

500 Exchange Street, Providence, Rhode Island 02903-2699
(401) 459-1000 www.BCBSRI.com

July 19, 2012

Commissioner Christopher F. Koller
Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Bldg. 69-1
Cranston, RI 02920

RE: Notice of Proposed Conditions Relating to the 2012 Rate Factor Decision

Dear Commissioner:

This letter responds to the Notice of Proposed Conditions Relating to the 2012 Rate Factor Decision issued on July 12, 2012. Blue Cross & Blue Shield of Rhode Island (“BCBSRI”) has supported the hospital contracting conditions since their initial adoption in July 2010. As we have often discussed, the conditions have advanced the critical goals of affordability, quality, and accountability within the context of payer and hospital contractual relationships. In fact, the Conditions have accelerated the rate at which these critical changes have been implemented.

As I commented in my May 21, 2012 letter, however, while the conditions have been an incredibly effective tool in our negotiations with hospitals the timing of renewal of each hospital contract has not allowed for all of our hospital contracts to conform to the conditions. Over the next year we will renegotiate our contracts with the majority of hospitals in Rhode Island and, in doing so, our contracts will be in compliance with the current conditions no later than January 1, 2014.

I share your goal of moving forward with delivery system and payment reform as quickly as possible, but we must be mindful not to push hospitals “off a cliff.” These changes will take time, and it is important to move as quickly as possible while ensuring financial stability and a high quality of care. While the proposed conditions may be an appropriate next step for some hospitals, they may push too far too fast for those who are not yet operating under the current conditions. As a result, I urge that we adopt a moderated approach that would set the standard for hospital contracts that do not yet incorporate the current conditions and that are entered into prior to December 31, 2013 to be subject to the existing Conditions while contracts that already incorporate the conditions adopted in 2010 and 2011 would be subject to the proposed conditions (subject to the further comments below). We will be happy to work with you to draft language that would accomplish this.

BCSBRI believes that the effectiveness of the conditions is wholly dependent upon the uniform enforcement of the Conditions across all carriers and hospitals in Rhode Island. Overall, the

proposed changes seem to adopt both more flexibility and more standardization. For example, the modifications to Condition 2 encourage variations from the CMS price index while the modifications to Condition 3 adopt exclusively the CMS hospital value-based purchasing program to the exclusion of other national standards and programs. On the one-hand carriers and hospitals are encouraged to be innovative while on the other, carriers and hospitals are tied exclusively to pre-determined quality standards.

BCBSRI's specific comments are as follows:

Condition 2: While we support the ability of carriers and hospitals to increase base reimbursement in cases where alternative payment mechanisms are adopted, we are concerned with the how the exception process, as proposed, would operate. We would anticipate that hospitals would demand that exceptions be sought and that this would insert the Commissioner into negotiations that are private and likely to be politically charged. We believe it is best to allow limited flexibility, in the discretion of the carrier, without involving the Commissioner in such negotiations. In the event the Commissioner seeks to limit these increases, we suggest that the carrier be required to provide justification to the Commissioner beyond a narrowly defined corridor of increase.

We suggest that proposed Condition 2 be modified to read (BCBSRI changes are marked with strikethrough and underline):

"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 Carriers shall have the discretion to exceed 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. Should the Index limit be exceeded by more than an additional two percentage points, Carrier shall disclose the justification for the amount beyond the additional two percentage points to the Commissioner. ~~Carriers are encouraged to file such requests."~~

Condition 3: BCBSRI's hospital quality program is not limited to those standards contained in the CMS Hospital Value-Based Purchasing Program for Medicare. Our program includes other nationally recognized standards which, we believe, are necessary and appropriate

to ensure high quality care. More importantly, for the larger hospitals and/or hospital systems, we wish to reserve the right to innovate, creating mutually agreed upon clinical quality improvement programs that may have no precedent nationally. In addition, given the significant and appropriate shift in reimbursement away from fee for service toward quality based reimbursement, it is important that payments be allowed to be made on an interim basis with an annual settlement after the measurement period. Otherwise, we risk that hospitals will not be able to make the investments necessary to implement the necessary quality programs. If measures are not met, then the hospital would reimburse the carrier at the end of the settlement period.

We suggest that proposed Condition 3 be modified to read (BCBSRI changes are marked with strikethrough and underline):

“Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract over the previous contract year by agreeing to improving or attaining mutually agreed-to performance levels for all measures in the CMS Hospital Value-Based Purchasing Program for Medicare, plus one or more of the following

- 1) other nationally accepted clinical quality, service quality, or efficiency-based measures
- 2) mutually agreed upon metrics of clinical quality that may have no clear precedent nationally
- 3) mutually agreed upon clinical quality improvement activities that support new models of care coordination.

The measures, performance levels, payment levels, and payment mechanisms must be articulated in the contract, and any Carrier may make interim payments in the event that interim measures of performance have been met, provided that a final settlement must occur after the measurement period, after which if the annual measures, performance levels have not been met the hospital(s) shall be required to remit payment back to the carrier.”

Condition 5: We are generally supportive of the proposed changes to Condition 5. As you know, BCBSRI has adopted standards for the quality of inpatient discharges and transitions of care in its standard hospital quality contract. We request clarification that, by including that the hospital must measure and report the nine best practices on quality of inpatient discharges and transitions of care, that the carriers are not limited in any way from requiring that certain standards in each of the nine areas be met (as opposed to just measured and reported). Further, we do not read the proposed language as limiting the ability of a carrier from adopting other standards in relation to quality of other services.

Condition 6: Again, we are generally supportive of the proposed changes to this condition. In fact, we encourage the condition to be written more broadly so as to allow carriers to make this information available to consumers.

We suggest that proposed Condition 6 be modified to read (BCBSRI changes are marked with strikethrough and underline):

“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 support of innovative provider payment arrangements ~~and~~ (2) an affirmative obligation of the issuer to provide such information to those providers when requested; and (3) a specific exemption for information shared with consumers.”

Consent: As was the case last year, it is anticipated that the carriers will be required to execute a consent to the conditions. It is unclear whether Exhibit A as attached to the Notice of Proposed Conditions is the form that each carrier is expected to execute. As you may recall, in 2011, BCBSRI raised significant concerns regarding the consent and the final language was negotiated to the agreement of both the OHIC and BCBSRI. All carriers signed that consent. While BCBSRI will sign a consent that is the same as the one executed in 2011, we are unable to agree to the consent contained in Exhibit A to the Notice of Proposed Conditions. I will be happy to have Monica Neronha provide acceptable language to Mr. Olson at the appropriate time.

Process: The last paragraph of the Notice of Proposed Conditions requires additional clarification. While we appreciate the understanding of the Commissioner that contract negotiations are protracted and difficult, the exception that appears to be contemplated in this paragraph appears to swallow the rule. We believe that all hospital contracts should be required to comply with the conditions. Instead, it may be true that in its application, despite the best efforts of the hospital and the carrier, a delay in implementation of a particular provision may occur. In such a case, the good faith and diligent efforts of the parties should be considered to meet the requirements of the conditions.

I want to thank you for issuing the Notice of Proposed Conditions and accepting public comment on this important topic. As you know, I am personally committed to transforming the delivery system in Rhode Island. BCBSRI is proud of the leadership role it has taken, and will continue to take, in this area.

Commissioner Koller
July 19, 2012
Page 5 of 5

If you have any questions regarding these comments, please do not hesitate to contact Monica Neronha or Gus Manocchia.

Be well.



Peter Andruszkiewicz
President & Chief Executive Officer

cc: Patrick Tigue, Principal Policy Associate, OHIC
Dr. Augustine Manocchia
Monica Neronha

Patrick Tigie - Comments on 2013 Hospital Contracting Conditions

From: <Patrick.Ross@tufts-health.com>
To: "Patrick Tigie" <patrick.tigie@ohic.ri.gov>
Date: 7/20/2012 1:32 PM
Subject: Comments on 2013 Hospital Contracting Conditions

Below please find comments regarding the Office of the Health Insurance Commissioner's (OHIC's) proposed Conditions for Hospital Contracting for 2013. Please let me know if you have any questions. Thank you.

1. Units of Service

- While Tufts Health Plan has made progress on this measure for 2012, with one provider transitioning to DRG-based reimbursement, it continues to be difficult to move hospital contracts to alternative payment models, given our small membership in the state.

2. Rate of Increase

- Tufts Health Plan is concerned that the proposed language signals to providers that unit cost increases do not need to be at or below inflation if the provider is willing to engage in a risk-based arrangement. Tufts Health Plan believes that risk-based contracts must be paired with reasonable rates of increase and must provide value to our members and employer customers.

3. Quality Incentives

- While Tufts Health Plan appreciates the removal of the requirement that providers have the opportunity to earn at least 2% related to quality, the condition still implies quality payment will be in addition to a hospital's contractual rate of increase at the CMS Index. As a result, it sets the expectation that rate increases may be far in excess of inflation.
- Tufts Health plan also has concerns that "efficiency-based measures" were eliminated from the Condition.

4. Administrative Simplification

- Tufts Health Plan would appreciate additional examples of and targets for administrative efficiencies. The proposed process documentation, benchmarking and reporting will create administrative burden and cost for Tufts Health Plan that may be far greater than the value of the anticipated administrative simplification achieved by providers. Additionally, we question the value of requiring this reporting off-cycle. For Tufts Health Plan, contracts subject to these conditions would be effective on January 1, 2013. If the time frame for submitting these report remains 90 days, this does not allow sufficient time for meaningful progress to be made on these measures prior to the date set for reporting.

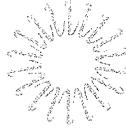
5. Care Coordination

- Tufts Health Plan appreciates the proposed language which clearly articulates expectations. The terms proposed are consistent with language we have used in our provider contracts.

6. Transparency

- No comment

Confidential and Proprietary: This email message and any attached files contain information intended for the exclusive use of the individual



Lifespan

July 20, 2012

Mr. Christopher F. Koller
Health Insurance Commissioner
Office of the Health Insurance Commissioner
1511 Pontiac Avenue
Building 69-1
Cranston, RI 02920

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

External Affairs

The Coro Building
167 Point Street
Providence, RI 02903

Tel 401 444-3720
Fax 401 444-2201
Email mmontella@lifespan.org

Mark Montella
Senior Vice President

Dear Commissioner Koller:

Thank you for the opportunity to submit the following comments regarding the Health Insurance Commissioner's ("OHIC") Notice of Proposed Conditions Relating to the 2012 Rate Factor Decision.

Regarding the proposed changes to the Conditions we respectfully submit the following comments:

Rate of Increase: We support the Commissioner's encouragement for carriers and providers to move toward payment relationships that will align fiscal responsibility for the cost of care for populations. However, we believe creating incentives to encourage this alignment would be more helpful than a process that simply approves limited exceptions, yet should the limited exception model prevail, any exceptions should be publicly reported in detail. Additionally, we have concerns that current efforts underway to meet these goals may be inadvertently affected by future decisions made by OHIC.

Quality Incentives: We support providing the opportunity for hospitals to be paid for mutually agreed upon quality metrics and to have the measures, performance levels, and payouts articulated in contracts. However, we are concerned that the proposed language to have payments made after the measurement period would in certain cases add administrative complexity and negatively impact the cash flow to hospitals.

Transparency: We support providing appropriate information to consumers to make informed decisions about the care they are purchasing but we disagree with the proposal outlined in this condition. We are deeply concerned with OHIC's interference on private parties engaging in commerce and have confidence the parties are capable of individually negotiating risk arrangements, including which contract terms will be shared within those arrangements.

Lifespan is committed to providing high quality, efficient care to all Rhode Islanders. We thank you for the opportunity to provide comments regarding OHIC's Notice of Proposed Conditions Relating to the 2012 Rate Factor Decision.

Sincerely,

Mark Montella
Senior Vice President