PAYER ACCOUNTABILITY

Support SB 1574/HB 1475 Health Care Services by Senator Jones/Rep. Berfield

PRIOR AUTHORIZATION

- Improve the timeliness of prior authorization by putting timeframes in Florida law – require payers to make a determination on urgent requests within 24 hours and nonurgent requests within 72 hours after receiving all necessary information
- Establish a more efficient process to request and share approval or denial of the authorization with both the provider and the patient
- Public reporting of metrics such as % of prior authorizations denied, % of those appealed, % of those appealed overturned
- Require the person reviewing the request for the authorization to have expertise in that field
- Require transparency over which services require prior authorization by posting these requirements on payers' website and sharing publicly
- Requiring payers to provide 60 days' notice prior to changing these policies
- Align Florida's payers with federal rules set forth for Medicaid Managed Care, Medicare Advantage, and CHIP

DOWN-CODING

- After care has been authorized and provided, health plans will retroactively alter the service code or other codes that were billed according to national billing rules
- Many times, the details on what was down-coded and the reason for that change are not provided, thus requiring additional work by the provider to understand why the full amount wasn't paid
- Payers down-code claims without reviewing the medical record, which contains details on the patient's condition, history, previous treatment and other issues to justify why the patient needed that care/procedure
- Payers should be required to provide the reason for the down coding, require review of the medical record before a decision to down code is made, prohibit down coding for services ordered by an in-network provider, and require transparency of down coding policies

PROMPT PAYMENT OF CLAIMS

- The primary reason for payers not adhering to the prompt pay requirements set forth in statute is that the claim is not "clean". Florida law does not currently define "clean claim"
- Payers often deny the claim by requesting additional information and this could go back and forth several times before the plan ultimately says the claim can be processed.
- Define "clean claim" as the completed UB92 or its successor and require payers to identify any needed documentation in advance
- Providing more clarity around clean claims will reduce administrative costs for payers and providers

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PAYER ACCOUNTABILITY

Certain payer policies and administrative practices delay patient care, overburden clinicians, and withhold critical payments from providers.

Hospitals treat any patient, regardless of their ability to pay, and work with public or private payers to recoup payment for the services they provide. Through certain policies and practices, payers unjustly apply utilization management tools and prior authorizations that lead to increases in administrative costs and dangerous delays in patient care.

Many health plans apply **prior authorization requirements** in ways that create dangerous **delays in care**, contribute to **clinician burnout**, and significantly **drive-up administrative costs** for the health care system.

FHA-Collected Data

- FHA's Payer Scorecard found 16.4% of health plan denials were due to prior auth
- 23% of the Medicaid managed care claims were denied due to authorizations
- Prior authorization issues delayed 1 in 5 discharges and required patients to stay an extra 4.5 days in the hospital on average. PA delayed 29,000 discharges from 2022-2023

Florida's hospitals are grappling with a **lack of oversight of Florida prompt pay statute.** Florida law requires payment to be made within 90 days of receipt, but health plans are unfairly applying utilization management tools to delay these payments.

Florida hospitals-specific data (2022-2023):

- 71% of commercial claims & 69% of Medicaid claims were unpaid after 30 days; most other industries cannot imagine this reality
    - More than 10% of these claims remained unpaid after a year
- 9% of commercial claims submitted by hospitals are denied initially but less than 2% are ultimately denied, showing the claim was appropriate but payment delayed for nonclinical reasons
- Most common reason for denial: additional documentation
- 76% of Medicaid claims denials are eventually overturned

Leslie Fisk, 62, of New Smyrna Beach, Florida, was diagnosed in 2021 with lung and brain cancer. After seven rounds of chemotherapy last year, her insurance company denied radiation treatment recommended by her doctors, deeming it medically unnecessary.

"I remember losing my mind. I need this radiation for my lungs," Fisk said. After fighting Florida Health Care Plans' denial "tooth and nail," Fisk said, the insurance company relented. Fisk called the whole process "horribly traumatic."

"You have to navigate the most complicated system on the planet," she said. "If you're just sitting there waiting for them to take care of you, they won't."

(Health News Florida)