SB 405: Medicaid Expansion
Third-Party Administrator RFP

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for the Children, Families, Health, and Human Services Interim Committee
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Background

Senate Bill 405, the Medicaid expansion bill approved by the 2015 Legislature, requires the state to contract with a private company to handle many aspects of providing Medicaid coverage to newly eligible adults. Known as a third-party administrator (TPA), the company will have a broad range of duties.

The Department of Public Health and Human Services (DPHHS) operates the existing Medicaid program, which primarily serves certain low-income elderly, blind, and disabled adults, as well as pregnant women, children, and adults with dependent children. The TPA will administer the Medicaid benefits for what is known as the "Medicaid expansion group" — all other adults, including some additional parents, who are 19 to 64 years of age and whose income is at or below 138 percent of the federal poverty level.

DPHHS issued a Request for Proposal for TPA services on July 1 and received four proposals by the Aug. 18 deadline. The agency plans to award a contract by Oct. 1. The contract would run until Dec. 31, 2017, and could be extended by one-year intervals for up to seven years.

This briefing paper provides an overview of the RFP and potential costs of TPA services.

What Will the TPA Do?

SB 405 listed the general duties of the TPA, and the RFP provides more detail on how the TPA will carry out those duties. Following is a summary of some of the key requirements.

- **Establish Provider Networks.** The TPA must contract with health care providers who will agree to provide care to the new enrollees. The TPA must notify the state if the ratio of providers to enrollees changes by 5 percent or more for any provider type. The TPA also will negotiate reimbursement rates with providers. The rates are to be comparable to those paid under the existing Medicaid program.

- **Determine the Benefit Plan.** The company must determine how medical, vision, and behavioral health benefits will be provided to the new enrollees, within the guidelines provided by DPHHS.

- **Pay Medical Claims.** The TPA must pay or deny 95 percent of medical claims within 30 days unless a claim is subject to review. The company also will have to authorize the use of certain medical and mental health services before an enrollee can obtain the services and will review some claims after services are provided, to ensure accuracy. The company must report on inappropriate use of benefits every three months.

- **Collect Premiums and Monitor Copayments.** SB 405 requires the new Medicaid enrollees to pay monthly premiums equal to 2 percent of their income. It also requires that they pay a portion of the costs of medical care they receive. The TPA must bill for

and collect the premiums and report to DPHHS if people have not paid their premiums. People with incomes of 100 to 138 percent of poverty may lose Medicaid coverage if they fail to pay the premiums.

The company also must track the copayments that enrollees make for medical care so DPHHS can cap the total premium and copayment costs at 5 percent of income.

- **Create a Wellness Program.** The TPA must put in place "innovative" models of care to improve the overall health of enrollees. As part of that effort, the company must conduct a health risk assessment for each enrollee so it can provide targeted wellness activities. The company also must provide:

    - monthly reports on wellness activities and outcomes;

    - quarterly and yearly reports on the findings of the health risk assessments; and

    - yearly reports with blood pressure, diabetes, tobacco use, and tobacco cessation information on the new enrollees.

- **Help Administer the Medicaid Program.** The TPA must handle general administrative duties. Those include reporting on the use and costs of the program, creating websites for enrollees and health care providers, and operating a customer service center.

- **Exchange Data with the State.** The company must meet numerous information technology requirements to make sure its IT system is able to share data with the state's system as quickly as possible.

Costs of Using a TPA

The TPA will receive a flat monthly fee for each person served in the expansion group. The state has estimated in various documents and presentations that 45,000 to 70,000 people will eventually sign up for coverage.

Companies seeking to serve as the TPA were asked to indicate the "per member per month" (PMPM) fee they will charge for administering the benefits provided to the Medicaid expansion group. The PMPM fee will be the same for the first six months of the contract regardless of the number of people who sign up. After that, the fee will vary based on the levels of enrollment, starting with up to 15,000 enrollees and topping out at more than 70,000 enrollees. The fee generally decreases as the number of enrollees increases because of the economies of scale in serving a larger number of people.

The four companies bidding on the contract are Allegiance Benefit Plan Management, Blue Cross Blue Shield of Montana, PacificSource Health Plans, and Sanford Health Plan. They submitted PMPM fees that range from $26.39 to $47.65 for enrollment of up to 15,000 people. The fees ranged from $25 to $42.30 for enrollment of more than 70,000 people. The tables on Page 4 show, for each company, the potential costs of the initial two-year contract at a low and high level of enrollment.

The companies also were allowed to submit their estimated costs for developing the necessary information technology from Oct. 1 through Dec. 31. Blue Cross requested reimbursement for $3.75 million in IT development costs, while PacificSource listed IT costs of $632,000. Sanford said it would negotiate the payment as part of the contract. Allegiance indicated its costs would be $150 an hour but did not provide the number of anticipated hours for which it would charge.

Scoring the Proposals

A committee is meeting periodically to evaluate and score the proposals submitted by the four companies. It expects to wrap up its work by mid-September. The contract will go to the company that scores the highest number of points, out of a total of 1,150 points.

The company with the lowest proposed costs will receive the total amount of points available for that category. All other cost proposals will receive a percentage of the points available for the costs category based on their relationship to the lowest proposal.

The table below shows the maximum number of points that could be awarded for each element of the proposal.

Category	Elements of the Category	Point Value	% of Total
Scope of Project	• Processing Enrollment in Program • Handling Premiums and Copayments • IT for Enrollment and Wellness Data • IT for Tracking Premiums and Copayments	150 points	13%
	• Creating/Maintaining Adequate Provider Network	100 points	8.7%
	• Processing and Paying Medical Claims • IT System for Claims Processing	150 points	13%
	• Utilization Review of Medical/Mental Health Services	50 points	4.4%
	• Administrative Services/Information Management • Enrollee Web Portal and Correspondence • Reporting and Data Activities	100 points	8.7%
	• Wellness Programs and Incentives	120 points	10.4%
	• General IT Requirements • Meeting National Standards and Controls • Maintaining HIPAA Confidentiality	60 points	5.2%
Offeror Qualifications	• General Qualifications • Company Profile • Key Personnel Requirements • Implementation of Work Plan	40 points	3.5%
Costs	• Per Member Per Month Reimbursement • Benefit Plan and Provider Reimbursement Rates	330 points	28.7%
	• IT Development Costs	50 points	4.4%
Total		**1,150 points**	**100%**

Potential Contract Costs

The tables below show some potential costs for the initial two-year contract, based on the PMPM fees the companies would charge for two different levels of enrollment — at the lower and higher ends of the possible spectrum of enrollment.

The costs do not include the additional IT development costs the state may cover. They also do not include the medical costs that new enrollees will incur.

Total costs for Allegiance were not immediately apparent because the cost proposal section of the company's proposal did not provide a PMPM fee for the first six months of the contract.

Potential TPA Costs at 15,000 Enrollees

Company	Jan. 1-June 30, 2016	July 1-Dec. 31, 2016	2017	Total
Allegiance Benefit Plan Management	Not Provided	$2,727,000	$5,454,000	Not Available
Blue Cross Blue Shield	$2,375,100	$2,285,100	$4,707,306[1]	$9,367,506
PacificSource Health Plans	$4,288,500	$4,288,500	$8,577,000	$17,154,000
Sanford Health Plan	$3,982,500	$3,982,500	$7,965,000	$15,930,000

Potential TPA Costs at 70,000 Enrollees

Company	Jan. 1-June 30, 2016	July 1-Dec. 31, 2016	2017	Total
Allegiance Benefit Plan Management	Not Provided	$11,088,000	$22,176,000	Not Available
Blue Cross Blue Shield of Montana	$11,083,800	$10,500,000	$21,630,000[1]	$43,213,800
PacificSource Health Plans	$20,013,000	$11,415,600	$22,831,200	$54,259,800
Sanford Health Plan	$18,585,000	$17,816,400	$35,632,800	$72,034,200

The companies also were asked to indicate how their PMPM fees would increase in subsequent years if the contract is renewed, with increases limited to a maximum of 3 percent each year.

PacificSource said its fees would increase by 2.5 percent each year. Allegiance and Blue Cross each said their fees would mirror the increase in the Consumer Price Index up to 3 percent a year, while Sanford said its fees would increase 3 percent in each subsequent year.

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[1] Blue Cross Blue Shield split its proposed PMPM fee into two years and provided two options for its second-year fee. One involved a flat rate plus a share of cost savings generated through medical management. The other involved an increase equal to the change in the Consumer Price Index up to 3 percent. The figures in the tables above reflect a 3 percent increase over 2016 fees.