

New Mexico Medical Insurance Pool

Request for Proposal: #2024002

For

Provider Network

Technical and Cost Questionnaire

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

 (Company name)

Proposal Due: September 13, 2024

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**New Mexico Medical Insurance Pool**

**Request for Proposal**

For

Provider Network

**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 from 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 for the service categories you are bidding on 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 standards 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. Clearly define whether you are offering a rental network, network management services, or a fully integrated network management program.

12. Provide the key contact information requested below.

| Title | Contact Name | Years with Company (as of 8/24) | Location City/State | Phone Number | E-mail Address |
| --- | --- | --- | --- | --- | --- |
| Primary RFP Contact |  |  |  |  |  |
| Secondary RFP Contact |  |  |  |  |  |
| Network Manager |  |  |  |  |  |

13. Provide the resume of the proposed Network 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 |  |

15. 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**.

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

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

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

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

20. 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**.

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

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

22. 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 not, please explain.

23. Does your company agree to meet the deadlines as indicated in the Draft Implementation Plan (Appendix L)? If not, please explain in detail in **Attachment F.**

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

#  Provider Network Size and Fit

Respond to the following questions for the provider network you are proposing. If your company is offering more than one network, please respond to each of the following questions for each network offered.

25. Review the Provider Network 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.

26. What is the name of the medical network(s) you are proposing?

27. Provide a count of currently participating providers by type and New Mexico county in your proposed network(s) as **Attachment G**. Please use the form found after the Required Attachments section of this document. Do not count providers more than once within a county due to multiple specialties, office locations, or provider category.

28. Provide the web address where your medical provider directory can be found.

29. Describe your process for provider directory management and ensuring provider demographic data accuracy for claims payment and member access purposes. How frequently are updates made?

30. Do you have the capability to load provider directory data directly into claims processing systems and member portals/apps to ensure real-time accuracy?

31. What notification processes do you have to alert impacted health plans, claims processors, and members when significant provider data corrections are made? How do you ensure that all stakeholders are informed promptly?

32. 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 twenty (20) miles of at least one (1) PCP
* Within thirty (30) and sixty (60) miles of at least one (1) specialist
* Within thirty (30) and sixty (60) miles of at least one (1) behavioral health provider
* Within thirty (30) and sixty (60) miles of at least one (1) pharmacy
* Do not include facilities, such as hospitals, labs, or outpatient surgical centers.
* Use New Mexico providers and those in contiguous counties.
* 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.

|   | **Response** |
| --- | --- |
| Percent of participants within 5 miles of one network PCP |  |
| Number of participants who do not have access to one network PCP within 5 miles |  |
|   |  |
| Percent of participants within 20 miles of one network PCP |  |
| Number of participants who do not have access to one network PCP within 20 miles |  |
|   |  |
| Percent of participants within 30 miles of one network specialist |  |
| Number of participants who do not have access to one network specialist within 30 miles |  |
|   |  |
| Percent of participants within 60 miles of one network specialist |  |
| Number of participants who do not have access to one network specialist within 60 miles |  |
|   |  |
| Percent of participants within 30 miles of one network behavioral health provider |  |
| Number of participants who do not have access to one behavioral health provider within 30 miles |  |
|   |  |
| Percent of participants within 60 miles of one network behavioral health provider |  |
| Number of participants who do not have access to one network behavioral health provider within 60 miles |  |

33. Using the Network Analysis Worksheet (**Appendix H**), indicate which providers are in the proposed network. The answer should be added to the spreadsheet in the green column and included as **Attachment I**. Match on provider ID number as there may be multiple names under a single ID.

# Provider Network Features

Respond to the following questions for the provider network you are proposing. If your company is offering more than one network, please respond to each of the following questions for each network offered. Address only features that you are including within your bid.

34. Do you have additional network arrangements available for enrollees traveling out-of-state or living part of the year in another state? If yes, please describe.

35. Describe your network arrangements with prominent facilities that may be out of state, such as Mayo Clinic, Sloan- Kettering, M.D. Anderson, Colorado Children’s, and so forth.

36. Explain the network’s policy for allowing enrollees to go across state lines for care and how it affects reimbursement and claims processing.

37. A list of all New Mexico hospitals has been included as Appendix M. Provide a list of the New Mexico hospitals that are NOT in your network as **Attachment J**.

38. Provide a list of the network’s facilities for transplant services as **Attachment K**. Include the name, location, and organ transplant types for each facility. Do you use a subcontracted transplant network or do you have your own transplant network?

39. Describe how you manage provider relations and the process for adding specialists or new providers if requested.

40. Describe your network arrangements for telemedicine services, including geographic limitations and access issues.

41. Could the Pool contract with one of your networks without contracting for other services offered by your company, such as claim administration or utilization management?

42. Describe your organization’s repricing function, including all the steps that occur from the date the claim in received until the date it has been repriced and sent to the claim adjudicators.

43. Does your repricing process include the ability to identify claims requiring pre-authorization prior to repricing? Explain your ability to ensure timely claims timelines for services requiring pre-authorizations.

44. Describe your capabilities to integrate your network pricing processes with other vendors, like PBMs, Care Management, and Utilization Management.

45. Would you allow the Pool to do direct contracting outside of the network if it was advantageous to the Pool to do so?

46. Does your company have the ability to do Single Case Agreements in situations where an enrollee needs to use an out-of-network provider? If so, explain the process.

47. Would you allow the Pool to maintain two or more networks, one similar to the current EPO network and one with a different network structure for a different population or plan?

48. Describe your network arrangements for dialysis patients. Do you use a subcontracted network or do you have your own dialysis contracts? Would you allow the Pool to contract directly with dialysis centers in order to supplement your networks?

49. Does your network include Federally Qualified Health Centers (FQHCs) and other community health providers? If not, would you agree to add them to your network or allow the Pool to contract directly with these providers?

50. A large percentage of NMMIP’s enrollment is Spanish-speaking. How does your network accommodate enrollees who are not English-speaking?

# Provider Network Cost and Fees

Respond to the following questions for the provider network you are proposing. If your company is offering more than one network, please respond to each of the following questions for each network offered.

51. Complete the table below with your proposed per member per month network access fees. Below the table, please provide details of what services are included in each fee. Include details about any additional costs or fees.

|  | **2025** | **2026**  | **2027** |
| --- | --- | --- | --- |
| Network access fee |  |  |  |
| Fee for Single Case Agreements |  |  |  |
| Bill Review/Audit |  |  |  |
| Any other fees (such as implementation fee or percent of savings) |  |  |  |

52. In order to compare the value of medical provider network discounts between the qualified bidders for this program, we have compiled and attached a sample claim data set as **Appendix I,** called Network Repricing Worksheet. The claims are a subset of NMMIP claims incurred in 2023. They include the following information:

* Physician Services – A claim number and line number, the provider tax ID, provider name, 5-digit zip code, procedure code, procedure modifier (if any), place of service, units or days, and billed charges
* Inpatient Hospital – A claim number and line number, the provider tax ID, provider name, 5-digit zip code, the revenue code, the DRG, units or days, and billed charges
* Outpatient Hospital (excludes dialysis) – A claim number and line number, tax ID, hospital name, 5-digit zip code, the revenue code, and billed charges
* Outpatient Hospital (Dialysis) -- A claim number and line number, tax ID, hospital name, 5-digit zip code, the revenue code, and billed charges

Please complete the column highlighted in green for each provider based on your company’s negotiated reimbursement arrangements that would be applicable if you were selected as the Pool’s network, following the instructions on the spreadsheet. If the listed hospital provider (inpatient and outpatient) is not in your network, use an alternate network provider in the same or nearby location. If none is available, assume billed charges and make an explanatory note next to the green column.

The total re-priced amount for each category of claims will be automatically calculated and transferred to the summary page. Please attach the completed file to your proposal as **Attachment L.** A complete response to this question is mandatory. Confidentiality may be requested. See the Rights section of the Background Information document for information about confidentiality.

# References

53. 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 |  |

# 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 providers by county  |
| H | Geo Access reports - medical providers |
| I | Network Analysis Worksheet |
| J | List of out-of-network hospitals in New Mexico |
| K | List of transplant facilities |
| L | Network Repricing Worksheet |
| M | Campaign Contribution Disclosure Form (See **Appendix J**) |
| N | List of potential contract revisions |

**Attachment G**

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

| **County** | **PCPs\*** | **Specialists** | **Behavioral Health Providers** |
| --- | --- | --- | --- |
| 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 |  |  |  |

\* PCPs are defined as family practice, general practice, internists, OB/GYNs, nurse practitioners, and physician assistants.