other factors on which you based the rating?  
(3 = Excellent; 2 = Satisfactory; 1 = Unsatisfactory; 0 = Unacceptable)

Name: \_\_\_\_\_ Rating:

Name: \_\_\_\_\_ Rating:

Name: \_\_\_\_\_ Rating:

Name: \_\_\_\_\_ Rating:

COMMENTS:

7. How satisfied are you with the products developed by the vendor?  
\_\_\_\_\_ (3 = Excellent; 2 = Satisfactory; 1 = Unsatisfactory; 0 = Unacceptable)  
COMMENTS:

8. With which aspect(s) of this vendor's services are you most satisfied?  
COMMENTS:

9. With which aspect(s) of this vendor's services are you least satisfied?

COMMENTS:

10. Would you recommend this vendor's services to your organization again?

COMMENTS:

**APPENDIX I**  
**ADDITIONAL INFORMATION**

## ADDITIONAL INFORMATION

*Initial Core Set of Adult Health Care Quality Measures,*<sup>i</sup>

*CMS' Initial Set of Children's Health Care Quality Measures,*<sup>ii</sup>

*The Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators,*<sup>iii</sup>

*AHRQ Pediatric Quality Indicators.*<sup>iv</sup>

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<sup>i</sup> <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-%E2%80%93Adult-Health-Care-Quality-Measures.html>

<sup>ii</sup> <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html>

<sup>iii</sup> [http://www.qualityindicators.ahrq.gov/Modules/PQI\\_TechSpec.aspx](http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx)

<sup>iv</sup> [http://www.qualityindicators.ahrq.gov/Modules/PDI\\_TechSpec.aspx](http://www.qualityindicators.ahrq.gov/Modules/PDI_TechSpec.aspx)