Study on Contracting for Administration of UMP

UMP Third Party Administration

Engrossed Substitute Senate Bill 5693; Section 212(7); Chapter 297; Laws of 2022

December 31, 2023

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Executive summary

Background

Engrossed Substitute Senate Bill 5693 (2022), Section 212(7) directed the Health Care Authority (HCA)to study and report on options for transferring administrative functions for the Uniform Medical Plan (UMP) from its currently contracted third-party administrator (TPA) to HCA.

> …The health care authority must prepare a report on the uniform medical plan administrative services that were provided by contract prior to 2010, those that have been procured through the third-party administration contract since, what elements of those services could be provided either directly or through discrete provider contracts, and the resources the authority would need to administer these functions. The report must also compare the cost of the administration of components before and after the transition to the current contracts; include assumptions about the impacts on claims; include a description of the performance guarantees in the current contracts; and provide an implementation plan to enable the health care authority to resume self-administration for some or all of the administrative services at the end of the current contract.

As of November 2023, more than half of all PEBB and SEBB members are enrolled in a UMP Plan (385,000 out of 673,000 members).

UMP Administrative Services – Current and Pre-2011

The current TPA contract for UMP consists of the following administrative services:

- Provider network contracting
- Claims administration and appeals
- Utilization, complex case, chronic condition, and quality management and improvement
- Medical drug management
- Disabled dependents certifications
- Member services, member communications, and online services
- Fraud, waste, and abuse detection
- Operations and data reporting

Prior to 2011, HCA administered the provider network contracting in-house. HCA directly contracted with health service providers and hospitals within Washington State. Other UMP administrative services were performed by the UMP TPA at that time, which was UMR[1], a United Healthcare company.

The 2011 UMP TPA contract consolidated all UMP medical administrative services into a single contract, which was awarded to Regence BlueShield of Washington. When the 2011 UMP TPA contract was set to expire at the end of 2019, a competitive procurement was conducted, and Regence was again awarded the UMP TPA contract for an initial term of 2020 to 2029 (with a possible 7-year extension after 2029). View the current UMP TPA contract online. Out of Regence's concern over proprietary information, data

[1] https://www.umr.com/tpa-ap-web/?navDeepDive=publicHomeDefaultContentMWienu

pertaining to performance standards and guarantees, network requirements, and administrative costs have been redacted.

This report will not include the cost of the administrative components before the transition to the current contract because those records were beyond retention limits.

Returning UMP TPA Administrative Functions to HCA

To assess the feasibility of HCA providing some or all of the UMP TPA administrative services, HCA contracted with Mercer Health & Benefits, LLC to provide insights into current self-insurance industry practices and to analyze potential cost impacts.

Mercer concluded that, of the eight administrative services in the current UMP TPA contract, the provider network contracting, and disabled dependent certifications could reasonably be administered by HCA. Mercer concluded that the remaining administrative services would best be done by a TPA due to the high startup costs and efficiencies of scale. However, such costs might be offset as part of broader health policy reform or investments in the agency that could bring scale or efficiencies to this work.

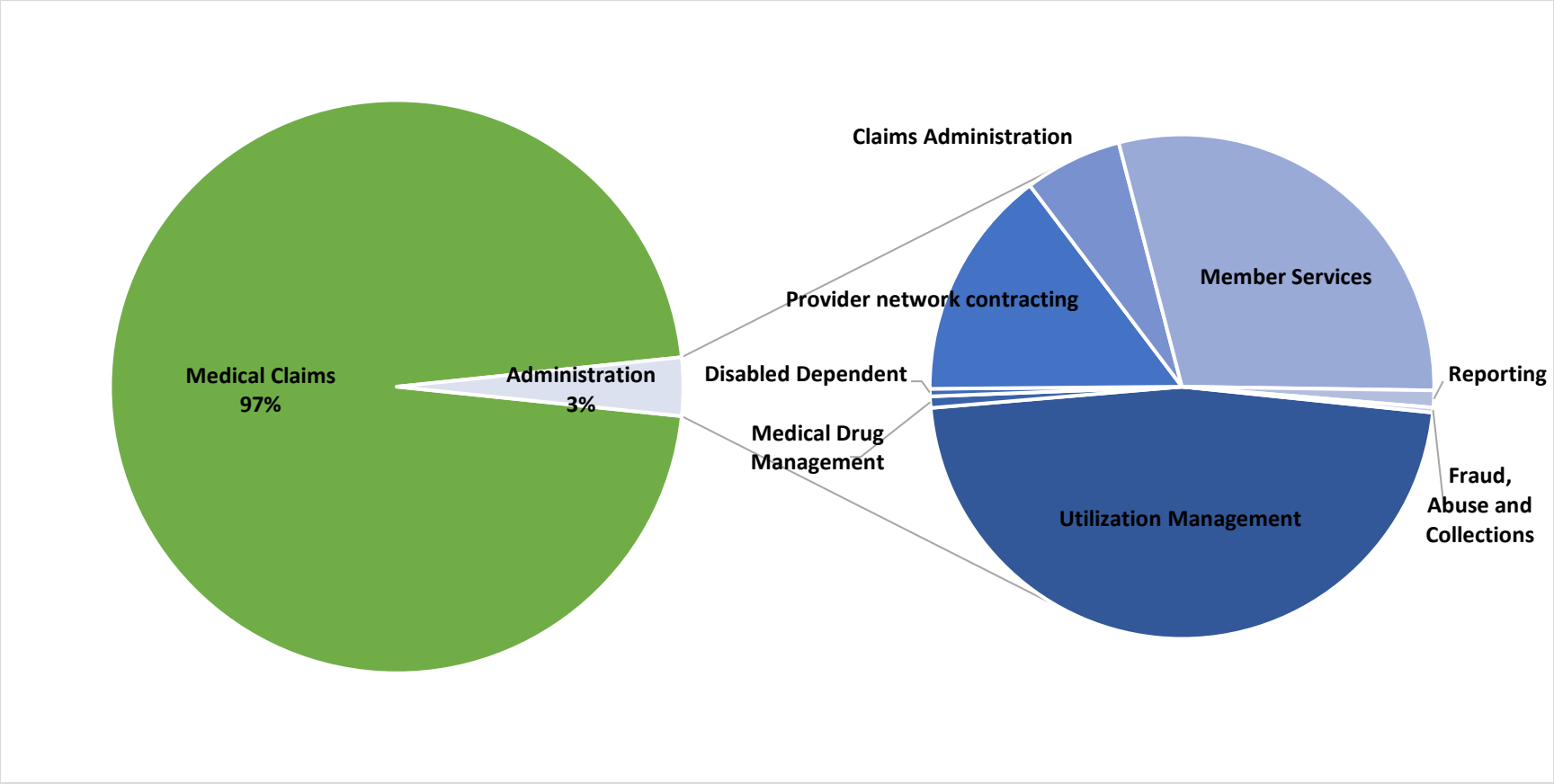
This report analyzes the option of bringing the provider network contracting back into HCA or keeping the network contracting with a third-party administrator.

Operationally, bringing the provider network contracting back in-house at HCA would require 58 additional FTEs as detailed in the FTE contractor list document. (for comparison, the combined PEBB and SEBB Programs currently have a approximately 170 FTEs). Including the costs for program support staff, contracted staff, and additional implementation costs, HCA would need an additional $39 million over the three-year implementation period to bring provider network contracting back in-house. Disabled dependent certifications represent a nominal cost that does not require separate accounting.

Administrative and Claims Costs

Administrative costs for UMP represent 3 percent of the total annual costs of UMP, compared to the approximately $1.8 billion in medical claims costs each year. The UMP TPA contract's administrative costs are paid on a Per-Subscriber Per-Month (PSPM) basis, meaning that the UMP TPA contractor is paid a monthly amount for each subscriber (the "subscriber" is either the employee or retiree who is enrolled in a UMP medical plan and does not include dependents). As shown in the chart below, utilization management and member services are the largest portions of the administrative cost, followed by provider network contracting, and claims administration.

Medical claims vs administration costs



Mercer estimated that if the enrollment in UMP medical plans remained flat after a transition of provider network contracting to HCA, there could be an administrative cost savings of approximately $10.6 million (again, using numbers based on the 2022 plan year) by bringing provider contracting in-house. However, the medical claims costs under HCA-negotiated provider network contract rates are unlikely to match existing medical claims costs, and may result in higher overall UMP costs.

To assess the impact of HCA administering provider network contracting in-house, Mercer modeled adjustments to network discounts to reflect reasonable outcomes of restated 2022 actual medical claims. Mercer estimated UMP would have experienced an increase of medical claims costs between $104 million (6 percent increase) and $267 million (15 percent increase) in 2022 if the provider contracts had been negotiated by HCA directly. As unit costs continue to rise and utilization patterns change over time, Mercer would expect overall increases to future claims costs for all populations, which was not included in the modeling.

In 2011 when HCA transferred the UMP TPA provider network services to Regence, HCA transferred its existing provider contracts to Regence to use in its provider network services for UMP. The terms of these legacy HCA provider contracts contained UMP-favorable rates with hospitals and provider groups. Due to contractual terms, state procurement rules, and other legal barriers, the legacy HCA provider contracts likely cannot be transferred back to HCA. Thus, HCA would likely have to execute new provider contracts to build the UMP network. New contracts may not be able to secure the same historical preferred discounts UMP experiences today, which could increase claims costs.

There has been significant hospital and provider network consolidation, including regional and several large national systems entering the state since 2011. With this consolidation comes larger providers who take up more of the market space and in turn less market competition.

Estimated implementation and medical claims costs

	Implementation Costs			Go-Live Costs Per Year	
	Calendar Year 1: 2027	Calendar Year 2: 2028	Calendar Year 3: 2029	Most Likely Outcome	Worst Case Outcome
Claims Costs Increase				$ 103,988,000	$ 267,397,000
TPA Administrative Savings - Provider Contracting	$ -	$ -	$ -	$ (10,656,000)	$ (10,656,000)
HCA Staffing and Associated Costs	$ 8,104,000	$ 8,117,000	$ 8,117,000	$ 8,117,000	$ 8,117,000
Other Contracted Costs	$ 2,831,000	$ 3,351,000	$ 8,371,000	$ 3,867,000	$ 3,867,000
Net Cost Increase	**$ 10,935,000**	**$ 11,468,000**	**$ 16,488,000**	**$ 105,316,000**	**$ 268,725,000**

The current UMP TPA contract also contains numerous performance standards and guarantees (PGs) that put more than a third of the total administrative cost at risk, with the specific performance guarantee tied to provider network contracting (Overall Trend Performance Guarantee) being the largest component. The provider network contracting-specific PG has not been missed since the contract was entered into. PGs are crucial elements in the UMP TPA contract in holding the TPA accountable for its services' performance.

Implementation Plan

HCA developed an implementation plan based on Mercer's recommendation transferring to HCA two administrative services that are currently done by UMP's TPA, with the rest of the services being contracted to outside organizations. The implementation would require three years, leading up to the first year after the current UMP TPA contract expires.

Background

HCA purchases and manages health care and other insurance benefits for more than 385,000 eligible public employees, state and school retirees, continuation coverage members, and their dependents through the Public Employees Benefits Board (PEBB) Program. Employers who access PEBB Program coverage include state agencies, institutions of higher education, and a variety of public agencies who contract with HCA for these benefits (e.g., counties, municipalities, tribal governments, and political subdivisions). The PEBB Program, in its current form, dates back to the 1980s; prior to HCA's administration of the PEBB Program benefits for state employee and higher education employee benefits were provided through the Department of Personnel and the State Employee Insurance Board.

In 1993, the State of Washington passed significant legislation that paralleled the national efforts on reforming health care. This legislation addressed numerous aspects of health care reform including consolidation of the insurance benefit purchasing for all of K-12 employees and retirees into the State Employee Insurance Board. Also in the 1993 legislation was a slight change to the State Employee Insurance Board program: Public Employees Benefits Board or PEBB.

Starting in the 1996 plan year, UMP began requiring an employee contribution to the premium, and subsequently implemented payroll deductions from employees. Additional health plan options had since been added to the School Employee Benefits Board portfolio, with UMP being the third-highest cost plan.

On June 30, 2017, Engrossed House Bill (EHB) 2242 created the School Employees Benefits Board (SEBB) Program for all school employees working for Washington State school districts, educational services districts (ESDs), and charter schools. The 2017 legislation established minimal eligibility criteria for participation in the SEBB Program. The School Employees Benefits Board established additional eligibility criteria and designed and approved benefit offerings. The first date HCA was authorized to offer benefits to the SEBB Program was January 1, 2020.

The PEBB and SEBB Programs offer the following insurance benefits: medical and pharmacy, dental, vision, life, accidental death or dismemberment, long-term disability. The medical benefits include several health plan options that include both fully and self-insured health plans, as well as Medicare plans for eligible members. The self-insured medical plans are administered by Regence BlueShield, and the suite of self-funded plans all contain the name Uniform Medical Plan or UMP. total enrolled members in both the PEBB and SEBB Programs.

The Uniform Medical Plan (UMP) is the PEBB and SEBB programs' branded self-insured portfolio, which includes Preferred Provider Organization (PPO), Accountable Care Program (ACP) and Consumer-Directed or HighDeductible Health Plan (CDHP/HDHP) plan options. More than half of the PEBB and SEBB members are enrolled in a UMP plan, with a current enrollment of around 385,000 out of 673,000 members as of November 2023. The current approximate number of enrolled members in either fully insured or self-insured (UMP) medical plans are listed in the table below.

Table 1: Current number of UMP enrolled members

	Fully Insured	Self-Insured (UMP)
PEBB Actives	65,000	219,000
PEBB Retirees	65,000	50,000
SEBB Actives	158,000	116,000
Totals	287,000	385,000

The total membership enrolled in either PEBB or SEBB medical benefits is approximately 673,000 covered lives. The breakdown of members and their dependents between the PEBB active, PEBB retirees, and SEBB actives is shown in the table below.

Table 2: PEBB and SEBB Total Member Coverage for November 2023

	Subscribers	Dependents	Total Members
PEBB Actives	143,000	139,000	282,000
PEBB Retirees	83,000	33,000	116,000
SEBB Actives	132,000	143,000	275,000
Totals	358,000	315,000	673,000

Here is a look at the past five years of PEBB and SEBB UMP program enrollment:

Table 3: PEBB and SEBB UMP Program Enrollment – past five years

	2019	2020	2021	2022	2023
PEBB	260,000	263,000	264,000	268,000	269,000
SEBB	N/A	95,000	99,000	110,000	116,000
Totals	260,000	358,000	363,000	378,000	385,000

Pre-2011 UMP Administrative Services

Pre-1988

Prior to 1988, the then-called "State Employees Insurance Board" offered state employees a choice between either UMP or a Group Health plan. The single UMP plan option was a PPO fully-insured product. Employees did not have to pay any premium, and coverage was essentially 100% (with minimal cost-sharing requirements). Importantly, there was also no utilization management, and that along with the financial crisis of 1987, resulted in the plan experiencing a $42 million dollar loss.

1988

Facing a significant cost increase due to the huge loss in 1987, the Legislature established the Health Care Authority, required that UMP and UDP (Uniform Dental Plan) become self-insured and self-administered, and State Employees Insurance Board became the State Employees Benefits Board, which was required to establish eligibility and benefit design for UMP and UDP.

1992-1994

By 1992, HCA had hired staff to conduct provider network contracting. The provider network that had been purchased from Sound Health was not meeting the legislative goals for UMP. The non-exclusive preferred provider network was brought in-house to HCA, meaning that HCA was responsible for recruiting, contracting, provider credentialing, and providing customer service. Any provider that met the comprehensive criteria for credentialing was allowed to contract with UMP. Around this time UMP contracted with over 5,000 providers and about 65 hospitals in Washington.

HCA used the All Patient Diagnosis Related Group (APDRG) classification methodology for hospital reimbursement. Around this same time, the Resource Based Relative Value Scale (RBRVS) Steering Committee was established, with HCA leading the multi-agency project. UMP, the Department of Labor & Industries, and Medical Assistance Administration (Medicaid) developed a methodology for professional service reimbursement based on the relative value of each medical service.

2003-2004

A little more than a decade after restructuring UMP into a self-insured plan, it continued to develop in complexity and sophistication. UMP implemented a number of changes, including:

- Standard coordination of benefits was implemented (instead of nonduplication), giving Medicare retirees enrolled in UMP up to 100% coverage of claims.
- The Claims investigation unit started to analyze the STARSentinel product and develop procedures, processes for investigating providers whose billing practices, utilization of services, or other data is identified as aberrant.
- Express Scripts became UMP's pharmacy benefit manager.

2004-2011

Provider Network Services

By 2011, HCA directly contracted with 84 inpatient hospitals, including critical access hospitals in the State. HCA contracted for an out-of-state network from Beech Street Network. This contractor managed all networks outside of Washington State and worldwide, with claims submitted from PEBB enrollees

In addition to the network contracting, HCA conducted provider credentialing. Provider credentialing is a regulated process of assessing the qualifications of specific types of providers. This important safety check requires health care providers to prove they have proper education, training, and licenses to care for patients. HCA's credentialing process used Kitsap Medical as a primary source verification service. Initially, there was no credentialing committee and no monitoring of the national practitioner database between the three-year credentialing cycles. However, over time HCA became part of the credentialing program that was developed to align itself with the current National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Commission (URAC) standards and established processes to consolidate and centralize credentialing used for the provider community.

The TPA during this time, UMR (now called United Healthcare), established the primary source of clinical policies. The Health Technology Clinical Committee (HTCC) developed some policies, as required by RCW 70.14.120, including medical determinations and a process to integrate the HTCC guidance into benefit coverage. Few claims were reviewed for medical necessity.

Of significant note of contrast to the current UMP TPA contract, there were no performance guarantees around network performance, members' access, cost, utilization, or quality targets because HCA was the contracting entity for the network.

Due to concerns about long-term sustainability of administrating all services of the plan by HCA, HCA began to contract out some of the administrative services to a new third-party administrator, as shown in the table below.

Table 4: UMP Administrative Services before 2011

Administrative Function	
Provider Network Contracting	• HCA set fees for services by provider classifications based mainly on the Medicare pricing methodology. • Additional updates included refinements to the payment systems to price more representative to a non-Medicare population. • Qualified providers who accepted the terms were included in the UMP network. • Contracting was performed in-house with internal credentialing staff assisted by outside vendors and national databases. • Provider payments were revisited every few years to reflect actual cost of delivering care. • HCA contracted with a national renal network to provide coverage outside of Washington.
Claims Administration	• Outsourced to a TPA (UMR).
Utilization, Complex Case, Chronic Condition, and Quality Management and Improvement	• Outsourced to the TPA (UMR) with some additional services provided by HCA staff, including an in-house medical director.

	• TPA services were included in the administrative fees.
Disabled Dependents Certifications	• The HCA and TPA (UMR) provided a combination of services relating to Disabled Dependent Certifications. The TPA initiated and submitted administrative records to HCA who reviewed and approved or denied certification.
Member Services, Member Communications, and Online Services	• Customer service was limited mainly to claims issues. Many communications were handled internally by the HCA. • Online services were very limited.
Fraud, Waste, and Abuse Detection	• STARSentinel product.
UMP Contracted Vendors	• Sound Health (Providence) for provider network (most of fee schedule based on percentage of billed charges, access limited and credentialing criteria minimal) • Control Data, Texas, third party administrator • August International, California, utilization/case management • Mail-Order Pharmacy, National RX (Merck-Medco)

2011 UMP TPA contract

Provider Network Services Contract

In the 2011 contract, the TPA changed to Regence BlueShield and was required to provide a network contracting and credentialing program consistent with NCQA or URAC accreditation standards, and to maintain a provider network that meets or exceeds nationally accepted access standards for all applicable HCA approved provider categories. The contract had specifications on what services the provider network must provide access to and gives a breakdown of compliance standards based on provider type in urban versus rural areas. The TPA was responsible for meeting all Washington State Office of the Insurance Commissioner (OIC) standards for the state provider network. Regence BlueShield must provide documentation that the state provider network is in place annually.

Regence BlueShield was also responsible for providing an out-of-state provider network from January 1, 2011, through the term of the contract. Because Regence BlueShield is a member of the Blue Cross Blue Shield Association, the BlueCard Network of physicians and hospitals was used for network services outside of Washington.

Transition of provider contracts from 2010-2013

HCA retained the state hospital network for benefit year 2011, with Regence BlueShield being responsible for paying state hospital claims using HCA's contracted reimbursement methodology. HCA retained the hospital network until December 31, 2012. Regence was responsible for completing the transition of the UMP state hospital network to the Regence Network by January 1, 2013.

The reason for this arrangement was that analyses indicated that the pre-2011 HCA contracted payments to facilities were lower than the Regence commercial contracts. In addition, payments for professional providers were deemed to be similar between pre-2011 HCA contracts and Regence's existing commercial contracts..

Starting in 2011, Regence also took responsibility for providing claims services, transferred from UMR.

2020 UMP TPA

HCA released a UMP TPA Request for Proposal (RFP) in July 2016. The RFP included clinical programs, utilization and case management, performance guarantees, value-based purchasing requirements, pooled hour reserve, and medical pharmacy rebates. A copy of the RFP, approximately 206 pages, is provided in the appendix.

The purpose of this RFP was to contract with an experienced entity to provide two categories of services for the HCA's current and possibly future self-insured medical plans, including its largest, the UMP plans.

The initial contract term was set from January 1, 2018, through December 31, 2029. Implementation began in January 2018 and went through December 2019. Administration services began January 1, 2020. The contract may be extended for up to an additional seven years in increments of not less than one year.

The RFP was to contract for the following two services for UMP:

1. Administrative Services, including Clinical Management Services, claims adjudication clinical and quality management and improvement, member services, development and maintenance of a statewide and national provider network, account management, and online tools and services.
2. Health transformation services, such as assistance with development and implementation of health transformation and Value-Based Payment strategies related to UMP in alignment with Healthier Washington initiatives, including offering an Accountable Care Organization (ACO) commercial product that includes key components of HCA's Accountable Care Networks (ACNs). The Apparently Successful Bidder (ASB) will be expected to change its own business practices and payment strategies to accelerate health transformation.

HCA selected an ASB that demonstrated:

A. Strong alignment with HCA's purchasing and health transformation vision, including HCA's Value-based Roadmap, as well as a demonstrated commitment and capability to implement other Value Based Payment models.

B. Commitment to active partnering and engagement with HCA, members and their employing organizations, other UMP contractors, and other key health partners to drive innovation in health care purchasing and delivery system reform in Washington State; and

C. Capacity and flexibility to implement HCA directed initiatives specific to UMP.

Table 5: Procurement Schedule

Activity	Due date/time
Pre-Bid Conference #1	July 22, 2016
Pre-Bid Conference #2	September 7, 2016
RFP Released	November 21, 2016
Letters of Intent and DSA for Data Files Due	December 16, 2016
Round 1 - Bidder Questions Due	January 4, 2017
Anticipated Release of Responses to Bidder Questions	January 20, 2017
Round 2 - Bidder Questions Due	February 24, 2017
Repricing Files Due to Milliman	March 1, 2017
Anticipated Release of Responses to Bidder Questions	March 15, 2017
Complaints Deadline	April 14, 2017
Repricing Files Finalized	April 21, 2017
Proposals Due	April 21, 2017 – 3:00 pm PT

Activity	Due date/time
Evaluation Period	April 24 – July 7, 2017
Finalist Announcement for Oral Presentations	July 7, 2017
Finalist Oral Presentations	July 17 – 21, 2017
Anticipated Announcement of ASB	August 25, 2017
Debrief Period	August 31 – September 5, 2017
Protest Period End Date	September 12, 2017
Contract Negotiations	September 13 – December 30, 2017
Contract Signed	December 31, 2017
Contract Implementation	January 2018 – January 2020

Current UMP TPA contract

The current UMP TPA contract with Regence to provide administrative services to all UMP Medical Plan Options. These services include Clinical Management Services, implementation of HCA clinical and coverage policies, adjudication of worldwide Claims, Quality Management and Quality Improvement, Clinical Management, Member services, development and maintenance of a statewide and national provider network, account management, and online tools and services. Additionally, the contract contains a set of performance guarantees that put a percentage of the administrative fees at risk subject to the Regence's performance of the contracted administrative services.

UMP Medical Plan Options

UMP includes multiple medical plan options across the PEBB and SEBB programs, ranging from large preferred -provider organization (PPO) network models (UMP Classic, Select, Achieve 1, and Achieve 2) to narrower Accountable Care Networks (ACNs) with UMP Plus, and a Health Savings Account IRS-Qualified High Deductible Health Plan (UMP CDHP/HDHP), plus a Coordination of Benefits Medicare plan with creditable prescription drug coverage (UMP Classic Medicare).

Administrative Services

Provider network

Regence continues to provide network contracting and a credentialing program with the same elements as described in the 2011 UMP TPA contract section above (network using NCQA/URAC accreditation standards, etc.).

Section 7 states that Regence is responsible for providing a network contracting and credentialing program consistent with NCQA or URAC accreditation standards

Regence is responsible for providing an out-of-state provider network for the term of the contract. Regence uses the Blue Card network for national and worldwide claims. Regence has dedicated staff to handle worldwide claims management, payment, and customer service.

Currently, the UMP Plus has ACNs through the University of Washington medical system as well as the Puget Sound High Value Network . Center's of Excellence (COEs) are administered via Premera and were assumed to remain with Premera.

Claims Services

The current contract with Regence contains the claims services as detailed in Section 3.2 of the contract. These services include the following:

- claims adjudication and processing;
- appeals and complaints management;
- coordination of benefits;
- subrojaction
- reports, and customer service.

Appeals, complaints, and grievances includes the administration, documentation, and tracking of first- and second-level appeals, Independent Review Organization (IRO) requests, pre-authorizations, complaints, and grievances, and the processing of associated correspondence.

Section 3.12 of the 2020 contract specifies that Regence is responsible for administering appeals and complaints on behalf of HCA, and it outlines the process to which they must adhere, though there is an exception process that requires HCA review. HCA does require an Appeals and Complaints administrative service. Appeals services are assumed to stay with TPA because of the claims and medical information needed to process appeals.

Account management are the services required to meet the requirements of the contract, including performance guarantees and HCA requests.

Utilization Management

Utilization Management is the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of applicable health benefits plan. It is also known as utilization review. Complex case management is the identification, management, and provision of benefits for members with complex, serious, or difficult health care needs. Chronic condition includes the identification, management, and provision of benefits for members with multiple, persistent, severe health care needs. Quality management and improvement is a systematic and continuous set of actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

Regence currently operates a utilization management program, complex case management, chronic condition, and quality management and improvement that complies with HCA policies where applicable and uses Regence's policies where HCA has none. The TPA contract requires Regence to provide specific business functions related to utilization management, complex case management, chronic condition, and quality management and improvement by:

- Using HCA's evidence-based medical policies, including Bree Collaborative recommendations
- Promoting adherence to Utilization Management processes, including clinical performance and consumer experience measurement
- Meeting or exceeding NCQA or URAC standards
- Monitoring medical necessity through pre-authorization and retrospective reviews
- Developing and implementing care management strategies to improve member health outcomes
- Complying with OIC standards
- Including UMP Plans coverage criteria
- Including Utilization Management for physical and behavioral health
- Supporting timely and appropriate care, member safety, quality of care, and shared decision making
- Using HCA-certified shared decision-making tools when available
- Facilitating appropriate and timely referrals to other benefit programs
- Allowing for an NCQA accreditation review at the request of HCA, among other functions
- Identifying members with complex, serious, or difficult health care needs
- Developing and implementing care coordination strategies to improve member outcomes, considering health conditions and social determinants
- Ensuring members received necessary inpatient and outpatient/ambulatory health care services
- Documenting and identifying members eligible for complex case management
- Providing leadership and oversight for quality management and improvement for all clinical management programs

- Establishing and maintaining logs that document, prioritize, and track clinical issues
- Implementing HTCC decisions
- Supporting care transformation, among other functions

Based on the current contract, Regence is responsible for a large amount of administration for these services. This includes medical policies, the appeals process, clinical programs, and staffing. For medical policies, Section 3.8 of the 2020 contract specifies Regence is responsible for developing, implementing, and managing customized HCA medical policies or exclusions. As specified by Section 3.3.3, Regence is responsible for providing all the clinical programs outlined in the contract.

The contract also specifies that Regence is responsible for naming two clinical program managers to serve as points of contact for the HCA clinical programs manager and to attend weekly meetings regarding the clinical programs for UMPs. Regence is responsible for appropriate staffing, and Section 3.13.3 outlines account management staffing levels to which they must adhere. These are all process- and staff-intensive to administer.

Section 3.1.5 of the contract states that Regence must implement and follow coverage determinations made by the HTCC, and that Regence must maintain a coverage determination documentation spreadsheet and send it to HCA on a monthly basis.

More information on these services provided to HCA by Regence can be found in Sections 3.4 (Utilization Management), 3.6 (Complex Case management), 3.7 (Chronic Condition Management), and 3.5 (Quality Management and Improvement) in the current contract.

Medical Drug Management

Medical drug management is the provision of the medical pharmacy benefit aligned with the UMP Pharmacy Benefit Manager that ensures the appropriate use, cost-effectiveness, and member communication relating to pharmacy benefits. It also includes the TPA policies around drugs that are covered under the medical benefit.

For more information on current medical drug management services provided by Regence see Section 3.10 of the contract.

Member Services

Section 3.15 specifies that Regence will work in collaboration with HCA communication staff to develop, print, and distribute member communications. Examples of these materials are certificates of coverage, welcome packets for new enrollees, and updated explanations of benefits. For a full list of communication materials Regence is responsible for, see the contract Section 3.15.

Section 5 of the contract, UMP Plus Administrative Services, states that HCA contracted directly with two ACNs to offer UMP Plus to non-Medicare members, with Regence being responsible for administering member communications (Section 1.2) and network administration (Section 1.3).

Regence is responsible for providing resources for adequate member services. These services include having at least two staff members for every PEBB and SEBB annual OE benefits fair, providing Interactive Voice Response (IVR) access to eligibility and claims information for providers, providing language translation services, etc… Regence is also responsible for providing and an online service for members.

More information on current services provided to HCA by Regence as the UMP TPA can be found in Section 3.14 (Member Services), and 3.16 (Online Services) of the contract.

Fraud, Waste, and Abuse

Fraud, waste, and abuse detection and prevention includes the services required to manage a program that detects, prevents, and addresses fraud, waste, and abuse.

In the current system, HCA maintains strong regulatory oversight. For instance, according to Section 3.2.5: Fraud, Waste, and Abuse Detection and Prevention, Regence is responsible for administering this program; however, they routinely provide HCA with specific reports on their efforts in this area. Section 3.2.4: Erroneous Payments & Misquotes states that if HCA or Regence determines Regence made an erroneous payment to a provider, Regence must attempt to recover that payment while keeping HCA informed of the status of those efforts through monthly meetings. Furthermore, HCA is not responsible for reimbursing Regence for claims costs for misquotes or erroneous payments made by Regence. These contract sections demonstrate that while HCA has oversight, HCA is not directly involved in the administration of the fraud, waste and abuseprograms.

Performance guarantees

The current UMP TPA contract with Regence contains performance guarantees that require Regence meet certain performance levels. If Regence fails to meet a performance guarantee, it is assessed a fee that is applied as a credit for future administrative fees, which on an annual basis can account for over 40% of its administrative fees. These performance guarantees are evaluated on either a quarterly or annual basis and are consistent with industry best practices based on a review by Mercer's audit group.

The following categories of performance guarantees are part of the current contract:

- Ongoing Core Measures (examples such as the time to answer calls, the time to process claims, and reporting)
- Appeals and Complaints
- Reporting
- Overall Trend Guarantee
- Account Management Satisfaction
- Value-Based Guarantee
- Clinical Outcomes

Examples of the some performance guarantee categorical breakdowns can be found below in the table List of Performance Guarantees.

For the clinical metrics, results for PEBB were either not substantially better than the Washington State provider community results or were below the 50th percentile. Member experience reported via surveys are positive with 81% of PEBB members rating the UMP eight or above on a 10-point scale.

Regence is currently accountable to HCA through performance guarantees for managing claim trend, non-hospital unit cost growth, Alternative Payment Model (APM) adoption, and clinical quality outcomes. HCA also has performance guarantees to help achieve its goals to advance value-based purchasing (VBP) and APM adoption through all state-financed health care programs. Regence has been implementing APMs within the UMP network for several years and is subject to performance guarantees to make additional progress. To meet the expectations of the VBP strategies performance guarantees, Regence

must have 85% of total provider payments that meet the criteria of HCP-LAN2 APM Categories 2C and above and 38.25% of total provider payments in Categories 3A or above[3]. Notably, the value-based performance guarantees include portions of Regence's non-HCA book of business, giving HCA additional leverage to increase statewide health care spending into APMs. To date, Regence has met the required thresholds.

While the amount of each category of performance guarantee cannot be disclosed, the total amount could total more than 40 percent of Regence's annual adminirative fees (which is paid as a credit on the next year's administrative fees). Additionally, there were additional performance guarantees of upto 25 percent of Regence's implementation fees imposed during implementation of the new contract.

Based upon the performance guarantee reports, Regence currently meets or exceeds the performance metrics. The performance guarantees were reviewed by Mercer's audit group, which found the current measurements consistent with industry best practices. The following are a few observations to consider in future performance guarantee negotiations.

[2] "Alternative Payment Models: The APM Framework", *Health Care Payment Learning & Action Network*. http://hcp-lan.org/workproducts/apm-framework-onepager.pdf, accessed July 25, 2023

[3] **APM Framework Refresh White Paper (hcp-lan.org)** https://hcp-lan.org/workproducts/apm-figure-1-final.pdf

Table 6: List of performance guarantees

6.2.2 - Ongoing Core Measure Performance Guarantees
<3% Call Abandonment Rate (Customer Service)
≤ 30 Second Speed of Answer (Customer Service)
97% Clean Claims in 15 days/99.5% All Claims in 30 days (Claims Processing)
55% Online Prior Authorizations Web-Based or Online (2020 - 2024)/60% (2025+)
99% Financial Claims Payment Accuracy (Claims Processing)
99% Procedural Coding Accuracy (Claims Processing)
≥ 98% Claims Adjudication Accuracy (Claims Processing)
100% of HCA identified HTCC Determinations included in Web-Based Reviews
HSA Trustee Customer Service Requirements (1-8)
Provide 97% of all ACN Reports to HCA
99.8% of Total Calls will not have Misquotes
6.2.3 - Appeals and Complaints Performance Guarantees
6.2.3-1 98% of Non-Expedited Appeals/Complaints (first & second levels only) sent in 30 Calendar Days
6.2.3-2 93% of Expedited Appeals sent in 72 hours & 93% of Independent Review Requests sent in 3 Business Days
6.2.4 - Reporting Performance Guarantees
Submit UMP Plan Data within HCA-requested timeframes
Provide HIPAA 834 to other HCA vendors weekly
Eligibility audit
Annual Written Plan for Fraud/Abuse and Improper Payment Data
Contracts provided to HCA within 5 Business Days
Non-ACN Reports in Table 3.17.7
6.2.5 - Overall Trend Guarantees Tables E-1.1, 1.2 & 1.3 (Excludes SEBB & Medicare)
Unit Cost Margin (Effective 2021)
Utilization Trend Margin
6.2.6 - Account Management Satisfaction Performance Guarantee
6.2.7 - Value-Based Guarantee (Excludes SEBB & Medicare)
6.2.8 - Clinical Outcomes Measures Guarantee - includes PEBB Classic, Select, CDHP & Plus Plans (excludes SEBB & Medicare) (effective 2021)
6.2.8-2 Clinical Performance Guarantees
6.2.8-3 Member Experience Performance Guarantees

Future UMP administration options

As stated in the executive summary, Mercer concluded that, of the eight administrative services in the current UMP TPA contract, the provider network contracting, and disabled dependent certifications could reasonably be administered by HCA. This section focuses on provider network contracting since disabled dependent certifications represent a nominal cost that does not require separate accounting.

According to a recent report from the Office of Financial Management (OFM), the percentage of hospitals that are part of a health care organization grew from 27% in 1986 to over 46% in 2017. The percentage of hospital beds in hospital systems increased further, growing from 19% in 1986 to over 70% in 2017. Over the same period, the number of hospital organizations declined from 98 to 63, while the number of hospitals declined from 106 to 98, indicating significant horizontal consolidation. Patient admissions to system hospitals followed the opposite trend, jumping from 20% in 1986 to nearly 80% in 2017. The most significant of these changes occurred in the most recent decade and coupled with the potential of the Coronavirus Disease 2019 Public Health Emergency to drive additional consolidation. These trends may continue, further increasing the negotiating strength of Washington's hospital systems. Furthermore, while value-based purchasing strategies often seek to incentivize integrated delivery models, vertical integration can also contribute to rising costs.

Network policy considerations

Should HCA self-administer a provider network for UMP instead of contracting out those responsibilities to a TPA, there are several key functions that will need to be established. HCA, with Mercer's help, identified the minimum FTEs necessary to complete the work outlined below. The associated costs and details are outlined in the UMP TPA cost analysis section of this report.

Washington State provider contracting

Rate contracting with each hospital system and with all individual provider practices necessary for network adequacy would require HCA to be able to contract for ancillary providers and durable medical equipment (DME). In addition, actuarial support and contract modeling software is needed to model the net impact of the contract, which would have to take into account reimbursement rates for diagnosis related group hospital stays, outlier cases, professional fees, fees specifically for diagnostic testing (labs and radiology), passthrough medications, hospital based DME, outpatient surgery centers, ancillary services, and rehabilitation services. Challenges would also come in maintaining competitive rates with large carriers who have more market share than HCA in the commercial market. These are the resources needed only for the hospital contracting services; professional contracting would take additional resources.

Network integrity oversight

If HCA begins administering provider network contracting, there would need to be a credentialing process that meets NCQA or URAC accreditation standards. This may mean reviewing hospital staff processes, which would require annual review of the hospital's credentialing policies and procedures, as well as reviewing their credentialing activity annually. Due to the nature of this work, HCA would assume continued outsourcing of credentialling to a TPA.

Credentialing actions includes primary source verification, credentialing chart review of each chart, review of every "B" file (any chart with an action against the provider or organization), issuing a provider contract

or a denial, and managing a credentialing appeals process that requires different people than those involved in the initial decision. Much of this work is done by a credentialing committee, which NCQA and URAC both specify having the committee include community members.

In the event that a hospital or provider would need to be suspended from the network, the TPA would need to run a disruption analysis and to communicate with the impacted members.

Regardless of whether the credentialing is deemed necessary or not, the TPA would need to monitor the National Practitioner Data Bank and CMS to remain up to date on actions taken against providers or facilities.

If medical management and claims payment stay with a TPA while HCA handles network provider contracting, there will need to be a strong data and communication link between the network management, as difficulties with providers not following the clinical coverage criteria would need to be dealt with by the provider relations staff.

Plan interface

HCA would need to hire experienced staff to perform the functions outlined and support with adequate staff and resources to provide ongoing provider network administration. If the provider network services are insourced, creation and establishing the infrastructure and processes may introduce areas of risk that were previously entrusted to the TPA. Given the impact of contract rebates and terms on claims adjudication, issues could cascade from adjudication, utilization management and case management, to members as well as performance guarantees around claims and member services.

This process would require an experienced staff member who would oversee the work described in this section. Ongoing network management would require staff to manage renewals, contract changes due to mergers and acquisitions, regulatory changes, and problem solving related to existing contracts.

This work would also require dedicated data analysts, an experienced actuary contractor, and additional supports to remain current with incoming and changing information.

The program, from development to implementation and maintenance, would require regular legal support and would be best served by staff with health plan contracting and compliance experience.

The administrative cost assumptions of HCA handling provider network contracting are detailed below in the UMP TPA cost analysis section.

Performance guarantees

The scale and access provided by HCA's self-administered network would be at risk if providers view HCA's offered rates and terms as less favorable than those currently agreed to with Regence, that has an even wider presence in the state's commercial market. This scenario could limit the scale and breadth of the resulting provider network. If negotiations are unsuccessful at replicating the current Regence network, some UMP members may lose in-network access to preferred providers.

Regence is currently accountable to HCA through performance guarantees for managing claim trend, non-hospital unit cost growth, APM adoption, and clinical quality outcomes. The overall cost trend performance guarantee is worth up to a third of all administrative fees at risk each year. Under an HCA-managed provider network, HCA would assume responsibility and accountability for these

performance areas, requiring investment in strategic development, program and project management, risk mitigation, and provider engagement.

Under an HCA-managed provider network, HCA would assume responsibility and accountability for these performance areas, requiring investment in strategic development, program and project management, risk mitigation, and provider engagement.

UMP TPA cost analysis

Claims impacts

HCA contracted with Mercer Health & Benefits LLC to provide an analysis about the impacts to claims costs if HCA were to directly contract with Washington State providers and no longer contract with Regence for this service.

Before 2010, HCA did direct provider contracting. Since then,, there have been significant changes in the provider market and contracting approaches. There has been significant consolidation of hospital systems, which has increased their negotiating power with plans. There has been similar consolidation within provider groups. Larger clinical groups have organized into more integrated delivery models, such as Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes. Additionally, contract terms have become more complex, and the nature of the arrangements has embraced more Alternative Payment Models (APMs). The four largest consolidated health care organizations in the Western Washington and Eastern Washington markets around the cities of Seattle and Spokane, respectively, represent more than 80% of each local market

Due to these changes, it is assumed that HCA would have a direct contracting disadvantage compared to a TPA because of the larger total market share of a TPA when considering commercial market share.

To assess the impact of HCA administering provider network contracting in-house, Mercer modeled adjustments to the network discounts to reflect reasonable outcomes of restated 2022 actual medical claims. Mercer used UMP claims data from calendar year 2022 as it was the last full year of data available. When creating assumptions and costs estimate, the analysis treated the TPA contract as if it ended in 2022.

The following assumptions were used in this analysis:

- Claims assumptions based on 2022 incurred medical claims, paid through February 2023
- No trend or completion factors were applied to the claims (actual claims costs will likely increase significantly over the next several years by end of the current contract due to a rise in unit costs due to inflationary pressures).
- No assumed changes in enrollment
- No assumed changes to the underlying network and no additional programs added.
- HCA would continue to contract for non-Washington claims and the assumption was that HCA would continue to use the existing BlueCard network for non-Washington claims.

This analysis is broken down into three scenarios:

1. The status quo "Baseline" scenario assumes no change to underlying provider contracts and represents 2022 actual claims.
2. The "Most Likely" scenario assumes that HCA will experience an overall 5.8 percent increase in claims as compared to the Baseline scenario.
3. The "Worst" scenario assumes that HCA experiences an overall 15 percent increase in claims as compared to the Baseline scenario. (on next page)

Table 7: Claims Repricing Scenarios

	PEBB			SEBB			PEBB & SEBB		
	WA	non-WA	Total	WA	non-WA	Total	WA	non-WA	Total
Plan Year 2022	**Scenario - Baseline (aka "Best Outcome - Least Likely")**								
Subscriber Months	1,654,237	94,486	1,748,723	617,561	8,208	625,769	2,271,798	102,694	2,374,492
Member Months	3,051,253	167,758	3,219,011	1,431,321	16,791	1,448,112	4,482,574	184,549	4,667,123
PMPM Claims	$ 370.93	$ 1,002.92	$ 403.87	$ 308.92	$ 2,610.36	$ 355.60	$ 351.13	$ 1,149.17	$ 382.69
Claims Adj	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PMPM Adj Claims	$ 370.93	$ 1,002.92	$ 403.87	$ 308.92	$ 2,610.36	$ 355.60	$ 351.13	$ 1,149.17	$ 382.69
Total Claims	**$ 1,131,813,969**	**$ 168,247,501**	**$ 1,300,061,469**	**$ 442,156,668**	**$ 43,830,630**	**$ 485,987,298**	**$ 1,573,970,636**	**$ 212,078,131**	**$ 1,786,048,767**
Plan Year 2022	**Scenario - Most Likey Case**								
Subscriber Months	1,654,237	94,486	1,748,723	617,561	8,208	625,769	2,271,798	102,694	2,374,492
Member Months	3,051,253	167,758	3,219,011	1,431,321	16,791	1,448,112	4,482,574	184,549	4,667,123
PMPM Claims	$ 370.93	$ 1,002.93	$ 403.87	$ 308.92	$ 2,610.36	$ 335.60	$ 351.13	$ 1,149.17	$ 382.69
Claims Adj	7.0%	0.0%	6.1%	5.6%	0.0%	5.1%	6.6%	0.0%	5.8%
PMPM Adj Claims	$ 396.90	$ 1,002.93	$ 428.48	$ 326.21	$ 2,610.36	$ 352.70	$ 374.33	$ 1,149.17	$ 404.97
Total Claims	**$ 1,211,040,946**	**$ 168,247,501**	**$ 1,379,288,447**	**$ 466,917,441**	**$ 43,830,630**	**$ 510,748,071**	**$ 1,677,958,388**	**$ 212,078,131**	**$ 1,890,036,518**
Plan Year 2022	**Scenario - Worst Case Outcome**								
Subscriber Months	1,654,237	94,486	1,748,723	617,561	8,208	625,769	2,271,798	102,694	2,374,492
Member Months	3,051,253	167,758	3,219,011	1,431,321	16,791	1,448,112	4,482,574	184,549	4,667,123
PMPM Claims	$ 370.93	$ 1,002.92	$ 403.87	$ 308.92	$ 2,610.36	$ 335.60	$ 351.13	$ 1,149.17	$ 382.69
Claims Adj	18.0%	0.0%	15.7%	14.4%	0.0%	13.1%	17.0%	0.0%	15.0%
PMPM Adj Claims	$ 437.70	$ 1,002.92	$ 467.16	$ 353.40	$ 2,610.36	$ 379.57	$ 410.78	$ 1,149.17	$ 439.98
Total Claims	**$ 1,335,540,483**	**$ 168,247,501**	**$ 1,503,787,984**	**$ 505,827,228**	**$ 43,830,630**	**$ 549,657,858**	**$ 1,841,367,711**	**$ 212,078,131**	**$ 2,053,445,842**

Unit cost increases are the changes in allowed cost for specific services negotiated by the plan administrator. The UMP prior to hiring Regence attempted to tie the cost increase to Medicare, which means that the underlying unit cost increases are the same as the CMS Medicare increase mentioned above. Regence negotiates their cost increases with the providers. Some allowed costs may be tied to the Medicare payments; however, many are not. As Regence is the owner of those contracts, the underlying increase is not specified and can only be determined via data analysis. Such analyses are beyond the scope of this report.

Allowed amount data was provided by Milliman, HCA's actuarial contractor, that allowed for an analysis of the Washington claims as a percent of Medicare. For 2022, PEBB and SEBB combined allowed costs were 168% of Medicare.

The UMP reimbursement levels are currently lower than what is typically seen in the commercial marketplace. According to a Rand study of commercial plans, in Washington inpatient hospitals are reimbursed around 200% of Medicare based on 2020 Washington all payers claims database (APCD) and around 150% for outpatient services. Professional services are around 150% of Medicare. Rand defines commercial to include self-insured data reported to the APCD, fully insured business including those enrolled in plans offered by the Washington Health Benefits Exchange.

Administrative Impacts

In addition to the above assumed claims cost increases for Washington state providers, below are the assumed administrative cost assumptions associated with HCA managing provider network contracting.

The UMP TPA contract is paid on a Per-Subscriber Per-Month (PSPM) basis, meaning that the UMP TPA Regence is paid a monthly amount for each subscriber (the "subscriber" is either the employee or retiree who is enrolled in a UMP medical plan). It is important to note that administrative costs are substantially lower than claim costs for UMP, representing 3 percent of the total annual cost to UMP versus annual medical claim expenses that are approximately $1.8 billion.

Based on enrollment for plan year 2022, it is estimated there would be an administrative savings of approximately $10.6 million for HCA managing provider contracting in house.

The table below represents a high-level overview of the impact to administrative costs if HCA were to resume provider contracting.

Table 8: Total Administrative Costs

	Implementation			Go-Live
	Calendar Year 1: 2027	**Calendar Year 2: 2028**	**Calendar Year 3: 2029**	**Ongoing Costs, Per Year**
Current TPA Cost	$ 71,845,000	$ 71,845,000	$ 71,845,000	$ 71,845,000
Utilization Management				
Medical Drug Management				
Disabled Dependent				
Provider network contracting				
Claims Administration				
Member Services				
Reporting				
Fraud, Abuse and Collections				
Decreased TPA Costs				$ (10,656,000)
Increased HCA Administrative Costs	$ 10,935,000	$ 11,468,000	$ 16,488,000	$ 11,984,000
Total Administrative Costs	**$ 82,780,000**	**$ 83,313,000**	**$ 88,333,000**	**$ 73,173,000**

The table below represents the total cost (~$39 million) for staff and contracted services estimated if HCA were to complete specified work activities that are currently done by Regence. If HCA were to resume this work, all positions and contracted services would need to begin 36 months prior to the end of the TPA providing these services. This will create an overlap in costs;. HCA would need to continue paying the TPA for these services, while simultaneously having new staff begin negotiating provider contracts in preparation for the end of these services by the TPA.

Table 9: Increased Administrative Cost by Object

		Implementation			Go-Live
		Calendar Year 1: 2027	**Calendar Year 2: 2028**	**Calendar Year 3: 2029**	**Ongoing Costs, Per Year**
	FTE	58.00	58.00	58.00	58.00
A	Salaries and Wages	$ 6,015,000	$ 6,015,000	$ 6,015,000	$ 6,015,000
B	Employee Benefits	$ 1,971,000	$ 1,984,000	$ 1,984,000	$ 1,984,000
C	Professional Service Contracts	$ 2,831,000	$ 3,351,000	$ 8,371,000	$ 3,867,000
E	Goods and Other Services	$ 118,000	$ 118,000	$ 118,000	$ 118,000
Total Administrative Costs		**$ 10,935,000**	**$ 11,468,000**	**$ 16,488,000**	**$ 11,984,000**

Regence's staffing structure benefits from an economy of scale, as employees assuming the roles can work across benefit contracts with various employers. HCA may not benefit from a comparable economy of scale, as staff responsibilities are likely to have significant requirements unique to employer sponsored insurance offerings. This may result in an increase in staffing costs compared to the current Regence contract.

HCA would require at least 58 full-time employees (FTEs) if the agency were to resume provider contracting (the list of estimated FTEs is listed below). In addition to increases in staffing, this transition will require funding for administrative costs associated with the expansion of responsibilities.

Direct HCA Staff

Section Manager: Leads all FTEs for UMP Provider Contracting within HCA and coordinates needs for third party administrator.

- 1.0 FTE WMS 3

Provider Contracting: Includes identification and solicitation of providers, rate, and contract negotiations. Analysis of financial impact of contract changes, administration of contracts.

- Professional contracting:
  - 2.0 FTE WMS 2: Contracting lead responsible for provider network adequacy and quality
  - 5.0 FTE Management Analyst 4: Adequate staff to support ongoing relationships with network providers.
- Hospital contracting:
  - 2.0 FTE WMS 2: Contracting lead responsible for facility network adequacy and quality
  - 4.0 FTE Management Analyst 4: Adequate staff to support ongoing relationships with network hospitals.

Plan Interface: Includes communication and data links needed between HCA provider contracting and interfacing needs of the TPA for all other services.

- 4.0 FTE Management Analyst 5

Data Analytics: Contract modeling and ongoing financial performance of network participants.

- 1.0 FTE WMS 3 Finance Supervisor
- 4.0 FTE WMS 2 Finance staff

Network oversight: Responsible for professional quality of the network, oversight and auditing of TPA credentialing and following accreditation requirements, monitoring any actions against network providers, and structuring and monitoring the credentialing appeals process.

- 2.0 FTE WMS 5 Medical Director oversight
- 1.0 FTE WMS 2
- 2.0 FTE Management Analyst 3

Monitoring National Practitioner Data Bank: Review of the licensing boards, National Practitioner Data Bank, and CMS actions.

- 2.0 FTE Management Analyst 4

Legal Support: Available for contract oversight and compliance issues related to quality.

- 4.0 FTE WMS 2

Communications: Manage communications with the network regarding any changes in benefits, payment issues, compliance issues, or clinical quality improvement processes. Manage member communications in the event of any network changes or decisions by providers and organizations to stop participating in the

network; this must follow regulatory requirements in terms of the timing of communications if an agreement is not anticipated.

- 1.0 FTE Communications Consultant 5
- 2.0 FTE Communications Consultant 4

Contracts Specialist: Maintain hospital contracts, review, and approve updated annual addendums and amendments. Create new agreements as new facilities and providers are added.

- 4.0 FTE WMS 2
- 4.0 FTE Contracts Specialists 3

Data Management: Maintain operational information on the current status of network participants, including the contract structure, rates, any changes of coverage, or newly approved coverage; to interface with both the claims payment system and the customer service system.

- 1.0 FTE IT Data Management – Senior/Specialist
- 3.0 FTE IT Data Management – Journey

Information Technology Services: Provide support through development and ongoing maintenance and operations.

- 1.0 FTE IT Business Analyst Senior
- 1.0 FTE IT Quality Assurance Journey

Agency Support/Shared Services: Provide agency support for new positions as outlined above.

- 1.0 FTE Fiscal Analyst 3
- 1.0 FTE IT Customer Support – Entry
- 2.0 FTE Human Resources Consultant 3
- 0.50 FTE Facilities Planner 1
- 1.0 FTE Administrative Assistant 2
- 0.50 FTE Budget Analyst 4
- 1.0 FTE Program Specialist 4

Contracted Costs

Attorney General (AG) Support: HCA anticipates AG support will be necessary to resume provider contracting. HCA anticipates costs of $1.3M per year in preparation of the end of the TPA contract, and $900,000 in the ongoing years.

Actuarial Support: Actuarial support is necessary if HCA were to resume provider contracting work previously completed by the TPA. HCA anticipates costs of $700,000 per year for this additional support.

Project Management: Project Management is necessary if HCA were to implement provider contracting and would need a full-time project manager for implantation plus one year after the transition to coordinate all aspects of the needed resources. It is assumed that HCA would need an additional $500,000 per year for the four years.

Change Management Contractor: Change management drives the successful adoption and usage of change within the business. It allows employees to understand and commit to the shift and work effectively during it. It is assumed that HCA would need $300,000 per year for the implementation period as well as one year after the transition.

Provider Information Management System Development: Update existing ProviderOne system to accommodate provider network management. System supports provider certification, encounter data repository, and reporting needs. HCA anticipates a one-time $4.5M in implementation costs and $960,000 per year in ongoing costs.

Professional Services Contracts: IT Project management support, IT Project Coordinator, and independent external Quality Assurance as required by Office of Chief Information (OCIO) for all oversight projects (>$500,000 or longer than 4 months project duration). HCA anticipates one-time funding of $2 million in implementation costs.

Implementation plan

HCA developed a high-level implementation plan in the event that the Legislature instructs HCA to not extend the current UMP TPA contract, which terminates at the end of 2029 and can be extended through 2036.

The implementation plan assumes commencement of planning activities in early 2024 and includes the development of a strategic plan, project roadmap, and budget request to the Legislature. A key component of this work would require funding for a project manager.

The below implementation plan considers six key elements and phases of administration between 2024, the presumed initiation year, and 2029 the initial term end date of the TPA contract. 2029 is the initial end date of the existing contract, but the contract can be extended through 2036 (an additional seven years). The seven elements include:

1. Planning,
2. technology procurement and implementation,
3. legal support,
4. staff hiring,
5. direct contracting,
6. and internal and external program management.

Planning: The plan accounts for time dedicated to approvals, requests for proposals, and the development and launch of a comprehensive implementation work plan.

Technology procurement and implementation: Technology procurement and implementation would also begin in 2024 and continue through 2029. This process includes hiring a procurement consultant and identifying and contracting for the software and/or cloud-based systems required such as contact management, claims, vendor payment, financial reporting, and human resources (HR). It also includes program design.

Legal support: The implementation plan would require contracts and legal support beginning in early 2024 to ensure time to review any RFP planning and documentation. Between 2025 and 2029, contract development and review will require continued legal consultation. Development of the provider appeals, and grievance process will require legal support beginning in 2027.

Staff hiring: HCA will need to hire new staff to support program design and implementation beginning no later than 2027, with teams continuing to grow through 2029. Appropriate funding for this project would need to pass the Governor's budget in 2025. HCA will need to hire new staff well in advance of the TPA contract end dates. The UMP cost analysis section of this report details staff titles included in the implementation plan.

Direct contracting: Given the competitive provider contract environment in Washington State, if HCA is to perform direct provider contracting added then HCA will need to begin such effort as early as 2025, continuing through plan launch in 2029. This work would be driven by the team hired under the staffing section above.

Internal and external program management: Additional vendors may be required to effectively support contract management including, but not limited to, a program manager.

Conclusion

HCA could assume some UMP administrative services that are currently provided by the UMP TPA contract, however the likely increase in claims costs could far exceed any potential administrative cost savings. Maintaining the current UMP TPA contracted services and the established provider network contracting terms would continue substantial claims savings to the State and reasonable premiums for UMP members.

In order to maximize innovation opportunities and minimize risk and administrative costs, the UMP's administrative services are substantially benefited by being managed through a TPA. The marketplace of third party administrators, has existing infrastructure that allows it to scale with emerging innovations and established partnerships that offer competitive advantages as TPA's can combine commercial plans with UMP, thus providing greater combined purchasing, ensure cost-effective compliance with federal and state insurance regulations around licensure, provider directory, credentialing, and certification requirements. Adding external process flows for foundational components for claims adjudication like contract rates, and terms to a TPA's currently integrated systems create risk that could financially impact claims, utilization management and case management, members, and financial/service performance guarantees.

Using a TPA significantly reduces HCA's exposure to PHI and HIPAA, as well as having to contract with state provider systems and avoids conflicts of interest an employer has to consider.

Unsuccessful negotiations on rates or terms with providers could impact network composition and breath which may impact initiatives such as Multi-Payer Primary Care Transformation (PCTM) and moving the market to more value-based contracting. Given the UMP plans are the only plans available to all active employees, early and Medicare retirees, and has a worldwide network, maintaining broad geographic coverage is necessary.

If HCA did more direct administrative services of UMP, increased costs to the state might be offset as part of broader health policy reform that could make accepting the claims increase an acceptable trade-off. If an overall systemic change was implemented, such as regulatory reforms around provider participation or contracting, it may be acceptable for HCA to leverage new in-house responsibilities to consider how provider contracting incentives and structure could help reinforce new value based purchasing concepts and payment models within the commercial market.

Appendix A: Administrative & Health Transformation Services Contract between Regence BlueShield and the State of Washington State Health Care Authority (HCA Contract #K-1807)

- View the Administrative and Health Transformation Services contract between Regence BlueShield and HCA.

Appendix B: Washington State Health Care Authority Request for Proposal (RFP) No. K1807

- View Washington State Health Care Authority Request for Proposal (RFP) No. K1807

Appendix C: Claims Projection Assumptions: Report by Mercer Health & Benefits LLC

- View Mercer Health & Benefits LLC's Claim Projection Assumption report.

Appendix D: Administrative Fee Assumptions – Report by Mercer Health & Benefits LLC

- View Mercer Health & Benefits LLC's report Administrative Fee Assumptions