Issue Brief

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CMS Issues Proposal to Advance Interoperability and Improve Prior Authorization

The Centers for Medicare and Medicaid Services (CMS) have issued a proposed rule regarding Advancing Interoperability and Improving Prior Authorization Processes.

The proposals would place new requirements on Medicare Advantage (MA) organizations, state Medicaid and CHIP Fee-for-Service (FFS) programs, Medicaid managed care plans and Children's Health Insurance Program (CHIP) managed care entities, and Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs), (collectively "impacted payers"), to improve the electronic exchange of health care data and streamline processes related to prior authorization.

To encourage providers to adopt the electronic prior authorization processes, the proposed rule would also add a new measure for eligible hospitals and critical access hospitals (CAHs), and for the Merit-based Incentive Payment System (MIPS).

A copy of the 403-page document is available at: https://public-inspection.federalregister.gov/2022-26479.pdf. The proposal is scheduled for publication on December 13. A 90-day comment period is being provided.

CMS notes that the proposals in this rule do not directly pertain to Medicare FFS. However, if the proposals are finalized, CMS plans to implement these provisions for Medicare FFS so that people with Medicare FFS could also benefit from their data availability.

Most of the implementation dates for the proposals would begin in 2026, including those for the Application Programming Interface (API) proposals, prior authorization decision timeframes for certain impacted payers, and certain reporting proposals.

COMMENT

This proposal is word intensive. That is, much material is repeated as the material applies to the various impacted entities.

CMS seems to always say it is changing payment requirements to improve overall operations, burden and costs. Yet, this rule revokes CMS' December 2020 **Interoperability and Prior Authorization Proposed Rule.**

CMS notes that the proposal includes five key provisions and five Requests for Information (RFIs).

Our emphasis in this analysis pertains to those items regarding fee-for-service and critical access hospitals (CAHs). These items are discussed beginning on page 150 of the display copy of the rule.

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CMS has also provided a concise and helpful 3½ page fact sheet. We are extracting much from the fact sheet with added items from the rule itself.

After each detailed section, CMS provides a "summary" of its actions. The summaries are long and repeat much of the discussion sections.

We are providing, once again, page numbers of material from the display proposal.

II. Provisions of the Proposed Rule

A. Patient Access Application Programming Interface (API) (Page 20)

In the *Interoperability and Patient Access* final rule, CMS finalized a policy to require certain impacted payers to implement a Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) Patient Access API. In this rule, starting January 1, 2026, via the already-established Patient Access API, CMS proposes to require the regulated payers to include information about patients' prior authorization decisions to help patients better understand their payer's prior authorization process and its impact on their care.
This proposed rule would also require impacted payers to report annual metrics to CMS about patient use of the Patient Access API.

B. Provider Access API (Page 54)

In order to better facilitate coordination of care, and support movement toward value-based payment models, CMS is proposing to require impacted payers to build and maintain a Provider Access API to share patient data with in-network providers with whom the patient has a treatment relationship. CMS is proposing that they make patient claims and encounter data (excluding cost information), data elements identified in the United States Core Data for Interoperability (USCDI) version 1, and prior authorization requests and decisions available to in-network providers beginning January 1, 2026.

As this data would be shared upon the provider's request, CMS is also proposing to require payers to provide a mechanism for patients to opt out of making their data available to providers through this API.

C. Payer-to-Payer Data Exchange FHIR® (Page 96)

In the *Interoperability and Patient Access* final rule, CMS required that, at a patient's request, certain impacted payers must exchange certain patient health information, and maintain that information, thus creating a longitudinal health record for the patient that is maintained with their current payer. While CMS encouraged payers to use an FHIR API for this data exchange, it did not require it. In December 2021, CMS announced enforcement discretion for this policy until identified implementation challenges could be addressed in future rulemaking; CMS seeks to address those challenges in this proposed rule.

In an effort to ensure a patient's data can follow them throughout their health care journey, CMS is proposing to require that payers would exchange patient data when a patient changes health plans with the patient's permission. Those data would include claims and encounter data (excluding cost information), data elements identified in the United States Core Data for Interoperability (USCDI) version 1, and prior authorization requests and decisions. For all impacted payers, CMS is considering a proposal that would require this exchange only if the patient opts in to data sharing.

Finally, CMS is proposing that if an enrollee has concurrent coverage with two

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or more payers, these impacted payers must make the enrollee's data available to the concurrent payer at least quarterly.

Improving Prior Authorization Processes (Page 150)

Prior authorization is an administrative process used in health care for providers to request approval from payers to provide items or services. The prior authorization request is made before those medical items or services are rendered. While prior authorization has a role in health care, in that it can ensure that covered items and services are medically necessary and covered by the payer, patients, providers, and payers alike have experienced burden from the process.

This section of the proposed rule addresses the topic of prior authorization and includes both technical and operational proposals that are intended to improve the prior authorization process for payers, providers, and patients. CMS proposes to require payers to do the following: implement and maintain an API to support and streamline the prior authorization process; respond to prior authorization requests within certain timeframes; provide a clear reason for prior authorization denials; and publicly report on prior authorization approvals, denials, and appeals.

A. Prior Authorization Requirements, Documentation and Decision (PARDD) Application Programming Interface (*API)* (Page 161)

CMS is proposing to require impacted payers to build and maintain a Fast Healthcare Interoperability Resources (FHIR) API (PARDD API) that would automate the process for providers to determine whether a prior authorization is required, identify prior authorization information and documentation requirements, as well as facilitate the exchange of prior authorization requests and decisions from their electronic health records (EHRs) or practice management system. CMS notes that under HIPAA, covered entities are required to use the current adopted standard for prior authorization transactions, which is the X12 278 version 5010. This proposed rule does not propose to modify the HIPAA rules in any way, nor would they hinder the use of that standard.

CMS says that should this proposal be finalized as proposed, CMS would also recommend using certain HL7 FHIR Da Vinci Implementation Guides (IGs) which have been developed specifically to support the functionality of the PARDD API. These include:

- The HL7 FHIR Da Vinci Coverage Requirements Discovery (CRD) Implementation Guide.
- The HL7 FHIR Da Vinci Documentation Templates and Rules (DTR) Implementation Guide.
- The HL7 FHIR Da Vinci Prior Authorization Support (PAS) Implementation Guide.

CMS proposes that payers would be required to implement the PARDD API for all prior authorization rules and requirements for items and services, excluding drugs, by January 1, 2026 (for Medicaid managed care plans and CHIP managed care entities, by the rating period beginning on or after January 1, 2026, and for QHP issuers on the FFEs, for plan years beginning on or after January 1, 2026).

B. Denial Reason (Page 172)

CMS is proposing to require impacted payers to include a specific reason when they deny a prior authorization request, regardless of the method used to send the prior authorization decision, to both

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facilitate better communication and understanding between the provider and payer and, if necessary, a successful resubmission of the prior authorization request.

Integrated organization determination notices must be written in plain language, available in a language and format that is accessible to the enrollee, and explain: (1) the applicable integrated plan's determination; (2) the date the determination was made; (3) the date the determination will take effect; (4) the reasons for the determination; (5) the enrollee's right to file an integrated reconsideration and the ability for someone else to file an appeal on the enrollee's behalf; (6) procedures for exercising an enrollee's rights to an integrated reconsideration; (7) the circumstances under which expedited resolution is available and how to request it; and (8) if applicable, the enrollee's rights to have benefits continue pending the resolution of the integrated appeal process.

C. Prior Authorization Time Frames (Page 178)

CMS is proposing to require impacted payers (not including QHP issuers on the FFEs) to send prior authorization decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests. CMS is, however, also seeking comment on alternative time frames with shorter turnaround times, for example, 48 hours for expedited requests and five calendar days for standard requests.

CMS seeks comment on what operational or procedural changes payers or providers would need to make in their workflows or systems to reduce decision timeframes from 14 days to 7 calendar days (for standard prior authorization requests) and from 72 hours to 1 day or 24 hours (for expedited prior authorization requests).

In summary, to address prior authorization decision timeframes, CMS is proposing to require, beginning January 1, 2026, that MA organizations and applicable integrated plans, Medicaid FFS programs, and CHIP FFS programs *must provide notice of prior authorization decisions as expeditiously as a beneficiary's health condition requires* (for CHIP FFS, alternatively stated as in accordance with the medical needs of the patient), but no later than 7 calendar days for standard requests.

D. Prior Authorization Metrics (Page 206)

CMS is proposing to require impacted payers to publicly report certain prior authorization metrics by posting them directly on the payer's website or via publicly accessible hyperlink(s) on an annual basis.

CMS proposes that impacted payers make reports available annually on all of the following:

- A list of all items and services that require prior authorization.
- The percentage of standard prior authorization requests that were approved, aggregated for all items and services.
- The percentage of standard prior authorization requests that were denied, aggregated for all items and services.
- The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.
- The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.
- The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.

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- The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a determination by the payer, plan, or issuer, for standard prior authorizations, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a decision by the payer, plan or issuer, for expedited prior authorizations, aggregated for all items and services.

If finalized, these prior authorization policies would take effect January 1, 2026, with the initial set of metrics proposed to be reported by March 31, 2026.

Electronic Prior Authorization Measure for MIPS Eligible Clinicians and Hospitals and Critical Access Hospitals (CAHs) (Page 229)

CMS is proposing a new electronic prior authorization measure for MIPS eligible clinicians under the Promoting Interoperability performance category of MIPS, as well as for eligible hospitals and critical access hospitals (CAHs) under the Medicare Promoting Interoperability Program. To meet the measure, a prior authorization must be requested electronically from a PARDD API using data from certified EHR technology (CEHRT).

Under this proposal, MIPS eligible clinicians, eligible hospitals, and CAHs would be required to report the number of prior authorizations for medical items and services (excluding drugs) that are requested electronically from a PARDD API using data from CEHRT.

CMS says it intends for the new measure, titled "Electronic Prior Authorization," to be included in the Health Information Exchange (HIE) objective for the MIPS Promoting Interoperability performance category and in the HIE objective for the Medicare Promoting Interoperability Program. This measure aims to address stakeholder concerns regarding possible low provider utilization of APIs established by payers for electronic prior authorization, as described in letters from commenters in response to the December 2020 CMS Interoperability proposed rule.

CMS is proposing the following specifications for the Electronic Prior Authorization measure:

a. For MIPS eligible clinicians under the MIPS Promoting Interoperability Performance Category--Electronic Prior Authorization

- Measure Description: For at least one medical item or service (excluding drugs)ordered by the MIPS eligible clinician during the performance period, the prior authorization is requested electronically from a PARDD API using data from CEHRT. The MIPS eligible clinician would be required to report a numerator and denominator for the measure or (if applicable) report an exclusion:
- Denominator: The number of unique prior authorizations requested for medical items and services (excluding drugs) ordered by the MIPS eligible clinician during the performance period, excluding prior authorizations that cannot be requested using the PARDD API because the payer does not offer an API that meets the PARDD API requirements.
- Numerator: The number of unique prior authorizations in the denominator that are requested electronically from a PARDD API using data from CEHRT.
- Exclusion: Any MIPS eligible clinician who:

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- (1) Does not order any medical items or services (excluding drugs) requiring prior
- authorization during the applicable performance period; or
- (2) Only orders medical items or services (excluding drugs) requiring prior authorization
- from a payer that does not offer an API that meets the PARDD API requirements.

b. For Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program--Electronic Prior Authorization

- Measure Description: For at least one hospital discharge and medical item or service (excluding drugs) ordered during the EHR reporting period, the prior authorization is requested electronically from a PARDD API using data from CEHRT. The eligible hospital or CAH would be required to report a numerator and denominator for the measure or (if applicable) report an exclusion:
- Denominator: The number of unique prior authorizations requested for medical items and services (excluding drugs) ordered for patients discharged from the eligible hospital or CAH inpatient or emergency department (place of service (POS) code 21 or 23) during the EHR reporting period, excluding prior authorizations that cannot be requested using the PARDD API because the payer does not offer an API that meets the PARDD API requirements.
- Numerator: The number of unique prior authorizations in the denominator that are requested electronically from a PARDD API using data from CEHRT.
- Exclusions: Any eligible hospital or CAH that:
  - (1) Does not order any medical items or services (excluding drugs) requiring prior
  - authorization during the applicable EHR reporting period; or
  - (2) Only orders medical items or services (excluding drugs) requiring prior authorization
  - from a payer that does not offer an API that meets the PARDD API requirements.

CMS proposes that beginning with the CY 2026 performance period/CY 2028 MIPS payment year for MIPS eligible clinicians and the CY 2026 EHR reporting period for eligible hospitals and CAHs, a MIPS eligible clinician, eligible hospital, or CAH that fails to report the measure or claim an exclusion would not satisfy the MIPS Promoting Interoperability performance category or Medicare Promoting Interoperability Program reporting requirements.

Interoperability Standards for APIs (Page 239)

In the December 2020 CMS' *Interoperability and Prior Authorization* proposed rule, CMS proposed to require the use of certain Implementation Guides (IGs) for the implementation of the APIs in that proposed rule.

After careful consideration of these IGs, their development cycles, and CMS' role in advancing interoperability and supporting innovation, the agency believes that while these IGs will continue to play a critical role in supporting interoperability, CMS is not ready to propose them as a requirement. These IGs will continue to be refined over time as stakeholders have the opportunity to test and implement with their technology. CMS will continue to monitor and evaluate the development of the IGs and for future rulemaking consideration. Therefore, while CMS is strongly recommending payers use certain IGs for the Patient Access, Provider Access, Payer-to-Payer, and PARDD APIs, CMS not proposing to require their use.

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CMS is recommending the use of the CARIN IG for Blue Button®, HL7® FHIR® Da Vinci PDex IG, HL7® FHIR® Da Vinci PDex U.S. Drug Formulary IG, HL7® FHIR® Da Vinci PDex Plan Net IG, and Da Vinci CRD IG, DTR IG, PAS IGs for the Patient Access, Provider Access, Provider Directory, Payer-to-Payer, and PARDD APIs.

Requests for Information (RFI) (Page 253)

Accelerating the Adoption of Standards Related to Social Risk Factor Data

CMS is reissuing its request for information on barriers to adopting standards, and opportunities to accelerate adoption of standards, related to social risk data. CMS says it recognizes that social risk factors (e.g., housing instability, food insecurity) influence patient health and health care utilization. CMS further understands that providers in value-based payment arrangements rely on comprehensive, high-quality social risk data. Given the importance of these data, CMS looks to understand how to better standardize and liberate these data.

Electronic Exchange of Behavioral Health Information (Page 259)

CMS is reissuing its request for information to inform potential future rulemaking on how to advance electronic data exchange among behavioral health providers. CMS seeks comments on how CMS might leverage APIs, or other solutions, to facilitate electronic data exchange with behavioral health providers who have lagged behind other provider types in EHR adoption.

Improving the Electronic Exchange of Information in Medicare Fee-for-Service (FFS) (Page 264)

In the Medicare FFS program, the ordering provider or supplier can often be different from the rendering provider or supplier of items or services, which creates unique obstacles to the coordination of patient care and exchange of medical information needed to ensure accurate and timely payment. CMS seeks comment on how Medicare FFS might best support improvements to the exchange of medical documentation between and among providers/suppliers and patients, as well as how CMS might best inform and support the movement and consistency of health data to providers for their use to inform care and treat patients.

Advancing the Trusted Exchange Framework and Common Agreement (TEFCA) (Page 264)

Earlier this year, the Office of the National Coordinator for Health IT (ONC) announced the release of the Trusted Exchange Framework and Common Agreement (TEFCA) Version 1. CMS says it believes that the ability for stakeholders to connect to networks enabling exchange under TEFCA can support and advance the payer requirements that CMS proposes in this rule. CMS seeks comment on how enabling exchange under TEFCA can support these proposals, as well as policies in the CMS *Interoperability and Patient Access* final rule. CMS also seeks comment on the approach to incentivizing or encouraging payers to enable exchange under TEFCA.

Advancing Interoperability and Improving Prior Authorization Processes for Maternal Health (Page 267)

The Biden-Harris Administration has prioritized addressing the nation's maternity care crisis, with both the White House and CMS issuing their coordinated approaches to addressing the crisis. CMS seeks comment from the public on evidence-based policies it could pursue that leverage health IT, data sharing, and interoperability to improve maternal health outcomes. CMS also seeks comment

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on leveraging the USCDI to address maternal health, as well as improving prior authorization policies that can negatively impact maternal health outcomes.

FINAL THOUGHTS

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

The issue of prior authorization should be simple. However, CMS is demonstrating its complexities and problems. The proposed use of a 3-day expedited time frame does not appear extremely helpful to the patient seeking services. The idea of a one-day turnaround would be helpful, if adopted.

If this rule is finalized, it would not be effective until January 2026, three years from now. Yes, adopting changes takes time, however, waiting three years to simplify the issue seems too long.