Approval of Contract for Health Plan Provider Services

Administration Committee
May 25, 2021

Rosa Medina-Cristobal
Vice President, Human Resources

Karen Rogers
Holmes Murphy & Associates
Recommendation

- Approval of a resolution authorizing the Interim President & Chief Executive Officer or his designee to award a five-year contract to Blue Cross Blue Shield of Texas, (BCBSTX) for health plan provider services [Contract No. C-2058374-01], for a total authorized amount not to exceed $11,419,016.
Background

- Last contract information – C-2026895-01, was a three-year contract with two, one-year options, only four years were executed.
- Vendor – HealthSCOPE Benefits
- Amount – Not to exceed amount of $8,253,939
- Expiration date – December 31, 2021
- Key features:
  - To provide self-insured medical coverage for DART’s employees, retirees, and eligible dependents to create a sustainable benefits plan offering, that combines innovation, quality of care, member engagement, transparency, and cost savings to both DART and its employees.
TPA RFP Process and Results
RFP Background and Scope of Work

- A Request for Proposals (RFP) was selected as the best procurement method because factors other than cost were needed in selection of an award.
- As in all RFPs, the Authority reserved the right to accept offers other than the lowest priced offer, reject any or all offers in part or in total for any reason, and to accept any offer if it is considered best for its interest or is most advantageous.
- The RFP was issued on November 12, 2020
- Timely proposals were received on January 7, 2021
- A total of six proposals were received.
- The evaluation process consisted of a responsiveness review, technical evaluation, price evaluation, oral presentations, and a best and final offer.
- Requested services included:
  - Medical plan administration for all three plans:
    - PPO network-based plan to replace the current Open Access plan
    - ACO network-based plan to replace BSWQA ACO plans
  - Flexible Spending Accounts (FSA), Health Reimbursement Account (HRA), COBRA, and Retiree Direct Bill administration
  - Wellness portal services and embedded wellness programming
  - Integration with Pharmacy Benefit Manager
RFP Evaluation Process

Minimum Qualifications

- Minimum qualifications are requirements used to ensure that only responsive proposals and responsible firms progress through the evaluation process.
- Procurement/Contract Specialist conducts responsive/responsible review.

Technical Evaluation

- Proposals are evaluated based on technical criteria outlined in the RFP by SEC.
- Evaluation criteria and possible points are outlined in RFP (or addenda based on Proposer questions). The SEC evaluates and awards points based on criteria.

Price Evaluation

- Price proposals are evaluated against each other based on total cost for contract.
- Lowest price receives total price points, other proposals receive a percentage of the total points based on formula: lowest price/proposed price x total price points = awarded points.

Discussions and BAFO

- When needed Best and Final Offers are issued to those in the competitive range (acceptable/partially acceptable) scores.
- After a BAFO is issued, the Procurement Specialist identifies the proposals that are acceptable and partially acceptable. Best practice is to award to acceptable proposal that provide the overall best value.
## RFP Technical Criteria

<table>
<thead>
<tr>
<th>RFP Criteria</th>
<th>Total Maximum Points</th>
<th>Example of Sub Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Build &amp; Maintenance</td>
<td>325 Maximum Points</td>
<td>Experience and Ability to develop, build and maintain provider networks; Provider match; Network discounts; Sample project plan; etc.</td>
</tr>
<tr>
<td>Claims Administration</td>
<td>150 Maximum Points</td>
<td>Implementation timeline; Eligibility administration capabilities; Utilization review/case management capabilities, Disease management programs, etc.</td>
</tr>
<tr>
<td>Administrative Services</td>
<td>100 Maximum Points</td>
<td>Proposed approach to managing the work and ensuring program and cost control; Reports and communication; etc.</td>
</tr>
<tr>
<td>Utilization Management/Member Services</td>
<td>100 Maximum Points</td>
<td>Utilization management of professional, medical, and hospital care rendered; Member services provided by provider</td>
</tr>
<tr>
<td>General Questionnaire</td>
<td>25 Maximum Points</td>
<td>Financial strength; Organizational structure; References; HIPPA Compliance; etc.</td>
</tr>
<tr>
<td>Price</td>
<td>300 Maximum Points</td>
<td>Scored based on the formula: lowest price/proposed price x total price points = awarded points</td>
</tr>
</tbody>
</table>
RFP Technical Evaluation Process

- Six Suppliers submitted offers to administer all requested services.
- After a preliminary evaluation, five vendors were selected for finalist interviews and to provide Best and Final offers.
- After Best and Final Offers were received three offers were found to be responsive and determined to be acceptable.

<table>
<thead>
<tr>
<th>Firms</th>
<th>Network Build &amp; Maintenance</th>
<th>Claims Administration</th>
<th>Administrative Services</th>
<th>Utilization Management / Member Services</th>
<th>General Questionnaire</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Blue Shield</td>
<td>314</td>
<td>119.6</td>
<td>92.4</td>
<td>93</td>
<td>24.6</td>
<td>643.60</td>
</tr>
<tr>
<td>Cigna</td>
<td>313</td>
<td>130</td>
<td>68</td>
<td>94</td>
<td>24.6</td>
<td>647.60</td>
</tr>
<tr>
<td>United Healthcare</td>
<td>307</td>
<td>123.6</td>
<td>91</td>
<td>94</td>
<td>23</td>
<td>638.60</td>
</tr>
</tbody>
</table>

*The incumbent's response was deemed Unacceptable and therefore removed from consideration*
The following annual Total Amounts submitted by bidders are based on enrollment of 3,600 employees. Because DART is self-insured, the total price represents Administrative Service Fees only and does not include claims cost.

Price points were awarded based on the lowest proposed five-year base period amount.

### Overall Evaluation Results

<table>
<thead>
<tr>
<th>Firms</th>
<th>Total Amount Five Year Base Period</th>
<th>Pricing Score (Max Points 300)</th>
<th>Technical Score (Max Points 700)</th>
<th>Total Points (Max Points 1,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Blue Shield</td>
<td>$11,419,016</td>
<td>300.00</td>
<td>643.60</td>
<td>943.60</td>
</tr>
<tr>
<td>Cigna</td>
<td>$12,009,169</td>
<td>285.26</td>
<td>647.60</td>
<td>932.86</td>
</tr>
<tr>
<td>United Healthcare</td>
<td>$11,491,090</td>
<td>298.19</td>
<td>638.60</td>
<td>936.79</td>
</tr>
</tbody>
</table>

Blue Cross Blue Shield was determined to provide the overall best value for the Authority and was awarded the highest overall total score.
Current State & Plan
History
Annual health plan budget is $63.3M, with 77.4% of expenses attributed to medical claims, 19% to prescription drugs claims and 3.6% to administrative fees.

DART is self-funded and pays all claim expenses.

Based on data through March 2021, DART’s regressed annual medical trend is 2.4%, and prescription drug (Rx) trend is 5.5%.

DART contracts with third-party administrator (currently HealthSCOPE) to provide claim processing, provider network contracting, member services, and claim management services.

2020 provider discounts were 54.3% off billed charges with 89% in-network utilization.

Industry norm for Dallas area is provider discounts of 57% and 95% in-network utilization.
Multi-year cost share strategy to achieve 80/20

- The agency has an 85/15 cost share strategy with a glide path to reach 80/20 in the future
- For DART to achieve 80/20 cost share by 2030, controlling medical and pharmacy trend will be most important aspect
- Without controlling trend, significant changes in design or contributions will need to occur
- Even if DART’s current regressed trends are continued (0% for Medical, 5.1% for Rx), DART will need to increase employee contributions 6.5% per year through 2030 to achieve the 80/20 cost share
2017 Forecast

Financial Plan Healthcare Cost Impact of “bending the curve”
Health Plan History

- Four years ago, DART was experiencing unsustainable increases in medical and pharmacy claims
- The overall health of the population was not improving year over year
- DART moved to a progressive model that is administered by HealthSCOPE
  - Open Access Plan:
    - There is no provider network; all providers are accessible to participants
    - A Referenced Based Reimbursement model (% of Medicare) to reimburse claims
    - This plan has limited clinical interventions and has the lowest overall health scores and highest cost per person
  - ACO (Accountable Care Organization) Plans:
    - DART contracts directly with the Baylor Scott and White Quality Alliance’s ACO, a narrow network offering with Baylor and Methodist facilities and physicians
    - These plans have more robust clinical interventions and have seen improved health scores in the last two years
- The goal of this transition was to manage the increasing medical trend and improve the overall health of the population
Health Plan Challenges

- Open Access DART plan has experienced significant administrative challenges and disrupted DART’s plan participants due to Referenced Based Reimbursement Model (56% of DART enrolled employees)
  - Members were balance-billed by providers; DART took on additional cost to protect employees
  - In 2020, only 16% of claims under processed Reference Based Reimbursement (RBR) versus the planned 100% of claims, which eroded projected savings
- Open Access plan has seen rising chronic conditions and declining overall health with limited member advocacy and clinical support programs
  - While several external programs have been implemented to assist this population, including MedWatch, MyPHA, and the nearsite clinic through Methodist, this has increased administrative costs to DART
- ACO contract with Baylor includes a significant shared savings provision and DART has paid over $500K per year in shared savings in addition to administrative fees.
  - The shared savings agreement allows for exclusion of large claims requiring DART to pay shared savings even when total cost increased
  - In addition, the ACO plan has not significantly out-performed the OAD plan in health risk management
Health Plan Current Health Status

- The overall health of the population has declined for membership in the Open Access Plan (OAP) while the Accountable Care Organization (ACO) plans have seen moderate improvements.
- Chronic disease continues to increase while the overall general wellness within the population is decreasing.
- The number of high-cost claimants (over $50K) has increased each year from 14 Claimants per 1,000 in 2018 to 25 Claimants per 1,000 in 2020.
  - In 2020, 2.3% of DART plan participants drove 55% of medical claim cost.
- DART has opportunities to impact the cost of medical care through health risk reduction, chronic disease management, and appropriate pathways to care (navigation).

### Highest Cost Impactable Conditions

- Musculoskeletal System $6.9M (16%)
- Circulatory System $5.3M (12.2%)
- Neoplasms (Cancers) $2.9M (6.7%)
- Digestive System $2.6M (5.9%)

### Chronic Condition Prevalence

- Hypertension 25.7%
- Hyperlipidemia 16.25%
- Diabetes 12.9%
- Metabolic Disorders 21.6%
- Morbid Obesity 6.9%

### Employee Health Score*

1Q 2021: 1.8

---

*The Milliman Advanced Risk Adjusters tool uses each member’s medical and prescription drug claim history to predict the individual’s relative healthcare cost risk, as compared to average population risk. The rating reflects health risks, utilization, and costs.
Health Plan Challenges

• Employee feedback group held in late 2020 overwhelmingly preferred returning to a name-brand carrier with a strong provider network due to:
  – Lack of recognition of “HealthScope” among health care provider offices
  – Significant claims and customer service issues
  – Simplicity of a network-based plan
  – Valued Doctor/Patient relationships
Key Factors
**Network Build & Maintenance**

- This category was worth 325 points, the most valuable of the criteria.
- The questions in this category asked vendors to describe their ability to develop, build and maintain provider networks in the Dallas/Ft. Worth area.
- In addition, vendors were also asked about their ability to successfully negotiate provider and hospital contracts as well as the size of those contracts.
- These subsets are tied to Network Physician Match and Network Discounts.
• BCBS TX’s PPO network has a 98.3% provider match, which means virtually every employee will be able to stay with their doctors
• Aetna did not provide repricing file for their ACO network, therefore, analysis is not available

*2020 Actual is NOT based on the claim data set as the repricing analysis*
Network Discounts

- Bidding vendors were provided one year of submitted claims data to re-price using their participating provider information and negotiated provider contracts, which allows for measurement of provider discounts and provider match based on DART’s historical utilization.
- WebTPA/BSWQA repricing is a combination of the BSWQA results and the Aetna Signature network, proposed to be used as a wrap of the ACO as well as the PPO network for the Open Access plan.
  - Out of network repricing was not provided; analysis assumes a 30% discount assumption.
- Cigna charges a set monthly amount each month for all behavioral health services regardless of utilization by members on the plan. For purposes of this repricing, the actual claims utilization for behavioral health was used so that we could capture the true difference between the networks.
- BCBS TX was the only provider with exception of BSWQA who submitted re-pricing data for their ACO network in addition to their Choice PPO.
- Net effective discount includes both in-network and out-of-network claims.
- All re-pricing data files were equalized to exclude the same claims from the analysis (such as dental, vision, pharmacy).

*Repricing analysis based on historical data; actual results will vary based on future medical plan utilization.*
Network Discount Results

Repricing analysis indicates that BCBS TX has the highest provider discounts off billed charges for combined in and out of network claims

- BCBS TX discounts for PPO only (not shown above) were 60.47%

Aetna discounts were the next highest

Each percent increase in discounts represents a projected medical claim reduction of 2.2%, or approximately $1M per year for DART

2020 Actual is NOT based on the claim data set as the repricing analysis
M/WBE Analysis

- RFP Goal – 15% M/WBE
  - 15% represents a percentage of the overall total administrative fees being proposed.
  - BCBS TX has complied with all M/WBE provisions and is using five local partners, as well as one in Houston and Nashville, to meet the goal.
BCBS TX Health Advocacy Services

- BCBS TX offered Health Advocacy program as an optional buy-up during the Best and Final Offer
- The Health Advocacy Services program closely aligns with DART’s health plan goals to:
  - Increase health literacy, navigation, advocacy, and improve health risks by providing individuals with tools, resources and services
  - Control medical trend
- Additional 5-year program cost is $2M, ~$400K per year
- BCBS TX has offered Performance Guarantees with 70% of program fees at risk for ROI (20%) and Engagement (50%)
  - ROI = Savings from Health Advocacy clinical program components divided by billed fee
  - Engagement guarantees includes:
    - Outreach to 99% of households
    - Contact with 90% or more of high-cost claimants and their health care provider
    - Member Satisfaction response of “Very Satisfied or Somewhat Satisfied” for 85% or more survey respondents
- Health Advocacy Services three-year case study indicated client exceeded goal of 6% target trend savings
  - 1% medical trend deflection is worth ~$650K per year to DART’s budget
## BCBS TX Health Advocacy Services

<table>
<thead>
<tr>
<th>Program Components</th>
<th>Wellbeing Management (Core Offering)</th>
<th>Additional Services in Health Advocacy Program</th>
</tr>
</thead>
</table>
| Utilization Management              | • Inpatient & Outpatient Precertification  
• Specialty Drug Prior Authorization                                                      | **Outpatient Expansion:** Advanced Imaging, Cardiology, Sleep Medicine, Pain Management, Joint & Spine Surgery |
| Holistic Health Management          | • Health Advisors  
• Target 1% of population based on high risk and need  
• Specialty Case Management for High-Risk Maternity, NICU, Transplant | • Designated Clinical Health Advocates  
• 100% outreach to all claimants $100K+  
• 100% Pre-Admission & Post Discharge Outreach  
• Concierge Oncology Support  
• Certified Diabetes Educator  
• Caregiver Support                                                                 |
| Wellness, Coaching                  | 24/7 Nurseline Well On Target Portal                                                               | • Interactive Health Coaching via Well on Target  
• Incentive Management                                                                 |
| Concierge Services / Navigation     | Customer Service 8-6pm M-F                                                                         | • **24/7 Customer Service support**  
• Appointment scheduling assistance  
• Integrated (clinical and non-clinical) Health Advocate team  
• Enhanced member services  
• Referral to other benefit programs  
• Health Hub centralized digital member app and benefits hub |

---

- **Wellbeing Management** (Core Offering)
- **Additional Services in Health Advocacy Program**
## Implementation Milestones

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2022 Communication and Implementation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kick-off meeting: define objectives, deliverables and owners</td>
<td>DART/BCBS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create project management infrastructure</td>
<td>BCBS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research and review of current and historical plans, culture, and communications, etc.</td>
<td>DART/BCBS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create OE guide and build communication pieces</td>
<td>DART/BCBS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Build OE schedule for meetings</td>
<td>DART</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open the pre-Enrollment hotline / educate team on DART benefits</td>
<td>BCBS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Begin Open Enrollment</td>
<td>DART</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End Open Enrollment</td>
<td>DART</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communicate Eligibility and load into system</td>
<td>DART/BCBS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verify claims system is built according to DART’s benefit intent</td>
<td>BCBS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits are effective</td>
<td>DART/BCBS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Recommended Action

- Approval of a resolution authorizing the Interim President & Chief Executive Officer or his designee to award a five-year contract to Blue Cross Blue Shield of Texas, (BCBSTX) for health plan provider services [Contract No. C-2058374-01], for a total authorized amount not to exceed $11,419,016.