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INSIGHTS

CMS Releases Final Rule on Health Plan Prior Authorization and Interoperability

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On January 17, 2024, the Centers for Medicare and Medicaid Services (CMS) released a final rule on prior authorization and interoperability. This change applies to all government-funded plans, including Medicare Advantage (MA) organizations, Medicaid and the Children's Health Insurance Program (CHIP) fee-for-service (FFS) programs, Medicaid managed care plans, CHIP managed care entities, and issuers of Qualified Health Plans (QHPs) offered on the Federally Facilitated Exchanges (FFEs), (collectively "impacted payers"). The press release can be found here, the fact sheet can be found here, and the technical fact sheet can be found here.

IMPACT ON PLANS

The final rule creates new deadlines for plans to respond to prior authorization (PA) requests and it also allows beneficiaries to have more transparency into any PA decisions. Beginning in 2026, the above-listed plans will be required to respond to urgent prior authorization requests from clinicians/hospitals within 72 hours. For non-urgent requests, responses must be submitted within 7 days. In addition, insurers must provide a reason for any denial of claims (which has not existed in the past). For patients, this rule also finalizes the requirement that patients must have access to prior authorization decisions through their plan portal or Patient Access Prior Authorization application programming interface (API) by 2027. (Plans were already required by CMS last year to create a Patient Access API – this rule builds on last year's rule by also requiring prior authorization requests to be included on the API.) Plans are also required to implement and maintain a Payer-to-Payer API to exchange patient data for when a patient moves between payers to ensure continued access to their health data and support continuity of care between payers. Finally, plans are required to post prior authorization metrics annually on their websites.

IMPACT ON PROVIDERS

On the provider side, CMS is implementing a new quality metric entitled "Electronic Prior Authorization" under the Merit-based Incentive Payment System (MIPS) for clinicians/hospitals to report on their use of electronic prior authorization requests. It will be a "yes" field only. This new metric will apply to MIPS-eligible clinicians, eligible hospitals, and Critical Access Hospitals (CAHs.)

We trust you found this summary useful. Please reach out to us with any questions.

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