Resolution 26-309

Improving Post-Acute Care Access Through Prior-Authorization Transparency and Network Adequacy

FMA Medical Students Section

Whereas, Florida hospitals are experiencing persistent delays in discharging medically stable patients to inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), long-term acute care hospitals (LTACHs), and home health services;[1] and

Whereas, The Florida Hospital Association reported that more than 117,000 patients experienced delays exceeding one day in discharge to post-acute or home care settings, resulting in more than 403,000 avoidable hospital days statewide;[1] and

Whereas, Delays in discharge to post-acute care settings have downstream effects that constrain the hospital system, including prolonged hospital length of stay, hospital crowding, limited inpatient bed availability, emergency department boarding, and reduced hospital throughput;[2] and

Whereas, Medically unnecessary hospital days increase risks of hospital-acquired infection, delirium, deconditioning, venous thromboembolism, pressure injury, and functional decline, particularly among elderly and medically complex patients;[3] and

Whereas, Delays in post-acute placement disproportionately affect elderly and medically complex patients, including patients recovering from stroke, trauma, major surgery, or critical illness;[3] and

Whereas, Post-acute placement is a clinical decision, not merely an administrative one, because discharge setting can affect functional recovery, survival, and care continuity;[4,5] and

Whereas, The Florida Hospital Association reported that prior authorization accounted for 55% of delays in hospital discharge to SNFs, and that one-third of patients waiting more than 10 days for discharge experienced delays related to prior authorization;[1] and

Whereas, The U.S. Department of Health and Human Services Office of Inspector General found that some Medicare Advantage prior-authorization denials, including denials for post-acute and rehabilitation services, involved requests that met Medicare coverage rules, raising concerns about beneficiary access to medically necessary care;[6] and

Whereas, The Centers for Medicare & Medicaid Services (CMS) finalized the Interoperability and Prior Authorization Final Rule (CMS-0057-F), which beginning in 2026 requires covered government-sponsored payers to publicly report aggregate prior-authorization metrics and requires most impacted payers to issue prior-authorization decisions within set timeframes, but does not extend these requirements to most commercial insurers or require reporting by service category, such as post-acute care;[7] and

Whereas, CMS's 2024 Medicaid and CHIP managed care final rule (42 C.F.R. § 438.68) requires states to establish network-adequacy standards, set maximum wait times, conduct secret-shopper surveys, and remediate provider shortfalls, but applies these requirements to Medicaid

managed care generally and does not set standards specific to post-acute and rehabilitation providers;[8] and

Whereas, Existing Florida Medical Association policy supports efforts to reduce unnecessary prior authorization barriers and delays that interfere with timely medically necessary care;[9] and

Whereas, Prior authorization and related administrative requirements impose substantial burdens on physicians and their care teams, detracting from direct patient care;[10] and

Whereas, Prolonged hospitalization attributable to administrative delays increases healthcare expenditures and consumes hospital capacity without corresponding clinical benefit;[1,11] and

Whereas, Timely transfer to appropriate rehabilitation and post-acute care settings supports functional recovery, mobility, and continuity of care;[1,3,12] therefore be it

RESOLVED, That the Florida Medical Association supports requiring Medicaid managed care plans and commercial insurers operating in Florida to annually publish post-acute care prior authorization performance data, including request volume, approval and denial rates, decision-time metrics, and appeal overturn rates, stratified by service type, including inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), long-term acute care hospitals (LTACHs), and home health services, in a consolidated, publicly accessible format; and be it further

RESOLVED, That the Florida Medical Association supports establishing and enforcing network adequacy standards for post-acute and rehabilitation providers, including IRFs, SNFs, LTACHs, and home health agencies, to ensure timely patient access to medically necessary post-acute care services.

Fiscal Note:

Description	Amount	Budget Narrative
100 Staff hours	$20,000	Can be accomplished with current staff
Total	$20,000	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: III – Legislation and Miscellaneous

References

1. Florida Hospital Association. *2025 Patients Awaiting Discharge*. Accessed May 11, 2026.
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3. Creditor MC. Hazards of hospitalization of the elderly. *Ann Intern Med*. 1993;118(3):219-223. doi:10.7326/0003-4819-118-3-199302010-00011
4. Hong I, Goodwin JS, Reistetter TA, et al. Comparison of functional status improvements among patients with stroke receiving postacute care in inpatient rehabilitation vs skilled nursing facilities. *JAMA Netw Open*. 2019;2(12). doi:10.1001/jamanetworkopen.2019.16646
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6. US Department of Health and Human Services, Office of Inspector General. *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*. Published April 27, 2022. Report No. OEI-09-18-00260. Accessed May 11, 2026.
7. Centers for Medicare & Medicaid Services. *Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes*. Final rule. *Fed Regist*. 2024;89:8758-8885.
8. Centers for Medicare & Medicaid Services. *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality*. Final rule. *Fed Regist*. 2024;89:41002-41131. See also 42 CFR § 438.68.
9. Florida Medical Association. *FMA Public Policy Compendium*. Policy P 260.034, Prior Authorization. Accessed May 11, 2026.
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11. McGarry BE, Wilcock AD, Gandhi AD, Grabowski DC, Barnett ML. Extended hospital stays in Medicare Advantage and traditional Medicare. *JAMA Intern Med*. 2025;185(11):1362-1369. doi:10.1001/jamainternmed.2025.4411
12. Wang H, Camicia M, Terdiman J, Hung YY, Sandel ME. Time to inpatient rehabilitation hospital admission and functional outcomes of stroke patients. *PM R*. 2011;3(4):296-304. doi:10.1016/j.pmrj.2010.12.018

Relevant FMA Policies

P 260.034 PRIOR AUTHORIZATION
The Florida Medical Association is directed to call on insurers and payers to eliminate complex barriers and reinstate physicians as the primary authorities for patient treatment; and further that the formulary must be transparent, oppose preauthorization of commonly used peer-review supported medication or procedure; and further, a standardized short simple focused universal prior authorization form, available written and electronically must be used, and physicians should be compensated for their time completing this form; and further, if a health plan or insurer does not use the standardized universal prior authorization form or fails to provide a decision within 48

hours that the prior authorization will automatically be deemed granted; and further, reviews should be no more frequent than annually for those with chronic disorders. (Sub Res 11-407, HOD 2011) (Reaffirmed HOD 2019)
P 260.049 PRIOR AUTHORIZATION FOR IN-PATIENT CARE AND NON-EMERGENT PROCEDURES
The Florida Medical Association supports legislation to prohibit insurance carriers from requiring prior authorization for patients who are being treated in the hospital; the FMA supports legislation that would prohibit insurance carriers from requiring prior authorization for treatment associated with an emergency condition. (Amended Res 18-406, HOD 2018)

P 260.050 SHAM REVIEWS AND TRANSPARENT AUTHORIZATION PROCESS The Florida Medical Association supports legislation to mandate that all treatment guidelines and authorization protocols implemented by insurance carriers must be 1) transparent and readily available to their insured and treating physician and 2) that Medical Directors making coverage determinations on the grounds of Medical Necessity must certify that they have directly reviewed the relevant medical records and received input from a physician in the same specialty as the treating physician, prior to the denial. (Amended Res 18-407, HOD 2018)

P 285.015 MEDICAL DIRECTORS IN POST-ACUTE CARE FACILITIES
The Florida Medical Association believes that that medical directors of post-acute care facilities, including but not limited to adult living facilities, nursing homes, rehabilitation facilities, skilled nursing units, and subacute care units, should be physicians licensed under Florida Statutes 458 and 459; and further opposes any attempts to abolish mandates that only physicians licensed under F.S. 458 and F.S. 459 be medical directors at post-acute care facilities. (Res 96-13, A-1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014) (Reaffirmed HOD 2022)

P 325.029 PREVENT PATIENTS FROM BEING “TRAPPED” INTO MEDICARE ADVANTAGE PLANS
Our FMA will write a letter to the Florida insurance commissioner requesting that seniors receive a document from the State of Florida describing that Medicare Advantage plans are NOT Medicare but rather plans that are administered by private companies, and networks and in network physicians can change and be restricted in the future, the preapproval process may delay or deny care felt necessary by a physician, out of pocket costs may be much higher with chronic conditions than original Medicare especially if due to restricted networks and one has to get care out of network, and patients who joint Medicare Advantage plans often find it difficult to go back to original Medicare and purchase a secondary medigap plan if they have preexisting conditions and seniors should be made aware of the differences in fees and commissions that insurance brokers are paid between Medicare Advantage plans and a Medigap plans; and further, our FMA will design a handout that physicians who wish to inform their patients can print for their waiting rooms and place on their websites describing the information above regarding the differences in coverage, cost, and potential difficulties in leaving a Medicare Advantage plan. (Res 25-401, adopted as amended, HOD 2025)

Relevant AMA Policies

PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT REFORM H-320.939
Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and **Utilization Management Reform** Principles, AMA model legislation, Prior Authorization Physician Survey and

other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.

1. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
2. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and **utilization management** processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
3. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

MANAGED CARE H-285.998
The American Medical Association supports requiring a physician of the same specialty to be involved in utilization-management decisions to deny or reduce coverage based on medical necessity.

CONTINUITY OF CARE FOR PATIENTS DISCHARGED FROM HOSPITALS H-125.974
The American Medical Association supports attention to coverage and continuity issues after hospital discharge, including discharge medication reconciliation.