



**Blue Cross
Blue Shield**
of Michigan

Home Health Care Provider Class Plan

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PROVIDER CLASS

A provider class includes health care facilities or health care professionals who have a contract or reimbursement arrangement with BCBSM to render services to BCBSM's members. Qualification standards and the scope of services for which reimbursement is made may differ for the types of providers within a provider class.

Definition

A home health care provider under this provider class plan is a public agency or private organization that provides physician-prescribed skilled nursing services to members who are confined to their homes. At least one of the following services must be provided through a centralized administration that uses coordinated planning, evaluation and follow-up procedures:

- ◆ Physical therapy
- ◆ Occupational therapy
- ◆ Speech therapy
- ◆ Medical social services
- ◆ Nutritional therapy

Scope of Services

Home health care providers primarily render skilled nursing care. They also provide one or more of the following types of services in order to maximize the health, independence, dignity and comfort of the patient:

- ◆ Physical and occupational therapies
- ◆ Speech-language pathology
- ◆ Medical social work
- ◆ Nutrition counseling
- ◆ Home health aide services

P.A. 350 GOALS AND OBJECTIVES

Provider class plans are developed and maintained pursuant to section 504 of P.A. 350, which requires BCBSM to provide subscribers reasonable cost, access to, and quality of health care services in accordance with the following goals and objectives.

Cost Goal

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

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

Where “I” means the arithmetic average of the percentage changes in the implicit price deflator for gross domestic product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made; and,

Where “REG” means the arithmetic average of the percentage changes in the per capita gross domestic product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made.

Objectives

- Limit the rate of increase in total payments per member for home health care providers to the compound rate of inflation and real economic growth as specified in Public Act 350, giving consideration to Michigan and national health care market conditions.
- Provide equitable reimbursement to home health care providers in return for high quality services which are medically necessary.

Access Goal

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

Objectives

- Participate with all home health care providers that meet BCBSM’s qualification standards for participation.
- Provide members with current addresses and telephone numbers of all participating home health care providers.
- Review reimbursement levels periodically and adjust as necessary.

Quality of Care Goal

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

Objectives

- Apply and monitor provider participation requirements and performance standards.
- Meet annually with home health care providers.
- Provide information such as changes in payable services, group benefit changes, billing requirements, and other educational materials to all participating providers on a regular basis.
- Maintain and update, as necessary, an appeals process that allows providers to appeal individual claims disputes or utilization review audits. This process is described in Addendum E of the Home Health Care Facility Participation Agreement.

BCBSM POLICIES AND PROGRAMS

BCBSM maintains a comprehensive set of policies and programs that work toward achieving the provider class plan objectives. These policies and programs are designed to help BCBSM meet the P.A.350 goals by limiting cost, maintaining accessibility, and ensuring quality of health care services to its members. To that extent, the following policies and programs may, individually or in combination, affect achievement of one or more of the P.A. 350 goals. BCBSM annually reports its performance against the goals and objectives for each provider class plan.

Provider Participation

BCBSM may issue a participating contract that covers all members of a provider class or it may offer a separate and individual contract on a per claim basis, if applicable to the provider class.

Participation Policy

Participation for home health care is on a formal basis only. There is no “per claim” participation. Home health care services rendered by a non-participating home health care provider are not reimbursed.

Qualification Standards

Participating home health care providers must meet the following qualifications:

- Current Medicare-certification as a home health care provider or accreditation for home health care by:
 - ◆ The Community Health Accreditation Program, Inc. (CHAP), or
 - ◆ The Joint Commission on Accreditation of HealthCare Organization (JCAHO)
- Current membership in any one of the following professional organizations:
 - ◆ American Public Health Association (APHA)
 - ◆ National League for Nursing (NLN)
 - ◆ Michigan League for Nursing (MLN)
 - ◆ American Federation of Home Care Providers, Inc. (AFHCP)
 - ◆ American Association for Homecare (AAH)
 - ◆ National Association of Home Care (NAHC)
 - ◆ Visiting Nurses Association of America (VNAA)
 - ◆ Michigan Home Health Association (MHHA)
- Written policies and procedures that meet generally acceptable standards for home health care services to assure the quality of patient care, and demonstrate compliance with such policies and procedures

- Demonstrated program evaluation and utilization review programs to assess the appropriateness, adequacy and effectiveness of the program's administrative and clinical components
- Multi-disciplinary staff composed of all of the following:
 - ◆ A nursing administrator or coordinator who is a Michigan licensed registered nurse and who directs the activities of nurses, therapists and other staff members
 - ◆ A business office manager who handles the business and financial aspects of the program
 - ◆ A physician coordinator, licensed in Michigan, who serves as consultant, advisor, and liaison between the facility and the medical community
 - ◆ Registered nurses, licensed in Michigan
 - ◆ Michigan licensed physical or occupational therapists, or Michigan registered social workers, as appropriate to the services provided by the facility
- Provisions for skilled nursing services and one of the following professional types of service: physical therapy, speech therapy, nutritional therapy, occupational therapy, or medical social services
- BCBSM's Evidence of Necessity requirements, as applicable
- Governing board must be legally responsible for the total operation of the facility, and for ensuring that quality medical care is provided in a safe environment. The governing board, or as an alternative, a community advisory board responsible to the governing board, shall include persons representative of a cross section of the community who are interested in the welfare and proper functioning of the home health care provider as a community facility.
- Absence of inappropriate utilization or practice patterns, as identified through valid subscriber complaints, audits and peer review, and absence of fraud or illegal activities
- Maintenance of adequate patient and financial records

Termination of Contract

Participation may be terminated by BCBSM if the provider fails to meet any qualification standard. Other stipulations for terminating the participation agreement by either party are outlined in the Home Health Care Facility Participation Agreement.

Provider Programs

BCBSM strives to ensure the appropriateness and quality of services delivered to subscribers through a combination of communication, education, and quality assurance programs that oversee and support health care providers.

Utilization Management Initiatives

BCBSM requires that home health care providers develop and implement their own utilization management and quality assessment programs. These programs must:

- Assess the quality of care provided to patients to ensure that proper services are provided at the proper time by qualified individuals
- Identify, refer, report and follow up on quality of care issues and problems
- Monitor all aspects of patient care delivery

The utilization and quality assessment plan must be written and identify purposes, goals, mechanisms and personnel responsible for all aspects of the plan including:

- Quality, content and completeness of the medical records
- Clinical performance
- Quality and appropriateness of treatment and services
- Medication utilization
- Patient satisfaction

Education/Communications

- Participating home health care providers receive the *Hospital & Facility News* on a monthly basis.
- BCBSM's regional field services representatives visit home health care providers on-site for individualized provider education, and provide on-going assistance to facility staff, as needed.
- Provider participation information is available on the BCBSM corporate web page or through the Provider Inquiry and Customer Service Inquiry toll-free hotlines.
- A home health care liaison committee meets with BCBSM on an annual basis to discuss issues with BCBSM.

Performance Monitoring

- Home health care providers are surveyed regularly, to ensure that professional credentials and qualification standards are maintained and up-to-date.
- Suspected fraudulent activity, reported to BCBSM by providers, subscribers, and BCBSM staff, is referred to Corporate Financial Investigations for further investigation.
- Utilization review audits, when conducted, work to ensure that providers rendered services appropriately and within the scope of members' benefits.
- BCBSM uses InterQual ISD-HC® (Intensity, Severity and Discharge Screens, Home Care) criteria to determine medical necessity. These criteria are supplemented by a limited number of BCBSM medical policy rules. BCBSM medical policy rules must be met before InterQual ISD-HC criteria can be applied. BCBSM's prospective and retrospective utilization management areas use these criteria.

Reimbursement Policies

BCBSM reimburses participating home health care providers for covered services deemed medically necessary by BCBSM. Addendum A of the attached Home Health Care Facility Participation Agreement describes determination of medical necessity.

Covered Services

BCBSM reimburses for the following services when provided by a participating home health care provider in accordance with member certificates:

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

Reimbursement Methods

Freestanding Home Health Care Providers

Reimbursement is made only for covered services provided by a participating home health care provider. For each covered service, BCBSM pays the provider the lesser of allowable costs or billed charges, less member deductibles or copayments.

An interim percentage of charge payment rate is initially determined for each home health care provider based on information submitted to BCBSM when the provider applies for participation. Thereafter, the provider's interim percentage of charge payment rate may be adjusted, as necessary, to reflect retrospective settlement following BCBSM's audit or review of the provider's annual Home Health Cost Report.

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

BCBSM will periodically review freestanding home health care provider reimbursement to determine if modifications are necessary. BCBSM does not guarantee the review process will result in increased reimbursement.

Hospital-Based Home Health Care Providers

Reimbursement is made only for covered services provided by a participating home health care provider. Reimbursement is determined by the parent hospital's peer group assignment as defined in Exhibit B of the Participating Hospital Agreement (PHA), and as supplemented by

the PHA Payment Manual. A home health care provider that is owned and operated by a hospital and considered a peer group 1-4, 6 or 7 hospital, will be reimbursed using a prospectively established hospital-specific cost-to-charge ratio for home health care services, less member copayments and deductibles. This cost-to-charge ratio will be established and updated in accordance with the policies explained in Exhibit B, Section VI of the PHA.

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

BCBSM will review its reimbursement methodology for hospital-based home health care providers periodically to determine if modifications are necessary. BCBSM does not guarantee the review process will result in increased reimbursement.

Hold Harmless Provisions

Participating home health care providers agree to accept BCBSM's payment as payment in full. Member copayments or deductibles are subtracted from BCBSM's payment before it is sent to the provider. Participating providers hold members harmless from:

- Balance billing, unless the services rendered are not covered services
- Medically unnecessary services, as determined by BCBSM, unless the member acknowledges that BCBSM will not pay for the services and agrees in writing before the services are rendered to assume financial liability
- Financial obligation for covered services provided but not billed to BCBSM within 12 months under the circumstances specified in the participation agreement

Appeals Process

Participating providers have the right to appeal BCBSM decisions regarding individual claims disputes and utilization review audit determinations. The complete process is described in Addendum E of the Home Health Care Facility Participation Agreement.

HOME HEALTH CARE FACILITY PARTICIPATION AGREEMENT

See attachment.