

**STATE OF MICHIGAN**  
**DEPARTMENT OF ENERGY, LABOR AND ECONOMIC GROWTH**  
**OFFICE OF FINANCIAL AND INSURANCE REGULATION**

**Before the Commissioner**

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

No. 09-019-BC

/

Issued and entered  
This 8<sup>TH</sup> day of July 2009  
by Ken Ross  
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 (Commissioner) issued Order No. 09-001-BC on January 15, 2009, 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 2006 and 2007.

II

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

1. Jurisdiction and authority over this matter are vested in the Commissioner pursuant to the Act.
2. BCBSM has complied with all applicable provisions of the Act.
3. All procedural requirements of the Act have been met.
4. The staff reviewed relevant data pertaining to the 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.

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

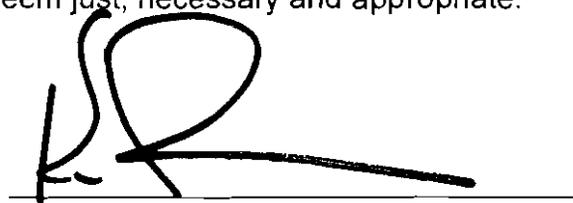
III

ORDER

Therefore, it is ORDERED that:

1. The attached 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 2006 and 2007.
2. Pursuant to Section 510(2) of the Act, the Commissioner shall notify BCBSM and each person who has requested a copy of such determination by certified or registered mail.
3. Pursuant to Section 515(1) and (2), any appeal must be filed within 30 days of the date of this determination report. The request for an appeal shall identify the issue or issues involved and how the person is aggrieved.

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

A handwritten signature in black ink, consisting of a large, stylized 'K' and 'R' followed by a horizontal line extending to the right.

Ken Ross  
Commissioner

HOSPITAL  
PROVIDER CLASS PLAN  
DETERMINATION REPORT  
for calendar years 2006 and 2007

Office of Financial and Insurance Regulation

State of Michigan

HOSPITAL  
PROVIDER CLASS PLAN  
DETERMINATION REPORT

Table of Contents

	<u>Page</u>
Executive Summary . . . . .	i
Introduction . . . . .	1
Provider Class Plans - Legal Background . . . . .	1
Overview of the Hospital Provider Class Plan . . . . .	3
The Changing Role of the Physician in the Health Care System . . . . .	7
History of the Hospital Provider Class Plan . . . . .	8
Review Process . . . . .	9
Summary of Written Input . . . . .	9
Discussion of Goals Achievement/Findings and Conclusions . . . . .	10
A.    Access . . . . .	10
B.    Quality of Care . . . . .	15
C.    Cost . . . . .	28
Determination Summary . . . . .	42

## 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 2006 and 2007. 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 2006-2007 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 2006 and 2007.

### 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 2006 and 2007, 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 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 2006 and 2007.

### Cost Goal

The cost goal requires that the arrangements BCBSM maintains with each provider class will assure a rate of change in the total corporation payment per member that is not higher than the compound rate of inflation and real economic growth. Achievement of the cost goal is measured by application of the cost formula specified in the Act, which is estimated to be 5.0% 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 an increase of 21.8% over the two years being reviewed, BCBSM did not meet the cost goal stated in the Act for 2006 and 2007.

### Overall Balance of Goals

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

## Introduction

The purpose of this report is to determine whether Blue Cross Blue Shield of Michigan (BCBSM) met the access, quality of care, and cost goals outlined in the Nonprofit Health Care Corporation Reform Act, MCLA 550.1101 et seq. (Act), with respect to the hospital provider class plan for the calendar years 2006 and 2007.

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

## Provider Class Plans - Legal Background

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

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

Determination Report  
Order No. 09-019-BC

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.

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

- (a) That the provider class plan achieves the goals of the corporation as provided in Section 504 of the Act.
- (b) That although the provider class plan does not substantially achieve one or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained and submitted to support a determination that the failure to achieve one or more of the goals was reasonable due to the factors listed in Section 509(4) of the Act.
- (c) That the provider class plan does not substantially achieve one or more of the goals of the corporation as provided in Section 504 of the Act.

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

### Overview of the 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 2006-2007, payments to hospitals represented an average of 13.3% 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 reviews. For the purpose of provider class plan reviews by the Office of Financial and Insurance Regulation (OFIR), paid claims data is categorized by nine geographic regions. A map, which depicts these geographic regions, is included in Attachment A.

Hospitals are subject to certain qualification standards set by BCBSM. BCBSM states that these 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 for participation in the Medicare Program.
3. The hospital must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association, or the Commission on Accreditation of Rehabilitation Facilities; or such other accreditation organizations as may be approved through the Contract Administration Process (CAP), unless the hospital is located in a 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 Medicare certification requirements on the basis of a survey conducted by an appropriate state agency.

Determination Report  
Order No. 09-019-BC

4. The hospital must have written policies and procedures that meet generally accepted standards for hospital services to assure the quality of patient care and demonstrate compliance with such policies and procedures.
5. The hospital must comply with applicable Certificate of Need requirements of the Michigan Public Health Code.
6. The hospital must have written policies and procedures that meet generally accepted standards for hospital services to assure the quality of patient care and demonstrate compliance with such policies and procedures.
7. The hospital must have a governing body that is 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 hospital as a community facility.
8. The hospital shall follow generally accepted accounting principles and practices.
9. The hospital shall not have inappropriate utilization or practice patterns, as identified through valid subscriber complaints, audits and peer review, or have participated in fraud or illegal activities.

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 and outpatient surgery, laboratory, radiology, physical therapy, occupational therapy and speech therapy services are reimbursed on a prospective price basis to hospitals in Peer Groups 1-4. Inpatient prices are determined using Medicare's diagnostic related groupings (DRGs), plus a hospital specific amount for capital, graduate medical education, uncompensated care and margin. Additional amounts are reimbursed for qualified catastrophic cases. Prices for outpatient surgery, laboratory, and radiology services are based on freestanding (facility and professional) provider levels. Prices for physical therapy, occupational therapy and speech therapy services are based on freestanding provider levels, plus a hospital specific amount for uncompensated care and margin. Freestanding provider levels are based on community pricing which is founded on the premise that payment for services provided in a hospital or non-hospital setting should be the same.

Determination Report  
Order No. 09-019-BC

Hospitals have the opportunity to earn additional amounts on both inpatient and outpatient payments under a pay-for-performance program that is described in the cost goal section of this determination report.

Inpatient prices are updated annually using a formula that is based on the National Hospital Input Price Index (NHIPI). BCBSM does not guarantee the annual updates will result in increased reimbursement. Hospital reimbursement and cost levels are assessed every three years to determine whether there is a need for pricing adjustments. Prices for outpatient laboratory, radiology, physical therapy, occupational therapy, speech therapy, and office-based surgery services are updated annually using the professional physician fee updates which is based on the Centers for Medicare and Medicaid Services' (CMS) Resource Based Relative Value Scale system and a BCBSM conversion factor. BCBSM does not guarantee the annual updates will result in increased reimbursement.

Other outpatient services may be cost-based until transitioned to community pricing. Outpatient cost-based services that are not routinely available through community providers will be transitioned to fixed statewide base prices using detailed claims information reported by hospitals in accordance with guidelines established by BCBSM.

Peer Group 5 consists of 43 small rural hospitals that are reimbursed a percent of charges for both inpatient and outpatient services, not to exceed 100% of their covered charges. The reimbursement for Peer Group 5 is hospital-specific. Hospitals must attest that their rates are at least as favorable as those for other non-governmental commercial insurers. These hospitals also began participating in a pay for performance program in 2007 that put a portion of the hospital reimbursement at risk. 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 consists of psychiatric and rehabilitation hospitals and Medicare-exempt psychiatric and rehabilitation units of acute care hospitals. Inpatient services are reimbursed based on the lesser of the hospital's covered charge or BCBSM's per diem level. Annual updates are determined using the same update factor as Peer Groups 1-4. BCBSM does not guarantee the annual updates will result in increased reimbursement. BCBSM states that outpatient services are reimbursed the same as Peer Groups 1-4.

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 be considered "freestanding" and be reimbursed under a separate agreement. In such cases, the hospital will be granted participation status as a freestanding entity and will be given a reasonable amount of time to comply with such standards.

Determination Report  
Order No. 09-019-BC

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. 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 Web site 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.
- 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 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.

### The Changing Role of the Physician in the Health Care System

Physicians have traditionally been the primary decision makers in the level of care and the volume of services that are provided to their patients. Physicians have made virtually all the decisions determining the cost of medical services. Physician practice patterns have therefore affected the utilization and related costs for not only BCBSM's physician provider classes, but also each of the other provider classes, particularly the hospital provider class.

Yet, some of the power to control health care costs shifted from physicians to managed care plans during the 1990s. Cost containment efforts by Medicare and third party payers shifted numerous procedures and treatment regimens to outpatient settings. These changes have resulted in hospitals and physicians competing for the right to provide the same services. It used to be that physicians saw patients in their offices and sent out patients to the hospital for diagnostic testing, therapeutic services and ambulatory surgery services. In recent years, however, many office based physicians have moved into larger practices, loosened their affiliations with general hospitals, have begun providing more ancillary services and even invested in clinics and outpatient ambulatory care facilities that compete with hospitals for outpatient services.<sup>1</sup> Undoubtedly, this shift in services from the hospital setting to a physician based setting encourages physicians to diagnose conditions using the diagnostic services available in the office based setting. Given physicians are able to be reimbursed for both the office visit and the diagnostic testing, more income can be achieved by ordering testing services in lieu of taking more time with the patient and using the physician's cognitive skills to diagnose and treat patient conditions based on a thorough physical examination and complex decision making. The use of diagnostic testing clearly cuts down the time spent with each patient and allows physicians to also maximize the number of patients seen by each physician.

The ability by physicians to provide their patients with the services once typically provided in a hospital based setting not only affects the usage and cost of physician based services but also affects the costs that can be charged by hospitals. It also has an influence on where patients may opt to receive services. As increases in health care costs continue to cause higher and higher levels of patient cost sharing, patients will be drawn to non-hospital based facilities with lower overhead costs to receive services, if they receive them at all. This shift in patient services from hospitals to freestanding facilities has a negative effect on hospitals inasmuch as hospitals have large fixed facility and equipment expenses, costs associated with specialty units such as emergency rooms, burn units, and intensive care units; graduate medical education; and, the costs incurred for the provision of under

---

<sup>1</sup> Pham, Hoangmal and Paul Ginsburg, "Unhealthy Trends: The Future of Physician Services," Health Affairs. Vol. 25, No. 6, p. 1587.

Determination Report  
Order No. 09-019-BC

funded care to the poor and for charity care. The change in the relationship between physicians, hospitals and patients has forced payers such as BCBSM to look for ways to influence cost savings using performance measures based on the quality of care provided and outcome measures.

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 first filed the hospital provider class plan with OFIR pursuant to Section 506(1) of the Act 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."

Since 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. The plan was rewritten 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 reflect BCBSM's participation in the Interplan Teleprocessing System (ITS) and the disclosure requirements of the Blue Cross and Blue Shield Association.

On June 30, 2006, during the two year period under review, BCBSM filed a revised hospital provider class plan and participating hospital agreement. This filing was deemed

Determination Report  
Order No. 09-019-BC

incomplete by OFIR as 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 in the marketplace by permitting others 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.

#### Review Process

On January 15, 2009, the Commissioner issued Order No. 09-001-BC, which provided written notice to BCBSM, health care providers, and other interested parties of his intent to make a determination with respect to the hospital and ambulatory surgical facilities provider class plans for the calendar years 2006 and 2007. Order No. 09-001-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 and ambulatory surgical facility provider class plans were sent to all those on OFIR's interested persons list for both provider classes and posted on OFIR's website, providing interested parties until March 17, 2009 to prepare and submit testimony.

#### Summary of Written Input:

No testimony was submitted with regard to BCBSM's hospital provider class plan.

Discussion of Goals Achievement/Findings and Conclusions

Access Goal:

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

In order to achieve compliance with the access goal, BCBSM needs to be able to assure, that in any given area of the state, a BCBSM member has reasonable access to 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 the OFIR in January 2009, by BCBSM, shows the number of Michigan participating hospitals and membership by geographic region for calendar years 2006 and 2007:

Hospitals and Membership per Region

	2006		2007	
	Hospitals	Members*	Hospitals	Members*
<b>Region 1</b>	50	129,353	48	94,404
<b>Region 2</b>	9	20,364	9	12,596
<b>Region 3</b>	8	20,960	8	14,501
<b>Region 4</b>	6	13,004	6	8,231
<b>Region 5</b>	20	33,788	20	22,723
<b>Region 6</b>	22	47,820	22	32,685
<b>Region 7</b>	18	23,706	18	15,818
<b>Region 8</b>	14	15,397	14	9,812
<b>Region 9</b>	14	6,993	14	3,857
<b>Totals</b>	161	311,385	159	214,627

\*Excludes Medicare, Medicaid and BCBSM PPO recipients

Determination Report  
Order No. 09-019-BC

BCBSM states that it maintained an average statewide formal participation rate of 100% during 2006 and 2007. 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 2007. Review of this regional map reveals there is a hospital facility located in 74 of Michigan's 83 counties, with the northern most portion of Michigan's Lower Peninsula having the fewest number of hospitals available to BCBSM members. Oakland County actually experienced a growth in the number of BCBSM participating hospitals. BCBSM states that Henry Ford West Bloomfield Hospital and Providence Park Hospital in Novi began participating in 2005. Both of these hospitals are new facilities owned and operated by large metropolitan Detroit health systems. Henry Ford West Bloomfield Hospital, part of the Henry Ford Health System, is a 300 bed acute care hospital. Providence Park Hospital, part of the St. John Health System, is a 200 bed acute care hospital.

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 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. In January 2007, BCBSM added "Record Select", an online service that allows providers to select pertinent articles by category. The articles are compiled monthly and held until BCBSM notifies the providers through e-mail when the articles are available. These articles can be reviewed online or downloaded and saved to a personal computer. BCBSM states more than 2,000 providers have signed up for this service and a specific article category has been created for hospitals.

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.

Participating hospitals can access a comprehensive online provider manual on web-DENIS, which contains detailed instructions for servicing BCBSM members. This replaced

Determination Report  
Order No. 09-019-BC

the hard copy version of the *Guide for Participating Hospitals (Guide)*. BCBSM states its provider manuals are updated as necessary, allowing hospitals to obtain information on a real time basis. Topics detailed in the *Guide* 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.

BCBSM states it offers providers the options of speaking with provider services representatives, writing to its inquiry department, and having a provider consultant visit provider offices to help guide and educate the provider's staff. In addition, BCBSM trainers educate providers with seminars on various topics such as benefits and eligibility, billing, claims tracking and adjustments. BCBSM also offers providers the ability to download enrollment applications through BCBSM's website at [www.bcbsm.com](http://www.bcbsm.com).

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](http://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.

Web-DENIS also has *Partner Links* that connect providers to BCBSM's partner sites, including the Council for Affordable Quality Healthcare, Institute for Safe Medication Practices, Michigan State Medical Society and the Michigan Health and Hospital Association. In March 2007, web-DENIS added capability to respond to requests from providers for specific service type information regarding members of other BCBS plans. As a result, a provider can request and receive specific member benefit information, such as eligibility, benefit limitations, patient liability and coverage by place of service.

Another avenue for hospitals to obtain needed information from BCBSM is CAREN<sup>+</sup>, an integrated voice response system which provides information on eligibility, benefits, deductibles and copays. In 2006 CAREN<sup>+</sup> was enhanced to include interactive voice response technology that enables providers to enter contract numbers by voice or text. In addition, security measures were added to CAREN<sup>+</sup> to safeguard BCBSM members' protected health information.

BCBSM states the results of the 2007 BCBSM Hospital Patient Account Manager Satisfaction Survey indicated satisfaction with web-DENIS remained high at 94%. Satisfaction with the accuracy of patient information provided by CAREN<sup>+</sup> and web-DENIS was also high at 86%. Respondents also found policy changes and BCBSM news through web-DENIS alerts was also useful.

BCBSM states it conducts annual surveys as a continued commitment to enhancing relationships with hospitals. The surveys measure overall satisfaction in doing business with BCBSM and several key elements such as service, claims processing and online tools. BCBSM uses the responses it receives to assess what is working well and where opportunities for improvement exist. The goal of the survey process is to identify ways to make it easier for hospitals to do business with BCBSM.

During the two year period under review, BCBSM made changes to the annual survey process to enable hospitals and their staffs to provide more specific feedback. BCBSM modified the annual survey by alternating the target audience between hospital staff and senior hospital executives. In 2006, BCBSM's annual survey consisted of BCBSM leadership meeting face-to-face with hospital CEOs and in 2007, hospital patient account managers were surveyed by phone.

Instead of mailing a survey, BCBSM leaders sat down with hospital leaders in 2006 for personal discussions about how BCBSM is doing and how it can improve. The survey results showed as much good news and positive responses as they revealed opportunities for improvement. Some of the issues earning high marks included collaboration on cost-savings and health care quality programs, claims payment and the responsiveness of the provider consulting staff. Some opportunities for improvement included the contracting and inquiry process, incentive programs and reimbursement model.

In 2007, the satisfaction survey was conducted with BCBSM hospital patient account managers, an audience that had not been surveyed since 2001. The intent of the survey was to evaluate their perceptions of how easy it was to do business with BCBSM compared to other insurers. The survey showed that 81% of hospital account managers are more satisfied with their overall relationship and the ease of doing business with BCBSM, a nine percent increase compared to 2001 results. In addition, more than two-thirds of the respondents would recommend BCBSM to their colleagues and when compared to other insurers, 71% of survey respondents consider BCBSM to be better overall. The helpfulness of provider consultants and high satisfaction with BCBSM's online tools contributed to the positive results. Opportunities for improvement were cited for decreasing phone wait times, increasing training and support and providing more accurate and consistent responses.

BCBSM contends its provider affiliation strategy is a fundamental approach to doing business that fosters an ongoing commitment to excellent performance and dialogue with providers. To better serve our communities and customers, BCBSM promotes business relationships with providers so they will collaborate with BCBSM to improve the health status of patients and the quality and cost effectiveness of care; help BCBSM deliver

Determination Report  
Order No. 09-019-BC

outstanding customer service to members; and, value BCBSM as a health plan of choice and recommend it to patients and others.

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

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

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

BCBSM's adjustment rate initiative was designed to reduce the number of claims that are manually adjusted to process through BCBSM's claim system. During 2006, claim rejections were reduced by 30% in select claim categories. The reduction is the result of clarification of billing and reimbursement guidelines, removal of unnecessary edits and standardization of medical policy rejections. Some of the projects included minimizing the need for additional information requests, aligning billing and reimbursement policies related to emergency services and eliminating billing requirements regarding newborns and mothers being billed on a single claim form.

In response to requests from providers, BCBSM streamlined the hospital pre-certification process in 2007 to create an easier and more efficient process. Pre-certification is a process that requires the review of patients' symptoms and proposed treatment to determine, in advance, whether they meet BCBSM's criteria for inpatient treatment. BCBSM placed greater reliance on providers to manage patient lengths of stay. This change diminished the administrative burden of obtaining frequent recertification without significantly increasing lengths of stay.

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

Determination Report  
Order No. 09-019-BC

During 2007, BCBSM added more professional fee schedules on web-DENIS to help providers conduct business more efficiently with BCBSM. In addition, improvements were made to answer provider calls faster, which reduced wait time to less than sixty seconds.

BCBSM states it increased face-to-face feedback opportunities through provider outreach fairs. The fairs were held throughout the state, giving providers the opportunity to interact with BCBSM representatives and to discuss web-DENIS, provider training, electronic data interchange and other topics. Total attendance at the outreach fairs in 2006 and 2007 was approximately 2,000 each year. Many of the outreach fairs were held in hospitals located throughout the state. Although BCBSM does require providers to sign in at the fairs, BCBSM does not keep statistics on the types of providers attending its outreach fairs. As such BCBSM does not know how many hospital representatives attended the fairs.

BCBSM's 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 it revised its reimbursement methodology during the review period. The revised reimbursement methodology was designed with input from the Michigan Health and Hospital Association (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.

#### 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 assure 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 2-year period under review, BCBSM was able to maintain a 100% formal participation rate with hospital providers. As such, it is evident BCBSM 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 2006 and 2007.

#### Quality of Care Goal:

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

Determination Report  
Order No. 09-019-BC

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 obtain Medicare certification. BCBSM states the minimum health and safety standards required by the Centers for Medicare and Medicaid Services (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 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.

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

Determination Report  
Order No. 09-019-BC

cases for potential intervention by BlueHealthConnection programs and helps ensure that claims will be paid appropriately.

Pre-certification of admissions 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 BlueHealthConnection programs and helps ensure that claims will be paid appropriately.

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 psychiatric care, substance abuse treatment, rehabilitation therapy, skilled nursing care and certain admissions to Peer Group 5 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 and 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 Appendix A 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. 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 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:

Determination Report  
Order No. 09-019-BC

- 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

BCBSM's readmission team identifies admissions that occur within 14 days of a previous discharge to determine whether the admissions should be combined, resulting in a single DRG payment. BCBSM combines the two admissions for payment when: a) the patient was discharged prematurely on the first admission which necessitated a return to the hospital; b) the patient's condition was noted but not properly treated, causing the patient to return to the hospital for more care; and, c) the procedure was postponed for the convenience of the patient or provider. BCBSM states in 2008, it increased the number of readmission auditors in order to be able to audit 100 hospitals each year.

- 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. BCBSM states it reviews all catastrophic cases where the outlier amount is greater than \$10,000.
- Focus Reviews: Focus reviews involve a review of problematic diagnoses or services. Hospitals are selected for review through quarterly analyses of the pre-notification and pre-certification paid claims file. Cases are reviewed for the appropriateness of admission and each day of care. Hospitals are also reviewed for compliance with pre-notification and focused pre-certification requirements.

BCBSM states this audit activity was discontinued because the intended goal of these audits was achieved, meaning that hospitals were admitting the appropriate patients to the inpatient setting. BCBSM states hospitals are required to apply InterQual level of care criteria and clinical judgment to determine when a patient should be treated in the inpatient setting. Upon review, BCBSM found hospitals were applying the criteria appropriately. BCBSM states it decided to discontinue the audits and monitor trends, but could resurrect the audits of specific hospitals if the trends show a need for closer scrutiny.

Determination Report  
Order No. 09-019-BC

- 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.

BCBSM states the guiding principles for hospital outpatient audits changed in 2007 as the result of a significant change to the PHA. The revised PHA limits audit recoveries so fewer hospital outpatient audits were done by BCBSM in 2007. Prior to 2007, outpatient audits were based on a statistically valid random sample and recoveries were extrapolated from the error rate in the sample. Beginning in 2007, extrapolation was prohibited. As a direct result of this change the audit strategy also changed and recoveries decreased significantly. BCBSM states it has the resources to complete approximately 100 audits each year, with areas having the highest potential for overpayments selected for review. Current hot topics for this audit type include emergency room and physical therapy services.

- 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.

BCBSM makes a formal appeals process available to hospitals. BCBSM's appeal process, as described in Attachment B, is available to providers that disagree with BCBSM determinations as the result of audit findings. 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 implemented the Hospital Pay for Performance (P4P) program in 2006 as part of the revised PHA. This program rewards hospitals for performance on quality and efficiency measures. The program was developed via a collaborative effort with the Michigan Health

Determination Report  
 Order No. 09-019-BC

and Hospital Association, hospitals, physicians, pharmacists, and other quality experts. BCBSM states its P4P program replaces BCBSM's earlier Hospital Incentive Program and offers expanded quality improvement measures, efficiency measures and the opportunity for hospitals to earn a higher incentive rate.

The 2006 P4P program gave top performing hospitals in Peer Groups 1-4 the opportunity to earn up to an additional three percent on their inpatient and outpatient operating programs is they met specific performance thresholds. This amount is a significant increase from the prior reward level, which was capped at four percent of inpatient payments only. The potential reward amount increased again in 2007 to four percent of inpatient and outpatient operating payments. Hospitals were also given the opportunity to earn up to an additional one percent based on a comparison of Michigan hospital costs to other states in the region.

BCBSM states a P4P program for the 43 Peer Group 5 hospitals was implemented in 2007 and will be phased in over several years. The Peer Group 5 P4P program will not affect hospital payments until 2009.

The goals of the P4P program are to:

- Promote consistent delivery of clinically sound health care services (best practices)
- Provide incentives to encourage continuous quality improvement
- Promote patient safety, including medication safety and other safe hospital practices
- Reduce health care costs through quality of care improvements
- Encourage participation in multi-institutional, hospital-based collaborative quality initiatives

The following table shows the weights assigned to each component of the P4P program to calculate provider performance payments for hospitals in Peer Groups 1-4 during the two year period under review:

Program Component	2006 Weight	2007 Weight
Pre-Qualifying Conditions	0%	0%
Quality	60%	45%-55%
Community Health Initiatives*	10%	NA
Collaborative Quality Initiatives	30%	10%-20%
Efficiency	NA	35%

\*In 2006, 10% of the P4P incentive applied to community health initiatives related to smoking cessation, physical activity and nutrition

Determination Report  
Order No. 09-019-BC

In 2007, hospitals were required to meet the following three pre-qualifying conditions to participate in the P4P program:

1. Publicly report performance on all applicable quality indicators to the Centers for Medicare & Medicaid Services. This 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. Maintain participation in all selected collaborative initiatives for which it is eligible. If a hospital fails to meet this condition, it will forfeit its eligibility for payment under the Collaborative Quality Initiatives (CQI) component (described below), but it will not be precluded from earning payment for the quality or efficiency components of the program.
3. Implement and maintain a culture of safety, medication safety and patient safety practices and patient safety technology. This component, which includes specific criteria for maintaining a culture of safety, was scored as a separate measure prior to 2007. It was changed into a pre-qualifying condition in 2007.

Hospitals were evaluated on the following six quality indicators identified in BCBSM's 2007 P4P Program Scoring Thresholds and Reporting Requirements:

- Heart failure
- Pneumonia
- Surgical infection prevention
- Acute myocardial infarction (AMI) "perfect care"
- Central line associated blood stream infection rates
- ICU ventilator bundle

The AMI "perfect care" indicator was scored at the patient level for the first time in 2007. This methodology, which is also called an "all or none" measurement, requires a hospital to meet the requirement 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. The AMI perfect care indicator is based on five individual measures:

- Aspirin at arrival
- Aspirin prescribed at discharge
- Angiotensin converting enzyme inhibitors (ACEI) or angiotensin receptor blockers (ARB) for left ventricular systolic dysfunction (LVSD)
- Beta-blocker prescribed at discharge
- Beta-blocker at arrival

The indicator for ICU central line associated blood stream infection rates was new in 2007. This measure compares the performance of Michigan hospitals to a national indicator. It is measured on a statewide basis, with all hospitals receiving the same score.

BCBSM states that beginning in 2006, hospital efficiency was measured by hospitals' standardized inpatient cost per case relative to the statewide mean. Hospitals were rewarded based on their performance relative to the statewide mean.

The inclusion of Collaborative Quality Initiatives (CQIs) was included in the P4P when the program began in 2006. Hospitals were evaluated on their participation in the following six CQIs:

- *BCBSM Cardiac Consortium Angioplasty Project* – a hospital partnership spearhead by BCBSM and the University of Michigan. This project developed a clinical registry used to assess risk and monitor quality improvement for patients undergoing heart procedures like balloon angioplasty and stenting. This registry includes a patient's individual medical history and provides physicians the resources they need to rigorously examine angioplasty practice, to better define optimal care and to use what is learned to improve patient outcomes.

BCBSM states the project resulted in safer and improved care for angioplasty patients across the state, saving lives, avoiding serious complications and saving \$8 million per year on care provided to patients treated at the 16 partner hospitals. Results include higher usage of medicines that prevent complications, use of more appropriate amounts of dye, and less heparin use. There are now fewer complications like kidney failure and heart attacks.

- *Michigan Society of Cardiovascular and Thoracic Surgeons Quality Improvement Initiative*: 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 Cardiovascular and Thoracic Surgeons will: a) enable greater in-depth analysis of patient data; b) help coordinate best practices among surgeons in all 31 Michigan hospitals offering 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. BCBSM states 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 Bariatric Surgery Collaborative*: This partnership with physicians and

Determination Report  
Order No. 09-019-BC

hospitals is designed to make weight reducing bariatric surgery safer and potentially less costly across the state. BCBSM states it currently funds project coordination, creation of the data registry and most of the data collection costs at 22 participating hospitals.

All Michigan hospitals performing bariatric surgery are invited to 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, at the same time, help reduce costs for these increasingly common and expensive procedures. Currently there appears to be wide variation in the ways this surgery is performed and how pre- and post-operative care is structured.

- *Michigan Surgery Quality Collaborative:* Sixteen of the largest Michigan hospitals participate in an initiative that evaluates the results of general and vascular surgery procedures performed in their institutions. It is a pioneering 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.
- *Michigan Breast Oncology Initiative:* In 2006, BCBSM expanded its pilot program to improve the quality of care for the more than 7,000 Michigan women diagnosed with breast cancer each year. The program expansion increases the number of Michigan hospitals participating in the initiative. Working with researchers at the University of Michigan Health System, BCBSM invited five new hospitals to participate in 2006. The number of participating hospitals grew to 17 in 2007. This initiative is contributing comprehensive data on diagnostic testing, chemotherapy, radiation therapy and surgery to a registry established by the National Comprehensive Cancer Network. BCBSM expects this initiative to help physicians learn what works best in cancer treatment.
- *MHA Keystone Project on Hospital Associated Infections:* This initiative, introduced in April 2006, is a BCBSM partnership with the Michigan Hospital Association (MHA) and Michigan hospitals to reduce inpatient infection rates in general medicine and surgical wards. The project involves the collection and analysis of specific data from the 109 participating hospitals to provide feedback and develop solutions to reduce hospital-acquired infections. The goals of this program are to improve patient outcomes and reduce hospital costs as a result of lower infection rates.

For each of the above initiatives, BCBSM sponsors an academic leader to develop and coordinate clinical registries on these specific procedures or conditions. BCBSM is funding a substantial portion of the data collection costs, the project coordination and coordination of quality improvement efforts. Although BCBSM provides financial support, the data and results belong to the participant hospitals. The goal of these initiatives is to evaluate and improve the quality of care while ultimately reducing health care delivery costs.

Hospitals have the potential to earn up to an additional one percent of their combined inpatient and outpatient operating payments based on a comparison of the statewide average cost-per-adjusted admission with a regional benchmark. This comparison is not a hospital-specific measure, but instead is applied equally to all eligible hospitals participating in the P4P program. The inclusion of the regional benchmark comparison in the P4P program gives hospitals the opportunity to earn a maximum of 5% in incentives on BCBSM inpatient and outpatient payments. This regional benchmark cost comparison was available for the first time in 2007.

In 2007, 86 hospitals were eligible for additional reimbursement for meeting the P4P criteria. These hospitals received incentive payments totaling approximately \$100 million. BCBSM believes hospital performance has continued to improve under the P4P programs. Statewide performance on program measures in 2005 was 72%. In 2006, statewide performance rose to 78%. Performance remained at 78% in 2007 although some program components and scoring requirements were modified between 2005 and 2007. Incentive payments to hospitals totaled approximately \$75 million in 2006 and \$100 million in 2007.

BCBSM states the 90 Michigan hospitals that participated in the P4P program in 2006 achieved near perfect scores on two measures for treating patients suffering from heart attacks. These hospitals performed at a higher rate than comparable Michigan hospitals that didn't participate in the program and they also outscored the national average of hospitals around the country. Because of the strong results, BCBSM and participating hospitals implement the "perfect care" measurement to evaluate quality of care for treating patients with acute myocardial infarctions in 2007.

BCBSM's other quality initiatives included the Advanced Cardiovascular Imaging Consortium, Cardiac Centers of Excellence, the Michigan Quality Improvement Consortium, and the Michigan Health and Safety Coalition.

The BCBSM Advanced Cardiovascular Imaging Consortium was launched in 2007. The Advanced Cardiovascular Imaging Consortium is a group of providers charged with developing and monitoring the best uses, techniques and interpretation of coronary computed tomography angiography (CCTA). This initiative studies the use of CCTA, a promising, noninvasive technology that could replace conventional cardiac catheterization

in the future. CCTA uses contrast materials in the arteries and high-resolution CT machinery to obtain detailed images of blood vessels and the heart. William Beaumont Hospital is coordinating the program with data provided by participating providers in the Advanced Cardiovascular Imaging Consortium.

BCBSM states consortium providers collect and report data to a central data base to document the use of CCTA, develop best practice guidelines for providers and start a continuous quality improvement program in cardiovascular imaging. Each participating consortium group will be able to compare its data with aggregate performance data from all groups in the study.

BCBSM established the Cardiac Centers of Excellence Program (CCOE) in 1996 to assist members in making informed choices about their cardiac care, as well as to enhance long-term relationships between BCBSM and providers to improve quality in cardiac care through research and collaboration. Research has demonstrated that where people receive cardiac services matters in terms of outcomes. Hospitals that perform a high volume of these services and carefully monitor their performance achieve the best results for cardiac patients. The procedures covered in the program are coronary artery bypass graft; percutaneous transluminal coronary angioplasty; cardiac value repair or replacement; and, cardiac or coronary artery catheterization.

The CCOE program identifies hospitals committed to continuous internal and external reviews of their cardiac care, with a common goal of improving the quality of care – which ultimately leads to positive outcomes and cost savings. While members are encouraged to use hospitals in the CCOE program, they will not incur additional out-of-pocket costs if they choose another network hospital for cardiac services.

The hospital selection process includes a comprehensive review of staff credentials, cardiac procedure volumes, frequency of medical complications and deaths associated with cardiac procedures, and the hospital's methods for monitoring and evaluating care, including continuous quality improvement efforts. Hospitals are subject to periodic re-evaluations as criteria change with advancements in medicine. Hospitals must reapply every two years to maintain their status as a cardiac center of excellence. In 2006, BCBSM designated 13 Michigan hospitals as cardiac centers of excellence.

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 published 10 additional guidelines in 2006-2007 on the following clinical topics:

- Routine prenatal and postnatal care
- Pediatric obesity
- Chronic kidney disease
- Pediatric preventive services
- Low back pain
- Attention deficit hyperactivity disorder
- Chronic obstructive pulmonary disorder
- Medical management post myocardial infarction
- Acute bronchitis
- Upper respiratory infection in pediatrics

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. The MH&SC is chaired by BCBSM and includes a number of key stakeholders committed to improving patient safety in all health care settings.

The coalition was named the State Commission on Patient Safety by Governor Jennifer Granholm. Three regional public hearings were held to receive testimony on patient safety concerns from health care stakeholders including physicians, hospitals, nurses, pharmacists and other health care professionals, health care organizations, professional associations, purchasers, health plans and consumers. A report containing 13 broad recommendations on how to improve patient safety in Michigan was presented to the Governor in November 2005 and released to the public in March 2006.

BCBSM states 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. As of December 31, 2007, 58% of eligible Michigan hospitals, urban and rural, participated in the Leapfrog survey. Results from the first year of the hospital survey indicated opportunity for improvement in ICU care. The MH&SC convened a collaborative to develop a hospital toolkit for implementing the ICU hospital guideline. This toolkit was shared in hardcopy and electronically with hospitals and ICU physicians and nurses.

Determination Report  
Order No. 09-019-BC

The MH&SC sponsors an annual educational conference on patient safety, which draws over 200 clinical and management professionals working in all settings of health care. The 2007 program addressed safety in hospital and outpatient settings.

BCBSM states, during the two year period under review, BCBSM maintained effective relations 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 members appointed by BCBSM and the Michigan Health and Hospital Association. 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 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.

Staff review of the minutes of these committees reveals that hospital providers have regular, routine communication with BCBSM and have significant influence 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 2006 and 2007, 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 2006 and 2007.

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 2006 and 2007 shall not exceed 5.0%.

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

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

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

Determination Report  
Order No. 09-019-BC

"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](http://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](http://research.stlouisfed.org/fred2/data/GNPC96.txt) and [research.stlouisfed.org/fred2/data/GNPDEF.txt](http://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

2006	3.2
2007	2.5

2 yr. average 2.9

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

% change in per capita GNP in constant dollars

2004	2.5
2005	2.2
2006	1.1
2007	2.1

4 yr. average 2.0

Using the latest population and economic statistics available, the cost goal for the period under review is estimated to be 5.0%, as shown below:

Inflation = 2.9

Real Economic Growth = 2.0

Determination Report  
 Order No. 09-019-BC

$$\frac{[(100 + 2.9) \times (100 + 2.0)]}{100} - 100 = 5.0\%$$

Section 517 of the Act requires BCBSM to transmit an annual report to the OFIR, 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) of the Act.

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 ambulatory surgery facilities provider class plan for the calendar years 2006 and 2007, as filed with the OFIR by BCBSM, are presented below. Cost data reflect claims incurred in the calendar year and paid through February 28th of the following year.

Section 517 of the Act requires BCBSM to transmit an annual report to the Division of Insurance, 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 2006 and 2007, as filed with OFIR by BCBSM, 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**

Hospital	2005	2006	2007	Average Yearly Rate of Change
Total Payments	\$708,524,619	\$510,956,936	\$433,278,189	
Total Members	520,269	311,385	214,627	
<b>Cost Performance</b>				
Payments/1000 Members	\$1,361,843	\$1,640,917	\$2,018,750	<b>21.8%</b>
Rate of Change (%)		20.5%	23.0%	<b>21.8%</b>

Determination Report  
 Order No. 09-019-BC

The two-year arithmetic average increase for the hospital provider class plan equals 21.8%. Overall hospital cost performance for BCBSM's traditional plan showed the trend in hospital payments per 1000 members increasing, while membership continued to decline as more and more customer groups opt for BCBSM's PPO plans which are not subject to the provider class plan review process as this time.

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.

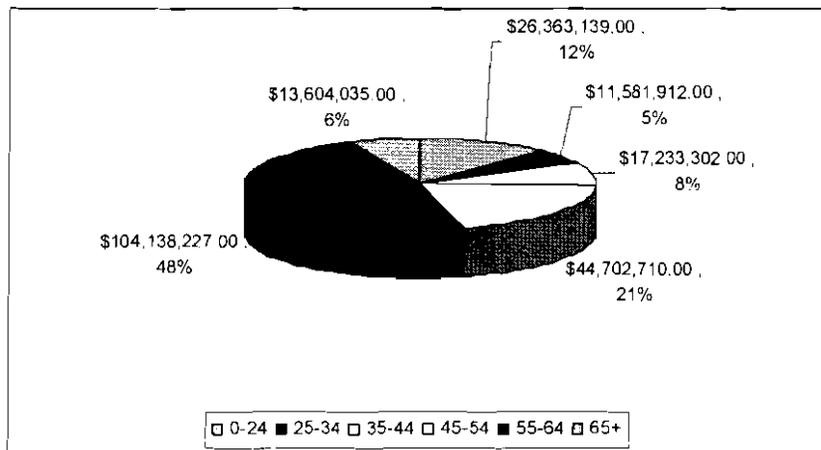
<b>Inpatient</b>			
	2005	2006	2007
<b>Payments</b>			
Total	\$350,911,094	\$247,635,267	\$217,634,171
Per 1,000 members	\$674,480	\$795,270	\$1,014,011
% of change		17.9%	27.5%
<b>Admissions</b>			
Total	36,683	24,089	20,692
Per 1,000 members	70.51	77.36	96.41
% change		9.7%	24.6%
<b>Payment/Admission</b>			
% of change	\$9,566.04	\$10,280.01	\$10,517.79
		7.5%	0.0%
<b>Members</b>			
	520,269	311,385	214,627
<b>Outpatient</b>			
	2005	2006	2007
<b>Payments</b>			
Total	\$357,613,525	\$263,321,669	\$215,644,018
Per 1,000 members	\$687,363	\$845,647	\$1,004,738
% of change		23.0%	18.8%
<b>Visit</b>			
Total	1,005,813	675,396	526,658
Per 1,000 members	1,933.26	2,169.01	2,453.83
% change		12.2%	13.1%
<b>Payment/Visit</b>			
% of change	\$355.55	\$389.88	\$409.46
		9.7%	0.5%
<b>Members</b>			
	520,269	311,385	214,627

Determination Report  
Order No. 09-019-BC

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

Hospital inpatient costs increased \$340,000 per 1,000 members, or an average of 22.7% during the two year period under review. The cost increase was the result of a significant rise in admissions that averaged 17.5%. As membership decreased and utilization increased during the reporting period, the percentage of patients using benefits increased from 6% in 2006 to 7.5% in 2007.

BCBSM states that members aged 55 years and older were responsible for 54% of the inpatient payout during 2007.



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 approaching Medicare eligibility, there is a general expectation that increased demands on the public health system and medical and social services will occur.

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 impact 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 and approaches Medicare eligibility. It is predicted that by 2025, nearly half of the population will have one or more chronic diseases.<sup>2</sup> Hypertension and arthritis are two of

<sup>2</sup>Chronic Conditions: Making the Case for Ongoing Care," Partnership for Solutions, September 2004 Update.

Determination Report  
Order No. 09-019-BC

the most typical chronic conditions requiring medical management. 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 hope they can minimize activity limitations and be more active in their later years.

Data from Trust for America's Health, a non-profit, non-partisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority, reveals that Michigan outranks most states in the percent of the adult population with chronic conditions such as:

- ❖ Obesity – Michigan ranked 10<sup>th</sup> in the nation, with an obesity rate of 28.2% compared to the national rate of 26.3% (2004-2007 average). An additional 36.1% of Michiganders are considered overweight, while only 35.7% are neither overweight nor obese. Obesity is considered a major risk factor for a number of chronic conditions including diabetes, hypertension, cardiovascular disease and cancer.
- ❖ Diabetes – Michigan ranked 13<sup>th</sup> in the nation, with an adult diabetes rate of 8.8% compared to the national rate of 8.0% (2004-2007 average).
- ❖ Hypertension – Michigan ranked 16<sup>th</sup> in the nation, with 28.6% of the population diagnosed with hypertension compared to the national rate of 27.8% (2003-2007 average).
- ❖ Cancer – Michigan ranked 8<sup>th</sup> in the nation in the estimated number of new cases of cancer in 2008.<sup>3</sup>

As shown in the table below, the circulatory, musculoskeletal, digestive and respiratory diagnostic categories accounted for 55% or \$445 million of BCBSM's total inpatient payments.

---

<sup>3</sup>"The State of Your Health: Michigan". healthyamericans.org (through 2007).

Determination Report  
Order No. 09-019-BC

Inpatient Care by Major Diagnostic Category (MDC)	Two Year Average Rate of Change				Three year			Average Pay/Day	Average Pay/Adm	Pct of Payout
	Per 1000 Members									
	Payments	Days	Adm	Pmt/Adm	Payments	Days/Service	Adm			
Circulatory systems	14.2%	8.4%	7.1%	6.7%	\$159,277,983	37,959	10,009	\$4,196	\$15,913	19.5%
Musculoskeletal	27.2%	17.2%	16.1%	9.5%	\$147,573,202	38,882	11,016	\$3,795	\$13,396	18.1%
Digestive System	29.5%	17.7%	15.3%	12.4%	\$72,333,666	35,841	7,693	\$2,018	\$9,403	8.9%
Respiratory System	22.7%	12.7%	8.4%	13.4%	\$66,191,534	31,544	6,759	\$2,098	\$9,793	8.1%
Pregnancy	-5.4%	4.1%	2.1%	-7.9%	\$45,269,571	27,081	10,587	\$1,672	\$4,276	5.5%
Nervous System	34.2%	20.0%	15.0%	16.7%	\$43,728,566	15,475	3,346	\$2,826	\$13,069	5.4%
Nutritional Disease	24.2%	16.1%	14.6%	8.6%	\$33,698,139	11,114	3,396	\$3,032	\$9,923	4.1%
Factors Influencing Health	26.3%	18.7%	12.2%	12.2%	\$31,433,306	19,736	2,917	\$1,593	\$10,776	3.9%
Female Reproductive System	14.7%	0.4%	4.1%	9.9%	\$30,877,552	10,371	4,351	\$2,977	\$7,097	3.8%
Hepatobiliary Sys/Pancreas	28.1%	17.8%	19.3%	7.3%	\$23,384,781	11,019	2,110	\$2,122	\$11,083	2.9%
Mental Disorders	31.2%	22.6%	22.5%	7.1%	\$23,384,181	27,771	4,687	\$842	\$4,989	2.9%
Kidney/Urinary Tract	24.4%	15.4%	14.7%	8.4%	\$22,727,783	9,356	2,488	\$2,429	\$9,135	2.8%
Neoplasms	22.5%	11.6%	7.6%	13.3%	\$21,439,507	7,879	830	\$2,721	\$25,831	2.6%
Newborns in Perinatal Period	30.9%	61.8%	386.7%	-35.8%	\$21,282,171	13,765	2,936	\$1,546	\$7,249	2.6%
Injury Poisoning	34.9%	24.3%	22.9%	9.3%	\$18,640,254	9,329	1,932	\$1,998	\$9,648	2.3%
Infectious Disease	49.1%	26.1%	26.3%	17.8%	\$18,013,188	9,666	1,329	\$1,864	\$13,554	2.2%
Skin/Subcutaneous Disease	22.1%	14.6%	13.0%	8.1%	\$12,332,013	7,288	1,965	\$1,692	\$6,276	1.5%
Disease of the Blood	28.6%	20.6%	19.3%	7.7%	\$7,723,372	3,954	899	\$1,953	\$8,591	0.9%
Male Reproductive System	31.0%	10.5%	12.6%	16.1%	\$6,929,193	1,692	779	\$2,095	\$8,895	0.8%
ENT Disease	16.6%	7.7%	9.0%	7.9%	\$6,678,289	2,695	966	\$2,478	\$6,913	0.8%
Burns	75.0%	32.0%	3.3%	68.4%	\$948,986	269	52	\$3,528	\$18,250	0.1%
Alcohol/Drug Abuse	52.0%	34.3%	37.3%	11.1%	\$928,716	1,017	242	\$913	\$3,939	0.1%
Diseases of the Eye	-20.2%	-18.8%	-2.8%	-16.4%	\$509,574	293	84	\$1,739	\$6,066	0.1%
Other	371.8%	348.8%	259.8%	27.5%	\$469,343	191	65	\$2,457	\$7,221	0.1%
HIV Infections	130.3%	142.0%	110.2%	10.3%	\$405,658	250	26	\$1,623	\$15,602	0.0%
Total	22.7%	16.4%	17.2%	4.9%	\$816,180,528	334,437	81,464	\$2,440	\$10,019	100.0%

Circulatory conditions accounted for 19.5% of the total inpatient payout, with this category experiencing an average payment per 1000 member increase of 14.2%. The increase was impacted almost equally between price and use which increased by 6.7% and 7.1%, respectively. Disorders of the circulatory system generally include any injury or disease that damages the heart, blood or blood vessels, such as peripheral artery disease, aneurysms, or renal disease. These types of disorders can result in a decreased flow of blood which can ultimately lead to heart attack, stroke or even gangrene. The American

Determination Report  
Order No. 09-019-BC

Heart Association reports that coronary heart disease is the single leading cause of death in America.<sup>4</sup>

Musculoskeletal conditions had the second highest payout at 18.1% of total inpatient patients. The number of admissions per 1000 members for this category increased an average of 16.1%, while price increased an average of 9.5%. BCBSM states that musculoskeletal conditions cost the United States economy more than \$215 billion a year. Approximately 33% of U.S. adults are affected by musculoskeletal signs or symptoms, including limitation of motion and joint and extremity pain that interfere with people's ability to function at work, home, and enjoy recreational activities. Given musculoskeletal disorders tend to be associated with aging, they are likely to become more prevalent as the population ages.<sup>5</sup>

Payments per 1000 for digestive conditions increased approximately 30% during 2007. Conditions for this population included diagnoses such as bowel procedures, gastrointestinal disorders, hernias and appendectomies. BCBSM states that although digestive disorders can affect people of any age, many digestive disorders occur more frequently in older individuals. In particular, older adults are more likely to develop diverticulosis and to experience digestive tract disorders (e.g. constipation) as a side effect of taking certain drugs.<sup>6</sup>

Respiratory conditions had an increased payment per 1000 of 22.7%. Conditions afflicting members during 2007 included respiratory failure, pneumonia, lung cancer and chronic obstructive pulmonary disease (COPD).

BCBSM states it is also meaningful to examine cost and use experience by diagnosis code. The table below shows the top 10 diagnostic related groups by payout.

Diagnostic Related Group	Two Year Average Rate of Change Per 1000 Members				Three year			Average Pay/Day	Average Pay/Adm	Pct of Payout
	Payments	Days	Adm	Pmt/Adm	Payments	Days/Service	Adm			
Major joint replacement	246.1%	232.7%	227.3%	8.2%	\$33,771,215	6,352	1,949	\$5,317	\$17,327	4.1%
ECMO/Trach 96+ hrs w/major OR	59.6%	35.6%	53.3%	4.4%	\$16,010,919	4,129	105	\$3,878	\$152,485	2.0%
Normal vaginal delivery	-16.7%	4.8%	1.8%	-17.9%	\$15,833,616	9,940	5,138	\$1,583	\$3,082	1.9%
Uterine & Adnexa Procedure	7.9%	-4.5%	-0.1%	8.0%	\$14,104,038	4,665	2,230	\$3,023	\$6,325	1.7%
Obesity surgical procedures	12.2%	-3.9%	7.6%	4.5%	\$13,813,320	2,459	1,029	\$5,617	\$13,424	1.7%
Cesarean section w/o comp	0.0%	5.5%	5.8%	-6.2%	\$13,366,960	7,005	2,244	\$1,908	\$5,957	1.6%
Percutaneous Cardio w/stent	207.7%	190.2%	209.0%	3.2%	\$12,685,684	1,251	910	\$10,140	\$13,940	1.6%
Rehabilitation	10.6%	6.0%	3.0%	7.9%	\$12,173,830	10,005	832	\$1,217	\$14,632	1.5%
Trach 96+ hrs w/o major OR	36.3%	1.2%	25.6%	10.7%	\$8,728,037	2,573	94	\$3,393	\$92,862	1.1%
Percutaneous Cardio w/med stent	222.4%	214.7%	208.5%	5.6%	\$8,091,602	1,171	421	\$6,910	\$19,220	1.0%
Top 10	47.0%	19.5%	21.1%	45.2%	\$148,580,221	49,550	14,952	\$4,300	\$9,937	18.2%
Top 50	36.8%	19.9%	26.6%	8.0%	\$336,195,390	117,853	31,036	\$2,853	\$10,832	41.0%
Grand Total	22.7%	16.4%	17.2%	4.9%	\$816,180,532	334,437	81,464	\$2,440	\$10,019	100.0%

<sup>4</sup>[www.americanheart.org/presenter.jhtml?identifier=4591](http://www.americanheart.org/presenter.jhtml?identifier=4591).

<sup>5</sup>[www.healthline.com/qalecontent/musculoskeletal-disorders](http://www.healthline.com/qalecontent/musculoskeletal-disorders).

<sup>6</sup>"Effects of Aging," [www.merck.com/mmhe/print/sec09/ch118/ch118j.html](http://www.merck.com/mmhe/print/sec09/ch118/ch118j.html).

BCBSM's top 10 diagnostic related groups accounted for \$149 million or 18.2% of total inpatient payout, and had an average increase in payments per 1000 members of 47%. Joint replacement, extracorporeal membrane oxygenation (ECMO) or tracheotomy, child birth and obesity conditions were among the top five DRGs by payout. These DRGs, as well as others included in the top 50 DRGs, reflect the circulatory, musculoskeletal, digestive and respiratory major diagnostic categories and served as drivers in BCBSM's increased hospital inpatient trend.

Limb and joint replacement accounted for the highest payout for inpatient cost with 4.1% of the total payments. The average payment per admission for this service was \$17,327. According to findings presented at the March 2006 annual meeting of the American Academy of Orthopedic Surgery, the number of knee replacements will likely increase by 673% and the number of hip replacements will likely increase by 174% by 2030.<sup>7</sup> As the baby boomer generation ages, many seek joint replacement surgeries to allow them to remain much more active than prior generations who tended to adapt their lifestyles to their aging frame. BCBSM states studies suggest that the demand for these surgeries may overwhelm supply. Another factor to consider is that as the number of joint replacement surgeries increase, so too will the need for rehabilitation services.

In intensive care medicine, extracorporeal membrane oxygenation (ECMO) is a technique providing both cardiac and respiratory support oxygen to patients whose heart and lungs are so severely damaged that they can no longer function properly. ECMO is basically a form of long-term heart-lung bypass used to treat infants, children, and adults in cardiac and/or respiratory failure despite maximal medical therapy. Respiratory failure can result from acute respiratory distress syndrome, pneumonia, congenital diaphragmatic hernia and asthma that do not respond to standard treatment protocols. During the two year period under review, ECMO was the second highest payout with an increase in payments per 1000 members of nearly 60%, predominately the result of an increase in use of 53%.

Operating room procedures for obesity ranked as the fifth highest payout by DRG and had an average payment per admission of \$13,424. This DRG specifically relates to bariatric surgery - a surgical procedure for obese patients in their effort to achieve extreme weight loss. There is no question that obesity is a major risk factor for a variety of chronic conditions including diabetes, hypertension, cardiovascular disease, arthritis and cancer. BCBSM states that the Michigan Department of Community Health has conservatively estimated the direct cost of medical care for obesity at \$58 million per year.

BCBSM states the total three year payout for outpatient hospital care was \$837 million during the two year period under review. The two year average outpatient increase in payments per 1000 members was 20.9%, the result of a 12.7% rise in utilization and a

<sup>7</sup> "Joint Replacements Among Baby Boomers Likely to Increase". National Center for Policy Analysis. [www.ncpa.org/sub/dpd/index.php?/Article\\_Category=16](http://www.ncpa.org/sub/dpd/index.php?/Article_Category=16).

Determination Report  
 Order No. 09-019-BC

7.3% increase 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 70 to 78% in 2006 and 2007, respectively.

The table below shows that surgery, laboratory/pathology and diagnostic radiology accounted for 70% 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.

2005-2007 Outpatient Payments by Type of Service

Type of Service	Per 1000 Members			Three year	Pct of
	Payments	Services	Pay/Serv	Payments	Payout
Surgery	19.4%	12.2%	6.4%	\$260,219,372	31.1%
Laboratory/Pathology	18.6%	13.1%	4.8%	\$163,993,462	19.6%
Diagnostic X-ray	25.6%	15.3%	9.1%	\$155,872,058	18.6%
Outpat Med Emergency, Non-Acc	19.2%	10.8%	7.6%	\$97,853,359	11.7%
Chemotherapy	32.4%	21.9%	8.0%	\$39,718,792	4.7%
Physical Therapy	16.7%	10.8%	5.2%	\$42,568,375	5.1%
Outpat Med Emergency, Accident	14.1%	6.1%	7.5%	\$28,292,587	3.4%
Therapeutic X-ray	42.5%	29.6%	23.6%	\$25,730,475	3.1%
Maternity	3.6%	0.5%	-1.3%	\$11,836,025	1.4%
All Others	23.1%	4.6%	17.2%	\$10,494,706	1.3%
Grand Total	20.9%	12.7%	7.3%	\$836,579,211	100.0%

BCBSM's review of the surgical and diagnostic radiology types of service has led to the realization the traditional hospital membership is an older, potentially less healthy population. The outpatient diagnoses for this population included cancer diagnoses and screenings, circulatory conditions including chest pain, hypertension, atrial fibrillation and coronary atherosclerosis and musculoskeletal conditions such as joint pain, arthritis, knee and shoulder problems and lumbago. BCBSM states these conditions were recurring themes throughout analysis of the hospital cost section from the broadly defined type of service categories to the detailed diagnostic code descriptions.

Determination Report  
Order No. 09-019-BC

2005-2007 Outpatient Hospital Payments by MDC

Outpatient Care Major Diagnostic Category (MDC)	Two Year Average Rate of Change			Three year		Average	Percentage of Total	
	Per 1000 Members			Payments	Visits	Pay/Visit	Payout	Visits
	Payments	Visits	Pmt/Visit					
Musculoskeletal	17.5%	11.4%	5.5%	\$160,720,850	428,294	\$375	19.5%	14.0%
Digestive System	17.5%	11.9%	5.0%	\$96,836,613	283,890	\$341	18.1%	9.3%
Factors Influencing Health	25.8%	14.6%	9.8%	\$87,537,229	522,023	\$168	8.9%	17.0%
Respiratory System	15.1%	9.4%	5.3%	\$65,213,180	183,540	\$355	8.1%	6.0%
Circulatory System	19.9%	16.0%	3.4%	\$65,124,066	203,361	\$320	5.5%	6.6%
Skin/Subcutaneous Disease	28.3%	13.3%	13.3%	\$61,562,519	201,723	\$305	5.4%	6.6%
Kidney/Urinary Tract	20.4%	13.8%	5.9%	\$43,821,976	176,146	\$249	4.1%	5.7%
ENT Disease	14.1%	5.9%	7.8%	\$37,766,902	144,979	\$260	3.9%	4.7%
Nutritional Disease	23.5%	14.0%	8.3%	\$34,461,566	343,402	\$100	3.8%	11.2%
Female Reproductive System	19.3%	8.7%	9.8%	\$32,882,429	106,092	\$310	2.9%	3.5%
Nervous System	19.0%	11.5%	6.8%	\$31,429,751	67,518	\$466	2.9%	2.2%
Neoplasms	24.3%	17.5%	5.9%	\$29,384,672	65,686	\$447	2.8%	2.1%
Hepatobiliary Sys/Pancreas	21.4%	14.3%	6.2%	\$18,813,600	46,398	\$405	2.6%	1.5%
Diseases of the Eye	21.4%	10.0%	10.3%	\$15,667,233	28,988	\$540	2.6%	0.9%
Disease of the Blood	40.8%	12.4%	25.2%	\$14,958,666	99,880	\$150	2.3%	3.3%
Male Reproductive System	34.6%	14.6%	17.3%	\$12,730,573	33,077	\$385	2.2%	1.1%
Pregnancy	3.6%	2.4%	1.2%	\$7,722,287	36,687	\$210	1.5%	1.2%
Injury Poisoning	22.4%	10.2%	11.1%	\$6,765,124	22,945	\$295	0.9%	0.7%
Infectious Disease	10.4%	4.2%	6.1%	\$3,733,403	31,703	\$118	0.8%	1.0%
Mental Disorders	31.0%	15.5%	13.3%	\$3,485,611	21,102	\$165	0.8%	0.7%
Alcohol/Drug Abuse	48.8%	18.4%	23.9%	\$1,027,944	4,913	\$209	0.1%	0.2%
Newborns in Perinatal Period	73.6%	7.8%	63.3%	\$410,145	3,351	\$122	0.1%	0.1%
Burns	8.8%	8.5%	0.3%	\$409,114	1,660	\$246	0.1%	0.1%
HIV Infections	74.8%	29.9%	34.3%	\$313,851	1,791	\$175	0.1%	0.0%
Other	25.7%	5.8%	18.7%	\$684,565	1,851	\$370	0.0%	0.1%
Unknown	590.6%	338.6%	31.9%	\$3,115,343	5,635	\$553	0.4%	0.2%
Total	20.9%	12.7%	4.9%	\$836,579,212	3,066,635	\$273	100.0%	100.0%

The above table shows the distribution of hospital outpatient costs, utilization and price by major diagnostic category. Most of these categories had an average payment increase over 10%. Musculoskeletal and digestive disorders accounted for 19.2% and 11.6% of total payout, respectively. Musculoskeletal conditions include back pain, joint pain, arthritic disorders and sprains and tears which are all conditions associated with physical activity. As the population becomes more active and/or ages (e.g. baby boomers), the risk associated with physical activity will increase. Digestive disorders include abdominal pain, hernia and colon disorders and cancer. These conditions typically are impacted by a member's diet, weight, level of stress as well as lifestyle choices.

Determination Report  
Order No. 09-019-BC

The payout for musculoskeletal services was approximately \$160 million, and had an average increase in payments per 1000 members of 17.5%, the result of an 11.4% increase in use and 5.5% increase in price. The utilization increases was a significant factor in both 2006 and 2007. Digestive disorders ranked second in terms of total payout and had an average increase in payments per 1000 members of 17.5% primarily due to increased utilization.

The top 50 diagnoses for outpatient hospital services are illustrated in Exhibit 1. The top 50 diagnoses represent about \$277 million or 33.1% of total outpatient payments. The highest ranking by payout was for chest pain, a circulatory condition. The average payment increase per 1000 members for this service was 9% due to an average increase in utilization of 4.8% and a rise in price of 4.2%. Circulatory disorders include conditions such as chest pain, coronary atherosclerosis, atrial fibrillation and hypertension.

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<sup>®</sup>. BlueHealthConnection<sup>®</sup> 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<sup>®</sup> 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<sup>®</sup> nurses also advocate for the appropriate care setting for recommended services.

BCBSM states its BCBSM BlueHealthConnection<sup>®</sup> Guided Self-Management Satisfaction Survey is an annual survey used to measure users' overall satisfaction with BlueHealthConnection<sup>®</sup>. In 2007, overall satisfaction with BlueHealthConnection<sup>®</sup> remained high with a 90% satisfaction rate. The program achieved similar satisfaction rates in 2005 and 2006. Recommendations from the 2007 survey were very positive with an emphasis on:

- Continuing to promote and expand the BlueHealthConnection<sup>®</sup> offerings.
- Expansion of the information available through BlueHealthConnection<sup>®</sup>.

Determination Report  
Order No. 09-019-BC

- Continuing to increase the amount of information available online (versus printed material).

BCBSM believes with BlueHealthConnection<sup>®</sup>, 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. BCBSM estimates its BlueHealthConnection<sup>®</sup> savings for fourth quarter 2006 through third quarter 2007 amounted to \$36.6 million.

Member awareness of BlueHealthConnection<sup>®</sup> is promoted through online tools on the BCBSM website as well as materials that can be displayed and distributed to members by their employers. In addition, BCBSM also has a targeted outreach program that uses claims data to identify members who are at risk for specific medical conditions. Lastly, providers are informed about BlueHealthConnection<sup>®</sup> resources available to their BCBSM patients through articles published in the *Record*.

BCBSM states it has as 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 also ensure that sound medical criteria are met before BCBSM authorizes payment for procedures, hospitalizations and certain high-cost drugs. BCBSM has updated its pre-certification and pre-notification programs to make them less cumbersome for providers to use and more seamless to its members. The pre-certification program reviews hospital admissions, while pre-notification identifies potential case management referrals. Case management is a collaborative process that coordinates and evaluates options and services to meet a member's health needs through communication and available resources to promote quality, cost-effective outcomes. Radiology management controls the costs of diagnostic imaging, nuclear medicine and cardiology procedures by requiring prior authorization when these tests are performed on an outpatient basis. Utilization review conducts post-care audits to assure appropriate billing practices among providers and recovers payments that cannot be supported by medical record documentation. These programs remain effective in managing inpatient admissions, the most costly form of care.

BCBSM states its efforts in other programs also contribute to managing utilization. An example is BCBSM medical policy decisions about which procedures to cover. BCBSM continually reviews and evaluates new health services to determine which technologies are

safe, effective and value added. Medical necessity guidelines are established based on quality considerations and using evidence based literature and clinical research.

BCBSM also states its quality management programs, many of which are discussed in the Quality Management Initiatives 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 certain health care settings.

BCBSM also participates in the Michigan Health Information Network (MHIN), an initiative of Governor Jennifer Granholm. The goal of MHIN is for medical records to move electronically with patients statewide, not only improving quality of care, but also reducing costs. BCBSM states many functions of the health care system can be made more efficient by harnessing the power of technology.

The characteristics of the population can significantly affect the consumption of health care resources. Without question, the aging population has a high correlation to health care utilization rates. BCBSM states during the two year period under review, membership in its traditional program decreased by 58.7%, or approximately 306,000 members. Even though membership declined, the ratio of patients to membership increased from 5.6% in 2005 to 7.5% in 2007 for inpatient services and 63.7% in 2005 to 78.1% in 2007 for inpatient care. Reasons behind the declining membership include traditional members moving to managed care products that are not currently subject to the provider class plan review process, members losing health care benefits through their employers, work force reductions, aggressive competitor pricing and a declining economy.

BCBSM's traditional membership declined in each age category with the greatest decrease in the age category of 50 and over. BCBSM states while this age group had the most significant decrease in membership, it accounted for more than 50% of the total payout for the hospital provider class. Further, the age group of 50-64 represents 40% of the 2007 traditional hospital membership, while accounting for 26% of the Michigan population.

#### Findings and Conclusions - Cost

Based on the cost information analyzed during this review, it is determined that BCBSM did not meet the cost goal stated in the Act for the hospital provider class during the two year period under review.

BCBSM has implemented a pay for performance incentive program for hospitals to reward hospitals for performance on quality and efficiency measures. BCBSM also has made a variety of programs available in an effort to control hospital costs as well as overall costs during the two year period under review, including its BlueHealthConnection<sup>®</sup> case management program and Cardiac Centers of Excellence programs. It also is involved in initiatives such as the Michigan Quality Improvement Consortium and Michigan Health and

Determination Report  
Order No. 09-019-BC

Safety Coalition in an effort to develop evidence based practice guidelines for the treatment of specific costly health conditions and to promote patient safety in all health care settings.

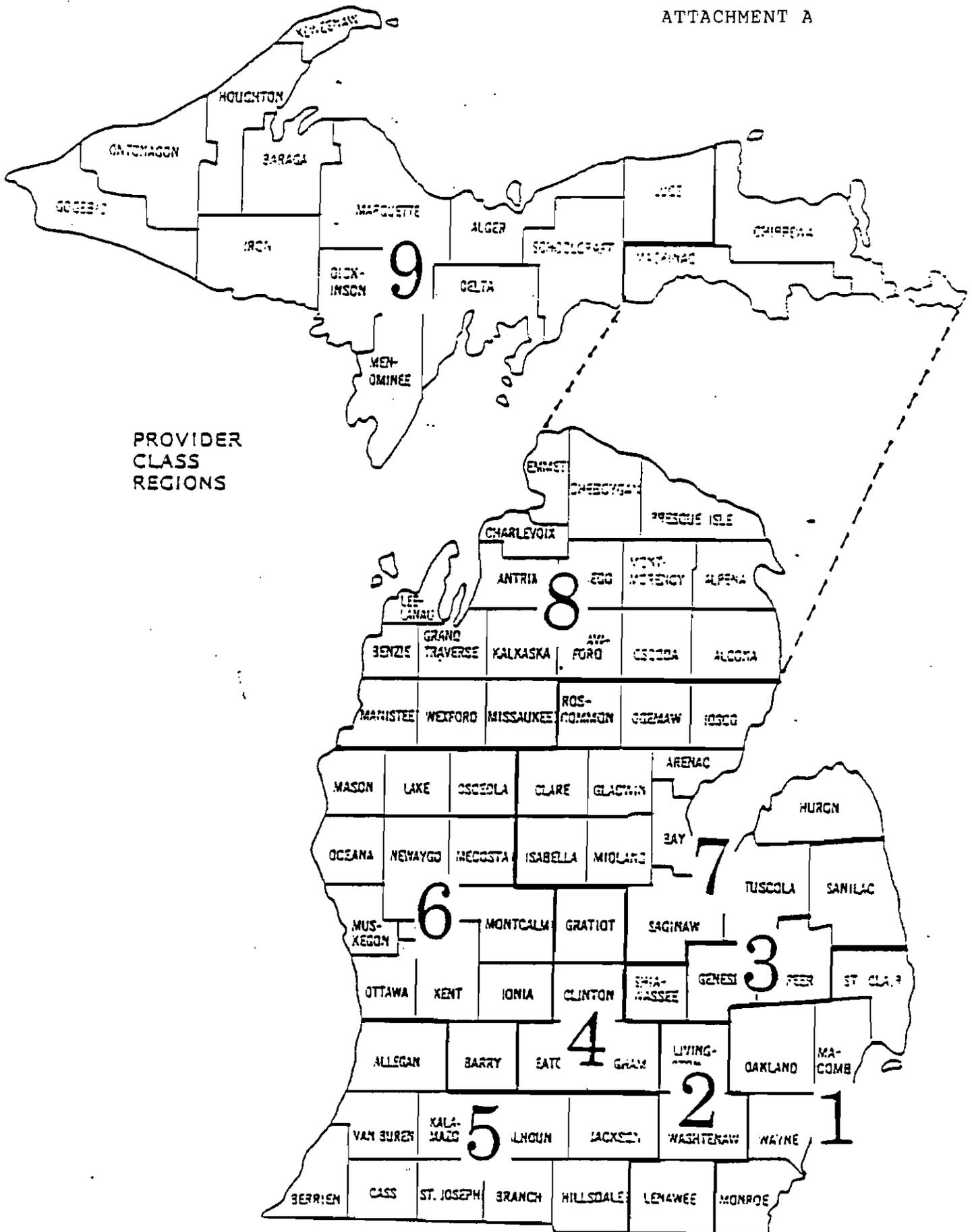
BCBSM's efforts are many, yet there are other factors that impact BCBSM's ability to contain costs within the constraints of the cost goal specified in the Act. The most prominent factors include an aging population, particularly the baby boomer generation, and the overall health status of Michigan residents. Many Michigan residents have one or more chronic conditions. Michiganders are also living longer because of the development of cutting-edge technologies in medical diagnosis and treatment and the significant advances made in prescription drug therapy used to treat chronic conditions. Thus, as people with chronic conditions tend to have greater health care needs and are the most frequent users of health care services (regardless of age); the costs associated with these needs are disproportionately high.

As noted above, Michigan ranks poorly on many measures of lifestyle factors and health status related to the development of chronic conditions, including obesity, diabetes, hypertension and cancer. Growing rates in these areas will continue to fuel increased use of health care services and will continue to be a major driver of higher health care spending.

Because of this, it is not necessary to require that a change to the current hospital provider class plan be filed pursuant to Section 511 of the Act. BCBSM is encouraged to continue to work closely with hospital providers, as well as all provider class plan groups, to find new, innovative programs and evidence based practice guidelines that instill responsible cost controls so that all the goals and objectives of the corporation can be achieved.

Determination Summary

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



PROVIDER CLASS REGIONS

## APPEAL PROCESS

### I. Appeals of Reimbursement Policies

#### A. General Requirements

BCBSM shall establish and communicate to Hospital a procedure by which Hospital may obtain a timely BCBSM decision of the interpretation and application of Reimbursement Policies as applied to Hospital's specific circumstances. Prior to taking any other action, Hospital shall submit any dispute concerning the proper interpretation and application of Reimbursement Policies as applied to Hospital's specific circumstances to BCBSM for its decision.

At the conclusion of each point in the appeal process, BCBSM will forward the findings to the Hospital. At the conclusion of the appeal or at any point in the appeal process, if the Hospital agrees with or chooses not to dispute the findings, the appropriate adjustments will be finalized.

If the Hospital disagrees with BCBSM's decision rendered during the appeal process and wishes to have a specific adjustment reviewed at a higher level, the Hospital may do so by submitting a request in writing within the time frame specified for each review level in this exhibit. The request must include the following:

- Area of dispute
- Reason for disagreement
- Dollar value of appeal
- Additional documentation specific to the area of dispute and an explanation of its relevance. Hospital must make a good faith effort to submit all such documentation with its appeal
- Fiscal years covered

#### B. Hospital Applications

If Hospital fails to meet any of the designated time frames, its appeal will be denied. If BCBSM fails to meet any of the designated time frames, Hospital may petition BCBSM in writing for an immediate decision. If BCBSM does not render a decision on all issues involved in Hospital's appeal within ten (10) days of receiving Hospital's petition, the appeal will be decided in favor of Hospital with respect to all issues not expressed in BCBSM's opinion, if any. Hospital must enter the process at the BCBSM Management Review level and must proceed through each level of the process.

Following is the appeals process:

1. BCBSM Management Review. If the Hospital disagrees with BCBSM's decision, the Hospital may request Management Review. The written request for the Management Review along with the required documentation listed above must be submitted within ninety (90) days of receipt of BCBSM's notification with respect to the determination under appeal. BCBSM will conduct the Management Review meeting and provide a written response to the Hospital. BCBSM will acknowledge receipt of the appeal within fourteen (14) days and will render a management decision within one hundred twenty (120) days of receipt of appeal.

2. Internal Review Committee (IRC). If Hospital disagrees with the final Management Review decision, Hospital may request review by the IRC within thirty (30) days of receipt of the Management Review decision. The request for review should be submitted in writing, by certified mail, to the Director of Provider Contracting. The IRC will schedule a hearing that shall occur within one hundred twenty (120) days of receipt of the request for IRC review and will notify Hospital of its decision within thirty (30) days after the hearing.
3. Provider Relations Committee. If Hospital disagrees with the decision of the IRC, it may request review by the Provider Relations Committee (PRC) of the BCBSM board of directors. Hospital must submit its request in writing, by certified mail for PRC review within thirty (30) days of receipt of the IRC decision letter. BCBSM will schedule a hearing before the PRC which shall occur within one hundred eighty (180) days of receipt of Hospital's request for PRC review. The PRC will issue its decision within thirty (30) days after the PRC meets to consider the appeal.

## II. Appeals of BCBSM Adverse Determinations

Hospital has the following appeal rights with respect to Prospective, Concurrent and Retrospective Reviews.

### A. Prospective or Concurrent Reviews

BCBSM will provide an expedited appeal process for review of adverse determinations on imminent or ongoing services. If Hospital disagrees with an adverse determination on prospective or concurrent review, Hospital may request internal appeal. The Hospital must submit a written request to BCBSM within thirty (30) days of discharge. The request must include the following:

- Patient's name
- Contract number
- Dates of service
- Complete medical record
- Any additional supporting information

BCBSM will decide the appeal and report its decision to Hospital within thirty (30) days of receipt of Hospital's written request for appeal. If Hospital continues to disagree with BCBSM's determination, it may request an External Review as provided in Section C.

### B. Retrospective Reviews

After the audit is complete, BBSM will notify Hospital of the audit determination in a reporting letter sent via certified mail. Hospital will have fifty (50) calendar days from receipt of the letter in which to submit a written request for internal review if it does not agree with the BCBSM determination. Hospital must submit written rationale and all supporting documentation explaining the basis for its disagreement with its request for Internal Review. The name of the attending physician must be included with the request.

Hospital's request for Internal Review, along with written rationale and all supporting documentation, must be postmarked no later than fifty (50) calendar days from its receipt of the reporting letter. BCBSM's decision will be maintained if Hospital does not submit its request, written rationale and all supporting documentation within this time frame.

BCBSM will notify Hospital of the Internal Review decision by letter postmarked no later than fifty (50) calendar days following its receipt of Hospital's request for Internal Review. Hospital's appeal will be granted if BCBSM does not respond within this time frame.

C. External Appeal

If the Hospital continues to disagree with BCBSM's determination under A. or B., the Hospital may request an External Appeal. BCBSM has no appeal rights and is bound by the decision if a Hospital chooses not to appeal.

Hospital must submit its written request for External Review within twenty (20) calendar days of receipt of BCBSM's decision. The request must include:

- Patient's name
- Contract number
- Dates of service

Neither party may submit to the external review agency any information or arguments not previously submitted to the other.

BCBSM will report the decision of the external peer review agency to Hospital within forty-five (45) days of receipt of Hospital's written request for appeal. The decision of the external peer review agency is final.

External appeals in cases involving Medical Necessity, site of care or quality of care will be reviewed by a peer review organization composed of practicing physicians. Cases involving DRG coding disagreement will be sent to an independent coding expert for a determination. (Disputes involving benefit determination are not appealable externally.)

In all cases in which the peer review agency upholds BCBSM's decision, Hospital will pay the cost of the appeal.

**APPENDIX 1**

**BCBSM Hospital Audit Activities  
2006 – 2007**

<b>Audit Activity</b>	<b>2006</b>	<b>2007</b>
DRG Validation		
Number of Hospitals	94	99
Cases Reviewed	19,369	19,568
Identified Savings	\$13,643,715	\$14,168,760
Cases Appealed	2,050	2,025
Recoveries to date	\$11,429,616	\$11,121,578
Catastrophic Claims		
Cases Audited	2,038	1,951
Identified Savings	\$4,416,502	\$5,417,733
Cases Appealed	656	693
Finalized Savings	\$3,524,478	\$3,861,617
Readmission Audits		
Number of Audits	59	67
Identified Savings	\$2,647,943	\$5,679,593
Cases Appealed	48	57
Finalized Savings	\$3,287,670	\$4,160,430
Focus Compliance Audits		
Number of Hospitals	29	Discontinued
Cases Reviewed	1,724	
Identified Savings	\$1,656,136	
Cases Appealed	34	
Peer Group 5		
Number of Hospitals	4	32
Cases Reviewed	58	863
Identified Savings	\$1,656,134	\$279,961
Cases Appealed	34	291
Transfer Audits		
Number of Hospitals	53	69
Cases Reviewed	143	155
Savings	\$661,798	\$504,805
Hospital Outpatient Audits		
Number of Audits	97	44
Identified Savings	\$9,341,978	\$1,914,028
Recoveries	\$4,271,470	\$8,226
Number of Appeals	67	49

APPENDIX 2  
Hospital Provider Class  
2005-2007 Outpatient Payments by Top 50 Diagnoses

Outpatient Hospital by Top 50 Diagnoses	Two year average rate of change Per 1000 Members			2005-2007	2005-2007	Avg	% of Total Payout
	Payments	Visits	Pmt/Vst	Payments	Visits	Pmt/Vst	
Chest Pain Nos	9.0%	4.8%	4.2%	\$ 17,810,974	20,273	\$ 879	2.1%
Malign Neopl Breast Nos	39.7%	19.1%	17.0%	\$ 16,665,016	19,371	\$ 860	2.0%
Chest Pain Nec	14.5%	8.9%	5.1%	\$ 13,108,179	8,458	\$ 1,550	1.6%
Crrry Athrsci Natve Vssl	26.6%	12.7%	12.6%	\$ 11,070,479	6,986	\$ 1,585	1.3%
Screen Mammogram Nec	32.5%	14.0%	16.2%	\$ 9,818,706	100,008	\$ 98	1.2%
Antineoplastic Chemo Enc	478.7%	387.9%	6.2%	\$ 9,418,421	2,945	\$ 3,197	1.1%
Lumbago	19.2%	9.6%	8.8%	\$ 9,022,278	17,032	\$ 530	1.1%
Malign Neopl Prostate	40.0%	18.3%	19.2%	\$ 8,835,722	9,510	\$ 929	1.1%
Benign Neoplasm Lg Bowel	16.5%	10.3%	5.7%	\$ 7,998,535	10,437	\$ 766	1.0%
Abdmnal Pain Unspcf Site	23.1%	15.1%	6.9%	\$ 7,956,146	22,558	\$ 353	1.0%
Headache	19.5%	10.4%	8.3%	\$ 7,176,059	11,909	\$ 603	0.9%
Calculus Of Kidney	20.4%	15.9%	3.9%	\$ 6,999,952	9,898	\$ 707	0.8%
Calculus Of Ureter	12.2%	6.4%	5.5%	\$ 6,475,272	4,161	\$ 1,556	0.8%
Hypertension Nos	19.5%	13.0%	5.9%	\$ 6,000,728	42,834	\$ 140	0.7%
Hyperlipidemia Nec/Nos	14.1%	8.0%	5.6%	\$ 5,877,932	77,996	\$ 75	0.7%
Oth Lymph Unsp Xtrndi Org	15.0%	8.5%	6.5%	\$ 5,734,930	5,290	\$ 1,084	0.7%
Cholelith W Cholecys Nec	19.9%	12.4%	7.1%	\$ 5,560,910	1,571	\$ 3,540	0.7%
Screen Malig Neop-Colon	45.3%	34.4%	8.2%	\$ 5,391,181	9,442	\$ 571	0.6%
Mal Neo Bronch/Lung Nos	14.3%	10.8%	3.4%	\$ 4,900,759	5,386	\$ 910	0.6%
Regional Enteritis Nos	25.2%	11.2%	12.9%	\$ 4,552,966	4,062	\$ 1,121	0.5%
Joint Pain-L/Leg	23.6%	13.5%	8.9%	\$ 4,363,729	11,626	\$ 375	0.5%
Dmii Wo Cmp Nt St Unentr	25.2%	20.6%	3.8%	\$ 4,293,914	49,059	\$ 88	0.5%
Cervicalgia	24.4%	15.7%	7.5%	\$ 4,235,291	7,922	\$ 535	0.5%
Tear Med Menisc Kneec-Cur	19.7%	6.4%	12.4%	\$ 3,981,574	2,843	\$ 1,400	0.5%
Rheumatoid Arthritis	28.3%	17.3%	9.2%	\$ 3,947,912	8,544	\$ 462	0.5%
Atrial Fibrillation	96.5%	29.3%	51.8%	\$ 3,945,098	20,965	\$ 188	0.5%
Excessive Menstruation	15.6%	11.5%	3.4%	\$ 3,943,453	4,630	\$ 852	0.5%
Pain In Limb	20.8%	12.3%	7.4%	\$ 3,898,385	14,192	\$ 275	0.5%
Dizziness And Giddiness	24.0%	10.2%	12.3%	\$ 3,896,215	6,813	\$ 572	0.5%
Unilat Inguinal Hernia	7.6%	2.5%	4.8%	\$ 3,871,562	2,030	\$ 1,907	0.5%
Rotator Cuff Synd Nos	11.4%	4.0%	7.1%	\$ 3,854,053	2,656	\$ 1,451	0.5%
Abdmnal Pain Oth Spcf St	15.2%	8.9%	5.9%	\$ 3,809,934	5,446	\$ 700	0.5%
Syncope And Collapse	25.2%	11.6%	12.2%	\$ 3,776,474	5,102	\$ 740	0.5%
Anemia Nos	29.8%	11.8%	16.1%	\$ 3,736,451	25,718	\$ 145	0.4%
Joint Pain-Shlder	28.0%	15.7%	10.7%	\$ 3,645,836	8,142	\$ 448	0.4%
Malignant Neo Colon Nos	7.7%	20.6%	-10.8%	\$ 3,552,881	3,311	\$ 1,073	0.4%
Dvrtclo Colon W/O Hmrhg	12.3%	5.1%	7.0%	\$ 3,451,104	5,195	\$ 664	0.4%
Respiratory Abnorm Nec	18.2%	9.6%	7.5%	\$ 3,413,584	5,613	\$ 608	0.4%
Malign Neopl Ovary	63.4%	37.0%	16.8%	\$ 3,361,281	4,580	\$ 734	0.4%
Screen Mal Neop-Cervix	27.8%	14.4%	11.5%	\$ 3,329,889	70,660	\$ 47	0.4%
Sprain Rotator Cuff	32.3%	14.5%	15.3%	\$ 3,326,757	2,465	\$ 1,350	0.4%
Malaise And Fatigue Nec	18.2%	12.1%	5.4%	\$ 3,247,773	23,571	\$ 138	0.4%
Malign Neopl Breast Nec	63.3%	25.0%	29.7%	\$ 3,187,001	4,532	\$ 703	0.4%
Other Lung Disease Nec	34.8%	21.6%	10.7%	\$ 3,076,417	4,893	\$ 629	0.4%
Urin Tract Infection Nos	21.5%	14.8%	6.0%	\$ 3,027,231	34,408	\$ 88	0.4%
Mal Neo Breast Up-Outer	28.0%	18.6%	20.6%	\$ 2,955,532	1,643	\$ 1,799	0.4%
Obstructive Sleep Apnea	294.1%	298.6%	-0.7%	\$ 2,940,936	2,601	\$ 1,131	0.4%
Mult Myelm W/O Remission	34.3%	32.8%	0.9%	\$ 2,812,511	3,131	\$ 898	0.3%
End Stage Renal Disease	317.0%	247.7%	25.1%	\$ 2,753,976	941	\$ 2,927	0.3%
Cataract Nos	33.8%	24.4%	7.5%	\$ 2,677,495	1,328	\$ 2,016	0.3%
Top 50 Total	28.8%	14.8%	12.2%	\$ 276,687,392	734,687	\$ 377	33.1%
<b>GRAND TOTAL</b>	<b>20.9%</b>	<b>12.7%</b>	<b>7.3%</b>	<b>\$ 836,579,212</b>	<b>2,207,867</b>	<b>\$ 379</b>	<b>100.0%</b>