

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

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

**Exhibit A - Rate Approval Conditions**

For all health plan contracts between hospitals licensed in Rhode Island and [issuer 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 [issuer 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 [issuer 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.<sup>1</sup> 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 an issuer, supported by the hospital's written agreement with the issuer's request, the Commissioner may approve exceptions to the Index limit for those hospital contracts which the issuer 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. Issuers 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 over the previous contract year by attaining mutually agreed-to performance levels for all or a subset of measures in the CMS Hospital Value-Based Purchasing Program for Medicare. An issuer's quality incentive program may also include one or more of the following: (i) other nationally accepted clinical quality, service quality, or efficiency-based measures; (ii) mutually agreed upon metrics of clinical quality that may have no clear precedent nationally, and (iii) 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. A

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<sup>1</sup> Available at <https://www.cms.gov/MedicareProgramRatesStats/downloads/mktbskt-pps-hospital-2006.pdf>

issuer may make interim payments in the event that interim measures of performance have been met; provided that the interim payments must be commensurate with the achievement of the interim measures; and provided further that a final settlement may only occur after the measurement period; and provided further that if the annual measures of performance have not been achieved, the hospital shall be required to remit interim payments back to the issuer.

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, 2013 [issuer name] 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 pursuant to Para. A, above, 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, [issuer name] 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. Include terms that require the hospital to measure and self-report to the designated Medicare Quality Improvement Organization (QIO) in a format and on a schedule 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 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: (i) a specific exemption for payment information shared to or by providers in shared risk arrangements similar to those described in Condition No. 1, above, who seek such information for the purposes of improved care coordination, or support for innovative provider payment arrangements and (ii) an affirmative obligation of the issuer to provide such payment information to those providers when requested.

#### **Consent of [issuer name]**

I. Upon the filing of these Conditions with OHIC, and the approval by the Commissioner of the modified rates incorporated into this filing, [issuer name] understands and agrees that these Conditions constitute valid obligations of [issuer name], legally enforceable by the Commissioner.

II. [Issuer name] waives its rights to an administrative hearing with respect to the above-referenced 2012 Rate Factor filing and with respect to the enforceability of these Conditions; provided,

however, the [issuer name] shall have a right to a hearing on any charge or allegation brought by OHIC that the [issuer name] failed to adhere to, or violated any of the requirements of these Conditions, and the [issuer name] shall have the right to appeal any adverse determination resulting from such charge or allegation.

III. [Issuer name] waives its right to judicial review with respect to the above-referenced 2012 Rate Factor filing and with respect to the enforceability of these Conditions; provided, however, the [issuer name] shall have a right to a hearing on any charge or allegation brought by OHIC that the [issuer name] failed to adhere to, or violated any of the requirements of these Conditions, and the [issuer name] shall have the right to appeal any adverse determination resulting from such charge or allegation.

IV. [Issuer name] acknowledges and agrees that it consents to the legal obligations imposed by these Conditions, and that it does so knowingly, voluntarily and unconditionally.

By: \_\_\_\_\_ Date: \_\_\_\_\_

Title: [ \_\_\_\_\_ ]