

New Mexico Medical Insurance Pool

Request for Proposal: #2024003

For

Pharmacy Benefit Management

Technical and Cost Questionnaire

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

(Company name)

Proposal Due: September 20, 2024

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**New Mexico Medical Insurance Pool**

**Request for Proposal**

For

Pharmacy Benefit Management Services

**Technical and Cost Questionnaire**

**Instructions Related to This Questionnaire**

This Word document should be saved to your hard drive or network before beginning to complete it, using any file name of your choice. Some boxes require x’s only while others allow you to type in a response. There are no limits on the amount of text allowed; however, we request that answers be concise yet complete. Answer only the questions asked and refrain from making references to other preprinted material.

After entering your answers, partially or completely, you should save the document before closing. You can then reopen it later for additional edits. Once this document contains all your responses, save it. Submit it by the due date as described in the Background Information document.

If you find that this document does not allow you to respond completely to any given question, you can submit additional information separately. To do so, create a separate document in any format with additional information, referencing the question number in this document. Include the additional file with your submission.

# General Information

1. Please indicate your organization’s legal name and primary address.

2. Confirm your ability to perform all the work requirements outlined in the Scope of Work section of the Background Information document.

Agree  Disagree, as described:

3. Confirm that your organization is willing to agree to a contract term of January 1, 2025 through December 31, 2027, with the potential for one one-year extension.

Agree  Disagree, as described:

4. Confirm that your fees include the cost of all services outlined in the Scope of Work section of the Background Information document and that your proposal is binding for a 120-day period following the deadline for receipt of proposals.

Agree  Disagree, as described:

5. Confirm that you are willing to agree to performance standards with monetary penalties no less than the minimum standards outlined in the Performance Standards document **Appendix E,** and that any subcontractors will be held to the same standards. Note that the performance standard include deadlines for contract execution and meeting implementation deadlines.

Agree  Disagree, as described:

6. Confirm that you are willing to agree that all records, files, and reports associated with this program are and will remain the property of the Pool and are to be turned over to a successor contractor should there be one.

Agree  Disagree, as described:

7. Confirm that you are willing to agree to provide the Pool or its designee with access to all records, files, and reports associated with this program for audit purposes.

Agree  Disagree, as described:

8. Confirm that you are willing to agree to keep Pool records confidential per HIPAA requirements and will not use the list of Pool enrollees for any reason associated with other business.

Agree  Disagree, as described:

9. Confirm that you will maintain secure computer systems that protect all private information related to Pool enrollees in accordance with New Mexico and federal laws.

Agree  Disagree, as described:

10. Confirm that you will comply with the Minimum Insurance Requirements as described in the Background Information document.

Agree  Disagree, as described:

# Organizational Information and Experience

11. Provide the key contact information requested below.

| Title | Contact Name | Years with Company (as of 8/2024) | Location City/State | Phone Number | E-mail Address |
| --- | --- | --- | --- | --- | --- |
| Primary RFP Contact |  |  |  |  |  |
| Secondary RFP Contact |  |  |  |  |  |
| Account Manager |  |  |  |  |  |

12. Provide the resume of the proposed Account Manager as **Attachment A.**

14. Complete the following table with information about your company.

|  |  |
| --- | --- |
| Number of years in business |  |
| Number of employees in all locations |  |
| Number of years providing proposed services |  |

14. Has your company been certified by the New Mexico State Taxation and Revenue Department as a resident business, Native American resident business, resident veteran business, or Native American resident veteran business to receive a preference pursuant to NMSA 1978 §13-1-21? If yes, please provide a copy of the certificate as **Attachment B**.

15. Provide a brief history of your company’s mergers and acquisitions.

16. Is your company in the process of a merger or acquisition, or is a merger or acquisition anticipated? If yes, please describe.

17. Provide your company’s audited financial statements for the past two years as **Attachment C**.

18. Are there any restrictions or pending reviews by state or federal authorities for noncompliance with state or federal regulations? If so, please explain in **Attachment D.**

19. Are there any legal actions pending against the company that may have a significant impact on the plan’s financial status? If yes, please explain as **Attachment E**.

20. Will your company use subcontractors in administering the proposed program? If yes, please complete the following table.

| Subcontractor Name | Services Provided | When Used? |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

21. If your company uses subcontractors in administering the proposed program, do you agree to allow NMMIP staff to interact directly with the subcontractors to deal with performance issues? If no, please explain.

22. Does your company agree to meet the deadlines as indicated in the Draft Implementation Plan (**Appendix M**)? If no, please explain in detail in **Attachment F**.

23. Review the Sample Contract (**Appendix L**) and provide a list of any provisions you require to be changed or added in **Attachment K**.

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# Pharmacy Benefit Management

24. Review the Pharmacy Benefit Management Services Scope of Work requirements listed in the Background Information document. Is your company willing and able to provide each and every item listed? If not, please list any requirements that your company is unable to provide.

25. Provide the name of the PBM.

26. Review NMMIP’s abridged formulary in **Appendix N**. Will your company be able to administer this formulary and work with NMMIP staff and Board to modify it when needed to meet specific concerns?

27. Indicate which pharmacy chains are included in your pharmacy network.

| ***Chain*** | ***Y/N*** |
| --- | --- |
| Albertsons |  |
| Costco |  |
| CVS |  |
| KMart |  |
| Kroger |  |
| Safeway |  |
| Smith’s |  |
| Target |  |
| Walgreens |  |
| Walmart |  |
| Other (list) |  |

28. Complete the following table to describe the processes you have in place to manage specialty and other high cost drugs.

|  | **Brief Description** |
| --- | --- |
| Review of appropriate prescribing |  |
| Advising patients of lower cost alternatives |  |
| Monitoring compliance |  |
| Insuring timely and safe delivery |  |
| Monitor use of opioids |  |
| Prior authorization |  |
| Step therapy |  |

29. Briefly explain your company’s approach to mail order prescriptions.

30. How and when are members notified when there is a change in the PBM network or the specialty pharmacy?

31. The rapidly rising cost and utilization of specialty drugs is of major concern to NMMIP and its enrollees. What is your organization doing to help prevent price escalation by specialty drug manufacturers?

32. Describe your company’s pharmacy quality monitoring program.

33. Describe your ability to combine medical and pharmacy claim data to support plan designs with integrated deductibles and maximum out of pockets.

34. Describe the PBM’s experience in administering State Pharmaceutical Assistance Programs (SPAPs) for Medicare members purchasing Medicare Part D drug plans. If your company is not currently performing this service, is your company willing to agree to learn the process and perform the administration of SPAPs for NMMIP?

35. Provide the web address where your pharmacy provider directory can be found.

36. Provide a count of currently participating pharmacies by New Mexico county in your proposed network(s) as **Attachment G**. Please use the form found after the Required Attachments section of this document.

37. Based on the Pool participant zip code information included in the census data for this RFP, provide a GeoAccess report as **Attachment H**, using the following criteria:

* The requested access standard is the count and percent of enrollees:
* Within five (5) and fifteen (15) miles of at least one (1) pharmacy
* Provide an accessibility summary for enrollees with and without desired access.
* Provide a report of New Mexico counties meeting and not meeting the standard.
* Include all enrollees in the census data. There are 3,548 enrollees listed.
* Also complete the table below with the requested information.

|  |  |
| --- | --- |
|  |  |
| Percent of participants within 5 miles of one network pharmacy |  |
| Number of participants who do not have access to one network pharmacy within 5 miles |  |
|  |  |
| Percent of participants within 15 miles of one network pharmacy |  |
| Number of participants who do not have access to one network pharmacy within 15 miles |  |

# References

38. In the following tables, provide three references from representative clients for the services you are proposing. Include at least one public sector client.

| **Reference 1** |  |
| --- | --- |
| Company Name and Address |  |
| Contact Name and Title |  |
| Phone Number |  |
| Number of Participants |  |
| Contract Start Date |  |
| Type of Coverage Provided |  |

| **Reference 2** |  |
| --- | --- |
| Company Name and Address |  |
| Contact Name and Title |  |
| Phone Number |  |
| Number of Participants |  |
| Contract Start Date |  |
| Type of Coverage Provided |  |

| **Reference 3** |  |
| --- | --- |
| Company Name and Address |  |
| Contact Name and Title |  |
| Phone Number |  |
| Number of Participants |  |
| Contract Start Date |  |
| Type of Coverage Provided |  |

# Pharmacy Benefit Management Fee and Discount Quotation

39. To assist with the development of your pharmacy fee quotation, we have provided a file (**Appendix J. NMMIP 2023 Pharmacy Claim File**) which includes twelve months of actual NMMIP pharmacy claims, covering the calendar year 2023.

Complete the following table with your proposed pharmacy fees and discounts. If generic drugs are reimbursed off MAC logic, proved the equivalent discount off AWP.

|  | **Calendar Year** | | |
| --- | --- | --- | --- |
| **A. Fees** | **2025** | **2026** | **2027** |
| Management fee PMPM (if any) |  |  |  |
| Retail administrative fee per script (if any) |  |  |  |
| Retail dispensing fee generic |  |  |  |
| Retail dispensing fee brand |  |  |  |
| Mail order administrative fee per script (if any) |  |  |  |
| Specialty drug dispensing fee (if any) |  |  |  |
| Direct member reimbursement fee |  |  |  |
| Prior authorization fee |  |  |  |
| Other fees – retail |  |  |  |
| Other fees – mail order |  |  |  |
| Other fees – specialty |  |  |  |
| **B. Discounts** |  |  |  |
| Retail 30-day discount off AWP generic |  |  |  |
| Retail 30-day discount off AWP brand |  |  |  |
| Retail 90-day discount off AWP generic |  |  |  |
| Retail 90-day discount off AWP brand |  |  |  |
| Mail order 90-day discount off AWP generic |  |  |  |
| Mail order 90-day discount off AWP brand |  |  |  |
| Compound drugs |  |  |  |
| Specialty drug discount off AWP (or attach a schedule if it varies) |  |  |  |

40. Provide your company’s rebate guarantees per eligible script in the table below.

|  | **2025** | **2026** | **2027** |
| --- | --- | --- | --- |
| Retail 30-day supply |  |  |  |
| Retail 90-day supply |  |  |  |
| Mail order 90-day supply |  |  |  |
| Specialty drug |  |  |  |

41. New Mexico Senate Bill 51 (see **Appendix K**) requires application of the value of manufacturer rebates to a member’s cost sharing at the point of sale. Is your company experienced in administering rebates in this way? If so, please explain if your company is administering this approach for other New Mexico clients or for clients in other states.

42. Describe the rebate process, including timing of rebate payments to NMMIP (how often, how long after end of period). What documentation will be provided to support the rebate payments?

43. In order to compare the value of pharmacy discounts between the qualified bidders for this program, we have compiled and attached a sample claim data set as **Appendix H**, called Pharmacy Pricing Worksheet. The claims are a subset of a recent month’s actual pharmacy claims. The exhibit includes the following information:

* NDC Code
* Drug Description
* AHFS Classification
* Quantity
* Days Supply

Please complete the column highlighted in green for each drug based on your PBM’s contractual arrangements that would be applicable if you were selected as the Pool’s PBM, following the instructions on the spreadsheet.

Attach the completed worksheet to your proposal as **Attachment J.**

# Required Attachments

| **Attachment** | **Description** |
| --- | --- |
| A | Account Manager resume |
| B | New Mexico Resident and Veteran Preference Business/ Contractor Certificate (if applicable) |
| C | Audited financials last two years |
| D | Explanation of pending state or federal reviews |
| E | Explanation of legal actions against the company |
| F | Implementation plan timeline revisions |
| G | Listing of pharmacies by county |
| H | Geo Access reports - pharmacies |
| I | Campaign Contribution Disclosure Form (See **Appendix I**) |
| J | Pharmacy Pricing Worksheet |
| K | List of potential contract revisions |

**Attachment G**

Please complete the following table indicating the number of pharmacies in the proposed network.

| **County** | **Pharmacies** |
| --- | --- |
| Bernalillo |  |
| Catron |  |
| Chaves |  |
| Cibola |  |
| Colfax |  |
| Curry |  |
| De Baca |  |
| Dona Ana |  |
| Eddy |  |
| Grant |  |
| Guadalupe |  |
| Harding |  |
| Hidalgo |  |
| Lea |  |
| Lincoln |  |
| Los Alamos |  |
| Luna |  |
| McKinley |  |
| Mora |  |
| Otero |  |
| Quay |  |
| Rio Arriba |  |
| Roosevelt |  |
| Sandoval |  |
| San Juan |  |
| San Miguel |  |
| Santa Fe |  |
| Sierra |  |
| Socorro |  |
| Taos |  |
| Torrance |  |
| Union |  |
| Valencia |  |