Estrada, Michele (DIFS)

From: Alex Gillespie <alex@3firefighters.com>
Sent: Friday, March 26, 2021 11:00 AM
To: Estrada, Michele (DIFS)

My name is Alexandria .I work at 1st Call Home Healthcare at 22367 Starks Dr, Clinton Twp, MI 48036. I oppose the DIFS proposed administrative rules for the auto no-fault fee schedule. Rule set 2020-114 IF

--
Alexandria Gillespie
Recruiter/HR assistant
1st Call Home Healthcare
586-782-6363 ext. 103

Estrada, Michele (DIFS)

From: Debbie Walker <caremi@preferhome.com>
Sent: Friday, March 26, 2021 10:58 AM
To: Estrada, Michele (DIFS)
Subject: DIFS

My name is Deborah Walker. I work at 1st Call Home Healthcare at 22367 Starks Dr, Clinton Twp, MI 48036. I oppose the DIFS proposed administrative rules for the auto no-fault fee schedule. Rule set 2020-114 IF

Deborah Walker
Care Coordinator

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Estrada, Michele (DIFS)

From: Deb Emery <debemerycm@outlook.com>
Sent: Friday, March 26, 2021 10:57 AM
To: Estrada, Michele (DIFS)
Subject: 2020-114 IF Administrative Rules for No-Fault Fee Schedule

Good afternoon Ms. Estrada,

I would like to express my support for the opinion provide by CPAN and the MBIPC during the public hearing today.

Please contact me should you have any questions.

Sincerely,

Debra Emery
4780 Clear Lake Road
North Branch, MI 48461

Estrada, Michele (DIFS)

From: Eric Noyes <ENoyes@cccis.com>
Sent: Friday, March 26, 2021 12:57 PM
To: Estrada, Michele (DIFS)
Subject: FW: DIFS Proposed Rule Set 2020-114 IF -- No-Fault Fee Schedule (Additional Comments/Questions)

Dear Ms. Estrada:

On behalf of CCC Information Services Inc., please allow me to submit a few additional questions to those I sent to your attention last Friday (3/19/21) via the below e-mail. Thank you for DIFS' consideration of these additional points as part of its rulemaking process with respect to Proposed Rule Set 2020-114 IF, relating to the Department's proposed fee-schedule rules.

Rule 500.205(6) provides for annual CPI adjustments to providers' January 1, 2019 average charge amounts and charge description master amounts. DIFS has already issued bulletins addressing this adjustment in the amount of 4.11% for dates of service July 2, 2021 through July 1, 2022. One question is with respect to the mechanism for recognizing these annual adjustments, i.e., whether providers are required to apply the annual percentage increase to their 1/1/19 charge amounts prior to submitting bills to payors or, conversely, whether providers will submit non-adjusted charge amounts and payors will be responsible for calculating the applicable percentage increase?

A second question is whether the CPI percentage adjustment is calculated on a "simple" or "compound" basis, i.e., is each year's percentage change applied to a provider's original 1/1/19 charge amount (simple) or does each year's adjustment apply to the provider's cumulative charge amount as calculated over time, i.e., to a provider's then-current charge amount that reflects all prior years' adjustments (compound)?

Our other question is with respect to pharmacy reimbursement. Pharmacies typically bill using National Drug Codes. However, Medicare uses the ASP fee schedule, which is based on HCPCS codes. Therefore, to the extent pharmacies don't bill using the Medicare ASP drug pricing fee schedule, by what methodology should they be reimbursed?

Thank you again for DIFS' consideration of these and our prior questions regarding the proposed fee schedule regulations.

Eric Noyes
Assistant General Counsel
CCC Information Services Inc.
222 Merchandise Mart Plaza, Suite 900
Chicago, IL 60654
(847) 877-5653
enoyes@cccis.com

From: Eric Noyes
Sent: Friday, March 19, 2021 3:12 PM
To: EstradaM1@michigan.gov
Subject: DIFS Proposed Rule Set 2020-114 IF -- No-Fault Fee Schedule

Dear Ms. Estrada:

I am an Assistant General Counsel and regulatory attorney with CCC Information Services Inc., whose affiliate Auto Injury Solutions, Inc. ("AIS") supports no-fault/PIP insurers nationwide, including in Michigan, with a variety of claim-related services and tools, including reimbursement-related applications used in fee-schedule states. In anticipation of the Department's March 26, 2021 public hearing, and in conjunction with its ongoing rulemaking process, I write to provide AIS' comments and questions regarding proposed Rule Set 2020-114 IF relating to the implementation of the medical fee schedule in Michigan's no-fault statute, MCL 500.3157. We recognize that other stakeholders may be submitting similar questions to the Department, and we further recognize that it may not be feasible to fully address all questions at the March 26th hearing. We believe, however, that these questions involve significant issues, including the application of appropriate Medicare fee schedules to provider charges, ensuring correct reimbursement calculations, and facilitating payor access to necessary provider information in order to ensure correct and timely reimbursements. We respectfully ask that the Department take these questions and issues into consideration and attempt to address them as it proceeds through the fee-schedule rule making process. Thank you very much for your and the Department's time and attention as it develops these important regulations. Our questions are as follows:

- Do the "applicable" Medicare fee schedules referenced in proposed Rule 3 include the following schedules: Physician, DMEPOS, Clinic Laboratory, ASP Drug Pricing, Ambulatory Surgical Center?

- Should the following facilities be reimbursed pursuant to Medicare: Hospices, Critical Access Facilities, Long-Term Care Facilities, Rehabilitation Facilities, Skilled Nursing Facilities and Children's Hospitals?

- With respect to the Physician fee schedule, which value should be used to calculate reimbursement – participating, non-participating, limiting?

- What is the correct method for reimbursing inpatient and outpatient facilities -- Medicare Part A, i.e., pursuant to the inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS), respectively?

- Proposed Rule 3 provides that amounts payable under the applicable fee schedules cannot exceed average amounts charged by providers as of January 1, 2019. It will therefore be necessary for payors 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 payors 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. A process by which payors must attempt to obtain this information for every provider submitting a bill would be

cumbersome and, in a certain number of instances, would likely result in payors not obtaining the necessary information in a timely manner or at all. Can DIFS provide guidance to address payor access to providers' January 1, 2019 average charge amounts?

- Pursuant to section 3157(7) of Michigan's no-fault statute, in situations where Medicare does not provide an amount payable for a service, payors' reimbursements are to be based on providers' charge description master rates or average charge amounts as of January 1, 2019. Similar to the above concern, a process by which payors must seek this information from individual providers would be cumbersome and could lead to incomplete or no information being obtained. While proposed Rule 5 obligates providers to furnish DIFS with their January 1, 2019 charge description masters, average charges and regional averages upon the Department's request, there is no formal or centralized mechanism for such information to be made available to payors to ensure correct and timely reimbursement. Can DIFS provide guidance on this issue?

- Section 3157(8) of Michigan's PIP statute provides that amounts allowed for payment or reimbursement under subsections (2), (3), (5) or (6) of section 3157 must not exceed providers' average amounts charged as of January 1, 2019. These subsections address enhanced reimbursement to providers who have qualifying indigent volumes, as well as providers who qualify as freestanding rehabilitation facilities and Level I or Level II trauma centers. Proposed Rule 4 does not contain language, similar to the language in proposed Rule 3, stating that enhanced reimbursement amounts payable pursuant to subsections (2), (3), (5) and (6) must not exceed providers' average charge amounts on January 1, 2019. Can DIFS clarify whether amounts paid under the enhanced reimbursement provisions of the statute are thus limited?

- Will DIFS issue guidance addressing how payors should reimburse providers when no Medicare, charge description master or average charge amount information is available to payors?

- The proposed rules require providers in certain circumstances to provide DIFS with information regarding their "regional averages." Section 3157 of Michigan's PIP statute does not appear to contain any provisions regarding regional averages. Can DIFS clarify the purpose for such information – e.g., as a potential alternative basis for reimbursement where Medicare, charge description master amounts and average charge amounts are not available?

- Rule 4 provides that "[n]o less frequently than annually" DIFS will publish bulletins identifying providers that qualify for enhanced reimbursement. Will DIFS provide dates certain on which these bulletins will be issued each year?

Thank you again for your kind consideration.

Eric Noyes
Assistant General Counsel
CCC Information Services Inc.
222 Merchandise Mart Plaza, Suite 900
Chicago, IL 60654
(847) 877-5653
enoyes@cccis.com

March 26, 2021

Re: Comments on Administrative Rules for No-Fault Fee Schedule Rule Set 2020-114 IF

Michele Estrada
Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
P.O. Box 30220
Lansing, MI 48909-7720

Submitted electronically to EstradaM1@michigan.gov

Dear Ms. Estrada:

On behalf of Henry Ford Health System (Henry Ford), I want to thank you for the opportunity to comment on the Administrative Rules for No-Fault Fee Schedule, Rule Set 2020-114 IF, which the Department of Insurance and Financial Services (DIFS) promulgated to implement MCL 500.3157. Among other things, MCL 500.3157 establishes the amount hospitals can be reimbursed for treating injured persons covered by personal protection insurance. For Henry Ford, it is critical that a reasonable reimbursement level be established for the auto no-fault fee schedule to ensure that we are able to continue to provide these important services in the communities we serve.

Henry Ford is a Michigan-based, not-for-profit corporation and one of the nation's largest integrated health care systems, with over 33,000 employees. Headquartered in Detroit, we have been committed to improving the health and wellbeing of the community, including children, for over 100 years. In addition, Henry Ford offers health care services across the continuum through a diverse network of facilities in Southeast Michigan (Metro Detroit) and South Central Michigan (Jackson). In the Detroit area, Henry Ford includes four acute-care hospitals, including our flagship, Henry Ford Hospital (HFH), a large academic hospital located within the city of Detroit; an inpatient psychiatric facility; and a network of outpatient medical facilities staffed by members of the Henry Ford Medical group (HFMG). Henry Ford Allegiance Health (HFAH) has served the Jackson community since 1918. HFAH provides comprehensive, advanced inpatient and outpatient care, and works with an integrated network of physicians, the Jackson Health Network, which serves more than 40 facilities.

Henry Ford plays an important role in providing care to victims of auto accidents, providing high-level Trauma, Emergency Medicine and other specialty services that care for trauma patients as well as access to essential rehabilitative health care services for patients injured in these accidents. Specifically, Henry Ford has five trauma centers located in Detroit, Clinton Township, West Bloomfield, Wyandotte, and Jackson. HFH is a Level I Trauma Center, HFAH and Henry Ford Macomb Hospital are Level II Trauma Centers, and Henry Ford Wyandotte Hospital and Henry Ford West Bloomfield Hospital are Level III Trauma Centers. Each center has been verified by the American College of Surgeons (ACS) for its for expertise in providing high-quality trauma care.

Henry Ford supports the Michigan Health & Hospital Association's (MHA) comments on the Administrative Rules for No-Fault Fee Schedule, with the definition of Medicare payment being the main area of concern.

As detailed in the MHA's comment letter to DIFS on the administrative rule for the no-fault fee schedule, Henry Ford supports:

1. **Definition of "Fee Schedule"**: Henry Ford agrees with the MHA that the definition of "fee schedule" needs to be more precisely defined, since there is no definitive schedule of "fee-for-service" payments under Parts A, B or D of the Medicare program, since multiple factors influence payment include the prevailing wage index in the geographic region in which the hospital is located; whether or not the hospital is a teaching hospitals; whether or not a hospital qualifies as a disproportionate share hospital (DSH), and more.

   We support the MHA's proposed definition:

   (h) "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. ***For purposes of this definition, "prospective payment system" means the Medicare inpatient acute, post-acute, and outpatient prospective payment systems, inclusive of all hospital-specific adjustments including without limitation adjustments for acuity, area wage index, capital, teaching (both direct and indirect), disproportionate share, new technology, low volume, organ acquisition cost, routine and ancillary pass-through cost for allied health programs, outlier, and for sole community hospital, rural referral centers and critical access hospitals, the equivalent hospital specific payment for providing inpatient or outpatient services to Medicare beneficiaries.***

2. **Proposed R 500.203(1):** Provides that an amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019." We support the MHA's proposed changes:

   When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. ***Except for hospitals reimbursed under a Medicare prospective payment system or reimbursed by Medicare as a sole community hospital, rural referral center or critical access hospital****, an amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019****, as adjusted pursuant to R 500.205(6)****.* ***A no-fault insurer will pay to a hospital that is reimbursed under Medicare an amount equal to (1) the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program multiplied by (2) the applicable Medicare reimbursement percentage under the Amended Act.***

3. **Alternative Methodology for Hospital Payment**

   Henry Ford agrees with MHA and believes that, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, that DIFS consider an alternative methodology. MHA outlined this alternative methodology in a letter, dated December 4, 2020, to Anita Fox, Director of DIFS. Under this alternative methodology, the no-fault insurer would pay the hospital's claim using a formula that considers the hospital's Medicare payment-to-charge ratio (in the aggregate), which would be updated and published annually by DIFS similar to the existing Worker's Compensation methodology. The formula would allow providers and insurers to determine the reimbursement providers are eligible to receive from insurers under the Amended Act. The Auto No-Fault Payment ratio would be hospital-specific, with the source of the data for each hospital's Auto No-Fault Payment being the hospital's most recently filed Medicare cost report, updated annually on July 1.

Henry Ford believes, as MHA stated in its comment letter, that in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, the Auto No-Fault Payment Factor serves as a reasonable proxy of the Medicare payment to which a hospital would be entitled with respect to any particular claim a hospital submits to an insurer. MHA further believes that payment based on the Auto No-Fault Payment Factor enables the efficient implementation and administration of the Amended Act. The alternative would be a time consuming and costly case-by-case computation that would be administratively burdensome to hospital and insurer alike.

It is critical for Henry Ford that we are able to continue to provide trauma care to victims of auto accidents in the areas we serve, and an appropriate level of compensation for that care is essential to providing this important service to the people in our communities.

Thank you again for the opportunity to comment on the Administrative Rules for No-Fault Fee Schedule, which, among other things, establishes the amount that hospitals can be reimbursed for treating injured persons covered by personal protection insurance.

Sincerely,

J. Douglas Clark
Senior Vice President
Corporate Financial Services

HURLEY
MEDICAL CENTER

One Hurley Plaza
Flint, Michigan 48503

RECEIVED
APR 01 2021
DIFS/OGC

Via Email

March 25, 2021

Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
P.O. Box 30220
Lansing, MI 48909-7720

Michele Estrada
EstradaM1@michigan.gov

Re: Comments on Administrative Rules for No-Fault Fee Schedule
Rule Set 2020-114 IF

Dear Ms. Estrada:

As a Level I Trauma center as certified by the American College of Surgeons, Hurley Medical Center (Hurley) would like to share our comments and concerns regarding the Administrative Rules for No-Fault Fee Schedule, Rule Set 2020-114 IF, which DIFS communicated to implement MCL 500.3157. Among other things, MCL 500.3157 establishes the amount hospitals can be reimbursed for treating injured persons covered by personal protection insurance.

Hurley is the Northern most Level I Trauma center in Michigan, as such Hurley treats some of the most traumatic auto accident victims in the state. The care we provide to these patients usually results in the some of the highest cost per care cases at Hurley each year. It is vitally important that Hurley receive a proper payment level to cover our costs as well as provide for continued investment in our facility to remain a top trauma center. A clearly defined auto payment rate that is based on our current Medicare payment level for our inpatient acute, inpatient rehab and outpatient services is needed.

We also have great concern that the lack of clarity in the proposal will lead to unnecessary stress and burden on Hurley and particularly our Revenue Cycle department as they code, bill and attempt to collect on the thousands of auto claims Hurley encounters each year. This ultimately will lead to an unnecessary increase in expenses attributable to treating some of the most traumatic cases Hurley sees.

We respectfully submit the following comments:

1. Definition of "Fee Schedule"

Proposed R 500.201(h) defines "fee schedule" to mean "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 the service is rendered."

This proposed definition is very vague and does not properly address the complexity of our Medicare rate. Hurley supports the following language which the Michigan Health and Hospital Association (MHA) has previously presented to DIFS. This definition accurately reflects Medicare rate that Hurley is paid.

(h) "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. ***For purposes of this definition, "prospective payment system" means the Medicare inpatient acute, post-acute, outpatient prospective payment system, inclusive of all hospital-specific adjustments including without limitation adjustments for acuity, area wage index, capital, teaching (both direct and indirect), disproportionate share, new technology, low volume, organ acquisition cost, routine and ancillary pass-through cost for allied health programs, outlier, and (B) for sole community hospital, rural referral centers and critical access hospitals, the equivalent hospital specific payment for providing inpatient or outpatient services to Medicare beneficiaries.***

2. Proposed R 500.203(1)

Proposed R 500.203(1) provides as follows: "When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. An amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019."

For acute inpatient hospital services, the prospective payment system ("PPS") is based on a nationally established payment formula consisting of the applicable diagnostic related group relating to the patient's treatment and the standardized amount, as adjusted by a variety of factors, all of which are updated annually. Similarly, the PPS for outpatient hospital services and for capital-related costs are based on nationally established payment formulas updated annually. While not applicable to Hurley it should be noted further, Medicare payment for sole community hospitals and rural referral centers based on annually updated national payment formulas. For critical access hospitals, payment is set at 101% of allowable

cost. Thus, this rule should be revised as follows to assure proper payment to hospitals based on their entitlement to Medicare payment:

When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. ***Except for hospitals reimbursed under a Medicare prospective payment system or reimbursed by Medicare as a sole community hospital, rural referral center or critical access hospital****, an amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019****, as adjusted pursuant to R 500.205(6)****.* ***A no-fault insurer will pay to a hospital that is reimbursed under Medicare an amount equal to (1) the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program multiplied by (2) the applicable Medicare reimbursement percentage under the Amended Act.***

3. Hurley further supports the following alternative method for determining the amounts payable under Medicare as required by the Amended Act. This method has been previously communicated by the MHA in a letter dated December 4, 2020, to Anita Fox, Director of DIFS.

Under this alternative, the no-fault insurer would pay the hospital's claim using a formula that takes into account Hurley's Medicare payment-to-charge ratio (in the aggregate) which would be updated and published annually by DIFS similar to the existing Worker's Compensation methodology. The formula would allow providers and insurers to determine the reimbursement providers are eligible to receive from insurers under the Amended Act. The formula for determining the reimbursement is as follows:

Auto No-Fault Payment = Auto No-Fault Payment Factor x Auto No-Fault Billed Charges

(1) Where the **"Auto No-Fault Payment Factor" = (Aggregate Medicare Payments / Aggregate Medicare Charges) x (Statutory Auto No-Fault Payment Multiplier)**

Aggregate Medicare Payments and Aggregate Medicare Charges for all services provided by a hospital are taken from each hospital's most recently available filed Medicare cost report to establish a single, unique ratio for that hospital, updated annually on July 1.

Annually, DIFS would publish each hospital's Auto No-Fault Payment Factor calculated by the Michigan Department of Health and Human Services (MDHHS) using Medicare cost report data.

The Statutory Auto No-Fault Payment Multiplier is the applicable Medicare reimbursement percentage under the Amended Act (*i.e.*, 200%, 230%, or 240%). DIFS would publish the applicable Medicare reimbursement percentage for each hospital.

(2) **Example calculation of the Auto No-Fault Payment Factor and the Auto No-Fault payment based on the following assumptions:**

When the hospital submits to the insurer the hospital's bill for services, the insurer would determine payment to the hospital by reference to the published Medicare reimbursement percentage for the hospital and the Auto No-Fault Payment Factor published for the hospital. The following is an example of how payment would be computed:

Amount Billed by the Hospital to Insurer = $500

Aggregate Medicare Payment to Hospital = $2,200,000

Aggregate Hospital Charges to Medicare = $7,100,000

Auto No-Fault Payment Multiplier = 240%

Auto No- Fault Payment Factor = ($2.2 Million / $7.10 Million) x (2.4) =

0.7437 Auto No-Fault Payment = (0.7437) x ($500) = $371.85

Under this example, $371.85 is the amount of reimbursement the hospital should receive from the insurer.

The Auto No-Fault Payment ratio would be hospital-specific. Thus, the source of the data for each hospital's Auto No-Fault Payment would be the hospital's most recently filed Medicare cost report, updated annually on July 1.

Hurley supports the MHA proposal that the Medicare cost report would be the data source for Medicare payments and charges used to develop the Auto No-Fault Payment Factor for inpatient and outpatient services as well as for other hospital services, such as inpatient rehabilitation facility, home health and skilled nursing facility services. The Auto No-Fault Payment Factor would be subject to an annual update based on the hospital's most recently filed cost report as of July 1 of each year, although as provided by the Amended Act the allowable reimbursement that ties to the amount payable under Medicare must not exceed the average amount charged by the provider for the services on Jan. 1, 2019, as adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment. See MCL 500.3157(8) and (9).

Hurley believes that, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, the Auto No-Fault Payment Factor serves as a reasonable proxy of the Medicare payment to which a hospital would be entitled with respect to any particular claim a hospital submits to an insurer. Hurley further believes that payment based on the Auto No-Fault Payment Factor enables the efficient implementation and administration of the Amended Act. The alternative would be a time consuming and costly case-by-case computation that would be administratively burdensome to hospital and insurer alike.

Respectfully submitted,

Melany Gavulic
Chief Executive Officer

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MEDICAL CENTER

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Flint , Michigan 48503

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Insurance Alliance of Michigan

March 26, 2021

Anita Fox, Esq.
Director
Department of Insurance and Financial Services
530 W. Allegan St., 8th Floor
Lansing, Michigan 48933-7720

Re: DIFS Proposed Rule 2020-114 IF
No-Fault Medical Fee Schedule

Dear Director Fox:

The Insurance Alliance of Michigan (IAM) is the statewide trade association representing property and casualty insurers operating in Michigan. IAM members write approximately 75 percent of the automobile insurance market in the state. On behalf of the members of the IAM, I write to express our thoughts regarding Proposed Rule 2020-114 IF, draft dated February 19, 2021, pertaining to the implementation of the medical fee schedule of Insurance Code Sec. 3157 (MCL 500.3157).

As you know, while a portion of the premium savings seen by auto insurance consumers is due to the level of PIP benefits chosen, the projected savings attributable to the coming fee schedule is significant, impacts premium at all selection options, and its implementation will be critical to maintaining savings to consumers. As well, reducing the cost of individual medical products and services ensures that consumers' chosen levels of PIP benefit dollars go as far as possible to provide the necessary care in the event of auto accident injury. Clarity, certainty, efficiency and fairness should be top of mind in this process.

With that said, our comments on the draft dated February 19 are as follows:

Fee Schedule:

The main foundation of the Sec. 3157 medical fee schedule provisions is the federal Medicare fee schedule. As an aside, while MCL 500.3157(15)(f) defines "Medicare" in part to mean "fee for service payments under part A, B or D of the federal Medicare program…," R500.203(1) only references "Medicare part A or B…." Is this a distinction the Department intends to make?

Overall, however, there is not one Medicare fee schedule, however, but several. This includes, but is not limited to "participating," "non-participating," "durable medical equipment," etc. As amounts differ, which Medicare fee schedule Michigan no-fault insurers must use will determine liabilities to insurers,

which in turn impacts the premium charged as well as how far selected PIP benefits remain available to provide coverage for reasonable and necessary medical assistance.

R500.203 generally provides that the appropriate, "applicable" Medicare fee schedule should be referenced "[w]hen calculating the amount payable." Where relevant with respect to the Medicare "participating" and "non-participating" provider distinction, however, we urge the Department to determine that the "participating" fee schedule is the standard for products and services provided under no-fault personal injury protection. The "non-participating" fee schedule is generally higher in total as it allows for the billing of the claimant on top of the amount paid by the insurer, which would run counter to lowering costs.

For those products and services for which there is not a corresponding Medicare fee, Sec. 3157 provides the alternative of a percentage of the providers "charge description master" (CDM) or, if none exists, a percentage of the average charged for the product or service. There are an untold number of medical providers with, and without a CDM. And, unlike the Medicare fee schedules, CDMs are not publicly accessible or objectively verifiable documents.

We appreciate that the Department appears intent on gathering CDM and average charge information provided by medical providers, becoming we hope a clearinghouse of this information. R500.205. However, the language is permissive in that the Department ultimately may, or may not, request this information. We would urge the Department be more definitive with its intentions and request the rules *require* a medical provider who bills a no-fault insurer for services provided to submit to the Department its CDM, average charges, or regional average, as applicable.

Also unclear is whether auto insurers would have access to this CDM, average charge, or regional average information collected by the Department in order to verify, and respond to, incoming charges related to auto accident claims. Such access to a Departmental database is critical and could allow a dramatically more efficient claims handling and payment process. Otherwise, there is nothing in statute or rule that ensures no-fault carriers will have access to relevant pricing information. Therefore, we would request the Department to state clearly that auto insurers would have access to this information.

Relatedly, new providers to the Michigan market which do not have a CDM, or average charge as of January 1, 2019, are required to "submit to the department a regional average" of charges. R500.205(1)(c). Taken in concert with R500.205(4), such providers would be able to choose which "national database" to submit as evidence of the "regional average." The Department should determine a process for its approval of a submitted database, or more clearly provide criteria any such national database would have to meet in advance. Either would provide auto insurers greater clarity to determine the reasonableness of charges submitted.

Keep in mind, auto insurers generally have 30 days generally to pay claims received before interest and other penalties begin to accrue.

<u>Information Retention</u>:

Proposed R500.205(3) requires providers to retain its CDM, or average or regional charge information, as of January 1, 2019, "until the provider permanently ceases to render services to injured persons for accidental bodily injuries covered by personal protection insurance…." We would suggest providers be required to retain this information for three (3) years after they cease rendering services as this

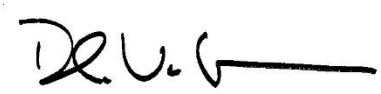
information could be relevant to later utilization review and related administrative appeals processes, as well as providers merging, being acquired by others, or otherwise reincorporating over time.

Conclusion:

Thank you very much for your time and attention. We believe the broad understanding of no-fault reform was to reduce costs in the system to the ultimate and ongoing benefit of the auto insurance consumer. We continue to look forward to working with DIFS on the development and implementation of these rules, and more broadly on no-fault auto insurance reform.

Please let me know if you would like to discuss any of the comments provided in this letter.

Sincerely,



Dyck E. Van Koevering
General Counsel

Estrada, Michele (DIFS)

From: Jason Groth <jason@3firefighters.com>
Sent: Friday, March 26, 2021 10:30 AM
To: Estrada, Michele (DIFS)

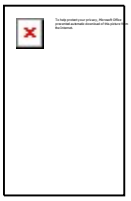
My name is Jason Groth and I am the COO for 1st Call Home Healthcare at 22367 Starks Dr, Clinton Twp, MI 48036. I oppose the DIFS proposed administrative rules for the auto no-fault fee schedule. Rule set 2020-114 IF

Sincerely,

Jason Groth
1st Call Home Healthcare
Co-Owner and Chief Operating Officer

Email: jason@3firefighters.com
Web: www.3firefighters.com

Phone: 1-800-908-3890
Fax: 1-888-604-6233



Estrada, Michele (DIFS)

From: John Prosser III <johnprosser3@comcast.net>
Sent: Friday, March 26, 2021 2:43 PM
To: Estrada, Michele (DIFS)
Subject: No fault fee schedule

I am writing to oppose the no-fault fee schedule as it stands. If post-acute reimbursement is not addressed (currently set to become 55% of 2019 chargemaster) many post-acute medical providers will be forced to close around the state. This will result in the displacement of hundreds of Michiganders as they seek new places to live and receive treatment. Many if not most of them will end up in nursing homes. Meanwhile thousands of jobs will be lost, and the variety of services available to injured Michiganders will be greatly diminished. All of this can be prevented by aligning the post acute fee schedule with the fee schedule that was passed in the 2019 no-fault reform. Many providers will have to provide notice of a cessation of services to their clients with enough time for them to find alternative arrangements before the July 1 deadline, which will effectively close many of these businesses immediately. There is still time to act so I ask that you please support changes to the proposed reimbursement rates for post-acute providers before these rules go into effect.

Thank you,

John Prosser
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Troy, MI 48084
johnprosser3@comcast.net

Estrada, Michele (DIFS)

From: Jordan Badley <jordan@3firefighters.com>
Sent: Friday, March 26, 2021 10:35 AM
To: Estrada, Michele (DIFS)
Subject: Rule set 2020-114 IF

My name is Jordan Badley. I work at 1st Call Home Healthcare at 22367 Starks Dr, Clinton Twp, MI 48036. I oppose the DIFS proposed administrative rules for the auto no-fault fee schedule. Rule set 2020-114 IF

BARBARA ANN

Karmanos

CANCER INSTITUTE

Wayne State University

Via Email

March 24, 2021

Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
P.O. Box 30220
Lansing, MI 48909-7720

Michele Estrada
EstradaM1@michigan.gov

Re: Comments on Administrative Rules for No-Fault Fee Schedule
Rule Set 2020-114 IF

Dear Ms. Estrada:

Karmanos Cancer Center submits this letter to the Department of Insurance and Financial Services ("DIFS") for consideration with respect to the public comment period for the Administrative Rules for No-Fault Fee Schedule, Rule Set 2020-114 IF, which DIFS promulgated to implement MCL 500.3157. Among other things, MCL 500.3157 establishes the amount hospitals can be reimbursed for treating injured persons covered by personal protection insurance.

We respectfully submit the following comments.

1. **Definition of "Fee Schedule"**

Proposed R 500.201(h) defines "fee schedule" to mean "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 the service is rendered."

In order to fully implement the intent of Public Act 21 of 2019 and Public Act 22 of 2019 (the "Amended Act"), that no-fault insurance payment to a hospital be based on the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program, we recommend that the definition of "fee schedule" be more precisely defined as follows for hospitals reimbursed under Medicare by adding the following language. This clarification is necessary because there does not exist a definitive schedule of "fee for service payments under part A,

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NCI Designated Comprehensive Cancer Center

B, or D of the federal Medicare program." This is because Medicare payment to hospitals depends on many factors including prevailing wage rates in the area where a hospital is located, whether a hospital trains residents or treats a disproportionate share of low-income patients, and whether the hospital is a sole community hospital, to name just a few of these factors. Further, this additional clarification regarding hospital payment would enable implementation of the Amended Act in a manner that best serves the interests of auto no-fault consumers, insurers and hospitals and other providers.

(h) "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. ***For purposes of this definition, "prospective payment system" means the Medicare inpatient acute, post-acute, outpatient prospective payment system, inclusive of all hospital-specific adjustments including without limitation adjustments for acuity, area wage index, capital, teaching (both direct and indirect), disproportionate share, new technology, low volume, organ acquisition cost, routine and ancillary pass-through cost for allied health programs, outlier, and (B) for sole community hospital, rural referral centers and critical access hospitals, the equivalent hospital specific payment for providing inpatient or outpatient services to Medicare beneficiaries.***

2. Proposed R 500.203(1)

Proposed R 500.203(1) provides as follows: "When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. An amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019."

For acute inpatient hospital services, the prospective payment system ("PPS") is based on a nationally established payment formula consisting of the applicable diagnostic related group relating to the patient's treatment and the standardized amount, as adjusted by a variety of factors, all of which are updated annually. Similarly, the PPS for outpatient hospital services and for capital-related costs are based on nationally established payment formulas updated annually. Further, Medicare payment for sole community hospitals and rural referral centers is based on annually updated national payment formulas. For critical access hospitals, payment is set at 101% of allowable cost. Thus, this rule should be revised as follows to assure proper payment to hospitals based on their entitlement to Medicare payment:

When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. ***Except for hospitals reimbursed under a Medicare prospective payment system or reimbursed by Medicare as a sole community hospital, rural referral center or critical access hospital****, an amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019****, as adjusted pursuant to R 500.205(6)****.* ***A no-fault insurer will pay to a hospital that is reimbursed under Medicare an amount equal to (1) the actual Medicare payment to which the***

hospital otherwise would be entitled to receive from the Medicare program multiplied by (2) the applicable Medicare reimbursement percentage under the Amended Act.

3. Alternatively, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, **Karmanos Cancer Center** suggests that DIFS consider an alternative methodology for hospital payment which could be promulgated in a DIFS bulletin.

Under this alternative, which the Michigan Health and Hospital Association ("MHA") previously outlined in a letter dated December 4, 2020, to Anita Fox, Director of DIFS, the no-fault insurer would pay the hospital's claim using a formula that takes into account the hospital's Medicare payment-to-charge ratio (in the aggregate) which would be updated and published annually by DIFS similar to the existing Worker's Compensation methodology. The formula would allow providers and insurers to determine the reimbursement providers are eligible to receive from insurers under the Amended Act. The formula for determining the reimbursement is as follows:

Auto No-Fault Payment = Auto No-Fault Payment Factor x Auto No-Fault Billed Charges

(1) Where the **"Auto No-Fault Payment Factor" = (Aggregate Medicare Payments / Aggregate Medicare Charges) x (Statutory Auto No-Fault Payment Multiplier)**

Aggregate Medicare Payments and Aggregate Medicare Charges for all services provided by a hospital are taken from each hospital's most recently available filed Medicare cost report to establish a single, unique ratio for that hospital, updated annually on July 1.

Annually, DIFS would publish each hospital's Auto No-Fault Payment Factor calculated by the Michigan Department of Health and Human Services (MDHHS) using Medicare cost report data.

The Statutory Auto No-Fault Payment Multiplier is the applicable Medicare reimbursement percentage under the Amended Act (*i.e.*, 200%, 230%, or 240%). DIFS would publish the applicable Medicare reimbursement percentage for each hospital.

(2) Example calculation of the Auto No-Fault Payment Factor and the Auto No-Fault payment based on the following assumptions:

When the hospital submits to the insurer the hospital's bill for services, the insurer would determine payment to the hospital by reference to the published Medicare reimbursement percentage for the hospital and the Auto No-Fault Payment Factor published for the hospital. The following is an example of how payment would be computed:

Amount Billed by the Hospital to Insurer = $500 Aggregate

Medicare Payment to Hospital = $2,200,000 Aggregate Hospital

Charges to Medicare = $7,100,000 Auto No-Fault Payment

Multiplier = 240%

Auto No- Fault Payment Factor = ($2.2 Million / $7.10 Million) x (2.4) = 0.7437 Auto No-

Fault Payment = (0.7437) x ($500) = $371.85

Under this example, $371.85 is the amount of reimbursement the hospital should receive from the insurer.

The Auto No-Fault Payment ratio would be hospital-specific. Thus, the source of the data for each hospital's Auto No-Fault Payment would be the hospital's most recently filed Medicare cost report, updated annually on July 1.

Karmanos Cancer Center proposes that the Medicare cost report would be the data source for Medicare payments and charges used to develop the Auto No-Fault Payment Factor for inpatient and the outpatient services as well as for other hospital services, such as inpatient rehabilitation facility, home health and skilled nursing facility services. The Auto No-Fault Payment Factor would be subject to an annual update based on the hospital's most recently filed cost report as of July 1 of each year, although as provided by the Amended Act the allowable reimbursement that ties to the amount payable under Medicare must not exceed the average amount charged by the provider for the services on Jan. 1, 2019, as adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment. See MCL 500.3157(8) and (9).

Karmanos Cancer Center believes that, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, the Auto No-Fault Payment Factor serves as a reasonable proxy of the Medicare payment to which a hospital would be entitled with respect to any particular claim a hospital submits to an insurer. **Karmanos Cancer Center** further believes that payment based on the Auto No-Fault Payment Factor enables the efficient implementation and administration of the Amended Act. The alternative would be a time consuming and costly case-by-case computation that would be administratively burdensome to hospital and insurer alike.

Respectfully submitted,

Justin Klamerus, M.D.
President & CEO
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NCI Comprehensive Cancer Center
A Cancer Center Designated by the National Cancer Institute

Estrada, Michele (DIFS)

From: Kathy Coll <kcoll@willowbrookrehab.com>
Sent: Friday, March 26, 2021 1:49 PM
To: Estrada, Michele (DIFS)
Subject: comment Administrative Rules for No-Fault Fee Schedule Rule set 2020-114 IF

Good Afternoon Michelle,
Let me contribute comment following the hearing today contesting rule 51C which is inconsistent with language of reform legislation, introduces redundancy with likelihood of confusion, and would pose an undue burden to providers of care who treat patients within the PIP system. Thank you for holding the hearing and the opportunity to submit comments.
Kathleen Coll

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PUBLIC COMMENTS
AND OBJECTIONS

TO: Anita Fox, DIFS Director

FROM: Sinas Dramis Law Firm
By Catherine E. Tucker, Esq. and George T. Sinas, Esq.
On Behalf of the Following Associations and Providers:

A. Coalition Protecting Auto No-Fault

B. Health Partners, Inc.

DATE: March 26, 2021

RE: **Public Comments and Objections Regarding DIFS' Draft "*No-Fault Fee Schedule*" Rules Released on February 19, 2021**

INTRODUCTION

Nearly 2 years ago, the Michigan Legislature passed vast and sweeping changes to the Michigan No-Fault Automobile Insurance Act ("*the No-Fault Act"*) and the Michigan Insurance Code, which Governor Whitmer signed into law on June 11, 2019. Among the many changes to the No-Fault Act was the addition of a series of fee schedules to govern reimbursement to certain providers for treatment rendered to injured persons for accidental bodily injury covered by personal protection insurance. *See* MCL 500.3157.

Importantly, the No-Fault Act neither authorizes nor obligates the Department of Insurance and Financial Services ("*DIFS*") to promulgate *any* administrative rules or regulations with regard to the fee schedule created by the new law and set forth in §3157. That this statutory provision does not authorize DIFS to promulgate any rules relative to the fee schedule is particularly notable given that the amended statute expressly required DIFS to promulgate rules regarding "*utilization review*" under §3157a. Consistent with the long-established maxim of statutory construction *expressio unius est exclusio alterius* (i.e., the express mention of one thing implies the exclusion of other similar things), the omission of any similar requirement that DIFS promulgate rules regarding the new fee schedule under §3157 clearly implies that the Legislature did ***not*** intend for it to do so. *Stowers v Wolodzko*, 386 Mich 119, 133 (1971).

Regardless, on February 19, 2021, DIFS released a set of "*No-Fault Fee Schedule*" rules designed to govern various matters relative to the fee schedule set forth in §3157. ***In doing so, DIFS has impermissibly exceeded its administrative authority and deviated from the plain language and legislative intent underlying the No-Fault Act in material ways that raise very serious concerns for the medical provider community in Michigan.***

Of the most significant concern is DIFS' draft **Rule 5(1)(c) which would impose a cumbersome submission requirement and a substantial reimbursement limitation on certain providers rendering treatment to injured persons under the No-Fault Act, which have absolutely no basis in the statute itself**. Specifically, Rule 5(1)(c) would require providers who ***(a) did not have a charge description master in effect on January 1, 2019; or (b) did not charge for the treatment on January 1, 2019*** to derive and submit to DIFS a "*regional average*" for the treatment based on an unidentified "*national database of fees.*" Further, Rule 5(1)(c) could be construed to limit reimbursement to those providers to the percentages set forth in §3157(7) as applied to that "*regional average,*" despite the fact that our Legislature has imposed no such limitation on that category of providers.

Also of great concern are DIFS' draft **Rules 3(2); 5(1), (2) and (4); and 6(2), which would affirmatively require** ***all providers rendering treatment under the No-Fault Act to provide various documents, information, and other materials regarding their fees and related matters to DIFS,*** **despite the fact that the statute imposes no such requirement.**

Further, these rules would require private medical providers to disclose these ***sensitive, proprietary materials*** to a governmental agency *even in cases where a provider has not pursued an administrative appeal.* Nothing in the No-Fault Act, which is the statute that governs this matter, requires this type of disclosure except for the limited purpose of "*utilization review*" within the meaning of §3157a(6).[1] Further, the "*utilization review*" process authorized by the Legislature only compels a provider to disclose certain materials to DIFS ***if and when*** the provider *elects* to pursue an appeal through DIFS.

Accordingly, we write now to assert our objections to Rules 3(2); 5(1), (2) and (4); and 6(2). A thorough analysis of these draft rules, our objections to them and the legal authority and principles that form the basis for those objections are set forth below.

APPLICABLE LEGAL AUTHORITY AND PRINCIPLES

The foundational legal principle underlying the objections raised herein is that ***"[t]o be enforceable, administrative rules must be constitutionally valid, procedurally valid and substantively valid***." *Michigan Farm Bureau v Dep't of Envtl Quality,* 292 Mich App 106, 129 (2011), citing LeDuc, *Michigan Administrative Law* (2001), §4.30, p 214.

Analyzing the ***constitutional validity*** of administrative rules requires a careful review of the provisions of the state or federal constitution implicated by the rules. Where a rule violates a constitutional provision, it will be rendered invalid and unenforceable. LeDuc, *Michigan Administrative Law* (2019), §4:31. See also *Herrick Dist Library v Library of Michigan*, 293 Mich App 571 (2011) (holding that DOE rule was constitutionally invalid because it violated §9, Article VIII of the Michigan Constitution). One important provision of the Michigan Constitution implicated in the context of administrative rulemaking is §1 of Article IV, which expressly vests *"[t]he legislative power of the State of Michigan"* in the "*senate and a house of representatives*" – not any agency.

In assessing the ***substantive validity*** of rules promulgated by a State administrative agency, Michigan courts employ the following 3-part conjunctive test:

> "*(1) whether the rule is* ***within the subject matter of the enabling statute****, (2) if so, whether it* ***complies with the underlying legislative intent****, and (3) if it meets the first two requirements, [whether] it is arbitrary and capricious."*
> [*Lutrell v Dept of Corrections,* 421 Mich 93, 100 (1984) (*emphasis added*).]

Failure to satisfy any prong of that 3-part test makes an administrative rule both ***substantively invalid and unenforceable***. *Michigan Farm Bureau,* 292 Mich App at 129.

[1] "*[U]tilization review*" is defined as "*the* ***initial evaluation by an insurer or the association*** *created under section 3104 of the appropriateness in terms of both* ***the level and the quality of treatment****, products, services, or accommodations provided under this chapter based on medically accepted standards*." MCL 500.3157a(6).

With regard to the first prong (*i.e., "whether the rule is within the subject matter of the enabling statute"*), Michigan appellate courts have long and consistently held that administrative agencies like DIFS have no power or authority other than that expressly conferred to them by "*clear and unmistakable*" statutory language. *Mason Co Civil Research Council v Mason Co*, 343 Mich 313, 326 (1955). *See also York v Detroit (After Remand)*, 438 Mich 744, 767 (1991). As the Court of Appeals has explained:

> *"**[T]he powers of administrative agencies . . . are limited to those expressly granted by the Legislature**. And though an agency may have implied powers, our caselaw narrowly restricts such authority to that " 'necessary to the due and efficient exercise of the powers expressly granted' by the enabling statute."* [*Herrick*, 293 Mich App at 574 (*emphasis added; internal citations omitted).*]

Regarding the second prong (i.e., "*whether [the rule] complies with the underlying legislative intent*"), it is important to bear in mind that the legislative intent underlying the enabling statute – i.e., the No-Fault Act – was to provide a comprehensive scheme of compulsory insurance which would ensure prompt payment for the medical expenses and other losses incurred by auto accident victims in Michigan. As the Michigan Supreme Court has explained:

> *"The Michigan No–Fault Insurance Act, which became law on October 1, 1973, was offered as an innovative social and legal response to the long delays, inequitable payment structure, and high legal costs inherent in the tort (or "fault") liability system. **The goal of the no-fault insurance system was to provide victims of motor vehicle accidents with assured, adequate, and prompt reparation for certain economic losses**. The Legislature believed this goal could be most effectively achieved through a system of compulsory insurance, whereby every Michigan motorist would be required to purchase no-fault insurance . . . Under this system, victims of motor vehicle accidents would receive insurance benefits for their injuries as a substitute for their common-law remedy in tort."* [*Shavers v Attorney General,* 402 Mich 554, 578–579, (1978) (*emphasis added*).]

The No-Fault Act was specifically "*designed to **minimize administrative delays and factual disputes that would interfere with achievement of the goal of expeditious compensation** of damages suffered in motor vehicle accidents*." *Miller v State Farm Mut Automobile Ins Co*, 410 Mich 538, 568 (1981) (*emphasis added*). In accordance with this goal, "*even when there is some doubt about the insured's entitlement to the payment,*" the Act and "*court decisions*" interpreting it "*encourage prompt payment of insurance benefits*." *Mich Educ Employees Mut Ins Co v Morris*, 460 Mich 180, 199-200 (1999).

With this legislative intent, and these legal principles in mind, we turn now to our objections, which will be fully detailed in the following section.

OBJECTIONS

I. OBJECTION #1: TO THE EXTENT THAT RULE 5(1)(C) IMPOSES REIMBURSEMENT LIMITATIONS AND REQUIREMENTS THAT DO NOT EXIST UNDER THE NO-FAULT ACT, IT IS INVALID AND UNENFORCEABLE.

Our primary objection to the "*No-Fault Fee Schedule*" rule set is to Rule 5(1)(c). Draft Rule 5, as a whole, governs "*Charge description masters; average amount charged; regional average; submissions to department*" and purports to establish various requirements – most of which are not set forth in the enabling statute itself – relative to those matters. Specifically, Rule 5(1) provides, in relevant part, as follows:

> "*Upon the department's request**, a provider** that renders a service to an injured person for an accidental bodily injury covered by personal protection insurance under chapter 31 of the act [] **shall make the following submissions to the department**, in a form and manner prescribed by the department, as applicable:*
> *(a) If a provider has a charge description master that was in effect on January 1, 2019, the provider shall submit to the department the provider's charge description matter that was in effect on January 1, 2019.*
> *(b) If a provider offered or rendered services on January 1, 2019, and does not have a charge description master that was in effect on January 1, 2019, or has a charge description master that was in effect on January 1, 2019, the provider shall submit to the department the provider's average amount charged for any service offered or rendered on January 1, 2019, that is not included in a charge description master submitted to the department under subdivision(a) . . .*
> ***(c) If a provider does not meet the criteria under subdivision (a) or (b) of this subrule, the provider shall submit to the department a regional average. A regional average must reflect the amount of the charge if the service had been rendered on January 1, 2019, and be adjusted in a manner consistent with subrule (6) of this rule.***

R. 500.205(1) (*emphasis added*).

Rule 1(i) defines a "***[r]egional average**,*" as referenced in Rule 5(1)(c), as "*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 the director.*" R. 500.201(1)(i) (*emphasis added*).

A. DRAFT RULE 5(1)(C) EXCEEDS THE SCOPE AND IS INCONSISTENT WITH THE PLAIN LANGUAGE AND LEGISLATIVE INTENT UNDERLYING THE NO-FAULT ACT AND IS, THEREFORE, SUBSTANTIVELY INVALID.

Nothing in the fee schedule set forth in §3157, or in any other provision of the No-Fault Act, requires a provider who *(a) did not have a charge description master in effect on January 1, 2019; or (b) did not offer or render services on January 1, 2019* to derive or submit a "*regional average*" to DIFS, as DIFS' draft Rule 5(1)(c) would do. Nor is there any statutory provision that limits reimbursement to such a provider under the Act to a so-called "*regional average*" calculated to "*reflect the amount of the charge if the service had been rendered on January 1, 2019,"* as Rule 5(1)(c) could be interpreted to do.

The reimbursement limitations set forth under §3157(7) of the No-Fault Act only apply to providers who ***(a) had a "charge description master in effect on January 1, 2019"; or (b) "charged for the treatment on January 1, 2019."*** MCL 500.3157(7). Specifically, in this regard, the statute provides as follows:

> *"(7) If Medicare does not provide an amount payable for a treatment or rehabilitative occupational training under subsection (2), (3), (5), or (6), the physician, hospital, clinic, or other person that renders the treatment or training is not eligible for payment or reimbursement under this chapter of more than the following, as applicable:*
>
> *(a) For a person to which subsection (2) applies,* ***the applicable following percentage of the amount payable for the treatment or training under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, the applicable following percentage of the average amount the person charged for the treatment on January 1, 2019****:*
>
> *(i) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 55%.*
>
> *(ii) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 54%.*
>
> *(iii) For treatment or training rendered after July 1, 2023, 52.5%.*
>
> *(b) For a person to which subsection (3) applies,* ***the applicable following percentage of the amount payable for the treatment or training under the person's charge description master in effect on January 1, 2019*** *or, if the person did not have a charge description master on that date,* ***the applicable following percentage of the average amount the person charged for the treatment or training on January 1, 2019****:*

(i) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 70%.
(ii) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 68%
(iii) For treatment or training rendered after July 1, 2023, 66.5%.

(c) For a person to which subsection (5) applies, 78% of the amount payable for the treatment or training ***under the person's charge description master in effect on January 1, 2019*** *or, if the person did not have a charge description master on that date, 78% of* ***the average amount the person charged for the treatment on January 1, 2019****.*

(d) For a person to which subsection (6) applies, ***the applicable following percentage of the amount payable for the treatment under the person's charge description master in effect on January 1, 2019*** *or, if the person did not have a charge description master on that date,* ***the applicable following percentage of the average amount the person charged for the treatment on January 1, 2019****:*
(i) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 75%.
(ii) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 73%.
(iii) For treatment or training rendered after July 1, 2023, 71%.

In examining the plain language of this statutory provision, which is the "*most reliable evidence*" of the Legislature's intent, it is clear that §3157(7) does not apply to or govern reimbursement for providers who ***(a) did not have a charge description master in effect on January 1, 2019; or (b) did not charge for the treatment on January 1, 2019.*** *Whitman v City of Burton*, 493 Mich 303, 311 (2013). The express – and repeated – reference in §3157(7) to providers who *did* have a "*charge description master in effect on January 1, 2019*" or "*charged for the treatment on January 1, 2019*" makes plain that the Legislature did not intend it to apply to those who did *not*. This interpretation is in accord with the statutory construction maxim *expressio unius est exclusio alterius* – i.e., the express mention of one thing implies the exclusion of others. *Stowers*, 386 Mich at 133.

Concerningly, despite the plain language of the statute, DIFS' draft Rule 5(1)(c) could be interpreted to impose an additional limitation on those providers who ***(a) did not have a charge description master in effect on January 1, 2019; or (b) did not charge for the treatment on January 1, 2019.*** In particular, it could be construed to limit reimbursement to that category of providers to the percentages set forth in §3157**(7)** as applied to a so-called "*regional average*" that has absolutely no origin in the statute itself.

If interpreted and enforced in this way, Rule 5(1)(c) would result in the ***unlawful imposition of a significant reimbursement limitation*** with no basis in the No-Fault Act. Specifically, it would result in the imposition of a limit on reimbursement for providers rendering treatment after July 1, 2021 who ***(a) did not have a charge description master in effect on January 1, 2019; or (b) did not charge for the treatment on January 1, 2019***. Nothing in §3157, or in any other provision of the statute, authorizes DIFS to impose any such limitation. To the extent that the Legislature did not address reimbursement for this category of providers, it is not the prerogative of an administrative agency like DIFS to "*fill in the blank*" or to "*read a requirement into a statute the Legislature has 'seen fit to omit.'*" *Book-Gilbert v Greenleaf*, 302 Mich App 538, 542 (2013). And to the extent that DIFS now seeks to do so through Rule 5(1)(c), it unlawfully usurps the "*legislative power*" conferred by our State constitution exclusively on the Legislature. MI Const, Art IV, §1.

Further, to the extent that Rule 5(1)(c) forces providers to derive or submit to DIFS a "*regional average*" based on an "*national database of fees*" in order to simply get paid for treatment rendered to auto accident victims, it is wholly inconsistent with the legislative intent underlying §3157 and the entire no-fault scheme. As noted above, the "*goal of the no-fault insurance system was to provide . . . assured, adequate, and prompt reparation*" for losses due to motor vehicle accidents and to "*minimize administrative delays and factual disputes that would interfere with achievement of [that] goal of expeditious compensation.*" *Shavers,* 402 Mich at 578–579; *Miller*, 410 Mich at 568. If adopted, Rule 5(1)(c) will do just the opposite. Specifically, Rule 5(1)(c) will only serve to promote delays and disputes for that category of providers that it purports to govern. Preconditioning reimbursement on identifying and submitting a so-called "*regional average*" to DIFS will only serve to lengthen – not "*expedit[e]*" – the process for obtaining compensation and promote – not "*minimize*" – administrative disputes. *Miller, supra; Shavers, supra.*

Rule 5(1)(c) clearly, unmistakably and impermissibly exceeds the scope of the enabling statute – the No-Fault Act – and is entirely inconsistent with the legislative intent underlying the Act. Since it fails the first two prongs of the test that Michigan courts have adopted for assessing the substantive validity of an administrative rule, Rule 5(1)(c) is both invalid and unenforceable. *Michigan Farm Bureau,* 292 Mich App at 129.

II. OBJECTION #2: TO THE EXTENT THAT RULES 3, 5 AND 6 IMPOSE AN AFFIRMATIVE OBLIGATION ON PROVIDERS TO MAKE SUBMISSIONS TO DIFS THAT ARE NOT REQUIRED BY THE STATUTE, THESE RULES ARE SUBSTANTIVELY INVALID AND UNENFORCEABLE.

Our secondary objection to DIFS' draft "*No-Fault Fee Schedule*" rule set is to those Rules which *require* providers to submit documents, information, and other materials regarding their fees and other related matters *directly to DIFS*, despite the fact that absolutely nothing in the No-Fault Act imposes any such requirement. Specifically, proposed Rule 3, which governs "*Medicare calculation; posting of fee schedule; [and] requests for information*," provides, in relevant part, as follows:

> *"The department may request, and* ***a provider or insurer must provide, any documents, materials, or information the department considers necessary to ensure compliance with this rule****. Documents, materials, and information submitted to the department pursuant to this rule are confidential and not subject to disclosure under the freedom of information act . . ."*

R. 500.203(2) (*emphasis added).*

Likewise, Rule 5, which governs "*Charge description master; average amount charged; regional average; [and] submissions to department*" provides, in relevant part, as follows:

> *(1) "Upon the department's request,* ***a provider*** *that renders a service to an injured person for an accidental bodily injury covered by personal protection insurance under chapter 31 of the act, MCL 500.3101 to 500.3179,* ***shall make the following submissions to the department****, in a form and manner prescribed by the department, as applicable:*
>
> *(a) If a provider has a charge description master that was in effect on January 1, 2019,* ***the provider shall submit to the department the provider's charge description matter that was in effect on January 1, 2019****.*
>
> ***(b)*** *If a provider offered or rendered services on January 1, 2019, and does not have a charge description master that was in effect on January 1, 2019, or has a charge description master that was in effect on January 1, 2019,* ***the provider shall submit to the department the provider's average amount charged for any service offered or rendered on January 1, 2019, that is not included in a charge description master submitted to the department under subdivision(a) of this subrule.***
>
> *(c) If a provider does not meet the criteria under subdivision (a) or (b) of this subrule,* ***the provider shall submit to the department a regional***

> ***average***. *A regional average must reflect the amount of the charge if the service had been rendered on January 1, 2019, and be adjusted in a manner consistent with subrule (6) of this rule.*
>
> *(2) A provider that submits information under subrules (1)(a) through (c)* ***must also submit an attestation that the information provided is accurate*** *. . .*
>
> ***
>
> *(4) Upon request by the department, a provider submitting its charge description master in effect on January 1, 2019; average amount charged for services on January 1, 2019; or regional average under this rule* ***shall also submit to the department any documents, materials, and information the department considers necessary to assess the submission's accuracy.*** *If the provider submits a regional average, the provider must identify the national database, the edition date, and the geographical region used . . ."*

R 500.205(1); (2); and (4) (*emphasis added*).

Further, draft Rule 6, which governs "*Neurological rehabilitation clinic accreditation; information submission*," dictates, in relevant part, as follows:

> *"A neurological rehabilitation clinic that seeks payment or reimbursement for services rendered to an injured person for an accidental bodily injury covered by personal protection insurance under chapter 31 of the act, MCL 500.3101 to 500.3179,* ***shall, upon the department's request, submit on a form prescribed by the department the following information****, as applicable:*
>
> *(a)* ***Proof of accreditation by CARF*** *or a similar organization recognized by the director as referenced in subrule (1) of this rule.*
>
> *(b) If a neurological rehabilitation clinic is in the process of becoming accredited on July 1, 2021,* ***information concerning its status in the accreditation process with updates provided to the department every 6 months thereafter*** *until the neurological rehabilitation clinic is accredited."*

R 500.206(2) (*emphasis added*).

A. DRAFT RULES 3(2); 5(1), (2) AND (4); AND 6(2) IMPERMISSIBLY EXCEED THE SCOPE OF THE NO-FAULT ACT.

Michigan courts have long held that administrative agencies have no authority other than that expressly conferred to them by "*clear and unmistakable*" statutory language. *Mason,* 343 Mich at 326. As an administrative agency, DIFS' powers "*are limited to those expressly granted by the Legislature*." *Herrick,* 293 Mich App at 574. **Nothing in §3157 of the No-Fault Act expressly, or impliedly, empowers DIFS to require providers to make submissions relative to matters arising under that statutory provision, like those that it now seeks to require under Rules 3(2); Rule 5(1), (2) and (4); and 6(2).** Further**, nothing in §3157a authorizes DIFS to require providers to supply information or documentation***, except for the limited purpose of "utilization review" under that section*. MCL 500.3157(1). And, as noted above, that section narrowly defines "*utilization review*" as "*the* ***initial evaluation by an insurer or the association*** *created under section 3104 of the* ***appropriateness in terms of both the level and the quality of treatment, products, services, or accommodations provided . . .***" MCL 500.3157a(6) (*emphasis added).*

Importantly, the "*utilization review*" process authorized by the Legislature *only requires* a provides to supply ***certain*** materials ***to DIFS*** *if and when* a provider elects to appeal an insurer's denial, pursuant to §3157a(5). Specifically, under the Utilization Review Rules, which were promulgated by DIFS under the authority vested in it by §3157a(3)[2], DIFS can only request such a disclosure ***if and when*** a provider ***voluntarily chooses*** to pursue an appeal of an initial determination by an insurer as to the appropriateness of the amount or cost of its treatment. R. 500.66; MCL 500.3157a(5).[3] Those Rules, which became effective on December 18, 2020, impose no disclosure requirement ***at any time*** before a provider initiates an appeal. Further, under those Rules, no requirement for a provider to supply information to DIFS ***exists at all*** in those cases in which no appeal is pursued.

There is absolutely nothing in the No-Fault Act that authorizes a *governmental agency* to engage in what would amount to a wholesale "*fishing expedition*" into what *private businesses* charge for their services. In this regard, ***it is critically important to note that information regarding what private business charge for their services in inherently and fundamentally proprietary***. Neither the statute nor these rules provide any guidance as to how to this sensitive information can be protected from public release,

---

[2] Notably, while §3157a(3) authorizes DIFS to "*provide procedures related to utilization review*," that same statutory provision specifically limits procedures regarding the acquisition of "*necessary records, medical bills, and other information*" to the "*treatment, products, services, or accommodations provided*." MCL 500.3157a(3)(b)(i). **Nothing in §3157a(3) authorizes DIFS to promulgate rules or to establish procedures for the acquisition of records regarding providers' charges, fees or other related matters.**

[3] Both the No-Fault Act and the Utilization Review Rules make clear that a provider appeal to DIFS is entirely voluntary, not mandatory: *"A provider* ***may*** *appeal a determination made by an insurer made under R 500.65 on a form prescribed by the department."* MCL 500.3157a(5); R 500.66(1).

other than by limiting its access when a request is submitted under the Freedom of Information Act ("*FOIA*"). Theoretically, this means that DIFS could obtain this proprietary information and disclose it in other ways, including through its administrative orders and decisions. Absent further clarification from the Legislature, DIFS should not be allowed to confer the power to compel the disclosure of such sensitive information upon itself. Accordingly, to the extent that Rules 3(2); 5(1), (2) and (4); and 6(2) compel private medical providers to produce information, documentation, or other materials ***to DIFS*** regarding their fees and related matters, these rules clearly, unmistakably, and impermissibly exceed the scope of the enabling statute.

Finally, to the extent that DIFS is relying on §24517 of the Public Health Code as authority for it to compel such disclosures, this reliance is wholly misplaced. It is a well-established maxim of statutory construction that "*where two statutes or provisions conflict and one is specific to the subject matter while the other is only generally applicable, the specific statute prevails*." *Slater v Ann Arbor Pub Sch Bd of Ed*, 250 Mich App 419, 434–35 (2002). There can be no dispute that the No-Fault Act is the specific statute that governs this matter. Nor can there be any dispute that the Act does not requires any such disclosures.

B. DRAFT RULES 3(2); 5(1), (2) AND (4); AND 6(2) ARE INCONSISTENT WITH THE LEGISLATIVE INTENT OF THE ACT.

In addition to not "*fall[ing] within the subject matter*" of the No-Fault Act, Rules 3(2); 5(1), (2) and (4); and 6(2) also contravene its "*underlying legislative intent*." *Lutrell,* 421 Mich at 100. A review of the plain language of the statute, which is the "*most reliable evidence*" of the Legislature's intent, makes clear that matters related to the fee schedule are to be governed by and conducted according to the parameters and procedures set forth in §3157 of the Act. *Whitman*, 493 Mich at 311. Since nothing in §3157, or in any other provision of the statute, empowers DIFS to require providers to affirmatively submit any information, documents, or other materials to DIFS, *except in cases of an appeal to DIFS under the procedure establish by the new UR Rules*, it is equally clear that the Legislature did *not* intend that DIFS impose any such requirement.

Had the Legislature intended for DIFS to impose any additional submission requirements on providers with regard to matters arising under §3157 of the statute, it would have explicitly authorized it to do so, as it did with the subjects specifically identified in §3157a(3). Yet, it clearly did not. And one of the basic principles of statutory construction is that it is improper to "*read a requirement into a statute the Legislature has 'seen fit to omit.'*" *Book-Gilbert*, 302 Mich App at 542.[4] Accordingly, to the extent that the above-referenced Rules seek now to impose requirements on providers that the Legislature has "*'seen fit to omit,*" they are wholly inconsistent with the intent of the Act.

[4] *See also Potter v McLeary*, 484 Mich 397, 422 n 30 (2009) (holding that courts must "*refrain from adding requirements to a statute that are not contained within its language*").

Further, to the extent that the Rules referenced above require providers to spend considerable additional time and resources making cumbersome submissions to DIFS, *even in cases where no dispute exists and no provider appeal has been pursued*, they are entirely inconsistent with the legislative purpose underlying our no-fault scheme. That purpose, as the Supreme Court has reminded us, is to provide "*assured, adequate, and prompt reparation*" for losses suffered as a result of motor vehicle accidents – and to minimize "a*dministrative delays and factual disputes*." *Shavers, supra*; *Miller, supra*. Contrary to that purpose, Rules 3(2); 5(1); (2) and (4); and 6(2) will impose unnecessary bureaucracy, instigate disputes and undermine the goal of "*expeditious compensation*." *Miller, supra.*

CONCLUSION

For the reasons stated above, the draft administrative rules identified herein – ***Rules 3(2); 5(1), (2) and (4); and 6(2)*** – are invalid and unenforceable as a matter of law. *Michigan Farm Bureau, supra.* Insofar as they exceed the scope of the enabling statute and are inconsistent with its underlying legislative intent, all fail the first two prongs of the conjunctive test adopted by Michigan appellate courts to assess substantive validity. In addition, to the extent that these rules represent an effort by an administrative agency to "*usurp*"the "*legislative power*" that has been vested in the Legislature by §1 of Article IV of the Michigan Constitution, they are constitutionally invalid. *Herrick, supra* at 582.

Accordingly, on behalf of our clients in the Michigan medical provider community, who will be uniquely affected by and share a special interest in the promulgation and enforcement of this rule set, **we strongly object to adoption of the *"No-Fault Fee Schedule"* rules as written**. ***In summary, our objections are as follows***:

1. **Rule 5(1)(c)** impermissibly exceeds the scope of the No-Fault Act by requiring a provider who *(a) did not have a charge description master in effect on January 1, 2019; or (b) did not offer or render services on January 1, 2019* to derive and submit a "*regional average*" to DIFS – ***a requirement found nowhere in the statute.***

2. **Rule 5(1(c)** impermissibly exceeds the scope of the No-Fault Act to the extent that it seeks to limit reimbursement to providers who *(a) did not have a charge description master in effect on January 1, 2019; or (b) did not charge for the treatment on January 1, 2019* to the percentages set forth in §3157(7) as applied to a so-called "*regional average*" ***– a limitation that has no basis in the statute.***

3. **Rules 3(2); 5(1), (2) and (4); and 6(2)** exceed the scope of the No-Fault Act by requiring providers to disclose documents, information and other materials regarding their fees ***directly to DIFS***, even in cases where the provider has not pursued a DIFS appeal – ***a requirement that does not exist in the statute.***

4. **Rules 3(2); 5(1), (2) and (4); and 6(2)** exceed the scope of the No-Fault Act by authorizing DIFS to compel disclosure of sensitive, proprietary business information without properly restraining its release (except through FOIA).

On the basis of these objections, and for all of the reasons more fully set forth herein**, we respectfully request that DIFS withdraw draft Rules 3(2); 5(1), (2) and (4); and 6(2) from consideration altogether.** In promulgating – or modifying – any rules regarding the "*No-Fault Fee Schedule,*" DIFS' authority is limited to the "*clear and unmistakable*" language of the amended statute. *Mason,* 343 Mich at 326. Further, DIFS should be guided by the overarching intention of Michigan's auto no-fault reparations system which is to simplify the claim-making process, to avoid unnecessary administrative delay and bureaucracy, and to promote the expeditious payment of no-fault claims. *See Shavers, supra; Miller; supra; Morris, supra.*

Estrada, Michele (DIFS)

From: Lenny Treece <ltreece2@hcaccg.com>
Sent: Friday, March 26, 2021 4:46 PM
To: Estrada, Michele (DIFS)
Cc: Larry Treece; Lance Treece; Luke Treece
Subject: Fee Schedule

Hello My name is Lenny Treece and I am the Vice President of Health Care Associates located at 3101 Prairie St. Grandville, Mi 49418.
We oppose the DIFS rules as they have been writen.

Thanks,

Lenny J. Treece
Health Care Associates
616-531-9973
VP Operations

HealthCall

Joel R. Szirtes
Phone: (248) 440-1483
E-Mail: jszirtes@HCHS.com

January 29, 2021

National Indemnity Company
Attention: Dawn Burrow / Claims Department
P.O. Box 31361
Omaha, Nebraska 68131-0361
Claim Numbers: 70-21-401675 and 00401675
Phone: (402) 916-3800
Fax: (402) 916-3031

RE: Billing Code Updates for Services Rendered by HealthCall

To Whom It May Concern:

In preparation for the changes to the No-Fault Act scheduled to commence on July 1, 2020, HealthCall will be updating its billing codes and billing increments, where necessary, from the CPT codes to the Medicare HCPCS codes for ease of reference and to streamline the comparison to the Medicare fee schedule. Please note that some of the codes will remain the same, as set forth below. These codes are widely used across the medical industry and are standard codes used for the services identified below. Accordingly, beginning on January 1, 2020, HealthCall will be implementing the following billing code schedule:

Service Description	Old Code	Old Code Description	Updated Code	Updated Code Description
Home Health Aide	S9122	CPT Code for "Home health aide or certified nurse assistant, providing care in the home; per hour"	G0156	HCPCS Code for "Services of home health/hospice aide in home health or hospice settings, each 15 minutes"
Licensed Practical Nurse	S9124	CPT Code for "Nursing care, in the home; by licensed practical nurse; per hour"	GO300	HCPCS Code for "Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes"
Registered Nurse	S9123	CPT Code for "Nursing care, in the home; by registered nurse, per hour"	GO299	HCPCS Code for "Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes"

HealthCall

Supervisory Nurse Visit (RN)	G0154	HCPCS Code for "Direct skilled nursing services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 minutes	G0162	HCPCS Code for "Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting."
Physical Therapy	GO159	HCPCS Code for "Services performed by a qualified physical therapist, in the home health setting, in the establishment of delivery of a safe and effective physical therapy maintenance program, each 15 minutes"	G0159	Same
Occupational Therapy	GO160	HCPCS Code for "Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes"	G0160	Same
Speech & Language Pathology	GO161	HCPCS Code for "Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes"	G0161	Same

We intend to keep our rates the same, in line with the market, even though the amended No-Fault Act does permit a higher reimbursement rate. ***Please review the above-referenced codes and confirm in writing that you intend to honor the current customary rates charged by HealthCall.*** HealthCall's interpretation of the amended No-Fault Act is that all of the services it provides have a reimbursement amount under Medicare, and therefore, all of its services are reimbursable under the amended No-Fault Act once it takes effect on July 1, 2020. If you disagree, HealthCall requests a written explanation. To assist HealthCall with fiscal planning and preparation for the No-Fault amendments, we would appreciate a response ***by no later than February 15, 2021.***

Best regards,

Joel R. Szabo
Chief Operating Officer

CC: Clark Hill
Jennifer Green, Esq
151 S. Old Woodward, Suite 200
Birmingham, MI 48009
jgreen@clarkhill.com

HealthCall
28000 WOODWARD AVENUE, SUITE 100
ROYAL OAK, MICHIGAN 48067
HCHS.COM

National Indemnity Company
Attention: Dawn Burrow / Claims Department
P.O. Box 31361
Omaha, Nebraska 68131-0361
Claim Numbers: 70-21-401675 and 00401675

MICHIGAN CATASTROPHIC CLAIMS ASSOCIATION

17584 Laurel Park Drive North ♦Livonia, MI 48152♦ Phone (734) 953-2779 ♦Fax (734) 953-9511

March 26, 2021

Sarah Wohlford
Department of Insurance
and Financial Services
530 W. Allegan St., Floor 8
Lansing, Michigan 48933-1521
wohlfords@michigan.gov

Via Email Only

RE: *The MCCA's Public Comments to Administrative Rules for No-Fault Fee Schedule*
Rule Set 2020-114 IF

Dear Ms. Wohlford:

Attached are the Michigan Catastrophic Claims Association's (the "MCCA's") public comments on the No-Fault Fee Schedule rule set 2020-114 IF promulgated by the Department of Insurance and Financial Services.

Should you have any questions, please feel free to contact me.

Very truly yours,

MICHIGAN CATASTROPHIC CLAIMS ASSOCIATION

/s/ KJ Miller

KJ Miller
Assistant General Counsel

The Michigan Catastrophic Claims Association's Public Comments On DIFS's Administrative Rules for No-Fault Fee Schedule

Rule Set 2020-114 IF

The Department of Insurance and Financial Services ("DIFS") has promulgated a No-Fault Fee Schedule rule set. According to DIFS's Notice of Public Hearing, "[t]his is a new rule set that implements the provisions of MCL 500.3157 by doing the following: a) defining the applicable Medicare fee schedule; b) establishing procedures for determining which health care providers are entitled to enhanced reimbursement rates; c) establishing procedures for the department to collect information related to rates charged by health care providers as of January 1, 2019, for the purposes of calculating reimbursement rates; d) establishing a date and methodology for determining the adjustment of reimbursement rates; and e) establishing procedures for the department to administer the accreditation requirements under MCL 500.3157.

The Michigan Catastrophic Claims Association (the "MCCA") offers the following comments and proposed changes to the draft rules.

1. Defining Medicare.

Under proposed rule 500.201(e), "'Medicare'" means that term as defined in section 3157(15)(f) of the act, MCL 500.3157." Yet, the definition of Medicare in section 3157(15)(f) is ambiguous and already has led to confusion: The statutory definition does not distinguish between Medicare utilization adjustments to amounts payable under the fee schedule and Medicare eligibility requirements.

Section 3157(15)(f) defines Medicare as "fee for service payments under part A, B, or D of the federal Medicare program . . ., ***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 adjustments, or sequestration." The language in bold italics is the language which is subject to differing interpretations. When the language is read as highlighted, isolated from the other language that follows the words "***such as***," it appears to mean that anytime Medicare provides a rate for a service, regardless whether there is any limitation under Medicare guidelines relating to utilization (that is, how often such a service is provided), then that rate is an "amount payable" that must be paid at 200%. Yet, when considered in the context of the other items on the list that follow the words "***such as***," a different meaning is found. The list that follows the words "such as" is a list of adjustments to a Medicare amount payable, not an instruction to ignore Medicare eligibility requirements for a service.

For example, Medicare provides an amount payable for an attendant care *visit* under certain rare circumstances. *See* Medicare Benefit Policy Manual, Ch. 7 – Home Health Services § 30. The visit is billed in 15 minute increments of $15.80, which equals $63.20 per hour. *See* 83 Fed. Reg. 56518 (2018) (Table 35). At 200% of that rate, multiplied by the medical cost component of CPI at 4.11%, the hourly rate for basic attendant care equals $126.92 per hour, approximately four or five times

the current hourly agency rate charged by providers. Likewise, Medicare provides an amount payable for a skilled nursing care *visit* under certain circumstances. *See* Medicare Benefit Policy Manual, Ch. 7 – Home Health Services § 30. The visit is billed in 15 minute increments of $49.05, which equals $196.20 per hour. *See* 83 Fed. Reg. 56518 (2018) (Table 35). At 200% of that rate, multiplied by the medical cost component of CPI at 4.11%, the hourly rate for skilled nursing care equals $394.01 per hour, approximately five or six times the current hourly agency rate charged by providers. In a similar way, Medicare provides an amount payable for extended care services in a skilled nursing facility, but also provides a long list of eligibility requirements for qualifying for such care and only considers payment for a limited period of time. *See* Medicare Benefit Policy Manual, Ch. 8 – Coverage of Extended Care (SNF) Services Under Hospital Insurance §§ 20, 30-30.4, 30.6-.7. Medicare does not provide an amount payable for the vast majority of residential care facility claims that the MCCA reimburses. Some providers seem to agree. *See* HB 4486 and SB 314 (proposing a residential care provider-created fee schedule). Certainly, the amendments to the No-Fault Insurance Act were not intended to increase rates by four to six times current rates, especially on two of the MCCA's largest cost drivers, agency-provided in home attendant care (17.61% of all MCCA payments), and residential care (19.90%).

Turning to the list that follows the words "such as" in section 3157(15)(f) further demonstrates that the statute does not intend to ignore Medicare eligibility requirements for a service. We start with the last item on the list—"***sequestration***." "Sequestration" stems from the Budget Control Act of 2011, which required an off-the-top 2% reduction on payments to Medicare providers as part of a federal deficit reduction plan. The revised No-Fault Insurance Act does not take into account this 2% off-the-top reduction in payments to providers. Next to the last on the list of items to be ignored in determining an amount payable is "***bad debt adjustments***." This refers to bad debts attributable to unpaid deductibles and coinsurance. When determining a reasonable cost for a service, Medicare permits providers to increase the amount payable by including a percentage of their bad debts as part of the cost. *See* 42 C.F.R. § 413.89. The revised No-Fault Insurance Act does not take this kind of adjustment into account. Nor does the No-Fault Insurance Act take into account "***recaptures***." Recaptures refers to the principle that there should be an appropriate allowance for depreciation on buildings and equipment used in the provision of patient care when determining an allowable cost. That is, the amount payable is increased to account for depreciation on buildings and equipment. *See* 42 C.F.R. § 413.134. Next on this list is "***readmissions***." According to the Centers of Medicare & Medicaid Services ("CMS"), readmissions refers to CMS's Hospital Readmission Reduction Program, which is a value-based purchasing program that reduces payments to hospitals with excess readmissions. *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program. The revised No-Fault Insurance Act ignores these reductions in payments to hospitals that have avoidable readmissions. Finally, we have "***limitation or supplemental payments related to utilization***." Just as with the other items on this list, limitation or supplemental payments related to utilization refers to adjustments to the amount payable—either an upward or downward adjustment to the amount payable—

related to utilization. An example of this is the Medicare Low Utilization Payment Adjustment ("LUPA"), which is an upward adjustment to an amount payable under the Medicare fee schedule for low utilization—that is, the flip side of the readmissions penalty. *See* 42 C.F.R. § 484.230. The revised No-Fault Insurance Act ignores these adjustments in payments for low utilization.

Already, insurance companies have received notice that providers intend to rely on the strategies outlined above, such as ignoring Medicare eligibility requirements for a service, in order to avoid reducing the fees they charge for their services. *See, e.g*., Letter from Health Call (attached) (threatening to use visit codes, also known as G-codes, to avoid reducing agency attendant care rates). Yet, the proposed rules and the statute state "An 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 500.203(1). Using the calculation of 200% of a Medicare rate without regard to Medicare qualifying criteria would often, if not always, exceed the average amount charged before the revised statute took effect, resulting in a higher payment rather than a reduction in costs. To avoid the ambiguity in section 3157(15)(f) and to provide guidance to insurance companies, providers, and bill review companies, DIFS proposed Rule 500.201(e) could simply add the following language: "Nothing in section 3157(15)(f) abrogates the Medicare qualifying criteria for coverage of home health benefits, extended care services in a skilled nursing facility, or family-provided services."

2. Defining the Applicable Medicare Fee Schedule.

A further ambiguity found in the statute that could be resolved in the proposed rules is which Medicare fee schedule applies. The proposed rules purport to "define the applicable Medicare schedule." Rule 500.202(a). Rule 500.203(1) states, "When calculating the amount payable for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized." Yet, section 3157 also includes Medicare part D. If an applicable fee schedule is not available to be used when calculating an amount payable for a service under part D, the draft rules could include guidance on how to calculate these amounts. Further, Medicare fee schedules distinguish between participating and non-participating providers, with the non-participating schedule generally identifying higher amounts payable, as it allows charging the patient in addition to Medicare. In addition, there are several different types of modifiers and initiatives that are utilized under Medicare fee schedules that impact rates. To avoid the ambiguity in section 3157(15)(f) and to provide guidance to insurance companies, providers, and bill review companies, DIFS proposed Rule 500.201(e) could simply add the following language: "Rates under the applicable Medicare fee schedule are those used to pay participating providers and should be calculated using modifiers identified in the National Correct Coding InitiativeI."

The Michigan Catastrophic Claims Association's Public Comments On DIFS's Administrative Rules for No-Fault Fee Schedule

Rule Set 2020-114 IF

The Department of Insurance and Financial Services ("DIFS") has promulgated a No-Fault Fee Schedule rule set. According to DIFS's Notice of Public Hearing, "[t]his is a new rule set that implements the provisions of MCL 500.3157 by doing the following: a) defining the applicable Medicare fee schedule; b) establishing procedures for determining which health care providers are entitled to enhanced reimbursement rates; c) establishing procedures for the department to collect information related to rates charged by health care providers as of January 1, 2019, for the purposes of calculating reimbursement rates; d) establishing a date and methodology for determining the adjustment of reimbursement rates; and e) establishing procedures for the department to administer the accreditation requirements under MCL 500.3157.

The Michigan Catastrophic Claims Association (the "MCCA") offers the following comments and proposed changes to the draft rules.

1. Defining Medicare.

Under proposed rule 500.201(e), "'Medicare'" means that term as defined in section 3157(15)(f) of the act, MCL 500.3157." Yet, the definition of Medicare in section 3157(15)(f) is ambiguous and already has led to confusion: The statutory definition does not distinguish between Medicare utilization adjustments to amounts payable under the fee schedule and Medicare eligibility requirements.

Section 3157(15)(f) defines Medicare as "fee for service payments under part A, B, or D of the federal Medicare program . . ., ***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 adjustments, or sequestration." The language in bold italics is the language which is subject to differing interpretations. When the language is read as highlighted, isolated from the other language that follows the words "***such as***," it appears to mean that anytime Medicare provides a rate for a service, regardless whether there is any limitation under Medicare guidelines relating to utilization (that is, how often such a service is provided), then that rate is an "amount payable" that must be paid at 200%. Yet, when considered in the context of the other items on the list that follow the words "***such as***," a different meaning is found. The list that follows the words "such as" is a list of adjustments to a Medicare amount payable, not an instruction to ignore Medicare eligibility requirements for a service.

For example, Medicare provides an amount payable for an attendant care *visit* under certain rare circumstances. *See* Medicare Benefit Policy Manual, Ch. 7 – Home Health Services § 30. The visit is billed in 15 minute increments of $15.80, which equals $63.20 per hour. *See* 83 Fed. Reg. 56518 (2018) (Table 35). At 200% of that rate, multiplied by the medical cost component of CPI at 4.11%, the hourly rate for basic attendant care equals $126.92 per hour, approximately four or five times

the current hourly agency rate charged by providers. Likewise, Medicare provides an amount payable for a skilled nursing care *visit* under certain circumstances. *See* Medicare Benefit Policy Manual, Ch. 7 – Home Health Services § 30. The visit is billed in 15 minute increments of $49.05, which equals $196.20 per hour. *See* 83 Fed. Reg. 56518 (2018) (Table 35). At 200% of that rate, multiplied by the medical cost component of CPI at 4.11%, the hourly rate for skilled nursing care equals $394.01 per hour, approximately five or six times the current hourly agency rate charged by providers. In a similar way, Medicare provides an amount payable for extended care services in a skilled nursing facility, but also provides a long list of eligibility requirements for qualifying for such care and only considers payment for a limited period of time. *See* Medicare Benefit Policy Manual, Ch. 8 – Coverage of Extended Care (SNF) Services Under Hospital Insurance §§ 20, 30-30.4, 30.6-.7. Medicare does not provide an amount payable for the vast majority of residential care facility claims that the MCCA reimburses. Some providers seem to agree. *See* HB 4486 and SB 314 (proposing a residential care provider-created fee schedule). Certainly, the amendments to the No-Fault Insurance Act were not intended to increase rates by four to six times current rates, especially on two of the MCCA's largest cost drivers, agency-provided in home attendant care (17.61% of all MCCA payments), and residential care (19.90%).

Turning to the list that follows the words "such as" in section 3157(15)(f) further demonstrates that the statute does not intend to ignore Medicare eligibility requirements for a service. We start with the last item on the list—"***sequestration***." "Sequestration" stems from the Budget Control Act of 2011, which required an off-the-top 2% reduction on payments to Medicare providers as part of a federal deficit reduction plan. The revised No-Fault Insurance Act does not take into account this 2% off-the-top reduction in payments to providers. Next to the last on the list of items to be ignored in determining an amount payable is "***bad debt adjustments***." This refers to bad debts attributable to unpaid deductibles and coinsurance. When determining a reasonable cost for a service, Medicare permits providers to increase the amount payable by including a percentage of their bad debts as part of the cost. *See* 42 C.F.R. § 413.89. The revised No-Fault Insurance Act does not take this kind of adjustment into account. Nor does the No-Fault Insurance Act take into account "***recaptures***." Recaptures refers to the principle that there should be an appropriate allowance for depreciation on buildings and equipment used in the provision of patient care when determining an allowable cost. That is, the amount payable is increased to account for depreciation on buildings and equipment. *See* 42 C.F.R. § 413.134. Next on this list is "***readmissions***." According to the Centers of Medicare & Medicaid Services ("CMS"), readmissions refers to CMS's Hospital Readmission Reduction Program, which is a value-based purchasing program that reduces payments to hospitals with excess readmissions. *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program. The revised No-Fault Insurance Act ignores these reductions in payments to hospitals that have avoidable readmissions. Finally, we have "***limitation or supplemental payments related to utilization***." Just as with the other items on this list, limitation or supplemental payments related to utilization refers to adjustments to the amount payable—either an upward or downward adjustment to the amount payable—

related to utilization. An example of this is the Medicare Low Utilization Payment Adjustment ("LUPA"), which is an upward adjustment to an amount payable under the Medicare fee schedule for low utilization—that is, the flip side of the readmissions penalty. *See* 42 C.F.R. § 484.230. The revised No-Fault Insurance Act ignores these adjustments in payments for low utilization.

Already, insurance companies have received notice that providers intend to rely on the strategies outlined above, such as ignoring Medicare eligibility requirements for a service, in order to avoid reducing the fees they charge for their services. *See, e.g*., Letter from Health Call (attached) (threatening to use visit codes, also known as G-codes, to avoid reducing agency attendant care rates). Yet, the proposed rules and the statute state "An 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 500.203(1). Using the calculation of 200% of a Medicare rate without regard to Medicare qualifying criteria would often, if not always, exceed the average amount charged before the revised statute took effect, resulting in a higher payment rather than a reduction in costs. To avoid the ambiguity in section 3157(15)(f) and to provide guidance to insurance companies, providers, and bill review companies, DIFS proposed Rule 500.201(e) could simply add the following language: "Nothing in section 3157(15)(f) abrogates the Medicare qualifying criteria for coverage of home health benefits, extended care services in a skilled nursing facility, or family-provided services."

2. Defining the Applicable Medicare Fee Schedule.

A further ambiguity found in the statute that could be resolved in the proposed rules is which Medicare fee schedule applies. The proposed rules purport to "define the applicable Medicare schedule." Rule 500.202(a). Rule 500.203(1) states, "When calculating the amount payable for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized." Yet, section 3157 also includes Medicare part D. If an applicable fee schedule is not available to be used when calculating an amount payable for a service under part D, the draft rules could include guidance on how to calculate these amounts. Further, Medicare fee schedules distinguish between participating and non-participating providers, with the non-participating schedule generally identifying higher amounts payable, as it allows charging the patient in addition to Medicare. In addition, there are several different types of modifiers and initiatives that are utilized under Medicare fee schedules that impact rates. To avoid the ambiguity in section 3157(15)(f) and to provide guidance to insurance companies, providers, and bill review companies, DIFS proposed Rule 500.201(e) could simply add the following language: "Rates under the applicable Medicare fee schedule are those used to pay participating providers and should be calculated using modifiers identified in the National Correct Coding Initiative."

McLaren
BAY SPECIAL CARE

Via Email

March 24, 2021

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Lansing, MI 48909-7720

Michele Estrada
EstradaM1@michigan.gov

Re: Comments on Administrative Rules for No-Fault Fee Schedule
Rule Set 2020-114 IF

Dear Ms. Estrada:

McLaren Bay Special Care submits this letter to the Department of Insurance and Financial Services ("DIFS") for consideration with respect to the public comment period for the Administrative Rules for No-Fault Fee Schedule, Rule Set 2020-114 IF, which DIFS promulgated to implement MCL 500.3157. Among other things, MCL 500.3157 establishes the amount hospitals can be reimbursed for treating injured persons covered by personal protection insurance.

We respectfully submit the following comments.

1. **Definition of "Fee Schedule"**

Proposed R 500.201(h) defines "fee schedule" to mean "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 the service is rendered."

> *In order to fully implement the intent of Public Act 21 of 2019 and Public Act 22 of 2019 (the "Amended Act"), that no-fault insurance payment to a hospital be based on the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program, we recommend that the definition of "fee schedule" be more precisely defined as follows for hospitals reimbursed under Medicare by adding the following language. This clarification is necessary because there does not exist a definitive schedule of "fee for service payments under part A, B, or D of the federal Medicare program." This is because Medicare payment to hospitals depends on many factors including prevailing wage rates in the area where a hospital is located, whether a hospital trains residents or treats a disproportionate share of low-income patients,*

and whether the hospital is a sole community hospital, to name just a few of these factors. Further, this additional clarification regarding hospital payment would enable implementation of the Amended Act in a manner that best serves the interests of auto no-fault consumers, insurers and hospitals and other providers.

(h) "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. ***For purposes of this definition, "prospective payment system" means the Medicare inpatient acute, post-acute, outpatient prospective payment system, inclusive of all hospital-specific adjustments including without limitation adjustments for acuity, area wage index, capital, teaching (both direct and indirect), disproportionate share, new technology, low volume, organ acquisition cost, routine and ancillary pass-through cost for allied health programs, outlier, and (B) for sole community hospital, rural referral centers and critical access hospitals, the equivalent hospital specific payment for providing inpatient or outpatient services to Medicare beneficiaries.***

2. Proposed R 500.203(1)

Proposed R 500.203(1) provides as follows: "When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. An amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019."

For acute inpatient hospital services, the prospective payment system ("PPS") is based on a nationally established payment formula consisting of the applicable diagnostic related group relating to the patient's treatment and the standardized amount, as adjusted by a variety of factors, all of which are updated annually. Similarly, the PPS for outpatient hospital services and for capital-related costs are based on nationally established payment formulas updated annually. Further, Medicare payment for sole community hospitals and rural referral centers is based on annually updated national payment formulas. For critical access hospitals, payment is set at 101% of allowable cost. Thus, this rule should be revised as follows to assure proper payment to hospitals based on their entitlement to Medicare payment:

When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized.

Except for hospitals reimbursed under a Medicare prospective payment system or reimbursed by Medicare as a sole community hospital, rural referral center or critical access hospital*, an amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019****, as adjusted pursuant to R 500.205(6)****. A no-fault insurer will pay to a hospital that is reimbursed under Medicare an amount equal to (1) the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program multiplied by (2) the applicable Medicare reimbursement percentage under the Amended Act.***

3. Alternatively, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, **McLaren Bay Special Care** suggests that DIFS consider an alternative methodology for hospital payment which could be promulgated in a DIFS bulletin.

Under this alternative, which the Michigan Health and Hospital Association ("MHA") previously outlined in a letter dated December 4, 2020, to Anita Fox, Director of DIFS, the no-fault insurer would pay the hospital's claim using a formula that takes into account the hospital's Medicare payment-to-charge ratio (in the aggregate) which would be updated and published annually by DIFS similar to the existing Worker's Compensation methodology. The formula would allow providers and insurers to determine the reimbursement providers are eligible to receive from insurers under the Amended Act. The formula for determining the reimbursement is as follows:

Auto No-Fault Payment = Auto No-Fault Payment Factor x Auto No-Fault Billed Charges

(1) Where the **"Auto No-Fault Payment Factor" = (Aggregate Medicare Payments / Aggregate Medicare Charges) x (Statutory Auto No-Fault Payment Multiplier)**

Aggregate Medicare Payments and Aggregate Medicare Charges for all services provided by a hospital are taken from each hospital's most recently available filed Medicare cost report to establish a single, unique ratio for that hospital, updated annually on July 1.

Annually, DIFS would publish each hospital's Auto No-Fault Payment Factor calculated by the Michigan Department of Health and Human
Services (MDHHS) using Medicare cost report data.

The Statutory Auto No-Fault Payment Multiplier is the applicable Medicare reimbursement percentage under the Amended Act (*i.e.*, 200%, 230%, or 240%). DIFS would publish the applicable Medicare reimbursement percentage for each hospital.

(2) **Example calculation of the Auto No-Fault Payment Factor and the Auto No-Fault payment based on the following assumptions:**

When the hospital submits to the insurer the hospital's bill for services, the insurer would determine payment to the hospital by reference to the published Medicare reimbursement percentage for the hospital and the Auto No-Fault Payment Factor published for the hospital. The following is an example of how payment would be computed:

Amount Billed by the Hospital to Insurer = $500

Aggregate Medicare Payment to Hospital =

$2,200,000 Aggregate Hospital Charges to

Medicare = $7,100,000 Auto No-Fault Payment

Multiplier = 240%

Auto No- Fault Payment Factor = ($2.2 Million / $7.10 Million) x (2.4) =

0.7437 Auto No-Fault Payment = (0.7437) x ($500) = $371.85

Under this example, $371.85 is the amount of reimbursement the hospital should receive from the insurer.

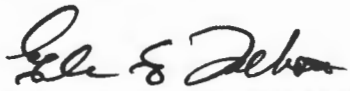
The Auto No-Fault Payment ratio would be hospital-specific. Thus, the source of the data for each hospital's Auto No-Fault Payment would be the hospital's most recently filed Medicare cost report, updated annually on July 1.

McLaren Bay Special Care proposes that the Medicare cost report would be the data source for Medicare payments and charges used to develop the Auto No-Fault Payment Factor for inpatient and the outpatient services as well as for other hospital services, such as inpatient rehabilitation facility, home health and skilled nursing facility services. The Auto No-Fault Payment Factor would be subject to an annual update based on the hospital's most recently filed cost report as of July 1 of each year, although as provided by

the Amended Act the allowable reimbursement that ties to the amount payable under Medicare must not exceed the average amount charged by the provider for the services on Jan. 1, 2019, as adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment. See MCL 500.3157(8) and (9).

McLaren Bay Special Care believes that, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, the Auto No-Fault Payment Factor serves as a reasonable proxy of the Medicare payment to which a hospital would be entitled with respect to any particular claim a hospital submits to an insurer. **McLaren Bay Special Care** further believes that payment based on the Auto No-Fault Payment Factor enables the efficient implementation and administration of the Amended Act. The alternative would be a time consuming and costly case-by-case computation that would be administratively burdensome to hospital and insurer alike.

Respectfully submitted,



Ellen E. Talbott, RN, MSN, CPHQ
President & CEO
McLaren Bay Special Care

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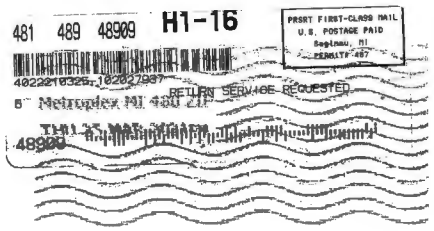

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Michele Estrada
EstradaM1@michigan.gov

Re: Comments on Administrative Rules for No-Fault Fee Schedule Rule Set 2020-114 IF

Dear Ms. Estrada:

McLaren Central Michigan submits this letter to the Department of Insurance and Financial Services ("DIFS") for consideration with respect to the public comment period for the Administrative Rules for No-Fault Fee Schedule, Rule Set 2020-114 IF, which DIFS promulgated to implement MCL 500.3157. Among other things, MCL 500.3157 establishes the amount hospitals can be reimbursed for treating injured persons covered by personal protection insurance.

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be entitled to receive from the Medicare program, we recommend that the definition of "fee schedule" be more precisely defined as follows for hospitals reimbursed under Medicare by adding the following language. This clarification is necessary because there does not exist a definitive schedule of "fee for service payments under part A, B, or D of the federal Medicare program." This is because Medicare payment to hospitals depends on many factors including prevailing wage rates in the area where a hospital is located, whether a hospital trains residents or treats a disproportionate share of low-income patients, and whether the hospital is a sole community hospital, to name just a few of these factors. Further, this additional clarification regarding hospital payment would enable implementation of the Amended Act in a manner that best serves the interests of auto no-fault consumers, insurers and hospitals and other providers.

(h) "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. ***For purposes of this definition, "prospective payment system" means the Medicare inpatient acute, post-acute, outpatient prospective payment system, inclusive of all hospital-specific adjustments including without limitation adjustments for acuity, area wage index, capital, teaching (both direct and indirect), disproportionate share, new technology, low volume, organ acquisition cost, routine and ancillary pass-through cost for allied health programs, outlier, and (B) for sole community hospital, rural referral centers and critical access hospitals, the equivalent hospital specific payment for providing inpatient or outpatient services to Medicare beneficiaries.***

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Under this alternative, which the Michigan Health and Hospital Association ("MHA") previously outlined in a letter dated December 4, 2020, to Anita Fox, Director of DIFS, the no-fault insurer would pay the hospital's claim using a formula that takes into account the hospital's Medicare payment-to-charge ratio (in the aggregate) which would be updated and published annually by DIFS similar to the existing Worker's Compensation methodology. The formula would allow providers and insurers to determine the reimbursement providers are eligible to receive from insurers under the Amended Act. The formula for determining the reimbursement is as follows:

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Darrell Lentz
President & CEO
McLaren Central Michigan

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March 24, 2021

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Michele Estrada
EstradaM1@michigan.gov

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Rule Set 2020-114 IF

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The Statutory Auto No-Fault Payment Multiplier is the applicable Medicare reimbursement percentage under the Amended Act (*i.e.*, 200%, 230%, or 240%). DIFS would publish the applicable Medicare reimbursement percentage for each hospital.

(2) **Example calculation of the Auto No-Fault Payment Factor and the Auto No-Fault payment based on the following assumptions:**

When the hospital submits to the insurer the hospital's bill for services, the insurer would determine payment to the hospital by reference to the published Medicare reimbursement percentage for the hospital and the Auto No-Fault Payment Factor published for the hospital. The following is an example of how payment would be computed:

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(2.4) = 0.7437 Auto No-Fault Payment = (0.7437) x ($500) =

$371.85

McLaren
FLINT

Under this example, $371.85 is the amount of reimbursement the hospital should receive from the insurer.

The Auto No-Fault Payment ratio would be hospital-specific. Thus, the source of the data for each hospital's Auto No-Fault Payment would be the hospital's most recently filed Medicare cost report, updated annually on July 1.

McLaren Flint proposes that the Medicare cost report would be the data source for Medicare payments and charges used to develop the Auto No-Fault Payment Factor for inpatient and the outpatient services as well as for other hospital services, such as inpatient rehabilitation facility, home health and skilled nursing facility services. The Auto No-Fault Payment Factor would be subject to an annual update based on the hospital's most recently filed cost report as of July 1 of each year, although as provided by the Amended Act the allowable reimbursement that ties to the amount payable under Medicare must not exceed the average amount charged by the provider for the services on Jan. 1, 2019, as adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment. See MCL 500.3157(8) and (9).

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Respectfully submitted,

Chad Grant
President & CEO
McLaren Flint

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March 24, 2021

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Michele Estrada
EstradaM1@michigan.gov

Re: Comments on Administrative Rules for No-Fault Fee Schedule
Rule Set 2020-114 IF

Dear Ms. Estrada:

McLaren Orthopedic Hospital submits this letter to the Department of Insurance and Financial Services ("DIFS") for consideration with respect to the public comment period for the Administrative Rules for No-Fault Fee Schedule, Rule Set 2020-114 IF, which DIFS promulgated to implement MCL 500.3157. Among other things, MCL 500.3157 establishes the amount hospitals can be reimbursed for treating injured persons covered by personal protection insurance.

We respectfully submit the following comments.

1. Definition of "Fee Schedule"

Proposed R 500.201(h) defines "fee schedule" to mean "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 the service is rendered."

In order to fully implement the intent of Public Act 21 of 2019 and Public Act 22 of 2019 (the "Amended Act"), that no-fault insurance payment to a hospital be based on the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program, we recommend that the definition of "fee schedule" be more precisely defined as follows for hospitals reimbursed under Medicare by adding the following language. This clarification is necessary because there does not exist a definitive schedule of "fee for service payments under part A, B, or D of the federal Medicare program." This is because Medicare payment to hospitals

depends on many factors including prevailing wage rates in the area where a hospital is located, whether a hospital trains residents or treats a disproportionate share of low-income patients, and whether the hospital is a sole community hospital, to name just a few of these factors. Further, this additional clarification regarding hospital payment would enable implementation of the Amended Act in a manner that best serves the interests of auto no-fault consumers, insurers and hospitals and other providers.

(h) "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. ***For purposes of this definition, "prospective payment system" means the Medicare inpatient acute, post-acute, outpatient prospective payment system, inclusive of all hospital-specific adjustments including without limitation adjustments for acuity, area wage index, capital, teaching (both direct and indirect), disproportionate share, new technology, low volume, organ acquisition cost, routine and ancillary pass-through cost for allied health programs, outlier, and (B) for sole community hospital, rural referral centers and critical access hospitals, the equivalent hospital specific payment for providing inpatient or outpatient services to Medicare beneficiaries.***

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3. Alternatively, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, **McLaren Orthopedic Hospital** suggests that DIFS consider an alternative methodology for hospital payment which could be promulgated in a DIFS bulletin.

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Auto No-Fault Payment = Auto No-Fault Payment Factor x Auto No-Fault Billed Charges

(1) Where the **"Auto No-Fault Payment Factor" = (Aggregate Medicare Payments / Aggregate Medicare Charges) x (Statutory Auto No-Fault Payment Multiplier)**

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Respectfully submitted,

Kirk Ray
President & CEO
McLaren Orthopedic Hospital

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Via Email

March 24, 2021

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Michele Estrada
EstradaM1@michigan.gov

Re: Comments on Administrative Rules for No-Fault Fee Schedule
Rule Set 2020-114 IF

Dear Ms. Estrada:

McLaren Greater Lansing submits this letter to the Department of Insurance and Financial Services ("DIFS") for consideration with respect to the public comment period for the Administrative Rules for No-Fault Fee Schedule, Rule Set 2020-114 IF, which DIFS promulgated to implement MCL 500.3157. Among other things, MCL 500.3157 establishes the amount hospitals can be reimbursed for treating injured persons covered by personal protection insurance.

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Kirk Ray
President & CEO
McLaren Greater Lansing

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March 24, 2021

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Michele Estrada
EstradaM1@michigan.gov

Re: Comments on Administrative Rules for No-Fault Fee Schedule Rule Set 2020-114 IF

Dear Ms. Estrada:

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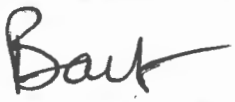

Barton Buxton, Ed.D.
President & CEO
McLaren Health Management Group

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March 24, 2021

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Michele Estrada
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Re: Comments on Administrative Rules for No-Fault Fee Schedule Rule Set 2020-114 IF

Dear Ms. Estrada:

McLaren Lapeer Region submits this letter to the Department of Insurance and Financial Services ("DIFS") for consideration with respect to the public comment period for the Administrative Rules for No-Fault Fee Schedule, Rule Set 2020-114 IF, which DIFS promulgated to implement MCL 500.3157. Among other things, MCL 500.3157 establishes the amount hospitals can be reimbursed for treating injured persons covered by personal protection insurance.

We respectfully submit the following comments.

1. **Definition of "Fee Schedule"**

Proposed R 500.201(h) defines "fee schedule" to mean "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 the service is rendered."

In order to fully implement the intent of Public Act 21 of 2019 and Public Act 22 of 2019 (the "Amended Act"), that no-fault insurance payment to a hospital be based on the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program, we recommend that the definition of "fee schedule" be more precisely defined as follows for hospitals reimbursed under Medicare by adding the following language. This clarification is necessary because there does not exist a definitive schedule of "fee for service payments under part A, B, or D of the federal Medicare program." This is because Medicare payment to hospitals depends on many factors including prevailing wage rates in the area where a hospital is located, whether a hospital trains

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residents or treats a disproportionate share of low-income patients, and whether the hospital is a sole community hospital, to name just a few of these factors. Further, this additional clarification regarding hospital payment would enable implementation of the Amended Act in a manner that best serves the interests of auto no-fault consumers, insurers and hospitals and other providers.

(h) "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. ***For purposes of this definition, "prospective payment system" means the Medicare inpatient acute, post-acute, outpatient prospective payment system, inclusive of all hospital-specific adjustments including without limitation adjustments for acuity, area wage index, capital, teaching (both direct and indirect), disproportionate share, new technology, low volume, organ acquisition cost, routine and ancillary pass-through cost for allied health programs, outlier, and (B) for sole community hospital, rural referral centers and critical access hospitals, the equivalent hospital specific payment for providing inpatient or outpatient services to Medicare beneficiaries.***

2. Proposed R 500.203(1)

Proposed R 500.203(1) provides as follows: "When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. An amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019."

For acute inpatient hospital services, the prospective payment system ("PPS") is based on a nationally established payment formula consisting of the applicable diagnostic related group relating to the patient's treatment and the standardized amount, as adjusted by a variety of factors, all of which are updated annually. Similarly, the PPS for outpatient hospital services and for capital-related costs are based on nationally established payment formulas updated annually. Further, Medicare payment for sole community hospitals and rural referral centers is based on annually updated national payment formulas. For critical access hospitals, payment is set at 101% of allowable cost. Thus, this rule should be revised as follows to assure proper payment to hospitals based on their entitlement to Medicare payment:

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3. Alternatively, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, **McLaren Lapeer Region** suggests that DIFS consider an alternative methodology for hospital payment which could be promulgated in a DIFS bulletin.

Under this alternative, which the Michigan Health and Hospital Association ("MHA") previously outlined in a letter dated December 4, 2020, to Anita Fox, Director of DIFS, the no-fault insurer would pay the hospital's claim using a formula that takes into account the hospital's Medicare payment-to-charge ratio (in the aggregate) which would be updated and published annually by DIFS similar to the existing Worker's Compensation methodology. The formula would allow providers and insurers to determine the reimbursement providers are eligible to receive from insurers under the Amended Act. The formula for determining the reimbursement is as follows:

Auto No-Fault Payment = Auto No-Fault Payment Factor x Auto No-Fault Billed Charges

(1) Where the **"Auto No-Fault Payment Factor" = (Aggregate Medicare Payments / Aggregate Medicare Charges) x (Statutory Auto No-Fault Payment Multiplier)**

Aggregate Medicare Payments and Aggregate Medicare Charges for all services provided by a hospital are taken from each hospital's most recently available filed Medicare cost report to establish a single, unique ratio for that hospital, updated annually on July 1.

Annually, DIFS would publish each hospital's Auto No-Fault Payment Factor calculated by the Michigan Department of Health and Human
Services (MDHHS) using Medicare cost report data.

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The Statutory Auto No-Fault Payment Multiplier is the applicable Medicare reimbursement percentage under the Amended Act (*i.e.*, 200%, 230%, or 240%). DIFS would publish the applicable Medicare reimbursement percentage for each hospital.

(2) **Example calculation of the Auto No-Fault Payment Factor and the Auto No-Fault payment based on the following assumptions:**

When the hospital submits to the insurer the hospital's bill for services, the insurer would determine payment to the hospital by reference to the published Medicare reimbursement percentage for the hospital and the Auto No-Fault Payment Factor published for the hospital. The following is an example of how payment would be computed:

Amount Billed by the Hospital to Insurer = $500

Aggregate Medicare Payment to Hospital =

$2,200,000 Aggregate Hospital Charges to

Medicare = $7,100,000 Auto No-Fault Payment

Multiplier = 240%

Auto No- Fault Payment Factor = ($2.2 Million / $7.10 Million) x (2.4) =

0.7437 Auto No-Fault Payment = (0.7437) x ($500) = $371.85

Under this example, $371.85 is the amount of reimbursement the hospital should receive from the insurer.

The Auto No-Fault Payment ratio would be hospital-specific. Thus, the source of the data for each hospital's Auto No-Fault Payment would be the hospital's most recently filed Medicare cost report, updated annually on July 1.

McLaren Lapeer Region proposes that the Medicare cost report would be the data source for Medicare payments and charges used to develop the Auto No-Fault Payment Factor for inpatient and the outpatient services as well as for other hospital services, such as inpatient rehabilitation facility, home health and skilled nursing facility services. The Auto No-Fault Payment Factor would be subject to an annual update based on the hospital's most recently filed cost report as of July 1 of each year, although as provided by

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the Amended Act the allowable reimbursement that ties to the amount payable under Medicare must not exceed the average amount charged by the provider for the services on Jan. 1, 2019, as adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment. See MCL 500.3157(8) and (9).

McLaren Lapeer Region believes that, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, the Auto No-Fault Payment Factor serves as a reasonable proxy of the Medicare payment to which a hospital would be entitled with respect to any particular claim a hospital submits to an insurer. **McLaren Lapeer Region** further believes that payment based on the Auto No-Fault Payment Factor enables the efficient implementation and administration of the Amended Act. The alternative would be a time consuming and costly case-by-case computation that would be administratively burdensome to hospital and insurer alike.

Respectfully submitted,

Chris Candela
President & CEO
McLaren Lapeer Region

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Tom Brisse
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March 24, 2021

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Rule Set 2020-114 IF

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We respectfully submit the following comments.

1. <u>Definition of "Fee Schedule"</u>

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(h) "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. ***For purposes of this definition, "prospective payment system" means the Medicare inpatient acute, post-acute, outpatient prospective payment system, inclusive of all hospital-specific adjustments including without limitation adjustments for acuity, area wage index, capital, teaching (both direct and indirect), disproportionate share, new technology, low volume, organ acquisition cost, routine and ancillary pass-through cost for allied health programs, outlier, and (B) for sole community hospital, rural referral centers and critical access hospitals, the equivalent hospital specific payment for providing inpatient or outpatient services to Medicare beneficiaries.***

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For acute inpatient hospital services, the prospective payment system ("PPS") is based on a nationally established payment formula consisting of the applicable diagnostic related group relating to the patient's treatment and the standardized amount, as adjusted by a variety of factors, all of which are updated annually. Similarly, the PPS for outpatient hospital services and for capital-related costs are based on nationally established payment formulas updated annually. Further, Medicare payment for sole community hospitals and rural referral centers is based on annually updated national payment formulas. For critical access hospitals, payment is set at 101% of allowable cost. Thus, this rule should be revised as follows to assure proper payment to hospitals based on their entitlement to Medicare payment:

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Under this alternative, which the Michigan Health and Hospital Association ("MHA") previously outlined in a letter dated December 4, 2020, to Anita Fox, Director of DIFS, the no-fault insurer would pay the hospital's claim using a formula that takes into account the hospital's Medicare payment-to-charge ratio (in the aggregate) which would be updated and published annually by DIFS similar to the existing Worker's Compensation methodology. The formula would allow providers and insurers to determine the reimbursement providers are eligible to receive from insurers under the Amended Act. The formula for determining the reimbursement is as follows:

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(1) Where the "Auto No-Fault Payment Factor" = (Aggregate Medicare Payments / Aggregate Medicare Charges) x (Statutory Auto No-Fault Payment Multiplier)

Aggregate Medicare Payments and Aggregate Medicare Charges for all services provided by a hospital are taken from each hospital's most recently available filed Medicare cost report to establish a single, unique ratio for that hospital, updated annually on July 1.

Annually, DIFS would publish each hospital's Auto No-Fault Payment Factor calculated by the Michigan Department of Health and Human
Services (MDHHS) using Medicare cost report data.

The Statutory Auto No-Fault Payment Multiplier is the applicable Medicare reimbursement percentage under the Amended Act (*i.e.*, 200%, 230%, or 240%). DIFS would publish the applicable Medicare reimbursement percentage for each hospital.

(2) Example calculation of the Auto No-Fault Payment Factor and the Auto No-Fault payment based on the following assumptions:

When the hospital submits to the insurer the hospital's bill for services, the insurer would determine payment to the hospital by reference to the published Medicare reimbursement percentage for the hospital and the Auto No-Fault Payment Factor published for the hospital. The following is an example of how payment would be computed:

Amount Billed by the Hospital to Insurer = $500 Aggregate Medicare Payment to Hospital = $2,200,000 Aggregate Hospital Charges to Medicare = $7,100,000 Auto No-Fault Payment Multiplier = 240%

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McLaren Macomb proposes that the Medicare cost report would be the data source for Medicare payments and charges used to develop the Auto No-Fault Payment Factor for inpatient and the outpatient services as well as for other hospital services, such as inpatient rehabilitation facility, home health and skilled nursing facility services. The Auto No-Fault Payment Factor would be subject to an annual update based on the hospital's most recently filed cost report as of July 1 of each year, although as provided by the Amended Act the allowable reimbursement that ties to the amount payable under Medicare must not exceed the average amount charged by the provider for the services on Jan. 1, 2019, as adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment. See MCL 500.3157(8) and (9).

McLaren Macomb believes that, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, the Auto No-Fault Payment Factor serves as a reasonable proxy of the Medicare payment to which a hospital would be entitled with respect to any particular claim a hospital submits to an insurer. **McLaren Macomb** further believes that payment based on the Auto No-Fault Payment Factor enables the efficient implementation and administration of the Amended Act. The alternative would be a time consuming and costly case-by-case computation that would be administratively burdensome to hospital and insurer alike.

Respectfully submitted,

Thomas M. Brisse
President & CEO
McLaren Macomb

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Michele Estrada
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Re: Comments on Administrative Rules for No-Fault Fee Schedule
Rule Set 2020-114 IF

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language. This clarification is necessary because there does not exist a definitive schedule of "fee for service payments under part A, B, or D of the federal Medicare program." This is because Medicare payment to hospitals depends on many factors including prevailing wage rates in the area where a hospital is located, whether a hospital trains residents or treats a disproportionate share of low-income patients, and whether the hospital is a sole community hospital, to name just a few of these factors. Further, this additional clarification regarding hospital payment would enable implementation of the Amended Act in a manner that best serves the interests of auto no-fault consumers, insurers and hospitals and other providers.

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Respectfully submitted,

Todd Burch
President & CEO
McLaren Northern Region

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Michelle Estrada
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Via Email

March 24, 2021

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Michele Estrada
EstradaM1@michigan.gov

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relating to the patient's treatment and the standardized amount, as adjusted by a variety of factors, all of which are updated annually. Similarly, the PPS for outpatient hospital services and for capital-related costs are based on nationally established payment formulas updated annually. Further, Medicare payment for sole community hospitals and rural referral centers is based on annually updated national payment formulas. For critical access hospitals, payment is set at 101% of allowable cost. Thus, this rule should be revised as follows to assure proper payment to hospitals based on their entitlement to Medicare payment:

When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. ***Except for hospitals reimbursed under a Medicare prospective payment system or reimbursed by Medicare as a sole community hospital, rural referral center or critical access hospital****, an amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019****, as adjusted pursuant to R 500.205(6)****.* ***A no-fault insurer will pay to a hospital that is reimbursed under Medicare an amount equal to (1) the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program multiplied by (2) the applicable Medicare reimbursement percentage under the Amended Act.***

3. Alternatively, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, **McLaren Northern Region** suggests that DIFS consider an alternative methodology for hospital payment which could be promulgated in a DIFS bulletin.

Under this alternative, which the Michigan Health and Hospital Association ("MHA") previously outlined in a letter dated December 4, 2020, to Anita Fox, Director of DIFS, the no-fault insurer would pay the hospital's claim using a formula that takes into account the hospital's Medicare payment-to-charge ratio (in the aggregate) which would be updated and published annually by DIFS similar to the existing Worker's Compensation

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methodology. The formula would allow providers and insurers to determine the reimbursement providers are eligible to receive from insurers under the Amended Act. The formula for determining the reimbursement is as follows:

Auto No-Fault Payment = Auto No-Fault Payment Factor x Auto No-Fault Billed Charges

(1) Where the **"Auto No-Fault Payment Factor" = (Aggregate Medicare Payments / Aggregate Medicare Charges) x (Statutory Auto No-Fault Payment Multiplier)**

Aggregate Medicare Payments and Aggregate Medicare Charges for all services provided by a hospital are taken from each hospital's most recently available filed Medicare cost report to establish a single, unique ratio for that hospital, updated annually on July 1.

Annually, DIFS would publish each hospital's Auto No-Fault Payment Factor calculated by the Michigan Department of Health and Human Services (MDHHS) using Medicare cost report data.

The Statutory Auto No-Fault Payment Multiplier is the applicable Medicare reimbursement percentage under the Amended Act (*i.e.*, 200%, 230%, or 240%). DIFS would publish the applicable Medicare reimbursement percentage for each hospital.

(2) **Example calculation of the Auto No-Fault Payment Factor and the Auto No-Fault payment based on the following assumptions:**

When the hospital submits to the insurer the hospital's bill for services, the insurer would determine payment to the hospital by reference to the published Medicare reimbursement percentage for the hospital and the Auto No-Fault Payment Factor published for the hospital. The following is an example of how payment would be computed:

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Amount Billed by the Hospital to

Insurer = $500 Aggregate

Medicare Payment to Hospital =

$2,200,000 Aggregate Hospital

Charges to Medicare =

$7,100,000 Auto No-Fault

Payment Multiplier = 240%

Auto No- Fault Payment Factor = ($2.2 Million / $7.10

Million) x (2.4) = 0.7437 Auto No-Fault Payment =

(0.7437) x ($500) = $371.85

Under this example, $371.85 is the amount of reimbursement the hospital should receive from the insurer.

The Auto No-Fault Payment ratio would be hospital-specific. Thus, the source of the data for each hospital's Auto No-Fault Payment would be the hospital's most recently filed Medicare cost report, updated annually on July 1.

McLaren Northern Region proposes that the Medicare cost report would be the data source for Medicare payments and charges used to develop the Auto No-Fault Payment Factor for inpatient and the outpatient services as well as for other hospital services, such as inpatient rehabilitation facility, home health and skilled nursing facility services. The Auto No-Fault Payment Factor would be subject to an annual update based on the hospital's most recently filed cost report as of July 1 of each year, although as provided by the Amended Act the allowable reimbursement that ties to the amount payable under

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Medicare must not exceed the average amount charged by the provider for the services on Jan. 1, 2019, as adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment. See MCL 500.3157(8) and (9).

McLaren Northern Region believes that, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, the Auto No-Fault Payment Factor serves as a reasonable proxy of the Medicare payment to which a hospital would be entitled with respect to any particular claim a hospital submits to an insurer. **McLaren Northern Region** further believes that payment based on the Auto No-Fault Payment Factor enables the efficient implementation and administration of the Amended Act. The alternative would be a time consuming and costly case-by-case computation that would be administratively burdensome to hospital and insurer alike.

Respectfully submitted,

Todd Burch
President & CEO
McLaren Northern Region

Estrada, Michele (DIFS)

From: Melissa Radtke <melissa@3firefighters.com>
Sent: Friday, March 26, 2021 10:33 AM
To: Estrada, Michele (DIFS)
Subject: DIFS proposed administrative rules

My name is Melissa Sharp. I work at 1st Call Home Healthcare at 22367 Starks Dr, Clinton Twp, MI 48036. I oppose the DIFS proposed administrative rules for the auto no-fault fee schedule. Rule set 2020-114 IF

--
Melissa Radtke Sharp
Intake/Patient Services
Auto/WC Division
1st Call Home Healthcare
586-307-6298 Ext 903

METRO HEALTH
UNIVERSITY OF MICHIGAN HEALTH

March 25, 2021

VIA Email

Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
P.O. Box 30220
Lansing, MI 48909-7720

Michele Estrada
EstradaM1@michigan.gov

RE: *Comments on Administrative Rules for No-Fault Fee Schedule*
Rule Set 2020-114 IF

Dear Ms. Estrada:

Thank you for the opportunity to submit comments to the Department of Insurance and Financial Services (DIFS) for consideration regarding the Administrative Rules for Auto No Fault (ANF) Fee Schedule. Specifically addressing Rule Set 2020-114 IF, which DIFS promulgated to implement MCL 500.3157. Among other things, MCL 500.3157 establishes the amount hospitals can be reimbursed (paid) for treating injured persons covered by ANF personal protection insurance.

Before commenting it is important to share a little about who we are as a teaching hospital. Metro Health - University of Michigan Health (MH-UMH) is located in west Michigan. MH-UMH is an award-winning leader in the west Michigan community and has 500 physicians on staff who serve more than 150,000 patients annually across west Michigan and beyond. Metro Health Hospital is a 208-bed general acute care teaching hospital that provides a comprehensive suite of inpatient and outpatient healthcare services including cancer and cardiac care, robotic and traditional surgery, family practice, sports medicine, neurology, and pulmonology.

MH-UMH is designated as a Level II Trauma Center. As a Level II Trauma Center, MH-UMH can initiate definitive care for all injured patients. Elements of Level II Trauma Centers Include: 24-hour immediate coverage by general surgeons, as well as coverage by the specialties of orthopedic surgery, neurosurgery, anesthesiology, emergency medicine, radiology, and critical care. It is critical that DIFS establishes a proper and fair payment model, so hospitals such as ours, will be properly paid.

Our comments on the proposed ANF Administrative Rules focus on the following areas:

- Definition of “Fee Schedule”
- Proposed R 500.203(1) – Calculating the amount due a provider
- Suggestion for alternative payment model

Definition of "Fee Schedule"

Proposed R 500.201(h) defines "fee schedule" to mean 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 the service is rendered." It is very important to note that the plain language of "fee schedule" is not a payment model term used in Medicare for hospital payments, rather the prospective payment system (PPS) would be the more proper hospital payment term, and MH-UMH encourages DIFS to use that term in all instances of the Rule. The only appropriate time to use the term "fee schedule" in reference to a Medicare payment would be for payments made to a physician for their services. This schedule is referred to as the Physician Fee Schedule (PFS), and again that schedule is only proper for Medicare payment for the time spent by a physician. MH-UMH would encourage DIFS to make a clear distinction between the two Medicare Payment systems.

Therefore, in order to fully implement the intent of Public Act 21 of 2019 and Public Act 22 of 2019 (the "Amended Act"), that no-fault insurance payment to a hospital be based on the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program, MH-UMH recommends that the definition of "fee schedule" be more precisely defined as follows for hospitals reimbursed under Medicare by adding the following language. This clarification is critical, as noted above, as there does not exist a definitive schedule of "fee for service payments under part A, B, or D of the federal Medicare program." This is because Medicare payment to hospitals depends on many factors including prevailing wage rates in the area where a hospital is located, whether a hospital trains residents or treats a disproportionate share of low-income patients, to name just a few of these factors. Further, this additional clarification regarding hospital payment would enable implementation of the Amended Act in a manner that best serves the interests of auto no-fault consumers, insurers and hospitals and other providers.

DIFS needs to consider changing the reference to "Fee Schedule" or define it better to mean, as applicable, the Medicare **prospective payment system** in effect on the date the service is rendered and for the locality in which such service is rendered. **For purposes of this definition, "prospective payment system" means the Medicare inpatient acute, post-acute, outpatient prospective payment system, inclusive of all hospital-specific adjustments including without limitation adjustments for acuity, area wage index, capital, teaching (both direct and indirect), disproportionate share (inclusive of a hospital's share of the national uncompensated care pool), new technology, low volume, organ acquisition cost, routine and ancillary pass-through cost for allied health programs, and most importantly outlier payments, for the equivalent hospital specific payment for providing inpatient or outpatient services to Medicare beneficiaries. And only use Fee Schedule in reference to payments made to a physician.**

Proposed R 500.203(1) – Calculating the amount due a provider

Proposed R 500.203(1) provides as follows: "When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. An amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019."

For acute inpatient hospital services, PPS is based on a nationally established payment formula consisting of the applicable diagnostic related group relating to the patient's treatment and the standardized amount, as adjusted by a variety of factors, all of which are updated annually. Similarly, the PPS for outpatient hospital services and

for capital-related costs are based on nationally established payment formulas updated annually. Thus, this rule should be revised as follows to assure proper payment to hospitals based on their expected Medicare payment: When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized only for physician payment. **Then address separately, hospitals reimbursed under a Medicare prospective payment system**, and, then the amount payable pursuant to the physician fee schedule or PPS may not exceed the average amount charged by the provider for the service on January 1, 2019**, as adjusted pursuant to R 500.205(6)**. **A no-fault insurer will pay to a hospital that is reimbursed under Medicare an amount equal to (1) the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program multiplied by (2) the applicable Medicare reimbursement percentage under the Amended Act.**

Suggestion for alternative payment model

Alternatively, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, MH-UMH joins with the Michigan Health and Hospital Association (MHA) and suggests that DIFS consider one of two alternative methodologies for hospital payment which could be promulgated in a DIFS bulletin.

Under alternative 1, which MHA (after working closely with its member hospitals) previously outlined in a letter dated December 4, 2020, to Anita Fox, Director of DIFS, the no-fault insurer would pay the hospital's claim using a formula that takes into account the hospital's Medicare payment-to-charge ratio (in the aggregate) which would be updated and published annually by DIFS similar to the existing Worker's Compensation methodology. The formula would allow providers and insurers to determine the reimbursement (payment) providers are eligible to receive from insurers under the Amended Act. The formula for determining the reimbursement is as follows:

Auto No-Fault Payment = Auto No-Fault Payment Factor x Auto No-Fault Billed Charges

(1) **Where the "Auto No-Fault Payment Factor" = (Aggregate Medicare Payments / Aggregate Medicare Charges) x (Statutory Auto No-Fault Payment Multiplier)**

Aggregate Medicare Payments and Aggregate Medicare Charges for all services provided by a hospital are taken from each hospital's most recently available filed Medicare cost report to establish a single, unique ratio for that hospital, updated annually on July 1.

Annually, DIFS would publish each hospital's Auto No-Fault Payment Factor calculated by the Michigan Department of Health and Human Services (MDHHS) using Medicare cost report data.

The Statutory Auto No-Fault Payment Multiplier is the applicable Medicare reimbursement percentage under the Amended Act (*i.e.*, 200%, 230%, or 240%). DIFS would publish the applicable Medicare reimbursement percentage for each hospital.

(2) Example calculation of the Auto No-Fault Payment Factor and the Auto No-Fault payment based on the following assumptions:

When the hospital submits to the insurer the hospital's bill for services, the insurer would determine payment to the hospital by reference to the published Medicare reimbursement percentage for the hospital and the Auto No-Fault Payment Factor published for the hospital. The following is an example of how payment would be computed:

Amount Billed by the Hospital to Insurer = $500 Aggregate Medicare Payment to Hospital = $2,200,000 Aggregate Hospital Charges to Medicare = $7,100,000 Auto No-Fault Payment Multiplier = 240%

Auto No- Fault Payment Factor = ($2.2 Million / $7.10 Million) x (2.4) = 0.7437 Auto No-Fault Payment = (0.7437) x ($500) = $371.85

Under this example, $371.85 is the amount of reimbursement the hospital should receive from the insurer. The Auto No-Fault Payment ratio would be hospital specific. Thus, the source of the data for each hospital's Auto No-Fault Payment would be the hospital's most recently filed Medicare cost report, updated annually on July 1.

MH-UMH proposes that the Medicare cost report would be the data source for Medicare payments and charges used to develop the Auto No-Fault Payment Factor for inpatient and the outpatient services as well as for other hospital services, such as inpatient rehabilitation facility, home health and skilled nursing facility services. The Auto No-Fault Payment Factor would be subject to an annual update based on the hospital's most recently filed cost report as of July 1 of each year, although as provided by the Amended Act the allowable reimbursement that ties to the amount payable under Medicare must not exceed the average amount charged by the provider for the services on Jan. 1, 2019, as adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment. See MCL 500.3157(8) and (9).

MH-UMH further suggests Alternative 2, using a hospital specific DRG Grouper Model.

This model would allow an auto insurance provider to price a claim the exact same way as Medicare and then apply the applicable update factor to that calculated payment.

Key considerations of Hospital specific DRG Grouper model

1) More complex to implement for auto insurance payers and generally more difficult to process and price claims individually. But, an accurate payment result.
2) Applies a hospital specific rate and prices each claim on the merits of the diagnosis and the intensity of services provided, considering outlier prevalence will be specific with this population.
3) Minimizes risk for recoveries for medical necessity reviews since payments based on DRGs are generally independent of charges.

MH-UMH believes that, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, the Auto No-Fault Payment Factor (alternative 1) serves as a reasonable proxy of the Medicare payment to which a hospital would be entitled with respect to any particular claim a hospital submits to an insurer. MH-UMH further believes that either payment based on the Auto No-Fault Payment Factor or hospital specific DRG Grouper

enables the efficient implementation and administration of the Amended Act. Both alternatives have merit, and both could be implemented, and either is a better alternative than the current proposed rule.

In conclusion, the draft of the Administrative Rule cannot be allowed to move forward without addressing the items noted above. To allow this proposal to move forward would allow the auto insurance industry to wreak havoc on the payments to hospitals for the care rendered to auto insurance members. This clear lack of direction would cause a tremendous administrative burden on the billing and revenue cycle team at MH-UMH and would add cost to the already very expense heath care industry. This administrative burden is in addition to the routine work our care management and utilization teams will need to certify each patient. Moreover, we are concerned about the incremental effort to support the recently outlined appeal process and we expect this work to be supported by a multi-disciplinary group from our revenue cycle team and clinical staff evaluating and responding to medical necessity challenges.

Thank you again for the opportunity to comment on the proposed ANF Administrative Rules. We also very much appreciate DIFS efforts in furtherance of promoting regulatory flexibility and efficiency, so healthcare providers like MH-UMH can focus on providing high-quality, high-value care to our ANF patients.

Sincerely,

Kris Kurtz
Chief Financial Officer
Metro Health – University of Michigan Health

Via Email

March 26, 2021

Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
P.O. Box 30220
Lansing, MI 48909-7720

Michele Estrada
EstradaM1@michigan.gov

Re: Comments on Administrative Rules for No-Fault Fee Schedule Rule Set 2020-114 IF

Dear Ms. Estrada:

The Michigan Health and Hospital Association (MHA) submits this letter to the Department of Insurance and Financial Services (DIFS) for consideration with respect to the public comment period for the Administrative Rules for No-Fault Fee Schedule, Rule Set 2020-114 IF, which DIFS promulgated to implement MCL 500.3157. Among other things, MCL 500.3157 establishes the amount hospitals can be reimbursed for treating injured persons covered by personal protection insurance.

We respectfully submit the following comments.

1. <u>Definition of "Fee Schedule"</u>

Proposed R 500.201(h) defines "fee schedule" to mean "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 the service is rendered."

In order to fully implement the intent of Public Act 21 of 2019 and Public Act 22 of 2019 (the "Amended Act"), that no-fault insurance payment to a hospital be based on the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program, we recommend that the definition of "fee schedule" be more precisely defined as follows for hospitals reimbursed under Medicare by adding the following language. This clarification is necessary because there does not exist a definitive schedule of "fee for service payments under part A, B, or D of the federal Medicare program." This is because Medicare payment to hospitals depends on many factors including prevailing wage rates in the area where

a hospital is located, whether a hospital trains residents or treats a disproportionate share of low-income patients, and whether the hospital is a sole community hospital, to name just a few of these factors. Further, this additional clarification regarding hospital payment would enable implementation of the Amended Act in a manner that best serves the interests of auto no-fault consumers, insurers and hospitals and other providers.

(h) "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. ***For purposes of this definition, "prospective payment system" means the Medicare inpatient acute, post-acute, outpatient prospective payment system, inclusive of all hospital-specific adjustments including without limitation adjustments for acuity, area wage index, capital, teaching (both direct and indirect), disproportionate share, new technology, low volume, organ acquisition cost, routine and ancillary pass-through cost for allied health programs, outlier, and (B) for sole community hospital, rural referral centers and critical access hospitals, the equivalent hospital specific payment for providing inpatient or outpatient services to Medicare beneficiaries.***

2. Proposed R 500.203(1)

Proposed R 500.203(1) provides as follows: "When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. An amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019."

For acute inpatient hospital services, the prospective payment system ("PPS") is based on a nationally established payment formula consisting of the applicable diagnostic related group relating to the patient's treatment and the standardized amount, as adjusted by a variety of factors, all of which are updated annually. Similarly, the PPS for outpatient hospital services and for capital-related costs are based on nationally established payment formulas updated annually. Further, Medicare payment for sole community hospitals and rural referral centers based on annually updated national payment formulas. For critical access hospitals, payment is set at 101% of allowable cost. Thus, this rule should be revised as follows to assure proper payment to hospitals based on their entitlement to Medicare payment:

When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. ***Except for hospitals reimbursed under a Medicare prospective payment system or reimbursed***

by Medicare as a sole community hospital, Medicare dependent hospital, rural referral center, or critical access hospital*, an amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019****, as adjusted pursuant to R 500.205(6)****. **A no-fault insurer will pay to a hospital that is reimbursed under Medicare an amount equal to (1) the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program multiplied by (2) the applicable Medicare reimbursement percentage under the Amended Act.***

3. Alternatively, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, MHA suggests that DIFS consider an alternative methodology for hospital payment which could be promulgated in a DIFS bulletin.

Under this alternative, which MHA previously outlined in a letter dated December 4, 2020, to Anita Fox, Director of DIFS, the no-fault insurer would pay the hospital's claim using a formula that takes into account the hospital's Medicare payment-to-charge ratio (in the aggregate) which would be updated and published annually by DIFS similar to the existing Worker's Compensation methodology. The formula would allow providers and insurers to determine the reimbursement providers are eligible to receive from insurers under the Amended Act. The formula for determining the reimbursement is as follows:

Auto No-Fault Payment = Auto No-Fault Payment Factor x Auto No-Fault Billed Charges

(1) Where the **"Auto No-Fault Payment Factor" = (Aggregate Medicare Payments / Aggregate Medicare Charges) x (Statutory Auto No-Fault Payment Multiplier)**

Aggregate Medicare Payments and Aggregate Medicare Charges for all services provided by a hospital are taken from each hospital's most recently available filed Medicare cost report to establish a single, unique ratio for that hospital, updated annually on July 1.

Annually, DIFS would publish each hospital's Auto No-Fault Payment Factor calculated by the Michigan Department of Health and Human Services (MDHHS) using Medicare cost report data.

The Statutory Auto No-Fault Payment Multiplier is the applicable Medicare reimbursement percentage under the Amended Act (*i.e*., 200%, 230%, or 240%). DIFS would publish the applicable Medicare reimbursement percentage for each hospital.

(2) Example calculation of the Auto No-Fault Payment Factor and the Auto No-Fault payment based on the following assumptions:

When the hospital submits to the insurer the hospital's bill for services, the insurer would determine payment to the hospital by reference to the published Medicare reimbursement percentage for the hospital and the Auto No-Fault Payment Factor published for the hospital. The following is an example of how payment would be computed:

Amount Billed by the Hospital to Insurer = $500

Aggregate Medicare Payment to Hospital = $2,200,000

Aggregate Hospital Charges to Medicare = $7,100,000

Auto No-Fault Payment Multiplier = 240%

Auto No- Fault Payment Factor = ($2.2 Million / $7.10 Million) x (2.4) = 0.7437

Auto No-Fault Payment = (0.7437) x ($500) = $371.85

Under this example, $371.85 is the amount of reimbursement the hospital should receive from the insurer.

The Auto No-Fault Payment ratio would be hospital-specific. Thus, the source of the data for each hospital's Auto No-Fault Payment would be the hospital's most recently filed Medicare cost report, updated annually on July 1.

MHA proposes that the Medicare cost report would be the data source for Medicare payments and charges used to develop the Auto No-Fault Payment Factor for inpatient and the outpatient services as well as for other hospital services, such as inpatient rehabilitation facility, home health and skilled nursing facility services. The Auto No-Fault Payment Factor would be subject to an annual update based on the hospital's most recently filed cost report as of July 1 of each year, although as provided by the Amended Act the allowable reimbursement that ties to the amount payable under Medicare must not exceed the average amount charged by the provider for the services on Jan. 1, 2019, as adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment. See MCL 500.3157(8) and (9).

MHA believes that, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, the Auto No-Fault Payment Factor serves as a reasonable proxy of the Medicare payment to which a hospital would be entitled with respect to any particular claim a hospital submits to an insurer. MHA further

believes that payment based on the Auto No-Fault Payment Factor enables the efficient implementation and administration of the Amended Act. The alternative would be a time consuming and costly case-by-case computation that would be administratively burdensome to hospital and insurer alike.

Respectfully submitted,

Laura Appel | Senior Vice President
Michigan Health & Hospital Association
Office: (517) 703-8606 | Cell: (517) 285-2962
lappel@mha.org | www.mha.org

Estrada, Michele (DIFS)

From: Mike Barnhard <Mike@3firefighters.com>
Sent: Friday, March 26, 2021 1:26 PM
To: Estrada, Michele (DIFS)
Subject: admin rule

My name is Michael Barnhard, I am the Co-Owner and CFO at 1st Call Home Healthcare at 22367 Starks Dr, Clinton Twp, MI 48036. I oppose the DIFS proposed administrative rules for the auto no-fault fee schedule. Rule set 2020-114 IF

Estrada, Michele (DIFS)

From: Michelle Heskett <Michelleh@3firefighters.com>
Sent: Friday, March 26, 2021 5:40 PM
To: Estrada, Michele (DIFS)
Subject: Oppose

My name is Michelle Heskett.I work at 1st Call Home Healthcare at 22367 Starks Dr, Clinton Twp, MI 48036. I oppose the DIFS proposed administrative rules for the auto no-fault fee schedule. Rule set 2020-114 IF

--

Michelle Heskett, LPN
Auto Patient Care Coordinator
1st Call Home Health Care
22367 Starks Drive
Clinton Twp., MI 48036
800-908-3890

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Health System Finance

2301 Commonwealth
Ann Arbor, Michigan 48105-
734-647-2579

March 23, 2021

VIA Email

Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
P.O. Box 30220
Lansing, MI 48909-7720

Michele Estrada
EstradaM1@michigan.gov

RE: ***Comments on Administrative Rules for No-Fault Fee Schedule***

Rule Set 2020-114 IF

Dear Ms. Estrada:

Thank you for the opportunity to submit comments to the Department of Insurance and Financial Services (DIFS) for consideration regarding the Administrative Rules for Auto No Fault (ANF) Fee Schedule. Specifically addressing Rule Set 2020-114 IF, which DIFS promulgated to implement MCL 500.3157. Among other things, MCL 500.3157 establishes the amount hospitals can be reimbursed (paid) for treating injured persons covered by ANF personal protection insurance.

Before commenting it is important to share a little about who we are as an academic medical center. Michigan Medicine (MM) is known state-wide, for excellence in our tripartite mission of patient care, education, and research. MM is located in Washtenaw County, and operates three facilities that all fall under Medicare certification number 23-0046 and Medicaid NPI 1003878539: University Hospital and Frankel Cardiovascular Center, C.S. Mott Children's Hospital (Mott Hospital), and Von Voigtlander Women's Hospital. Collectively these facilities include 1,043 licensed beds and perform more than 53,000 annual inpatient discharges and 2,450,000 outpatient visits. In total, MM employs more than 28,000 faculty and staff.

MM is consistently recognized as our region's provider of choice and University Hospital was recognized as the number fifteen hospital in the world and number 5 in the nation in Newsweek's world's best hospitals list. In addition, Mott Hospital is nationally ranked in all ten pediatric specialties that *U.S. News & World Report* rated for 2020-2021 and is the only hospital in Michigan to hold that distinction.

MM is also designated as a level 1 trauma center, and as such MM will see the most critically injured auto accident victims from around the entire State of Michigan. Because of our expertise and reputation, we will likely treat auto accident cases that other health care providers in the state are unable to provide care for. It is critical that DIFS establishes a proper and fair payment model, so hospitals such as ours that are the safety net of the most critically injured auto accident cases, are paid properly.

Our comments on the proposed ANF Administrative Rules focus on the following areas:

- Definition of "Fee Schedule"
- Proposed R 500.203(1) – Calculating the amount due a provider
- Suggestion for alternative payment model
- Consideration for expansion of the high indigent volume payment model

Definition of "Fee Schedule"

Proposed R 500.201(h) defines "fee schedule" to mean 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 the service is rendered." It is very important to note that the plain language of "fee schedule" is not a payment model term used in Medicare for hospital payments, rather the prospective payment system (PPS) would be the more proper hospital payment term, and MM encourages DIFS to use that term in all instances of the Rule. The only appropriate time to use the term "fee schedule" in reference to a Medicare payment would be for payments made to a physician for their services. This schedule is referred to as the Physician Fee Schedule (PFS), and again that schedule is only proper for Medicare payment for the time spent by a physician. MM would encourage DIFS to make a clear distinction between the two Medicare Payment systems.

In order to fully implement the intent of Public Act 21 of 2019 and Public Act 22 of 2019 (the "Amended Act"), that no-fault insurance payment to a hospital be based on the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare

program, MM recommends that the definition of "fee schedule" be more precisely defined as follows for hospitals reimbursed under Medicare by adding the following language. This clarification is critical as there does not exist a definitive schedule of "fee for service payments under part A, B, or D of the federal Medicare program." This is because Medicare payment to hospitals depends on many factors including prevailing wage rates in the area where a hospital is located, whether a hospital trains residents or treats a disproportionate share of low-income patients, to name just a few of these factors. This additional clarification regarding hospital payment would enable implementation of the Amended Act in a manner that best serves the interests of auto no-fault consumers, insurers, hospitals and other providers.

DIFS needs to consider changing the reference to "Fee Schedule" or define it better to mean, as applicable, the Medicare **prospective payment system** in effect on the date the service is rendered and for the locality in which such service is rendered. **For purposes of this definition, "prospective payment system" means the Medicare inpatient acute, post-acute, outpatient prospective payment system, inclusive of all hospital-specific adjustments including without limitation adjustments for acuity, area wage index, capital, teaching (both direct and indirect), disproportionate share (inclusive of the national uncompensated care pool), new technology, low volume, organ acquisition cost, routine and ancillary pass-through cost for allied health programs, and outlier payments, for the equivalent hospital specific payment for providing inpatient or outpatient services to Medicare beneficiaries. And only use Fee Schedule in reference to payments made to a physician.**

Proposed R 500.203(1) – Calculating the amount due a provider

Proposed R 500.203(1) provides as follows: "When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. An amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019."

For acute inpatient hospital services, PPS is based on a nationally established payment formula consisting of the applicable diagnostic related group relating to the patient's treatment and the standardized amount, as adjusted by a variety of factors, all of which are updated annually. Similarly, the PPS for outpatient hospital services and for capital-related costs are based on nationally established payment formulas updated annually. Thus, this rule should be revised as follows to assure proper payment to hospitals based on their expected Medicare payment:

When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized only for physician payment. **And, then address separately, hospitals reimbursed under a Medicare prospective payment system**, And, then the amount payable pursuant to the

physician fee schedule or PPS may not exceed the average amount charged by the provider for the service on January 1, 2019**, as adjusted pursuant to R 500.205(6)**. **A no-fault insurer will pay to a hospital that is reimbursed under Medicare an amount equal to (1) the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program multiplied by (2) the applicable Medicare reimbursement percentage under the Amended Act.**

Suggestion for alternative payment model

Alternatively, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, MM joins with the Michigan Health and Hospital Association (MHA) and suggests that DIFS consider one of two alternative methodologies for hospital payment which could be promulgated in a DIFS bulletin.

Under alternative 1, which MHA (after working closely with its member hospitals) previously outlined in a letter dated December 4, 2020, to Anita Fox, Director of DIFS, the no-fault insurer would pay the hospital's claim using a formula that takes into account the hospital's Medicare payment-to-charge ratio (in the aggregate) which would be updated and published annually by DIFS similar to the existing Worker's Compensation methodology. The formula would allow providers and insurers to determine the reimbursement (payment) providers are eligible to receive from insurers under the Amended Act. The formula for determining the payment is as follows:

Auto No-Fault Payment = Auto No-Fault Payment Factor x Auto No-Fault

Billed Charges

(1) Where the **"Auto No-Fault Payment Factor" = (Provider Specific Aggregate Medicare Payments / Provider Specific Aggregate Medicare Charges) x (Statutory Auto No-Fault Payment Multiplier)**

Aggregate Medicare Payments and Aggregate Medicare Charges for all services provided by a hospital are taken from each hospital's most recently available filed Medicare cost report to establish a single, unique ratio for that hospital, updated annually on July 1.

Annually, DIFS would publish each hospital's Auto No-Fault Payment Factor calculated by the Michigan Department of Health and Human Services (MDHHS) using Medicare cost report data.

The Statutory Auto No-Fault Payment Multiplier is the applicable Medicare reimbursement percentage under the Amended Act (*i.e.*, 200%, 230%, or 240%). DIFS would publish the applicable Medicare reimbursement percentage for each hospital.

(2) Example calculation of the Auto No-Fault Payment Factor and the Auto No-Fault payment based on the following assumptions:

When the hospital submits to the insurer the hospital's bill for services, the insurer would determine payment to the hospital by reference to the published Medicare reimbursement percentage for the hospital and the Auto No-Fault Payment Factor published for the hospital. The following is an example of how payment would be computed:

Assumptions: Amount Billed by the Hospital to Insurer = $500; Aggregate Medicare Payment to Hospital = $2,200,000; Aggregate Hospital Charges to Medicare = $7,100,000; and Auto No-Fault Payment Multiplier = 240%

Provider Specific Auto No- Fault Payment Factor = 0.7437 - ($2.2 Million / $7.10 Million) x (2.4)

Auto No-Fault Payment = $371.85 - (0.7437) x ($500)

Under this example, $371.85 is the amount of payment the hospital should receive from the insurer.

MM proposes that the Medicare cost report would be the data source for Medicare payments and charges used to develop the Auto No-Fault Payment Factor for inpatient and the outpatient services as well as for other hospital services, such as inpatient rehabilitation facility, home health and skilled nursing facility services. The Auto No-Fault Payment Factor would be subject to an annual update based on the hospital's most recently filed cost report as of July 1 of each year. This would require an amendment to the current language provided by the Amended Act that states the allowable reimbursement that ties to the amount payable under Medicare must not exceed the average amount charged by the provider for the services on Jan. 1, 2019, as adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment. See MCL 500.3157(8) and (9).

MM believes the above discussed approach would be the simplest to execute and to explain to all constituencies. Below we are offering a second option should DIFS find the above unworkable. This option proposes to use a hospital specific DRG Grouper Model.

This model would allow an auto insurance provider to price a claim the exact same way as Medicare and then apply the applicable update factor to that calculated payment.

Key considerations of Hospital specific DRG Grouper model

1) More complex to implement for auto insurance payers and generally more difficult to process and price claims individually. But, an accurate payment results.

2) Applies a hospital specific rate and prices each claim on the merits of the diagnosis and the intensity of services provided, considering outlier prevalence will be specific with this population.

While the second option is more complex, MM believes it the best way to properly pay a provider for ANF services rendered. MM would be glad to model and walk DIFS staff through the results, if time allows, and would partner with DIFS in drafting the potential DIFS Bulletin release mentioned above.

MM believes that, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, the Auto No-Fault Payment Factor (option 1) serves as a reasonable proxy of the Medicare payment to which a hospital would be entitled with respect to any particular claim a hospital submits to an insurer. MM further believes that either payment based on the Auto No-Fault Payment Factor or hospital specific DRG Grouper enables the efficient implementation and administration of the Amended Act. Both alternatives have merit, and both could be implemented, and either is better alternative than the current proposed rule.

Consideration for expansion of the high indigent volume payment model

MM believes that the C.S. Mott Children's Hospital needs to be recognized by DIFS as a high indigent volume provider and reimbursed up to 250% Medicare rates.

Background: The Operating structure of our health system, which functions under the legal authority of the University of Michigan and not separate legal entities, at times creates unintended consequences. This Act is one of those times in which our system is disadvantaged. Specifically, the act allows for a higher payment multiplier for hospitals that experience a Medicaid case load greater than 30%. This threshold as High Indigent Volume Provider did not include C.S. Mott Children's Hospital as it is not visible to DIFS under our legal and operating structure. If C.S. Mott were separately incorporated it would meet the 30% qualification criteria.

Proposal: Hospitals that are operated as part of a multiple hospital campus operating as one provider need should have the right to petition DIFS for qualification as a High Medicaid Providers. In order to demonstrate that an individual pediatric hospital within a multihospital one provider structure qualifies, the individual Children's Hospital would need to demonstrate the following:

They

1) Operate both a Level 1 Pediatric Trauma Center and a Level 1 Adult Trauma Center under the joint provider number in question.

2) Are certified by the Michigan Department of Health & Human Services as operating a Level 4 Neonatal Intensive Care Unit. This designation is reserved for only those hospitals licensed with the most advanced capabilities.

3) Annually provide care for greater than 2,000 discharges for Medicaid beneficiaries (defined as patients covered by Medicaid Traditional ("Fee for Service"), Medicaid Health Plans ("MCO" or "HMO"), and/or Patients covered by Children's Special Health Care Services ("CSHCS").

In conclusion, the draft of the Administrative Rule, cannot be allowed to move forward without addressing the items noted above. To allow this proposal to move forward would allow the auto insurance industry to wreak havoc on the payments to hospitals for the care rendered to auto insurance members. This clear lack of direction would cause a tremendous administrative burden on the billing and revenue cycle team at MM, and would actually add cost to the already very expense heath care industry. This administrative burden is in addition to the routine work our care management and utilization teams will need to certify each patient. Moreover, we are concerned about the incremental effort to support the recently outlined appeal process and we expect this work to be supported by a multi-disciplinary group from our revenue cycle team and clinical staff evaluating and responding to medical necessity challenges.

I and our health system appreciate the opportunity to comment on the proposed ANF Administrative Rules. We also very much appreciate DIFS efforts in furtherance of promoting regulatory flexibility and efficiency, so healthcare providers like MM can focus on providing high-quality, high-value care to our ANF patients. Please let us know if you have any questions, by contacting Kimberly Ross, the Government Relations Officer for MM via email at roskimbe@med.umich.edu.

Sincerely,

Paul CAstillo

Paul Castillo.
Chief Financial Officer
Michigan Medicine

March 26, 2021

Ms. Michele Estrada
Department of Insurance and Financial Services
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P.O. Box 30220
Lansing, MI 48909-7720
Email: EstradaM1@michigan.gov

Re: Commentary/Questions regarding Admininistrative Rules Set 2020-114 IF
No –Fault Fee Schedule R500.201-R500.225

Dear Ms. Estrada,

Thank you in advance for your review of our comments and questions in relation to the Administrative Rules for the Michigan No-Fault Fee Schedule. By way of introduction, our company Mitchell International has been designing and implementing fee schedules based on statutory and regulatory language in the auto space for over 35 years. In addition we have extensive experience in all states implementing workers' compensation fee schedules in all jurisdictions. We administer these fee schedules for our customers (insurance companies, payors, review companies and third party administrators) through the use of technology solutions that can address large volumes of information (billing data) for insurers/payers to pay what is owed on claims accurately and within the framework of the insurance departments rules/guidelines.

Our objective is to be consistent, fair, objective and use industry standards in the application of rules and pricing information. In particular this Michigan No-Fault fee schedule in its current form is unpresidented in any jurisdiction and is considered administratively burdeonsome for insurers to use in a consistent manner across the industry. The non-specific use of terminology is inconsistent and in our experience has cause undue litigation and cost to be expended that trickles down to the claimant's policy expense. The inconsistencies are related to the wording in MCL 500.3157 inconjunction with the current draft of the Administrative Rules.

We are outlining below some of the main concerns and analysis we have performed on the Administrative Rules that we hope you will find helpful and potentially consistent with others who may be providing comments. We understand creating a fee schedule can be very technical and cumbersome however there are great examples from other states that can be reviewed to provide insight into appropriate and fair compensation plus limiting the administrative burdeon on the provider and payer. Each section below is described along with our comments and concerns.

Administrative Rule Review Comments:

R500.201 – Definitions

(h) **"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.

Questions/Comments:

1. Medicare has many "ala carte" fee schedules, for example: Anesthesia is a separate fee schedule and is not called out. Does that mean any sections not defined as part of a fee schedule are not to be included in using Medicare?
2. Part A, APC, Nursing and Rehab, Home health… are not listed as a fee schedule– In other states part A is inclusive of a fee schedule definition, we don't believe this is clearly written as a rule.
3. Often times Medicare does not have a fee schedule effective date of January 1 and continuous updates are done – sometimes as many as 3-4 before the fee schedule is considered "updated" this update process by Medicare is real-time for Medicare providers however a nightmare when the schedules are used for auto and workers compensation. States like Florida have chosen an effective date of March 1st for updates to be done for Medicare rates as usually by that time all the updates are ironed out. With one effective date it makes the schedules easier to manage. We would also suggest that if the quarterly updates from Medicare are to be used, that should be called out as well. In other words using the term "in effect on the date of service" could potentially be a fee schedule that was updated later and the carrier will need to go back and change the amount paid.
4. Using a term like "in effect" can have a negative impact on providers specifically for Part A. The cost reports from Medicare are continuously updated throughout the year to make errata changes and updates for new services and rate changes. Would providing retrospective payments be appropriate or should the provider be responsible for making the request similar to regulations in New York No-Fault?
5. Not using the term "participating fee schedule" is confusing and will cause carriers to use different levels of payment from Medicare (Limiting vs. Participating). We ask the level be called out in the rules to eliminate confusion and inconsistency. There are many variants the Medicare fee schedule utilized. DIFS may want to call out the file name along with stating "100% of the established fee schedule amount" will be used to calculate the Medicare base rate prior to modification by fee schedule rules. We would also suggest DIFS provide the URLs and data file links to be used by the carriers for payment files from the CMS site, similar to many workers compensation fee schedules.
6. Is it the intent of the fee schedule to use Medicare's reimbursement rules? There are many examples however the most prevalent are the National Correct Coding Initiative (NCCI) edits that monitor the codes billed by the provider for unbundling and packaged services under Medicare. Is it the department's intent to use NCCI edits specifically? Many of these edits are not based on the AMA's CPT manual and are based on Medicare payment policies on what they consider payable under Medicare. Often these policies differ from the expectations of a provider providing services to an auto accident victim. Other examples are payment policies based on the diagnosis. For example, Medicare will only reimburse for chiropractic manipulation if there is a subluxation (dislocation) of the spine. This is rarely a diagnosis as most care is rendered for soft tissue injuries.

7. Would the Medicare rate still apply after the time limits or parameters Medicare has set for payment of their fee schedule? Example, if Medicare pays for 11 weeks of care with specific fee schedule amounts, after 11 weeks is the provider paid the average charge in effect 1/1/2019? There is no other fee schedule in the US that applies a different rate after a Medicare timeline is exceeded. This would be an administrative complexity for the carriers and providers to administer plus usually has no bearing on the care necessary for an auto accident victim.

(i) **"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 the director.

Questions/Comments:

1. Regional average is a new term and seemingly an additional method for calculation of fee schedule elements. There is really only one database that has a national presence, should that be called out (FAIR Health) as the database source? Otherwise there will be differing prices provided to the Department which will drive inconsistency leading to appeals and suits.
2. Since the "average charge" term is being used to describe a rate – is this a statistical term, meaning median? If so, FAIR Health would need to calculate their databases to provide this information. They will also need to provide the rate that was in their database on the releases that were in effect January 1 2019.
3. If rates are used from a national database from 1/1/2019, will these need to be updated with the consumer price index (CPI) for 2020 and 2021? If so will the department supply these rates to the insurers for repricing the bills inclusive of the CPI for the effective start date of 7/2/2021?
4. FAIR Health does provide products using their data to providers to assist in setting up out of network rates which this would be considered an out of network (FYI).
5. When using the average charge (and this will come up in multiple situations) and the provider has a contract with a network that modifies the average charge paid to the provider due to an all-inclusive workers comp, auto and health contract there will be potential to pay less than the average charge (FYI). Should this be clarified?
6. As a suggestion to the department, perhaps consider only using data from a national database for the regional average and the providers average to eliminate questions and maintenance of data and application of consistency to all providers.

R 500.202 Scope and applicability

(c) Establish procedures for the department to collect information related to amounts charged by health care providers as of January 1, 2019, for the purposes of calculating payment or reimbursement.

Questions/Comments:

1. Is there an expectation that providers will submit to the department every code they billed and the associated charge that was billed 1/1/2019? If so, how will the department verify these were truly the providers charge? Will they provide what they billed under WC, Auto and Health separately? Will they provide if they had agreements with patients to have cash payments in addition? Will they provide their network agreements for payment across all coverage types?

2. The Scope and Applicability section under these rules is limited. There should be scope and applicability for defining update schedules of rates and specific timeframes. In addition the scope and applicability in the use of any Medicare reimbursement policies should be outlined.
3. If the Department is going to provide any data to insurers for review of claims it needs to be done very quickly. The systems used by carriers handle billions and billions of dollars of provider charges and payment of what is owed on claims in support of their customers is paramount. In addition the ability to test and validate results is very important to insure claims are handled fairly for all. Without the data being available last minute programming and assembly of this data will need to occur making it very difficult for complete testing. When and how will this data be provided?
4. Would the Department consider pushing the effective date for is July 2, 2021 still the effective date even with the additional database assembly and maintenance that needs to happen in the next 4 months?

R 500-203 Medicare calculation; posting of fee schedule; requests for information.

Rule 3. (1) When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. An amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019.

Questions/Comments:

1. Calculating amounts for part A and B, the applicable fee schedule shall be used. Does this mean all fee schedules are used without exception? We do understand emergency services like Ambulance are exempt however is there any modifications to this statement?
2. One of the largest concerns in this rule is that "An amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the services on January 1, 2019.
    a. Is it the department's intent that carriers do a comparison of individual provider charges from 1/1/2019 to the current Medicare rate? Is the provider charge the floor and Medicare rate (fee schedule) the ceiling?
    b. Is the intent not to maximize the fee schedule and pay the Medicare rate regardless if the provider charges less but not to go below the provider charge that was in effect 1/1/2019?
    c. Will the department adjust the provider charge in effect on 1/1/2019 with the appropriate CPI for the July 2, 2021 effective date or will there be an expectation that the carrier do that work?
    d. If this comparison is specific to a provider, carriers and the department will need a unique identifier for a provider in order to identify that individual provider charges for comparison. What if a provider works at multiple locations and/or offices? Example is that there are providers who work in emergency services that also have a separate private practice. What if the evaluation and management charges are different for each of these providers' employments? To that end, will the department expect comparison with a combination of NPIN and TIN to insure proper analysis of the provider's average charge.

e. As mentioned previously if the average charge is not to be exceeded, provider contracts may modify this payment. Has this exception been accounted for?
f. For part A payments – it is an impossible task to ask a facility to provide their charges for each individual DRG – although the DRG class may be the same across patients there are modifying circumstances that can alter the payment for each and it is not a pure line by line comparison that can be done. Similarly for the APG's (APCs) used for pricing outpatient under Medicare, they use a "bundled methodology" and it is dependent upon many factors, again not a simple code to code group pays the same or has an average charge.
g. When the department provides data for Charge Description Master, (CDM) Providers Average Charge and Regional Average (3 different data points), will there be a distinguishing factor that lets the carriers know each one of these data points? For example if a provider has a CDM and an average charge and they are different from each other will there be two data points for this specific provider by code? It will be important to know if the average OR regional average is used in order to enforce the provider contracted rates.
h. We would suggest a global database based on charge data (market rates) be used that is not specific to a provider that would stay updated and current to account for new codes and CPI (FAIR Health) to be used instead of the burden of collecting CDI, Average Charge and development of regional averages. FAIR Health's data is specific to geographic are in Michigan and contains current market rates for provider charges. FAIR Health supplies "gap fill" data in many jurisdictions in workers compensation to account for these gaps when the Medicare Fee Schedule is utilized as a basis for fee scheduling. FAIR Health is utilized in many states in workers compensation to address the "gaps" of Medicare – this is called "Gap Fill" data.
i. For the CDM, it has been our experience when receiving these documents from providers that they vary in format and content. For the most part there is no consistency in reporting (I.e., use of CPT codes), rather a conglomeration of services described. Examples have included large price ranges and not specific cost by procedure, for example a menesectomy of the knee has been described as ranging from $2,500 to $10,000 depending upon the complexity of the procedure which can be modified and identified with a modifier when billing. How will the department overcome receiving data in these varying formats and codify this information for consumption in bill review systems for the carriers?

R 500.204 Eligibility for enhanced reimbursement

Questions Comments:

1. For 1-3 in this rule it appears the information will be provided to the insurers by various bulletins, DOH and lists that outline those providers subject to the enhance reimbursements. Will providers have a specific designation that will aid in the accurate identification and subsequent payment that will include the NPI as mandatory with addition TIN numbers supplied to insure accurate payment?
2. It will be impossible to pay providers accurately without NPI as a designating factor (I.e., Trauma facilities). Every carrier has their own provider database that can differ in data collection and structure and most don't include NPI today in data capture.

R 500.205 Charge description master; average amount charged; regional average; submissions to department

Questions/Comments:

1. Will the department request a specific format and provide a specific format to the carriers for use of this data? If so can that format be provided now?
2. As described previously, for any data point used in payment of the claim (CDM, Average amount charged; regional charge) it will be important to know the source of that data. Will the Department maintain records on where the data was obtained for future litigation and evidence to substantiate the payment?
3. Should the EOR/EOB contain the source of the information or that it falls into an approved amount from the Department as a singular description? Will there be a need to communicate back to the provider the source of the data?
4. What happens if the provider does not submit data to the department for approval or use in CDM, Average Charge or Regional Average? If the bill is presented for payment to the carrier and this information is unavailable, can the carrier deny the bill until this information comes from the state?
5. There are timelines for payment of claims. If the data is unavailable to make the payment at the time the bill is submitted, what should the carrier do?
6. It appears that payment systems will need to be versatile enough to allow for updating on a regular basis. It has been our experience that provider, especially the smaller less technology savvy providers have the ability to submit everything timely and completely. This may be over burdensome for many providers to do in this short time frame AND also have the department verify attestations and other data to insure that is what the provider billed or the CDM is accurate.
7. Every year CPT is updated with new codes and amendments. There is no average charge, fee schedule amounts, regional averages available as both Medicare and the charge database vendors need to observe the market rates. Sometime they are able to produce a rate based on similarities of other codes but often times these new codes will have no rates. Has the Department contemplated what will happen when this situation occurs?
8. Under number (4) in this section a provider code potentially submit multiple charge rates for the same procedure depending upon geography. Example, if the provider has an office in Detroit vs. Holland MI the economics are different and rates can vary. Will the Department have an expectation that regional differences are accounted for average charge in effect on 1//1/2019.
9. Under number (6) in this section is it the intent that the rate be an aggregate? Will the rate be cumulative? It is our impression that it is a cumulative rate which would be similar with other fee schedule applications in other states. Although asked before, will all rate provided by DIFS be inclusive of the CPI? Will there be more than one CPI for 2021 since it is two years out from the rates other than Medicare?
10. Is the fee schedule is considered a 'maximum' schedule or not, no matter if provider is contracted in a network, meaning we can't price higher than state fee schedule. If it is 'maximum', then is it the intent that the fee schedule is the floor or the ceiling? pricing could not price over Allowable.

Thank you for getting this far through our thoughtful document and we hope that you will consider most of our commentary when issuing your final rules. As always, we are very willing to engage, assist, consult and provide information to DIFS to assist in implementation of the new fee schedule. We find that working with provider groups and payers together often times removes conflicts and ambiguity in fee schedules. We very much appreciate your openness to commentary and understand this work is not easy, it is complex.

All the Best and Sincerely,

Michele Hibbert, CCSP, OHCC
Sr. Vice President Regulatory Compliance Management
Casualty Solutions Group - Mitchell International, Inc.
Mitchell|Genex|Coventry

MSMS
MICHIGAN STATE MEDICAL SOCIETY

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March 26, 2021

Via email: EstradaM1@michigan.gov
Anita Fox, Director
Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
Attention: Michele Estrada
P.O. Box 30220
Lansing, MI 48909-7720

Re: Administrative Rules for No-Fault Fee Schedule - Rule Set 2020-114 IF

Dear Director Fox:

I am writing on behalf of the Michigan State Medical Society (MSMS) regarding the proposed No-Fault Fee Schedule rules. MSMS represents approximately 15,000 Michigan physicians, residents and medical students of all specialties and practice settings.

MSMS questions the statutory authority of the Michigan Department of Insurance and Financial Services (DIFS) to promulgate Rule Set 2020-114 IF (the "Proposed Rules"). Additionally, MSMS has serious concerns regarding the impact various provisions within the Proposed Rules will likely have on physicians, other health care providers, and patients injured in automobile accidents.

Statutory Authority to Promulgate the Proposed Rules

Currently, the Proposed Rules identify a section of the recent Surprise Billing legislation as DIFS' authority to promulgate rules regarding Chapter 31 of the Insurance Code (the "No-Fault Act"). The Proposed Rules presented for public comment state – "By authority conferred on the director of the department of insurance and financial services by section 24517 of the public health code, 1978 PA 368, MCL 333.24517." However, MCL 333.24517 specifically limits DIFS' rule making authority to sections 24510 and 24511 of the Public Health Code. Neither of these sections relates to the fee schedule under MCL 500.3157 adopted in the 2019 amendments to the No-Fault Act.

In addition, the No-Fault Act neither authorizes nor obligates DIFS to promulgate any administrative rules with regard to the fee schedule created by the 2019 amendments. In fact, the only section that specifically addresses the promulgation of rules relative to the 2019 amendments is Section 3157a regarding utilization review. Thus, the Legislature did not provide DIFS the authority to promulgate rules related to Section 3157 or other provisions in the legislation. This conclusion is consistent with the long-established rule of statutory construction *expressio unius est exclusio alterius* – i.e., the express mention of one thing implies the exclusion of other similar things. *Stowers v Wolodzko*, 386 Mich 119, 133 (1971).

Although DIFS references MCL 500.210 in its Request for Rulemaking as an additional basis of its statutory authority to promulgate the Proposed Rules, MCL 500.210 limits DIFS' rule making authority to rules and regulations "which are necessary to effectuate the purposes and to execute and enforce

the insurance laws of [Michigan]." As further discussed below, the Proposed Rules go beyond this standard. Therefore, we oppose Rule Set 2020-114 IF in its entirety and respectfully request that DIFS withdraw it.

Scope of the Proposed Rules and Burden on Providers

MSMS believes the following Proposed Rules exceed the scope and purpose of the No-Fault Act:

- Rule 3, subrule (2) – Section 3157 of the No-Fault Act only requires the submission of documentation and information to DIFS for the purpose of determining whether the provider qualifies for enhanced payments due to an increased caseload of patients who are indigent. As currently written, this rule is overly broad and should be limited to amounts payable under Section 3157, subsections (4)(a) and (5). Without this qualification, the rule exceeds the scope and purpose of the No-Fault Act.

- Rule 5, subdivision (1)(c) – This rule creates a new payment and reimbursement standard which is not provided for in Section 3157. This rule should be removed as it clearly exceeds the scope and purpose of the No-Fault Act.

- Rule 5, subrules (1), (2) and (4) – As noted under the comments for Rule 3, Section 3157 does not require a provider to provide documents, information, and other materials regarding their fees directly to DIFS, except when the provider is seeking enhanced payment above the standard fee schedule. These provisions exceed the scope and purpose of the No-Fault Act and should be removed.

MSMS also believes the following Proposed Rules are ill-defined and inconsistent with the No-Fault Act, which will impose an undue burden on physicians and other providers:

- Rule 1(i) – The definition of "regional average" refers to a "provider's geographical region" without defining "geographical region." This is potentially problematic if such region is overly broad (e.g., multiple states vs in-state counties) as to negatively skew the regional average for certain services. In addition, the regional average, as currently defined, fails to consider qualifications and other factors which may be unique to a provider and warrant alternative payment or reimbursement for services rendered by the provider.

- Rules 3, 5, and 6 – These rules would require the disclosure of proprietary business information without statutory authority and without proper safeguards to ensure confidentiality.

Thank you for the opportunity to comment. Should you have any questions regarding our opposition, MSMS would be happy to discuss further. Your consideration of our recommendations is appreciated.

Sincerely,

Julie L. Novak
Chief Executive Officer

Insurance Alliance of Michigan

January 28, 2021

Anita Fox, Esq.
Director
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530 W. Allegan St., 8th Floor
Lansing, Michigan 48933-7720

Re: DIFS Proposed Rule 2020-114 IF
No-Fault Medical Fee Schedule
Proper Amount, Variation, Verification, Updates

Dear Director Fox:

The Insurance Alliance of Michigan (IAM) is the statewide trade association representing property and casualty insurers operating in Michigan. IAM members write approximately 75 percent of the automobile insurance market in the state. On behalf of the members of the IAM, I write to express our thoughts regarding Proposed Rule 2020-114 IF pertaining to the implementation of the medical fee schedule of the Insurance Code Sec 3157.

While neither the Regulatory Impact Statement nor draft rule are out, we hope to begin a full discussion on this very important topic as soon as possible. As you know, while a portion of the premium savings seen by auto insurance consumers is due to the level of PIP benefits chosen, the projected savings attributable to the coming fee schedule is significant, impacts premium at all selection options, and its implementation will be critical to maintaining savings to consumers. As well, reducing the cost of individual medical products and services ensures that consumers' chosen levels of PIP benefit dollars go as far as possible to provide the necessary care in the event of auto accident injury. Clarity, certainty, efficiency and fairness should be top of mind in this process.

With that said, our initial comments are as follows:

Fee Schedule:

The main foundation of the Sec. 3157 medical fee schedule provisions is the federal Medicare fee schedule. There is not one Medicare fee schedule, however, but several. This includes "participating," "non-participating," "durable medical equipment," etc. As amounts differ, which Medicare fee schedule Michigan no-fault insurers must use will determine liabilities to insurers, which in turn impacts the premium charged as well as how far selected PIP benefits remain available to provide coverage for reasonable and necessary medical assistance.

If DIFS intends to determine a standard, which we're unclear whether it has the authority to do, we would urge the Medicare "participating" fee schedule. The "non-participating" fee schedule is generally higher in total as it allows for the billing of the claimant on top of the amount paid by the insurer, which would run counter to lowering costs. Absent DIFS making such a determination, we urge that auto insurers have the flexibility to use which Medicare fee schedules exist and are appropriate to the specific situation.

For those products and services for which there is not a corresponding Medicare fee, Sec. 3157 provides the alternative of a percentage of the providers "charge description master" (CDM) or, if none exists, a percentage of the average charged for the product or service. There are an untold number of medical providers with, and without a CDM. And, unlike the Medicare fee schedule, CDMs are not publicly accessible or objectively verifiable documents.

Therefore, if no fee exists under Medicare and the next step is the CDM, how are auto insurers to obtain the document? How are insurers to know any version provided is what was in place on January 1, 2019? Would providers include a signed affidavit along with the CDM attesting to this question? We would recommend a clearing house for this information be developed. If not at DIFS, could another state department serve as a clearing house for CDMs?

Many of these same questions exist where a CDM does not exist and auto insurers are attempting to determine the average charge as of January 1, 2019. Is this average a measurement of what the provider had in the market generally? What the provider on average charged the specific auto insurer involved as of January 2019? What if a specific provider's submitted or indicated "average" charge differs from the auto insurer's experience with that same provider?

Other questions would include: What if a provider's CDM has been requested, but not received? At what point do auto insurers switch to an evaluation of average charges? Finally, what if a provider is part of a voluntary provider network with different pricing parameters? Keep in mind, auto insurers generally have 30 days generally to pay claims received before interest and other penalties begin to accrue.

<u>Modifiers</u>:

As discussed above, per the terms of Sec. 3157, there are alternative methods for determining the proper limit of charges in a particular situation – Medicare, CDM, and average charges. Beyond that, each method has similar modifiers that would increase amounts owed including the percentage of indigent population served by the particular medical provider, as well as whether the provider has a level I or Level II trauma center. DIFS' Request for Rulemaking provides that the Department will determine criteria for making such determinations. We would urge DIFS to develop a process that is transparent and fair to both medical providers and auto insurers, but more importantly takes into account the impact on consumers in terms of the cost of the benefits as well as the efficient use of the level of benefit chosen.

<u>Automatic Updates/Indexing</u>:

Insurance Code Secs. 3157(8) and (9) provides for updates to both the Medicare fee schedule, as well as the application of medical CPI to both the 2019 CDM or average charge measurements. While CPI is an

annual adjustment, the Medicare fee schedule updates as frequently as every quarter. Keeping track of the different update cycles, overlayed by dates of medical service, will create considerable complexity and confusion among medical providers and auto insurers alike. IAM would suggest DIFS consider a common and appropriately timed schedule of updates to provide clarity and certainty for all parties.

Fee Schedule as Maximum Owed:

IAM understands certain medical providers may be arguing that the statutory language of Sec. 3157 which establishes a maximum of what a provider is entitled to, should at the same time also be interpreted as the minimum of what a provider is entitled to. In other words, while the statute specifically states that a medical provider is "not eligible for payment or reimbursement under this chapter for *more* than the following…," medical providers argue there should be no ability to pay less.

Such an interpretation would be directly counter to statute. As well, making the maximum also the minimum could only result in less cost reductions, higher auto insurance premium, and consumers' benefit dollars expiring sooner.

New Entrants into the Market:

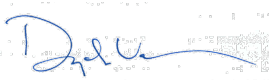
Sec. 3157(7) provides that where there is not a Medicare rate available, the provider is not entitled to more than a percentage of its CDM in effect, or average charge as of "January 1, 2019." Of concern to insurers is how to treat new providers in the market who did not have a CDM or average charge as of January 1, 2019. These could be entirely new entities moving into Michigan, or possibly existing entities that were merged, acquired, or reincorporated after January 1, 2019.

Conclusion:

Thank you very much for your time and attention and we hope these initials thoughts will be helpful. We believe the broad understanding of no-fault reform was to reduce costs in the system to the ultimate and ongoing benefit of the auto insurance consumer. We continue to look forward to working with DIFS on the development and implementation of these rules, and more broadly on no-fault auto insurance reform.

Please let me know if you would like to discuss any of the comments provided in this letter.

Sincerely,



Dyck E. Van Koevering
General Counsel

Estrada, Michele (DIFS)

From: Rosie Pung <rpung02@gmail.com>
Sent: Friday, March 26, 2021 11:33 AM
To: Estrada, Michele (DIFS)
Cc: 'Rosie Pung'
Subject: Public Hearing Administrative Rules for No-Fault Fee Schedule Comment

Ms. Estrada,

I attended today's public hearing regarding Administrative Rules for No-Fault Fee Schedule Rule Set 2020-114 IF.

I do not support the proposed changes to the No-Fault Schedule rule set by DIFS.

I support Katie Tucker, Esquire, representing Michigan Brain Injury Council (MBIPC) , statements and Maureen Kinsella, Esquire, representing Coalition Protecting Auto No-Fault (CPAN) statements. I am a member in good standing with MBIPC and CPAN as well as provider of services that will be affected.

Rosie (Rosalyn) Pung, RN, ASN, BSN, MSN, CCM
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Sparrow

Improving the health of the people in our communities by
providing quality, compassionate care to everyone, every time

March 26, 2021

Michael Estrada
Office of Research, Rules, and Appeals
Michigan Department of Insurance and Financial Services
P.O. Box 30220
Lansing, MI 48909-7720
Electronically submitted: EstradaM1@michigan.gov

Re: Comments on Administrative Rules for No-Fault Fee Schedule Rule Set 2020-114 IF

Dear Ms. Estrada:

Sparrow Health System (Sparrow) respectfully submits this comment letter to the Department of Insurance and Financial Services (DIFS) for consideration with respect to the public comment period for the Administrative Rules for No-Fault Fee Schedule, Rule Set 2020-114 IF, which DIFS promulgated to implement MCL 500.3157. Among other things, MCL 500.3157 establishes the amount hospitals can be reimbursed for treating injured persons covered by personal protection insurance.

1. Definition of "Fee Schedule"

Proposed R 500.201(h) defines "fee schedule" to mean "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 the service is rendered."

In order to fully implement the intent of Public Act 21 of 2019 and Public Act 22 of 2019 (the "Amended Act"), that no-fault insurance payment to a hospital be based on the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program, we recommend that the definition of "fee schedule" be more precisely defined as follows for hospitals reimbursed under Medicare by adding the following language. This clarification is necessary because there does not exist a definitive schedule of "fee for service payments under part A, B, or D of the federal Medicare program." This is because Medicare payment to hospitals depends on many factors including prevailing wage rates in the area where a hospital is located, whether a hospital trains residents or treats a disproportionate share of low-income patients, and whether the hospital is a sole community hospital, to name just a few of these factors. Further, this additional clarification regarding hospital payment would enable implementation of the Amended Act in a manner that best serves the interests of auto no-fault consumers, insurers and hospitals and other providers.

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(h) "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. ***For purposes of this definition, "prospective payment system" means the Medicare inpatient acute, post-acute, outpatient prospective payment system, inclusive of all hospital-specific adjustments including without limitation adjustments for acuity, area wage index, capital, teaching (both direct and indirect), disproportionate share, new technology, low volume, organ acquisition cost, routine and ancillary pass-through cost for allied health programs, outlier, and (B) for sole community hospital, rural referral centers and critical access hospitals, the equivalent hospital specific payment for providing inpatient or outpatient services to Medicare beneficiaries.***

2. Proposed R 500.203(1)

Proposed R 500.203(1) provides as follows: "When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. An amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019."

For acute inpatient hospital services, the prospective payment system (PPS) is based on a nationally established payment formula consisting of the applicable diagnostic related group relating to the patient's treatment and the standardized amount, as adjusted by a variety of factors, all of which are updated annually. Similarly, the PPS for outpatient hospital services and for capital-related costs are based on nationally established payment formulas updated annually. Further, Medicare payment for sole community hospitals and rural referral centers based on annually updated national payment formulas. For critical access hospitals, payment is set at 101% of allowable cost. Thus, this rule should be revised as follows to assure proper payment to hospitals based on their entitlement to Medicare payment:

When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. ***Except for hospitals reimbursed under a Medicare prospective payment system or reimbursed by Medicare as a sole community hospital, rural referral center or critical access hospital****, an amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019,* ***as adjusted pursuant to R 500.205(6)****.* ***A no-fault insurer will pay to a hospital that is reimbursed under Medicare an amount equal to (1) the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program multiplied by (2) the applicable Medicare reimbursement percentage under the Amended Act.***

3. Alternatively, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, Sparrow suggests that DIFS consider an alternative methodology for hospital payment which could be promulgated in a DIFS bulletin.

Under this alternative, which the Michigan Hospital Association previously outlined in a letter dated December 4, 2020, to Anita Fox, Director of DIFS, the no-fault insurer would pay the hospital's claim using a formula that takes into account the hospital's Medicare payment-to-charge ratio (in the aggregate) which would be updated and published annually by DIFS similar to the existing Worker's Compensation methodology. The formula would allow providers and insurers to determine the reimbursement providers are eligible to receive from insurers under the Amended Act. The formula for determining the reimbursement is as follows:

Auto No-Fault Payment = Auto No-Fault Payment Factor x Auto No-Fault Billed Charges

(1) Where the **"Auto No-Fault Payment Factor" = (Aggregate Medicare Payments / Aggregate Medicare Charges) x (Statutory Auto No-Fault Payment Multiplier)**

Aggregate Medicare Payments and Aggregate Medicare Charges for all services provided by a hospital are taken from each hospital's most recently available filed Medicare cost report to establish a single, unique ratio for that hospital, updated annually on July 1.

Annually, DIFS would publish each hospital's Auto No-Fault Payment Factor calculated by the Michigan Department of Health and Human Services (MDHHS) using Medicare cost report data.

The Statutory Auto No-Fault Payment Multiplier is the applicable Medicare reimbursement percentage under the Amended Act (*i.e.*, 200%, 230%, or 240%). DIFS would publish the applicable Medicare reimbursement percentage for each hospital.

(2) Example calculation of the Auto No-Fault Payment Factor and the Auto No-Fault payment based on the following assumptions:

When a hospital submits to the insurer the hospital's bill for services, the insurer would determine payment to the hospital by reference to the published Medicare reimbursement percentage for the hospital and the Auto No-Fault Payment Factor published for the hospital. The following is an example of how payment would be computed:

Amount Billed by the Hospital to Insurer = $500

Aggregate Medicare Payment to Hospital = $2,200,000

Aggregate Hospital Charges to Medicare = $7,100,000

Auto No-Fault Payment Multiplier = 240%

Auto No- Fault Payment Factor = ($2.2 Million / $7.10 Million) x (2.4) = 0.7437

Auto No-Fault Payment = (0.7437) x ($500) = $371.85

Under this example, $371.85 is the amount of reimbursement the hospital should receive from the insurer.

The Auto No-Fault Payment ratio would be hospital specific. Thus, the source of the data for each hospital's Auto No-Fault Payment would be the hospital's most recently filed Medicare cost report, updated annually on July 1.

Sparrow proposes that the Medicare cost report would be the data source for Medicare payments and charges used to develop the Auto No-Fault Payment Factor for inpatient and the outpatient services as well as for other hospital services, such as inpatient rehabilitation facility, home health and skilled nursing facility services. The Auto No-Fault Payment Factor would be subject to an annual update based on the hospital's most recently filed cost report as of July 1 of each year, although as provided by the Amended Act the allowable reimbursement that ties to the amount payable under Medicare must not exceed the average amount charged by the provider for the services on Jan. 1, 2019, as adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment. See MCL 500.3157(8) and (9).

Sparrow believes that, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, the Auto No-Fault Payment Factor serves as a reasonable proxy of the Medicare payment to which a hospital would be entitled with respect to any particular claim a hospital submits to an insurer. MHA further believes that payment based on the Auto No-Fault Payment Factor enables the efficient implementation and administration of the Amended Act. The alternative would be a time consuming and costly case-by-case computation that would be administratively burdensome to the hospital and insurer alike.

With regards,

John A. Shaski
Government Relations Officer

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p 616.486.2537
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Chad.Tuttle@spectrumhealth.org

Chad Tuttle
Senior Vice President, Hospital &
Post-Acute Operations
Spectrum Health West Michigan

March 26, 2021

Michele Estrada
EstradaM1@michigan.gov
Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals
P.O. Box 30220
Lansing, MI 48909-7720

Via Email

Re: Comments on the Administrative Rules for No-Fault Fee Schedule (Rule Set 2020-114 IF)

Dear Ms. Estrada:

Spectrum Health appreciates the opportunity to provide comments on the Administrative Rules for No-Fault Fee Schedule (Rule Set 2020-114 IF). Spectrum Health System, is a not-for-profit, integrated health system, committed to improving the health and wellness of our communities. We live our mission every day with 31,000 compassionate professionals, 4,600 medical staff experts, 3,300 committed volunteers and a health plan serving one million members. Our talented physicians and caregivers are privileged to offer a full continuum of care and wellness services to our communities through 14 hospitals, including Helen DeVos Children's Hospital, 150 ambulatory sites and telehealth offerings. Spectrum Health is the largest provider of post- acute services in West Michigan, We provide post-acute services to 3,500 people each day, this includes many patients with traumatic neurological injuries and other injuries obtained as a result of an auto accident. We pursue health care solutions for today and tomorrow that diversify our offerings. Locally governed and based in Grand Rapids, Michigan, our health system provided $585 million in community benefit in fiscal year 2019. It is from the perspective of an integrated health system we respectfully offer the following comments.

1. **Definition of "Fee Schedule"**

Proposed R 500.201(h) defines "fee schedule" to mean "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 the service is rendered."

In order to fully implement the intent of Public Act 21 of 2019 and Public Act 22 of 2019 (the "Amended Act"), that no-fault insurance payment to a hospital be based on the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program, ***Spectrum Health recommends that the definition of "fee schedule" be more precisely defined as follows for hospitals reimbursed under Medicare by adding the following language.*** *This clarification is necessary because there does not exist a definitive schedule of "fee for service payments under part A, B, or D of the federal Medicare program." This is because Medicare payment to hospitals depends on many factors including prevailing wage rates in the area where a hospital is located, whether a hospital trains residents or treats a disproportionate share of low-income patients, and whether the hospital is a sole community hospital, to name just a few of these factors. Further, this additional clarification regarding hospital payment would enable*

implementation of the Amended Act in a manner that best serves the interests of auto no-fault consumers, insurers and hospitals and other providers.

(h) "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. ***For purposes of this definition, "prospective payment system" means the Medicare acute inpatient, home health, inpatient rehabilitation facility, long-term care hospital, skilled nursing facility, and outpatient prospective payment system, inclusive of all hospital-specific adjustments including without limitation adjustments for acuity, area wage index, capital, teaching (both direct and indirect), disproportionate share, new technology, low volume, organ acquisition cost, routine and ancillary pass-through cost for allied health programs, and outlier payments, and for sole community hospitals, rural referral centers and critical access hospitals, the equivalent hospital specific payment for providing inpatient or outpatient services to Medicare beneficiaries.***

2. **Proposed R 500.203(1)**

Proposed R 500.203(1) provides as follows: "When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. An amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019. This regulation does not apply to any provider to whom MCL 500.2157(2)-(9) do not apply."

For acute inpatient hospital services, the prospective payment system ("PPS") is based on a nationally established payment formula consisting of the applicable diagnostic related group relating to the patient's treatment and the standardized amount, as adjusted by a variety of factors, all of which are updated annually. Similarly, the PPS for outpatient hospital services and for capital-related costs are based on nationally established payment formulas updated annually. Further, Medicare payment for sole community hospitals and rural referral centers based on annually updated national payment formulas. For critical access hospitals, payment is set at 101% of allowable cost. ***Thus, this rule should be revised as follows to assure proper payment to hospitals based on their entitlement to Medicare payment:***

When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the applicable fee schedule shall be utilized. An amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019, ***adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment.***. ***A no-fault insurer will pay to a hospital that is reimbursed under Medicare an amount equal to (1) the actual Medicare payment to which the hospital otherwise would be entitled to receive from the Medicare program multiplied by (2) the applicable Medicare reimbursement percentage under the Amended Act.***

3. **Addition of "regional average" to the fee schedule scheme**

Proposed R 500.205(1)(c) states: *"If a provider does not meet the criteria under subdivision (a) or (b) of this subrule,* ***the provider shall submit to the department a regional average. A regional average must reflect the amount of the charge if the service had been rendered on January 1, 2019****, and be adjusted in a manner consistent with subrule (6) of this rule." Spectrum Health has concerns with this addition to the established fee schedule as it was not established in statute.* It is unclear what resource the provider must utilize to provide a "regional average." Further, it is unclear if the "regional average" or 55% of the regional average will be applied to the provider's reimbursement limit.

Spectrum Health respectfully requests DIFS remove the provision for providers to provide the "regional average" for services they did not have a charge master or average charge for as of January 1, 2019. *In addition to being unclear and cumbersome to providers, it is an added element to the fee schedule that is not part of the statute.*

4. **CPI Adjustment**

Proposed R 500.205(6) provides as follows: "An average amount charged for each service on January 1, 2019, or amount listed on a charge description master in effect on January 1, 2019, must be adjusted annually by the percentage change in the medical care component of the consumer price index for the year preceding the adjustment. **Beginning in 2021, and annually thereafter, the department shall issue a bulletin no later than March 1 of each year setting forth the applicable percentage change in the medical care component of the consumer price index for the year preceding the adjustment.** This percentage change shall apply to services rendered between July 2 of that year and July 1 of the following year."

Spectrum Health believes that 2019 should be included in the annual adjustment. The medical care component of the CPI for 2019 was 4.6% and without it, there would be significant financial implications.

5. **Disclosures**

Proposed R 500.203(2), R 500.205(1), (2) and (4); and R 500.206(2) all require disclosure of documents, information, and other materials regarding their fees directly to DIFS. This includes in instances where a provider has not sought a DIFS appeal. Further these proposed rules require disclosures of sensitive, proprietary business information without properly restraining its release (except through the Freedom of Information Act (FOIA).

Spectrum Health is concerned with these disclosures, believe they exceed the scope of the No-Fault Act, and respectfully request they be removed.

6. **Alternative Methodology for Hospital Payment**

Finally, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, Spectrum Health suggests that

DIFS consider an alternative methodology for hospital payment which could be promulgated in a DIFS bulletin.
Under this alternative, the no-fault insurer would pay the hospital's claim using a formula that takes into account the hospital's Medicare payment-to-charge ratio (in the aggregate) which would be updated and published annually by DIFS similar to the existing Worker's Compensation methodology. The formula would allow providers and insurers to determine the reimbursement providers are eligible to receive from insurers under the Amended Act. The formula for determining the reimbursement is as follows:

Auto No-Fault Payment = Auto No-Fault Payment Factor x Auto No-Fault Billed Charges

1. Where the **"Auto No-Fault Payment Factor" = (Aggregate Medicare Payments / Aggregate Medicare Charges) x (Statutory Auto No-Fault Payment Multiplier)**

   Aggregate Medicare Payments and Aggregate Medicare Charges for all services provided by a hospital are taken from each hospital's most recently available filed Medicare cost report to establish a single, unique ratio for that hospital, updated annually on July 1.

   Annually, DIFS would publish each hospital's Auto No-Fault Payment Factor calculated by the Michigan Department of Health and Human Services (MDHHS) using Medicare cost report data.

   The Statutory Auto No-Fault Payment Multiplier is the applicable Medicare reimbursement percentage under the Amended Act (*i.e.*, 200%, 230%, or 240%). DIFS would publish the applicable Medicare reimbursement percentage for each hospital.

2. **Example calculation of the Auto No-Fault Payment Factor and the Auto No-Fault payment based on the following assumptions:**

   When the hospital submits to the insurer the hospital's bill for services, the insurer would determine payment to the hospital by reference to the published Medicare reimbursement percentage for the hospital and the Auto No-Fault Payment Factor published for the hospital. The following is an example of how payment would be computed:

   Amount Billed by the Hospital to Insurer = $500 Aggregate

   Medicare Payment to Hospital = $2,200,000 Aggregate Hospital

   Charges to Medicare = $7,100,000 Auto No-Fault Payment

   Multiplier = 240%

   Auto No- Fault Payment Factor = ($2.2 Million / $7.10 Million) x (2.4) = 0.7437 Auto No-Fault Payment = (0.7437) x ($500) = $371.85

   Under this example, $371.85 is the amount of reimbursement the hospital should receive from the insurer.

   The Auto No-Fault Payment ratio would be hospital specific. Thus, the source of the data for each hospital's Auto No-Fault Payment would be the hospital's most recently filed Medicare cost report, updated annually on July 1. This

would allow for adjustments to ensure Spectrum Health is able to maintain the additional costs associated with providing critical infrastructure (Level I trauma) necessary to provide adequate medical response to accidents in the State of Michigan.

Spectrum Health proposes that the Medicare cost report would be the data source for Medicare payments and charges used to develop the Auto No-Fault Payment Factor for inpatient and the outpatient services as well as for other hospital services, such as inpatient rehabilitation facility, home health and skilled nursing facility services. The Auto No-Fault Payment Factor would be subject to an annual update based on the hospital's most recently filed cost report as of July 1 of each year, although as provided by the Amended Act the allowable reimbursement that ties to the amount payable under Medicare must not exceed the average amount charged by the provider for the services on Jan. 1, 2019, as adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment. See MCL 500.3157(8) and (9).

Spectrum Health believes that, in the absence of a more precise regulatory definition of "fee schedule," and for purposes of determining the amount payable under Medicare as required by the Amended Act, the Auto No-Fault Payment Factor serves as a reasonable proxy of the Medicare payment to which a hospital would be entitled with respect to any particular claim a hospital submits to an insurer. Spectrum Health further believes that payment based on the Auto No-Fault Payment Factor enables the efficient implementation and administration of the Amended Act. The alternative would be a time consuming and costly case-by-case computation that would be administratively burdensome to health care provider and insurer alike and would add administrative costs and potentially additional litigation expense.

Conclusion

Thank you for consideration of our comments. Should you have questions regarding our comments please feel free to contact David Walker, Government Relations Advisor at David.Walkerii@spectrumhealth.org.

Sincerely,

Chad Tuttle, MBA, NHA
Senior Vice President, Hospital and Post-Acute Operations
Spectrum Health West Michigan

Estrada, Michele (DIFS)

From: Stephanie Goins <stephanie@3firefighters.com>
Sent: Friday, March 26, 2021 10:45 AM
To: Estrada, Michele (DIFS)
Subject: Rule set 2020-114 IF

My name is Stephanie Goins. I work at 1st Call Home Healthcare at 22367 Starks Dr, Clinton Twp, MI 48036. I oppose the DIFS proposed administrative rules for the auto no-fault fee schedule. Rule set 2020-114 IF

Thank you.

Estrada, Michele (DIFS)

From: Patricia Szymanski <trish@3firefighters.com>
Sent: Friday, March 26, 2021 3:27 PM
To: Estrada, Michele (DIFS)
Subject: Auto Law

My name is Trish Szymanski.I work at 1st Call Home Healthcare at 22367 Starks Dr, Clinton Twp, MI 48036. I oppose the DIFS proposed administrative rules for the auto no-fault fee schedule. Rule set 2020-114 IF

--

Patricia Szymanski
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Estrada, Michele (DIFS)

From: Wendy Klotz <wendyklotz4735@gmail.com>
Sent: Friday, March 26, 2021 11:17 AM
To: Estrada, Michele (DIFS)
Subject: Oppose DIFS Proposed Administrative rules for the auto-no-fault fee schedule

My name is Wendy Mlynarek. I work at 1st Call Home Healthcare at 22367 Starks Dr, Clinton Twp, MI 48036. I oppose the DIFS proposed administrative rules for the auto no-fault fee schedule. Rule set 2020-114 IF