Attachment D – CHIRP Preprint

19d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract.

The CHIRP will include two rate increase components: UHRIP and ACIA. The total value of the UHRIP component will be equal to a percentage of the estimated Medicare gap on a per-class basis. Allocation of funds across hospital classes will be proportional to the combined Medicare gap of each hospital class within an SDA to the total Medicare gap of all hospital classes within the SDA. The total value of the ACIA component will be equal to a percentage of the Average Commercial Rate (ACR) gap, less payments received under UHRIP. The ACIA rate increase percentage is calculated separately for inpatient and outpatient services at the individual hospital level and capped at 90% of the SDA/class aggregate ACR. Allocation of funds across hospitals will be a uniform percentage of each participating hospital's individually calculated ACR gap.

The total value of the UHRIP component means the total estimated payments for UHRIP. The total dollars in the UHRIP component are equal to a percentage of the Medicare UPL gap not to exceed 100%. This percentage is determined at an SDA and class level. The Medicare gap is calculated separately for inpatient and outpatient services and is aggregated by SDA and class. For example: if the inpatient Medicare gap for a class and SDA totaled $1 million and the percentage of the Medicare gap was set to 100%, the total inpatient UHRIP value would be set to $1 million. If the class and SDA had $5 million in estimated inpatient encounters, the inpatient rate would be 20% ($1 million divided by $5 million). The intention of the state is to ensure that UHRIP incentivizes providers to advance certain quality goals and objectives by increasing payments to approximately what Medicare would have paid on the same encounters, aggregated for the class in the SDA.