Fact Sheet

Illinois Health and Hospital Association
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Eliminate Confusing Prior Authorization Practices, Improve Patient Access

Standardize State Prior Authorization Process, HB 4980 (Rep. Gabel)

IHA Position: IHA strongly supports HB 4980 to standardize the process of requesting prior authorization across all MCOs so that individuals covered under the Illinois Medicaid program have their requests for medical service reviewed under the same standards. This will create consistency across the Medicaid program, eliminating confusion driven by numerous practices and policies, improving patient access to care while easing costly administrative burden for Illinois' hospitals and health systems. We urge Illinois lawmakers to co-sponsor and vote YES on HB 4980.

Background: Illinois' core five Medicaid Managed Care Organizations (MCOs) each have their own, individual prior authorization process that providers must adhere to when requesting authorization to provide a level of care or a medical procedure. This creates confusion and contributes to errors that MCOs take advantage of to deny and delay care. A U.S. Dept. of Health and Human Services' (HHS) Office of Inspector General report found that **the average prior authorization denial rate for Medicaid managed care is 12.5%**--over double that of Medicare Advantage health plans at 5.7%--and **prior authorization denial rates in Illinois are as high as 41%.** Nearly one in five, or **22% of Medicaid clients reported that their health insurance denied or delayed prior approval** for a treatment, service, visit or drug before they received it.

When prior authorization requirements are imposed unequally within Medicaid MCOs, the impact on historically marginalized groups is magnified. The American Academy of Family Physicians says prior authorizations "can worsen health disparities and create barriers to care for medically underserved patients, patients of color, LGBTQ+ patients, rural patients and those at risk for poor health outcomes." The Association of Black Cardiologists says these prior authorization practices are particularly burdensome for providers operating within tight financial margins and for those caring for minority and underserved populations, contributing to treatment disparities.

Standardization of prior authorization practices is being sought by stakeholders at all levels, in an effort to streamline the prior authorization practice and reduce associated burden on patients and providers. Notably**: Medicare recently required all Medicare Advantage plan prior authorization programs to be no more restrictive than traditional Medicare, paving the way for further future standardization.**

In response, HB 4980:

- Clarifies definitions related to "service authorization requests."
- Defines "Utilization Review Organization" (URO) to ensure the organizations responsible for making the determinations on service authorization requests are basing them on national standards of care.
- Requires HFS to contract with a single URO and implement a single service authorization program for all service authorization requests for inpatient, outpatient in a hospital setting or post-acute placement.
- Prohibits MCOs from implementing a URO process for the purpose of approving services for payment.
- Allows hospitals to dispute or appeal a service authorization determination by the URO on behalf of the patient without obtaining a signed Appointment of Representative (AOR) form.
- Requires the state to develop a standard AOR form to be used by all MCOs.
- Requires the state to impose sanctions for MCOs that violate these provisions.
- Requires the Department to develop a list of "inpatient only services," similar to Medicare, which must be covered as inpatient level of care due to their complexity.

PLEASE CO-SPONSOR AND SUPPORT HB 4980

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