MICHIGAN LEGISLATURE

April 21, 2022

Director Anita Fox
DIFS
530 W. Allegan Street, 7th Floor
Lansing, MI 48933

Director Fox:

Since the implementation of certain elements of the auto no-fault reform law (PA 21 and 22 of 2019), our offices have received detailed information about non-payment, under payment, and other challenges post-acute providers are experiencing.

For us to fully understand the ability of DIFS to respond to these concerns, and the Department's actions in response to these challenges, we respectfully request a written response to the questions posed below.

Your timely response is appreciated. Please submit your written response to the undersigned by May 6, 2022.

Sincerely,

Sen. Stephanie Chang
District 1

Sen. Doug Wozniak
District 8

Sen. Jim Runestad
District 15

Sen. Dale Zorn
District 17

Sen. Erika Geiss
District 6

Sen. Mallory McMorrow
District 13

Rep. Phil Green
District 84

Rep. Julie Rogers
District 60

Rep. Robert Bezotte
District 47

Rep. Yousef Rabhi
District 53

Rep. Ben Frederick
District 85

1. **Issue(s): Timely and reasonable payments**

Our offices continue to see examples from providers of continued problems with timely payments as well as payments well below the 200% of Medicare and 55% of 2019 charge masters (for various reasons), as applicable. We are now 9 months post-implementation, and these problems persist despite bulletins from DIFS attempting to address some of these concerns.

Providers do not know when (or even if) they will be paid and how much – we have seen enough examples to support this statement as fact. This is in direct conflict with the intent of the legislation that seeks to contain cost within a predictable and steady market. It is unreasonable to expect providers to have to file complaints or utilization review appeals for every bill that is underpaid or not paid. Therefore,

- What can DIFS do beyond responding to individual claim complaints and utilization review appeals?
- Does this problem require legislative intervention?
- Would a fee schedule with specific codes and uniform reasonable rates (rather than a 55% of 2019 charges for certain services, for example) reduce untimely and unreasonable payments?

2. **Issue(s): Complaints**

The number of complaints to DIFS has been used by some as a public barometer for the extent of the problems being caused by the fee schedule and the family provided attendant care hourly limit. It is necessary for us to have a better understanding of the definition and context of complaints filed to DIFS. Therefore,

- Public comments by DIFS have stated that there have been a little over 100 complaints related to care disruptions since July 1, 2021; however, public records obtained from a FOIA request states that there were over 1,300 auto insurance complaints from July 1, 2021 through January 31, 2022. What is the cause for the discrepancy between these numbers?
- Does the Department categorize types of complaints received? If so, please provide the numbers for each category of complaint from July 1, 2021, through March 30, 2022.
- What determines when a consumer or providers complaint is formally counted as a "complaint file" by the Department?
    - Is this definition clearly articulated to consumers or providers that contact DIFS with a potential complaint?
- To what degree does the Department verify information being provided by insurance companies during a complaint investigation?
    - If an insurance company states they have located an alternative provider that will provide the level of care needed (due to the current provider stating they are unable to provide care), does the Department get direct confirmation from this alternative provider?

- If an insurance company states they have submitted a negotiated reimbursement level to a provider, does the Department verify this with documented evidence of the proposed negotiated rate?

- How does the Department define when a complaint is determined to be "resolved"?

- If a single individual (or provider) files multiple and distinct complaints, are they counted under one "complaint file"?

- If the Department is saying they received 100 complaints over a period of time, does that represent 100 different individuals? For example, if one person filed 20 different complaints over that period of time, would that "n" only be counted as 1 of the 100?

- If a claim is in litigation, does DIFS pause their pursuit of a complaint to the Department regarding that claim?

3. **Issue(s): Utilization Review Process**

- To date, what is the percentage of auto no-fault utilization orders determined by DIFS that resulted in the favor of the insurer?

- Does the Department have contracts with certain Independent Review Organizations (IROs) that they utilize in the utilization review process? If so, please provide a list of these contracted IROs.

  - If no, please provide a detailed description of how IROs are selected for individual appeals.

- On average, how long does it take for DIFS to determine its final order (i.e. from the date they receive the initial appeal to the date they publish their order)?

- We are hearing that insurers are using sources intended for worker's compensation cases/return to work on catastrophic injuries resulting in a cut-off of therapy services. Does DIFS have any authority to regulate the sources used by insurers in their initial internal utilization review process?

  - If DIFS does not have this authority (or willingness) to regulate, does this require legislative intervention?

- During the utilization review process, does the Department discuss the case with the prescribing physician of the service being denied by the insurer?

4. **Issue(s): Provider Relief Fund**

Another public barometer used by some to determine if there is indeed unattainable financial hardships being endured by post-acute providers is the funds distribution from the Provider Relief Fund, created through PA 65 of 2021. We have heard from providers that the statutory process makes access to the funds extremely difficult, if not impossible. Therefore,

- To date, how much money has been distributed from the funds to providers?

- To date, how much administrative cost has been incurred by the Department for this fund?

- How many applications have been denied?

- What is the average amount of time it has taken the Department to provide a final determination (i.e., from the date of application submission to the date of the final determination)?

- What are the five most common reasons for application denials?

- Please provide the Department's interpretation of the following requirements:
    - A provider must demonstrate that they "bill at the at rates below the cost of providing service"
    - A provider must supply "full financial statements"
    - A provider must provide "supporting invoices for all charges and payments that were charged to and paid by auto insurers for motor-vehicle-accident-related care in 2019"
    - Definition of "systematic deficit"

- The Department has made public statements about making efforts to make the application process easier for providers. Please detail these efforts.

- It is our understanding that the Department was approached by the Michigan Brain Injury Provider Council to collaborate on ideas of how to make the Provider Relief Fund more accessible; but, there was no response or interest voiced in doing so. Please explain why the Department did not engage in this dialogue.

5. **Issue(s): MCCA**

- Given that the MCCA reimburses claims when they exceed $585,000, why would amending the fee schedule to ensure reasonable reimbursement to long-term care providers specifically raise premiums beyond the MCCA assessment fee (which would be applied only to consumers who choose lifetime coverage plans)? In other words, why would premiums for those choosing plans with less monetary caps increase with a finite fee schedule amendment for long-term care providers?

- Are you aware of the MCCA intervening in claims processes (pre-approving/denying services and rates) for claims before they reach the $585,000 threshold?
    - If so, is this within their statutory authority?
        - If not, is this an area that DIFS should regulate? Or does this require legislative intervention?

6. **Issue(s): Accreditation**

Despite the efforts of DIFS to clarify who does and does not require accreditation through their website's FAQ, there still remains uncertainty amongst providers who must be in the process of accreditation to comply with the statute. Therefore,

- In the Department's FAQ, the following types of services are determined to NOT require accreditation: Recreational Therapy, Vocational Rehabilitation, Psychotherapy, Speech-Language Pathology, among other "ancillary" services; however, it states that an "individual provider that 'provides post-acute brain and spinal rehabilitation care' must be accredited". Please provide clarity on the services provided by "stand-alone individual providers" that require accreditation.

- The FAQ states that providers of attendant care "do not 'provide[] post-acute brain and spinal rehabilitation care'". Please define attendant care and explain how these services are not considered "care".

7. **Issue(s): CPI Adjustment**
   It has been demonstrated to us that insurers are not automatically including annual CPI adjustment into their payments, per statutory requirement. This is causing providers to needlessly appeal the payment to recoup the difference. Therefore,

   - Does DIFS have any authority to enforce insurers are including their CPI adjustment in their payment?

   - Does this require legislative intervention, for example in the form of a penalty to insurers for not including this in their initial payment?

8. **Issue(s): Applying Late Fee**
   It has been demonstrated to us that insurers are not automatically including the 12% late fee when not paying within 30 days of receipt of the charge. This is causing providers to needlessly appeal the payment to recoup this fee. Therefore,

   - Does DIFS have any authority to enforce insurers are including their CPI adjustment in their payment?

   - Does this require legislative intervention, for example in the form of a penalty to insurers for not including this in their initial payment?

9. **Issue(s): Medicare Fee Schedule Applicability**
   It has been demonstrated to us that there remains confusion in certain elements of the medical fee schedule. Therefore,

   - How does the Department interpret this element of PA 21: "'*Medicare' means fee for service payments under part A, B, or D of the federal Medicare program established under subchapter XVIII of the social security act, 42 USC 1395 to 1395lll, without regard to the limitations unrelated to the rates in the fee schedule*"?

   - Are providers that provide services with a payable Medicare code subject to billing rules used by the Medicare program?

   - Home Health is having a specific issue with the 55% reimbursement cap being applied to skilled visits (i.e. physical therapy, occupational therapy, speech-language pathology, nursing). These services have a payable amount in the Medicare system. These visits are listed withs payable amounts in the National Per Visit Payment Schedule which are payable in Low Utilization Episodes when a full episode is not completed. Why are insurers able to subject these services to the 55% reimbursement cap and not the 200% Medicare cap?

   - We have been informed of insurers applying the 55% reimbursement cap to dental and oral surgeon services for crash-related care. These services have dental codes provided by the American Dental Association. Why are auto insurers allowed to apply the 55% reimbursement cap to these services?