STATE OF MICHIGAN
MI Supreme Court

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ELLEN M ANDARY V USAA CASUALTY INSURANCE COMPANY	164772

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Charles Raimi City of Detroit Law Department 29746	raimic@detroitmi.gov	e-Serve
Peter Ellsworth Dickinson Wright PLLC P23657	pellsworth@dickinsonwright.com	e-Serve
Kriss Gillengerten Sinas Dramis Law Firm	krissgillengerten@sinasdramis.com	e-Serve
Mary Massaron Plunkett Cooney P43885	MMASSARON@PLUNKETTCOONEY.COM	e-Serve
Lauren Kissel Sinas Dramis Law Firm 82971	lauren@sinasdramis.com	e-Serve
Jordan Wiener Hewson & Van Hellemont, P.C. P70956	jwiener@vanhewpc.com	e-Serve
Jeffery Stuckey Dickinson Wright PLLC 34648	JStuckey@dickinsonwright.com	e-Serve
Jacquelyn A. Klima Kerr, Russell and Weber, PLC P69403	jklima@kerr-russell.com	e-Serve
Miriam Aukerman American Civil Liberties Union of Michigan P63165	maukerman@aclumich.org	e-Serve
Nancy Thomas Miller Canfield	thomasn@millercanfield.com	e-Serve
Christopher Kerr Michigan Department of Attorney General P57131	kerrc2@michigan.gov	e-Serve
Stephen Hulst RMPC	sjhulst@rhoadesmckee.com	e-Serve

70257		
Liisa Speaker Speaker Law Firm P65728	lspeaker@speakerlaw.com	e-Serve
Paul Hudson Miller Canfield 69844	hudson@millercanfield.com	e-Serve
Kyle Williams Disability Rights Michigan P77227	kwilliams@drmich.org	e-Serve
Latisha DeRouin	tish@granzottolaw.com	e-Serve
Courtney Kissel Dykema 74179	ckissel@dykema.com	e-Serve
Steven Hicks Attorney at Law P49966	steve@chair2consulting.com	e-Serve
Marla Linderman Richelew Linderman Law PLLC 55759	lindermanlaw@sbcglobal.net	e-Serve
Nicholas Gable Disability Rights Michigan P79069	ngable@drmich.org	e-Serve
Peggy McGregor Mark Granzotto, PC	pm@granzottolaw.com	e-Serve
George Sinas Sinas Dramis Law Firm P25643	georgesinas@sinasdramis.com	e-Serve
Mark Granzotto Mark Granzotto, PC 31492	mg@granzottolaw.com	e-Serve
Lisa Gore American Civil Liberties Union of Michigan	lgore@aclumich.org	e-Serve
Jill Wheaton Dykema 49921	jwheaton@dykema.com	e-Serve
KJ Miller Michigan Catastrophic Claims Association P62014	kjmiller@micatastrophic.com	e-Serve
Ryan Shannon Dickinson Wright PLLC P74535	rshannon@dickinsonwright.com	e-Serve
Stephen Sinas Sinas Dramis Law Firm P71039	stevesinas@sinasdramis.com	e-Serve
Joanne Geha Swanson Kerr, Russell and Weber, PLC 33594	jswanson@kerr-russell.com	e-Serve
Michelle Everett Vandeveer Garzia 76943	meverett@vgpclaw.com	e-Serve

Donald Brownell Vandeveer Garzia P48848	dbrownell@vgpclaw.com	e-Serve
Lori McAllister Dykema 39501	lmcallister@dykema.com	e-Serve
Taylor Pan Hewson & Van Hellemont P75350	tpan@vanhewpc.com	e-Serve
Wayne Miller Miller & Tischler, P.C. 31112	wmiller@msapc.net	e-Serve
Daniel Korobkin American Civil Liberties Union Fund of Michigan P72842	DKOROBKIN@ACLUMICH.ORG	e-Serve
Sajid Islam Vandeveer Garzia P81829	sislam@vgpclaw.com	e-Serve
Kathryn Haroney ACLU of Michigan	kharoney@aclumich.org	e-Serve

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/s/ Steven Hicks
Signature

Attorney at Law

STATE OF MICHIGAN
IN THE MICHIGAN SUPREME COURT

ELLEN M. ANDARY, a legally incapacitated adult, by and through her Guardian and Conservator, MICHAEL T. ANDARY, M.D., PHILIP KRUEGER, a legally incapacitated adult, by and through his Guardian, RONALD KRUEGER, & MORIAH, INC., d/b/a EISENHOWER CENTER, a Michigan corporation,

Plaintiffs-Appellees,

v

USAA CASUALTY INSURANCE COMPANY, a foreign corporation, and CITIZENS INSURANCE COMPANY OF AMERICA, a Michigan corporation,

Defendants-Appellants.

Supreme Court Case No. 164772

Court of Appeals Case No. 356487

Ingham County Circuit Court
Case No. 2019-000738-CZ

BRIEF AMICUS CURIAE ON BEHALF OF MICHIGAN BRAIN INJURY PROVIDER COUNCIL (MBIPC) IN SUPPORT OF PLAINTIFFS-APPELLEES' POSITION

Prepared by:

Steven A. Hicks (P49966)
Counsel for Amicus Curiae MBIPC
216 North Chestnut Street
Lansing, MI 48933
(517) 881-5564
steve@chair2consulting.com

TABLE OF CONTENTS

TABLE OF CONTENTS, Continued

APPENDIX – LIST OF EXHIBITS

INDEX OF AUTHORITIES

Cases

Statutes

Constitution

INTRODUCTION[1]

The trial court's decision to apply retroactively the No-Fault Act as amended in 2019 ensured that post-acute care and rehabilitation services not covered by Medicare would no longer be provided as needed for those persons most seriously injured in motor vehicle accidents in Michigan, including the brain injured. The Court of Appeals' recent published decision to reverse the trial court's ruling (and this Court's subsequent order declining to stay the precedential effect of that decision) restored the ability for persons seriously injured in motor vehicle accidents before the No-Fault Act was amended to recover the PIP benefits contractually (and statutorily) owed to them. It alleviated – albeit only momentarily, pending this Court's ruling on whether to affirm that decision – the devastating loss of post-acute care and rehabilitation services imposed on them. Further, it also temporarily paused the hemorrhaging of the post-acute care and rehabilitation services industry in Michigan.

Reducing reimbursement for post-acute care/rehabilitation services not covered by Medicare by 45% (as required under the amended No-Fault Act) has led to devastating job losses over the past 18 months in the post-acute care/rehabilitation services industry in Michigan. It also has endangered the health and safety of those persons most seriously injured in motor vehicle accidents in Michigan, including the brain injured. If this Court reverses the Court of Appeals' holding that these changes do not apply retroactively, the dismantling of the post-acute care/rehabilitation services industry in Michigan will resume immediately and it will guarantee that the model system previously adopted in Michigan for

[1]This brief amicus curiae was authored solely by the undersigned counsel on behalf of MBIPC and no monetary contribution was made by a party or counsel for a party that was intended to fund the preparation or submission of its amicus briefing in this case.

the purpose of rehabilitating persons injured in motor vehicle accidents in Michigan comes to the calamitous end that was first predicted in 2019 when the No-Fault Act was amended.

If the Court of Appeals' published decision is reversed and the amended No-Fault Act applies retroactively, post-acute care/rehabilitation services not covered by Medicare will no longer be available as needed to persons injured in motor vehicle accidents in Michigan, because there will be few, if any, post acute care/rehabilitation providers willing to provide those services at reimbursement rates reduced by 45%. Current, often long-term, residents of post-acute care/rehabilitation facilities in Michigan, who have not been discharged while this case was pending, will be discharged. It will continue the massive disruption to the post-acute care and rehabilitation system in Michigan that has been occurring since the reduced reimbursement rates first became effective on July 1, 2021.

In a nutshell, reversing the Court of Appeals' published decision not to apply the reduced reimbursement rates for post-acute care/rehabilitation services retroactively will resume the "sea-change" in how some of the most vulnerable patients in Michigan are treated. Tragic consequences will again result that are unlike anything seen in Michigan since government funding for mental health was drastically reduced under the Engler administration and mental health facilities like the Lafayette Clinic in Detroit closed and patients were similarly discharged into communities unable to adequately care for them. Clearly, that result is not what the Legislature intended when it amended the No-Fault Act.

Persons seriously injured in motor vehicle accidents before the No-Fault Act was amended in 2019 should not be subject to such drastic reductions in reimbursement for post-acute care/rehabilitation services because ample premiums were paid to ensure that those persons had the protection afforded by the No-Fault Act when the accident occurred.

The health and well-being – and in some cases, survival – of auto accident victims needing post-acute care/rehabilitation services, depends on whether this Court agrees with the Court of Appeals that the amended No-Fault Act does not apply retroactively. The same can be said of the post-acute care/rehabilitation services industry that now serves them.

Without such "legacy" patients, the existing post-acute care/rehabilitation services industry that has served those persons most seriously injured in motor vehicle accidents in Michigan will end. That process of dismantling the post-acute care/rehabilitation services industry began when the reduced reimbursement rates became effective on July 1, 2021. It is now in a temporary holding pattern awaiting a decision from this Court on how the amended No-Fault Act will be applied. MBIPC strongly encourages this Court to uphold the Court of Appeals' decision so that existing "legacy" patients continue to receive post-acute care/rehabilitation services as needed and that the post-acute care/rehabilitation services industry in Michigan can continue to do its important work of providing essential services.

AMICUS CURIAE'S INTEREST

The Michigan Brain Injury Provider Council (MBIPC) is a trade association that serves providers in professions related to brain injury rehabilitation. Its members include large residential rehabilitation facilities like Eisenhower Center as well as small businesses that provide attendant care, transportation, guardianship, durable medical equipment, case management, vocational rehabilitation, and home modifications for brain injured persons.

Post-acute services are an essential part of the care, recovery, and rehabilitation of persons injured in motor vehicle accidents in Michigan, including the brain injured. But, unlike expenses incurred for treatment provided immediately after a person is injured in a

motor vehicle accident, most post-acute care/rehabilitation services are not covered by the Medicare program. Instead, post-acute care/rehabilitation providers are paid by no-fault, workers compensation, or in a some non-auto cases, Medicaid, under its waiver program.

In Michigan, the No-Fault Act has long protected persons injured in motor vehicle accidents by ensuring that lifetime medical care was provided. It has done so by mandating that post-acute care/rehabilitation services be reimbursed at reasonable and customary rates. But, effective July 1, 2021, reimbursement rates for post-acute care/rehabilitation services were cut by 45% based on what was charged on January 1, 2019. See MCL 500.3157(7)(a). Without proper reimbursement, many post-acute care/rehabilitation providers either stopped or drastically reduced services provided for auto accident victims.

In 2021, shortly before the reduced reimbursement rates under the amended No-Fault Act were effective, MBIPC conducted a state-wide survey of post-acute care/ rehabilitation providers engaged in professions related to brain injury rehabilitation.[2] That survey concluded that "facilities will be forced to lay off thousand of workers, discontinue catastrophic care for thousands of auto accident patients and potentially go out of business" if reimbursement is cut by 45%.[3] An independent study drew similar conclusions about the dramatic impact that applying the reduced reimbursement rates under the amended No-Fault Act would have on post-acute care/rehabilitation providers in Michigan.[4]

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[2]Appx 1, Ex. 1, MBIPC Survey of Brain Injury Providers (March 2021).

[3]The same cannot be said of providers whose services are covered by Medicare as the amended No-Fault Act caps reimbursement at rates roughly double what Medicare is paying. See MCL 500.3157(2)-(6). It does not slash rates for them across the board by 45%. But, it also does not guarantee reimbursement roughly double to Medicare rates.

[4]Appx 3, Ex. 2, IBH Analytics No-Fault Business Survey (April 2021).

While the Department of Financial and Insurance Services (DIFS) claimed publicly that the amended No-Fault Act would not change the care provided[5], the truth was that few post-acute care/rehabilitation providers could afford to continue providing services at such reduced reimbursement rates. Subsequent surveys confirmed the predictions about the devastating effects that reduced reimbursement rates have had on the post-acute care/ rehabilitation industry in Michigan. Due to those changes, far fewer options existed after July 1, 2021, when caring for those seriously injured in motor vehicle accidents in Michigan.

If the Court of Appeals' decision is reversed, residential facilities will be unable to care for persons injured in motor vehicle accidents, and private agencies will not provide in-home attendant care services for them, because it is impossible to operate at such rates. Given the limited number of licensed nursing homes operating in Michigan and the fact that the needs of the brain injured often makes nursing homes unsuitable for them, the care needs of those persons most seriously injured in motor vehicle accidents will not be met.[6]

The decision to affirm or reverse the Court of Appeals' holding in this case will determine whether providers currently serving the brain injured in Michigan can continue caring for persons injured in motor vehicle accidents. MBIPC shares Eisenhower Center's interest in ensuring that post-acute care/rehabilitation services continue to be provided to persons injured in motor vehicle accidents in Michigan. It also shares the concerns of persons injured in motor vehicle accidents before the No-Fault Act was amended, who, like

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[5]See https://www.youtube.com/watch?v=gBhlWJ6Cn_0&t=2958s, at 48.18–49:32, where DIFS director Anita Fox addresses a question regarding PIP benefits for an injured person's on-going care needs resulting from a prior motor vehicle accident.

[6]Appx 5, Ex. 3, CPAN Home Care Survey and Fact Sheet (April 2021).

Philip Krueger, will be discharged from post-acute residential facilities if such drastically reduced reimbursement rates apply retroactively. Accordingly, MBIPC requests that this Court consider its position and affirm the Court of Appeals' published decision in this case.

QUESTIONS PRESENTED

This Court has asked the parties to address whether the Court of Appeals erred (1) by holding "that claimants injured before the effective date of 2019 PA 21 are not subject to the limitations on benefits set forth in MCL 500.3157(7) and MCL 500.3157(10)"; 2) by holding "that application of the amended statute to such claimants would violate the Contracts Clause of the Michigan Constitution; and 3) by "remand[ing] the case to the circuit court for discovery to determine whether the no-fault amendments, even when applied prospectively, pass constitutional muster." MBIPC agrees with how Plaintiffs-Appellees have answered the questions asked. Accordingly, MBIPC similarly encourages this Court to affirm the Court of Appeals' published decision. Simply put, the future of the post-acute care/rehabilitation services industry in Michigan depends on whether this Court affirms the Court of Appeals' holding that the No-Fault Act as amended in 2019 cannot be applied retroactively to persons injured in motor vehicle accidents before it was enacted.

FACTUAL BACKGROUND

MBIPC, as amicus curiae in this case, adopts the Statement of Facts provided in Plaintiffs/Appellees' Brief on Appeal. As previously stated, Eisenhower Center is a member of MBIPC and its interests in this important case are similar to other members of MBIPC. Eisenhower is a large institution that provides post-acute care/rehabilitation services to persons seriously injured in motor vehicle accidents in Michigan, including the brain injured.

The interests of smaller businesses that provide post-acute care/rehabilitation (and other related services) are the same or similar to Eisenhower when it comes to applying fee caps on reimbursement rates for services not covered by the Medicare program. Large or small, reducing reimbursement by 45% from what was charged on January 1, 2021, has created an existential crisis for the vast post-acute care/rehabilitation services industry in Michigan.

The survey information from 2021 accurately predicted what would happen. In actuality, it has been worse than expected based on subsequent survey results. This factual background section will describe what has happened to the post-acute care/rehabilitation industry in Michigan, since the reduced reimbursement rates became effective on July 1, 2021. It will also describe how post-acute care/rehabilitation services provided for those persons most seriously injured in motor vehicle accidents in Michigan, including the brain injured, have dramatically changed due to the reduced reimbursement rates applied to post-acute care/rehabilitation providers under the amended No-Fault Act.

Since the No-Fault Act was adopted in Michigan, 47,124 claims have been reported to the Michigan Catastrophic Claims Association (MCCA).[7] Of those reported claims, 16,880 claims were still open according to the MCCA as of June 30, 2022. That is over 35%! And, more than one-third of the claims reported to the MCCA involved brain injuries. Presumably, the brain injured also account for the vast majority of open claims with the MCCA. Historically, the vast majority of the payments made by the MCCA , i.e., over 70%, are for services not typically compensated under the Medicare program. Services not covered under Medicare include agency-provided attendant care, family-provided attendant

[7]See MCCA Claims Statistics, which can be located on-line on its website at http://www.michigancatastrophic.com/Consumer-Information/Claim-Statistics.

care, residential care, transportation, rehabilitation services, and case management. Post-acute care services are an integral part of post-acute rehabilitation for those persons catastrophically injured in motor vehicle accidents in Michigan, especially the brain injured.

For decades, all "reasonably necessary" services were reimbursed by PIP insurers at the "reasonable and customary" rates charged by providers that rendered care for persons injured in motor vehicle accidents in Michigan, including brain injured persons. See MCL 500.3107(1)(a) and MCL 500.3157 (before the No-Fault Act was amended). Contracts signed by the parties affirmed that "reasonable and customary" rates would be paid for services provided and services would be provided based on the parties' mutual understanding that rates would be what was customarily charged. The contracting parties thus agreed that rules established before the No-Fault Act was amended would be applied.

Under the amended No-Fault Act, however, reimbursement for services not covered by Medicare is limited to just 55% of the amount charged for those services on January 1, 2019. In contrast, services covered by the Medicare program are reimbursed at double the current Medicare reimbursement rate. Thus, effectively, the new law provides for a 45% pay cut for those providing post-acute rehabilitation services on behalf of persons injured in a motor vehicle accident, because few of the services provided are covered by Medicare. As such, it directly contradicts existing contractual agreements regarding services provided, which incorporated the parties' understanding that "reasonably and customary" rates would be paid, so long as the charge was reasonable, based on the pre-amended No-Fault Act.

After the reduced reimbursement rates for post-acute care/rehabilitation services not covered by Medicare became effective on July 1, 2021, an independent survey of providers was conducted by the Brain Injury Association of Michigan (BIAMI) and the Michigan Public

Health Institute (MPHI).[8] That survey was designed to "document the impact of the fee structure changes . . . on the availability of services for people with catastropohic injuries from a car crash." Results from Phase I of that survey were released in December, 2021. It included results from a survey conducted from September 29, 2021 to October 20, 2021.

Even at that early stage, it was clear that the post-acute care/rehabilitation services industry in Michigan had been dealt a devastating blow – exactly as MBIPC (and IBH) had predicted before the reduced rates became effective on July 1, 2021. Based on the survey results, participating providers had eliminated 26% of the jobs in that short 3 month period. During that period, 9% of patients were discharged according to the survey results. Nearly all providers (96%) "reported that their services were impacted by the 55% reimbursement cap. The "most impacted services" included: private duty/attendant care (28%), case management (27%), therapy (21%), and outpatient therapy/treatment (20%). The most impacted operations included: 51% having to "significantly reduce services", 35% no longer accepting "new patients with auto insurance funding", 11% "discharge[d] patients", and 8% "close[d] operations completely". Even more startling, 63% "reported that they anticipated not being able to serve patients with auto insurance funding within the next 12 months."

In August 2022, BIAMI and MPHI released results from Phase II of its study "tracking the impact of the fee changes" under the amended No-Fault Act.[9] It was based on a second survey of "brain injury service providers, distributed between March 9 and May 15, 2022." The second survey documented a 41% loss of revenue among the participating

[8]Appx 7, Ex. 4, BIAMI/MPHI Provider Survey Results, Phase I, December, 2021.

[9]Appx 18, Ex. 5, BIAMI/MPHI Provider Survey Results, Phase II, August, 2022.

providers that amounted to over $80 million during the preceding 12 month period. Since July 2021, 4,082 jobs were eliminated, which was roughly 29% of participating providers' workforce. Patient discharges surged since the previous survey was conducted from 9% to 42%, which reflected a total of 6,587 patients being discharged out of a total of 15,596 patients. Nearly all providers (73% to 90%) reported services "have been either eliminated, reduced, or impacted in other ways" including residential/support living (12% eliminated, 71% reduced); community/home base therapy (9% eliminated, 67% reduced); outpatient therapy/treatment (8% eliminated, 59% reduced); private duty/attendant care (20% eliminated, 54% reduced) and case management (51% reduced, 20% impacted). Ten business had closed and fourteen more expected to be closed within the next 12 months.

Health Partners, Inc, for example, is a company that "specialized" for 29 years in providing "rehabilitation homecare programs and private homecare solutions" for its clients in Michigan.[10] But, on June 30, 2021, it "laid off 565 employees and stopped serving 100 patients who required 24 hour care by [n]urses, or [h]ome [h]ealth [a]ides." It did so because "100% of the services that Health Partners provided are not compensable by Medicare." For Health Partners, the "55% non-Medicare fee scheduled was unsustainable and un-survivable." Accordingly, it shut down its operations completely on July 30, 2021.

The Lighthouse, Inc, is a medical provider in Michigan that "specializes in brain injury rehabilitation."[11] As a result of the reduced reimbursement rates under the amended No-Fault Act, The Lighthouse has sustained "[a] loss in revenue of approximately $7 million per

[10]Appx 36, Ex. 6, Health Partners Affidavit, January 31, 2023.

[11]Appx 37, Ex. 7, The Lighthouse Affidavit, November 7, 2022.

year" and "[a] change in an annual margin of 10% since the fee structure was implemented" so that "[a] forecasted margin of negative 16%" is projected for fiscal year 2022-2023. It has sustained a "[l]oss of jobs due to lower admissions" and is "down about 70 full-time staff from before the law was enacted." Fewer admissions occurred as cost of services was more than revenue received. Staffing at 1:1 ratio was "significantly reduced or eliminated" as reimbursement was less than it cost to pay for staffing to provide services. "Day programming services were discontinued." Transportation services were "reduced or limited in distance" due to low "reimbursement levels". Therapy outings were decreased in "scope, distance and duration" in order to "reduce expenses" due to "decreased program revenue".

Even providers such as Origami Rehabilitation, Inc, in Lansing that have strong organizational support from entities like Michigan State University and Peckham, Inc, have been devastated by the reduced reimbursement levels under the amended No-Fault Act.[12] Origami projected a 2022 budget loss of 11.5%, which is $765,000. As of October 2022, Origami was on track for a negative 12.3% margin, which would equate to a $789,000 loss. Program services decreased by 21% from 2021 to 2022 due to the no-fault changes, which resulted in a loss in revenue of $1,315,790. If not for COVID relief grant funds that improved the bottom line in 2022, the loss would have been much greater, i.e., $1,888,619. The residential program previously accounted for nearly half of Origami's operation, but it has restructured by, among other things, eliminating 16 full-time positions, discontinuing 1:1 supervision, discontinuing 1:1 community outings, and reducing residential staffing. Origami projects a loss of almost $2 million if the Court of Appeals' decision is not affirmed.

[12]Appx 40, Ex. 8, Origami Rehabilitation Affidavit, October 21, 2022.

ARGUMENT

I. THE COURT OF APPEALS CORRECTLY CONCLUDED THAT REDUCED REIMBURSEMENT RATES FOR POST-ACUTE CARE/REHABILITATION SERVICES THAT ARE NOT COVERED MEDICARE CANNOT BE APPLIED RETROACTIVELY TO PERSONS INJURED IN MOTOR VEHICLE ACCIDENTS BEFORE THE NO-FAULT ACT WAS AMENDED, AND AS A CONSEQUENCE, THE POST-ACUTE CARE/REHABILITATION SERVICES INDUSTRY IN MICHIGAN MAY NOW BE ABLE TO SURVIVE AND TRANSITION FROM THE EXISTING MODEL FOR HOW SUCH ESSENTIAL SERVICES ARE PROVIDED.

As previously discussed, the survival of the post-acute care/rehabilitation industry in Michigan depends on whether reduced reimbursement rates under the amended No-Fault Act apply retroactively to persons injured in motor vehicle accidents before it was enacted. The United States Supreme Court has observed that '[t]he largest category of cases in which we have applied the presumption against statutory retroactivity has involved new provisions affecting contractual or property rights, matters in which predictability and stability are of prime importance.'" *Landgraf v USI Film Products,* 511 US 244, 271, 114 S Ct 1483, 128 L Ed 2d 229 (1994). In this case, contractual rights have clearly been violated.

As the Court of Appeals majority opinion noted, "retroactive application would alter the injured plaintiffs' settled rights and expectations under the pre-amendment no-fault act". Slip op at 11. But, that is true not only for Andary and Kreuger, i.e., "the injured plaintiffs". It is also the case for post-acute care/rehabilitation providers like Eisenhower who have long served persons seriously injured in motor vehicle accidents in Michigan. Post-acute care/rehabilitation providers also have "settled rights and expectations" under the No-Fault Act. Reducing reimbursement rates retroactively impermissibly alters contract rights and business expectations of such providers to be properly compensated for services rendered.

For example, before the No-Fault Act was amended, Eisenhower and Krueger entered into a binding agreement regarding the post-acute care/rehabilitation services provided for him. That agreement did not place any caps on reimbursement for services. It provided that Eisenhower would be paid its reasonable and customary rates for services provided for Krueger as a resident in its post-acute rehabilitation facilities. That agreement conformed with the No-Fault Act's requirements under MCL 500.3157 that all amounts charged be reasonable and not more than the amount customarily charged by that provider in cases where the injured person was not insured. But, if the amended No-Fault Act is applies retroactively, Eisenhower will not recover its "reasonable and customary rates" for services provided for Krueger as contractually agreed. It will be paid only 55% of what it charged on January 1, 2019, as its services are not covered under the Medicare program.

Oddly, the trial court assumed, but never squarely addressed, whether the reduced reimbursement rates for post-acute care/rehabilitation services not covered by Medicare applied retroactively to persons injured before the No-Fault Act was amended. Instead, it simply stated that "[t]hese limitations are expected to apply to individuals injured in motor vehicle accidents prior to June 11, 2019", because the amended No-Fault Act was effective immediately. It also further observed that the Michigan Supreme Court previously applied changes to the workers compensation statute retroactively when it decided *Romein v Gen Motors Corp*, 436 Mich 515, 462 NW2d 555 (1990). It then equated this case to the *Romein* case without actually addressing whether the amended No-Fault Act applied retroactively.

The Court of Appeals' majority opinion corrected the trial court's oversight by addressing whether the amended No-Fault Act applied retroactively. Respectfully, it reached the only tenable holding given that the amended No-Fault Act contains no "clear,

direct, and unequivocal language" indicating that it should be applied retroactively to the vast detriment of persons injured in motor vehicle accidents before the law was amended. The majority opinion faithfully applied this Court's previous holding in *LaFontaine Saline, Inc v Chrysler Group, LLC*, 496 Mich 26, 852 NW2d 78 (2014) in its decision. Slip op at 6-9.

In contrast, the dissenting opinion largely ignored the factors adopted in *LaFontaine*, supra. It instead concluded that a simultaneously enacted provision requiring that savings be passed on to insureds, and not simply pocketed by insurers, was "plain and unambiguous" language establishing that the Legislature intended the reduction in PIP benefits to apply retroactively. As Plaintiffs/Appellees' briefing has demonstrated, the defense's position, and the dissenting opinion's adoption of that view, is weak because there is no "clear, direct and unequivocal language" that supports retroactive application.

The defense's reliance on this Court's previous decisions under the workers' compensation statute is also misplaced. The issues in *Romein* are not the same or even similar to the issues in this case. By incorporating new limitation on reimbursement rates and by capping attendant care services that can be reimbursed, the amended No-Fault Act arguably bears a closer resemblance now to the workers' compensation statute in Michigan. But, that was not the case before the No-Fault Act was amended in 2019 and the new limitations on reimbursement for post-acute care/rehabilitation services were added. PIP coverage also was "heavily regulated" but, unlike workers compensation in Michigan, no fee limitations or attendant care caps existed until MCL 500.3157 was amended in 2019.

Even more importantly, the issue of retroactive application in *Romein* differed greatly from this case because the changes to workers compensation at issue in *Romein* were passed as "curative" legislation that was designed to promptly correct this Court's holding

that certain changes made to the coordination of benefits provision under the WDCA applied retroactively to persons injured before the WDCA was amended. There is no similar legislative history in this case, and thus, the decision in *Romein* to apply the subsequently passed "curative" legislation retroactively should have no bearing. Yet, the result in that case was the linchpin in the trial court's decision to apply these amendments retroactively. The Court of Appeals, in its majority opinion, recognized that the trial court erred by relying on *Romein* and it correctly distinguished *Romein* in reversing that holding. Slip op at 9-11.

The trial court erred by not squarely addressing the question of whether the amended No-Fault Act applied retroactively to persons injured in motor vehicle accidents before it was enacted. Instead, the trial court simply concluded that it was proper to apply the amended No-Fault Act retroactively because that was what the Court did in *Romein*. The dissenting opinion would simply compound the trial court's mistake by misreading this Court's holding in *Romein* and failing to distinguish it from the circumstances in this case.

Effectively, the dissenting opinion simply held that the amended No-Fault Act applied retroactively because *Romein* applied changes to the workers' compensation statute retroactively, without addressing the factual and statutory distinctions between these cases. The majority opinion, in contrast, provided a comprehensive analysis of *Romein* and a thorough explanation of why its holding on retroactive application did not apply in this case. This Court should affirm the Court of Appeals' published decision as *Romein* clearly should have no bearing on the outcome in this case given the differences between the two cases.

Moreover, this Court should affirm the Court of Appeals' decision on the retroactivity question because failing to do so would irreparably harm both providers of post-acute care/rehabilitation services and those persons seriously injured in motor vehicle accidents.

If not applied retroactively, there will be no period of adjustment in Michigan to a world where post-acute care/rehabilitation services for persons injured in motor vehicle accidents are no longer reimbursed at levels that allow post-acute care/rehabilitation providers to continue operating in Michigan. Applying the amended No-Fault Act retroactively maintains the status quo for existing "legacy" patients needing post-acute care/rehabilitation services. It also would ensure that providers will have an opportunity to adjust their business models to account for the drastic reduction in reimbursement for post-acute rehabilitation services. Effectively, it would save post-acute care/ rehabilitation providers from shutting down immediately. Even more importantly, it would ensure that the health and safety of existing patients that need the post-acute care rehabilitation services currently provided for them.

II. THE COURT OF APPEALS CORRECTLY HELD THAT REDUCING RATES OF REIMBURSEMENT FOR POST-ACUTE CARE/REHABILITATION SERVICES RETROACTIVELY WOULD BE AN UNCONSTITUTIONAL VIOLATION OF THE CONTRACTS CLAUSE, AND WITH THAT HOLDING ENSURED ACCESS TO SUCH SERVICES FOR THOSE PERSONS MOST SERIOUSLY INJURED IN MOTOR VEHICLE ACCIDENTS BEFORE THE NO-FAULT ACT WAS AMENDED.

MBIPC agrees with the Court of Appeals majority opinion that "retroactively applying the amendments [to the No-Fault Act] violates the Contracts Clause of the Michigan Constitution." Mich Const 1963, Art 1, § 10. MBIPC will rely on Plaintiffs/Appellees' briefing on this issue as it pertains primarily to the contracts between Plaintiffs (Andary and Krueger) as PIP insureds and Defendants (USAA and Citizens as PIP insurers obligated to protect them by providing the coverage secured. But, MBIPC will note again the disastrous effect on post-acute care/rehabilitation services that will result from not applying the amended No-Fault Act retroactively. Without such "legacy" patients, the post-acute care/rehabilitation services industry in Michigan will cease to exist as it did before the No-

Fault Act was amended. Even assuming the existing fee caps are modified legislatively, and appropriate fee schedules are adopted to replace them, there will be few providers left that are capable of rendering high-level post-acute care/rehabilitation services as needed. As previously stated, retroactive application of the amended No-Fault Act has triggered an existential crisis throughout the post-acute care/rehabilitation services industry in Michigan.

III. THE COURT OF APPEALS CORRECTLY CONCLUDED THAT DISCOVERY IS NEEDED TO DETERMINE WHETHER APPLYING THE FEE CAPS IMPOSED BY THE AMENDED NO-FAULT ACT WOULD BE AN UNCONSTITUTIONAL VIOLATION OF THE EQUAL PROTECTION AND DUE PROCESS CLAUSES OF THE MICHIGAN CONSTITUTION EVEN IF APPLIED PROSPECTIVELY ONLY.

A. Reducing reimbursement for post-acute care/rehabilitation services not covered by Medicare arguably violates the due process clause because post-acute care/rehabilitation services providers in Michigan have an existing protected property right to continue their business operations.

The Due Process Clause of the Michigan Constitution prohibits depriving a person of life, liberty, or property, without due process. Mich Const 1963, Art 1, § 17. It thus protects an individual's property rights, including the right to own a business in Michigan. Yet, the amended No-Fault Act arbitrarily cuts post-acute care/rehabilitation services not covered by the Medicare program by 45%. It thus arguably violates the due process rights of providers like Eisenhower because such drastic reductions in revenue make it impossible for post-acute care/rehabilitation services providers to continue doing business in Michigan.

As noted previously, most payments made by the MCCA reimburse providers rendering services not covered under the Medicare program. Yet, the No-Fault Act now reduces reimbursement for those services by 45%. It also bases that reduction arbitrarily on the amount that providers were charging on January 1, 2019, before the new law was enacted. As such, it perversely rewards providers that were overcharging as of January 1,

2019, while punishing providers that did not overcharge for services provided. If the goal was to reign in costs, uniformly arbitrary cuts in reimbursement was not the way to do so. The only way to achieve that goal would be to adopt a fee schedule that stops providers from overcharging, instead of rewarding them for doing so. Yet, that is not what the Legislature did. Instead, it imposed caps that unjustly punished post-acute care/ rehabilitation providers with fair, affordable rates before the No-Fault Act was amended.

Not surprisingly, such a drastic change in reimbursement has undermined the viability of the post-acute care rehabilitation services industry in Michigan. Presumably, few, if any, businesses can afford for revenues to be reduced by 45% without jeopardizing their ability to continue operating. Regardless of the level of scrutiny applied, the Legislature's decision to impose uniformly arbitrary reductions in reimbursement for services not covered under the Medicare program arguably violates the due process clause of the Michigan Constitution. Accordingly, discovery is needed to determine whether there was truly any basis for the Legislature doing what it did in the unjust, unfair manner that it chose to do so.

B. Reducing reimbursement for post-acute care/rehabilitation services not covered by Medicare arguably violates the equal protection clause by treating providers of post-acute care/rehabilitation services differently than businesses providing services covered by the Medicare program.

The amended No-Fault Act treats similarly situated medical providers dissimilarly by separating them into two distinct classes. The first class is limited to providers that render Medicare compensable services to persons injured in motor vehicle accidents. The second class consists of providers that render non-Medicare compensable services to the same group of persons. Providers in the second class have dramatically reduced rights in

comparison to the first class as reimbursement is limited to slightly more than half of what they charged as reasonable and customary rates for services rendered on January 1, 2019.

Such a drastic reduction assumes that rates charged for services not compensable under Medicare were vastly inflated before the No-Fault Act was amended. It also perversely rewards providers whose charges were most excessive by imposing a uniformly arbitrary reduction of 45%. Unlike the rates applied to services that are covered by Medicare, which is capped at basically double the Medicare reimbursement rate, the fee caps that are imposed on most post-acute care/rehabilitation services are not pegged to established fee schedules or independent audits of typical charges for services provided.

The defense argued below that such fee caps do not violate Eisenhower's equal protection rights, because the Legislature's decision to impose them was a rational response to providers charging too much for the services provided. But, the new law does not squarely address the problem of some providers charging too much for post-acute care/rehabilitation services. Instead, it rewards them for doing so and it punishes providers whose customary rates were reasonable before the No-Fault Act was amended. Whatever level of scrutiny is applied, the Legislature's decision to impose a uniformly arbitrary reduction in reimbursement for all services not covered by Medicare does not pass constitutional muster under the equal protection clause. See Mich Const 1963, Art 1, § 2.

CONCLUSION

Applying retroactively the recent changes that the Legislature made to the No-Fault Act will have a devastating effect not only on providers of post-acute care/rehabilitation services in Michigan, but also persons injured in motor vehicle accidents in Michigan before

the No-Fault Act was amended. Accordingly, this Court should affirm the Court of Appeals' published ruling that the reduced reimbursement rates for post-acute care/rehabilitation services under the amended No-Fault Act do not apply retroactively and that applying such fee caps retroactively would violate the contracts clause of the Michigan Constitution. Prospective application of vastly reduced reimbursement rates for post-acute care/rehabilitation services will be similarly devastating both for persons seriously injured in motor vehicle accidents and for the post-acute care/rehabilitation industry in Michigan. This Court should affirm the decision to remand Eisenhower's equal protection and due process claims for discovery to determine whether there was a rational basis for uniformly and arbitrarily reducing reimbursement for post-acute care/rehabilitation services providers.

RELIEF REQUESTED

MBIPC requests that this Court affirm the Court of Appeals' decision as it correctly held that the amended No-Fault Act does not apply retroactively and that applying it retroactively would violate the Contracts Clause of the Michigan Constitution. It also asks that this Court affirm the Court of Appeals' decision to remand the equal protection and due process claims to the trial court for discovery to address whether it is constitutional to apply the reduced reimbursement rates for post-acute care/rehabilitation services prospectively.

Respectfully submitted:

Dated: February 6, 2023

/s/ Steven A. Hicks
Steven A. Hicks (P49966)
Counsel for Amicus Curiae MBIPC
216 North Chestnut Street
Lansing, MI 48933
(517) 881-5564
steve@chair2consulting.com

STATE OF MICHIGAN
IN THE MICHIGAN SUPREME COURT

ELLEN M. ANDARY, a legally incapacitated adult, by and through her Guardian and Conservator, MICHAEL T. ANDARY, M.D., PHILIP KRUEGER, a legally incapacitated adult, by and through his Guardian, RONALD KRUEGER, & MORIAH, INC., d/b/a EISENHOWER CENTER, a Michigan corporation,

Plaintiffs-Appellees,

v

USAA CASUALTY INSURANCE COMPANY, a foreign corporation, and CITIZENS INSURANCE COMPANY OF AMERICA, a Michigan corporation,

Defendants-Appellants.

Supreme Court Case No. 164772

Court of Appeals Case No. 356487

Ingham County Circuit Court
Case No. 2019-000738-CZ

AMICUS CURIAE MBIPC'S APPENDIX

List of Exhibits

MBIPC
Michigan Brain Injury Provider Council

Support HB 4486

Support Access to Care

House Bill 4486 is needed to protect access to care for thousands of individuals and families, and must be passed into law quickly to prevent the closing of brain injury rehabilitation centers throughout the state. HB 4486 maintains access to care and averts mass job layoffs. This legislation does not add cost to the system.

4,800 to 6,200 Patients
Lose Access to Care

Doors Shut on Michigan Patients

Nearly 8 in 10 of all respondents (79%) expect a decrease in the number of no-fault patients at their facility if HB 4486 does not get enacted. On average, each facility expects to lose 31 to 40 no-fault patients — this extrapolates to 4,800 to 6,200 patients across the state losing care from these facilities.

Community-Based
Centers Close

Nearly 9 in 10 post-acute care facilities have little or no confidence in staying in business

Eighty-six percent (86%) of post-acute care facilities have either no confidence at all (65%) or very little confidence (21%) that they can operate their business at a sustainable level under the auto no-fault fee schedule set to go into effect July 1.

3,250–4,650
Lose Jobs Across Michigan

Pink Slips Statewide

Nearly all respondents (90%) expect a decrease in the number of jobs at their facility if House Bill 4486 does not get enacted. On average, each facility expects to lose 21 to 30 jobs — this extrapolates to 3,250 to 4,650 jobs lost across the state that are directly connected to these facilities. This does not even account for thousands of lost jobs dependent on these community facilities.

MBIPC
Michigan Brain Injury Provider Council

Survey

Under the New Auto No-Fault Law Fee Schedule, Michigan Expected to Lose Nearly 5,000 Health Care Jobs, More Than 6,000 Patients to Lose Care

A recent survey of brain injury rehabilitation care providers across the state indicates that nearly all are planning for the worst, including going out of business, if legislators don't fix technical issues in the fee schedule set by the new auto no-fault reform law. This new fee schedule goes into effect July 1 this year. Because of a technical error in the language of the fee schedule, the codes established treat these post-acute care facilities more negatively than other health care providers, slashing the amount they can charge for care by nearly half. It unfairly and severely diminishes their ability to be reimbursed for the care provided to patients with catastrophic injuries from automobile accidents.

To quantify the impact of the new auto no-fault law fee schedule on the industry, the Michigan Brain Injury Provider Council (MBIPC) commissioned a survey of care providers in professions related to brain injury rehabilitation. According to this statewide survey of over 110 brain injury rehabilitation care providers, their facilities will be forced to lay off thousands of workers, discontinue catastrophic care for thousands of auto accident patients and potentially go out of business, if a legislative fix to this flawed fee schedule isn't passed.

Here is a summary of the survey's findings:

» **Nearly nine in ten post-acute care facilities have little or no confidence in staying in business:** More than six in ten (65%) post-acute care facilities have no confidence at all that they can operate their business at a sustainable level under the new auto no-fault fee schedule in its current form. Another 21% are only slightly confident. Only 3% say they are either somewhat or extremely confident they will be able to continue their business at a sustainable level.

» **Thousands of patients potentially losing care across the state:** Nearly eight in ten of all respondents (79%) expect a decrease in the number of auto no-fault patients for which their facility can provide care, if the fee schedule goes forward unchanged. When asked to quantify how many patients will potentially lose care, the average response was between 31 to 40 expected patients lost per facility; meaning that between 4,800 and 6,200 patients across the state will potentially lose care from these facilities alone.

- Nearly four in ten (38%) expect that care to be lost immediately, while more than eight in ten (85%) expect it to be lost within the first few months after the new fee schedule goes into effect.
- The facilities surveyed currently provide care for between 6,350 and 7,800 post-acute care patients across Michigan.

» **Thousands of jobs potentially lost across the state:** Nine in ten facilities (90%) expect to decrease their number of employees if the fee schedule goes forward unchanged. When asked to quantify how many jobs will be lost, the average response was between 21 and 30 expected jobs lost per facility; meaning that between 3,250 to 4,650 jobs will potentially be lost across all facilities in the state. This estimate does not account for indirect jobs lost.

- More than four in ten (45%) expect to lose those jobs immediately, while more than eight in ten (85%) expect those job losses within the first few months after the new fee schedule goes into effect.
- The facilities surveyed currently provide jobs for between 6,350 and 7,800 post-acute care practitioners across Michigan.

This survey of more than 110 post-acute care facilities across Michigan was commissioned by MBIPC and conducted by ROI Insight, a Michigan-based market research company.

MICHIGAN NO-FAULT LAW CHANGE BUSINESS IMPACT

Survey Details

IBH Analytics conducted an industry survey to determine the impact of changes to Michigan's No-Fault Insurance laws that came into effect in July of 2020. IBH Analytics surveyed firms who serve those who have suffered injuries from vehicle accidents. The firms invited to participate in the survey were contacted via an email list provided and are all located in the State of Michigan. Firms self-reported their projected impacts once the laws come into full effect.

Impact to Services

A negative impact to services provided: 90% of firms estimate a reduction in services offered for TBI clients once the law is in full effect. 0% believe that they will be able to expand their services for TBI clients and only 10% believe that their services will stay the same once the law is enacted.

Exiting the business: 57% of firms stated they are either very likely or likely to exit the business of serving individuals who have experienced a vehicle accident. 29% of firms reported they were unlikely or very unlikely to exit the business of serving individuals who have experienced a vehicle accident 14% of firms that were indifferent to this question.

Fee schedule to sustain quality services: Almost all firms note they cannot sustain quality services at the fee schedule enacted to begin July 2021. The average pay cut an organization can withstand while continuing to provide quality services is 13.7% compared to enacted pay cut of 45%.

Impact to Revenue

Confidence in replacing no-fault revenue severely diminished: 72% of firms are not at all confident that they would be able to replace No-Fault revenue due to the law that has been enacted. 16% are only slightly confident in their ability to replace No-Fault revenue while 8% are moderately confident. Only 3% of firms are highly confident that they would be able to replace No-Fault revenue.

Change in annual revenue: 81% of firms estimate a decrease in annual revenue due to the law enacted. Approximately half of these estimate a decrease in revenue of 50% or more with 9% estimating a 100% decrease in revenue. 19% of all firms estimate no change or a positive change to the firm's annual revenue due to the newly enacted law.

REVENUE AND EMPLOYEE IMPACT

Across all organization settings the average number of full-time employees in 2021 is projected to decrease from 2019. The table to the right shows the average annual revenue percent change estimate by organization setting along with 2019 and projected 2021 average full-time employee counts.

With the number of full-time employees projected to decrease in 2021, industry layoffs are expected to occur.

Percent Change in Revenue by Organization Setting with Full-Time Employee Summaries

Organization Setting	Number of Firms	Revenue Percent Change	2019 FTE	Projected 2021 FTE
Acute Care Hospital	5	-39%	308	254
Inpatient Rehabilitation Unit within an Acute Care Hospital	5	-45%	153	119
Specialty Care Hospital (Long Term Acute Care Hospital)	4	-39%	33	29
Free Standing Rehab Hospital	3	-48%	29	25
Subacute Rehabilitation Facility	6	-38%	749	314
TBI Residential Program (AFC licensed beds)	13	-45%	1,360	755
TBI Residential Program (Semi-independent or apartments)	12	-46%	1,002	510
Outpatient Rehabilitation (Hospital Based or affiliated)	4	-45%	127	97
Outpatient Rehabilitation (Non-Hospital Based – Private)	19	-45%	1,212	627
Vocational Programs/ Sheltered Workshops	9	-37%	1,042	496
Private Practice	20	-36%	388	329
Home Health Care	13	-31%	1,555	1,030

SUMMARY OF IMPACTS

72% of firms are not at all confident that they will be able to replace the lost No-Fault revenue

OVER HALF of firms are likely or very likely to exit the business of serving individuals who have experienced a vehicle accident

9 OF 10 firms estimate a reduction of services once the law is in full effect

13.7% the average pay cut a firm can withstand while continuing to provide quality services

This survey was completed by IBH Analytics. The survey was a twenty-two question survey conducted online. The sample size was seventy-one firms. Not all firms answered each question. Areas of focus included: impact to services, revenue impact, and employee impact. Organization setting refers to the setting in which firms treat injuries from vehicle accidents. Firms could select more than one setting.

CPAN survey finds vast majority of Michigan accident victims who receive in-home care are concerned about their future

APRIL 30, 2021

HOME CARE ELEMENTS OF NO-FAULT REFORM WILL CAUSE CHAOS FOR VULNERABLE PATIENTS

LANSING, Mich.—(April 29, 2021)—A new **CPAN** survey of Michigan auto accident victims and their home-based attendant caregivers—often family members—finds that the majority are deeply worried about how they'll continue to function after impending cuts to reimbursement rates are enacted.

2019 changes to the no-fault insurance law which take effect this July limit reimbursement for in-home family-provided attendant care to 56 hours per week—even if the patient requires help and supervision around the clock. If the patient requires additional care beyond 56 hours per week, he or she will have to turn to a commercial agency. In addition to this hourly limitation, a new fee schedule cuts reimbursement rates for attendant care by 45% after July 1, 2021. This will have a devastating impact on both the family members and the commercial agencies that provide home health care. Family members will be unable to adequately be compensated for their services and commercial home health care agencies will be forced to lay off staff or close their doors entirely, leaving many patients without recourse to get the care they need.

CPAN's survey found that the majority of provider respondents (56%) deliver home-based attendant care services to patients that need 24/7 care. Nearly half of accident victims have been receiving attendant care for more than five years and rely on routines that allow them to live with some measure of independence and dignity. Fifty percent of accident victims are cared for at home exclusively by family members.

There were 568 total responses to the survey, which gave users the opportunity to anonymously tell their heartbreaking stories.

"I had to quit my job in 2009 due to the severity of issues she encounters on a daily basis," one caregiver said. "Things have worsened over the past couple years and I have to be with her 24/7 because NO ONE understands her or her reactions as I do. She has five types of seizures, a traumatic brain injury, is non-verbal, has left side hemiparesis and has over 50 allergies to medications… she requires my attention every second of the day. Her survival is crucial to my diligence and detail of her everyday care."

Another caregiver added: "If we are limited to 56 hours of care a week, Angie will drastically lose her care… care that keeps her from injury or death."

Said another: "Our family doesn't want our daughter to go into a group home or other facility… my daughter would be extremely lonely without her loved ones nearby."

A whopping 81% of patients said they are concerned that the services they receive are going to be affected by the 56 hours per week limitation, throwing vulnerable Michigan residents into chaos while they're contending with a resurgent pandemic that continues to rage across the state.

"I have been providing attendant care to my brother for almost 14 years," a caregiver said. "I made a decision to walk away from my career to help with his

care. I knew family being involved was the key to him surviving. I am the one who changes his trach (tracheostomy tube) monthly. I am the one who drives him to all his appointments. I am the one who is there to wipe his tears when he gets depressed."

In addition to issues with access to care, patients and family members are concerned about having to rely on commercial providers. In many cases, family-provided attendant care is best suited for the patient's needs. Having to get additional care from a commercial agency would result in a disruption of the care system that the patient is used to and oftentimes does not provide the patient with the same level of care and dedication that a family member provides.

Another caregiver said: "My daughter requires all of her needs to be done by others. Hygiene, dressing, meds, feeding, positioning, everything. Many of these functions require two caregivers to [perform]. My wife and I want to provide care to our daughter and want to be compensated the same as anyone else would be. She is familiar with us and we provide the absolute best care available. We do use professional caregivers also. Problems we have with professional caregivers are, they don't show up, they are late, it could be a different caregiver every day, every time we have a new caregiver, they have to learn all the procedures for caring for our daughter. Our daughter is a human being not a robot without feelings. She deserves the most appropriate care at a reasonable price that is available, family provides that care."

CPAN President **Devin Hutchings** said the survey was conducted to provide lawmakers and other decision makers with data around attendant care, since there is no database of individuals who receive home-based care stemming from auto accidents. Home-based care is an important tool in health care delivery and often critical for the progress in patient recovery.

Hutchings said our lawmakers need to understand the ripple impact of these changes on patients and the health care community in our state.

"As Michigan's watchdog for policyholders and accident victims, it is important to gather this information, especially as coronavirus is still spreading," Hutchings said. "The cuts to home-based, family-provided care impacts not only current accident victims, but also anyone who needs care in the future. We will continue to fight to ensure that these vulnerable Michiganders receive the access to the care they need."

Please see an additional fact sheet on the survey here (/s/Attendant-Care-Fact-Sheet.pdf).

NEXT

Statewide Business Survey Finds New No-Fault Fee Schedule Will Have Devastating Impact on Services, Jobs, and Patients
(/news/statewide-business-survey-finds-fee-schedule-impact-on-services-jobs-and-patients)

Phase I
Provider Survey Results from a Study Tracking Impact of Fee Changes in No-Fault Auto Insurance Reform

December 2021

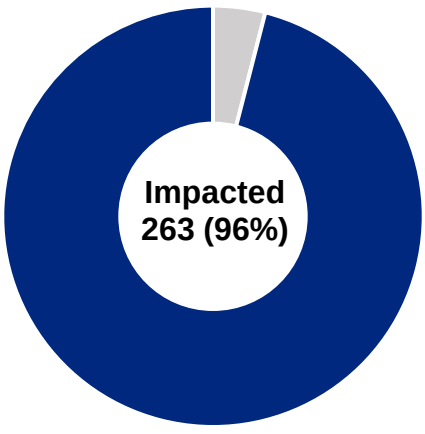
Table of Contents

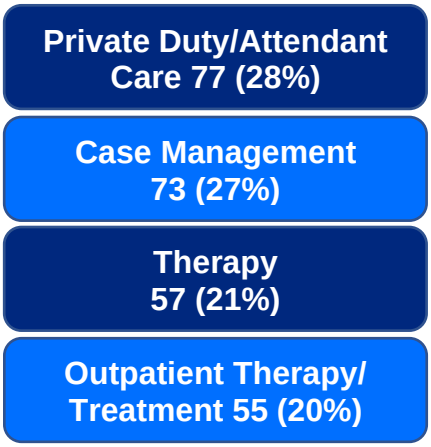
Executive Summary

The Brain Injury Association of Michigan (BIAMI) commissioned this independent study by the Michigan Public Health Institute (MPHI) to document the impact of the fee structure changes in the 2019 Michigan no-fault auto insurance reform law, that took effect on July 1, 2021, on the availability of services for people with catastrophic injuries resulting from a car crash. MPHI was chosen because of its expertise and depth of understanding of public health research. This report summarizes the results from the first survey of brain injury service providers, distributed between September 29, 2021 and October 20, 2021. Two additional provider surveys are planned in 2022 to document this fluid situation.

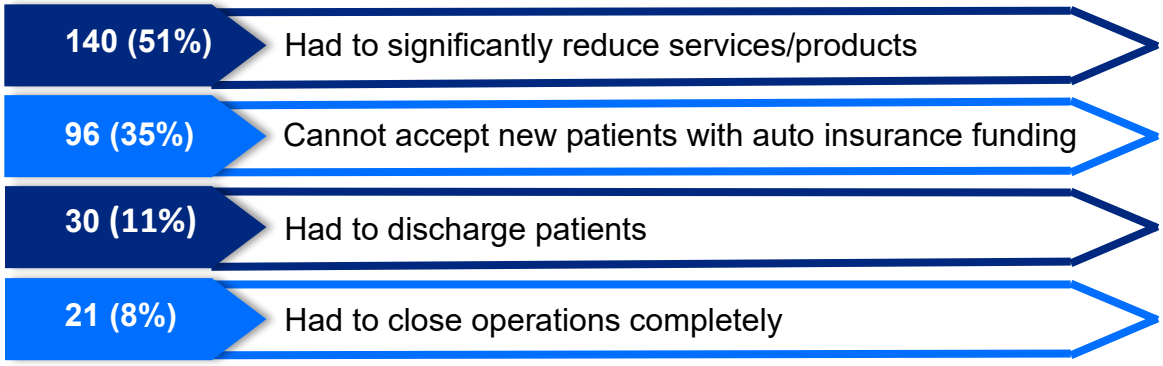
Results

- 349 providers participated in the survey, representing 273 unique organizations that collectively had more than 16,296 employees, served more than 16,753 patients before July 1, 2021
- Out of 11,733 employees from the 140 organizations that provided employment data, **3,049 (26%)** jobs were eliminated
- Out of 16,751 patients served by the 208 organizations that provided patient discharge data, **1,548 (9%)** patients had to be discharged
- Top services provided were case management, private duty/attendant care, outpatient therapy/treatment, and therapy services
- 263 (96%) organizations reported that their services were impacted by the 55% reimbursement cap. The most impacted services are:





- The 55% reimbursement cap also impacted operations of the organizations:



- Despite 89 organizations reporting either no impact on services, no reduction in revenue, or no reduction in workforce, 56 (63%) of them reported that they anticipated not being able to serve patients with auto insurance funding within the next 12 months.

About this Study

Limitations

The target population of this survey are providers representing the organizations that provided services and care to auto crash survivors. However, MPHI does not have a mailing list of the target population. Therefore, the survey was distributed as a public link, sent to BIAMI's networks and their members by BIAMI and partners. Although the networks are extensive, there is no way to know whether the survey invitation reached all target providers, and whether the respondents are representative of the target population.

This report should be viewed as initial impact from the no-fault auto insurance fee structure changes on the responding service providers. The follow-up surveys will add questions to understand how providers are impacted by 1) the 200% Medicare rate cap for covered services, and 2) the insurance companies' utilization review processes.

MPHI Research Team

MPHI is a public-private partner with a variety of public health, government, and community organizations and is committed to conducting public health work based on strong scientific evidence and the needs of Michigan residents. This study is headed by Dr. Clare Tanner, director of the Center for Data Management and Translational Research (CDMTR). The team includes, Dr. Shaohui Zhai, Statistician; Dr. Issidoros Sarinopoulos, Senior Research Scientist; and Kayla Kubehl, Research Assistant, of CDMTR.

Methodology

Survey Development

The Auto Crash Service Providers Survey was collaboratively developed by MPHI and BIAMI in August and September 2021. The survey contained ten questions about their employer organizations, also collected individual names and contact information in order to recontact them for the subsequent surveys. MPHI researchers trained in survey development finalized all questions to ensure readability, clarity, and lack of bias.

Survey Implementation

The survey was implemented in REDCap (Research Electronic Data Capture) by MPHI. REDCap is a secure web application for building and managing online surveys and databases. While REDCap can be used to collect virtually any type of data in any environment (including compliance with 21 CFR Part 11, FISMA, HIPAA, and GDPR), it is specifically geared to support online and offline data capture for research studies and operations.

MPHI and BIAMI pre-tested the online survey internally before launching a pilot test. The pretest made sure that the survey was implemented as designed. The pilot test was conducted between September 3 and 21, 2021 with 5 providers. The survey went live on September 29, 2021.

Survey Distribution

The survey was distributed by BIAMI to their members and networks, between September 29 and October 20, 2021, using an invitation message developed by MPHI and BIAMI. The invitation contained a public survey link to the survey, instructions on how to access, complete, save, submit, and print out a PDF copy of the survey, as well as how to contact MPHI for questions and assistance. Two rounds of reminders were sent out by BIAMI.

Internal Review Board Approval

MPHI's Internal Review Board (IRB) operates following FDA regulations and is formally designated to review and monitor biomedical research involving human subjects with the authority to approve or disapprove research. This review is designed to ensure that researchers protect the rights and welfare of research participants. The IRB review assures that appropriate steps are taken to protect the rights and welfare of research participants. MPHI's IRB panel reviews research protocols and related materials to ensure protection of the rights and welfare of research participants.

The MPHI research team submitted a Human Participant Protections Application to the MPHI IRB, and provided all the project materials, including the consent page, the survey questions, the pilot testing protocol, and the survey distribution plan. The MPHI IRB approved the pilot testing on September 1, 2021, and the full approval of the project was granted on September 27, 2021.

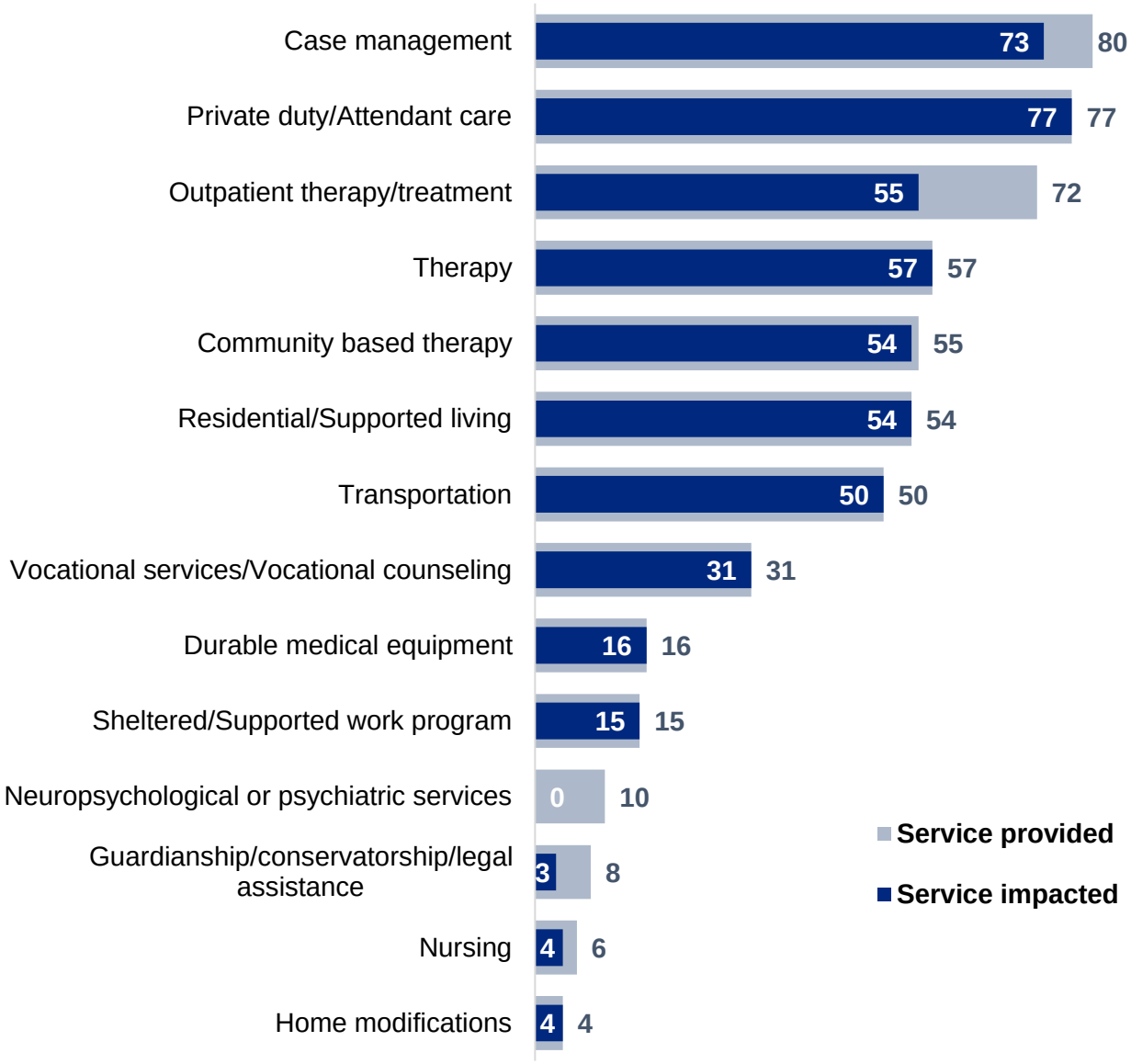
Provider Survey Results

A total of 349 providers participated in the first survey, representing 273 unique organizations that collectively had more than 16,296 employees, and served more than 16,753 patients.

Impact of the 55% reimbursement cap on services

Among the 273 organizations, 10 (4%) reported no impact on services, 263 (96%) reported impact on almost all the services provided.

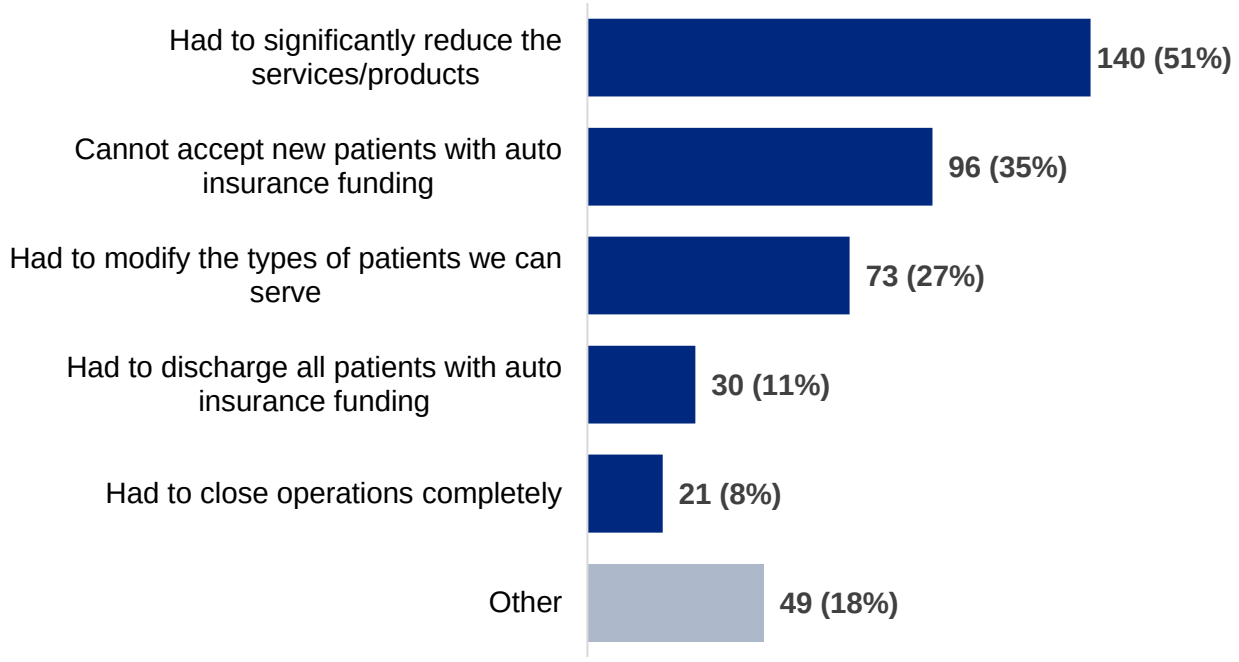
Services provided and impacted (n= 273 organizations)



Impact of the 55% reimbursement cap on operations

Providers were asked about the impact on the general operations of their organizations. About half (140, 51%) of the organizations reported having to significantly reduce their services and/or products. In addition to the answer options presented in the following chart, 49 (18%) organizations also reported other impacts, including difficulty getting reimbursement from insurance companies, having lost money, having to cut employees pay, having to downsize the workforce.

Impact on organizational operations (n=273 organizations)

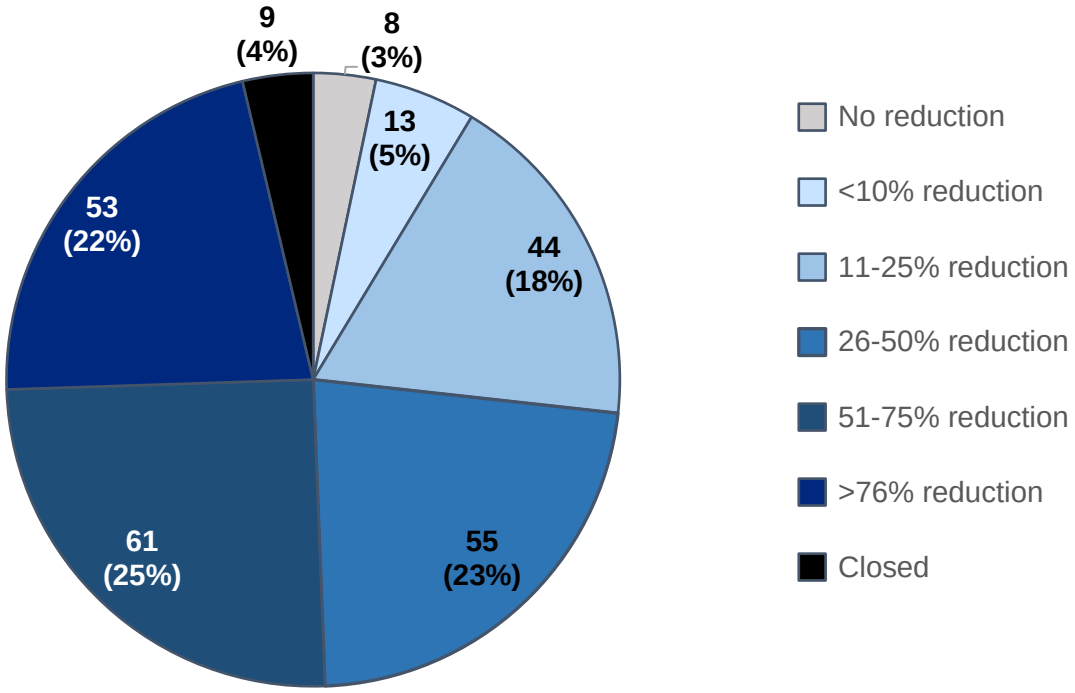


Impact of the 55% reimbursement cap on revenue, workforce, and patients

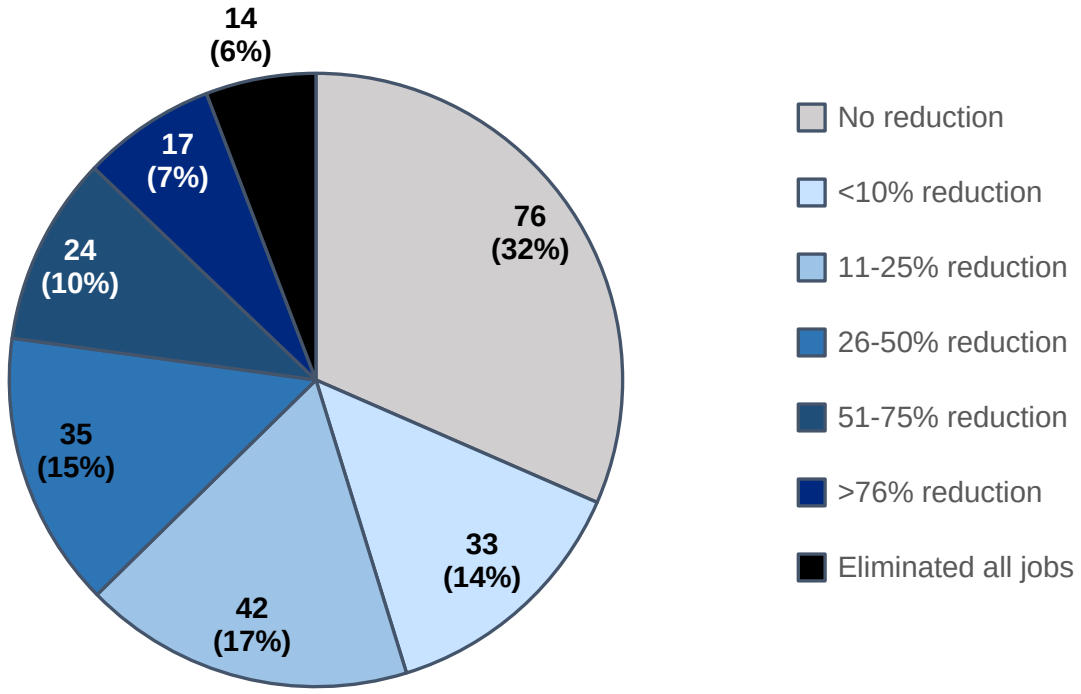
Providers were asked about the impacts on their organizational revenue, workforce, job losses, and patient discharges.

- 235 (97%) of the 243 organizations that responded to the revenue question reported a reduction in revenue, ranging from less than 10% reduction, to completely closed operations (chart below)
- 165 (68%) of the 241 organizations that responded to the workforce question reported a reduction in workforce, ranging from less than 10% reduction, to eliminating all jobs (chart below)
- The 140 organizations that provided both the employee and job loss numbers collectively experienced 3,049 job losses out of 11,733 employees (26%)
- The 208 organizations that provided both the patient and discharge numbers had to discharge a total of 1,548 out of 16,751 patients they served (9%).

Extent of revenue reduction to date reported by providers (n=243 organizations)



Extent of workforce reduction to date reported by providers (n=241 organizations)

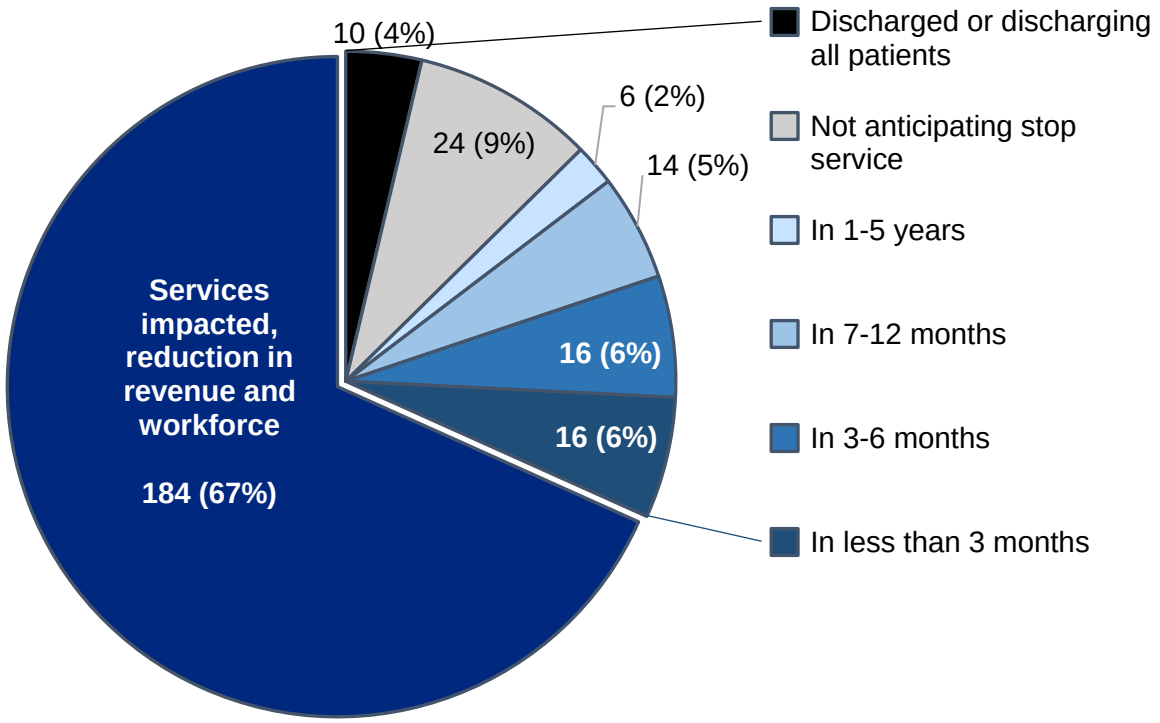


Forecasted continuing impact

184 (67%) organizations reported a reduction on both revenue and workforce, and impact on services. The rest 89 (33%) organizations who reported no impact to date in one or more areas surveyed (revenue, workforce, or services) were asked for how long they forecasted being able to continue their services to patients with auto insurance funding, and 86 of them provided an answer:

- 56 (63%) of the 89 organizations forecasted that they anticipate not being able to continue services within the next 12 months
- 24 (27%) of the 89 organizations forecasted they will be able to continue serving patients with auto insurance funding.

Forecasted length of time being able to continue services to patients with auto insurance funding (n=273 organizations)



Provider perspectives

Providers were asked to describe in their own words what these changes meant to them. Thematic qualitative analysis was conducted on the answers of all the providers who participated in the survey, regardless whether they represented the same organizations. 286 out of the 349 participating providers provided an answer. Responses fell within the following themes (from most to least common).

Financial loss or closures (n=129): Providers are at a financial loss since they are not being paid or reimbursed. Several have needed to dip into personal funds to keep their organizations operating or have needed to limit the services they provide to clients.

"I have had to endure the loss of revenue, a pay cut, limits on resources I can use with my clients."

Transportation shortages (n=40): Transportation has become problematic and reduced, which prevents clients from receiving needed therapies and care. It takes time to regain progress from even one week of missed therapy.

"While the services that we provide have all been covered thus far, we have had several patients not be able to attend their treatment due to a loss of medical transportation and several patients are clearly deteriorating even with treatment due to a loss of attendant care and issues with case management services."

Code confusion (n=36): Insurance codes have become an issue. Many providers have not needed these in the past and find the coding system confusing. Some do not know what codes to provide and find answers from the insurance companies unhelpful.

"The other unbelievable thing is that every insurance company and adjustor is doing something different and not consistently paying, they are not paying the required amount, or they send the bill back several times stating the right codes are not entered, and they don't offer any assistance as to what codes to use."

Patient discharge (n=27): Providers have needed to discharge patients, or the organizations will continue to lose money. Many providers are no longer taking no fault auto patients. They fear negative outcomes could impact the community, and patients may end up in jail.

"The patients we serve are human beings that were unfortunately innocently injured catastrophically in a motor vehicle accident. It is horrendous that we are now being forced to discharge them because they have no resources or are being denied benefits when we have all been told that they are unlimited and lifetime for the injuries they sustained."

Downsizing (n=23): Providers indicated the changes led them to lay off staff or downsize their organizations to adjust for lack of reimbursement.

"Other employees will need to be laid off to include case managers who have been with this organization for over 15 years, and administrative assistance for billing, invoicing, reports, etc."

Aide shortages leading to worsening patient health (n=14): Lack of reimbursement led to aide shortages and decline in services available to patients. Providers attest to worsening health outcomes, including increase of seizures, pain, number of sleep disturbances, and overall stress.

"$13.25 per hour for a CAN [certified nursing assistant] is less than what a high school student would earn working at McDonald's. PCA's [patient care assistant] are getting offered $25-$30 per hour in hospitals and the patients of ANF [auto no-fault funding] will not be able to find caregivers whether they work for an agency or 'make a deal' with the insurance companies."

Unsustainable (n=12): The work providers complete cannot be sustained for much longer due to pay cut and will result in business closures if something is not changed soon.

"We have stayed in this fight for our clients and for staff but will not be able to sustain without some immediate changes."

Inadequate insurance communication (n=12): Providers are frustrated with the lack of communication with insurance companies, including explanations regarding what services will be covered. Providers are also frustrated that they are providing the same services that were previously covered by insurance.

"Communication regarding billing with insurance companies has become more difficult as we used to be able to speak right to adjusters, who could make decisions, however now we are most often referred to processing companies by adjusters and then back to the adjusters by the processing companies, creating significant inefficiencies and frustrations for all."

Stressed (n=5): Providers face increased stress in trying to work in the new system. They knew the law would occur but did not anticipate for the consequences that it would enact.

"I think we anticipated some cuts but didn't expect the insurance companies wouldn't pay at all."

This project was funded by BIAMI.

The study was conducted by MPHI with assistance from BIAMI.

Phase II
Provider Survey Results from a Study Tracking Impact of Fee Changes in No-Fault Auto Insurance Reform

August 2022

Table of Contents

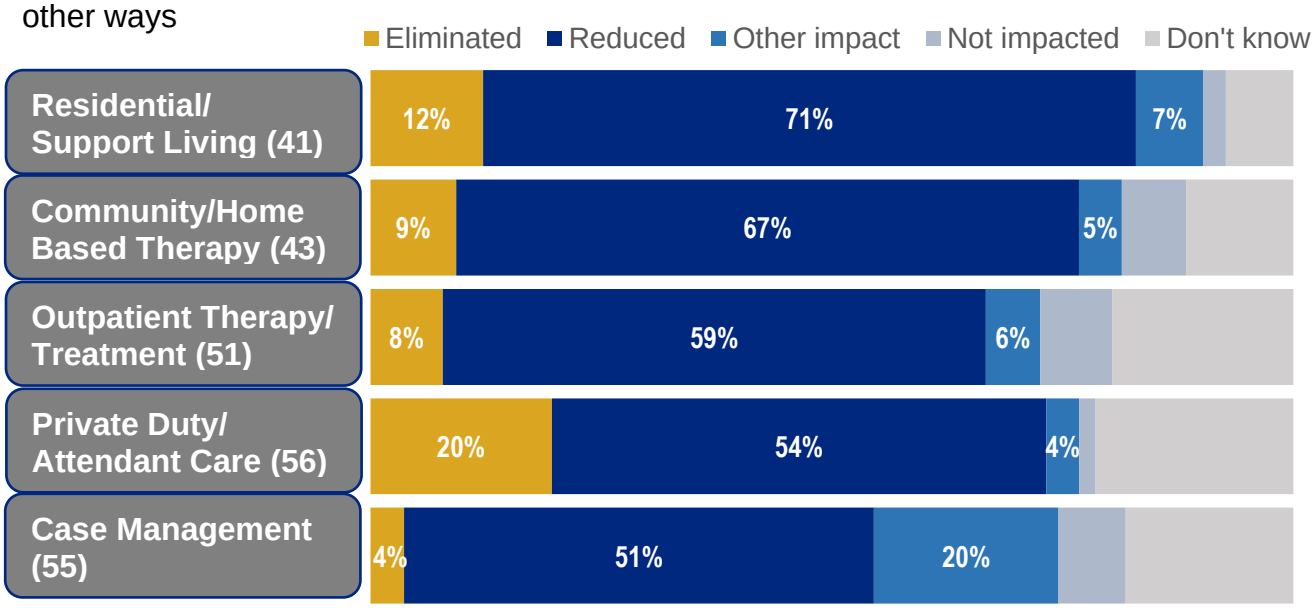
Executive Summary

The Brain Injury Association of Michigan (BIAMI) commissioned this independent study by the Michigan Public Health Institute (MPHI) to document the impact of the fee structure changes in the 2019 Michigan no-fault auto insurance reform law that took effect on July 1, 2021, on the availability of services for people with catastrophic injuries resulting from a car crash. MPHI was chosen because of its expertise and depth of understanding of public health research. This report summarizes the results from the second survey of brain injury service providers, distributed between March 9 and May 15, 2022. The report on the first survey was released in January 2022.

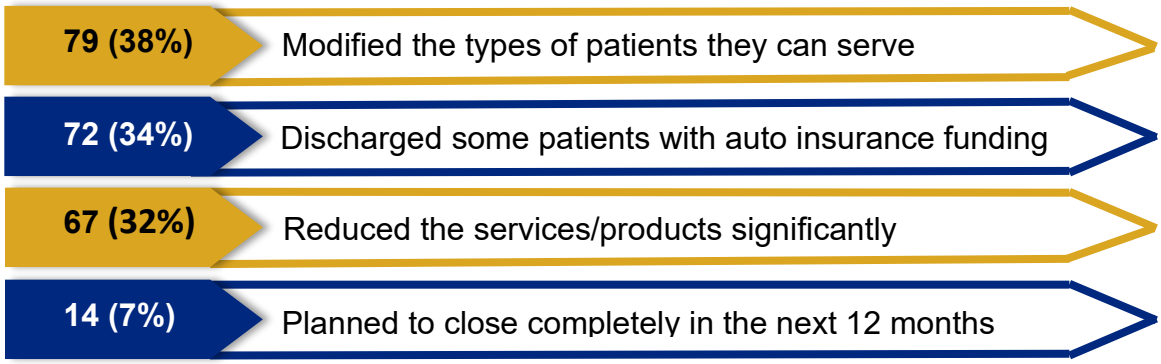
Results

General Impact

- 209 unique organizations participated in the second survey, including 166 organizations that also participated in the first survey
- The 73 organizations with data on amount of revenue loss reported a combined total of **$81,366,027** loss in revenue during the last 12-month period
- The 109 organizations with data on percentage of revenue loss reported an average of **41%** loss of revenue during the last 12-month period
- Out of 19,994 employees from the 154 organizations with employment data, **4,082 (29%) jobs were eliminated** since July 2021
- In terms of patients with auto insurance funding, the 144 organizations with patient count data reported serving a total of 15,596 patients before July 2021 and 8,739 currently, that is a total of **6,857 discharges** and an average of **42% reduction in their capacity of serving patients with auto insurance funding since July 2021**
- Among the top five services most frequently provided, **73-90%** of organizations reported that these services have been either eliminated, reduced, or impacted in other ways



- Among the 209 organizations, there have been **10 business closures** due to the changes and **expected 14 more closures** in the next 12 months.



Impact of Fee Caps and Reimbursement

- 119 (57%) organizations reported being impacted by the 55% fee cap, while 52 (25%) reported being impacted by the 200% Medicare cap
- Of the 99 organizations impacted by the 55% cap and with data on profit margin, **67 (68%)** reported **no more than 20% annual profit margin** prior to July 2021
- Of the 48 organizations impacted by the 200% cap and with data on Medicare reimbursement rates, **24 (50%)** reported that **none of their Medicare payable claims have been paid at 200%** Medicare rates since July 2021
- Of the 140 organizations with data on overall reimbursement, **7 (5%)** reported that they **had not received any reimbursement** since July 2021
- The 84 organizations with data on denied services reported an average of **28% of their patients had been denied services** since July 2021, due to insurance company utilization review process

Utilization Review Process with DIFS

- 49 organizations have filed appeals with DIFS through utilization review process on denied services since July 2021. Of those **36 (73%) have not gotten any services reinstated**

- 48 organizations have filed a total of 1,284 complaints to DIFS since July 2021, **176 (14%) have been resolved** in their favor

About this Study

Limitations

The target population of this survey are providers representing the organizations that provided services and care to auto crash survivors. MPHI does not have a mailing list of the target population. The first survey was distributed as a public link, sent to BIAMI's networks and their members by BIAMI and partners. The respondent list from the first survey was invited to participate in the second survey, and the second survey was also distributed through a public link. There is no way to know whether the survey invitations reached all target providers, and whether the respondents are representative of the target population.

MPHI Research Team

MPHI is a public-private partner with a variety of public health, government, and community organizations and is committed to conducting public health work based on strong scientific evidence and the needs of Michigan residents. This study is conducted by a team from MPHI's Center for Data Management and Translational Research (CDMTR), including Dr. Clare Tanner, director; Dr. Shaohui Zhai, Statistician; Dr. Issidoros Sarinopoulos, Senior Research Scientist; and Kayla Kubehl, Research Assistant.

Methodology

Survey Development

The Auto Crash Service Providers Surveys were collaboratively developed by MPHI and BIAMI. The surveys contained questions about their employer organizations, also collected individual names and contact information in order to recontact them for the subsequent surveys. MPHI researchers trained in survey development finalized all questions to ensure readability, clarity, and lack of bias.

Survey Implementation

The survey was implemented in REDCap (Research Electronic Data Capture) by MPHI. REDCap is a secure web application for building and managing online surveys and databases. While REDCap can be used to collect virtually any type of data in any environment (including compliance with 21 CFR Part 11, FISMA, HIPAA, and GDPR), it is specifically geared to support online and offline data capture for research studies and operations.

Survey Distribution

The second survey was distributed in two batches, one was by MPHI through email to the first survey respondents who provided contact emails, the other was by BIAMI and partners through a public link to their members and networks to recruit organizations that did not respond to the first survey. The survey was distributed between March 9 and May 15, 2022. At least three rounds of reminders were sent out during the distribution period.

Internal Review Board Approval

MPHI's Internal Review Board (IRB) operates following FDA regulations and is formally designated to review and monitor biomedical research involving human subjects with the authority to approve or disapprove research. This review is designed to ensure researchers protect the rights and welfare of research participants. The IRB review assures appropriate steps are taken to protect the rights and welfare of research participants. MPHI's IRB panel reviews research protocols and related materials to ensure protection of the rights and welfare of research participants.

The MPHI research team submitted a Human Participant Protections Application to the MPHI IRB, and the approval of the project was granted on September 27, 2021.

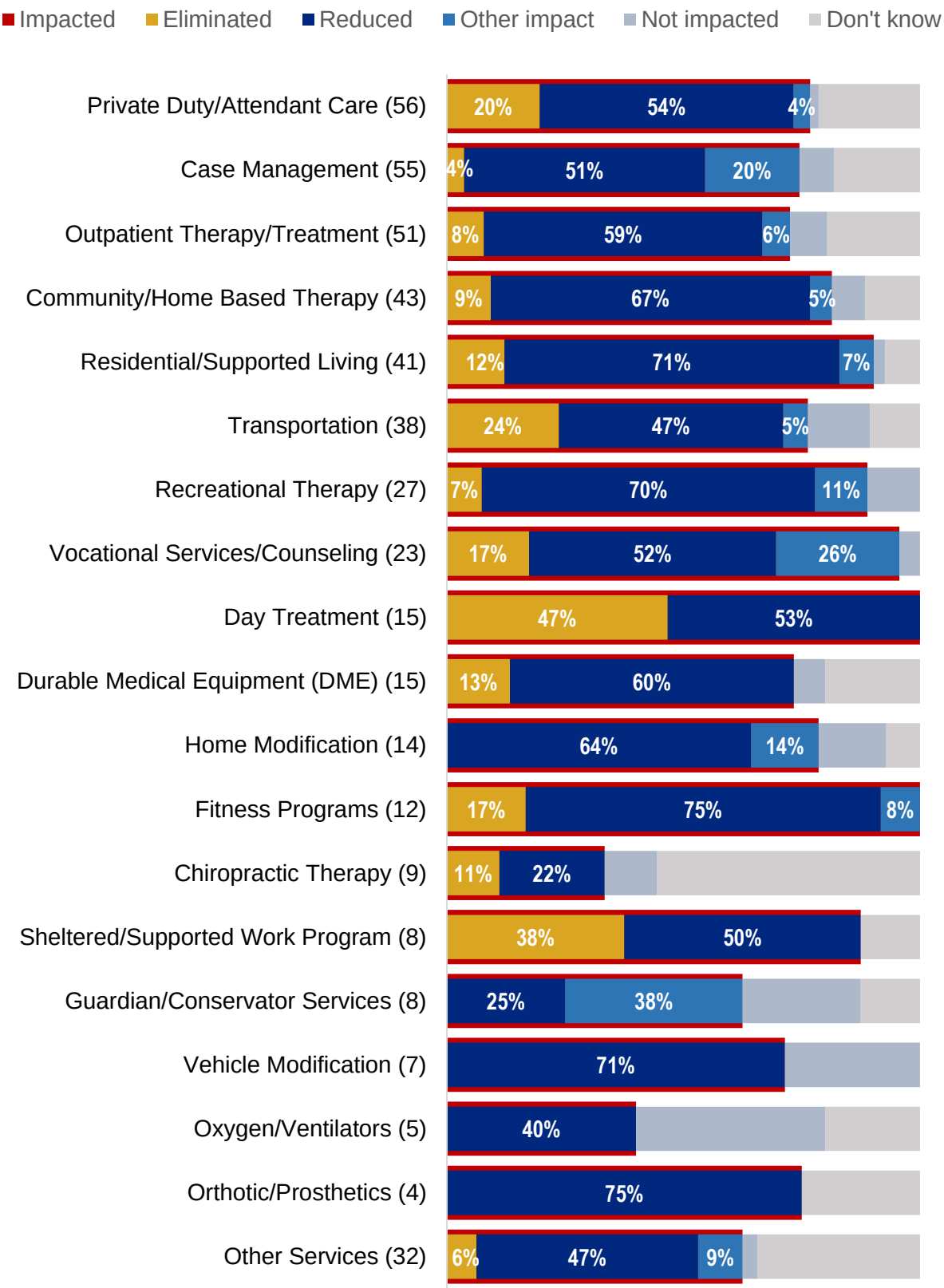
Provider Survey Results

Services Provided and Impacted

Respondents reported the services their organizations provided before July 2021, and how these services were impacted by the fee caps that took effect in July 2021. The chart on the next page presents the service categories and the percentages of the organizations reporting these services being eliminated, reduced, other impact, or no impact.

- The number of organizations that provided the listed services ranged from 4 (Orthotic/Prosthetics) to 56 (Private Duty/Attendant Care).
- Every type of service has been impacted – with a majority of organizations across all service categories except three (*Orthotic/Prosthetics, Chiropractic Therapy, and Guardian/Conservator Services*) reporting having to eliminate or reduce services.
- The top 8 services provided by at least 20 organizations are, *Private Duty/Attendant Care, Case Management, Outpatient Therapy/Treatment, Community/Home Based Therapy, Residential/Supported Living, Transportation, Recreational Therapy, and Vocational Services/Counseling Services.*
- Among these commonly provided 8 services, those most impacted are:
  - *Residential/Supported Living:* 83% organizations reported eliminating or reducing services
  - *Recreational Therapy:* 77% organizations reported eliminating or reducing services
  - *Community/Home Based Therapy:* 76% organizations report eliminating or reducing services
- It is also worth noting that 24% of *Transportation* and 20% of *Private Duty/Attendant Care services* organizations reported eliminating those services entirely.
- 32 organizations reported providing other services not in the answer options, including general healthcare, medical technology, neuropsychology, driver rehabilitation, and various therapy services. 62% of the organizations reported these services being either eliminated, reduced, or impacted in other ways.
- Other impacts reported include, decreased or delayed reimbursement, reduced salary and benefits, and reduced staff.

Services provided and how they were impacted (n=209)

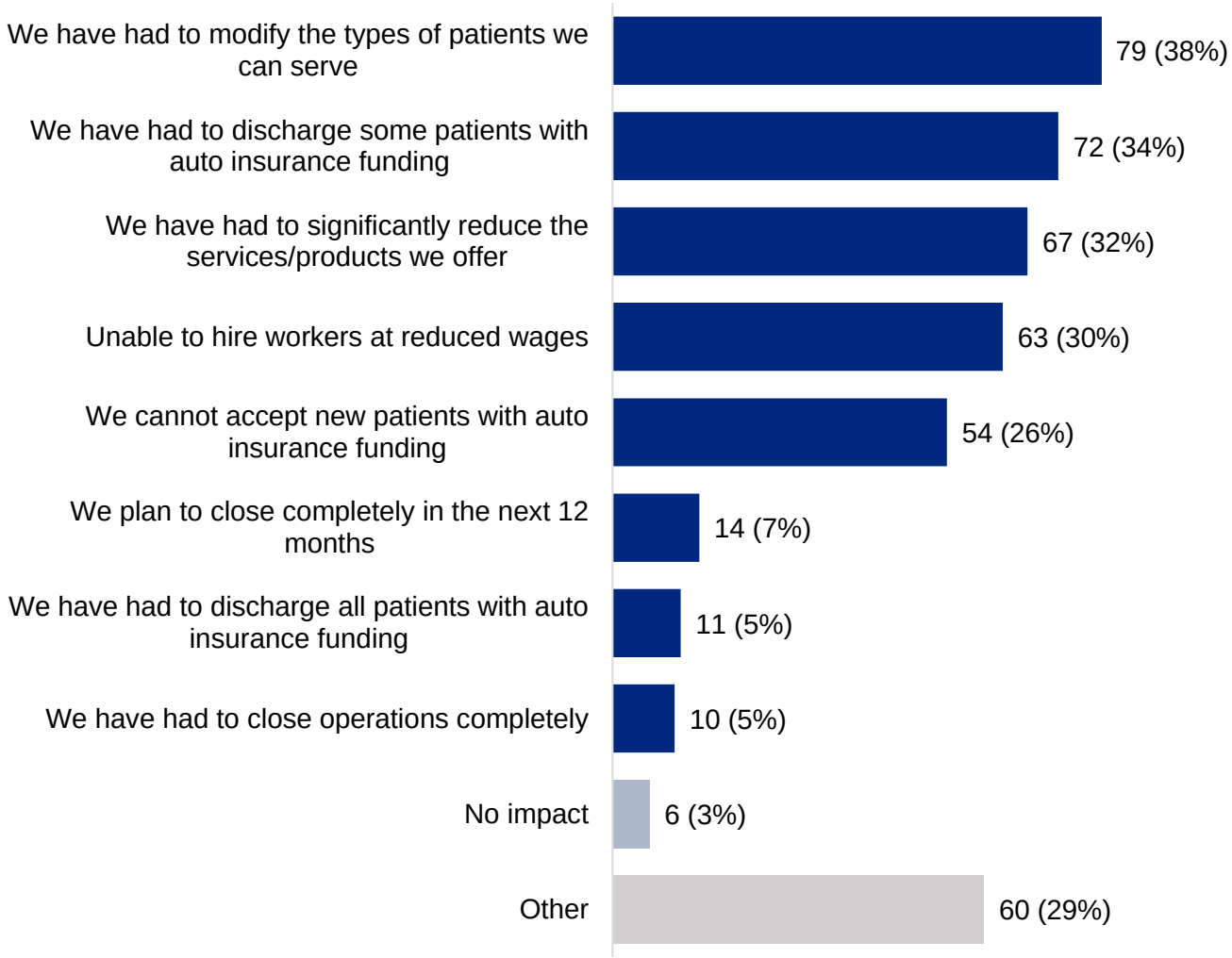


Impact on business operations

Providers were asked about the impact on the general operations of their organizations.

- 79 (38%) organizations reported having to modify the types of patients they serve, such as by looking at the insurance/PIP coverage to determine if they will serve a new patient.
- 10 (5%) had to close completely, and another 14 (7%) plan to close in the next 12 months.
- 60 (29%) reported other impacts, including difficulty getting reimbursement from insurance companies (partial payment, no payment, inconsistency in payment, more required documentations), having lost money, having to cut employees pay, and having to downsize the workforce.

Impact on organizational operations (n=209 organizations)

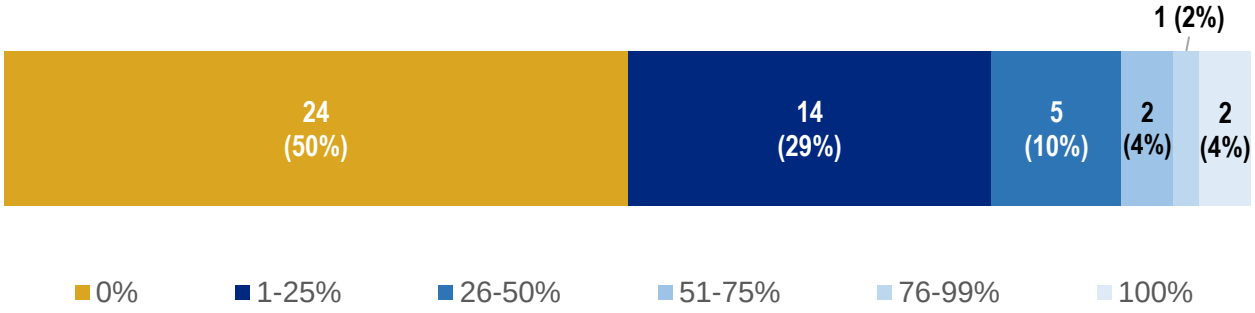


Impact of the 200% reimbursement cap for Medicare payable codes

52 (25%) of the 209 organizations reported that their businesses have been impacted by the 200% reimbursement cap for Medicare payable codes.

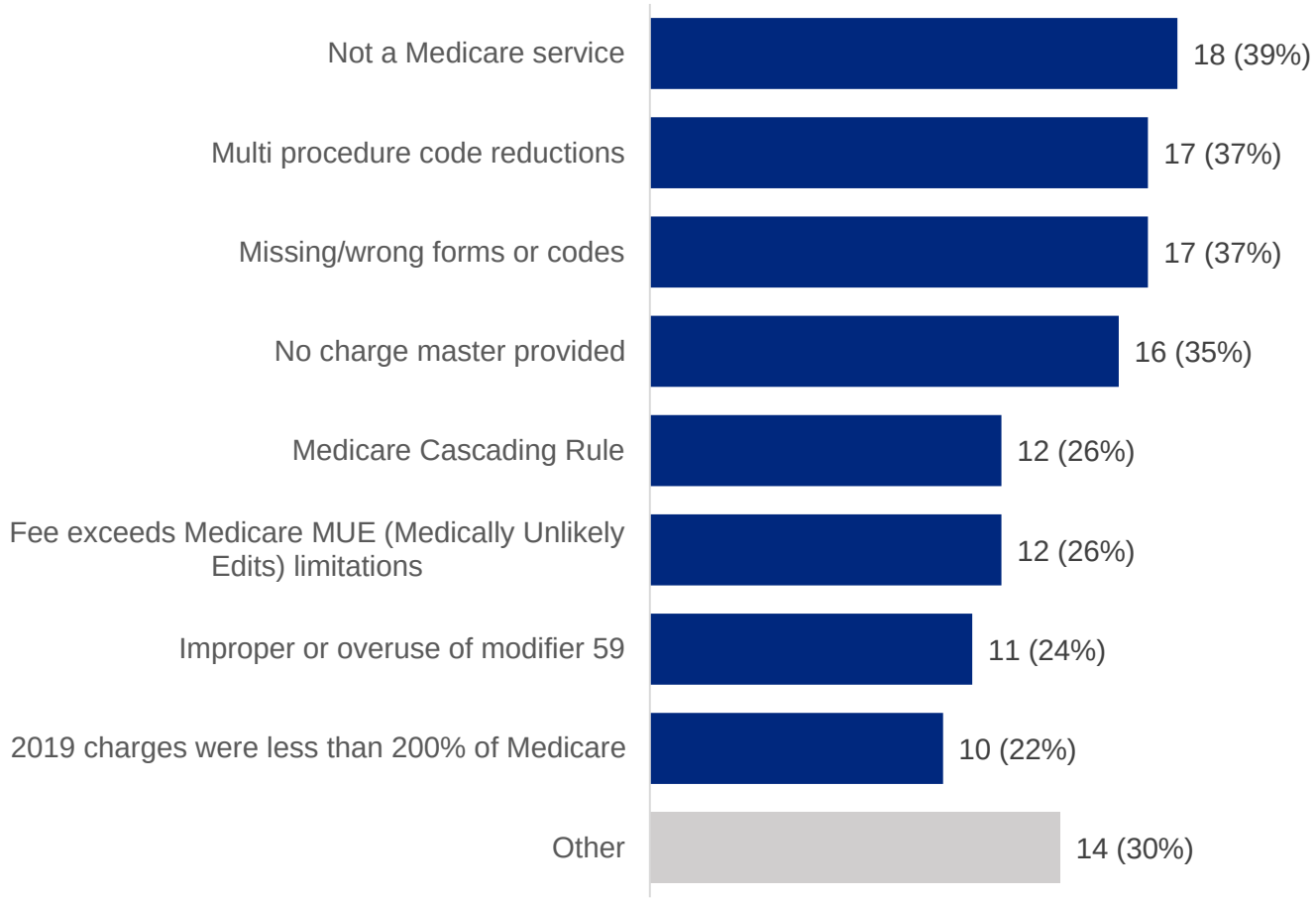
- 24 (50%) of the 48 organizations with data reported they were never reimbursed at 200% of Medicare payable rates; 2 (4%) organizations reported that all their Medicare payable claims were reimbursed at 200% of the Medicare rates.
- 37 (77%) of the 48 organizations with data reported that same Medicare payable codes were reimbursed at inconsistent rates most of the time; 3 (6%) organizations reported that same Medicare payable codes were reimbursed at the same rates consistently.
- When reimbursed at less than 200% Medicare rates, the top reasons were, *not a Medicare service*, *multi procedure code reductions*, *missing/wrong form or codes*, and *no charge master provided.*
- When reimbursed at less than 200% Medicare rates, 33 (73%) organizations have attempted to rebill. Of those, 11 (33%) reported never being able to recoup the remaining balance, and 15 (45%) reported being able to recoup the balance only up to one quarter of the time.

Percentage of claims funded by auto insurance have been paid at 200% Medicare rates (n=48 organizations)

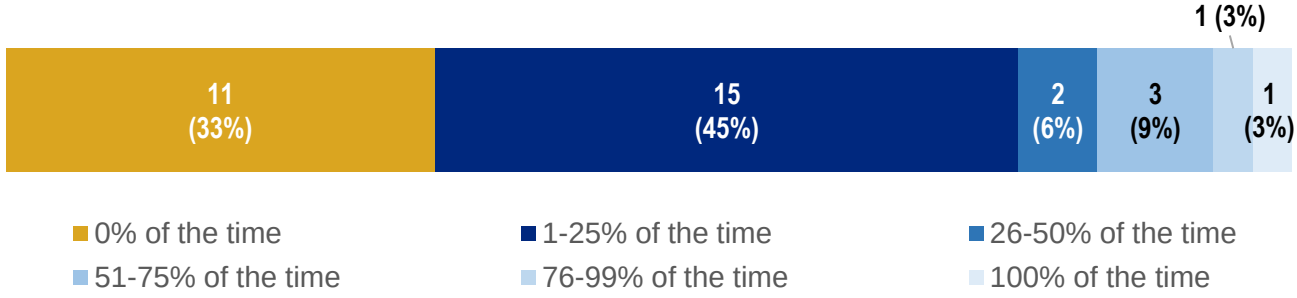


Frequency being reimbursed at inconsistent rate for the same Medicare payable codes (n=48 organizations)

Reasons for being reimbursed at less than 200% Medicare rates (n=46 organizations)



Percent of the time being able to recoup remaining balance when rebilled (n=33 organizations)

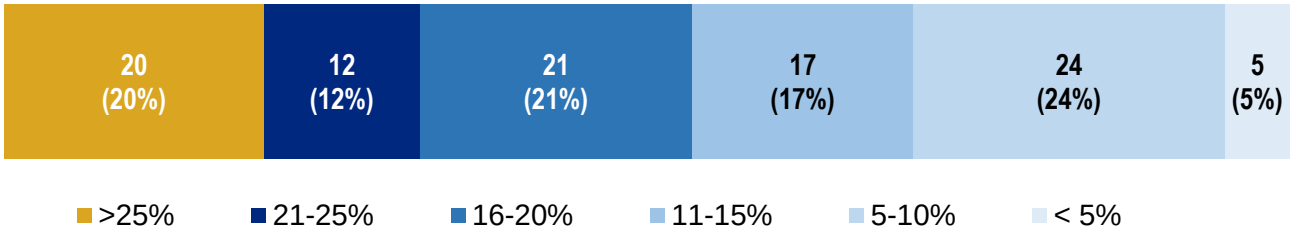


Impact of 55% of 2019 charges for non-payable Medicare codes

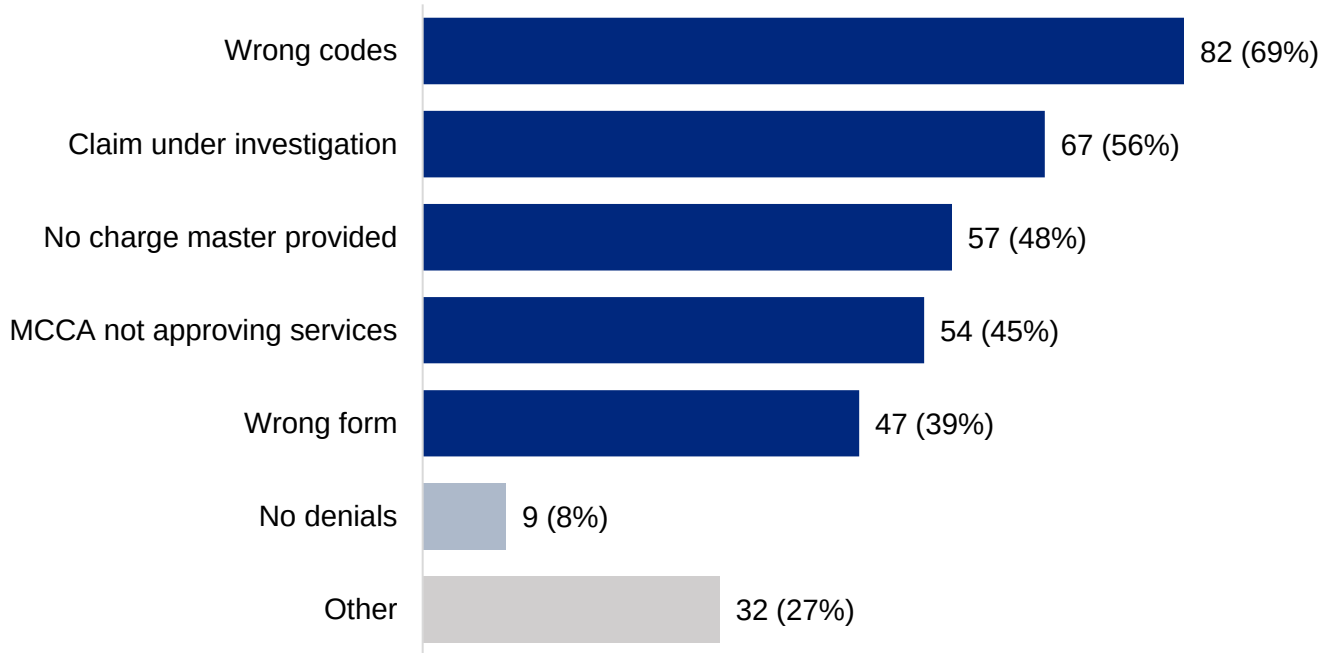
119 (57%) of the 209 organizations reported that their businesses have been impacted by the 55% reimbursement cap of 2019 charges for non-Medicare payable codes.

- 67 (68%) organizations reported having annual profit margin no more than 20% before July 2021 (n=99).
- Top two reasons for denial of claims *were wrong codes* and *claim under investigation.* Other reasons for denials include not enough documentation for services provided, services were medically unnecessary, and client had received the maximum amount.
- 9 (8%) organizations did not experience claims denied.

Average annual profit margin prior to July 1, 2021 (n=99 organizations)



Reasons for denial of claims (n=119 organizations)

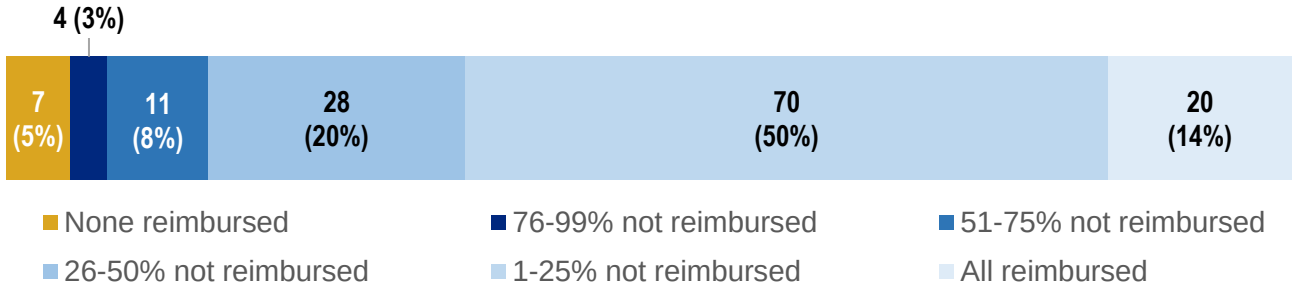


Reimbursement

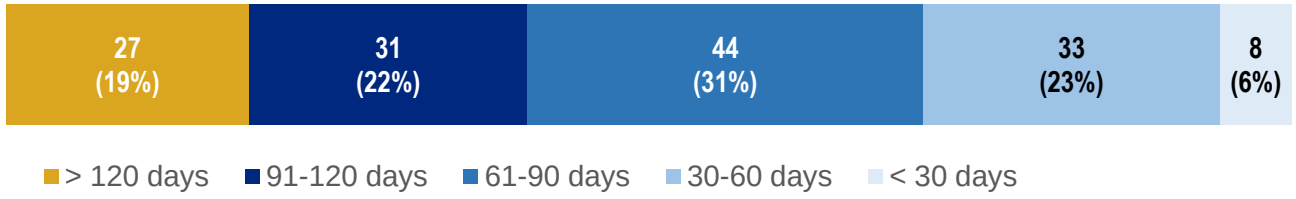
Respondents were asked about reimbursement for the services they provided to their auto insurance funded patients.

- 7 (5%) have not received any reimbursement at all since July 2021 (n=140).
- 27 (19%) organizations reported having to wait for more than 120 days before receiving any reimbursement (n=143).
- 84 organizations reported an average of 28% patients had been denied services since July 2021 due to insurance company utilization review process, 6 of them reported 100% of their patients have been denied services (n=84).

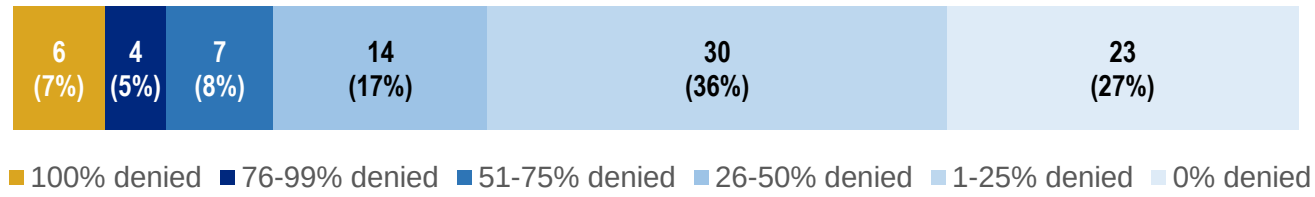
Proportion of claims that have not received any reimbursement since July 1, 2021 (n=140 organizations)



Days to wait to receive reimbursement (n=143 organizations)



Proportion of patients denied services since July 2021 (n=84 organizations)

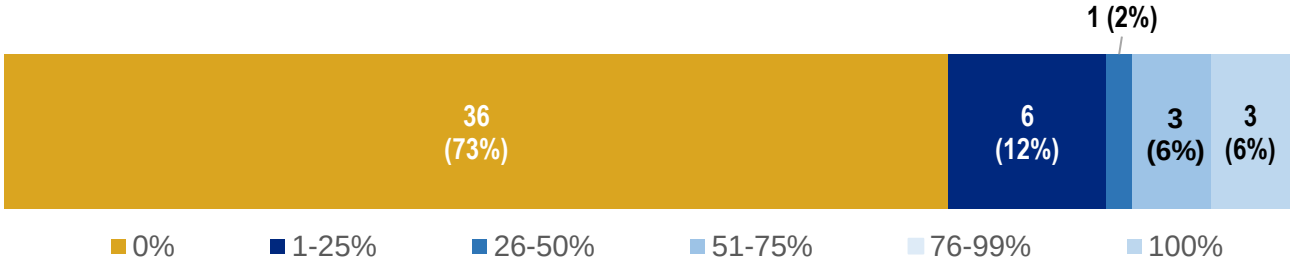


Working with DIFS and Insurance Adjusters

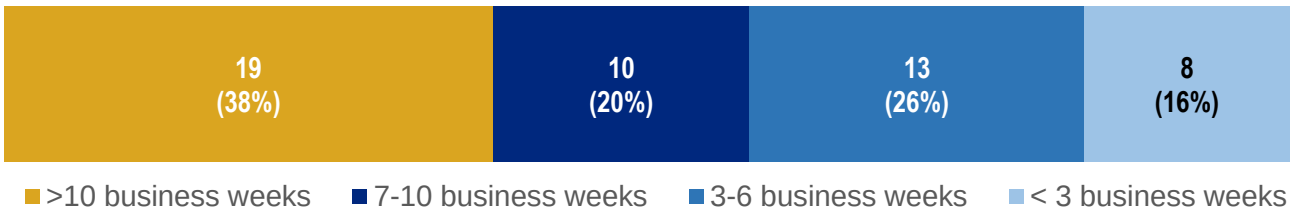
Under Michigan's auto insurance law, medical care provided to a person injured in an auto crash must meet requirements for medical appropriateness. Auto insurers must establish utilization review programs to make these determinations, which can be appealed by health care providers to the Michigan Department of Insurance and Financial Services (DIFS) Utilization Review section. Respondents were asked about their experiences with the DIFS Utilization Review process, filing a complaint to DIFS, and working with insurance adjusters.

- 54 organizations have filed appeals with DIFS through the Utilization Review Process on denied services since July 1, 2021. Among the 49 reported, 36 (73%) organizations reported that none of their appeals resulted in reinstatement of services for their patients.
- 29 (58%) organizations reported having to wait for more than 7 weeks to get a determination from DIFS (n=50).
- 48 organizations have filed a total of 1,284 complaints to DIFS since July 2021, 176 (14%) of the complaints were resolved in their favor.
- 92 (69%) organizations reported that their ability to productively discuss cases with insurance adjusters has gotten worse, compared to before July 2021 (n=134).
- 69 (51%) reported having heard from insurance adjusters that the MCCA is directing pre-approval of services and/or reimbursement (n=134).

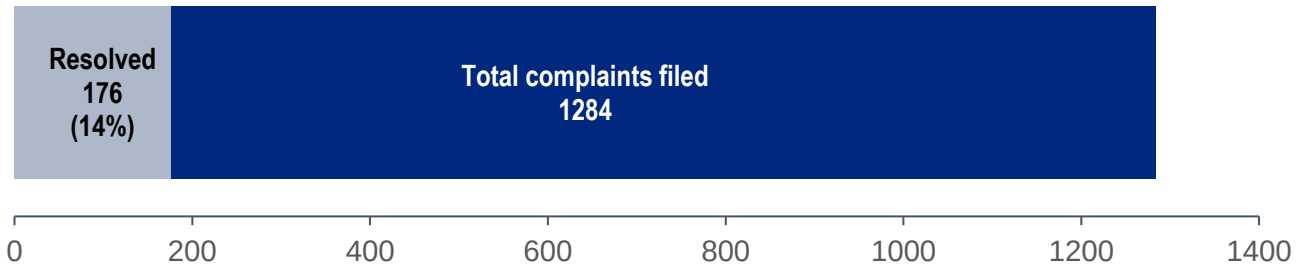
Proportion of appeals to DIFS Utilization Review resulted in reinstatement of services for patients (n=49 organizations)



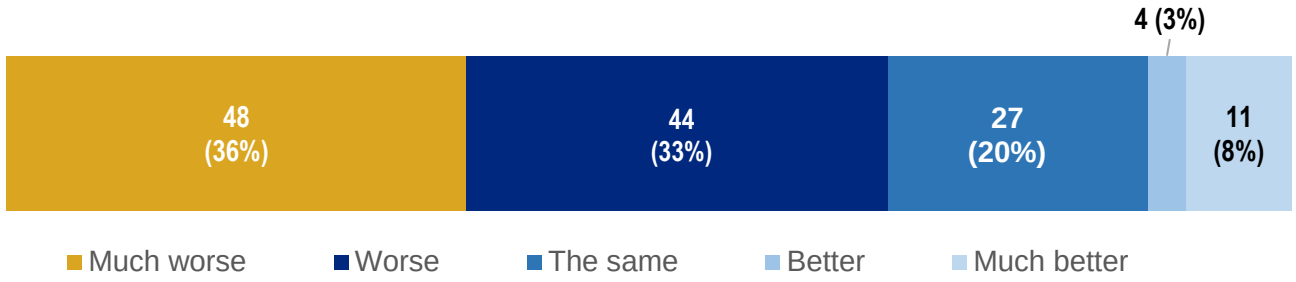
Weeks to get a determination from DIFS (n=50 organizations)



Total number of complaints filed to DIFS and resolved in provider's favor since July 2021 (n=48 organizations)



Organization's ability to productively discuss cases with insurance adjusters, compared to before July 2021. (n=134 organizations)



Respondents were asked if they have tried to contact their state representatives and/or senators about issues resulted from the fee caps. 107 (78%) of the 136 respondents who answered this question have tried. Of those, 67 (63%) had dialogues, 40 (37%) got no responses.

Provider perspectives

104 providers described in their own words what these changes meant to them. Responses fell within the following 15 themes, accompanied by selected quotes.

Financial loss Providers are at a financial loss since they are not being paid or reimbursed.	*"I had no income for six months I cannot hire and am working 100 + hours a week myself due to short staffing. I lost a client I had been caring for nine years. She employed 32 hours a day."*
Patient discharge or discontinued services Providers have needed to discharge patients, or the organizations will continue to lose money.	*"It has been an injustice to our clients as they have had to be discharged from services for needs that are no longer being covered leaving them and their families w/ minimal resources and emotional upheaval."*
Aide shortages Lack of reimbursement led to aide shortages and burnout among staff.	*"Finding caregivers is impossible, we are thankful that the handful we have haven't left us but will when we can no longer pay them."*
Difficulty to work with insurers Providers sense that insurance companies are putting up unnecessary barriers over and above the payment caps.	*"[Insurance company] makes us use US mail (during pandemic) there are at least 25 pages per patient bill per month, many get 'lost ' and unpaid, we end up having to retain an attorney to get paid at all."*
Transportation shortages Transportation has become problematic and reduced, which prevents clients from receiving needed therapies and care.	*"They will not pay for travel code T2003 even with the charge master. They will only pay for travel code S0215 and only pay mileage - not travel time and it is a fight and very difficult. Most of my clients are home bound and cannot drive"*
Code confusion	*"I would like to add in general there is much more billing issues where the billing companies coding invoices wrong, and I have to spend a lot more time calling insurance companies and billing companies to try to get paid and correct these issues."*

Inadequate insurance or DIFS help Providers are frustrated with the lack of help and communication with insurance companies or DIFS, including explanations regarding what services will be covered.	*"To date we've received 0 communication from any auto insurance carrier that we're waiting to be re-imbursed for services."*
Unable to accept no-fault auto patients	*"Since October 1, 2021, our organization has had to stop accepting auto insurance clients and it feels terrible to deny services to those individuals who truly need in-home care."*
More paperwork and longer wait Providers indicated they are spending more time completing paperwork and waiting for payments than they did prior to the changes.	*"It is more time-consuming and takes much longer."*
Stress Providers face increased stress in trying to work in the new system.	*"We are under stress and do not see consistency in reimbursements and fear that the insurance company will continue to target anyone that had a contract before the law change and leave them destitute."*
Out of businesses Providers have been unable to sustain the new changes and have had to close their companies altogether.	*"It forced us out of business, we could not find a way to absorb a 45% fee cut and provide services."*
Downsizing Providers indicated the changes led them to lay off staff or downsize their organizations to adjust for lack of reimbursement.	*"We have had to reduce staffing ratios, we cannot provide 1:1 service even though it is still needed, but the reimbursement is not enough to cover our costs for 1:1 staffing."*
Limited referrals The changes have caused some providers to have less referrals being submitted.	*"The fee schedule changes have impacted smaller providers by severely limiting referrals for services. We know of other providers in Northern Michigan that have not had new referrals in six months, and we have not had any new referrals in that time either."*

Fear for auto crash survivors' transition to nursing homes Providers indicated they did not feel auto crash survivors would transition well to living in nursing homes. Some even expressed survivors would die as a result.	*"The client has already/previously said she will run away, hitchhike somewhere, dies before she lives in a home."* *"Without the full no-fault reimbursement for ALL of my daughter's needs, she probably would have had to be in a nursing home, and I'm sure she would have been neglected & abused & would have lost her life very early on."*
Lack of company growth Providers indicated the changes stunted the growth of their companies.	*"I have to turn away care constantly, which affects my business growth, my therapists, my ability to hire and the quality of life of the patients."*

This project was funded by BIAMI.

The study was conducted by MPHI with assistance from BIAMI.

AFFIDAVIT OF JOHN G. PROSSER II

State of Michigan)

)

COUNTY of Oakland)

I, John G Prosser II, being first duly sworn, deposes and states as follows:

1. I am the Vice President and Partner of Health Partners Inc., a Michigan Medical Provider that specialized in rehabilitation homecare programs and private homecare solutions, for 29 years.
2. On June 30th 2021 Health Partners ceased providing services. We laid off 565 employees and stopped serving 100 patients who required 24 hour care by Nurses, or Home Health Aides.
3. Of the field staff, approximately 46 were family members of the patient and employed by Health Partners to provide attendant care services to their injured family member.
4. 100% of the services that Health Partners provided are were not compensable by Medicare. As of July 1st 2021 reimbursements for our services were capped at 55% of what Health Partners was charging for services on January 1st 2019, pursuant to the no-fault amendments, MCL 500.3157(7)
5. That 55% non-Medicare fee schedule was unsustainable and un-survivable for Health Partners.
6. I am an adult competent to testify and I can completely testify as to the facts contained in this affidavit and my statements are made voluntarily and I make this affidavit based on the personal knowledge of the statements contained herein

FURTHER AFFIANT SAYETH NOT.

John G. Prosser II

X

1/31/2023

Joseph Scanlon
Notary Public, State of Michigan
County of Oakland
My Commission Expires 01/04/2025
Acting in the County Of Oakland

AFFIDAVIT OF Brant L. Wilson

I, Brant L. Wilson, being first duly sworn, deposes and states as follows:

1. I am the CEO/President of The Lighthouse, Inc., a Michigan medical provider that specializes in brain injury rehabilitation.

2. As a result of the implementation of the fee structure on July 2, 2021, which caps reimbursement for services without a payable Medicare code to 55% of what The Lighthouse, Inc. charged as of January 1, 2019, the following has occurred to our RESIDENTIAL PROGRAM:

   a. **A loss in revenue** of approximately $7 million per year.

   b. **A change in an annual margin** of 10% since the fee structure was implemented.

   c. **A forecasted margin** of negative 16% (-16%) for FY 2022-23.

   d. **Loss of Jobs** due to lower admissions. We are currently down about 70 full time staff from before the law was enacted.

   e. Fewer admissions based on the cost of service being more than revenue received.

   f. **Decreased cash flow** (appx $2 Million dollars) due to increase in delayed payments that lead to costly and time-consuming litigation. Sometimes taking over a year to recoup payment for services provided.

   g. **Increased legal expenses** of the business in order to litigate reduced or delayed payments from auto insurance companies.

   h. **Day Programming services** were discontinued. Costs of operating the program were more than the reimbursement that was received. At the time the program was cut, 10 clients had their services stopped.

   i. **1:1 Ratio Staffing Services** were significantly reduced or eliminated and only utilized in the most extreme of circumstances where the health and well being of the client and staff would certainly be compromised if placed in group status. Reimbursement for these services were reduced to levels less than it cost to pay the 1:1 staff. 10 out of 15 clients had these services eliminated. 3 out of 15 were reduced in hours they received this service.

   j. **Hospital Staffing Services** – Discontinued providing staff to provide 1:1 care when residents are in the hospital due to no reimbursement from insurance companies. This has resulted in at least 3 residents returning from hospital stays with skin breakdown.

k. **Transportation services:** These services were reduced and limited in distance from the facility due to reimbursement levels. Family members are now charged for transportation for home visits.

l. **Therapy outings** – Scope, distance and duration of therapy outings had to be decreased due to program need to reduce expenses considering decreased program revenue.

m. **Admissions –** Potential admission calls as of October 2022 for year of 2022 were categorized as follows: (This does not include calls for CMH potentials)

- 6% resulted in admission
- 32% had no available funding for LH
- 12% declined due to not sufficient staff
- 6% declined because they needed 1:1 staffing
- 1% declined needed apartment
- 3% decline due to age
- 3% declined because accident was after 2019
- 9% declined due to rates or issues from auto insurance or MCCA
- 12% did not forward records
- 16% other

Currently we are assessing if an individual who has auto insurance was injured prior to June 11, 2019 or not. If they were injured after 2019, we will consider them for a brief admission (1-2 months) if they are from the local community. All other potentials who were injured after 2019 we are declining.

Comparison data from 2020: 16% of potential calls resulted in admissions.

Changes to the auto law also resulted in increased time from date of inquiry to actual admission due to the fact that case managers had to gather market survey fee schedules from 3-5 other providers to submit to the MCCA. They then had to wait for pre-approval from the MCCA as well as the rate the MCCA would agree to pay for the potential client's stay at The Lighthouse.

3. If there is no permanent change made to the government imposed reimbursement cap for non-payable Medicare codes, The Lighthouse, Inc.'s residential program will not be able to sustain its ability to serve people funded by Michigan auto insurance within the next 12 months.

4. I am an adult competent to testify and I can completely testify as to the facts contained in this Affidavit. I have read the contents of this Affidavit and my statements are made voluntarily and I make this Affidavit base upon the personal knowledge of the statements contained herein.

FURTHER, AFFIANT SAYETH NOT.

11-7-22

Brant L. Wilson

ROBERT HARRISON
Notary Public, State of Michigan
County of Tuscola
My Commission Expires Jul. 04, 2028
Acting In the County of Tuscola

Subscribed and sworn before me on this 7th date of ~~October~~ November, 2022.

Notary Public Robert Harrison

origami REHABILITATION

AFFIDAVIT OF ORIGAMI REHABILITATION

I, Jennifer Muckey, being first duly sworn, deposes and states as follows:

1. I am the Director of Operations of Origami Rehabilitation, a Michigan medical provider that specializes in neurological rehabilitation. Origami Rehabilitation is a CARF accredited, 501(c)(3) non-profit organization based in Lansing, MI. Origami provides comprehensive post-acute rehabilitation for children, adolescents, and adults with neurological, developmental, mental health, and orthopedic conditions through their residential and outpatient programs. Since opening in 1997, Origami has served nearly 3000 individuals and their families throughout the mid-Michigan area.

2. As a result of the implementation of the auto no-fault (ANF) reform fee structure on July 2, 2021, which caps reimbursement for services without a payable Medicare code to 55% of what Origami Rehabilitation charged as of January 1, 2019, the following has occurred to Origami's residential program:
    a. As a non-profit organization, Origami Rehabilitation is governed by two parent organizations, Michigan State University and Peckham, Inc. This organizational structure has afforded Origami additional time to continue business operations under the ANF reform compared to for-profit post-acute rehab providers. Where some for-profit businesses have had to close, merge, or be acquired to protect the great financial losses resulting from the ANF reform, Origami's board of directors approved a projected 2022 budget loss of -11.5% ($765,000 loss). As of October business, Origami is on track for a -12.3% margin ($789,000 loss).

    Origami's revenue for program services decreased by 21% from 2021 to 2022 due to ANF reform, which is a loss in revenue of $1,315,790.

    Of note, Origami received $1.1M in COVID relief grant funds which improved the bottom line in 2022. This is not regenerating revenue. Without this financial help in 2022, the loss due to ANF reform would have been $1,888,619 (-29.6% margin).

    b. Revenue: Origami's revenue structure contains 4 lines of business: Residential, Outpatient, Fundraising/Grants, and Miscellaneous Income. The residential program has historically been the largest revenue producing line of business, making up 46% of the total budget in 2021 (outpatient 40%, miscellaneous 11%, fundraising/grants 3%).

Due to the residential program contributing to most of Origami's revenue and the reimbursement cuts to this specific line of business since the ANF reform, Origami is no longer a sustainable business. This is noted within the 2020 financial review from Origami's auditor's Maner Costerisan with the footnote: *"The majority of the Organization's program service revenues for 2020 and 2019 are from insurance companies under Michigan Auto No-Fault personal injury protection. In May of 2019, the Legislature in the State of Michigan passed a bill that significantly changed insurance coverage for Auto No-Fault claims. The approved bill was signed by the Governor on May 30, 2019. If carried out in its current state, it would have a material impact on how the Organization is able to treat some of its current and future clients effective July 2021".*

c. Expenses: Origami's expenses are comprised of 3 primary categories: Employment Expenses, Contractual Expenses, and Operational Expenses. In 2021 and 2022, Origami's employment expenses made up 66% of total expenses, with 4% contributed to contractual expenses, and the remaining 30% contributed to operational expenses such as utilities, facilities, information systems, and depreciation.

   To recruit and retain the bulk of Origami's workforce within 2021, Origami had to increase the starting wages by 19% for entry level direct care positions ($12.50/hour starting wage increased to $14.25/hour). Origami evaluates employment compensation for all positions annually to ensure wages remain fair and competitive using sources such as the Bureau of Labor Statistics.

d. A change in an annual margin of 11.7% 5-year average to 1.8% in 2021 and a projected -12.3% in 2022.

e. A forecasted margin of -35.8% (loss of $1,939,477) for FY 2022-23 if the Andary decision is not upheld by the Michigan Supreme Court.

f. To sustain operations through 2022, Origami had to restructure the residential program and the results of that restructure are as follows:
   i. Discontinue 1:1 community outings provided by Origami staff.
   ii. Transition all community-based services to onsite as available (salon, podiatry, primary care, etc.)
   iii. Medical appointments beyond 30 miles and/or longer than 60 minutes requires non-Origami transport and support.
   iv. No longer able to serve individuals who need intensive medical oversight and 1:1 levels of supervision.
   v. Discontinuation of job coaching services.
   vi. Reduced staffing ratios for residential homes.
   vii. Wage freeze for all senior leadership positions.

viii. Discontinuation of employee related Wellness Committee initiatives.
ix. Discontinuation of house stock medical items and require direct purchase by clients (pharmacy, durable medical equipment, etc.).
x. Discontinuation of community-based clinical services for outpatient clients.
xi. Reduction of supplies for therapeutic recreational treatment activities.
xii. Discontinuation of CARF accreditation for vocational and home & community-based services.
xiii. Elimination of 16.8 FTE positions (direct care staff, rehabilitation aides, Human Resources Assistant, Residential Care Coordinator).

g. This impacts access to care. Without access to rehabilitation programs like Origami, individuals are forced into compromising options including:
   i. Residing at a nursing home that lacks brain injury specialty and experience
   ii. Residing at a non-skilled adult foster care group home
   iii. Residing at home without proper supervision needs for the individual's (and perhaps community) safety and well-being

3. If there is no permanent change made to the government-imposed reimbursement cap for non-payable Medicare codes, Origami's residential program will not be able to sustain its ability to serve people funded by Michigan auto insurance beyond 2023.

   Origami's leadership team and board of directors has been working on a pivot and sustain plan to continue Origami's business and mission beyond 2023. This plan contains several potential initiatives and financial scenario projections including additional lines of business serving adults with autism, hospice, and continued expansion of the Outpatient Program. All financial projections have not been sustainable to continue operations while maintaining quality, safety standards necessary to serve these populations.

   Without a fix to the fee cuts to the residential program, Origami's continuum of care is unable to continue operations beyond 2022.

   In summary, Origami's ability to continue serving through 2022 is due to the non-profit status and the support from the board of directors to use the cash reserve and the addition of a line of credit of $1,000,000 to support operations in hope of a legislative change to fix the erroneous errors and consequences from the 2019 ANF reform. Without a fix to the 45% reimbursement cut under the reform, Origami's operations will cease to exist beyond 2023.

4. I am an adult competent to testify and I can completely testify as to the facts contained in this Affidavit. I have read the contents of this Affidavit and my statements are made voluntarily and I make this Affidavit based upon the personal knowledge of the statements contained herein.

FURTHER, AFFIANT SAYETH NOT.

Jennifer Muckey, Director of Operations

Subscribed and sworn before me on this 21st date of October 2022.

Notary Public

SHELLEY SANBORN
Notary Public - State of Michigan
Ingham County
My Commission Expires Jan 1, 2023
Acting in the County of Ingham