OFFICE OF THE HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

In re: 2012 Small and Large Group Rate Factor Decision
Docket No. OHIC-2012-RH-2

Notice of Proposed Conditions Relating to the 2012 Rate Factor Decision

Christopher F. Koller, Commissioner, hereby provides Notice that the Commissioner may attach to his decision to approve, disapprove or modify rates filed in the above-captioned matter the Proposed Conditions set forth in Exhibit A, below ("Proposed Conditions").

Interested individuals and organizations may submit comments or other relevant information concerning the Proposed Conditions in writing, either by United States mail with postage pre-paid thereon to the Office of the Health Insurance Commissioner, 1511 Pontiac Ave., Building 69-1, Cranston, RI 02920, attention Patrick M. Tigue, Principal Policy Associate, or by e-mail to Patrick.Tigue@ohic.ri.gov

Comments or other relevant information concerning the Proposed Conditions must be received at the OHIC office no later than the close of business on July 20, 2012.

Introduction

In 2009, at the advice of its Health Insurance Advisory Council, the State of Rhode Island Office of the Health Insurance Commissioner ("OHIC") directed commercial health insurance issuers with significant market shares in the state to comply with a set of four criteria, collectively termed the Affordability Standards, aimed at improving the affordability of health care in Rhode Island. Specifically, the Affordability Standards required issuers to:

1. Expand and improve primary care infrastructure;
2. Spread the adoption of the patient-centered medical home;
3. Standardize electronic medical record incentives; and
4. Work toward comprehensive payment reform across the delivery system

The Affordability Standards went into effect in 2010. To support Standard No. 4, in July 2010 as part of its rate factor decisions OHIC issued six conditions for issuer contracts with hospitals in Rhode Island ("Conditions") to be implemented by issuers upon contract execution, renewal, or extension.

The rationale for the six conditions, and the rationale for the Proposed Conditions (to the extent that the Proposed Conditions remain the same), is set forth in the "Notice of Proposed Conditions Relating to the 2011 Rate Factor Decision" issued by Commissioner Koller on June 10, 2011. Such Notice is incorporated by reference herein.

Since the six Conditions were issued, OHIC has not made significant changes to them. However, OHIC is now interested in using the currently underway 2012 rate factor

review process (for rates effective in 2013) to make changes to the Conditions that will enhance their ability to promote delivery system reform. Below is each Condition in its current form, a brief summary of evidence of compliance and policy effects for each Condition, and any proposed language that would change each Condition (with changes shown in italics).

Proposed Conditions

The Conditions are proposed to be amended as set forth in Exhibit A. Below is each condition in its current form, a brief summary of evidence of compliance and policy effects for each condition, and any proposed language that would change each condition (with additional language shown in italics, and with deletions shown "struck through").

1. **Units of Service:**
   - **Current Form:** 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, e.g. inpatient Diagnosis Related Groupings (DRGs) and outpatient Ambulatory Payment Classifications (APCs) in a form substantially derived from the Centers for Medicare and Medicaid Services (CMS). Nothing in this requirement prevents contract terms that provide additional or stronger payment incentives toward quality and efficiency such as performance bonuses, bundled payments, global payments, or the formation of supporting functions such as Accountable Care Organizations.
   - **Evidence of Compliance and Policy Effects:** Generally, units of service have been moved from per diems to efficiency-based services such as DRGs and APCs. Blue Cross & Blue Shield of Rhode Island (BCBSRI) and United Healthcare (United) have demonstrated compliance with this condition while Tufts Health Plan (Tufts) did not fully meet the condition (although OHIC is sympathetic with the issuer's argument that more volume is necessary to be able to meet the condition).
   - **Proposed Language:** No new language is under consideration at this time.
2. **Rate of Increase:**
   - **Current Form:** Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the CMS National Prospective Payment System Hospital Input Price Index (Index), for all contractual and optional years covered by the contract. The Index applicable to the new contract year will be based on the most recent Hospital 4 Quarter Moving Average Percent Change published and available as of the signing of the contract. For renewal and optional years it will be based on the applicable most recent Index 4 Quarter Moving Average Percent Change period available prior to the new contract year.

- **Evidence of Compliance and Policy Effects:** Generally, price increases have been limited as required. BCBSRI and Tufts have complied with the condition while United met the condition with two hospital contracts but not with a third.
- **Proposed Language:** Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the CMS National Prospective Payment System Hospital Input Price Index (Index), for all contractual and optional years covered by the contract. The Index applicable to the new contract year will be based on the most recent Hospital 4 Quarter Moving Average Percent Change published and available as of the signing of the contract. For renewal and optional years it will be based on the applicable most recent Index 4 Quarter Moving Average Percent Change period available prior to the new contract year. *Upon written request of a carrier, the Commissioner may approve exceptions to the Index limit for those hospital contracts which the carrier demonstrates, to the Commissioner's satisfaction, align significant financial responsibility for the total costs of care for a defined population and set of services in manners generally consistent with the alternative Medicare payment mechanisms proposed under the Affordable Care Act. Carriers are encouraged to file such requests.*

3. Quality Incentives:

- **Current Form:** Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract by at least two additional 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. The measures, performance levels, and payouts must be articulated in the contract.
- **Evidence of Compliance and Policy Effects:** Generally, the use of quality incentives has been increased. However, issuers appear to not have fully worked out the programmatic details related to their quality incentives at the time of contract signing.
- **Proposed Language:** Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract over the previous contract year by improving or attaining mutually agreed-to performance levels for *all or a subset of measures in the CMS Hospital Value-Based Purchasing Program* for Medicare. The measures, performance levels, *payment levels, and payment mechanisms must* be articulated in the contract *and any payments must occur after the measurement period.*

4. Administrative Simplification:

- **Current Form:** Include terms that define the parties' mutual obligations for greater administrative efficiencies, such as improvements in claims and eligibility verification processes, and identify commitments on the part of each. On or before January 1, 2012 each issuer shall file with OHIC, in a format approved by the

Commissioner, a report identifying and describing each hospital or hospital system contract subject to these conditions, the specific and substantive programs or initiatives designed to achieve greater, administrative efficiencies, the benchmarks used to measure progress, the progress achieved by the issuer and the hospital or hospital system during the previous calendar year with respect to each program or initiative, and the planned activities of the issuer and the hospital or hospital system during the succeeding calendar year. The report shall include a demonstration that the hospital or hospital system has had an opportunity to participate in and review the report, and shall include any comments of the hospital or hospital system concerning the report. In the event a contract with a hospital or hospital system is not executed before October 1, 2011, an issuer shall have 90 days from the date the contract is signed to submit a report in accordance with this condition with respect to such contract.

- **Evidence of Compliance and Policy Effects:** Some collaborative efforts to improve administrative simplification have been initiated, however, OHIC has lacked the ability to monitor this condition as robustly as it would prefer thus far. To the extent that it has been able to monitor this condition, OHIC has noted that BCBSRI and Tufts appear to not have fully worked out the programmatic details related to their administrative simplification efforts at the time of contract signing while United has complied with the condition with one contract, partially complied with a second, and failed to comply with a third.
- **Proposed Language:** Include terms that define the parties' mutual obligations for greater administrative efficiencies, such as improvements in claims and eligibility verification processes, and identify commitments on the part of each. On or before January 1, *2013* each issuer shall file with OHIC, in a format approved by the Commissioner, a report identifying and describing each hospital or hospital system contract subject to these conditions, the specific and substantive programs or initiatives designed to achieve greater, administrative efficiencies, the benchmarks used to measure progress, the progress achieved by the issuer and the hospital or hospital system during the previous calendar year with respect to each program or initiative, and the planned activities of the issuer and the hospital or hospital system during the succeeding calendar year. The report shall include a demonstration that the hospital or hospital system has had an opportunity to participate in and review the report, and shall include any comments of the hospital or hospital system concerning the report. In the event a contract with a hospital or hospital system is not executed before October 1, *2012*, an issuer shall have 90 days from the date the contract is signed to submit a report in accordance with this condition with respect to such contract.

5. Care Coordination:

- **Current Form:** 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 using standards developed by Quality Partners of Rhode Island, the Beacon Program of the Rhode Island Quality Institute, or other nationally accepted sources. On or before January 1, 2012 each issuer shall file with OHIC, in a format approved by the Commissioner, a report identifying and describing for each hospital or hospital system contract subject to these conditions, the specific and substantive programs or initiatives designed to achieve improved clinical communications, the benchmarks used to measure progress, the progress achieved by the issuer and the hospital or hospital system during the previous calendar year with respect to each program or initiative, and the planned activities of the issuer and the hospital or hospital system during the succeeding calendar year. The report shall include a demonstration that the hospital or hospital system has had an opportunity to participate in and review the report, and shall include any comments of the hospital or hospital system concerning the report. In the event a contract with a hospital or hospital system is not executed before October 1, 2011, an issuer shall have 90 days from the date the contract is signed to submit a report in accordance with this condition with respect to such contract.

- **Evidence of Compliance and Policy Effects:** Some collaborative efforts to improve care coordination have been initiated. BCBSRI and Tufts appear to not have fully worked out the programmatic details related to their care coordination efforts at the time of contract signing while United has complied with the condition with one contract, partially complied with a second, and failed to comply with a third.
- **Proposed Changes:** ~~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 using standards developed by Quality Partners of Rhode Island, the Beacon Program of the Rhode Island Quality Institute, or other nationally accepted sources. On or before January 1, 2012 each issuer shall file with OHIC, in a format approved by the Commissioner, a report identifying and describing for each hospital or hospital system contract subject to these conditions, the specific and substantive programs or initiatives designed to achieve improved clinical communications, the benchmarks used to measure progress, the progress achieved by the issuer and the hospital or hospital system during the previous calendar year with respect to each program or initiative, and the planned activities of the issuer and the hospital or hospital system during the succeeding calendar year. The report shall include a demonstration that the hospital or hospital system has had an opportunity to participate in and review the report, and shall include any comments of the hospital or hospital system concerning the report.~~ *Include terms that require the hospital to measure and self-report to the designated Medicare Quality Improvement Organization (QIO) in a format determined by the Medicare QIO its performance for the following nine best practices that have been documented to lead to improved quality of inpatient discharges and transitions of care: (1) notify primary care physician (PCP) about hospital utilization, (2)*

provide receiving clinicians with hospital clinician's contact information upon discharge, (3) provide patient with effective education prior to discharge, (4) provide patient with written discharge instructions prior to discharge, (5) provide patient with follow-up phone number prior to discharge, (6) perform medication reconciliation prior to discharge, (7) schedule patient outpatient follow-up appointment prior to discharge, (8) provide PCP with summary clinical information at discharge, and (9) invite PCP to participate in end-of-life discussions during hospital visit. ~~In the event a contract with a hospital or hospital system is not executed before October 1, *2012*, an issuer shall have 90 days from the date the contract is signed to submit a report in accordance with this condition with respect to such contract.~~

6. Transparency:

- **Current Form:** Include terms that 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; provided that the issuer or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying confidentiality.
- **Evidence of Compliance and Policy Effects:** Transparency and accountability for contracting activity were significantly increased. All three issuers have complied with the condition.
- **Proposed Changes:** Include terms that 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; provided that the issuer or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying confidentiality. *Any contractual language forbidding the disclosure of contractual or payment information shall have: (1) a specific exemption for information shared to or by providers in shared risk arrangements similar to those described in condition one who seek such information for the purposes of improved care coordination and (2) an affirmative obligation of the issuer to provide such information to those providers when requested.*

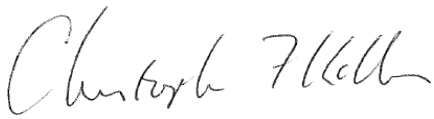
Process

In connection with OHIC's ongoing review of small group and large group rates, the Commissioner intends to condition any approval of a carrier's rate factors, with or without administrative hearing, upon the carrier's execution of a consent to the Proposed Conditions, and a resubmission of a SERFF filing that reflects an executed consent to the Proposed Conditions.

During last year's rate review, carriers have sought clarification from the Office concerning how the Office would review a carrier's failure to comply with one or more

terms of the Conditions. The Office understands that such failure to comply may arise from circumstances beyond the carrier's control; for example, the refusal of a Rhode Island hospital to agree with one or more contractual terms required by the Conditions. In those or similar circumstances the Commissioner will determine what consequences, if any, should be imposed on the carrier, after providing the carrier with an opportunity to demonstrate that it has been unable to comply, notwithstanding the good faith, diligent and rigorous efforts of the carrier, and after consideration of all other relevant circumstances including impacts on policyholders.

Dated at Cranston, Rhode Island, this 29th day of June, 2012.



Christopher F. Koller, Commissioner

Exhibit A
Office of the Health Insurance Commissioner
State of Rhode Island and Providence Plantations

In re 2012 Rate Factor Review	**)**	
[carrier name] SERFF Tr Num: [ ]	**)**	**RH 2012-2**

Exhibit A - Rate Approval Conditions

For all health plan contracts between hospitals licensed in Rhode Island and [carrier name] which expire between now and July 1, 2013, or which would expire but for the amendment or renewal of the contract, subsequent contracts for commercially-insured enrollment shall include the following terms. The Commissioner, upon petition by [carrier name] for good cause shown, or in his or her discretion as necessary to carry out the purpose of the laws and regulations administered by the Office, may modify or waive one or more of the requirements of these Conditions. Nothing in these Conditions is intended to require that [carrier name] must contract with all hospitals licensed in Rhode Island. Consistent with statutes enforced by the Department of Health, health insurers must demonstrate the adequacy of their hospital network. Such health plan contracts shall:

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, e.g. inpatient Diagnosis Related Groupings (DRGs) and outpatient Ambulatory Payment Classifications (APCs) in a form substantially derived from CMS. Nothing in this requirement prevents contract terms that provide additional or stronger payment incentives toward quality and efficiency such as performance bonuses, bundled payments, global payments or the formation of supporting functions such as Accountable Care Organizations.

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.[1] The Index applicable to the new contract year will be based on the most recent Hospital 4 Quarter Moving Average Percent Change published and available as of the signing of the contract. For renewal and optional years it will be based on the applicable most recent Index 4 Quarter Moving Average Percent Change period available prior to the new contract year. Upon written request of a carrier, the Commissioner may approve exceptions to the Index limit for those hospital contracts which the carrier demonstrates, to the Commissioner's satisfaction, align significant financial responsibility for the total

[1] Available at https://www.cms.gov/MedicareProgramRatesStats/downloads/mktbskt-pps-hospital-2006.pdf

costs of care for a defined population and set of services in manners generally consistent with the alternative Medicare payment mechanisms proposed under the Affordable Care Act. Carriers are encouraged to file such requests.

3. Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract by at least two (2) additional 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. The measures, performance levels and payouts must be articulated in the contract.

4. Include terms that define the parties' mutual obligations for greater administrative efficiencies, such as improvements in claims and eligibility verification processes, and identify commitments on the part of each. On or before January 1, 2012 [carrier name] shall file with OHIC a report approved by the Commissioner identifying and describing for each hospital or hospital system the specific programs or initiatives designed to achieve greater administrative efficiencies, the benchmarks used to measure progress, the progress achieved by the carrier and the hospital or hospital system during the previous calendar year with respect to each program or initiative, and the planned activities of the carrier and the hospital or hospital system during the succeeding calendar year. The report shall include a demonstration that the hospital or hospital system has had an opportunity to participate in and review the report, and shall include any comments of the hospital or hospital system concerning the report.

5. Include terms that require the hospital to measure and self-report to the designated Medicare Quality Improvement Organization (QIO) in a format determined by the Medicare QIO its performance for the following nine best practices that have been documented to lead to improved quality of inpatient discharges and transitions of care: (1) notify primary care physician (PCP) about hospital utilization, (2) provide receiving clinicians with hospital clinician's contact information upon discharge, (3) provide patient with effective education prior to discharge, (4) provide patient with written discharge instructions prior to discharge, (5) provide patient with follow-up phone number prior to discharge, (6) perform medication reconciliation prior to discharge, (7) schedule patient outpatient follow-up appointment prior to discharge, (8) provide PCP with summary clinical information at discharge, and (9) invite PCP to participate in end-of-life discussions during hospital visit.

6. Include terms that 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; provided that the carrier or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying confidentiality. Any contractual language forbidding the disclosure of contractual or payment information shall have: (1) a specific exemption for information shared to or by providers in shared

risk arrangements similar to those described in condition one who seek such information for the purposes of improved care coordination and (2) an affirmative obligation of the issuer to provide such information to those providers when requested.

Consent of [carrier name]

I. [Carrier name] hereby admits the jurisdiction of the Rhode Island Office of the Health Insurance Commissioner ("OHIC") over the subject matter of this Exhibit A – Rate Approval Conditions ("Conditions"), as set forth above, and admits that the Commissioner retains jurisdiction over this matter for purposes of monitoring and enforcing these Conditions.

II. [Carrier name] knowingly, voluntarily and unconditionally waives any and all rights to a hearing before OHIC in connection with these Conditions, and to all other procedures otherwise available under the law with respect to the filing and imposition of these Conditions. [Carrier name] acknowledges that, upon the filing of these Conditions with OHIC, and upon approval by the Commissioner of the modified rates incorporated into this filing, these Conditions constitute valid obligations of [carrier name], legally enforceable by the Commissioner.

III. [Carrier name] knowingly, voluntarily and unconditionally waives any right it may have to judicial or administrative review by way of suit, appeal, or extraordinary remedy resulting from the filing of these Conditions; provided, however, the [carrier name] shall have a right to a hearing on any charge or allegation brought by OHIC that the [carrier name] failed to adhere to, or violated any of the requirements of these Conditions , and the Company shall have the right to appeal any adverse determination resulting from such charge or allegation.

IV. [Carrier name] acknowledges and agrees that it consents to the legal obligations imposed by these Conditions, and that it does so knowingly, voluntarily and unconditionally, and that no promise was made, nor was any coercion used, to induce the [carrier name] to give such consent.

By: _____ Date: _____

Title: [ ]