Senate Fiscal Agency
P.O. Box 30036
Lansing, Michigan 48909-7536

BILL ANALYSIS

Telephone: (517) 373-5383
Fax: (517) 373-1986

Senate Bills 530 and 531 (as introduced 9-26-23)
Sponsor: Senator Mary Cavanagh (S.B. 530)
Senator Sarah Anthony (S.B. 531)
Committee: Finance, Insurance, and Consumer Protection

Date Completed: 10-4-23

INTRODUCTION

Taken together, the bills would modify the reimbursement that a physician, hospital, clinic, or other person (provider) would receive for the treatment of an individual who was covered by personal protection insurance (PIP) for an accidental bodily injury involving a motor vehicle. A provider would have to be reimbursed at an amount of 250% of the amount payable for the treatment or training under Medicare and at amounts specified by the bill if Medicare did not provide an amount payable. Reimbursements specified by the bill would be based on when the treatment was rendered, the type of treatment, and certain eligibility requirements. The reimbursements also would have to be annually adjusted by the Consumer Price Index (CPI).

The bills are tie-barred.

FISCAL IMPACT

The bill would not have a significant fiscal impact on the Department of Insurance and Financial Services (DIFS) and would have no fiscal impact on local units of government. Existing appropriations and staff likely would be sufficient to manage implementation activities resulting from the bill.

There would be no direct fiscal impact to the Medicaid program under the changes proposed in the bill. The proposed changes in the provider reimbursement limits and the defined fee schedule are applicable to treatment and training for accidental bodily injury covered by PIP. As the bill does not modify the existing PIP tiers that permit qualified individuals enrolled in Medicaid to purchase a PIP coverage of $50,000, there is not likely to be any changes in insurance coverage behavior. As the State Medicaid program negotiates a fee schedule for Medicaid fee-for-service individuals and Medicaid managed care health plans negotiate rates on behalf of the Medicaid managed care enrollees, the bill would have no direct change in underlying Medicaid payments made to providers of Medicaid services.

MCL 500.3157 (S.B. 530)
500.2111f (S.B. 531)

Legislative Analyst: Eleni Lionas
Fiscal Analyst: John P. Maxwell
Elizabeth Raczkowski

CONTENT

Senate Bill 530 would amend Chapter 31 (Motor Vehicle Personal and Property Protection) of the Insurance Code to do the following:

-- Modify how providers would be reimbursed for the treatment of an individual covered by PIP for an accidental bodily injury.
-- Modify the percentages for which providers could be reimbursed for treating or training an individual covered by PIP following an accidental bodily injury.
-- Specify the amounts that a provider would have to be reimbursed if Medicare did not provide an amount payable for treatment or rehabilitation of an individual covered by PIP for an accidental bodily injury.
-- Specify reimbursement amounts for caregivers and chiropractors for the treatment of an individual covered by PIP for an accidental bodily injury.
-- Require the proposed reimbursement amounts to adjust annually at the rate of the CPI.
-- Require a provider that rendered home care or residential services to be accredited to be eligible for reimbursement.
-- Specify how an insurer would have to pay benefits to a personal caregiver.

Senate Bill 531 would amend the Insurance Code to modify Michigan Complied Law references to reflect changes proposed by Senate Bill 530.

Senate Bill 530 is described in greater detail below.

Senate Bill 530

Generally, all drivers in the State must have PIP, and an insurer issuing PIP is liable for accidental bodily injury involving a motor vehicle. These benefits under PIP are due regardless of fault in the motor vehicle accident that caused the bodily injury. Among other things, Chapter 31 prescribes the reimbursement rates discussed below, rates at which insurers issuing PIP must pay providers for treatment of an injured person involved in a motor vehicle accident and covered by PIP.

Reasonable Cost for Treatment

The Code allows a provider to charge a reasonable amount for providing treatment or rehabilitative occupational training to an injured individual for accidental bodily injury covered by PIP. The charge may not exceed the amount the provider customarily charges for similar treatment or training in cases where insurance is not involved.

Current Reimbursement for Treatment or Training

Generally, a provider that treats or provides rehabilitative occupational training to an injured person for an accidental bodily injury for a person covered by PIP is not eligible for payment or reimbursement for more than the following:

-- For treatment or training rendered after July 1, 2021, and before July 2, 2022, 200% of the amount payable to the person for that treatment or training under Medicare.
-- For treatment or training rendered after July 1, 2022, and before July 2, 2023, 195% of the amount payable to the person for that treatment or training under Medicare.
-- For treatment or training rendered after July 1, 2023, 190% of the amount payable to the person for the treatment or training under Medicare.

If Medicare does not provide an amount payable for a treatment or training described above the provider is not eligible for payment or reimbursement of more than the applicable percentage of the amount payable for the treatment or training under the individual's charge description master, or if there were no charge description master, between 52.5% and 55% of the amount that was charged based on the date of treatment.

("Charge description master" means a uniform schedule of charges represented by the person as its gross billed charge for a given service or item, regardless of payer type.)

After July 1, 2021, a provider who is a freestanding rehabilitation facility or whose clientele meets specified indigent standards established by DIFS that renders treatment or rehabilitative occupational training to an injured person for accidental bodily injury covered by personal protection insurance is eligible for payment or reimbursement of no more than the following:

-- For treatment or training rendered after July 1, 2021, and before July 2, 2022, 230% of the amount payable to the person for the treatment under Medicare.
-- For treatment or training rendered after July 1, 2023, 220% of the amount payable to the person for the treatment or training under Medicare.

If Medicare does not provide an amount payable for a treatment or training described above, the provider is not eligible for payment or reimbursement of more than the applicable percentage of the amount payable for the treatment or training under the individual's charge description master or, if there were no charge description master, the provider will be reimbursed between 66.58% and 70% of the amount that was charged for the service based on the date of treatment. If Medicare does not provide an amount payable for a treatment or training described above and the provider is a freestanding rehabilitation facility or has clientele that meets specified indigent standards, the provider is not eligible for payment or reimbursement of more 78% of the amount payable for the treatment or training under the individual's charge description master or if the person did not have a charge description master, 78% of the average amount based on the date.

The Code sets maximum payment levels for Level I and Level II trauma centers when providing emergency treatment to an individual before the individual is stabilized and transferred and the individual is covered by PIP. The amounts are subject to when the treatment is rendered and are a percentage of the amount payable to the hospital for the treatment under Medicare. If Medicare does not provide an amount payable for a treatment or training described above the provider is not eligible for payment or reimbursement of more the applicable percentage of the amount payable for the treatment or training under the individual's charge description master or, if there were no charge description master, the provider will be reimbursed between 71% and 75% of the amount that was charged for the service, based on the date of treatment.

For any change to an amount payable under Medicare, the change must be applied to the amount allowed for payment or reimbursement; however, the amount allowed may not exceed the average amount charged by a provider on January 1, 2019.

Under the Code, for care rendered in an injured person's home, the insurer is only required to pay benefits for attendant care up to certain hourly limitations. Additionally, the Code specifies the eligibility requirements for the attendant care. The insurer may contract to pay benefits for attendant care for more than the hourly limitation.

A neurological rehabilitation clinic is not entitled to payment or reimbursement for treatment, training, product, service, or accommodation unless the clinic has certain accreditation.

The bill would delete all the provisions described above.

Proposed Reimbursement for Treatment or Training

Instead, under the bill, a provider that rendered treatment or rehabilitative occupational training to an injured person for an accidental bodily injury that occurred after June 10, 2019, and was covered by PIP would have to be reimbursed at an amount of 250% of the amount payable for the treatment or training under Medicare, subject to the following conditions:

-- For any change to the amount payable under Medicare that occurred after the bill's effective date, the change would have to be applied to the amount allowed for reimbursement.
-- The only aspect of Medicare that applied to an insurer's reimbursement obligation would have to be the amount payable under Medicare for the Current Procedural Technology code that pertained to that treatment or training.

The bill specifies that all other aspects of the billing practices, requirements, or other reimbursement limitations that applied under the Medicare system would not apply to an insurer's reimbursement obligations described above.

Under the bill, if Medicare did not provide an amount payable for a treatment or rehabilitative occupational training to an injured person for accidental bodily injury that occurred after June 19, 2019, and that individual was covered by PIP, the provider would have to be reimbursed in the manner described below:

Service	Metro Detroit	Rest of State
HHA/CNA Supervision Level Services, using code S9122 with modifier 01.	$32.78/hour	$32.92/hour
HHA/CNA Basic Care Level Services, using code S9122 with modifier 02.	$36.57/hour	$34.97/hour
HHA/CNA High-Tech Care Level Services using code S 9122 with modifier 03.	$40.37/hour	$38.60/hour
Licensed Practical Nurse Home Health Care Level Services, using code S9124.	$77.50/hour	$74.50/hour
Licensed Practical Nurse Home Health Care Level Services, using code T1031.	$181.15/visit	$178.95/visit
Registered Nurse Home Health Care Level Services, using code S9123.	$86.56/hour	$82.76/hour
Registered Nurse Home Health Care Level Services, using code T1030.	$220.88/visit	$211.19/visit
Residential Services Level 1, using code T2048 with modifier 01.	$454.65/day	$434.71/day
Residential Services Level 2, using code T2048 with modifier 02.	$599.62/day	$573.32/day
Residential Services Level 3, using code T2048 with modifier 03.	$754.46/day	$721.37/day
Residential Services Bed Hold, using code T2048 with modifier 04.	55% daily rate per care level	
One-on-One Staffing: Aide Services, using code S5125.	$9.66/15 minutes	$9.24/15 minutes
Day Treatment: Half Day, using code H2001 with modifier 01.	$216.77/day	$207.26/day

Service	Metro Detroit	Rest of State
Day Treatment: Full Day, using code H2001 with modifier 02.	$433.96/day	$414.93/day
Day Treatment: 15 minutes, using code H2032.	$18.36/15 minutes	$17.81/15 minutes
Home- and Community-Based Therapies, using codes 97535, 97110, 97530, 97537, 92507, 97129, or 97130, with Place of Service codes 12 or 99.	$82.23/15 minutes	$78.63/15 minutes
In-Home Occupational Therapy, using code S9129.	$269.55/visit	$256.07/visit
In-Home Physical Therapy, using code S9131.	$267.71/visit	$254.32/visit
In-Home Speech Language Pathology, using code S9128.	$291.00/visit	$274.45/visit
Job Development/Job Placement, using code H2015.	$45.03/15 minutes	$43.06/15 minutes
Job Coaching, using code H2025.	$21.44/15 minutes	$20.50/15 minutes
Enclave Work Site – Group, using code H2023.	$17.25/15 minutes	$16.49/15 minutes
Case Management, using code T1016.	$42.90/15 minutes	$41.01/15 minutes
Pharmacy – Generic Drugs, Dispensing Fee, using an unidentified code.	$6.36/ Prescription	$6.53/ Prescription
Pharmacy – Generic Drugs, Drug Payment, using an unidentified code.	12% discount to average wholesale price.	
Pharmacy – Name Brand Drugs, Dispensing Fee, using an unidentified code.	$4.05/prescription	
Pharmacy – Name Brand Drugs, Drug Payment, using an unidentified code.	12% discount to average wholesale price.	
Pharmacy – Custom Compounds, Dispensing Fee, using an unidentified code.	$14.45/prescription	
Pharmacy – Custom Compounds, Drug Payment, using an unidentified code.	12% discount to average wholesale price.	
Pharmacy – Commercially Manufactured Topicals, Dispensing Fee.	$9.83/prescription	
Nonemergency Medical Transport – Charge per Mile while Rider Is in the Vehicle, using code S0215,	$3.47/mile	
Nonemergency Medical Transport – Wheelchair Van Pickup Fee – Weekday, using code A0130 with modifier 01.	$39.30/pick up	
Nonemergency Medical Transport – Nonwheelchair Van Pickup Fee – Weekday, using code A0100 with modifier 01.	$36.61/pick up	
Nonemergency Medical Transport – Wheelchair Van Pickup Fee – Weekend, using code A0130 with modifier 02.	$45.37/pick up	
Nonemergency Medical Transport – Nonwheelchair Van Pickup Fee – Weekend, using code A0100 with modifier 02.	$40.46/pick up	
Nonemergency Medical Transport – Wait Time, using code T2007.	$8.45/15 minutes	

These reimbursements also would apply to a service with a substantially similar code or modifier.

Additionally, a personal caregiver who rendered home care services to an injured person for accidental bodily injury that occurred after June 10, 2019, and was covered by PIP would have to be reimbursed as follows:

Service	Metro Detroit	Rest of State
HHA/CNA Supervision Level Services.	$19.67/hour	$19.37/hour
HHA/CNA Basic Care Level Services.	$21.94/hour	$20.98/hour
HHA/CNA High-Tech Care Level Services.	$24.22/hour	$23.16/hour
Licensed Practical Nurse Home Health Care Level Services.	$46.50/hour	$44.70/hour
Registered Nurse Home Health Care Level Services.	$51.94/hour	$49.66/hour

A chiropractic provider that rendered home care services to an injured person for accidental bodily injury that occurred after June 10, 2019, and was covered by PIP would have to be reimbursed as follows:

Service	Metro Detroit	Rest of State
Low-level laser treatment using code S8948	$25.24/15 minutes	$24.61/15 minutes
Vertebral axial decompression using code S9090	$48.63/hour	$47.41/hour

An amount applied as proposed above would have to be adjusted by the percentage change in the medical care component of the of the CPI for the year preceding the adjustment.

Under the bill, for treatment and training provided to an injured person for accidental bodily injury that occurred after June 10, 2019, and the treatment or training was covered by PIP but the provisions described above did not apply, reimbursement would have to be issued in accordance with Section 3107(1)(a) and the provider would have to charge a reasonable amount for the treatment or training where the charge could not exceed the amount the provider customarily charged for similar treatment or training in cases without insurance.

(Generally, Section 3107(1)(a) specifies the allowable expenses for reasonable charges incurred for necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation.)

A provider that rendered home care or residential services would not be entitled to payment for a treatment or training unless the provider was accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Community Health Accreditation Partner Program, the Accreditation Commission for Health Care, or a similar organization recognized for accreditation by the DIFS Director. This provision would not apply to a provider that was in or was beginning the process of accreditation, as verified by the accrediting body, within one year after the bill's effective date, unless three years had passed, and the provider was still not accredited.

The accreditation requirement would not apply to a personal caregiver. For care rendered by a personal caregiver, the insurer would only be required to pay benefits for a maximum of 16 hours per day per individual but could contract to pay more. A personal caregiver could not seek payment from an insurer for care rendered to more than two injured persons at the same time.

For all treatment or training provided to an injured person for accidental bodily injury that occurred before June 11, 2019, and that was covered by PIP, the reimbursement would have to be issued in accordance with Section 3107(1)(a) and the provider would have to charge a reasonable amount for the treatment or training where the charge could not exceed the

amount the provider customarily charged for similar treatment or training in cases without insurance.

Definitions

"BADLs" would mean basic activities of daily living and may include bathing, dressing, grooming, toileting, personal hygiene, feeding, and other basic self-care activities.

"Case management" would mean services provided by a case manager with a health professional degree and current license or national certification in a health or human services profession. The term would include, assessing, planning, implementing, coordinating, monitoring, and evaluating the options and services required to meet the injured person's health and human service needs.

"Day treatment" would mean daytime programs that provide educational, prevocational, or vocational or therapeutic activity services and that are supervised by paraprofessional staff with program design and oversight by health care professionals.

"Day treatment – 15 minute" would mean day treatment for which 15-minute units are used and reimbursed for services rendered that are not otherwise covered by full day or half day codes.

"Day treatment – Full Day" would mean treatment provided for five to seven hours per day.

"Day treatment – Half Day" would mean treatment provided for two and a half to three and a half hours per day.

"Enclave Work Site – Group" would mean a community-based work site of a competitive employer external to a residential services program where a group of injured persons work under the supervision of staff from the program.

"HHA/CNA Basic Care Level Services" would mean services generally performed at the care level of a home health aide or certified nursing assistant for the purpose of providing personal care or assisting an injured person with the performance of BADLs or IADLs in the home or other place of residence.

HHA/CNA High-Tech Care Level Services" would mean services generally performed at the care level of a home health aide or certified nursing assistant for the purpose of providing personal care, assisting with the performance of BADLs and IADLs, and providing additional interventions for an injured person, including, but not limited to, basic bowel and bladder program management, complex transfers, basic behavior and cognitive management, vital sign monitoring, orthopedic brace care, basic skin integrity care, pediatric patient care, and other forms of monitoring and care that do not require direct care or oversight by a licensed nurse, in the home or other place of residence.

"HHA/CNA Supervision Level Services" would mean services generally performed at the care level of a home health aide or certified nursing assistant for the purpose of providing direct supervision to ensure the health and safety of an injured person in the home or other place of residence.

"Home- and Community-Based Therapies" would mean those services that are performed by licensed, registered, or certified professionals, using current procedural terminology codes within their scope of practice, and performing services in the home or community setting, as

an extension of an outpatient rehabilitation program or community-based private practice model.

"Home care" would mean home health aide, nursing, and other similar services provided to an injured person in the home or place of residence, other than in a hospital, nursing home, or county medical facility, unless ordered by a physician for safety reasons.

"In-Home Occupational Therapy" would mean occupational therapy services performed in the home or other place of residence.

"In-Home Physical Therapy" would mean physical therapy services performed in the home or other place of residence.

"In-Home Speech Language Pathology" would mean speech language pathology services performed in the home or other place of residence.

"IADLs" would mean instrumental activities of daily living and may include health and medication management, money and financial management, menu planning, grocery shopping, cooking, cleaning, laundry, transportation, community mobility or access, planning and organization, and other similar activities.

"Job Coaching" would mean services performed to assist an injured person with learning, accommodating, or performing specific job tasks and developing interpersonal and other employment-related skills.

"Job Development/Job Placement" would mean services performed by an individual with a bachelor's degree or higher with additional vocational training for the purpose of assisting an injured person with job placement and development of interpersonal and other employment-related skills.

"Licensed Practical Nurse Home Health Care Level Services" would mean skilled nursing services performed at the care level of a licensed practical nurse in the home or place of residence.

Currently "Medicare" means the fee for service payments under Part A, B, or D of the Federal Medicare Program without regard to the limitations unrelated to the rates and fee schedule such as limitations or supplemental payments related to unitization, readmissions, recaptures, bad debt adjustments, or sequestration.

Under the bill, "Medicare" would mean, the fee for service payments under Parts A, B, or D of the Federal Medicare Program. The term would not include adjustments related to readmissions, bad debt adjustments, or sequestration. The term would include payments to providers, reimbursed under a prospective payment system, including the inpatient acute, inpatient psychiatric, inpatient rehabilitation, long-term acute care, skilled nursing, hospice, and outpatient prospective payment systems and any other hospital payment system designated by the United States Department of Health and Human Services. Additionally, the term would include all facility adjustments, including adjustments for acuity, area wage index, capital, direct and indirect graduate medical education, disproportionate share components, new technology, low volume, organ acquisition cost, routine and ancillary cost for allied health programs, and outlier. For sole community hospitals, rural referral centers, rural emergency hospitals, and critical access hospitals, Medicare means the equivalent hospital-specific payment for providing inpatient or outpatient services to Medicare beneficiaries.

"Metro Detroit" would mean services provided in the county of Wayne, Washtenaw, Oakland, or Macomb.

"One-on-One Staffing – Aide Services" would mean direct supervision of a single injured person by an aide or other caregiver to ensure the injured person's health, safety, or adherence to medical recommendations or to enable the injured person to participate in therapeutic activities or other treatment.

"Personal caregiver" would mean an individual who is any of the following:

-- An individual who is related to the injured person.
-- An individual who is domiciled in the household of the injured person.
-- An individual with whom the injured person had a business or social relationship before the injury.
-- An individual who is employed or contracted to perform home care services directly by an injured person or the injured person's legal representative.
-- An individual who is not employed or contracted to perform home care services by an agency or other organization.

"Provider" would mean a physician, hospital, clinic or other person that renders treatment or training to an injured person.

"Registered Nurse Home Health Care Level Services" would mean skilled nursing services generally performed at the level of a registered nurse, in the home or other place of residence.

"Residential services" would mean post-acute brain or spinal cord rehabilitation treatment or training rendered in an accredited residential program that may include direct assistance with BADLs or IADLs on a continual or intermittent basis, direct supervision for health and safety, and medical or behavioral oversight or intervention. The term would not include one-on-one staffing or supervision beyond program-level supervision, nursing treatment or intervention, medical supplies, durable medical equipment, individualized interventions, and therapeutic services, individual or group therapy services, vocational services and supports, day programs, or transportation to appointments or activities not sponsored by the program.

"Residential Services Bed Hold" would mean a temporary leave of absence for an injured person from the accredited residential program in which the injured person permanently resides. The first two consecutive days of any leave of absence would have to be reimbursed at the applicable residential services level rate, and any consecutive day or days of leave after the first two days would have to be reimbursed at the Residential Services Bed Hold Rate.

"Residential Services Level 1" would mean residential services provided to an injured person who generally requires at least one of the following:

-- Minimal assistance on a routine basis to perform some BADLs.
-- Minimal to moderate assistance to perform at least some IADLs.
-- Ongoing supervision in a structured living environment.
-- Minimal assistance on a routine basis to manage one or more medical conditions.
-- Intermittent support to manage mood or promote behavioral stability.

"Residential Services Level 2" would mean residential services provided to an injured person who may require any Residential Level 1 Services and who generally requires at least one of the following:

-- Minimal to moderate assistance or supervision to perform most BADLs.

-- Minimal to moderate assistance for functional mobility.
-- Moderate to maximum assistance to perform most IADLs.
-- Direct care on a routine basis to monitor and manage one or more medical condition.
-- One or more impromptu specialized interventions to address behavioral concerns, including mild to moderate aggression.

"Residential Services Level 3" would mean residential services provided to an injured person who may require any Residential Level 1 or Level 2 Services and who generally requires at least one of the following:

-- Maximum to total assistance to perform more BADLs.
-- Maximum to total assistance for functional mobility.
-- Moderate to maximum assistance to perform most IADLs.
-- Daily direct care and/or oversight by a licensed health care professional to manage one or more medical conditions.
-- One or more impromptu specialized interventions or individual behavioral plans for consistent therapeutic response to address behavioral or mental health concerns, including verbal or physical aggression.

"Rest of State" would mean services provided in a county in the State other than the counties of Wayne, Washtenaw, Oakland, and Macomb.

SAS\S2324\s530sa

This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.