

OHIC - April 2011
Large and Small Group Rate Factor Review
Survey: Provider Contracting Practices.

Background

The Health Insurance Advisory Council of the Office of the Health Insurance Commissioner has promulgated Affordability Standards for Commercial Health Insurers in Rhode Island:

Health plans will improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care. Achievement of this goal will not add to overall medical spend in the short-term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are as follows:

- 1. Expand and improve the primary care infrastructure in the state -- with limitations on ability to pass on cost in premiums*
- 2. Spread Adoption of the "Chronic Care Model" Medical Home*
- 3. Standardize electronic medical record (EMR) incentives*
- 4. Work toward comprehensive payment reform across the delivery system*

To support standard four, OHIC has issued in connection with its review of 2010 large and small group rate factors six conditions for health insurer contracts with hospitals in Rhode Island, to be implemented by health insurers upon contract execution, renewal or extension (see OHIC's July 2010 Rate Factor Decision – Additional Conditions, for the complete text of the conditions):

1. Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service.
2. Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract
3. Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract by at least additional two percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality or efficiency-based measures.
4. Include terms that define the parties' mutual obligations for greater administrative efficiencies,
5. Include terms that promote and measure improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.

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6. Include terms that explicitly relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement.

The purpose of this survey is to assess the pace and nature of provider payment reform in Rhode Island, given a baseline survey last year and the Advisory Council's Affordability Standards, and to consider the information survey responses in connection with OHIC's 2011 Rate Factor Decision.

Directions:

1. Please fill out all parts of survey.
2. As no providers are identified and no financial details are solicited, none of this information will be considered proprietary or confidential.
3. Any contract excerpts provided will be summarized for review.
4. Please contact the Office of the Health Insurance Commissioner with any questions.

Part 1. Hospital Inpatient Services

- Please fill out one row in the chart below for each general service institution (no specialty care, no rehab) with whom you contract in RI.
- Institution means hospital system if all contractual terms other than \$ amounts apply identically across all inpatient facilities in the contract.
- Incentives refer to activities or measures resulting in additional payments by the insurer.

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)? ³	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2010 Rate Factor Decision - Additional Conditions? ²	Comments
		<input type="checkbox"/> DRG <input type="checkbox"/> Per Diem <input type="checkbox"/> % of Charges <input type="checkbox"/> Bundled Services <input type="checkbox"/> Capitation or other budgeting <input type="checkbox"/> Others (please specify)		If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. ³ _____	<input type="checkbox"/> admission reductions <input type="checkbox"/> day reductions <input type="checkbox"/> process/structural changes (e.g. discharge practices) <input type="checkbox"/> Others (please specify)		

Additional Questions for Hospital Inpatient Services

- List the five most common areas of quality and service incentives in your company's inpatient contracts:
 -
 -
 -
 -
 -
- Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2010 spent on quality incentive payments. _____
- Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2010 paid through units of service based on efficient resource use (i.e DRG, Capitation, Bundled Service or partial/global budgeting): _____
- Estimated Payments in first six months of CY 2010 for Inpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: _____ (add comments or caveats)

Other Comments on Quality/Efficiency Incentives in Hospital Inpatient Contracting:

¹ Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.

² Attach analysis and relevant documentation from contracts to demonstrate compliance status.

³ % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Part 2. Hospital Outpatient Services

- Please fill out one row in the chart below for each general service institution (no specialty care, no rehab) with whom you contract in RI.
- Institution means hospital system if all contractual terms other than dollar amounts apply identically across all inpatient facilities in the contract.
- Outpatient Services include any services not involving an admission and covered under the contract with the institution.

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n) ⁴ ?	Utilization Incentives in Contract: (check all that apply)	Comments
	<input type="checkbox"/> Procedure-based methodology – using plan, provider or industry coding. . <input type="checkbox"/> APC Code <input type="checkbox"/> Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. ⁵	<input type="checkbox"/> Visit/Volume Reduction <input type="checkbox"/> Others (please specify)	

Additional Questions for Hospital Outpatient Services

1. List the five most common areas of quality and service incentives in your company's hospital outpatient contracts:
 - i.
 - ii.
 - iii.
 - iv.
 - v.
2. Percent of total payments to RI Hospitals for outpatient services in CY 2010 spent on quality incentive payments. _____
3. Percent of total payments to RI Hospitals for inpatient services in CY 2010 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): _____
4. Estimated Payments in first six months of CY 2010 for Outpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: _____ (add comments or caveats)

Other Comments on Quality/Efficiency Incentives in Hospital Outpatient Contracting:

⁴ Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.

⁵ % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

Part 3: Professional Groups

- "Professional Groups" is defined as non institutional/non facility groups with a valid contract and a single tax id number.
- Please provide information for the top 10 groups (measured by \$ paid in 2010), filling in one row per group (10 rows in the table total).

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n) ⁶ ?	Utilization Incentives in Contract: (check all that apply)	Comments
		<input type="checkbox"/> Procedure-based methodology – using CPT, plan, provider or other coding. . <input type="checkbox"/> APC Code <input type="checkbox"/> Full/ Partial Capitation <input type="checkbox"/> Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. ⁷ _____	<input type="checkbox"/> Visit/Volume Reduction <input type="checkbox"/> use of ancillary/referred services <input type="checkbox"/> use of diagnostic tests <input type="checkbox"/> over all efficiency of care <input type="checkbox"/> use of pharmacy services <input type="checkbox"/> Others (please specify)	

Additional Questions for Professional Groups

1. List the five most common areas of quality and service incentives in your company's professional group contracts:
 - i.
 - ii.
 - iii.
 - iv.
 - v.
2. Percent of total payments to these ten professional groups in CY 2010 spent on quality incentive payments. _____
3. Percent of total payments to these ten professional groups in CY 2010 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): _____
4. Estimated Payments in first six months of CY 2010 for Professional Group Services as % of what Medicare would have paid for similar set. of services: _____ (add comments or caveats)

Other Comments on Quality/Efficiency Incentives in Professional Group Contracting:

⁶ Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.

⁷ % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.