Approval of Contract for Health Plan Provider Services

Committee-of-the-Whole
June 8, 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
- Six responsive 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>
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</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>
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<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>
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<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>
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<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>
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<tr>
<td>General Questionnaire</td>
<td>25 Maximum Points</td>
<td>Financial strength; Organizational structure; References; HIPPA Compliance; etc.</td>
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<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>
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Evaluation Process Summary

12 Proposals Received

Minimum Qualification Evaluation: 6 proposals are found responsive and six are not. Responsive proposals move forward to technical evaluation.

Technical Evaluation: 3 firms received acceptable scores (within 1.5% of highest score); 1 firm received partially acceptable score (5% lower than highest); 2 are found unacceptable (more than 10% lower than highest score)

Price Evaluation: Initial price points awarded to determine BAFO participants.

BAFO Results: Three acceptable proposals within 2% of each other; Partially Acceptable proposal came back with unbalanced price when compared to other proposals.

Final Evaluation Meeting: SEC rejected unbalanced proposal (low tech score/unreasonable price); award recommendation to highest ranked acceptable firm
Changes in Procurement

• During the RFP process the Procurement Department experienced several unexpected staff changes.
• The award approval process moved forward without review and final recommendation from the SEC.
• New VP of Procurement was hired, reviewed the evaluation process/materials and determined that SEC had not reviewed BAFO or made final award recommendation.
• Final Evaluation meeting occurred on May 7, 2021. SEC rejected one proposal for being only partially acceptable and materially unbalanced.
• BAFO price points awarded based on SEC determination to award only to acceptable and balanced proposals.
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*
Overall Evaluation Results

- 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.

<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><strong>943.60</strong></td>
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<tr>
<td>Cigna</td>
<td>$12,009,169</td>
<td>285.26</td>
<td>647.60</td>
<td><strong>932.86</strong></td>
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<tr>
<td>United Healthcare</td>
<td>$11,491,090</td>
<td>298.19</td>
<td>638.60</td>
<td><strong>936.79</strong></td>
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- 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.

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.
Current Cost Share

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 or plan design will need to change
• Three models assume a lower trend than industry trend, in line with DART's historical trends
• Higher employee contribution increases achieve 80/20 at the fastest pace, but will cause more employee disruption
• All models assume no changes in plan design; however, design changes can be used to reduce cost and reach 80/20 at a faster pace
Multi-Year Cost Strategy

• Employee Contributions increase 8% each year beginning 2022
• 80/20 achieved in 2030
• Average employee contribution increases from $204 in 2021 to $408 in 2030

• Employee Contributions increase 15% each year beginning 2022
• 80/20 achieved in 2026
• Average employee contribution increases from $204 in 2021 to $368 in 2026

• Employee Contributions increase 19% each year beginning 2022
• 80/20 achieved in 2024
• Average employee contribution increases from $204 in 2021 to $344 in 2024
2017 Forecast

Financial Plan Healthcare Cost Impact of “bending the curve”

- $206 million; 25.6% of projected budget
- $44 million; 8.8% of FY17 Budget
- $96 million; 12.1% of projected budget
- $33 million

DART Medical Costs (1.97%)
DART Medical Costs (8.5%)
DART Medical Costs (4.25%)
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 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
Additional Savings
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%
- Each percent increase in discounts represents a projected medical claim reduction of 2.2%, or approximately $1M per year for DART
- Effective 1/1/2022, all new employees will be offered only the ACO plan

- Depending on plan enrollment and provider utilization, expect claim savings of $2.5-$4.5 in plan year 2022 as a result of improved discounts
- ACO Plans = 37% of total savings $1.1-$1.7M
- OAD Plan = 62% of total savings $1.5-$2.8 M
- The savings is higher in the OAD plan because the people in that plan utilize services more than those in the ACO

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

<table>
<thead>
<tr>
<th>Program Components</th>
<th>Wellbeing Management (Core Offering)</th>
<th>Additional Services in Health Advocacy Program</th>
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</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 |
# Implementation Milestones

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

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