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CMS Issues "Advancing Interoperability and Improving Prior Authorization Processes" Proposed Rule

On Tuesday (Dec. 6), the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule, "Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, etc." The rule, which formally withdraws the December 2020 CMS interoperability and prior authorization rule and builds on CMS' May 2020 interoperability final rule, includes new requirements for insurers participating in Medicare Advantage (MA), Medicaid, the Children's Health Insurance Program, and the Affordable Care Act exchanges, as well as performance measures for providers to improve electronic health care data exchange between providers and insurers and streamline the prior authorization process for items and services. If finalized, CMS intends to implement many of the provisions for Medicare fee-for-service (FFS) and seeks comment on ways to apply these requirements to Medicare FFS. The proposed rule also includes five requests for information on how to build on these proposals and better incorporate data on behavioral health, maternal health, and social factors.

CMS estimated the proposed rule would indirectly save health care providers $15 billion over 10 years – and sources say it could significantly reduce the projected cost of the House-passed, bipartisan Improving Seniors' Timely Access to Care Act (H.R. 3173), which the Congressional Budget Office previously estimated to be $16 billion. While the rule contains several new requirements for insurers, CMS concluded the rule's provisions would pose no "significant burden" to most insurers and those who do experience some burden can request extensions or exemptions.

CMS Administrator Chiquita Brooks-LaSure said, "The prior authorization and interoperability proposals we are announcing today would streamline the prior authorization process and promote health care data sharing to improve the care experience across providers, patients, and caregivers – helping us to address avoidable delays in patient care and achieve better health outcomes for all."

The proposals have been met with mixed feedback, with provider groups generally supporting the provisions and insurer groups raising concerns.

Ashley Thompson, Senior Vice President of Public Policy Analysis and Development for the American Hospital Association, said, "Prior authorization is often used in a manner that results in dangerous delays in care for patients, burdens health care providers and adds unnecessary costs to the health care system." Thompson added, "The AHA looks forward to carefully reviewing the proposed rule, and we continue to urge the Senate to pass the Improving Seniors' Timely Access to Care Act to codify these protections in law."

Matt Eyles, President and CEO of AHIP, said, "It is important to note that a gap remains in our nation's privacy framework." He added, "Personal health information shared with entities that are not required to comply with [the Health Insurance Portability and Accountability Act] will not be as robustly protected as other health care data. We strongly recommend that CMS work with Congress to address this gap."

Stakeholders can submit comments on the proposed rule through March 13, 2023.

- For more information on the proposed rule: Press release, Fact Sheet, Proposed Rule

Interoperability Provisions in the Proposed Rule

The proposed rule includes three new insurer requirements that aim to improve interoperability and the electronic exchange of health information.

- **Patient Access application programming interface (API).** Beginning Jan. 1, 2026, the proposed rule would require insurers to include information about patients' prior authorization decisions in Patient Access APIs, which were established under the May 2020 interoperability final rule. Insurers would have one business day after receiving the prior authorization request or other status changes to make the data available. In addition, insurers would be required to report annual metrics to CMS on patients' use of the Patient Access API.
- **Provider Access API.** Beginning Jan. 1, 2026, insurers would be required to establish and maintain a Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) Provider Access API to share patient claims and encounter data (excluding cost information), as well as United States Core Data for Interoperability (USCDI) version 1 data elements and prior authorization requests and decisions with in-network providers. Insurers would be required to make patient data with a date of service on or after Jan. 1, 2016, available in the API and they would have one business day to share provider requested data.
- **Payer-to-Payer API.** Beginning Jan. 1, 2026, insurers would be required to establish and maintain a Payer-to-Payer API, compliant with HL7® FHIR®, that includes patient claims and encounter data (excluding cost information), as well as United States Core Data for Interoperability (USCDI) version 1 data elements and prior authorization requests and decisions with a date of service on or after Jan. 1, 2016. Insurers would be required to use the API to share relevant data with other insurers, with enrollee permission, when the enrollee changes health plans. In cases where an enrollee has additional health insurance, CMS proposed requiring insurers to make enrollee data available on a quarterly basis with the other insurers. Although CMS would not currently require insurers to honor active prior authorization decisions from a former insurer, the agency included a request for comment whether such practices should be adopted in future rulemaking.

Prior Authorization Provisions in the Proposed Rule

The proposed rule includes four new insurer requirements that aim to streamline the prior authorization process for items and services.

- **Prior Authorization Requirements, Documentation and Decision (PARDD) API**: Beginning Jan. 1, 2026, insurers would be required to establish a FHIR PARDD API that providers can use to determine if a prior authorization is required for a given item or service, facilitate the prior authorization request, and indicate the status of the request. CMS said the data included would need to comply with existing HIPAA requirements.
- **Denial Reason.** Beginning Jan. 1, 2026, insurers would be required to inform the provider why a prior authorization was denied in all denial decisions with the exception of drug-related prior authorizations. CMS said this proposal would make it easier for providers to resubmit a prior authorization request if necessary.
- **Decision time frames.** Beginning Jan. 1, 2026, most insurers would be required to send providers prior authorization decisions within 72 hours for expedited requests and within seven calendar days for

standard, non-urgent requests. In comparison, the current response time frame for Medicare Advantage is double what CMS proposed. CMS also is seeking comments on shorter time frames.

- **Public reporting**. Beginning March 31, 2026, insurers would be required to publicly report certain prior authorization metrics, including how often patient data are transferred electronically.

The proposed rule also includes a new "Electronic Prior Authorization" performance measure to encourage providers to adopt electronic prior authorization processes. CMS would add the new measure to the Promoting Interoperability performance category of the Merit-based Incentive Payment System (MIPS) program and the Medicare Promoting Interoperability Program. To comply, MIPS eligible clinicians and eligible hospitals and critical access hospitals under the Promoting Interoperability program, would be required to request at least one medical item or service electronically via a PARDD API during the applicable performance/reporting period.

Requests for Information

CMS' prosed rule also included five requests for information on ways to:

- Adopt standards for social risk factor data;
- Advance the Trusted Exchange Framework and Common Agreement (TEFCA);
- Facilitate the electronic exchange of behavioral health information among behavioral health providers;
- Improve the exchange of medical documentation between Medicare FFS providers; and
- Improve maternal health outcomes by leveraging interoperability and electronic data sharing.

If you have questions, please contact Heather Meade or Heather Bell.