AAOS
American Association of Orthopaedic Surgeons

CMS Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule (CMS-0057-P) Summary

This proposed rule published on December 12, 2022, will decrease provider burden while improving accessibility of health information for patients. This proposed rule adds on to the policies finalized in the CMS Interoperability and Patient Access final rule (CMS-9115-F) published in May 2020 and policies introduced in the CMS Interoperability proposed rule (CMS-9123-P) published December 2020, **which CMS is withdrawing via this proposed rule**. New requirements will enhance electronic healthcare data exchange between payers, providers, and patients and includes requirements for Medicare Advantage plans. These improvements will also advance operations associated with prior authorization, increasing interoperability within the healthcare market. Most of the implementation for this rule will begin in January 2026. The new requirements for the proposed rule would be implemented in the following areas:

- The Medicare Advantage (MA) organizations, state Medicaid fee-for-service (FFS) programs, state Children's Health Insurance Program (CHIP) FFS programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally facilitated Exchanges (FFEs).

Comments are due by March 13, 2023. The rule can be accessed on the Federal Register here: https://www.federalregister.gov/documents/2022/12/13/2022-26479/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

Updates to Provider Access API

Increased data sharing allows providers to build sustainable systems to manage, reduce, and eliminate medical errors, overall reducing provider burden (Page 54). In order to effectively execute Application Programming Interface (APIs), CMS proposes that impacted payers administer and maintain a Provider Access API consistent with technical standards finalized in the CMS Interoperability and Patient Access final rule. This includes health data distribution to providers regarding specified reasoning when a prior authorization request was denied. Also, with access to more data, providers have an opportunity to reduce or eliminate duplicate tests, decreasing the chances of diagnostic errors.

Fast Healthcare Interoperability Resources (FHIR)API ensures all patient data is accessible to providers. The application of FHIR APIs will allow providers to request data for an individual patient on a need basis, making information more comprehensive for providers to improve the care experience for patients. Some data elements included under the FHIR-based exchange include Immunizations, Procedures, Assessments, and Plans of Treatment.

Providers would have access to request patient data through their practice management systems, Electronic Health Records (EHRs), and other technology solution for treatment and care coordination. Though this is not a proposed requirement, CMS encourages payers to share patient data via API with both out-of-network providers as well as providers with verified treatment relationships with the patient, to the extent permitted by law.

The Provider Access API compliance date is January 1, 2026.

Improving Prior Authorization Processes

The primary source of burden and burnout for providers stems from barriers in the prior authorization process. CMS proposes that beginning January 1, 2026, impacted payers would be authorized to implement and maintain a FHIR Prior Authorization Documentations and Decision (PARDD) API. Under this proposal providers will have full access to prior authorization rulings, including approvals, denials, and requests for information. An additional requirement through the PARDD API includes specified reasons for denied prior authorization decisions. (Page 169, 173).

TABLE 4: REGULATORY REFERENCES FOR CURRENT FEDERAL PRIOR AUTHORIZATION DECISION TIMEFRAMES AMONG IMPACTED PAYERS

Payer	Expedited Prior Authorization Decision Timeframes	Standard Prior Authorization Decision Timeframes
Medicare Advantage and Applicable Integrated Plans	No later than 72 hours after receiving the request for items or services. * 42 CFR 422.572(a) 42 CFR 422.631(d)(2)(iv)	No later than 14 calendar days after receiving the request for items or services. * 42 CFR 422.568(b)(1) 42 CFR 422.631(d)(2)(i)(B) The enrollee can request an extension of up to 14 additional calendar days from the standard timeframe for the decision on prior authorization. Payers can initiate an extension of up to 14 days if the payer needs additional information to approve the request and the extension is in the enrollee's interest. 42 CFR 422.568(b)(1) 42 CFR 422.631(d)(2)(ii)
Medicaid Managed Care	As expeditiously as the beneficiary's health condition requires, but no later than 72 hours after receiving the request. 42 CFR 438.210(d)(2)	As expeditiously as the beneficiary's health condition requires and within state-established time frames that may not exceed 14 calendar days following receipt of the request. 42 CFR 438.210(d)(1) The beneficiary or provider can request an extension of up to 14 additional calendar days from the standard decision timeframe. Payers can initiate an extension of up to 14 days if they can justify to the state Medicaid agency the need for additional information and how the extension is in the beneficiary's interest. 42 CFR 438.210(d)(1)(ii)
CHIP Managed Care	As expeditiously as the beneficiary's health condition requires, but no later than 72 hours after receiving the request. 42 CFR 457.1230(d)	As expeditiously as the beneficiary's condition requires and within state-established timeframes that may not exceed 14 calendar days following receipt of the request for service. 42 CFR 457.1230(d) The beneficiary can request an extension of 14 additional calendar days from the standard timeframe to make a decision on prior authorization. Payers can initiate an extension of up to 14 additional calendar days if they can justify (to the state agency upon request) a need for additional information and how the extension is in the beneficiary's interest. 42 CFR 457.1230(d)
Medicaid Fee-for-Service	Not specified in Federal regulation	Not specified in Federal regulation

CHIP Fee-for-Service	No current Federal regulation	14 calendar days following receipt of the calendar request for items and services. The beneficiary can request an extension of 14 additional calendar days from the standard timeframe to make a decision on prior authorization. Payers can initiate an extension if they can justify a need for additional information. 42 CFR 457.495(d)
QHP Issuers on the FFEs	Notification of a plan's benefit determination for urgent care claims should be provided within 72 hours. Extensions allowed if claimant does not provide sufficient information. 45 CFR 147.136(b)(3)(i) 29 CFR 2560.503-1(f)(2)(i)	Notification of a plan's benefit determination for pre-service claims should be provided within 15 days. Limited extensions of this timeframe are allowed depending on circumstances. 45 CFR 147.136(b)(3)(i) 29 CFR 2560.503-1(f)(2)(iii)(A)

* Applicable integrated plans may have shorter timeframes as required by a state (42 CFR 422.629(c)) allows states to implement timeframes that are more protective of enrollees).

Gold Carding Programs for Prior Authorization

Some payers have implemented "gold-carding" to providers with a consistent history of complying with documentation submission requirements. CMS utilizes a similar technique to gold-carding in the Medicare FFS Review Choice Demonstration for Home Health Services (Page 213). CMS believes that prior authorization programs could help alleviate provider burden therefore, CMS urges payers to enforce a gold-carding approach prior to authorization exemptions to join CMS to build an infrastructure that would support clinicians to provide care in a timely and value-based manner. Home health agencies in select states that choose specific choice options and have a review affirmation rate or claim approval rate of 90 percent or greater over 6 months are awarded the opportunity to continue in the pre-claim review option or pick a selective post-payment review or sport check review process. In addition, to encourage the adoption and establishment of gold-carting programs, CMS examines gold-carding measures as a factor in quality ratings for MA organizations and QHPs as a means for payers to increase their scores in the quality star ratings.

Statutory Authorities to Require Improvements in Prior Authorization Processes, Decision and Notification Timeframe Proposals

CMS proposes that (MA) organizations implement the PARDD API using particular implementation specifications discussed in section II.D.3.a. (Page 215). The expected outcome is to improve the overall prior authorization process, addressing the existing gaps that affect providers' accessibility to information about prior authorization rules and regulations. PARDD API will disperse the coverage and documentation obligations for prior authorization, displaying if authorization is required for a specific task or service and what documentation is essential to support an authorization request. The proposed API would also maintain the obligation of MA organization in section 1852(c)(1)(G) of the Act by providing providers with identical information that is often provided to enrollees about benefit coverage

subjected to prior authorization. This guarantees limitations and regulations surrounding access to service coverage are communicated efficiently and effectively.

Updates to Electronic Prior Authorization for MIPS Promoting Interoperability Performance Category and the Medicare Promoting Interoperability Program

Health information technology (HIT) and provider participation are crucial for the promotion of electronic authorization solutions, increasing the adoption of technology throughout healthcare. CMS proposes to add a new measure titled "Electronic Prior Authorization" under the Health Information Exchange (HIE) objective of the Merit-based Incentive Payment System (MIPS) Promoting Interoperability performance section. The proposal's objective is to address stakeholders' concerns in reference to low provider utilization of APIs established by payers for electronic prior authorization.

All MIPS-eligible clinicians must report these measures beginning with the CY 2026 performance period/CY 2028 MIPS payment year.

CMS Proposes the following specifications for the Electronic Prior Authorization measure:

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

- Measure Description: Prior authorization should be requested from PARDD API using data from Certified Electronic Health Record Technology (CEHRT**)** for at least one medical item or service (excluding drugs)
    - All MIPS-eligible clinicians must 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 outlined in section II.D.3.a of this proposed rule.
- 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:
    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 outlined in section II.D.3.a of this proposed rule during the applicable performance period.

CMS invited public comment on the proposal, including questions such as:

- What challenges will providers face in identifying those payers that have the PARDD API technology in order to accurately include eligible prior authorization requests in the denominator?
- What challenges will providers face in performing the actions included in the measure specifications and successfully reporting the measure if certification criteria are not available in the ONC Health IT Certification Program at the time providers are required to report the measure under the Medicare Promoting Interoperability Program or MIPS Promoting Interoperability performance category?

Request for Information: Improving the Exchange of Information in Medicare Fee for Service

CMS is interested in public comments on what specific adjustments or improvements are required in health IT to better equip providers or suppliers with medical documentation submissions. Comments on questions such as the following are requested:

- How might CMS encourage more electronic exchange of medical information (for example, orders, progress notes, prior authorization requests, and/or plans of care) between providers/suppliers and with CMS and its contractors at the time an item or service is ordered?
    - When possible, please describe specific recommendations to facilitate improved data exchange between providers or suppliers, and with CMS and its contractors, to support more efficient, timely, and accurate claims and prior authorization communications. Are there specific process changes that you believe would improve the exchange of medical documentation between ordering and rendering providers or suppliers?

- Are there changes necessary to health IT to account for the need for providers/suppliers (ordering and rendering) to exchange medical documentation, either to improve the process in general or to expedite processing to ensure beneficiary care is not delayed?
    - How could existing certification criteria or updates to certification criteria under the ONC Health IT Certification program support specific exchange needs?

- What additional steps in the area of health IT and the exchange of information could CMS take to assist providers or suppliers in the claim submission process?
    - Are there changes in technology or processes that could also reduce the number of claims re-submissions and/or improper payments?

[See pages 266-267 for further questions.]
