Advancing Interoperability and Improving the Prior Authorization Process

The Centers for Medicare & Medicaid Services (CMS) released a proposed rule that outlines policy changes to the prior authorization (PA) process for several of the agency's benefit programs. The rule will help alleviate burdensome procedures of prior authorization by streamlining the process for both patients and providers. The proposed rule also outlines requests for information (RFI). Given the complexity of the changes and the required update to the electronic processes outlined in the rule, once finalized the policies will not go into effect until January 1, 2026. The rule and fact sheet provide additional information. **Comments are due March 13, 2023.**

Patient Access to Application Programming Interface (API), pg. 20

To provide improved coordinated care and to create health care interactions that are collaborative among patients, providers and payers, the proposed rule includes provisions that require payers to include information about PA decisions and actions within the patient accessible API. Previously finalized in rulemaking, payers are required to provide information in the patient access API that includes adjudicated claims, encounters with capitated providers, clinical data, including laboratory test results, no later than one business day after a claim has been adjudicated or clinical data received by the API. Under the proposed rule, payers would be required to also provide information about PA requests and decision no later than one business day after the payer receives the PA request. The list of required information on the PA can be found on page 24 of the proposed rule.

As noted throughout the rule, none of the policies outlined apply to PA for drugs of any kind. However, CMS is seeking comment from stakeholders whether the agency should "*consider policies to require impacted payers to include information about prior authorizations for drugs, when the payer covers drugs and on how future rulemaking to make information about prior authorizations for drugs available through these APIs might interact with existing prior authorization requirements and standards.*"

Provider Access to Application Programming Interface, pg.54

The rule provides provisions on the PA process, but also included are provisions that will require payers to maintain a provider access API that allows the provider to initiate a request for access to patient data (immunizations, procedures, treatment plans, prior PA requests), before or during a patient encounter. This proposal would apply to in-network providers who have a relationship with the patient. It would require payers to share information related to PA requests and decisions (including related administrative and clinical documentation) for items and services provided to the patient, again excluding drugs. As with other provisions, the payer will be required to share the requested data no later than one business day after the provider initiates a request. CMS is seeking

comments on its "*proposal and the impact on payers to implement and maintain a Provider Access API to provide access to specified patient information*."

Improving the Prior Authorization Process, pg. 150

Proposed Requirement for Payers: Implement an Application Programming Interface (API) for Prior Authorization Requirements, Documentation, and Decision (PARDD API), pg. 161

The prior authorization process has been noted as a particular area of concern that contributes to physician burnout. As such, the proposed rule creates mechanisms required by payers to facilitate the PA process, by creating an application interface to submit PAs. Included in the rule:

- The PARDD API must be populated with a list of covered items and services (excluding drugs) that require PA and includes the documentation requirements when requesting PA for the listed services.

- The means by which the documentation is submitted must include functionality that allows for the submission of required documentation including forms, medical records and other items needed for the PA request.

- Any response from the payer to the provider must include information that outlines the approval (if approved), how long the approval is valid, and if denied there must be a specific reason provided or a request for more information to support the PA.

Requirement for Payers to Provide Status of Prior Authorization and Reason for Denial of Prior Authorizations, pg. 172

The agency notes that improving timely and clear communication between payer and provider is key to streamlining PA and repeats throughout the rule the need for improved communication between provider and payer. One of the most oft stated reasons for frustration and increased administrative burden is the PA denials. To fix the denial process, CMS has proposed the following provisions:

- Payers will be **required** to provide the specific reason that a PA was denied, regardless of how the PA was requested.

- PA decisions sent through the PARDD API that come from the payer to the provider must include if the payer approves the service and for how long, if the PA is denied and the reason, and if additional information is requested.

Note that the provisions listed above and other throughout the rule are not meant to supersede or replace existing Federal or state requirements but are meant to reinforce said provisions.

Requirements for Prior Authorization Decision Timeframes and Communications, pg. 178

To reduce wait times for decisions on PA submissions, the agency has proposed timeframes required for payers to send PA decisions to providers. The agency is requesting comments on the timeframes proposed and if they will provide benefits and operational impact to both providers and payers. Proposed timeframes are:

- Seven calendar days for a standard request

- Seventy-two hours for expedited/urgent requests

CMS is also requesting comments for shorter timeframes for decisions, to include 5 days for a standard decision and 48 hours for an expedited request.

Public Reporting of Prior Authorization Metrics, pg. 206

The agency is seeking to increase transparency within the PA process and has proposed to require that plans publicly report prior authorization metrics, either on the payer's website or other publicly available hyperlinks. An extensive list of the required data elements can be found on page 208 of the rule.

Electronic Prior Authorization for the Merit-based Incentive Payment System (MIPS) Promoting Interoperability Performance Category and the Medicare Promoting Interoperability Program, pg. 229

CMS proposes to implement a new 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, related to electronic prior authorization. The new measure, titled "Electronic Prior Authorization," would 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 low provider utilization of APIs established by payers for electronic prior authorization. CMS believes this measure would further enable the electronic exchange of health information to improve the quality of healthcare, such as promoting care coordination.

For the purposes of this new measure, CMS is proposing that a prior authorization request must be made electronically using the PARDD API using data from certified EHR technology to satisfy the measure. Additionally, 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 is proposing to require MIPS eligible clinicians to report this measure beginning with the CY 2026 performance period/CY 2028 MIPS payment year and for eligible hospitals and CAHs to report this measure beginning with the CY 2026 EHR reporting period. However, CMS proposes that the measure will not be scored in 2026, and therefore, would not affect the total score for the MIPS Promoting Interoperability performance category or the Medicare Promoting Interoperability Program. CMS has asked for comments on the technical elements of the measure. For more information and for specific areas of comment, see page 237 of the proposed rule.

Requests for Information, pg. 253

Request for Information: Accelerating the Adoption of Standards Related to Social Risk Factor Data – pg. 253

CMS previously issued this RFI in the December 2020 Interoperability proposed rule and respondents had requested additional time to comment on this issue. CMS recognizes the impact that social risk factors have on patient health, utilization and outcomes, and how this impacts the broader health care system. Giving providers and payers access to data on social risk factors can help them to address these factors and improve health outcomes, particularly in value-based payment arrangements. However, social risk factor data is often fragmented, duplicative, out-of-date, and unstandardized, as there are no clear standards for capturing, recording, and exchanging these data. Non-interoperable data can result in missed opportunities to address the root causes of poor health outcomes and health inequities.

CMS is seeking input on barriers that the health care industry faces to using industry standards and opportunities to accelerate adoption of data collection standards related to social risk factor data, including exchange of information with community-based organizations. This includes providers who serve minority and underserved communities. CMS specifically would like feedback on the following questions:

- What are best practices regarding frequency of collection of social risk and social needs data? What are factors to be considered around expiration, if any, of certain social needs data?

- What are best practices regarding workforce training on collecting social risk and social needs data? How could CMS best support such training?

- What are the challenges in representing and exchanging social risk and social needs data from different commonly used screening tools? How do these challenges vary across screening tools or social needs (for example, housing or food access)?

- What are the barriers to the exchange of social risk and social needs data across healthcare providers? What are key challenges related to exchange of social risk and social needs data between healthcare providers and community-based organizations? If Federal or other regulations are perceived or actual barriers, please identify the specific regulation, policy, or guidance and clarifying language that would be necessary to resolve the cited barrier. If no specific language or policy is known, please provide a citation where more information is available related to this barrier.

- What mechanisms (EHRs, Health Information Exchanges [HIEs], software, cloud-based data platforms, etc.) and/or standards are currently used to capture, exchange, and use social risk and social needs data? What challenges, if any, occur in translating, collecting, or transferring social risk factor data in these platforms to Z codes on claims?

- How can payers promote exchange of social risk and social needs data? Are there promising practices used by MA organizations, state Medicaid agencies, Medicaid managed care plans, commercial health plans, or other payers that can potentially be further leveraged in other settings?

- What specific strategies, tactics, or policies would help CMS and other Federal agencies facilitate greater standardization in the capture, recording, and exchange of social risk factor data? Are there best practices (related to contracting language, requirements in Federal programs, etc.) that could be adopted, and by which agency?

- What are the most promising efforts that exist to date in resolving the challenges previously cited in this proposed rule? Which gaps remain that are not being addressed by existing efforts?

- What privacy issues should be considered when formulating policy for collecting and exchanging social risk and social needs data? Are there certain data elements that patients may wish to exercise more control over than others?

- What are best practices that are currently addressing other challenges previously cited in this proposed rule, such as integration of social risk and social needs data into clinical workflow, adoption, and use of commonly used screening tools with associated health IT standards and value sets, and integration of social risk data and social needs data into the patient's longitudinal health record?

- Please identify potential existing, emerging, or possible new policy levers that CMS could use to better incentivize use and interoperability of social risk factor data.

- Please identify opportunities and approaches that would help CMS facilitate and inform effective infrastructure investments to address gaps and challenges for advancing the interoperability of social risk factor data.

Request for Information: Electronic Exchange of Behavioral Health Information, pg. 259

CMS previously issued this RFI in the December 2020 Interoperability proposed rule and respondents had requested additional time to comment on this issue. Behavioral health providers have adopted EHRs at a significantly lower rate than other healthcare providers. This has led to behavioral health providers having less ability to electronically share health information across providers and with patients.

CMS is interested in evaluating whether using other applications that exchange data using the Fast Healthcare Interoperability Resources (FHIR) APIs and do not require implementation of a full EHR system might be a way to help behavioral health providers exchange health data to improve care quality and coordination. The agency is interested in innovative approaches to addressing the need to facilitate the electronic exchange of behavioral health information, as well as approaches to support the exchange of health information to behavioral health providers to inform care and the provision of behavioral health services. To this end, CMS is interested in public comments on how the agency can best support electronic data exchange of behavioral health information between and among behavioral health providers, other healthcare providers, and patients, as well as how to support the movement of health data to behavioral health providers for their use to inform care and treatment for individuals with behavioral health needs. The agency is specifically seeking comment on the following questions:

- Can applications using FHIR APIs facilitate electronic data exchange between behavioral health providers and with other healthcare providers, as well as their patients, without greater EHR adoption? Is EHR adoption needed first? What opportunities do FHIR APIs provide to bridge the gap? What needs might not be addressed by using applications with more limited functionality than traditional EHRs?

- How can existing criteria under the ONC Health IT Certification Program ensure applications used by behavioral health providers enable interoperability? What updates to existing criteria, or new criteria, could better support exchange by these clinicians?

- What levers could CMS consider using to facilitate greater electronic health data exchange from and to behavioral health providers? What costs, resources, and/or burdens are associated with these options? Is there additional sub-regulatory guidance and/or technical assistance that CMS or HHS could provide that would be helpful?

- Are there particular considerations for electronic data exchange for behavioral health providers who practice independently, are community-based, or are non-traditional providers? What about rural-based behavioral health providers? How could an API-based solution help address these considerations?

- Are there state or Federal regulations or payment rules that are perceived as creating barriers to technical integration of systems within these practices? What additional policy issues, technical considerations, and operational realities should we consider when looking at ways to best facilitate the secure electronic exchange of health information that is maintained by behavioral health providers including sensitive health information?

- What are current drivers at the Federal, state, or local level that are effectively supporting greater adoption of health IT for behavioral health providers? What new regulations guidance, or other policy levers (including new authorities) could benefit community providers or include incentives for community providers to encourage greater adoption of health IT?

- What methods and approaches have stakeholders utilized to help advance health IT adoption among behavioral health providers, for instance, effective practices for braiding/blending of funds and as part of value-based models? How are stakeholders effectively strengthening system capacity, connecting to care, and creating healthy environments today?

- What levers and approaches could CMS consider using and advancing to facilitate greater electronic health data exchange from and to community-based health providers including use of relevant health IT standards and certification criteria for health IT as feasible? What costs, resources, and/or burdens are associated with these options?

- What privacy and security considerations would be the biggest barriers for community-based providers to engage in information exchange, and which could be addressed by Federal policy, which by technology, and which by process?

Request for Information: Improving the Exchange of Information in Medicare Fee for Service, pg. 264

CMS recognizes that in the Medicare fee for service (FFS) program, the ordering provider or supplier may be different than the provider who renders the items or services, and that this can make it challenging to coordinate patient care and exchange medical information to ensure timely and accurate payment. Certain providers, such as home health agencies, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, and ambulance providers are not eligible for incentive payments for health IT adoption and therefore may still use paper systems to exchange data. This can lead to delays in the receipt of orders, prior authorization decisions, and payments. Delays can also occur even if the ordering and rendering physicians do use health IT to exchange information, but the compatibility of the systems does not lead to the easy exchange of information. In cases where prior authorization is required, this could lead to delays in healthcare decisions and in the delivery of care to patients.

CMS acknowledges that it will take time to effectively resolve the inconsistent use and lack of uniform health IT. The agency is interested in public comments on how Medicare FFS may support improvements to the exchange of medical documentation between providers or suppliers and patients can, as well as how to best support the movement and consistency of health data to providers or suppliers to inform care and treat beneficiaries. The agency also is interested in comments on what specific changes or improvements in health IT could assist providers or suppliers in submitting medical documentation to CMS and its contractors so that claims are not denied or deemed as improper payments. The agency is specifically seeking comment on the following questions:

- 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? Is there policy, technical, or other needs that must be accounted for considering the unique roles of 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 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?

- What levers could CMS consider using to facilitate greater collaboration and exchange of information among providers/suppliers? What costs, resources, and/or burdens are associated with this type of collaboration? Are there changes that could reduce improper payments and the administrative burden often encountered by rendering providers/suppliers who need medical record documentation from ordering providers or suppliers?

- Are there state or Federal regulations or payment rules that are perceived as creating barriers to the exchange of information between ordering and rendering providers/suppliers? What additional policy issues, technical considerations, and operational realities should we consider when looking at ways to best facilitate the secure exchange of information between providers or suppliers and with Medicare FFS?