



A nonprofit corporation and independent licensee
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Home Health Care Provider Class Plan Detailed Report 2005-2006

EXECUTIVE SUMMARY

Goal Achievement

BCBSM met the access and quality of care goals during the reporting period. Although the cost goal for the home health care provider class was not independently met, there is competent, material and substantial information to support a determination that the failure to achieve the goal was reasonable in accordance with Section 510(1)(b) of PA 350.

Cost Performance

The two-year average percent change in payments per 1000 members increased 7.3 percent during the reporting period, exceeding the PA 350 cost goal of 5.3 percent. The increase in payments was primarily due to an average increase in utilization of 6.7 percent. Payment per claim also had a slight increase of an average of 0.6 percent during the reporting period. There were a number of factors that influenced home health care costs. The major factors were:

- ◆ Patients received more services per person as compared to prior years, even though membership decreased during this reporting period. This increased utilization of home health care resulted from the recent trend of moving care to less expensive settings. Inpatient hospital lengths of stay have decreased, often necessitating follow-up care in the home. In addition, many procedures that used to be performed on an inpatient basis have been moved to the outpatient hospital setting. These patients also may require home care after a procedure.
- ◆ A majority of the costs were attributable to members aged 45-54. These members are more apt to suffer from chronic conditions, injuries and disabilities that require medical treatment. The demand for services in this age group will continue to rise as they age.
- ◆ High utilization in the musculoskeletal system and nervous system major diagnostic codes accounted for a significant portion of the cost increase.
- ◆ Top diagnoses included the care following surgical procedures, with many being orthopedic procedures. Patients with chronic disease were also frequent users of home health care services.

Access Performance

There was a 65 percent formal participation rate of home health care providers throughout the state to ensure the availability of home health care services to each BCBSM member. In addition there were 54 branch locations that members could use for home health services. The major factors affecting access performance during this reporting period included:

- ◆ Effective communications with home health care providers, such as BCBSM publications, on-line assistant tools, and provider consultants helped maintain a strong working relationship with home health care providers.

- ◆ BCBSM's reimbursement methodology, which is outlined in the provider manual and participation agreement, provided home health care providers with equitable income to provide services to our members.

Quality of Care Performance

BCBSM ensured that home health care providers met and abided by reasonable standards of health care quality. Major factors affecting quality of care performance during this reporting period included:

- ◆ Qualification standards required for participation ensured that providers had the appropriate certification, accreditation, policies and programs in place to ensure quality care to BCBSM members.
- ◆ Quality controls implemented through a variety of utilization management requirements such as physician referrals and homebound policy, audits that helped enforce that only medically necessary services were rendered and termination criteria.
- ◆ Quality management initiatives, including programs promoting safety, improving community health and ensuring delivery of high quality health care.
- ◆ Effective provider relations through the liaison committee meetings and a formal appeals process ensuring quality communication with home health care providers.

PLAN OVERVIEW

Providers

Freestanding and hospital-based facilities

Qualifications

Current Medicare certification as a home health care provider or accreditation by the Community Health Accreditation Program, Inc. or the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Commission for Health Care.

Other requirements are detailed in the Home Health Care Provider Class Plan.

Participation Status

Formal basis only

Covered Services

BCBSM reimburses for one or more of the following services when provided by a participating home health care provider to maximize the health, independence, dignity and comfort of the patient in accordance with member certificates:

- ◆ Skilled nursing care
- ◆ Physical therapy
- ◆ Occupational therapy
- ◆ Speech and language pathology
- ◆ Nutritional assessment and counseling
- ◆ Social services
- ◆ Home health aide services

Reimbursement

Hospital-Based Home Health Care Providers

Reimbursement is determined by the parent hospital's peer group assignment as defined in Exhibit B of the Participating Hospital Agreement (PHA). Peer group assignment is a grouping of hospitals that share similar characteristics such as bed capacity, location, graduate teaching characteristics and specialty type. A home health care provider that is owned and operated by a peer group 1-4 (large, teaching or does not fall in peer group 5 hospital), 6 (psychiatric hospital) or 7 (rehabilitation hospital) is reimbursed for covered services based on a prospectively established hospital-specific cost-to-charge ratio for home health care services, less member copayments and deductibles. This cost-to-charge ratio is established and updated in accordance with the policies explained in the PHA.

A home health care provider that is owned and operated by a peer group 5 rural hospital is reimbursed for covered services at the same level established for that hospital's acute care services in accordance with Exhibit B of the PHA, less applicable copayments and deductibles.

Freestanding Home Health Care Providers

Covered services are reimbursed at the lesser of the allowable costs or provider's billed charges, less member deductibles or copayments. An interim percentage of charge payment rate is initially determined for each facility based on information submitted to BCBSM when the home health care provider applies for participation. Thereafter, the provider's interim percentage of charge payment rate may be adjusted to reflect retrospective settlement following BCBSM's audit or review of the facility's annual Home Health Cost Report

Final payment settlement is limited to the lesser of allowable costs, as determined by BCBSM, or billed charges for covered services.

Benefit Issues

The number of home care visits available to members is dependent on benefit limitations. For home health care to be considered a covered benefit, the following must apply:

- ◆ Home health care services are provided as an alternative to facility care
- ◆ Services are provided for conditions with a chance of substantial improvement to the degree that home health care is no longer required
- ◆ Skilled care must be required for home health services to be considered a benefit
- ◆ Members must be considered homebound to receive services
- ◆ The services are intermittent, medically necessary and appropriate
- ◆ Home health care services must also be prescribed by a physician and must have a detailed treatment plan
- ◆ Services must be provided by a participating facility

Plan Updates

The Home Health Care Provider Class Plan was updated in April 2006 to reflect the fact that social workers are licensed with the state of Michigan, not registered.

PA 350 of 1980

EXTERNAL INFLUENCES

Market Share

Table 1 illustrates BCBSM's commercial (private) market share for members with home health care benefits. As shown, BCBSM's share of the commercial market in Michigan decreased slightly in each region except region 2 and region 4 between 2006 and 2005. Total market share in Michigan decreased from 36.7 percent in 2005 to 35.3 percent in 2006. The loss in BCBSM membership is due to the combination of corporate downsizing by BCBSM customers and loss of groups to competitors.

Table 1
Home Health Care Provider
BCBSM Share of Michigan Market

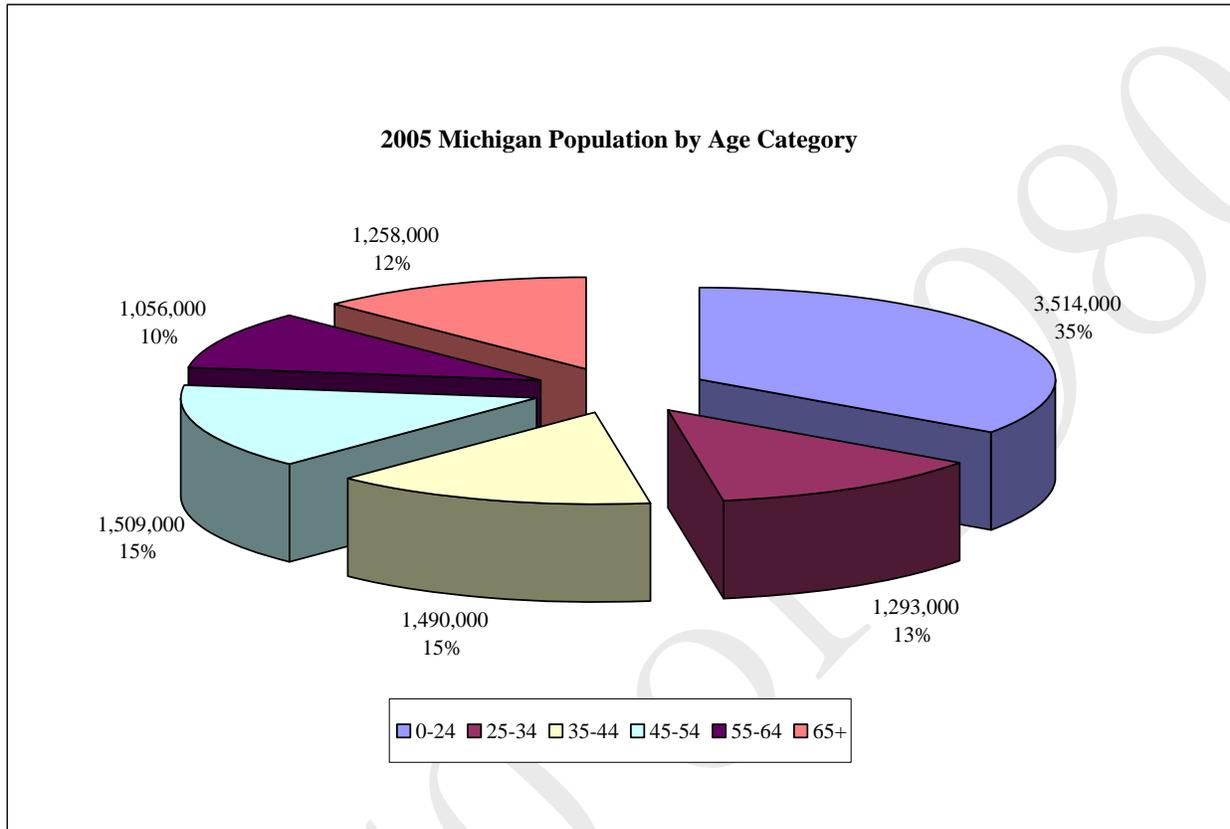
Region	2006			2005		
	Michigan Population*	BCBSM Home Health Members	Market Share	Michigan Population*	BCBSM Home Health Members	Market Share
1	3,185,649	1,123,934	35.3%	3,150,264	1,138,068	36.1%
2	524,273	141,671	27.0%	516,193	138,063	26.7%
3	452,036	196,984	43.6%	450,618	200,579	44.5%
4	376,840	204,823	54.4%	375,916	202,519	53.9%
5	791,283	236,741	29.9%	770,569	235,320	30.5%
6	1,048,234	276,972	26.4%	1,021,815	278,708	27.3%
7	473,316	222,060	46.9%	467,616	225,108	48.1%
8	341,938	159,518	46.7%	327,006	163,260	49.9%
9	181,436	81,424	44.9%	172,403	82,647	47.9%
Statewide	7,375,005	2,644,127	35.9%	7,252,401	2,664,271	36.7%

* Excludes Medicare and Medicaid recipients

Demographics

Changing trends in the statistical characteristics of a population may significantly affect that population's consumption of health care resources. The aging population also has a high correlation to health care use rates. Michigan residents aged 45-64 years comprised 25.3 percent of the state's overall population compared to 24.5 percent for the same age group in the United States. Michigan's median age of 36.8 is slightly higher than the national median age of 36.2. Chart 1 provides a distribution of Michigan's population in 2005 by age group.

Chart 1
2005 Michigan Population by Age Category



Epidemiological Factors

Home health care services are rendered in the home to an individual who is confined to the home. Such services are provided to individuals who do not need institutional care, but who need nursing services or therapy.

Home health care often follows an inpatient hospital admission, but can also occur after a skilled nursing facility admission or be referred by a physician. Hospitals are motivated to discharge patients sooner, so they send patients who still need some care home with a referral for the follow-up care to occur at home. Cost-conscious physicians also may refer patients for home care after an office visit instead of directing them to a hospital when the necessary care can be performed safely in a home setting.

An example of a physician-referral situation that would save a costly inpatient admission is a bed-ridden multiple sclerosis patient develops a urinary tract infection that requires IV antibiotics and a catheter. The physician could admit the patient to a hospital for a few days, with follow-up home care to complete the course of antibiotics. Or, the physician could refer the patient directly to home health care for several daily visits, costing much less than the hospital admission.

Medical advances such as the Vacuum Assisted Closure Therapy System have enabled patient care to continue safely in a home environment instead of a more costly setting. The V.A.C. System results in economic value and improved clinical outcomes for a variety of chronic and acute wound types, such as pressure ulcers, diabetic wounds, abdominal wounds, partial-thickness burns, trauma wounds, flaps and grafts. The V.A.C. System involves packing the wound with a foam dressing, applying an adhesive drape and attaching a suction device. Healing time is reduced by a considerable amount and can allow a patient with a severe wound to go home directly from an inpatient admission instead of spending time in a skilled nursing facility.¹

Home care can be used in follow-up care and treatment for many surgeries, illnesses or chronic conditions. BCBSM experience shows frequent use of the home health benefit following surgical procedures (both orthopedic and non-orthopedic). Increased musculoskeletal conditions such as arthritis, back pain, and bone and joint injuries are occurring with the aging population. More frequent occurrences of these conditions will likely lead to more surgeries and subsequently a need for more home health care. In addition, chronic disease is a problem affecting a significant portion of the United States population. Some recent statistics include:

- ◆ Estimates of chronic disease populations in the United States are:
 - ◆ Overweight/Obesity: 120 million
 - ◆ Hypertension: 50 million
 - ◆ Emphysema: 20 million
 - ◆ Diabetes: 20 million
 - ◆ Heart Failure: 5 million
- ◆ Chronic disease is the leading cause of death in the US affecting over 100 million people. It causes, on average, 1.7 million deaths a year in America.
- ◆ The senior population aged 65 and older will nearly double from 42 million to 80 million in the next three decades. They make up the largest group contributing to chronic illnesses: 90 percent of seniors have at least one chronic disease and 77 percent have two or more chronic diseases²
- ◆ Forty five percent of the US population has at least one chronic condition and these patients represent over 75 percent of the care consumed in all care settings³

According to 2006 statistics, Michigan continues to be one of the least healthy states in the nation. The state ranks as the 11th heaviest state with an adult obesity rate of 25.6 percent. Michigan ranks 13th in the nation for adult diabetes and hypertension rates, at 7.9 percent and 27.3 percent, respectively.⁴

Chronic diseases have dramatically affected use in every care setting. Patients with chronic conditions account for:⁵

¹ www.kci1.com/35.asp

² icarehealthmonitoring.com/resources-chronicillnessstatistics.php

³ BCBSM Value Report, March 2005, Delivering “Value through Medical Management”

⁴ www.healthyamericans.org/reports/obesity2006/print.php?StateID=MI

⁵ Blues Advantage, Summer 2005

- ◆ 96 percent of home care visits
- ◆ 60 percent of hospital admissions
- ◆ 80 percent of hospital stays
- ◆ 83 percent of prescription drug use
- ◆ 55 percent of emergency room visits
- ◆ 66 percent of physician visits

Increased use of home health care could reduce the number of hospital admissions and lengths of hospital stays. In addition, if home health care was prescribed more often following inpatient admissions, readmission rates might decrease.

Economic Factors

National Health Expenditures and Projections

National health expenditures rose 6.9 percent in 2005 and were projected to have risen 6.8 percent in 2006. The home health care component of national health expenditures rose 11.1 percent in 2005 and was projected to have risen 12.5 percent in 2006. Driven primarily by a growth in public spending, the home health care component has out-paced overall health expenditures since 2003 and is expected to continue to do so for several years. In 2005, home health care spending accounted for approximately 2.4 percent of total national health expenditures.⁶

Inflationary Factors

As mentioned in the epidemiology section, the impact of chronic disease on health care costs cannot be ignored. Diagnoses related to obesity, diabetes and cardiovascular disease have consistently affected health care costs. The aging population has led to increased incidence of musculoskeletal disease and utilization of other health services. Use of home health care as a treatment alternative is anticipated to continue to increase. Technological advances, such as the V.A.C. System, that enable more care to be provided in the home setting will also contribute to increased use of home health care.

Health Care Cost Containment

Home health care agencies provide care in a cost-effective alternative location of service, saving money by avoiding inpatient admissions, or by reducing lengths of stay at inpatient hospitals or skilled nursing facilities. As long as the requirements for appropriate use of home health care are met (e.g., physician referral, homebound patient, skilled care necessary) the potential for overuse should be minimal.

More generally, governmental officials and policymakers agree that health care costs need to be controlled, but there is no consensus on the best way to control costs, and the debate continues

⁶ <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf>

on the federal and state level. Some proposals include price controls and strict budgets on health care spending. Others favor free market competition, while public health advocates maintain that health care costs would decrease if all Americans adopted healthy lifestyles and subsequently needed less medical care.

Without agreement on a single solution, many approaches have been used to control health care spending, including provider pay-for-performance programs, consumer engagement, and promotion of healthy lifestyles. Programs like these have the potential to mitigate future cost increases and address some of the root cost drivers. Efforts to require public reporting of quality measures and to assess the appropriateness of new technologies will also make the health care system more accountable.

In 2006, Michigan's Governor Granholm proposed a three tier strategy to address the rising cost of health care in Michigan. The first component, the Michigan First Health Care Plan will expand access to quality, affordable health insurance. The second tier involves promoting healthy lifestyles through programs such as Michigan Steps Up which encourages healthy behaviors such as moving more, eating better and not smoking. The third piece involves advancing health information technology which will improve patient care, leading to reduced health care costs.

BCBSM sponsors several cost containment programs, such as BlueHealthConnection[®], social mission programs designed to improve the health of Michigan residents and utilization review audits, which are detailed elsewhere in this report.

Federal, State and Professional Regulation and Programs

A program that was not new during the reporting period but nevertheless affected quality of care was the Centers for Medicare and Medicaid Services' (CMS) Conditions of Participation (CoP) and Conditions for Coverage (CfC) that health care organizations must meet to begin and continue to participate in the Medicare and Medicaid programs. These minimum health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CoPs and CfCs apply to many facilities, including home health agencies. In turn, Medicare certification as a home health care agency is one of BCBSM's qualification standards under the Home Health Care Provider Class Plan.

The Michigan Health Information Network (MHIN) was initiated in late 2005 by Michigan's governor, Jennifer Granholm. The goal of the MHIN is for medical records to move electronically with patients statewide, improving quality of care and reducing cost. This project continues to move forward, with a report generated in 2006 outlining a plan to accelerate the use of health information technology and to establish a statewide health information exchange. In 2006, PA 137 created Michigan's first Health Information Technology Commission and appropriated \$5 million to fund regional health information exchange projects in 2007.

COST GOAL PERFORMANCE

“Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.” This is expressed by the following formula:

$$\left(\frac{(100 + I) * (100 + REG)}{100} \right) - 100$$

PA 350 Cost Objectives

Objective 1

Strive toward meeting the cost goal within the confines of Michigan and national health care market conditions.

Objective 2

Provide equitable reimbursement to participating providers through the reimbursement methodology outlined in the participating agreement.

Performance - Cost Goal and Objectives

BCBSM’s two-year average increase in payments per 1000 members was 7.3 percent for the home health care provider class. This exceeds the PA 350 cost goal, which was 5.3 percent. Although the home health care provider class did not independently achieve the cost goal, there is competent, material and substantial information to support a determination that the failure to achieve the goal was reasonable in accordance with Section 510(1)(b) of PA 350. Table 2 illustrates the cost performance for the reporting period of 2005-2006. The two-year average increase of 7.3 percent results from annual increases in payments per 1000 members of 6.8 percent in 2006 and 7.8 percent in 2005.

Table 2
Home Health Care Provider Class
2006-2004 Performance against Cost Goal

	2006	2005	2004
Payments			
Total	\$24,143,611	\$22,779,161	\$22,034,899
Per 1,000 members	\$9,131.03	\$8,549.87	\$7,931.54
% change	6.8%	7.8%	
Claims			
Total	22,014	21,028	20,325
Per 1,000 members	8.33	7.89	7.32
% change	5.5%	7.9%	
Payment/Claim			
	\$1,096.74	\$1,083.28	\$1,084.13
% change	1.2%	-0.1%	
Members			
	2,644,127	2,664,271	2,778,136
Achievement of Cost Goal			
Two Year Average Percent Change:	7.3%	<i>2006 percent of Total Payout reported to OFIS*</i> 0.7%	
P.A. 350 Cost Goal	5.3%		
Goal Not Met		<i>2006 ASC Business</i>	61.3%

*Payout reported to OFIS includes Traditional claims for the hospital, MD, DO, clinical laboratory, fully licensed psychologist, podiatrist and chiropractor provider classes. Traditional and PPO claims are included for the outpatient psychiatric care and substance abuse provider classes. Traditional, PPO and POS claims are included for the SNF, home health care, rehabilitation therapy, ASF, hospice, ESRD, DME/P&O, ambulance, nurse specialists, HIT, dental, vision, hearing and pharmacy provider classes. See the technical notes section for more details.

The cost section of this report provides a detailed analysis of factors impacting the increases in home health care costs. The tables provided in this discussion represent the most significant health care benefit categories such as major diagnostic categories and top diagnoses. Regional data and additional supporting data for each individual year are found in Appendix C.

Cost, Use and Price

The home health care provider class accounted for 0.7 percent of total BCBSM payments during this reporting period. Overall home health care cost performance shows the trend in payments per 1000 members increasing, while membership continues to decline. The home health care payment per 1000 members increased approximately \$1,200 or 15.1 percent from 2004 to 2006, while membership decreased approximately 134,000 members or 9.5 percent.

The increase in payments was primarily driven by increased utilization which increased 7.9 percent in 2005 and 5.5 percent in 2006 for an average increase during the reporting period of 6.7 percent. This increase in utilization is not surprising given the recent trends of moving care to less expensive settings. Lengths of stay in the inpatient hospital setting have decreased, and

many inpatient procedures have been moved to the outpatient setting. Both of these trends in care may require follow-up care in the home setting.

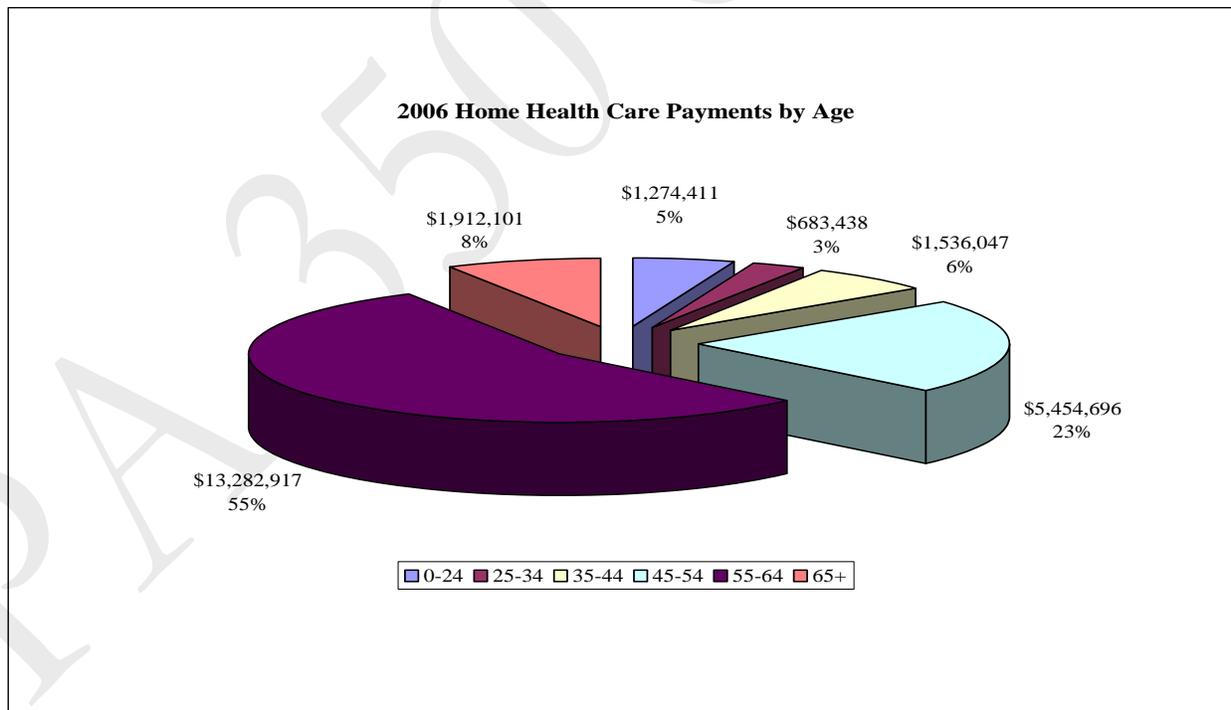
The number of members using the home health care benefit rose from 15,028 in 2004 to 15,079 in 2005 to 15,710 in 2006. This is an increase over the two year period of 4.5 percent. The percentage of members using the benefit rose under 1 percent in each year.

Payment per claim was relatively stable during the reporting period, decreasing 0.1 percent in 2005 and increasing 1.2 percent in 2006 for an average increase of 0.6 percent.

BCBSM's trend in increased home health care payments was somewhat lower than data reported by the Centers for Medicare and Medicaid, which has seen home health spending grow most swiftly among the health service sectors at 12.5 percent in 2006 and 11.2 percent in 2005. They are projecting this trend to moderate and settle to 7.3 percent in the next ten years⁷.

As shown in Chart 2, the age group responsible for 55 percent of BCBSM's total home health care payout during 2006 was members aged 55-64. An additional 24 percent of payout was attributable to members aged 45-54. As the baby boomers age and health care advances continue to reduce the mortality rate, increased costs in these age categories are expected.

Chart 2
Home Health Care Provider Class
2006 Payments by Age



⁷ Centers for Medicare and Medicaid Services, Office of the Actuary: National Health Expenditure Amounts, and Annual Percent Change by Type of Expenditure: Calendar Years 2001-2016; released in January 2007

Worldwide, trends in aging show the average life span is expected to increase, and with the growing number of older adults there is an expectation of increased demands on the public health system and medical and social services. Increased life expectancies have impacted the number of chronic conditions, injuries and disabilities that require medical treatment.

Major Diagnostic Category

Major diagnostic categories are formed by dividing all possible principle diagnoses into 25 mutually exclusive diagnosis areas. The diagnoses in each MDC correspond to a single organ system or etiology and in general are associated with a particular medical specialty. As shown in Table 3, average payment per 1000 members increased in each major diagnostic category, with the exception of digestive system, kidney and urinary tract, hepatobiliary system and female reproductive system. Utilization also increased in most MDCs. Changes in utilization were the primary drivers of the trends in payment per member for nearly all MDCs. Payment per claim was relatively stable in most MDCs, with sporadic trend variation in MDCs with lower total payments and claims.

Table 3
Home Health Care Provider Class
2006-2004 Inpatient Payments by Major Diagnostic Category

Home Health Care by Major Diagnostic Category	2004-2006 Payments	2004-2006 Claims	2004-2006 Avg Pymt/Claim	Pct of Total Payout	Two year average rate of change		
					Pymts/Mem	Claims/Mem	Pymt/Claim
Factors Influencing Health Status	\$ 21,135,311.20	20,906	\$ 1,010.97	30.6%	1.4%	3.6%	-2.1%
Musculoskeletal System	\$ 14,761,180.09	12,486	\$ 1,182.22	21.4%	21.6%	19.1%	2.2%
Nervous System	\$ 8,245,658.91	5,121	\$ 1,610.17	12.0%	9.8%	14.0%	-3.9%
Injury, Poisonings & Toxic Effect of Drugs	\$ 4,124,480.59	2,920	\$ 1,412.49	6.0%	7.4%	8.7%	-1.2%
Skin, Subcutaneous Tissue & Breast	\$ 4,164,928.16	3,155	\$ 1,320.10	6.0%	1.2%	7.0%	-5.0%
Circulatory System	\$ 4,151,501.42	4,493	\$ 923.99	6.0%	2.0%	2.0%	0.5%
Endocrine, Nutritional & Metabolic	\$ 3,198,625.05	3,321	\$ 963.15	4.6%	12.0%	9.5%	2.6%
Respiratory System	\$ 2,763,674.90	2,921	\$ 946.14	4.0%	6.2%	2.1%	4.4%
Digestive System	\$ 1,906,440.48	2,085	\$ 914.36	2.8%	-1.2%	-1.2%	0.3%
Kidney & Urinary Tract	\$ 933,959.39	923	\$ 1,011.87	1.4%	-12.5%	-11.7%	-0.4%
Myeloproliferative, Poorly Diff. Neoplasms	\$ 683,336.97	906	\$ 754.24	1.0%	2.5%	-0.1%	2.4%
Newborns/Neonates w/ Cond from Perinatal Per	\$ 457,926.95	807	\$ 567.44	0.7%	35.3%	3.1%	31.5%
Hepatobiliary System/Pancreas	\$ 510,076.47	607	\$ 840.32	0.7%	-1.9%	-6.2%	4.3%
Ear, Nose, Mouth & Throat	\$ 342,789.77	400	\$ 856.97	0.5%	12.4%	1.6%	7.0%
Blood/Blood Forming Organs & Immunological	\$ 335,433.47	309	\$ 1,085.55	0.5%	6.6%	-8.5%	16.0%
Infectious and Parasitic Diseases	\$ 323,709.07	303	\$ 1,068.35	0.5%	15.8%	0.5%	5.3%
Pregnancy, Childbirth & Puerperium	\$ 236,681.98	994	\$ 238.11	0.3%	2.3%	-3.1%	5.5%
Female Reproductive System	\$ 248,719.55	238	\$ 1,045.04	0.4%	-17.8%	-14.9%	-2.6%
Burns	\$ 162,072.38	129	\$ 1,256.38	0.2%	67.1%	14.5%	29.7%
Mental Disease and Disorders	\$ 106,095.52	94	\$ 1,128.68	0.2%	64.7%	22.0%	39.0%
Male Reproductive System	\$ 112,103.75	203	\$ 552.24	0.2%	9.5%	-24.2%	48.5%
Other	\$ 27,726.81	19	\$ 1,459.31	0.0%	280.6%	120.7%	29.0%
Alcohol/Drug Use	\$ 7,236.81	7	\$ 1,033.83	0.0%	n/a	n/a	n/a
Disease of Eye	\$ 16,451.49	18	\$ 913.97	0.0%	88.1%	169.3%	-27.1%
Human Immunodeficiency Virus Infections	\$ 1,549.85	2	\$ 774.93	0.0%	n/a	n/a	n/a
Total	\$ 68,957,671.03	63,367	\$ 1,088.23	100.0%	7.3%	6.7%	0.6%

Over 64 percent of home health care claims payout in 2004-2006, or \$44.1 million, fell into the factors influencing health status, musculoskeletal system and nervous system MDCs. The health status factor MDC represents care performed when there is an unspecified debility including

cases where physical therapy is provided without nursing care. These three categories also accounted for 60.8 percent of the claims. The high utilization in these categories contributed to the overall increase in payments.

While the factors influencing health status MDC accounted for 30.6 percent of total home health care payout, the trends were not significant, with an average increase in payments per 1000 members of 1.4 percent resulting from a 3.6 percent increase in utilization and 2.1 percent decrease in payment per claim.

Trends for the musculoskeletal system MDC were more dramatic, with a 21.6 percent increase in payment per 1000 members, a 19.1 percent increase in utilization and a 2.2 percent increase in payment per claim, combining to account for 21.4 percent of home health care payments. Musculoskeletal conditions include arthritis, osteoporosis, broken or deteriorated bones, trauma, back or joint pain. These are the most common causes of severe long-term pain and physical disability; and, joint diseases account for half of all chronic conditions in the elderly. In the United States, musculoskeletal conditions cost more than \$254 billion a year, and one in every seven Americans has a musculoskeletal impairment that limits or decreases their ability to function at home, work or play. The aging population will result in significant increases in musculoskeletal conditions, with corresponding increased costs.^{8,9}

Accounting for 12 percent of total payout, the nervous system MDC had increases of 9.8 percent in payments per 1000 members and 14 percent in utilization per 1000 members with a decrease of 3.9 percent in payment per claim. This MDC encompasses diseases such as cerebral palsy, multiple sclerosis, muscular dystrophy and dementia as well as conditions like strokes and spinal injuries. Treatment for disabilities caused by these diseases and conditions is often appropriate in the home setting.

Other categories with notable trends among the top ten MDCs were the endocrine, nutritional and metabolic MDC with a 9.5 percent increase in utilization per 1000 members driving a 12.0 percent change in payments per member and the kidney and urinary tract MDC with an 11.7 percent decrease in utilization per 1000 members which influenced a 12.5 decrease in payment per 1000 members.

The most recent national data available for home health care patients by diagnostic category is from 2000. At that time, the top five categories ranked by the number of patients needing care were: diseases of the circulatory system; injury and poisoning; diseases of the musculoskeletal system; endocrine, nutritional and metabolic diseases and immunity disorders; and diseases of the respiratory system. The BCBSM data in Table 3 above were ranked by payments from 2004-2006. While the ranking variables are different, it appears that BCBSM experience is similar to national experience, with the national top five categories being among BCBSM's top eight categories.¹⁰

⁸ Medical Reporter.health.org/tmr1099/orthopaedics.html

⁹ United States Bone and Joint Decade, www.usbjd.org/patients_public/index.cfm?pg=faq.cfm

¹⁰ <http://www.cdc.gov/nchs/data/nhhcsd/curhomecare00.pdf> Table 12

Top 25 Diagnosis Classification

Table 4 shows the top 25 diagnosis classifications by payout. Diagnosis codes provide brief descriptions of the nature of the condition being treated. These codes begin with three digits but may gain greater specification by the addition of a fourth or fifth digit for clarification of anatomical site or kind of procedure. For purposes of this analysis, the diagnosis codes were summarized at the three digit level.

Table 4
Home Health Care Provider Class
2006-2004 Payments by Top 25 Diagnosis Classifications

3 Digit ICD9 Code	Diagnosis Classification	2004-2006 Payments	2004-2006 Claims	2004-2006 Avg Pymt/Claim	Pct of Total Payout	Two year average rate of change		
						Pymts/Mem	Claims/Mem	Pymt/Claim
V58	Encounter for other procedures & aftercare	\$ 9,173,643.29	10,352	\$ 886.17	13.3%	20.9%	20.6%	0.3%
V54	Other orthopedic aftercare	\$ 7,700,622.93	6,477	\$ 1,188.92	11.2%	53.7%	50.0%	2.6%
V57	Care using rehabilitation procedures	\$ 9,611,147.22	7,967	\$ 1,206.37	13.9%	-16.2%	-13.3%	-3.5%
998	Other complications of procedures	\$ 3,265,137.61	2,300	\$ 1,419.63	4.7%	9.1%	8.0%	1.1%
250	Diabetes mellitus	\$ 2,557,745.43	2,455	\$ 1,041.85	3.7%	14.7%	16.7%	-1.7%
781	Symptoms involving nervous/musculoskeletal systems	\$ 2,277,729.64	1,925	\$ 1,183.24	3.3%	21.6%	13.3%	7.4%
715	Osteoarthritis and allied disorders	\$ 2,282,358.25	1,927	\$ 1,184.41	3.3%	-0.8%	-5.5%	4.9%
707	Chronic ulcer of skin	\$ 1,988,111.70	1,057	\$ 1,880.90	2.9%	0.4%	7.9%	-6.5%
434	Occlusion of cerebral arteries	\$ 883,162.91	519	\$ 1,701.66	1.3%	310.9%	273.3%	9.2%
682	Other cellulitis and abscess	\$ 1,327,310.35	1,262	\$ 1,051.75	1.9%	13.3%	12.2%	2.0%
428	Heart failure	\$ 1,044,190.73	1,042	\$ 1,002.10	1.5%	20.0%	17.7%	3.5%
340	Multiple sclerosis	\$ 1,100,280.47	589	\$ 1,868.05	1.6%	11.5%	15.6%	-4.8%
728	Disorders of muscle, ligament, and fascia	\$ 508,476.62	364	\$ 1,396.91	0.7%	33.1%	37.4%	-3.5%
V55	Attention to artificial openings	\$ 671,517.24	859	\$ 781.74	1.0%	-3.2%	-9.9%	7.6%
V53	Fitting/adjustment of other device	\$ 506,627.35	456	\$ 1,111.02	0.7%	21.4%	9.3%	11.8%
414	Other forms of chronic ischemic heart disease	\$ 780,282.01	983	\$ 793.78	1.1%	-17.9%	-14.8%	-3.2%
496	Chronic airway obstruction, not elsewhere classified	\$ 543,970.38	572	\$ 951.00	0.8%	0.4%	-3.3%	4.3%
716	Other/unspecified arthropathies	\$ 438,658.39	305	\$ 1,438.22	0.6%	10.1%	-9.1%	18.8%
162	Malignant neoplasm of trachea, bronchus, & lung	\$ 521,635.49	609	\$ 856.54	0.8%	-2.9%	-8.0%	5.8%
436	Acute, but ill-defined, cerebrovascular disease	\$ 807,395.50	404	\$ 1,998.50	1.2%	-38.6%	-35.8%	4.4%
879	Open wound of other sited, except limbs	\$ 527,904.39	363	\$ 1,454.28	0.8%	-4.0%	1.7%	-6.4%
996	Complications peculiar to certain procedures	\$ 455,212.91	406	\$ 1,121.21	0.7%	2.4%	11.2%	-7.9%
486	Pneumonia, organism unspecified	\$ 440,521.35	467	\$ 943.30	0.6%	5.0%	9.7%	-3.6%
401	Essential hypertension	\$ 416,348.63	444	\$ 937.72	0.6%	20.2%	19.5%	-1.8%
438	Late effects of cerebrovascular disease	\$ 409,834.82	212	\$ 1,933.18	0.6%	30.0%	27.3%	-1.7%
	Other	\$ 18,717,845.42	19,051	\$ 982.51	27.1%	-0.4%	-1.3%	0.8%
	Total	\$ 68,957,671.03	63,367	\$ 1,088.23	100.0%	7.3%	6.7%	0.6%

As shown in Table 4 the top 25 diagnoses totaled approximately 73 percent of total payout. The top three diagnoses were encounter for other procedures and aftercare, other orthopedic aftercare, and care using rehabilitation procedures. The first category encompasses care required after surgeries not specified in other codes as well as procedures such as change of dressings or removal of sutures. Other orthopedic aftercare includes care following joint replacement or traumatic fracture. Physical, occupational and speech therapy would be included in care using rehabilitation procedures.

Trends for the reporting period in most of the top 25 diagnosis classifications were driven by utilization. Encounters for other procedures and aftercare had a two-year average increase in claims per 1000 members of 20.6 percent which accounted for most of the 20.9 percent increase in payments per 1000 members. The other orthopedic aftercare classification had a dramatic 50.0 percent increase in utilization contributing to a 53.7 percent increase in payments per 1000 members. Care using rehabilitation procedures had a utilization decrease of 13.3 percent per 1000 members which influenced the 16.2 percent decrease in payments per 1000 members.

Trends in seeking lower-cost treatment locations have resulted in more surgical aftercare occurring in the home setting. This is consistent with the results by diagnosis classification seen in Table 4. Patients with chronic disease are also frequent users of home health care services. Our data confirms this, with diabetes, osteoarthritis, heart failure and multiple sclerosis appearing in the top 12 diagnoses. High incidences of chronic disease in our aging population and continued prevalence of health-damaging behaviors among our population indicate that health care costs will continue to increase. As this occurs, and convenient lower-cost alternatives to care are sought, home health care will remain an important component of the continuum of care.

Cost Containment Programs

The health care industry has responded to chronic disease trends with a shift toward disease management programs as a means to controlling cost. The purpose of disease management is to empower participants so they can better manage and improve their own health while controlling costs. BCBSM also has broadened its scope of medical care management design. BCBSM no longer directs all of its attention to provider costs and provider utilization, but has added member-centric programs. Highlights of BCBSM's cost containment programs are described below:

Member-focused Health Management

BlueHealthConnection®

BCBSM's BlueHealthConnection® is an integrated care management program, addressing member needs relative to chronic conditions and health care decision support. Members have access to important clinical assistance and education tools to help make their health care decisions. The program also involves the provider for meaningful partnership in the care process.

The program has evolved to be more member-centric. BlueHealthConnection® provides members with 24/7 access to health information either by telephone, Internet or mail. Instead of just organizing program outreaches around different conditions and diseases, target populations are stratified into four risk segments to allocate resources most efficiently and effectively. The highest risk segment receives the most contacts, on average six to twelve mailings per year. The other segments are moderate high, moderate and low risk. Welcome letters, magnets, postcards, information sheets and invitation-to-call cards are some of the many ways BCBSM reached out to members.

With BlueHealthConnection®, BCBSM has gone beyond traditional disease management and achieved a whole-person approach to care management. Members' needs are met by helping them cope with health conditions they and their loved ones are struggling to manage. This program allows BCBSM to become their health care partner and their advocate, as well as a single source for health management information.

BlueHealthConnection[®] nurses help patients manage symptoms of minor illnesses or injuries, provide general information such as tips for healthy lifestyles or side effects of prescription drugs, manage chronic diseases, discuss treatment options, support weight loss and tobacco cessation efforts, and provide case management for the sickest one percent of the population.

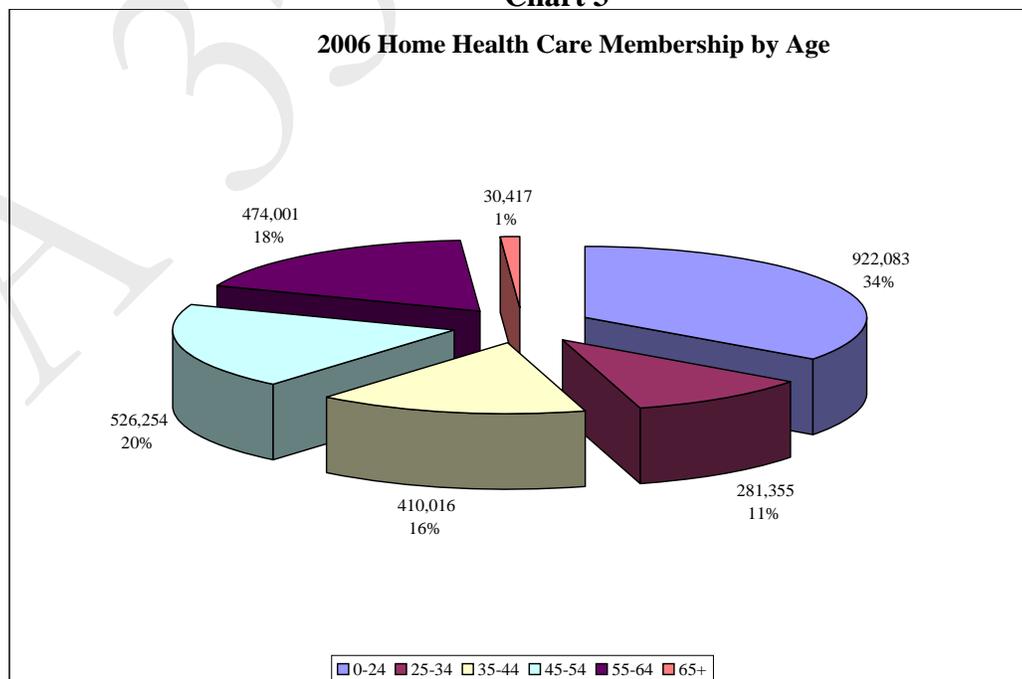
BlueHealthConnection[®] nurses advocate for the appropriate care setting for recommended services. For example, a patient with a chronic disease such as congestive heart failure may be called regularly to monitor the patient’s weight. If a weight increase is noted, indicating fluid collecting in the lungs, the nurse would refer a patient to his or her physician for care or would call the patient’s physician recommending administration of IV diuretics in the home. The involvement of the nurse in this example is effective because care is sought before further complications necessitate an inpatient admission and a lower cost setting for care is used.

Membership

During this reporting period, membership decreased by 4.8 percent or approximately 134,000 members, while utilization increased 6.7 percent. Although membership has declined, the ratio of patients using home health care to total membership eligible for the benefit increased slightly from 0.54 percent in 2004 to 0.59 percent in 2006. The membership decline is primarily attributable to loss of small groups and corporate downsizing.

Chart 3 shows 2006 home health care membership by age category. The distribution between age categories was consistent during the reporting period. It is interesting to note that the 55-64 age category has 18 percent of the members, but accounts for 55 percent of the payout (see Chart 2). BCBSM membership in this age category represents a higher percentage than the Michigan and national populations which are approximately 10 percent (see Chart 1).

Chart 3



ACCESS GOAL PERFORMANCE

“There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber.”

PA 350 Access Objectives

Objective 1

Provide direct reimbursement to participating providers who render medically necessary, high-quality services to BCBSM members.

Objective 2

Communicate with participating providers about coverage determinations, billing, benefits, provider appeals processes, BCBSM’s record keeping requirements and the participating agreement and its administration.

Objective 3

Maintain and periodically update a printed or Web site directory of participating providers.

Performance - Access Goal and Objectives

Formal participation rates are derived by comparing the number of BCBSM participating providers to the number of total Medicare certified and accredited providers throughout the state of Michigan based on the Center for Medicare and Medicaid Services state directory. BCBSM participating and total state counts represent the primary location of the home health care providers. Home health care providers may have additional branches located throughout the state.

As shown in Table 5 below, BCBSM maintained a 65 percent participation rate in 2006 as compared to 62 percent in 2004. The number of participating providers has increased 19 percent from 170 home health care providers in 2004 to 202 in 2006.

Table 5
Home Health Care Detailed Report
Participation 2006 -2004

Home Health Care Providers

Formal Participation Rates	2006	2005	2004
Number of Participating: Providers	202	184	170
Accredited or Certified Providers	312	308	274
Formal Par Rates:	65%	60%	62.0%

The home health care providers' participation rate averaged 62.3 percent statewide during 2004 to 2006. While the statewide participation rate for 2006 was 65 percent, the regional participation rate was greater than 80 percent for nearly all of the regions statewide, as shown in Table 6. The 48 percent participation rate in region one is the result of recently approved Medicare home health care facilities that have not yet requested formal participation with BCBSM. Some of these facilities may choose to be Medicare specific facilities only; however, participation in region one is expected to increase as trends show Medicare acceptance is generally followed with a participation request with BCBSM.

Table 6
Home Health Care Detailed Reports
2006 Access by Region

	2006		
Region	Number of Participating Providers	Total Providers	Participation Rate
1	90	189	48%
2	8	12	67%
3	12	12	100%
4	8	8	100%
5	18	22	82%
6	26	26	100%
7	18	21	86%
8	8	8	100%
9	14	14	100%
Statewide	202	312	65%

Chart 4 on page 27 provides a regional map defining the PA 350 regions and showing the 2006 distribution of participating home health care providers by county. Below are the main factors that helped achieve the access goal, which are highlighted in this section:

- ◆ Provider communication via BCBSM publications, on-line assistant tools, and provider consultants
- ◆ BCBSM's reimbursement methodologies for freestanding and hospital based providers

Provider Communications

Enhanced channels of communication helped establish and maintain a good rapport with participating providers.

Publications and Services

BCBSM distributes to all providers a publication called *The Record*. It is a monthly source that communicates billing, reimbursement, group-specific benefit changes, and day-to-day business information from BCBSM. *The Record* was created with input from provider focus groups as an ongoing effort to improve communications with providers and to make BCBSM information more accessible to them.

Participating home health care providers could access a comprehensive online provider manual on web-DENIS, which contains detailed instructions for servicing BCBSM members. The manual is updated as necessary allowing home health care providers to obtain information on a real time basis. Topics detailed in the manual include:

- ◆ Member eligibility requirements
- ◆ Benefits and exclusions
- ◆ Criteria guidelines for services
- ◆ Documentation guidelines
- ◆ Claim submission information
- ◆ Appeals process
- ◆ Utilization review
- ◆ BCBSM departments to contact for assistance

BCBSM offers providers the options of speaking with provider service representatives, writing to our inquiry department, and having a provider consultant visit provider offices to help guide and educate their staff. In addition, BCBSM trainers educated providers with seminars on various topics such as how to use web-DENIS, benefits, claims processing and adjustments. Computer based training tools have also been developed to expand the reach of the training sessions.

Inquiry Systems

In 2005, web-DENIS expanded from a private access network of electronic self-service features supporting provider inquiries to an Internet-based program via a new secured provider portal on www.bcbsm.com. This new program continued quick delivery of contract eligibility, claims status, online manuals, newsletters, fee schedules, reports and much more information needed to make doing business with BCBSM easier. BCBSM designed the Internet site to promote secure, effective, and personalized use of the Internet for existing web-DENIS users and to encourage new providers to begin to use web-DENIS.

In April 2005, partnering with Michigan Department of Community Health, BCBSM expanded web-DENIS to offer Medicaid eligibility, an option that allows providers immediate access to critical benefit information. In 2006, BCBSM retired private connection options used to access web-DENIS prior to Internet access capability, since most providers using web-DENIS have switched to using their Internet connection. BCBSM also added additional fee schedules, medical policy documents and more provider training modules to web-DENIS in 2006

In addition, BCBSM added easy-to-find links. *Partner Links* connects providers to BCBSM's partner sites, including the Council for Affordable Quality Healthcare, Institute for Safe Medication Practices, Michigan State Medical Society and the Michigan Health and Hospital Association.

Another avenue for home health care providers to obtain needed information from BCBSM is CAREN⁺, an integrated voice response system which, provides information on eligibility, benefits, deductibles and copayments. In 2005, CAREN⁺ became speech enabled so providers can enter contract numbers by voice or text, with additional voice capability enhancements introduced in 2006. In addition, security measures were added to CAREN⁺ to safeguard our members' protected health information.

BCBSM's ongoing communication with providers enhanced relationships with them and improved formal participation.

Reimbursement

BCBSM's reimbursement methodology is designed to be equitable while maintaining appropriate participation levels. BCBSM reimburses participating home health care providers for covered services deemed medically necessary by BCBSM, as described in Addendum A of the Home Health Care Facility Participation Agreement. This agreement is contained in the Appendix E of this document.

Reimbursement policies differ for hospital-based and freestanding home health care providers as described on page 4 of this agreement. BCBSM will periodically review hospital-based and freestanding home health care provider reimbursement to determine if modifications are necessary. BCBSM does not guarantee the review process will result in increased reimbursement.

Provider Programs

Provider Affiliation Strategy Programs

BCBSM's provider affiliation strategy is a fundamental approach to doing business that fosters an ongoing commitment to excellent performance and dialogue with providers. To better serve our communities and customers, BCBSM promotes business relationships with providers so they will:

- ◆ Collaborate with BCBSM to improve the health status of patients and the quality and cost effectiveness of care
- ◆ Help BCBSM deliver outstanding customer service to members
- ◆ Value BCBSM as a health plan of choice and recommend it to patients and others

This strategy will yield increased provider satisfaction through:

- ◆ Enhanced ease of doing business
- ◆ Responsive and accurate service
- ◆ Predictable and fair reimbursement
- ◆ A trusting and predictable relationship
- ◆ Recognition and support of their role as patient care givers

The Provider Affiliation Strategy focuses on the following key elements that support a strong relationship with providers:

- ◆ Prompt and accurate claims payment
- ◆ Consistent, accurate and responsive service
- ◆ Timely and effective communication
- ◆ Partnerships to promote and facilitate better health care

Prompt, Accurate Claims Payment

BCBSM initiated programs to improve the quality and timeliness of system changes to improve the percentage of claims reimbursed on the first submission. At the same time, BCBSM also initiated a process to reduce the number of initial claim rejections.

BCBSM's adjustment rate initiative has reduced the number of claims that are manually adjusted to process through BCBSM's claim system. Significant reductions have been achieved, primarily because of continued decline in coordination of benefit adjustments due to program and process changes, medical policy adjustments due to policy simplifications, and other reductions resulting from the quick identification and resolution of issues that cause payment or rejection problems.

In 2005, BCBSM collaborated with providers to revise the policy on patient liabilities. The group attempted to balance the provider's need for efficient collection and prompt payment with BCBSM's objective to reduce member and provider billing inquiries. As a result of these

efforts, BCBSM now allows providers to collect percentage copayments and a limited dollar amount of the deductible at the time of service.

Responsive Service

BCBSM's Provider Consulting Services increased provider satisfaction by building relationships through enhanced visibility, communication and consultative services. Provider consultants advocate for the priority and resolution of issues identified by providers to assure their needs are communicated to and acted upon by BCBSM. Consultants assisted home health care providers with complex billing issues, answered their benefit questions and educated their staffs on billing policies and procedures. Consultants also provided written materials that may help providers' staffs in their daily work.

In recent years, BCBSM has enhanced the focus of Provider Consulting Services. On-site call volume standards were established for consultants and the positions were redefined to provide more direct assistance to providers. Visits from BCBSM provider consultants to all providers have increased significantly as a result of these changes.

Effective Communications

"E-Gateway" is a new way to access information that offers a broad array of online resources and services with many features, including search functionalities, news, reference tools, access to online forms and communication capabilities. As mentioned, web-DENIS is now available on the Internet.

In 2005, BCBSM's Provider Communications department initiated a Web-based communications platform that allows the sharing of articles and other information in online presentations with audio.

BCBSM increased face-to-face feedback opportunities through provider outreach fairs. These fairs were held throughout the state, giving providers the opportunity to interact with BCBSM representatives to discuss web-DENIS, provider training, electronic claims and other issues. In 2006, more than 2000 providers attended the fairs.

QUALITY OF CARE GOAL PERFORMANCE

“Providers will meet and abide by reasonable standards of health care quality.”

PA 350 Quality of Care Objectives

Objective 1

Ensure BCBSM members receive quality care by requiring participating providers to meet BCBSM’s qualification and performance standards.

Objective 2

Meet with specialty liaison societies to discuss issues of interest and concern.

Objective 3

Maintain and update, as necessary, an appeals process that allows participating providers to appeal individual claims disputes regarding utilization review audits.

Performance - Quality of Care Goal and Objectives

BCBSM’s approach to achieving the quality of care objective for the home health care provider class was to:

- ◆ Ensure the quality of care by enforcing qualification standards for participation
- ◆ Maintain quality controls through utilization management and audits
- ◆ Implement quality management initiatives that promote safety, improve the health of the community and ensure the delivery of high quality health care
- ◆ Develop strong relationships with participating providers by offering them various avenues to receive information and to voice concerns

Qualification Standards

A home health care facility must meet and maintain qualification standards. BCBSM requires these standards to ensure our members are receiving quality care. Highlights of BCBSM standards are detailed below:

Medicare Certification

BCBSM requires home health care providers to have current Medicare certification as a home health agency. Medicare certification assures BCBSM that all providers meet the same federal standards for participation to provide home health care services to ensure the health and safety of BCBSM patients. Medicare expects a home health provider to provide primarily skilled nursing services and other therapeutic services.

Certification from Medicare ensures that policies are established by a group of professionals associated with the home health care facility, which includes one or more physicians and one or more registered professional nurses to govern the services provided. Clinical records must be maintained for all patients. Medicare also reviews federal requirements focusing on the health and safety of individuals who are furnished services by the home health care provider.

National Accreditation Organization

Home health care providers may choose to obtain accreditation from the Community Health Accreditation Program, Inc. (CHAP); Joint Commission on Accreditation of Healthcare Organization (JCAHO); or Accreditation Commission for Health Care (ACHC) as an alternative to obtaining Medicare certification. The following provides background on these national accreditation organizations and how they help increase the level of quality for home health care services.

Community Health Accreditation Program, Inc

CHAP is an independent, non-profit accrediting body. It was the first accrediting body for community-based health care organizations in the United States and was created in 1965 as a joint venture between the American Public Health Association (APHA) and the National League for Nursing (NLN). These organizations accomplished the futuristic view that accreditation was the needed mechanism for recognizing excellence in community health practice. In 1988, CHAP became a separately incorporated, non-profit subsidiary of the NLN under the CHAP name. In 2001, it was spun-off by the NLN and became an independent, non-profit corporation.

CHAP was the accepted source of authority by CMS in 1992 for home health. In 2006, CMS granted CHAP full deeming authority. This means that instead of state surveys, CHAP has regulatory authorization to survey agencies providing home health care services to determine whether they meet the Medicare Conditions of Participation. CHAP strives to objectively validate the excellence of community health care practice through consistent measurement of the delivery of quality services, to motivate providers to achieve continuous improvement by adhering to standards of excellence, and to assist the public in the selection of community health services and providers with demonstrated excellence.

Joint Commission on Accreditation of HealthCare Organization

The Joint Commission evaluates and accredits nearly 15,000 health care organizations and programs in the United States. An independent, not-for-profit organization, the Joint Commission is the nation's predominant standards-setting and accrediting body in health care. Since 1951, the Joint Commission has maintained state-of-the-art standards that focus on improving the quality and safety of care provided by health care organizations. The Joint

Commission's comprehensive accreditation process evaluates an organization's compliance with these standards and other accreditation requirements. Joint Commission accreditation is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. To earn and maintain the Joint Commission's Gold Seal of Approval™, an organization must undergo an on-site survey by a Joint Commission survey team at least every three years.

The Joint Commission is governed by a 29-member Board of Commissioners that includes physicians, administrators, nurses, employers, a labor representative, health plan leaders, quality experts, ethicists, a consumer advocate and educators. The Board of Commissioners brings to the Joint Commission's diverse experience in health care, business and public policy. The Joint Commission's corporate members are the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Hospital Association, and the American Medical Association.

Accreditation Commission for Health Care

ACHC is a not-for-profit organization that has been a symbol of quality since 1986. ACHC is the only national health care accrediting organization started at the grass-roots level by a few home care providers endeavoring to create a viable option of accreditation sensitive to the needs of small providers. The company began offering services nationally in 1996. The design of the accreditation is based on standards that are patient-care focused, relevant, realistic and written in easily understood language. ACHC has a self-assessment process that helps home health care providers identify and organize evidence of compliance. This philosophy has not changed in twenty years of service and ACHC is firmly committed to requiring what is right and best for the patient. In past years, ACHC has endeavored to respond to unmet needs in the industry. It was the first, with help from industry experts, to develop accrediting programs for the niche market areas listed below:

- ◆ Specialty Pharmacy
- ◆ Women's Post-Breast Surgery Fitter Services
- ◆ Respiratory Nebulizer Medication Programs
- ◆ Medical Supply Provider Services
- ◆ Rehabilitation Technology Supplier Services

Governing Board

A home health care provider must establish a governing board, or as an alternative, a community advisory board, which must include persons representative of a cross section of the community who are interested in the welfare and proper functioning of the home health care provider as a community facility. The board is legally responsible for the total operation of the facility and ensuring quality medical care is provided in a safe environment. This means the home health care provider, through the governing body, must assume the full legal authority and responsibility for the operations of the facility, including policies, procedures, services, organization and budget preparation. These responsibilities must be clearly defined in a written agreement.

Policies and Procedures

The home health care provider must have written policies and procedures that meet generally acceptable standards for home health care services. The staff must comply with federal regulations, accepted health standards established by national organizations, boards and councils, and the home health care facility's own policies and procedures. These policies and programs are to monitor employees and personnel serving the home health care facility. They ensure that services provided to patients meet acceptable professional practices standards. The program helps monitor the professional skills of its staff to determine if the skills are appropriate for the care required by the patients. BCBSM tries to assure the quality of patient care by requiring these policies and procedures.

Professional Organization

There are many professional organizations the home health care provider may have a current membership with as shown in the table below:

Professional Organization	Description
American Public Health Association (APHA)	Founded in 1872, the APHA is the oldest, largest and most diverse organization of public health professionals in the world. The association works to protect all Americans and their communities from preventable, serious health threats.
National League for Nursing (NLN)	Founded in 1893 as the American Society of Superintendents of Training Schools for Nurses, the NLN was the first nursing organization in the United States. The NLN advances excellence in nursing education that prepares the nursing workforce to meet the needs of diverse populations in an ever-changing healthcare environment
Michigan League for Nursing (MLN)	Since 1952, the MLN has provided members with the resources that they need for professional and personal growth. Today, MLN is comprised of more than 1,000 individual nurses, healthcare professionals, consumers and more than 125 health care agencies.
American Association of Homecare (AAHomecare)	The AAHomecare was formed in 2000 and works to strengthen access to care for the millions of Americans who require medical care in their homes. AAHomecare represents healthcare providers, equipment manufacturers, and other organizations in the homecare community. Membership reflects a broad cross-section of the homecare community, including providers of all sizes operating approximately 3,000 locations in all 50 states.

Professional Organization	Description
National Association for Home Care (NAHC)	<p>Since NAHC's inception in 1982, it has become the nation's largest trade association representing the interests and concerns of home care agencies, hospices, home care aide organizations, and medical equipment suppliers. NAHC is the one organization dedicated to making home care and hospice providers' lives easier.</p>
Visiting Nurses Association of America (VNAA)	<p>The VNAA is the official not-for-profit national association of community-based home health organizations known as Visiting Nurse Associations (VNAs).</p> <p>VNAs created the profession of home health care more than 100 years ago. They have a united mission to bring compassionate, high-quality and cost-effective home care to individuals in their respective communities.</p> <p>In this new century, not-for-profit VNAs continue their unparalleled selfless tradition by offering quality of life and independence to all Americans through comprehensive home health care. Today, guided by their charitable missions, VNAs care for nearly 4 million people annually.</p>
Michigan Home Health Association (MHHA)	<p>Established in 1981, the MHHA is the state trade association for providers of home health care. The Association provides a unified voice for all components of home health care and promotes high standards of patient care in the delivery of home health services. The Association advocates for the role of home care services within the total health care system. Its membership consists of over 300 certified, private duty, hospice, home medical equipment and pharmacy/infusion organizations.</p>

Facility Staff

The home health care provider must offer skilled nursing services and one other professional type of therapy such as physical, speech, nutritional, occupational or social services. The home health care facility must have a multi-disciplinary staff composed of all the following:

- ◆ A nursing administrator or coordinator who is a Michigan licensed registered nurse and directs the activities of nurses, therapists and other staff members
- ◆ A business office manager who handles the business and financial aspects of the program
- ◆ A physician coordinator, licensed in Michigan, who serves as a consultant, advisor, and a liaison between home health care facility and the medical community

- ◆ Registered nurses, licensed in Michigan
- ◆ Michigan licensed physical therapist, registered occupational therapist, or licensed social worker, as additional services offered by the home health care provider

Quality Controls

BCBSM has various programs and criteria that were established to help with our quality control as stated below:

Utilization Management

Specific criteria that focus on safety and effectiveness are required before BCBSM members can use home health care services. The criteria needed are the following:

- ◆ The member's primary care physician or plan medical director must refer the member for home health care services
- ◆ The home health care provider must apply InterQual[®] criteria to determine if the patient is eligible for home health care
- ◆ The home health care program must represent a cost-effective alternative to covered services which the member would otherwise have to receive in a hospital or other more costly setting
- ◆ The member must be medically in need of skilled nursing care or skilled rehabilitation therapy and the rehabilitation services must be expected to cause significant improvement of the member's condition within 60 days or meet the definition of terminally ill, not ready for traditional hospice services
- ◆ The member must be willing to accept home care and have a suitable support system available
- ◆ Member must be homebound as determined by Medicare's definition

Homebound means unable to leave home unassisted; that is, leaving the home takes considerable and taxing effort. The patient will be deemed homebound per Medicare if the patient meets one of the following conditions:

- ◆ Is certified by a physician as an individual with a permanent and severe, disabling condition that is not expected to improve
- ◆ Is dependent upon assistance from another individual with at least three out of the five activities of daily living specified (eating, toileting, transferring, bathing, and dressing) for the rest of the patient's life
- ◆ Requires skilled nursing services for the rest of his or her life, and the skilled nursing is more than medication management
- ◆ Requires an attendant to visit on a daily basis to monitor and treat a medical condition or to assist the beneficiary with activities of daily living
- ◆ Requires technological assistance or the assistance of another person to leave the home
- ◆ Does not regularly work in a paid position full-time or part-time outside the home

The patient will still be considered homebound if any absence from the home is attributable to receiving health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed, certified, or accredited. Any other absence of a patient from the home shall not disqualify him/her if the absence is of infrequent or of relatively short duration, including but not limited to religious services.

BCBSM implemented the 2006 InterQual[®] home health care criteria on July 31, 2006. Below highlights the modifications:

- ◆ BCBSM's criteria require that the patient must be receiving skilled services in order to meet home health care criteria
- ◆ All home health care visits must be made to the patient's home. Telephonic visits are not sufficient to meet BCBSM criteria
- ◆ Skilled nursing visits, which are provided for 8 hours or more per day, do not meet BCBSM's criteria
- ◆ Hospice and palliative care services do not meet BCBSM home health care criteria and are administered under the hospice benefit. Hospice and palliative care includes, but is not limited to, services such as spiritual counseling, bereavement counseling and respite care
- ◆ Social work visits may be approved with sufficient documentation when nursing or physical therapy home health care services have been approved

Audits

BCBSM uses the InterQual[®] clinical criteria screening tool to assess both the appropriate location of care and the medical necessity of the proposed procedure. The InterQual[®] criteria are a set of comprehensive and objective guidelines. They are based on best practices, clinical data and medical literature that are updated annually. This tool allows for consistent, reproducible reviews and ensures that patients receive the right care in the right setting.

BCBSM also monitors provider performance through the utilization review process. Audits can determine if services were medically necessary and rendered in accordance with members' benefits. The home care benefit is meant to be short term, and many audit findings discover overuse of services.

BCBSM auditors use InterQual[®] Procedures Criteria that is subject to BCBSM medical policy, benefit policy and payment policy to review and approve services. If a service cannot be approved using these criteria, the auditor refers the service to one of our medical consultants.

BCBSM medical consultants use national society guidelines and current practice parameters, when available, to approve services. If the consultants cannot approve a service using the current guidelines and standards, they use their medical education, training and experience to make the audit decision. This peer-review process is conducted by medical consultants with the same or similar specialty as the provider being audited. After this two-step review of medical record documentation, BCBSM may seek recovery of payments from providers whose documentation does not meet the guidelines.

During utilization review audits, paid claims data and the corresponding medical records are reviewed to ensure that home health care was appropriate and the services rendered were performed for the appropriate indications, in appropriate settings, and were accurately billed and paid. The results of the audits are provided in Table 7.

At the conclusion of an audit, a departure conference with the facility representative, led by a BCBSM auditor, provides preliminary findings identified during the audit. The departure conference also serves as an opportunity for education. Methods to enhance correct coding and billing practices are discussed and facilities are encouraged to build on existing strengths. As a result, performance can and should immediately improve.

Table 7
Home Health Care Detailed Report
Audit Results

	2006	2005
Number of Audits	10	13
Initial Identified Savings	\$263,000	\$370,000
Year-end Recoveries	\$111,000	\$165,000
Referred to Corporate Financial Investigation	1	0

Audits conducted in 2006 addressed lack of medical necessity, services billed not documented and progress notes not meeting therapy guidelines.

Medical necessity is determined after review of the patient’s history, physical examination, and any pertinent laboratory, imaging and other information that support the rationale for the planned service. Regularly scheduled services must meet medical necessity criteria. BCBSM monitors claims for services that appear to be regularly scheduled and performed and will audit such services for medical necessity.

In 2006, there were six providers that initiated appeals. These appeals represented 86 cases in which the decision in 60 were maintained, seven were reversed and 19 were revised. In 2005, there were six providers that initiated appeals. These appeals represented 118 cases in which the decision in 62 were maintained, ten reversed and 46 revised.

BCBSM will continue to audit home health care facilities to ensure compliance with the program and to review medical necessity.

Termination of Contract

Participation may be terminated by BCBSM if the provider fails to meet any of the qualification standards. The home health care provider must have an absence of inappropriate utilization or practice patterns, as identified through valid subscriber complaints, audits and peer review, and refrain from fraud and illegal activities.

The participating agreement states that the home health care provider or BCBSM may terminate the contract with or without cause, upon 60 days written notice to the other party. The contract

can be terminated immediately, where there is a material breach of the participating agreement that is not corrected within 30 business days of written notice from the other party. BCBSM could terminate the contract with 60 days notice if home health care provider fails to meet the qualification standards. The contract can be automatically terminated if the home health care provider has its Medicare certification or accreditation suspended or revoked or if an officer, director, owner or principal of the home health care provider is convicted of a felony or other violation of law.

The contract may also be terminated by bankruptcy or insolvency of either party. In addition, BCBSM may terminate the contract if there is a change in the ownership or the home health care facility ceases providing home health care services to BCBSM members. Finally, BCBSM may immediately terminate the contract if so ordered by the Office of Financial and Insurance Services.

Quality Management Initiatives

The goal of BCBSM's social mission is to improve the health status of Michigan residents by focusing resources on areas of greatest importance where BCBSM is uniquely positioned to deliver results. Healthier residents should consequently reduce health care costs.

BCBSM executed and publicized health initiatives that address the root causes of critical health issues such as:

- ◆ Community programs addressing geographic, racial and ethnic disparities
- ◆ Programs designed to improve the health status of children (e.g., immunization rates and adequate prenatal care)
- ◆ Programs designed to address obesity
- ◆ Smoking cessation programs

BCBSM recognizes the importance of these programs in addressing risk factors underlying the chronic diseases many Michigan residents face.

BCBSM also sponsors programs such as *WalkingWorks*[™], a wellness program designed to promote good health, and *Healthy ME!*[™], a free program for Michigan elementary schools that blends facts about healthy lifestyles with friendly characters, upbeat songs and humor. By encouraging the adoption of healthier, more active lifestyles, these programs will help control costs in the future.

Provider Relations

During this review period, BCBSM maintained effective relations with home health care providers through a liaison committee and a formal appeals process.

Liaison Committee

Effective provider communications helped BCBSM and home health care providers address issues that affect the quality of care rendered to members.

Through BCBSM's liaison process, specialized teams dedicated to the resolution of liaison issues were developed to improve service to the home health care facilities and professional specialties. BCBSM and the Michigan Home Health Association met three times in 2006 and twice in 2005. Topics discussed included coding modifiers, removing edits, billing supplies, supervision requirements for physical therapy assistants, discussion of home health care audits, InterQual® training and Medicare Advantage.

Provider Appeals Process

In accordance with PA 350, sections 402(1), 403 and 404, BCBSM makes a formal appeals process available to participating home health care providers. A description of the process can be found in Exhibit E of the Home Health Care Facility Participating Agreement. The process to appeal BCBSM adverse determinations serves to resolve disagreements about prospective, concurrent and retrospective reviews. Disputes about claims are resolved through the appeals of reimbursement policies process. There were no requests for OFIS determinations received during the 2005/2006 reporting period.

CONCLUSION

Cost Goal

The cost goal for the home health care provider class was not met for this reporting period since overall home health care payments had an average two-year increase of 7.3 percent. The increase was primarily attributable to increased utilization which results from the movement of care to less expensive settings. Home health care is a cost-effective alternative to long inpatient hospital or skilled nursing facility stays. Care following surgical procedures drove BCBSM's home health care costs, and an aging population was responsible for the majority of the services used. Home health care costs will probably continue to increase as the prevalence of chronic disease in an aging population necessitates more medical services and technological advances enable more care to be shifted to alternate settings.

Access Goal

BCBSM met the access goal for the home health care provider class. BCBSM offered Medicare certified and accredited providers the opportunity to participate by signing a formal participation agreement. BCBSM achieved more than sixty percent participation of home health care providers in both years of the reporting period. In regions where there were fewer home health care agencies, the participation rate was as high as eighty percent or more. In addition there were 54 branch locations throughout the state that members could use to access home health care services. This level of participation minimized out-of-pocket expenses for members. Effective provider communications, BCBSM's reimbursement methodology and responsive service all helped achieve the access goal.

Quality of Care Goal

BCBSM achieved the quality of care goal. Home health care facilities were required to meet qualification standards to ensure they were capable of providing high quality care to BCBSM members. Quality controls, which included utilization management, audits, and termination guidelines, ensured that services rendered were medically necessary, appropriate for the patient's condition and in accordance with the participating agreement. Quality management initiatives such as improving patient outcomes, Michigan Health and Safety Coalition and community health improvements designed to improve health status. Finally, BCBSM offered home health care facilities several means to maintain open lines of communication, including liaison committee meetings and a provider's appeals process.

APPENDIX A

Overview of Public Act 350

This section briefly describes the provider class plan annual reporting requirements mandated under Public Act 350.

Annual reporting requirements

The provider class plan annual reports are submitted pursuant to section 517 of PA 350, which requires BCBSM to submit to the Commissioner an annual report for each provider class that shows the level of BCBSM's achievement of the goals provided in section 504.

PA 350 Goals

The term "goals", used in section 517 above, refers to specific cost, access and quality goals described in section 504. This section states:

"A health care corporation shall, with respect to providers, contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of health care services in accordance with the following goals:

Cost Goal

"Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." This is expressed by the following formula:

$$\frac{((100 + I) \times (100 + REG))}{(100)} - 100$$

Access Goal

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

Quality of Health Care Goal

"Providers will meet and abide by reasonable standards of health care quality."

Calculation of 2005 – 2006 Cost Goal

P.A. 350 Cost Goal Formula

The P.A. 350 cost goal formula , as stated in the Act is:

$$\frac{((100 + I) \times (100 + \text{REG}))}{100} - 100$$

Goal Calculations (see attached sheet for yearly indicators)

<u>Year of Determination</u>	<u>2007</u>
I (CY 2006 - 2005)	2.979% (matches the CPI closely)
REG (CY 2006 - 2003)	2.295%

Applying these indices into the formula, the cost goal becomes:

$$\frac{((100 + I\%) \times (100 + \text{REG}\%))}{100} - 100 = \mathbf{5.275\%}$$

PA 350 Cost Goal Projections

Year	Population (1)	Real GDP (2)	Per Capita GDP	Implicit GDP Price Deflator (2)	Percent Change	
					PC GDP	IPD
2002	287,449,000	\$ 10,048,800,000,000	\$ 34,958.55	104.19		
2003	290,116,000	\$ 10,301,000,000,000	\$ 35,506.49	106.40	1.567%	2.125%
2004	292,801,000	\$ 10,703,500,000,000	\$ 36,555.54	109.43	2.955%	2.840%
2005	295,507,000	\$ 11,048,600,000,000	\$ 37,388.62	112.74	2.279%	3.026%
2006	298,217,215	\$ 11,415,300,000,000	\$ 38,278.47	116.04	2.380%	2.932%

(1) Population projections based on 2000 census released May 11, 2004
www.census.gov/ipc/www/usinterimproj/usproj_detail_file_RTT (Total Resident Population)

(2) c/y 2002-2006 source-March 2007 Economic Indicators-Dept. of Commerce, Bureau of Economic Analysis

Definitions

Section 504 of the Act also provides the following definitions for terms used in the cost goal calculation:

“Gross Domestic Product (GDP) in constant dollars’ means that term as defined and annually published by the United States Department of Commerce, Bureau of Economic Analysis.”

“Implicit price deflator for gross national product’ means that term as defined and annually published by the United States Department of Commerce, Bureau of Economic Analysis.”

“Inflation’ (I) means the arithmetic average of the percentage changes in the implicit price deflator for gross national product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made.”

“Compound rate of inflation and real economic growth’ means the ratio of the quantity 100 plus inflation multiplied by the quantity 100 plus real economic growth to 100; minus 100.”

“Rate of change in the total corporation payment per member to each provider class’ means the arithmetic average of the percentage changes in the corporation payment per member for that provider class over the 2 years immediately preceding the Commissioner's determination.”

“Real economic growth’ (REG) means the arithmetic average of the percentage changes in the per capita gross national product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made.”

Determination Process

Under PA 350, the commissioner is required to consider information presented in the annual report, as well as all other relevant factors that might affect the performance of a particular provider class, in making a determination with respect to that class.

Section 509 of the Act outlines factors that should be considered by the commissioner to “determine if the health care corporation has substantially achieved the goals of a corporation as provided in section 504 and achieved the objectives contained in the provider class plan.” Many of these factors are beyond BCBSM's direct control and may adversely impact the cost and use of health care services for a particular provider class. Specifically, section 509(4) states:

The commissioner shall consider all of the following in making a determination...:

(a) Annual reports transmitted pursuant to section 517.

(b) The overall balance of the goals provided in section 504, achieved by the health care corporation under the plan. The commissioner shall give weight to each of the goals provided in section 504, shall not focus on one goal independently of the other goals of the corporation, and shall assure that no portion of the corporation's fair share of reasonable costs to the provider are borne by other health care purchasers.

(c) Information submitted or obtained for the record concerning:

- ◆ *Demographic trends;*
- ◆ *Epidemiological trends;*
- ◆ *Long-term economic trends, including changes in prices of goods and services purchased by a provider class not already reflected in the calculation in section 504(2)(d);*
- ◆ *Sudden changes in circumstances;*
- ◆ *Administrative agency or judicial actions;*
- ◆ *Changes in health care practices and technology; and,*
- ◆ *Changes in benefits that affect the ability of the health care corporation to reasonably achieve the goals provided in section 504.*

(d) Health care legislation of this state or of the federal government. As used in this subdivision, 'health care legislation' does not include Act No. 218 of the Public Acts of 1956, as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws.

(e) Comments received from an individual provider of the appropriate provider group, or from an organization or association that represents the appropriate provider class, and comments received pursuant to section 505(2).

After considering the information and factors described in section 509(4), the goals of a health care corporation as provided in sections 504, and the objectives contained in the provider class plan, the commissioner shall determine one of the following [as stated under section 510(1)]:

(a) That the provider class plan achieves the goals of the corporation as provided in section 504.

(b) That although the provider class plan does not substantially achieve one or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve one or more of the goals was reasonable due to factors listed in section 509(4).

(c) That a provider class plan does not substantially achieve one or more of the goals of the corporation as provided in section 504.

A determination made by the commissioner under section 510 1(a) or 1(b) would require no further action by the corporation. Upon a 511(1)(c) determination by the commissioner, under section 511, the corporation:

(1) Within 6 months or a period determined by the commissioner..., shall transmit to the commissioner a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner pursuant to section 510(2). In developing a provider class plan under this subsection, the corporation shall obtain advice and consultation from providers in the provider class and subscribers, using procedures established pursuant to section 505.

If after 6 months or a period determined by the commissioner..., the health care corporation has failed to act pursuant to subsection (1), the commissioner shall prepare a provider class plan..., for that provider class.

The findings of the commissioner may be disputed by any party through an appeals process available under section 515 of PA 350.

APPENDIX B

Technical Notes

The data indices presented in the 2004, 2005, and 2006 databases and analyzed in the annual reports reflect a defined subset of BCBSM claims experience. The data specifications and collection methodologies are discussed in the following sections.

Data Elements and Collection

The basic statistics analyzed for each provider class are total payments and utilization, from which an average price per utilization unit is derived. These data were collected from BCBSM data files that are based on claims submitted to the Corporation and approved for payment to the provider or in some cases, the subscriber.

The data collection period captures health care services incurred during specific twelve-month calendar years and paid through fourteen months. For example, the 2006 dataset includes all services incurred between 1/1/06 and 12/31/06, and paid from 1/1/06 through 2/28/07. It is reasonable to expect that for facility provider classes, over 97 percent of total experience is captured.

Participation rates are based on providers who sign a BCBSM participation agreement and the total number of licensed providers registered with BCBSM.

Scope of the Data

Provider Class Accountability

PA 350 requires BCBSM to report its Traditional product for the purposes of provider class accountability. However, for the ancillary provider classes, including pharmacy, BCBSM's PPO product care experience is included. BCBSM membership systems capture members' product line information only once, reflecting the member's hospital/medical-surgical coverage (e.g., a member with PPO pharmacy coverage but Traditional hospital/medical-surgical coverage is considered a Traditional member). The following providers do not have a PPO network therefore Traditional and PPO members are both reported:

- ◆ Skilled nursing facilities
- ◆ Substance abuse facilities
- ◆ Home health care facilities
- ◆ Outpatient psychiatric care facilities
- ◆ Outpatient physical therapy facilities
- ◆ Ambulatory surgical facilities
- ◆ Hospice providers
- ◆ DME-P&O providers

- ◆ Ambulance providers
- ◆ Home infusion therapy providers
- ◆ Nurse specialists (CRNA, CNM, CNP)

Underwritten groups and administrative services contract groups are included. For ancillary provider classes, complementary claims and membership data is included. The data excludes the Federal Employee Program and non-Michigan liability such as claims paid through the Inter-Plan Teleprocessing System for out-of-state Blue members. Claims incurred out-of-state by BCBSM members are also excluded.

Blue Care Network data are excluded from the reporting requirements referred to in PA 350 Section 502(a) (11) and the HMO Act.

Regional Experience

Regions selected for analysis are compatible with Michigan Metropolitan Statistical Areas (MSAs) and provide an acceptable basis for analysis of access as well as of provider practice patterns. Regions one through nine represent groups of Michigan counties. Michigan claims experience with unidentified zip codes was allocated among the nine regions according to the distribution of data with identifiable zip codes.

Membership

This report includes all BCBSM Traditional and PPO members residing in Michigan.

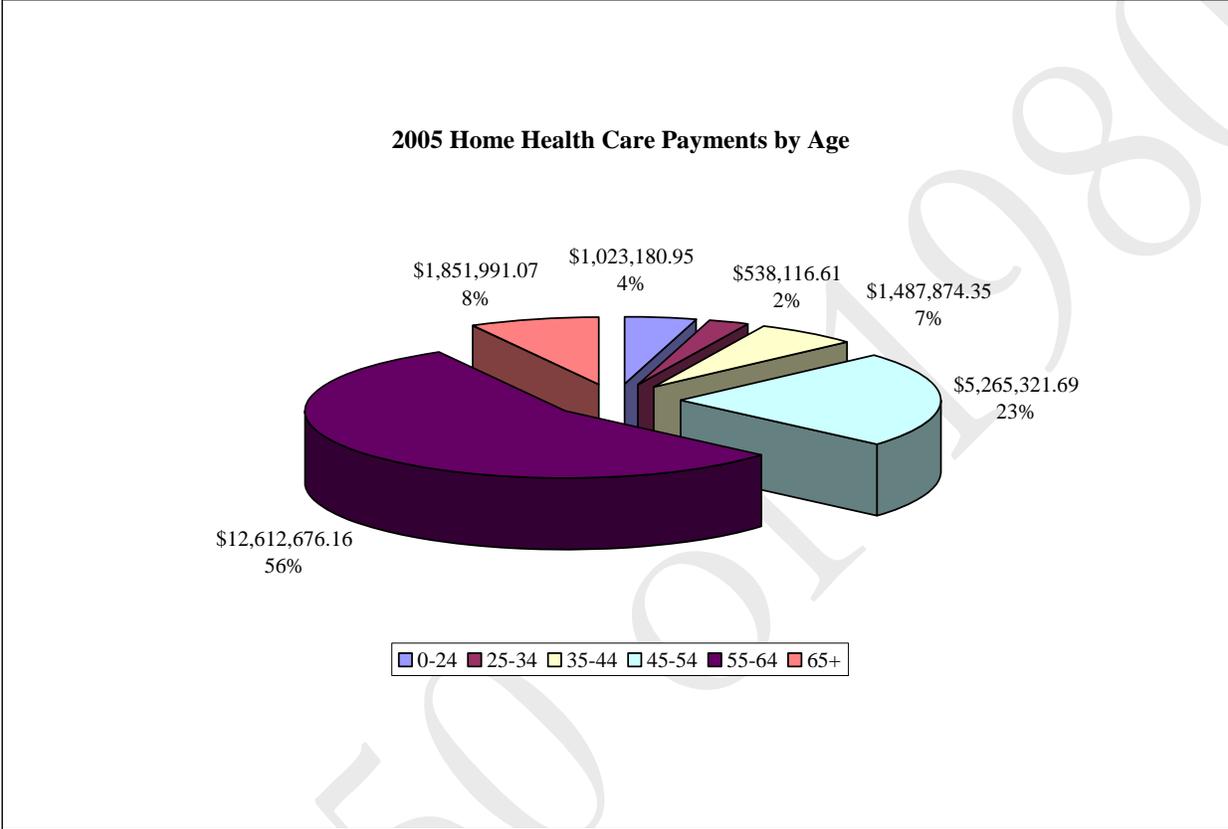
The regions used for analysis pertain to the location where services were delivered. For example, region one experience represents payments to region one providers for services rendered to BCBSM members regardless of residency. This is because subscribers who live in one region may receive services in another region because they reside near a border or want services from a provider in another region.

APPENDIX C

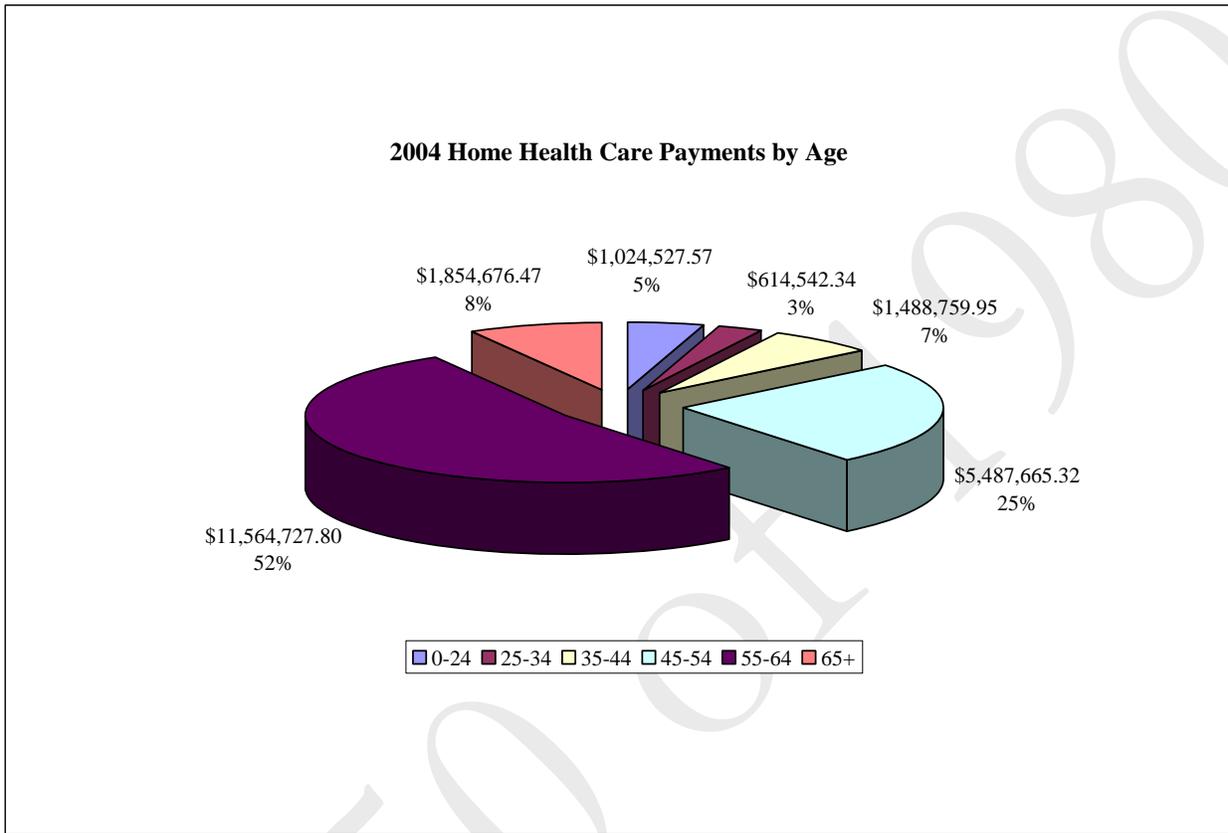
Supporting Tables and Charts

Table # found in body	Appendix #	Description
Chart 2	C1	2005 Payments by Age
	C2	2004 Payments by Age
Table 5	C3	2006 Cost, Use, and Price Experience by MDC
	C4	2005 Cost, Use, and Price Experience by MDC
	C5	2004 Cost, Use, and Price Experience by MDC
Table 6	C6	2006 Cost, Use, and Price Experience by 3 Digit Diagnosis Classification
	C7	2005 Cost, Use, and Price Experience by 3 Digit Diagnosis Classification
	C8	2004 Cost, Use, and Price Experience by 3 Digit Diagnosis Classification
N/A	C9	Regional Data - Two Year Trends
	C10	2004-2006 Regional Data

Appendix – C1
Home Health Care Detailed Report
2005 Payments by Age



Appendix – C2
Home Health Care Detailed Report
2004 Payments by Age



Appendix – C3
Home Health Care Detailed Report
2006 Cost, Use, and Price Experience by MDC

Home Health Care by Major Diagnostic Category	2006 Payments	2006 Claims	2006 Avg Pymt/Claim	Pct of Total Payout	Average rate of change		
					Pymt/Mem	Claims/Mem	Pymt/Claim
Factors Influencing Health Status	\$ 6,870,619.79	6,960	\$ 987.16	28.5%	-4.2%	-1.4%	-2.8%
Musculoskeletal System	\$ 5,742,313.76	4,752	\$ 1,208.40	23.8%	17.3%	13.8%	3.0%
Nervous System	\$ 3,038,720.85	1,928	\$ 1,576.10	12.6%	20.9%	19.0%	1.6%
Injury, Poisonings & Toxic Effect of Drugs	\$ 1,428,273.37	1,019	\$ 1,401.64	5.9%	3.3%	3.4%	-0.1%
Skin, Subcutaneous Tissue & Breast	\$ 1,397,356.79	1,087	\$ 1,285.52	5.8%	5.7%	2.6%	3.1%
Circulatory System	\$ 1,372,423.73	1,523	\$ 901.13	5.7%	-0.7%	7.5%	-7.6%
Endocrine, Nutritional & Metabolic	\$ 1,187,510.87	1,218	\$ 974.97	4.9%	18.1%	19.5%	-1.2%
Respiratory System	\$ 949,099.23	947	\$ 1,002.22	3.9%	2.9%	-5.8%	9.2%
Digestive System	\$ 620,654.73	686	\$ 904.74	2.6%	1.3%	5.2%	-3.7%
Kidney & Urinary Tract	\$ 263,056.78	269	\$ 977.91	1.1%	-14.4%	-6.5%	-8.5%
Myeloproliferative, Poorly Diff. Neoplasms	\$ 220,232.03	292	\$ 754.22	0.9%	-7.8%	-3.8%	-4.1%
Newborns/Neonates w/ Cond from Perinatal Per	\$ 199,066.81	269	\$ 740.03	0.8%	38.7%	-0.3%	39.2%
Hepatobiliary System/Pancreas	\$ 169,724.90	192	\$ 883.98	0.7%	14.1%	6.9%	6.7%
Ear, Nose, Mouth & Throat	\$ 130,898.62	139	\$ 941.72	0.5%	54.6%	27.3%	21.4%
Blood/Blood Forming Organs & Immunological	\$ 121,238.90	95	\$ 1,276.20	0.5%	23.1%	2.9%	19.6%
Infectious and Parasitic Diseases	\$ 119,975.91	104	\$ 1,153.61	0.5%	80.4%	31.0%	37.7%
Pregnancy, Childbirth & Puerperium	\$ 80,745.56	316	\$ 255.52	0.3%	9.3%	-1.7%	11.2%
Female Reproductive System	\$ 67,941.35	68	\$ 999.14	0.3%	-6.3%	0.8%	-7.0%
Burns	\$ 49,481.15	38	\$ 1,302.14	0.2%	-38.8%	-30.4%	-12.1%
Mental Disease and Disorders	\$ 46,881.15	38	\$ 1,233.71	0.2%	19.4%	32.0%	-9.6%
Male Reproductive System	\$ 39,652.65	45	\$ 881.17	0.2%	6.0%	-37.9%	70.7%
Other	\$ 13,710.08	12	\$ 1,142.51	0.1%	645.4%	202.3%	146.6%
Alcohol/Drug Use	\$ 7,236.81	7	\$ 1,033.83	0.0%	n/a	n/a	n/a
Disease of Eye	\$ 6,794.93	10	\$ 679.49	0.0%	249.6%	403.8%	-30.6%
Human Immunodeficiency Virus Infections	\$ -	-	n/a	0.0%	n/a	n/a	n/a
Total	\$ 24,143,610.75	22,014	\$ 1,096.74	100.0%	6.8%	5.5%	1.2%

Appendix – C4
Home Health Care Detailed Report
2005 Cost, Use, and Price Experience by MDC

Home Health Care by Major Diagnostic Category	2005 Payments	2005 Claims	2005 Avg Pymt/Claim	Pct of Total Payout	Average rate of change		
					Pymt/Mem	Claims/Mem	Pymt/Claim
Factors Influencing Health Status	\$ 7,227,378.93	7,115	\$ 1,015.79	31.7%	7.1%	8.6%	-1.4%
Musculoskeletal System	\$ 4,932,936.94	4,206	\$ 1,172.83	21.7%	25.9%	24.3%	1.3%
Nervous System	\$ 2,532,199.83	1,632	\$ 1,551.59	11.1%	-1.3%	9.0%	-9.4%
Injury, Poisonings & Toxic Effect of Drugs	\$ 1,392,781.65	993	\$ 1,402.60	6.1%	11.4%	14.0%	-2.3%
Skin, Subcutaneous Tissue & Breast	\$ 1,331,980.14	1,068	\$ 1,247.17	5.8%	-3.3%	11.4%	-13.1%
Circulatory System	\$ 1,393,255.55	1,428	\$ 975.67	6.1%	4.8%	-3.4%	8.6%
Endocrine, Nutritional & Metabolic	\$ 1,013,430.13	1,027	\$ 986.79	4.4%	5.9%	-0.5%	6.4%
Respiratory System	\$ 929,676.32	1,013	\$ 917.75	4.1%	9.6%	9.9%	-0.3%
Digestive System	\$ 617,313.64	657	\$ 939.59	2.7%	-3.7%	-7.7%	4.3%
Kidney & Urinary Tract	\$ 309,797.56	290	\$ 1,068.27	1.4%	-10.5%	-16.9%	7.7%
Myeloproliferative, Poorly Diff. Neoplasms	\$ 240,673.69	306	\$ 786.52	1.1%	12.8%	3.6%	8.9%
Newborns/Neonates w/ Cond from Perinatal Per	\$ 144,579.60	272	\$ 531.54	0.6%	31.9%	6.6%	23.7%
Hepatobiliary System/Pancreas	\$ 149,923.40	181	\$ 828.31	0.7%	-17.9%	-19.3%	1.8%
Ear, Nose, Mouth & Throat	\$ 85,337.01	110	\$ 775.79	0.4%	-29.7%	-24.0%	-7.4%
Blood/Blood Forming Organs & Immunological	\$ 99,261.44	93	\$ 1,067.33	0.4%	-9.9%	-19.9%	12.4%
Infectious and Parasitic Diseases	\$ 67,009.05	80	\$ 837.61	0.3%	-48.9%	-29.9%	-27.1%
Pregnancy, Childbirth & Puerperium	\$ 74,447.28	324	\$ 229.78	0.3%	-4.7%	-4.6%	-0.2%
Female Reproductive System	\$ 73,086.15	68	\$ 1,074.80	0.3%	-29.2%	-30.5%	1.8%
Burns	\$ 81,477.10	55	\$ 1,481.40	0.4%	173.1%	59.3%	71.4%
Mental Disease and Disorders	\$ 39,571.64	29	\$ 1,364.54	0.2%	110.1%	12.0%	87.6%
Male Reproductive System	\$ 37,682.33	73	\$ 516.20	0.2%	13.0%	-10.4%	26.2%
Other	\$ 1,853.40	4	\$ 463.35	0.0%	-84.1%	39.0%	-88.6%
Alcohol/Drug Use	\$ -	-	n/a	0.0%	n/a	n/a	n/a
Disease of Eye	\$ 1,958.20	2	\$ 979.10	0.0%	-73.5%	-65.2%	-23.7%
Human Immunodeficiency Virus Infections	\$ 1,549.85	2	\$ 774.93	0.0%	n/a	n/a	n/a
Total	\$ 22,779,160.83	21,028	\$ 1,083.28	100.0%	7.8%	7.9%	-0.1%

Appendix – C5
Home Health Care Detailed Report
2004 Cost, Use, and Price Experience by MDC

Home Health Care by Major Diagnostic Category	2004 Payments	2004 Claims	2004 Avg Pymt/Claim	Pct of Total Payout
Factors Influencing Health Status	\$ 7,037,312.48	6,831	\$ 1,030.20	31.9%
Musculoskeletal System	\$ 4,085,929.39	3,528	\$ 1,158.14	18.5%
Nervous System	\$ 2,674,738.23	1,561	\$ 1,713.48	12.1%
Injury, Poisonings & Toxic Effect of Drugs	\$ 1,303,425.57	908	\$ 1,435.49	5.9%
Skin, Subcutaneous Tissue & Breast	\$ 1,435,591.23	1,000	\$ 1,435.59	6.5%
Circulatory System	\$ 1,385,822.14	1,542	\$ 898.72	6.3%
Endocrine, Nutritional & Metabolic	\$ 997,684.05	1,076	\$ 927.22	4.5%
Respiratory System	\$ 884,899.35	961	\$ 920.81	4.0%
Digestive System	\$ 668,472.11	742	\$ 900.91	3.0%
Kidney & Urinary Tract	\$ 361,105.05	364	\$ 992.05	1.6%
Myeloproliferative, Poorly Diff. Neoplasms	\$ 222,431.25	308	\$ 722.18	1.0%
Newborns/Neonates w/ Cond from Perinatal Per	\$ 114,280.54	266	\$ 429.63	0.5%
Hepatobiliary System/Pancreas	\$ 190,428.17	234	\$ 813.80	0.9%
Ear, Nose, Mouth & Throat	\$ 126,554.14	151	\$ 838.11	0.6%
Blood/Blood Forming Organs & Immunillogical	\$ 114,933.13	121	\$ 949.86	0.5%
Infections and Parasitic Diseases	\$ 136,724.11	119	\$ 1,148.94	0.6%
Pregnancy, Childbirth & Puerperium	\$ 81,489.14	354	\$ 230.20	0.4%
Female Reproductive System	\$ 107,692.05	102	\$ 1,055.80	0.5%
Burns	\$ 31,114.13	36	\$ 864.28	0.1%
Mental Disease and Disorders	\$ 19,642.73	27	\$ 727.51	0.1%
Male Reproductive System	\$ 34,768.77	85	\$ 409.04	0.2%
Other	\$ 12,163.33	3	\$ 4,054.44	0.1%
Alcohol/Drug Use	\$ -	-	n/a	0.0%
Disease of Eye	\$ 7,698.36	6	\$ 1,283.06	0.0%
Human Immunodeficiency Virus Infections	\$ -	-	n/a	0.0%
Total	\$ 22,034,899.45	20,325	\$ 1,084.13	100.0%

Appendix – C6
Home Health Care Detailed Report
2006 Cost, Use, and Price Experience by 3 Digit Diagnosis Classification

3 Digit ICD9 Code	Diagnosis Classification	2006 Payments	2006 Claims	2006 Avg Pymt/Claim	Pct of Total Payout	Average rate of change		
						Pymt/Mem	Claims/Mem	Pymt/Claim
V58	Encounter for other procedures & aftercare	\$ 3,578,247.76	4,000	\$ 894.56	14.8%	19.3%	16.5%	2.3%
V54	Other orthopedic aftercare	\$ 3,377,184.26	2,779	\$ 1,215.25	14.0%	23.3%	19.5%	3.2%
V57	Care using rehabilitation procedures	\$ 2,486,520.45	2,155	\$ 1,153.84	10.3%	-25.5%	-21.7%	-4.8%
998	Other complications of procedures	\$ 1,146,891.83	796	\$ 1,440.82	4.8%	4.6%	2.2%	2.4%
250	Diabetes mellitus	\$ 969,608.33	946	\$ 1,024.96	4.0%	20.3%	22.5%	-1.8%
781	Symptoms involving nervous/musculoskeletal system	\$ 899,566.04	707	\$ 1,272.37	3.7%	22.7%	11.5%	10.1%
715	Osteoarthritis and allied disorders	\$ 737,769.43	595	\$ 1,239.95	3.1%	-1.7%	-5.1%	3.6%
707	Chronic ulcer of skin	\$ 648,218.59	361	\$ 1,795.62	2.7%	-1.6%	-1.2%	-0.5%
434	Occlusion of cerebral arteries	\$ 552,490.19	314	\$ 1,759.52	2.3%	96.4%	82.9%	7.4%
682	Other cellulitis and abscess	\$ 491,782.55	445	\$ 1,105.13	2.0%	14.5%	1.4%	12.8%
428	Heart failure	\$ 424,962.07	418	\$ 1,016.66	1.8%	44.9%	48.3%	-2.3%
340	Multiple sclerosis	\$ 418,998.11	229	\$ 1,829.69	1.7%	37.4%	30.4%	5.4%
728	Disorders of muscle, ligament, and fascia	\$ 226,411.34	166	\$ 1,363.92	0.9%	61.2%	64.0%	-1.7%
V55	Attention to artificial openings	\$ 214,589.72	250	\$ 858.36	0.9%	0.0%	-11.6%	13.2%
V53	Fitting/adjustment of other device	\$ 200,488.59	167	\$ 1,200.53	0.8%	23.7%	19.3%	3.7%
414	Other forms of chronic ischemic heart disease	\$ 191,771.24	273	\$ 702.46	0.8%	-31.3%	-12.7%	-21.4%
496	Chronic airway obstruction, not elsewhere classified	\$ 168,612.90	168	\$ 1,003.65	0.7%	-13.4%	-19.4%	7.5%
716	Other/unspecified arthropathies	\$ 164,822.31	94	\$ 1,753.43	0.7%	47.4%	15.5%	27.6%
162	Malignant neoplasm of trachea, bronchus, & lung	\$ 164,651.63	185	\$ 890.01	0.7%	-4.3%	-3.9%	-0.4%
436	Acute, but ill-defined, cerebrovascular disease	\$ 152,478.82	77	\$ 1,980.24	0.6%	-22.0%	-7.6%	-15.5%
879	Open wound of other sited, except limbs	\$ 151,313.13	114	\$ 1,327.31	0.6%	-22.7%	-12.3%	-11.8%
996	Complications peculiar to certain procedures	\$ 148,412.14	147	\$ 1,009.61	0.6%	-4.9%	10.5%	-14.0%
486	Pneumonia, organism unspecified	\$ 147,314.52	159	\$ 926.51	0.6%	-2.4%	-4.1%	1.7%
401	Essential hypertension	\$ 138,384.58	159	\$ 870.34	0.6%	-16.5%	-2.3%	-14.5%
438	Late effects of cerebrovascular disease	\$ 137,655.84	81	\$ 1,699.45	0.6%	-19.4%	6.0%	-24.0%
	Other	\$ 6,204,464.38	6,229	\$ 996.06	25.7%	5.7%	3.1%	2.6%
	Total	\$ 24,143,610.75	22,014	\$ 1,096.74	100.0%	6.8%	5.5%	1.2%

Appendix – C7
Home Health Care Detailed Report
2005 Cost, Use, and Price Experience by 3 Digit Diagnosis Classification

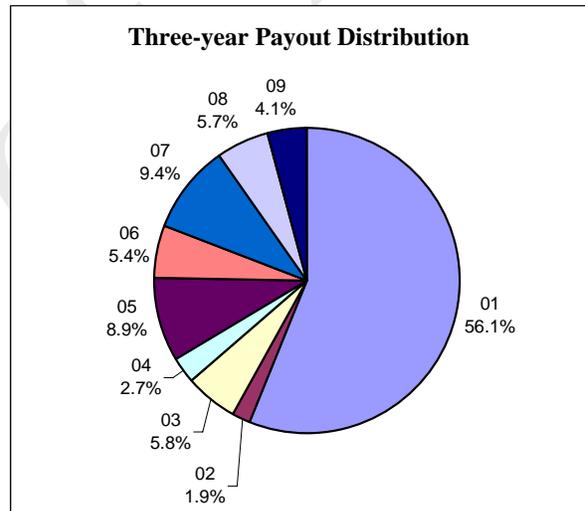
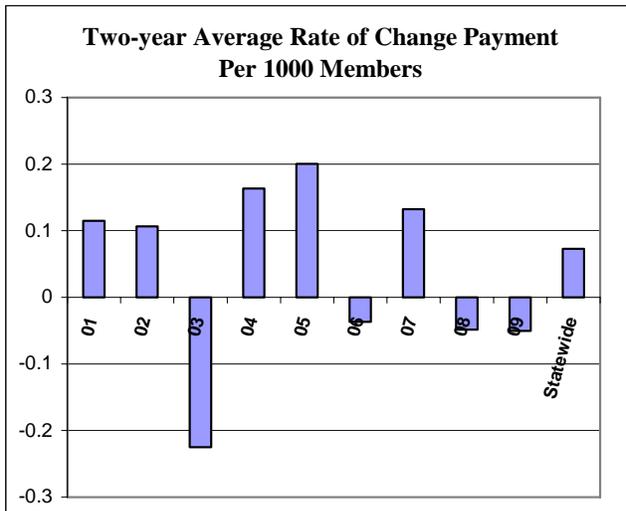
3 Digit ICD9 Code	Diagnosis Classification	2005 Payments	2005 Claims	2005 Avg Pymt/Claim	Pct of Total Payout	Average rate of change		
						Pymt/Mem	ClaimsMem	Pymt/Claim
V58	Encounter for other procedures & aftercare	\$ 3,023,259.45	3,459	\$ 874.03	13.3%	22.6%	24.7%	-1.7%
V54	Other orthopedic aftercare	\$ 2,759,689.43	2,344	\$ 1,177.34	12.1%	84.0%	80.5%	1.9%
V57	Care using rehabilitation procedures	\$ 3,361,900.25	2,773	\$ 1,212.37	14.8%	-6.8%	-4.9%	-2.1%
998	Other complications of procedures	\$ 1,104,986.33	785	\$ 1,407.63	4.9%	13.7%	13.8%	-0.1%
250	Diabetes mellitus	\$ 812,022.07	778	\$ 1,043.73	3.6%	9.1%	11.0%	-1.7%
781	Symptoms involving nervous/musculoskeletal system	\$ 738,644.47	639	\$ 1,155.94	3.2%	20.4%	15.1%	4.7%
715	Osteoarthritis and allied disorders	\$ 756,366.26	632	\$ 1,196.78	3.3%	0.1%	-5.9%	6.3%
707	Chronic ulcer of skin	\$ 663,903.95	368	\$ 1,804.09	2.9%	2.4%	17.0%	-12.5%
434	Occlusion of cerebral arteries	\$ 283,422.23	173	\$ 1,638.28	1.2%	525.5%	463.7%	11.0%
682	Other cellulitis and abscess	\$ 432,924.29	442	\$ 979.47	1.9%	12.1%	22.9%	-8.8%
428	Heart failure	\$ 295,440.44	284	\$ 1,040.28	1.3%	-4.9%	-12.9%	9.2%
340	Multiple sclerosis	\$ 307,365.92	177	\$ 1,736.53	1.3%	-14.3%	0.9%	-15.0%
728	Disorders of muscle, ligament, and fascia	\$ 141,550.96	102	\$ 1,387.75	0.6%	5.0%	10.8%	-5.2%
V55	Attention to artificial openings	\$ 216,166.72	285	\$ 758.48	0.9%	-6.4%	-8.3%	2.1%
V53	Fitting/adjustment of other device	\$ 163,275.67	141	\$ 1,157.98	0.7%	19.2%	-0.7%	20.0%
414	Other forms of chronic ischemic heart disease	\$ 281,352.57	315	\$ 893.18	1.2%	-4.5%	-16.8%	14.9%
496	Chronic airway obstruction, not elsewhere classified	\$ 196,110.26	210	\$ 933.86	0.9%	14.1%	12.9%	1.1%
716	Other/unspecified arthropathies	\$ 112,677.95	82	\$ 1,374.12	0.5%	-27.1%	-33.7%	10.0%
162	Malignant neoplasm of trachea, bronchus, & lung	\$ 173,414.03	194	\$ 893.89	0.8%	-1.5%	-12.0%	12.0%
436	Acute, but ill-defined, cerebrovascular disease	\$ 196,895.52	84	\$ 2,343.99	0.9%	-55.2%	-64.0%	24.4%
879	Open wound of other sited, except limbs	\$ 197,194.17	131	\$ 1,505.30	0.9%	14.6%	15.8%	-1.0%
996	Complications peculiar to certain procedures	\$ 157,307.47	134	\$ 1,173.94	0.7%	9.7%	11.8%	-1.8%
486	Pneumonia, organism unspecified	\$ 152,138.47	167	\$ 911.01	0.7%	12.5%	23.5%	-8.9%
401	Essential hypertension	\$ 166,937.60	164	\$ 1,017.91	0.7%	56.8%	41.3%	10.9%
438	Late effects of cerebrovascular disease	\$ 172,118.84	77	\$ 2,235.31	0.8%	79.4%	48.7%	20.6%
	Other	\$ 5,912,095.51	6,088	\$ 971.11	26.0%	-6.6%	-5.7%	-0.9%
	Total	\$ 22,779,160.83	21,028	\$ 1,083.28	100.0%	7.8%	7.9%	-0.1%

Appendix – C8
Home Health Care Detailed Report
2004 Cost, Use, and Price Experience by 3 Digit Diagnosis Classification

3 Digit ICD9 Code	Diagnosis Classification	2004 Payments	2004 Claims	2004 Avg Pymt/Claim	Pct of Total Payout
V58	Encounter for other procedures & aftercare	\$ 2,572,136.08	2,893	\$ 889.09	11.7%
V54	Other orthopedic aftercare	\$ 1,563,749.24	1,354	\$ 1,154.91	7.1%
V57	Care using rehabilitation procedures	\$ 3,762,726.52	3,039	\$ 1,238.15	17.1%
998	Other complications of procedures	\$ 1,013,259.45	719	\$ 1,409.26	4.6%
250	Diabetes mellitus	\$ 776,115.03	731	\$ 1,061.72	3.5%
781	Symptoms involving nervous/musculoskeletal system	\$ 639,519.13	579	\$ 1,104.52	2.9%
715	Osteoarthritis and allied disorders	\$ 788,222.56	700	\$ 1,126.03	3.6%
707	Chronic ulcer of skin	\$ 675,989.16	328	\$ 2,060.94	3.1%
434	Occlusion of cerebral arteries	\$ 47,250.49	32	\$ 1,476.58	0.2%
682	Other cellulitis and abscess	\$ 402,603.51	375	\$ 1,073.61	1.8%
428	Heart failure	\$ 323,788.22	340	\$ 952.32	1.5%
340	Multiple sclerosis	\$ 373,916.44	183	\$ 2,043.26	1.7%
728	Disorders of muscle, ligament, and fascia	\$ 140,514.32	96	\$ 1,463.69	0.6%
V55	Attention to artificial openings	\$ 240,760.80	324	\$ 743.09	1.1%
V53	Fitting/adjustment of other device	\$ 142,863.09	148	\$ 965.29	0.6%
414	Other forms of chronic ischemic heart disease	\$ 307,158.20	395	\$ 777.62	1.4%
496	Chronic airway obstruction, not elsewhere classified	\$ 179,247.22	194	\$ 923.95	0.8%
716	Other/unspecified arthropathies	\$ 161,158.13	129	\$ 1,249.29	0.7%
162	Malignant neoplasm of trachea, bronchus, & lung	\$ 183,569.83	230	\$ 798.13	0.8%
436	Acute, but ill-defined, cerebrovascular disease	\$ 458,021.16	243	\$ 1,884.86	2.1%
879	Open wound of other sited, except limbs	\$ 179,397.09	118	\$ 1,520.31	0.8%
996	Complications peculiar to certain procedures	\$ 149,493.30	125	\$ 1,195.95	0.7%
486	Pneumonia, organism unspecified	\$ 141,068.36	141	\$ 1,000.48	0.6%
401	Essential hypertension	\$ 111,026.45	121	\$ 917.57	0.5%
438	Late effects of cerebrovascular disease	\$ 100,060.14	54	\$ 1,852.97	0.5%
	Other	\$ 6,601,285.53	6,734	\$ 980.29	30.0%
	Total	\$ 22,034,899.45	20,325	\$ 1,084.13	100.0%

Appendix – C9
Home Health Care Detailed Report
Regional Data – Two Year Trends

Region	Two-year Average Rate of Change			Three-year Payout	% of Total Payout
	Payments Per 1000 Members	Claims Per 1000 Members	Payment Per Claim		
01	11.5%	10.9%	0.5%	\$38,678,084	56.1%
02	10.6%	11.2%	0.0%	\$1,284,001	1.9%
03	-22.5%	-16.0%	-7.7%	\$3,977,981	5.8%
04	16.3%	3.5%	12.1%	\$1,877,511	2.7%
05	20.0%	15.8%	4.0%	\$6,136,627	8.9%
06	-3.7%	-1.1%	-2.5%	\$3,717,044	5.4%
07	13.2%	16.8%	-2.8%	\$6,516,382	9.4%
08	-4.8%	-14.0%	14.5%	\$3,919,204	5.7%
09	-5.0%	7.2%	-12.0%	\$2,850,837	4.1%
Statewide	7.3%	6.7%	0.6%	\$68,957,671	100.0%



Appendix – 10
Home Health Care Detailed Report
2004-2006 Regional Data

Year	PC	Region	Payments	Claims	Per 1000 members		Pymt/Claim	Percent change of			Members
					Payments	Claims		Pymt/1000	Clms/1000	Pymt/Claim	
2006	08	01	\$14,080,064	12,861	\$ 12,527.48	11.44	\$ 1,094.79	11.7%	12.3%	-0.5%	1,123,934
2006	08	02	\$483,272	613	\$ 3,411.22	4.33	\$ 788.55	17.2%	22.6%	-4.4%	141,671
2006	08	03	\$989,838	1,171	\$ 5,024.98	5.94	\$ 845.26	-15.1%	-16.5%	1.7%	196,984
2006	08	04	\$677,830	627	\$ 3,309.35	3.06	\$ 1,081.88	-0.5%	-9.5%	9.9%	204,823
2006	08	05	\$2,331,996	1,888	\$ 9,850.40	7.97	\$ 1,235.45	11.2%	4.0%	6.9%	236,741
2006	08	06	\$1,151,483	1,166	\$ 4,157.40	4.21	\$ 987.14	-9.2%	-8.2%	-1.0%	276,972
2006	08	07	\$2,427,555	2,153	\$ 10,931.98	9.70	\$ 1,127.53	19.2%	26.7%	-5.9%	222,060
2006	08	08	\$1,187,892	994	\$ 7,446.76	6.23	\$ 1,194.49	-5.4%	-30.0%	35.2%	159,518
2006	08	09	\$813,681	541	\$ 9,993.14	6.65	\$ 1,503.77	-20.7%	-4.2%	-17.2%	81,424
Total			\$24,143,611	22,014	\$ 9,131.03	8.33	\$ 1,096.74	6.8%	5.5%	1.2%	2,644,127

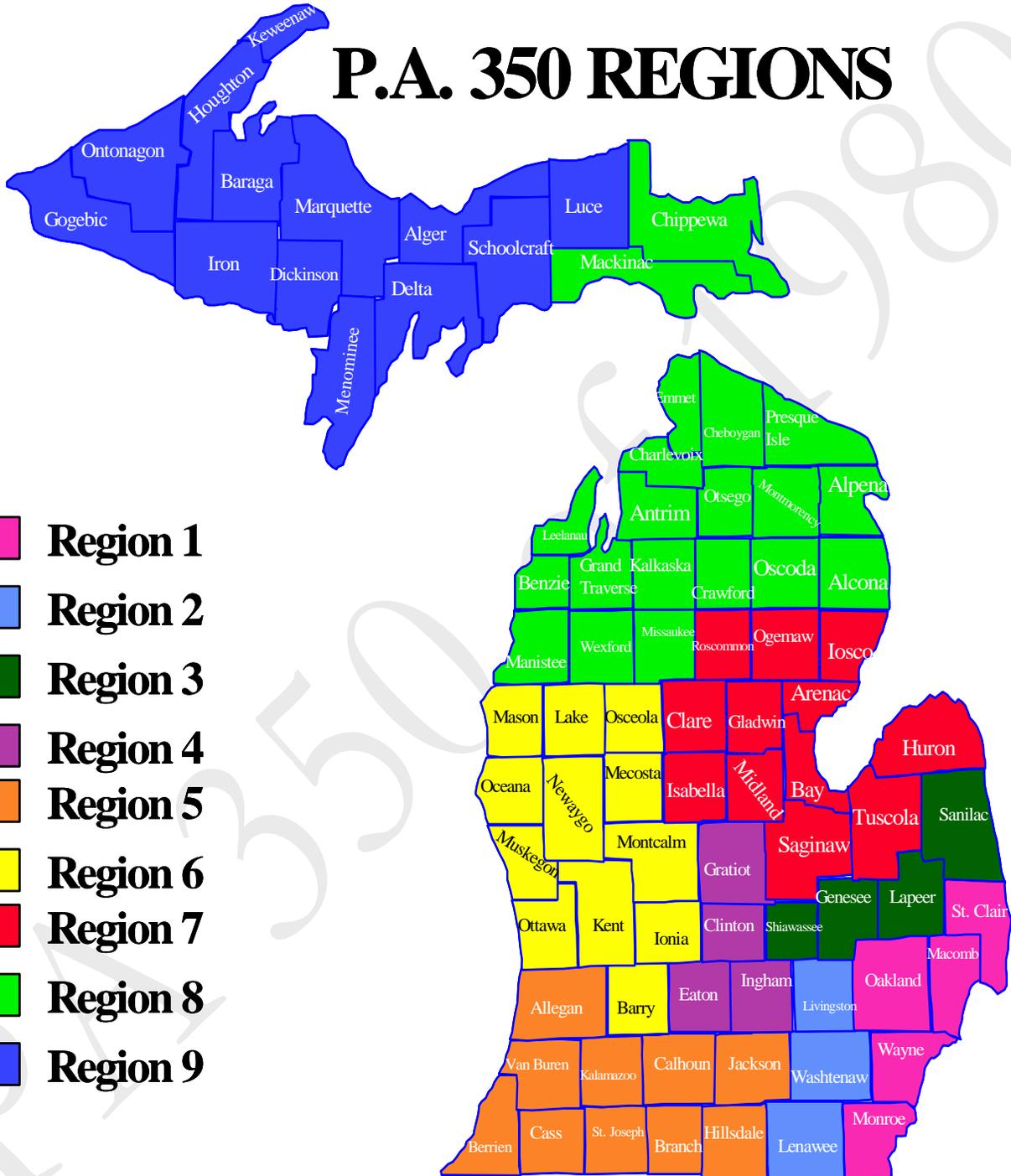
Year	PC	Region	Payments	Claims	Per 1000 members		Pymt/Claim	Percent change of			Members
					Payments	Claims		Pymt/1000	Clms/1000	Pymt/Claim	
2005	08	01	\$12,764,810	11,596	\$ 11,216.21	10.19	\$ 1,100.82	11.3%	9.5%	1.6%	1,138,068
2005	08	02	\$401,988	487	\$ 2,911.62	3.53	\$ 825.23	4.1%	-0.3%	4.4%	138,063
2005	08	03	\$1,187,119	1,428	\$ 5,918.46	7.12	\$ 831.45	-29.9%	-15.5%	-17.0%	200,579
2005	08	04	\$673,849	684	\$ 3,327.34	3.38	\$ 984.86	33.2%	16.5%	14.3%	202,519
2005	08	05	\$2,084,879	1,804	\$ 8,859.76	7.67	\$ 1,155.68	28.9%	27.5%	1.1%	235,320
2005	08	06	\$1,275,407	1,279	\$ 4,576.14	4.59	\$ 997.32	1.8%	6.0%	-3.9%	278,708
2005	08	07	\$2,064,046	1,722	\$ 9,169.15	7.65	\$ 1,198.43	7.2%	6.9%	0.3%	225,108
2005	08	08	\$1,285,297	1,455	\$ 7,872.68	8.91	\$ 883.58	-4.3%	2.0%	-6.2%	163,260
2005	08	09	\$1,041,765	573	\$ 12,605.07	6.94	\$ 1,816.98	10.7%	18.6%	-6.7%	82,647
Total			\$22,779,161	21,028	\$ 8,549.87	7.89	\$ 1,083.28	7.8%	7.9%	-0.1%	2,664,271

Year	PC	Region	Payments	Claims	Per 1000 members		Pymt/Claim	Members
					Payments	Claims		
2004	08	01	\$11,833,211	10,923	\$ 10,076.64	\$ 9.30	\$ 1,083.33	1,174,321
2004	08	02	\$398,741	504	\$ 2,796.30	\$ 3.54	\$ 790.48	142,596
2004	08	03	\$1,801,024	1,798	\$ 8,439.18	\$ 8.43	\$ 1,001.65	213,412
2004	08	04	\$525,831	610	\$ 2,498.31	\$ 2.90	\$ 861.47	210,475
2004	08	05	\$1,719,752	1,504	\$ 6,872.76	\$ 6.01	\$ 1,143.11	250,227
2004	08	06	\$1,290,154	1,243	\$ 4,493.87	\$ 4.33	\$ 1,038.06	287,092
2004	08	07	\$2,024,780	1,695	\$ 8,550.40	\$ 7.16	\$ 1,194.27	236,805
2004	08	08	\$1,446,014	1,535	\$ 8,223.95	\$ 8.73	\$ 941.81	175,830
2004	08	09	\$995,391	511	\$ 11,391.81	\$ 5.85	\$ 1,947.74	87,378
Total			\$22,034,899	20,325	\$ 7,931.54	\$ 7.32	\$ 1,084.13	2,778,136

APPENDIX D

P.A. 350 REGIONS

- Region 1**
- Region 2**
- Region 3**
- Region 4**
- Region 5**
- Region 6**
- Region 7**
- Region 8**
- Region 9**



APPENDIX E – Participation Agreements (Attached)

Home Health Care Facility Participation Agreement

PA 350 of 1980