



APTA Private Practice

Small business professionals restoring function to America - one patient at a time.

REDUCE ADMINISTRATIVE BURDENS ASSOCIATED WITH PRIOR AUTHORIZATION

RECOMMENDATION: APTA Private Practice urges Congress to pass the bipartisan Improving Senior's Timely Access to Care Act (H.R.8702/S.4532) to streamline and standardize how Medicare Advantage plans use prior authorization as well as increasing oversight and transparency of its use.

Health insurers, including many Medicare Advantage (MA) plans, require providers to obtain prior authorization for certain medical treatments or tests—including physical therapy care—before they can provide care to their patients. Prior authorization is often described as a tool to ensure people receive clinically appropriate treatments and help control the cost of care. In a 2018 report, the Department of Health & Human Services' (HHS) Office of the Inspector General (OIG) raised concerns that prior authorization was being used to limit services and payment, after an audit revealed that MA plans ultimately approved 75% of requests that were originally denied. In April 2022 another HHS OIG report found that “Although some of the denials that we reviewed were ultimately reversed by the [MA Organizations (MAOs)], avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs.”

Prior authorization frequently results in administrative burdens for providers which diverts precious time away from patient care and delays approval for necessary physical therapy services. As evidenced by both OIG reports, it is not uncommon for therapists to follow all required guidelines from the MA plan and still receive rejections. Furthermore, it is not clinically appropriate to ration care solely based upon the volume of services. In many cases, the patient understands that delaying care may severely hinder their recovery, but is wholly unaware of the presence of prior authorization and utilization management hurdles that result in physical therapists and other providers being forced to decide between furnishing an uncovered service at their own expense or risk the patient's health and well-being by waiting for a plan to authorize medically necessary care.

In January 2024, the Centers for Medicare and Medicaid Services (CMS) released its final rule implementing new requirements for payers to automate their prior authorization processes. Beginning in 2026, payers will have to respond to standard requests in seven calendar days and 72 hours for expedited requests as well provide a specific reason for a denial. The final rule also includes new reporting requirements for payers on their prior authorization metrics.

Despite CMS' work in this area, stakeholders believe it important to have legislation to codify many of these prior authorization provisions to ensure CMS continues to implement the final rule and these standards are maintained in the future.

Building on the rule and previous versions of the legislation, the new ***Improving Seniors' Timely Access to Care Act (H.R. 8702/S. 4532)*** would:

- Require MA plans to establish an electronic prior authorization process
- Allow the Secretary to establish timeframes and require a report on a process for real-time determinations
- Improve transparency by requiring MA plans to report on the extent of their use of prior authorization, the rate of approvals or denials, and the average response time for authorization requests

While there is more work to do to eliminate barriers to care through prior authorizations, this legislation is a step in the right direction to address delayed access to care and administrative burden on providers.

Please Cosponsor H.R. 8702/S.4532! This legislation is led in the House of Representatives by Representatives Mike Kelly (R-PA), Suzan DelBene (D-WA), Ami Bera (D-CA), and Larry Bucshon (R-IN) and in the Senate by Senators Roger Marshall (R-KS), Kyrsten Sinema (I-AZ), John Thune (R-SD) and Sherrod Brown (D-OH).