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CMS Clarifies Prior Auth Not to Be Used to Delay, Deny Care

On Feb. 6, a Frequently Asked Questions (FAQ) memo released by CMS reiterated and clarified the agency's stance that prior authorization use by Medicare Advantage plans "should not function to delay or discourage care."

The memo addressed to all Medicare Advantage Organizations (MAOs) and Medicare-Medicaid plans, was intended to clarify the agency's expectations of how Medicare advantage plans must comply with new rules that became effective on Jan. 1, 2024. The memo addresses several concerns expressed by health care providers, including by the American Hospital Association (AHA) in a letter to CMS in October. The AHA letter indicated that some Medicare plans had signaled an intent to continue operating as they had been, rather than conform to the new rules.

In general, CMS' new rules require that MAOS make medical necessity determinations in line with traditional Medicare coverage criteria. In their FAQ, CMS addresses the use of algorithms or artificial intelligence tools by health plans, which some providers have found are used inappropriately to deny care. CMS indicates in the FAQ that while these tools might be able to assist plans in making coverage determinations it is still up to the plan to make sure all the rules are followed. CMS specifically states, "for inpatient admissions, algorithms or artificial intelligence alone cannot be used as the basis to deny admission or downgrade to an observation status."

Hospitals have also raised concerns about how the two-midnight rule is implemented by health plans. In the FAQ, CMS clarifies that whether the inpatient admission meets the two-midnight benchmark must be based on the "expectation of the admitting physician," and while the MAO may evaluate the decision, the "evaluation should defer to the judgment of the physician as long as that judgment was reasonable based on the complex medical factors documented in the medical record."

Finally, while CMS allows the use of prior authorization, the agency reiterates that it may only be used to confirm if a service is medically necessary and is not to be used to delay or deny care. Medicare Advantage plans are also required to establish a utilization review committee to review their policies annually and to ensure they are consistent with traditional Medicare policies.

The new FAQ was released just two days before a new CMS regulation on interoperability and prior authorizations was finalized and published in the federal register. This latest regulation is intended to streamline and reduce the burden associated with prior authorizations, promote greater transparency in medical necessity criteria, and improve electronic exchange of health care information.

It is expected that these regulations will help providers automatically determine whether prior authorization is required for a particular service, rather than having to navigate numerous health plan bulletins to determine if there has been a change in the prior authorization policies. The final regulations also require that the plan provide a specific reason for prior authorization denials. Further, CMS will require additional public reporting of several metrics related to prior authorizations. These new regulations will become effective in 2026 and 2027.

Other Articles in this Issue

- Join Us at the Second Annual Health Care Quality Showcase on Advocacy Day 2024
- Rick Pollack, President/CEO of the American Hospital Association, to be Keynote Speaker at 2024 Advocacy Day