1. NCHA is making a formal public records request for the Vendor's report and all supporting documentation used to determine both the current payment rates and the future service rates as a percentage of 2018 Medicare rates referenced in Treasurer Folwell and Dee Jones' October 3, 2018 letter to providers.

   Ok, thank you for letting us know. We look forward to responding.

2. We request a written report outlining the step-by-step approach used to determine the Medicare percentages for inpatient, outpatient, Critical Access inpatient, Critical Access outpatient, and professional for both current service rates and future services rates outlined in the October 3, 2018 letter to providers.

   - Blue Cross NC gathered one year of State Health Plan (Plan) medical claims data for the period of 10/1/2016-09/30/2017 paid through 04/30/2018 by facilities/providers.
   - The claims data set was then evaluated by Optum to acquire 100% Medicare pricing (using 2018 Medicare rates), inclusive of all facility specific factors (i.e. wage index, gme, ime, CAH, DSH, SCH, etc.).
   - Blue Cross NC then calculated the % of Medicare allowable under current BCBS NC contracts paid to each facility/provider.
   - Blue Cross NC then categorized the information as follows:
     - Academic,
     - Community,
     - Tertiary,
     - Critical Access,
     - Professional having subcategories:
       - Independent PCP,
       - System PCP,
       - Specialist,
       - MHSA,
       - Non-Physician
   - Plan staff used the categorized data to analyze minimum, median and maximum levels in the various categories.
   - It became apparent that there was wide variability in the rates that the Plan is paying across the system, even among like-providers.
   - The Plan tried multiple scenarios to determine a reasonable approach based on the medians to approximate a $300 million savings to the Plan. At the same time, the Plan attempted to improve rates for rural providers, independent PCP's and MHSA providers. This premise influenced the %'s for those important provider categories.

3. Please help us better understand the immediate implications as well as the January 1, 2020 implications of the following three options outlined in the Letter of Intent signed by Dale Folwell and Dee Jones:

   Option 1 – Complete Participation interest form with positive response
   Option 2 – Complete Participation interest form with a negative response
   Option 3 – Do not complete the form and submit no response

   a. If a provider indicates they are interested in learning more about participating in the Plan's network, they will receive additional information about their specific rates from Blue Cross NC. The next wave of information will be communicated over the next several months. As this will be either a new contract or an amendment to their current provider contract with Blue Cross NC, providers will have the option to opt in or out.

   b. If providers do not respond or indicate they have no interest in learning more, they may remain in Blue Cross NC's Blue Options network, but effective January 1, 2020, they will be considered non-network for all Plan members and will be reimbursed at the non-network cost-share and reimbursement rate. Any Blue Cross NC non-network payment rules will also apply. Non-network reimbursements are sent to the member, not the provider.

Please outline the action timeline related each of the option described above.

4. CMS has designed the outpatient prospective payment system (OPPS) so that a single payment is made for a bundle of items and services. Each bundle consists of a primary service and ancillary items and services that are packaged with the primary service. In recent years, CMS took substantial steps to expand the size of payment bundles in the OPPS so that the OPPS has fewer primary services (also called "separately payable services") and more packaged items and services. The OPPS is very complex and includes a number of adjustments before final payment is determined. Please confirm that all the required adjustments were made in your vendor's analysis of the Plan's 2017 claims payment data to determine the relationship between current service rates to 2018 Medicare rates, including but not limited to:

   - Wage index adjustment
   - Surgical discounting
   - Packaging items and services into the payment for the associated primary procedure or services. Examples of packaged items/services include:
     - All supplies
     - Ancillary services
     - Anesthesia
     - Operating and recovery room use
     - Clinical diagnostic laboratory tests
     - Procedures described by add-on codes

- Implantable medical devices
- Drugs under a per-day drug threshold packaging amount
- Drugs, biologicals, and radiopharmaceuticals functioning as supplies
- Guidance services
- Image processing services
- Intraoperative services
- Imaging supervision and interpretation services
- Observation services

· Comprehensive ambulatory payment classifications (C–APCs), which (for select services) combine all services (with exceptions) on a claim into a single payment bundle, whether they have separately payable status or packaged status under the OPPS.

· Packaging clinical diagnostic tests covered under the clinical lab fee schedule (CLFS) when provided on the same date as a primary service. Previously, clinical diagnostic tests had always been paid separately under the CLFS. Exceptions include molecular pathology.

· Pay Part B payments for drugs to 340B hospitals/vaccines, purchased through the 340B program at the average sales price (ASP) minus 22.5 percent. Pay hospitals 40% of the OPPS rate for nonexcepted services rendered in an off-campus provider-based department.

Optum performed the repricing of 2017 State Health Plan medical claims, using their Optum EASYGroup pricing software and rate files which account for methodologies (e.g. bundled APCs) and rate adjustments/factors (e.g. rural hospital adjustments, disproportionate share, etc.) as described. Regulatory updates are made in a timely way to EASYGroup and were reflected as of the time the repricing was completed.

4. Please explain whether your vendor included the rural adjustment (currently an increased payment of 7.1 percent) for most services furnished by Sole Community Hospitals, which includes Essential Access Community Hospitals located in rural areas, in the analysis of the Plan's 2017 claims payment data to determine the relationship between current service rates to 2018 Medicare rates.

   Yes, Optum has confirmed that their EASYGroup software accounts for rural hospital adjustments.

5. Please explain how your vendor addressed pass-through payments for specific drugs, biologicals, and devices used in the delivery of services meeting the criteria for pass-through status (these items are generally too new to be well represented in the data used to set payment rates) in the analysis of the Plan's 2017 claims payment data to determine the relationship between current service rates to 2018 Medicare rates.

Our strategy does not include Pharmacy or Durable Medical Equipment. Optum has confirmed that they followed 2018 CMS rules for all of the following:

- CMS provides an additional payment for High Cost Medical Devices, Drugs and Biologicals—CMS provides this payment for a period of 2 to 3 years
- Payment for pass-through device categories, (identified from prior years, as there are no new 2018 pass through devices)
- Drugs reimbursed on APC (APC rate * units)
- Drugs reimbursed on a fee schedule have transitioned to ASP (average sales price) pricing under OPPS
- Drug/Biological pass-through – paid based on Average Sales Price (ASP) fee schedule

6. Please explain how your vendor addressed the following additional amounts and adjustments to the standard IPPS payment rate:

   · Hospital engages in teaching medical residents to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals
   · Hospital treats a disproportionate share of low-income patients
   · Cases that involve certain approved new technologies
   · High-cost outlier cases
   · Adjustments under the Hospital Value Based Program, the Hospital Acquired Conditions Reduction Program, and the Hospital Readmissions Reduction Program

   Optum has confirmed that these adjustments are accounted for in EASYGroup and were taken into account in the repricing.

7. Please define the threshold that will trigger outlier payments beginning January 1, 2020 and how these outlier inpatient cases will be reimbursed.

   Any inpatient outlier (high charge) threshold would be established in the 2020 contracts. At this time, we have not determined what the high charge threshold will be.

8. Critical Access hospitals are paid for most inpatient and outpatient services rendered to Medicare patients at 101 percent of reasonable costs. Please explain, in detail, how the Medicare percentages for Critical Access inpatient and outpatient were calculated. If the interim rates were used as a basis, please explain how the final cost report settlement was incorporated into the assessment.

EASYGroup recognizes Critical Access Hospitals (CAHs) and applies the appropriate methodology, including any adjustments/factors. The attached information contains more detail regarding the components of EASYGroup.

9. Approximately 28.9% of total State Health Plan payments for fiscal year 2017 – 2018 were made to Pharmacies. In addition, the State Health Plan has reported that the percentage increase in PMPM Pharmacy payments from fiscal year 2015 to fiscal year 2018 was 14.4%. This percentage increase was significantly higher than any other payment category. Please explain why the State Health Plan elected to exclude Pharmacies from the new referenced-based pricing model especially since pharmacy payments are having such a profound impact on the Plan's financial results?

The Plan has done a lot of work with our Pharmacy benefit over the last few years including moving to a new Pharmacy Benefit Manager and moving to a closed, custom formulary, therefore the Plan felt attention on the medical benefit should come first.

10. Please confirm that the State Health Plan has engaged a Third Party Administrator with a long history of accurately processing and paying Medicare hospital and professional claims in a timely manner.

The State Health Plan's Third Party Administrator (TPA) has experience administering Medicare-based reimbursement.

11. The Centers for Medicare & Medicaid Services (CMS) has proposed significant changes to the Medicare Physician Fee Schedule and the Outpatient Prospective Payment System through its calendar 2019 proposed rules. Please explain how annual changes finalized by CMS will be incorporated into the proposed payment system.

Initially, the reimbursement rates will be updated on an annual basis using the rates provided by CMS in October. Therefore, the 2020 rates will be based on the Medicare reimbursement rates established in October 2019.

12. CMS makes significant changes to its prospective payment systems annually and throughout the year. Please confirm that these changes will be incorporated into the proposed payment system with effective dates that coincide with CMS's effective dates. Also, please confirm that the timeliness of claim payments will not be delayed while system changes are implemented to incorporate the final changes.

The Plan plans to make the annual updates effective, which is consistent with Blue Cross NC operations today. We do not expect significant delays in claims payment due to these updates.

13. Please describe in details the State Health Plan's Network Adequacy Standards that will ensure the health plan's ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network hospitals, primary care physicians, and specialist physicians without unreasonable travel or delay. Please provide a copy of the Plan's written Network Adequacy Standards that addresses the following: travel time, geographic variation and population dispersion, geographic accessibility of providers, provider-covered person ratios, waiting times for an appointment with participating providers, specialty providers (e.g., critical access hospitals, sole community hospitals, essential community providers, academic medical centers, rural hospitals, cardiologists, radiologist, anesthesiologists, pathologists, orthopedic surgeons, and emergency room physicians)), and specialty services (e.g., cardiology and heart surgery, cancer, spine care, trauma center, special children's care, etc.).

Currently, the Plan follows Access to Care Standards outlined by Blue Cross NC and will continued to do so. The Plan is required to follow the Access to Care Standards outlined here: https://www.bluecrossnc.com/providers/resources/national-committee-quality-assurance-standards/access-care-standards

14. Please share the Plan's allowed amount benchmarks for non-participating facility-based and physician provider payments.

a. Inpatient 125%
b. Outpatient 150%
c. CAH Inpt 150%
d. CAH Outpt 170%
e. Professional 130%

15. Please share how the Plan will notify members that physicians, including hospital based and specialty physicians, have privileges at a participating hospital. How frequently will the Plan's Provider Directory be updated (e.g., real-time, monthly, or some other timeframe (please specify))?

The online provider directory is updated daily from Monday through Friday of each week. The directory listing includes information regarding facilities with which the provider is affiliated.

16. Please describe how the Treasurer's office to address State Health Plan employees that do not honor their provider obligations especially when they receive direct payment for services rendered by an out-of-network provider and are unduly enriched by failing to honor their obligations?

The process will remain the same as it does today, which holds the member responsible for any payments due to their provider.