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Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

COMMENTS OF THE MAINE HOSPITAL ASSOCIATION

In Support Of

LD 1407 – *An Act to Amend the Maine Insurance Code Regarding Payments by Health Insurance Carriers to Providers*

April 19, 2023

Senator Bailey, Representative Perry and members of the Heath Care, Insurance and Financial Services Committee, my name is Jeffrey Austin and please accept these comments in support of LD 1407 on behalf of the Maine Hospital Association.

I am happy to answer any questions on any section of the bill, but I would like to use my 3 minutes to discuss section 3.

I hear about this carrier issue more than any other. By far.

Some carriers insist on having a provision in their contracts that allows them to materially change the contract at any time, with 90-days notice.

Who signs a contract that allows the other side to unilaterally change the terms? Apparently, hospitals do.

I don't like asking you to intervene in contract disputes. However, we are not asking that you take our side on a substantive contract provision. But, whatever contract terms we agree to, they shouldn't be unilaterally changed by one party to the contract.

This one issue is threatening relationships between our members and carriers. If a carrier insists on a contract term such as this, our only choice in such a situation is to walk away from the contract.

That happens everyday in business when the parties can't agree to terms.

Yet, when Maine Med tried that with Anthem, this committee didn't like it and demanded a public hearing on the dispute.

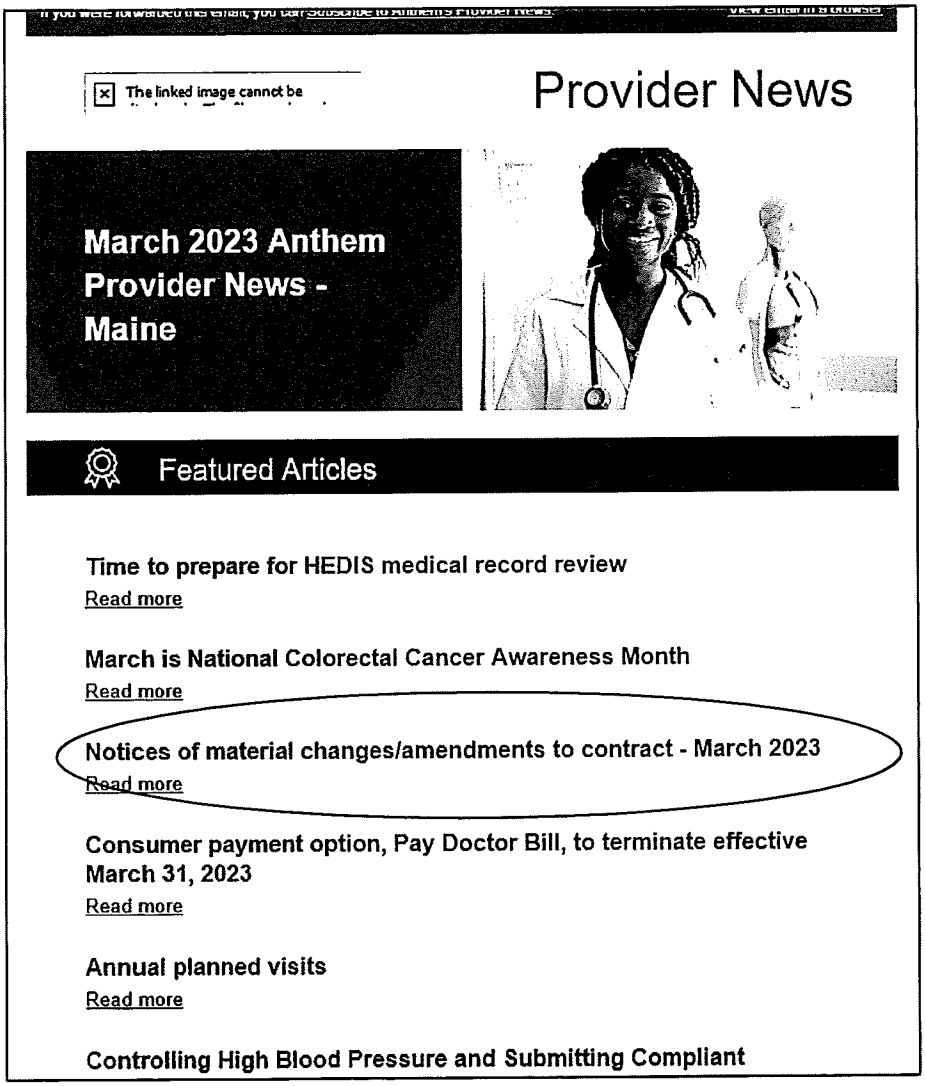
We think it is in the public interest to avoid these stand-offs. This bill is a very modest effort to avoid these disputes.

I want to highlight one aspect of the process of making these unilateral changes that our members find cynical on the part of carriers.

Carriers don't really inform providers of what the policy changes are.

Attached is an example of what Anthem provides to our membership.

You get an email notifying you that a number of policy changes are being made.



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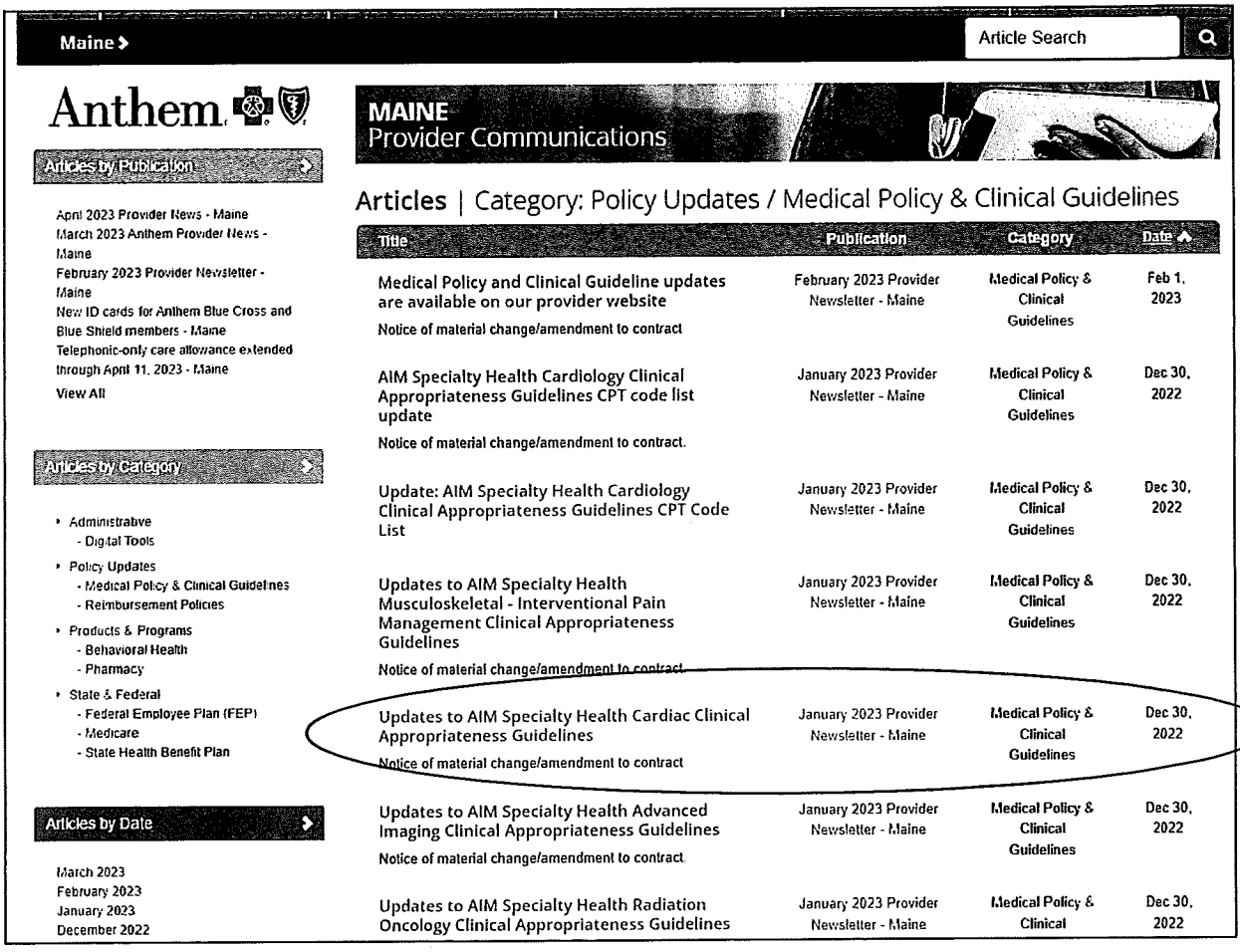
When you click through you see a list of changes to the contract. Some months there are no changes, other months there are a lot. There is no rhyme or reason to the pattern of changes.

But the real challenge is actually determining what the changes are.



Some changes, like CPT updates, are generally no a big deal. But other "policy" changes basically determine when medical providers are allowed to conduct certain tests or procedures.

When you click what is circled, a page opens with following bulleted list:

Effective for dates of service on and after April 9, 2023, the following updates will apply to the *AIM Specialty Health.* Cardiology Clinical Appropriateness Guidelines. As part of the AIM guideline annual review process, these updates are focused on advancing efforts to drive clinically appropriate and affordable healthcare services.*

Cardiac Imaging — Updates by section
Stress testing with imaging:

- *Suspected coronary artery disease (CAD) without symptoms — Indications removed*
- *Suspected CAD with symptoms — Indications modified*

- *Need for testing determined by pretest probability*
- *Definition of chest pain expanded to include ischemic equivalent pain elsewhere*
- *Dyspnea included as standalone symptom*
- *Imaging modality to be selected by the treating physician*
- *Exercise preferred over pharmacologic testing in patients referred for stress testing with imaging*
- *Patients with atypical symptoms to undergo non-imaging stress testing (assuming capable of exercise and no precluding resting EKG abnormalities)*
- *Established CAD without symptoms — Indications removed*
- *Established CAD with symptoms — Indications removed*

CT coronary angiography (CCTA):

- *Indications added — Considerable expansion in use for evaluation of CAD (now a first-line modality)*
- *Indications added — Preoperative testing indications*
- *Indications added — Abnormal prior testing indications*
- *Indications removed — Suspected anomalous coronary arteries (basis for suspicion required)*

Fractional Flow Reserve from CCTA (FFR-CT):

- *Indication modified — 40% to 90% coronary stenosis in symptomatic patient who has failed* ***guideline-directed medical therapy*** *and has undergone CCTA within preceding 90 days*

Stress Cardiac MRI:

- *Indications added — Considerable expansion in use for evaluation of CAD (now a first-line modality)*
- *Indications added — Preoperative testing indications*
- *Indications added — Abnormal prior testing indications*

Resting Cardiac MRI:

- *Indication added — Fabry disease*
- *Indications modified — Suspected myocarditis (basis for suspicion required)*
- *Indications modified — Arrhythmogenic right ventricular dysplasia (ARVD) requirements clarified*
- *Indications modified — Suspected anomalous coronary arteries (basis for suspicion required)*

Resting transthoracic echocardiography (TTE):

- *Valvular heart disease — updated frequency of surveillance in patients with prosthetic valves and those who had transcatheter valve replacement/repair; removed requirement of valvular dysfunction for those who had surgical mitral valve repair; removed moderate/severe mitral regurgitation for those who had transcatheter mitral valve repair*

Diagnostic Coronary Angiography:

- *Indications modified — Clarification that patients with established CAD who have failed GDMT may undergo coronary angiography regardless of how initial diagnosis was made*

This is all the information that is offered by the carrier.

There are 24 bullets, or distinct changes to the Anthem policy on when advanced cardiac imaging is permitted.

But this is it.

The Anthem Advanced Cardiac Imaging "Clinical Appropriateness Guidelines" are 98 pages of dense clinical terminology.

When Anthem updates its guidelines, it does not provide hyperlinks to the change.

Nor does it even provide underlines and strikethroughs.

Imagine trying to do your job on this committee if all you were handed was the updated law and a bullet list of changes. No underlines, no strikethroughs. No page numbers or hyperlinks.

You couldn't do your job. And neither can our members do this job.

But the policy question is – Why? Why doesn't Anthem make it just a little easier to find the unilateral changes to their guidelines? Because they financially win when we fail.

If we don't follow their guidelines, claims get denied. So, make it harder to follow the guidelines.

Unilateral policy changes are unfair, but opaque unilateral changes are impossible to digest by providers and lead to our failure to follow their rules.

When that happens, the carriers win and providers, and frequently patients, lose.

Please help us manage these issues.

Thank you for considering our testimony.

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