New Mexico Department of Health, Public Health Division
Rural Primary Health Care Act (RPHCA) Program

Legal Notice of Request for Proposals

The New Mexico Department of Health (DOH), Public Health Division (PHD), Rural Primary Health Care Act (RPHCA) Program is issuing a Request for Proposals (RFP) to provide financial assistance to eligible programs that demonstrate a need for assistance in order to sustain a minimum level of delivery of primary care services in health care underserved areas of New Mexico pursuant to the Rural Primary Health Care Act (24-1A, NMSA, 1978). Eligible programs must be a New Mexico non-profit community-based entity, a local government or tribal government that provides primary health care services. Additional eligibility requirements must also be met. These services must be provided in accordance with applicable federal, state, and local laws.

The proposed contracts shall become effective upon approval of the Department of Finance and Administration and shall continue for a four-year period at the discretion of the DOH contingent upon sufficient funding and satisfactory Scope of Work performance.

The RFP can be downloaded from the Department of Health website at https://nmhealth.org.

Offerors may contact: Crystal Begay, Office of Primary Care & Rural Health, 300 San Mateo Blvd. NE, Ste. 900, Albuquerque, New Mexico 87108. Email communication to Crystal.Begay@state.nm.us is preferable.

Offerors interested in submitting a proposal must submit the "Acknowledgement of Receipt of RFP/Intent to Submit form by **Monday, March 25, 2019.**

Proposals must be received for review by 5:00 pm MST on Monday, April 8, 2019. The PHD reserves the right to cancel this RFP and/or to reject any proposal in whole or in part. The content of any proposal shall not be disclosed to competing Offerors during the negotiation process.

If you are a person with a disability who is in need of a reader, amplifier, sign language interpreter or any other form of auxiliary aid or service to participate, please contact the New Mexico Relay Network at 1-800-659-8331. Public documents including the RFP can be provided in various accessible forms. Contact the New Mexico Relay Network if a summary or other type of accessible form is needed.

REQUEST FOR PROPOSALS
Rural Primary Health Care Act (RPHCA)

Date of Issuance: **March 7, 2019**

Deadline for Submission: **April 8, 2019**

NEW MEXICO
DEPARTMENT OF
HEALTH

PUBLIC HEALTH DIVISION (PHD)
Population and Community Health Bureau
Office of Primary Care and Rural Health (OPCRH)

Contact: Crystal Begay
New Mexico Department of Health
Office of Primary Care and Rural Health
300 San Mateo Blvd. NE, Suite 900
Albuquerque, New Mexico 87108
Telephone: (505) 222-8679
Email: Crystal.Begay@state.nm.us

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I. INTRODUCTION

A. Purpose of this Request for Proposals

The purpose of this request for proposal (RFP) is to provide financial assistance to eligible programs that have applied for, **and demonstrated a need for**, basic assistance in order to sustain a minimum level of delivery of primary health care services in health care underserved areas (HCUAs) of New Mexico pursuant to the provisions of the Rural Primary Health Care Act (RPHCA), 24-1A, NMSA, 1978 (see appendix F). The RPHCA RFP will result in multiple Offerors being selected for contracts.

The RPHCA Program provides State funding for primary care clinic sites throughout New Mexico and has documented providing over a 1,000,000 patient encounters to over 382,000 patients in fiscal year 2018. Clinics funded by RPHCA represent a significant component of the health care safety net for New Mexico. All RPHCA funded clinics must utilize sliding fee scales and cannot turn away a patient solely based on their inability to pay. During these challenging economic times, the need for ensuring access to affordable health care has never been stronger.

B. Background Information

This section provides background on the Department of Health, the Public Health Division, and the operating environment of the Department which may be helpful to the Offeror in preparing the proposal. The information is provided as an overview and is not intended to be a complete and exhaustive description.

Department of Health Vision/Mission

The vision of the New Mexico Department of Health (DEPARTMENT) is that New Mexico is a healthy community in which to live and grow.

The mission of the DEPARTMENT is to promote health and sound health policy, prevent disease and disability, improve health services systems and assure that essential public health functions and safety net services are available to New Mexicans.

Public Health Division Mission

The mission of the Public Health Division (DIVISION or PHD) of the DEPARTMENT is to work with individuals, families, and communities in New Mexico to achieve optimal health. We provide public health leadership by assessing health status of the population, developing health policy, sharing expertise with the community, assuring access to coordinated systems of care and delivering services to promote health and to prevent disease, injury, disability and premature death.

C. Summary Scope of Work

Contracts resulting from this RFP will require contractors, at a minimum to:

A. Ensure the provisions of primary care services in underserved areas of the state by providing the following:

1. Annual Projected Level of Operations forms.

2. Contract Action Plan, which must include:

a. Estimated level of services
b. Staffing
c. Hours of operation, including after-hours coverage and emergency care
d. Prenatal care services
e. Family planning services
f. Dental services
g. Behavioral health services
h. Ancillary services
i. Specialty clinics
j. Referral relationships with EMS (emergency medical services), hospital, dental, behavioral health and other services
k. Integration methods for improving coordination of care across settings
l. Collaboration with public and private providers, school-based health centers, and tribal programs to maximize delivery of primary care services
m. Recruitment and retention plan for healthcare providers, including:
n. Total dollar amount of RPHCA funding used towards healthcare provider salaries and benefits
o. Total dollar amount of RPHCA funding used towards healthcare provider recruitment (*This amount reflects recruitment efforts/methods, such as how much is used for advertisement of positions, recruitment agencies, etc. If using New Mexico Health Resources to recruit and/or post job listings, please indicate*).
p. Rate of retention of healthcare providers at the clinic (*On average, how many years are providers staying? If providers are leaving, are they leaving New Mexico?)*
q. Governing Board and/or Local/Regional Advisory Board information
r. Evaluation methods
s. Other pertinent information

3. Submit a detailed Quality Improvement/Assurance (QI/QA) Plan for each clinic site ensuring that it includes:
   a. Clinical services and management services.
   b. Systematic collection and evaluation of patient records.
   c. Periodic assessment of the appropriateness of the utilization of services and the quality of services provided.

B. Submit data and reports through the Online RPHCA Reporting System by providing:

1. Monthly Level of Operations Data for each clinic site for services provided in the previous month. Should the actual level of services fall below 90% of the projected level for a period exceeding 60 days the contract may be renegotiated including reviewing and adjusting the amount of payment.
2. Summary Monthly Narrative Report on the status of the activities toward accomplishment of the scope of work, any significant issues and changes, and progress toward meeting the Annual Projected Level of Operations projections.

C. Ensure policies and procedures states that no person will be denied services because of their inability to pay. These policies and procedures should address the provision of services to medically indigent persons below poverty not covered by third party payors and those between 100 percent and 200 percent of poverty guidelines without third party coverage. The facility must also:

   1. Post a notice in a conspicuous location in the patient waiting area that a sliding fee discount is available to eligible persons with income up to 200 percent of poverty and are not covered by third party payors, and
   2. Advertise in the community, local media and other areas that a sliding fee discount is available to eligible persons with income up to 200 percent of poverty and are not covered by third party payors.

D. Assess all patients without third party coverage for Medicaid eligibility, and participate, as appropriate, in on-site Medicaid eligibility determination, presumptive eligibility and Early Periodic Screening, Diagnosis, and Treatment (EPSDT).

E. Review Medicaid and Medicare reimbursements to assure maximization of generated revenues and, if appropriate, participate in reimbursement programs under the Rural Health Clinic Services Act or Federally Qualified Health Centers Certification.

F. Maintain for inspection the appropriate and most current facility licensure from the AGENCY Health Facility Licensing & Certification Bureau by providing:

   1. Current Operator's License.
   2. Current New Mexico professional licenses or certifications, and Board certification if applicable, for all services providers whose salaries or contracts are supported in whole or part by RPHCA funds.

G. Authorize the Agency access to all the Health Resources and Services Administration (HRSA) documentation (if HRSA funded) regarding:

   1. Site visit reports and findings relating to the operation of the health centers.
   2. Scheduled visits by HRSA. Notify the AGENCY in advance of the HRSA visit.

H. Participate in clinic site visit(s) conducted by the AGENCY.

I. Participate and complete the New Mexico Health Resources, Inc. Annual Salary surveys and Quarterly Vacancy Surveys regarding health care recruitment and retention,

J. Work with the County and/or Tribal Community Health Improvement Council(s) to ensure coordination of its work with the Council's health

improvement plan and activities.

K. Ensure majority of Governing Board shall be consumers of the primary health care services it provides and is generally representative of the target population it serves.

L. Ensure diversity of programs and structure, and that programs offered meet the Federal cultural and linguistic access standards to better serve the target population.

M. Display the AGENCY and RPHCA as a funding source by:

1. Posting notice in a conspicuous location in the facility's patient waiting area stating the funding source.
2. Posting on CONTRACTOR website stating the funding source.

Reporting and Invoicing

N. Submit for AGENCY approval the Annual Projected Level of Operations forms, Contract Action Plan and Quality Improvement/Assurance Plan by the third (3rd) working day in August in each fiscal year.

O. Submit for AGENCY approval the Monthly Level of Operations and Summary Monthly Narrative Report by the second (2nd) Friday of each month in each fiscal year.

P. Submit for AGENCY approval a monthly invoice for the previous completed month's services by the third (3rd) working day of each month in each fiscal year.

Performance Measures

Q. Program Performance Accountability: Expand health care access in rural and underserved areas. Report will address:

1. Total number of medical and dental encounters at community-based primary care centers.
2. Number of medical and dental encounters that are Medicaid, Medicare, private insurance, self-pay.

R. Population Based Accountability: Improve health outcomes for the people of New Mexico.

Objective: To prevent or reduce diabetes complications through improved quality of clinical care and increased access to services to ensure healthier living (*DOH FY19 Strategic Plan*). Report will address:

1. Extent of HbA1c testing for patients with diabetes (*how much is done?*);
2. Percent of patients with HbA1c levels less than 9% (*how well it was*

done?); and

3. Change measured against calendar 2017 baseline and subsequent data (*Is anyone better off?*).

Appendix I is a sample of a RPHCA contract.

D. Scope of Procurement

Professional Services Contracts shall become effective upon approval of the Department of Finance and Administration and shall continue for a four-year period at the discretion of the Department of Health (DOH) contingent upon sufficient funding and satisfactory Scope of Work performance.

Memorandum of Agreements with governmental entities will be for one year, and will require annual renewal for the four-year period at the discretion of the DOH, contingent upon sufficient funding and satisfactory Scope of Work performance.

E. Procurement Manager

The Agency has designated a Procurement Manager who is responsible for the conduct of this procurement whose name, address and telephone numbers are listed below:

Crystal Begay, Procurement Manager
New Mexico Department of Health
Office of Primary Care & Rural Health
300 San Mateo Blvd. NE Suite 900
Albuquerque, NM, 87108
Phone: 505-222-8679
E-mail: Crystal.Begay@state.nm.us

All deliveries via express carrier (including proposal delivery) should be addressed as follows:

Crystal Begay, Procurement Manager
New Mexico Department of Health
Office of Primary Care & Rural Health
300 San Mateo Blvd. NE Suite 900
Albuquerque, NM, 87108

Any inquiries or requests regarding this procurement should be submitted to the Procurement Manager in writing. Offerors may contact ONLY the Procurement Manager regarding the procurement. Other state employees do not have the authority to respond on behalf of the Agency.

F. Definition of Terminology

This section contains definitions and abbreviations that are used throughout this procurement document.

"**Agency**" means the Department of Health.

"**Bad Debt**" means primary care encounters where the debt has been written off because of failure to pay.

"**Close of Business" or "COB"** means 5:00 pm Mountain Time.

"**Consumer**" means a person who is not employed by the Offeror and is an actual or prospective recipient of these services.

"**Contract**" means a written agreement for the procurement of tangible personal property or services.

"**Contractor**" means a successful Offeror who enters into a binding contract.

"**Department**" means the Department of Health.

"**Determination**" means the written documentation of a decision by the Procurement Manager including findings of fact supporting a decision. A determination becomes part of the procurement file.

"**Desirable**" the terms "may", "can", "should", "preferably", or "prefers" identify at desirable or discretionary item or factor (as opposed to "mandatory").

"**Division**" means the Public Health Division of the New Mexico Department of Health.

"**DOH**" means the Department of Health for the State of New Mexico.

"**Evaluation Committee**" means a body appointed by the Agency management 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 Public Health Division (PHD) for contract award. It contains all written determinations resulting from the procurement.

"**Finalist**" is defined as an Offeror who meets all the mandatory specifications of this Request for Proposals and whose score on evaluation factors is sufficiently high to merit further consideration by the Evaluation Committee.

"**Fiscal Year**" means the state fiscal year which runs from July 1 through June 30 (e.g., FY20 is July 1, 2019 through June 30, 2020).

"**Health care personnel**" means health care professionals who contribute to ensuring adequate availability of primary health care services including but not limited to: licensed practical nurses, registered nurses, pharmacists, physician assistants, nurse practitioners, certified nurse midwives, primary care physicians (family practice, general practice, pediatrics, obstetrics and gynecology, and internal medicine), dentists and dental hygienists.

"**Health Care Underserved Area (HCUA)**" means a geographic area where it has been determined by the Department of Health, through the use of indices and other standards set by the Department, that sufficient primary health care is not being provided to the citizens of that area.

"**Mandatory**" The terms "must", "shall", "will", "is required" or "are required", identify a mandatory item or factor (as opposed to "desirable'). Failure to meet a mandatory item or factor will result in the rejection of the Offeror's proposal.

"**Medically Indigent**" means individuals who are unable to afford all medical care that they require. This includes both those individuals below the federal poverty level not covered by Medicaid, Medicare or other third party health care insurance and those individuals between 100 percent and 200 percent of federal poverty levels who are not covered by any third party health insurance. Medically indigent individuals are usually expected to pay for some portion of the cost of their health care based upon the level of their income.

"**Minimum level of primary health care services**" means basic primary health care services provided to the general population by health care personnel.

"**Non-profit Corporation**" means an organization which can provide satisfactory evidence of exemption from requirements from payment of federal income tax pursuant to Section 501(c)(3) of the Internal Revenue Act.

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

"**Patient Collections**" means receipts generated from patient encounters for primary health care services. Patient collections include revenues from Medicaid, Medicare, private insurance, and other third party sources or self-pay.

"**Primary health care services**" means services provided at the first level of basic or general health care for an individual's health needs, including medical, dental and behavioral health diagnostic and treatment services and supportive services. Any dental or behavioral health services shall be provided in conjunction with primary medical services. Primary health care services are those provided as part of either general practice, family practice, obstetrics, gynecology, pediatrics or general internal medicine.

"**Prior Approval**" means written permission provided, in response to written requests, by an authorized official of the Public Health Division in advance of the performance of an act.

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

"**Request for Proposals**" or "**RFP**" 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.

"**State Procurement Agent**" or "**SPA**" means the purchasing agent for the State of New Mexico or a designated representative.

"**Subcontract**" means an agreement whereby a Contractor transfers money to an organization or individual by a contractual agreement to acquire services from a third party.

"**Subcontractor**" means an organization, which provides services with funds awarded as a result of this RFP under a negotiated agreement with the successful Offeror.

"**Total revenues**" means all receipts collected in support of primary health care services. Includes but not limited to: patient collections; Section 329, 330 and 340 Federal Funds, P.L. 93-638 or IHS support; Title V, X and WIC programs; other federal grants; other state grants/contracts; and local income, including city, county or other unit of government, direct grant or value of donated property or facilities. In addition, other revenues including but not limited to: gifts, cash donations or grants from private foundations, church organizations, or other sources, general operating revenues from clinic services and interest, dividends, and other income derived from certificates of deposit, saving accounts and other investments.

"**Users**" means the total number of clients/patients that use or are projected to use the clinic during the requested time period. If a patient visits the clinic several times, they are counted only once per fiscal year as a user.

II. CONDITIONS GOVERNING THE PROCUREMENT

This section of the RFP contains the schedule for the procurement, describes the major procurement events and the conditions governing the procurement.

A. Sequence of Events

Action	Responsibility	Date
Issuance of RFP	Agency	03/07/2019

Submission of Acknowledgement of Receipt of RFP and Intent to Submit Form	Potential Offerors	03/25/2019-COB
Deadline to Submit Questions	Potential Offerors	03/25/2019-COB
Response to Written Questions/RFP Amendments	Agency	04/01/2019
Submission of Proposal	Offerors	04/08/2019-COB
Proposal Evaluation	Evaluation Committee	04/24/2019 *(approx. date)*
Selection of Finalists	Agency	05/08/2019
Contract Award	Agency	05/17/2019
Finalize Contract	Agency Offeror	05/22/2019
Protest Deadline	Offeror	06/01/2019-COB

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

B. Explanation of Events

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

1. Issue of RFP

The New Mexico Department of Health, Office of Primary Care and Rural Health is issuing the RFP on March 7, 2019.

2. Acknowledgement of Receipt of RFP / Intent to Submit

Potential offers must email "Acknowledgement of Receipt of RFP and Intent to Submit form" that accompanies this document (See Appendix A) to have their organization placed on the procurement distribution list. The form should indicate the authorized representative of the organization, be dated and returned by email, by close of business on March 25, 2019 to the Procurement Manager. The procurement distribution list will be used for the distribution of written responses to questions and any RFP amendments.

Failure to return the Acknowledgement of Receipt of RFP and Intent to Submit form shall constitute a presumption of receipt and withdrawal from the procurement process. Therefore, the Offeror's organization name shall be deleted from the procurement distribution list.

3. Deadline to Submit Written Questions

Potential offers may submit written questions as to the intent or clarity of this RFP until close of business on March 25, 2019. All written questions must be submitted in writing or via e-mail to the Procurement Manager (See Section I, Paragraph D).

4. Response to Written Questions/RFP Amendments

Written responses to written questions and any RFP amendments will be emailed on April 01, 2019 to all potential offers whose organization name appears on the procurement distribution list.

5. Submission of Proposal

ALL OFFEROR PROPOSALS MUST BE RECEIVED FOR REVIEW AND EVALUATION BY THE PROCUREMENT MANAGER OR DESIGNEE **NO LATER THAN 5:00 PM MOUNTAIN TIME ON APRIL 8, 2019**. Proposals received after this deadline will not be accepted.

This RFP process will require hard copies one (1) original and three (3) copies. Proposals must be mailed to the address listed in Section I, Paragraph D.

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 any proposal shall not be disclosed to competing offers prior to contract award.

6. Proposal Evaluation

An evaluation committee appointed by the agency management will perform the evaluation of proposals. The evaluation committee meeting(s) will take place around April 24th, 2019. The Procurement Manager may 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.

7. Selection of Finalists

The Evaluation Committee will make recommendations to the Public Health Division. Once Public Health Division approval is received, the Procurement Manager will notify the finalists. Only finalists will be invited to participate in the subsequent steps of the procurement.

8. Contract Awards

The contracts shall be awarded to the Offerors whose proposals are most advantageous, taking into consideration the evaluation factors set forth in the RFP. The most advantageous proposal may or may not have received the most points. The award is subject to appropriate State approvals.

9. Finalize Contracts

The contracts will be finalized with the most advantageous Offerors upon Department of Finance and Administration approval. In the event that mutually agreeable terms cannot be reached within the time specified, the Agency reserves the right to finalize a contract with the next most advantageous Offeror without undertaking a new procurement process.

10. Protest Deadline

Any protest by an Offeror must be timely and in conformance with Section 13-1-172 NMSA 1978 and applicable procurement regulations. The fifteen (15) day protest period for responsive Offerors shall begin on the day following the contract award and will end as of close of business on June 1, 2019. Protests must be written

and must include the name and address of the protestor and the request for proposal's name. It must also contain a statement of grounds for protest including appropriate supporting exhibits, and it must specify the ruling requested from the Agency. The protest must be delivered to the Agency's Administrative Services Division. Protests received after the deadline will not be accepted.

Administrative Services Division
New Mexico Department of Health
General Accounting Bureau
P.O. Box 26110
Santa Fe, New Mexico 87502-6110

C. General Requirements

This procurement will be conducted in accordance with the applicable procurement regulations.

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 Sections IV and V of this RFP. Additional information about the required Letter of Transmittal can be found in Section III-C-2-a).

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.

3. Prime Contractor Responsibility

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

4. Subcontractors

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. Offerors' Rights to Withdraw Proposal

Offerors will be allowed to withdraw their proposals at any time prior to the deadline for receipt 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. The proposals will be kept confidential until negotiations and the award are completed by the Agency. At that time, all proposals and documents pertaining to the proposals will be open to the public, except for the material that is proprietary or confidential. The Procurement Manager will not disclose or make public any pages of a proposal on which the 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. and data that qualifies as a trade secret in accordance with the Uniform Trade Secrets Act, NMSA 1978, 57-3A-1 to 57-3A-7.
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 State Purchasing Agent 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 the 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 termination 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 Appendix I, "Contract Terms and Conditions". However, the Agency reserves the right to negotiate with a successful Offeror provisions in addition to those contained in this RFP. The contents of this RFP, as revised and/or supplemented, and the successful Offeror's proposal will be incorporated into and become part of the contract.

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

Should an Offeror object to any of the Agency terms and conditions, as contained in this Section or in Appendix I, that 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 of the Sample Contract 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.

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

16. Offeror's Terms and Conditions

Offerors must submit with the proposal a complete set of any additional terms and conditions, which 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, (such terms and conditions having been proposed during the procurement process, that is, the RFP process prior to selection as successful Offeror), 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

Eligible Offerors requesting funding shall:

a. be a New Mexico nonprofit community-based entity with 501(c)(3) tax exempt status, a local government, or tribal government, which provides primary health care services to residents of a health care underserved area (HCUA) designated for primary health care needs;

b. have a governing board whose membership is generally representative of the HCUA(s) it serves, including consumers of the primary health care services it provides. An eligible program which is a local government or tribal government and/or is multi-purpose or provides services in more than one HCUA shall have a local or regional primary health care advisory board whose membership is generally representative of the HCUA(s) being served. A majority of the advisory board shall be consumers of the primary health care services. The local or regional primary health care advisory board shall have opportunity for consideration of and input into the decisions regarding budgets, scope of services, payment policies and procedures, hours of operation and staffing. The eligible program shall be able to demonstrate the ability to meet the governing board and/or the advisory board requirements or have a practical plan for its establishment and implementation;

c. not employ persons related to board members by consanguinity or affinity within the third degree. This includes spouse, mother, father, brother, sister,

grandparent, aunt, uncle, niece, nephew, mother-in-law, father-in-law, and sister-in-law;

d. have as its purpose to sustain or provide a minimum level of primary health care services as defined in Subsection D of 7.29.3.6 NMAC (see Appendix F). Services may additionally include medical support, diagnostic and treatment services, pharmacy, laboratory, radiology, preventive health services, behavioral health services, patient follow-up and/or dental and dental support services. Any dental and/or behavioral health services shall be provided in conjunction with primary medical care services;

e. have policies and procedures which ensure that no person will be denied primary health care services they require because of inability to pay. These policies and procedures should address medically indigent persons below poverty not covered by third party payors and those between 100 percent and 200 percent of poverty without third party coverage. The eligible program should be able to demonstrate either the successful impact of these policies and procedures, or have a practical plan for their implementation;

f. have billing policies and procedures which maximize patient collections, except where Federal rules or contractual obligations prohibit the use of such measures. The program should be able to demonstrate either the successful impact of these policies and procedures, or have a practical plan for their implementation;

g. have viable systems and infrastructure to deliver primary health care services including facility, staff and financial management systems;

h. have comprehensive policies and procedures governing the primary health care operations which assure the delivery of effective, efficient and quality care;

i. have been in operation for more than six months prior to July 1, 2018 providing basic primary care services in the HCUA for which funding is requested; and

j. have the following documents submitted as Attachments to the proposal to support the Determination of Eligibility of the Offeror:
   - Governing/Advisory Board Roster (Appendix C);
   - Sliding Fee Scale and Policy;
   - IRS tax exempt determination letter;
   - Registration with NM Department of Taxation and Revenue; and
   - By-Laws and Articles of Incorporation.

19. <u>Right to Waive Minor Irregularities</u>

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 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 its needs of the agency.

21. Notice of Penalties

The Procurement Code, NMSA 1978, Sections 13-1-28 through 13-1-199, imposes civil and 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 an 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 this RFP shall become the 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 publish or disclose such information to any third party without the procuring Agency’s written permission.

26. Electronic mail address required

Some communication regarding this procurement will be conducted by electronic mail (e-mail). Offeror must have a valid e-mail address to receive this correspondence.

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.

28. New Mexico Employees Health Coverage.

A. If the Offeror has, or grows to, six (6) or more employees who work, or who are expected to work, an average of at least 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 if the expected annual value in the aggregate of any and all contracts between Contractor and the State exceed $250,000 dollars.

B. Offeror must agree 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. Offeror must 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://www.insurenewmexico.state.nm.us/.

D. 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.

29. Campaign Contribution Disclosure Form

Offer must complete, sign, and return the Campaign Contribution Disclosure Form APPENDIX J, as part of their proposal. This requirement applies regardless whether a covered contribution was 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. Letter of Transmittal

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

1. identify the submitting organization;
2. identify the name and title of the person authorized by the organization to contractually obligate the organization;
3. identify the name, title and telephone number of the person authorized to negotiate the contract on behalf of the organization;

4. identify the names, titles and telephone numbers of persons to be contacted for clarification;
5. explicitly indicate acceptance of the Conditions Governing the Procurement stated in Section II, Paragraph C.1;
6. be signed by the person authorized to contractually obligate the organization; and
7. acknowledge receipt of any and all amendments to this RFP.

31. 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. Out-of-state Contractors that have no facilities and no employees working in New Mexico are exempt if the contract is directly with the out-of-state contractor and fulfilled directly by the out-of-state contractor, and not passed through a local vendor.

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, Offeror 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 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.

32. Disclosure Regarding Responsibility

A. Any prospective Contractor and any of its Principals who enter into a contract greater than sixty thousand dollars ($60,000.00) with any state agency or local public body for professional services, tangible personal property, services or construction agrees to disclose whether the Contractor, or any principal of the Contractor's company:

1. is presently debarred, suspended, proposed for debarment, or declared ineligible for award of contract by any federal entity, state agency or local public body;

2. has within a three-year period preceding this offer, been convicted in a criminal matter or had a civil judgment rendered against them for:

a. the commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) contract or subcontract;
b. violation of Federal or state antitrust statutes related to the submission of offers; or
c. the commission in any federal or state jurisdiction of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, violation of Federal criminal tax law, or receiving stolen property;

3. is presently indicted for, or otherwise criminally or civilly charged by any (federal state or local) government entity with the commission of any of the offenses enumerated in paragraph A of this disclosure;
4. has, preceding this offer, been notified of any delinquent Federal or state taxes in an amount that exceeds $3,000.00 of which the liability remains unsatisfied. Taxes are considered delinquent if the following criteria apply.
   a. The tax liability is finally determined. The liability is finally determined if it has been assessed. A liability is not finally determined if there is a pending administrative or judicial challenge. In the case of a judicial challenge of the liability, the liability is not finally determined until all judicial appeal rights have been exhausted.
   b. The taxpayer is delinquent in making payment. A taxpayer is delinquent if the taxpayer has failed to pay the tax liability when full payment was due and required. A taxpayer is not delinquent in cases where enforced collection action is precluded.
   c. Have within a three-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 Contractor shall provide immediate written notice to the State Purchasing Agent or other party to this Agreement if, at any time during the term of this Agreement, the Contractor learns that the Contractor's disclosure was at any time erroneous or became erroneous by reason of changed circumstances.

D. A disclosure that any of the items in this requirement exist will not necessarily result in termination of this Agreement. However, the disclosure will be considered in the determination of the Contractor's responsibility and ability to perform under this Agreement. Failure of the Contractor to furnish a disclosure or 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 a Contractor 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 during the term of this Agreement. If during the performance of the contract, the Contractor is indicted for or otherwise criminally or civilly charged by any government entity (federal, state or local) with commission of any offenses named in this document the Contractor must provide immediate written notice to the State Purchasing Agent or other party to this Agreement. If it is later determined that the Contractor knowingly rendered an erroneous disclosure, in addition to other remedies available to the Government, the State Purchasing Agent or Central Purchasing Officer may terminate the involved contract for cause. Still further the State Purchasing Agent or Central Purchasing Officer may suspend or debar the Contractor from eligibility for future solicitations until such time as the matter is resolved to the satisfaction of the State Purchasing Agent or Central Purchasing Officer.

33. New Mexico Preferences

To ensure adequate consideration and application of NMSA 1978, § 13-1-21 (as amended), Offerors must include a copy of their preference certificate with their proposal. Certificates for preferences must be obtained through the New Mexico Department of Taxation & Revenue http://www.tax.newmexico.gov/Businesses/in-state-veteran-preference-certification.aspx.

A. **New Mexico Business Preference**
A copy of the certification must accompany your proposal**.**

B. **New Mexico Resident Veterans Business Preference**
A copy of the certification must accompany your proposal.

An agency shall not award a business both a resident business preference and a resident veteran business preference.

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

III. RESPONSE FORMAT AND ORGANIZATION

A. Number of Responses

Offerors may submit one proposal. In no case will more than one proposal from a single Offeror be accepted.

B. Number of Copies

Offers shall deliver one (1) original and three (3) copies of their proposal to the location specified in Section I, Paragraph D on or before the closing date and time for receipt of proposals.

C. Proposal Format

1. All proposals must be typewritten, single spaced, no less than size 10 font, standard 8 1/2 x 11-page size using Microsoft Word. Primary Care Data forms may be converted by the Offeror to Microsoft Excel forms, provided that all data elements remain. Proposals should be placed within a binder with tabs delineating each section.

2. **Proposal Organization**

   The proposal must be organized and indexed in the following format and must contain, as a minimum, all listed items in the sequence indicated in Section IV, Specifications. Within each section of their proposal, offerors should address the items in the order in which they appear in this RFP. All forms provided in the RFP must be thoroughly completed and included in the appropriate section of the proposal.

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

   The proposal summary may be included by offerors to provide the Evaluation Committee with an overview of the technical and business features of the proposal; however, this material will not be used in the evaluation process unless specifically referenced from other portions of the offeror's proposal.

   Offerors may attach other materials that they feel may improve the quality of their responses. However, these materials should be included as items in a separate appendix.

   The various required documentation shall be grouped. The information provided in Section 1 and Section 2 will be used to determine eligibility and may or may not be shared with the Evaluation Committee. Submissions 3 and 4 will be shared with the Evaluation Committee.

   a. Section 1

   Letter of Transmittal

   Each proposal must be accompanied by a letter of transmittal. The letter of transmittal MUST:

   i. identify the submitting organization;
   ii. identify the name and title of the person authorized by the organization to contractually obligate the organization;

iii. identify the name, title and telephone number of the person authorized to negotiate the contract on behalf of the organization;
iv. identify the names, titles and telephone numbers of persons to be contacted for clarification;
v. explicitly indicate acceptance of the Conditions Governing the Procurement stated in Section II, Paragraph C.1;
vi. be signed by the person authorized to contractually obligate the organization; and
vii. acknowledge receipt of any and all amendments to this RFP.

The Letter of Transmittal must be signed and the original mailed/delivered separately to meet the April 8, 2019 deadline.

Mail to: Crystal Begay, RPHCA Program Manager
300 San Mateo Blvd. NE, Suite 900
Albuquerque, NM 87108

b. Section 2

Determination of Eligibility (Narrative) Information Section: The information provided by the Offeror in this section shall be utilized by the RPHCA Program to determine whether the Offeror is eligible to be considered for funding. A maximum of 2 pages is allowed for responding to eligibility criteria found on pages 15-16 and referencing supporting attachments. Offerors must also submit, as Attachments, the specific information listed in Section II, C-18-, j, page 19, with the Determination of Eligibility Narrative.

1. Governing/Advisory Board Roster (Appendix C)
2. Sliding Fee Scale and Policy
3. IRS tax exempt determination letter
4. Registration with NM Department of Taxation and Revenue
5. By-Laws and Articles of Incorporation
6. Campaign Contribution Disclosure Form (Appendix J)

c. Section 3

HCUA- Specific (Narrative) Information Section: The information provided in this section shall be used by the Evaluation Committee to evaluate the proposals according to the criteria listed in Section IV, Specifications, pages 27-34. Provide the required narrative information for each HCUA for which funding is being requested. Include any attachments supporting this section in this submission.

d. Section 4

Proposal Summary Page: Each Offeror is required to submit only **ONE** Proposal Summary Page, outlining basic information and HCUA specific requested funding.

Primary Care Data Forms: If applying for a single HCUA, the Offeror must include Primary Care Data Forms (Appendix D charts 1-11a). If the proposal is for multiple HCUAs, Offeror must include Primary Care Data Forms (Appendix D charts 1-11a) for each HCUA for which financial assistance is being requested AND the Combined Primary Care Data Forms (Appendix E charts 12-19a). All forms are required to be complete, accurate and consistent with information in the narrative sections.

IV. SPECIFICATIONS

A. Information

Offerors should respond in the form of a thorough narrative to each mandatory specification. The narratives along with required data forms and supporting materials will be evaluated and awarded points accordingly. Proposals submitted must provide information sufficient to describe the activities and expenditures to be supported by this proposal, and to allow for a complete evaluation of the proposal. Performance under prior contracts, including state agency-generated evaluations of prior performance may be considered.

B. MANDATORY SPECIFICATIONS

Determination of Eligibility (Narrative) Information Section: The information provided by the Offeror in this section shall be utilized by the Division to determine whether the Offeror is eligible to receive funding. A maximum of 2 pages is allowed for responding to eligibility criteria found on pages 18-19 and referencing supporting attachments. Offerors must also submit the required attachments listed in Section II, C-18, page 18 with the Determination of Eligibility Narrative. **This section is not scored by evaluation committee.**

HCUA Specific Narratives

Offerors must respond to the following elements for each HCUA:

1. Primary Care need in the HCUA: **Maximum Points -- 15**
(maximum 3 pages per HCUA)

Proposals will be evaluated upon the degree to which the information provided in the proposal adequately documents and identifies each HCUA and delineates the primary care service needs of each area. Proposals shall briefly describe the need for primary care services in the HCUA. This description should at a minimum:

a. specifically identify each HCUA that funding is being requested for; (see Appendix H)

b. discuss the demand for primary care services and describe the unmet need for services in the HCUA;

c. provide demographic data of each HCUA;

d. provide relevant economic and special health needs information for each HCUA;

e. indicate the Health Professional Shortage Areas and/or Medically Underserved Areas in each HCUA;

f. document the percentage and number of medically indigent persons residing in the HCUA;

g. identify all entities addressing the primary care needs of the HCUA including public (Public Health Office, School-Based Health Centers, Indian Health Services), private providers, universities, etc., and what approximate portion this RFP proposal represents; and

h. identify the extent to which all entities are meeting the primary care needs of the HCUA.

In addition, the Offeror shall complete the information on the Primary Care Data Forms (Appendix D, charts 1-11a), **AND if the RFP proposal is for multiple HCUAs, ALSO complete Combined Primary Care Data Forms (Appendix E, charts 12-19a).** Narrative information should be consistent with required charts and attachments.

Evaluation of the Primary Care need in the HCUA will focus on issues including, but not limited to:

- the potential demand for primary care services within the HCUA;
- the severity of need within the HCUA as demonstrated within the proposal;
- the number and percent of medically indigent population residing in the HCUA; and
- the Offeror's ability to describe other entities addressing primary care needs in the HCUA.

2. Offeror Description and Capacity:

Proposals shall be evaluated based upon the degree to which the information provided in the proposal demonstrates the Offeror's ability, both past performance and proposed plans, to deliver and administer effective and appropriate primary care services through adequate organizational capacity, policies and procedures.

a. Organizational Capacity: **Maximum Points -- 10**
(maximum 5 pages)

Offerors must demonstrate the adequacy and effectiveness of the applicant's organization to provide primary care services in the HCUA. The Offeror must describe the following:

1) Length of time in operation within each HCUA for which funding is requested. Describe/list specific dates for facility operation; (must be consistent with Chart 1A-Clinics)

2) Organizational Capacity: describe the organizational capacity including, the Governing and/or Local Advisory Boards, their relationship, their operating guidelines and level of responsibility, and the degree to which the boards are representative and responsive to the population of the HCUA(s); (must be consistent with Appendix C-Governing Board & Local/Regional Advisory Board)

3) Staff: describe the staffing organization of health professional, administrative staff, subcontractors, volunteers, etc. who provide primary care services and administer aspects of the center's operations;

4) Staff Turnover: describe the current status of staff vacancies. Describe short term and long term proposed solutions to turnover problems.

5) Financial Management Systems: describe the financial management systems including billing, accounting, budget management and other systems to maximize patient generated revenues, and to meet the RPHCA monthly reporting requirements. Identify billing software used;

6) Clinical Management Systems: describe patient flow, records, hospital and specialty referrals and follow-up procedures. Identify clinical management software used; and

7) Local Health System: describe the structure of the local health system and how the Offeror participates as part of that system. Include as part of the local health system, such things as hospitals, other primary care providers, emergency services provisions, after hours coverage provisions, coordination with public health offices, behavioral health services, dental services, school-based health centers and other entities.

In addition, the Offeror shall complete the information on the Primary Care Data Forms (Appendix D, charts 1-11a, and if proposal is for multiple HCUAs, also complete Combined Primary Care Data Forms (Appendix E, charts 12-19a). Narrative information should be consistent with required charts and attachments.

Evaluation of the Organizational Capacity section will focus on issues including the:

- capability of the Offeror to govern the provision of primary care services in a community responsive manner. Evaluation will include a review of the applicant's HCUA specific board or program advisory council structure and functions;

- capability of the Offeror to meet RPHCA reporting requirements and manage its finances. Evaluation will include a review of the applicant's latest audit report management letter, and prior RPHCA reporting history;

- reasonableness of staff numbers, staff organization, provider staffing levels;

- consistency of narrative information when compared to Primary Care Data Charts; and

- participation of the Offeror in the local health system including referral system for local specialists, local primary care providers and hospitals; after hours provisions; emergency services provisions; behavioral health services, dental programs, school health programs, school-based health centers, and coordination and referral with public health programs (e.g. WIC, EPSDT, family planning, HIV, immunization and communicable disease).

b. Policies and Procedures: **Maximum Points -- 10**
(maximum 4 pages)

Offerors are to describe the key policies and procedures needed to provide and administer primary care services for the underserved. The Offerors must demonstrate, by past performance, and by proposed plans, the adequacy and effectiveness of those policies and procedures including:

1) sliding fee discount policy to provide primary care service in the HCUA, including addressing how the needs of the medically indigent will be met;

2) billing and collections to maximize patient generated revenue, if applicable;

3) clinical policies and pathways to ensure quality care, including pain management; and

4) policies dealing with patient complaints and community concerns.

Evaluation of the Policies and Procedures section will include a review of the following issues:

- the description of a satisfactory level of service to patients who are eligible for Medicaid, Medicare and sliding fee discounts;

- the reasonableness of efforts to maximize generated revenue;

- the description of quality care efforts for the underserved; and

- the description of efforts to effectively address patient and community concerns.

Narrative information should be consistent with required charts and attachments.

c. Operations and Activities: **Maximum Points -- 15**
(maximum 6 pages)

Offerors are to present a feasible and appropriate Implementation and Operational Plan to provide and sustain a minimum level of community based primary health care services which can be conducted effectively during the contract period. The plan shall describe:

1) the specific primary care services provided by the Offeror in the HCUA including medical services, dental services, behavioral health and ancillary services;

2) how the proposed services shall address the unmet need for primary care in the HCUA, including the needs of the underserved population;

3) the ongoing operations of the clinic(s) within the HCUA(s), including details for providing primary care services, health professional recruitment, and facility management;

4) the process for referring patients for additional services;

5) the hours of operation, after-hours coverage, walk-ins, and hospital coverage;

6) all activities performed to ensure that "no person will be denied primary health care services they require because of inability to pay". These activities should include staff education and training, and proactive responses to community concerns and perceptions that persons unable to pay will not be seen;

7) evaluation and monitoring methods for determining status of proposed activities, and for determining quality performance; and

8) The Offeror shall complete the information on the Primary Care Data Forms (Appendix D, charts 1-11a), and if proposal is for multiple HCUAs, also complete Combined Primary Care Data Forms (Appendix E, charts 12-19a).

Narrative information should be consistent with required charts and attachments.

Evaluation of the Operations and Activities will focus on issues including, but not limited to:

- the Offeror's clarity and conciseness in describing the Operations and Activities of the organization to sustain a minimal level of primary care services;

- the Offeror's ability to meet current and future unmet primary care needs in the HCUA, including the underserved population;

- the Offeror's process to refer patients to comprehensive primary care services and ancillary services such as dental, lab, x-ray, etc.;

- the Offeror's mechanisms to evaluate and monitor the proposed activities, and provide quality performance improvement; and

- the Offeror's description of past performance and proposed plans for future delivery of primary care services.

3. Demonstrated Community Participation/Collaboration: Maximum Points -- 10
(maximum 4 pages)

Proposals shall be evaluated upon the degree to which they demonstrate the effective efforts of the Offeror to participate in collaborative efforts with residents, other public and private health care services, community groups, and agencies in the development of community-based primary care services. Collaborative efforts should be designed to avoid duplication and improve integration of local health services. This section should address the following:

a. identify collaborative efforts which have **already occurred** in the preparation of this proposal and those that **will occur** if the proposal is funded. (*include groups involved in collaboration, the nature of their involvement and the degree of their participation, including, but not limited to, private physicians, public health offices, citizens groups, health and human service agencies, government, health care planning groups, local, county and/or tribal health councils, emergency medical services, specialty medical services, dental services, home health services and hospital services, school-based health centers, and specific Department of Health programs);*

b. Identify and describe outcomes of the collaborative efforts to date and the proposed outcome of future efforts. Describe impact on the community and the population served;

c. identify and describe any new mechanisms for integrating other sources of funds for the provision of community based primary care services;

d. identify and describe involvement in local, county and/or tribal health councils, and school-based health centers;

e. include letters from community groups that document collaboration efforts (letters will not impact the maximum page total); and

f. include letters of support (will not impact the maximum page total). Letters of support are strongly encouraged from the local or regional public health offices, local, county and/or tribal health councils, and school-based health centers representing the HCUAs where services will be provided.

Evaluation of Demonstrated Community Participation/Collaboration will focus on issues including, but not limited to:

- the extent of collaborative efforts with community and provider groups **in preparation of the proposal** for funding assistance;

- the extent of planned **future collaborative efforts** with community and provider groups if the proposal is funded;

- the description of proposed outcomes for the collaborative efforts in the development of primary care services, including avoiding duplication and improving integration of services; and

- the degree to which the Offeror demonstrates knowledge of and involvement with the community.

4. Proposed Budget: **Maximum Points -- 10**
(maximum 4 pages)

Proposals shall be evaluated upon the degree to which the Offeror presents a detailed budget that reflects the described HCUA-specific program activities, and demonstrates the need for financial assistance for those activities. The proposed budget will be for the time period of July 1, 2019 to June 30, 2020. The budget narrative shall reflect:

a. a description of the total operating budget for all primary care services and activities;

b. the projected revenues from all sources, including grants, patient generated revenues, etc.;

c. the projected expenditures;

d. the specific expenditures to be made with RPHCA funds, with sufficient details to allow the Division to ensure that all proposed expenditures are eligible for reimbursement and are justifiable. Indicate whether the financial assistance will support existing operations or developing activities and operations;

e. a description of all other anticipated support of the project, including in-kind materials and services, or direct financial support; and

f. a description of any of variances in budget information for the fiscal years identified in the Primary Care Data charts.

In addition, the Offeror must provide numeric budgetary information on the Primary Care Data Forms found in Appendix D and Appendix E (if applicable). Narrative information should be consistent with required charts and attachments.

Evaluation of the Proposed Budget will include:

- reasonableness of proposed budget;

- ability to describe proposed expenditures and revenues, including any surplus of funds or shortfalls; and

- ability to describe non-RPHCA contributions.

5. Demonstrated Financial Need for RPHCA Funding **Maximum Points -- 25**
(maximum 4 pages)

Proposals shall be evaluated and ranked upon the degree to which the information provided in the proposal adequately documents and identifies the relative financial need of the Offeror to provide primary care services in a HCUA. The financial need information must be provided for each HCUA.

The Demonstrated Financial Need shall address:

a. justification of the financial need necessary to sustain the provision of primary care services within the HCUA;

b. if the Offeror is a federally-funded community health center, justification of the need for additional funding through RPHCA;

c. steps to be taken to ensure efficient cost-effective operation; and

d. possible consequences and brief description of a sustainability plan if funding is reduced or not received.

In addition, the Offeror shall complete the information on the Primary Care Data Forms (Appendix D, charts 1-11a), and if proposal is for multiple HCUAs, also complete Combined Primary Care Data Forms (Appendix E, charts 12-19a). Narrative information should be consistent with required charts and attachments.

Evaluation of the Financial Need will focus on, but not be limited to, the following: reasonableness of Offeror justification of financial need;

- reasonableness of Offeror justification of RPHCA funding need if Offeror is a federally-funded community health center;

- feasibility of identified steps to be taken to ensure efficient cost-effective operation; and

- reasonableness of stated consequences and brief description of a sustainability plan if funding is reduced or not received.

6. <u>Proposal Format/Organization</u> **Maximum Points -- 5**

Proposals shall receive up to 5 points if organized and formatted according to RFP instructions.

V. EVALUATION

A. <u>Evaluation Point Summary</u>

The following is a summary of evaluation factors with point value assigned to each. These, along with the general requirements, will be used in the evaluation of Offeror proposals.

COMPONENT	MAXIMUM POINTS AVAILABLE
1. Primary Care need in the HCUA	15
2. Offeror Description and Capability	

Organizational Capacity	10
Policies and Procedures	10
Operations & Activities	15
3. Demonstrated Community Participation/Collaboration	10
4. Proposed Budget	10
5. Demonstrated Financial Need for RPHCA Funding	25
6. Proposal Format/Organization	5
TOTAL	**100**

B. Evaluation Process

The evaluation process will follow the steps listed below:

1. All Offeror proposals will be reviewed for compliance with the mandatory requirements 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 I, Paragraph D.

3. The Evaluation Committee may use other sources of information to perform the evaluation.

4. Responsive proposals will be evaluated on the factors in Section IV that 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 Offerors whose proposals are the most advantageous to DOH, taking into consideration the evaluation factors in Section IV, will be recommended for contract award as specified in Section II, Paragraph B.7. Please note, however, that a serious deficiency in the response to any one factor may be grounds for rejection regardless of overall score.

5. The Evaluation Committee may make such investigations as necessary to determine the ability of the Offeror to adhere to the requirements specified within this RFP. The Evaluation Committee will reject the proposal of any 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.

VI. CHECKLIST

_____ **Acknowledgement of Receipt of RFP and Intent to Submit form (Appendix A) must be emailed no later than 03/25/19.**

Letter of Transmittal

_____ **Must be signed and mailed/delivered separately by 04/08/19 deadline.** (see page 21)

Determination of Eligibility

____ **Determination of Offeror Eligibility Narrative** (not more than 2 pages)

____ **Attachments/Appendices supporting Determination of Eligibility**

- ____ Governing/Advisory Board Roster (Appendix C)
- ____ Sliding Fee Scale and Policy
- ____ IRS tax exempt determination letter
- ____ Registration with NM Department of Taxation and Revenue
- ____ By-Laws and Articles of Incorporation
- ____ Campaign Contribution Form (Appendix J)

Narrative Response

Narrative Information Section for Each HCUA

____ Primary Care need in the HCUA (not more than 3 pages per HCUA)

____ Offeror Description and Capability narrative

- ____ Organizational Capacity (not more than 5 pages)
- ____ Policies and Procedures (not more than 4 pages)
- ____ Operations and Activities (not more than 6 pages)

____ Demonstrated Community Participation/Collaboration narrative (not more than 4 pages)

____ Proposed Budget narrative (not more than 4 pages)

____ Demonstrated Financial Need narrative (not more than 4 pages)

Attachments supporting Offeror Description and Capability

____ Any attachments addressing Description and Capability

Attachments supporting Community Participation/Collaboration

____ Documentation of Collaboration, Letters of support

Attachments supporting Proposed Budget and Demonstrated Financial Need

____ Audit Report Management Letter (most recent)

____ If a federally funded Community Health Center, a copy of most recent award notification

Proposal Summary Page and Primary Care Data Forms

____ Proposal Summary Page (Appendix B)

____ Primary Care Data Forms Appendix D, charts 1-11a)
and, if applying for multiple HCUAs,

____ Combined Primary Care Data Forms (Appendix E, charts 12-19a)

Overall Quality of the Proposal

____ Have you read your proposal thoroughly before submitting? *Especially if multiple people are preparing the proposal.*

____ Have you addressed **ALL** the requirements in each section*? It is acceptable to include the evaluative criteria language in addition to your response.*

____ Have you adhered to the page limits?

____ Have you checked for grammar and spelling?

____ Have you answered the questions in the specific sections where they are asked? *Do not make reviewers have to search through the proposal for your responses!*

____ Have you spelled out acronyms the first time used?

____ Have you prepared the proposal with language and explanations that are easily understandable by independent reviewers who are NOT primary care experts?

____ Does your proposed budget show the revenues being equal to the expenditures?

APPENDIX A

ACKNOWLEDGEMENT OF RECEIPT OF RFP
and
INTENT TO SUBMIT FORM

ACKNOWLEDGEMENT OF RECEIPT OF RFP:
In acknowledgement of receipt of this Request for Proposal the named individual agrees that he/she has received a complete copy, beginning with the title page and table of contents, and ending with Appendix J.

The acknowledgement of receipt should be **emailed to the Procurement Manager no later than close of business on 03/25/19**. Only potential Offerors who elect to return by email this form completed with the indicated intention of submitting a proposal will receive copies of all Offeror written questions and the Agency written responses to those questions as well as RFP amendments, if any are issued.

CONTACT PERSON NAME: _____

PHONE NO.: _____

E-MAIL: _____ **(REQUIRED)**

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

This above stated name and email address will be used for all correspondence related to the Request for Proposal.

INTENT TO SUBMIT:

_____ (enter organization name) does___/does not ___ (**mark one**) intend to respond to this Request for Proposals.

Crystal Begay, Procurement Manager
Department of Health
Office of Primary Care & Rural Health
E-mail: Crystal.Begay@state.nm.us

APPENDIX B

PROPOSAL SUMMARY PAGE

Offeror Name (must be consistent with Fed. Tax ID)			
Street Address			
Mailing Address			
City, State, Zip			
Contact Person		**Title**	
Phone #			
Federal Tax ID #		**NM CRS Tax ID #**	

Please list the HCUAs and RPHCA base funding support which you received in FY 2019 and are requesting in FY 2020 (July 1, 2019 to June 30, 2020)

HCUA	FY18 RPHCA BASE CONTRACT AMOUNT	Projected FY19 Encounters	FY20 RPHCA BASE REQUEST	Projected FY20 Encounters
GRAND TOTAL (ALL REQUESTS)				

APPENDIX C

GOVERNING BOARD & LOCAL/REGIONAL ADVISORY BOARD

Name/ Office Held	Board (G/A)	Gender (M/F)	Ethnicity	Occupation/ Expertise	(L)ive (W)ork in service area	Board Term Expires	Years Continuous Service	Consumer of Services (Y/N)

Instructions:

This chart is to be completed by all Offerors to identify all Governing Board members and Local/Regional Advisory Board members, where applicable.

* Identify the required information for each Governing Board Member.
* Identify the required information for each member of each Local/Regional Advisory Board.

In the second column, Board (G/A), the **G** stands for Governing Board Member and the **A** stands for Local/Regional Advisory Board Member.

APPENDIX D

PRIMARY CARE DATA FORMS (Charts 1-11a)

Chart 1

Offeror Name	
Health Care Underserved Area (HCUA)	

Chart 1A - Clinics

Clinics Within **HCUA**	Date (M/Y) Started Operations

Chart 2

Type of Request	Amount
Basic	

Chart 3 – HCUA Population Information

Total HCUA Population (insert #)_____			
% below Poverty Level	%	% White (non-Hispanic)	%
% over age 65	%	% White (Hispanic)	%
% under age 18	%	% Native American	%
		% Black	%
% Female	%	% Other	%
% Male	%		

Please identify, in the space provided below, the source and date of these population figures. In addition please identify the geographic area the population data represents (county, sub county, census tract, etc.).

Instructions:

Overall for all forms
All charts are expected to be completed with the required information for each HCUA for which funding assistance is requested.

Chart 1
Identify the name of the Offeror;

Identify the Health Care Underserved Area (HCUA) proposed to be served by the Offeror. This could be a town, census tract, county, population, etc. See Appendix H for New Mexico HCUA designations.

Chart 1A - Clinics
Identify the names of the clinics **within the HCUA** and the month and year they started operations - even if there is only one clinic site. Add/remove rows as needed.

Chart 2 - Type of Request
Indicate the requested amount for the HCUA. Compare the requested amount on this form to be sure that it is consistent with the amount identified:

- on the proposal cover sheet;
- RPHCA funds identified in **Chart 8A**; and
- amount requested in narrative.

Chart 3 – HCUA Population Information
Identify the total population of the HCUA to be served by the Offeror. See Appendix H for the New Mexico HCUA designations.

Indicate percentage of the population for the categories listed. All percentages should be rounded off to the first decimal place after the decimal point (tenths - e.g. 12.3%).

Please identify the source and date of these population figures. In addition please identify the geographic area the population data represents (county, sub county, census tract, etc.).

Chart 4 – Payment Source for Medical/Dental/Behavioral Health Encounters

		Actual FY18		Projected FY19		Proposed FY20	
1	Users						
2	Total Medical/Dental/ Behavioral Health Encounters						
3	Encounters per User						
Medical/Behavioral Health Encounters							
4	Medicaid		%		%		%
5	Medicare		%		%		%
6	Other 3rd Party		%		%		%
7	Sliding Fee		%		%		%
8	100% Self Pay		%		%		%
9	Other		%		%		%
10	Total Medical/Behavioral Health Encounters		100%		100%		100%
Dental Encounters							
11	Medicaid		%		%		%
12	Other 3rd Party		%		%		%
13	Sliding Fee		%		%		%
14	100% Self Pay		%		%		%
15	Other		%		%		%
16	Total Dental Encounters		100%		100%		100%

Instructions:

Chart 4 - Payment Source for Medical/Dental/Behavioral Health Encounters

Users: identify the total number of patients that use or are projected to use the clinic during the requested fiscal year. If a patient uses both medical and dental services, they are counted only once as a user.

> **Users refers to unduplicated users.** If a patient visits the clinic several times, they are counted only once per fiscal year as a user. A patient can only generate one encounter per day (even with multiple visits). The encounter is credited to the highest level provider who sees the patient. An exception to the number of encounters per day is if a patient comes in for different services (medical and dental) in the same day, two encounters can be logged.

Total Medical/Dental/Behavioral Health Encounters: Identify the total number of encounters for both medical, dental and behavioral health services.

> **Total Number of Medical/Dental/Behavioral Health Encounters should include only face-to-face encounters with a provider for medical/dental/behavioral services that are documented in a patient's chart**. **This includes** face-to-face, charted encounters with the following types of providers: physician, nurse practitioner, physician assistant, certified nurse midwife, dentist, registered dental hygienist, behavioral health professionals, registered nurse, licensed practical nurse, nutritionist, social workers, lab technicians, health educators and family planning counselors. It also can include encounters at specialty clinics and health fairs **where services are charted**, etc. This **does not include** emergency medical services, home health, school nurses or inpatient care.

Encounters per User: calculate by dividing the total number of encounters by the number of users.

- row 2 ÷ row 1

Medical/Dental/Behavioral Health Encounters: Identify the number and percentage of the total that is represented in the payment source categories.

> Rows 4-9 should add up to the 100% total. Rows 11-15 should also add up to the 100% total. Please round all percentages to the first decimal place after the decimal point (tenths of a percent). All the categories should add up to the Total Primary Care Encounters in each of the sections (medical and dental). The sum of rows 10 and 16 should add up to the Total Medical/Dental/Behavioral Health Encounters found in the row 2.

Other 3rd Party includes private insurance, county indigent funds paid on a per claim basis, or other revenues paid per encounter.

Sliding Fee includes charity care.

100% Self Pay are those patients that pay the total bill themselves (not those that pay just a co-payment).

Other should include non-charging (free) services that might include family planning counseling, flu shots, immunizations, etc. These must be face-to-face, documented encounters.

If you do not provide dental services in the HCUA, please write "N/A" in dental related sections. All calculations will be verified by the Office of Primary Care and Rural Health data. If there are any discrepancies, the Office's numbers will be used.

Chart 5 - Selected Administrative and Health Professional Salaries

Job Classification	Actual FY18		Projected FY19		Proposed FY20	
	FTE	Annual Salary	FTE	Annual Salary	FTE	Annual Salary
Chief Executive Officer						
Chief Financial Officer						
Medical Director						
Dental Director						
Chief of Operations						

Instructions:

Chart 5 - Selected Administrative and Health Professional Salaries

Selected Administrative Staff:
Indicate the portion of FTE and portion of annual salary for the Administrative positions listed, if applicable. Use appropriate titles for Offerors organization. Chief Executive Officer can also be classified as Executive Director, Administrator, President, etc.

The FTEs and salary should reflect the prorated amount of time dedicated to primary care in the HCUA for which funds are being requested.

Please round all FTEs off to the second decimal place after the decimal point (hundredths).

FTEs should be based on payroll time of 40 hours per work week.

Chart 6 - Summary of Medical/Dental/Behavioral Health Providers and Support Staff

		Actual FY18			Projected FY19			Proposed FY20		
POSITION		**No.**	**FTE**	**Encounters**	**No.**	**FTE**	**Encounters**	**No.**	**FTE**	**Encounters**
Providers										
1	Physician									
2	Nurse Practitioner									
3	Physician Assistant									
4	Certified Nurse Midwife									
5	Behavioral Health Provider									
6	Dentist									
7	Dental Hygienist									
8	Total Providers									
Support Staff										
9	Community Health Worker									
10	Other Clinical Staff									
11	Administrative Staff									
12	Total Support Staff									
13	Other Staff									

Instructions:

Chart 6 - Summary of Medical/Dental/Behavioral Health Providers and Support Staff

Overall: Please complete the following information for your medical/dental/behavioral health providers and support staff for the requested time periods.

Identify the number of positions, the combined FTE equivalency, and encounters generated for each of the following **position types**:

- Physician;
- Nurse Practitioner;
- Physician Assistant;
- Certified Nurse Midwife;
- Behavioral Health Provider;
- Dentist; and
- Dental Hygienist.

Total Providers: The sum of providers listed in rows 1-7.

All FTEs should be rounded off to the second decimal place after the decimal point (hundredths - 1.25).

Provider FTEs should not include time dedicated to administrative duties or traveling time. FTEs should be based on clinical hours - time spent seeing patients. If a physician is mainly doing chart review for other providers, their FTE or percentage of FTE should be under administration. If this time is recorded as a physician, their productivity will indicate a very low number and lead to interpretation of inefficiency.

Support Staff: Identify the number of positions, and the combined FTE equivalency for the following position types:

- Community Health Worker: include community health representatives and promotoras;
- Other Clinical Staff: include those certified or licensed medical/dental staff involved in the direct provision of services such as RNs, LPNs, dental assistants, nurse aids, medical technicians, etc.
- Administrative Staff: Include administrative staff such as CEO, CFO, medical director, receptionist, billing clerks, medical records, other support staff, etc.

Total Support Staff: The sum of rows 9 to 11 (Community Health Workers, Other Clinical Staff and Administrative Staff).

Other Staff: Include nutritionists, lab technicians, etc.

Chart 7 - Patient Generated Income and Charges

		Actual FY18	Projected FY19	Percent Increase %	Proposed FY20	Percent Increase %
Medical Revenues						
1	Total Medical/ Behavioral Health Charges					
2	Medicaid					
3	Medicare					
4	Other 3rd Party Collections					
5	100% Self Pay					
6	Other Self Pay					
7	Total Collections					
8	Sliding Fee					
9	Other Discounts/ Adjustments					
10	Total Adjustments					
11	Bad Debt (write offs)					
12	Medical Patient Generated Revenue					
Dental Revenues						
13	Total Dental Charges					
14	Medicaid					
15	Other 3rd Party Collections					
16	100% Self Pay					
17	Other Self Pay					
18	Total Collections					
19	Sliding Fee Discounts					
20	Other Discounts/ Adjustments					
21	Total Adjustments					
22	Bad Debt (write offs)					
23	Dental Patient Generated Revenue					
24	**Total Patient Generated Revenue**					
25	**Total Medical/Dental/ Behavioral Health Charges**					

Instructions:

Chart 7 - Patient Generated Income and Charges

Patient generated revenues are to be categorized into medical and dental sections. For those programs **not providing dental services** please indicate such with "N/A".

Identify the amount charged for primary care medical and dental services. **Medical/Dental/Behavioral Health Charges** are the total charges to patients and third party payors for services prior to any adjustments.

Identify the primary care revenues for the following **Medical / Dental / Behavioral Health Revenues** categories:

- **Medicaid**
- **Medicare**
- **Other 3rd Party Collections** include private insurance, county indigent funds paid on a per claim basis, or other revenues paid per encounter.
- **100% Self Pay** are those monies collected from patients who are paying their full bill (no adjustments).
- **Other Self Pay** are those monies collected as part of a co-payment for Medicaid, insurance, sliding fee, etc.

Total Collections: To calculate the total collections take the sum of the revenue categories:

- Medical: rows 2-6
- Dental: rows 14-17

Identify the following **Medical / Dental / Behavioral Health** discounts/adjustments to charges:

- **Sliding Fee Discounts** are the amounts discounted from a patient's bill - not The amount that they pay.
- **Other Discounts or adjustments** to charges other than sliding fee discounts.

Total Adjustments: The sum of the discount categories.

- Medical: row 8 + row 9
- Dental: row 19 + row 20

Bad Debt (write offs): Bad Debt is the amount of money written off due to the failure of payment by the patient or other third party payor in accordance with Offerors' policies and procedures.

Identify for medical and dental **Patient Generated Revenues** by subtracting Total Adjustments and Bad Debt from Total Charges.

- Medical: row 7 - (row 10 + row 11)
- Dental: row 18 - (row 21 + row 22)

Identify the **Total Patient Generated Revenues** which are calculated by:

- row 12 + row 23

Identify the **Total Medical / Dental / Behavioral Health Charges:** which are the total charges to patients and third party payors for services prior to any adjustments.

- row 1 + row 13

Identify the **percentages** of increase/decrease between twelve-month periods for **FY18**- Projected **FY19**, and Proposed **FY20.** Please round all percentages to the first decimal place after the decimal point (tenths of a percent).

Chart 8 Part A - Detailed Medical/Dental/Behavioral Health Revenues

	Medical/Dental/ Behavioral Health Revenues	Actual FY18	Projected FY19	Percent Increase %	Proposed FY20	Percent Increase %
1	Patient Generated Revenues					
2	Federal Grants/Contracts					
3	RPHCA Base Contract					
4	Other OPCRH Contracts					
5	Other DOH Contracts					
6	Other State Contracts					
7	Other Revenue (specify)					
8	**Total Medical/Dental/ Behavioral Health Revenues**					

Instructions:

Chart 8 Part A - Detailed Medical/Dental/Behavioral Health Revenues

This should only reflect revenues for medical, dental, and behavioral health services. **Do not include** revenues for non-primary care services such as EMS, etc.

Revenues should reflect **receipts**. Please provide actual receipts for **FY18**. Use projected receipts dollars for the full fiscal years **FY19** and **FY20.**

Identify the **Revenue** from the following sources:

- Patient Generated Revenues
- Federal Grants/Contracts does not include Medicare or Medicaid payments.
- RPHCA Base Contract projections for **FY19** should include RPHCA amounts you are contracted to receive and expected to receive during State **FY19**. **FY20** should include RPHCA amounts you are requesting in your proposal.
- Other Office of Primary Care and Rural Health (OPCRH) including New Mexico Health Corps, Women's contracts, etc.
- Other DOH Contracts including chronic disease activities, special appropriations
- Other State Contracts include, but are not limited to: special legislative appropriations
- Other Revenues is the sum of all other revenues not covered in the lines above. List all other revenues below or on an additional sheet, if necessary. Total these other revenues in row 6.

Total Medical / Dental / Behavioral Health Revenues is the sum of rows 1-7.

Identify the **percentages** of increase/decrease between twelve-month periods for **FY18** - Projected **FY19,** and Proposed **FY20**. Please round all percentages to the first decimal place after the decimal point (tenths of a percent). Decreases should be shown in parentheses.

Explain variances or peculiarities in the data in the narrative section.

All dollar amounts should be rounded off to the nearest dollar (no cents).

Chart 8 Part B - Detailed Medical/Dental/Behavioral Health Expenditures

	Medical/Dental/ Behavioral Health Expenditures	Actual FY18	Projected FY19	Percent Increase %	Proposed FY20	Percent Increase %	FY20 RPHCA Requested Budget
1	Salaries						
2	Fringe						
3	Travel						
4	Continuing Medical Education						
5	Supplies						
6	Facility						
	Ancillary Services						
7	Lab						
8	Pharmacy						
9	X-ray						
10	Contract Services						
11	Equipment						
12	Other (specify below)						
13	**Total Medical/ Dental/ Behavioral Health Expenditures**						

Instructions:

Chart 8 Part B - Detailed Medical/Dental/Behavioral Health Expenditures:

This should only reflect expenditures for medical, dental and behavioral health. **Do not include** expenses related to EMS or other like services.

Identify actual **Expenditures** for **FY18.** Use projected expenditures for the full **FY19** and **FY20**.

Identify the **Expenditures** for the following categories:

- Salaries;
- Fringe;
- Travel (in state/out of state);
- Continuing Medical Education;
- Supplies;
- Facility including rent and utilities;
- Ancillary Services including Lab, Pharmacy, X-ray;
- Contract Services;
- Equipment; and
- Other - **Total all** other expenditure categories not identified above. Identify the specific line item categories below or on an additional sheet, if necessary.

Total Medical/Dental/Behavioral Health **Expenditures** is the sum of rows 1-12.

Identify the **percentages** of increase/decrease between the twelve-month periods for **FY18** and projected **FY19**, as well as between projected **FY19** and **FY20**. Please round all percentages to the first number after the decimal place after the decimal point (tenths of a percent). Decreases should be shown in parentheses.

FY20 RPHCA Requested Budget: Identify the proposed line item expenditures the requested RPHCA funds will be used for.

Explain variances or peculiarities in the data in the budget narrative section.

All dollar amounts should be rounded off to the nearest dollar (no cents).

Chart 9 - HCUA Financial Totals

	Actual FY18	Projected FY19	Proposed FY20
Total Medical/Dental/Behavioral Health Revenues			
Total Medical/Dental/Behavioral Health Expenditures			
Net Revenue			

Chart 10 - Fund Balance

Note: Complete Chart 10 only if proposal is for a single HCUA, multiple HCUA proposals use Chart 18

	Last Audit	
Date		
Restricted Fund Balance		
Non-restricted Fund Balance		
Total Fund Balance		

Chart 11 - Reimbursement

Note: Complete Chart 11 only if proposal is for a single HCUA, multiple HCUA proposals use Chart 19

	Medicaid		Medicare
	Medical	Dental	
FQHC Reimbursement Rate			
RHC Reimbursement Rate			

Chart 11a – Medicaid MCO Rates

Note: Complete Chart 11a only if proposal is for a single HCUA, multiple HCUA proposals use Chart 19a

Medicaid MCO Rates					
MCO Name					
Medicaid Payment Rate (Medical)					
Medicaid Payment Rate (Dental)					
Number of Enrollees as of 06/30/18					

Instructions:

Chart 9 - HCUA Financial Totals

Identify the **Total Medical/Dental/Behavioral Health Revenues** generated within the HCUA. Include only those revenues generated by medical and/or dental services. This should be the same number identified as Total Medical/Dental/Behavioral Health Revenues in **Chart 8 Part A row 8**.

Identify the **Total Medical/Dental/Behavioral Health Expenditures** generated within the HCUA. Include only those expenses generated by medical and/or dental services. This should be the same number identified as Total Medical/Dental/Behavioral Health Expenditures in **Chart 8 Part B row 13**.

Net Revenue is calculated by subtracting Total Medical/Dental/Behavioral Health Expenditures from Total Medical/Dental/Behavioral Health Revenues. If the result is a negative number, please enclose it in parentheses.

Chart 10 - Fund Balance

Note: Complete Chart 10 only if proposal is for a single HCUA only, multiple HCUA proposals use Chart 18

Indicate the date of the last audit for which included the fund balance information.

Total Fund Balance should be the sum of the Restricted Fund Balance and the Non-restricted Fund Balance. Please round off all figures to the nearest dollar.

Chart 11 –Reimbursement Rates

Note: Complete Chart 11 only if proposal is for a single HCUA, multiple HCUA proposals use Chart 19

If applicable, identify the current **FY19** reimbursement rates (in dollars and cents) for the following categories:

- FQHC (Federally Qualified Health Center)
- RHC (Rural Health Center)

Chart 11a - Medicaid MCO Rates

Note: Complete Chart 11a only if proposal is for a single HCUA, multiple HCUA proposals use Chart 19a

- Name (Indicate Name of Managed Care Organization where a contractual agreement for Medicaid - Medical and/or Dental exists)
- Indicate the Medicaid Payment per member per month for each MCO (Medical and/or Dental)
- Indicate the number of enrollees assigned as of June 30, 2018.

APPENDIX E

COMBINED PRIMARY CARE DATA FORMS (Charts 12-19a)

Chart 12 - Payment Source for Medical/Dental/Behavioral Health Encounters – Multiple HCUAs

		Actual FY18		Projected FY19		Proposed FY20	
1	Users						
2	Total Medical/ Dental/Behavioral Health Encounters						
3	Encounters per User						
Medical/Behavioral Health Encounters							
4	Medicaid		%		%		%
5	Medicare		%		%		%
6	Other 3rd Party		%		%		%
7	Sliding Fee		%		%		%
8	100% Self Pay		%		%		%
9	Other		%		%		%
10	Total Medical/ Behavioral Health Encounters		100%		100%		100%
Dental Encounters							
11	Medicaid		%		%		%
12	Other 3rd Party		%		%		%
13	Sliding Fee		%		%		%
14	100% Self Pay		%		%		%
15	Other		%		%		%
16	Total Dental Encounters		100%		100%		100%

COMBINED PRIMARY CARE DATA FORMS (Charts 12-19a)

Instructions:

Chart 12- Payment Source for Medical/Dental/Behavioral Health Encounters – Multiple HCUAs:

Users: identify the total number of patients that use or are projected to use the clinic during the requested fiscal year. If a patient uses both medical and dental services, they are counted only once as a user.

> **Users refers to unduplicated users.** If a patient visits the clinic several times, they are counted only once per year as a user. A patient can only generate one encounter per day (even with multiple visits). The encounter is credited to the highest level provider who sees the patient. An exception to the number of encounters per day is if a patient comes in for different services (medical and dental) in the same day, two encounters can be logged.

Total Medical/Dental/Behavioral Health Encounters: Identify the total number of encounters for both medical and dental services.

> **Total Number of Medical/Dental/Behavioral Health Encounters should include only face-to-face encounters with a provider for medical/dental services that are documented in a patient's chart**. **This includes** face-to-face, charted encounters with the following types of providers: physician, nurse practitioner, physician assistant, certified nurse midwife, dentist, registered dental hygienist, behavioral health professionals, nutritionist, social workers, lab technicians, health educators and family planning counselors. It also can include encounters at specialty clinics and health fairs **where services are charted**, etc. This **does not include** emergency medical services, home health, school nurses or inpatient care.

Encounters/Users: calculate by dividing the total number of encounters by the number of users.

- row 2 ÷ row 1

Medical/Dental/Behavioral Health Encounters: Identify the number and percentage of the total that is represented in the payment source categories.

> Rows 4-9 should add up to the 100% total. Rows 11-15 should also add up to the 100% total. Please round all percentages to the first decimal place after the decimal point (tenths of a percent). All the categories should add up to the Total Encounters in each of the sections (medical/behavioral health and dental). The sum of rows 10 and 16 should add up to the Total Medical/Dental/Behavioral Health Encounters found in the row 2.

Other 3rd Party includes private insurance, county indigent funds paid on a per claim basis, or other revenues paid per encounter.

Sliding Fee includes charity care.

100% Self Pay are those patients that pay the total bill themselves (not those that pay a co-payment).

Other should include non-charging (free) services that might include family planning counseling, flu shots, immunizations, etc. These must be face-to-face, documented encounters.

Explain variances or peculiarities in the data within the narrative.

If you do not provide dental services in the HCUA, please write "N/A" in dental related sections. All calculations will be verified by the Office of Primary Care and Rural Health data. If there are any discrepancies, the Office's numbers will be used.

Chart 13 - Selected Administrative and Health Professional Salaries – Multiple HCUAs

Job Classification	Actual FY18		Projected FY19		Proposed FY20	
	FTE	Annual Salary	FTE	Annual Salary	FTE	Annual Salary
Chief Executive Officer						
Chief Financial Officer						
Medical Director						
Dental Director						
Chief of Operations						

Instructions:

Chart 13 - Selected Administrative and Health Professional Salaries – Multiple HCUAs

Selected Administrative Staff: Combine the FTE and salary information for the Administrative positions listed in all Chart 5 forms for each HCUA request.

Indicate the portion of FTE and portion of annual salary for the Administrative positions listed, if applicable. Use appropriate titles for Offeror's organization. Chief Executive Officer can also be classified as Executive Director, Administrator, President, etc.

Please round all FTEs off to the second decimal place after the decimal point (hundredths).

FTEs should be based on payroll time of 40 hours per work week.

Chart 14- Summary of Medical/Dental/Behavioral Health Providers and Support Staff – Multiple HCUAs

		Actual FY18			Projected FY19			Proposed FY20		
POSITION		**No.**	**FTE**	**Encounters**	**No.**	**FTE**	**Encounters**	**No.**	**FTE**	**Encounters**
Providers										
1	Physician									
2	Nurse Practitioner									
3	Physician Assistant									
4	Certified Nurse Midwife									
5	Behavioral Health Provider									
6	Dentist									
7	Dental Hygienist									
8	Total Providers									
Support Staff										
9	Community Health Worker									
10	Other Clinical Staff									
11	Administrative Staff									
12	Total Support Staff									
13	Other Staff									

Instructions:

Chart 14 - Summary of Medical/Dental/Behavioral Health Providers and Support Staff – Multiple HCUAs

Overall: Please complete the following information for your medical/dental/behavioral health providers and support staff for the requested time periods.

Identify the number of positions, the combined FTE equivalency, and encounters generated for the following **position types**:

- Physician
- Nurse Practitioner
- Physician Assistant
- Certified Nurse Midwife
- Behavioral Health Professionals
- Dentist
- Dental Hygienist

Total Providers: The sum of providers listed in rows 1-7.

All FTEs should be rounded off to the second decimal place after the decimal point (hundredths - 1.25).

Provider FTEs should not include time dedicated to administrative duties or traveling time. FTEs should be based on clinical hours - time spent seeing patients. If a physician is mainly doing chart review for other providers, their FTE or percentage of FTE should be under administration. If this time is recorded as a physician, their productivity will indicate a very low number and lead to interpretation of inefficiency.

Support Staff: Identify the number of positions, and the combined FTE equivalency for the following position types:

- Community Health Workers: include community health representatives, and promotoras
- Other Clinical Staff: include those certified or licensed medical/dental staff involved in the direct provision of services such as RNs, LPNs, dental assistants, nurse aids, and medical technicians, etc.
- Administrative Staff: Include administrative staff such as CEO, CFO, medical director, receptionist, billing clerks, medical records, other support staff, etc.

Total Support Staff: The sum of rows 9-11 (Community Health Workers, Other Clinical Staff and Administrative Staff).

Other Staff: Include nutritionists, lab technicians, etc.

Chart 15 - Patient Generated Income and Charges – Multiple HCUAs

		Actual FY18	Projected FY19	Percent Increase %	Proposed FY20	Percent Increase %
Medical/Behavioral Health Revenues						
1	Total Medical/ Behavioral Health Charges					
2	Medicaid					
3	Medicare					
4	Other 3rd Party Collections					
5	100% Self Pay					
6	Other Self Pay					
7	Total Collections					
8	Sliding Fee Discounts					
9	Other Discounts					
10	Total Adjustments					
11	Bad Debt (write offs)					
12	Medical/ Patient Generated Revenue					
Dental Revenues						
13	Total Dental Charges					
14	Medicaid					
15	Other 3rd Party Collections					
16	100% Self Pay					
17	Other Self Pay					
18	Total Collections					
19	Sliding Fee Discounts					
20	Other Discounts					
21	Total Adjustments					
22	Bad Debt					
23	Dental Patient Generated Revenue					
24	**Total Patient Generated Revenue**					
25	**Total Medical/Dental/ Behavioral Health Charges**					

Instructions:

Chart 15 - Patient Generated Income and Charges – Multiple HCUAs

Patient generated revenues are to be categorized into medical and dental sections. For those programs **not providing dental services** please indicate such with "N/A".

Identify the amount charged for primary care medical and dental services. **Medical/Dental/Behavioral Health Charges** are the total charges to patients and third party payors for services prior to adjustments.

Identify the primary care revenues for the following **Medical/Dental/Behavioral Health Revenues** categories:

- **Medicaid**
- **Medicare**
- **Other 3rd Party Collections** include private insurance, county indigent funds paid on a per claim basis, or other revenues paid per encounter.
- **100% Self Pay** are those monies collected from patients who are paying their full bill (no adjustments).
- **Other Self Pay** are those monies collected as part of a co-payment for Medicaid, insurance, sliding fee, etc. These two categories should add up to the total amount collected from patients (this is not a calculation on the chart).

Total Collections: To calculate the total collections take the sum of the revenue categories:

- Medical: rows 2-6
- Dental: rows 14-17

Identify the following **Medical/Dental/Behavioral Health** discounts/adjustments to charges:

- **Sliding Fee Discounts** are the amounts discounted from a patient's bill - not the amount paid.
- **Other Discounts or adjustments** to charges for other reasons besides sliding fee discounts.

Total Adjustments: The sum of the discount categories.

- Medical: row 8 + row 9
- Dental: row 19 + row 20

Bad Debt: **(write offs)** Bad Debt is the amount of money written off due to the failure of payment by the patient or other third party payor in accordance with Offerors' policies and procedures.

Identify for medical and dental **Patient Generated Revenues** by subtracting Total Adjustments and Bad Debt from Total Charges.

- Medical: row 7 - (row 10 + row 11)
- Dental: row 18 - (row 21 + row 22)

Identify the **Total Patient Generated Revenues** which are calculated by:

- row 12 + row 23

Identify the **Total Medical/Dental/Behavioral Health Charges:** which are the total charges to patients and third party payors for services prior to any adjustments.

- row 1 + row 13

Identify the **percentages** of increase/decrease between twelve-month periods for **FY18** - Projected **FY19** - Proposed **FY20.** Please round all percentages to the first decimal place after the decimal point (tenths of a percent).

Explain variances or peculiarities in the data in the narrative section. All dollar amounts should be rounded off to the nearest dollar (no cents).

Chart 16 Part A - Detailed Medical/Dental/Behavioral Health Revenues – Multiple HCUAs

	Medical/Dental/ Behavioral Health Revenues	Actual FY18	Projected FY19	Percent Increase %	Proposed FY20	Percent Increase %
1	Patient Generated Revenues					
2	Federal Grants/Contracts					
3	RPHCA Base Contract					
4	Other OPCRH Contracts					
5	Other DOH Contracts					
6	Other State Contracts					
7	Other Revenue (specify)					
8	**Total Medical/Dental/ Behavioral Health Revenues**					

Instructions:

Chart 16 Part A - Detailed Medical/Dental/Behavioral Health Revenues – Multiple HCUAs

This should only reflect revenues for medical and dental services. **Do not include** revenues for non-primary care services such as EMS, etc.

Revenues should reflect **receipts**. Please provide actual receipts for **FY18**. Use projected receipts dollars for the **FY19** and **FY20**.

Identify the **Revenue** from the following sources:

- Patient Generated Revenues
- Federal Grants/Contracts does not include Medicare or Medicaid payments.
- RPHCA Base Contract projections for **FY19** should include RPHCA amounts you are contracted to receive and expected to receive during State **FY19**. **FY20** should include RPHCA amounts you are requesting in your proposal.
- Other Office of Primary Care and Rural Health (OPCRH) including New Mexico Health Corps, Women's contracts, etc.
- Other DOH Contracts including chronic disease activities, special appropriations
- Other State Contracts include, but are not limited to: special legislative appropriations
- Other Revenues is the sum of all other revenues not covered in the lines above. List all other revenues below or on an additional sheet, if necessary. Total these other revenues in row 6.

Total Medical/Dental/Behavioral Health Revenues is the sum of rows 1-7.

Identify the **percentages** of increase/decrease between twelve-month periods for **FY17-18** and **FY19-20**. Please round all percentages to the first decimal place after the decimal point (tenths of a percent). Decreases should be shown in parentheses.

Explain variances or peculiarities in the data in the narrative section.

All dollar amounts should be rounded off to the nearest dollar (no cents).

Chart 16 Part B - Detailed Medical/Dental/Behavioral Health Expenditures – Multiple HCUAs

	Medical/Dental/ Behavioral Health Expenditures	Actual FY18	Projected FY19	Percent Increase %	Proposed FY20	Percent Increase %	FY20 RPHCA Requested Budget
1	Salaries						
2	Fringe						
3	Travel						
4	Continuing Medical Education						
5	Supplies						
6	Facility						
	Ancillary Services						
7	Lab						
8	Pharmacy						
9	X-ray						
10	Contract Services						
11	Equipment						
12	Other (specify below)						
13	**Total Medical/ Dental/ Behavioral Health Expenditures**						

Instructions:

Chart 16 Part B - Detailed Medical/Dental/Behavioral Health Expenditures – Multiple HCUAs

This should only reflect expenditures for medical, dental and behavioral health. **Do not include** expenses related to EMS or other like services.

Identify actual **Expenditures** for **FY18.** Use projected expenditures for the **FY19** and **FY20**.

Identify the **Expenditures** for the following categories:

- Salaries
- Fringe
- Travel (in state/out of state)
- Continuing Medical Education
- Supplies
- Facility including rent and utilities
- Ancillary Services including Lab, Pharmacy, X-ray
- Contract Services
- Equipment
- Other - Total all other expenditure categories not identified above. Identify the specific line item categories below or on an additional sheet, if necessary.

Total Medical/Dental/Behavioral Health Expenditures is the sum of rows 1-12.

Identify the percentages of increase/decrease between the twelve-month periods for **FY18** and projected **FY19**, as well as between projected **FY19** and proposed **FY20**. Please round all percentages to the first decimal place after the decimal point (tenths of a percent). Decreases should be shown in parentheses.

FY20 RPHCA Requested Budget - Identify the proposed line item expenditures for the requested RPHCA funds.

Explain variances or peculiarities in the data in the narrative section.

Chart 17 – Offeror Financial Totals – Multiple HCUAs

	Actual FY18	Projected FY19	Proposed FY20
Total Medical/Dental/Behavioral Health Revenues			
Total Medical/Dental/Behavioral Health Expenditures			
Net Revenue			

Chart 18 - Fund Balance – Multiple HCUAs

	Last Audit	
Date		
Restricted Fund Balance		
Non-restricted Fund Balance		
Total Fund Balance		

Chart 19 – Reimbursement

	Medicaid		Medicare
	Medical	Dental	
FQHC Reimbursement Rate			
RHC Reimbursement Rate			

Chart 19a – Medicaid MCO Rates

Medicaid MCO Rates					
MCO Name					
Medicaid Payment Rate (Medical)					
Medicaid Payment Rate (Dental)					
Number of Enrollees as of 06/30/18					

Instructions:

Chart 17 – Offeror Financial Totals

Identify the **Total Medical/Dental/Behavioral Health Revenues** generated within ALL HCUAs. Include only those revenues generated by medical and/or dental services. This should be the same number identified as Total Medical / Dental / Behavioral Health Revenues in **Chart 16 Part A row 8**.

Identify the **Total Medical/Dental/Behavioral Health Expenditures** generated within ALL HCUAs. Include only those expenses generated by medical and/or dental services. This should be the same number identified as Total Medical/Dental/Behavioral Health Expenditures in **Chart 16 Part B row 13**.

Net Revenue is calculated by subtracting Total Medical / Dental / Behavioral Health Expenditures from Total Medical/Dental/Behavioral Health Revenues. If the result is a negative number, please enclose it in parentheses.

Chart 18 - Fund Balance

Indicate the date of the last audit for which you obtained the fund balance information.

Indicate the amount of restricted fund balance from the last audit.

Indicate the amount of Non-restricted Fund Balance from the last audit.

Total Fund Balance should be the sum of the Restricted Fund Balance and the Non-restricted Fund Balance. Please round off all figures to the nearest dollar.

Chart 19 – Reimbursement Rates

Identify the current **FY19** reimbursement rates (in dollars and cents) as appropriate, for the following categories:

- FQHC (Federally Qualified Health Center)
- RHC (Rural Health Center)

Chart 19a - Medicaid MCO Rates

- Name (Indicate Name of Managed Care Organization that you have contractual agreements for Medicaid - Medical and Dental)
- indicate your Medicaid Payment per member per month for each MCO (Medical and Dental)

Indicate the number of enrollees as of June 30, 2018.

APPENDIX F

RURAL PRIMARY HEALTH CARE ACT (RPHCA)

24-1A-1. Short title.

This act [24-1A-1 to 24-1A-3, 24-1A-4 NMSA 1978] may be cited as the "Rural Primary Health Care Act".

24-1A-2. Purpose of act.

The purpose of the Rural Primary Health Care Act [24-1A-1 to 24-1A-3, 24-1A-4 NMSA 1978] is to recruit and retain health care personnel and assist in the provision of primary health care services through eligible programs in underserved areas of the state in order to better serve the health needs of the public.

24-1A-3. Definitions.

As used in the Rural Primary Health Care Act [24-1A-1 to 24-1A-3, 24-1A-4 NMSA 1978]:

A. "health care underserved areas" means a geographic area in which it has been determined by the department of health, through the use of indices and other standards set by the department, that sufficient primary health care is not being provided to the citizens of that area;

B. "eligible programs" means nonprofit community-based entities that provide or commit to provide primary health care services for residents of health care underserved areas and includes rural health facilities and those serving primarily low-income populations;

C. "department" means the department of health; and

D. "primary health care" means the first level of basic or general health care for an individual's health needs, including diagnostic and treatment services.

24-1A-3.1. Department; technical and financial assistance.

To the extent funds are made available for the purposes of the Rural Primary Health Care Act [24-1A-1 to 24-1A-3, 24-1A-4 NMSA 1978], the department is authorized to:

A. provide for a program to recruit and retain health care personnel in health care underserved areas;

B. develop plans for and coordinate the efforts of other public and private entities assisting in the provision of primary health care services through eligible programs;

C. provide for technical assistance to eligible programs in the areas of administrative and financial management, clinical services, outreach and planning;

D. provide for distribution of financial assistance to eligible programs that have applied for and demonstrated a need for assistance in order to sustain a minimum level of delivery of primary health care services; and

E. provide a program for enabling the development of new primary care health care services or facilities, and that program:

(1) shall give preference to communities that have few or no community-based primary care services;

(2) may require in-kind support from local communities where primary care health care services or facilities are established;

(3) may require primary care health care services or facilities to assure provision of health care to the medically indigent; and

(4) shall permit the implementation of innovative and creative uses of local or statewide health care resources, or both, other than those listed in Paragraphs (2) and (3) of this subsection.

24-1A-4. Rules and regulations.

Subject to the State Rules Act [Chapter 14, Article 4 NMSA 1978], the department shall adopt rules and regulations for recruiting health care personnel in health care underserved areas, and shall establish a formula for distribution of financial assistance to eligible programs which shall take into account the relative needs of applicants for assistance, provided that funds may not be expended for land or facility acquisition or debt amortization and further provided that a local match of ten percent shall be required from each local recipient for each request for assistance.

APPENDIX G

RPHCA RULE 7.29.3 NMAC

TITLE 7 HEALTH
CHAPTER 29 PRIMARY AND RURAL HEALTH CARE SERVICES
PART 3 RURAL PRIMARY HEALTH CARE ACT

7.29.3.1 ISSUING AGENCY: New Mexico Department of Health.
[7.29.3.1 NMAC – Rp, 7 NMAC 29.3.1, 10/16/06]

7.29.3.2 SCOPE: Rural Primary Health Care Act Rules shall apply to the use of the funds by eligible programs available pursuant to the Rural Primary Health Care Act, Sections 24-1A-1 to 24-1A-4 NMSA 1978.
[7.29.3.2 NMAC – Rp, 7 NMAC 29.3.2, 10/16/06]

7.29.3.3 STATUTORY AUTHORITY: The Rural Primary Health Care Act, Sections 9-7-6(F) and 24-1A-4 NMSA 1978, as amended.
[7.29.3.3 NMAC – Rp, 7 NMAC 29.3.3, 10/16/06]

7.29.3.4 DURATION: Permanent.
[7.29.3.2 NMAC – Rp, 10/16/06]

7.29.3.5 EFFECTIVE DATE: October 16, 2006, unless a later date is cited at the end of a section.
[7.29.3.5 NMAC – Rp, 7 NMAC 29.3.5, 10/16/06]

7.29.3.6 OBJECTIVE: The objective of 7.29.3 NMAC is to establish standards and procedures for regulating programs under the Rural Primary Health Care Act. The purpose of the Rural Primary Health Care Act is to assist in the provision of primary health care services in underserved areas of the state in order to better serve the health care needs of the public. This purpose will be accomplished through, but not limited to, the following activities:

A. assist communities in the recruitment, placement, and retention of health care personnel in underserved areas of the state which includes the coordination of such effort with health professional education programs at post-secondary schools and other institutions involved in the training of health professional personnel;

B. develop plans and encourage coordination between publicly supported programs, and between public and private sector providers;

C. provide technical assistance;

D. distribute financial assistance to eligible programs in order to sustain or provide a minimum level of primary health care services; and which assist in the provision of primary health care services in underserved areas in order to better serve the health needs of the public; and

E. provide a program for enabling the development of new primary health care services and facilities.
[7.29.3.6 NMAC – Rp, 7 NMAC 29.3.6, 10/16/06]

7.29.3.7 DEFINITIONS:

A. **"Act"** means the Rural Primary Health Care Act, Sections 24-1A-1 to 24-1A-4 NMSA 1978.

B. **"Department"** means the department of health.

C. **"Eligible programs"** means nonprofit community based entities that provide or commit to provide primary health care services for residents of health care underserved areas and include rural health facilities and those serving primarily low income populations.

D. **"Health care personnel"** means health care professionals who contribute to ensuring adequate availability of primary health care services including but not limited to: licensed practical nurses, registered nurses, pharmacists, physician assistants, nurse practitioners, certified nurse midwives, primary care physicians (family practice, general practice, pediatrics, obstetrics and gynecology, and internal medicine), dentists and dental hygienists.

E. **"Health care underserved areas"** (HCUA) means geographic areas where it has been determined by the department of health, through the use of indices and other standards set by the department, that sufficient primary health care is not being provided to the citizens of that area. These designations may recognize

need for either general or special health care services. HCUA designations may give consideration to federally designated health professional shortage areas (HPSA) and medically underserved areas (MUA).

F. **"Medically indigent"** means individuals who are unable to afford all medical care that they require. This includes both those individuals below the federal poverty level not covered by Medicaid, Medicare or other third party health care insurance and those individuals between 100 percent and 200 percent of federal poverty levels who are not covered by any third party health insurance. Medically indigent individuals are usually expected to pay for some portion of the cost of their health care based upon the level of their income.

G. **"Minimum level of primary health care services"** means basic primary health care services provided to the general population by health care personnel.

H. **"Nonprofit community based entities"** means nonprofit organizations with an internal revenue service 501c(3) tax exempt status which have a governing board whose membership is broadly representative of the area served including consumer representatives. Nonprofit community based entities also include local governments and tribal governments. Nonprofit community based entities which are local governments, tribal governments and/or are multi-purpose or provide services in more than one HCUA, shall have local or regional primary health care advisory boards whose membership is generally representative of the area served.

I. **"Patient collections"** means receipts generated from patient encounters for primary health care services. Patient collections include revenues from medicaid, medicare, private insurance, Title XX, and other third party sources or self-pay.

J. **"Primary health care advisory board"** means a board, advisory to an organization's governing board, which has responsibility for consideration of and input into matters related to the provision of primary health care services in a local HCUA or regional combination of HCUAs being served. A majority of the advisory board shall be consumers of primary health care services.

K. **"Primary health care services"** are those provided at the first level of basic or general health care for an individual's health needs, including medical, dental and behavioral health diagnostic and treatment services and supportive services. Any dental or behavioral health services shall be provided in conjunction with primary medical services. Primary health care services are those provided as part of either general practice, family practice, obstetrics, gynecology, pediatrics or general internal medicine.

L. **"Total revenues"** means all receipts collected in support of primary health care services. Includes but not limited to: patient collections; Section 329, 330 and 340 Federal Funds, P.L. 93-638 or IHS support; Title V, X and WIC programs; other federal grants; other state grants/contracts; and local income, including city, county or other unit of government, direct grant or value of donated property or facilities. In addition, other revenues including but not limited to: gifts, cash donations or grants from private foundations, church organizations, or other sources, general operating revenues from clinic services and interest, dividends, and other income derived from certificates of deposit, saving accounts and other investments.

[7.29.3.7 NMAC – Rp, 7 NMAC 29.3.7, 10/16/06]

7.29.3.8 FUND DISTRIBUTION:

A. Duty of the department: To the extent funds are made available for the purposes of the act Section 24-1A-3.1D NMSA 1978, the department, in accordance with applicable procurement procedures, shall provide for the distribution of financial assistance to eligible programs which have applied for and demonstrated a need for assistance in order to sustain the delivery of a minimum level of primary health care services.

B. Eligibility: To receive financial assistance through Section 24-1A-3.1D NMSA 1978, of the act, an eligible program shall:

(1) be a New Mexico nonprofit community based entity with federal internal revenue service 501c(3) tax exempt status, a local government or a tribal government which provide or commits to provide primary health care services to residents of an health care underserved area (HCUA) designated for primary health care needs;

(2) have a governing board whose membership is generally representative of the HCUA(s) it serves, including consumers of the primary health care services it provides. An eligible program which is a local government or tribal government and/or is multi-purpose or provides services in more than one HCUA shall have a local or regional primary health care advisory board whose membership is generally representative of the HCUA(s) being served. A majority of the advisory board shall be consumers of the primary health care services. The local or regional primary health care advisory board shall have opportunity for consideration of and input into the decisions regarding budgets, scope of services, payment policies and procedures, hours of operation and staffing. The eligible program shall be able to demonstrate the ability to meet the governing board and/or the advisory board requirements or have a practical plan for its establishment and implementation;

(3) have as its purpose to sustain or provide a minimum level of primary health care services as defined in Subsection D of 7.29.3.6 NMAC. Services may additionally include medical support, diagnostic and treatment services, pharmacy, laboratory, radiology, preventive health services, behavioral health services, patient

follow-up and/or dental and dental support services. Any dental and/or behavioral health services shall be provided in conjunction with primary medical care services;

(4) have policies and procedures which assure that no person will be denied primary health care services they require because of inability to pay. These policies and procedures should address medically indigent persons below poverty not covered by third party payors and those between 100 percent and 200 percent of poverty without third party coverage. The eligible program should be able to demonstrate either the successful impact of these policies and procedures, or have a practical plan for their implementation;

(5) have billing policies and procedures which maximize patient collections, except where Federal rules or contractual obligations prohibit the use of such measures. The program should be able to demonstrate either the successful impact of these policies and procedures, or have a practical plan for their implementation;

(6) have viable systems and infrastructure to deliver primary health care services including facility, staff and financial management systems;

(7) have comprehensive policies and procedures governing the primary health care operations which assure the delivery of effective, efficient and quality care; and

(8) meet other requirements as determined by the department.

C. Eligible items/uses of expenditures: Funds made available under Section 24-1A-3.1D NMSA of the act may be used for the following types of expenditures:

(1) salaries and benefits for the employees of contractor in support of the provision of primary health care services;

(2) purchase, repair and/or maintenance of necessary medical and dental equipment;

(3) purchase of office, medical, and/or dental supplies;

(4) in-state travel to obtain training or improve coordination in order to better support or provide primary health care services;

(5) general operating expenses;

(6) programs or plans to improve the coordination, effectiveness or efficiency of the delivery of primary health care services; and

(7) contracts for medical and dental personnel services.

D. Ineligible item/uses of expenditures: Costs which are not eligible for funding under Section 24.1A-3.1.D., NMSA 1978, of the act include:

(1) land acquisition;

(2) building, construction, renovation;

(3) debt amortization;

(4) emergency medical services (EMS) including stand-by, dispatch, transport, ambulance runs, equipment and salary, fringe benefits and other costs associated with personnel to provide emergency medical services;

(5) home health care or visiting nurses services;

(6) school nurse programs;

(7) in-patient care;

(8) non-primary health care specialty care including but not limited to surgery, outpatient specialty care and long term care;

(9) freestanding services not otherwise meeting the definition of primary health care;

(10) political activity; and

(11) lobbying.

E. Distribution of financial assistance: In any state fiscal year, the distribution of financial assistance to eligible programs selected pursuant to these rules shall be determined according to the following guidelines.

(1) The award amount will be set by the department reflecting the demonstrated need of the eligible program in its proposal. The demonstrated need of an applicant will be established by the department based upon information contained in the proposal. The department reserves the right to award an amount less than the full amount of demonstrated need.

(2) In any state fiscal year, a maximum award to an eligible program for use in a single HCUA designated for primary health care needs shall not exceed an amount greater than 10 percent of the funds made available by the department for the purposes of distribution of financial assistance under Subsection D of 7.29.3.6 NMAC of these rules, except that eligible programs which are found to have exceptional need may be funded in an amount not to exceed 15 percent of the funds available.

(3) The relative need of an eligible program for financial assistance as demonstrated in the proposal.

(4) The relative need for primary health care services of the HCUA served by the eligible program as reflected in the proposal or other department documents which demonstrate the relative need for primary health care services. Consideration will be given by the department to avoiding the funding of duplicative services and to

sustain the provision of a minimum level of primary health care services by eligible organizations which demonstrate the ability to deliver and maintain quality, effective, efficient and appropriate primary health care services.

(5) The degree to which the eligible program has adequate structures and procedures to administer and deliver primary health care services, including but not limited to staffing, the ability to administer effective and appropriate primary health care services, effective and appropriate financial management systems and adequate systems to maximize patient revenues.

(6) The priority given by the department for the proposed use of the funds.

(7) Other guidelines as determined by the department.

F. Evaluation of proposals: Each proposal will be evaluated and ranked with consideration given to the following factors:

(1) the relative need of an eligible program for financial assistance to sustain or provide primary health care services in a HCUA designated for primary health care needs as demonstrated in the proposal process. Financial need will be evaluated based on several factors, including but not limited to:

(a) the applicant's dependence upon patient collections as a percentage of total revenues available to the applicant for primary health care services;

(b) the extent to which write-offs and adjustments to charges, based on appropriate sliding fee scale implementation, affect the ability of the eligible program to sustain the delivery of primary health care services to an HCUA designated for primary health care needs, as demonstrated in the proposal;

(c) the existence of fund balances which may be used by the applicant to sustain or provide a minimum level of primary health care services in an HCUA designated for primary health care needs;

(d) the projected deficit as demonstrated in the proposal which will impact the ability to sustain or provide a minimum level of primary health care services in an HCUA designated for primary health care needs;

(e) the probable impact which any projected deficit as demonstrated in the proposal will have on the provision of primary health care in an HCUA; and

(f) other need criteria developed by the department.

(2) the relative need of the HCUA served by the applicant for primary health care services, as reflected in the proposal and measured by, including but not limited to:

(a) the severity of need within the HCUA as indicated in department documents or demonstrated in the proposal;

(b) the number and/or percentage of medically indigent population residing in the HCUA; and

(c) other need criteria developed by the department;

(3) the degree to which the applicant has adequate structure and procedures to administer and deliver primary health care services including, but not limited to, staffing, ability to administer effective and appropriate primary health care services, effective and appropriate financial management systems and adequate systems to maximize patient revenues;

(4) the priority given by the department will be for application proposals which have shown need under Subsection E of 7.29.3.9 NMAC of these rules and will be evaluated based on the following criteria, including but not limited to:

(a) proposals where state funds are critical in assuring that any basic primary health care services can be provided in an HCUA designated for primary health care needs. This could include, but not be limited to, support for compensation of providers which is needed for their recruitment and/or retention;

(b) proposals where state funds will be used to supplement the quality/quantity of basic primary health care services in an HCUA designated for primary health care needs. This could include, but not be limited to, support for compensation of providers which is needed for their recruitment and/or retention;

(c) proposals which demonstrate coordination and/or innovative relationships with those funded by the department including, but not limited to, local public health division offices, mental health programs, and substance abuse program and/or other health care services;

(d) proposals where state funds will be used to maintain or expand the comprehensiveness of services beyond basic primary medical services in an HCUA designated for primary health care needs. This could include, but not be limited to, support for compensation of providers which is needed for their recruitment and/or retention; and

(e) other priorities as established by the department.

(5) other factors established by the department.

G. Reports: The department will monitor the performance of the contractor(s) to ensure compliance with the intent of the act.

H. Award of contracts: The department will award contracts in accordance with the New Mexico Procurement Code and applicable department rules.

I. Protest procedure: Any Offeror or contractor who is aggrieved in connection with the award process may use the protest procedure established by the New Mexico Procurement Code and applicable department rules.

[7.29.3.8 NMAC – Rp, 7 NMAC 29.3.8, 10/16/06]

7.29.3.9 NEW PRIMARY HEALTH CARE SERVICES/FACILITIES:

A. Duty of the department: To the extent funds are made available for the purposes of the act, Section 24-1A.3.1E NMSA 1978, the department shall provide a program for enabling the development of new primary health care services or facilities. The department in establishing the program for new primary health care services or facilities will give consideration to proposals for planning as well as for implementation.

B. Eligibility: To be eligible to receive funds to assist in planning for the development of primary health care services or facilities in HCUA(s) designated for primary health care needs, eligible program(s) shall:

(1) be a New Mexico nonprofit community based entity with Federal Internal Revenue Service 501c(3) tax exempt status, local government or tribal government;

(2) have a local or regional primary health care advisory board whose membership is generally representative of the HCUA(s) for which it is developing the primary health care plan; and

(3) meet other requirements as determined by the department.

[7.29.3.9 NMAC – Rp, 7 NMAC 29.3.9, 10/16/06]

7.29.3.10 PERSONNEL RECRUITMENT:

A. Duty of the department: To the extent funds are made available for the purposes of the act, Section 24-1A-3.1A NMSA 1978, the department may contract, in accordance with applicable procurement procedures, with New Mexico nonprofit entities to assist communities in the recruitment, placement, and retention of health care personnel in health care underserved areas of the state and to coordinate such effort with health professional education programs. Such efforts shall be consistent with priorities set out by the department. The department will monitor the performance of the contractor to ensure compliance with the intent of the act.

B. Eligibility: In order to contract pursuant to this part of the rules, the entity shall meet the following requirements:

(1) be a New Mexico nonprofit entity which has obtained and maintains a federal internal revenue service 501c(3) tax exempt status;

(2) have a governing board of directors which is representative of the geographic areas and ethnic populations in New Mexico and is comprised of both health care providers and consumers;

(3) have the capability to carry out the purposes of Subsection A of 7.29.3.8 NMAC of these rules, including qualified professional staff;

(4) not be a health care provider or association of health care providers;

(5) meet other requirements as determined by the department.

C. Reports: The department will monitor the performance of the contractor(s) to ensure compliance with the intent of the act. The contractor shall submit to the department all financial and program reports required by the contract.

D. Selection of candidates: The contractor shall conduct all recruitment activities based upon the following considerations:

(1) all candidates shall be considered on an equal opportunity basis without regards to race, age, color, national origin, gender, sexual orientation, handicap or disability or religion or ethnicity; and

(2) whenever possible, emphasis will be placed upon assisting native New Mexicans, New Mexico residents and graduates from New Mexico health professional education programs in relocating to health care underserved areas.

[7.29.3.10 NMAC – Rp, 7 NMAC 29.3.8, 10/16/06]

APPENDIX H

NEW MEXICO HCUA DESIGNATIONS

All counties in New Mexico are designated HCUAs (Health Care Underserved Areas) with the following exceptions:

Los Alamos - not a HCUA

Bernalillo - Partial county HCUA designations

- South Valley
- North Valley
- Homeless Special Population
- Urban Indian Special Population

Santa Fe - Partial county HCUA designations

- Cerrillos/Madrid/Edgewood Service Area
- Santa Fe-Westside Service Area

APPENDIX I

{This sample contract is subject to change as requested by the Agency, subject to the approval of the Department of Finance and Administration}.

Contract Terms and Conditions

STATE OF NEW MEXICO
(NAME OF AGENCY)

PROFESSIONAL SERVICES CONTRACT #_____

THIS AGREEMENT is made and entered into by and between the State of New Mexico, **DEPARTMENT OF HEALTH**, hereinafter referred to as the "Agency," 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 the following work:

A. Ensure the provision of primary care services in underserved areas of the state by providing the following:

1. Annual Projected Level of Operations forms

2. Contract Action Plan, which must include:
   a. Estimated level of services
   b. Staffing
   c. Hours of operation, including after-hours coverage and emergency care
   d. Prenatal care services
   e. Family planning services
   f. Dental services
   g. Behavioral health services
   h. Ancillary services
   i. Specialty clinics
   j. Referral relationships with EMS (emergency medical services), hospital, dental, behavioral health, and other services
   k. Integration methods for improving coordination of care across settings
   l. Collaboration with public and private providers, school-based health centers, and tribal programs to maximize delivery of primary care health care services
   m. Recruitment and retention plan for healthcare providers, including:

n. Total dollar amount of RPHCA funding used towards healthcare provider salaries and benefits.
o. Total dollar amount of RPHCA funding used towards healthcare provider recruitment (*This amount reflects recruitment efforts/methods, such as how much is used for advertisement of positions, recruitment agencies, etc. If using New Mexico Health Resources to recruit and/or post job listings, please indicate).*
p. Rate of retention of healthcare providers at the clinic (*On average, how many years are providers staying? If providers are leaving, are they leaving to another clinic within the community, to another New Mexico community, or leaving New Mexico?*)
q. Governing Board and/or Local/Regional Advisory Board information
r. Evaluation methods
s. Other pertinent information

3. Submit a detailed Quality Improvement/Assurance (QI/QA) Plan for each clinic site ensuring that it includes:
   a. Clinical services and management services.
   b. Systematic collection and evaluation of patient records.
   c. Periodic assessment of the appropriateness of the utilization of services and the quality of services provided.

B. Submit data and reports through the Online RPHCA Reporting System by providing:

1. Monthly Level of Operations Data for each clinic site for services provided in the previous month. Should the actual level of services fall below 90% of the projected level for a period exceeding 60 days the contract may be renegotiated including reviewing and adjusting the amount of payment.

2. Summary Monthly Narrative Report on the status of the activities toward accomplishment of the scope of work, any significant issues and changes, and progress toward meeting the Annual Projected Level of Operation projections.

C. Ensure policies and procedures states that no person will be denied services because of their inability to pay. These policies and procedures should address the provision of services to medically indigent persons below poverty not covered by third party payors and those between 100 percent and 200 percent of poverty guidelines without third party coverage. The facility must also:

1. Post a notice in a conspicuous location in the patient waiting area that a sliding fee discount is available to eligible persons with income up to 200 percent of poverty and are not covered by third party payors, and
2. Advertise in the community, local media and other areas that a sliding fee discount is available to eligible persons with income up to 200 percent of poverty and are not covered by third party payors.

D. Assess all patients without third party coverage for Medicaid eligibility, and participate, as appropriate, in on-site Medicaid eligibility determination, presumptive eligibility and Early Periodic Screening, Diagnosis, and Treatment (EPSDT).

E. Review Medicaid and Medicare reimbursements to assure maximization of generated revenues and, if appropriate, participate in reimbursement programs under the Rural Health Clinic Services Act or Federally Qualified Health Centers Certification.

F. Maintain for inspection the appropriate and most current facility licensure from the AGENCY Health Facility Licensing & Certification Bureau by providing:

1. Current Operator's License.
2. Current New Mexico professional licenses or certifications, and Board certification if applicable, for all service providers whose salaries or contracts or contracts are supported in whole or part by RPHCA funds.

G. Authorize the AGENCY access to all Health Resources and Services Administration (HRSA) documentation (if HRSA funded) regarding:

1. Site visit reports and findings relating to the operation of the health centers.
2. Scheduled visits by HRSA. Notify the AGENCY in advance of the HRSA visit.

H. Participate in clinic site visit(s) conducted by the AGENCY.

I. Participate and complete the New Mexico Health Resources, Inc. Annual Salary Surveys and Quarterly Vacancy Surveys regarding health care recruitment and retention.

J. Work with the County and/or Tribal Community Health Improvement Council(s) to ensure coordination of its work with the Council's health improvement plan and activities.

K. Ensure majority of governing Board shall be consumers of the primary health care services it provides and is generally representative of the target population it serves.

L. Ensure diversity of programs and structure, and that programs offered meet the Federal cultural and linguistic access standards to better serve the target population.

M. Display the AGENCY and RPHCA as a funding source by:

1. Posting notice in a conspicuous location in the facility's patient waiting area stating the funding source.
2. Posting on CONTRACTOR websites stating the funding source.

<u>Reporting and Invoicing</u>

N. Submit for AGENCY approval the Annual Project Level of Operations forms, Contract Action Plan, and Quality Improvement/Assurance Plan by the third (3^{rd}) working day in August in each fiscal year.

O. Submit for AGENCY approval the Monthly Level of Operations and Summary Monthly Narrative Report by the second (2nd) Friday of each month in each fiscal year.

P. Submit for AGENCY approval a monthly invoice for the previous completed month's services by the third (3rd) working day of each month in each fiscal year.

Performance Measures

CONTRACTOR shall substantially perform and report annually the following Performance Measures:

Q. Program Performance Accountability: Expand health care access in rural and underserved areas. Report will address:

1. Total number of medical and dental encounters at community-based primary care centers.
2. Number of medical and dental encounters that are Medicaid, Medicare, private insurance, self-pay.

R. Population Based Accountability: Improve health outcomes for the people of New Mexico.

Objective: To prevent or reduce diabetes complications through improved quality of clinical care and increased access to services to ensure healthier living (*DOH FY19 Strategic Plan*). Report will address:

1. Extent of HbA1c testing for patients with diabetes (*how much is done?*);
2. Percent of patients with HbA1c levels less than 9% (*how well it was done?*); and
3. Change measured against calendar 2017 baseline and subsequent data (*Is anyone better off?*).

S. Notify the AGENCY in writing within 30 days of receipt of official notification of:

1. Changes in funding to support the activities identified in this contract from the following types of sources: state, federal, private foundation grants or contracts. The AGENCY may reevaluate the need for financial assistance.
2. Changes to points of contact.

T. Performance will be monitored and evaluated by periodic on-site work reviews, review of narrative and data reports, and scheduled consultations with the AGENCY.

U. Failure to comply with above items A-T may result in payment delays and the AGENCY will reevaluate the need for financial assistance.

BUDGET

Deliverables	FY20	FY21	FY22	FY23	Grand Total
Baseline Reports (4) - Annual Projected Level of Operations;					

Contract Action Plan; Quality Improvement/Assurance Plan; and Report on Extent of HbA1c testing for patients with diabetes for each reporting clinic site, received and approved by AGENCY by the third (3rd) working day in August, with an invoice not to exceed a total of $XXXX					
Monthly Services - A monthly invoice equivalent to 1/12 draw, which represents adherence to the requirements outlined in the scope of work, received and approved by AGENCY by the third (3rd) working day of each month, in the amount of $XXXX not to exceed a total of $XXXX.					
TOTAL BUDGET					

2. <u>Compensation.</u>

A. The Agency shall pay to the Contractor in full payment for services satisfactorily performed based on deliverables, such compensation not to exceed (AMOUNT), including gross receipts tax if applicable. **The total amount payable to the Contractor under this agreement shall not exceed (AMOUNT).**

The Agency shall pay to the Contractor in full payment for services satisfactorily performed pursuant to the Scope of Work at the rate of _____ dollars ($_____) in FY20, such compensation not to exceed (AMOUNT), including gross receipts tax if applicable.

The Agency shall pay to the Contractor in full payment for services satisfactorily performed pursuant to the Scope of Work at the rate of _____ dollars ($_____) in FY21, such compensation not to exceed (AMOUNT), including gross receipts tax if applicable.

The Agency shall pay to the Contractor in full payment for services satisfactorily performed pursuant to the Scope of Work at the rate of _____ dollars ($_____) in FY22, such compensation not to exceed (AMOUNT), including gross receipts tax if applicable.

The Agency shall pay to the Contractor in full payment for services satisfactorily performed pursuant to the Scope of Work at the rate of _____ dollars ($_____) in FY23, such compensation not to exceed (AMOUNT), including gross receipts tax if applicable.

These amounts are a maximum and not a guarantee that the work assigned to be performed by Contractor under this agreement shall equal the amount stated herein. The parties do not intend for the Contractor to continue to provide services without compensation when the total compensation amount is reached. Contractor is responsible for notifying the Agency when the services provided under this agreement reach the total compensation amount. In no event will the Contractor be paid for services provided in excess of the total compensation amount without this agreement being amended in writing prior to those services in excess of the total compensation amount being provided.

B. Payment in FY20, FY21, FY22, and FY23 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 Agency no later than fifteen (15) days after the termination of the Fiscal Year in which the services were delivered or within fifteen (15) days after the last day of the month in which services were performed; or, for deliverable based agreements, unless submitted within fifteen (15) days after the last day of the month during with a deliverable was completed. Invoices received after such date WILL NOT BE PAID. Invoices shall be submitted monthly. For deliverable based agreements, payment shall be made upon acceptance of each completed deliverable and upon the receipt and acceptance of a detailed, certified payment Invoice. The Contractor shall submit to the Agency at the close of each month a signed invoice reflecting the total allowable costs incurred during the preceding month; or for deliverable based agreements, at the close of each month during which a deliverable was completed a signed invoice reflecting the total allowable costs incurred during completion of the deliverable.

C. Contractor must submit a detailed statement accounting for all services performed and expenses incurred. If the Agency 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 Agency 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. <u>Term.</u>

THIS AGREEMENT SHALL NOT BECOME EFFECTIVE UNTIL APPROVED BY THE DFA. This agreement shall terminate on **June 30, 2023** unless terminated pursuant to paragraph 4 (Termination), or paragraph 5 (Appropriations). In accordance with NMSA 1978, § 13-1-150, no agreement term for a professional services agreement, including extensions and renewals, shall exceed four years, except as set forth in NMSA 1978, § 13-1-150.

4. Termination.

A. Grounds. The Agency may terminate this agreement for convenience or cause. The Contractor may only terminate this agreement based upon the Agency's uncured, material breach of this agreement.

B. Notice; Agency Opportunity to Cure.

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

2. Contractor shall give Agency written notice of termination at least thirty (30) days prior to the intended date of termination, which notice shall (i) identify all the Agency's material breaches of this agreement upon which the termination is based and (ii) state what the Agency must do to cure such material breaches. Contractor's notice of termination shall only be effective (i) if the Agency does not cure all material breaches within the thirty (30) day notice period or (ii) in the case of material breaches that cannot be cured within thirty (30) days, the Agency 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 Agency; (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 Agency'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. If this agreement is terminated pursuant to its provisions, or if the parties mutually agree to discontinue their contractual relationship, or upon expiration of the term of the AGREEMENT, immediately upon expiration or receipt by either the Agency 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 Agency, except as provided in part (4) of this paragraph, below; 2) comply with all directives issued by the Agency in the notice of termination as to the performance of work under this agreement; and 3) take such action as the Agency shall direct for the protection, preservation, retention or transfer of all property titled to the Agency and records generated under this agreement, and 4) if providing health services or client support as part of the scope of work of this agreement, continue to provide essential services and supports to ensure the health and safety of individual clients as directed by the Agency during the period of termination

management. This requirement is not avoided by an inadvertent expiration of term for the agreement. In this event the Agency may temporarily extend the term, enter into a new short-term agreement or otherwise enter into an agreement, consistent with the New Mexico Procurement Code until all transition of services are completed. As of the date of termination of this agreement, the Contractor shall furnish to the Agency: (a) a complete detailed inventory of nonexpendable Agency property or equipment provided to or purchased by the Contractor with agreement funds as defined in Article 31 (Property) of this agreement, and (b) a final closing of the financial records and books of accounts which were required to be kept by the Contractor under the provisions of this agreement regarding financial records. Any non-expendable personal property or equipment provided to or purchased by the Contractor with agreement funds shall become property of the Agency upon termination and shall be submitted to the agency as soon as practicable.

5. Appropriations.

The terms of this agreement are contingent upon sufficient funds appropriated, allocated, and authorized by the Legislature of the State of New Mexico and/or by the federal government for the performance of this agreement. If sufficient appropriations, allocations and authorizations are not made by the Legislature of the State of New Mexico and/or if the federal government makes insufficient allocations, necessitating a decrease in the amount of agreement funds available for expenditure by the Agency, this agreement may be terminated or amended to a lower amount of funds upon written notice being given by the Agency to the Contractor. The Agency's decision as to whether sufficient appropriations are available shall be accepted by the Contractor and shall be final and binding on the Contractor. If the Agency 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 Agency and are not employees of the Agency. The Contractor and its agents and employees shall not be deemed employees for any purpose within the meaning or application of any federal or state unemployment or insurance laws or workers compensation laws or otherwise. Contractor, its agents and employees shall not be entitled to any of the benefits afforded employees of the Agency including but not limited to accruing leave, retirement, insurance, bonding, use of state property or state vehicles, or any other consideration not specified in this agreement. The Contractor acknowledges that all sums received hereunder are personally reportable by the Contractor for income tax purposes as self-employment or business income and are reportable for self-employment 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 Agency.

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 Agency. 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 Agency, 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 and records 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 Agency, or the express written authorization of the client when the record is a client record.

11. Product of Service -- Copyright.

A. 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 Agency 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.

B. Client information developed under this agreement may not be used by the Contractor or be transferred to a third party in any form, including aggregate data, without the express written permission of the Agency, except to fulfill the provisions of the Scope of Work under this agreement.

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, Article 16 NMSA 1978. Without in anyway limiting the generality of the foregoing, the Contractor specifically represents and warrants that:

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

2) this agreement complies with NMSA 1978, § 10-16-7(A) 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 NMSA 1978, § 10-16-7(A) and this agreement was awarded pursuant to a competitive process;

3) in accordance with NMSA 1978, § 10-16-8(A), (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 Agency's making this agreement;

4) this agreement complies with NMSA 1978, § 10-16-9(A)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 NMSA 1978, § 10-16-7(A), this agreement is not a sole source or small purchase agreement, and this agreement was awarded in accordance with the provisions of the Procurement Code;

5) in accordance with NMSA 1978, § 10-16-13, 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 NMSA 1978, § 10-16-3 and § 10-16-13.3, 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 Agency.

C. Contractor's representations and warranties in Paragraphs A and B of this Article 12 are material representations of fact upon which the Agency relied when this agreement was entered into by the parties. Contractor shall provide immediate written notice to the Agency 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 Agency and

notwithstanding anything in the agreement to the contrary, the Agency 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. From time to time and in accordance with changes in state and Agency policy, this agreement shall be amended to comport with current policy, rules, regulations, and law.

B. If the Agency 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, NMSA 1978 §§ 13-1-28 through 13-1-199, 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 NMSA 1978, § 38-3-1 (G). 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 Agency.

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 three (3) years from the date of final payment under this agreement. The records shall be subject to inspection by the Agency, the Department of Finance and Administration and the State Auditor. The Agency shall have the right to audit billings both before and after payment. Payment under this agreement shall not foreclose the right of the Agency to recover excessive or illegal payments.

B. The Contractor receiving state or federal funds from the Agency shall comply, if applicable, with auditing requirements under the Single Audit Act (31 U.S.C. §7501, et seq.) and the New Mexico State Auditor's rules and regulations. If the Contractor is determined to be a sub recipient and not a vendor under the federal Single Audit Act, the Contractor shall comply with the audit requirements of the Single Audit Act. This includes the Contractor retaining its financial records for a period five years after the time the audit was released.

C. If the Contractor receives more than $750,000 in federal funding, or more than $750,000 from the Agency, in any single fiscal year, the Contractor shall prepare annual financial statements and obtain an audit of, or an opinion on, the financial statements from an external Certified Public Accountant.

D. The Contractor shall maintain the financial statements for a period of no less than six years and shall make the financial statements and the CPA's audit or opinion available to the Agency upon request.

E. Applicable annual financial reports shall be submitted to the Agency no later than six months following the close of the Contractor's fiscal year.

F. To ensure proper delivery and receipt, the Contractor shall submit their annual audit report or financial reports (if no audit was required to):

Department of Health
Financial Accounting Bureau Chief Suite N-3150
P.O. Box 26110
Santa Fe, New Mexico 87502-6110

G. The Agency may take corrective action as deemed necessary for Contractor's failure to comply with 19-A through 19-F above. Corrective action may include, but is not limited to, termination of agreement and preclusion from engaging Contractor in the future.

20. Indemnification.

The Contractor shall defend, indemnify and hold harmless the Agency 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 Agency and the Risk Management Division of the New Mexico General Services Department by certified mail.

21. New Mexico Employees Health Coverage.

A. If the Offeror has, or grows to, six (6) or more employees who work, or who are expected to work, an average of at least 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 if the expected annual value in the aggregate of any and all contracts between Contractor and the State exceed $250,000 dollars.

B. Offeror must 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. Offeror must 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://www.insurenewmexico.state.nm.us/.

D. 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); theses 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.

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 agreement, to complete and submit the PE10-249 form on the annual anniversary of the initial report submittal for agreements up to one (1) year in duration. If contractor has two hundred fifty (250) or more employees contractor must complete and submit the PE250 form on the annual anniversary of the

initial report submittal for agreements up to one (1) year in duration. For agreements 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 agreement 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 agreement, whichever comes first. Should contractor not meet the size requirement for reporting at agreement 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 agreement if said subcontractor(s) meets, or grows to meet, the stated employee size thresholds during the term of the agreement. Contractor further agrees that, should one or more subcontractor not meet the size requirement for reporting at agreement 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 though contractor itself may not meet the size requirement for reporting and be required to report itself.

Notwithstanding the foregoing, if this agreement 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 Agency:

New Mexico Department of Health

P.O. Box 26110

1190 St. Francis Drive,

Santa Fe, NM 87502-6110

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 agreement.

27. Licensure.

The Contractor agrees to retain professional licensure, accreditation, credentialing or continuing education required to perform the scope of professional services provided for the Agency. The Contractor agrees to make evidence of licensure or other regulatory requirements for the scope of professional services available to the Agency if requested in writing.

28. Liability Insurance.

The Contractor shall maintain professional or general liability insurance, as applicable, for all services provided under this agreement and Contractor shall supply evidence of such coverage upon the Agency's request.

29. Federal Grant or Other Federally Funded Agreements.

A. Lobbying. The Contractor shall not use any funds provided under this agreement, either directly or indirectly, for the purpose of conducting lobbying activities or hiring a lobbyist or lobbyists on its behalf at the federal, state, or local government level, as defined in the Lobbyist Regulation Act, NMSA 1978, Sections 2-11-1, *et. seq.*, and applicable federal law. No federal appropriated funds can be paid or will be paid, by or on behalf of the Contractor, or any person for influencing or attempting to influence an officer or employee of any Department, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal agreement, or the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or modification of any federal agreement, grant, loan, or cooperative agreement. If any funds other than federal

appropriated funds have been paid or will be paid to any person influencing or attempting to influence an officer or employee of any Department, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection of any applicable federal agreement, grant, loan, or cooperative agreement, the Contractor shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

B. Suspension and Debarment. For agreements that involve the expenditure of federal funds, each party represents that neither it, nor any of its management or any other employees or independent contractors who will have any involvement in the services or products supplied under this agreement, have been excluded from participation in any government healthcare program, debarred from or under any other federal program (including but not limited to debarment under the Generic Drug Enforcement Act), or convicted of any offense defined in 42 U.S.C. Section 1320a-7, and that it, its employees, and independent contractors are not otherwise ineligible for participation in federal healthcare or education programs. Further, each party represents that it is not aware of any such pending action(s) (including criminal actions) against it or its employees or independent contractors. Each party shall notify the other party immediately upon becoming aware of any pending or final action in any of these areas.

C. Political Activity. No funds hereunder shall be used for any partisan political activity or to further the election or defeat of any candidate for public office.

D. Grantor and Contractor Information.

1. If applicable, funding under this agreement is from the Catalog of Federal Domestic Assistance (CFDA) Program:

i. CFDA Number – N/A

ii. Program Title – N/A

iii. AGENCY/OFFICE – N/A

iv. GRANT NUMBER – N/A

2. CONTRACTOR'S Dun and Bradstreet Data Universal Numbering System Number (DUNS Number) is N/A

E. Contractor Employee Whistleblower Rights and Requirement to Inform Employees of Whistleblower Rights (Sept. 2013) [Federal Grant funded projects only].

1. This agreement and employees working on this agreement will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L.112-239) and FAR 3.908.

2. The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

3. The Contractor shall insert the substance of this clause, including this paragraph (3), in all subcontracts over the simplified acquisition threshold.

F. For agreements and subgrants that involve the expenditure of federal funds for amounts in excess of $150,000, requires the Contractor to agree to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401-7671q) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251-1387). Violations must be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

G. Byrd Anti-Lobbying Amendment (31 U.S.C. 1352) — For agreements that involve the expenditure of federal funds, Contractors that apply or bid for an agreement exceeding $100,000 must file the required certification. Each tier certifies to the tier above that it will not and has not used federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal agreement, grant or any other award covered by 31 U.S.C. 1352. Each tier must also disclose any lobbying with non-federal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier to tier up to the non-federal award.

H. For agreements that involve the expenditure of federal funds, Contractor must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. The requirements of Section 6002 include procuring only items designated in guidelines of the Environmental Protection Agency (EPA) at 40 CFR part 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of the quantity acquired during the preceding fiscal year exceeded $10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

30. Governing Bodies.

The parties agree that if the Contractor has one or more Governing Bodies, the Governing Bodies of the Contractor shall have the right and responsibility to establish policy for the Contractor and shall be elected to ensure that such policy is established by the Governing Bodies in an impartial and independent manner. Nothing herein shall in any way restrict the authority of the Governing Bodies from appropriately delegating day-to-day management responsibilities to its employees, agent, or agents. By such delegation, employees and/or agents of the Contractor must conduct the operation of the Contractor consistent with the policies and procedures approved by the Governing Bodies.

31. Property.

A. Title to all property furnished by the Agency shall remain in the Agency. Title to all property acquired by the Contractor, including acquisition through lease-purchase agreement, for the cost of which the Contractor is to be reimbursed as a direct item of cost under this agreement shall immediately vest in the Agency upon delivery of such property to the Contractor. Title to other property, the costs of which is to be reimbursed to the Contractor under this agreement, shall immediately vest in the Agency upon 1) issuance for use of such property in the performance of this agreement or 2) use of such property in the performance of this agreement or 3) reimbursement of the cost thereof by the Agency, whichever first occurs.

B. Title to the Agency property shall not be affected or lose its identity by reason of affixation to any realty or attachment at law.

C. The Contractor shall maintain a property inventory and administer a program of maintenance, repair, and protection of Agency property so as to assure its full availability and usefulness for performance under this agreement. In the event the Contractor is indemnified, reimbursed, or otherwise compensated for any loss or destruction of, or damage to Agency property during the period of this agreement, it shall use the proceeds to repair or replace the Agency property.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date of signature by the DFA Contracts Review Bureau below.

By: _____ Date:_____

Agency

By: _____ Date:_____

Agency's Legal Counsel – Certifying legal sufficiency

By: _____ Date:_____

Agency's 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 and is effective on the date shown:

By: _____ Date:_____

DFA Contracts Review Bureau

APPENDIX J

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 HE/SHE/IT, HIS/HER/ITS FAMILY MEMBER, OR 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 proces**s" 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 Title (Position)

_____

Date

—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 Title (Position)

_____

Date