Department of Insurance and Financial Services
Proposed Rulemaking
R 500.241, R 500.242, R 500.243, R 500.244, and R 500.245, Michigan Administrative Code

Testimony – By Antonio Bonfiglio, M.D.

- My name is Dr. Antonio Bonfiglio and I serve as the Chief Medical Officer at Ascension Macomb-Oakland Hospital in Warren, Michigan. I would like to express my gratitude to Governor Whitmer, Director Anita Fox, and their staff for working with our group on proposed rules guiding implementation of Michigan's Surprise Medical Billing Act.

- I am a Board-Certified Emergency Doctor and Past-President of the Michigan College of Emergency Physicians. I am employed by TeamHealth, a national hospital clinical staffing organization based in Knoxville, Tennessee. TeamHealth operates in 47 states, employing more than 15,000 clinicians across the country.

- In Michigan, TeamHealth employs more than 400 frontline workers, and operates at 12 hospital emergency departments primarily in Metro Detroit.

- In this state during 2020, TeamHealth, provided emergency care to nearly 375,000 patients, of which approximately 55,000 were uninsured Michiganders.

- TeamHealth does not "Surprise Bill" patience, but instead manages out-of-network billing issues directly with insurance carriers.

- I am here today to express reservations over the draft rules for the Act and respectfully request consideration of the modifications we delivered to the Department and attached to my written testimony.

- I, along with many of my colleagues, are concerned the proposed rules are alarmingly vague, likely leading to a rapid downward spiral in service reimbursements and correlated compensation made to frontline workers. This will ultimately impact the delivery of care throughout Michigan.

- We are convinced that without more developed rules, payers will systematically terminate managed care contracts to redefine the median "in network" rates moving forward and reduce overall payments to emergency medical physicians.

- Some experts predict hospital emergency departments will see unsustainable reductions in reimbursements of 20% or more - leading to one of the following scenarios:

    1. Hospitals will subsidize emergency care to make up the corresponding reductions from insurance payments – which in many cases will be beyond the hospitals existing financial capabilities.

    2. Proportionate cutbacks in manpower used to staff emergency departments. And/or,

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Hospitals making up the difference is the least likely scenario, leaving reductions in staff levels and/or cuts in compensation our reality, leading to the following:

1. Greater difficulty drawing skilled frontline workers to rural and urban areas; especially those with indigent and low

reimbursement populations, compounding already existing provider shortages.
2. Exacerbate pressures already on overworked staff, which is particularly alarming during the current Covid-19 pandemic.
3. Reduction in compensation for emergency physicians and frontline providers.
4. Emergency providers leaving Michigan.
5. Increased waiting times in emergency departments.
6. Likely reduction in the delivery and quality of care.
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- I am perplexed that the State has not anticipated these scenarios, and the impact the Act will have on emergency medicine without more clearly defined rules. Think about this a moment – a 20% reduction in compensation and increased workload thrust upon our very frontline caregivers during a pandemic. And this is over and above the already severe economic pressures shouldered in emergency departments since Covid-19 began.

- To compound matters, as I mentioned, TeamHealth physicians provided care to 55,000 uninsured Michiganders annually, as mandated by law. Though we openly embrace this service as part of our mission, policymakers need to note, if paid, the average amount from this population is just 3 ½% of our ***breakeven*** cost - meaning we write off the balance 96 ½% as uncompensated services.

- Also, Medicaid payments for emergency providers is roughly 16% of our cost to deliver care – forcing providers to absorb the balance 86% of this cost.

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dollars are directed exclusively to brick and mortar hospitals, and not frontline providers and groups.

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- Presently, uncompensated care along with reimbursements from low payers like Medicaid and Medicare are offset and cross-subsidized by a range of in and out-of-network commercial payers, yielding our current economic market equilibrium in Michigan. But as noted, these amounts will quickly begin to drop by 20%, or so, unless the administration uses its authority to craft some guardrails moving forward.

- We believe implementing rules as we submitted are within the administration's authority and spirit of the Michigan Surprise Billing Act. Nothing within our proposed rule amendments is prohibited by the Act, in fact, encouraged, as demonstrated by statements like "including, but not limited to…" Specifically, Public Act 234, of 2020, allows the department to promulgate rules for two sections addressing:

    - Median in-network rates, and
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- Moreover, our proposed changes are equitable, serving the public good by helping Michigan avoid undesirable and chaotic outcomes for emergency care, while maintaining the level of service and medical safety-net Michiganders rely upon.

- In closing, my focus is delivering care to my patients, however, the vagueness of the Administration's proposed rules is alarming and will likely lead to a downward spiral in emergency care. As an industry we are respectfully asking the Whitmer Administration to find the way to modify your rules, and to include more clear procedures centering on median amounts and complicating factors, like those we provided.

- Thank you

Testimony – Antonio Bonfiglio - Supporting Documentation

"MEDIAN AMOUNT"

- Public Act 234 of 2020 does not contain a specific definition of "median amount."

- Emergency providers view the proposed Rules as too vague, allowing payers to inappropriately ratchet down rates currently expected in the marketplace. This consequence has nothing to do with Surprise Medical billing as contemplated in the act, nor legislative intent.
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- Nothing prohibits the Department from establishing the base year as 2019, and adjust moving forward using the Consumer Price Index, discounting 2020 as an outlier year in light of Covid-19.
- Tying the median amount to the CPI is also logical and not prohibited by the PA234'20. In fact, significant precedence is established using the CPI within and outside of government mandates.
- Section 24510, Subsection (2) grants the Department the authority to "consult an *external* database that contains the negotiated rates under the patient's health benefit plan for the applicable health care service." This language allows the Department to establish a generally accepted factfinder such as Fairhealth, for the "external database," along with establishing a date in time as the benchmark period. This is only logical.
- Moreover, nothing prohibits the need to establish an unbiased source and create a starting point for the department, payers, and

providers to follow. Otherwise, chaos will ensue as detailed by my colleague in his earlier statement - which certainly cannot be the intent of PA 234'20 - particularly during a pandemic.

- In fact, using the last full year of provider/payer agreements sets the stage for steady market adjustments, with rules tied to nationally accepted metrics, such as the CPI.
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- Following, we are requesting logical steps to prevent carriers from using rates from a lower paying region, to dilute the rate for higher paying areas of the state, and for the Department to codify this moving forward.
- And to limit the payment data to include only rates applicable to those controlled by this Act also stands to reason.
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"COMPLICATING FACTOR"

- Section 24511, subsection (8) of Public Act 234 of 2020 defines complicating factors and lays out three priorities, namely:
    - Increased intensity, time, or technical difficulty of the health care service.
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- However, clearly, the statute is relying on the department to develop and expand the definition by including the term: "…including, but not limited to…".

- To this, we are simply requesting the Rules include clearly delineated medical conditions by accepting generally accepted medical diagnosis and coding terminology tools.

- We also request a clear and generally standardized procedure, via form or otherwise, that affords a provider a mechanism to inform payers of a complicating factor when an "out-of-network" patient presents for emergency care, and next steps when a disagreement over reimbursement or complicating factors occurs.

- And we request a requirement that insured be noticed by the payer of plan benefits in accordance with the Act.

- We also ask for specific guidance as to the medical conditions and diagnoses the department deems sufficient to constitute complicating factors by using commonly accepted medical

terminology and numerical coding methodologies (icd-10) as well as a method for identifying the presence of a complicating factor on the medical claim form submitted to the health plan for payment.

- And finally, we are requesting the Department establish and publish an annual list of accepted “complicating factors” for the industry to reference.

- Together, these modifications to the proposed rules are reasonable and necessary to help emergency providers deliver expected care, while maintaining market equilibrium for the industry.

Department of Insurance and Financial Services Proposed Rulemaking

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Personnel Testimony – By Belinda Chandler, CAE

My name is Belinda Chandler, and I am the Executive Director of the Michigan College of Emergency Physicians and would like to thank the Whitmer administration, Department Director Anita Fox, and her staff for allowing me to present today. I am also happy to follow our past present, Dr. Antonio Bonfiglio.

The Michigan College of Emergency Physician has over 2,000 members and we have been before this committee on behalf of our members regarding surprise billing. We would like to continue the conversation regarding the proposed rules guiding implementation of Michigan's Surprise Billing Act.

During the legislative process, we stressed how this bill would create a significant financial burden for many emergency departments, particularly in the rural area, and ultimately limit access to care.

We also stressed that Medicare is not an appropriate benchmark for determining out-of-network payments since the Medicare program was established for the purpose of reimbursing medical services for an age-specific population, and, as such, rates do not appropriately reflect key underage-65 health services. Additionally, a federal bill was simultaneously being discussed yet Michigan continued to move forward House Bill 4459 and 4460 for a vote.

Now with the passing of the federal law, Michiganders will face dual arbitration systems with conflicting requirements. All ERISA plans will be handled by the federal system while non-ERISA plans will be handled in Michigan. Discrepancies between these laws will only lead to confusion over what arbitration system will be used. Hospitals' emergency departments will be at risk for reductions in their manpower as they are forced to subsidize the reduction in insurance payments.

The Michigan College of Emergency Physicians is requesting that instead of two costly and confusing processes, consideration be given to allowing the federal law to take precedence and give our Michigan patients continuity in the arbitration process. Not doing so only achieves different payments, coverage, and chaos in navigating the varying array of requirements for resolving disputes.

Thank you.

(Proposed Rule Modifications for Consideration – TeamHealth – 2-2-21)

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

INSURANCE

SURPRISE MEDICAL BILLING

Filed with the secretary of state on

These rules take effect immediately upon filing with the secretary of state unless adopted under section 33, 44, or 45a (6) of the administrative procedures act of 1969, 1969 PA 306, MCL 24.233, 24.244, or 24.245a. Rules adopted under these sections become effective 7 days after filing with the secretary of 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)

R 500.241, R 500.242, R 500.243, R 500.244, and R 500.245 are added to the Michigan Administrative Code as follows:

R 500.241 Definitions.

Rule 1. (1) As used in these rules:

(a) "Act" means the public health code, 1978 PA 368, MCL 333.1101 to 333.25211.

(b) "Median amount" means the median amount negotiated by the carrier for the region and provider specialty, excluding any in-network coinsurance, copayments, or deductibles. The carrier shall determine the region and provider specialty.

(i) THE MEDIAN AMOUNT SHALL REFLECT THE ACTUAL AMOUNTS PAID TO CONTRACTED PROVIDERS IN THE YEAR [2019], KNOWN AS THE BASE YEAR.

(ii) THE BASE YEAR SHALL BE ADJUSTED IN AN AMOUNT EQUAL TO THE CHANGE IN THE ANNUAL CONSUMER PRICE INDEX FOLLOWING THE URBAN (CPI-U) TO REFLECT THE MEDIAN AMOUNT IN THE CURRENT BENEFIT YEAR.

(iii) THE MEDIAN AMOUNT SHALL BE REFLECTIVE OF PAYMENTS MADE SOLELY TO INDIVIDUALLY CONTRACTED PROVIDERS, EACH OF WHOM WERE CONTRACTED WITH THE CARRIER IN THE NONPARTICIPATING PROVIDER'S RECOGNIZED SPECIALTY DURING THE BASE YEAR.

(iv) THE DEPARTMENT SHALL ENSURE THAT THE MEDIAN AMOUNT IS WEIGHTED IN A MANNER THAT BEST REPRESENTS THE FREQUENCY OF PAYMENTS ISSUED TO INDIVIDUALLY CONTRACTED PROVIDERS IN THE NONPARTICIPATING PROVIDER'S RECOGNIZED SPECIALTY DURING THE BASE YEAR.

(v) THE MEDIAN AMOUNT SHALL NOT REFLECT PAYMENTS MADE TO CONTRACTED PROVIDERS OR PROVIDER GROUPS WHO WERE NOT LISTED IN

THE CARRIER'S PROVIDER DIRECTORY UNDER THE SAME SPECIALTY AS THAT OF THE NONPARTICIPATING PROVIDER.

(c) "COMPLICATING FACTOR' MEANS:

(i) A FACTOR THAT IS NOT NORMALLY INCIDENT TO A HEALTH CARE SERVICE, INCLUDING, BUT NOT LIMITED TO THE FOLLOWING:

(a) INCREASED INTENSITY, TIME, OR TECHNICAL DIFFICULTY OF THE HEALTH CARE SERVICE;

(b) THE SEVERITY OF THE PATIENT'S CONDITION; AND,

(c) THE PHYSICAL OR MENTAL EFFORT REQUIRED IN PROVIDING THE HEALTH CARE SERVICE.

(ii) THE DEPARTMENT SHALL DELINEATE MEDICAL CONDITIONS THAT CONSTITUTE 'COMPLICATING FACTORS' BY UTILIZING GENERALLY ACCEPTED MEDICAL DIAGNOSIS AND CODING TERMINOLOGY TOOLS AND RESOURCES DETERMINED BY THE INTERNATIONAL CLASSIFICATION OF DISEASE, TENTH EDITION (ICD-10), AND THE AMERICAN MEDICAL ASSOCIATION'S COMMON PROCEDURE TERMINOLOGY (CPT) WITH BOTH SERVING AS RECOGNIZED RESOURCES FOR CARRYING OUT THE ACT, IN ACCORDANCE WITH R500.245(1).

(2) THE DEPARTMENT SHALL INSTRUCT CARRIER'S TO IDENTIFY A METHOD BY WHICH A NONPARTICIPATING PROVIDER MAY INDICATE THE PRESENCE OF A 'COMPLICATING FACTOR' ON THE CLAIM SUBMISSION FORM WHETHER FILED ELECTRONICALLY OR ON PAPER, WHICH SHALL BE DEEMED SUFFICIENT FOR THE CARRIER TO RECOGNIZE, PROCESS AND ISSUE A SUPPLEMENTAL OUT-OF-NETWORK PAYMENT IN ACCORDANCE WITH THIS ACT.

THE DEPARTMENT SHALL REQUIRE THE CARRIER TO NOTICE THE NONPARTICIPATING PROVIDER AS PART OF THE CARRIER'S EXPLANATION OF BENEFITS, EITHER ELECTRONICALLY OR IN PAPER FORM, THAT THE MEDIAN AMOUNT PAYMENT ISSUED INCLUDES A SUPPLEMENTAL 'COMPLICATING FACTOR' PAYMENT AT THE STIPULATED ADD-ON PAYMENT PERCENTAGE INCREASE REQUIRED BY THIS ACT.

THE CARRIER MAY ALSO CHOOSE TO DENY THE NONPARTICIPATING PROVIDER'S CLAIM FOR A SUPPLEMENTAL 'COMPLICATING FACTOR' PAYMENT BUT MUST NOTIFY THE NONPARTICIPATING PROVIDER BY COMMUNICATING ANY DENIAL ON ITS EXPLANATION OF BENEFITS FORM, EITHER ELECTRONICALLY OR ON PAPER, AND IN DOING SO, ADVISE THE NON-PARTICIPATING PROVIDER THAT HE OR SHE MAY CHOOSE TO APPEAL THE CARRIER'S DETERMINATION BY COMMUNICATING WITH THE DEPARTMENT ON A FORM SPECIFIED BY THE DEPARTMENT AND BY ACCESSING THE ARBITRATION PROVISIONS MADE AVAILABLE BY THE DEPARTMENT.

(3) THE DEPARTMENT SHALL REQUIRE THE CARRIER TO IDENTIFY ON ALL MEMBER INSURANCE IDENTIFICATION CARDS AND EXPLANATION OF

BENEFITS, EITHER ELECTRONICALLY OR ON PAPER, PLAN BENEFITS TO BE ADMINISTERED, PAID OR DENIED IN ACCORDANCE WITH THIS ACT.

(4) THE DEPARTMENT SHALL ESTABLISH AND PUBLISH A SCHEDULE OR LIST, WHICH SHALL BE UPDATED ANNUALLY DELINEATING MEDICAL SERVICES AND CONDITIONS THE DEPARTMENT DEEMS MEET THE DEFINITION OF A 'COMPLICATING FACTOR'.

THE SCHEDULE THE DEPARTMENT PUBLISHES SHALL BE CROSS-REFERENCED TO GENERALLY ACCEPTED MEDICAL DOCUMENTATION TOOLS AND RESOURCES IN ACCORDANCE WITH 500.241, SUBSECTION (1)(C) OF THE ACT, MCL 333.24511.

(5) A term defined in the act for the purposes of article 18 of the act, MCL 333.24501 to 333.24517, has the same meaning when used in these rules.

R 500.242 Scope and applicability.

Rule 2. These rules do the following:

(a) Establish procedures for the department to review and resolve requests for calculation review OF THE MEDIAN AMOUNT submitted pursuant to section 24510 of the act, MCL 333.24510.

(b) Establish procedures for approving arbitrators to provide binding arbitration pursuant to section 24511 of the act, MCL 333.24511.

R 500.243 Requests for calculation review.

Rule 3. (1) A nonparticipating provider must make a request for calculation review on a form provided by the department.

(2) In response to a request from a nonparticipating provider for a calculation review under section 24510 of the act, MCL 333.24510, the department shall do the following within 14 days of the date of the request:

(a) Notify the carrier of the request for a calculation review.

(b) Request data on the carrier's median amount or any documents, materials, or other information the department believes is necessary to assist in reviewing the request for calculation review.

(c) CONSULT OR REQUEST SUPPORTING INFORMATION FROM A NATIONALLY RECOGNIZED PHYSICIAN ALLOWABLE DATABASE IN ACCORDANCE WITH R500.244(2).

(3) A carrier must respond within 7 days of the date of the department's request under subrule (2)(b) of this rule. If the information provided is incomplete, the department may, at its discretion, request additional information, or issue a determination based solely on the information provided as of the date on which the carrier's response was due. If the department makes 1 or more requests for additional information, the department shall extend the time period permitted for the carrier's response for a number of days the department considers appropriate.

(4) The department shall issue a determination resolving the request for a calculation review no later than 14 days after the carrier submits a timely and complete response under

subrule (3) of this rule or after the expiration of the time period within which the carrier was required to respond, including any extensions provided under subrule (3) of this rule.

R 500.244 Median amount; access to database.

Rule 4. (1) Subject to subrule (3) of this rule, a carrier may satisfy the requirement under R 500.243 by providing the department with access to a database that contains all of the carrier's median amounts. The database must meet all of the following requirements:

(a) Be updated no less frequently than quarterly.

(b) Be searchable by region, provider specialty, and health care service.

(c) Include negotiated rates for all health care services covered by the carrier, GEOGRAPHICALLY ADJUSTED AND IF APPLICABLE, ISOLATED BY PLAN PRODUCT TYPE SO NOT TO BLEND OR MERGE VARYING CONTRACT RATE STRUCTURES FOR THE PURPOSES OF ARTIFICIALLY ADJUSTING THE MEDAIN. THIS SHALL BE FURTHER LIMITED TO PROVIDERS REPORTED IN THE CARRIER'S CURRENTLY PUBLISHED PROVIDER DIRECTORY, SORTED FOR EACH GIVEN SPECIALTY;

(d) REPRESENT CONTRACTED PAYMENT RATES FOR COMMERCIAL HEALTH BENEFIT PLANS ONLY, THAT ARE REGULATED BY THE DEPARTMENT, AND WHICH. SHALL NOT INCLUDE PROVIDER CONTRACT RATES ASSOCIATED WITH BENEFIT PLANS THE CARRIER ADMINISTERS ON BEHALF OF MEDICARE, MEDICAID OR OTHER GOVERNMENT HEALTH BENEFIT PROGRAMS.

(e) Be continuously accessible to the department.

(2) For the purposes of conducting a calculation review under section 24510 of the act, MCL 333.24510, the department may, at its discretion, consult any external database described under section 24510(2) of the act, MCL 333.24510, without regard to whether a carrier made the database accessible to the department or whether the database otherwise meets the requirements under subrule (1) of this rule.

SUCH DATABASE SHALL BE NATIONALLY RECOGNIZED, GEOGRAPHICALLY ADJUSTED AND SPECIALTY SPECIFIC, SORTED BY GEOGRAPHIC ALLOWABLE PAYMENT PERCENTILES, PROCURED BY A NOT-FOR-PROFIT ENTITY, WHICH IS NOT AFFILIATED, EITHER DIRECTLY OR INDIRECTLY, WITH AN INSURANCE CARRIER OR HEALTH. BENEFIT PLAN.

(3) A carrier's provision of access to a database under this rule does not preclude the department from requesting additional documents, materials, or other information that the department determines is necessary for conducting a review under section 24510 of the act, MCL 333.24510.

R 500.245 Approval of arbitrators.

Rule 5. (1) The department shall create and maintain a list of arbitrators trained by the American Arbitration Association or American Health Lawyers Association WHO POSSESS KNOWLEDGE OF MEDICAL REIMBURSEMENT AND EXPERIENCE IN THE USE OF MEDICAL TERMINOLOGY AND MEDICAL CODING, INCLUDING BUT NOT LIMITED TO THE INTERNATIONAL CLASSIFICATION OF DISEASE, TENTH EDITION (ICD-10), AND THE AMERICAN MEDICAL ASSOCIATION'S COMMON PROCEDURE TERMINOLOGY (CPT) AND WHO SHALL BE approved by the director.

This list must be updated no less frequently than annually and must be posted on the department's website.

THE ARBITRATOR AND DEPARTMENT MAY CHOOSE TO SEEK THE ASSISTANCE OF MEDICAL PROFESSIONALS LICENSED IN THE STATE OF MICHIGAN AND TRAINED IN THE MEDICAL SPECIALITY IN THE DISPUTE IN QUESTION FOR THE PURPOSE OF ASSISTING THE ARBITRATOR RULE ON THE PRESENCE OF OR LACK THEREOF OF A COMPLICATING FACTOR.

THE SELECTED MEDICAL PROFESSIONAL SHALL HAVE NO AFFILIATION OR RELATIONSHIP WITH EITHER OF THE PARTIES.

(2) Arbitrators seeking to be included in the list under subrule (1) of this rule must apply on a form prescribed by the department.

(3) The department shall approve or disapprove an application no later than 60 days after the date of receipt of the application. Applicants whose application has been disapproved may reapply at any time.

(4) If approved for inclusion in the list under subrule (1) of this rule, arbitrators must annually provide to the department, on a form prescribed by the department, an attestation acknowledging that the information provided to the department in the arbitrator's application under subrule (2) of this rule remains complete and accurate.

(5) Arbitrators included on the department's list under subrule (1) of this rule must notify the department of any changes to the information contained in the arbitrator's application under subrule (2) of this rule within 30 days of the change. An arbitrator's failure to inform the department of these changes may result in revocation of the arbitrator's approval and removal from the list under subrule (1) of this rule.

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- And we request a requirement that insured be noticed by the payer of plan benefits in accordance with the Act.

- We also ask for specific guidance as to the medical conditions and diagnoses the department deems sufficient to constitute complicating factors by using commonly accepted medical

terminology and numerical coding methodologies (icd-10) as well as a method for identifying the presence of a complicating factor on the medical claim form submitted to the health plan for payment.

- And finally, we are requesting the Department establish and publish an annual list of accepted “complicating factors” for the industry to reference.

- Together, these modifications to the proposed rules are reasonable and necessary to help emergency providers deliver expected care, while maintaining market equilibrium for the industry.

March 11, 2021

To: Department of Insurance and Financial Services
RE: Surprise Billing Draft Rules

Via Email to: Michele Estrada: estradam1@michigan.gov

MAHP Commentary on Proposed
Surprise Medical Billing Rules

To Whom It May Concern:

The Michigan Association of Health Plans (MAHP) represents ten health insurers licensed in the State of Michigan who insure over 3.1 million Michiganders in various lines of business. Our work is focused on providing Michiganders with high-quality, competitive, and affordable health insurance that improves their quality of life. The Surprise Medical Billing Legislation accomplishes all of MAHPs stated goals.

Representative Hauck, the Chief Sponsor of the bill package, stated the Surprise Billing Package was designed to "ban the practice of Surprise Medical Billing."[1] Governor Whitmer, in her State of the State Address commented that the legislation she signed put an "…end to surprise medical billing."[2] These statements, by members of opposite parties and different branches of government, confirm the intent of the statute was intended to offer broad-based protections and we encourage the Department of Insurance and Financial Services (DIFS) and the Department of Licensing and Regulatory Affairs (LARA) to utilize all regulatory authority to ensure the practice of Surprise Medical Billing is stopped and violators of these Acts are deterred from future surprise medical bills.

Specific Commentary on
Surprise Medical Billing Draft Rules

The Proposed Surprise Medical Billing Rules ("Proposed Rules") should be amended to reflect the following changes:

CR 500.243(1) Request for Calculation Review Rule 3

As Proposed by DIFS: A nonparticipating provider must make a request for calculation review on a form provided by the department.

[1] Representative Roger Hauck and Frank Liberati's Testimony on October 17, 2019 – House Health Policy Committee. Accessed February 18, 2021.
https://www.house.mi.gov/SharedVideo/PlayVideoArchive.html?video=HEAL-101719.mp4
[2] Governor Gretchen Whitmer's State of the State Address, January 27, 2021, Accessed February 18, 2021
https://wwmt.com/news/state/read-gov-gretchen-whitmers-full-state-of-the-state-address

MAHP Proposed: A nonparticipating provider must make a ***detailed*** request, ***which includes the nonparticipating provider's rationale***, for calculation review on a form provided by the department.

Rationale: Under the proposed rules, Carriers must produce the data and information, which includes provider type and region, upon which its reimbursement was issued. In order to specifically address any nonparticipating provider's request for rate review, the nonparticipating provider should be required to submit a detailed reasoning as to why it believes the reimbursement was incorrect.

CR 500.243(2) Request for Calculation Review Rule 3

As Proposed by DIFS: Request data on the carrier's median amount or any documents, materials, or other information the department believes is necessary to assist in reviewing the request for calculation review.

MAHP Proposed: Request data on the carrier's median amount or any documents, materials, or other information the department believes is necessary to assist in reviewing the request for calculation review. ***The department shall provide the carrier with a written reasoning for requesting any materials it believes are necessary beyond the median amount calculation.***

Rationale: The statute is very limited regarding the data production for a rate review case. The statutory language is that the department *may* request data *or other information that the department believes is necessary.* Thus, if additional information is required beyond the rate calculation a stated reason as to how the department developed its belief should be required.

CR 500.243(3) Request for Calculation Review Rule 3

As Proposed by DIFS: A carrier must respond within 7 days of the date of the department's request under subrule (2)(b) of this rule. If the information provided is incomplete, the department may, at its discretion, request additional information, or issue a determination based solely on the information provided as of the date on which the carrier's response was due. If the department makes 1 or more requests for additional information, the department shall extend the time period permitted for the carrier's response for a number of days the department considers appropriate.

MAHP Proposed: A carrier must respond within ***14*** days, ***excluding any state-recognized holidays,*** of the date of the department's request under subrule (2)(b) of this rule. If the information provided is incomplete, the department may, at its discretion ***and with a description as to why the department believes the information is incomplete***, request additional information, or issue a determination based solely on the information provided as of the date on which the carrier's response was due. If the

department makes 1 or more requests for additional information, the department shall extend the time period permitted for the carrier's response by ***14 days.***

Rationale: Since there is no timeline defined in the statute, all timeframes should be consistent. DIFS has taken 14 days in order to start its review under 500.243(2). Carrier's responses as well as responses to any additional information requests should receive the same grace period for response.

MAHP appreciates the opportunity to comment on these proposed rules and our Plans look forward to collaborating with DIFS to respond to any legitimate nonparticipating provider concerns related to their reimbursement.

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(Proposed Rule Modifications for Consideration – TeamHealth – 2-2-21)

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

INSURANCE

SURPRISE MEDICAL BILLING

Filed with the secretary of state on

These rules take effect immediately upon filing with the secretary of state unless adopted under section 33, 44, or 45a (6) of the administrative procedures act of 1969, 1969 PA 306, MCL 24.233, 24.244, or 24.245a. Rules adopted under these sections become effective 7 days after filing with the secretary of 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)

R 500.241, R 500.242, R 500.243, R 500.244, and R 500.245 are added to the Michigan Administrative Code as follows:

R 500.241 Definitions.

Rule 1. (1) As used in these rules:

(a) "Act" means the public health code, 1978 PA 368, MCL 333.1101 to 333.25211.

(b) "Median amount" means the median amount negotiated by the carrier for the region and provider specialty, excluding any in-network coinsurance, copayments, or deductibles. The carrier shall determine the region and provider specialty.

(i) THE MEDIAN AMOUNT SHALL REFLECT THE ACTUAL AMOUNTS PAID TO CONTRACTED PROVIDERS IN THE YEAR [2019], KNOWN AS THE BASE YEAR.

(ii) THE BASE YEAR SHALL BE ADJUSTED IN AN AMOUNT EQUAL TO THE CHANGE IN THE ANNUAL CONSUMER PRICE INDEX FOLLOWING THE URBAN (CPI-U) TO REFLECT THE MEDIAN AMOUNT IN THE CURRENT BENEFIT YEAR.

(iii) THE MEDIAN AMOUNT SHALL BE REFLECTIVE OF PAYMENTS MADE SOLELY TO INDIVIDUALLY CONTRACTED PROVIDERS, EACH OF WHOM WERE CONTRACTED WITH THE CARRIER IN THE NONPARTICIPATING PROVIDER'S RECOGNIZED SPECIALTY DURING THE BASE YEAR.

(iv) THE DEPARTMENT SHALL ENSURE THAT THE MEDIAN AMOUNT IS WEIGHTED IN A MANNER THAT BEST REPRESENTS THE FREQUENCY OF PAYMENTS ISSUED TO INDIVIDUALLY CONTRACTED PROVIDERS IN THE NONPARTICIPATING PROVIDER'S RECOGNIZED SPECIALTY DURING THE BASE YEAR.

(v) THE MEDIAN AMOUNT SHALL NOT REFLECT PAYMENTS MADE TO CONTRACTED PROVIDERS OR PROVIDER GROUPS WHO WERE NOT LISTED IN

THE CARRIER'S PROVIDER DIRECTORY UNDER THE SAME SPECIALTY AS THAT OF THE NONPARTICIPATING PROVIDER.

(c) "COMPLICATING FACTOR' MEANS:

(i) A FACTOR THAT IS NOT NORMALLY INCIDENT TO A HEALTH CARE SERVICE, INCLUDING, BUT NOT LIMITED TO THE FOLLOWING:

(a) INCREASED INTENSITY, TIME, OR TECHNICAL DIFFICULTY OF THE HEALTH CARE SERVICE;

(b) THE SEVERITY OF THE PATIENT'S CONDITION; AND,

(c) THE PHYSICAL OR MENTAL EFFORT REQUIRED IN PROVIDING THE HEALTH CARE SERVICE.

(ii) THE DEPARTMENT SHALL DELINEATE MEDICAL CONDITIONS THAT CONSTITUTE 'COMPLICATING FACTORS' BY UTILIZING GENERALLY ACCEPTED MEDICAL DIAGNOSIS AND CODING TERMINOLOGY TOOLS AND RESOURCES DETERMINED BY THE INTERNATIONAL CLASSIFICATION OF DISEASE, TENTH EDITION (ICD-10), AND THE AMERICAN MEDICAL ASSOCIATION'S COMMON PROCEDURE TERMINOLOGY (CPT) WITH BOTH SERVING AS RECOGNIZED RESOURCES FOR CARRYING OUT THE ACT, IN ACCORDANCE WITH R500.245(1).

(2) THE DEPARTMENT SHALL INSTRUCT CARRIER'S TO IDENTIFY A METHOD BY WHICH A NONPARTICIPATING PROVIDER MAY INDICATE THE PRESENCE OF A 'COMPLICATING FACTOR' ON THE CLAIM SUBMISSION FORM WHETHER FILED ELECTRONICALLY OR ON PAPER, WHICH SHALL BE DEEMED SUFFICIENT FOR THE CARRIER TO RECOGNIZE, PROCESS AND ISSUE A SUPPLEMENTAL OUT-OF-NETWORK PAYMENT IN ACCORDANCE WITH THIS ACT.

THE DEPARTMENT SHALL REQUIRE THE CARRIER TO NOTICE THE NONPARTICIPATING PROVIDER AS PART OF THE CARRIER'S EXPLANATION OF BENEFITS, EITHER ELECTRONICALLY OR IN PAPER FORM, THAT THE MEDIAN AMOUNT PAYMENT ISSUED INCLUDES A SUPPLEMENTAL 'COMPLICATING FACTOR' PAYMENT AT THE STIPULATED ADD-ON PAYMENT PERCENTAGE INCREASE REQUIRED BY THIS ACT.

THE CARRIER MAY ALSO CHOOSE TO DENY THE NONPARTICIPATING PROVIDER'S CLAIM FOR A SUPPLEMENTAL 'COMPLICATING FACTOR' PAYMENT BUT MUST NOTIFY THE NONPARTICIPATING PROVIDER BY COMMUNICATING ANY DENIAL ON ITS EXPLANATION OF BENEFITS FORM, EITHER ELECTRONICALLY OR ON PAPER, AND IN DOING SO, ADVISE THE NON-PARTICIPATING PROVIDER THAT HE OR SHE MAY CHOOSE TO APPEAL THE CARRIER'S DETERMINATION BY COMMUNICATING WITH THE DEPARTMENT ON A FORM SPECIFIED BY THE DEPARTMENT AND BY ACCESSING THE ARBITRATION PROVISIONS MADE AVAILABLE BY THE DEPARTMENT.

(3) THE DEPARTMENT SHALL REQUIRE THE CARRIER TO IDENTIFY ON ALL MEMBER INSURANCE IDENTIFICATION CARDS AND EXPLANATION OF

BENEFITS, EITHER ELECTRONICALLY OR ON PAPER, PLAN BENEFITS TO BE ADMINISTERED, PAID OR DENIED IN ACCORDANCE WITH THIS ACT.

(4) THE DEPARTMENT SHALL ESTABLISH AND PUBLISH A SCHEDULE OR LIST, WHICH SHALL BE UPDATED ANNUALLY DELINEATING MEDICAL SERVICES AND CONDITIONS THE DEPARTMENT DEEMS MEET THE DEFINITION OF A 'COMPLICATING FACTOR'.

THE SCHEDULE THE DEPARTMENT PUBLISHES SHALL BE CROSS-REFERENCED TO GENERALLY ACCEPTED MEDICAL DOCUMENTATION TOOLS AND RESOURCES IN ACCORDANCE WITH 500.241, SUBSECTION (1)(C) OF THE ACT, MCL 333.24511.

(5) A term defined in the act for the purposes of article 18 of the act, MCL 333.24501 to 333.24517, has the same meaning when used in these rules.

R 500.242 Scope and applicability.

Rule 2. These rules do the following:

(a) Establish procedures for the department to review and resolve requests for calculation review OF THE MEDIAN AMOUNT submitted pursuant to section 24510 of the act, MCL 333.24510.

(b) Establish procedures for approving arbitrators to provide binding arbitration pursuant to section 24511 of the act, MCL 333.24511.

R 500.243 Requests for calculation review.

Rule 3. (1) A nonparticipating provider must make a request for calculation review on a form provided by the department.

(2) In response to a request from a nonparticipating provider for a calculation review under section 24510 of the act, MCL 333.24510, the department shall do the following within 14 days of the date of the request:

(a) Notify the carrier of the request for a calculation review.

(b) Request data on the carrier's median amount or any documents, materials, or other information the department believes is necessary to assist in reviewing the request for calculation review.

(c) CONSULT OR REQUEST SUPPORTING INFORMATION FROM A NATIONALLY RECOGNIZED PHYSICIAN ALLOWABLE DATABASE IN ACCORDANCE WITH R500.244(2).

(3) A carrier must respond within 7 days of the date of the department's request under subrule (2)(b) of this rule. If the information provided is incomplete, the department may, at its discretion, request additional information, or issue a determination based solely on the information provided as of the date on which the carrier's response was due. If the department makes 1 or more requests for additional information, the department shall extend the time period permitted for the carrier's response for a number of days the department considers appropriate.

(4) The department shall issue a determination resolving the request for a calculation review no later than 14 days after the carrier submits a timely and complete response under

subrule (3) of this rule or after the expiration of the time period within which the carrier was required to respond, including any extensions provided under subrule (3) of this rule.

R 500.244 Median amount; access to database.

Rule 4. (1) Subject to subrule (3) of this rule, a carrier may satisfy the requirement under R 500.243 by providing the department with access to a database that contains all of the carrier's median amounts. The database must meet all of the following requirements:

(a) Be updated no less frequently than quarterly.

(b) Be searchable by region, provider specialty, and health care service.

(c) Include negotiated rates for all health care services covered by the carrier, GEOGRAPHICALLY ADJUSTED AND IF APPLICABLE, ISOLATED BY PLAN PRODUCT TYPE SO NOT TO BLEND OR MERGE VARYING CONTRACT RATE STRUCTURES FOR THE PURPOSES OF ARTIFICIALLY ADJUSTING THE MEDAIN. THIS SHALL BE FURTHER LIMITED TO PROVIDERS REPORTED IN THE CARRIER'S CURRENTLY PUBLISHED PROVIDER DIRECTORY, SORTED FOR EACH GIVEN SPECIALTY;

(d) REPRESENT CONTRACTED PAYMENT RATES FOR COMMERCIAL HEALTH BENEFIT PLANS ONLY, THAT ARE REGULATED BY THE DEPARTMENT, AND WHICH. SHALL NOT INCLUDE PROVIDER CONTRACT RATES ASSOCIATED WITH BENEFIT PLANS THE CARRIER ADMINISTERS ON BEHALF OF MEDICARE, MEDICAID OR OTHER GOVERNMENT HEALTH BENEFIT PROGRAMS.

(e) Be continuously accessible to the department.

(2) For the purposes of conducting a calculation review under section 24510 of the act, MCL 333.24510, the department may, at its discretion, consult any external database described under section 24510(2) of the act, MCL 333.24510, without regard to whether a carrier made the database accessible to the department or whether the database otherwise meets the requirements under subrule (1) of this rule.

SUCH DATABASE SHALL BE NATIONALLY RECOGNIZED, GEOGRAPHICALLY ADJUSTED AND SPECIALTY SPECIFIC, SORTED BY GEOGRAPHIC ALLOWABLE PAYMENT PERCENTILES, PROCURED BY A NOT-FOR-PROFIT ENTITY, WHICH IS NOT AFFILIATED, EITHER DIRECTLY OR INDIRECTLY, WITH AN INSURANCE CARRIER OR HEALTH. BENEFIT PLAN.

(3) A carrier's provision of access to a database under this rule does not preclude the department from requesting additional documents, materials, or other information that the department determines is necessary for conducting a review under section 24510 of the act, MCL 333.24510.

R 500.245 Approval of arbitrators.

Rule 5. (1) The department shall create and maintain a list of arbitrators trained by the American Arbitration Association or American Health Lawyers Association WHO POSSESS KNOWLEDGE OF MEDICAL REIMBURSEMENT AND EXPERIENCE IN THE USE OF MEDICAL TERMINOLOGY AND MEDICAL CODING, INCLUDING BUT NOT LIMITED TO THE INTERNATIONAL CLASSIFICATION OF DISEASE, TENTH EDITION (ICD-10), AND THE AMERICAN MEDICAL ASSOCIATION'S COMMON PROCEDURE TERMINOLOGY (CPT) AND WHO SHALL BE approved by the director.

This list must be updated no less frequently than annually and must be posted on the department's website.

THE ARBITRATOR AND DEPARTMENT MAY CHOOSE TO SEEK THE ASSISTANCE OF MEDICAL PROFESSIONALS LICENSED IN THE STATE OF MICHIGAN AND TRAINED IN THE MEDICAL SPECIALITY IN THE DISPUTE IN QUESTION FOR THE PURPOSE OF ASSISTING THE ARBITRATOR RULE ON THE PRESENCE OF OR LACK THEREOF OF A COMPLICATING FACTOR.

THE SELECTED MEDICAL PROFESSIONAL SHALL HAVE NO AFFILIATION OR RELATIONSHIP WITH EITHER OF THE PARTIES.

(2) Arbitrators seeking to be included in the list under subrule (1) of this rule must apply on a form prescribed by the department.

(3) The department shall approve or disapprove an application no later than 60 days after the date of receipt of the application. Applicants whose application has been disapproved may reapply at any time.

(4) If approved for inclusion in the list under subrule (1) of this rule, arbitrators must annually provide to the department, on a form prescribed by the department, an attestation acknowledging that the information provided to the department in the arbitrator's application under subrule (2) of this rule remains complete and accurate.

(5) Arbitrators included on the department's list under subrule (1) of this rule must notify the department of any changes to the information contained in the arbitrator's application under subrule (2) of this rule within 30 days of the change. An arbitrator's failure to inform the department of these changes may result in revocation of the arbitrator's approval and removal from the list under subrule (1) of this rule.