Care for the Common Good

Ensuring Fair Coverage for Patients and Providers

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 Practices for Patients and Providers and Addressing Barriers to Payment

Two-thirds of the U.S. population receives health benefits from a private sector health insurance plan. Employers—and the Medicare and Medicaid programs—rely on private health plans to administer their health benefits. Approximately one-third of Medicare beneficiaries are enrolled in a private Medicare Advantage (MA) health plan, and nearly all states enroll some or all of their beneficiaries into Medicaid managed care plans. As such, legislators should provide oversight to ensure commercial insurance plan practices are fair, efficient and improve patient health outcomes.

Patient care should be top priority. Unfortunately, too often health insurers restrict access to health care services by abusing utilization management programs and changing health plan rules and coverage in the middle of a contract year. Prior authorization is an example of one widely-used practice by health insurers that results in delayed patient care, delayed discharge to a setting with more specialized care, and impacts patient safety.

A 2021 survey by the American Medical Association of more than 1,000 physicians found that more than one-third (34%) of physicians reported that prior authorization led to a serious adverse event, such as hospitalization, disability, or even death, for a patient in their care. Also, more than nine in ten physicians (93%) reported care delays while waiting for health insurers to authorize necessary care, and more than four in five physicians (82%) said patients abandon treatment due to authorization struggles with health insurers.[1]

There is significant industry variation in submission processes, standard treatments, documentation requirements and definitions of medically necessary care. In addition, some insurers require calls with the clinical team, often referred to as "peer-to-peer" increasing the burden to short-staffed providers. As a result, patients may wait days for medically necessary procedures, treatments or prescriptions.

Trinity Health's Experience with Egregious Insurer Practices

- Prior authorization requirements are routinely used to delay critical care.
- Administrative burden associated with commercial plan denials costs Trinity Health $10 million per month.
- 8% to 10% of Trinity Health's total hospital encounters are routinely denied on first submission.
- Requirement to submit excessive documentation is top reason for payment denial.
- Trinity Health pursues 80% to 90% of denied claims (re-submission, correction or appeal), but it is too costly to pursue all.
- Documentation denials are almost always eventually approved.
- Clinical denials require an arduous appeal process with success 55% to 65% of the time; yet creates unnecessary burden.

A recent U.S. Department of Health and Human Services Office of Inspector General report concluded MA plans have a pattern of denying prior authorization and payment requests that meet Medicare coverage and billing rules. The report also affirms the findings of the Centers for Medicare and Medicaid Services' (CMS) annual audits of MA plans and highlights "widespread and persistent problems related to inappropriate denials of services and payment."[1]

There are also examples of member-centered health insurers that use fair practices. The MA plan managed by Trinity Health "MediGold" plays a vital role in our integrated delivery network and provides key care coordination for our patients. MediGold utilizes industry standard and transparent guidelines for many decisions on precertification and other authorization approval processes, removing ambiguity of guidelines for providers. Consistent, transparent, industry standard practices are best for patients, providers and taxpayers.

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[1] American Medical Association, "2021 AMA Prior Authorization (PA) Physician Survey." Accessed at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

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Problematic reimbursement/coverage, delays and denials 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 patient, leading to delays in care.
- Observation status and short-stay denials even when clinical indicators meet standards for c inpatient level of care.
- Reimbursement for sepsis that is inconsistent with standard coding and diagnosis so as to not reimburse for early-stage care.
- Site of service exclusions for coverage of emergency care and diagnostic testing.
- Inaccurate enrollment files based on payer error.
- Utilization management and implementation of new policies to delay payment.

Insurers Reap Hidden Fees by Slashing Payments. You May Get the Bill
New York Times, April 7, 2024

Excerpt: In some instances, the fees paid to an insurance company and MultiPlan for processing a claim far exceeded the amount paid to providers who treated the patient. Court records show, for example, that Cigna took in nearly $4.47 million from employers for processing claims from eight addiction treatment centers in California, while the centers received $2.56 million. MultiPlan pocketed $1.22 million.

Inappropriate prior authorization and payment denials 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 up and add burden to the health care system.

Working together, insurers and providers can be expected to deliver value-based care to all. This requires risk-based contracting with Medicare, Medicaid and commercial insurers to enable meaningful health improvements and sustainable cost savings without compromising quality of care or access.

What Can Policymakers Do?

Prior Authorization Recommendations:

Standardize Prior Authorization Requirements and Processes:

- Set standard guidelines for prior authorization.
- Standardize the format for communicating services subject to prior authorization.
- Standardize the format and content for prior authorization requests and responses.
- Require 24/7 prior authorization capabilities by insurers.
- Establish standard timelines for responses by insurers.
- Require full and complete denials in writing.
- Standardize appeals process with opportunity for external review.

Reimbursement Delays and Denials Recommendations:

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

- Set standard guidelines for payment denials.
- Implement financial penalties for inappropriate denials.
- Test provider network adequacy.
- Publish performance data to compare insurers.
- Increase frequency of insurer audits.
- Increase oversight to determine insurers that are exceeding established standard performance.
- Impose penalties for insurers not in compliance with standard performance thresholds.
- Require insurer policies and utilization management programs to be standardized and transparent, including information required from providers, and be effective at the start of a plan year.
- Require insurers to appropriately reimburse for sepsis in a manner consistent with the CMS quality measure.