

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of the Hospital Provider
Class Plan Determination Report
pursuant to Public Act 350 of 1980

/ No. 12-026-BC

Issued and entered
this 18th day of July 2012
by R. Kevin Clinton
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 Regulation (OFIR) issued Order No. 12-001-BC on January 12, 2012, giving notice to Blue Cross and Blue Shield of Michigan (BCBSM), and to each person who requested a copy of such notice, of his intent to make a determination with respect to the hospital provider class plan for calendar years 2009 and 2010.

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. All procedural requirements of the Act have been met.
3. The OFIR staff reviewed relevant data pertaining to the hospital 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 hospital provider class plan.

4. Section 509(1) of the Act provides that, in performing BCBSM provider class plan review and determination:

The commissioner may determine if the health care corporation has substantially achieved the goals of a corporation as provided in section 504 and achieved the objectives contained in the provider class plan . . .

5. Section 504(1) of the Act requires that:

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

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

(b) Providers will meet and abide by reasonable standards of health care quality.

(c) Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.

6. In addition, section 509(4) provides that:

The commissioner shall consider all of the following in making a determination pursuant to subsection [509](1):

(a) Annual reports transmitted pursuant to section 517.

(b) The overall balance of the goals provided in section 504, achieved by the health care corporation under the plan. **The commissioner** shall give weight to each of the goals provided in section 504, shall not focus on 1 goal independently of the other goals of the corporation, and **shall assure that no portion of the corporation's fair share of reasonable costs to the provider are borne by other health care purchasers.**

(c) Information submitted or obtained for the record concerning: demographic trends; epidemiological trends; and long-term economic trends, including changes in prices of goods and services purchased by a provider class not already reflected in the calculation in section 504(2)(d); sudden changes in circumstances; administrative agency or judicial actions; changes in health care practices and technology; and changes in benefits that affect the ability of the health care corporation to reasonably achieve the goals provided in section 504.

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

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

7. Finally, with respect to hospital provider class plans, section 516(2) requires that:

(a) To the extent practicable, reimbursement control shall be expressed in the aggregate to individual hospitals.

(b) **No portion of the health care corporation's fair share of hospitals' reasonable financial requirements shall be borne by other health care purchasers.** However, this subdivision shall not preclude reimbursement arrangements which include financial incentives and disincentives.

(c) The health care corporation's programs and policies shall not unreasonably interfere with the hospital's ability and responsibility to manage its operations.
(Emphasis added).

8. The Act's requirements that "no portion of the corporation's fair share of reasonable costs to the provider are borne by other health care purchasers" and that "[n]o portion of the health care corporation's fair share of hospitals' reasonable financial requirements shall be borne by other health care purchasers" are requisite elements of BCBSM's cost goal under Section 504(1) of the Act. (See Sections 509(4)(b) and 516(2)(b) of the Act, respectively.)

9. BCBSM's hospital provider class plan Cost Objectives ("Cost Objectives") state that BCBSM shall "[p]rovide equitable reimbursement to participating providers through the reimbursement methodology outlined in the participating agreement."

10. BCBSM's hospital provider class plan, peer group 1-4 reimbursement methodology, does not recognize government shortfalls related to Medicaid and Medicare programs.

11. Government shortfalls related to Medicaid and Medicare programs are necessary factors in determining "reasonable costs to the provider" and "hospitals' reasonable financial requirements."

12. By failing to recognize government shortfalls related to Medicaid and Medicare, BCBSM's peer group 1-4 reimbursement methodology has caused or is likely to cause other health care purchasers to bear portions of BCBSM's fair share of "reasonable costs to the provider" and/or "hospitals' reasonable financial requirements."

13. By failing to recognize government shortfalls related to Medicaid and Medicare, BCBSM's peer group 1-4 reimbursement methodology fails to "provide equitable

reimbursement to participating providers.”

14. BCBSM's provider class plan fails to comply with the Act's requirements that “no portion of the corporation's fair share of reasonable costs to the provider are borne by other health care purchasers,” and that “[n]o portion of the health care corporation's fair share of hospitals' reasonable financial requirements shall be borne by other health care purchasers.” (See Sections 509(4)(b) and 516(2)(b) of the Act, respectively).

15. By failing to recognize government shortfalls related to Medicaid and Medicare as a factor in determining “reasonable costs to the provider” and “hospitals' reasonable financial requirements,” BCBSM's hospital provider class plan fails to substantially achieve the cost goal of section 504(1) and fails to achieve the Cost Goal Objectives contained in the hospital provider class plan.

III

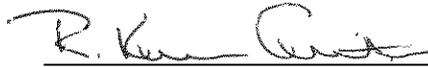
ORDER

Therefore, it is ORDERED that:

1. BCBSM's hospital provider class plan does not substantially achieve the cost goal as provided in Section 504(1) of the Act, and fails to achieve its stated Cost Goal Objective.
2. BCBSM's hospital provider class plan, peer group 1-4 reimbursement methodology, must recognize government shortfalls related to Medicaid and Medicare programs in order to substantially achieve the cost goal as provided in Section 504(1) of the Act, and to achieve its stated Cost Goal Objective.
3. The attached hospital 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 hospital provider class plan for the calendar years 2009 and 2010.
4. Pursuant to section 511(1) of the Act, within 6 months from the date of this Order, BCBSM shall transmit to OFIR a hospital provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in this Order and further detailed in the attached determination report.

5. To the extent that BCBSM's participating hospital agreement and hospital reimbursement arrangements contain "Most Favored Nation" clauses, such agreements and arrangements are subject to the Commissioner's Order No. 12-035-M, and BCBSM shall comply with Order No. 12-035-M in submitting any "Most Favored Nation" clauses for the Commissioner's review.

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.



R. Kevin Clinton
Commissioner

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 2009 and 2010. 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 2009-2010 hospital provider class plan annual report, public testimony, 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 hospital services whenever necessary. In analyzing BCBSM's performance on the access goal, substantial consideration was given to the formal participation rates of hospitals. BCBSM was able to maintain a formal participation rate of 100% with Michigan hospitals during the two year period under review. BCBSM also instituted a variety of ways for hospital providers to keep informed about BCBSM programs and policies. As such, it is determined that BCBSM generally met the access goal stated in the Act for calendar years 2009 and 2010.

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 hospital services, that it verifies that providers adhere to such guidelines and that it maintains effective methods of communication with its providers. During calendar years 2009 and 2010, BCBSM has continued in its efforts toward promoting patient safety and delivering high quality care through quality management initiatives such as the participating hospital agreement (PHA) Pay For Performance program, BCBSM's Cardiovascular Consortium, and Cardiac Centers of Excellence. BCBSM has also been an active participant in the Michigan Quality Improvement Consortium and the Michigan Health & Safety Coalition initiatives dealing with evidence based practice and safety standards. Further, the ongoing activities of the PHA Advisory Committee illustrate BCBSM's willingness to work with the provider community to assure that its members are receiving, and will continue to receive, quality health care services. 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 2009 and 2010.

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 1.7% for the period under review. As the rate of change in the total corporation payment per member for the hospital provider class has been calculated to be a decrease of 0.3% over the two years being reviewed, BCBSM met the cost goal based on the statutory cost goal formula stated in the Act for 2009 and 2010.

However, even though BCBSM met the statutory cost goal formula as defined in the Act, it has been determined that BCBSM has failed to meet the cost objective within the hospital provider class plan, that it provide equitable reimbursement to participating providers through the reimbursement methodology outlined in the PHA. BCBSM has not sufficiently demonstrated to the Commissioner that it has equitably compensated hospitals in accordance with Sections 509(4)(b) and 516(2)(b) of the Act to assure that BCBSM participating hospitals' reasonable financial requirements are not being borne by other health care purchasers. BCBSM's reimbursement methodologies as delineated in the PHA on file with the Commissioner do not properly and justly account for governmental shortfalls from the Medicaid and Medicare programs for all its participating hospitals within the PHA, particularly those in Peer Groups 1-4. Inasmuch as BCBSM sets and controls its reimbursement methodologies for hospitals and it has not sufficiently demonstrated that its reimbursement methodologies equitably account for governmental shortfalls from the Medicaid and Medicare programs for all its participating hospitals, particularly Peer Group 1-4 hospitals, it is hereby determined that BCBSM's failure to meet the cost objective and the requirements of Sections 509(4)(b) and 516(2)(b) of the Act are clearly within BCBSM's control.

As such, it will be necessary for BCBSM to prepare a modified hospital provider class plan within the six month period provided in Section 511(1) of the Act and file a plan with the Commissioner for approval that recognizes and specifically delineates provisions in the PHA governing hospital reimbursement that equitably accounts for Medicaid and Medicare losses for all hospitals in all peer groups.

Overall Balance of Goals

In summary, BCBSM did not substantially achieve one of the three statutory goals for the hospital provider class plan for the two year period under review. Because it has been determined that BCBSM's failure to meet the cost goal was within BCBSM's control, BCBSM must submit a new hospital provider class plan within six months that substantially achieves the goals, achieves the objectives and substantially overcomes the deficiencies enumerated in the findings section of this determination report.

Introduction

The purpose of this report is to determine whether Blue Cross Blue Shield of Michigan (BCBSM) has met the access, quality of care, and cost goals outlined in the Nonprofit Health Care Corporation Reform Act, MCL 550.1101 et seq. (Act), with respect to the hospital provider class plan for the calendar years 2009 and 2010.

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.” A provider class plan is a document that includes measurable objectives for meeting the access, quality of care, and cost goals outlined in the Act. It should be noted that, pursuant to the Act, the nonprofit health care corporation establishes provider contracts.

Section 504(1) of the Act requires BCBSM to contract with or enter into reimbursement arrangements 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 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 receiving 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.

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Section 509(4) of the Act requires the Commissioner of the Office of Financial and Insurance Regulation (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.

Pursuant to Section 509(4)(b) of the Act, the Commissioner shall also assure an overall balance of the goals, so that one goal is not focused on independently of the other goals, and so that no portion of BCBSM's fair share of reasonable costs to the provider are borne by other health care purchasers.

As a final consideration specifically germane to hospital provider class plans, under Section 516(2)(b) of the Act, the Commissioner must ensure that “[n]o portion of [BCBSM’s] fair share of hospitals’ reasonable financial requirements shall be borne by other health care purchasers.”

After careful consideration of all of the information that was submitted or obtained for the record and the criteria delineated in Sections 509(4)(b) and 516(2)(b), 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.

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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 of the Act, BCBSM has failed to submit a revised provider class plan, the Commissioner must prepare a provider class plan for that provider class.

Overview of the Hospital Provider Class Plan

The hospital provider class for BCBSM covers all short-term general acute care hospitals, short-term acute psychiatric care hospitals and intensive rehabilitation programs. Hospitals provide inpatient diagnostic, therapeutic, and surgical services for injured or acutely ill persons requiring the daily direction or supervision of a physician.

The scope of a hospital's licensure covers a variety of inpatient acute and outpatient services. Services provided at a hospital include, but are not limited to: room and board, surgery, anesthesia, maternity care and delivery, newborn care, emergency treatment, dialysis, physical therapy, chemotherapy, pathology and laboratory, diagnostic radiology, observation, and medical supplies.

For the period 2009-2010, payments to hospitals represented an average of 8.1% of the total benefit payments made to health care providers on behalf of BCBSM members enrolled in BCBSM's traditional program, the only benefit program subject to provider class plan review. For the purpose of provider class plan review by the Office of Financial and Insurance Regulation (OFIR), paid claims data is categorized by nine geographic regions. A map depicting these geographic regions is included in Attachment A.

Hospitals are subject to certain qualification standards set by BCBSM. These qualification standards include, but are not limited to:

1. The hospital must be licensed as required by the laws of the state of Michigan as an acute hospital and/or as a psychiatric care hospital or unit.
2. The hospital must comply with the certification standards established by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) for participation in the Medicare Program.
3. The hospital must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission); the American Osteopathic Association; the Commission on Accreditation of Rehabilitation Facilities; or Det Norske Veritas or such other accreditation organizations as may be approved through the Contract Administration Process, unless the hospital is located in a

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rural census category. If a hospital is located in a rural census category, the accreditation requirements may be waived at the request of the hospital, if the hospital demonstrates that CMS has certified the hospital's compliance with the Medicare certification requirements on the basis of a survey conducted by an appropriate state agency.

4. The hospital must comply with applicable Certificate of Need requirements of the Michigan Public Health Code.
5. The hospital must have a governing body that is legally responsible for the conduct of the hospital. The hospital must have a governing body, or advisory body responsible to the governing body, that includes persons generally representative of the community in the hospital's service area.
6. The hospital shall follow generally accepted accounting principles and practices.
7. The hospital shall have programs of utilization management and quality assessment.

Hospital reimbursement is based on a hospital's Peer Group designation. Peer Groups 1-4 include larger and medium sized acute care general hospitals. Peer Group 5 hospitals are small rural hospitals, with Peer Groups 6 and 7 consisting of psychiatric and rehabilitation hospitals and Medicare-exempt psychiatric and rehabilitation units of acute care hospitals.

Inpatient services in Peer Groups 1-4 are priced-based using Medicare's diagnostic related groupings (DRGs) classification system. An individual hospital is reimbursed the lesser of the billed charge or the DRG specific price. Annual updates are determined based on the National Hospital Input Price Index with adjustment. BCBSM reimbursement for outpatient surgery, laboratory, radiology, physical therapy, and speech therapy is price-based. The remaining outpatient services are reimbursed on an outpatient payment-to-charge ratio basis until such time that they can be priced.

Peer Group 5 hospitals are reimbursed controlled charges for both inpatient and outpatient services. "Controlled charges" refers to a method of reimbursement in which a base ratio is set for inpatient and outpatient services. This ratio determines future percent-of-charges increases/decreases based on the relationship of the hospital's attested charge-increase percentage to the annual update factor. BCBSM states the reimbursement levels for inpatient and outpatient services are updated annually using the same formula used for Peer Group 1 through 4 hospitals.

Peer Groups 6 and 7 inpatient services are reimbursed on a per diem basis. Reimbursement is the lesser of the billed charge or per diem payment. Annual updates

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and outpatient services reimbursement are the same as described in Peer Groups 1-4 hospitals.

Other hospital-based non-acute services that can be provided under another provider class plan such as, but not limited to, residential substance abuse, home health care agencies, and skilled nursing facilities, will be reimbursed using a hospital-specific cost-to-charge ratio set at a level not to exceed billed charges. BCBSM may require these services to be considered “freestanding” and reimbursed under a separate agreement.

BCBSM states it is considering alternative reimbursement methodologies such as “bundled” or “fixed” price arrangements covering all services per episode of care, when the reimbursement methodologies in this plan are not appropriate for payment of certain services, such as bone marrow transplants and bariatric surgery. These types of alternative reimbursement methodologies shall be determined through the Contract Administration Process.

During the review period, a hospital 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 hospital provider class plan are as follows:

Access:

- To provide direct reimbursement to participating providers that render medically necessary, high-quality services to BCBSM members.
- To communicate with participating providers about coverage determinations, billing, benefits, provider appeal processes, BCBSM’s record keeping requirements, and the participating agreement and its administration.
- To maintain and periodically update a printed or website-based directory of participating providers.

Quality of Care:

- To ensure BCBSM members receive quality care by requiring participating providers to meet BCBSM’s qualification and performance standards.
- To obtain continuous input from hospitals through the Contract Administration Process.
- To meet with provider organizations such as the Michigan Health and Hospital Association to discuss issues of interest and concern.

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- To maintain and update, as necessary, an appeals process that allows participating providers to appeal reimbursement policy disputes or disputes regarding utilization review audits.

Cost:

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

History of the Hospital Provider Class Plan

BCBSM had an existing reimbursement arrangement with hospitals in effect when the Act took effect on August 27, 1985. BCBSM filed the first hospital provider class plan pursuant to Section 506(1) of the Act with OFIR on February 18, 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."

Because the hospital provider class plan met the filing requirements of Section 506 of the Act stated above, OFIR notified BCBSM by letter on July 15, 1987 that the hospital 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 hospital plan, to include an appeal process for utilization review audits performed by the corporation. This amendment to the hospital provider class plan was made by BCBSM in accordance with Section 508(1) of the Act.

The hospital provider class plan was modified by BCBSM on October 2, 1989 by revising the hospital reimbursement methodology based on a Peer Group designation for each hospital. The hospital provider class plan was amended by BCBSM again on March 24, 1992, to reflect changes in the participation agreement's appeals and outpatient services sections. BCBSM again amended the hospital provider class plan on February 6, 1995 to

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reflect BCBSM's participation in the Interplan Teleprocessing System and the disclosure requirements of the Blue Cross and Blue Shield Association (BCBSA).

On June 30, 2006 BCBSM filed a revised hospital provider class plan and participating hospital agreement. This filing was deemed incomplete by OFIR because the participating hospital agreement failed to contain a template of BCBSM's reimbursement policy described as Exhibit B to the hospital participation agreement. Discussions took place between BCBSM and OFIR to determine what type of reimbursement policy could be filed with OFIR that could be subject to public review while keeping certain information confidential so not to place BCBSM at a competitive disadvantage by permitting competitors to calculate actual hospital payment rates. During this discussion phase, BCBSM filed another revised hospital provider class plan with OFIR on July 27, 2007 which, although it described BCBSM's reimbursement arrangement, also failed to contain Exhibit B to the hospital participation agreement. Discussions with BCBSM as well as discussions between OFIR staff and OFIR's Freedom of Information Officer continued until April 2008, when BCBSM was advised to file a hospital provider class plan with OFIR that contained a template of Exhibit B, its payment methodology, without revealing actual payment fees or percentages. BCBSM complied with OFIR's request and filed a complete hospital provider class plan on May 23, 2008. BCBSM also filed a revised hospital provider class plan on January 6, 2009. The documents were revised to allow BCBSM to set hospital rates for outpatient laboratory, radiology and surgery at the same levels that are paid to freestanding facilities for these services. On July 2, 2009, BCBSM filed another revision to the hospital provider class plan. The participation agreement was revised to reflect changes in BCBSM's hospital pay-for-performance program.

Another modification to the hospital provider class plan was filed by BCBSM on August 12, 2011. The provider class plan was revised to: 1) clarify that certain ancillary services would be paid according to community pricing; 2) update outdated language; 3) and include mandates from recent MICHild and BCBSA audits.

Review Process

On January 12, 2012 the Commissioner issued Order No. 12-001-BC, providing written notice to BCBSM, health care providers, and other interested parties of his intent to make a determination with respect to the hospital provider class plan for the calendar years 2009 and 2010. Order No. 12-001-BC also called for any person with comments on matters concerning the provider class plan to submit such comments to OFIR 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 hospital provider class plan were sent to all those on OFIR's interested persons list, Michigan hospitals and posted on OFIR's website, providing interested parties until April 9, 2012 to prepare and submit testimony.

Summary of Written Input:

The testimony submitted with regard to BCBSM's hospital provider class plan is summarized in Attachment B. Although Peer Group 5 hospitals were pleased with BCBSM's performance, Beaumont Hospital, the Michigan Association of Health Plans, and Priority Health contend that BCBSM is not paying its fair share of government shortfalls to Peer Group 1-4 hospitals, thereby shifting those costs to other health carriers. Many of the groups providing testimony believe that BCBSM should be required to amend its hospital provider class plan to require BCBSM to take into account losses attributable to the Medicare and Medicaid programs. These groups believe that this change could be easily accomplished by applying the Peer Group 5 reimbursement model to all Michigan hospitals.

Discussion of Goals Achievement/Findings and Conclusions

Access Goal:

The access goal in Section 504(1) of the Act requires 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 must be able to assure that, in any given area of the state, a BCBSM member has reasonable access to hospital services covered under the terms of that member's certificate whenever such treatment is required. In analyzing BCBSM's performance on the access goal, OFIR staff examined several aspects of how access to hospital 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 to OFIR in December 2011 by BCBSM shows the number of Michigan participating hospitals and membership by geographic region for calendar years 2009 and 2010:

Hospitals and Membership per Region

Region	Hospitals	2009		2010	
		Members*	Hospitals	Members*	Hospitals
Region 1	48	64,576	48	49,673	
Region 2	9	9,159	9	7,425	
Region 3	8	10,185	8	7,957	
Region 4	6	5,552	6	4,940	
Region 5	19	18,664	19	13,672	
Region 6	20	19,975	20	18,266	
Region 7	18	10,011	18	8,632	
Region 8	14	6,374	14	5,199	
Region 9	14	3,156	14	2,751	
Totals	156	147,633	156	118,515	

*Excludes Medicare and Medicaid recipients

BCBSM states that it maintained an average statewide formal participation rate of 100% during 2009 and 2010. BCBSM also maintains participation agreements with two hospitals in Toledo, Ohio, that are not included in the above participation rates.

BCBSM provided a regional map showing the location of participating hospitals by county for 2010. Review of this regional map reveals that during the two-year period under review, there is a hospital facility located in 72 of Michigan's 83 counties, with the northernmost portion of Michigan's Lower Peninsula having the fewest number of hospitals available to BCBSM members.

In April 2012, Cheboygan Memorial Hospital closed its doors after being forced to shut down after a proposed sale of the facility to Flint-based McLaren Health Care Corporation was blocked due to federal certification and licensing problems. The purchase deal was revived and approved in federal bankruptcy court after McLaren-Northern Michigan and CMS resolved their differences and the Cheboygan hospital reopened in May 2012, functioning as a campus of McLaren-Northern Michigan - Petoskey. The slimmed-down Cheboygan campus no longer provides inpatient care but focuses on emergency care, diagnostic services, and minor same-day surgical services. BCBSM members requiring inpatient care are referred to McLaren-Northern Michigan's Petoskey location.

BCBSM believes enhanced channels of communication help establish and maintain good rapport with participating providers. Satisfaction surveys have confirmed that communication is important to hospitals doing business with BCBSM. Recent survey

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results indicate that BCBSM was rated higher in the area of communication when compared to competitors.

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

Hospitals receive *Hospital Update*, a bimonthly publication for hospital leadership that highlights BCBSM initiatives to solve problems and improve patient care and day-to-day business transactions. *Hospital Update* offers articles on topics such as initiatives for safer surgeries and timely news regarding the Participating Hospital Agreement (PHA) and its advisory committees. Hospitals also receive *Physician Update*, a monthly newsletter from BCBSM's corporate medical director. This publication provides executive summaries of important topics of interest and BCBSM programs to physicians and hospital executives.

Web-DENIS, an electronic inquiry system, gives providers online access to health insurance information for BCBSM members. This 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 program offers quick delivery of contract eligibility, claims status, online manuals, newsletters, fee schedules, reports and much more information needed to make doing business with BCBSM easier.

BCBSM states it continues to enhance web-DENIS capabilities. During 2008, BCBSM introduced a new search tool, Explainer, to web-DENIS. Explainer offers more information than the previous search tool and includes medical, benefit, and payment policy information. Payment policy information provides member cost-sharing and dollar maximums with detail available at the procedure and revenue code levels for selected time periods. BCBSM simplified web-DENIS by standardizing the look of the screens for members' claims processed on the local and NASCO claims systems. In 2009, web-DENIS added new claims tracking and screen printing capabilities. Information on members' other active coverage is now included with BCBSM eligibility information.

Participating hospitals can access a comprehensive online provider manual on web-DENIS, which contains detailed instructions for servicing BCBSM members. BCBSM states its provider manuals are updated as necessary, allowing hospitals to obtain information on a real-time basis. Topics detailed in the provider manual include member eligibility requirements, benefits and exclusions, criteria guidelines for services, documentation guidelines, claim submission information, appeal processes, utilization review, and BCBSM departments to contact for clarification of issues.

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BCBSM believes that its Provider Consulting Services increase 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. Also, BCBSM members have easy access to provider directories by going to the www.bcbsm.com home page and following the directions to search for a provider in their local area.

Another avenue for hospitals to obtain needed information from BCBSM is CAREN⁺, an integrated voice response system which provides information on eligibility, benefits, deductibles, and copays. CAREN⁺ will transfer the caller directly to a service representative if they say “representative.” Several enhancements have been made to CAREN⁺ to speed up inquiries and improve privacy. For example, protected health information can be keyed in using the telephone keypad to prevent other patients from overhearing information verbally told to CAREN⁺. The system repeats the information back to the caller to verify accuracy.

BCBSM states it conducts annual surveys as a continued commitment to enhancing relationships with hospitals. These surveys measure overall satisfaction in doing business with BCBSM and several key elements such as service, claims processing, and online tools. The goal of this survey process is to identify ways to make it easier for hospitals to do business with BCBSM.

BCBSM conducted a hospital CEO satisfaction survey in January 2010. The survey focused on executive relationships and interactions with BCBSM. Some of the areas in which BCBSM earned high marks included having positive overall relationships with BCBSM, receiving quality service from BCBSM, and believing that BCBSM is the health care improvement leader in Michigan. Hospital CEOs listed some opportunities for improvement that included the contracting process, reimbursement model, and communication regarding reimbursement, health care reform, and BCBSM’s future direction. Hospital CEOs indicated to BCBSM that hospitals needed a relationship with BCBSM outside of the contracting process. BCBSM states in response to these comments that it established the Executive Outreach Program. This program pairs a hospital CEO and/or CFO with a BCBSM executive who is charged with meeting or communicating with their assigned hospital a few times each year.

In February 2010, BCBSM conducted a Hospital Patient Account Manager Satisfaction Survey. The intent of this survey was to evaluate how account managers perceived how easy it was to do business with BCBSM compared to other health carriers. The survey showed overall high satisfaction with BCBSM, provider inquiry and provider consultant services. Areas identified for continuous improvement based on their overall impact on satisfaction were communication, provider inquiry, provider consultant services, and claims processing. Account managers specifically stated that they wanted to see better benefit

information and more tailored communications. BCBSM states it is currently in the process of a multi-year program to enhance its benefit information and to ensure that all its self-help tools and provider inquiry areas are accessing the same data sources. This will ensure that BCBSM is giving consistent answers across all points of contact. BCBSM has also altered the hours of its call centers based on the feedback by the hospital community. To address satisfaction with BCBSM's provider consultants, BCBSM provider consultants have made a concentrated effort to increase their training schedules with specific concentrations in Southeast Michigan and the Upper Peninsula.

BCBSM states the BCBSA Member Touchpoint Measures (MTM) Program assesses operational and service performance of all BCBS plans by measuring on a quarterly basis the accuracy of the subscriber level enrollment process so that claims and bills are processed correctly; customer service representatives answer inquiries promptly and correctly; customers and providers receive correct benefit and eligibility information; and the subscriber has access to all benefits and network providers. BCBSM states its MTM scores have increased steadily over the past few years when compared to the other 55 Blue plans. During the two-year period under review, BCBSM earned a 100 percent score in BCBSA's MTM program in each of the last three quarters of 2010.

In 2010, BCBSA also added two new MTM metrics to its program: the First Call Resolution and Blue Experience Metric. First Call Resolution tracks a plan's ability to resolve a customer's issue with just one call. Blue Experience Metric captures the "voice of the customer." In particular, it focuses on a customer's experience related to wellness programs, customer service, claims payment, provider/network access, and member education.

Testimony submitted for review of BCBSM's hospital provider class plan alleges that BCBSM's dominant market share allows it to enjoy financial advantages that other health carriers do not have, forcing health care providers such as hospitals to accept the contract reimbursement rates and terms BCBSM sets forth in its participation agreements even though BCBSM's reimbursement oftentimes fails to reasonably cover the financial requirements of most hospitals. This topic is discussed in detail in the cost goal section of this determination report.

Findings and Conclusions - Access

Access to hospital care services by BCBSM members is influenced by a variety of factors, including the physical location and bed capacity of participating hospitals and the ability of hospitals to recruit physicians. In order to achieve compliance with the access goal, BCBSM needs to be able to ensure that in any given area of the state a member has reasonable access to certificate-covered hospital services, whenever such services are required. During the two-year period under review, BCBSM was able to maintain a 100% formal participation rate with hospital providers. As such, it is evident BCBSM members

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had no difficulty in obtaining reasonable access to hospital services. BCBSM also instituted a variety of ways for hospital providers to keep informed about BCBSM programs and policies. Based on the information analyzed during this review, it is therefore determined that BCBSM met the access goal stated in the Act for calendar years 2009 and 2010.

Quality of Care Goal:

The quality of care goal in Section 504(1) of the Act requires 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, OFIR staff examined BCBSM's achievement of its quality of care objectives, the methods BCBSM utilized in establishing and maintaining appropriate standards of health care quality, and BCBSM's methods of communication with hospitals. We reviewed these factors to assure that BCBSM not only encouraged provider compliance with the expected standards of hospital 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 hospital 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 hospital 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 hospitals and providing hospitals 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 hospital providers, BCBSM requires that these providers meet the participation qualifications and performance standards listed on pages 3 and 4 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. One of these qualification standards is that each hospital must obtain Medicare certification. BCBSM states the minimum health and safety standards required by CMS for participation in the Medicaid and Medicare programs are the foundation for improving and protecting the health and safety of beneficiaries.

BCBSM also requires participating hospitals to comply with Michigan's Certificate of Need (CON) Program. The CON Program strives to achieve a balance between cost, quality of care, and access to health care. The CON Commission is an 11-member independent body appointed by the Governor that approves CON review standards for determining need and ongoing quality assurance standards for health facilities and covered clinical services.

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BCBSM has developed an integrated utilization management strategy designed to address utilization problems in an efficient and cost-effective manner. BCBSM uses an admission pre-certification process to manage inpatient utilization and provide interventions that ensure members receive appropriate, high quality, and cost-effective care. Pre-notification is an electronic process that allows participating hospitals to notify BCBSM of inpatient admissions using web-DENIS. Timely pre-notification allows BCBSM to quickly identify cases for potential intervention by BCBSM care management programs.

Pre-certification of admissions ensures the inpatient setting is medically appropriate for the patient's condition and level of care. Pre-certification is a telephonic process and is only required of hospitals when admissions do not meet InterQual criteria or the admission is not eligible for pre-notification. Admissions for routine maternity, psychiatric care, substance abuse treatment, rehabilitation therapy, observation stays and certain admissions to Peer Group 6 and 7 hospitals are not eligible for pre-notification and must be pre-certified.

BCBSM relies upon its auditing process to ensure hospitals' inpatient admissions and outpatient services were appropriate; that the services rendered were performed for the appropriate indications in appropriate settings; and that services were accurately billed and paid. BCBSM's hospital audit activities are summarized in Attachment C to this determination report. Providers are selected for audit based on a number of factors, including random selection, prior audit history, referrals from internal or external sources, and the length of time since the last audit.

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

Within six weeks, the facility receives a letter detailing the final results of the audit. This letter identifies individual problem cases (e.g., diagnosis errors, billing errors, inappropriate settings, coding errors, and incorrect DRG selection), problem patterns, and any refunds due to BCBSM. The letter also specifies related corrective actions. Finally, the letter describes the appeals process available to providers who disagree with BCBSM's audit findings. BCBSM conducts a variety of audits that review hospital performance for medical appropriateness, appropriateness of setting, and compliance with benefits and billing requirements.

BCBSM states its routine auditing functions include the following types of audits:

- Medical Necessity Reviews: Reviews for medical necessity verify the care and treatment are appropriate for the symptoms and consistent with the diagnosis. BCBSM

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verifies the type, level, and length of care and the setting are necessary to provide safe and appropriate care based on InterQual criteria for inpatient care.

- DRG Validation Reviews: DRG validation audits were conducted for hospitals in Peer Groups 1 through 4 to verify the accuracy of ICD-9-CM codes, diagnoses and procedures from medical records and the DRG assigned by BCBSM.

BCBSM states every DRG reimbursed hospital is audited at least once per year. Larger volume hospitals are audited semi-annually or quarterly. BCBSM selects cases for review that have the highest probability of being inaccurate. BCBSM states it is staffed to audit about 8-10% of all admissions.

- Readmission Case Reviews: Readmission audits identify admissions that occur within 14 days of a previous discharge that should be combined resulting in a single DRG payment because the patient was either:
 - Discharged prematurely, necessitating an unplanned hospital readmission;
 - The subsequent admission was planned without a medical reason for the delay in services; or
 - The readmission is for continued care and services rendered during the previous admission.
- Catastrophic Case Reviews: Catastrophic cases are subject to review and recovery of over payments. A case is defined as catastrophic if its calculated cost exceeds the DRG payment by at least \$30,000. Payment for catastrophic cases is 75% of the excess cost. The cost is determined by applying the hospital specific cost-to-charge ratio to covered charges. Catastrophic case reviews are performed on Peer Group 1 through 4 hospitals, which are reimbursed for inpatient admissions based on DRGs.
- Hospital Outpatient Audits: Hospital outpatient audits are conducted to verify that services billed are covered; ordered by a physician; and have a documented result, billed correctly with appropriate procedure codes, diagnosis codes, and revenue codes and to determine whether services were medically appropriate. Services reviewed include, but are not limited to, observation beds, cardiac rehabilitation, laboratory, radiology, physical therapy, occupational therapy, speech and language pathology services, high-dollar services, emergency room services, and outpatient surgery. The review focuses on verifying that services billed and paid are benefits under the member's contract and that the services billed match the services that were ordered and performed.
- Transfer Audits – Transfers between hospitals may result in overpayments when facilities bill the incorrect discharge status for patients who were transferred to another

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acute facility. BCBSM conducts transfer audits in order to determine whether facilities are billing correctly for this service.

- Financial Investigations: BCBSM's Corporate and Financial Investigations (CFI) department follows up on reports of improper activity by patients and providers and, if improper activity is substantiated, refers information for possible legal action. CFI reviews information from a number of different sources to determine when an investigation is necessary.

Hospitals are informed of BCBSM's appeal process through BCBSM's publication of the *Record*, the online provider manual, and the PHA. Hospitals may also file requests for a review and determination from the Commissioner if the hospital believes BCBSM has violated Sections 402 or 403 of the Act.

BCBSM states it continues its commitment to "best in class" quality management through several innovative programs geared to improve quality of patient care.

BCBSM has two hospital pay-for-performance programs (P4P). One program is designed for large and medium sized acute care hospitals. This program gives top performing hospitals in Peer Groups 1-4 the opportunity to earn up to an additional five percent on their inpatient and outpatient operating payments if they meet specific performance thresholds. A description of BCBSM's 2010 Pay for Performance program is attached as Attachment D.

The other program is designed specifically for small rural hospitals. This program determines six percentage points of reimbursement for Peer Group 5 hospitals.

The additional percentage a hospital earned, based on its 2010 performance, was reflected in its BCBSM payments beginning July 1, 2011.

In 2010, hospitals were required to meet three pre-qualifying conditions to participate in the P4P program:

- Publically report performance on all applicable quality indicators to the Hospital Quality Alliance for publication on the CMS Hospital Compare website. This condition was applicable to the entire program. If a hospital failed to meet this condition, it forfeited its eligibility for the entire P4P program.
- Demonstrate an active commitment to patient safety via Hospital CEO attestation. For 2010, this includes conducting regular patient safety walk-rounds with hospital leadership, assessing and improving patient safety performance by fully meeting one of the following options: 1) completing and submitting the National Quality Forum Safe Practices section of the Leapfrog Hospital survey; 2) completing the Joint Commission Periodic

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Performance Review of National Patient Safety Goals; 3) participating in a federally-qualified patient safety organization; or 4) complying with the Agency for Healthcare Research Patient Safety indicators; and, ensuring results of the patient safety assessment and improvement activities are shared with the hospital's governing body and incorporated into a board-approved, multidisciplinary patient safety plan that is regularly reviewed and updated.

BCBSM states this prequalifying condition applies only to the quality indicator measures of the program. If a hospital failed to meet this condition it forfeited its eligibility for payment for the quality indicators, but it was not precluded from earning payment for the collaborative quality initiative (CQI) or efficiency components of the program.

- Maintain high performance (95% or more) on five intensive care unit ventilator bundle measures. Those measures included weaning assessments; following simple commands; head of bed evaluated to 30 degrees or higher; deep vein thrombosis prophylaxis; and stress ulcer disease prophylaxis.

BCBSM states that if a hospital's performance fell below the established threshold, the hospital was requested to file an action plan with a timeline for bringing performance back up to the established threshold. If a hospital failed to either file the action plan or meet the goals of the plan within the agreed timeframe, it was not eligible for payment for the quality indicator measures of the program. However, it would not be precluded from earning payment for CQI or efficiency measures of the program.

BCBSM states hospitals were evaluated on the following six quality indicators in the 2010 P4P program:

- Heart failure
- Pneumonia
- Surgical infection prevention
- Acute myocardial infarction
- Central line associated blood stream infection rates
- Acute myocardial infarction – percutaneous coronary intervention

Most of these indicators were scored on a "perfect care" basis. This scoring methodology requires a hospital to meet the requirements for all applicable measures for each patient. If one or more of the measures was not met and the measure was not contraindicated, the hospital did not receive credit for that patient.

In 2010, hospital efficiency was distributed according to two measures: a hospitals'

standardized inpatient cost per case relative to the statewide mean and a hospital trend measure.

Further, hospitals in 2010 were evaluated on their participation in the following six CQIs:

- BCBSM Cardio Consortium (BMC2) – There are two cardiac initiatives. The first is designed to decrease complications of those who undergo peripheral vascular intervention (PVI). The second one aims to improve the care of patients with coronary disease who undergo angioplasty by reducing complications such as kidney damage, the need for blood transfusions and the need for open heart surgery (PCI). Results of the peripheral arterial disease initiative has been positive, with a 7.2% decrease in post-PVI blood transfusions and significant improvement in the use of essential medical therapies, including antiplatelet and statin medications among physicians at participating sites. The objectives of the PCI initiative are to reduce vascular access complications, reduce the post PCI transfusion rate, reduce the rate of contrast induced nephropathy, acute kidney failure that can develop as a result of the dyes used in procedures and reduce nephropathy requiring dialysis. Results from the initiative showed a: 1) 30% reduction in hospital deaths; 2) 38% reduction in contrast-induced nephropathy; 3) 31% reduction in blood transfusions after angioplasty; 4) 19% reduction in vascular complications; 5) 49% reduction in emergency revascularization; and, 6) 28% reduction in gastrointestinal bleeding. BCBSM states the estimated savings from the PCI initiative is \$15.2 million annually in statewide health care costs.
- Michigan Bariatric Surgery Collaborative (MBSC) – This partnership with physicians and hospitals is designed to make weight-reducing bariatric surgery safer and potentially less costly across the state. Michigan hospitals performing bariatric surgery may share information on procedures and outcomes in a data registry. The data are used to help determine which practices produce the least risk, fewest complications, and the best results while reducing costs for these increasingly common and expensive procedures. Top line results showed overall complication rates decreased by 24% and visits to the emergency room following surgery declined 31%.
- Michigan Breast Oncology Quality Improvement Initiative (MiBOQI) – This program was started as a pilot project to improve the quality of care for the more than 7,000 Michigan women diagnosed with breast cancer each year. In 2006, working with researchers at the University of Michigan Health System, BCBSM invited five new hospitals to participate in the program. The number grew to 17 in 2007. The initiative is contributing comprehensive data on diagnostic testing, chemotherapy, radiation therapy, and surgery to a registry established by the

National Comprehensive Cancer Network. It will help physicians learn what works best in breast cancer treatment.

- Michigan Society of Thoracic and Cardiovascular Surgeons Quality Collaborative (MSTCVS) – This project aims to reduce the risk of complications and improve treatment methods before and after cardiac surgery for thousands of Michigan patients. This collaboration with the Michigan Society of Thoracic and Cardiovascular Surgeons will: a) enable greater in-depth analysis of patient data; b) help coordinate best practices among surgeons in all 31 hospitals in Michigan that offer cardiac surgery; and, c) engage surgeons in an effort to delve more deeply than ever before into cardiac surgery outcomes and to take what is learned and apply it to better patient care statewide. This project builds upon data already compiled in the Society of Thoracic Surgeon national database. There are about 20,000 adult cardiac operations in Michigan annually.
- Michigan Surgical Quality Collaborative (MSQC) – Sixteen of the largest hospitals in Michigan are participating in an initiative that evaluates the results of general and vascular surgery procedures performed in their institutions. This collaboration is an effort between the American College of Surgeons and BCBSM to evaluate and improve the quality of surgical care while ultimately reducing health care delivery costs. Data on the outcome of surgeries is being submitted to the American College of Surgeons' National Surgery Quality Improvement Program. The goal is to use the data to reduce infection, illness, or death associated with selected surgical procedures.
- The MHA Keystone Center is funded by Michigan hospitals, state and federal grants and donations from BCBSM. Nearly every Michigan hospital has participated in at least one of the center's pioneering patient safety collaborations. Their efforts have created new quality standards in an attempt to reduce hospital associated infections and risk in surgical, obstetrical, and emergency department settings across Michigan.

MHA Keystone Hospital Associated Infection (HAI), the largest of the collaboratives, seeks to prevent HAIs, which occur in approximately one of every 20 hospitalized patients. These infections are estimated to result in 99,000 associated deaths and \$6.65 billion in excess health care costs nationally each year. Development of HAIs puts patients at risk of mortality, longer lengths of stay, and higher costs. HAI launched statewide in 2007, the same year it was included in the CQI component of the P4P, starting with a strategic and manageable list of targeted infections. Only interventions feasible at the bedside and consistent with evidence for scientific merit are used in this program. Interventions include a focus on reducing catheter-associated urinary tract infections (CA-UTI) and avoiding central line associated bloodstream infections.

Interventions to reduce CA-UTI, the most frequent of HAIs, are separated into two prevention bundles. The first bundle involves the timely removal of nonessential catheters and appropriate care of necessary catheters. A second bundle of interventions addresses the insertion of catheters, including both appropriate placement and proper insertion technique.

BCBSM states that the MHA Keystone Center reports that hospitals that have implemented the first CA-UTI bundle have experienced a reduction in indwelling catheters from 19% to 14% between January 2007 and December 2010, resulting in an estimated 26% reduction of patients with urinary catheters and a 30% improvement in appropriate use.

BCBSM's other quality initiatives included the Blue Distinction Centers, the Michigan Quality Improvement Consortium, and the Michigan Health and Safety Coalition.

BCBSM centers of excellence in hospital care are now called the Blue Distinction Centers for Specialty Care[®]. BCBSM and Blue Care Network, together with BCBSA, have awarded the national Blue Distinction Centers for Specialty Care designation to Michigan hospitals that meet strict requirements for delivering quality health care in specific specialties.

The designation is based on rigorous, evidence-based, objective selection established in collaboration with expert physicians and medical organizations' recommendations. BCBSM's goal is to help consumers find quality specialty care, while enabling and encouraging health care professionals to improve the overall quality and delivery of care nationwide. The four Blue Distinction designations are: Blue Distinction Centers for Bariatric Surgery[®], Blue Distinction Centers for Cardiac Care[®], Blue Distinction Centers for Complex and Rare Cancers[®], and Blue Distinction Centers for Transplants[®].

Another quality initiative, the Michigan Quality Improvement Consortium (MQIC), is a collaborative effort by physicians and others from Michigan HMOs, the Michigan State Medical Society, the Michigan Osteopathic Association, the Michigan Association of Health Plans, the Michigan Peer Review Organization, and BCBSM. The consortium uses a collaborative approach to develop and implement guidelines for the treatment of common conditions as well as performance measures to show how often the guidelines are being used. The guidelines support the delivery of consistent, evidence-based health care services that will improve health outcomes for Michigan patients.

MQIC has developed evidence-based practice guidelines for the treatment of diabetes, asthma, depression, heart failure, and tobacco control. MQIC released two new clinical practice guidelines in 2009-2010 on the following clinical topics:

- Office Based Surgery Clinical Practice Guidelines were released in March 2009 (the title was changed to In Office Use of Sedation in March 2011).

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- Prevention of Pregnancy in Adolescents 12-17 Years Clinical Practice Guidelines were released in May 2010.

MQIC guidelines are based on scientific evidence as reported in the most current national guidelines and feedback from MQIC-participating health plans, providers, the Michigan Department of Community Health, and medical specialty societies.

BCBSM states it also provides leadership and significant funding and staff support to the Michigan Health & Safety Coalition (MH&SC), an independent non-profit organization. In addition to BCBSM, MH&SC members include professional and provider organizations, consumers, purchaser groups, and the Michigan Department of Community Health. The MH&SC is committed to improving patient safety in all health care settings. The MH&SC actively promotes hospital participation in the Leapfrog Group's annual survey of safety and quality and is a licensee of Leapfrog's data set, which is used for safety analysis and improvement. The 2009 survey included participation from 89 Michigan hospitals.

BCBSM states that, during the two-year period under review, it maintained effective relationships with hospitals through the contract administration process and a formal appeals process. The participating hospital agreement (PHA) provides for an ongoing contract administration process (CAP) through which participating hospitals can provide non-binding input and recommendations to BCBSM. The CAP is organized through several committees comprised of BCBSM staff or appointees, Michigan Health and Hospital Association (MHA) staff or appointees, and representatives from participating hospitals. The committees, all under the umbrella of BCBSM's Board of Directors, include the PHA Advisory Committee, Staff Liaison Group, Payment Practices Committee, Utilization Management and Quality Assessment Committee, and the Benefit Administration Committee.

The PHA Advisory Committee is made up of BCBSM board members and hospital CEOs. The group is charged with providing input and making non-binding recommendations to the BCBSM Board of Directors regarding the administration of and any modifications to the PHA.

The Staff Liaison Group is comprised of MHA and BCBSM executive staff and the co-chairpersons of the Benefit Administration Committee, Utilization Management and Quality Assessment Committee, and Payment Practices Committee. The Staff Liaison Group meets as necessary to oversee and coordinate the activities of these three committees and to develop recommendations and reports to the PHA Advisory Committee.

The Utilization Management and Quality Assessment Committee includes BCBSM senior and mid-level management, MHA staff, and representatives from the participating hospitals. The committee provides input on matters related to utilization, quality, and health management activities.

The Benefit Administration Committee handles matters related to problems administering the PHA. The Committee consists of BCBSM and MHA administrative staff and personnel from participating hospitals.

OFIR staff review of the minutes of these committees reveals that hospital providers have regular, routine communication with BCBSM and have been allowed to provide input on the benefit structure and payment policies of hospital services.

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 2009 and 2010, BCBSM has continued in its efforts toward promoting patient safety and delivering high quality care through quality management initiatives such as the PHA Pay for Performance program, BCBSM's Cardiovascular Consortium, and Cardiac Centers of Excellence. BCBSM has also been an active participant in the Michigan Quality Improvement and the Michigan Health & Safety Coalition initiatives dealing with evidence-based practice and safety standards. Further, the ongoing activities of the PHA Advisory Committee illustrate BCBSM's willingness to work with the provider community to assure that its members are receiving, and will continue to receive, quality health care services. 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 2009 and 2010.

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 hospital provider class for calendar years 2009 and 2010 shall not exceed 1.7%.

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

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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 December 2008 population data obtained from monthly population estimates published by the Bureau of Census, as obtained from the U. S. Census Bureau (www.census.gov/popest/national/NA-EST2008-01.html) and economic statistics for the GNP and implicit GNP price deflator from the U. S. Department of Commerce, Bureau of Economic Analysis as published in December 2008 by the Federal Research Bank of St. Louis (research.stlouisfed.org/fred2/data/GNPC96.txt and research.stlouisfed.org/fred2/data/GNPDEF.txt), the following calculations have been derived:

I = Inflation as defined in the cost goal formula:

% change in implicit GNP price deflator

2009	0.4
2010	1.4

2 yr. average 0.9

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

% change in per capita GNP in constant dollars

2007	2.0
2008	(1.2)
2009	(0.5)
2010	2.9

4 yr. average 0.8

Using the latest population and economic statistics available, the cost goal for the period under review is estimated to be 1.7%, as shown below:

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Inflation = 0.9

Real Economic Growth = 0.8

$$\frac{[(100 + 0.9) \times (100 + 0.8)]}{100} - 100 = 1.7\%$$

Section 517 of the Act requires BCBSM to transmit an annual report to the Commissioner, 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 hospital provider class plan for the calendar years 2009 and 2010, as filed with OFIR, are presented below. Cost data reflect claims incurred in the calendar year and paid through February 28th of the following year.

Hospital Performance Against Cost Goal - Traditional

Hospital	2008	2009	2010	Average Yearly Rate of Change
Total Payments	\$430,509,286	\$410,852,747	\$324,247,675	
Total Members	156,325	147,633	118,515	
Cost Performance				
Payments/1,000 Members	\$2,753,941	\$2,782,940	\$2,735,924	(0.3)%
Rate of Change (%)		1.1%	(1.7)%	(0.3)%

The two-year arithmetic average increase for the hospital provider class plan equals (0.3)% which is less than BCBSM’s projected required cost goal of 1.7%. Overall hospital cost performance for BCBSM’s traditional plan showed the trend in hospital payments per 1,000 members remaining relatively flat, while membership continued to decline. The hospital payment per 1,000 members decreased approximately \$47,016 or 0.3% from 2009 to 2010 while membership decreased approximately 19.7%, or approximately 30,000 members.

BCBSM’s cost, use, and price trends for the hospital provider class for the two-year period under review for both inpatient and outpatient services are identified below.

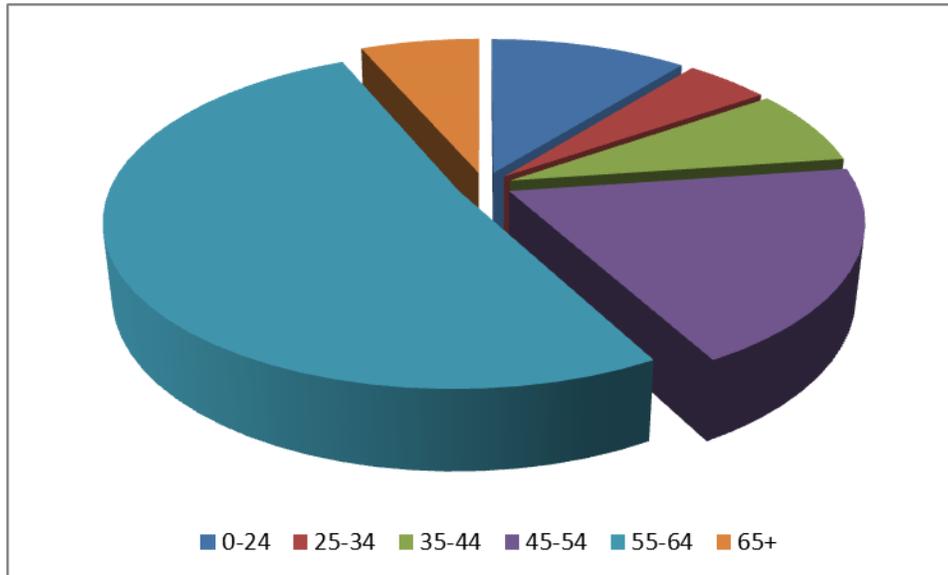
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Inpatient – Traditional			
	2008	2009	2010
Payments			
Total	\$225,782,685	\$233,925,115	\$176,189,256
Per 1,000 members	\$1,444,318	\$1,584,508	\$1,486,643
% of change		9.7%	(6.2)%
Admissions			
Total	20,121	18,423	12,916
Per 1,000 members	128.71	124.79	108.98
% change		(3.0)%	(12.7)%
Payment/Admission	\$11,221.25	\$12,697.45	\$13,641.16
% of change		13.2%	7.4%
Members	156,325	147,633	118,515
Outpatient – Traditional			
	2008	2009	2010
Payments			
Total	\$204,726,602	\$176,927,632	\$215,644,018
Per 1,000 members	\$1,309,623	\$1,198,432	\$1,249,281
% of change		(8.5)%	4.2%
Visit			
Total	4,212,154	4,340,073	3,573,764
Per 1,000 members	26,944.89	29,397.79	30,154.56
% change		9.1%	2.6%
Payment/Visit	\$48.60	\$40.77	\$41.43
% of change		(16.1)%	1.6%
Members	156,325	147,633	118,515

BCBSM states that hospital inpatient costs decreased \$97,865 per 1,000 members, or an average of 6.2% during this reporting period. The cost decrease was the result of a significant decrease in admissions that averaged 7.8%. BCBSM notes that as membership and utilization declined during the two-year period under review, the percentage of patients using benefits also declined from 10.1% in 2008 to 8.8% in 2010.

A number of factors affect BCBSM's cost goal performance. Many of these factors are described below:

BCBSM states that members aged 55 years and older were responsible for 52% of inpatient payout during 2010.



Across the country, trends in aging show the average life span continues to rise and with the growing number of individuals from the baby boomer generation reaching Medicare eligibility, there is a general expectation that increased demands on the public health system and medical and social services will occur. It is estimated by 2030 that one billion people worldwide will be 65 years or older. The National Institute of Health reports that one in every eight people on earth will be of Medicare eligible age.

Increased life expectancies also impact the number of chronic conditions, injuries, and disabilities that require medical treatment. The following data illustrates the distribution of inpatient payments among each of the major diagnostic categories and their impact on overall costs. Major diagnostic categories (MDC) identify the main reason for an inpatient encounter.

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Inpatient Care by Major Diagnostic Category (MDC)	Two-year Average Rate of Change				Three year Payments	Adm	Average Pay/Adm	% of Payout
	Per 1,000 Members							
	Payments	Days	Adm	Pmt/Adm				
Nervous System	1.1%	-1.6%	-7.6%	8.3%	\$38,826,747	2,202	\$17,632	6.1%
Diseases of the Eye	1.7%	-1.5%	7.3%	-0.1%	\$358,404	54	\$6,637	0.1%
ENT Disease	6.2%	-9.9%	1.4%	5.4%	\$4,703,965	516	\$9,116	0.7%
Respiratory System	-1.6%	-12.9%	-8.7%	7.9%	\$51,534,740	4,063	\$12,684	8.1%
Circulatory System	-2.5%	-11.4%	-9.2%	7.4%	\$103,402,219	5,026	\$20,573	16.3%
Digestive System	9.0%	-2.6%	-0.6%	9.4%	\$58,720,479	4,815	\$12,195	9.2%
Hepatobiliary Sys/Pancreas	-0.3%	-10.6%	-7.2%	5.0%	\$24,237,509	1,594	\$15,205	3.8%
Musculoskeletal	11.7%	-2.9%	-1.7%	13.6%	\$124,440,600	6,712	\$18,540	19.6%
Skin/Subcutaneous Disease	16.5%	7.3%	4.8%	13.0%	\$9,918,866	1,232	\$8,051	1.6%
Nutritional Disease	-2.1%	-11.2%	-6.3%	4.5%	\$24,606,017	2,075	\$11,858	3.9%
Kidney/Urinary Tract	7.1%	-7.3%	-1.9%	9.1%	\$17,361,620	1,577	\$11,009	2.7%
Male Reproductive System	13.5%	2.5%	-0.4%	14.4%	\$4,940,908	461	\$10,718	0.8%
Female Reproductive System	-0.3%	-14.0%	-12.8%	13.9%	\$19,074,350	2,121	\$8,993	3.0%
Pregnancy	-9.5%	-14.3%	-13.6%	5.0%	\$24,659,070	5,585	\$4,415	3.9%
Newborns in Perinatal Period	-8.2%	-42.0%	-13.2%	5.6%	\$17,933,340	5,123	\$3,501	2.8%
Disease of the Blood	0.3%	-18.9%	-7.9%	9.0%	\$6,926,506	617	\$11,226	1.1%
Neoplasms	-7.0%	-15.8%	-7.1%	2.9%	\$17,017,009	489	\$34,800	2.7%
Infectious Disease	5.7%	-3.1%	2.8%	2.2%	\$26,623,449	1,138	\$23,395	4.2%
Mental Disorders	-17.9%	-20.8%	-21.9%	5.8%	\$15,151,643	2,497	\$6,068	2.4%
Alcohol/Drug Abuse	-13.2%	-14.7%	-12.0%	-1.4%	\$1,271,367	183	\$6,947	0.2%
Injury Poisoning	-0.9%	-13.9%	-6.6%	7.2%	\$16,294,711	1,307	\$12,467	2.6%
Burns	-18.6%	-39.3%	-18.1%	-3.3%	\$563,625	26	\$21,678	0.1%
Factors Influencing Health Status	2.3%	-11.7%	-8.1%	11.2%	\$24,675,353	1,835	\$13,447	3.9%
HIV Infections	57.0%	67.7%	8.1%	4.4%	\$1,048,718	16	\$65,545	0.2%
Other	1543.2%	1484.6%	17.6%	1117.8%	\$1,605,841	196	\$8,193	0.3%
Total	1.8%	-11.2%	-7.9%	10.3%	\$635,897,056	51,460	\$12,357	100.0%

As shown in the above table, the circulatory, musculoskeletal, digestive, and respiratory MDCs three-year payout accounted for 53% or almost \$338 million of total inpatient payments. Musculoskeletal conditions accounted for 19.6% of total inpatient payments. The total payment for this MDC increased 11.7%, caused by an almost 2% decrease in admissions per 1,000 members essentially offset by a 13.6% increase in the average price per admission, indicating more costly or intensive services were required. The Burden of Musculoskeletal Diseases reports that one of every four Americans has a musculoskeletal impairment that requires medical attention. Annual direct and indirect costs for bone and joint health are \$849 million or 7.7% of the gross domestic product. The burden of

musculoskeletal conditions expected to escalate in the next 10-20 years due to the aging population and sedentary lifestyles.¹

BCBSM notes that even though circulatory conditions had the second highest payout at 16.3% of total inpatient payments, the average payment per 1,000 members decreased 2.5%. This decrease was due to a 9.7% decrease in the average number of admissions partially offset by a 7.4% increase in the average price per admission. Circulatory diseases such as heart disease, stroke, peripheral-vascular diseases such as deep vein thrombosis and varicose veins are very common reasons for inpatient hospital admissions. As baby boomers age the likelihood of circulatory conditions will become even greater, having a great economic impact on our nation's health care resources.

Payments per 1,000 members for digestive conditions increased 9% during 2010, mainly due to a 9.4% increase in the average price per admission. The types of conditions included in this MDC include bowel procedures, gastrointestinal disorders, hernias, and appendectomies. Respiratory conditions accounted for 8.1% of BCBSM's total payout, despite payments per 1,000 members decreasing by 1.6%. This decrease was the result of an 8.7% decrease in admissions that was partially offset by a 7.9% increase in the average cost per admission. BCBSM notes that conditions afflicting members during 2010 included respiratory failure, pneumonia, pulmonary embolisms, COPD, and asthma.

BCBSM states it is useful when reviewing MDCs' cost and use experience to also examine diagnosis codes. Diagnostic related groupings (DRG) are a system for classifying inpatient care; the purpose is to provide a framework for specifying case mix. BCBSM's top ten DRGs accounted for almost \$72 million or 11.4% of BCBSM's total inpatient payout and had an average increase in payments per 1,000 members of 10.6%. Arthritis, back issues, Extracorporeal Membrane Oxygenation (ECMO), and mechanical ventilation were among the top DRG categories by payout.

¹ www.boneandjointburden.org

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Diagnostic Related Group	Two-year Average Rate of Change Per 1,000 Members				Three year		Average Pay/Adm	% of Payout
	Payments	Days	Adm	Pmt/Adm	Payments	Adm		
	Spinal fusion exc cervical w/o mcc	25.8%	5.8%	10.7%	14.0%	\$14,619,403		
Signs & symptoms of musculoskeletal system & conn tissue	6.1%	-2.8%	-1.6%	9.2%	\$11,410,699	581	\$19,640	1.8%
ECMO/Trach 96+ hrs. w/major OR	-7.4%	-9.9%	-11.8%	5.8%	\$12,238,998	67	\$182,672	1.9%
Septicemia or sepsis w/o mcc	32.2%	14.2%	21.0%	10.3%	\$5,397,662	255	\$21,168	0.9%
Uterine & adnexa procedure	16.7%	13.3%	6.5%	9.6%	\$5,804,366	954	\$6,021	0.9%
Rehabilitation	-1.2%	-12.0%	-7.8%	8.4%	\$5,862,129	465	\$12,607	0.9%
Vaginal Delivery w/o complications	14.7%	11.3%	11.4%	6.8%	\$4,472,820	109	\$41,035	0.7%
Urethral Stricture (age 0-17)	9.0%	6.0%	-2.6%	12.9%	\$4,484,322	318	\$14,102	0.7%
Obesity w/o complications	-6.2%	-18.0%	-13.5%	11.7%	\$5,265,627	146	\$36,066	0.8%
Splenectomy age > 17	19.5%	14.8%	8.3%	9.4%	\$6,178,707	1,033	\$5,981	1.0%
Top 10	10.5%	1.8%	2.7%	1.1%	\$72,164,779	14,952	\$20,761	11.4%
Top 50	11.1%	-1.4%	-0.5%	11.3%	\$278,887,228	31,036	\$12,692	43.9%
Grand Total	1.8%	-11.3%	-7.9%	10.3%	\$35,897,056	81,464	\$12,357	100.0%

Spinal fusions accounted for the highest inpatient cost with 2.3% of the total payments. The total average payment for spinal fusions increased 25.8% due to a 10.7% percent increase in admissions and a 14% increase in the average cost per admission. An aging population likely will result in an increase in lumbar surgery in the future. It is likely that as advancements in spinal fusion demonstrate to people that their quality of life can be enhanced that the demand for these surgeries and the subsequent rehabilitation therapy may overwhelm supply. Dartmouth researchers state that the rate of lumbar fusions in the United States has increased more than 250% over the past decade. In addition, the cost increase of spinal fusions has been more than 500% among Medicare patients.²

The second highest inpatient cost was for ECMO. ECMO is a technique providing both cardiac and oxygen respiratory support to patients whose heart and lungs are so severely damaged that they can no longer serve their function. ECMO is used mostly for newborns in pulmonary distress. During the two-year period under review, a decrease in payments per 1,000 members of 7.4% was reported for this DRG, due almost entirely to an 11.8% decrease in the average number of admissions.

Arthritis – both osteo and rheumatoid – were the primary reasons behind the inpatient costs associated with the musculoskeletal and connective tissue DRG category with 1.8% of the total payout during the two-year period under review. The average payment per admission for this DRG was \$19,640. An aging population, particularly the baby boomer generation,

² www.dartmouth.edu/~news/releases/2006/10/17.html

has created an increase in joint replacement surgery. Joint replacement surgery is known to be quite successful in improving quality of life, allowing those with painful joints to become active again. Findings presented at an annual meeting of the American Academy of Orthopedic Surgery reveals that the number of total knee replacements performed in the United States will leap by 673% and total hip replacements will increase by 174% by 2030.³

Mechanical ventilation is a life support therapy used to sustain breathing as well as provide oxygen and carbon dioxide removal to patients whose lungs are damaged so that they can no longer function properly. Mechanical ventilation is used in patients experiencing respiratory failure. The DRG for mechanical ventilation increased in payments per 1,000 members by nearly 32.2%, due to a 21% increase in the average number of admissions and of a 10.3% increase in the average price per admission.

BCBSM states the total payout for outpatient hospital care was \$530 million during the two-year period under review. The two-year average outpatient decrease in payments per 1,000 members was 2.1%, the result of a 5.8% rise in utilization and a 7.2% decrease in payment per service. BCBSM indicates that, similar to inpatient trends, members aged 55 years and older accounted for nearly 50% of the total payout, with the percentage of patients using outpatient benefits increasing from approximately 93 to 96% in 2009 and 2010, respectively. Thus, even though the number of BCBSM members is declining, the number of patients using the benefit has increased.

The table below shows that surgery, laboratory/pathology, and diagnostic radiology accounted for 76% of total outpatient payments. BCBSM states that in many respects, these top three types of service are often used in conjunction with one another to provide patient care. For example, many times, surgical procedures are coupled with laboratory/pathology services as physicians order a variety of blood and imaging tests to diagnose and treat a presented illness.

³ www.webmd.com/osteoarthritis/news/20060324/joint-replacement-surgery-on-rise

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Type of Service	Two-year Average Rate of Change Per 1,000 Members			Three year Payments	Pct of Payout
	Payments	Services	Pay/Serv		
Surgery	-21.4%	16.3%	-107.6%	\$223,056,754	42.1%
Laboratory/Pathology	30.7%	28.1%	-33.5%	\$82,160,518	15.5%
Diagnostic X-ray	14.5%	9.5%	-86.0%	\$99,426,294	18.8%
Outpat Med Emergency, Non-Acc	25.6%	14.9%	13.1%	\$59,207,679	11.2%
Chemotherapy	20.8%	81.1%	104.8%	\$30,933,533	5.8%
Physical Therapy	8.1%	16.8%	-50.5%	\$28,352,118	5.4%
Outpat Med Emergency, Accident	54.4%	26.3%	17969.5%	\$14,330,380	2.7%
Therapeutic X-ray	17.8%	20.8%	-271.2%	\$23,311,149	4.4%
Maternity	16.0%	24.5%	3.6%	\$7,363,207	1.4%
All Others	-114.8%	-20.4%	-33.0%	(\$38,438,979)	-7.3%
Grand Total	-2.1%	5.8%	-7.2%	\$529,702,653	100.0%

Given that BCBSM's traditional membership tends to be older it stands to reason that these individuals use more health care resources. In addition, advances in medical technology, patient treatment, and minimally invasive procedures for the treatment of many diseases will increase use of more outpatient services as people seek to manage health conditions and their quality of life more on an ambulatory basis.

The outpatient data confirms this as cancer diagnoses and screenings, cardiovascular conditions and screenings, atrial fibrillation and coronary atherosclerosis, obstructive sleep apnea, kidney stones, and abdominal pain ranked highest in total payout.

The following table shows the distribution of hospital outpatient costs, utilization and price by MDC.

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Outpatient Care Major Diagnostic Category (MDC)	Two-year Average Rate of Change Per 1,000 Members			Three year		Average	Pct of Total	
	Payments	Visits	Pmt/Visit	Payments	Visits	Pay/Visit	Payout	Visits
	Nervous System	-2.0%	14.2%	-13.9%	\$20,787,495	355,958	\$58	3.9%
Disease of the Eye	-10.0%	5.8%	-14.3%	\$8,625,121	105,077	\$82	1.6%	0.9%
Disease of ENT	-11.3%	-3.3%	-8.3%	\$20,605,218	442,973	\$47	3.9%	3.7%
Respiratory System	-4.3%	-0.7%	-2.8%	\$38,879,430	911,763	\$43	7.3%	7.5%
Circulatory System	7.2%	14.0%	-5.9%	\$48,295,124	850,047	\$57	9.1%	7.0%
Digestive System	-5.2%	0.7%	-5.4%	\$55,557,690	1,682,937	\$33	10.5%	13.9%
Hepatobiliary Sys/Pancreas	-2.8%	4.7%	-5.8%	\$12,446,250	311,217	\$40	2.3%	2.6%
Musculoskeletal	-4.3%	7.6%	-10.8%	\$95,590,557	1,721,613	\$56	18.0%	14.2%
Skin & Subcutaneous Disease	-3.0%	6.0%	-8.5%	\$38,577,597	739,366	\$52	7.3%	6.1%
Nutritional Disease	-15.4%	2.9%	-17.7%	\$18,562,452	903,831	\$21	3.5%	7.5%
Kidney/Urinary Tract	-7.8%	1.5%	-8.4%	\$26,483,976	770,908	\$34	5.0%	6.4%
Male Reproductive System	-1.4%	10.5%	-10.6%	\$9,660,490	133,713	\$72	1.8%	1.1%
Female Reproductive System	-12.4%	-1.6%	-10.6%	\$18,329,095	440,737	\$42	3.5%	3.6%
Pregnancy	-13.0%	10.1%	-3.1%	\$3,901,367	96,286	\$41	0.7%	0.8%
Newborns in Perinatal Period	-19.1%	6.9%	6.9%	\$161,634	3,229	\$50	0.0%	0.0%
Disease of the Blood	-5.5%	6.6%	-24.2%	\$10,838,385	427,634	\$25	2.0%	3.5%
Neoplasms	13.9%	6.6%	-11.6%	\$21,096,373	376,724	\$56	4.0%	3.1%
Infectious Disease	-11.3%	7.7%	6.6%	\$2,205,040	100,079	\$22	0.4%	0.8%
Mental Disorders	-4.6%	-3.1%	-16.3%	\$2,201,528	58,649	\$38	0.4%	0.5%
Alcohol/Drug Abuse	-12.3%	11.5%	-1.3%	\$719,505	24,371	\$30	0.1%	0.2%
Injury Poisoning	-8.9%	6.0%	-0.8%	\$4,015,744	77,841	\$52	0.8%	0.6%
Burns	-22.6%	13.7%	-13.0%	\$256,817	3,236	\$79	0.0%	0.0%
Factors Influencing Health Status	8.9%	17.9%	-10.5%	\$65,566,903	1,533,458	\$43	12.4%	12.6%
HIV Infections	-20.9%	-3.2%	-7.6%	\$200,912	5,827	\$34	0.0%	0.0%
Other	-7.2%	13.0%	-19.4%	\$389,381	9,145	\$43	0.1%	0.1%
Unknown	27.0%	37.2%	5.6%	\$5,758,569	39,372	\$146	1.1%	0.3%
Total	-2.1%	5.8%	-5.8%	\$529,712,653	12,125,991	\$44	100.0%	100.0%

Most MDC categories experienced average payment per member decreases. Diseases of the musculoskeletal system had the highest three-year payout, accounting for 18% of the total outpatient payout as well as 14.2% of the total visits. Payments per 1,000 members for this category, however, decreased 4.3%, the result of a 10.8% decrease in the average payment per visit, indicating a less severe illness mix. Musculoskeletal conditions include back pain, joint pain, arthritic disorders, and sprains and tears, which are all conditions associated with physical activity and/or aging. An estimated 40 million Americans have some form of arthritis or other rheumatic condition. As the population ages, particularly the

baby boomer generation, the number of people being treated for arthritic conditions is expected to climb. According to a new report published as a collaborative effort between the National Institutes of Health, the Centers for Disease Control and Prevention, the Arthritis Foundation, and the American College of Rheumatology, 59.4 million people or 18.2% of the population will suffer from some form of arthritis.⁴

Digestive disorders ranked second in terms of total payout at 10.5% while experiencing an average decrease in payments per 1,000 members of 5.2% primarily due to decreased price, indicating a less severe illness burden. The most common diagnoses by payment were abdominal pain, hernia and colon disorders, and cancer. BCBSM states that all these are conditions that may be affected by a member's diet, weight, level of stress, and lifestyle choices.

The type of care individuals receive in the hospital setting is directly related to the health status of these individuals. Health status is affected by a number of different factors including demographics, the environment, chronic disease, accidents, and injuries, as well as lifestyle choices. BCBSM states that increased life expectancies also affect the number of chronic conditions, injuries, and disabilities that require medical treatment.

Today's rates of chronic conditions are high, with the proportion of the population affected by one or more chronic diseases likely to grow as the baby boomer generation continues to age become eligible for Medicare. Currently, 78% of U.S. health care spending is for people with chronic conditions and almost one half of Americans live with at least one chronic disease or disability.⁵ Certain chronic conditions such as arthritis also affect a person's activity limitations, often requiring individuals to miss work or school or become disabled. People with chronic diseases tend to be the heaviest users of health care services. At the same time, technological advances continue to provide new treatment options which drive up health care costs. For example, advanced techniques and technologies have patients suffering from arthritis considering joint replacements at earlier ages than in the past, in the hope they can minimize activity limitations and be more active in their later years.

According to data from the Michigan Department of Community Health, Michigan outranks most states in the percent of the adult population with chronic conditions such as:

- ❖ Obesity – Michigan ranked 10th in the nation, with an obesity rate of nearly 30%. Obesity is considered a major risk factor for a number of chronic conditions including diabetes, hypertension, cardiovascular disease, and cancer.
- ❖ Diabetes – Michigan has an adult diabetes rate of 9.4% (up from 8.8% from the last review), compared to the national rate of 8.4%.

⁴ www.nih.gov/news/pr/may98/niams-05.htm

⁵ Michigan.gov/documents/Healthy_michigan_2010_1_88117.7.pdf

- ❖ Hypertension – Michigan ranked 16th in the nation, with 28.7% of the population diagnosed with hypertension.
- ❖ Cancer – Michigan ranked 8th in the nation in the estimated number of new cases of cancer.

Michigan also fares poorly with respect to the prevalence of lifestyle factors that contribute to chronic health conditions, such as smoking, lack of exercise, and diet. Chronic diseases, such as heart disease, stroke, cancer, and diabetes are among the most prevalent, costly, and preventable of all health problems⁶

BCBSM states that, along with the health care industry, it has responded to chronic disease trends with a shift toward disease management programs as a means of controlling costs. The purpose of disease management is to empower participants so they can better manage and improve their own health. BCBSM has also broadened its scope of medical care management design. BCBSM no longer directs all of its attention to provider costs and provider utilization, but has added member-centric programs.

One of BCBSM's member-focused health management programs is BlueHealthConnection[®]. 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 educational tools to help make their health care decisions.

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

The BCBSM BlueHealthConnection[®] Satisfaction Survey is an annual survey used to measure users' overall satisfaction with BlueHealthConnection[®]. In 2010, overall satisfaction with BlueHealthConnection[®] remained high with a 94% satisfaction rate. Key findings from the survey showed patient satisfaction with BCBSM's BlueHealthConnection[®] was very positive. In addition:

- More than 98% of respondents indicated the program helped them set goals to manage their health care needs for the Chronic Condition Management, Case Management (95%) and Wellness Coaching (95%) programs.

⁶ Healthyamericans.org/states/?stateid=MI

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- Over 98% of respondents enrolled in the Chronic Condition Management and Case Management programs felt that their case manager answered their questions and helped with their concerns.
- Most members responding to the survey believed the Wellness and Care Management program helped them to make lifestyles changes or health decisions.
- More than 9 out of 10 respondents said that their nurse helped them understand when to call their doctor.
- Nearly 90% of respondents indicated that they were satisfied with the Quit the Nic program and 100% of those members indicated their health coach was courteous and that they would participate in the program again.

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

BlueHealthConnection[®] provides industry-leading programs to support members managing chronic and complex medical conditions. A state-of-the-art predictive model is utilized to identify members at risk for specific medical conditions. Through case management, registered nurse case managers provide assistance to members with complex medical conditions by helping them understand treatment options, transition from hospital to home, and advocate for the appropriate care setting for recommended services. BCBSM registered nurses also work over the phone with members who have chronic conditions. BCBSM states that through a series of calls, members are empowered to better understand how to self-manage their condition and improve their health.

BCBSM states it has a social mission to help Michigan residents live healthier lives, resulting in reduced health care costs. Social mission programs address health issues with serious and sometimes fatal consequences that, in many cases, are preventable. During the two-year period under review, BCBSM continued previous programs that targeted domestic violence, smoking, depression, physical activity, and healthy weight. BCBSM recognizes the importance of these programs in addressing risk factors underlying the chronic diseases many Michigan residents face today.

BCBSM states its prior authorization programs effectively assure the appropriateness of setting and medical necessity of recommended treatment plans. These pre-authorization programs also provide "real-time" information that can be integrated with care management to identify and target members currently facing health care decisions. BCBSM's pre-certification efforts include a review of a patient's symptoms and proposed treatment to determine, in advance, whether they meet BCBSM criteria for inpatient treatment.

For Michigan-based hospitals, the provider is required to apply InterQual criteria to certify the case for the inpatient setting. InterQual is an automated clinical decision support

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criteria system used to identify intensity of service and severity of illness and screen proposed medical care based on patient-specific, best medical care processes. The facility provides a “pre-notification” of the admission through an online process and asserts that the admission meets the applicable criteria. This information is used not only to validate the admission (and is auditable as part of BCBSM’s retrospective review processes) but also integrates key “real time” information on hospital admissions for use in BCBSM’s care management programs, particularly case management. For non-DRG hospitals, pre-certification also verifies that the appropriate length of stay is assigned for elective, emergency, or maternity admissions. For DRG hospitals, appropriateness of setting is verified. For out-of-state hospitals, a telephonic pre-notification process is utilized.

BCBSM continues to take a series of retrospective approaches to utilization management. Post-care medical record audits for both utilization and financial perspective are performed, assuring that appropriate billing practices were applied. Refund requests from the provider are sought when irregularities in billing practices are found. In some cases, where providers have shown a pattern of utilization concern, prepayment utilization review restricts a provider’s billing privileges and the provider’s claims are manually reviewed by BCBSM.

BCBSM states its efforts in other programs also contribute to managing utilization. An example is BCBSM’s medical policy decisions about which procedures to cover. BCBSM uses a medical policy approach that uses claims system commands that prevent payment of non-covered services to avoid having to recover inappropriate payments. Claims edits not only prevent payment of customer-designed benefit restrictions administered by BCBSM, but also assure that medical policy rules (which define clinical appropriateness of care) are met.

BCBSM also states its quality management programs, many of which are discussed in the Quality of Care Goal section of this determination report, reassure groups and members that BCBSM selects and retains providers of the highest quality and collaborates with them to encourage using evidence based practices and safety in the health care settings. BCBSM states it is improving health care in Michigan through its Value Partnerships programs, a collection of clinically oriented initiatives among Michigan physicians, hospitals and BCBSM that are improving the quality of patient care across Michigan. BCBSM states its initiatives enhance clinical quality, decrease complications, manage costs, eliminate errors and improve health outcomes. For example, BCBSM reports that it:

- Saved more than \$65 million in three years through the appropriate use of high and low-tech radiology services;
- Reduced complications following bariatric surgery by 24%;
- Reduced radiation exposure by 53% for patients undergoing cardiac CT angiography – with no reduction of image quality.

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BCBSM also participates in the Michigan Health Information Network (MHIN). This is the state of Michigan's initiative to improve health care quality, cost, efficiency, and patient safety through electronic exchange of health information. It is focused on designing a system to create electronic medical records that can be securely and confidentially delivered amongst various providers that are involved in a patient's care. MHIN is also an essential part of ensuring that Michigan's health care providers utilize electronic health records (EHR) in a way that meets the federal criteria for Medicare and Medicaid EHR incentive programs. BCBSM states that its Executive Vice President of Health Care Value & Information Technology is its representative on the MHIN board.

BCBSM's overall traditional membership declined by almost 20% or about 30,000 members during the two-year period under review. BCBSM states the ratio of patients to members decreased in 2010 (by 3%) after experiencing an increase of 3.5% in 2009. Reasons behind declining membership include traditional members moving to managed care or PPO products, members losing health benefits through their employers, work force reductions, aggressive competitor pricing, and a declining economy. BCBSM data shows that its traditional membership declined in each age category during the two-year period of review except for the 46-64 and greater than 65 years age bands. Not surprisingly, this age had the most significant impact on costs and it accounted for more than 45% of the total payout.

Much of the testimony on BCBSM's hospital provider class plan indicated that OFIR should review BCBSM's overall performance, including its PPO and HMO business. OFIR obtained basic cost information from BCBSM with respect to its overall business and it is shown below. Given that HMOs are licensed and regulated under a separate chapter of the Insurance Code, that data is not described or discussed as it is not pertinent to this determination report. Any review of the contractual arrangements in existence between hospitals and Blue Care Network will be conducted separately from this review of BCBSM's hospital provider class plan.

Hospital Performance Against Cost Goal - PPO

PPO	2008	2009	2010	Average Yearly Rate of Change
Total Payments	\$3,230,109,435	\$3,180,980,856	\$3,186,653,869	
Total Members	2,396,811	2,294,693	2,156,515	
Cost Performance				
Payments/1,000 Members	\$1,347,670	\$1,386,234	\$1,477,687	4.7%
Rate of Change (%)		2.9%	6.6%	4.7%

As illustrated above, BCBSM's PPO line of business would not have achieved the statutory cost goal. It is notable, however, that BCBSM's overall hospital performance, including both the traditional and PPO hospital data, as shown in the following table, reveals that BCBSM would have achieved its statutory cost goal had all BCBSM data been provided for review:

TRAD & PPO	2008	2009	2010	Average Yearly Rate of Change
Total Payments	\$3,660,618,722	\$3,591,833,603	\$3,510,901,544	
Total Members	2,553,136	2,442,326	2,275,030	
Cost Performance				
Payments/1,000 Members	\$1,375,133	\$1,470,661	137513300.0%	(2.0)%
Rate of Change (%)		2.0%	(6.5)%	(2.0)%

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BCBSM provided similar inpatient and outpatient data for its PPO line of business and traditional and PPO business combined. This information is shown below:

Inpatient – PPO			
	2008	2009	2010
Payments			
Total	\$1,589,022,022	\$1,692,334,852	\$1,682,033,047
Per 1,000 members	\$662,97318	\$737,499	\$779,977
% of change		11.2%	5.8%
Admissions			
Total	164,738	154,832	144,810
Per 1,000 members	68.73	67.47	67.15
% change		(1.8)%	(0.5)%
Payment/Admission	\$9,645.755	\$10,930.14	\$11,615.45
% of change		13.3%	6.3%
Members			
	2,396,811	2,294,693	2,156,515

Outpatient – PPO			
	2008	2009	2010
Payments			
Total	\$1,641,087,413	\$1,488,646,004	\$1,504,620,822
Per 1,000 members	\$684,696	\$648,734	\$697,709
% of change		(5.3)%	7.5%
Visit			
Total	32,425,937	34,484,868	35,535,526
Per 1,000 members	13,528.78	15,028.10	16,478.22
% change		11.1%	9.6%
Payment/Visit	\$50.61	\$43.17	\$42.34
% of change		(14.7)%	(1.9)%
Members			
	2,396,811	2,294,693	2,156,515

This information reveals that hospital inpatient costs for BCBSM's PPO business increased an average of 8.5%. Although there was a slight decrease in inpatient admissions, the average price of admission increased an average of 9.8%. Outpatient care increased an average of 1.1%, with the total number of outpatient visits increasing an average of 10.4% while the payment per visit decreased an average of 8.3%. Membership in BCBSM's PPO programs declined an average of 5.5% during the two-year period under review, likely the result of Michigan's economic woes which resulted in workforce reductions and the loss of employer-sponsored health coverage.

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Inpatient – PPO and Traditional			
	2008	2009	2010
Payments			
Total	\$1,814,804,707	\$1,926,259,967	\$1,858,222,303
Per 1,000 members	\$710,814	\$788,699	\$816,790
% of change		11.0%	3.6%
Admissions			
Total	184,859	173,255	157,726
Per 1,000 members	72.40	70.94	69.33
% change		(2.0)%	(2.3)%
Payment/Admission	\$9,817.24	\$11,118.06	\$11,781.33
% of change		13.3%	6.0%
Members	2,553,136	2,442,326	2,275,030

Outpatient – PPO and Traditional			
	2008	2009	2010
Payments			
Total	\$1,845,814,015	\$1,665,573,636	\$1,652,679,241
Per 1,000 members	\$722,960	\$681,962	\$726,443
% of change		(5.7)%	6.5%
Visit			
Total	36,638,091	38,824,941	38,927,290
Per 1,000 members	14,350.23	15,896.71	17,110.67
% change		10.8%	7.6%
Payment/Visit	\$50.38	\$42.90	\$42.46
% of change		(14.8)%	(1.0)%
Members	2,553,136	2,442,326	2,275,030

The above chart reveals that hospital inpatient costs for BCBSM's traditional and PPO combined business increased an average of 7.3%. Although there was a slight decrease in inpatient admissions, the average price of admission increased an average of 9.7%. Outpatient care increased an average of 0.8%, with the total number of outpatient visits increasing an average of 9.2%, while the payment per visit decreased an average of 7.9%. Membership in BCBSM's traditional and PPO programs declined an average of 6.0% during the two-year period under review, likely the result of Michigan's economic woes, which resulted in work force reductions and the loss of employer-sponsored health coverage.

BCBSM states its reimbursement methodology is designed to be equitable to ensure and maintain appropriate provider participation levels. BCBSM's standard reimbursement policies are described on pages four and five of this report. BCBSM states that it revised its reimbursement methodology during the review period. The revised reimbursement methodology was designed with input from the MHA and other industry leadership to provide fair reimbursement based on the recognition of the cost of efficiently providing services to BCBSM members, as well as incentives for additional efficiency and quality initiatives. BCBSM acknowledges that because the contract governing its PPO business is entirely dependent on the reimbursement terms of the PHA, and specifically incorporates Exhibit B (reimbursement) of the PHA, that OFIR's review of the PHA is functionally a review of all of BCBSM's standard contracts.

Some of BCBSM's larger hospitals and some of BCBSM's HMO competitors have alleged that BCBSM is not covering its fair share of governmental shortfalls in Peer Group 1-4 reimbursement. Testimony provided indicates, for hospitals to cover all costs, including government shortfalls related to Medicaid and Medicare programs, plus a simple 3.5% margin, hospitals would have to collect 130.9% of cost from all payers, including BCBSM. The testimony further contends that because BCBSM represents 70% of the Michigan market, with BCBSM declining to recognize government shortfalls related to Medicaid and Medicare programs hospitals end up requiring other commercial health plans to pay 182% of cost.

Health providers and health insurance carriers have stated that BCBSM's decision not to recognize government shortfalls as part of its reimbursement model for Peer Group 1-4 hospitals is in direct conflict with its own trade association, which recognizes hospitals' need to recover a significant amount above cost from commercial health plans to make up for Medicaid and Medicare losses.

BCBSM, on the other hand, contends that OFIR's mission with respect to the provider class plan process is to determine whether the three statutory goals set forth in Section 504 of the Act have been achieved and that there is an overall balance of these goals. BCBSM contends that OFIR cannot focus on one goal independently of the other goals in the corporation. Lastly, BCBSM acknowledges that OFIR must ensure that "no portion of the corporation's fair share of reasonable costs to providers is born by other health care purchasers."

BCBSM notes that with respect to the review of the hospital provider class plan, OFIR is required to make additional determinations, including that no portion of BCBSM's fair share of hospitals' reasonable financial requirements shall be borne by other healthcare purchasers. BCBSM states it is also expected to include financial incentives and disincentives in its hospital contracts, which BCBSM believes that the Michigan Legislature understood could result in some cost-shifting to commercial insurers. Taken as a whole, BCBSM contends that the statutory scheme for provider class plan reviews charges OFIR,

at each potential stage of the review, with ensuring that no more than BCBSM's "fair share" of costs is shifted to commercial insurers.

BCBSM contends the Act distinguishes between requiring BCBSM to pay the same share as its competitors and requiring BCBSM to pay a fair share that takes into account the competitive disadvantages and social mission placed upon BCBSM by the Act and other Michigan statutes. Determining what constitutes BCBSM's fair share and whether BCBSM is using appropriate tools to ensure that it pays no more than its fair share is a regulatory decision for OFIR.

BCBSM states its overarching goal of BCBSM's payment models is to obtain the lowest available rate while still reimbursing efficient hospitals sufficiently to ensure continued access to quality services at a reasonable cost for the people of Michigan. These models represent baseline assumptions about the costs BCBSM must cover for each type of hospital; the absence of a specific cost from the model does not mean that BCBSM never (or even rarely) recognizes that cost in a hospital's final level of reimbursement. BCBSM contends that, with respect to Medicaid and Medicare shortfalls, BCBSM has negotiated many Letters of Understanding (LOU) with its participating hospitals which address Medicare and Medicaid shortfalls. BCBSM estimates that close to 70% of its participating hospitals have LOUs at any given time.

The MHA had requested on several occasions that the late Harold Cohen review and summarize issues that might be appropriate for consideration in evaluating BCBSM's current participating hospital agreement so MHA's hospital contingent could discuss pertinent issues with BCBSM. Cohen's 2010 update acknowledges that when BCBSM established its reimbursement model for Peer Groups 1-4 that Medicare was paying its fair share of full financial requirements to efficient and effective hospitals, but concluded that assumption is no longer valid. Cohen recommended that the Medicare shortfall be part of the definition of the obligation of all Michigan private sector payers as long as Michigan hospitals meet their obligation of having efficiently incurred costs.⁷

With respect to Medicaid, Cohen noted that his original model included the Medicaid shortfall in its definition of full financial requirements from the beginning, but acknowledged that none of the gross-up was assigned to BCBSM, thus producing a "sizable advantage" to BCBSM. Cohen's 2010 update concludes that due to the growing Medicaid shortfall and gross-up, the "sizable advantage" to BCBSM becomes unsustainable. In response to this concern, Cohen suggests assigning part of the Medicaid shortfall to BCBSM through the participating hospital agreement, potentially subject to a limit thereby preserving an element of price advantage on behalf of BCBSM.⁸

⁷ Exhibit Appendix 5 to BCBSM's May 9, 2012 response to Hospital Provider Class Plan Input, p. 3.

⁸ *Id.*, at p. 6.

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Review of the reimbursement methodology set forth in the PHA reveals that BCBSM's reimbursement methodology does not contain provisions demonstrating BCBSM's commitment to equitably recognize government shortfalls from Medicaid and Medicare programs across all peer groups. Whereas it is acknowledged that BCBSM addresses government shortfalls from the Medicare and Medicaid program in its reimbursement methodology for Peer Group 5 hospitals, OFIR contends that it is vitally important that government shortfalls from the Medicaid and Medicare programs be addressed within the PHA on file with OFIR and that BCBSM be able to demonstrate that it is indeed paying its fair share of these costs across all peer groups. Without these provisions being specifically addressed by BCBSM in the PHA, it cannot be determined that BCBSM met the cost objective for the cost goal within the applicable provider class plan, which is to provide *equitable* reimbursement to participating providers.

Further, inasmuch as BCBSM has acknowledged that it negotiates LOUs with 70% of its participating Peer Group 1-4 hospitals at any given time, it would appear the hospital participation agreement and reimbursement arrangement that BCBSM has on file with OFIR is ultimately not representative of the actual payment methodology BCBSM has with most of its participating hospitals and is further evidence that the underlying methodology is fundamentally flawed. Contrary to BCBSM's assertions noted above, OFIR's review of the LOU formats BCBSM submitted as part of this review revealed that governmental shortfalls relating to Medicaid and Medicare programs were not specifically addressed in those LOU formats at all.

Without specifically addressing the government shortfalls from Medicaid and Medicare programs directly in the PHA's reimbursement methodology, BCBSM has caused or has likely caused other health care purchasers to bear portions of BCBSM's fair share of "reasonable costs to the provider" and/or "hospitals' reasonable financial requirements." See MCL 550.1509(4)(b) and 550.1516(2)(b). This actual or potential cost shifting is further enhanced through application of the most favored nation (MFN) clauses, which are contained in the various LOUs with participating hospitals. It is noted that MFN clauses are more specifically addressed in the Commissioner's Order No. 12-035-M.

OFIR has concluded that BCBSM's hospital provider class plan must include a revised reimbursement methodology within the PHA that explicitly takes into account government shortfalls relating to Medicaid and Medicare programs in its payments to all participating hospitals in all peer groups for all BCBSM lines of business offered pursuant to the Act. As such, OFIR expects BCBSM to modify its hospital provider class plan to address the deficiencies delineated above.

Findings and Conclusions - Cost

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 1.7% for the period under review. As the rate of change in the total corporation payment per member for the hospital provider class has been calculated to be a decrease of 0.3% for its traditional business over the two years being reviewed, BCBSM met the cost goal based on the statutory cost goal formula stated in the Act for 2009 and 2010.

Section 509 of the Act requires that BCBSM meet not only the goals specified in the Act, but also the objectives set forth in the provider class plan as well. OFIR has determined that the PHA and reimbursement arrangement that BCBSM has on file with OFIR is ultimately not representative of the actual payment methodology BCBSM has with most of its participating hospitals because BCBSM enters into LOUs with most hospital providers. Nothing on file with OFIR demonstrates that BCBSM has complied with the cost objective in the provider class plan to provide “*equitable* reimbursement to participating providers,” as the PHA on file with OFIR fails to recognize governmental shortfalls from the Medicaid and Medicare programs with most of BCBSM’s participating hospitals, particularly with Peer Group 1-4 hospitals. Thus, BCBSM has not been able to sufficiently demonstrate to the Commissioner that it has equitably compensated hospitals in accordance with Sections 509(4)(b) and 516(2)(b) of the Act in such a way that BCBSM participating hospitals’ reasonable financial requirements are not being borne by other health care purchasers.

Because BCBSM sets and controls its reimbursement methodology for hospitals and it has not sufficiently demonstrated that its reimbursement methodologies justly account for governmental shortfalls from the Medicaid and Medicare programs, particularly its Peer Group 1-4 participating hospitals, BCBSM’s failure to meet the cost objective under the cost goal in the provider class plan and the requirements set forth in Sections 509(4)(b) and 516(2)(b) of the Act are clearly within BCBSM’s control.

Accordingly, BCBSM shall prepare and file with OFIR a modified hospital provider class plan within the six-month period provided in Section 511(1) of the Act. The modified hospital provider class plan shall delineate specific provisions in the PHA hospital reimbursement methodology that adequately account for Medicaid and Medicare losses as part of its reimbursement methodology in the PHA for all hospitals in all peer groups, for all BCBSM business conducted under that Act.

Determination Summary

In summary, BCBSM generally achieved two of three goals of the corporation during the two-year period under review for the hospital provider class. BCBSM’s failure to achieve the cost goal stems not from its failure to meet the statutory cost goal formula but rather

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from its failure to meet the cost objective within the provider class plan. Section 509(4)(b) of the Act requires that BCBSM's fair share of reasonable costs of participating hospitals not be borne by other health care purchasers. In addition, Section 516(2)(b) of the Act requires that no portion of BCBSM's fair share of hospitals' financial requirements shall be borne by other health care purchasers. BCBSM has not sufficiently demonstrated that its reimbursement methodologies properly and justly account for governmental shortfalls from the Medicaid and Medicare programs for all its participating hospitals. Therefore, pursuant to Section 510(1)(c) of the Act, it is hereby determined that BCBSM's hospital provider class plan does not substantially achieve the cost goal as required under Section 504 of the Act.

Thus, pursuant to Section 511(1) of the Act, BCBSM shall transmit to the Commissioner a hospital provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated herein within six months of the date of this determination report. The modified hospital provider class plan shall include a revised reimbursement methodology specifically delineated in the PHA that demonstrates BCBSM's commitment to recognize government shortfalls in its payments to all BCBSM's participating hospitals in all peer groups for all BCBSM lines of business offered pursuant to the Act. The modified hospital provider class plan shall properly address the deficiencies and recommendations presented herein regarding BCBSM's cost goal performance as well as comply with Sections 509(4)(b) and 516(2)(b) of the Act, which requires that no portion of BCBSM's fair share of hospitals' reasonable financial requirements be borne by other health care purchasers. The Commissioner additionally notes that if the revised participating hospital agreement and/or reimbursement arrangements utilize "Most Favored Nation" clauses, such agreements and arrangements are subject to the Commissioner's Order No. 12-035-M and BCBSM shall comply with all requirements of that Order, as applicable.

Section 511(1) of the Act states "...[I]n developing a provider class plan under this subsection, the corporation shall obtain advice and consultation from providers in the provider class and subscribers, using procedures established pursuant to Section 505." OFIR recommends BCBSM obtain provider input through the use of a town hall meeting approach; obtain written testimony from providers with respect to BCBSM's proposed modification; and/or some other mechanism that reaches a broader audience beyond BCBSM's usual advice and consultation method, whereby BCBSM merely presents its proposed changes to BCBSM's provider and customer group advisory boards.

SUMMARY OF WRITTEN TESTIMONY ON
BCBSM'S PROVIDER CLASS PLAN

Four smaller hospitals provided testimony indicating that BCBSM consistently performs at a high level for their patients. Karmon Bjella, CEO of Alpena Regional Medical Center, believes reimbursement is well defined, well implemented and questions are resolved in a timely fashion to the satisfaction of all parties. Further, Bjella believes that BCBSM is in the forefront of quality initiatives and quality monitoring, largely in part because of its organized efforts to obtain advance input from all stakeholders and works together to find good solutions. Jim Bogan, President and CEO of Portage Health, is in agreement that BCBSM has met the statutory goals.

Duane Miller, Vice President of Finance at Carson City Hospital, provided input that compared BCBSM to Priority Health. Miller believes the comparisons are striking and that the conclusion reached is that BCBSM is perhaps the best plan in Michigan at addressing access, quality of care and costs. Miller states that all hospitals are underpaid by Medicaid and Medicare in that payments either fail to cover hospital costs or do so but do not provide any operating margin. These governmental payment shortfalls limit the hospital's ability to care for patients by limiting its ability to recapitalize or to acquire and maintain the human, capital and equipment resources necessary to adequately meet the needs of the community. Currently, these shortfalls can be offset by only enhanced reimbursement by commercial payers. Miller states that BCBSM has been very deliberate in its cost reviews and rate setting, and has demonstrated its intent to help assure ongoing access to care for the rural communities served by the hospital.

Miller says that in contrast, Priority has effectively reduced Carson City Hospital's ability to provide adequate access to care by paying insufficient reimbursement rates. The HMO justifies those inadequate rates by the fact that they are accepted by other health care facilities, many of which are owned by Priority's major shareholder, Spectrum Health. Priority's operating policies and its significant underpayments to non-Spectrum health care facilities like Carson effectively discourage use of the non-Spectrum facilities by hindering their ability to acquire and maintain the resources necessary to adequately meet the needs of the community.

With respect to quality initiatives, BCBSM has aggressively and effectively instituted and promoted quality patient care initiatives for years. These initiatives have prompted significant changes in the behavior of health care providers, both professional and facility, and the changes have improved patient care. Priority has also established initiatives but has done so, whether intentionally or not, in a manner that has put rural-based hospitals at a comparative disadvantage by limiting the number of initiatives in which they can participate or by focusing on measures over which smaller and more rural providers, through no fault of their own, have reduced control or influence.

Miller believes that with respect to reimbursement, as long as underpayments by government payers effectively requires cost-shifting – and the resulting increase in the cost of care furnished to Michigan citizens – the burden should be borne equally by all commercial payers. Miller believes that BCBSM, with its cost reviews and rate setting sessions, does a much more effective job at reimbursement rate setting than Priority. Miller states that it makes this testimony not out of personal animus or desire to disparage anyone but out of genuine concern over the very real imbalance present in Michigan's health care and "insurance" market. It seems the market has some payers and providers acting in a manner that appears intended more to advance corporate agendas and margins than to advance adequate access to high quality patient care at a fair and equitable cost.

Timothy Johnson, President and CEO of Eaton Rapids Medical Center, noted that the number of small hospitals operating in the State of Michigan has plummeted from 209 to 135 during the last 20 years. Johnson believes that BCBSM does try to help and work with the hospitals. BCBSM pays claims quicker than most other commercial health insurers. Second, it is recognized for its pay for performance program, placing high value on the quality of patient care. BCBSM also provides good customer service. While these qualities are commendable and respected, it is not enough to help keep small hospitals open. Johnson states that the reimbursement rates paid by BCBSM, the states' largest health carrier, are not keeping up with the rising costs of operating small hospitals. This is something that must change or the number of small hospitals in Michigan will continue to decrease.

Three physician organizations whose members provide services in the hospital also opted to provide input although the input pertains more to physician services and will be placed on file for consideration when the medical doctor and doctors of osteopathy provider class plans are reviewed. Frederick Ganzi, M.D., President of Macatawa Anesthesia, P.C., states that BCBSM does not negotiate reimbursement at all. It simply publishes rates and expects providers to accept them. BCBSM's reimbursement is consistently below national and regional benchmarks for commercial payers, ranking consistently in the bottom 10% or even lower. BCBSM's size in the marketplace, along with its payment methods, makes it impossible for providers to consider departicipation. Ganzi states that economic realities essentially require that anesthesiologists accept whatever BCBSM pays them.

Ganzi states that the Medical Group Management Association (MGMA) conducts large annual, national surveys in providing benchmarking data over national reimbursement and income for medical groups. The American Society of Anesthesiologists (ASA) independently conducts a large annual survey of national reimbursement rates as well. Currently, MGMA's national median anesthesia rate is \$76, with BCBSM's payment being \$54.25. Similar trends are seen in the previous three years reimbursement rates as well.

Thus, BCBSM historically is well below the 50th percentile and over \$20 per unit below the national average. BCBSM also imposes a penalty for cases performed by nurse anesthetists, which no other commercial payer does. BCBSM reduces payment by 15% if it is performed by a nurse anesthetist. This reduction in Ganzi's practice results in payment of less than \$50 per unit from BCBSM, placing BCBSM in the bottom 1% of commercial carriers nationally. Ganzi states that this reimbursement mechanism makes it very difficult to recruit and retain excellent providers and threatens his practice's ability to staff properly when the average anesthesia group is getting paid \$76 per unit.

James Van Dan, M.D., from Anesthesia Practice Consultants (APC) states his anesthesia group practices at Spectrum Health facilities, Metro Health Hospital, MidTowne Surgical Center and several other independent surgical centers. Van Dam states that although they meet with BCBSM, the negotiations are distinctly one sided. BCBSM dictates the rates and because of its market penetration, APC has no option but to accept them. APC contends BCBSM rates are well below national and regional benchmarks for commercial payers. A survey of Midwest Managed Care Anesthesia Conversion Factors conducted in 2010 shows the median conversion factor to be between \$61.79 and \$65.00. BCBSM's conversion factor is \$52.00 with it increasing to \$54.25 in July 2012. This is below the 2010 25th percentile of every other payer, thus BCBSM's conversion factors started low and continue to fall behind. APC also states that it is difficult to recruit talented anesthesiologists when the national median conversion factor is paid \$76 and BCBSM pays APC \$54.25. APC has implemented a quality initiative program by employing five registered nurses to serve as liaisons between post-operative patients and anesthesia providers. APC strives to be an employer of choice for both clinical and non-clinical employees. As an employer of 180 people, APC has seen its operating costs increase more than the 2% in BCBSM reimbursement each year. APC's health insurance premiums increased 29.7% from 2011 to 2012. APC also continues to make additional investments in its infrastructure to address changes in the health care industry. BCBSM's payment rate undermines APC's ability to stay competitive and makes it difficult to provide the standard of care the community deserves.

Michele Hardy, President of Radiological Business Managers of Michigan (RBMM), states that it is a nonprofit professional organization representing radiology groups throughout Michigan. RBMM states that BCBSM has historically employed a reimbursement methodology under its standard participation agreement with physicians that generates a payment schedule using relative values and a single conversion factor which is the practice followed by CMS for Medicare. Each procedure or service covered by BCBSM has a relative value assigned to it that when multiplied by a single conversion factor (RVU) describes the compensation level for a particular service. The RVUs have been developed under a complex formula taking into consideration the level of physician work and practice expense required to perform the service. The conversion factor converts the RVU into an actual dollar amount. While the conversion factor changes annually, BCBSM has historically

applied one conversion factor to each procedure code, as is consistent with BCBSM's participation agreement.

RBMM states that BCBSM has recently made a change to this practice and disproportionately applied multiple conversion factors to covered diagnostic tests. This resulted in an unexpected decrease in payment rates which was not adequately disclosed to contracting physicians. The payment reductions do not reflect changes in the RVU of the diagnostic tests, in that it does not appear that BCBSM has revised its estimate of physician time and expense required to perform particular services. Instead, BCBSM is applying separate conversion factors to particular diagnostic tests, contrary to its standard practice for many years under the participation agreement to apply a single conversion factor. Moreover, BCBSM has altered its reimbursement methodology unilaterally and without proper notice to providers.

BCBSM does not negotiate with provider groups. It publishes a fee schedule each year that applies to all physicians. There is not an opportunity to negotiate for equitable rates. RBMM believes BCBSM's reimbursement methodology changes are relevant to OFIR's hospital provider class plan review. First, BCBSM's unilateral change in the reimbursement methodology is contrary to its participation agreements and calls into question whether BCBSM can fulfill its requirement to provide equitable reimbursement to participating providers. Thus, the practical application of BCBSM's reimbursement methodology warrants further review and consideration. Second, the rates BCBSM pays to physicians, including radiologists, directly impacts the availability of physician services in Michigan, including the services provided by hospital-based physicians.

Ms. Marjorie Mitchell, Executive Director of the Michigan Universal Health Care Access Network, states its objectives are to increase access, reduce costs and increase quality of care for all Michigan residents. Mitchell contends that OFIR cannot effectively evaluate BCBSM's traditional business without looking at the rest of BCBSM's business. Mitchell believes that while the Act may only require review of BCBSM's traditional business, there is nothing in the Act that prohibits OFIR from seeking and reviewing relevant data for BCBSM's PPO business as well.

Mitchell states OFIR needs to look at the full cost of health care, not just what BCBSM itself pays. BCBSM is likely satisfying its cost requirements because others are actually bearing a large share of the actual cost through inadequate provider reimbursement and skyrocketing deductibles and copays paid by members. Mitchell states OFIR should delve deeper into cost drivers for hospitals and discuss how those may be better controlled. The market basket of hospital services is always changing, but there needs to be a change in approach between hospitals, payers and the public as to how those services may be more effectively delivered and costs may be better controlled as a result. Reporting by BCBSM to address whether and how any savings gets back into the hands of the members should also be examined.

The trend in the health care industry is steadily moving to quality improvement. BCBSM needs to affirmatively demonstrate that quality improvement principles are required for hospitals both under its provider class plan and through the contract held between BCBSM and each Michigan hospital. BCBSM should also be required to demonstrate what quality improvement elements are in the provider class plan and contracts and how hospitals would demonstrate that any quality improvement requirements have been met.

Mitchell states that simply meeting BCBSM's quality of care objective is not sufficient to assure that hospitals actually meet and abide by reasonable standards of health care quality. It is also desirable that OFIR consider the actual experience of BCBSM members who received hospital services during the two year period under review. BCBSM should be asking and reporting about questions such as:

- Were BCBSM members satisfied with the quality of services they received?
- Were hospital costs reimbursed properly and with an adequate explanation of benefits?
- How many BCBSM members encountered disputes about medical necessity or prompt payment?
- Were the BCBSM members who had disputes satisfied with BCBSM's complaint resolution procedures?

Mr. Rick Murdock of the Michigan Association of Health Plans (MAHP) provided an industry perspective on BCBSM's hospital provider class plan. MAHP urges OFIR to require BCBSM to submit cost, quality and access data with respect to of BCBSM's managed care products. MAHP contends that the participating hospital agreement (PHA) governs BCBSM's PPO/POS and HMO products as well as BCBSM's traditional product. MAHP believes that BCBSM, by linking the PHA to its other products, should reasonably expect that the review of the PHA by the Commissioner would necessarily include all BCBSM's managed care products.

When negotiating with hospitals for reimbursement rates that differ from those established under the PHA's reimbursement model, BCBSM enters into side letters or Letters of Understanding (LOU). These negotiations result in reimbursement rates that apply to the PHA and the managed care products. In recent federal court litigation, BCBSM admitted that "to offer the most competitive rate structure to its customers, BCBSM marshals its aggregate purchasing power and concurrently negotiates the reimbursement rate for each of its three forms of health care product." Since rate negotiations involve all products, it is necessary for the Commissioner to review the cost information concerning all products in order to assess whether the cost goals in the Act are being met. Otherwise, BCBSM enjoys the benefit of "aggregate purchasing power" without any oversight or accountability as to whether the result advances the objectives of the Act.

MAHP states that BCBSM's reported total membership for 2010 was 4,310,963. BCBSM's traditional membership of 118,515 and claims payments of \$324.2 million is less than three percent of BCBSM's 2010 total membership and two percent of claims payments. MAHP contends that because BCBSM's traditional data is so small, OFIR does not have enough credible data to determine whether BCBSM is achieving the statutory goals outlined in the Act.

MAHP believes that because the goals of the Prudent Purchaser Act and HMO regulations are complementary with the statutory goals outlined in the Act and because OFIR has the power to review PPO and HMO provider arrangements, MAHP believes OFIR should review BCBSM's hospital provider class plan in conjunction with the TRUST and BCN participation agreements.

MAHP urges OFIR to issue a data call to hospitals to obtain more information concerning the level of BCBSM payment in comparison to other commercial health plans. Hospital-specific data is needed in order to assess whether BCBSM is meeting its obligations under the Act with respect to paying hospitals' reasonable financial requirements and whether BCBSM is using its market power to stifle competition. Many hospitals are reluctant to comment on the hospital provider class plan or provide competitively sensitive information that could be discovered by BCBSM, other health plans or competing hospitals. If the information is requested via a data call, the hospitals will be able to provide the information on a confidential basis. This proprietary data could be exempt from public disclosure under the Insurance Code and the Freedom of Information Act. MAHP urges OFIR to describe 1) the weighted average level of BCBSM and BCN payment (expressed as a percentage of charges); and 2) the weighted average level of payment from all commercial health plans (expressed as a percentage of charges). MAHP believes this information will not only identify substantial inequities in the market, it will also aid OFIR in evaluating BCBSM's compliance with the Act.

MAHP contends that the statutory cost goal cannot be measured without obtaining cost information relative to BCBSM's managed care products. MAHP notes that for many years, particularly outside of southeastern Michigan, Blue Care Network (BCN) had payment rates with hospitals that were in line with the rates of other HMOs and PPOs in the market. Those rates, however, were higher than the hospitals' rates with BCBSM. Beginning in 2004, BCBSM began a recontracting strategy that resulted in lower BCN rates, but higher BCBSM rates. The Sixth Circuit Court of Appeals described the recontracting in *DeLuca v. BCBSM* as follows:

Prior to 2004, the rates paid by BCBSM's traditional and PPO plans were lower than the HMO rates for many health care providers. Beginning around 2004, in an effort to increase the HMO's competitiveness and to simplify pricing structures, BCBSM negotiated a series of letters of understanding with various hospitals that altered these preexisting rate agreements. Typically, these agreements were structured to equalize the rates paid by the HMO with

those paid by the PPO plan. BCBSM agreed to make the rate adjustments budget-neutral for the health care providers by increasing the PPO and traditional plan rates to make up for the decrease in the HMO rates.

Not only does this re-contracting strategy raise serious issues about monopoly leveraging – BCN would not have been able to obtain those rates on its own – the effect of the strategy is that the BCBSM traditional rates have been increased in order to lower BCN rates. Consequently, any evaluation of BCBSM traditional hospital payments needs to be made in the context of total BCBSM/BCN payments.

MAHP states that numerous cases have been brought against BCBSM by public and private self-insured employers which claim that an undisclosed access fee was added to their hospital claims cost. BCBSM prepared talking points for its sales force which indicate that the access fee is 13.5% of hospital claims. OFIR would need to understand whether the hospital payment data presented by BCBSM includes or excludes the access fees in order to assess whether the cost goal was met.

The most important part of OFIR's review should be whether the objective is that BCBSM pays hospitals fairly so that there is not disproportionate cost shifting to other insurers and health plans. MAHP contends that this provision, delineated in Section 516(2)(b) of the Act, reflects the unmistakable legislative intent that there should be a level playing field among health plans and that BCBSM should not use its market power to pay less than its fair share. In the most favored nation (MFN) litigation against BCBSM, the Federal District Court analyzed this statute and noted its purpose was to avoid stifling competition:

The main goal of the NHCCRA is to assure access by the people to health care services; not for Blue Cross to enter into contracts with providers which discourages competition with other insurers-for-profit or otherwise. The NHCCRA states that no portion of Blue Cross' fair share of the hospitals' reasonable financial requirements shall be borne by other health care purchasers (MCL § 550.1516(2)(b)). Although the Act allows Blue Cross to include reimbursement arrangements which include financial incentives and disincentives, such arrangements cannot result in cost shifting to other health care purchasers. The purpose of the NHCCRA is to make certain that the people of Michigan are able to access health care services at a fair and reasonable price. There is no provision in NHCCRA that allows Blue Cross to stifle competition.

MAHP believes that BCBSM has generally refused to pay hospitals, other than small rural hospitals, amounts that cover their reasonable financial requirements. Ultimately, hospitals need to recover their financial requirements or they will close or curtail services. Given BCBSM's refusal to pay hospitals at a level that covers their financial requirements, hospitals have ended up shifting this cost disproportionately to

other health care purchasers, including MAHP member plans. The competitiveness of other health plans is stifled due to BCBSM not paying its fair share.

MAHP states that BCBSM will likely argue that the PHA reimbursement model recognizes reasonable hospital costs, including the costs associated with uncompensated care (charity and bad debt). The statute, however, uses the term "reasonable financial requirements." And this term is different from "reasonable costs". In the case of hospitals, the legislature deliberately specified that "no portion of [BCBSM's] fair share of hospitals' reasonable financial requirements shall be borne by other health care purchasers." Given the deliberate use of this language, the term "reasonable financial requirements" should be viewed as covering not only costs, but also financial requirements that arise from Medicare and Medicaid underpayments or so-called government program losses.

MAHP states that in 2009, the late Harold Cohen, Ph.D., prepared an extensive study of Michigan hospital costs and financial requirements (*More Than a Decade of Quality, Efficiency and Value Improvements at Michigan Hospitals*). Dr. Cohen found that Michigan hospitals were efficient, incurring costs below national and regional averages. Despite superior efficiency, Michigan hospitals incur substantial losses under Medicare and Medicaid. Cohen determined that in order for a commercial health plan to pay full financial requirements – an amount to cover costs plus government program losses and yield a 3.5% margin – the reimbursement per privately insured patient would need to be 130.9% of hospital costs.

MAHP states that although Cohen's analysis utilized payment and cost data from 2007, there have not been meaningful improvements in Medicare or Medicaid payments since that time so government program losses for most hospitals continue to increase. Between Medicare (\$276 million) and Medicaid (\$608 million), Michigan hospital losses associated with government programs amount to nearly \$1.0 billion annually. MAHP states that there can be no doubt that these losses comprise part of a hospital's reasonable financial requirements. MAHP also suggests that OFIR obtain the 2010 Cohen update to determine the reasonable financial requirements of Michigan hospitals and whether the PHA reimbursement model results in BCBSM paying its fair share.

MAHP contends that BCBSM does not dispute that, despite recognized efficiency, Michigan hospitals have losses under Medicare and Medicaid. BCBSM simply takes the position that it has no responsibility to recognize these losses. MAHP contends that this position conflicts with its own trade association that recognizes that hospitals need to recover a significant amount above cost from commercial health plans to make up for Medicare and Medicaid losses. The BCBSA reported that the average level of payment to cost for commercial health plans was 128% (comparable to Cohen's 130.9%).

The Milliman group prepared a report at the request of the Blue Cross trade association and other industry groups that examined the level of Medicare and Medicaid underfunding and the impact that it has on payment to providers and ultimately premiums. Milliman's conclusion was that in 2006, 18% of hospital costs nationally related to government program underfunding and that hospital/physician underfunding has resulted in premiums for family coverage that are approximately 11% higher than they would otherwise be.

MAHP states that BCBSM will likely claim that if it pays the cost shift, it will result in higher premiums. This is true of recognizing any hospital financial requirement. Premiums would not be as high if BCBSM did not have to recognize hospital nursing costs, capital costs or uncompensated care costs. The issue is ultimately one of market competitiveness. The premiums of MAHP member plans and other health care purchasers are higher due to BCBSM not recognizing its share. This, in turn, stifles competition, and it is exactly competition that is needed to reduce premiums.

MAHP states that BCBSM takes Medicare and Medicaid costs into account when developing the rates for Peer Group 5 hospitals (small rural hospitals). In contrast, the rate development for Peer Groups 1-4 does not include this component even though these hospitals lose money on Medicare patients regardless of whether they are urban or rural, teaching or non-teaching, etc. MAHP believes OFIR should require BCBSM to develop rates for Peer Group 1-4 hospitals on the same basis as Peer Group 5 hospitals.

MAHP contends that the PHA reimbursement model for Peer Group 1-4 hospitals does not result in BCBSM paying its fair share of hospitals' reasonable financial requirements. Per the Cohen analysis, the level of payment in relation to costs should be 130.9%, yet the model produces payment more likely in the range of 109% of cost. Because BCBSM represents 70% of the market, in order for a hospital to recover 130.9% of cost, it would need other health plans to pay 182% of cost. Thus, other health care purchasers end up paying hospitals more than their fair share due to the PHA reimbursement model. Because this model is used for all of BCBSM's managed care products, including BCN, the impact is wide spread and not limited to the traditional product. If other health care purchasers are paying BCBSM's share, it weakens their ability to provide competitive premiums.

MAHP states that the health care reforms relating to guaranty issue, elimination of pre-existing conditions and modified community rating that are scheduled to become effective on January 1, 2014 will level the playing field among different types of health plans with respect to issuing and rating coverage, but if BCBSM does not pay its fair share to hospitals, the playing field will always tilt in favor of BCBSM. Underpayment by BCBSM is likely to lead to more hospital consolidation. BCBSM's unwillingness to pay its fair share could lead to higher prices overall in the market by accelerating consolidation. Underpayment by a health plan with dominant market share can also lead to hospital closures and service curtailments.

MAHP believes that satisfaction of BCBSM's objectives and the access to and quality of care goals cannot be measured without obtaining 1) access information with respect to BCBSM's managed care products; and, 2) information from the hospitals pursuant to a data call. MAHP notes that to the extent BCBSM is paying below hospital financial requirements, issues with access to care will occur as hospitals terminate or threaten to terminate participation (which recently occurred in the case of Beaumont) or as hospitals close or reduce the scope of services due to underpayment.

MAHP believes OFIR should obtain from BCBSM quality data that it has of its performance relative to the performance of other BCBSM plans across the country, particularly those plans that have high market shares. OFIR's quality of care expectations of a company with BCBSM's dominant market share should be at least as stringent as other market leading Blue Cross plans. Further, MAHP notes that BCBSM's PHA contains a most favored nation clause that applies to Peer Group 5 hospitals. MAHP believes that this provision reduces competition and harms the market.

MAHP encourages OFIR to conduct a data call where hospitals would report their average reimbursement as a percentage of charges from BCBSM and their average reimbursement as a percentage of charges from other commercial payers. Obtaining this information would assist OFIR in appreciating the significant differentials in payment that exist and inform OFIR in making the determination of whether BCBSM is meeting the objective under the Act to pay hospitals' reasonable financial requirements or whether BCBSM is using its market power to stifle competition.

MAHP states that hospitals may be hesitant to respond to the data call due to the competitively sensitive nature of reimbursement rates. MAHP suggests that safeguards be followed for de-identifying the information so hospitals are not likely to object to furnishing this information, particularly since the information has already been compiled in connection with the subpoenas in the MFN litigation. For those hospitals that have not been subpoenaed for this information, it could be captured with little burden. In order to obtain and ensure the confidentiality of reimbursement levels (as a percentage of charges), the Commissioner should request that hospitals submit the information to a third party which in turn can de-identify the data and then submit the information by region to the Commissioner for review.

In conclusion, MAHP urges OFIR to disapprove BCBSM's hospital provider class plan unless it is amended in the following respects:

- Payment rates for Peer Group 1-4 hospitals should be made on the same basis as Peer Group 5 hospitals to ensure that BCBSM is paying its fair share of reasonable financial requirements.

- Payment rates for BCN should not be negotiated by BCBSM given BCBSM's dominant market share and BCN should compete in the market in establishing payment rates with hospitals.
- The MFN provision in the PHA with respect to Peer Group 5 should be eliminated.

Ms. Kimberly Thomas, General Counsel for Priority Health, states it is critical to go beyond an analysis of provider class plans for 2008 and 2009. Priority urges OFIR to expand the scope of its review of BCBSM to include calling for comments on all provider agreements and all BCBSM products (including BCBSM traditional, BCBSM TRUST, Blue Care Network, etc.) since the majority of BCBSM subscribers are currently covered by PPO or POS benefit certificates.

Many providers fear retribution from BCBSM if they respond candidly to OFIR's inquiry, particularly when they think nothing will be done to change the control that BCBSM wields. Priority believes OFIR should exercise its authority under the Act to do a confidential data call of providers requesting detailed information on BCBSM provider agreements. Priority recommends OFIR ask hospitals a series of specific questions to assess whether the goals related to BCBSM have been met. Topics would include detailed financial information on charges, payments, adjustments and reimbursements that would allow OFIR to compare BCBSM with commercial plans on net effective rate, reimbursement rates and methodologies and bad debt percentages and collection rates.

Priority believes that as Michigan prepares for federal health care reform, there is a short window of opportunity to bring about meaningful change in Michigan. In fact, there is probably no other single issue as critical to Michigan's economic wellbeing as health care.

The Governor has publicly called for a "health care regulatory environment in Michigan that encourages competition, market speed and innovation, efficiency and cost reduction, and high-quality, affordable and accessible health care." Priority states Michigan has a long ways to go before reaching that goal, but increased competition is key to getting there.

Priority states that a recent study from the American Medical Association (AMA) ranks Michigan as the fourth least competitive state in the country for health insurance. The three lowest states combined – Alabama, Alaska and Delaware – has only 65% of Michigan's total population. The study notes that BCBSM controls more than 70% of the privately insured market in Michigan while its next largest competitor holds less than a 10% market share. BCBSM told OFIR in 2007 that its market share had decreased from 4.2% in 2006 to 3.1% in 2007. Priority notes that

this data reflects only BCBSM's traditional product and does not take into account other more modern products that have grown in popularity.

According to the AMA study, BCBSM holds an 85% market share in 13 metropolitan statistical areas in Michigan. The report noted that concentrated health markets pose a potential for abuse of market power and concluded that, "The anti-competitive climate in Michigan...means consumers and employers have fewer choices."

The 2011 AMA report concludes that "concomitant large increases in premiums, insurer profitability, lower scope of benefits and high barriers to entry...strongly suggests that health insurers are exercising market power in many parts of the country and in turn causing competitive harm to consumers and providers of care." In Michigan, BCBSM is the dominant player and could be poised to become the only payer, which would raise prices, threaten quality, limit choices and choke innovation. It is well known in the health insurance industry that anticompetitive behavior can have significant negative ramifications, including: a) setting artificial prices; b) depriving the market of lower process, innovation, increased operational efficiency, alternative service-delivery models and differentiated products; c) deterring potential competitors from entering the health insurance market; d) crippling or eliminating existing competitors; and, e) increasing rates in areas where there is no competition.

Priority contends that BCBSM's market share allows it to enjoy financial advantages over its competitors, forcing health care providers to accept the contract rates and terms it sets. In 2010, the most recent year for which results are available, BCBSM and its affiliate, Blue Care Network of Michigan, generated nearly \$20 billion in revenue and nearly \$700 million in pre-tax profits while growing their surplus to more than \$300 million. Priority contends much of this growth was built upon the backs of providers and other carriers. This growth occurred even while the organization and its subsidiaries spent more than \$500 million to acquire out-of-state insurance companies. During this same period, Michigan lost more than 440,000 jobs and average earnings per worker increased less than 2% per year.

Quietly, over time, BCBSM has shed many of the burdens assigned to it under the Act, including following experience rather than community ratings and utilizing geography and age as determining factors for setting premiums. Priority notes that after 2014, there will be no "insurer of last resort", and all health plans will be required to accept all applicants. BCBSM continues to retain most of the benefits under the Act, which has allowed it to: a) build a super majority share of the insurance markets which exceeds the federal definition of "monopoly"; b) amass reserves of more than \$3 billion, which it has used to purchase out-of-state companies; c) negotiate agreements with hospitals, physician groups and other health care providers that make it nearly impossible for other insurance companies to compete; and, d) shift costs from itself to other insurers.

Priority contends that BCBSM's market concentration in Michigan has led to state and federal lawsuits that focus on its contracting practices and anti-competitive behavior. In 2010, the U.S. Department of Justice (DOJ) and Michigan Attorney General filed an antitrust lawsuit against BCBSM, charging that BCBSM's use of most favored nation and most favored nation plus provisions has shifted costs, reduced competition and raised prices paid by all health care consumers in Michigan. According to the DOJ, BCBSM currently has agreements containing MFNs with more than half of the general acute care hospitals in Michigan and is likely to see additional MFNs when other hospital contracts come up for renegotiation. Very few hospitals have refused BCBSM's demands for an MFN. BCBSM also has "equal to MFN" clauses with 40 small rural community hospitals which often are the sole health care provider for a given region. Lastly, BCBSM has agreements with at least 22 Michigan hospitals containing MFN plus clauses, including:

- a) Marquette General Hospital (MFN plus 23%). BCBSM raised its premiums in the Upper Peninsula by 250% from 1999-2004, well out of proportion to the rest of the state.
- b) Sparrow Hospital (MFN plus 12.5%). BCBSM agreed to raise its rates to Sparrow by \$5 million per year more than other standard contracts in exchange for this contract.
- c) Ascension Health (MFN plus 10%). BCBSM paid an additional \$2.5 million to secure this provision.
- d) Both Saginaw hospitals (MFN plus 39%).
- e) Three Beaumont Hospitals in Detroit (MFN plus 25%).

Aetna has also brought a lawsuit against BCBSM for anti-competitive behavior that focused on MFN provisions in hospital contracts. Aetna is seeking millions in damages, alleging BCBSM responded to increased competition with "an anticompetitive scheme aimed at impeding its competitors' ability to negotiate network contracts with hospitals in Michigan." This scheme included agreeing "to pay hospitals more money if the hospitals increased rates they demanded to treat patients covered by its competitors' plans." It states that BCBSM's market dominance forces hospitals to agree to its demands, even when BCBSM "seeks to restrain competition in ways that harm its competitors, plan sponsors and plan members."

Since 2009, BCBSM has already lost more than \$13 million in ten separate verdicts and settlements tied to administrative fees it charges self-funded employers in Michigan. It continues to face lawsuits from public and private employers over "fraudulent concealment" and other charges. Also, individuals and businesses have brought the first class action lawsuit against the entire Blue Cross Blue Shield Association in North Carolina, alleging a number of anti-trust violations against the entire association with each of the Blue Cross entities. These include: conspiracy by the Association and its member plans, illegal use of MFN provisions, attempted monopolization and unlawful maintenance of monopoly power.

Priority believes that OFIR should enforce regulations specifically intended to prevent cost shifting. Michigan law prohibits BCBSM from using its market power to enter into provider contracts that require or cause health care costs to be shifted to other insurers and requires BCBSM to have separate contracting and negotiations for each corporation or product. These practices create real barriers to entry of competitive coverage choices, stifle innovation and increase health care costs.

A 2009 independent analysis conducted by health care economist Harold Cohen and funded by the Michigan Health and Hospital Association shows that BCBSM pays significantly less to hospitals than any other insurer in the state, which requires hospitals to shift costs to other insurers. The report said that in order to cover providers' total costs, reimbursement per privately insured patient would need to be 130.9% of hospital costs. This took into account that a significant portion of a hospital's business (Medicare and Medicaid) pays well below. Anything below the threshold of 130.9% fails to compensate providers adequately, forcing them to turn to private insurers to make up the difference. Because Medicaid is intentionally underfunded, the state and federal governments have created a system that requires providers to cover Medicaid losses by shifting costs from Medicaid to other payers. Michigan will no longer be able to coerce rates below the amount required to cover these obligations. This is not good for the state, its businesses or its consumers.

Cohen's research found that BCBSM reimburses providers at approximately 120% once side letters and other individual arrangements are taken into consideration. Other commercial payers, on average, reimburse more than 186% of costs to ensure that providers do not lose money. To eliminate this cost shifting, the Cohen Report says that BCBSM would need to increase its reimbursement rates by 10%. Priority states that given BCBSM's current rich level of reserves, BCBSM would be able to appropriately do so immediately without passing along additional expense to its members.

Priority contends that hospital costs represent the single most significant portion of the medical costs incurred by a typical health plan. Negotiated discounts, therefore, are significant in a provider's ability to offer competitive rates, attract customers and continue to grow. Hospital costs have become "artificially inflated as a direct result of Blue Cross's anticompetitive contracts."

Priority states that while BCBSM claims that it uses provider discounts to bring down the costs of health care, there is clearly no correlation between the two. During a ten year period, group premium rate increases have fluctuated from 4.2% to 17.9%, yet what BCBSM pays hospitals has stayed well below those increases, remaining relatively flat. Hospitals tell Priority repeatedly that reimbursement rates from BCBSM remain inadequate to cover costs. When insurers negotiate contracts with providers, there is often a double digit disparity in the reimbursement rates between what BCBSM is paying and what others are required to pay. In some instances, the gap is more than 30%. Hospitals say this is necessary because BCBSM does not reimburse at sufficient rates to keep them in business.

Priority states that in one community it has a network and a product offering that is currently served by two health systems. Priority's efforts to enter into fair market contracts with those two health systems have been rebuffed. Those health systems indicated to Priority that "if we agree to rates that are closer to Blue Cross rates, the financial impact will plunge the system into operating losses. In essence we are overly subsidizing not only Medicaid and Medicare losses, but we are also subsidizing below fair value BCBSM rates to that facility."

Priority states it has a provider contract with the sole health system for a community. The financial pressure to that system is tremendous because BCBSM refuses to adequately cover its share of Medicaid and Medicare underpayments and bad debt. This forces that system to shift costs and requires Priority to overly subsidize those costs. This greatly hinders our ability to maintain a viable partnership with the system and to bring innovative health solutions to that community.

Priority initiated a network expansion in the Upper Peninsula of Michigan, which has extremely limited health care choices. Priority's discussion with a consortium of hospitals was lengthy and complex, eventually breaking down when Priority was advised it would have to pay at least 18% more for the primary quaternary facility in the Upper Peninsula.

Priority states that it regularly negotiates with physician groups whose work is critical to hospital operations. For one group, Priority proposed a multi-year contract that would allow both sides to better manage expenses and we were told that group was already being reimbursed at rates that are less than half of charges. "BCBSM dominates the market and... 'artificially' controls the market price. There's no way we can transition to such low rates over a multi-year period with you when the reimbursement situation may get worse in 3-4 years. We just can't do it." In another situation, a group of specialty physicians with an exclusive arrangement with a hospital has told Priority that BCBSM rates are "inadequate to enable the recruitment and retention" of specialists for the group.

During contract negotiations with employer groups, Priority regularly faces questions about the discounts it provides to hospitals. Employers are convinced that such discounts are the only way to manage rising health care costs, but that is not the case.

Federal health reform has forced a level playing field in all areas except provider contracting. New regulations will limit the flexibility of health plans in the areas of underwriting, premium rating and benefit design. Yet, provider payment rates remain untouched, continuing to give BCBSM a significant advantage over community based, non-profit health plans and other commercial insurers in Michigan. The new regulations, in combination with BCBSM's dominance in the market, will make it extremely difficult for other insurance carriers to make a profit.

Priority recommends OFIR consider the following measures to create a more competitive health insurance market in Michigan, end cost shifting and require BCBSM to pay providers fairly and appropriately:

- BCBSM must pay its fair share of losses that hospitals incur as a result of treating people covered by Medicaid, Medicare and the uninsured.
- The administration should make a call to action to the health care industry to increase access to more insurers at fair and competitive rates.
- OFIR should use an expedited appeal process for anyone who might be harmed.
- OFIR should end the use of MFN clauses, either contractual or implied, in all participating provider contracting practices.

Given BCBSM's current market dominance and resulting monopolistic practices:

- BCBSM should be prohibited from jointly negotiating or requiring providers to contract with all products offered by BCBSM and/or any of its affiliates.
- BCBSM should be required to file and receive approval of hospital agreements and all material amendments and side letters in the same manner OFIR requires of HMOs.
- The use of exclusive marketing agreements with trade association or agents/brokers by BCBSM should be prohibited.
- Competition on the exchange should be regulated by OFIR so that BCBSM or any other carrier's market share does not exceed the threshold defined by the U. S. Department of Justice classification of a monopoly.

Mr. Gene Michalski of Beaumont Health System states BCBSM is underpaying Michigan hospitals. Given BCBSM's market dominance, this underpayment challenges the financial viability of hospitals in Michigan. Beaumont concurs with the comments and points raised in the letter sent to OFIR by the Michigan Association of Health Plans (MAHP), in particular that the provider class plan review would be more meaningful if it is applied to the entire BCBSM and BCN commercial book of business. The PHA represents a very small portion of this total and the PHA Hospital Reimbursement Model is used to establish reimbursement rates for BCBSM's TRUST program and Blue Care Network (BCN). Beaumont supports the issue of a data call to better illustrate the existing inequities in the market. Beaumont states that the BCBSM Hospital Reimbursement Model does not cover the reasonable financial requirements of hospitals. These requirements include the need to offset losses related to Medicare and Medicaid shortfalls. Beaumont is especially disadvantaged on this point due to the various Medicaid funding programs that do not recognize the significant growth in Beaumont's Medicaid and indigent payer mix over the last ten years.

BCBSM's failure to pay hospitals reasonable financial requirements gives BCBSM an unfair advantage in the market. This advantage is not needed in order for BCBSM to be successful. Also, if BCBSM paid hospitals fairly, it would result in less cost shifting to all health care purchasers, including no-fault carriers. This implication should be considered in connection with auto insurance health care coverage reform. Beaumont believes the hospital provider class plan should be amended to require that BCBSM and BCN take into account losses hospitals absorb on Medicare and Medicaid programs as additional components in their Hospital Reimbursement Model. This could easily be accomplished by applying the Peer Group 5 reimbursement model to all Michigan hospitals.

As BCBSM prepared a response to all of the above input and BCBSM's response was obtained pursuant to a FOIA request of this office, MAHP submitted additional comments to OFIR since MAHP believes BCBSM misstated its position in its response or raised arguments that MAHP believes not to be valid.

In BCBSM's response it admitted that approximately 70% of hospitals are under side agreements or Letters of Understanding (LOU). If the very reimbursement arrangement that is under OFIR's review is subject to one-on-one variation 70% of the time, MAHP questions how the hospital provider class plan can be viewed as an accurate and complete reflection of BCBSM's reimbursement arrangement with hospitals? BCBSM is essentially asking OFIR to trust BCBSM that it is meeting the objectives of the Act when it negotiates reimbursement with these hospitals. MAHP believes the rejection of BCBSM's hospital provider class plan is warranted for just this reason alone.

MAHP notes that BCBSM, in its response, also discloses the enormous disparity in hospital payments between BCBSM and other commercial health plans. BCBSM's rates are 34% below market for inpatient services and 41% below market for outpatient services. MAHP contends that this unreasonably low reimbursement level is due to BCBSM's refusal to follow the mandate of the Act and pay its fair share of hospitals' reasonable financial requirements. BCBSM admitted that efficient hospitals have losses under Medicare and Medicaid but denies responsibility to pay its fair share. BCBSM's rationale for not paying government losses for Peer Group 1-4 hospitals is that those hospitals have the ability to shift government program losses to other health care purchasers. MAHP contends this is clearly a violation of Section 516 of the Act which unequivocally states that "no portion of [BCBSM's] fair share of hospitals' reasonable financial requirements shall be borne by other health care purchasers. MAHP believes that given BCBSM's enormous and unmerited rate advantage, BCBSM can meet the standards of the Act by paying its fair share of government program losses and still have favorable rates in the marketplace.

MAHP believes BCBSM's provided "hollow" arguments to justify why it used its dominant market position to lower hospital rates for its HMO subsidiary Blue Care Network (BCN). BCN is not an insurer of last resort nor does it have any social

mission obligations like BCBSM so whatever weight those arguments may have in the case of BCBSM, they should not be accorded any weight in the case of BCN. More importantly, MAHP states that BCBSM's "monopoly" leveraging – using its market share to advance BCN – has profoundly and adversely affected the ability of other HMOs to compete. Since 2004 when BCBSM began negotiating BCN hospital rates, BCN enrollment has grown 16% while the enrollment in other leading Michigan HMOs has declined 23%. Likewise, BCN's risk based capital has increased 52% since 2004, while the other leading HMOs had an average decrease of 34%. MAHP recommends OFIR require BCBSM to pay Peer Group 1-4 hospitals on the same basis as Peer Group 5 hospitals and discontinue establishing or negotiating BCN hospital rates.

BCBSM urged and welcomed review by OFIR of its PPO and HMO arrangements. MAHP believes BCBSM's position is somewhat unusual given the Act limits the focus of provider class plan reviews to BCBSM's traditional product. BCBSM would like nothing better than for OFIR to approve the contracts (including the PPO and HMO arrangements) so BCBSM can take that regulatory approval over to federal court and seek dismissal of the most-favored nation litigation. MAHP contends the record does not support approval of the hospital provider class plan but rather rejection or modification.

BCBSM indicated to OFIR that despite the fact that it has LOUs with approximately 70% of the hospitals at any given time, there was not a template for this document. MAHP states there are approximately 92 hospitals in Peer Groups 1-4 and 42 hospitals in Peer Group 5. Assuming that 70% of Peer Group 1-4 hospitals have side agreements with BCBSM, MAHP contends that the reimbursement model included in the PHA does not actually represent BCBSM's real reimbursement methodology. MAHP contends that even if the Peer Group 1-4 reimbursement model attached to the PHA is viewed as the "reimbursement arrangement", it is defective on its face. It plainly excludes government program losses, while the reimbursement model for Peer Group 5 hospitals includes them. BCBSM does not dispute that these losses constitute part of a hospital's reasonable financial requirements. Instead it argues that it can address those issues one-on-one in LOUs.

BCBSM provided the updated report of Dr. Harold Cohen which noted that, despite being more efficient, Michigan hospitals are incurring losses from Medicare. Cohen's report notes that when BCBSM established the Peer Group 1-4 model, Medicare was paying the costs of an efficient hospital, but that over time, this same assertion could no longer be made. Michigan hospitals, per 2007 data, are even lower cost relative to the nation than they were in 2004, which is an estimate of relative efficiency. In Michigan, Medicare does not come close to paying its fair share of full financial requirements. In 2007, Cohen's report states Medicare paid 87.5% of full financial requirements to Michigan hospitals. Medicaid was also reported as paying Michigan hospitals below cost. BCBSM was not paying any portion of either of these

governmental program losses, thus providing BCBSM with a price advantage that will drive out competition and allow BCBSM's market share to grow.

MAHP contends that BCBSM attempts to defend its practice of not recognizing government program losses in the case of Peer Group 1-4 hospitals on the basis that this forces hospitals to become more efficient. BCBSM noted that hospitals under high financial pressure had costs that were 9.4% lower than hospitals under lower financial pressure. What BCBSM did not reveal was that Michigan hospital costs are generally 12% lower than the national average. So, Michigan hospitals are thus incurring government program losses despite being efficient and despite lowering costs even more than hospitals under high financial pressure.

BCBSM's purported concern that paying government program losses will lead to higher hospital costs can easily be addressed by establishing efficiency conditions that Peer Group 1-4 hospitals would have to meet in order to recover government program losses. Cohen recommended that as long as Michigan hospital costs were 6-8% below the national average, BCBSM should pay its fair share of government program losses. The PHA already incorporates efficiency thresholds in determining payment rates and pay for performance incentives. BCBSM could easily apply an efficiency standard with respect to Medicare/Medicaid losses.

BCBSM's underlying rationale for recognizing government program losses in the case of Peer Group 5 hospitals and refusing to recognize government program losses in the case of Peer Group 1-4 hospitals has to do with the ability of the hospital to shift the losses to other commercial payers. BCBSM admitted in its response that because Peer Group 5 hospitals cannot shift their government program losses to other carriers that it needs to step up and pay its fair share. On the other hand, MAHP contends BCBSM clearly has deliberately designed its Peer Group 1-4 model in a manner that excludes government program losses, essentially ensuring that those hospitals shift the losses disproportionately to other health payers.

BCBSM claims that it should not bear its fair share of hospital government program losses due to its unique social mission under the Act as the insurer of last resort. BCBSM stated, "This disadvantage can only be offset if BCBSM can maintain its right to negotiate discounts and lower rates from hospitals and health care providers." MAHP states that due to HIPAA and other statutory changes over the years, BCBSM's only remaining insurer of last resort obligation is with respect to the non-group business segment which comprises only 2.5% of BCBSM's total business. MAHP contends that BCBSM is using the cloak of insurer of last resort to justify hospital pricing that affects 100% of its commercial business. Further, BCBSM reported an underwriting loss on the non-group business of \$39 million in 2011, less than half the value of its purported tax-exemption (per BCBSM December 2011 Monthly Financial Reporting Package).

BCBSM contends that the Michigan legislature desired for BCBSM to have the lowest rate possible. MAHP contends there is no legislative history to support this statement. BCBSM often quotes House Bill 4555 First Analysis (November 28, 1979) for the proposition that in order to meet its insurer of last resort obligation it must have an advantage over commercial insurers. MAHP contends that it is misleading and disingenuous to characterize one section of the analysis in support of BCBSM when in actuality the language cited was in the section of the analysis summarizing arguments against the House Bill. BCBSM was the principal party in opposition to the House Bill. Further, legislative bill analyses do not constitute official statements of legislative intent.

MAHP contends that BCBSM's failure to establish a payment model that explicitly refuses recognition of government program losses (even among the most efficient hospitals) has resulted in other health care purchasers having to absorb more than their fair share and a stifling of competition, thus impeding the ability of competition to lower premiums.

Exhibit 11 to BCBSM's response to the input OFIR received on the hospital provider class plan contains a power point presentation entitled "HVA Reimbursement Workshop: Review of Current State" prepared by McKinsey & Company". The McKinsey report found that BCBSM's payment rates for hospital services were 34% below the market average for inpatient services and 41% below the market average for outpatient services. Cohen, in his 2009 study, estimated the cost for commercial carriers to cover government program losses of Michigan hospitals would be approximately 17% of hospital cost. MAHP contends that if BCBSM were to recognize and pay these financial requirements consistent with the Act it would still have the best hospital rates in the market. Moreover, if BCBSM started paying its fair share of financial requirements the disproportionate cost shifting to other health care purchasers would decrease, thus stimulating greater competition.

In its response to OFIR, BCBSM suggests BCBSM's fair share of hospital financial requirements should not be equal to the share paid by other commercial payers. BCBSM asserts that "if BCBSM alone bears the cost of government shortfalls and uncompensated care then commercial insurers can free ride on BCBSM's reimbursements. MAHP contends that no one is advocating BCBSM alone pay government shortfalls – only that it pays its fair share. MAHP states "fair share" is a term defined in relation to BCBSM volume. If BCBSM represents 20% of a hospital's volume then it should cover 20% of the financial requirements arising from government shortfalls. This is the approach BCBSM uses in the Peer Group 5 reimbursement model and it is the same approach BCBSM uses when determining its share of costs for all hospitals. This approach ensures that BCBSM is paying its fair share. MAHP states that with respect to Peer Group 1-4 reimbursement there is currently free-riding - BCBSM is free-riding on other health care purchasers which are paying more than their fair share.

MAHP contends BCBSM should not establish or negotiate fees for its HMO subsidiary. BCN should have to negotiate rates based on its own merit. BCBSM responds that its practice of negotiating to lower BCN rates has been upheld by the U. S. Court of Appeals in *DeLuca v. BCBSM*, 628 F.3d (6th Cir. 2010). This decision, however, concerned only whether the practice violated ERISA fiduciary standards. The court did not address whether the practice was consistent with the Act. MAHP states OFIR can and should review the propriety of this practice in light of the Act's requirements for separateness and the impact on market competition.

MAHP contends no provision in the Act authorizes BCBSM to negotiate hospital rates on behalf of its HMO subsidiary (see Section 550.1207 of the Act). In the absence of a specific provision authorizing the practice it should be prohibited. BCBSM can only undertake actions that are within its statutory powers. Moreover, the Act generally reflects the principle that BCBSM is to avoid using its power and market position to advance the interests of its subsidiaries (see Section 550.1204(4) of the Act).

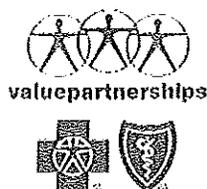
BCBSM asserts that negotiating hospital rates for BCN does not constitute monopoly leveraging but fails to note the actual consequences from this conduct which began about 2004. Despite a weak economy, MAHP states BCN has had robust enrollment growth while several commercial HMOs have suffered significant losses as high as 50%. Further its risk based capital ratio is more than two times its competitors. MAHP states that surplus accumulation and enrollment growth are two simple and credible measures of whether the use of BCBSM's monopoly has advanced BCN unfairly in the market. Moreover, whatever weight is given to the argument that BCBSM should have the lowest hospital rates given its insurer of last resort status, no weight should be accorded to BCN since it does not have this obligation.

MAHP urges OFIR to reject or modify BCBSM's hospital provider class plan. OFIR should require BCBSM to pay Peer Group 1-4 hospitals on the same basis as Peer Group 5 hospitals and discontinue BCBSM establishing or negotiating BCN hospital rates.

ATTACHMENT C

**BCBSM Hospital Audit Activities
2009-2010**

Audit Activity	2009	2010
DRG Validation		
Number of Hospitals	102	100
Cases Reviewed	19,293	17,499
Identified Savings	\$ 31,031,304	\$ 36,585,684
Recoveries to Date	\$ 24,707,242	\$ 24,010,997
Catastrophic Claims		
Cases Audited	159	141
Identified Savings	\$ 4,276,481.00	\$ 3,652,711.00
Recoveries to Date	\$ 3,246,244.00	\$ 2,401,064.00
Readmission Audits		
Number of Audits	120	113
Identified Savings	\$ 8,046,738.00	\$ 10,371,081.00
Recoveries to Date	\$ 7,133,059.00	\$ 6,948,064.00
Peer Group 5		
Number of Hospitals	6	5
Cases Reviewed	11	6
Identified Savings	\$ 4,348.00	\$0
Transfer Audits		
Number of Hospitals	66	63
Cases Reviewed	95	102
Savings	\$ 1,002,132.00	\$ 863,774.00
Hospital Outpatient Audits		
Number of Audits	190	180
Identified Savings	\$ 5,732,459.00	\$ 1,914,028.00
Recoveries to Date	\$ 3,508,502.00	\$ 4,742,347.00



Peer Group 1 - 4 2010 Hospital Pay-for-Performance Program

Program Overview

The Blue Cross Blue Shield of Michigan Hospital Pay-for-Performance program rewards short-term acute care hospitals for achievements and improvements in quality and efficiency. In 2010, a top-performing peer group 1 – 4 hospital participating in the program can earn up to an additional 5 percent of its inpatient and outpatient operating payments.¹

Hospitals must meet certain prequalifying conditions to be eligible to participate in the program. One half of each hospital's P4P score is then based on quality, including participation in selected initiatives. The other half is based on efficiency.

Hospital performance on the program measures (described below) is evaluated on a calendar-year basis. The amount a hospital earns, based on its 2010 performance, will be reflected in its BCBSM payments beginning July 1, 2011.

Program Prequalifying Conditions

Hospitals must meet certain prequalifying conditions to be eligible to participate in the P4P program. Hospitals do *not* earn payment for meeting the prequalifying conditions.

In 2010, a hospital must meet the three prequalifying conditions described below. These prequalifying conditions are unchanged from the 2009 program.

1. Publicly report performance on all applicable quality indicators to the Hospital Quality Alliance, for publication on the CMS Hospital Compare website.

This prequalifying condition is applicable to the entire program. If a hospital fails to meet this condition, it forfeits its eligibility for the entire P4P program.

2. Demonstrate an active commitment to patient safety. The specific requirements of this prequalifying condition are described in detail in Attachment A.

¹ If a hospital's reimbursement arrangement is not consistent with the Second Amended and Restated BCBSM Participating Hospital Agreement, the amount it can earn under the P4P program is limited to 4 percent of its inpatient operating payments only.

This prequalifying condition applies only to the quality indicator measures of the program. If a hospital fails to meet this condition it will forfeit its eligibility for payment for the quality indicators, but it will not be precluded from earning payment for the CQI or efficiency measures of the program.

3. Maintain high performance on five intensive care unit ventilator bundle measures (These measures are described in Attachment B). High performance is defined as a performance rate of 95 percent or better on each measure.

If a hospital's performance falls below the established threshold, the hospital will be requested to file an action plan with a timeline for bringing performance back up to the established threshold. If a hospital fails to either file the action plan or meet the goals of the plan within the agreed timeframe, it will not be eligible for payment for the quality indicator measures of the program. However, it will not be precluded from earning payment for the CQI or efficiency measures of the program.

Quality	50 percent
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One half of each hospital's P4P score is based on quality measures. This includes participation in selected collaborative quality initiatives and performance on specific quality indicators.

Collaborative Quality Initiatives – 5.0 percent - 16.5 percent

In 2010, hospitals will be evaluated on their active participation in the following CQIs.² (This list is unchanged from 2009.)

- Blue Cross Blue Shield of Michigan Cardiac Consortium
- Michigan Society of Cardiovascular and Thoracic Surgeons Quality Improvement Initiative
- Michigan Bariatric Surgery Collaborative
- Michigan Surgery Quality Collaborative
- Michigan Breast Oncology Initiative
- MHA Keystone project on hospital associated infections

Hospitals not eligible to participate in the Michigan Surgery Quality Collaborative will be asked to participate in the new Keystone Surgery initiative. However, only hospitals not eligible for MSQC will earn credit for participation in the Keystone Surgery Initiative.

² Active participation includes submitting data to the CQI coordinating center in a timely manner and active participation in CQI provider meetings.

Hospitals will earn 2.5 points for their participation in each of initiatives with the exception of the Michigan Surgery Quality Collaborative. Hospitals will earn 4 points for their participation in MSQC.

The weight of the CQI component is determined by the initiatives in which a hospital is eligible to participate. If a hospital is eligible for a specific initiative but chooses not to participate, it will forfeit the points allocated to that initiative.

Quality indicators – 33.5 percent - 45.0 percent

In 2010, the quality component of the P4P program is weighted from 33.5 to 45.0 percent. Hospitals will be evaluated on the following six quality indicators:

- Acute myocardial infarction - percutaneous coronary intervention
- Acute myocardial infarction
- Heart failure
- Pneumonia
- Surgical infection prevention
- Central line associated blood stream infection rates

Most of these indicators will be scored on a "perfect care" basis. (The exceptions are the AMI - PCI indicator and the CLA-BSI indicator). This scoring methodology requires a hospital meet the requirements for all applicable measures for each patient. If one or more of the measures is not met and the measure was not contraindicated, the hospital will not receive credit for that patient.

Attachment C includes a list of the specific measures included within each quality indicator. Performance thresholds for each measure will be established and communicated to hospitals during the first quarter of 2010.

Weight of the quality component and Individual measures

For each hospital, the weight of the quality indicators is inversely determined by the weight of the collaborative quality initiatives. Together, these two components equal 50 percent. Hospitals with a higher CQI weighting will have a lower weight applied to the quality indicators. Conversely, hospitals with a lower CQI weighting will have a higher weight applied to the quality indicators. An example of the inverse relationship between these two components is illustrated in the following table:

Relationship of CQI and Quality Program Weights

CQI	Quality	Total
5.0%	45.0%	50%
10.0%	40.0%	50%
16.5%	33.5%	50%

Within the quality indicator component, all six quality indicators are weighted equally. For example, if a hospital's quality indicator component is weighted at 45 percent, each of the six indicators is worth one-sixth of the total, or 7.5 percent. Similarly, if a hospital's quality indicator component is weighted at 33.5 percent, each of the six indicators is worth 5.6 percent.

If a hospital does not provide the services associated with a particular quality indicator, or has an insufficient number of cases, it will not be scored on that indicator and its weight will be reallocated across the remaining quality indicators.

Efficiency	50 percent
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One half of each hospital's P4P score is based on efficiency. The efficiency component is based on the creation and distribution of a reward pool. The amount in the reward pool is determined by a comparison of BCBSM hospital payment trends to a national benchmark.

Implementation of the efficiency reward pool and the focus on payment trends began in 2009 and is being phased in over a three year period. A summary of how the components change during each phase is provided on page 7.

Efficiency reward pool

Each year an efficiency reward pool will be established based on two factors:

1. A baseline reward level
2. Adjustments based on payment trends

Baseline reward level: The baseline reward level is equal to 75 percent of the value of the efficiency component.³ Stated another way, this is equal to the amount BCBSM would pay out if every hospital earned a *total* efficiency score of 75 percent.

Beginning in 2011 hospitals will have an opportunity to increase the baseline reward level to 100 percent of the value of the efficiency component. The methodology for determining whether hospitals earn this additional amount is under development and will be communicated to hospitals at a later date.

Adjustments based on payment trends. The value of the reward pool will be adjusted up or down based on a comparison of BCBSM hospital payment trends to a national benchmark, the Milliman Health Cost Index. This index shows the percent change in year-to-year payment trends for payors similar to BCBSM.

Adjustments to the reward pool will be based on a gain or loss share methodology, as described below:

³ 75% was chosen as the baseline reward level because it correlates to the historic level of efficiency payout before the payment trend measure was introduced.

- If the BCBSM payment trend is within 0.25 point of the national trend, performance will be considered to have met the benchmark. No gain or loss adjustments will be made to the reward pool.
- If the BCBSM trend is more than 0.25 point lower than the national trend, performance will be considered better than benchmark. The difference in payout BCBSM would have experienced if its trend had been equal to the benchmark (as describe above) will be considered a net gain to BCBSM, and the reward pool will be *increased* by 50 percent of this net gain.
- If the BCBSM trend is more than 0.25 point higher than the national trend, performance will be considered worse than the benchmark. The difference in payout BCBSM would have experienced if its trend had been equal to the benchmark (as described above) will be considered a net loss to BCBSM. The reward pool will be *decreased* by 50 percent of this net loss.

In 2010, BCBSM will limit the downward adjustments to the reward pool that may result from a loss share calculation. Specifically, the loss share calculation will be based on a difference of no more than 0.75 point from the national benchmark.

The calculations used to determine the level of the efficiency reward pool each year will be shared with the P4P Efficiency Group.

Distribution of the efficiency reward pool

Once the level of the reward pool has been established, it will be distributed to hospitals via the following two measures:

1. A comparison of each hospital's standardized inpatient cost-per-case compared to the statewide mean. In 2010 this measure is weighted at 20 of the 50 points allocated to efficiency. The following table shows how many points a hospital will earn, based on its position to the statewide mean:

<u>Hospital standardized inpatient cost per case relative to statewide mean</u>	<u>Efficiency amount earned</u>
More than 0.5 standard deviation below	20 points
Within 0.5 standard deviation, inclusive	15 points
More than 0.5 standard deviation above	10 points
More than one standard deviation above	0 points

Once hospital cost-per-case scores have been determined, BCBSM will calculate the total amount of money hospitals will earn statewide under this measure. This amount will then be subtracted from the efficiency reward pool.

2. A hospital payment trend measure. In 2010 this measure will be weighted at 30 of the 50 points allocated to efficiency.

The money remaining in the reward pool after the cost-per-case measure has been calculated will be distributed to hospitals under this measure. Scores will be calculated so the entire balance remaining in the reward pool is distributed. For example:⁴

- The amount of the efficiency reward pool after any gain or loss share adjustments is \$65 million.
- Hospitals earn \$25 million under the cost-per-case measure. This leaves \$40 million in the reward pool to be distributed under the payment trend measure.
- Hospital scores on the payment trend measure will be calculated so that hospitals are paid, in total, \$40 million on the measure.

For the 2010 program year (payment effective July 2011), all hospitals will earn the same statewide score on the payment trend measure. Beginning with the 2011 program year (payment effective July 2012), scores on the payment trend measure will become hospital-specific, with higher performing hospitals earning a relatively larger share of the reward pool. In some cases, very high-performing hospitals may earn a score that exceeds 100%.

Note: If a hospital's reimbursement arrangement does not comply with the Second Amended and Restated BCBSM Participating Hospital Agreement, its efficiency score will be capped at 100%.

Calculation of hospital scores on each measure, and the amount to be earned, will be made after the close of the 2010 measurement period, using the most recently available payment data available. The calculations and resulting payment amounts will be shared with the P4P Efficiency Group.

Implementation of the payment trend measure

As stated above, the payment trend measure was first introduced in 2009 and is being implemented over a three year period. During this period:

- The relative weight of the cost-per-case measure decreases and the relative weight of the prmpm measure increases. This means the amount of the reward pool earned under the cost-per-case measure will decrease and the amount distributed under the payment trend measure will increase.
- The measurement period for comparing BCBSM and national payment trends increases from one year to three years.
- The opportunity to earn the additional 25 percent of the reward pool will be implemented in year 3.

⁴ All dollar amounts in this example are illustrative only.

- Limits on the potential downward adjustments to the reward pool (described on page 5) will be phased out.
- Hospital scores on the payment trend measure will transition from a uniform statewide score to hospital-specific scores.

These transitions are summarized in the following table:

Payment Trend Measure Implementation Timetable

	Year 1	Year 2	Year 3
Program measurement year	2009	2010	2011
Payment effective date	July 2010	July 2011	July 2012
Weight of cost-per-case	30 points	20 points	15 points
Weight of pmpm	20 points	30 points	35 points
Trend Measurement period	One year 2008 - 2009	Two years 2008 - 2010	Three years 2008 - 2011
Reward pool – additional 25%	No	No	Yes
Limit on loss share calculation	Limited to 0.50 point from benchmark	Limited to 0.75 point from benchmark	Not applicable
Payment trend scores	Statewide	Statewide	Hospital specific

Hospital-specific payment trends

In preparation for the transition to hospital-specific scoring on the payment trend measure, BCBSM has developed a methodology for assigning its members to specific hospitals. In July 2009 we shared this methodology with hospital CEOs and provided each hospital an opportunity to verify the resulting service area assigned to it. Your hospital's performance on the measure will be determined by the experience of all BCBSM members living in the service area, regardless of whether or not the member receives services from your hospital. Your hospital may also share parts of its service area with one or more other hospitals. A map and list of the zip codes for the service area assigned to your hospital can be requested at P4Phospital@bcbsm.com.

Culture of safety prequalifying condition**ATTACHMENT A**

A prequalifying condition of the 2010 Hospital P4P program requires hospitals to demonstrate an active commitment to patient safety within their facility. This prequalifying condition applies only to the quality indicator measures of the program. If a hospital fails to meet the condition it will forfeit its eligibility for payment for the quality indicators, but it will not be precluded from earning payment for the CQI or efficiency measures.

The specific requirements of this prequalifying condition are as follows:

Hospitals must demonstrate an active commitment to patient safety within their facility by fully complying with the following three requirements:

1. Conducting regular patient safety walk-rounds with hospital leadership.
2. Assessing and improving patient safety performance by fully meeting one of the following options:
 - Completing and submitting the National Quality Forum Safe Practices section of the Leapfrog Hospital Survey
 - Completing the Joint Commission Periodic Performance Review of National Patient Safety Goals
 - Participating in a federally-qualified patient safety organization
 - Complying with the Agency for Healthcare Research Patient Safety indicators.
3. Ensuring results of the patient safety assessment and improvement activities are shared with the hospital's governing body and incorporated into a board-approved, multidisciplinary patient safety plan that is regularly reviewed and updated.

Hospital compliance with this pre-qualifying condition is determined via CEO attestation.

ICU Ventilator Bundle Measures**ATTACHMENT B**

As a prequalifying condition, hospitals are required to report on the five ICU ventilator bundle measures listed below and achieve a performance rate of 95 percent or better on each measure. If a hospital's performance falls below 95 percent, the hospital will be requested to file an action plan with a timeline for bringing performance up to the established threshold.

- **Assess weaning:** The proportion of ventilator patients receiving care in the ICU, without contraindications, who have had a trial of spontaneous breathing, or the measurement of a rapid-shallow breathing index to determine the patient's readiness to have mechanical ventilation removed.
- **Follow commands:** The proportion of ventilator patients receiving care in the ICU, without contraindications, given an opportunity to follow simple commands.
- **Head of bed greater than 30 degrees:** The proportion of ventilator patients receiving care in the ICU, without contraindications, who have the heads of their beds elevated to 30 degrees or higher to reduce the risk of acquiring ventilator-associated pneumonia.
- **DVT prophylaxis:** The proportion of ventilator patients receiving care in the ICU who receive chemical or mechanical prophylaxis as a means of reducing the risk of deep vein thrombosis.
- **Stress Ulcer Disease prophylaxis:** The proportion of ventilator patients receiving care in the ICU who receive SUD prophylaxis as a means of reducing the risk of stress-related gastrointestinal hemorrhage.

Quality Indicators**ATTACHMENT C**

Hospitals are evaluated on their performance on six quality indicators, shown below with their individual measures. Each of these measures is based on national standards, such as core measures from the Centers for Medicare & Medicaid Services and The Joint Commission (JCAHO).

The indicators for AMI, heart failure, pneumonia and surgical infection prevention will be scored as "perfect care" indicators. This scoring methodology requires a hospital to meet the requirements for all applicable measures for each patient. If one or more of the measures is not met, and the measure was not contraindicated, the hospital will not receive credit for that patient.

- **Acute myocardial infarction** (scored as a "perfect care" measure)
 - Aspirin at arrival (AMI-1)
 - Aspirin prescribed at discharge (AMI-2)
 - Angiotensin converting enzyme inhibitors or angiotensin receptor blockers for LVSD (AMI-3)
 - Beta blocker prescribed at discharge (AMI-5)
- **Heart failure** (scored as a "perfect care" measure)
 - Assessment of left ventricular function (HF-2)
 - Left ventricular ejection fraction less than 40 percent prescribed ACEI or ARB at discharge (HF-3)
 - Discharge instructions (HF-1)
- **Pneumonia** (scored as a "perfect care" measure)
 - Initial antibiotic selection (for non-ICU patients) consistent with current recommendations (PN-6b)
 - Pneumococcal vaccine (screening or administration) prior to discharge (PN-2)

Quality indicators (continued)

ATTACHMENT C

- **Surgical infection prevention for select surgeries (scored as a "perfect care" measure)**
 - Prophylactic antibiotic received within one hour prior to surgical incision (SCIP-INF-1a)
 - Prophylactic antibiotics discontinued within the appropriate time after surgery (SCIP-INF-3a)

NOTE: SIP measures are scored for the following select surgeries:

- coronary artery bypass graft and other cardiac surgery
 - hip and knee arthroplasty
 - colon surgery
 - hysterectomy
- **Acute myocardial infarction–percutaneous coronary intervention**
 - Timing of the procedure (percent of patients receiving the procedure within 90 minutes), scored on a statewide basis (AMI-8a)
 - Percent of patients eligible for the procedure who actually receive it

- **Central line-associated bloodstream infections per 1000 central line days**

This is a statewide measure that compares the number of central line-associated bloodstream infections (adult ICUs) in Michigan to the national rate. Rates are calculated as follows:

$$\frac{\text{Number of central line-associated BSIs}}{\text{Number of central line days}} \times 1000$$

This measure is consistent with the National Healthcare Safety Network system from the Centers for Disease Control and Prevention. The national rate use in the comparison is provided by NHSP.

**STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION**

Before the Commissioner of the Office of Financial and Insurance Regulation

In the matter of:

Most Favored Nation Clauses
_____ /

Order No. 12-035-M

**Issued and entered
this 18th day of July 2012
by R. Kevin Clinton
Commissioner**

Order Requiring Submission of Most Favored Nation Clauses

It has come to the Commissioner's attention that certain insurers have included provisions, commonly known as "most favored nation" clauses, in their provider agreements. For purposes of this Order, "insurer" means an insurer, health maintenance organization, or nonprofit health care corporation. In general, most favored nation clauses prohibit a provider from charging an insurer a rate that is higher than the lowest reimbursement rate the provider accepts from any other insurer.

Specifically, a most favored nation clause is one that:

- (1) Prohibits, or grants a contracting insurer an option to prohibit, a provider from contracting with another party to provide health care services at a lower rate than the payment or reimbursement rate specified in the contract with the contracting insurer;
- (2) Requires, or grants a contracting insurer an option to require, a provider to accept a lower payment or reimbursement rate if the provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the contracting insurer;
- (3) Requires, or grants a contracting insurer an option to require, termination or renegotiation of an existing provider contract if a provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the contracting insurer; or
- (4) Requires a provider to disclose, to the insurer or its designee, the provider's contractual payment or reimbursement rates with other parties.

Insurers operating under Michigan certificates of authority should be aware that the use of most favored nation clauses may violate the Michigan Insurance Code, MCL 500.100 *et seq.*; the Nonprofit Health Care Corporation Reform Act, PA 350 of 1980, MCL 550.1101 *et seq.*; and/or the Prudent Purchaser Act, PA 233 of 1984, MCL 550.51 *et seq.*

THEREFORE, IT IS ORDERED that, as of February 1, 2013, the use of most favored nation clauses in insurer provider contracts, including currently effective provider contracts, is strictly prohibited, unless the most favored nation clause has been filed with and previously approved by the Commissioner.

FURTHER, IT IS ORDERED that, as of February 1, 2013, any attempt by an insurer to enforce a most favored nation clause in any provider contract, without the Commissioner's prior approval, is prohibited and will result in appropriate administrative action.

This Order does not constitute a determination regarding the permissibility of the use of any particular most favored nation clause, nor is it issued with the intent to preempt general antitrust enforcement in this area.



R. Kevin Clinton
Commissioner