Michigan

Michigan - HB 4502

Sponsor: Representative Luke Meerman (R)

Actions: 03/11/2021 Introduced; Referred to House Health Policy Committee

Summary: Summary

This bill clarifies that a cardiac catheterization service does not include outpatient services for which the federal centers for medicare and medicaid services have approved a procedural terminology code as an outpatient service.

This bill amends MCL 333.22203. This bill makes certain technical amendments to the statutory language. This bill clarifies that a cardiac catheterization service does not include outpatient services for which the federal centers for medicare and medicaid services have approved a procedural terminology code as an outpatient service.

Bill Links 3/11/2021 Version

Michigan - HB 4862

Sponsor: Representative Luke Meerman (R)

Actions: 05/27/2021 Hearing held
05/18/2021 Introduced; Referred to House Health Policy Committee

Summary: Summary for 5/18/2021 Version

This measure provides that a person may provide positron emission tomography scanner services without obtaining a certificate of need if the services are provided by one or more different fixed scanners.

This measure takes effect 90 days following enactment.

Bill Links 5/18/2021 Version

Michigan - HB 5074

Sponsor: Representative Bronna Kahle (R)

Actions: 10/28/2021 Hearing held; passed committee
10/14/2021 Hearing held
06/22/2021 Introduced; referred to the House Committee on Health Policy

Summary: Summary for 6/22/2021 Version

This measure directs the Michigan Public Health Advisory Commission to make all revisions to certificate of need review standards available to the public within 30 days before conducting a hearing.

Within 30 days following a public hearing, the Commission chairperson must submit the proposed final action to the governor and each member of the joint committee along with all written and recorded public testimony.

Bill Links 6/22/2021 Version

Michigan - HB 5075

Sponsor: Representative David LaGrand (D)

Actions:
10/28/2021 Hearing held; passed committee
10/14/2021 Hearing held
06/22/2021 Introduced; referred to the House Committee on Health Policy

Summary: Summary for 6/22/2021 Version

This measure directs the Public Health Advisory Commission to establish a joint committee to review the certificate of need program and standards.

The joint committee must hold an annual hearing to review; action taken in the preceding year, proposed actions, impact on access to health care, and any other relevant information.

Bill Links 6/22/2021 Version

Michigan - HB 5076

Sponsor: Representative Andrew Beeler (R)

Actions:
10/28/2021 Hearing held; passed committee
10/14/2021 Hearing held
10/12/2021 Hearing held
06/22/2021 Introduced; referred to the House Committee on Health Policy

Summary: Summary for 6/22/2021 Version

This measure directs the Public Health Advisory Commission to conduct an annual review on the state certificate of need standards.

Reports developed by the Commission must be made publicly available within 7 days of presentation to the Commission.

Bill Links 6/22/2021 Version

Michigan - HB 5077

Sponsor: Representative Sara Cambensy (D)

Actions:
10/28/2021 Hearing held; passed committee
10/14/2021 Hearing held
06/22/2021 Introduced; referred to the House Committee on Health Policy

Summary: Summary for 6/22/2021 Version

This measure establishes rules for which the Michigan Public Health Commission must adhere to while developing standards for certificate of need.

This measure does not include an effective date.

Bill Links 6/22/2021 Version

Michigan - SB 12

Sponsor: Senator Dale Zorn (R)

Actions:
03/23/2021 Hearing held: passed committee; referred to Senate Committee of the Whole
03/18/2021 Hearing held
03/11/2021 Hearing Held
01/13/2021 Introduced; referred to Senate Health Policy and Human Services Committee

Summary: Summary for 1/13/2021 Version

This measure amends Michigan Public Health Code to require a certificate of need for cardiac catheterization services.

This measure applies to the certificate of need requirements for cardiac catheterization services.

This measure clarifies that cardiac catheterization service does not include outpatient services, for which the Centers for Medicare and Medicaid have approved a current procedural terminology code as an outpatient service.

Cardiac catheterization services are considered covered services, under this measure, except as modified by the Certificate of Need Commission.

This measure does not provide any enforcement mechanisms or an effective date.

Bill Links 1/13/2021 Version

Michigan - SB 181

Sponsor: Senator Curt VanderWall (R)

Actions:
03/24/2021 Passed Senate; Referred to House Health Policy Committee
03/23/2021 Passed committee
03/18/2021 Hearing held
02/24/2021 Introduced; referred to Senate Health Policy and Human Services Committee

Summary: Summary for 2/24/2021 Version

This measure amends statute to modify the definitions of "change in bed capacity", "covered capital expenditure", and "covered clinical service".

This measure is applicable to certificate of need.

This measure amends "change in bed capacity" to no longer include an increase in licensed psychiatric beds.

This measure amends "covered capital expenditure" to go from $2,500,000 to $10,000,000.

This measure amends "covered clinical service" to include air ambulance services until June 1, 2021.

This measure does not take effect unless SB 182 and 183 are enacted.

Bill Links 2/24/2021 Version

Michigan - SB 247

Sponsor: Senator Curt VanderWall (R)

Actions:
03/03/2022 Hearing held
04/29/2021 Passed Senate; Referred to House Health Policy Committee
04/27/2021 Hearing held; substituted; passed committee
04/22/2021 Hearing held
03/16/2021 Introduced; referred to Senate Health Policy and Human Services Committee

Summary: Summary for 3/16/2021 Version

This measure amends the Michigan Insurance Code to make changes to requirements for prior authorization and step therapy protocols.

This measure applies to insurers, utilization review organizations, and providers.

Prior Authorization
This measure states that the prescription drug prior authorization workgroup is required to develop a standard methodology for use by prescribers to request and receive prior authorization from an

insurer if a health insurance policy requires prior authorization for prescription drug benefits. This measure amends code to require the Department of Health and Human Services to work with the Department of Insurance and Financial Services.

This measure provides that for an insurer that delivers, issues for delivery, or renews a health insurance policy in this state, if the health insurance policy requires prior authorization for any benefit, the insurer or its respective utilization review organization shall post its current prior authorization requirement noticeably and readily accessible on the insurer's public website. The posted prior authorization requirements must be described in detail, written in easily understandable language, and readily available to the health provider at the point of care. Further, the measure requires the prior authorization requirements to be based on peer-reviewed clinical review criteria, as outlined in this measure The measure states that prior to establishing the clinical review criteria, an insurer or utilization review organization must obtain input from actively practicing physicians who represent major areas of the specialty, are within the provider network, and are within the service area where the criteria are to be employed. The bill further provides that at least annually, insurers must make statistics regarding prior authorization available on the insurer's public website in a readily accessible format, and as specified in this measure.

Additionally, health insurers, by January 1, 2022, are required to make available a standardized electronic prior authorization request transaction process utilizing a web-based system. Beginning January 1, 2022, an insurer or their designee utilization review organization, is required to use only a standard electronic prior authorization transaction process unless a health professional is not able to use it because of a temporary technological or electrical failure.

This measure conditions that if an insurer either intends either to implement a new prior authorization requirement or restriction or amends an existing requirement or restriction, the insurer must ensure that the new or amended requirement is not implemented unless the insurer's public website has been updated to reflect the new or amended requirement or restriction. Additionally, in this case, the measure requires that the insurer must provide contracted health care providers with written notice of the new or amended requirement or restriction no less than 60 days before the requirement or restriction is implemented. The measure also conditions that insurers must adopt a transparent program, developed in consultation with health care providers participating with that insurer, that promotes the modification of prior authorization requirements based on the performance of the health care providers with respect to adherence to evidence-based medical guidelines and other quality criteria.

This measure states that a prior authorization request that has not been certified as urgent by the health care provider will be considered to have been granted by the insurer or its designee utilization review organization if the insurer fails to grant the request, deny the request, or require additional information of the health care provider within 48 hours after the time of the submission. If additional information is requested by an insurer or its designee utilization review organization, a prior authorization request under this subsection is not considered granted if the health care provider fails to submit the additional information within 48 hours after the time of the original submission of a prior authorization request under this section. If additional information is requested by an insurer or its designee utilization review organization, a prior authorization request is considered to have been granted by the insurer if the insurer fails to grant the request, deny the request, or otherwise respond to the request of the health care provider within 48 hours after the time of the submission of additional information. For urgent prior authorization requests certified by a health care provider, such requests will be considered to have been granted by the insurer or its designee utilization review organization if the insurer fails to grant the request, deny the request, or require additional information of the health care provider within 24 hours after the time of the submission. Any prior authorization request granted under the aforementioned circumstances will be valid for 1 year or until the last day of coverage, whichever occurs first.

This measure states that prior authorization requirements must be based on peer-reviewed clinical review criteria. The criteria must be developed by either an entity that works directly with clinicians to develop the clinical review criteria, an entity that does not have a financial stake in the outcome of the clinical care decisions made using the criteria, or a professional medical specialty society. The clinical review criteria must be publicly available free of charge.

The measure removes language stating that a prior authorization request that has not been certified for expedited review by the prescriber is considered to have been granted by the insurer if the insurer fails to grant the request, deny the request, or require additional information from the prescriber within 15 days of the request. Additionally, language is removed stating that a prior authorization request that has been certified for expedited review by the prescriber is considered to have been granted by the insurer if the insurer fails to grant the request, deny the request, or require additional information within 72 hours of the request.

Adverse Determination Decisions

For a health care service provided by a health professional not licensed to engage in the practice of medicine, or osteopathic medicine and surgery, the physician may consider input from a health professional who is in the same profession as the health professional providing the health care service. The physician will make the adverse determination under the clinical direction of 1 of the insurer's medical directors who is responsible for the provision of health care items and services provided to insureds or enrollees.

Additionally, this measure states that an adverse determination of a prescription drug benefit is required to have been made by a licensed pharmacist.

If an insurer denies a prior authorization, the insurer or its designee utilization review organization must, upon issuing the denial, notify the health professional of the reasons for the denial and related evidence-based criteria. The measure provides that an appeal of the denial must be reviewed by a physician, under which certain conditions apply.

Step Therapy

This measure prohibits an insurer from doing any of the following:

1. Requiring the insured's or enrollee's physician to participate in a step therapy protocol if the physician considers that the step therapy protocol is not in the insured's or enrollee's best interest;
2. Requiring the insured's or enrollee's physician to obtain a waiver, exception, or other overrides before the physician makes a determination; or
3. Sanctioning the insured's or enrollee's physician for recommending or issuing a prescription, performing or recommending a procedure, or performing a test that may conflict with the insurer's step therapy protocol.

This measure does not provide an effective date.

Bill Links 4/29/2021 Version
3/16/2021 Version