POLICY DOCUMENT

PRIOR AUTHORIZATION

ISSUE BRIEF

MAY 2023

Issue

Health plan prior authorization practices can unnecessarily delay patients' access to needed care and create administrative burdens on providers when they vary significantly by plan. FHA supports legislation to minimize clinically unnecessary prior authorization requirements, set forth strict timeframes for plans to issue authorizations and to increase transparency of health plan processes, set.

Background

Health plans require providers to request prior authorization for a treatment or service to ensure it is covered and medically necessary. Historically, prior authorization focused on misuse or variations in care, but recently, the practice has become more common for all types of services. Prior authorizations can take several days and Florida law does not specific timeframes for authorization but only sets forth the requirement for health plans licensed under Ch. 641 to provide treatment authorization 24 hours a day, seven days a week and establish written procedures for requesting and granting authorizations While there is no timeframes for granting prior authorization in Florida statutes, Medicaid requires contracted managed care plans to process expedited requests within three business days and l standard authorizations to be processed within 14 days with an average turnaround time not to exceed seven within 7 days.

Prior authorization delays can have serious consequences for patient outcomes.

More than 90 percent of physicians report care delays while waiting for insurer authorization, according to a national survey conducted by the American Medical Association. Four out of five physicians indicated it can lead to treatment abandonment, and more than a -third reported serious adverse events occurred due to authorization delays. Providers typically appeal these decisions, and many, after review by a clinician are overturned. More than 60 percent of prior authorization denials appealed are ultimately overturned, according to the American Hospital Association. The U.S. Department of Health and Human Services Office of Inspector General reviewed Medicare Advantage claims denials and found 13% of prior authorization denials met Medicare coverage rules and should have been approved when initially requested. [1]

In addition to patient impacts, the burden on providers and administrative staff is significant, contributing to burnout and unnecessary costs. Hospitals employ a significant number of staff to obtain, monitor, and

[1] HHS Office of Inspector General Report on Medicare Advantage Organization denials of Prior Authorization Requests

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and appeal authorization requests in addition to communicating the status with the patient and other care providers.

FHA Advocacy

FHA supports legislation to minimize the burdens associated with the prior authorization process, sets forth timeframes for health plans to grant authorizations and increases transparency of health plan prior authorization requirements and timeliness metrics.

1. All health plans licensed in Florida (Ch. 627, 641 and Medicaid) to provide timely authorization for care with urgent requests being authorized within 24 hours and non-urgent requests within 5 business days.

2. Require each health plan to report by line of business:

- Implement and maintain FHIR-based Prior Authorization Requirements, Documentation, and Decision (PARDD) API.
- New timeframes for standard and expedited prior authorization requests (no later than 72 hours of receiving request and no later than seven calendar days after receiving a request for standards decisions.
- Provide a specific reason a prior authorization request is denied for providers to determine the best course of actions for the patient.
- Electronic exchange of patient data for patients from providers.
- Electronic prior authorization incentive measures
- Public reporting of metrics.