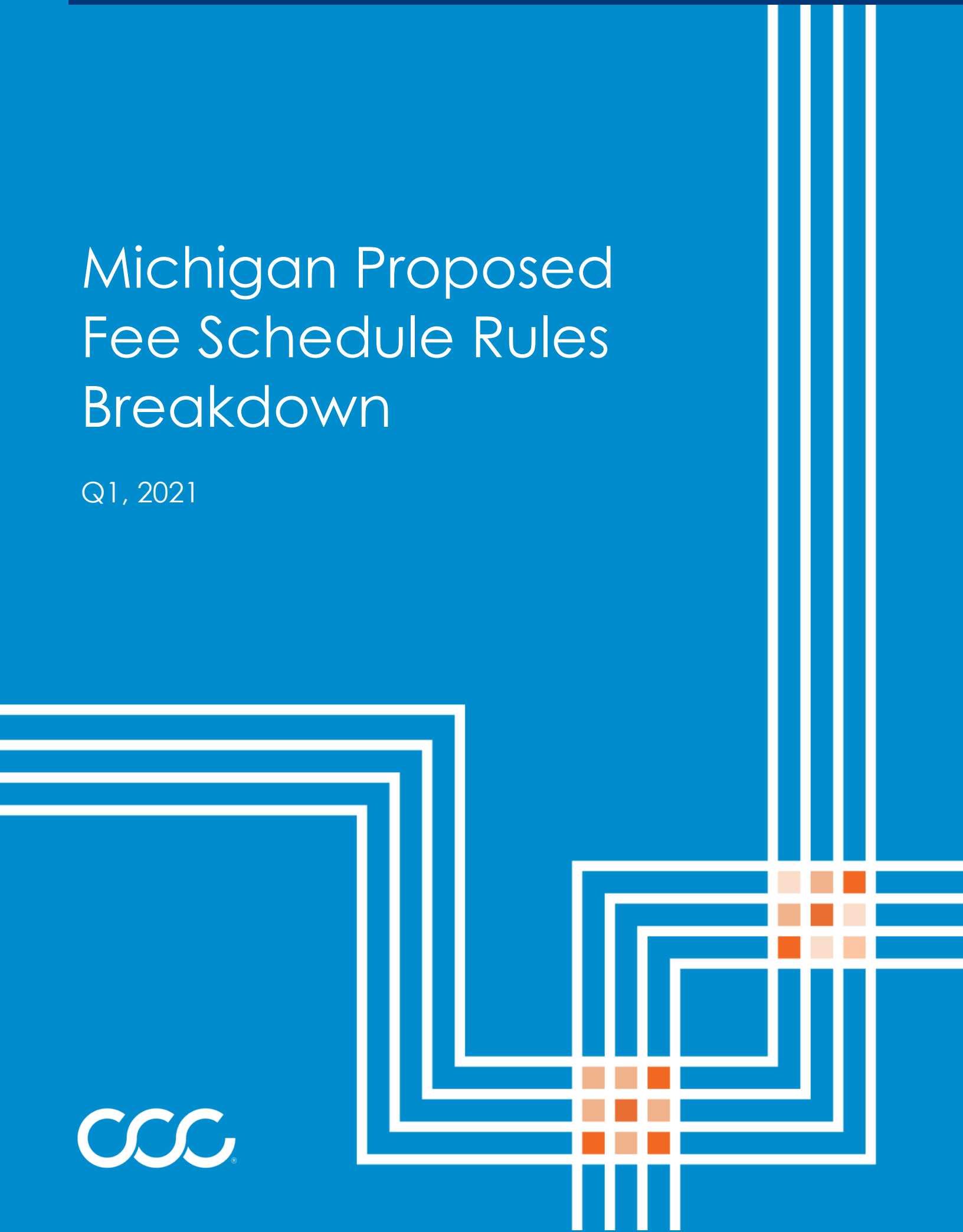
Michigan Proposed Fee Schedule Rules Breakdown

Q1, 2021



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EXECUTIVE **SUMMARY**[1]

The Michigan Department of Financial Services has proposed new administrative rules to implement the medical fee schedules contained in Michigan's automobile no-fault statute.[2] The proposed rules address certain issues arising under the fee schedule, including:

- The Medicare fee schedules applicable to reimbursements
- Providers that are eligible for enhanced reimbursement amounts
- Use of charge description masters, providers' average charged amounts and regional averages
- Procedures for DIFS to collect information on provider charges, and
- Facility accreditation procedures

Insurers will note that Michigan's proposed rules are neither as broad nor detailed as administrative rules promulgated by other fee schedule states, such as New York, New Jersey and Florida.

The Michigan fee schedule goes into effect on July 2, 2021 and will apply to charges for treatment and training rendered on or after that date. DIFS has stated that the fee schedule provisions will apply to both "new and existing claims" where treatment is rendered on or after July 2, 2021.

The proposed rules are subject to DIFS' full rulemaking process, including a public comment period. DIFS has scheduled a public hearing on the proposed rules for Friday, March 26, 2021 at 9:00 a.m.

CCC Casualty is closely monitoring developments regarding the Michigan fee schedules, the proposed rules and DIFS' rulemaking process. As we obtain more information, we will share with the Markets. We will continue to actively collaborate with customers to ensure timely and correct implementation of the fee schedules and DIFS' administrative rules.

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[1] This document provides an overview of the issues discussed herein. It is neither comprehensive nor exhaustive, and the reader is advised to consult the specific regulatory and statutory provisions at issue, as well as applicable guidance issued by the Michigan Department of Insurance and Financial Services, when evaluating, analyzing or implementing any statutory and/or regulatory changes. This document is for information purposes only and is not intended to provide, nor should it be deemed to constitute, legal advice.

[2] The statutory fee schedule provisions are set forth in section 3157 of the no-fault statute. M.C.L.A. 500.3157. The proposed rules issued by DIFS are set forth in Rules 500.201 through 500.206.

INTENT OF THE **PROPOSED RULES**

The Regulatory Impact Statement and Cost-Benefit Analysis (RIS) accompanying the proposed rules states as follows:

"The proposed rules are intended to ensure greater consistency in provider reimbursements for services rendered or supplies provided to people injured in motor vehicle accidents. The proposed rules may also result in fewer disputes between providers and insurers because DIFS will issue orders that resolve provider appeals based upon the implementation of the fee schedules contained in the proposed rules."

The RIS further states:

"The proposed rules help implement MCL 500.3157, which was intended to contain costs pertaining to no-fault benefits. Toward that end, the processes established by the proposed rules are intended to allow for consistency in reimbursement for no-fault benefits without unnecessarily burdening healthcare providers or automobile insurers."

In discussing the impact of the rules on affected stakeholders, the RIS states:

"Individual health care providers providing health or medical care to those injured in motor vehicle accidents will be most affected by the rules. DIFS does not collect specific data on how many individual health care providers practice in Michigan. However, during the promulgation of the Department's Utilization Review Rules, it was determined that there are approximately 43,000 licensed allopathic and osteopathic licensed physicians in Michigan, of which approximately 65% are active in providing patient care. This number does not include health care professionals other that physicians."

A REVIEW OF MICHIGAN'S NO-FAULT **FEE SCHEDULE PROVISIONS**

Operation of Michigan's Statutory Fee Schedule

We have previously advised customers as to how reimbursement under the Michigan fee schedules will be calculated based on provider setting and clientele. In short, reimbursement rates are provided as a percentage of the amount payable under Medicare or, where there is no amount payable under Medicare, as a percentage of the provider's charge description master or average charge for the treatment as of January 1, 2019.

Because the proposed rules largely address the fee schedule provisions relating to provider reimbursement, a brief summary of those provisions may be useful.

BASE REIMBURSEMENT

The fee schedule sets most provider reimbursements at a percentage markup over amounts payable by Medicare, as follows: (a) 200% of the applicable Medicare fee schedule amount from July 2, 2021 to July 1, 2022; (b) 195% of the applicable Medicare amount from July 2, 2022 to July 1, 2023; and (c) 190% of the applicable Medicare amount from July 2, 2023 forward.

ENHANCED REIMBURSEMENT AMOUNTS

The fee schedule provides for enhanced reimbursements for the following providers: (a) those that have qualifying "indigent volumes" as a percentage of their overall treatment volumes; (b) two "freestanding rehabilitation facilities," which are to be designated by DIFS on an annual basis; and (c) Level I and Level II trauma centers that render treatment as described in section 3157 of the no-fault statute.

- For providers with 20% or more but less than 30% indigent volume and for the two rehabilitation facilities designated by DIFS each year, reimbursement amounts are: (a) 230% of the applicable Medicare fee schedule amount from July 2, 2021 to July 1, 2022; (b) 225% of the applicable Medicare amount from July 2, 2022 to July 1, 2023; and (c) 220% of the applicable Medicare amount from July 2, 2023 forward.

- Providers with 30% or more indigent volumes will receive 250% of the applicable Medicare amount.

- Qualifying Level I and Level II trauma centers are eligible for reimbursement as follows: (a) 240% of the applicable Medicare fee schedule amount from July 2, 2021 to July 1, 2022; (b) 235% of the applicable Medicare amount from July 2, 2022 to July 1, 2023; and (c) 230% of the applicable Medicare amount from July 2, 2023 forward.

NO APPLICABLE MEDICARE AMOUNTS

In situations where Medicare does not provide an amount payable for a particular treatment, providers will receive a reimbursement at a reduced percentage of the amounts in their charge description masters in effect on January 1, 2019 or, if a provider did not have a charge description master on that date, a reduced percentage of the "average amount" the provider charged on January 1, 2019:

- Providers who would otherwise be eligible for a "basic" reimbursement amount, as set forth above, will receive payment at a rate of: (a) 55% from July 2, 2021 to July 1, 2022; (b) 54% from July 2, 2022 to July 1, 2023; and (c) 52.5% from July 2, 2023 forward.

- Providers with indigent volumes of 20% or more but less than 30%, as well as the two freestanding rehabilitation facilities designated by DIFS, will receive payment at a rate of: (a) 70% from July 2, 2021 to July 1, 2022; (b) 68% from July 2, 2022 to July 1, 2023; and (c) 66.5% from July 2, 2023 forward.

- Providers with indigent volumes of 30% or more will receive payment at a rate of 78%.

- Qualifying Level I and Level II trauma centers will receive payment at a rate of: (a) 75% from July 2, 2021 to July 1, 2022; (b) 73% from July 2, 2022 to July 1, 2023; and (c) 71% from July 2, 2023 forward.

The Proposed Rules

THE PROPOSED RULES' SCOPE AND APPLICABILITY – R. 500.202

As set forth in Rule 2, the proposed rules will do the following:

- Define the applicable Medicare fee schedule
- Establish procedures to determine which health care providers are entitled to enhanced reimbursement
- Establish procedures for DIFS to collect information related to provider charges in order to calculate payment or reimbursement
- Establish a methodology for adjusting provider charges using the medical care component of the consumer price index
- Establish procedures for DIFS to administer accreditation requirements for neurological rehabilitation clinics

SIGNIFICANT DEFINITIONS – 500.201

Rule 1 sets forth definitions for certain terms that appear in the proposed rules, including:

- "Charge description master" utilizes the definition contained in section 3157 of the no-fault statute – "a uniform schedule of charges represented by [a provider] as its gross billed charge for a given service or item, regardless of per type."

- "Medicare" utilizes the definition contained in section 3157 of the no-fault statute – "fee for service payments under part A, B, or D [of Medicare], without regard to the limitations unrelated to the rates in the fee schedule such as limitation or supplemental payments related to utilization, readmissions, recaptures, bad debt adjustment, or sequestration."

- "Provider" means "a physician, hospital, clinic, or other person providing services to an injured person."

- "Fee schedule" means "as applicable, the Medicare fee schedule or prospective payment system in effect on the date the service is rendered and for the locality in which such service is rendered."

- "Regional average" means "a charge for a service based on the average charge for the provider's geographical region established by a national database of fees not covered by Medicare that is approved by [DIFS]."

- "Service" is based on the definition of "treatment" contained in section 3157 of the no-fault statute, which states that treatment "includes, but is not limited to products, services, and accommodations." In addition, the Rules define "service" as including "training and rehabilitative occupational training," as described in the no-fault statute.

MEDICARE CALCULATION (BASE REIMBURSEMENT) – R. 500.203

Rule 3 states that when calculating the amount payable to a provider for a service under Medicare part A or B, "the applicable fee schedule shall be utilized." Payers will therefore need to identify the correct fee schedule to apply to a provider's request for reimbursement.

Critically, Rule 3 states that "[a]n amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019."

Rule 3 permits DIFS to request, and obligates providers and insurers to comply by providing, "information the department considers necessary to ensure compliance" with the rule. Such information will be deemed confidential and will not be subject to disclosure under Michigan's freedom of information act.

ELIGIBILITY FOR ENHANCED REIMBURSEMENT – R. 500.204

Rule 4 sets forth procedures for designating providers that are eligible for enhanced reimbursement amounts under the fee schedule.

- **Freestanding Rehabilitation Facilities:** DIFS will issue a bulletin at least annually designating not more than 2 qualifying "freestanding rehabilitation facilities." A facility that seeks to qualify as such must submit an application on a form to be developed by DIFS.

- **Providers with Indigent Volumes:** DIFS will issue a bulletin at least annually designating Michigan providers that render treatment to qualifying indigent volumes. In making its determination, DIFS will rely on data provided by Michigan's

Department of Health and Human Services regarding providers' indigent volumes as of July 1 of the immediately preceding year.

- **Trauma Centers:** DIFS will issue a bulletin at least annually listing which hospitals qualify as Level I or Level II trauma centers. The list must be based on the hospital's designation on January 1 of that year. The Regulatory Impact Statement and Cost Benefit Analysis accompanying the proposed rules states that Michigan's Department of Licensing and Regulatory Affairs will provide DIFS with the lists of Level I and Level II trauma centers.

CHARGE DESCRIPTION MASTERS, AVERAGE AMOUNTS CHARGED, REGIONAL AVERAGES – R. 500.205

Rule 5 establishes procedures for providers to submit information to DIFS, upon DIFS' request, regarding:

- Charge description masters in effect on January 1, 2019.

- If a provider did not have a charge description master in effect on January 1, 2019, or had a charge description master that did not list all of the services it offered or rendered on January 1, 2019, the provider must submit its "average amount charged" for any service offered or rendered on that date that is not included in a charge description master.

- If a provider cannot provide the information described above, it must submit a "regional average" to DIFS which reflects "the amount of the charge if the service had been rendered on January 1, 2019," and which must be adjusted as set forth below.

Rule 5 further states that providers must retain their January 1, 2019 charge description masters, as well as documentation containing their January 1, 2019 average charged amounts and regional averages until the provider "permanently ceases" to render services covered by PIP insurance.

Also, upon request by DIFS, a provider must submit documents and other materials DIFS deems necessary to assess the accuracy of the provider's information regarding its charge description master, average charged amounts or regional averages. If a provider submits a regional average, it must identify the national database, the edition date and the geographical region used to generate the average.

ANNUAL ADJUSTMENTS TO CERTAIN REIMBURSEMENT AMOUNTS – RULE 500.205

Rule 5 further provides that January 1, 2019 charge description master amounts and average amounts charged "must be adjusted annually by the percentage change in the medical care component of the consumer price index for the year preceding the adjustment." This rule implements section 3157(9) of the fee schedule statute, requiring such adjustments.

Rule 5 states that DIFS will issue a bulletin no later than March 1 of each year setting forth the applicable percentage change, which will apply to services rendered between July 2 of that year and July 1 of the following year. To that end, on March 1, 2021, DIFS issued Bulletin 2021-10-INS, which states: "The fee schedule requires the Director to adjust the amounts payable that are to be applied under MCL 500.3157(7) or MCL 500.3157(8) on an annual basis by the percentage change in the medical component of the Consumer Price Index for the year preceding the adjustment. See MCL 500.3157(9)."

Consistent with that requirement, Bulletin 2021-10-INS states as follows, "This bulletin informs interested parties that any amount payable under a charge description master on January 1, 2019, that is payable under MCL 500.3157(7) or MCL 500.3157(8), shall be increased by 4.11% for dates of service July 2, 2021 through July 1, 2022."

NEUROLOGICAL REHABILITATION CLINIC ACCREDITATION – RULE 500.206

Section 3157(12) of the fee schedule statute provides that, subject to certain procedural exceptions, a neurological rehabilitation clinic will not be entitled to PIP reimbursement unless it is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or a similar organization recognized by DIFS.

Rule 6 states that DIFS will issue a bulletin "recognizing the organizations it deems similar to [CARF] for the accreditation of neurological rehabilitation clinics" and that such recognition shall remain in effect until revoked.

Rule 6 delineates the information a neurological rehabilitation clinic that seeks PIP reimbursement must submit to DIFS, if DIFS requests it.

Outstanding Questions

The proposed rules give rise to certain concerns, including:

- Rule 3 provides that amounts payable under the fee schedules cannot exceed average amounts charged by providers on January 1, 2019. It will therefore be necessary for payers to have access to providers' January 1, 2019 average charged amounts in order to compare them to fee schedule amounts. While Rule 3 provides that DIFS "may request" information to ensure compliance, it does not obligate providers to make their average charge amounts available to payers or to DIFS absent a request by the department. Nor does the rule state that DIFS will publish average charge amount data it does receive pursuant to request. It is hoped that DIFS will provide appropriate guidance and/or revise the proposed rules to create a formal mechanism by which payers will have ready access to providers' average charge data.

- Similarly, Rule 5 states that providers must furnish DIFS with their January 1, 2019 charge description masters, average charges and regional averages "[u]pon the department's request." This gives rise to the same concerns discussed above, i.e., in situations where Medicare does not provide an amount payable for a service, and payers' reimbursements are based on this alternative provider data, a formal mechanism should be created to ensure that payers can obtain the necessary information to ensure correct and compliant payments.

- Rule 4 provides that "[n]o less frequently than annually" DIFS will publish bulletins identifying providers that qualify for enhanced reimbursement. It is presently unknown, however, when DIFS will issue these bulletins.

- The Regulatory Impact Statement and Cost-Benefit Analysis accompanying the proposed rules states: "After the rules have been promulgated, DIFS will issue guidance to affected entities regarding compliance, including but not limited to instructions on viewing the applicable fee schedule, forms for submitting charge description masters and other information, and applications to determine eligibility for enhanced reimbursement." It would be preferable if, as set forth above, DIFS were to address these issues prior to issuing a final rules set.

These and other questions will undoubtedly be raised during DIFS March 26th public hearing and, it is hoped, by way of revisions to, or timely guidance surrounding, the proposed rules. CCC Casualty will be participating in the March 26th call, and we will

continue to actively monitor and report on developments regarding the proposed rules throughout the rulemaking process.