Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Trillium Member Advisory Committee Brief #002: What the Physical Health Authorization Data Means for the First Year of Trillium Whole Health Tailored Plan Operations.

What We Found in Our First Year

This report looks at the first year of our new health plan and focuses on how often providers asked us for "prior authorization" (permission) to give you physical health services, and how often we said "no" (a denial).

Good News: Your Doctors Are Joining In!

In our first year, the number of requests we received from doctors for your care grew from about 7,500 requests in Month 1 to over 57,000 requests by the end of the year.

What this means for you:

- **Access is Growing:** This huge increase (over six times more requests!) shows that more and more doctors and specialists are working with our plan. It means you have a larger network of providers who know how to ask us for the care you need.

The Problem We Fixed: Initial Hiccups in Getting Approval

When we first started, it was tough. In the third month, we were denying about **23% of all requests**. This was an unacceptable rate and meant too many members faced delays or confusion.

What caused the problem:

- **New Process Confusion:** Our plan's rules for *how* doctors need to ask for permission were new. Doctors and their staff were submitting requests with missing paperwork or incorrect codes, leading to **Administrative Denials**.
- **Unclear Guidelines:** Sometimes, doctors weren't clear on what medical information we needed to approve a treatment, leading to denials for **Medical Necessity**.

The Fix: We immediately saw this spike and quickly stepped in. Within three months (by Month 6), our denial rate dropped dramatically. Our average denial rate across the last six months of the year stabilized at approximately **1.2%**, meaning over 98% of requests are now approved quickly.

What this means for you:

- **Faster, Smoother Approvals:** You can be confident that your doctor's request is now very likely to be approved the first time. The process is now working smoothly, minimizing delays in your care.
- **Less Stress:** The plan has taken the burden of dealing with paperwork off your back. We worked with providers so they know the rules, which means less back-and-forth communication that could have involved you.

Where We Can Still Improve Your Experience: The Denial Breakdown

Now that we have fixed the initial paperwork problems, our focus is on why the remaining small number of requests are denied. By understanding these reasons, we can focus our improvements where they matter most for your care.

The table below shows the average breakdown of denials across the last six months (our "steady-state" of operation):

Denial Reason Code	Average Percentage of All Denials	What This Means for Your Care
Medical Services (MS)	43%	This is the main reason for denial. It means the specific care requested (like a specialized therapy or surgical procedure) did not meet the plan's clinical criteria for being medically necessary or covered. **Member Impact:** Requires a discussion between you and your doctor to explore alternatives or prepare for an appeal.
All Other (AO)	38%	This is a catch-all category. Common reasons include requests for services from providers outside of our network, services that are already covered without prior authorization, or other administrative misroutes.
Admin Denial	19%	This means your doctor's office made a paperwork error, such as submitting an incomplete form or missing a required signature. Although low overall, this rate should be zero—it's an unnecessary barrier to your care.
Medical Necessity Not Certified	1%	Extremely rare, this means the plan simply needs more clinical documentation from your doctor to make a decision, rather than an outright denial.

How we can improve your experience in Year 2:

1. **Clearer Communication on Denials:** If your care is denied, the explanation we give you should be crystal clear. We need to tell you *exactly* why (using simple language instead of technical codes), what criteria were used, and what steps you can take next (like appealing the decision or suggesting an alternative treatment).

2. **Targeted Provider Education:** We will work directly with the doctors who submit the most denials for **Medical Services (MS)**. By training these key providers on our clinical guidelines, we hope to prevent those clinically-driven denials from ever reaching you.
3. **Member Appeals Process:** While the denial rate is low, we must make the appeals process easy to understand and quick to navigate. If you disagree with a decision, we need to ensure your voice is heard without unnecessary hurdles.

Our Commitment to You: Our goal is 0% administrative denials and only medically necessary denials based on robust, transparent clinical guidelines. We have proven we can quickly fix our processes, and we are committed to making Year 2 even better for your access to care.