

STATE OF MICHIGAN
DEPARTMENT OF LABOR AND ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner

In the matter of the Home Health Care
Provider Class Plan Determination
Report pursuant to Public Act 350 of 1980

No. 08-001-BC

/ _____
Issued and entered
This 23rd day of January 2008
by Ken Ross
Acting Commissioner

ORDER ISSUING DETERMINATION REPORT

I

BACKGROUND

Pursuant to Public Act 350 of 1980, as amended (Act), being MCLA 550.1101 et seq.; MSA 24.660 (101) et seq., the Commissioner of the Office of Financial and Insurance Services (Commissioner) issued Order No. 07-042-BC on July 23, 2007, giving notice to Blue Cross and Blue Shield of Michigan (BCBSM), and to each person who requested a copy of such notice, of her intent to make a determination with respect to the home health care provider class plan for calendar years 2005 and 2006.

II

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Based upon the foregoing considerations it is FOUND and CONCLUDED that:

1. Jurisdiction and authority over this matter are vested in the Commissioner pursuant to the Act.
2. BCBSM has complied with all applicable provisions of the Act.
3. All procedural requirements of the Act have been met.
4. The staff reviewed relevant data pertaining to the home health care provider class plan as discussed in the attached report, including written comments received during the

input period on the provider class plan. The input period was designed to provide the public with an opportunity to present data, views, and arguments with respect to the home health care provider class plan.

5. Pursuant to Section 510(2) of the Act, a copy of the determination report and this order shall be sent to the health care corporation and each person who has requested a copy of such determination by certified or registered mail.

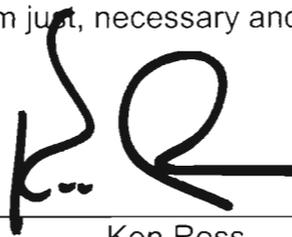
III

ORDER

Therefore, it is ORDERED that:

1. The attached home health care provider class plan determination report shall be incorporated by reference as part of this order and shall serve as the Commissioner's determination with respect to the home health care provider class plan for the calendar years 2005 and 2006.
2. Pursuant to Section 510(2) of the Act, the Commissioner shall notify BCBSM and each person who has requested a copy of such determination by certified or registered mail.
3. Pursuant to Section 515(1) and (2), any appeal must be filed within 30 days of the date of this determination report. The request for an appeal shall identify the issue or issues involved and how the person is aggrieved.

The Commissioner retains jurisdiction of the matters contained herein and the authority to enter such further order or orders as he shall deem just, necessary and appropriate.

A handwritten signature in black ink, appearing to be 'Ken Ross', written over a horizontal line.

Ken Ross
Acting Commissioner

HOME HEALTH CARE
PROVIDER CLASS PLAN
DETERMINATION REPORT
for calendar years 2005 and 2006

Office of Financial and Insurance Services
State of Michigan

HOME HEALTH CARE
PROVIDER CLASS PLAN
DETERMINATION REPORT

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EXECUTIVE SUMMARY

Pursuant to Public Act 350 of 1980, this report provides a review and determination of whether the arrangements Blue Cross and Blue Shield of Michigan (BCBSM) has established with health care providers have substantially achieved the access, quality of care, and cost goals set forth in the Nonprofit Health Care Corporation Reform Act for calendar years 2005 and 2006. The statutory goals specify that these arrangements, known as provider class plans, must assure subscribers reasonable access to, and reasonable cost and quality of, health care services covered under BCBSM's certificates.

The analysis and determination of goal performance is based on BCBSM's 2005-2006 home health care provider class plan annual report, additional data requested of BCBSM, and information on file with respect to this provider class plan. This material was supplemented as necessary by data from published sources. The determination report analyzes the level of achievement for each goal separately and discusses interaction and balance among the goals.

Access Goal

Achievement of the access goal requires BCBSM to be able to assure that, in any given area of the state, a BCBSM member has reasonable access to home health care services whenever necessary. In analyzing BCBSM's performance on the access goal, consideration was given to the formal participation rates of home health care providers. BCBSM was able to maintain a formal participation rate averaging 64.5% throughout Michigan during 2005 and 2006. BCBSM has made great strides since the 1992 review of this provider class plan to improve communication with home health care providers, making it easier for providers to participate and do business with BCBSM. Based on these facts, it is determined that BCBSM met the access goal during 2005 and 2006. BCBSM is encouraged, however, to work toward increasing the number of participating providers in the Southeastern Michigan region.

Quality of Care Goal

The quality of care goal requires BCBSM to assure that providers meet and abide by reasonable standards of health care quality. To achieve this goal, BCBSM must show that it makes providers aware of practice guidelines and protocols for home health care services, that it verifies that providers adhere to such guidelines and that it maintains effective methods of communication with its providers. During calendar years 2005 and 2006, BCBSM continued to monitor home health care provider qualification standards, and implemented and maintained a variety of quality control standards and utilization management initiatives. BCBSM kept the lines of communication open with home health care providers through its monthly publication of the *Record*, provider manuals and appeal processes and by holding regular liaison meetings with the Michigan Home Health Association. BCBSM also sponsored wellness programs to encourage members to adopt healthier, more active lifestyles. It is therefore determined that BCBSM met the statutory goal for calendar years 2005 and 2006.

Cost Goal

The cost goal requires that the arrangements BCBSM maintains with each provider class will assure a rate of change in the total corporation payment per member that is not higher than the compound rate of inflation and real economic growth. Achievement of the cost goal is measured by application of the cost formula specified in the Act, which is estimated to be 5.4% for the period under review. As the rate of change in the total corporation payment per member for the home health care provider class has been calculated to be an increase of 7.3% over the two years being reviewed, BCBSM did not meet the cost goal stated in the Act for 2005 and 2006.

Overall Balance of Goals

In summary, although BCBSM did not substantially achieve one of the three statutory goals for the home health care provider class plan for the two year period under review, a change in the plan is not required because, as discussed in the body of this report, there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve all of the goals is reasonable, due to factors listed in Section 509(4).

Introduction

The purpose of this report is to determine whether Blue Cross and Blue Shield of Michigan (BCBSM) met the access, quality of care, and cost goals outlined in the Nonprofit Health Care Corporation Reform Act, MCLA 550.1101 et seq. (Act), with respect to the home health care provider class plan for the calendar years 2005 and 2006.

In addition to the final determination, this report will: define a provider class plan, explain the statutory review process, and provide a detailed summary of the data considered in reaching the determination as well as a statement of findings, which support that determination.

Provider Class Plans - Legal Background

Section 107(7) of the Act, defines a provider class plan as “a document containing a reimbursement arrangement and objectives for a provider class, and, in the case of those providers with which a health care corporation contracts, provisions that are included in that contract.” Simply stated, a provider class plan is a document that includes measurable objectives for meeting the nonprofit health care corporation's access, quality of care, and cost goals outlined in the Act.

Section 504(1) of the Act requires BCBSM to contract with or enter into a reimbursement arrangement with providers in order to assure subscribers reasonable access to, and reasonable cost and quality of, health care services in accordance with the following goals:

1. BCBSM must contract with or enter into reimbursement arrangements with an appropriate number of providers throughout the state to assure the availability of certificate covered health care services to each subscriber. Section 502(1) of the Act specifically indicates that a participating contract with providers includes not only agreements in which the providers agree to participate with BCBSM for all BCBSM members being rendered care, but also agreements in which the provider agrees to participate only on a per-case basis. Participation with BCBSM means that a provider of health care services agrees to accept BCBSM's approved payment as payment in full for services provided to a BCBSM member.
2. BCBSM must establish and providers must meet and abide by reasonable standards of quality for health care services provided to members.
3. BCBSM must compensate providers in accordance with 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.

Section 509(4) of the Act requires the Commissioner of Financial and Insurance Services (Commissioner) to consider various types of information in making a determination with respect to the statutory goals. This information includes:

1. Annual reports filed by BCBSM, which pertain to each respective provider class;
2. Comments received from subscribers, providers, and provider organizations;
3. Health care legislation;
4. Demographic, epidemiological and economic trends;
5. Administrative agency or judicial actions; sudden changes in circumstances; and changes in health care benefits, practices and technology.

The Commissioner shall also assure an overall balance of the goals so that one goal is not focused on independently of the other statutory goals and so that no portion of BCBSM's fair share of reasonable costs to the provider are borne by other health care purchasers. After careful consideration of all of the information that was submitted or obtained for the record, the Commissioner must make one of the following determinations pursuant to Section 510(1) of the Act:

- (a) That the provider class plan achieves the goals of the corporation as provided in Section 504 of the Act.
- (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 and submitted to support a determination that the failure to achieve one or more of the goals was reasonable due to the factors listed in Section 509(4) of the Act.
- (c) That the provider class plan does not substantially achieve one or more of the goals of the corporation as provided in Section 504 of the Act.

If the Commissioner determines that the plan does not substantially achieve one or more of the goals, without a finding that such failure was reasonable, BCBSM must transmit to the Commissioner within six months a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings. If after six months or such additional time as provided for in Section 512, BCBSM has failed to submit a revised provider class plan as stated above, the Commissioner must then prepare a provider class plan for that provider class.

Overview of the Home Health Care Provider Class Plan

The home health care provider class for BCBSM covers the services provided by a public agency or private organization that provides skilled nursing care and various therapeutic services to members who are confined to their homes. The services must be provided through a centralized administration that uses coordinated planning, evaluation and follow-up procedures. Home health care providers primarily render skilled nursing care. They also provide one or more of the following types of services in order to maximize the health, independence, dignity and comfort of the patient including, physical therapy, occupational therapy, speech and language pathology, nutritional assessment and counseling, social services and home health aide services. These services are provided to BCBSM members by both hospital-based and freestanding home health care providers.

For the period 2005-2006, payments to home health care providers represented an average of 0.7% of the total benefit payments made to health care providers on behalf of BCBSM members. For the purpose of provider class plan reviews by the Office of Financial and Insurance Services (OFIS), paid claims data are categorized by nine geographic regions. A map, which depicts these geographic regions, is included in Attachment A.

Home health care providers are subject to certain qualification standards set by BCBSM. BCBSM's home health care provider class plan indicates providers must meet the following qualifications:

1. Current Medicare certification as a home health care provider or accreditation for home health care by at least one national accreditation organization approved by BCBSM, such as, the Community Health Accreditation Program (CHAP), the Joint Commission on Accreditation of HealthCare Organization (JCAHO) or the Accreditation Commission for Health Care (ACHC).
2. Current membership in any one of the following professional organizations:
 - American Public Health Association
 - National League for Nursing
 - Michigan League for Nursing
 - American Home Care Association
 - American Association for Homecare
 - National Association of Home Care
 - Visiting Nurses Association of America
 - Michigan Home Health Association
3. Have written policies and procedures that meet generally acceptable standards for home health care services to assure the quality of patient care, and demonstrate compliance with such policies and procedures.

4. Demonstrate program evaluation and utilization review programs to assess the appropriateness, adequacy and effectiveness of the program's administrative and clinical components.
5. Have a multi-disciplinary staff composed of a nursing administrator or coordinator who is a Michigan registered nurse and who 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 consultant, advisor, and liaison between the facility and the medical community; Michigan licensed registered nurses; and, Michigan licensed physical therapists, occupational therapists or social workers, as appropriate to the services provided by the facility.
6. Have provisions for skilled nursing services and one of the following professional types of service: physical therapy, speech therapy, nutritional therapy, occupational therapy or medical social services.
7. Meet BCBSM's Evidence of Necessity (EON) requirements, as applicable.
8. Have a governing board that is legally responsible for the total operation of the facility and for ensuring quality care is provided in a safe environment. The governing board, or as an alternative, a community advisory board responsible to the governing board, shall 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.
9. Have no inappropriate utilization or practice patterns, as identified through valid subscriber complaints, audits and peer review nor participation in fraud or illegal activities.
10. Maintain adequate patient and financial records.

Reimbursement for hospital based facilities is determined by the parent hospital's peer group assignment as defined in the BCBSM participating hospital agreement (PHA) and as supplemented by the PHA payment manual. A home health care provider that is owned and operated by a hospital and considered a peer group 1-4, 6 or 7 hospital will be reimbursed using a prospectively established hospital-specific cost-to-charge ratio for home health care services, less member co-payments and deductibles. A home health care provider that is owned and operated by a peer group 5 hospital is reimbursed at the same level established for that hospital's acute care services, less applicable co-payments and deductibles.

Freestanding home health care providers are reimbursed the lesser of allowable costs or billed charges, less member deductibles or co-payments. An interim percentage of charge payment rate is initially determined for each home health care provider based on information submitted to BCBSM when the provider applies for participation. Thereafter,

the provider's interim percentage of charge payment rate may be adjusted, as necessary, to reflect retrospective settlement following BCBSM's audit or review of the provider's annual home health cost report.

During the review period, home health care providers could participate with BCBSM only under its formal participation program. A formally participating provider has signed an agreement to accept BCBSM reimbursement as payment in full, excluding applicable co-payments or deductibles, for all covered services rendered to BCBSM members by the provider.

BCBSM is required to include as part of each provider class plan its objectives toward achieving the goals specified in the Act. BCBSM's objectives with regard to the home health care provider class plan are to:

Access:

- Provide direct reimbursement to participating providers who render medically necessary, high-quality services to BCBSM members.
- Communicate with participating providers about coverage determinations, billing, benefits, provider appeals processes, BCBSM's record keeping requirements and the participating agreement and its administration.
- Maintain and periodically update a printed or web site directory of participating providers.

Quality of Care:

- Ensure BCBSM members receive quality care by requiring participating providers to meet BCBSM's qualification and performance standards.
- Meet with specialty liaison societies to discuss issues of interest and concern.
- Maintain and update, as necessary, an appeals process that allows participating providers to appeal individual claims disputes regarding utilization review audits.

Cost:

- Strive toward meeting the cost goal within the confines of Michigan and national health care market conditions.
- Provide equitable reimbursement to participating providers through the reimbursement methodology outlined in the participation agreement.

History of the Home Health Care Provider Class Plan

BCBSM had an existing reimbursement arrangement with home health care providers in effect when the Act took effect on August 27, 1985. BCBSM first filed the home health care provider class plan with OFIS pursuant to Section 506(1) of the Act on June 15, 1987.

Section 506(2) states:

"Upon receipt of a provider class plan, the commissioner shall examine the plan and shall determine only if the plan contains a reimbursement arrangement and objectives for each goal provided in Section 504, and, for those providers with which a health care corporation contracts, provisions that are included in that contract."

Section 506(2) further states:

"For purposes of making the determination required by this subsection only, the commissioner shall liberally construe the items contained in a provider class plan."

Since the home health care provider class plan met the filing requirements of Section 506 of the Act stated above, OFIS notified BCBSM by letter on June 16, 1987 that the home health care provider class plan was placed into effect and retained for the Commissioner's records pursuant to Section 506(4).

On November 5, 1987, BCBSM amended all of its provider class plans, including the home health care plan, to include an appeal process for utilization review audits performed by the corporation. This amendment to the home health care provider class plan was made by BCBSM in accordance with Section 508(1) of the Act.

The home health care provider class plan was modified by BCBSM on May 6, 1988, February 6, 1995, December 26, 1997, December 20, 2000, April 6, 2006 and February 13, 2007. In December 2000, BCBSM made various changes to the provisions in the participation agreement including definitions, hold harmless, qualifications, reimbursement, termination, confidentiality, amendments, and compliance with BCBSM's policies. In 2006, the home health care provider class plan was modified to recognize the licensure of social workers. BCBSM again modified the home health care provider class plan in 2007 to include the Accreditation Commission for Health Care as an approved accrediting body under BCBSM's qualification standards.

Review Process

On July 23, 2007, the Commissioner issued Order No. 07-042-BC, which provided written notice to BCBSM, health care providers, and other interested parties of her intent to make a determination with respect to the home health care provider class plan for calendar years 2005 and 2006. Order No. 07-042-BC also called for any person with comments on matters concerning the provider class plan to submit such comments to OFIS in accordance with Section 505(2) of the Act. Section 505(2) requires the Commissioner to

establish and implement procedures whereby any person may offer advice and consultation on the development, modification, implementation, or review of a provider class plan. Requests for testimony on BCBSM's home health care provider class plan were sent to all those on OFIS' interested persons list for the home health care provider class and posted on OFIS' website, providing interested parties three months to prepare and submit testimony.

Summary of Written Input:

Requests for written testimony regarding the home health care provider class plan were sent to those on OFIS' interested persons list, including the Michigan Home Health Association, and posted on OFIS' website. The Michigan Home Health Association (MHHA) created a survey it sent to its certified and private duty member agencies to complete and return to both MHHA and OFIS. Seven home health care agencies responded to MHHA's request and provided comments to OFIS.

There was a general impression that BCBSM has established and maintained reasonable standards of health care quality for participating home health care providers. Some MHHA members indicated BCBSM reimbursement rates are low and lag behind actual costs, but acknowledge the present arrangement is much better than the previous authorization process. MHHA members believed OFIS should survey BCBSM members and analyze the number of provider choices available in service areas in relation to population demographics. MHHA members suggested a Home Health Compare website maintained by the Centers for Medicare & Medicaid Services as a resource tool. The website is designed to address quality criteria and performance measures of home health care providers.

MHHA indicated there was a general consensus among its members that BCBSM satisfactorily recognizes changes that have taken place in the health care industry, although it is believed home infusion therapy benefits need improvement for ambulatory patients. MHHA members indicated BCBSM processes claims in a reasonable and timely manner, with exception that out-of-state claims can be difficult to process. BCBSM's Medicare Advantage program and claims for supplies are cited by MHHA members as areas in need of improvement for the implementation of policy and claims processing systems changes.

MHHA members generally believe BCBSM has demonstrated the ability to provide prompt, reasonable explanations regarding reimbursement issues, medical necessity determinations and audit determinations, as well as establishing reasonable internal procedures for promptly resolving disputes, with exception of certain particularly complicated issues which may require the "out of process" attention of BCBSM senior management officials.

Discussion of Goals Achievement/Findings and Conclusions

Access Goal:

The access goal in Section 504(1) of the Act states that "[T]here will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

In order to achieve compliance with the access goal, BCBSM needs to be able to assure, that in any given area of the state, a BCBSM member has reasonable access to home health care services covered under the terms of that member's certificate whenever such treatment is required. In analyzing BCBSM's performance on the access goal, OFIS staff examined several aspects of how access to home health care services could be obtained, including the formal participation rates of providers, to get an overall picture of how well BCBSM was assuring the availability of certificate-covered health care services to each member throughout the state.

The following information, supplied by BCBSM in July 2007 and December 2007 shows the number of Michigan participating home health care providers and membership by geographic region for calendar years 2005 and 2006:

**Home Health Care Provider Class Plan
 Formal Participation Rates**

	2005			2006		
	No. of Par Providers	Total Providers	Par Rate %	No. of Par Providers	Total Providers	Par Rate %
Region 1	76	160	48%	90	189	48%
Region 2	7	12	58%	8	12	67%
Region 3	10	13	77%	12	12	100%
Region 4	8	8	100%	8	8	100%
Region 5	19	22	86%	18	22	82%
Region 6	25	29	86%	26	26	100%
Region 7	16	19	84%	18	8	86%
Region 8	8	8	100%	8	14	100%
Region 9	15	17	88%	14	14	100%
Statewide	184	288	64%	202	312	65%

BCBSM maintained an average statewide formal participation rate of 64.5% statewide during 2005 and 2006. BCBSM states regional rates for most regions were 80% or more. BCBSM cites the 48% participation in region one (Southeastern Michigan) as being the result of recently approved Medicare home health care providers that had not as yet requested formal participation with BCBSM. BCBSM acknowledged that some of these facilities may choose to be Medicare specific facilities only, but BCBSM expected participation in region one to increase in 2007 as trends show Medicare acceptance is generally followed with a participation request with BCBSM. OFIS requested from BCBSM its actual 2007 participation rates by region to determine whether an increase in participation for region one occurred as expected. In December 2007, BCBSM supplied the following home health care provider participation data:

**Home Health Care Provider Class Plan
 2007 Formal Participation Rates**

	2007		
	No. of Par Providers	Total Providers	Par Rate %
Region 1	108	243	44%
Region 2	8	14	57%
Region 3	11	13	85%
Region 4	7	7	100%
Region 5	18	22	82%
Region 6	25	26	96%
Region 7	19	23	83%
Region 8	8	8	100%
Region 9	14	14	100%
Statewide	218	370	59%

The above data illustrates that the number of total participating providers did indeed increase in region one, but it appears only about one-third of the new home health care providers in that region opted to enter into participation agreements with BCBSM, causing the overall participation rate in region one to actually decrease to 44%. BCBSM indicated that it is not possible to confirm how many of the 54 new home health care providers in region one opted to be Medicare only facilities. Small decreases in participation rates also occurred in region two (Ann Arbor area), region five (West Michigan) and region seven (Bay/Thumb area). On a positive note, participation rates increased in regions three (Flint) and nine (Upper Peninsula). Nonetheless, BCBSM's total participation rate decreased from 65% in 2006 to 59% in 2007.

In order to assess how the participation rates of home health care providers affect BCBSM member access to care, BCBSM was asked to provide the location of non-participating providers by county for 2006. Most of the non-participating providers are located in

Southeastern Michigan in Oakland and Wayne counties where there are still many participating home health care providers to provide care. Also, it is important to recognize many of the home health care facilities have branch locations through the region that are not counted as separate participating providers, meaning that there really are more home health care locations than what might be illustrated by the participation rate in the Southeastern Michigan region. BCBSM states there are 54 branch locations associated with home health care providers throughout Michigan. Of the 54 branches, 11 are located in Southeastern Michigan.

Review of the county data provided by BCBSM reveals there is only one home health care provider located in Lenawee County and that provider is not a BCBSM participating facility. Similarly, there are four facilities in Berrien County but only one participates with BCBSM. Several counties in northern Lower Michigan and in the Upper Peninsula have no facilities available to them at all. In reality, however, home health care is such that the facility comes to the BCBSM member rather than the member going to the facility, meaning home health care services can easily be obtained from a provider in a nearby county.

BCBSM's communication efforts also impact access to care as it helps establish and maintain a good rapport with participating providers. During the review of BCBSM's 1988-1989 home health care provider class plan, OFIS determined BCBSM did not effectively communicate with providers which may have caused BCBSM members to experience some difficulty in accessing home health care services. There was concern that providers had difficulty in obtaining consistent interpretations of BCBSM's policies and practices; BCBSM seemed unable to assist providers in coordinating care with its major/master medical program; there was a lack of participation standards for the delivery of home infusion therapy, and BCBSM's interpretation of eligibility criteria seemed to restrict rather than encourage utilization of home health care services.

Since the issuance of OFIS' 1992 determination report on the 1988-1989 home health care provider class plan, BCBSM has made great strides in improving communication with home health care providers through a variety of publications, services, inquiry systems and programs. BCBSM also established a separate provider class plan in 1996 for home infusion therapy and now has regular meetings with the Michigan Home Health Care Association members to discuss and resolve issues.

BCBSM distributes to all providers a publication called the *Record*. This monthly publication contains current information relating to billing, reimbursement, group-specific benefit changes, day-to-day business information and medical criteria modifications. 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.

As part of the review process, OFIS examined a copy of BCBSM's home health care provider manual obtained from BCBSM's Web-DENIS. The provider manual, revised in September 2005 and continuously updated online, includes information, such as

participation requirements, patient eligibility requirements, admission verification and pre-certification, benefits and exclusions, criteria and guidelines for services, documentation guidelines, claim submission information, and sections describing audit information, claims appeals processes, utilization review, and how to obtain information from BCBSM's provider inquiry department.

BCBSM states it offers providers the options of speaking with provider service representatives, writing to its inquiry department and having a provider consultant visit provider offices to help guide and educate their staff. BCBSM trainers also educate 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.

BCBSM states in 2005, its web-DENIS system 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 provides quick delivery of contract eligibility, claims status, online manuals, newsletters, fee schedules, reports and other types of required information designed 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 2006, BCBSM retired private connection options previously used to access web-DENIS before Internet access capability was implemented, inasmuch as most providers using web-DENIS have switched to using Internet connections. BCBSM added additional fee schedules, medical policy documents and more provider training modules to web-DENIS in 2006. Easy-to-find links such as *Partner Links* were also added. *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 co-payments. In 2005, CAREN⁺ became speech enabled so providers can enter contract numbers by voice or text, with additional voice capability enhancements introduced in 2006. New security measures were also added to CAREN⁺ to safeguard BCBSM's members' protected health information.

BCBSM has also instituted several provider affiliation strategy programs to foster an ongoing commitment to excellent performance and dialogue with providers. BCBSM states it promotes business relationship with providers so they will: 1) collaborate with BCBSM to improve the health status of patients and the quality and cost effectiveness of care; 2) help BCBSM deliver outstanding customer service to members; and 3) value BCBSM as a health plan of choice and recommend it to patients and others. The provider affiliation

strategy focuses on increasing provider satisfaction and creating a strong relationship with providers by providing a prompt and accurate claims payment system, consistent, accurate and responsive service; timely and effective communication, and partnerships to promote and facilitate better health care.

BCBSM initiated programs to improve the quality and timeliness of system changes to improve the percentage of claims reimbursed on the first submission and reduce the number of initial claim rejections. This initiative has reduced the number of claims that are manually adjusted to process through BCBSM's claim system. BCBSM states 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 simplification 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, BCBSM now allows providers to collect percentage co-payments and some deductible amounts at the time of 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, educated their staffs on billing policies and procedures and provided written materials that may help providers' staffs in their daily work. BCBSM states in recent years it 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.

"E-Gateway" is BCBSM's new secured provider portal on www.bcbsm.com. The portal allows providers to access web-DENIS through the Internet, which makes it easier for providers to do business with BCBSM. From BCBSM's web site, simple navigation leads providers to BCBSM's new secured platform into web-DENIS. BCBSM's improved presence on the World Wide Web focuses on enhanced communications and giving providers easy access to necessary resources. E-Gateway is a new way for providers 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. It also allows providers and their office staff to quickly view manuals, newsletters, fee schedules, reports and much more to help them conduct business with BCBSM.

BCBSM states it also added new, easy-to-find links to E-Gateway. Quick Links provides easy access to e-referrals, formularies, BlueHealth Connection[®] and professional and hospital/facility inquiries. The Partner Links connect providers to partner sites, which include the Council for Affordable Quality Healthcare, Institute for Safe Medication Practices, Michigan State Medical Society and Michigan Health and Hospital Association.

BCBSM also 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. BCBSM states more than 2000 providers attended its outreach fairs during 2006.

BCBSM's reimbursement methodology is designed to be equitable to ensure appropriate provider participation levels. Reimbursement policies, as described on page four of this report differ for hospital-based and freestanding home health care providers. BCBSM periodically reviews both hospital-based and freestanding home health care provider reimbursement to determine if modifications are necessary, but does not guarantee this review process will result in increased reimbursement.

Home health care providers having provided written input into this review indicated problems with the implementation of the Medicare Advantage program and with the processing of out-of-state claims. BCBSM acknowledges problems occurred initially with the Medicare Advantage program. Home health care providers electronically submitted "Request for Anticipated Payment" (RAP) claim forms. The RAP claims were rejected when the total charge amount submitted on the claim was not greater than zero. This was inappropriate since RAP claims do not require a charge amount to be submitted for Medicare. Electronic data interchange modifications were made to discontinue the rejection of these claims.

BCBSM states its BlueCard department processes out-of-state claims. The BlueCard department is not aware of any unique problems with home health care out-of-state claims. Home health care providers still experiencing problems with out-of-state claims are encouraged to contact BCBSM's provider inquiry area. BCBSM states any issue the provider inquiry department cannot resolve will be forwarded to the plan-to-plan servicing unit for resolution.

Findings and Conclusions - Access

In order to achieve compliance with the access goal, BCBSM needs to be able to assure that in any given area of the state a member has reasonable access to certificate-covered home health care services, whenever such services are required. The number of home health care providers participating with BCBSM in most Michigan regions is at an acceptable level. The participation rate in Southeastern Michigan is less than 50% and has been decreasing slightly each year despite the fact that more providers are participating in 2007 than during the two year period under review. The lack of complaints on file with

OFIS regarding the inability of BCBSM members to access home health care in Southeastern Michigan seems to illustrate access to such services, although not ideal, is not severely compromised. BCBSM has also made great strides since the last review of this provider class plan to improve communication with home health care providers. As such, it is determined that BCBSM generally met the access goal stated in the Act for calendar years 2005 and 2006. BCBSM is encouraged, however, to review the availability and accessibility of home health care services in Southeastern Michigan and work toward increasing access the number of participating providers in those areas.

Quality of Care Goal:

The quality of care goal in Section 504(1) of the Act states that "[P]roviders will meet and abide by reasonable standards of health care quality."

In analyzing BCBSM's performance on the quality of care goal, OFIS staff examined BCBSM's achievement of its quality of care objective, the methods BCBSM utilized in establishing and maintaining appropriate standards of health care quality, and BCBSM's methods of communication with home health care providers. We reviewed these factors to assure that BCBSM not only encouraged provider compliance with the expected standards of home health care services, but also that it kept abreast of new technological advances available to treat those BCBSM members that require such services. All of the above factors impact the quality of home health care services delivered to BCBSM members. The pertinent issues that were considered in reaching a determination with respect to the quality of care goal, based on the review of data provided by BCBSM and other sources during this review period, are described below.

BCBSM has taken a twofold approach to achieving its quality of care objectives for the home health care provider class. First, BCBSM attempts to promote the quality of health care delivered by providers through the enforcement of provider qualifications and utilization review programs and by assessing patterns of care in Michigan home health care providers and providing home health care providers with incentives to improve the quality of care. Second, BCBSM strives to forge strong relationships with participating providers by designing programs directed toward effective servicing and communication.

To ensure acceptable levels of care provided by home health care providers, BCBSM requires that these providers meet the participation qualifications and performance standards listed on pages three and four of this report. BCBSM states that provider qualification status is continually monitored to ensure subscriber access to competent providers who are not involved in fraud or illegal activities.

BCBSM has various programs and criteria to help with its quality controls, including utilization management, audits and, if necessary, termination of a provider's participation agreement. BCBSM states it has specific criteria that focus on safety and effectiveness that must be met before BCBSM members can use home health care services. The required criteria are as follows:

- 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, but not ready for traditional hospice services
- The member must be willing to accept home care and have a suitable support system
- Member must be homebound as determined by Medicare's definition

A patient is considered homebound when the attending physician certifies that the patient is confined to the home or is immobile due to illness, injury or surgery that restricts the patient's ability to leave his or her place of residence. If the patient does leave the home, the absences are infrequent or for periods of relatively short duration and require considerable effort or the assistance of another person. The patient does not have to be bed bound to be considered confined to 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 the patient for home health care services if the absence is of infrequent or of relatively short duration, such as attendance at religious services.

BCBSM uses the national published 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 annually updated best practices, clinical data and medical literature. This tool allows for consistent, reproducible reviews and ensures that patients receive the right care in the right setting. BCBSM implemented the 2006 InterQual home health care criteria on July 31, 2006. The InterQual criteria are also reviewed yearly by the BCBSM Criteria Review Committee. BCBSM makes any necessary changes that are required by its medical and benefit policies. BCBSM's modifications of InterQual's 2006 criteria include:

- 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

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- Skilled nursing visits provided for eight hours or more a day do not meet BCBSM's criteria
- Hospice and palliative care services do not meet BCBSM home health care criteria, but rather are administered under the hospice benefit. Hospice and palliative care include 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

Some of the comments received by home health care providers indicated some InterQual home health care criteria are too restrictive and may limit good patient outcomes. Providers did not, however, provide any substantive examples for OFIS to review. BCBSM states it has not changed its modifications for home health care providers for several years so home health care providers are very familiar with the criteria. BCBSM does not believe its criteria are too restrictive and is not aware of having received any comments or complaints about its criteria being too restrictive. Providers with InterQual criteria are encouraged to contact BCBSM via e-mail at its help line InterQualCriteria@bcbsm.com.

Home health care providers having provided written input into this review indicated BCBSM should utilize the Medicare Outcome and Assessment Information Set (OASIS) tool as a means of assessing home health care provider quality of care. Measures of quality collected through OASIS include:

- Improvement in Ambulation/Locomotion
- Improvement in Bathing
- Improvement in Transferring
- Improvement in Management of Oral Medication
- Improvement in Pain Interfering with Activity
- Acute Care Hospitalization
- Emergent Care
- Discharge to Community
- Improvement in Dyspnea (Shortness of Breath)
- Improvement in Urinary Incontinence

BCBSM acknowledges it does use the Medicare OASIS tool, but states BCBSM's terms and conditions of participation do not require home health care agencies to submit OASIS dataset information. BCBSM states it does not review provider outcome scores on the Medicare Compare website (www.medicare.gov/hhcompare). OFIS compared Mid-Michigan area home health care facilities on the Medicare Compare website and found the local home health care agencies were ranked above the national average in the above listed quality measures.

BCBSM remains committed in its efforts to improve the health status of Michigan residents by focusing resources on areas of greatest importance where BCBSM is uniquely

positioned to deliver results and consequently reduce health care costs. BCBSM executed and publicized health initiatives that focus on critical health issues such as: 1) community programs addressing geographic, racial and ethnic disparities; 2) programs designed to improve the health status of children; and, 3) programs designed to address obesity and smoking cessation programs. BCBSM also sponsors programs such as *Walking Works™*, 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. It is hoped that by encouraging kids to adopt healthier, more active lifestyles now, these programs will help control health care costs in the future.

Input received as part of the review process from home health care providers indicated it would be useful for OFIS to conduct patient satisfaction surveys in an effort to gauge quality of care. Given that OFIS would not be privy to confidential patient care data, OFIS asked BCBSM to provide information pertaining to any patient satisfaction surveys it had conducted related to the home health care provider class. Unfortunately, BCBSM stated it had not done any patient satisfaction surveys specific to home health care services. BCBSM did state, however, that it has conducted patient satisfaction surveys as part of its BlueHealthConnection®. The BlueHealthConnection® program is described in detail on page 30 of this determination report.

BCBSM also monitors provider performance through its 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 over use of these 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 a BCBSM medical consultant for review. 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 decisions. 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 fails to meet the guidelines.

During utilization review audits, paid claims data and the corresponding medical records are reviewed to ensure that home health care services were appropriate and the services rendered were performed for the appropriate indications, in appropriate settings and were accurately billed and paid. At the conclusion of the audit, a departure conference with the facility representative, led by a BCBSM auditor, provides preliminary findings identified in 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 noted below, BCBSM audited a total of twenty three home health care providers during the two year period under review.

Home Health Care Facilities Audit Results		
	2005	2006
Number of audits	13	10
Initial Identified Savings	\$370,000	\$260,000
Year-end Recoveries	\$165,000	\$111,000
Referred to CFI*	0	1

*Corporate Financial Investigations

Audits conducted during the two year period under review addressed lack of medical necessity, services billed but not documented and progress notes not meeting therapy guidelines. BCBSM states medical necessity is determined after review of the patient’s history, physical examination, and any pertinent laboratory, imaging and other information necessary to support the rationale for the planned services. 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.

Another measure of BCBSM’s achievement of the quality of care goal includes BCBSM’s ability to effectively communicate with providers. Given that the quality of care goal defined in the Act requires that “providers meet and abide by reasonable standards of health care quality,” it is necessary for providers to be made aware of BCBSM’s standards, for BCBSM to verify that its providers adhere to such standards and that BCBSM is responsive to provider inquiries, input, and appeals, as all of these factors impact the quality of home health care services given to BCBSM members.

The interests of home health care providers are currently represented by the Michigan Home Health Association (MHHA). BCBSM met with MHHA twice during 2005 and three times in both 2006 and 2007. These liaison meetings are dedicated to the resolution of issues of dispute in order to improve the quality of home health care services delivered to BCBSM members. The minutes of these meetings were obtained from BCBSM for review. Items discussed at these liaison meetings include billing policies for a variety of supplies such as glucose monitors, infant apnea monitors, rent to own items, oxygen, oxygen concentrators, flu vaccines, orthotics and Bi-PAP and CPAP machines. Other discussions were held regarding differences in Medicare and BCBSM policies (e.g. physical therapy aide supervision), how to handle private duty nursing claims, UPS signature logs, InterQual criteria training, recent home health care provider audit findings and the Medicare Advantage program. The minutes reveal BCBSM staff works diligently to research the issues raised during the liaison and find resolution to billing and policies issues as needed.

BCBSM states that it maintains open communications with home health care providers through its monthly publications, provider manuals, and its formal appeal process. All participating home health care providers receive BCBSM's monthly publication of the *Record*. BCBSM states the issues discussed in this publication are those that often impact providers' practice patterns and the achievement of utilization performance standards. BCBSM also has regional field services representatives that are available for on-site, individualized provider education and to address problems and concerns. Providers also receive direct mailings from BCBSM announcing changes in benefit programs and requesting provider feedback and these types of issues.

BCBSM also maintains a provider appeal process for home health care providers. The purpose of the appeal process is to resolve claim or audit disagreements. The appeal process is periodically published in the *Record* and is outlined in detail in both the online provider manual and the home health care facility participating agreement.

There are many different levels of the appeals process. The provider starts with a routine inquiry to BCBSM and can follow with a written complaint asking for a reconsideration review. If the provider is not satisfied with the reconsideration, he or she may submit a written request for a Managerial-Level Review Conference. During this conference, BCBSM and the provider discuss the dispute in an informal setting and explore possible resolutions of the dispute.

If the provider is dissatisfied with the managerial-level review, the provider can continue with BCBSM's appeal process, appeal to OFIS, initiate legal action, or if medical necessity issues are in dispute, request an external peer review for medical necessity issues. If this review is decided in favor of BCBSM, the provider will pay the costs of the external review. If the review is decided in favor of the provider, BCBSM pays the costs. If the findings are partially upheld and partially reversed, BCBSM and the provider share the costs of peer review in proportion to the results. The decision of the external review organization on medical necessity disputes is final and binding on both the provider and BCBSM.

For disputes involving administrative, billing and coding disputes, a provider may request a review by an internal review committee. BCBSM's Internal Review Committee is composed of three members of BCBSM senior management. If providers are unhappy with the Internal Review Committee decision, they can appeal to BCBSM's Provider Relations Committee. The Provider Relations Committee is a subcommittee of the BCBSM Board of Directors composed of BCBSM participating professionals, community leaders and BCBSM senior management.

Providers that go through BCBSM's appeals process and remain dissatisfied can appeal medical necessity issues and administrative and billing and coding issues to OFIS for an informal review and determination. If the provider remains dissatisfied, they can move to a contested case hearing pursuant to Section 550.1404(6) of the Act. Contested case hearing decisions are subject to appeal in the circuit court.

In 2005, there were six home health care providers that initiated appeals of BCBSM's audit findings. Of the 118 patient cases reviewed, 62 of BCBSM's decisions were maintained, ten reversed and 46 revised. Similarly, in 2006, six home health care providers initiated appeals of BCBSM's audit findings. Of the 86 patient cases reviewed, 60 of BCBSM's decisions were maintained, seven reversed and 19 revised. There were no home health care facility audit appeals to OFIS during the two-year period under review.

BCBSM states a home health care provider's participation agreement may be terminated by BCBSM if the provider fails to meet any of the qualification standards. Providers must also 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.

BCBSM may terminate a home health care provider's participation agreement with or without cause by giving the provider 60 days written notice. The participation agreement 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. There are several reasons why the participation agreement may be terminated by BCBSM: 1) if a home health care provider fails to meet BCBSM's qualification standards, 2) if the provider has its Medicare certification or accreditation suspended or revoked, 3) if an officer, director, owner or principal of the home health care provider is convicted of a felony or other violation of law, 4) bankruptcy or insolvency, 5) a change in ownership, or, 6) the home health care provider ceases providing home health care services to BCBSM members. BCBSM states there were no home health care providers terminated during the two year period under review and that all home health care facilities successfully completed the re-credentialing process.

Findings and Conclusions - Quality of Care

In order to meet the quality of care goal, the provider class plan must assure that "providers will meet and abide by reasonable standards of health care quality." During calendar years 2005 and 2006, BCBSM required all home health care providers to meet its qualification standards for participation and maintained communication with home health care providers through its monthly publications, appeal processes, provider manuals and online resources. Based on the information analyzed during this review, it is determined that BCBSM met the quality of care goal stated in the Act for the calendar years 2005 and 2006.

Cost Goal:

The cost goal in Section 504(1) of the Act states that "[P]roviders 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."

After application of the cost formula found in Section 504 of the Act and using economic statistics published by the U. S. Department of Commerce, it is hereby determined that the measure that will be used to determine BCBSM's achievement of the cost goal shall be as follows:

The rate of change in the total corporation payment per member for the home health care provider class for calendar years 2005 and 2006 shall not exceed 5.4%.

The pertinent issues that were considered in reaching a determination with respect to the cost goal are described below.

The cost goal formula, as stated in the Act, is

$$\frac{[(100 + I) \times (100 + \text{REG})]}{100} - 100 = \text{Compound rate of inflation and real economic growth}$$

"I" is "inflation" which is the arithmetic average of the percentage change in the implicit price deflator for GNP over the two calendar years immediately preceding the year in which the Commissioner's determination is being made.

"REG" is "real economic growth" which is the arithmetic average of the percentage change in per capita Gross National Product (GNP) in constant dollars over the four calendar years immediately preceding the year in which the Commissioner's determination is being made.

Given the July 2007 population data obtained from population reports (Series P-25) published by the Bureau of Census, as obtained from the U. S. Census Bureau (www.census.gov/popest/national/NA-EST2006-01.html), and economic statistics for the GNP and implicit GNP price deflator published in the June 2007 edition of "Economic Indicators," prepared for the Joint Economic Committee, by the Council of Economic Advisers (www.gpoaccess.gov/indicators/index.html), the following calculations have been derived:

I = Inflation as defined in the cost goal formula:

% change in implicit GNP price deflator

2006	3.0
2005	2.9
2 yr. average	3.0

REG = Real Economic Growth as defined in the cost goal formula:

% change in per capita GNP in constant dollars

2003	1.6
2004	2.9
2005	2.2
2006	2.3
4 yr. average	2.3

Using the latest population and economic statistics available, the cost goal for the period under review is estimated to be 5.4%, as shown below:

Inflation = 3.0

Real Economic Growth = 2.3

$$\frac{[(100 + 3.0) \times (100 + 2.3)]}{100} - 100 = 5.4\%$$

Section 517 of the Act requires BCBSM to transmit an annual report to OFIS, which includes data necessary to determine the compliance or noncompliance with the cost and other statutory goals. The report must be in accordance with forms and instructions prescribed by the Commissioner and must include information as necessary to evaluate the considerations of Section 509(4).

As stated in Section 504(2)(e) of the Act, the “[R]ate 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.” The cost and membership data for the home health care provider class plan for the calendar years 2005

and 2006, as filed with OFIS by BCBSM, are presented below. Cost data reflect claims incurred in the calendar year and paid through February 28th of the following year.

Total Utilization and Payment Experience

BCBSM Home Health Care Figures	2004	2005	2006	Average Yearly Rate of Change
Total Payments	\$22,034,899	\$22,779,161	\$24,143,611	
Total Members	2,778,136	2,664,271	2,644,127	
Cost Performance				
Payments/1000 Members	\$7,931.54	\$8,549.87	\$9,131.03	7.3%
Rate of Change (%)		7.8%	6.8%	7.3%

The two-year arithmetic average increase for the home health care provider class plan equals 7.3%.

Overall health care cost performance shows the trend in payments per 1000 members increasing as membership continues to decline. Payment per 1000 members increased approximately \$1,200 or 15.1% from 2004 to 2006, while membership decreased approximately 134,000 members or 9.5%. The increase in payments appears to be the result of increased utilization during the two year period under review. BCBSM attributes the increased utilization to recent trends of moving care to less expensive settings and the aging of the baby boomer generation.

Lengths of stay in the inpatient hospital setting have decreased while at the same time, many procedures done during inpatient stays ten to twenty years ago are now routinely done in the outpatient setting. Both of these health care trends may require the use of follow-up care in the home setting. As a result, the number of members using the home health care benefit rose from 15,028 in 2004 to 15,079 in 2005 and 15,710 in 2006. This increased use resulted in a 4.5% increase over the two year period under review. The percentage of members using the benefit rose under one percent each year. BCBSM states payment per claim remained relatively stable during the reporting period, increasing 0.1% in 2005 and moderately increasing 1.2% in 2006.

The increase in home health care payments was actually somewhat lower than data reported by the Centers for Medicare and Medicaid Services (CMS), which has seen home health spending increase among both programs during the two year period under review, with increases of 11.2% in 2005 and 12.5% in 2006. According a January 2007 report on national health expenditure amounts and annual percent change by type of expenditures for the time period 2001-2016 issued by CMS, the increased expenditures on home health care are expected to moderate and settle to 7.3% over the next ten years.

BCBSM reports payment data by major diagnostic category (MDC). Major diagnostic categories are formed by dividing all possible principle diagnoses into 25 mutually

exclusive categories. 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 below, during the two year period under review, the average payment per 1000 members increased in all but four MDCs. Use also increased in most MDCs. Review of the data reveals changes in utilization were the primary drivers of the payment per member trends in most MDCs, whereas payment per claim was relatively stable.

**Home Health Care Provider Class
 2006-2004 Payments by Major Diagnostic Category**

Home Health Care by Major Diagnostic Category	2004-2006	2004-2006	2004-2006	Pct of Total Payout	Two year average rate of change		
	Payments	Claims	Avg Pymt/Claim		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% of home health care claims payout during the two year period under review, or \$44.1 million, can be attributed to MDCs pertaining to health status and the musculoskeletal and nervous system categories. BCBSM states the health status MDC represents care performed when there is an unspecified debility including cases where physical therapy is provided without nursing care. These three MDCs also account for 60.8% of home health care claims. High utilization in these categories contributed to the overall increase in payments.

Even though the factors influencing the health status MDC accounted for 30.6% of the total home health care payout, these trends are not overly significant, with an average increase in payments per 1000 members of 1.4%, the result of a 3.6% increase in use, but a 2.1% decrease in payment per claim.

Trends for the musculoskeletal MDC are more significant, with a 21.6% increase in payment per 1000 members, a 19.1% increase in use and 2.2% increase in payment per claim, combining to account for 21.4% of home health care payments. Musculoskeletal conditions include arthritis, osteoporosis, broken or deteriorated bones, trauma, and back and joint pain. BCBSM states these are the most common causes of severe long-term pain and physical disability, with joint diseases accounting for half of all chronic conditions in the elderly. Musculoskeletal conditions are a leading cause of disability in the United States, accounting for more than 130 million patient visits to health care providers annually. It is estimated that \$254 billion a year is spent on the diagnosis and treatment of musculoskeletal conditions in the United States.¹

The nervous system MDC accounted for 12% of the total payout for the home health care provider class, with increases of 9.8% in payments per 1000 members and 14% in utilization per 1000 members, with a decrease of 3.9% in payment per claim. This MDC includes diseases such as cerebral palsy, multiple sclerosis, muscular dystrophy and dementia as well as conditions like strokes and spinal injuries. BCBSM states treatment for disabilities caused by these diseases and conditions is often appropriate in the home setting.

Of the remaining MDCs, BCBSM states those with notable trends among the top ten were the endocrine, nutritional and metabolic MDC with a 9.5% increase in utilization per 1000 members driving a 12% change in payments per member and the kidney and urinary tract MDC with an 11.7% decrease in use that resulted in a 12.5% decrease in payment.

BCBSM states the most recent national data available for home health care patients at the time its annual report was prepared was published in February 2004 and pertains to payments and utilization from calendar year 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 respiratory diseases. BCBSM states its review of the national data reveals its experience is similar to national experience.²

The table below reveals the top 25 diagnosis classifications by payout. Diagnosis codes provide brief descriptions of the nature of the condition being treated. Although diagnosis codes typically have four digits to specify the anatomical site or kind of procedure, the data below are summarized in broader classifications. The top diagnoses totaled approximately 73% of the total payout for the home health care provider class.

¹ www.usbjd.org/patients_public/index.cfm?pg=faq.cfm

² www.cdc.gov/nchs/data/nhhcsd/curhomecare00.pdf

2006-2004 Payments by Top 25 Diagnosis Classifications

5 Digit ICD9 Code	Diagnosis Classification	2004-2006 Payments	2004-2006 Claims	2004-2006 Avg Pmt./Claim	Per of Total Payout	Two year average rate of change			
						Payments	Members	Claims	Members
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%	-3.2%	
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	\$ 1,051.78	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%	-8.6%	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 site, except limbs	\$ 527,904.39	363	\$ 1,454.28	0.8%	-4.0%	1.7%	-6.1%	
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%	19.6%	-1.8%	
438	Late effects of cerebrovascular disease	\$ 409,834.82	212	\$ 1,933.18	0.6%	30.0%	27.2%	-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%	

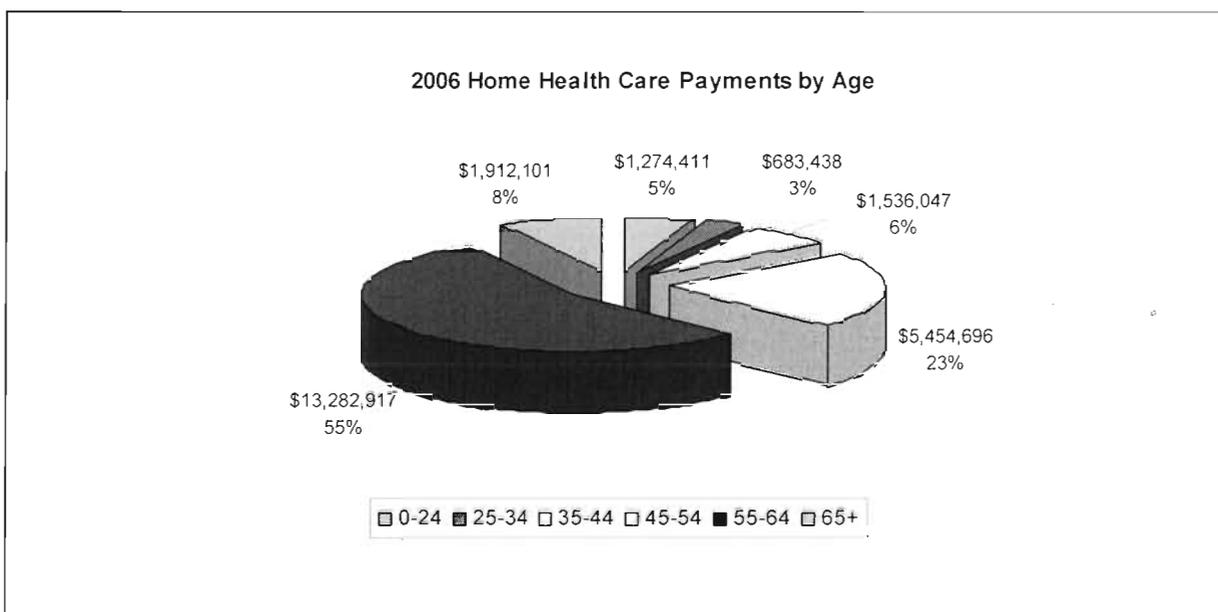
The top three diagnoses were encounters for other procedures and aftercare (e.g. maintenance chemotherapy or dressing changes or sutures), other orthopedic aftercare (e.g. joint replacement or traumatic fracture) and care using rehabilitation procedures (physical, occupational and speech therapy).

Review of the above data reveals trends in most of the 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%, which accounts for most of the 20.9% increase in payments per 1000 members. The other orthopedic aftercare classification had a dramatic 50% increase in utilization, thus contributing to a 53.7% increase in payments per 1000 members. Care using rehabilitation procedures had a utilization decrease of 13.3% per 1000 members which influenced the 16.2% decrease in payments per 1000 members.

As the above data illustrates, there is a definite trend to have more surgical aftercare provided to patients in a less expensive home care setting. Patients with chronic disease are also frequent users of home health care services. BCBSM states its data confirms this as diabetes, osteoarthritis; heart failure and multiple sclerosis appear in the top 12 diagnoses.

A key factor in BCBSM's increased payments for home health care services is the aging of Michigan's population. Michigan residents aged 45-64 years make up 25.3% of the state's overall population, slightly higher than the national average of 24.5%. Michigan's median

age of 36.8 is also slightly higher than the national median age of 36.2. As illustrated below, 55% of BCBSM's payments for home health care services in 2006 were attributed to members aged 55-64. Members aged 45-54 were responsible for an additional 24% of the home health care payout. As the baby boomer generation age and health care technology advances lengthen the average life span, these increased life expectancies will undoubtedly impact the number of people with chronic conditions, injuries and disabilities requiring continued medical treatment. Thus, increased costs in these age categories are seen as inevitable as older adults place increased demands on the nation's health and welfare systems.



The need for home health care services typically follows an inpatient hospital admission, but can also occur after a skilled nursing facility admission, an emergency room visit or from a physician referral. Hospitals today are paid based on the patient's diagnosis rather than on a daily basis so hospitals are motivated to discharge patients as soon as possible, so many patients will be sent home with a referral for follow-up care to be provided at home. BCBSM states it is not unusual for cost-conscious physicians to refer patients for home care after an office visit instead of hospitalizing them if the necessary care can be safely provided in a home setting.

BCBSM states that one example of a physician-referral situation that would save a costly inpatient admission is a bed-ridden multiple sclerosis patient who develops a urinary tract infection requiring IV antibiotics and a catheter. The physician could opt to admit the patient to the hospital for a few days and then follow-up with home care to complete the course of antibiotics; or, the patient could be referred directly to home health care for several daily visits and avoid the more costly hospital admission altogether.

An example of a home health care related medical advance is the Vacuum Assisted Closure (VAC) Therapy System. The VAC system enables patients with wounds such as pressure ulcers, diabetic wounds, abdominal wounds, partial-thickness burns, trauma wounds, flaps and grafts to receive treatment in a home setting rather than in a hospital or skilled nursing facility. The VAC system involves packing the wound with a foam dressing, applying an adhesive drape and attaching a suction device. The device aids wound healing by applying localized negative pressure that removes fluid from the wound and stimulates the growth of new tissue to obtain wound closure.³

Home care can be used in follow-up care and treatment for many surgeries, illnesses or chronic conditions. BCBSM states its experience shows frequent use of the home health care benefit following surgical procedures (both orthopedic and non-orthopedic). An aging population is more likely to develop musculoskeletal conditions such as arthritis, back pain, and bone and joint injuries. The pain from many of these conditions many times can be resolved or lessened by surgical procedures and consequently, a need for home health care services. BCBSM notes that chronic diseases are a significant problem in the United States population and cites these statistics:

- Estimates of chronic disease populations in the United States:
 - 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 United States affecting over 100 million people. It causes an average 1.7 million deaths a year.
- The senior population aged 65 and older will nearly double from 42 million to 80 million in the next three decades. This group has the most chronic conditions, as 90% of seniors have at least one chronic disease and 77% have two or more chronic diseases.⁴
- Forty five percent of the United States population has at least one chronic condition and use over 75% of the health care resources⁵

Michigan continues to be one of the least healthy states in the nation. A recent 2007 United Health Foundation report reveals in the past year, the prevalence of obesity increased from 26.2 percent to 28.8 percent of the population⁶. Michigan ranks 11th in the nation for adult diabetes and 13th for hypertension rates, at 8.3% and 27.3%, respectively.⁷

³ www.medscape.com/viewarticle/407550_1

⁴ icarehealthmonitoring.com/resources-chronicillnessstatistics.php

⁵ BCBSM Value Report, March 2005, Delivering "Value Through Medical Management"

⁶ www.unitedhealthfoundation.org/ahr2007/states/Michigan.html

⁷ www.healthamericans.org/reports/obesity2006/print.php?StateID=MI

BCBSM's "Blue Advantage" data from Summer 2005 reveals chronic diseases have dramatically affected use in every care setting. Patients with chronic conditions account for:

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

The causes of increasing health care costs nationwide are multiple and include: increasing use of cutting-edge technologies in medical diagnosis and treatment; significant advances in prescription drugs; demand by patients for new types of treatment and medications; people living longer; workforce shortages (e.g. nurses) that drive labor costs higher due to the need to pay overtime wages; soaring medical liability costs; and, increased patient volumes.

Employers have taken aggressive steps to try to control health care costs. For example, employers have implemented tactics such as increasing employee co-payments and deductibles to encourage cost-effective use of health care services and prescription drugs; increasing the employee share of premium contributions; capping the portion of health care costs paid by the employer and increasing the portion of premiums paid by the retired employees for themselves and their dependents.

The nation as well as Michigan's state government and legislative bodies are in agreement that rising health care costs need to somehow be controlled, but there is no consensus on how best to do so. Because there is no single best solution, many approaches to control health care spending are being used, including provider pay-for-performance programs, consumer education, and the promotion of healthy lifestyles. Unfortunately, whereas promoting healthy lifestyles is indeed important, getting the general population to adopt and actually maintain a healthy lifestyle is what it will take to ultimately have a positive effect on health care costs in the future.

There is a definite shift in the health care industry on both state and federal levels toward disease management programs as a way to controlling spiraling costs. Disease management aims at empowering participants to better manage and improve their own health, which in turn should help control costs of health care services. BCBSM states it has broadened its scope of medical care management design. BCBSM no longer directs all of its attention to provider costs and provider utilization but instead has developed member-focused health management programs.

BCBSM states its 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 own health care decisions. The program also involves the health care provider as part of the care process.

BlueHealthConnection[®] provides members with 24/7 access to health information by telephone, mail or online access. Instead of 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 three segments are the moderate high, moderate and low risk groups. Welcome letters, magnets, postcards, information sheets and invitation to call cards are some of the ways BCBSM reaches out to members.

BCBSM states with its implementation of the BlueHealthConnection[®] program, it 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. The program allows BCBSM to become their health care partner and their advocate in addition to being a great source for health management information.

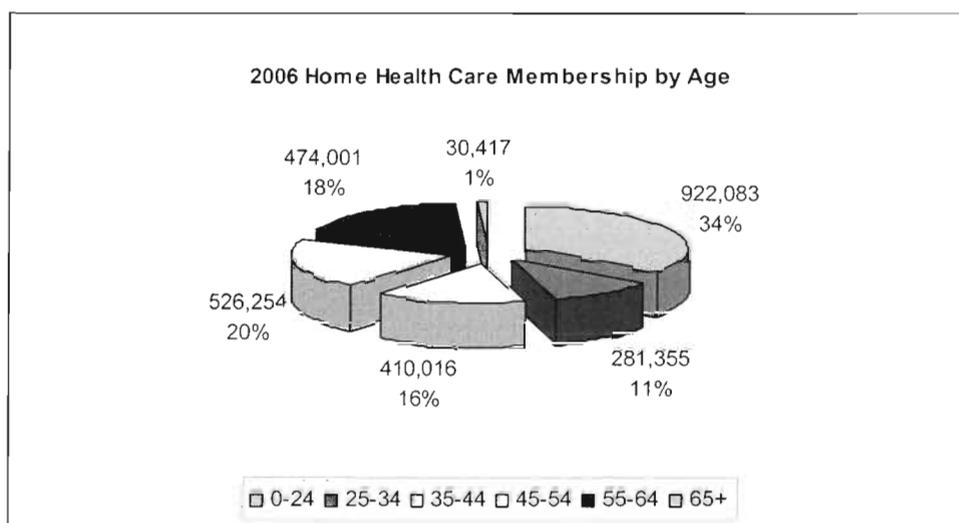
BlueHealthConnection[®] nurses help patients manage symptoms of minor illnesses or injuries, provide general information such as tips for healthy lifestyles or side effects of prescription drugs, manage chronic diseases, discuss treatment options, support weight loss and tobacco cessation efforts and provide case management for the very ill. BCBSM states its BlueHealthConnection[®] nurses also advocate for the appropriate care setting for recommended services. For example, a patient with a chronic disease, such as congestive heart failure, may be telephoned 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 nurse's involvement is effective because care is sought in a lower cost setting before further complications arise which might necessitate an inpatient admission.

Although BCBSM could not identify savings specific to the home health care provider class, BCBSM states the BlueHealthConnection[®] program has avoided an average \$30 million in health care costs each year since its launch in 2003, with savings of \$33.9 million in 2006. As part of this program, BCBSM sends out Disease Management Customer Satisfaction surveys to program participants. BCBSM states 90% of the participants completing the surveys were satisfied with the program.

Membership continued to decrease during the two year period under review. BCBSM states the membership decline is primarily attributable to the loss of small groups and corporate downsizing. Although membership decreased by 4.8%, or approximately 134,000 members, utilization of services increased 6.7%. The ratio of patients using home

health care to total membership eligible for the benefit increased slightly from 0.54% in 2004 to 0.59% in 2006.

The chart below from BCBSM's annual report on the home health care provider class plan shows 2006 home health care membership by age category. Comparing this data with the payout for home health care services reveals that members in the 55-64 age group comprise 18% of all members with home health care benefits, but account for 55% of the payment. BCBSM states its membership in this age category is greater than the Michigan and national populations which are approximately 10%.



Findings and Conclusions - Cost

Based on the cost information analyzed during this review, it is determined that BCBSM did not meet the cost goal stated in the Act for the home health care provider class during the two year period under review. This decision is based on the fact that the rate of change in the total corporation payment per member to the home health care provider class has been calculated to be 7.3% over the two years being reviewed and therefore exceeded the compound rate of inflation and real economic growth of 5.4%.

BCBSM made available a variety of programs in an effort to control home health care costs as well as health care costs generally during the two-year period under review, including its BlueHealthConnection[®], *Walking Works*[™], and Healthy ME![™] programs. BCBSM routinely audits home health care providers to determine that home health care services are being used effectively and efficiently. Nonetheless, there are other factors that impact BCBSM's ability to contain costs within the constraints of the cost goal specified in the Act. The most prominent factors include an aging population and the overall health status of Michigan residents. Michigan residents are living longer because of the development of

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cutting-edge technologies in medical diagnosis and treatment and the significant advances made in prescription drugs used to treat chronic illness. This increased longevity also increases the likelihood for Michigan residents to develop chronic conditions for which they seek out health care services. Also, many Michigan residents do not lead healthy lifestyles, which in turn, cause the development of debilitating conditions such as diabetes, hypertension, orthopedic conditions, and coronary heart disease.

Because of this, it is not necessary to require that a change to the current home health care provider class plan be filed pursuant to Section 511 of the Act. BCBSM is encouraged to continue its efforts to find new, innovative programs that instill responsible cost controls so that all the goals and objectives of the corporation can be achieved.

Determination Summary

In summary, BCBSM generally achieved two of the three goals of the corporation during the two-year period under review for the home health care provider class. Although the home health care provider class did not substantially achieve the cost goal, a change in the plan is not required because, as outlined above, there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve the cost goal was reasonable, due to factors listed in Section 509(4).

