Trillium HEALTH RESOURCES
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Trillium Medicaid Advisory Committee Brief: Health Plan Insights Pharmacy Benefits (First Edition-001), 11.11.25

Introduction

Welcome to the First Edition of the Trillium Member Advisory Committee Brief. This document is designed to serve as a formal record of the continuous exchange of critical information between Trillium Whole Health Plan and the Member Advisory Committee (MAC). It will be periodically created either in response to specific requests initiated by MAC members or CFAC, or to provide essential updates that Trillium deems necessary for committee members to receive, ensuring transparent and memorialized communication regarding plan operations and performance. The content below presents a deep dive into recent pharmacy claims data for the Trillium Whole Health plan Tailored plan.

Topic: Pharmacy Denials, Appeals, and Member Experience in Managed Care

Data Review: Denials and Appeals Over the past 15 months, pharmacy claims data revealed that most denials stemmed from "Prior Authorization Required" (approximately 30–47% monthly) and "Refill Too Soon" codes (18–24%), with other frequent issues such as formulary exclusions, service not covered, and quantity/days supply limitations. Denied claims volume ranged from 75,800 to 123,000 per month. Appeals activity increased steadily in 2025, with a consistently high rate of overturned decisions—often more than 60%, demonstrating many initial denials may be resolved upon further review. We had a higher rejection volume at go live and when the State institutes changes to the PDL each quarter.

Managed Care Comparison: National Trends Trillium was required to move into Medicaid Managed Care. Our local experience mirrors national findings as Medicaid moves into managed care:

- Managed care pharmacy denials surge, especially for prior authorization, which is denied at rates more than double that of Medicare Advantage (12.5% vs. 5.7% nationally).
- Frequent reasons for denial—including prior authorization, refill timing, and plan limitations—align precisely with those observed in this data set.
- Most Medicaid members do not appeal denied claims, but those who do are only successful about one third of the time—lower than our local overturned rate, but indicative of system friction and confusion.
- National policy and operational reviews highlight delayed, unclear denial communications and burdensome processes as key drivers of member frustration and delays.

Opportunities to Improve Member Experience To address these challenges and proactively enhance member satisfaction, Trillium needs to focus on:

- **Streamlining Prior Authorization:** Work with vendors to automate as much as possible, accelerate decision timeframes, and proactively approve frequently prescribed medications.

- **Clear, Timely Communication:** Deliver electronic denial and appeal notices instantly, use standardized and simple language and provide actionable next steps.
- **Support and Navigation:** Help members and providers with guided appeals processes to keep the paperwork from being a barrier to medically necessary treatment by dedicating support teams to assisting members and providers and easy ways to track claims and status changes.
- **Provider Collaboration and Education:** Engage providers with direct communication channels, best practice training, and access to real-time claim and authorization status.
- **Continuous Improvement:** Routinely reviewing overturned appeals to pinpoint process gaps and correct policies that lead to unnecessary denials, analyzing both clinical and operational drivers.

Strategic Focus Areas

- Automation via electronic prior authorization systems
- Clear, accessible member and provider education on denials and appeals
- Rapid notification and transparent communication standards, including electronic notices
- Dedicated case management for complex or repeatedly denied cases
- Real-time, actionable data analytics to track denial reasons, appeal rates, and resolution outcomes

Bottom Line Pharmacy claim denials and appeals locally reflect the core challenges and trends of managed Medicaid plans nationally: rising denials, especially for prior authorization and refill timing, and a high rate of appeals overturns. These patterns require a strategic focus on transparent communications, streamlined clinical review, and tailored member support to ensure improved access to care, member satisfaction, and operational excellence.