

MaineHealth

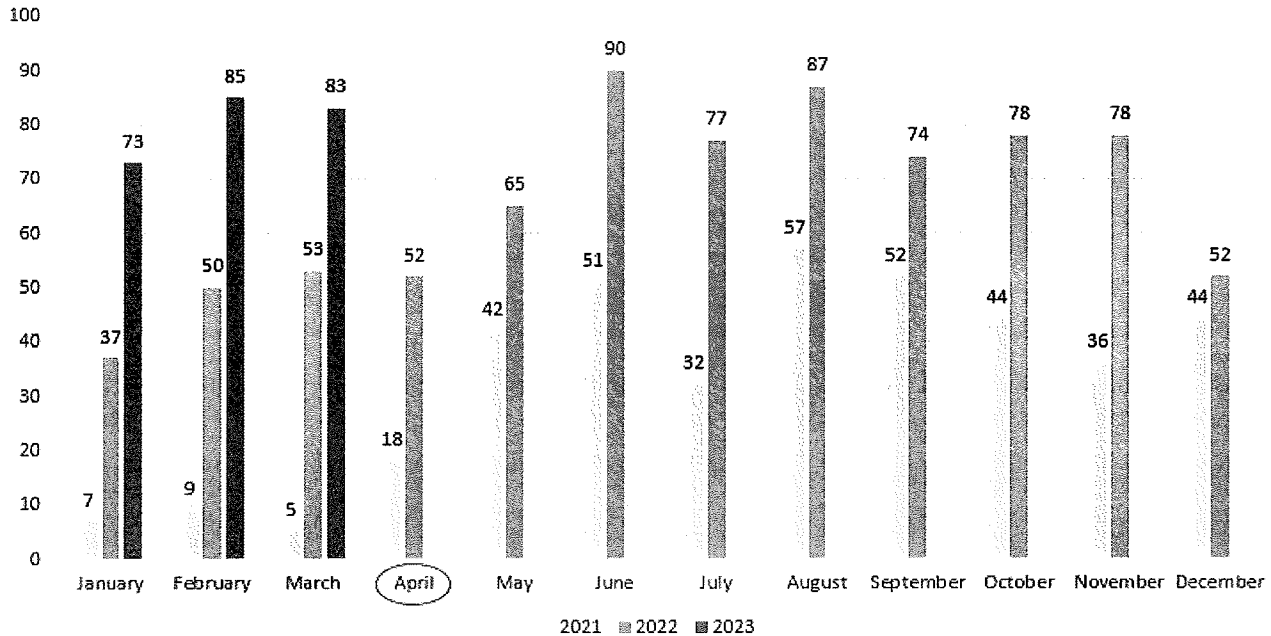
**Testimony of Ed Kimlin, MD
In Strong Support of LD 1407
“An Act to Amend the Maine Insurance Code Regarding Payments by Health
Insurance Carriers to Providers.”
April 24, 2024**

Senator Bailey, Representative Perry and members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services, I am Ed Kimlin MD, a physician from MaineHealth specializing in emergency medicine and with extensive inpatient utilization review experience. I am here to testify in strong support of LD 1407, “An Act to Amend the Maine Insurance Code Regarding Payments by Health Insurance Carriers to Providers.” This bill will take an important step towards creating a level playing field between health care providers and health insurance carriers in Maine.

The overarching concept of groups agreeing to contractual terms following private negotiations transcends healthcare policy and clinical medicine. With that said, the promotion of this concept has direct application to clinical scenarios that impact patients and providers throughout the state of Maine. This bill will help protect the fragile foundation supporting Maine’s health care providers – and the patients they serve – by providing a balanced process for making policy changes between contract negotiations. Accordingly, this testimony focuses on unilateral carrier policy changes that proved damaging to patients and hospitals in Maine.

In April 2021, a major health insurance carrier transitioned from MCG™ to InterQual™ as its hospital utilization review criteria vendor. Following this transition, that carrier’s inpatient denials spiked across the MaineHealth system and continued to rise through 2022 and 2023 with estimated associated financial losses exceeding \$3 million during that period:

MH IP Denials by Carrier X: 2021-2023



Of note, inpatient admission denials reduce hospital reimbursement while also withholding inpatient benefits from plan members, thereby potentially increasing out of pocket expenses to patients and risking patient financial liability for uncovered hospitalizations. When this carrier's leadership was asked about the change in denials frequency the leaders cited the use of InterQual™ criteria as the most likely root cause. The carrier clinical leadership explained that the carrier's medical directors switched to InterQual™ criteria as their guide in approving or denying inpatient admission requests from hospitals **notwithstanding express guidance from InterQual™ warning against this practice:**

InterQual® Level of Care Criteria

Acute Criteria Review Process

Important: The Criteria reflect clinical interpretations and analyses and cannot alone either resolve medical ambiguities of particular situations or provide the sole basis for definitive decisions. **The Criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient.**

Following this policy implementation, a member covered by this carrier was admitted to a MaineHealth hospital and ultimately died on Day 14 of that hospitalization. Unfortunately, her inpatient admission was denied for coverage by the carrier. Moreover the denial was upheld during a peer to peer appeal discussion between a MaineHealth physician (myself) and the carrier medical director, and also following urgent escalation of the case to the carrier's supervising medical director. The carrier's clinical leadership maintained that the patient's two-week hospitalization for a fatal infection (e.g. acute cholangitis) that led to several other serious issues (e.g. acute heart attack, acute heart failure, acute rhabdomyolysis, acute electrolyte disturbances and acute encephalopathy) did not meet InterQual™ criteria for inpatient admission. Accordingly, the hospital was offered observation reimbursement for the care provided while the patient's estate remained potentially

liable for the cost of her hospitalization. In this case, InterQual™ clearly failed as tool on which to base a final inpatient denial determination.

In August 2021 another large health insurance carrier enacted a policy that allowed for automatic down coding of emergency department reimbursements based solely on the presence of a “single non-complex diagnosis” found in combination with higher acuity level four or level five evaluation & management (“E/M”) codes. Although clinical documentation review is the cornerstone of E/M coding validation this policy unilaterally removed that critical step from the process. MaineHealth formally objected to this policy in October 2021 noting that the carrier’s justification for down coding (e.g. “coding criteria is not met”) cannot be determined by a review of the claim form in absence of clinical documentation. Ultimately, the carrier disregarded MaineHealth’s objection and implemented the policy in January 2022 thereby circumventing a fair and reasonable negotiation process.

In summary, this bill would ensure that providers have the opportunity to understand the impact of material policy changes, such as those made by these carriers, as well as a system for appealing them. The aforementioned examples highlight the types of unilateral policy changes being adopted by health insurance carriers. Based on my experience as a physician I urge the Committee to support LD 1407 to ensure a level playing field between health care providers and health insurance carriers in Maine.

Thank you, and I am happy to answer any questions.