Care for the **Common Good**

Ensuring Fair Coverage for Medicare Advantage Members

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation, serving diverse communities across 27 states. We advocate for public policies that promote care for the common good and advance our mission, including fair payment, a strong workforce, coverage for all that bridges social care, and total cost of care payment models.

Challenges to Ensure Fair Coverage for Medicare Advantage Members

More than 50% of Medicare beneficiaries are enrolled in a Medicare Advantage (MA) plan, an increase of 26% since 2010. The concentration of MA enrollment is in a few large for-profit plans. United Healthcare, Humana, and CVS Health had 58% of all MA enrollees in 2023.[1] Notably, these plans reported profits in the hundreds of billions of dollars in fiscal year 2023[2]; with profits from these plans coming at a cost to patients and providers through utilization controls, low reimbursement, and payment denials. Given the continued rapid growth and proportion of the Medicare market, policymakers must ensure MA plan guidelines allow patients to access necessary care, improve health outcomes, and reimburse providers fairly.

Many Medicare advantage plans restrict access to health care by abusing utilization management programs and refusing payment of eligible services provided to Medicare beneficiaries. Prior authorization is an example of one widely used practice that results in delayed or denied patient care, delayed discharge to post-acute care, and impacts patient safety. MA beneficiaries are more likely to report delays in care (22%) compared to those in traditional Medicare (13%).[3]

It doesn't have to be this way. Trinity Health owns a non-profit, mission-focused MA plan—MediGold—that plays a vital role in our integrated delivery network and provides care coordination for patients while using fair practices. MediGold is a highly-effective best practice plan model.

MediGold has a lower profit margin and lower administrative costs compared to commercial for-profit plans because they say "yes" more to providers and beneficiaries. In addition, MediGold utilizes standard and transparent guidelines for decisions on precertification and other authorization approval processes, removing ambiguity of guidelines for providers.

MediGold has Fair Practices and Provides Quality Care

- Top 20% nationally in federal star quality rating.
- Neary 90% medication adherence for Medicare beneficiaries who have diabetes, hypertension and/or high cholesterol.
- Federal surveys of members indicate:
  - 92% favorable rating of MediGold.
  - 86% report getting needed care.
  - 89%favorable of quality of health care received.
  - 88% report positive care coordination.
  - 92% obtain needed prescriptions.

MediGold limits the services that require prior authorization (for example, no prior authorization is required for contracted radiology and contracted skilled nursing facility care) and exceeds all federal turnaround time requirements for utilization management decisions.[4] In fact, patients report 100% timely decisions on appeals.[5] For services that require prior authorization, MediGold has fewer denied claims than for-profit MA plans. Not only has MediGold differentiated themselves from for-profit MA plans; they have done so while maintaining high quality scores and strong beneficiary satisfaction.

Inappropriate prior authorization and payment denials by for-profit MA plans restrict or delay patient access to care and contribute to health care provider burn out. Further, such utilization and payment tactics drive our nation's health care costs

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[1] MedPAC, Medicare Advantage Program: Status Report 2024 https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf.

[2] Fierce Healthcare: Medicare Advantage Headwinds Didn't Prevent Payers from Turning a Profit in 2023 https://www.fiercehealthcare.com/payers/medicare-advantage-headwinds-didnt-prevent-payers-turning-profit-2023.

[3] Commonwealth Fund: What do Medicare Beneficiaries Value About Their Coverage?, 2024 What Do Medicare Beneficiaries Value About Their Coverage? | Commonwealth Fund

[4] eCFR :: 42 CFR 422.568 -- Standard timeframes and notice requirements for organization determinations.

[5] Results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, a patient experience survey by the Centers for Medicare and Medicaid Services.

up and add burden to the health care system. The Centers for Medicare and Medicaid Services (CMS) has started to address some of these challenges through regulation in recent years, but more can be done.

Problematic reimbursement/coverage, delays and denials from MA plans include:

- Excessive, unreasonable requests for documentation (insurers are not always clear or transparent about what documentation is required when initial claims are filed).
- Failure to provide prior authorization when necessary to prevent harm and care for patients, leading to delays in care.
- Observation status and short-stay denials are rendered even when clinical indicators meet the standards for inpatient level of care.
- Reimbursement for sepsis that is inconsistent with standard coding and diagnosis, and not reimbursing for early-stage care that can prevent exacerbation of medical conditions.
- Consistently inaccurate enrollment files based on payer error.
- Utilization management and implementation of new policies to delay payment.

What Can Policymakers Do?

Standardize Utilization Management Requirements and Processes:

- Standardize services that should not require prior authorization, including skilled nursing facility stays.
- Standardize the format and content for prior authorization requests and responses for emergency and continued stay claims.
- Set standard guidelines for payment denials for continued stay.
- Require 7-day prior authorization capabilities by insurers for inpatient stays when providers are out of network.
- Decrease turnaround time requirements from 14 calendar days to 5 for patients discharging to next site of care.
- Require full and complete denials in writing.
- Standardize appeals process with dedicated timeframe with the opportunity for external review.

Increase Oversight of Insurers to Stop Inappropriate Payment Delays and Denials:

- Increase frequency of insurer audits for poor-performing MA plans.
- Implement penalties for inappropriate denials, reimbursement delays, and for noncompliance with performance thresholds.
- Increase monitoring of timely payment and increase penalties if plans fail to comply with prompt pay requirements outlined in 42 CFR §422.520.
- Publish performance data to compare insurers.
- Require insurer policies to be standardized, transparent, and effective at the start of a plan year, including information required from providers for reimbursement.
- Require insurers to appropriately reimburse for sepsis in a manner consistent with the CMS quality measure.
- Enforce existing regulations including the 2023 regulation that addresses plan marketing criteria and the 2024 regulation that improved the prior authorization process.

Expand Medicare Advantage Participation in Value-Based Payment Arrangements with Providers:

- Require Medicare Advantage plans to enter into contracts for value-based payment arrangements directly with providers and give providers accountability for total cost of care and outcomes.